A Cross-Cultural Study of Somatic Countertransference

by

Adrienne Margarian
B.A. M.A (Psych.) M.A. (Art Ther.) M. Psych.S. (Hons)

Submitted in fulfillment of the requirements for the degree of

Doctor of Philosophy

Deakin University

December 2015
DEAKIN UNIVERSITY
CANDIDATE DECLARATION

I certify the following about the thesis entitled (10 word maximum)
A Cross-Cultural Study of Somatic Countertransference
submitted for the degree of Doctor of Philosophy

a. I am the creator of all or part of the whole work(s) (including content and layout) and that where reference is made to the work of others, due acknowledgment is given.

b. The work(s) are not in any way a violation or infringement of any copyright, trademark, patent, or other rights whatsoever of any person.

c. That if the work(s) have been commissioned, sponsored or supported by any organisation, I have fulfilled all of the obligations required by such contract or agreement.

d. That any material in the thesis which has been accepted for a degree or diploma by any university or institution is identified in the text.

e. All research integrity requirements have been complied with.

'I certify that I am the student named below and that the information provided in the form is correct'

Full Name: Adrienne Louise Margarian

(Please Print)

Signed: Signature Redacted by Library

Date: 18th December 2015

Deakin University CRICOS Provider Code 00113B
I am the author of the thesis entitled A Cross-Cultural Study of Somatic Countertransference

submitted for the degree of Doctor of Philosophy

This thesis may be made available for consultation, loan and limited copying in accordance with the Copyright Act 1968.

'I certify that I am the student named below and that the information provided in the form is correct'

**Full Name:** .

**Adrienne Margarian**

(Please Print)

Signed: [Signature Redacted by Library]

Date: 11th February 2016

.................................................................
Acknowledgments

I would like to thank many people that encouraged me on this journey of exploring somatic experiences in psychotherapy practice. First of all my family has been incredibly supportive and patient. My husband Ruppen has been and continues to be a strong supporter of my academic and clinical pursuits. On many occasions he has provided words of encouragement all with good humor and kindness. My children Max and Stella additionally reminded me to ‘never give up’ nor forget to have fun along the way. Importantly my academic supervisors both Emeritus Professor Doug Kirsner and Associate Professor Matthew Sharpe as my primary supervisors and Associate Professor Russell Grigg guided me through the process with solid advice, sterns words on occasion and continual reassurance. In order to recruit Chinese participants I am indebted to Dr. Elise Snyder and Dr. Fonya Helm from the Chinese American Psychoanalytic Alliance (CAPA), Professor Heyong Shen and Dr. Li Qiong from South China Normal University in Guangzhou and Mable Lam, Dr. Brian Tam and Dr. Teresa Chan from the Hong Kong Institute of Analytical Psychology. Furthermore Dr. Geoffrey Blowers and Dr. John Bacon-Shone from Hong Kong University assisted me with answering ethical concerns pertaining to cross-cultural research in China, Hong Kong and Singapore. Surprising to me was the generosity of the Chinese participants, noted academics and experts who agreed to partake in this research project, I offer a special acknowledgement for their invaluable input which provides the raw material underpinning this research. In terms of generosity, I would also like to thank Deakin University for awarding me the Neil Archbold Travel Memorial Award and university Medal as this enabled me to present my work at the 3rd IAAP European Conference in Trieste, Italy in August 2015.
Other people I would like to thank include my clinical supervisor Dr. John Merchant who had written about psychic infections in his past research and therefore understood my ideas and direction before I did, Roshanak Vahdani for kindly agreeing to debrief any of the Chinese participants post interviewing if deemed necessary and my current Jungian analyst who has helped me stay sane along the way. Additionally I would like to thank my PhD mentor and neighbour Dr. Bernice Melville and fellow PhD candidate Jenny Caligari who both listened and empathized when I had hit a curve ball in the process. Finally I would like to dedicate this thesis to my family, especially my two Margarets and my Aunty Claire. Without the support of strong women past and present this thesis may not have come to fruition. For this I am truly grateful.
Publications


http://www.psychevisual.com/Video_by_Adrienne_Margarian_on_Working_with_Somatic.Countertransference_a_Cross_Cultural_perspective.html
# Table of Contents

**Acknowledgments**

**Abstract**

**Introduction: Somatic Countertransference**

- Subject and Rationale for this Thesis
- Qualifications, Scope
- Literature Review
- The Jungian and post-Jungian Contribution
- Other Contributions
- Research Prospectus

**Chapter 1  Research Design**

- Introduction: Structuring Hypotheses
- Considerations concerning the Quantitative and Qualitative Dimensions of this Research
- My Approach
- The Research Process
- Cultural Considerations
- Postscript. Further Research undertaken
- The Chinese Participants
- Somatic Countertransference: what was experienced?
- The Prevalence of Somatic Countertransference
- Supervision

**Chapter 2  The Therapist’s Body: a Tool for making Meaning, Reenactment and Containment**

- Somatic Countertransference holds Meaning and or can be a Reenactment
- The Therapist’s Body expresses Emotions that cannot be expressed (the Body does not lie)
- When Somatic Countertransference acts as a Defense against Emotion
- The use of the Therapist’s Body to move the Therapeutic Process along
- Somatic Countertransference as an Indication of intense Emotion
- Therapist’s Body as a Container and/or Tool
- Concluding Remarks
Chapter 3  Empathy and other Somatic Countertransference Matters

**Somatic Countertransference as Empathy**  116
**Somatic Countertransference changes or eases as the Process evolves**  124
**Specific Ways of working with Somatic Countertransference**  127
**Concluding Remarks**  141

Chapter 4  Psychic Infections and Shared Wounds: a Chinese Perspective

**What is a Psychic Infection and**  147
**What is meant by the Shared Wound?**  147
**What the Chinese Participants said about these Concepts?**  153
**Self-care and Management of Psychic Infection**  176
**How the Chinese Participants manage their Psychic Infections?**  184

Chapter 5  Somatic Countertransference: the Relevance of the Mind-body Continuum, Traditional Chinese Medicine (TCM), Taoism and Buddhist spiritual Practices

**The Mind-body Continuum in Chinese Psychotherapy**  190
**A Holistic Approach to the Mind and Body**  191
**Conflation of Physical and Feelings States**  195
**The Impact of the Chinese Language**  199

**Chinese Perceptions of Somatic Countertransference**  203
**Some Personal Explanations of Somatic Countertransference**  203
**The Influence of Traditional Chinese Medicine (TCM)**  207
**The Tao, I Ching and Buddhism**  219

Chapter 6  Somatic Countertransference: exploring Qi, Qi Gong Practice, Skype and a Japanese Perspective

**Qi and the Practice of Qi Gong**  229
**Qi Gong Practice**  237
**Qi and Skype**  241
**A Japanese Perspective on Somatic Countertransference from Kyoto**  244
**Western Perspectives on the Origins of Somatic Countertransference**  248
Chapter 7  Cross-Cultural Considerations  262

The Loss of Cultural Knowledge in China, Hong Kong and Singapore  262
The Integration of Chinese Culture into Psychotherapy Practice  269
Western Psychotherapy as a Last Resort  272
Is Western Psychotherapy Relevant to the Chinese?  276

Chapter 8  Concluding Remarks  284

Key Findings  284

Do Chinese Psychotherapists experience Somatic Countertransference?  285
If Chinese Psychotherapists experience Somatic Countertransference, how would they account for it according to their Beliefs and Cultural Practices?  292
How do you work with Somatic Countertransference when it presents in the Clinic?  294
How to manage the Negative Effects of Somatic Countertransference that manifests as Psychic Infections?  295

Hypotheses emerging from the Research  295
Recommendations for Future Research  297

Bibliography  302

Appendices  313
Abstract

This thesis is about the somatic experiences felt in the body of the psychotherapist in clinical practice: a phenomenon known as somatic countertransference. The aim of this research is to explore in depth how somatic countertransference in clinical practice comes about and how best to work with it and manage the potentially negative effects associated with it. Building on past knowledge from the Jungian and broader psychoanalytic traditions, this research undertakes the first cross-cultural study of somatic countertransference via in-depth interviews with 29 Chinese psychotherapists from Hong Kong, mainland China and Singapore in order to seek new knowledge from a culture known to perceive mind and body holistically. In addition, several academics and experts either working with somatic countertransference or with knowledge of Chinese and Eastern medical and spiritual practices were interviewed to augment the research data. The two core questions posed in this research were:

(1) Do Chinese psychotherapists experience somatic countertransference?

(2) How would they account for it from their spiritual, medical and philosophical traditions?

The research data both supported Western ideas about how to work and manage somatic countertransference, as well as suggesting new methodologies informed by Chinese healing and spiritual practices such as Qi Gong and Traditional Chinese Medicine (TCM). Additionally, by investigating the Chinese cultural traditions of TCM, Buddhism and Qi Gong, Western conceptualizations of how somatic countertransference occurs were supported.
Introduction: Somatic Countertransference

Subject and Rationale for this Thesis

In psychoanalytic therapy, feelings, thoughts, images, dreams and symbols are brought into the session experientially and for discussion. This is what the therapeutic process is about when two people, therapist and client in a room make sense and meaning out of the conscious and unconscious material of the client. Yet in Western versions of psychotherapy, the body, the physical self, is often left out. Many psychoanalysts like Joyce Mc Dougall, Dinora Pines, Mara Sidoli and others have written extensively about the body of the client. But only recently has there been a growing interest in the presence and importance of the body of the therapist in the therapeutic dyad (Mc Dougall, 1989, Pines, 1993, Sidoli, 2000, 1993). The sudden headache, an attack of nausea, and feeling restless, tired and sleepy are all reported experiences that therapists have encountered countertransferentially when working in therapy. This thesis is about such experiences. As Susie Orbach has noted, they have very often been ignored in psychoanalytic thinking:

Just as the patient’s symptomatic body is dismissed or read in a limited way, so too, the, physical sensations that a therapist experiences during the course of his or her work, the body countertransference, are usually understood in psychic terms and not explored for the physical meanings that can be made of them. (Orbach, 2004, p 143)

Nevertheless, this thesis is about acknowledging and validating that the body
of the therapist like the body of a client, can actively communicate. Just like a dream, a feeling, a thought, image or symbol, the body speaks. In the words of Robert Shaw, if the therapist’s body had hitherto been ignored in psychoanalytic theorizing, it was time for it to “come in from the cold” as it warrants investigation (Shaw, 2004, p 271). Like other forms of more commonly acknowledged countertransference, somatic countertransference is understood to have been born out of the transferential relationship emerging between the therapist and client. According to Freud and the entire ensuing tradition, as is well known, ‘transference’ refers to the often passionate or even erotic feelings that an analysand develops for their therapist in the context of the 'talking cure' (Gay, 1998). In analysis, the analysand’s unconscious wishes and complexes can be evinced in their own somatic feelings or reactions, as in hysterical ‘conversion symptoms’. Somatic countertransference is distinct however, not simply because it is physical but since it is felt in the body of the therapist in response to the analysand. It is a physical, somatic response of the therapist to the relationship with the client and the emerging transference.

Before investigating somatic countertransference, then, a more precise definition of countertransference is required. As I have discussed elsewhere, the notion of countertransference was first acknowledged by Freud with both annoyance and concern (Margarian, 2014). Freud first positioned countertransference as the feelings and reactions experienced by the psychoanalyst in relation to the transference emerging in the relationship (Freud, 1912, Gelso & Hayes, 2007). He felt that it was a hindrance and largely the result of personal unprocessed material that belonged to the therapist rather than the client and that it could impede the process of analysis. In relation to somatic countertransference, Young, Crossley and Shaw have suggested
provocatively that the lack of focus on the body in countertransference in the early years of psychoanalysis may reflect a larger reaction, aligned with the banishing of Wilhelm Reich from the psychoanalytic fraternity (Crossley cited in Shaw, 2004; Young, 2006).

Since this initial negative assessment of countertransference, today countertransference has been accepted in varying ways and degrees by different theorists and practitioners as an internal representation of what the patient is experiencing in relation to the transference. Some consider it as a form of vital communication from the unconscious of the client that provides essential information (Gelso & Hayes, 2007). In terms of this thesis, countertransference is noted to be material experienced by the therapist in relation to the transference and the emerging relationship between client and therapist. In addition, the somatic dimension of countertransference is considered as physical sensations felt in the body of the therapist. To this day within the broader psychoanalytic field, whether all material experienced by the therapist in the session is considered countertransference is hotly debated as to whether it is relevant or not to the psychotherapy process (Gelso & Hayes, 2007). Indeed this same concern is echoed in the literature about somatic countertransference, therefore there is an implied questioning about whether all physical experiences felt by the psychotherapist are pertinent to the psychotherapy process or not. This very question will be explored in this thesis, as we look at a sample of Chinese participant’s responses, which are analyzed in due course in later chapters.

For the purposes of this thesis, therefore:
Somatic countertransference is considered to be the physical sensations experienced by the therapist in relation to the transference emerging from the therapeutic relationship.

Importantly, when exploring examples of somatic countertransference in relation to the clinical literature and from the Chinese participants surveyed for this thesis, as we will do in due course, it is essential to keep in mind that somatic manifestations in the therapist’s body are rarely a straightforward matching of physical states in both psychotherapist and client. Rather they are symbolically represented in unusual and uncanny ways, as articulated by Beverley Zabriskie (Zabriskie, 2006). This will become clear as somatic countertransference is defined as a form of embodied countertransference, which is distinct from the commonly represented and experienced form known as reflective countertransference (Samuels, 1985). Additionally examples provided from clinical literature and the data from the Chinese psychotherapists will illustrate this point in due course.

As we will see presently in our survey of existing literature in this field, the research spanning past two decades on somatic countertransference generally agrees that for many therapists of various modalities, it is a common experience felt with some clients (Booth, Trimble & Egan, 2010, Shaw, 2003, 2004, Loughran, 2003, Egan & Carr, 2008, King, 2011). In short, clinical vignettes and empirical studies suggest that somatic countertransference is an important phenomenon and, if reflected upon and effectively harnessed, a tool for greater clinical insight. This collection of research findings all recommend continued investigation in order to validate and acknowledge that somatic countertransference is a potential and integral tool in psychotherapy. Whilst there is a divergence in opinion on how this clinical
phenomenon occurs, much of the research converging with this thesis’ contribution has recommended continued focus on the subject (Shaw, 2003). Additionally, the literature encourages not only greater understanding of how somatic countertransference evolves but also developing ways to manage and work with it for greater clinical efficacy. This thesis takes up these recommendations.

The aim of this research, specifically, as a contribution to contemporary scholarship in this field, is to conduct a cross-cultural study of somatic countertransference. Whilst the growing literature has evolved in the area of somatic countertransference, there has hitherto been nothing written or researched about it from a cross-cultural perspective. To investigate somatic countertransference from a Western perspective only, when so many studies have already undertaken this work, would be repetitive. Therefore the point of exploring this phenomenon cross-culturally is to add knowledge and different perspectives to the literature regarding this recognized vital psychotherapeutic tool.

Two prominent thinkers, namely Shaw and Bloom, in the area of somatic countertransference have articulated the importance of Eastern ideas and have both independently nominated this as an area for consideration for future research. Both Shaw and Bloom have separately suggested that Eastern medical practices could hold important information on how the bodies of both therapist and client behave in psychotherapy (Bloom, 2006, Shaw, 2003). Yet whilst they both express that this disparity in orientation between the West and East is an important area to consider, they do not take up the challenge. In agreement, Loughran considers that the ethnicity and cultural background of therapists and clients could be a vital
consideration for future research (Loughran, 2003). Bloom did not research this area further, though, because her work was focused on honing a therapeutic tool. Likewise, Shaw did not pursue these considerations because he views somatic countertransference as a Western phenomenon and therefore requires an assessment only from within Western referential parameters. From a Jungian perspective, this is a great shame because it is from the East that Carl Jung drew his inspiration for both his theories of individuation and synchronicity (Stein, 2005). As such, this thesis carries on a line of cross-cultural work in psychoanalysis hailing from Jung, and draws upon the East for inspiration. It also adds to the literature reflecting a current post-Jungian interest in the broader topic of countertransference.

The task of this thesis will be, for the first time, to explore systematically how two diverse cultures experience somatic countertransference in clinical practice. Western culture is often noted to perceive mind and body as separate entities according to the constructions of Cartesian dualism, or earlier forms of Platonic and Christian thought, whilst the Chinese culture approaches the mind and body on a continuum. As such, this study investigates somatic countertransference from an Eastern cultural perspective: namely from practitioners working in China, Singapore and Hong Kong. The point of this, as far as possible, is to bracket notions of a mind-body dualism in considering countertransference in the clinic, and to look at the phenomenon of somatic countertransference from a different cultural perspective.

In accordance with these thesis objectives, the questions that I am asking are:

(1) Do Chinese psychotherapists experience somatic countertransference? And

(2) If they do, how would they account for it according to their underlying
spiritual, philosophical and healing practices from their Chinese culture?

Arising from this area of investigation two further questions surfaced. Specifically they concern how best to work with somatic countertransference and how to manage the negative effects of somatic contagion in clinical practice. To explore these questions, the thesis is based around a focused study of 29 Chinese psychotherapists from Hong Kong, Singapore and Mainland China. As the thesis will demonstrate, the results of this survey provide a number of significant and novel considerations to existing thinking concerning somatic countertransference in the clinic. On the one hand, the clinical data validates the importance and clinical relevance of somatic countertransference already observed with Western psychotherapists. It further establishes that somatic countertransference is a cross-culturally viable aspect of psychotherapy, rather than, for instance, being somehow solely a Western experience or phenomenon. Nevertheless, by focusing on the responses from the Chinese psychotherapists, some differences emerge, which I will argue add depth and clarity to the existing knowledge base of somatic countertransference. As such, ideas about how somatic countertransference occurs and how best to work with it evolves from integrating Chinese clinical knowledge. These findings are explored in-depth in chapters 2, 3, 4, 5 and 6.

Qualifications, Scope

It is essential, having now stated the thesis’ aims and methodology, to also immediately clarify what this thesis will not do. First of all, the thesis will not question whether somatic countertransference arises from the unconscious of the psychotherapist or client will not be investigated, whether countertransference is positioned as occurring in the inter-subjective space, or as somehow solely belonging
in the ‘interior’ of the analysand. The idea regarding the inter subjective space is upheld in analytical psychology and relational psychoanalytic approaches to treatment, and is consistent with Lacanian emphases on the inter subjective genesis of the unconscious, and its manifestations. Yet whilst this purely theoretical question exploring somatic countertransference is deemed important by many thinkers such as Karen Gubb, my focus is more on how bodily countertransference evolves and how best to work and manage somatic countertransference clinically (Gubb, 2014). This is as much a practical as a purely theoretical question.

Although it also is a related topic, next, I will not explore ‘somatization’. ‘Somatization’ in psychoanalytic literature refers to the physical manifestations of unconscious material by the client, as for instance in conversion symptoms, mentioned above. Whilst somatization in the client is a closely linked topic it is focused on the client’s material and has been thoroughly examined in psychoanalytic and Jungian literature elsewhere. Furthermore, it extends the area of research to an unmanageable breadth. It is also noteworthy that somatization studies of Chinese patients have been replicated many times and remain contentious because they have been analyzed with reference to Western Cartesian dualism (Sun, 2013). On the one hand this indicates that the topic of somatization is well documented and on the other, this urges this proposed research to be alert to the pitfalls of studying phenomena cross-culturally. Specifically in this example, Western means of analysis have led to misunderstandings and incorrect representations of whether Chinese somatize their depression or not. Taking this into consideration I have remained mindful of this when exploring Chinese clinical practices. Whilst I am intrigued like many of the aforementioned researchers about why some therapists experience
somatic countertransference and others do not, I will not investigate this angle in any depth. Likewise, nor will I explore why somatic countertransference occurs with some patients and not others. Many researchers have suggested these topics for future research endeavors (Field, 1989).

Next, the area of touch in bodywork will not be investigated in this thesis as I consider that this is a contentious aspect of bodywork and not within my experience or therapeutic style as a psychotherapist. Like many thinkers in this field, I agree that there are various forms and ways to define countertransference and in the case of this study I will focus on somatic countertransference only. Importantly, I am aware that I am a white, Caucasian woman, born in Australia and therefore I am writing from a Western perspective. As such, I am conducting a cross-cultural study because I am an outsider looking in at a culture that is foreign to me. The focus of this thesis is therefore to bring to Western psychotherapy practice new ideas and ways to work with somatic countertransference from an Eastern perspective, whilst undertaking a thorough cross-cultural comparison from numerous sources.

Let me say one more thing concerning the importance of this subject, to conclude these opening sections establishing aims, methodology, and the scope of this study. This concerns the practical as well as theoretical dimensions to this research, or its subject matter. Countertransference is a living phenomenon experienced widely by practicing analysts across different schools and techniques and if it is ignored by practitioners, it can potentially pose physical and psychological problems for the therapist, as well as lost opportunities for processing the client’s unconscious material. In this way, a continued discussion and debate about somatic
countertransference is necessary for the future growth, development and refinement of therapeutic technique. This also has important implications for the training of prospective psychotherapists as some research has noted the possibility of burnout and illness in therapists that has not taken into consideration the role of the body in psychotherapy (Athanasiadou & Halewood, 2011, Forester, 2007, Egan & Carr, 2008, Urbano & Pantesco, 2011). If this thesis can in a small way contribute to addressing these practical issues also, it will have achieved one part of its intention.

**Literature Review**

In order to frame the work of this thesis, the remainder of this introduction will explore what has been written about somatic countertransference to date. This literature review will create a knowledge base and platform for comparison with the cross-cultural research this thesis undertakes, and thereby enable the novelty of our work to emerge.

*The Jungian and post-Jungian Contribution*

Carl Jung suggests that in working as an analyst we take in the infection of our patients and that this is the essence of countertransference. As such, Jung is comparing the experience of analysis with the role of the medicine man taking within him the illness of the patient in order to tame it. In an important comment that in one way underlies this thesis as a whole, Jung states:

One of the best-known symptoms of this kind is the counter-transference evoked by the transference. But the effects are often much more subtle, and their nature can best be conveyed by the old idea of the demon of sickness.
According to this, a sufferer can transmit his disease to a healthy person whose powers then subdue the demon. (Jung, 1954, p 72)

This is the very essence of somatic and embodied countertransference that we take into ourselves as therapists and analysts, the sickness of the patient so that we can metabolize it, symbolize it and render it palatable for the client in the therapeutic process. Furthermore, Jung has employed language about the body, which implies that countertransference and the therapeutic process is both a bodily and mental process. I believe Jung was rightly elevating the importance of countertransference by suggesting that it is an embodied experience on the behalf of the therapist. Indeed Jung alludes to countertransference as being a ‘highly important organ of information’ (Jung, 1954, p 71).

