The analyst’s body as tuning fork: embodied resonance in countertransference

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Abstract: This paper examines the phenomenon of embodied countertransference: where the analyst experiences a somatic reaction rather than the more common countertransference responses of thoughts, feelings, images, fantasies and dreams. Discussion of clinical material considers neurotic and syntonic aspects. The analogy is made of resonance with a tuning fork. Several questions are posed: Why does countertransference resonate in the bodies of some analysts but not all? Why do those analysts who are sensitive to this, experience it with some patients but not with others? And what are the conditions which are conducive to producing somatic responses?

It proposes that somatic reactions are more likely to occur when a number of conditions come together: when working with patients exhibiting borderline, psychotic or severe narcissistic elements; where there has been early severe childhood trauma; and where there is fear of expressing strong emotions directly. In addition another theoretical factor is proposed, namely the typology of the analyst.

Key words: analyst’s body, countertransference, embodied resonance.

Introduction

This paper is about embodied resonance in the countertransference, where the analyst has a somatic reaction to what is happening in the session, rather than the more commonly described countertransference response of thoughts, feelings, images, fantasies and dreams. In thinking about embodied countertransference I have found the notion of the resonance of a tuning fork helpful and I would suggest that resonance occurs when the analyst’s tuning fork vibrates with the patient’s psychic material through the unconscious. When this is experienced in the body, the feelings are not clear or thought through, and the analyst has to be able to sustain the state of not knowing and confusion even more than usual. Much of what has been written on this subject has focused on sleepiness, and erotic and sexual feelings, possibly because these are more frequently experienced by analysts. Other bodily sensations such as aches, pains, rumblings, coughing, nausea and suffocation have been less considered.
The phenomenon of embodied resonance raises several important questions:

1. Why does countertransference resonate in the bodies of some analysts but not all, and why do those analysts who are sensitive to this, experience it with some patients but not with others? Again, why does it happen at some times with these patients and not at other times?

2. What are the conditions in the analytic situation between analyst and patient which are conducive to producing somatic responses (as distinct from thoughts, feelings, images, fantasies and dreams)?

3. What is happening, and is there a theoretical framework for the phenomenon?

In order to explore these questions, I will report the case material and the particular powerful and memorable experience that first prompted my interest in this subject and I shall then give an overview of the relevant literature and current thinking about countertransference. I will be looking in particular at the area between analyst and patient, and also at factors existing in both analyst and patient. In addition I propose that there is another important factor which has so far been overlooked on this subject, the typology of the analyst, and I will discuss this in the last section of my paper.

Initial case material

M had been referred to me by a consultant psychiatrist who felt he would benefit from therapy in addition to the medication he took for treatment of his manic-depression. Eighteen months into the three times weekly work, he is in silence, deep in thought about his relationship with his mother. I have been feeling stuck and helpless, in a state of not knowing and not feeling, and we are now in silence again.

As I sit there I begin to feel a tightness in my chest and find it hard to breathe. Although I do not suffer from asthma, he does and I wonder if this is how it feels. The tightness increases, and it is hard to get enough air in or even to breathe out. I decide to break the silence and ask him how he is feeling. I do this as a way of trying to use what is happening to me in the countertransference, but mainly in the hope that if I say something I will be able to breathe again. He says he isn’t feeling anything, and looks at me blankly through his thick lenses. My anxiety increases, I am becoming afraid I soon won’t be able to breathe at all, and I blurt out, almost gasping, ‘How does your chest feel?’ He looks at me in shock, pulls his feet up, draws his legs up to his chest in a foetal position, and howls. As he starts to sob and weep I feel the tension run out of my chest, down through my solar plexus, and with relief I breathe in deeply and easily. He continues sobbing for the next 10 minutes until the end of the session. He is my last patient and he remains in my waiting room until he is able to get up and leave. Not a word has been spoken by him during this time.