The significant work of Andrew Samuels, a Jungian analyst from a post-Jungian perspective further advances the notion of embodied countertransference. In writing this thesis, as I am approaching my research from a post-Jungian, cross-cultural and clinical prospective, the work and ideas of Samuels are relevant. In a seminal paper written by Samuels in 1985, the term ‘embodied countertransference’ first made its appearance (Samuels, 1985, p 52). What Samuels described was a specific form of countertransference in which the analyst’s internal world is the access point to a patient’s inner experience. As such, he suggests that the analyst can embody the patient’s emotional experience and or unknown aspects of their psyche in a physical or felt sense. Samuels furthermore describes two forms of countertransference; reflective countertransference and embodied countertransference. It is the embodied form that is the focus of this thesis. It is this
type of countertransferential experience that can be felt as uncanny because it does not directly correlate with the client’s known material and also because it arises in surprising ways. Samuels describes feeling depressed after seeing a client as an example whereby the therapist has picked up on a direct experience felt but not named or owned by the client. Embodied countertransference conversely, can be dramatic and unexpected when it occurs because it can be picked up somatically. Therefore, it may present as a bodily felt experience. Equally importantly, it represents something that is unknown in the psyche of the client, which is distinctly different from the previous form of countertransference named by Samuels. Elsewhere, he provides an excellent example of embodied countertransference when he recalls feeling extremely thirsty during a session with a client. Samuels reports this to his patient by describing it with the evocative imagery of a parched desert. This honest evaluation of his felt experience leads the client to reveal previously undisclosed and deeply important material about the client’s past that not been explored in the analysis at that point in time (Samuels cited in Merchant, 2012).

In Samuels’s study of embodied countertransference, he asks 32 psychotherapists to note their experiences of countertransference and discovers that 46% of the total countertransference examples were instances of embodied countertransference. For Samuels this is significant and indicates that there are subtle differences in countertransference and that these refined definitions could add value and richness to the analytic process (Samuels, 1985). Whilst Samuels’ attempts to explain how embodied countertransference occurs which he surmises is via an intersubjective space between two people in the therapeutic relationship, for me the value
of his work is that he has astutely named a subtle and distinct subset of countertransference.

Understanding and refining countertransference and internal unconscious process, it should be noted, has been a historical pursuit by many therapists and psychoanalysts (Zachrisson, 2009). Gordon in 1965, in considering whether projective identification was relevant in Jungian depth psychology, developed two types of projective identification, orbital and nuclear\(^1\), that she expressed gave more definition to the dynamics played out between analyst and analysand (Gordon, 1965). Whilst projective identification is not a direct correlate of countertransference, it is still in the same experiential zone of unconscious transmission from the client to the analyst although it is essentially describing a defensive system employed by the client. Nonetheless, I would claim that Gordon’s work in the area of determining its relevance for Jungian depth psychology is important because she is redefining and investigating psychic processes occurring in the therapeutic dyad. Furthermore Gordon brought about a connection between the Kleinian concept of projective identification and Jungian thinking and therefore demonstrated its relevance for Jungian analysis. Likewise Racker in 1968 identified two subsets of countertransference. In what he named concordant countertransference, the analyst identifies with the client’s material in the countertransference whereby with complementary countertransference the analyst taps into an aspect of the client that is unknown by them (Racker, 1968).

\(^1\) Gordon describes two forms of projective identification as nuclear and orbital. The nuclear form of projective identification creates similar feelings that the client may have had as a child for example whereas the orbital form may cast the analyst in the role of a parental figure for the client (Gordon, 1965).
Whilst it could be argued that all countertransference is unknown to the patient, I sense that these secondary types distinguished as complementary, embodied and in the case of projective identification orbital, are distinctly different in that are suggesting that the therapist takes in an inner object or aspect of the client that has been unknown. Therefore, there is a deepening of our understanding with these definitions and an overlap with the notion that we can identify or be drawn into an experience that is unknown by the client as opposed to split off from the client. In a presentation given by Jan Weiner this point is clearly spelt out (Weiner, 2012). Weiner explained that when dealing with countertransference there is a distinct difference between unconscious material that has been split off but initially known by the client with material that has never been integrated or indeed known by the client (Weiner, 2012). This implies a continuum of unconscious material from fragments that may have been experienced or known but then integrated back into unconsciousness to material that has been entirely foreclosed from consciousness. I am suggesting that somatic countertransference is of this later kind because it has a distinctly different sense about it, which is apparent in the uncanny way it surfaces. This idea is consistent with what Samuels and Racker and others have endeavored to understand that countertransference contains unconscious material of various stages of integration and awareness of the material (Samuels, 1985, Racker, 1968). In essence, what Samuels has contributed is to bring to the experience of countertransference many variations and nuances including the physical realm enacted in the body of the therapist. Samuels succinctly states it as such:

There is a considerable difference between, on the one hand, my reflecting of the here and now state of my patient, feeling just what he is unconscious of at
the moment, and, on the other, my embodiment of an entity, theme or person of a longstanding, intrapsychic, inner world nature. One problem for the analyst is that, experientially, the two states may seem similar. (Samuels, 1985, p 52)

Again, Samuels is adding depth and colour to the experience of countertransference, where the somatic is just one of the embodied kinds that he defines. Determining what sort of countertransferential material a therapist is processing is difficult and therefore greater contemplation and understanding of this material is required. Following on from the important work of Samuels, Weiner, Gordon and Racker, this thesis is about deepening our understanding of countertransference, specifically somatic countertransference. By investigating somatic countertransference from a cross-cultural perspective, further knowledge about this phenomenon will be obtained.

The field of Jungian analysis is diverse with distinct schools of thought such as classical, archetypal, developmental (and more recently relational) schools of Jungian analysis. Likewise attending to the body of the client and the therapist is the focus of some Jungian analysts practice but not all. Anita Greene is one Jungian analyst with an interest in psychosomatic presentations, somatic countertransference and using touch as a part of her practice. This last aspect of her practice is commonly thought to be contentious and discussion lies outside of the scope of this thesis. Nonetheless, Greene advocates a heightened awareness of the body in analysis. This can occur in three ways; by watching the body of client and asking them to describe their bodily reactions, becoming more bodily aware and attuned as a therapist and finally integrating the body through the act of touching the client in an appropriate and consensual manner (Greene, 2001). She describes classic examples of somatic
countertransference, which seem consistent with the descriptions mentioned by other therapists from other modalities. For Barry Proner, he surmises that all analytic sessions contain somatic experiences for the analyst to consider (Proner, 2005). With a focus on psychosomatic patients, Sidoli like Greene advocates increased body awareness by the therapist (Sidoli, 2000, 1993). Both Sidoli and Greene are united in tuning to their body as a way to access preverbal communication that in particular may articulate trauma that was sustained in early life by the patient.

In describing the analyst’s capacity for picking up somatic countertransference, Stone likens the analyst’s body to a tuning fork (Stone, 2006). Stone takes up the idea of embodied countertransference and seems to construe it as physical, actual sensations manifesting in the analyst that are expressions of the patient’s inner world. He illustrates this with his case known as M. During a session with M, Stone experienced intense chest pains. Upon revealing this to his patient M, M bursts into tears, which coincides with a release of pain in Stone’s body. Stone is fascinated by this somatic countertransference and wants to know why some analysts experience it and some do not; why this happens with some patients and not others and what are the necessary conditions for these experiences to occur? Stone provides some ideas such as embodied countertransference is likely to occur when treating patients that possess a borderline psychotic structure. As such they are more likely to project feeling states too difficult to articulate into the body of the analyst (Stone, 2006). There is the idea that this material is likely to be expressing preverbal trauma and this is consistent with the thinking of Greene, Sidoli and Bloom (Greene, 2001, Sidoli, 2000, Bloom, 2006).
In trying to understand why some analysts can access this material and not others Stone reverts to Jungian typology. He implies that introverted intuitive types are likely to be operating at a sensate\(^2\) level unconsciously and this would naturally allow for transmission of bodily sensations emanating from the patient (Stone, 2006). This is truly a classical Jungian position to discuss typology and not in keeping with the orientation of this thesis, which endeavors to consider somatic countertransference from a post-Jungian viewpoint. What I think Stone contributes however are frank and revealing examples of somatic countertransference, which are largely taboo amongst other analysts (Stein, 1995). Stone is also focusing on the somatic attributes of embodied countertransference, thereby locating Samuel’s embodied countertransference in the area of the therapist’s body. Whereas Samuels is describing a subtype of countertransference that embodies an unknown aspect of the client and can manifest as physical sensations in the body of the therapist, Stone’s paper is providing clinical examples that really capture somatic countertransference with its visceral qualities, which I believe is a subset of embodied countertransference.

Post-Jungian thinking forays into somatic countertransferential territory present from unusual sources. The work of Barbara Miller is the result of studying Sami Healer’s shamanic practices over 15 years. From her explorations, Miller determines that there is a distinct parallel between Sami body diagnostics and analytical psychologists’ use of embodied countertransferential material. This is distinctly in the realm of the physical, which she demonstrates with examples of Sami healers using their bodies to diagnose illness in their patients in a similar way that an analyst will listen to and reflect upon physical disturbances in their body during a

---

\(^2\) Stone is referencing Jung’s psychological types for understanding why some analysts are more prone to somatic countertransference. Jung discusses his theory of psychological types in Volume 6 of the Collected Works (Jung, 1971/1989).
session. Miller explains that the Sami advocate speaking to sore parts of the body and urge their patients to tell their stories that have become lost and caught up in the body. Miller believes that as a result of this process, symptoms can dissipate and energy in the Sami patients can shift (Miller, 2011). Miller specifically calls for a widening of analytic experience and technique in which emotional material manifested in the body is addressed (Miller, 2011). Miller’s observations of the Sami’s approach I think parallels Stone’s example of a shift in his chest pain and the processing of material with his patient M, when the pain in Stone is named (Stone, 2006). This clinical material calls to mind Bloom’s recommendation to explore Eastern medical traditions and their focus on energy fields in the body (Bloom, 2006). Therefore the orientation to the East that this thesis undertakes is to build upon the already growing knowledge base in the area of somatic countertransference. Notably the work of Miller is brave in delving into the art of Sami healing and drawing upon a parallel with Jungian depth psychology.

Returning to Jung’s notion of psychic infection, John Merchant explains in his discussion of the parallel between shamanism and Jungian analysis that embodied countertransference is the physical manifestation of these infections. In his book, Merchant calls for a reassessment of the collective unconscious, a fresh approach to the archetypes based on emergent theories of development and as importantly that when selecting candidates for Jungian analysis training attention must be given to how candidates manage their psychic infections (Merchant, 2012). This sentiment is further echoed by other Jungian analysts namely David Sedgwick in his important and thorough exploration of countertransference and the concept of the wounded healer (Sedgwick, 1994). In essence, whilst the concept of somatic and embodied countertransference is not completely embraced by all Jungians, Merchant implies
that we need to have greater awareness of it. In terms of candidate selection this further implies that suitable candidates have developed a way to manage their somatic countertransference. Whilst somatic countertransference is not noted or experienced by all Jungian analysts, it does seem to be an important aspect of Jungian analysis that must not be ignored.

Two final but important contributions to the development of countertransference from a post-Jungian perspective are noted with the work of Jan Weiner and Jean Knox (Weiner, 2011, Knox, 2013). Weiner contends that countertransference can be likened to a form of active imagination. She reports that Jung developed the technique of active imagination, which can be integrated into our thinking about countertransference. As such, for Weiner, countertransference is a co-constructed experience that manifests and is expressed in the analyst. It requires an internal space between the client and therapist and imagination to unpack the meanings behind an experience of countertransferential and transferential reactions. I believe that Weiner is contributing to the discussion and refinement of countertransference in a distinctly Jungian and deeply intuitive way and that it could assist in the way we look at somatic countertransference (Weiner, 2011). Essentially it would enable somatic experiences to be worked with creatively and in a co-constructed manner with client and therapist making meaning of it. Knox on the other hand, refers to contemporary neuroscience findings to define two types of empathy, which she terms ‘feeling for’ and ‘feeling with’. Knox says:

---

3 Active imagination is a Jungian term which refers to the process of dialoguing with an image or symbol in dreams that allows for further insight.
Experienced therapists do indeed know that a key contribution is the capacity to mentalize, to take our own perspective on the unfolding dynamics in the consulting room and to draw on empathy as ‘feeling for’ the patient. But the other aspect of empathy, the emotional contagion that contributes to ‘feeling with’ the other, is also an essential part of our clinical practice. We need to identify with our patients, to understand their suffering ‘from the inside’ ...

(Knox, 2013 p 498).

Knox is stating here the importance of the contagious form of countertransference that psychotherapists experience and that this plays an important role for both understanding and assisting the client with affect regulation. Knox’s work draws heavily on Allan Schore’s work on right hemisphere research, which will be discussed in due course. Furthermore Knox agrees with Jung’s idea of the contagion that the therapist must manage and Merchant’s suggestion that psychic infections can manifest in countertransferential material (Knox, 2013, Merchant, 2012).

From within the Jungian field, it is notable that Samuels, Knox and Weiner are continuing in this tradition of redefining and refining our understanding of countertransference. Likewise, others such as Merchant and Miller are directly focusing on the actual experience of somatic countertransference resulting from psychic infections (Merchant, 2012, Miller, 2011). From their work we note a recommendation to explore these aspects of therapy when training analysts and refining analytic practice. As such, this thesis is extending these ideas and concerns about somatic countertransference by undertaking extensive research in the area from a cross-cultural perspective.
Other Contributions

Several other psychotherapeutic schools of thought have explored the clinical presence and significance of somatic countertransference. Dance Movement Therapy, relational psychoanalysis, humanistic and body psychotherapy, empirical studies into vicarious traumatization and current neuroscience have all contributed to contemporary thinking on somatic countertransference. At one end of the spectrum somatic countertransference is positioned as the preverbal communication remnants from early attachment trauma. This is supported namely by Dance Movement Therapy, numerous independent psychoanalysts and contemporary neuroscience on right hemisphere to right hemisphere communication conducted by Schore (Schore, 2012, 2014). In contrast, relational psychoanalysis notably with the work of Orbach and Petrucelli shifts its focus to the idea that the body be made the primary focus therefore encouraging staying with the physical sensations felt by therapist and client first prior to the analytic processing of such material (Orbach, 2004, Petrucelli, 2007). I think this is a deliberate attempt to move beyond Cartesian dualism by starting with the body first to allow a creative process for unpacking the potential meanings behind physical sensations felt by the therapist. Additionally the notion of the inter subjective space noted by relational psychoanalysis promotes the idea of ‘somatic thirdness’ as discussed by Rappaport (Rappaport, 2015, p 142). Finally empirical studies on trauma and vicarious traumatization have further sharpened the focus on somatic countertransference in mainstream psychology by highlighting the negative effects of unprocessed somatic material felt by psychotherapists. This has also been taken up by post-Jungians such as Merchant, Schellinski and Clark with reference to
the psychic infection enabled in unconscious-to-unconscious communications in psychoanalytic work (Merchant, 2012, Schellinski, 2013, Clark, 2010).

To commence with, the field of Dance Movement Therapy has been integral in focusing on the body of the therapist and the idea of somatic countertransference. Given that Dance Movement Therapy is a body orientated therapy, it is implied that the body will be observed, felt and experienced in a more heightened manner than with other therapeutic modalities. Through the work of Dosamantes–Beaudry who is recognized for bringing psychoanalytic concepts to Dance Movement Therapy, there is an integration of sorts with the relational notion of the inter subjective space and an appreciation of preverbal states that manifest somatically (Dosamantes-Beaudry, 1992, 2007, Vulcan, 2009). As such, she contends that bringing the body of the therapist into therapeutic focus facilitates an exploration of regressed preverbal and pre-oedipal states in the client. Important for this thesis is the work of Katya Bloom, who has written an impressive text that brings together psychoanalytic theories, knowledge from infant observations, object relations, neuroscience and dance movement techniques to formulate a way of understanding and decoding both the patient and the therapist’s body during psychotherapy (Bloom, 2006). Bloom’s interest in the healing traditions of the East and how energy fields represent the unconscious in the body intersects with the research undertaken in this thesis. It is this idea of integrating Eastern knowledge that is essential in this research project, exploring somatic countertransference from a Chinese perspective and therefore a holistic approach.
Whilst Dance Movement Therapy is essentially a body-focused treatment modality, it is the work of Susie Orbach that emphasizes the importance of the body for processing unconscious material. Aside from affirming the belief that the therapist’s body is a significant tool of enlightenment in psychotherapy, Orbach’s contribution is that we need to think about bodies differently. She encourages that we start with physical sensations rather than exploring them from a thinking/ mind aspect first. Following on, she suggests that the sensation itself needs to be sat with and experienced as a means to unpack its significance for the therapeutic relationship.

This idea of staying with the body rather than exploring the body via analytical process is not new in the discourse on mind body relations and Cartesian dualism. This is especially noted with the work of William W. Meissner and Sharone Bergner who both called for a revision of psychoanalytic theories of mind body relationships in order to refresh our ideas and improve our techniques in therapy (Meissner, 2006, Bergner, 2009). Similarly the work of Petrucelli, a clinician working with eating disordered clients encourages a focus on the physical shakeups in the psychotherapy session such as when a therapist misses their seat for example. Like others such as Forester and King, Petrucelli contends that dissociated material of the clients can be expressed through their focus and questioning of the therapist’s body and or by physical presence and shakeups that occur in the therapist’s body during a session (Forester, 2007, Petrucelli, 2007, King 2011).

In thinking about how the body of the therapist communicates, the work of Nathan Field is further illuminating. Like Orbach, Field dismisses commonly held ideas about somatic countertransference with his example of sleepiness with his client Miss C. In assessing his countertransference response of sleepiness with the case of
Miss C, he surmises that there was a mutual need to sleep in the sessions. What he determines is that the client has enacted this as a means to bring about a process of fusion between client and therapist. In trying to understand this, Field believes that his client has never been soothed adequately in her original mother infant attachment and therefore has brought about a reenactment to manage a self-cure of sorts. This is an interesting idea, which he describes as consistent with the idea of projective identification whereby the client wants the therapist to hold something for him/her. As such, in the case of Miss C, Field contends that his patient wanted to feel safe and mutually held and in time as this need was acknowledged and worked through, the sleepiness in both himself and Miss C dissipated. Whilst this is in alignment with the notion that somatic countertransference is a regressed preverbal form of expression, I think that Field is creatively working with this material by staying with the feeling of sleepiness rather than reverting to the commonly held belief that sleepiness enacted in the session is an attack on the therapist’s capacity to think (Field, 1989, Orbach, 2004). This process of arriving at a new way to work with this material aligns with the direction of this thesis that is exploring novel ways to understand and work with somatic countertransference in psychotherapy.

Another important development in contemporary psychoanalysis is the focus on the relationship between the analyst and client and the notion of inter subjectivity (Stolorow, Atwood & Orange, 2002). It is from this school of thought that Evelyn Rappaport has developed the concept of the ‘somatic third’ (Rappaport, 2015, p142). Basically, Rappaport contends that within inter subjective space that occurs between analyst and client, embodiment of feeling states occurs. She states it as such:
I expand on the concept of the third to include what I call the ‘somatic third’ in the space and place in which subjectivities become embodied and interactive/mutual regulation occurs when a patient and analyst enter the room, their bodies as well as their minds encounter each other. Multiple self-states of the patient engage with multiple self-states of the analyst in patterns of engagement unique to their particular dyadic process. (Rappaport, 2015, p 142)

I think Rappaport is building on the exploration of somatic countertransference from a relational psychoanalysis perspective. It embraces some of the previous ideas of preverbal material, builds on Knox’s idea of ‘feeling with’ and intersects with Jung’s seminal notion of the zone of mutual unconsciousness and psychic infection (Jung, 1946/1993). It also neatly accounts for Petrucelli and King’s therapeutic shakeups and how they contribute to meaning in the session (Petrucelli, 2007, King, 2011).

Perhaps the most important study of somatic countertransference has been undertaken by Robert Shaw. Shaw, an osteopath and psychotherapist, explored somatic countertransference in a sophisticated study that had phenomenology and grounded theory at the heart of it (Shaw, 2003, 2004). Essentially, Shaw wishes to dismantle the term ‘somatic countertransference’ with a preference for the term ‘body empathy’, whereby the therapist experiences resonance with his/her client and not a literal transmission of affect implied with the psychoanalytic concept of countertransference (Shaw, 2004, p 271). Through his research data, like other notable research, Shaw discovers that the somatic phenomenon is universally experienced by therapists and is construed as a useful tool for exploring the therapy
process that is evolving. As such, he implores that the therapist’s body be attended to
and maintains that this process is essential for the training and supervision of all
psychotherapists. Whilst Shaw is endeavoring to seek new answers and ways for
working with somatic countertransference, I think he is somewhat misguided in his
dismissal of psychoanalytic terms for describing this material. This is because such
terms such as 'countertransference' are not a reification of psychic processes but a
description that facilitates enquiry in psychotherapy. Shaw’s development of a new
way to work with somatic countertransference via a narrative process that invites co
creation of meaning between patient and therapist is not new material as he suggests.
The work of Jan Weiner, a post-Jungian encourages us to think that
countertransference be approached in an active imaginative process which seems
similar to Shaw’s suggestions. In short, his broad critique of psychoanalytic ways of
understanding and working with somatic countertransference does not truly appreciate
psychoanalytic thinking and its essential contributions to working with this material.
Nonetheless, Shaw is an important voice in this growing area of research because he
advocates attending to this material for the greater psychological health of the
therapist, that training psychotherapists be equipped with the tools to work with their
body in clinical settings and that Eastern healing traditions be referenced for a fuller
understanding of the role of the therapist’s body in psychotherapy practice. As such,
Shaw provides the means for researching somatic countertransference in a creative
and broadening fashion by suggesting an exploration of healing practices from
cultures that are holistic in their approach to the mind and body (Shaw, 2003, 2004).
Aside from Shaw’s important work, many other empirical studies in the area of
trauma research have further contributed to the focus on somatic countertransference
in the West over the past several decades. These studies are briefly explored in the following chapter on methodology and research design.

Finally, from a neuroscience perspective, two important areas of research stand out in relation to somatic countertransference. First of all, the work of Giacomo Rizzolatti on mirror neurons suggests that monkeys and humans both possess mirror neurons that enable us to unconsciously pick up and mimic the emotional states of others (Schellinski, 2013). This provides a neurological explanation for the capacity of the therapist to pick up or intuit what is occurring in others, which could manifest either physically or emotionally. Secondly, there is the groundbreaking work of Allan Schore and his exploration of the neurobiological underpinning of right-brain-to-right-brain communication which generates much excitement for imagining how human-to-human contact at an unconscious level, first noted in early development at a preverbal level, exists (Schore, 2014). As such, Schore is detailing the ‘social-emotional development of the infant’ and what this means for contemporary psychotherapy practice (Schore, 2012, p 2). This is in the zone of unconscious-to-unconscious communications that typify somatic countertransference, duly noted by Jung in his seminal writing (Jung, 1954).