Two days later he makes no mention of what occurred at the end of the previous session, and when at an apposite moment I refer to it, he has little
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memory of what happened, and he apparently had no feelings or thoughts while he was sobbing. For my part, I also had little idea what was going on beyond feeling empathically the pain and grief his body was expressing. To this day I have no clear idea what he felt or what this episode represented.

His father, whom he had greatly respected, died when M was in his teens, and his overpowering and neurotic mother had dominated him. In contrast to the image I had of his father, I never got a clear impression of his mother. Whenever I asked M how she had been towards him as a child, or if she ever touched, cuddled or kissed him, a kind of fog would descend over us. He seemed not to hear and his replies only succeeded in confusing me.

He always came on time, bringing with him an aura of depression. He did not find life easy. There were unpleasant side effects from the medication; he had frequent problems with colleagues, and he under-performed at work. He was not in a relationship with anyone other than me, and the consultant whom he saw from time to time. I did not find him an easy patient—in fact I felt quite incompetent much of the time. In this way, he succeeded in making me feel very like him.

This is the experience that has lived vividly with me since that session over 20 years ago, which has led to this paper. It has made me aware of how intense the transference-countertransference relationship can be even, or especially, when deeply unconscious.

Literature review

Attitudes to countertransference have developed considerably during the last 20 years, with analytical psychologists leading the way. Samuels in 1985 summarized the history of countertransference in psychoanalysis and analytical psychology thus:

Putting the Jungian and Freudian ideas together, we may...even speak of an analytical consensus and one which may be used as an assumption: that some countertransference reactions in the analyst stem from, and may be regarded as communications from the patient and that the analyst’s inner world, as it appears to him, is the via regia into the inner world of the patient.

(1985a, p. 51)

Field (1988) writing three years later, sees in the renewed interest in countertransference some easing in the hitherto phobic attitude and in the ‘censorship’ in writing about what goes on behind the consulting room door, but he notes that the subject of his paper, embodied countertransference, has been little discussed. As recently as 1994, Jacobs in his opening remarks in a paper on nonverbal communication states:

Although long recognized as an important pathway for communication, the nonverbal behavior of both patient and analyst is an aspect of the analytic situation that receives comparatively little attention either in supervision or in the teachings of
technique. With the exception of those colleagues who have a special interest in this area, it is uncommon for supervisors to regularly inquire about, or for students to regularly report on, the nonverbal behavior of their patients.... The result, all too often, is that in his clinical work the candidate uses his ears to the virtual exclusion of his eyes, focuses single-mindedly on the verbal material, and sooner or later develops a scotoma for material expressed in bodily language or through other verbal means.

(1994, p. 742)

In a research project into the countertransference responses of 30 psychotherapists, Samuels (1985a) found that in 46% of the cases the countertransference could be described as ‘embodied’. His paper develops Fordham’s concept of ‘syntonic’ countertransference into two connected but separate types of usable countertransference, ‘reflective’ and ‘embodied’, and he defines the latter as ‘intended to suggest a physical, actual, material, sensual expression in the analyst of something in the patient’s inner world, a drawing together and solidification of this’ (p. 52).

Samuels categorizes the responses into three distinct groups: bodily and behavioural responses; feeling responses; and fantasy responses. Examples his respondents gave of bodily responses were falling asleep, aches and pains, strange sensations and sexual arousal. Feeling states described were anger, depression and frustration, many of these also in the analyst’s body; and some fantasy responses were erotic, so also had a bodily aspect. He emphasizes however that even the bodily and feeling examples of countertransference ‘may be said to be images, because they are active in the psyche in the absence of a direct stimulus which could be said to have caused them to exist’.

This way of thinking takes us from the internalized image to the intermediate space between analyst and patient, and may help us to understand better the nature of embodied countertransference. The term Corbin (1972) used for this, ‘mundus imaginalis’, has parallels with Winnicott’s ‘transitional space’, ‘third area’ and ‘area of illusion’, with the ‘subtle body’ written about by Schwartz-Salant (1989), with Searles’ (1959) ‘pre-ambivalent symbiosis’, and with Balint’s (1968) ‘harmonious and interpenetrating mix-up’. Brown (1977) describes ‘an unanxious confusion’ as to whether his patient was outside or inside his abdomen. These terms were all coined by analysts who were particularly interested in all aspects of countertransference, and they came to similar conclusions about where and how it is experienced.

Discussing the results of the research project, Samuels (1985b) states:

...there is an empirical background to the claim that it is in his body, functioning as an organ of perception that provides an analyst with information about his patient.... We may go further and assert that, though it is the therapist’s own body that is involved and the sensation is quite real, that body is also an imaginal body – in Corbin’s phrase, a ‘subtle body’. That is, on one countertransference level the therapist’s body does not belong to him at all but to a virtual midpoint between him and his patient.

(p. 210)
Samuels’ respondents noted that patients with instinctual problems, for example, sex, aggression and eating disorders, were more likely to evoke a somatic response; in other words there seemed to be a special part played by the body in the evocation of countertransference in the analyst.

Field (1988) describes the three most common types of embodied countertransference reaction as sleepiness, trembling and sexual arousal, and he notes the difficulty and discomfort that these reactions can cause in analyst and patient. Conventionally, they can be seen as tiredness or erotic projection, clinically, as unconscious behaviour, pointing to a need for more analysis or supervision, but they may also in his view be seen as a kind of internalized body language that offers an additional means of access to primitive levels of communication. Far from being deviations from good professional practice it is possible that, for certain types of patient and in certain phases of the treatment, they may prove a vital part of the therapeutic process.

Field notes the lack of discussion about how it actually happens, and asks:

How does an unwanted bit of one person’s psyche contrive to cross the intervening space and lodge itself into the psyche of another? What can be the nature of this transformative process? and how does the now metabolized projection make its way back?

Field recognizes that there is no reliable way of knowing what thoughts and feelings belong to whom, and he describes work with a patient where they passed their physical nervous tension back and forth between them. At one moment it might be drowsiness, and the next erotic arousal, sometimes both together at the same time. At the outset he treated the phenomenon of embodied responses as a type of transference-countertransference manifestation, virtually paranormal in its capacity to bypass consciousness [but] it may make better sense to consider countertransference itself as part of a larger mystery; one in which unconscious bodily reactions are not marginal phenomena but a central feature, and nearer the heart of the matter.

Field agrees with Corbin’s view that the imaginal is not merely imaginary. It exists. It is that subtle place where subjective and objective, self and other, thought and feeling, the erotic and the spiritual, all meet; where communication happens directly, spontaneously.

Jacobs (1994) has written extensively on non-verbal aspects of countertransference, and provides a substantial review of the literature from Freud and Reich (in the 1930s), through Deutsch, Feldman, Meerloo and Needles (in the
The cases he describes are concerned mainly with patients' non-verbal actions, analysts' reactions, and patient/analyst interactions, and in the examples of his own bodily unconscious responses, they would generally fall into Samuels' category of 'reflective' countertransference. He is thoughtful about the nature of the countertransference, and phrases the question of what is happening as follows (1973):

Observations of nonverbal responses in the analyst...raise certain intriguing questions. Why is it, for example, that the analyst's comprehension initially takes a somatic form under some circumstances but not under others? How can we explain the fact that this route is more available to some analysts while others can make relatively little use of it? While a satisfactory elucidation of these problems must await further observation and research, certain tentative ideas may be put forth for consideration. In two of the cases discussed physical experiences of a traumatic nature played a central role....

It seems possible that the experience of being confronted consistently with material relating to intensely conflictual bodily experiences may serve to increase an analyst's own bodily awareness and facilitate this pathway as a route to comprehension.

(pp. 90–1)

He is in no doubt that the analyst's own childhood experience plays an important role in the bodily reactions, and that it unquestionably differs from individual to individual (p. 91).