In short, Schore is claiming that affective relational processes occur at a preverbal level in the right brain, persist over the life span and not just at infancy and are reenacted between analyst and patient in psychotherapy. By engaging with this process, true therapeutic change is possible which negates previous theories of psychological change that focus primarily on left-brain, cognitive processes (Schore, 2012). Crucially, Schore acknowledges the role of somatic countertransference and emphasizes the connectivity of mind-body largely ignored in Western thinking and
previous scientific pursuits. Whilst an important area of research relevant to somatic countertransference, this material is largely beyond the scope of the thesis and therefore only mentioned briefly. Nonetheless, the data provided by the Chinese psychotherapists attest to the clinical relevance of somatic countertransference and Schore’s notion of right hemisphere to right hemisphere dominance in psychotherapy process.

Whilst diverse in their approaches and theoretical underpinnings, many contributions from various psychotherapy schools together with empirical research and contemporary neuroscience strongly support the notion that somatic countertransference is a vital therapeutic tool. As in this thesis, it requires further investigation for improved clinical understanding and application.

**Research Prospectus**

In order to research somatic countertransference cross-culturally, the body of the thesis is organized according to the questions posed. Specifically the first question is whether somatic countertransference is cross-culturally relevant. In pursuing this question, two further questions emerged that look at how best to work with somatic countertransference and manage the negative effects of it clinically. The final question is to investigate how somatic countertransference is understood from a unique Chinese perspective. This final area of investigation provided new ideas for clinical technique and methods for preventing practitioner burnout from ill effects of working with this material.
Corresponding to the first question posed, I establish that somatic countertransference is cross-culturally relevant in Chinese psychotherapy and therefore pertinent to psychotherapy practice per se. Once the clinical relevance of somatic countertransference is addressed, the second question regarding in-depth ways to work and manage it with reference to both Western and Chinese psychotherapeutic styles is discussed in depth. Like Shaw’s study, the data collected from this research is richly candid and illuminating about the presence of somatic countertransference in psychotherapy practice (Shaw, 2003). This highly illustrative and informative case material provided the means to shape and navigate contemporary psychotherapy practice not noted in the numerous quantitative empirical studies discussed and noted in chapter 1. Furthermore, this area of discussion brought with it not only an affirmation of previously established ways to work with somatic countertransference but also some new ideas from Chinese and Japanese culture and further suggestions for managing the negative effects of these phenomena. This research project, for the first time, provides a practical approach for managing and working with somatic countertransference.

The final question posed in this thesis explores how somatic countertransference is understood from a Chinese perspective. This area of research references the Chinese notions of qi, yin and yang and psychic blockages as a means to conceptualize somatic countertransference and how it manifests in psychotherapy. As suggested by Bloom and Shaw yet not undertaken in previous research, this study pursues a diverse cultural perspective in order to seek out new knowledge and direction for clinical practice in the area of somatic countertransference (Bloom, 2006, Shaw, 2003). Additionally, like Samuels’ tentative attempt, this project
endeavors to explain how a zone of mutual unconsciousness allows for somatic sensations to manifest in the therapist’s body (Samuels, 1985).

The aforementioned questions governing this research project are dealt with in the following chapters. In chapter 1 entitled ‘Research Design’ I commence with a fundamental map for the research process undertaken. In this chapter I outline the research process in relation to how the data was collected and analyzed and how the research changed over time. I also provide a detailed description of the participants involved in this project. This includes a discussion of relevant issues such as the rate of prevalence of somatic countertransference amongst Chinese psychotherapists.

In chapter 2 entitled ‘The Therapist’s body: a tool for making meaning, reenactment and containment’, I commence the in-depth exploration of the clinical data provided by the Chinese participants and thereby establish somatic countertransference as a cross-cultural phenomenon. In this chapter specific themes are dealt with and, in chapter 3, further emergent themes are explored. In chapter 3, entitled ‘Empathy and other somatic countertransference matters’ the ensuring analysis of the data provided by the Chinese participants focuses specifically on how they experience and work with somatic countertransference which addresses the third question tabled in this thesis. From this analysis, a comparison with Western perceptions and ways of working with somatic countertransference is made as well the acknowledgement of new ideas about managing somatic countertransference. As such, these chapters are addressing the questions that focus on how to manage and work with somatic countertransference in clinical practice.
This focus on clinical practice is further taken up in the following chapter 4 named ‘Psychic infections and the shared wounds: a Chinese perspective’. This chapter investigates the theme of managing the negative effects of somatic countertransference described as psychic infections that are enabled by previous psychic wounding of the therapist. This chapter is important in that it highlights the understandable concern warranted when the therapist’s body can become ill as a consequence of unprocessed somatic countertransference. This is a significant finding that underlines the importance of acknowledging somatic countertransference for the health of the psychotherapist.

Chapter 5 entitled ‘Somatic countertransference: the relevance of the mind-body continuum, Traditional Chinese Medicine (TCM), Taoism and Buddhist spiritual practices’, responds to second the question about defining a uniquely Chinese perspective on somatic countertransference. In this chapter, ideas from Chinese healing and energy practices are discussed so as to provide new ways of conceptualizing how somatic countertransference occurs as well as providing new ways to manage somatic countertransference. Further associated with this investigation is a section detailing mind body as fused-state phenomenon that became apparent in the responses provided by the Chinese participants.

In chapter 6 entitled ‘Somatic countertransference: exploring qi, Qi Gong practice, Skype and a Japanese perspective’ I investigate the relevance of qi, qi Gong practice for our understanding of somatic countertransference. This further enriches our appreciation of whether somatic countertransference can be harnessed during Skype analysis. Additionally this chapter investigates a Japanese perspective on
somatic countertransference from Kyoto and culminates in an overall cross-cultural comparison with Western explanations of how somatic countertransference occurs in psychotherapy practice.

Chapter 7, entitled ‘Cross-Cultural Considerations’, brings together some additional ideas and questions that surfaced from the data analysis such as: how relevant is Western psychotherapy for the Chinese? Is there any possible intersection between Chinese philosophy and medical practices and Western psychotherapy? Essentially, when exploring the concept of somatic countertransference, what commonalities exist between Western and Chinese perspectives on this aspect of psychotherapeutic process?

Moreover, chapter 7 introduces some ways in which the Chinese participants integrate their culture or employ cultural practices first, before engaging in Western psychotherapy treatment. This chapter in a sense ties together all the loose ends that surfaced from the process of the data collection and analysis. Whilst important material that surfaced from the process, these themes nevertheless fell outside of the immediate area of research on somatic countertransference.

Finally, chapter 8, ‘Concluding remarks’, summarizes the core findings that surfaced from this research together with recommendations for future research. Importantly, it unites the central themes that emerge from this thesis.

This thesis provided numerous new and important findings that contribute to the current growing interest and research into somatic countertransference. First of
all, drawing on interviews with 29 Chinese psychotherapists, it establishes that somatic countertransference is a cross-cultural phenomenon demonstrated with the rich clinical examples provided. Furthermore, the clinical data illustrate how somatic countertransference was harnessed for greater therapeutic insight. Consistent with their cultural background underpinned by a holistic approach to mind and body, the clinical examples illustrate a conflation of feeling and physical states not noted with Western psychotherapy. This finding is deemed consistent with the notion of the mind-body continuum in Chinese medical practices and Jung’s concept of the psychoid level of the psyche that he wrote about in Volume 8 of the Collected Works (Jung, 1969).

Whilst Western ideas for working with somatic countertransference are acknowledged by the participants, new ways surfaced from Chinese cultural practices. These techniques for working with somatic countertransference promote original ideas informed by cultural practices such as Qi Gong, Buddhism and Traditional Chinese Medicine. Also the data establishes the notion of the shared wound whereby personal resonance with client material is acknowledged by the Chinese psychotherapists. This affirms the idea of the psychic infection as noted by Jung (Jung, 1937/1993). Also emerging from the exploration of the clinical data are Chinese cultural terms such as qi, yin and yang and psychic blockages. These terms support Jung’s seminal ideas on the zone of unconscious-to-unconscious communication and the notion of psychic infection (Jung, 1954, Jung, 1937/1993). Moreover, as qi is considered by Chunyi Lin, Qi Gong Master and Mr. John Dolic, Chinese Medical Practitioner to be an equivalent to the unconscious, methods of Qi Gong practice are explored for both harnessing and heightening one’s sensitivity to
somatic countertransference (Lin, Interview, 21 November, 2013, Dolic, Interview, 17 January, 2014). Additionally this undertaking provides ways for improving the self care of the psychotherapist with reference to the negative effects of somatic countertransference. Likewise, Chinese spiritual, philosophical and healing practices bring about new ways to conceptualize the analytic relationship through the application of *qi* and yin and yang concepts. These ideas further support Jung’s idea of the mutual zone of unconsciousness as well as the current neuro scientific research findings regarding right-hemisphere-to-right-hemisphere forms of preverbal communication (Jung, 1954, Schore, 2014).

Other new material included Traditional Chinese Medicine knowledge of body parts related to feeling states that could extend our understanding and management of somatic countertransference. In addition the practices of Qi Gong, Buddhist practices such as mindfulness meditation and Japanese methods of body monitoring are suggested for increasing sensitivity to unconscious processing as well as for management of the negative effects of somatic countertransference in clinical practice. Finally, this thesis promotes the notion that there are numerous ways to manage and perceive how the body of the therapist becomes enlivened or deadened within the therapy session and that it is essential to move beyond the restrictions of Cartesian dualism⁴ and standard developmental explanations of the phenomena.

By investigating the notion of somatic countertransference cross-culturally several gains have been made which contribute new knowledge in this area. First of

---

⁴ I note that by employing the term Cartesian dualism and by speaking about the body and the mind as separate entities I am endorsing the very split I want to avoid. The aim of this thesis is however to move beyond this implied duality in spite of the language used.
all, a fuller understanding of somatic countertransference and its various forms and clinical meanings is reached. Secondly, by researching the phenomenon cross-culturally, innovative and exciting ways to understand and manage somatic countertransference emerge. Essential to the two main aims, a greater appreciation that therapists can become psychically infected from unconscious communications from the psychotherapy process is illustrated from the data. This in turn leads to new ideas for how best to prepare and train psychotherapists and psychoanalysts for this possibility when working clinically.
Chapter 1: Research Design

In this chapter I outline the research process undertaken for this cross-cultural study of somatic countertransference. I commence with a general introduction that states my hypotheses in relation to my research questions. I then briefly review previous quantitative and qualitative research so that I may position my current study. This leads onto sections that detail my approach, the research process undertaken, cultural considerations, a description of further research carried out to complete the process and finally a detailed depiction of the participants who participated in this study.

Introduction: Structuring Hypotheses

As I have discussed in the Introduction, the aim of this research is to explore the phenomena of somatic countertransference cross-culturally. In essence, this thesis is about the phenomena of somatic countertransference in psychotherapeutic practice and how two different cultures experience and make meaning of them. One culture, under the broad banner of the West, traditionally theorizes mind and body as distinct according to the Western Cartesian model. The other culture, that from the East, experiences the mind and body as intrinsically connected. Indeed, as will be demonstrated by examples from the data in due course, Eastern approaches to healing and spirituality construes the mind and body holistically. In relation to this thesis, specifically the questions that that are being asked in this research are;

1. Do Chinese psychotherapists experience somatic countertransference?

2. If so, how would they account for it according to their culture?
Further arising from these two important questions and the data collected was the question of how to best work with somatic countertransference for enhanced clinical insight. In working with this material, the additional question of how to minimize the negative effects of somatic countertransference further manifested.

In light of the two main questions, my first working hypothesis was that most Western psychotherapists when they experience an ache or pain will not associate it with psychological phenomena in themselves or others with the exception of those practitioners that are aware of somatic countertransference. As identified by Loughran and Shaw, some psychotherapists have undergone specific body awareness training or through their own experience of psychotherapy developed a greater self-awareness of their bodies (Loughran, 2003, Shaw, 2004). Conversely, this first hypothesis suggested that Chinese psychotherapists may experience this pain as something from the body of either themselves or the patient that does not need to be spoken of because they may perceive body and mind on a continuum. Nonetheless, it is probable that somatic countertransference may be identified by some Chinese psychotherapists and their understanding of this phenomenon is likely to be informed by their cultural, spiritual and medical practices. Secondly, following on from these considerations, I hypothesized that their cultural background is likely to influence how they work with somatic countertransference psychotherapeutically and how they would explain it as psychotherapeutic phenomenon.
Considerations concerning the Quantitative and Qualitative Dimensions of this Research

As the phenomenon of somatic countertransference has developed from the mid 1980’s with the initial study conducted by Samuels to more recently with a focus on quantitative research, the primary aim has been to determine whether it is experienced by psychotherapists and analysts and whether it is therapeutically useful and/or potentially harmful if not acknowledged (Samuels, 1985). As such, the underlying questions underpinning this research particularly over the past decades have lent themselves to both quantitative and qualitative practices. The employment of Body Centered Countertransference Scale developed by Egan and Carr, for example, is a specific tool developed to determine whether therapists experience in their bodies physical symptoms that mimic trauma symptoms (Egan & Carr, 2008). They claim to have modeled this instrument on the Trauma Symptom Inventory (TSI) arising from the observation of vicarious traumatization in therapists treating clients suffering from trauma. This same tool has been made freely available to any researchers interested in determining the presence of somatic countertransference (Egan & Carr, 2008).

In the more recent study of 87 Irish Clinical Psychologists, by employing the Body Centered Countertransference questionnaire, it was established that 80% of the participants had experienced muscle tension in the previous six months (Booth, Trimble & Egan, 2010). This result replicated the previous result found in the similar study undertaken by Egan and Carr in 2008 on trauma specialists (Egan & Carr, 2008). In a similar manner, in his in depth interviews of 32 psychotherapists, Samuels defines two subsets of countertransference and determines that 46% of the responses
he obtained were aligned with the embodied countertransference that he defined. This is a straightforward quantitative process approached in two different ways through direct questioning on the one hand and via questionnaire on the other. The purpose of this can be twofold; on the one hand it is an attempt to validate the phenomena and on the other hand by confirming them may reduce the stigma and discomfort of discussing these experiences noted by Loughran (Loughran, 2003).

This research revisits this question of whether somatic countertransference is experienced by the participant group or not and does so more simply by the direct questioning method employed by Samuels (Samuels, 1985). This is because it is not the main aim of the research to simply validate whether it is a clinical phenomenon. Consistent with Samuels’ work, participants will be provided with a definition of somatic countertransference and asked whether or not they have experienced this in their practice (Samuels, 1985). The Body Centered Countertransference Scale, whilst it achieves this same purpose, has been designed with the criteria of trauma as a focus in order to assess whether therapists are experiencing the same symptoms as their clients as a process of vicarious traumatization. Therefore, the aim of the research focused on trauma is divergent from the primary aim of this proposed study that looks at whether somatic countertransference is experienced cross-culturally with Chinese psychotherapists and not specifically from an interest or perspective of trauma research. Furthermore, the Body Centered Countertransference Scale is a quantitative tool that will not address the second question that the proposed research is asking about how Chinese psychotherapists account for somatic countertransference. Furthermore, this quantitative measure will not probe for responses about how to work with somatic countertransference.
The common method of research identified from the reviewed research was the practice of in-depth interviewing, specifically a qualitative process. The method of in-depth interviewing is widely practiced as a means to elicit personal experiences of diverse phenomena and therefore can be guided by questions tailormade with the research aims in mind. Loughran, for example, with five in-depth interviews was focused on how therapists worked with the body (Loughran, 2003). Shaw on the other hand wanted to test out the idea of body empathy and co-constructed narratives in opposition to the psychoanalytic concept of somatic countertransference (Shaw, 2003). Likewise more recently the subject of the therapeutic value of stomach rumblings in psychotherapy was explored via in-depth interviews to yield countertransferential meaning (King, 2011). In seeking out a style of in depth interviewing practice, I explored ideas of Hollway and Jefferson who promote a free associative style of interviewing technique based on psychoanalytic practice (Hollway & Jefferson, 2000). This technique encourages less reliance on set questions with a greater focus on a conversation that emerges between interviewee and interviewer to facilitate greater depth and quality of information. This was a natural fit for the subject of psychotherapeutic practice and commensurate with my training as a psychotherapist. As such, in looking at how Chinese psychotherapists would account for somatic countertransference, the in depth interviewing process with a series of open-ended exploratory style questions embedded in a free floating conversational style between colleagues was employed.

Whilst there is a mix of qualitative and quantitative methods employed in the collection of data in the area of somatic countertransference, the most common form
of data analysis has been via the practice of grounded theory (Glaser & Strauss, 1967). The aim of grounded theory is to generate a theory in preference to testing a hypothesis, so in essence it would be a natural fit for the aim of this research in understanding how Chinese psychotherapists would account for somatic experiences. The work of Shaw, Loughran, Athanasiadou & Halewood, Egan & Carr, Booth, Trimble & Egan, King, Urbano & Pantesco, all employs grounded-theory practice of analyzing the data through a system of coding to determine the most commonly mentioned ideas to generate a theory to explain what has been investigated (Shaw, 2003, 2004, Loughran 2003, Athanasiadou & Halewood, 2011, Egan & Carr, 2008, Booth, Trimble, Egan, 2010, King, 2011, Pantesco & Urbano, 2011). Yet, in my review of the research conducted with this data analysis process in place, I experienced little added value by employing grounded-theory’s system of coding to generate recurring themes. Rather, by exploring and reading the specific accounts made by the participants, a richness of experience, shared themes and individual nuances were far more apparent and compelling. Notably, the work of Shaw and Loughran with their clinical accounts from their participants added the most interesting material for consideration in the emerging field of somatic countertransference (Shaw, 2003, 2004, Loughran, 2003). Whilst I acknowledge that Loughran employed grounded theory for her data analysis, it was reading the actual statements made by her five participants that added the most value (Loughran, 2003). Likewise, in Shaw’s study the grounded theory approach employed simply validated the finding that the therapist’s body was important in therapeutic work whilst it was his actual exploration of the statements made by his participants that provided the most interesting information (Shaw, 2003, 2004).
To return to the seminal work of Samuels, I found his research design provided a best fit for this cross-cultural study. To commence with, Samuels’ work in 1985 aimed to explore and contrast reflective and embodied styles of countertransference (Samuels, 1985). The embodied form of countertransference is in alignment with somatic countertransference in that it is an aspect of the inner world of the client that becomes embodied by the therapist. In the introduction I described that somatic countertransference like embodied countertransference is a subset of the broader category and experience of countertransference. Samuels like others has endeavored to give greater definition and colour to our understanding of countertransference. Furthermore, I have chosen the term somatic as I am focusing more so on the physical, visceral aspects of embodied countertransference. The strength of Samuels’ work is its simplicity in design whereby he interviews 32 psychotherapists and determines that 46% of them describe embodied countertransference therefore confirming that there is a definable subset of countertransference that is remarkable because it is experienced like an embodied inner world feeling, thought or image that belongs to the client but experienced in the body of the therapist. As importantly, Samuels is interested in understanding how we can account for embodied countertransference and turns to western philosophical traditions to theorize how this process is enabled. In contrast to Samuel’s study however, this study solicited responses from participants in order to understand how somatic countertransference occurs from the perspective of their Chinese cultural heritage. As such, an in-depth interview process based on a series of open-ended questions exploring whether somatic countertransference is experienced and how would be explained formed the basis of the research design of this research project. From this method of investigation, some unique Chinese ideas informed by their
collective and personal philosophical and medical practices emerged to account for somatic countertransference experienced by the participants.

**My Approach**

My approach that governs the aforementioned qualitative process of in depth interviewing can be described in the following terms.

This study operated from a clinical perspective, as the study of somatic countertransference is a clinical term and experience. The Chinese psychotherapists were interviewed about their clinical work and whether they have observed somatic countertransference in their practice. The study is a cross-cultural study, as I have deliberately interviewed psychotherapists from other countries that are culturally diverse from my own, namely Hong Kong, Singapore and China. As the study progressed two additional Chinese participants from Singapore were also included. As a cross-cultural researcher, I am a white, Caucasian woman born in Australia and therefore I am writing from a Western perspective. As such, I am conducting a cross-cultural study because I am a foreigner looking at a culture that is unfamiliar to me. As a practicing psychotherapist and psychologist working from a post-Jungian perspective in Sydney Australia, I am best acquainted with this style of psychotherapy. To define it further, I am researching from a post-Jungian perspective as I am interested in developmental theories and ideas that have occurred in post Jungian thinking. The work of Andrew Samuels, Jan Weiner, Jean Knox and John Merchant exemplify this departure from classical Jungian depth psychology (Samuels, 1985, Weiner, 2011, Merchant, 2012, Knox, 2003). Moreover, I have
undertaken a study that looks at in depth responses from interviews with clinicians about their experiences of somatic countertransference. It is a qualitative study as it is aimed at exploring experiences and personal, cultural and spiritual understandings of this phenomenon. In summing up, in conducting this study, I have undertaken a discourse analysis and researched from a clinical, cross-cultural and post-Jungian perspective.

The Research Process

In the following section I describe the research process in detail and in doing so outline the practical considerations that underpinned the study. I also illustrate how the project evolved and developed over time.

As previously stated, I am interested in focusing on a cross-cultural perspective from the East. I have chosen to explore Chinese psychotherapeutic practices for a number of reasons. Whilst there has been a long tradition of interest in psychoanalytic thinking in China, an emerging interest in psychoanalytic training has occurred specifically over the past few decades (Kirsner & Snyder, 2009, Varvin & Gerlach, 2011, Hsuan, 2015). This has been promoted and supported with the efforts of Dr. Elise Snyder, a psychoanalyst who developed an organization named The Chinese and American Psychoanalytic Association (CAPA) in 2005, which trains clinicians in psychodynamic psychotherapy via Skype technology. The organization largely operates on the benevolence of a number of American and other Western psychoanalysts and psychotherapists who have volunteered their time to analyze, supervise and teach Chinese candidates. In parallel, an increasing interest has
occurred in Jungian analytical psychology under the direction of Professor Heyong Shen of South China Normal University in Guangzhou, China. Professor Shen is a member of the IAAP\(^5\), has had a long association and interaction with the IAAP and actively teaches Jungian analytical psychology in a post-graduate degree at South China University. In Hong Kong, a similar group has emerged under the direction of Dr. Shirley Ma and Mabel Lam in an interest group known as HKIAP, the Hong Kong Institute of Analytical Psychology. What these developing groups and training initiatives demonstrate is an active and, hopefully, growing interest in psychotherapy and psychoanalytic thinking. As I have already discussed in the preceding chapter, Eastern perspectives are perceived as directly diverse from Western mind body dualism and it is via a dialogue with Chinese psychotherapists that I have tapped into the underlying thinking and beliefs that inform their clinical practice. This process I believe provided a unique insight into the clinical relevance of somatic countertransference from a Chinese perspective.