Writing about narcissism Schwartz-Salant (1982) points out that psychic and somatic information are not both available at the same time:

It is not possible to extract information from both the psychic and somatic unconscious simultaneously, with equal amounts from each. Rather, a relationship of complementarity exists: Orienting toward the somatic unconscious limits the information gained from the psychic unconscious, and vice versa.

(p. 122)

And in *The Borderline Personality* (1989, pp. 147–60) he graphically describes the case of a mildly borderline woman where both of them experienced intense bodily sensations in the sessions.

Dieckmann (1974) and three colleagues conducted a long-term research project into countertransference, and were surprised to find that even when countertransference interpretations were not given the entire process seemed to be guided by both participants (p. 75). They found that the chains of association of both analyst and patient were 'connected together in a psychologically meaningful way' (p. 73). He sees this phenomenon as fundamentally synchronistic, and that cause and effect alone are not adequate explanations of what is happening.

McLaughlin (1975), writing about the intermix of patient and analyst, sees sleepiness as constituting the most striking example of a true countertransference response. Refuge in sleep can be an escape from overwhelming attack,
and may be more prevalent in analysts who are by nature more active and skilled but required to be silent and passive. A sudden intervention or interpretation may have the effect of bringing them back to wakefulness.

He suggests that an eroticized transference can lead to sleepiness in the analyst, and he proposes three categories of patients who are most likely to induce sleepiness: those with passive-obssessional and narcissistic character disorders; those suffering from borderline and chronically psychotic conditions; and finally, those patients whose general character defences and areas of specific conflict are similar to the analyst, so that an entangled transference-countertransference relationship leads to the analyst withdrawing into sleepiness.

McDougall (1979) writes that patients who have suffered severe preverbal trauma may often be unable to communicate it verbally, and therefore do so through actions and somatic symptoms.

Other authors, who have written on the subject and have drawn similar conclusions, are Mindell (1985), Hazell (1994) who sees boredom as a signal of the patient’s emptiness, and Spiegelman (1996) who is well acquainted with embodied countertransference reactions, and writes:

I very often get ‘symptoms’ when a patient begins a session or after some moments of work. These are usually bodily reactions of various kinds, such as headaches, stomach aches, heartaches, shortness of breath, sphincter tensions, fatigue etc. They do not usually have a direct connection with what is being said, but whenever I reveal these reactions, I almost always discover that the patient is having, or had in the recent past, the same symptom or one related to it. Most of the time an underlying symbolic parallel is associated to the psychological content being discussed.

Any discussion must always keep the neurotic element of countertransference in mind, whether identification, idealization, collusion, erotic feelings, frustration, anger, boredom or contempt, to name the most common. Resonance occurs when the analyst’s bodily tuning fork vibrates with the patient’s psychic material through the unconscious. When this is experienced in the body, the feelings are not clear or thought through, and the analyst has to be able to sustain the state of not knowing and confusion even more than usual.

Two clinical cases

Before returning to the questions posed at the start, I want to introduce two other pieces of case material.

The first is from supervision. An experienced, highly intuitive trainee therapist had told his supervisor how he often had reactions in his body when seeing his patients. During the first session with a new patient he suddenly had a pain in the top of his left arm. His supervisor knew him well enough to recognize that this was probably significant, and said to him, ‘We must bear that pain in mind as the work proceeds’.

Session after session the therapist was struck with the pain, which at times was almost unbearable. Initially the patient was very closed up, but as her
trust gradually grew she was able to speak more about her life, and details of her difficult childhood emerged. As the patient was telling the therapist about her relationship with her mother, the pain in the therapist’s upper arm increased and he found himself holding it. In tears and great distress the patient recounted how when she was small her mother would get into rages, pull her dress or top off, and holding her by her right arm would mercilessly beat her at the top of her left arm with the bristle side of a hair brush, often drawing blood and leaving her bruised and terribly sore.

Following this session the therapist never had the pain again.