In attending the IAAP 5th International Conference of Analytical Psychology, and Chinese Culture, entitled Dreams, the Symbolic Language of the Psyche, Nature and Culture in Macau in June 2012, I met Ms Mable Lam, Psychotherapist and Prof Heyong Shen, Jungian Analyst. I also met young training psychotherapists interested in Jungian ideas and ways of clinical practice. The profession was clearly in a formative stage whereby an integration of classical Jungian ideas and Chinese philosophical traditions and practices was occurring. From informal discussions with conference attendees, it was apparent that their embracing of Jung felt distinctly recent and, consequently, that I would need to carefully consider my selection criteria

\(^5\) IAAP stands for International Association for Analytical Psychology.
to ensure that I would be able to recruit enough participants. In comparison with the work of Shaw and Loughran, I would be restricting my potential to recruit if I set similar selection criteria of professional registration and five or more years of psychotherapy practice experience (Loughran, 2003, Shaw 2003, 2004). Likewise, in their overview of the emergence of psychoanalysis in China Kirsner and Snyder echo similar sentiments by detailing that prior to the CAPA initiative, most psychotherapy was conducted by counsellors who had attended short training courses and that there appeared to be diversity in range of training experiences (Kirsner & Snyder, 2009).

Hsuan, a medical anthropologist records and observes the growing passion for training to be a psychotherapist in China in the past decade (Hsuan, 2015). He theorises that there is a fervent uptake of training courses that speaks of an entrepreneurial zeal rather than a growing interest in Western psychotherapeutic practices for psychological healing. Nonetheless, as it appears Jungian and psychoanalytic thinking is in its formative years in China and Hong Kong, I realised that this could provide an unforeseen advantage in that I would be able to interview participants new to psychotherapy practice and therefore less likely to have lost their inherent cultural and spiritual perspectives that may inform their practice. Another interesting consideration that arose from these informal discussions with conference attendees was the subject of therapist burnout. Chinese psychotherapists freely spoke of their concern about feeling fatigued and worn-out by their large caseloads and demanding clients. On closer inspection however, often the amount of clients seen by practitioners were likely to be five clients a week rather than up to 40 clients a week which is indicative of a large counselling practice. As such, this factor spoke directly to the possibility that unprocessed somatic countertransferenceal material had created
these detrimental affects, which the literature review has outlined as an area of concern.

Prior to conducting the research I established my selection criteria for participation as follows. I determined that the relevant characteristics of the participant group were that they have completed training in psychotherapy and currently practicing as psychotherapists, social workers, psychologists, dance movement therapists or psychiatrists. They would be either male or female and aged from 21 through to 80 years of age. In terms of gender, it is expected that there will be more female participants than male participants in the study. This is reflective of the general psychotherapy community, which is populated by more females than males (Shaw, 2003). Therefore this bias was expected and indicative of the profession and unlikely to negatively affect the results. Consistent with ethical guidelines there was no prior relationship between myself and the participants, so they would be able to self nominate from the recruitment processes I developed.

In order to recruit participants, I established contact with both Mable Lam, and Professor Heyong Shen, who both agreed to allow me to invite interested participants through their establishments. To facilitate this process, I presented a short talk outlining the proposed research, information about the clinical relevance of somatic countertransference and frame the research questions at both clinical placements. The purpose of this was twofold. It was a measure of goodwill to further develop the relationship between myself and these two organizations and allow me to address some practical concerns with the roll out of the project. Secondly the presentation could generate some interest amongst the audience to self nominate for participation.
Another organization that I approached was CAPA (Chinese American Psychoanalytic Alliance). After providing this organization with written material of the purposes of my research, in May 2013, I finally received confirmation that they would allow me to recruit from their student group. As such, Dr. Elise Snyder, President CAPA and Dr. Fonya Helm, CAPA Research Committee Chair, both endorsed my study and sent out on my behalf a broadcast email for recruitment purposes. This generated the most amount of interest from all three targeted organizations and resulted in Skype interviews across several months in 2013.

At the time of the presentations and in the plain language statements provided at recruitment, the risks and benefits of participation were outlined. The risks were identified that discussing somatic countertransference may cause personal and professional discomfort and embarrassment (Loughran, 2003). The benefits were articulated as providing the opportunity to discuss and process personal experiences of somatic countertransference which has been found to be enlightening and alleviating of potential discomfort (Forester, 2007). I further outlined that the process would be educational in that the participants could learn about somatic countertransference from the presentation and interview process and would be able to contribute new knowledge from their cultural perspective that would enrich clinical practice. For the greater community, I suggested that this study would provide the first cross-cultural data in the area of somatic countertransference. As such, I expressed optimism that it is likely to show case Chinese psychotherapy practices that are developing and emerging as a result of a recent interest in psychotherapy and psychoanalysis in China and Hong Kong. At the onset of this project I possessed the hope that the research outcomes would increase awareness and knowledge of somatic
countertransference so that this could be integrated in the training and practices of future psychotherapists cross-culturally. Specifically this could enable the body of the therapist to play a more central role in psychotherapy and the consequent increased awareness of the body could mitigate against burn out and illness associated with somatic countertransference.

In terms of managing potential discomfort about discussing somatic countertransference during the interview, I monitored the participant’s responses to the questions to minimize any discomfort. As I work as a psychologist and psychotherapist with knowledge of somatic countertransference, I felt reasonably equipped to manage and address any possible discomfort about this topic. I also provided access to a debriefing process post interview with a third party not directly associated with the study in the event that the interview was experienced as distressing. From exploring the results from the previous studies detailed, I was reasonably confident this third step was unlikely to be taken up given that the self nominated participants were interested in discussing somatic countertransference and trained to manage uncomfortable feelings as a result of their psychotherapeutic backgrounds. Consistent with this, no discomfort was reported nor any debriefing process undertaken by all 29 participants.

The recruitment process was rolled out in February 2013 commencing with the two presentations I gave in Hong Kong and Guangzhou. This was followed up by an advertisement placed on the HKIAP interest group yahoo website page after I joined as a member in February 2013. In addition, CAPA sent out a broadcast email to all students undertaking advanced training in May 2013. In June 2013, prior to my
field trip to Guangzhou and Hong Kong, another broadcast email was sent out amongst graduate and masters students at South China Normal University. Whilst in Hong Kong in June/July 2013, I was also invited to give a short talk on my research at Alliant University in Hong Kong. Furthermore in August 2013, I gave a paper at the 3rd International Asian Pacific Rim Conference of Counselling and Psychotherapy in Kuching, Malaysia, which resulted in the recruitment of two participants and one expert participant. In sum, the results of these recruitment drives yielded 29 Chinese participants with my first interview conducted in March 2013 after the first self-nominated participant contacted me. My last official interview was conducted in January 2014. The final breakdown of participants according to gender, country of origin, region in China, organization and occupation are as follows in tables 1-5.

Table 1

<table>
<thead>
<tr>
<th>Gender</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>20</td>
</tr>
<tr>
<td>Male</td>
<td>9</td>
</tr>
</tbody>
</table>
Table 2

Country

<table>
<thead>
<tr>
<th>Country</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>China</td>
<td>21</td>
</tr>
<tr>
<td>HK</td>
<td>6</td>
</tr>
<tr>
<td>Singapore</td>
<td>2</td>
</tr>
</tbody>
</table>

Table 3

China (Region)

<table>
<thead>
<tr>
<th>Region</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guangzhou</td>
<td>1</td>
</tr>
<tr>
<td>Shanghai</td>
<td>1</td>
</tr>
<tr>
<td>Beijing</td>
<td>3</td>
</tr>
<tr>
<td>Chengdu</td>
<td>2</td>
</tr>
<tr>
<td>Zhongzhou</td>
<td>6</td>
</tr>
<tr>
<td>Shenzhen</td>
<td>6</td>
</tr>
<tr>
<td>Wuhan</td>
<td>2</td>
</tr>
</tbody>
</table>
In rolling out the research, I followed a process of sending a plain language statement, consent and withdrawal of consent\(^6\) and a series of questions\(^7\) that may be explored to each interested participant. All documents were made available in Mandarin if requested and only two participants took this up. On one occasion only, the services of an interpreter was required. After the details of the research were understood, a time for Skype or face-to-face interviews was negotiated for each interested participant. The information package sent to all self-nominating participant further provided details of an independent person to whom the participant could seek debriefing post the interview process required and contact details for making a complaint about the research if deemed necessary. This included complaints about the study, the recruitment process or the debriefing process. This measure was required as a condition of my ethics approval for this research with Deakin University, Australia.

During the interview process, I taped the interview with audio taping equipment so that transcripts were generated and forwarded to the participants for them to sight and correct as a true representation of the interview. In terms of confidentiality, I ensured that all details relating to the participant remained anonymous and disguised as necessary to ensure that the participant was comfortable with the process and the material discussed. Accordingly, each participant was assigned a pseudonym to protect their identity commencing with the letter T and a corresponding number so that data was collected from T1 through to T29. These measures ensured confidentiality pertaining to the transcripts and the final data written up in this thesis.

\(^6\) See Attachment Plain Language statement, Consent and withdrawal of consent (See Appendices)

\(^7\) Series of Questions (See Appendices)
After the completion of the interview process, all participants were able to revoke their involvement if they deemed this necessary at the time of sighting their transcript. I stated in the information package that after this point in time, participation could not be revoked because the data will have all identifiable features removed and therefore I would be unable to determine what each participant has contributed. All transcripts were emailed to participants and a summary of the study results was sent via email if requested by the participant at the time of consent. This was because at the time of data collection completion, I had negotiated with all participants whether they would like to receive the summary of results in publication format.

In terms of the storage of the data, all transcripts were stored in a password encrypted computer file and printed copies stored in a locked filing cabinet at my office. This data was further stored on a computer backup system at Deakin University. This data is expected to be stored for five years after publication of the thesis, which is in accordance with Deakin University policy. Should the principal researcher leave Deakin University during this time, the data would become the responsibility of the Head of the School of Humanities and Social Sciences. According to Deakin University policy, the data can be disposed of 5 years after publication. As such, the hard copies of the transcripts will be shredded and any computer/software copies of the data will be erased at that time.

As previously stated, after the collection of data and assignment of non-identifiable codes to each participant the data was analyzed for thematic content and
integrated into appropriate chapters under specific headings and as anonymous quotes. As such, the data analysis process employed was a discourse analysis whereby verbal content provided by the participants was closely analyzed for recurring themes that were grouped for further exploration under themed headings in the following chapters.

**Cultural Considerations**

In order to conduct research in China and Hong I sought counsel from academics from Hong Kong University. In particular I consulted Dr. John Bacon-Shone, Statistician and Ethics specialist at Hong Kong University on 12th June 2012 regarding conducting research in both Hong Kong and China. It is notable that Dr. Bacon-Shone is an expert in this area as he conducts regular research in both China and Hong Kong and presides on the Ethics committee at Hong Kong University.

According to Dr. John Bacon-Shone, the research conducted in Hong Kong did not require additional regional ethics clearance providing that my research met requirements for ethical standards through Deakin University as the research is based at this Australian institution. By extension, it is expected that this also governs the research collected from Singapore. Regarding research in China, Dr. Bacon-Shone encouraged that I approach a university in China for sponsorship of a non commercial kind so that I am permitted to visit China and conduct research in China. By obtaining sponsorship via this method provides official permission to visit both China and to be able to conduct the research with the university's guidance. Furthermore, a visitor's visa which is supported by a university would enable the research to be conducted
legally. Dr. Bacon-Shone advised that the only issue with conducting research in China was that it must not be considered to be politically sensitive. He expressed the opinion that my research area and topic did not appear to be politically sensitive. He also stated that by being invited by a university ensured that the research project met the university's ethical standards. Dr. Bacon-Shone was of the opinion however that it was highly unlikely that there would be any additional ethical processes for clearance necessary in China from his knowledge and experience of working with Chinese universities. He emphasized that university sponsorship of this kind would be a necessary protective safeguard.

After seeking this advice, Prof Heyong Shen of South China Normal University, Guangzhou, P.R. China provided me with an invitation\(^8\) from South China Normal University, so that I could conduct my research in China and in accordance with their ethical requirements. From my research, I noted that the ethical processes at South China Normal University were not commensurate with Deakin University. This information was established by exploring their current website and was consistent with the opinion provided by Dr. John Bacon-Shone.

In terms of whether the research was deemed legal to conduct in China and Hong Kong, Dr. John Bacon-Shone, confirmed that the research conducted is lawful if conducted in Hong Kong providing that ethics clearance for the project has been provided by Deakin University. In relation to research conducted in China, Dr. Bacon-Shone stated that it was likely to be deemed lawful provided that a non-commercial sponsorship agreement is made between the student researcher and a

\(^8\) Invitation from South China Normal University (See Appendices)
university in China. This sponsorship provided permission to visit China, the university, to conduct the research and also implied that the research abided with any ethical or legal considerations required for conducting research in China at that university.

Regarding whether there would be any perceived cultural considerations while undertaking this research, I determined the following. Whilst the literature suggested that native Chinese people might be reluctant to disclose personal information, this factor was mitigated by the fact that the participants were psychotherapists who had been trained to speak about personal and sensitive material (Sun, 2013). This sentiment was echoed by Professor Geoffrey Blowers, Professor of Psychology and Associate Dean, Department of Psychology, Faculty of Social Sciences, Hong Kong University, whom I consulted with in June 2012. As such, the Chinese participants were expected to employ appropriate boundaries and confidentiality when discussing their clinical practice. In spite of this, due respect was given to ensure that the participants were able to answer in a manner that was commensurate with their style and cultural values.

Post Script- Further Research undertaken

In order to ensure that a thorough data collection was conducted I followed up most participants with an email to inquire whether they would be agreeable to a secondary interview or email ‘follow up’ about 3-6 months post the initial interview. Some participants were not approached because during the initial interview they confirmed they had no further information to add. Other participants however, expressed an
interest in adding to their data when their therapeutic work with particular clients had
advanced further. As such, emails were sent to 22 Chinese participants for a follow up
in either interview or email format. This was negotiated on an individual basis with
the information provided that it was not compulsory, rather that this process enabled
further data to be collected post initial interview reflection. Of the 22 that were
approached, 11 provided follow up data. Of these responses, 10 were provided in
email format and one via Skype interview. On occasion, the initial interview was
experienced to be like supervision with a number of participants expressing that they
wanted to understand their somatic experiences in the context of a particular case.
They were encouraged to take this up further with their respective supervisors.

After a preliminary analysis of the data collected from 29 Chinese
psychotherapists from China, Hong Kong and Singapore, I decided to seek further
interviews for expert opinion in Chinese cultural practices such as Qi Gong and
Chinese Traditional medicine as the participants collectively expressed a lack of
knowledge in this area. This specific requirement of established practitioners I felt
would enable me to explore some of the areas emerging form the collected data
regarding how to explain how somatic countertransference occurs and how to work
with it effectively. As such I sought a Qi Master and Qi Gong and TCM practitioner.
Specifically I interviewed Master Chunyi Lin from Spring Forrest QiGong in
Minniesotta and Mr. John Dolic, a TCM and Qi Gong Practitioner in Sydney,
Australia. Mr. Dolic is notable for being the first Westerner to study Chinese
Medicine in Beijing at the University of Chinese Medicine. Furthermore I met
Professor Yasuhiro Oyama, an Associate Professor of Clinical Psychology at Kyoto
University who also agreed to be interviewed to give his insight into working with the
therapist’s body from a Japanese perspective. Professor Oyama attended my presentation in Malaysia and accordingly revealed a strong interest in guiding his Clinical Psychology students to observe their bodies during psychotherapy practice. On the suggestion of Professor Oyama, other Japanese psychotherapists were approached for interview however these invitations were not taken up at the time writing up the research.

In addition, I acknowledged that in order to enrich my literature research, it would be necessary to interview Jungian analysts and psychoanalysts that are known to work with the body in clinical practice. Accordingly I approached Dr. Susie Orbach, psychoanalyst, Ms. Kristina Schellinski, Jungian Analyst and Dr. Angela Connolly, Jungian Analyst and IAAP Vice President. My rationale for selecting these people came about organically either through meeting them directly or reading their material as a part of my literature review. Dr. Susie Orbach, has written extensively on the body, namely the contemporary anxiety of the body encapsulated in current disturbing trends for dieting and plastic surgery. Her work on occasion has also focused on the role of the therapist’s body with a specific interest in staying with the body rather than applying analytic techniques to understanding bodily communications. Ms. Kristina Schellinski, has been interested in and has researched somatic countertransference for 15 years and it was by chance that I was able to speak and exchange ideas with her about this mutual area of interest. Dr. Angela Connolly, whilst I had met her at conferences in St Petersburg and Macau, wrote about somatic countertransference in late 2013 and I experienced her insights to be profound. Importantly, as I am writing from a post-Jungian perspective I felt that it was essential to integrate ideas from Jungian Analysts at the forefront of current clinical practice.
Finally I interviewed Dr. Stuart Twemlow, a psychiatrist and psychoanalyst at the Menninger Clinic in Houston, Texas. His contribution was that he has practiced psychoanalysis and martial arts for many years and therefore was able to step between two cultures and provide insight into whether somatic countertransference could be applied and understood in Chinese psychotherapeutic practice. In addition his practice of Martial Arts at a high level has had an impact on his psychoanalytic practice namely when working with at risk teenagers. It is these ideas and interests from these selected individuals that assisted in determining a Chinese perspective on the bodily experiences of the therapist and their meaning for the therapeutic relationship and therapeutic outcome.

All nominated experts agreed to an interview in a similar format to the Chinese participants, with the exception of Dr. Connolly who asked to write her responses in an email. The process of interview and transcription followed exactly the same process provided for the Chinese participants with the exception that they all agreed to be quoted and therefore their identity was not kept confidential. As such, after conducting a preliminary analysis of the data from the Chinese participants, further data was deemed necessary. This process also required additional Ethics clearance, which was accepted in late 2013, prior to commencing these specialist interviews.

The Chinese Participants

In this section I will describe the Chinese participants who were involved in the research project. This will include a description of the somatic countertransference
they experienced, the prevalence of these experiences if they indicated this to me during the interview and finally a comment about whether they processed this information in supervision or not. These findings are necessary to explore in the context of previous research reviewed that have indicated prevalence rates and the importance of processing somatic countertransference for the health and wellbeing of psychotherapists in supervision (Egan & Carr, 2008, Booth, Trimble & Egan, 2010, Athanasiadou & Halewood, 2011, Forester, 2007).

The data from 29 Chinese participants in this research project was gleaned from 21 residents of Mainland China, six residents from Hong Kong and two residents from Singapore (See Table 2). Table 3 details the regions in China, the Chinese mainland participants came from. Of this sample, two indicated they were psychiatrists, one a clinical psychologist, one a intern psychotherapist, 16 indicated that they were psychotherapists and the remaining nine participants confirmed they were counselors (See Table 5). In terms of gender, 20 participants were female and nine were male participants (See Table 1). According to Shaw, this gender split with a bias towards female participants is indicative of the psychotherapy field as a whole (Shaw, 2003). The age of the Chinese participants ranged from 24 to 60’s as anticipated in the design of the research. The issue of the title of counselor was explained by T11 as a recent law was passed in China in 2013 that stated that the title of counselor can only be used by people who have trained in counseling and currently providing a counseling service distinct from psychiatry and psychology. As such, T11 indicated that it was prohibited to call oneself a psychotherapist in China however amongst the CAPA trainees and graduates it was widely acknowledged as a distinct and more favorable term to employ as it delineated counseling and psychotherapy.
clearly. It also implies that psychotherapy addresses more complex behavioural problems and undertakes working with unconscious processes whereby counseling provides short-term solution focused interventions. This theme was only occasionally addressed when participants spoke of the difficult process of setting up a psychotherapy practice in China, an environment where ideas about mental health can be ill informed and antiquated. Table 5 details the professions of all the participants.

The length of clinical experience spanned from one to 20 years of psychotherapy practice, however all participants had completed post graduate training in psychotherapy through either CAPA, South China Normal University or specialist training for psychiatry or clinical psychology in Europe or United States. Nearly all participants indicated their clinical load per week in terms of number of sessions, which ranged from one session to 25 sessions per week. The amount of sessions per week was divided into three groups that being, 1-5 sessions per week, 5-10 sessions and greater than 10 sessions per. Of this grouping, only five participants indicated they held more than ten sessions per week with the remaining twenty-three split equally between up to five sessions and between five to 10 sessions. Only, one participant did not provide this information. In terms of clinical orientation or style, one participant T15, nominated Somatic Experiencing practice as her therapeutic style, T10 stated he was eclectic in his therapeutic approach, the two psychiatrists T1 and T3 confirmed they were training as Jungian analysts, 14 participants were either undertaking or had completed training through CAPA, a psychoanalytic psychotherapy training, seven completed Masters psychology degree at South China Normal University, a Jungian influenced psychotherapy training program. One participant, T26 was undertaking a doctoral clinical training with an American
University based in Hong Kong, another T28 specified that he was a Buddhist Psychotherapist the result of his practice as a Buddhist and finally one participant; T29 completed a Masters in Counselling with an eclectic approach. As such it would seem that the participants were largely psychoanalytic in their approach to therapy with a few exceptions to this approach duly noted. The client groups seen by the participants encountered a broad arrangement with adults, children, families, groups and individuals widely represented. Furthermore student counseling was a popular occupation choice taken up by twenty participants. When explored closely, a number of these participants suggested that the student counseling service they worked in could also be accessed by other consumers and or they supplemented this work with additional private practice work. Thus a complex yet well represented client range was illustrated. Only occasionally did participants mention diagnoses or types of patients they consulted so this variable was not explored in depth, rather it indicated that the client mix was diverse.

**Somatic Countertransference: what was experienced?**

An impressive and long list of somatic experiences was reported by the 29 Chinese participants. Importantly for this research all participants reported an example of somatic countertransference. The most common forms were sleepiness or drowsiness reported by nine practitioners, followed by headaches experienced by seven participants. In research conducted by Booth, Trimble and Egan, sleepiness was reported as the second most common form of somatic countertransference after muscle tension (Booth, Trimble & Egan, 2010). As such, this is a reasonably consistent finding that implies that sleepiness is likely to be a common somatic
experience felt by therapists cross-culturally. Equally, sore shoulders, exhaustion and heart palpitations were reported by three participants for each somatic sensation. Surprisingly exhaustion was only reported on three occasions, which was inconsistent with the idea that fatigue and burnout could be the result of not attending to somatic countertransference especially when working with traumatized clients (Forester, 2007, Egan and Carr, 2008). It could be argued however that exhaustion was adequately addressed and processed because the participants largely reported that they spoke about such experiences in their supervision. This important finding will be discussed in due course. Two participants reported for each of the following; blocked throat, stomachaches, panic feelings and sleep disturbance. Of the somatic countertransferential material the following array was reported individually by participants; stabbing chest pains, nervousness, breath holding, fast breathing, eyebrow raising, foot stamping, unease, face blushing, erections, tightness of chest, dizzy incident, neck pain, wanting to touch the client, itchiness, cough and throat itch, goose pimples, nausea, muscle pain, back pain, neck pain, tension and depression, wanting to vomit, body tightness, feeling sorrow for the patient, hand shaking, leg pain and the sensation of ants crawling on skin. I acknowledge there could be some doubling up on the experiences here but I have used the words expressed by the participants to be specific and cannot assume that for example ‘dizzy incident’ is the same as ‘panic feelings’. It is important to note that some of their somatic experiences were indeed feeling states such as ‘depression’, ‘feeling sorrow for the patient’ and ‘nervousness’. Some further specific somatic states are noted in the following reported examples; ‘skin numbness on her head’ which when explored aligned with the sensation of feeling shocked. The participant explicitly stated that this term when translated into Chinese is well known to Chinese people as indicating a feeling that
expresses shock or extreme surprise. Some of these examples will be discussed in chapter 5 that explores the mind body continuum experienced by Chinese participants in their clinical practice.

The Prevalence of Somatic Countertransference

First of all, all 29 Chinese psychotherapists provided an example of somatic countertransference from their clinical practice. Prevalence of somatic countertransference was explored in this study with prevalence defined as how often they experienced somatic countertransference as a part of their clinical practice overall. In terms of prevalence, an array of frequency occurred. Of the 29 participants interviewed, 19 were able to nominate a rate of prevalence while the remaining ten psychotherapists either were unable to nominate a rate of frequency or did not provide this information. Whilst I have previously stated that the prevalence rate appeared to be in a range from 10-50% according to preliminary findings, a closer inspection of the data demonstrates greater variation (Margarian, 2014). As such, 8 participants indicated that they experienced somatic countertransference either at 10% or less than 10% of the time of their clinical practice. Of these 8 participants, 3 participants nominated that they experienced these states 10% of their clinical time. In addition, three participants reported they experienced somatic countertransference 20% of their clinical time. Another participant, T24 stated that she experienced somatic states 20 to 40% of her clinical time. Similarly, T14 reported experiencing somatic states 20-30% of her clinical time. In the case of T15 who reported having somatic countertransference 50% of her clinical time, it is noteworthy that her psychotherapy style is Somatic Experiencing, which focuses on the body states of both the therapist
and client in a deliberate style driven manner. As such, this high rate of prevalence is indicative of her therapeutic style. Also, T18 stated that she experienced it 70-80% of her clinical time and finally T17 reported that it occurred 100% of his clinical time and provided his opinion that countertransference occurred all the time and it was pointless to divide feeling and physical states, as they are one and the same. In addition, T4 reported a weekly occurrence of somatic countertransference while T7 stated only having had six experiences in total which was consistent with her recent commencement as a therapist while T26, an intern psychotherapist only realized that such experiences could be therapeutically relevant after reading my recruitment email introducing the topic. She states the following:

To be fair, I started noticing it 3-4 months ago and I am aware that I feel more, I feel when the client is distressed, about to cry, really anxious, other than that, in session, it really depends on what the client is doing. I am starting to carry those sessions home, headaches, the jerking movements that come out in my nap. T26

Indeed a few participants noted the relevance of somatic experiences for psychotherapy after reading my introduction to my research.

Some specific and interesting comments were made about the prevalence of somatic experiences. For example, T1 stated that such experiences happened with ‘provocative and challenging’ clients and similarly T3 said that such experiences tended to happen when there were an indication of intense emotions around grief and loss. T2 suggested that somatic experiences in the therapist occurred at the beginning of treatment before an alliance and closeness was established in the therapeutic
relationship. Conversely T14 reported that somatic countertransference does not happen much at the commencement of treatment, she states the following:

*In my experience, it usually does not happen in the beginning of therapy. Because in the beginning, I guess most of the time, most of the patients and the therapist will contribute more, their attention, their energy more into this relationship at the beginning. Gradually, it need to cost some time to build a real working relationship, a working alliance, then the resistance comes up from the patient side. So feeling sleepy might occur in this stage. The other example of feeling hurt and tired in my shoulders and arms it occurred much, much later in the relationship. I cannot be sure of in which part of the relationship it will occur, it depends on the case. T14*

This statement demonstrates a different experience of when somatic countertransference occurs in the therapeutic treatment and suggests that when it occurs therapeutically is widely varied.

Whilst all participants for this study reported experiencing somatic countertransference and provided rich clinical examples, of the 2/3rds of the clinical sample who were able to nominate a rate of prevalence, half of the sample stated that they experienced it either 10% or less of their clinical time whilst the other half reported experiencing it in a range of 20-100% of their clinical time with patients or after the session during processing time. Previous research undertaken has not explored an overall rate of prevalence of somatic countertransference in clinical practice. Rather prevalence rates were investigated via a quantitative scale, the Body Centered Countertransference Scale (BCCS) in which therapists were asked to
estimate how frequently they experienced various forms of somatic countertransference such as muscle tension, sleepiness and headaches to name a few from an extensive list, over the past six months of their clinical practice. For example according to Egan and Carr’s 2008 study of 32 trauma therapists, they found that 83% of participants reported experiencing muscle tension (the highest prevalence rate determined) over the past six months (Egan & Carr, 2008). In a similar study by Booth, Trimble and Egan in 2010 of 87 Irish Clinical Psychologists, they determined that 79% of their sample had experienced muscle tension over the past six months, a close finding to the previous study (Booth, Trimble & Egan, 2010). Whilst the current study did not quantitatively explore each form of somatic countertransference for prevalence rates, the over all rates determined varied just as widely from 2- 100% when compared with these studies. In Booth, Trimble and Egan, prevalence ranged from 2% for (genital pain) to 79% for muscle tension. As such, whilst arrived at differently, overall prevalence rates versus rates for specific types of somatic countertransference were comparable. Importantly, these studies suggested that most therapists in their samples reported experiencing it. Consistent with this study, Booth, Trimble and Egan found that somatic countertransference occurred irrespective of what treatment modality the therapists practiced (Booth, Trimble & Egan, 2010). This further added weight to the idea that somatic countertransference may occur in all psychotherapists according to the work of Pearlman and Saakvitne (cited in Booth, Trimble & Egan, 2010). As noted in this study, whilst the majority of participants were largely psychoanalytic in their therapy style, there were notable exceptions therefore supporting the finding that somatic countertransference can occur in therapists that practice other therapeutic modalities (Booth, Trimble & Egan, 2010).
The question of whether somatic countertransference was discussed and processed in supervision was deemed a necessary line of investigation, as proposed by Loughran and others (Loughran, 2003, Forester, 2007, Egan and Carr, 2008). They claimed that being able to share and discuss this material assisted in processing it and facilitating greater body awareness amongst psychotherapists. Specifically Egan and Carr in 2008 determined a correlation between the presence of somatic countertransference and amount of sick days taken, therefore suggesting the importance of supervision for processing this material in order to prevent therapist burnout. Alarmingly, Loughran discussed the idea that it was embarrassing for some psychotherapists to disclose such material with colleagues and therefore it was unlikely to be brought to supervision (Loughran, 2003). Inconsistent with this idea, the Chinese participants provided a surprising finding, that being that they freely discussed such material with colleagues and supervisors.

From the data, 23 Chinese participants reported that they shared their somatic experiences either in formal supervision or with colleagues. A number of participants implied that it was a regular and well-received occurrence such as with psychotherapists T2, T3 and T6. In the case of T17, the psychotherapist who claimed to experience somatic countertransference 100%, stated, ‘*my body is my supervisor*’, implying the strong relevance and importance of the body for processing therapeutic material. Only on two occasions, T1 and T26 were adamant that it was not possible to speak of such experiences for fear that it would be perceived as too strange and embarrassing. Similarly, T16 recalled a colleague revealing a headache whilst
working with the client and that their group supervisor expressed that it was her
colleague’s material not relevant to the clinical work discussed. In the case of T5, she
had not realized how relevant somatic countertransference could be for clinical work
and with T8, there was a sense that it was explored in her supervision with little
therapeutic gain or insight. Like T5, T13 reported still developing her understanding
of somatic material and its relevance for clinical work. On two occasions, T28 and
T29 did not reveal whether they discussed this material in supervision or not.

In terms of whether somatic countertransference is discussed by Chinese
psychotherapists in their supervision, a clear finding emerged that strongly suggested
that somatic countertransference is discussed and explored in supervision and
amongst colleagues. What this implies is a level of openness about this component of
psychotherapeutic work and a level of sophisticated thinking observed by Wanlass
during her time in China (Scharff, Sehon, Wei & Wanlass, 2011). This is
understandable in that 27 of the 29 participants were recruited via snowball email that
targeted institutions and interest groups that were psycho dynamically orientated. This
further explained an appreciation and acceptance of the general term of
countertransference. In terms of the somatic aspect of the countertransference
explored and targeted, as already alluded to, it was felt that the Chinese
psychotherapists tended to fuse feeling and somatic states thereby readily expressing
that they had these experiences with their clients. This was notable in a confusion of
language whereby body and feeling states were fused for example, ‘a heavy heart’
and more telling when somatic countertransference was experienced as a feelings,
such as anger, fear or sadness. This will be discussed in a later chapter.
Another important finding was that few Chinese participants reported exhaustion connected with their clinical work. This is considered a consistent finding in light of the high uptake of processing this material in supervision discovered. Commensurate with Egan and Carr and Forester, this implies that exhaustion is ameliorated because somatic experiences are freely processed in supervision (Forester, 2008, Egan and Carr, 2008). What this speaks of is an apparent level of comfort when approaching the body, which is consistent with the idea that mind and body are deemed interlinked. I think this idea is captured with an astute comment made by T9:

*Yes, you know this makes me think of something about Chinese culture that I should say. Chinese people are used to feeling their body.* T9

The cross-cultural research conducted followed a process of qualitative research designed after exploring previous studies detailed above. The perceived area for further exploration in the area of somatic countertransference evolved around how do we understand and work with it. Accordingly, a cross-cultural study was conducted to further extend clinical findings and applicability. More specifically in focusing in on Chinese culture new data was collected that by passed the mind/body divide embedded in Cartesian dualism, a philosophy that underpins most analytic thinking and psychotherapeutic practices in the West. In order to explore this, a qualitative study was conducted whereby 29 Chinese psychotherapists were voluntarily recruited to discuss whether they had experienced somatic countertransference or not in their clinical work. Upon establishing this, the second phase of questioning was directed towards eliciting Chinese ways of explaining somatic countertransference in
accordance with their cultural, spiritual and medical practices. In addition responses elicited shed light on how to work effectively with somatic countertransference for greater therapeutic alliance, creativity and also to prevent burnout. The interview approach mimicked psychotherapeutic practice in that it engaged participants in a conversation about somatic countertransference rather than an interrogation as such. A preliminary analysis of data revealed that further information was necessary to look at uniquely Chinese ways of understanding somatic countertransference and as well as how to work with it. In addition, other notable experts were recruited to enrich the literature review therefore informing it from contemporary practice. This further enabled a strong cross-cultural comparison to emerge between Western and Chinese cultures and their approach to clinical practice in the area of the therapist’s body.

Finally the Chinese participants from this research revealed consistently that somatic countertransference is a viable cross-cultural clinical experience. They reported numerous experiences, some more commonly reported than others and with varying degrees of prevalence. These findings were relatively consistent with the research conducted in the West as cited. In relation to whether they discussed this material in supervision, it was strongly demonstrated that somatic countertransference overall was shared with colleagues and supervisors.

In summary, this chapter has outlined the underlying research processes employed with reference to the research questions and hypotheses. In addition the research process was detailed which included an outline of important cultural considerations. Finally a description of the participants was conducted which discussed some preliminary findings regarding somatic countertransference.

I think that every therapist should know about their body, that is a kind of side effect, the bad side. In all the jobs, there are good sides and the bad sides but if they don’t realize their body has been hurting in an unconscious or maybe conscious way. It is a challenge to understand, but by understanding your body at the same time you understand your client. …….. Because our body never lies to me, but the mind can lie about our body. T10

Countertransference has the somatic dimension whether you are aware of it or not, or sensitive enough to it or not. You regard it as trash or regard it as treasure ….. they are the same ontologically but they are two dimensions….. Yes images, associations, the body feelings, they are the same. Yes images, associations, the body feelings, they are the same. Like this cup has many faces. T17

As illustrated in the preceding quotes, for the Chinese psychotherapists interviewed for this study, overwhelmingly somatic countertransference was experienced as an opportunity for therapeutic investigation. The first quote speaks of the importance of attending to body states of the therapist and patient for further information about therapeutic process. It further implies that the body tells the truth that can somehow bypass consciousness. Similarly, T17 suggests that
countertransference is a phenomenon that has many dimensions and therefore there are numerous ways to integrate it into the therapeutic process.

This Chapter will capture these ideas by exploring in depth the research findings reported by the participants. As such, a number of themes about how somatic countertransference was experienced surfaced. Due to the breadth of themes, the material will be divided across this chapter and the following chapter 3. In relation to these emerging themes regarding how the Chinese psychotherapists experienced and worked with somatic countertransference, clinical examples will be grouped and discussed in the following sub groups entitled somatic countertransference holds meaning and/or can be a reenactment, the therapist’s body expresses emotions that cannot be expressed (the body doesn’t lie), when somatic countertransference acts as a defense against emotion, the use of the therapist’s body to move therapeutic process along, somatic countertransference as an indication of intense emotion and the therapist’s body as container and or tool.

In chapter 3, a continuation of these themes will be discussed commencing with somatic countertransference as empathy, how somatic countertransference changes or eases as therapeutic process evolves and finally specific ways of working with somatic countertransference. Whilst these themes became apparent in the data analysis they are noted to be overlapping in some instances and therefore not discreet categories. In addition and when relevant, a comparison with Western clinical ideas, the interviewed experts and Western examples will be undertaken. The task at hand is to understand somatic countertransference from a Chinese clinical perspective.
The identified Themes

**Somatic Countertransference holds Meaning and/or can be a Reenactment**

As we have seen in the literature review, the idea that somatic countertransference can be deeply meaningful for therapeutic process is a strong theme that surfaced from the diverse Western treatment modalities explored (Field, 1989, Sidoli, 2000, Ross, 2000, Green, 2001, Stone, 2006, Bloom, 2006). Furthermore, on occasion, the meaning of the somatic experience was conceived of as a reenactment of an earlier developmental experience or template (Field, 1989, Dosamantes-Beaudry, 1992). In terms of the participants, these same ideas were expressed with clinical examples that demonstrated the complexity and richness of what somatic countertransference can bring to the therapeutic work, namely meaningful material and or dissociative aspects related to earlier trauma. Additionally, the presence of somatic material seemed to suggest a reenactment of an earlier developmental phase (Dosamantes-Beaudry, 1992).

With a case of feeling drowsy with a borderline client, T1 was able to reflect on it and hypothesized it was a pattern, a dissociation, and therapeutically valuable communication about the inner state of her client. This idea of a dissociated aspect of a patient’s inner world played out in the therapist’s body is noted with the work of Petrucci and Forester (Petrucelli, 2007, Forester, 2007). In personal communications with Angela Connolly, Jungian Analyst and IAAP Vice President, she relates that they can be dissociated aspects from the mind that present in the body of the analyst and therefore supports this idea of unknown and split off material (Connolly, email,
Importantly, dissociative and split-off parts are indicative of earlier and primitive states of mind the result of relational trauma. T1 is therefore experiencing sleepiness in a way that is consistent with this idea tabled by Connolly and others (Connolly, email, 11 March, 2014, Petrucelli, 2007, Forester, 2007).

Like T1, T2 asked himself why he was experiencing certain somatic complaints in sessions with his clients, especially headaches and whether they were either positive or negative expressions? As such, both T1 and T2 both ponder and make meaning of their somatic statements in the therapy session. T2 recalls the following as such:

*I remember a new patient, I think the first time, she came to me and she asked a lot of questions about my quality because I look young, actually less than 33 years. How many years you have worked, how many patients, have you been analyzed? The tone of her voice was very much an attack, aggressive, so after this first session, I got a headache. I think I am angry and I really want to attack back is why I got a headache. I think this kind of headache is two ways, a good and bad part. The good part is that it can make me think what happened inside of me, what part of me been fixed or changed, there must be some part of me where there is something wrong. The bad part is that sometimes with the headache I need to withdraw, I cannot focus one hundred percent on this patient. Because of the headache, I cannot concentrate much on this particular patient. I need to take care of myself. I think this the negative part.*

T2
Whilst not specifying that somatic countertransference suggests earlier dissociated material, I think T2 is exploring the idea that there is an inherent meaning in any somatic presenting experience for the therapist in the session and after processing this material different outcomes can occur. This idea is strongly held by many psychotherapists and psychoanalysts noting their bodily experiences in Western clinical practice (Field, 1989, Sidoli, 2000, Ross, 2000, Green, 2001, Stone, 2006, Bloom, 2006, Orbach, 2009). Notably, Field’s discussion of his experience of sleepiness with a client illuminates that drowsiness can actually mean a return to an earlier and desired state of maternal attunement rather than simply being an attack on one’s thinking (Field, 1989, Orbach, 2004). In T2’s example, however, the headache seems to invite an attack on his capacity to think, an almost obliteration of the psychotherapist’s mind so that he was unable to think and be with his client. T2 thoughtfully responds to this dynamic by questioning what meaning this brings to the work with this client.

A number of Chinese participants spoke more specifically of their somatic experiences as a form of reenactment, as if some earlier developmental aspect was played out between them in the therapy session or in a parallel process in supervision. This also links back to Field’s idea of sleepiness with his client suggesting a return to an earlier denied phase of development (Field, 1989). T9 spoke about a difficult client she worked with who was somatically focused and had a history of constantly seeking reassurance from her mother for illnesses in an attempt to gain her attention. T9 realizes as we discuss this case in the interview, that she had started acting out the same pattern with her supervisor by becoming somatically focused in their supervision session and seeking her advice like her client had tried to do with both her as therapist and earlier with her mother. She explains it as such:
Yes, of course. I didn’t talk about this topic with my supervisor from CAPA because I haven’t had the chance to have the feeling to tell them but the interesting thing is that when I talk about what I remember, a new case, a new patient and she is has very serious somatic symptoms there are headaches, neck aches and eye aches and hard to breathe. When I introduced this case to my supervisor, suddenly I felt that I could not breath very well. I can feel her kind of neck and in some moments I could not see my supervisor clearly, this is from the eyes. And I couldn’t think very clearly and so at that moment, I can understand about my case, my patient. She really has these kinds of somatic symptoms. I didn’t know too much about her history in one session so it gave me so strong, how to say......pressure, after the session. This is what I talked about to my supervisor and I told her “yeah I could understand all her somatic symptoms right now”. She said “I agree with you and it maybe very hard to work with this patient.” Yes, it is really hard, not easy maybe because she is not ready to start yet. She just came to tell me all about her suffering ......

Maybe it is her pattern, her wish to come to see me is to be cured at once. In her history, she went to her mother each time when she had a problem, such as school, or with class mates and then she went home and cried out and her mother will help her to ask the teacher to solve the problem, every problem. So when she grew up, her mother didn’t help her any longer. Especially when she was in the senior school and she had to live at school. She had real big problem with the relationships with her dormitory mates, her classmates, but what she could do was study. She studied really well, the super one. So could not solve any problem between people in the relationships but what she could do was tell the mother, “I am not happy today, I
want to cry and so you should help me.” So when she came to see me and tell me the same thing and I need to help her but I don’t know how to help her and then I went to her (my) supervisor. And then I told my supervisor,” I need your help, you should help me.” At the same time, it is a pattern. T9

Parallel process in supervision is a well known and a clinically valid experience. In the work of Orbach, she notes a similar occurrence whereby she senses something in her body when working with a supervisee who is presenting a case. Orbach spoke of feeling disembodied as if she could not locate where she was. She discusses whether this was clinically meaningful, a reenactment in supervision, relevant to her supervisee’s client. She further reports that her supervisee had also felt this same sense of disembodiment and that the body was able to manifest this strange sensation in the supervision that mirrored the therapeutic process (Orbach, 1995). Likewise T9 has engaged in a similar parallel reenactment with her supervisor. This demonstrates that somatic manifestations in the client’s body can be deeply meaningful and that it is essential to observe it in the session and in supervision.

Elsewhere, I discuss two very rich and important somatic countertransference examples that demonstrate the therapeutic meaning that can be extracted from such clinical material (Margarian, 2014). Specifically, T12 spoke in depth of two long-term cases she worked with whom she named ‘Jason’ and ‘WJ’. In the case of WJ she reported the unusual somatic experience of feeling itchy, together with sleepiness. She also noted that she became fixated on watching her clock when they were in session together. As the work evolves, WJ reveals to T12 that he has a condition he names metaphorically ‘athlete’s foot’ in that he forces himself to stay up late so that he can
feel exhausted enough to sleep. He describes this obsessional behavior to her as being like an itch that he cannot stop scratching to the point that it will draw blood. Upon this revelation, T12 puts together the information and realizes that she has been re-enacting the same process in the presence of WJ. She has felt sleepy, itchy and time-focused, all closely paralleling WJ’s late night behaviors. T12 says the following:

Yes, it is different words in Chinese but it is it. He said that it is a metaphor, an analogy but it is inappropriate but then he described that it is like he has that athlete’s foot, really itchy, you have to scratch it until there is blood, until it is bloody and then you see blood and then he feels better. He described that. T12

When T12 and I discuss this example, we are both astonished by the richness and complexity of the somatic experiences felt by T12. They are commensurate with many examples written about in Western clinical literature such as in the work of Dosamantes-Beaudry, Stone and Field that speak of a reenactment (Dosamantes-Beaudry 1992, Stone, 2006, Field, 1989). Furthermore this strange and complex means of expression in the therapist’s body of the inner state of the client brings to mind the idea that embodied countertransference can seem uncanny (Zabriskie, 2006).