F was married with a two-year old daughter who was having difficulties sleeping and eating. She had also started head banging. F was intense and strikingly attractive, and resented no longer being able to control and manipulate men through her looks. She expressed anxiety being in the same room as me, that I would lose interest in her and become bored, and that I wouldn’t be strong or confrontative enough.

Her mother who had smoked heavily died from a heart condition when she was 11; F also smoked and was trying to stop. She described her mother as ‘warm and loving’ and said that after her death the family all became ‘close and protective’ towards each other, and in particular towards a younger sister who she said was ‘damaged’.

At first F looked forward to sessions but she soon became stuck, and angry that I would not fulfil her fantasies: I was not available to see her and phone whenever she wanted. Her anger with me was stated in a calm controlled way, never openly. The effect on me was a terrible pain in the right-hand side of my neck that I associated with her unexpressed anger towards her mother and me. She then told me she had suffered bad neck pains for many years, and it felt as if she was now projecting them into me.

As we approached a break her anxiety began to rise. Would I die too? Her daughter was not eating, and F was getting into conflicts with a close friend. I started getting severe headaches during sessions that lasted while I wrote up notes, but went as soon as my next patient arrived.

Her daughter’s head banging increased and my head was banging too. I began to wonder how close and protective the family really was, how warm and loving her mother had been, and how well F had been cared for as a baby. I felt I was dealing with someone in deep despair who lacked containment, who was afraid of her destructiveness and who projected her depression and damage into those around her.

I did not have to live up to her expectations of being strong and confronting, but when I tried to enable her to express her fears she became angry. This was expressed as disappointment, betrayal, mistrust, and stuckness, just like the feelings she was having towards her close friend. Her angry feelings were her defence against unbearable pain, loss, sadness and vulnerability. The ‘strong close family’ was in reality a closed defensive family system which protected them from these feelings. They survived by trusting only each other, being
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strong and never open to hurt. After her mother died the system could never be challenged without the family members suffering terrible pain.

These feelings resonated with my own experience of being sent away to boarding school at an early age. At the same time my mother would insist how close we all were as a family, resentfully covering feelings of anger and disappointment with my father, and envy of others who were more fortunate.

The result of my interpretation of her pain and anger was a pain in my neck and a feeling of rigidity in my body. I also had a permanent headache in her sessions. In my mind I now nicknamed her ‘La Belle Noiseuse’ after a film running at the time, little knowing how accurate the association would be: it means roughly, the ‘beautiful pain in the arse’. She became pregnant and was afraid her baby would be ‘damaged’ like her sister. My headaches got worse, and I then got a pain at the base of my spine, right in my coccyx, which lasted all day. She had literally become a pain in the arse.

Our relationship deteriorated after an Easter break when I returned refreshed but quite unprepared for what was to come. She had been abandoned and attacked me relentlessly. My whole body felt under assault: tense muscles, tight chest, headache, pain in bum—I wanted to shout out to keep her away. It was tragic. As her furious rage pushed me away her fears were fulfilled. She constellated a repetition of the abandonment and breakdown of trust which followed her mother’s death. During our last meeting she admitted for the first time that under her anxiety and anger she was frightened and needy, and she knew the feelings went back to her mother’s death and even earlier. We ended in sadness, regret, and relief too on my part. Our final meeting was nine months to the day after we first met.

Questions raised and answers proposed

In thinking about a theoretical framework, which can allow us to understand the phenomenon of embodied countertransference, I refer to the questions raised in the introduction to this paper.

The image of the ‘mundus imaginalis’, the ‘subtle field’, ‘transitional space’, or ‘harmonious interpenetrating mix-up’, are some of the terms which have been used to describe the area between analyst and patient. They relate to the field of transference, countertransference, projective identification, introjection, including embodied countertransference. The literature identifies certain recurring elements in the patient: the importance of narcissistic, borderline or psychotic elements; the existence of instinctual problems; having suffered bodily trauma; and traumatic events that have taken place in the pre-verbal period. The importance of some of these aspects being reflected in the analyst’s own personal experience is emphasized.