Similarly T14’s example of working with a difficult client is equally as compelling. T14 reported experiencing pain in her shoulders and arms and realized that it mimicked holding a difficult baby. She considers that her somatic expression was a close parallel to what it is like and must have been like for her patient’s mother to hold such a fussy and demanding baby. She says the following:
I remember one time, I worked with a female patient and she is somehow very emotionally primitive. She doesn't want to be responsible for herself and she kept blaming and blaming the therapy and she unconsciously to make me take over the responsibility of her unhappiness. To me, it is just like I am an exhausted mother trying to comfort this baby, she just cried and cried. I tried to hold her body into my arm but she doesn’t use her arm or any part of her body, so I feel very, very tired using my body. So my somatic countertransference is my neck and back and my arms, feel very tired in the therapy with her……..

Yes, she is a really difficult baby for a mother. Made the mother feel exhausted. So how I felt in my body was like an exhausted mother felt when she try to hold this baby well. T14

Once again the theme of re-enacting, via the therapist’s body, is illustrated with this example and consistent with the ideas of Dosamantes-Beaudry and Field, that within the inter-subjective field in psychotherapy, earlier states are acted out via the therapist’s body (Dosamantes-Beaudry, 1992, Field, 1989).

The Chinese participants provided other more subtle examples regarding the meaningful content generated by somatic experiences in the therapist’s body. For example T25, a psychotherapist working with dreams and sand play said the following in relation to how her body informs her:

Sometime when I am talking with my client with a very common topic I think for example, what happened this week? I will have some bodily response. For example (you cough to demonstrate a response). Just as if I have got a cold or I feel very cold.
I feel a little bit uncomfortable with the air conditioning, I am sensitive I think in this process and I will think about it a little bit, “what happened to me?” I think all this kind of phenomena that happens in the therapy is related to our relationship, I think, to the client. So I think it is meaningful. T25

T25 in particular senses when her body changes in relation to the dream and sand play work undertaken by her clients. This brings to mind the work of Petrucelli, Orbach and Carroll who all encourage the therapist to become acutely aware of when there are bodily shakeups or mishaps with the therapist’s body in the session (Petrucelli, 2007, Orbach, 2000, Carroll, 2006). Other similar examples included T16 feeling physically tense and frightened in the presence of a new client. This led her to cease their work together as she experienced this somatic countertransference as a warning of not to work with this client. T19, a school counselor reported that when her legs feel nervous in the presence of her student clients, it was likely to be an indication of their inability to move literally and symbolically in life. She has chosen to pay close attention to this physical clue and marry it in the psychotherapy work she undertakes with her many student clients. As such, she claimed that it was a useful and reliable symbolic communication about the inner state of her clients.

In the case of T20, her experience of feeling blocked in her chest led her to conclude about the unacknowledged emotional state of one of her clients and sadly interfered with her work with other clients. She says the following:

I told you I have three patients and they are all arranged in one morning, from 9 o’clock to 12 o’clock. So when I see the second patient, then from 11 o’clock the third
patient, so when I see the second patient I felt blocked here in my chest and it is a
very strong feeling. It stayed with me until I saw the third patient. And I can strongly
feel it and sense it and I know in myself that I didn’t focus on the third patient that I
am still in the mood of the second one. I can’t sense that during the third one, I am
still together with the second one and I have not got myself out of it. So I think that it
is a very strong countertransference myself, so I want to be supervised by (you
mentioned a name here of your supervisor), she is also a Jungian analyst. …….
During the session I wasn’t aware but I can feel something from this patient, she was
dervalued by her uncle. Her uncle was her father’s brother and it made me, I had a
somatic experience because I had the same devalued experience, so I had a very
strong somatic experience. Yes and during the session I told her that I felt blocked in
my chest, it was not very comfortable. T20

Later in a follow up T20 says the following:

I found that my somatic countertransference may indicate that I am having the same
feeling with the client, or my somatic contents might be the proper response to what
the client should have or should pay attention to it. Usually, when I tell them my
feelings, they will be more relax, as if they were understood or having me to bear the
negative emotions with them together. It’s very meaningful in the therapeutic work. It
helps me understanding my clients, and making the process forward. T20

T20 has found this somatic experience very meaningful both for the patient and
herself. It speaks of pre symbolic possibilities mentioned by Field, Dosamantes-
Beaudry and Bloom and also hints at the idea of the shared wound, whereby our
client’s material resonates with our own material. This is enabled by a shared zone of unconsciousness that allows for somatic experiences in the therapist’s body (Field, 1989, Dosamantes-Beaudry, 1992, Bloom, 2006). This idea of the shared wound has been written about by Sedgwick, Ross, Clark and Merchant and others, and it will be taken up in greater detail in chapter 4 (Sedgwick, 1994, Ross, 2000, Clark, 2010, Merchant, 2012). Similarly, T20 also notes that in sharing her experience there is some curative effect on the work, which was duly noted by Connolly in our interview. Connolly encouraged that when somatic countertransference occurs, it is essential to stay with the relational focus, as it is this aspect that provides the cure. Connolly inferred that analytic practice is less about interpreting and more about restoring the capacity to think and dream enabled by reverie in analytic process (Connolly, email, 11 March, 2014). This furthermore affirms the role of right brain affective processing established by Schore as necessary to engage for therapeutic process and change (Schore, 2012, 2014).

On a final note about making meaning from somatic countertransference for the therapeutic work and the theme of reenactment, T23 spoke about the meanings that each body part holds. This was also spoken about by T25, as being in accordance with Traditional Chinese Medicine where body parts are aligned with emotions and meaning. To have a part of a body activated in some way in psychotherapy would be worth considering for further collective and medical meaning. This idea will be taken up in greater detail in chapter 5 that details what Chinese culture and philosophies can teach us about somatic countertransference. Put simply, T23 says:
I think that every part of our body has its own meaning, symbolic meaning. Yes, so maybe when I get cold and I will ask myself, there some conflict in it?.... every part of the body maybe has its own feeling and its own meaning, so in some time, the throat hurt or the stomach was uncomfortable, maybe there are something we can’t eat, can’t digest, something we don’t want to accept in our psychology, we should understand our body. I think each part of the body has its own symbolic meaning.....So when you work with a client, if you feel some part is hurtful, we should listen this part and understand what it try to say. T23

As noted, a number of Chinese participants provided great clinical examples of how meaningful somatic countertransference could be when unpacked and processed either with the client, during supervision and or at a later time when appropriate with the client. Furthermore, a tendency towards reenactment was explored in terms of the therapeutic dyad and in another example via the parallel process of supervision. What is further apparent from these examples is that somatic manifestations can be meaningful in a number of different and unique ways ranging from reflecting earlier relational dynamics to specific symbolic possibilities captured in images and body parts.
The Therapist’s Body expresses Emotions that cannot be expressed (the Body does not lie).

The notion that the ‘body does not lie’ attributed to the seminal work of Joyce McDougall and taken up by other psychotherapists can also be added to the list of the how the therapist’s body can be harnessed in psychotherapy (McDougall, 1995). In short, the therapist’s body in some instances expresses underlying unconscious material whilst bypassing conscious processing. Many clinicians and theorists have written about this aspect of somatic countertransference and this was further expressed by a number of the Chinese participants in this study (Greene, 2001, Ross, 2000).

In discussion with T2, he explores how he has headaches and stomach aches in the presence of a client and believes that his body has picked up on something unarticulated by his client and at that time unknown to himself. He says the following about it:

Ok let me say it this way. Why does this particular thing happen, so in my particular case, the headache happens, because maybe I don’t want the conflict, I don’t want the attack or maybe unconsciously I want to attack something, I want the conflict very much. Once this kind of thing happens, so actually I want to avoid it consciously but my unconscious is eager so this kind of thing can happen. So my body knows. So for example, one day I may know myself much, much better than now, I do not need to use my body to tell me that, I don’t think. T2
T2 expresses the idea that the headache he developed during a session forces him to think more deeply about what is happening in the therapeutic relationship. On the one hand it urges him to take care and on the other to explore what is happening inside of him and whether it is relevant for his client. Furthermore, he suggests that it is revealing some unacknowledged truth. Whilst he is engaged in questioning what the headache means, T2 evidently believes that the body knows something that his conscious mind does not. Interestingly he adds that in time with further clinical development and skill he imagines that he may not require his body to act in such a deliberate way thereby suggesting that the body is a conduit for primitive unconscious communication. This idea is in agreement with some of the experts I interviewed, in particular Professor Yasuhiro Oyama of Kyoto University. He indicated that his experience of what he terms ‘salient somatic countertransference’ is less apparent with more clinical experience. He defines salient somatic countertransference as being a striking form of bodily sensation for the therapist such as headaches, aches and pains whereas ‘subtle somatic countertransference’ is akin to the continual bodily experiences that occur in the psychotherapy session and noted by constant monitoring. He says the following about it:

*In my early stage of psychotherapy practice, I often realized and suffered by salient somatic countertransferences, but now I always pay attention to subtle process of body feeling. So in this situation, salient attack or salient somatic countertransference is decreasing.* (Oyama, Interview, 5 December, 2013)

This implies with further clinical development, less somatic countertransference is needed as a form of communication for the therapist while ongoing monitoring of the therapist’s body is encouraged.
On this theme that the body of the therapist may be expressing something from the therapeutic encounter that is unknown to the patient, T11 curiously suggests that the body communicates potentially difficult and abhorrent material. She explains her ideas about bodily expressions as such:

*I don’t know whether it is Western or whether it is Chinese, of course there will be emotions, raw feelings, body reactions, especially when you are really nervous, anxious or frightened. Yes worried, yes I think the body reaction is a reaction of your emotions so you cannot tell, you have not realized what your feeling is at the moment, so since it is from your body reaction, it seems more obvious, you can think about it and reflect on that and you can understand your feeling at the moment better. Another thing is that I think that body reactions also help you, I mean that it is also kind of, you can take these things, maybe it some negative one or some positive. Negative parts if you don’t realize and you just use it to fight against your feelings and positive anyhow there is a kind of release. So I think that the important thing is whether you can realize it. .......... Anyhow, maybe sometimes your body reaction is safer, I mean compared with expressing a negative feeling or realizing it. Maybe they think they have a body reaction, “I have headache” that is better than saying “I want to have sex with my Dad”. T11*

T11 in this instance is positioning somatic material in either therapist or patient as holding the potential to conceal and or express threatening material. She demonstrates this with the example that a headache is the physical means to conceal
an Oedipal desire. As such she is giving the body a special ability. The previously explored example with T12 and her case of WJ with whom her experiences of clock watching and itchiness, were a continuation of this idea. T12 suggests that her somatic material in the session when processed led to the revelation of feelings and experiences relevant to the client. Likewise, feelings that cannot be expressed directly and which are potentially dangerous such as the Oedipal wish as noted by T11 are captured in such a way. In essence, T20 articulates this clearly in the following:

Yes and I am forming one idea in my mind and that is that the body does not lie. But our language, it does lie. And maybe when I am with a patient and I feel sleepy and bored, and of course I will not tell my patient that, so the language it does tell lies, but not the body. Except for the professional criminals! So our reactions from our body are more primordial. T20

This sentiment is echoed by T10:

Because our body never lies to me, but the mind can lie about our body. T10

Collectively these statements imply that the body communicates material that is split off and unknown by our consciousness. Furthermore these statements imply a split between mind and body, and that somehow the body is incapable of lying whereby the mind can lie. This is inconsistent with the notion of implied wholeness or unification of mind and body inherent in Chinese approaches to healing and spirituality. Likewise this same idea that the body can hold emotional states untainted by consciousness is expressed by T23:
And I think there are some situations when the body knows. The body has memory in the session, the patient remembers something and just his body knows but his conscious does not know. T23

This expresses the idea that the body holds material that predates rational thought and consciousness and therefore feelings are expressed in bodies in either patient or therapist. This further implies an extension of therapeutic tools that can deepen therapeutic experience.

As explored in the introduction numerous psychoanalytic psychotherapists from diverse modalities such as Jungian and Dance Therapy adhere to the idea that the body can express preverbal material (McDougall, 1989, Dosamantes-Beaudry, 1992, Field, 1989, Ross, 2000, Bloom, 2006). In interviewing Dr. Stuart Twemlow and Connolly and in the work of Weiner, there is a consensus that this material is not just preverbal, pre symbolic but potentially split off and unknown (Connolly, email, 11 March, 2014, Weiner, 2012, Twemlow, interview, 7 December, 2013). It is therefore possible to conclude that when it presents in its unusual and uncanny way in the body of the therapist, it is making something previously unknown, known. Whilst a split is inferred, the relationship between mind and body is a complex one that is clearly demonstrated in the themes that have evolved from the data analysis thus far. Noted by the Chinese participants and consistent with Western thinking, split off, dissociated unconsciousness material can be taken in and expressed by the body of the therapist. For the Chinese participants this was seen as the body having the capacity to express truth. Although demonstrated in this section, as we will come to see, this is
only one aspect of the many ways somatic countertransference can be understood and assist with clinical insight.

When Somatic Countertransference acts as a Defense against Emotion

As an indication of this complexity regarding the mind-body relationship, conversely there were examples provided by the Chinese participants that suggested that their somatic countertransference acted as a defense against the expression of real emotion. This idea is typically noted with the somatic experience of sleepiness in the therapist. Classically, this is conceived as being a defense or an attack on the therapist’s capacity to think thus preventing a thorough processing of the client’s material (Orbach, 2004). I agree that in some cases this is a correct assessment of the role of somatic countertransference particularly relevant to sleepiness, but I also note that it is only one aspect of what function somatic countertransference is performing at any time. Field cleverly illustrated this with his example of sleepiness as a somatic countertransference experience, which he expressed, was a demand from the client to be soothed (Field, 1989). Important for this thesis, somatic countertransference presents as having many dimensions and functions therefore promoting a broader understanding of what it is and how to work with it.

Paralleling the idea that sleepiness felt in the therapist is a defensive maneuver to prevent therapeutic exploration, T8 considers her drowsiness as a means to keep her and the client away from her client’s anger at the death of her father. Likewise T9 in a follow up noticed that she experiences headaches at times and has observed that
this can occur when a patient is intellectualizing. An excellent confirmation of this idea as somatic countertransference occurring defensively is demonstrated with T12’s case of Jason and how she fell asleep during their phone session. She considered that both of them were avoidant and afraid of their surfacing feelings. Furthermore she articulated that Jason might have been frightened that she would abandon him and likewise she was frightened he would abandon her. T12 reports her experience of Jason as such.

Like with Jason, the old patient, once I felt sleepy. When I went back to my home village for a home trip and I knew that it was difficult for Jason when I took a trip and rescheduled. I know it is difficult but I didn’t know how to work on that, I just felt afraid of his feelings. I know he would, he left earlier than I did, he cancelled sessions. I was very much afraid but I told myself to……..I took a plane and then I told myself to take a nap before the session to make sure that I would not be too tired. So I took a nap but when it was time for the session, I feel asleep. I told myself “don’t fall asleep.” But at the end of the session I woke up right at the end of the session……

I think we were both avoiding the feelings, he is afraid also and I am afraid too. Jason, when he has negative feelings towards me, he tries to hold, to repress these feelings, to be not aware of those feelings. Also at that time, I was afraid too. I didn’t know how to work on that. But he was the only patient I had and you know, in the training, you must have a patient, otherwise the training I couldn’t do. You must have a patient, so I am so afraid that he will abandon me. So he is avoiding and I am avoiding too. Also I think, he is very distant, he dissociates, I think me too. Maybe me falling asleep was the most safe way. We were talking, but we were not. T12
This is an excellent example of how sleepiness in the therapist can be a real indication of painful feelings that are killed off or attacked in the therapeutic alliance so that they are avoided and ultimately not explored. As noted previously, this classic position on sleepiness in the countertransference is noted yet challenged by both Orbach and Field (Orbach, 2004, Field, 1989).

As the previous research has shown, sleepiness is a commonly reported form of somatic countertransference (Booth, Trimble and Egan, 2010). In the words of T14, the following summation of sleepiness as a defense is said:

*The most frequent situation I will face about somatic countertransference is the feeling that I am just so sleepy. I just cannot help shutting my eyes during the therapy. I found that it occurred very often in the therapy and with different kinds of patients and most of the time this situation occurs because there is some block, unconsciously, my patient have or my patient put it between us. Maybe she doesn’t want me to feel something, maybe she doesn’t want herself to be seen or to be noticed or some of her unconscious or negative feelings, she don’t want to face. So this kind of very interesting process, she made me feel so sleepy and then I would not have any ability to explore further. And sometimes I will discuss this interesting phenomenon with my patients. Some of the patients will have some reaction to this. They will feel, most of the time after I talk with the patient about this kind of phenomenon, they will be interested and it will help them to talk further about themselves and sometimes suddenly my sleepy feeling will go. T14*
T14 is touching upon how revealing the somatic experience of sleepiness can be and that on occasion she will discuss it openly with her client. In her experience, if she noticed sleepiness in the session, she felt that it could provide an avenue for therapeutic exploration. As expressed in this section, somatic countertransference can be seen as a defensive maneuver and yet this is specific to the evolving therapeutic relationship at that point in time. This implies that somatic countertransference is highly variable, unique and particular to the relationship developing in the therapeutic process. T14 relates that she has revealed her sleepiness to her patient and that this can bring about further discussion and a release of the physical sensation in her body. This leads us to explore how the therapist’s body can be used for therapeutic change.

The use of the Therapist’s Body to move the Therapeutic Process along

As noted in the case of sleepiness in the therapist, T14 reports that by naming her experience to her patients in some cases enables an opening up of the therapeutic process. Likewise some Chinese participants reported that their bodies further facilitated the therapy in other ways. In an almost deliberate sense, T2 and T4 spoke about the benefit of remaining calm for the client, as if their physical/psychological state had an infectious and affecting quality to it. Another example mentioned by T8, suggests that her body can play a more decisive role and she recounts the following:

I remember another case example, that client’s little sister one year younger than her. So what happened she lost breast milk in five months. She doesn’t remember that of course because it was just five months. One time, when we talked about this topic, even she kept saying, “I don’t remember anything about how I was abandoned as a
infant. As she is talking about that, I suddenly feel my heart is pained, very bad. So I told her it is like “something is holding my heart”. Then even though she is smiling and saying something, after I say that to her. She start weeping, her tears are coming out and she is still smiling and said “I don’t know what is going on, I don’t know why these tears are coming out, but I don’t know remember anything”. After she say that, my pain disappeared. T8

Something transformative happens in this session as T8 and her patient explore an earlier, foundational time in the patient’s history. As understood from the data, when T8 names her physical experience to her patient, the patient bursts into tears with little understanding as to why she is crying, in parallel to the pain in T8 ceases. This calls to mind a similar example written about by Martin Stone, a Jungian Analyst who experienced chest pains whilst in a session with a patient he calls M and upon reporting it to his patient, the patient burst into tears and simultaneously Stone’s chest pains disappeared (Stone, 2006). These extraordinary examples demonstrate the potential for an unconscious-to-unconscious process in the room between two people and the role of the therapist in naming what is happening. Jung expressed that this was in the zone of mutual unconscious-to-unconscious communication whereby material from each person could affect the other (Jung, 1954). It also illustrates how relationally the bodies of two people work together in a therapeutic alliance, which is spoken about extensively in the work of Orbach (Orbach, 2004, 2009). In her own words, Orbach says the following:

By providing a relationship which can receive a sense of a hated, disintegrated or voided bodies, we begin the processes that will not only address their pain
but will deconstruct the defenses that have developed to manage the chaotic, disorganized or insecure body that constitutes the body subjectivity of the patient. In deconstructing those defenses we are enabling the patient to face the pain and fright that feeling rudderless within one’s body provokes. (Orbach, 2004, p 148)

This statement makes an important point about working relationally and the role of the therapist’s body, which is demonstrated in the numerous statements made by the Chinese participants. It further implies that the role of the therapist is to name what is happening in the moment and therefore assist in a breaking down of defenses. This was particularly evident with T8’s approach to naming her bodily states in the session, and with T14 revealing her sleepiness and what it could mean for the therapeutic relationship.

Returning to the work of T12, she stated that when she was able to name her somatic countertransference to her patients Jason and WJ, her somatic experiences ceased and it was as if they were no longer required in the relational matrix. She says the following about it:

_I am still working with Jason and WJ. Jason and I raised the frequency from twice weekly to three times weekly about two weeks ago. It’s very frightening for him. He is often 10 to 20 minutes late for most of the sessions. I check emails or click different webpages at the beginning of the sessions, because we are talking over phone. I still click although I know probably he can hear the sound from the other end of the line. I think I am expressing anger by doing this. I still have funny throat and feel itchy and_
scratch now and then when I talk with WJ. I think we are both avoiding talking about some negative feelings. I am more active, talk about things directly, then I stop clicking with Jason and the funny throat and itchy feeling is gone. I guess when I can put feelings into words, talk about things with the patient, then I do not need the somatic things any more. Or pay attention to the somatic countertransference you have when you are with your patient, it's a signal for unconscious feelings, try to understand that with your patient. T12

I think that T12 has astutely worked with her somatic countertransference to unblock difficult therapeutic relations. It is as if by acknowledging and working with her physical sensations she has unstuck or unblocked something in the therapy. Continuing on from this idea that two bodies can affect and infect each other, T14 has experienced that somatic countertransference, if worked with can bring about movement from a sense of feeling stuck in the therapeutic relationship. She says:

In my experience, it usually does not happen in the beginning of therapy. Because in the beginning, I guess most of the time, most of the patients and the therapist will contribute more, their attention, their energy more into this relationship at the beginning. Gradually, it need to cost some time to build a real working relationship, a working alliance, then the resistance comes up from the patient side. So feeling sleepy might occur in this stage. The other example of feeling hurt and tired in my shoulders and arms it occurred much, much later in the relationship. I cannot be sure of in which part of the relationship it will occur, it depends on the case. T14

I respond in the interview by saying:
Sounds very interesting. So it sounds as if at the start it is about unpacking a lot of material but then it starts to meet with some resistance and possibly my thought is where they get stuck and they cannot access emotion that is when you could pick it up in your body.

T14 responds as such:

*Yes, yes, at the time when they get stuck, maybe both of us get stuck…… Sometimes it can shift the stuck situation into a quite connected situation. Sometimes, not every time. T14*

Once again, the idea is that focusing on the therapist’s body enables an unpacking and processing of material that promotes a shift in the therapeutic relationship and outcome. This is particularly noted and written about by Petrucelli, Carroll and Orbach with their rich clinical examples of what happens when the therapist’s body is activated in therapy (Petrucelli, 2007, Orbach, 2004, Carroll, 2006). What T14 is saying here, is that for her, the body plays an integral role at a later stage of therapy and that the therapist needs to pay close attention to what is happening physically.

Commensurate with the calmness enabled by T2 and T4, and the idea that the therapist’s body aids the therapy process, Kristina Schellinski, Jungian analyst writes about how her body and the body of her client engaged in a process of mutually interactive gurgling sensations. This is documented in her case vignette 111, she writes:
Somatic counter-transference speaks up at the 10th session: right from her entering the room, I can feel in the pit of my stomach how “empty” she feels. I can “see” that she would need as much mothering as her own baby whose mothering she does attend to with some - unconscious – resentment. “What about me?” seems her silent scream. Something in me starts imagining: “If only the au pair girl could run a bath for you at night and fix your favorite food...” She laughs it off. “That’s impossible! You’re dreaming,” she says. Then her stomach gurgles. I listen. It’s like bubbles rising to the surface as if she were a ventriloquist. Embarrassed, she explains this is because she has not yet had breakfast. I do not think so; I think something deep inside her “heard” what she was longing for, beyond words, image, emotion, let alone feeling. Since then, when we get to a point where something essential is happening, her stomach does the talking. And my stomach gurgles, too. So now, we are talking and gurgling, two by two, in resonance. Our mirror neurons join in on the talking and we are listening. Now, she is heard, held and mirrored at that level of her being which once was beyond words. (Schellinski, 2013, p19)

This example speaks of a deep interactive process of a physical kind in the therapy session.

Similarly in Bodies, Orbach writes about a client that induces a bliss-like state in her, which she calls ‘wildcat sensations’. Orbach surmises that her client has used her body to try out what it is like to be in a ‘good enough’ body, thereby suggesting that the therapist’s body becomes a tool, a conduit for the therapeutic process (Orbach, 2009). I think Schellinski and Orbach’s examples illustrate how two bodies
in the therapeutic process relate and communicate with each other and that the body of the therapist is playing an active and important role in the process. Furthermore this idea was taken up with some Chinese psychotherapist’s ideas about their bodies in therapy. Importantly by exploring how somatic sensations in the therapist when acknowledged can effect the direction of therapy and how even a mutual bodily conversation can occur extends how somatic countertransference is understood. It is therefore more than simply split off and unacknowledged parts of psyche that are preverbal in nature.

**Somatic Countertransference as an Indication of Intense Emotion**

In terms of the therapist’s body acting as a barometer of intense emotion, some Chinese participants explored the idea that the therapist is more likely to pick up physical states when stronger emotions were lurking. T3 was clear about his opinion on this as he states:

*To a certain extent, it gives you a kind of indicator; it becomes a little bit demanding in a sense. It makes me the feeling of less easy; it might be that there is some heavy stuff to bring out. Try to, yes…..mainly the client is difficult. T3*

T3 also explored the idea that grief was usually attached to somatic presentations in psychotherapy and that such somatic manifestations usually occurred with difficult patients. This theme echoes strongly in Western opinion, namely the work of Samuels, Stone and noted in my interview with Stuart Twemlow (Samuels, 1985, Stone 2006, Twemlow, Interview, 7 December, 2013). They expressed the opinion
that such states are aroused in the therapist when working with patients with early
damage indicative of a borderline structure (Samuels, 1985, Stone 2006, Twemlow,
Interview, 7 December, 2013). In an interview with Stuart Twemlow, he spoke about
somatic countertransference occurring when the therapist is able to deeply empathize
and almost get inside the patient. He claims that this process takes years and these
depth somatic experiences can be very surprising. He alludes to an outburst of anger
he experienced after sessions he had with a particular patient and that it was his
secretary who pointed out that this seemed to occur regularly after their sessions. In
terms of the borderline structure, Twemlow puts it as such:

One of my worldly heroes in the field is Bion and as you probably know he called it
an alimentary system. He saw it all as a matter of giving and taking, like what we eat
and we excrete. And I think the borderline patient will show more of the somatic
reactions than psychotic. Those are the sorts of reactions you have to ineffable, non
verbal things, things you can’t speak about, they are like sensory, perceptual
reactions, that maybe not translatable into a word in English. (Twemlow, Interview, 7
December, 2013)

As a clinical indication of this from the study, T11 reported the first time she
worked with a borderline patient, she experienced an extreme somatic
countertransference commensurate with her client’s highly emotional presentation
and consistent with Twemlow’s above ideas about unspeakable material present in the
therapy session. She recalls it as such:

I think I have definitely, I remember maybe several years, maybe two or three years
ago when I worked with a really borderline patient. She was you know……when we
talked about her relationship with her father. She burst into tears and cried very, very loudly and it was like shouting, crying and in that moment and maybe everybody out in the corridor may hear her. I was very surprised because I have never seen a patient whose emotions were so strong and astonishing yes. So at that moment, I felt my head, the skin over here (you point to the right side of the top of your head) was numb. ….. In China we have a proverb and it means the skin of your head is numb and it means that you are astonished, you are shocked. If you have this emotional reaction over here. T11

This is a terrific example of how stirred up and psychically porous the therapist can become in relationship with a difficult patient. This is discussed in the work of Merchant and Sedgwick who suggests that’s there is a predisposition in the therapist that allows this material to pass through from patient to therapist (Sedgwick, 194, Merchant, 2012). This will be taken up in a following chapter on shared woundedness in greater detail. As importantly, it speaks of how strong emotions either lead to or start with bodily experiences in the therapist that are often felt in the present of a client with a borderline structure. This has been written about by Samuels in 1985 and with Connolly in our personal communications. (Samuels 1985, Connolly, Interview, 11 March, 2014)

T13 explores the idea that there is a possibility that a more primitive language, a pre verbal language is enacted when patients are unable to experience and process their feelings fully thereby leading to somatic expressions in the therapeutic exchange. She says the following:
I think compared to ordinary memory, body memory is more primitive and appeared before our ordinary memory. One of my clients, who failed to describe her feelings and emotions, can only tell me her body feelings. It’s a way to separate feeling to consciousness. So when therapist have some somatic countertransference to some client, it’s more like them are resonate at this deeper level.

It’s also a little like two person even if they speak different language but they can communicate with music (this is just a example for communication beyond language)? or body language. I think this is a more primitive (depend more on our biological intuition than language) communication or reaction. Or maybe it’s too strong for us to describe or feel those things in feelings or language or consciousness. Such as we will feel sick when we saw some disgusting things. T13

This idea is commonly held in Western thinking about preverbal states and how they can be aroused in the therapeutic exchange usually with patients that present with more primitive, unprocessed affects noted in Twemlow’s allusion to the work of Bion, written about by McDougall, Sidoli, Samuels and many others (Twemlow, Interview, 7 December, 2013, Samuels, 1985, McDougall, 1989, Sidoli, 2000).

According to Connolly, in our personal communications, somatic countertransference is likely to happen when there is profound dissociation and pre existing conditions suggestive of a borderline structure. (Connolly, email, 11 March, 2014) This is a persistent line of thought in Western thinking that somatic countertransference is likely to be enacted with patients with a borderline structure. Whilst some of the Chinese psychotherapists spoke of this in their clinical practice, it only represents part of what is happening and likely when somatic countertransference is experienced.
Therapist’s Body as a Container and/or a Tool

The idea that the body of the therapist acts as a container or as a tool was explored only by a few participants in this study. This is hardly surprising given that many Chinese participants expressed the idea that the mind and body exists on a continuum rather than split as per Cartesian dualism. Nonetheless, the notion that the body of the therapist somehow is able to contain and therefore express on behalf of the client unexpressed feelings, which are felt as physical states in the therapist was suggested by some of the therapists.

Participant T8 was perhaps the most vocal of this notion whereby she spoke of ‘speaking out’ emotions that her clients could not express, thus suggesting her body acted as a container for the therapeutic process. Another participant who articulated this idea was T20 by stating:

*We, as a therapist, we are containers, we contain their pictures, their feelings, their transformation, so we experience what the patient experiences.* T20

In a follow up email T20 states:

*Our body is closely related to the heart, which can also mean a lot to our psyche; body is the container.* T20

Again there is a sense that the therapist’s body can act like a container for unprocessed and unrecognized emotional content in psychotherapy. This connects
with the previous idea that this material is likely to be preverbal and unmetabolized (unprocessed) in nature therefore hinting at early psychological damage of a developmental origin (Connolly, 2013, Samuels, 1985). It also closely parallels many Western ideas about what somatic countertransference actually is.

In terms of behaving like a container, T10 states that he has experienced his body receiving and containing material from his patients. A clinical psychologist who was in New York during the 9/11 terrorist attacks working with the Chinese American community, T10 explains the following:

*I consider it is an energy transfer. Clients transfer the negative energy to me, maybe in an intangible way but when I look at it in my body, it will try to digest or accept at the same time. It maybe it is unconsciously, we don’t know. It just…or maybe I do it that way? I don’t know but maybe some other people they use other technique to better deal with it, I don’t know, as a defense mechanism, maybe they can filter it out. I realize that after I have seen a lot of PTSD patients, I started to realize that my body. Overall, it is a self-awareness process. Short term, it hurts. Long term, it is beneficial. T10*

What T10 is exploring here is in the realm of vicarious traumatization. T10 explained that like fellow New Yorkers at the time, whilst working clinically he became traumatized and noted hyper vigilance and startle response symptoms outside of work. As noted by Forester, the body is a natural fit or container for expressing dissociated and traumatized material held by the patient (Forester, 2007). T10 is also speaking about the role of energy within and between people which is what Bloom felt was
missing from understanding of somatic countertransference from a Western perspective (Bloom, 2006). In this case, T10 is speaking naturally about energy transmission, which is a noted Chinese concept and taken up in chapter 6 in an exploration of Qi Gong practice (Bloom, 2006).

In a similar manner, T23 reports that her client accessed her body to express a feeling, therefore consistent with the body as container idea. She reports the following:

_I remember a client I had worked with yes, his problem was that he just can’t feel his body. Even with the sand play and his dreams or something in his life, he never feels his body or emotions, nothing. When I ask him, he is always defensive so I feel this part, (you pointed to a part of your body) when he told me about his life I feel my body and I feel this emotion has come up. I say maybe this emotion is his, just from him. He borrowed my body to feel it. T23_

T23 indicates that by saying something about what she felt at that moment in relation to her body, something further may occur in the next session and that her body has acted as some sort of container for her client’s unspoken emotions. T23 concludes that:

_We all work with the body as a container, but we do not know why, we just do it. We do not know why we just do this work. Maybe this will help us to understand why we use the body as a container. T23_
The body as container idea is essentially a Western construct that suggests that because the body contains the emotion generated by self or other, it is not as one with the mind. Interestingly, it was taken up by a few Chinese participants; thereby suggesting its relevance in some clinical examples and therapeutic relationships.

Commensurate with the idea that the body acts as a container in the therapeutic session is the idea that the body is a tool to receive information. This idea is consistent with Shaw’s position that the therapist’s body resonates with the patient rather than endorsing the psychoanalytic idea of countertransference per se (Shaw, 2003). T4 calls his body his ‘receiving machine’ and states:

> So most of the time, with the patient that has some prominent character, we talk about some story with strong feelings; I will have some somatic response. I feel it is a direct communication, like a contagious, a contagion, I receive in my body, like my body is a tool to receive it, to feel it and will have a response...... Yes I feel that it is a good feel, so I can feel the patient. I feel it is a sensitive tool to detect the patient, so it is a basic tool to feel the patient. So the patient can influence me directly, through emotional energy. So I accept it in my body so I feel it is important. T4

In discussing his body as a tool that receives information, this flows onto the other idea that the energy omitted by the patient is like a contagion. This is in the realm of the psychic infection, which will be taken up in more detail in chapter 4. As such, T4 is experiencing what Jung primarily saw the role of the therapist that was, to take in the infection of his client to somehow tame and heal it (Jung, 1954).
Likewise, T6 spoke about taking in the pain of her clients. She provided a specific example in which during group therapy, she started to experience feelings associated with her client. In particular when a group member spoke about the pain of his childhood, she started to cry, which was most unlike her usual composure during group therapy. It was surprising to her. T6 explains it as such:

So at the end of the session, he came over and said goodbye to me. He was very emotional, it was the first time I have ever seen him emotional. He was holding my hands to him. He was holding my hands for a long time and he said “thank you so much”. I think it was very helpful for me and at that point, clearly his eyes were red, a little bit red his eyes and this was very unusual for him to actually be a little bit emotional. I don’t know what was happening there, maybe he is saying thanks, or for my tears, I don’t know. Because I care for him? He didn’t say that, but I can see that he’s trying to express himself by the way that he is holding my hands. So he’s not very good with his words.

But I am I experiencing her pain and suffering at this point at the same time, that will be much more correct the things that I am describing. Also I let her know that I am feeling this pain. “I feel your pain as well.” So that is kind of directly that I am taking her pain away. So actually when I am feeling the pain, the pain has transferred to my body from her body. So actually I feel that I use my body to be a tool for this therapeutic purpose. You see? Yes so that is why some of the patients are after counseling I feel so exhausted, because a lot of my clients take away my energy, and replace back some negative stuff. So that is why I feel very low and tired and go straight to bed. T6
Please note that T6 changes the gender of her client in this example. This example is extraordinary because later another member of the group, after a period of absence, stated that she dreamt that T6 cried for her in a group without prior knowledge of this incident. These parallel and uncanny experiences one somatic and another in the dream state of another group member speaks of synchronicity and parallel experiences that may be beyond the scope of this thesis. Nonetheless it expresses the complexity and the idea of shared zone of mutual unconsciousness thought to be in activation when somatic states arise or indeed when two or more people meet. This idea has been expressed by Jung, and in more depth by contemporary Jungians such as Samuels and Schellinski (Jung, 1954, Samuels, 1985, Schellinski, 2013).

As discussed in a previous section and in more depth in the following section on techniques with somatic countertransference, T15 confirms that her body is indeed a tool. She outlines a process of working with the body of the client and her own body and claims that in doing so the therapeutic work is less difficult than therapies reliant on verbal expression, namely interpretation. She phrases this in terms of somatic experiencing as a treatment modality.

T17 spoke about his body behaving like an instrument upon which his clients played a tune, he stated:

*My body is like a piano. They play it and it makes the music, the tune, the keys, the speed, the frequency, the melody. I am a piano well-tuned and well prepared but the pianist, the patient’s association.* T17
T17 speaks of somatic countertransference happening 100% of the time for him and provided the example of wanting to vomit when his client spoke about her father. He later learnt in the session that the client’s father had taken his own life by poisoning himself, which T17 had experienced in the session. He stated that the physical sensations he experienced mimicked the taking in of toxic poison and strong desire to expel it from his system. In this instance T17’s body as instrument was tuned into a traumatic experience for his client and his client’s father by association.

Another participant T25, working with dreams and sand play spoke about her body as a tool to receive important unexpressed emotional states. For her, the body adds another dimension in the complex interplay between image, the unconscious and dreams. She provides an example of a client she worked long term with, she says:

*My clients bring me dreams and sand play and we talk about… we do the dream in the sand tray and we talk about it and we experience it and work with it very carefully and very deeply. And that sand play, a very powerful image is about a serpent, a very big snake and both of us had somatic experiences in the therapy. In the session and he was tense, and uncomfortable in his body and I also have some somatic responses in the same time. I feel very hurt in my legs. We also talked about our somatic responses at that time ….. I think it was very helpful to talk about it with my client. First of all, for my client we can share some experience, he can feel I have some response. I was involved in the work and in his inner experience. Pain, depression, just like this and he may feel that I accept his feelings, this is the first. Second, I think I really feel that*
kind of feeling in my body or use my body as tool for me to understand his symptoms, I think it is really helpful for me to really experience it. T25

Once more, T25 like other Chinese psychotherapists perceives the role of her body as a clinical tool that can express emotions and therefore assist in understanding the client. Inherent in this is the idea that body can both contain and or act as a tool for expression of unacknowledged emotional states. From a Western perspective Stuart Twemlow, summarizes it as such:

When I think of somatic countertransference, I will simply tell you what I see it as. Sleepiness is something that any analyst doing the work will experience many times and boredom similarly. Winnicott is one of the few who wrote about that. It is one of those things that analysts don’t talk about but happen. What is interesting is that when you realize that you are thoroughly inside the head of another person. By inside the head I mean, you really are tracking empathically how they are experiencing the world. And that takes, in my experience, a couple of years. I think of somatic countertransference, the value of it to me clinically is when it occurs; the patient is involved in a very primitive reaction to me. Because usually what happens is, I will get a reaction, let us say, anxiety or might get bored or something and then, if I am not tired, I will say, “Okay what started this”? It is a somatic one when I suddenly become voraciously hungry or I develop a blinding headache. Or on one occasion, I forgot how many children a patient had, fundamental things about their life and this is someone I have been analyzing for years. In other words I acted as if I was mentally retarded. (Twemlow, Interview, 7 December, 2013)
Twemlow is saying many things here about somatic countertransference. Notably, he explains that the therapist’s body acts like a container for the unexpressed or difficult to unpack emotions and as a tool to receive these emotions, which bring about a resonance with the client. In a sense, the idea that the body can contain and receive information through somatic countertransference, whilst engendering empathy are closely related aspects of this phenomenon.

Concluding Remarks

This chapter has commenced the important process of analyzing the responses made by Chinese participants so that a cross-cultural exploration of somatic countertransference is undertaken. So far, what is apparent is that there are many areas of both consensus about how somatic countertransference is experienced but also areas of difference notably with reference to attending to the meaning of body parts suggested by TCM practice. Importantly, how somatic countertransference is defined is broadening beyond the commonly held notion that it is material of a preverbal unconscious level. Whilst not discounting this idea, other ways of identifying and working with somatic countertransference from a Chinese perspective is emerging. The following chapter will continue this process by exploring the prevalence of the mind-body continuum in Chinese psychotherapy practice as well as further themes identified by the Chinese participants.
Chapter 3: Empathy and Other Somatic Countertransference Matters

The following chapter continues our in-depth analysis of how Chinese psychotherapists understand and work with somatic countertransference. The themes explored in this chapter include somatic countertransference as empathy, how somatic countertransference changes as therapy evolves and finally ways to work with somatic countertransference.

Somatic Countertransference as Empathy

The idea of somatic countertransference as a form of empathy was in some cases discussed, in relation to the notion that the body contains feelings. This idea can cause confusion, as if somatic countertransference is simply empathy in action. This idea has been well explored by others, in particular the work of Robert Shaw, who dismisses the term somatic countertransference in preference for somatic resonance that occurs in some parallel process in the therapeutic alliance and not via some form of transmission (Shaw, 2003). It is also closely related to the idea of linking, as proposed by Rowan that suggests that somatic countertransference is a form of empathy that occurs across all treatment styles (Rowan, 1998). In the introduction, I have argued this assessment of somatic countertransference is limiting our capacity to fully explore the ideas and potential of mutual unconsciousness communication as suggested with the idea of somatic countertransference. Furthermore, Shaw has
proposed that the term that countertransference, whether somatic or otherwise, is a reification of a process that is largely mysterious (Shaw, 2003).

As I have expressed it, I think this argument misconstrues how countertransference is understood and used therapeutically. In addition, this confusion extends to our understanding of empathy. Is somatic countertransference simply a form of empathy? I think the answer would be yes and no. If it is a parallel somatic state identified by both analyst and client in psychotherapy, it would point in the direction of empathy as suggested by Rowan, but to state that it is just a form of empathy is once more limiting what it is (Rowan, 1998). The following examples however illustrate that somatic countertransference for some Chinese psychotherapists illustrated an empathic therapeutic experience.

T10 spoke of the idea that he experiences his body to synchronize with his patients:

I consider it is an energy transfer. Clients transfer the negative energy to me, maybe in an intangible way but when I look at it in my body, it will try to digest or accept at the same time. It maybe it is unconsciously, we don’t know. It just…or maybe I do it that way? I don’t know but maybe some other people they use other technique to better deal with it, I don’t know, as a defense mechanism, maybe they can filter it out. I realize that after I have seen a lot of PTSD patients, I started to realize that my body. Overall, it is a self-awareness process. AND Empathy, sympathy, maybe my body is trying to synchronize, so that I can feel what my client feels in a wrong way. T10
The term ‘synchronize’ is used elsewhere in Asia, in some interesting clinical studies conducted in Kyoto, Japan. One study conducted by Nagaoka and Komori, demonstrated that there is a time of optimal synchronized physical states between client and patient in the session, thereby suggesting that some form of bodily alignment occurs as the session evolves which seems consistent with what T10 is speaking about (Nagaoka & Komori, 2008). T10 in this instance is suggesting that he is experiencing empathy with his client physically or what he names as a form of synchrony.

Returning to the idea that somatic countertransference is a form of empathy, similarly the idea that there is an energy transfer is taken up with T15:

*I also believe in energy. I think before how come I got so severe shoulder pain, it is because I am really absorbed in what the client is saying and taking the energy and being influenced. I have one experience when working with an obese client. In that time, I not only dream of her and of her family members and then the next day and the weeks following, I got very severe shoulder pain. I noticed that it must be something from that client because otherwise, I am not doing manual work. I shouldn’t have that pain. I sit in an office and I see clients, how come I have that pain? T15

These examples are at odds with Shaw’s dismissal of transmission between client and patient and yet a number of Chinese participants freely spoke of energy within and between people and that energy flows in the room. Extending the idea of energy transmission suggests that somatic countertransference is a manifestation of energy
between people. This theme will be explored in more detail in chapter 6, which discusses Chinese ways of understanding somatic countertransference with reference to the Chinese concept of *qi*. Presently, these examples indicate that empathy and energy are somehow related when discussing therapeutic experiences of somatic states as anticipated in the work of Bloom (Bloom, 2006).

Consistent with the theme of empathy generated when somatic countertransference is present, is the implication that the therapeutic relationship is becoming deeper in connection. T13 says it as such:

*One of my clients, who failed to describe her feelings and emotions, can only tell me her body feelings. It’s a way to separate feeling to consciousness. So when therapist have some somatic countertransference to some client, it’s more like they are resonate at this deeper level or body language. I think this is a more primitive (depend more on our biological intuition than language) communication or reaction. Or maybe it’s too strong for us to describe or feel those things in feelings or language or consciousness. Such as we will feel sick when we saw some disgusting things. If the experience or feelings is beyond language or understanding, then maybe it’s possible that we can communicate with bodies, in the somatic transference and countertransference way. T13*

T15 agrees with this idea that that bodily expression facilitates deeper connection between therapist and client in therapy. In terms of forging a deeper connection, T15 explains somatic experiencing theory before emphasizing that this approach, a body
orientated psychotherapeutic style, encourages a deeper bond in the alliance. T15 says:

Dr. Peter Levine is the founder of Somatic Experiencing and also they run training courses in Australia. He developed the theory from observing animals in the wild. Although they face lots of stress in life, they don’t have PTSD. Why? Because, he said that when our sympathetic system is triggered animals when they have got a lot of energy in their nervous system, even if the threat is not there, they will still run or will still shake or do whatever they need to do to release all those survival energy. But for human beings, we use our head a lot and then we will when the threat is not there, we immediately use our mind to stop ourselves. We don’t stop and shake, we don’t run. It is ridiculous to do run at that moment then the energy was stuck inside our nervous system and that’s why it makes us suffer. The theory is like that and also another sign is when the therapist is settled, then feeling his own body, actually he will have a deeper connection with the client. More easy pick up the resonance from the client. But we put too much focus on the client and not pay attention to ourselves, actually we don’t have that connection with the client. T15

Interestingly, a deeper connection is also only possible according to T15, a Levine advocate, if she attends her bodily reactions as well as her clients. This idea has been discussed by other Western psychotherapists. In Kristina Schellinski’s paper she states it as such:

Often, the analysand will feel the same or something similar, a tingling, warm energy rising, up from the feet. Then I know that I am connected with the other; and that the other is connecting to what we are working on, and that we
both are being connected to what is being constellation, by the Self.