The answers provided by writers referred to above do not in my mind bring sufficient understanding to the phenomenon of embodied countertransference. Might there be another factor that makes an analyst’s body respond like a
tuning fork to a patient’s unconscious material? I want to suggest that this is more common when the following three conditions come together:

1. When working with borderline or psychotic patients. The more they are trapped in an autistic pocket, or are at that moment in a borderline (or even psychotic) state, as distinct to a more conscious neurotic state, the more they will project their embodied feelings into the analyst. This could explain why the analyst might feel the countertransference in the body at one time and not at another. In more conscious states, the transference-countertransference relationship will be manifested in thoughts, feelings and fantasies.

2. When the patient’s fear of strong emotion inhibits the possibility of the emotion or feelings being consciously and directly expressed in the analysis. This connects with Samuels’ research observation of patients having instinctual problems, with Jacobs’ link to childhood trauma, and with MacDougall’s reference to severe pre-verbal trauma. Where the analyst cannot verbalize his or her own intuitive feelings, that may be when the body picks them up.

3. When the analyst has a particular typology. This factor, with the exception of a paper by Greene (2001), has not to date, as far as I know, been considered in discussion of embodied countertransference, but I suggest that where analysts have introverted intuition as the superior function they are more likely to be open to countertransference responses in the body. The study of typology is an aspect of Jung’s psychology that has been neglected in recent years by the majority of Jungian analysts, not only in Britain. Writing this paper originally for the 50th anniversary conference of the Journal of Analytical Psychology, I found 29 articles on typology in the JAP; 19 were in the first 25 years, and there were only five in the last 15 years. This may be why its role has not been considered before.

I would emphasize that it is when all three of the above conditions come together that countertransference is most likely to be embodied.

Typology

In order to link these ideas about the typology of the analyst with the transference-countertransference relationship, I would like to refer to the diagram below which is taken from Jung’s ‘The psychology of the transference’:

In this diagram, the two-way arrows indicate two-way relationships, between the analyst’s and the patient’s conscious and unconscious processes. The relationship I am most interested in is ‘f’, between the analyst’s unconscious and the patient’s unconscious, which functions on a deep archetypal level. We only begin to understand this after either analyst and/or patient have engaged with the other conscious and unconscious connections, and have begun to unravel the material arising from these. Jung points out the problem:
In describing the transference problem with the help of this series of illustrations, I have not always kept these different possibilities [of relationships a to e] apart; for in real life they are invariably mixed up.

(Jung 1946, para. 424)

This is where the importance of the analyst’s typology comes in. Jung associated the superior function with the ego, and the inferior, or least conscious, function with the anima or animus. Beebe (1984) has developed Jung’s model of and thinking about typology, distinguishing clearly between function and attitude. In his view ‘the functions alternate according to attitude, from most to least conscious or differentiated. Listing [the] functions according to degree of differentiation (downward, from most to least) and in terms of the attitude taken by each function (whether extraverted or introverted), it is possible to give…a type profile’ (p. 150).

Beebe describes his type profile to be:

- extraverted intuition
- introverted thinking
- extraverted feeling
- introverted sensation

You can see how the superior function (intuition) is also opposite in attitude (extraverted) to the inferior introverted sensation, and how the two auxiliary functions have different attitudes.

Based on the Myers-Briggs Type Indicator test, I came out as INFJ: distinctly intuitive, moderately feeling, slightly introverted and slightly judging. According to this, my type profile is in theory:

- introverted intuition
- extraverted feeling
- introverted thinking
- extraverted sensation

This corresponds more or less to the way I would type myself if asked to do so. There is no doubt my feeling function is extraverted, and my inferior sensation function fascinates but constantly lets me down.
Extraverted sensation is directed outwards, tuned into external information, whether verbal or non-verbal, overt or subliminal, but when this is the inferior function and operating unconsciously, the analyst is unaware of it. Because it operates in this way, the body can be unexpectedly and spontaneously invaded and even overwhelmed. Greene (2001) comments that introverted intuitives, with undeveloped sensation function, are relatively unaware of their own and their patients’ non-verbal communication.

Jung writes in ‘General description of the types’:

The superior function is always an expression of the conscious personality, of its aims, will, and general performance, whereas the less differentiated functions fall into the category of things that simply ‘happen’ to one. (1921, para. 575)

When feelings or thoughts are engaged, and more consciousness and light come to bear on what is happening in the body, the symptoms will often fade away. A colleague was telling me recently that she was suddenly overwhelmed with feelings of sleepiness in a session, and she interpreted that the patient might be angry with her. This was at first denied, but when the patient could acknowledge the anger, the sleepy feeling vanished and she was as wide awake as if a light had been switched on.

If my hypothesis is correct, it may also explain why the experience of embodied countertransference is not uncommon among analysts. Bradway (1964) and subsequently Bradway and Detloff (1976 & 1996) conducted a large long-term research project in California into the incidence of psychological types among Jungian analysts. The test they used is the Gray-Wheelwright test, and comparisons were made between these results and self-typing by the analysts. The congruence between them was remarkable, and in their conclusions to the 1976 paper the authors write:

1. Jungian analysts as a group are markedly differentiated from the general (non-analytic) population in the higher incidence of introvert-intuitive types and the low incidence of sensation types.
2. A nearly perfect concordance was shown between self-typing and the G-W in the introvert-extravert classification.
3. A greater than chance concordance was shown between self-typing and the G-W in the sensation-intuition classification and the thinking-feeling classification. (p. 143)

The total of introverted intuitive analysts was over 60%, compared with 14% for the general population, in the original study and in the 1974 and 1993 follow-ups. By this time the number taking part in the survey had gone up from 28 to 196 analysts. What is also remarkable is the consistency with which they dominated the typology of those involved (they are roughly equally divided between thinking and feeling types).

Plaut (1972) conducted a survey among all the members of the IAAP eligible to attend the 1971 Congress, and 173 out of a possible 378 replied. The
results match Bradway and Detloff reasonably well. Fifty-one percent had intuition as primary function, with 60% of them having feeling as second function, and 40% thinking. Twenty-nine percent were primary feeling function, with over 70% of them having intuition as their secondary function.

These results are summarized in the table below:

**Bradway and Detloff surveys (1964 to 1993)**

<table>
<thead>
<tr>
<th>Function</th>
<th>Analysts</th>
<th>General population</th>
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<tr>
<td>Introverted intuition</td>
<td>60%</td>
<td>14%</td>
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<tr>
<td>(divided roughly equally between thinking and feeling types)</td>
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Figures consistent through surveys conducted from 1964 to 1993 (when the number of analysts taking part increased from 28 to 196)

**Plaut survey (1972)** of 173 analysts (out of total 378) attending 1971 IAAP Congress

- Intuition as primary function 51%
  - 60% of whom have feeling (and 40% have thinking) as their secondary function.
- Feeling as primary function 29%
  - 70% of whom have intuition (and 30% have sensation) as their secondary function.

It would also be interesting to know if these results would be repeated among non-Jungian therapists.

I want to emphasize that the whole concept of typology is a dynamic one, not something which is fixed in the psyche. Adler explains this succinctly:

> …these types are not static positions but a dynamic interaction of polaristic psychic patterns of behaviour and adjustment in which any one-sidedness is complemented by its opposite, thus forming the starting point for further assimilations of unconscious contents.

(1967, p. 341)

**Summary**

In this paper I have considered the phenomenon of embodied countertransference responses, as distinct from countertransference expressed in thoughts, feelings, images, fantasies and dreams. Much of what has been written on the subject has focused on sleepiness and erotic and sexual reactions in the analyst, whereas the cases I have given relate to other physical sensations such as pains, aches and feelings of suffocation. The first case was a one-off experience; in the other cases the somatic sensations built up and continued over longer periods, and in the final case they remained with me even after the sessions ended.
A review of the literature led me to suggest that the analyst’s body could be usefully imagined as a tuning fork, resonating with some patients but not with others, and only at certain times. Embodied resonance is most likely to occur when the following three conditions come together: the pathology of the patient, as summarized below; the patient’s inhibition to express strong emotions directly and consciously; and the typology of the analyst.

It was noted that somatic reactions are more frequent with patients exhibiting borderline, psychotic or severe narcissistic elements; where there are basic instinctual problems (sex, aggression, eating disorders); or where there has been early severe childhood trauma. The analyst’s own personal experience, and thus the neurotic countertransference, must always be borne in mind, wherever embodied reactions occur.

I suggest that another important factor is the typology of the analyst. The particular typology of superior introverted intuition, with auxiliary feeling or thinking, and inferior extraverted sensation, is much more frequent among Jungian analysts than among the general population; it thus also explains why the phenomenon of somatic countertransference may be more common than analytic discourse has so far acknowledged.

I believe that further study is needed to investigate my hypothesis, and would like to end with the following quotation from Jung (1913):

I must emphasize the statement that this question of types is the question of our psychology and that every further advancement is probably perceived by way of this question. The difference between the types is almost alarming in its extent.

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TRANSLATIONS OF ABSTRACT

Cet article étudie le phénomène de la résonance corporelle: quand le vécu de l’analyste est une réaction somatique plutôt que les réactions contre-transférentielles plus habituelles que sont les pensées, émotions, images, fantasmes et rêves. L’analogie d’un diapason est utilisée. Plusieurs questions sont posées : Pourquoi le contre-transfert se manifeste-t-il dans le corps de certains analystes et pas de tous ? Pourquoi ces analystes qui ont cette sensibilité là, en ont l’expérience avec certains patients et pas d’autres ? Et quelles sont les conditions qui ont tendance à produire ces réponses somatiques ?

L’article avance que les réactions somatiques ont plus de chance de se produire lorsqu’un certain nombre de conditions sont réunies: lors du travail avec des patients comportant des traits de personnalité limite, psychotique ou gravement narcissique; lorsqu’il y a eu des traumatismes précoces sévères; et lorsqu’il y a une peur d’exprimer directement des émotions fortes. Un facteur théorique supplémentaire est proposé, celui de la typologie de l’analyste.

In dieser Arbeit wird das Phänomen der körperlichen Gegenübertragung untersucht: Hier erfährt der Analytiker/die Analytikerin eher eine somatische Reaktion als die gewöhnlichen Gegenübertragungsreaktionen wie Gedanken, Gefühle, Bilder, Fantasien und Träume. Die Diskussion des klinischen Materials berücksichtigt neurotische und
syntone Aspekte. Dabei wird die Analogie mit der Resonanz einer Stimmgabel herangezogen. Verschiedene Fragen werden gestellt: Warum ruft die Gegenübertragung eine körperliche Resonanz bei einigen Analytikern/Analytikerinnen hervor, aber nicht bei allen? Warum erleben Analytiker, die hierfür empfänglich sind, dies mit einigen Patienten, aber nicht mit anderen? Und: Was sind die Bedingungen, die förderlich sind, um somatische Reaktionen hervorzurufen?

In der Arbeit wird angenommen, dass die körperlichen Reaktionen häufiger auftreten, wenn einige Bedingungen zusammenkommen, z.B. bei der Arbeit mit Patienten/Patientinnen, die Borderline-Elemente, psychotische oder schwere narzisstische Störungen zeigen; bei schweren frühen Traumen in der Kindheit und, wenn es Angst gibt, starke Gefühle direkt auszudrücken. Zusätzlich wird ein anderer theoretischer Faktor angenommen, nämlich die Typologie des Analytikers/der Analytikerin.

References


—— (1946). ‘The psychology of the transference’. In The Practice of Psychotherapy. CW 16.