(Schellinski, 2013, p 5)

Essentially what is being proposed here is that when the therapist and client can access bodily states in the session, whether the somatic experiences align or not, there is a deep sense of connection occurring between therapist and client.

Moreover, empathy was implied when the Chinese participants received feedback that their somatic experiences matched their patients’. This occurred with the work of T19 who explained that she shared her feelings with her clients, namely nervousness, they would resonate with this feeling and this would establish a bond between them and accordingly a sense of calm prevailed in the sessions.

Likewise T20 suggests that when the therapist experiences somatic countertransference, there is a possible deepening in the relationship. This implies change, growth, and potential transformation of the therapeutic alliance. She states it as such:

*I think that after that, the relationship goes deeper. The relationship between the patient and the therapist goes deeper. Maybe it more unconscious. So consciously the patient will say “Oh yes I have the same feeling.” I don’t have that experience but I can feel that they just understand it, in silence. So I believe this happens at an unconscious level, it is deeper and the second one. The patience feels less lonely, she realizes that her experience is experienced by another person so that can reassure her and help her feel less lonely. I don’t know how to answer it because it is dynamic you know. The somatic experience happens in every session or in the important sessions I
should say. So it happens in the importance sessions or the weak experience, the somatic experiences may happen in those not so important sessions. Maybe it happens in the important sessions, maybe it is a turning point; maybe it can change the theme of the session.

I believe what I told you at first about the blockage in my chest, I think that that session could be quite an important session. Because that feeling was very strong both to me and to the patient. So to the question of what happened later, I think it is too dynamic to answer it. There are many possibilities. T20

I think T20 is summing up that when the physical enters the relationship, the therapeutic process can change and there are many possibilities unique to the relationship that can evolve from such experiences. This idea is echoed by Western clinicians such as Orbach and Petrucelli to name two of many (Orbach, 2004, Petrucelli, 2007). Furthermore it extends the idea of what somatic countertransference is. It is therefore moving beyond the classically held idea that it is in the realm of preverbal material enacted in the therapeutic relationship.

Interestingly, some Chinese participants wanted to discuss the difference between empathy and somatic countertransference, specifically T22 who responded to my question about how would she explain how somatic countertransference occurs, she states:

Before I came here I thought about this question and I think that in our work, maybe sometimes I can’t differentiate very clearly about the countertransference or empathy. I can’t know, the patient show an image, he opens his mouth and then I can feel here,
(you point to your chest) it is impressed, I can move it. Here I want to say: once a client, a lady, put a black snake in a sand tray, [and] its head is heading to me. It opens its mouth, I saw this image, then I felt my chest if not smooth, I want to open my mouth openly to cry out. I think it is an example of empathy. T22

In a follow up T22 is still trying to make sense of the difference between somatic countertransference and empathy, she says:

When the client is depressed, I felt my chest is blocked. I think it is Somatic empathy, but not Somatic countertransference. ........ when I felt restlessness, fretful and bored, I think it is countertransference, because I do not like someone so slow, so bored when he/ she speaks, talks and expresses something. And at the same time, I felt my heart is blocked, my head pain, my temple is also pain a little. Some time I also felt my body is hard, rigid. I think it is Somatic countertransference maybe. T22

What I think T22 is expressing here is that empathy implies a consistent feeling with her client’s internal state, whereas somatic countertransference suggests a state that is more difficult to understand and sometimes is at odds with her client’s internal state. Furthermore, somatic countertransference for T22 suggests greater feeling states both emotionally and physically. This consideration brings to mind Andrew Samuel’s original definitions of reflective and embodied countertransference whereby reflective can closely mimic the client’s internal state whilst embodied is more about the therapist embodying an inner state that is unknown to the client (Samuels, 1985). Additionally, empathy and somatic countertransference both hint at energy transmission, which is consistent with the Chinese concept of qi, which are explored in chapter 6. In addition it speaks of the difference between known and unknown
aspects of countertransference explored by Weiner and Connolly in personal communications (Weiner, 2012, Connolly, Email, 11 March, 2014). Again it suggests that empathy and somatic countertransference are not entirely the same experience but are somehow connected and related.

In summary, the exploration of these ideas held by Chinese participants lead to the possibility that empathy could be positioned as a subset of syntonic somatic countertransference and overall the result of energy transmission between two people in psychotherapy.

*Somatic Countertransference changes or eases as Therapeutic Process evolves*

One often spoken about aspect of somatic countertransference was that it changed with the progression of the therapy and or with the naming of it in the session. Furthermore for some Chinese participants, somatic countertransference was more likely to occur at the start of the work whilst for others it occurred later as the relationship developed and deepened. In the first example it was suggested that this was because at the start of therapy, somatic countertransference could occur because they were primitive, preverbal communications unknown and unprocessed by the client. Understandably, ideas about this varied from therapist to therapist. Once more this suggests a greater complexity and breadth of the experience of somatic countertransference that needs to be thought of with respect to the therapeutic relationship it has evolved from.

In the case of T2, he was of the opinion that these experiences were more often at the commencement of therapy. He recounted an example of a nervous
stomach that ceased when he worked through something with the patient. He implies that their words brought about calmness to the work and somehow the non-verbal was made verbal and therefore no longer in the body. It was as if the therapist’s body had processed something for the client that emerged in the therapy. Whilst not indicating when it was more likely to occur, T8 well versed in the importance of naming physical states she had, reported that this often brought about a physical release in her body and a shift in the work with her clients. Consistent with this idea, T14 stated that when the therapeutic work becomes stuck, naming the somatic countertransference brings about a release in the experienced discomfort. For T17 in describing his technique, he reported that for some patients they would describe a somatic response to his interpretation, that ‘something was dissolved’. This parallels the example provided by Stone, whereby his somatic symptoms dissipates as he discusses it with his client (Stone, 2006). T17 explained that he could observe visual changes in their appearance that suggested that they have relaxed. With a note of caution, however, T17 warned that not every blockage gets dissolved and that you have to wait and listen to your client.

In the work of Schellinski, she notes that there is a process of taking in via the therapist’s body, holding and then handing back and a corresponding release of material in her body as the analysand takes ownership. In a case vignette she reports the following:

*I worked with a middle-aged, recovered alcoholic man, who consulted me due to a marital upset caused by an affair during his midlife crisis. In his presence, the region in my belly, where I presume my liver lives, often hurt. He felt a similar ache during*
the hour. He would then gesture towards his belly, and let his hand rest where the liver is, a symbol for the seat of life. When he touched that region, getting in touch with the immense solitude in his life, and connecting it to a pain he had felt since early childhood, and was feeling now again in his current situation, I would get instant relief in my body. He then carried his pain consciously; my body had carried it intermittently. I had received it, held it, and reflected it back to him, so that he could “take it in”. It helped him to be more “grounded” in himself. (Schellinski, Interview, 16 January, 2013)

This illustrates this process of change and indeed an easing of the physical symptoms as noted by participants T2, T8 and T17.

At the opposite end of the continuum, some Chinese participants like T14, reported that somatic countertransference was more likely to occur as the therapeutic alliance deepened which is consistent with the idea reported by Stuart Twemlow in our interview, that over time a greater empathy and connection with the client is forged (Twemlow, Interview, 7 December, 2013). As such, the importance of somatic countertransference was not just explored in the many themes of what it meant for the therapists and their clients in their work but also to the extent that it could be a barometer of therapeutic change. This implies that somatic countertransference can provide a marker for therapeutic change and progress. Importantly this diverse finding indicates that there is variation when Chinese psychotherapists experience somatic countertransference in the therapeutic alliance, which suggests that there is no single or correct answer for when it manifests clinically. Therefore, somatic countertransference is experienced in many different ways and ascribed diverse clinical meanings and levels of importance by individual Chinese psychotherapists.
Specific Ways of working with Somatic Countertransference

Where analyst and analysand enter into one shared space, soma may tell through the body of the analyst what psyche may not speak; we may hear the psyche of the analysand mutter through the matter of the analyst. (Schellinski, 2013, p 3)

Schellinski in this above quote states clearly what was discovered and confirmed by the data collected from the Chinese participants. There is little doubt that the data analysis illustrated various experiences of somatic countertransference in psychotherapy from a Chinese perspective, united with the West in that the therapist’s body appears to play an integral role. What was also explored was that the Chinese therapeutic approaches appeared on a continuum from those strongly influenced by Western-inspired training in psychoanalytic and Jungian traditions and other Western treatment modalities to techniques stimulated by Chinese culture underpinned by Confucian, Taoist, Buddhist and Traditional Chinese Medical practices (TCM). This variation will be explored in more detail accordingly.

To commence with consistent, a number of Chinese participants provided techniques for working with somatic countertransference that paralleled Western psychotherapy practice. For example, T2 reported how he approached somatic experiences with the following statement:
Yes, usually two things. One, most of the time, analyze myself, my feelings, why has this happened? What did this patient do to make me feel that kind of feeling? Or second thing is that I will talk to my analyst or my supervisor. T2

This process of analyzing one’s somatic experience takes time and focused reflection to discern whose pain or somatic experiences are being embodied. This is a common approach to exploring any experience of countertransference from a Western perspective (Field, 1989, Stone, 2006). In a seminal paper on countertransference entitled “Power, Shamanism, and Maieutics”, Stein points out that we must always proceed with great care when reflecting on whose psychic material belongs where (Stein, 1995). As such, when exploring any form of countertransference, somatic or otherwise, the key is reflection. This was taken up by T9 who nominated the importance of reflecting upon and questioning whose material is it? In addition, T6 spoke of needing to work out whose physical sensation she was holding and says the following:

Yes and I am aware that it is not mine so I can use it for therapeutic purpose. If I didn’t know that, if I thought there was something wrong with me or maybe I start to become anxious about how to face her problem or how to…… so I would not be out to use this because I thought it was mine. Or maybe sometimes it could be yours. So you just have to define if it is yours or hers? I think this is a very important for the therapist to have this kind of awareness. T6

This discernment of where the somatic material is coming from is core to understanding somatic countertransference (Margarian, in press). This process of reflection was indeed shared by other Chinese participants and therefore a common
process. T18 said when working with somatic countertransference she requires time to reflect and said the following:

Well you remind me, maybe different ways I work with the feeling. I have my own supervisor and I have my own therapist and I will talk with them individually for different parts. Maybe I will try to define what is the subjective countertransference and what is the objective countertransference. Maybe some of the somatic countertransference is also related to myself. Also sometimes if the feeling is really strong I will let myself to be a lone, to be by myself in the therapy room for a while after the session. To stay with it and have some time to think about it. T18

This process of reflection during or post-session individually or in supervision is a common psychoanalytic practice cited by many analysts and therapists who acknowledge the presence of embodied somatic experiences in the countertransference. Notably, Orbach in our interview encouraged greater self-awareness and reflection on bodily states by suggesting creating a separate space in clinical notes to track when bodily states occurred together with what was occurring verbally at that time (Orbach, Interview, 18 December, 2013).

T15 a practitioner of somatic experiencing, a Western therapeutic approach stated the following about her work:

Sometimes even if it is just my own way reaction to a client, sometimes I will also let them know what I am feeling in my body. I think because it is also useful for them,
expanding their perspective and when I also invite them to sense their own body sensations, actually they can also deepen the effect of the sessions. It is not just talking and the idea go away. If they explore deeper in their bodies sometimes, deeper issues surface will surface and then sometimes what is trapped inside will have a chance to be released and if there is any transformation, if they pay attention to bodily changes inside, actually, the change can have a more long lasting effect, an anchor in the body. Not just an idea so when they leave the room, nothing will happen, it will not be there anymore. So I think paying attention to my body and also asking them to pay attention to their body maybe benefit. Also sometimes apart from the client, it is also a good hint for myself. Like it is my discomfort, it is not something really I have picked up from client then I need to find a supervisor to discuss how come I got that sensation in that session. To clarify what happened during the session. T15

T15 is defining a specific technique of observing her client’s and her own body. Furthermore she is explicit in sharing this material to ensure that the work remains body focused.

The idea of speaking about one’s somatic experience with the clients was equally a question for consideration amongst the Chinese as with Western psychotherapists. There is varied opinion about whether it is appropriate and therapeutically advisable to share this material noted in the clinical literature. In particular, Schellinski states:

However, there is need for another note of caution: making somatic
countertransference explicit, can also be perceived – especially in initial phases of analysis, or with certain types of analysands as intrusive and crossing boundaries. Care must be taken, when addressing somatic countertransference in session, in order not to provoke resistance in clients who have not been able to develop a sense of self in the body, or for its boundaries. (Schellinski, 2013, p18)

I think this view is widely held and sound as the potential for rupture in the therapeutic alliance is too great a risk. Yet in terms of the Chinese participants, T8 was adamant that it is essential to ‘*speak out the emotion*’ as if she was holding or speaking for her clients a bodily encoded feeling they were unable to access. She provided numerous examples of her capacity for speaking out feelings and suggested that this was well received by her clients. In summary, T8 explained that when she experiences a feeling, she names it out aloud so that the therapy is shaken up. For example, T8 says:

*Yes, yes, as I remember one time I saw a client and I saw her for a couple sessions. And every time I saw her, I felt extremely tired. I feel so sleepy. I cannot help to yawning. I never do that but just with that client. I cannot help but do that. Another is client she cannot take a taxi because when the taxi is too fast, she will want to go to the toilet or want to stop the car. So that is her issue. So at the very beginning she was not good at speaking her feelings but when she speaks, I feel my shoulders are extremely tired. So when I do group counseling when there is some emotion, when clients are not able to speak it out, I will feel it in my body, like extremely heavy.*

………
And if I speak out my feeling that my body feels so tired there, and she starts to speak out some feelings then I feel a release. I feel very released.

Because when she is unable to say something and I feel very sore, my arms and during that time when I have not told her what I feel, my body, my arms feel very tired. So I don’t know what that means and I say “do you have any feelings that you want to say?” And when the client says something, I feel my arms released. Yes, that is something I don’t like. Yes, if the people don’t speak out their emotions, I feel my body can catch it. That it is very tired. T8

T8 is a strong advocate for speaking out aloud to her client what she is feeling in her body at any given time. As expressed earlier, at times the themes noted in the data intersect with each other. In this instance, T8 is speaking about a particular style she has developed. By observing and monitoring her body when with patients, she senses that her body acts as a container that catches unexpressed feelings. T8 reports that she experiences a release as she names the feeling, as if this very act unleashes some physical pain inside her. As such, her work encapsulates a number of themes, and her process of naming her bodily states to her clients is a personal approach to working with somatic material. Yet it also seems a parallel fit with the somatic experiencing style practiced by T15 the somatic experiencing practitioner. She advocates focusing and observing both the body of the client and therapist simultaneously. T15 says:

Sometimes yes, first of all I need to check whether it is my own reaction or whether it is from the client, because they may not be the same. And sometimes I will use what I sense as a hint, guiding my questions and guiding my client to explore more. So my body sense and her body sense, so that will be a hint. What I felt in body sometimes
helps. Sometimes if I feel something in myself, I will just ask if they feel in their chest, abdomen, or their back, just a hint to ask them because sometimes I am not quite sure whether it is my own reaction or whether I am picking up something from them? So to check it, I just guide them to ask them if there is anything in the same area that I feel something. T15

Like T8 and T15, T20 has used her bodily experiences to understand her clients in similar a manner:

Yes. Sometimes in the session, I feel that I have some somatic experience and I ask myself whether I have had some kind of experience and I will also tell the client that, “when you say this, or this or when you are telling me this I have some kind of somatic or some feeling in me.” Most of the cases they don’t feel that my somatic experience are strange or they couldn’t understand and most of the time, they seem to understand my somatic experiences and my feelings. As if I was saying their feelings. T20

Again, there is a sense that for some participants sharing their experience with their clients is a part of working with somatic countertransference. Conversely (and in accordance with Schellinski), T17 suggests remaining cautious. He states that to share somatic countertransference with patients is akin to a therapist acting out. As such the divided opinion on this echoed sentiments in the West in the few examples that spoke of whether they shared this material with clients or not. Some participants took a more moderate approach stating that it was dependent on the state of the therapeutic alliance and relationship at the time when the somatic countertransference occurred. For example, T14 stated the following:
It depends, if it happens for the first time and I feel sleepy and tired in the therapy, I think I will not say anything to the patient. I need to figure out if it is my part or her part. For example, I see a female patient in the afternoon from 3pm to 4pm. Then 15 minutes later, I will see another female patient. Several weeks passed, I gradually found that I would feel very, very sleepy with the first patient and the next patient, just 15 minutes later; I will quickly get very energetic. I am sure the sleepy feeling is not my problem, I am sure it is because I did get enough sleep last night, it is somatic countertransference. It also needs to be related to what I heard or what happened in the therapy, the context. So several weeks later, I tried to make an explanation and an interpretation to this patient. T14

I think this is sound clinical practice to ‘wait and see’ and utilize one’s clinical intuition about when to reveal material or not.

Another participant T24, also reports the importance of reflection and adds that paying attention to the effect of spoken words provides additional clues to what is happening in the session. As such, T24 writes down words that she thinks brings about a somatic reaction. She says:

Yes, I will reflect on my body reaction, I will reflect on it. When I have a headache, I will think does this come from my own life because something has affected me, and I will reflect on whether it has come from some words that the patient has said, all these stories, or the stories influenced me. So I will reflect on where those negative reactions come from. T24
In the above examples, the collective approach to working with somatic countertransference with Chinese psychotherapists closely parallels Western psychotherapeutic ways of managing such experiences. It cannot be underestimated just how important it is to reflect within and post session about the presence of the body.

Overall, I sense this approach of ‘waiting and seeing’ and utilizing the material in an appropriate manner reflects what a number of Western psychotherapists actively working with somatic countertransference are likely to do. It brings to mind Orbach’s approach that is not prescriptive yet largely situational in the space between therapist and client. She says the following when I asked about her approach to working with somatic countertransference:

*With some people, it is all internal to me; I just reflect on it, I might notice it. With another person I might raise it and say, “look an interesting thing is happening and I think it is because”.... This is how I might look at it. Or with another person I might say, “look you are a sixty old man and what I have noticed is that when you come in your walk is like a little boy and what that arouses in me and I don’t know if it is just here or whether it is everywhere else?” So I would have many different ways, I suppose I don’t know what I can say, is it linked to the individual, or is it linked to my experience, is it what is in our relationship? I can’t systematize it any further than I already have which I think it is a shame that I can’t. It doesn’t feel honest to do it. (Orbach, Interview, 18 December, 2013).*

Yet other more culturally influenced techniques surfaced with the following examples. In a follow up interview with T4, he reveals that after our initial discussion he has pursued meditation as a means to heighten his bodily awareness and also to
provide a technique for relaxation and calmness during and post sessions. T4 says the following:

Later I began to do meditation, I went to a temple for a week meditation and went to some lectures on meditation and how to exercise the body. So I can become more relax and easily to know other people. If you are calm, it is easy to receive the information from other people, if you exercise mediation it is easy to be calm and you can read other people’s minds easily. It was a direct communication, like you read people’s mind. I think it is possible in fact with some people; they are so acute and sensitive to other’s people. So when some people say something, he will quickly grasp what is being talked about, it is empathy through our body. We try to slow down our breath and try to keep calm, try to keep still; we can receive more information from other people...........T4

When I asked T4 if these practices have had an impact on his work, he says the following:

From August, I began to meditate every day. Twice a day, in the morning and the afternoon. I find I became calm more easy than before....when I provide therapy for the patient; I can easily feel my body reactions especially when I become calm. I can feel the breath slows down. Then I find the patient’s body movement, I try to keep quiet and still and I try not to change my gesture when I provide therapy. I feel like I also do meditation during the session. I haven’t change my therapy style I only try to make me more sensitive to my body reactions and to my fantasies and I try to keep quiet, more quiet and more calm. So then I can receive the information from the patient. T4
I then asked T4 if he found that as a result of this if he was experiencing more information. T4 states:

Yes. But I often try to say something from my whole body reaction for the patient, then I deduce from my reaction, the patient’s inner mind. What is happening in the patient’s mind? I feel that I know myself so that I can know the patient. T4

This is a good example of integrating Eastern cultural practices into psychotherapeutic practice. This kind of integrative approach is not entirely new, as noted by Shaw. Many Western psychotherapists integrate Eastern ideas of meditation and breathing techniques into their practices but what I have experienced as interesting is that T4 sought out a spiritual practice to heighten his sensitivity as well as to manage the physical presence of his own body and the body of the other in the therapy session (Shaw, 2003). Similarly, T17 stated that his deliberate practices of mindfulness and breathing techniques in preparation before seeing a client facilitate this same state of sensitivity and receptivity to others. He states the following:

Three minutes before I see my patient, I already prepare well and I sit on my chair and get myself in mindfulness state. I watch lower belly and I watch my breath, actually my breath is not only through these two nostrils, it is through the body. When the patient opens the door, I start to record my body sensation. Sometimes the body sensation in the figure and sometimes the body sensation are in the background. But this self-aware is constantly working. Why it becomes the figure or profile it means something like projective identification, mostly the somatic one, or maybe it is the
feeling of the patient, or maybe it is the feeling of the object when the patient evacuating. Through the somatic feeling, my patient taught me the original theme of all the things that have happened. Like I surfacing on the patient's associations. To see where it takes me to and I feel that there is some blockage, I feel it or when I feel it I take it in my mind through I dissolve it. Finally I interpret based on my understanding of this blockage. If I offer correct interpretation, naturally for the patient, they will also have a somatic response. T17

This is a very unique and personal approach born out of a particular interest and marriage of psychoanalysis, mindfulness mediation, Buddhist practice and TCM. Indeed for T17 and other participants' responses preempt the following chapters exploring how Chinese cultural practices explain how somatic countertransference may arise and add to a deeper understanding of how to work with it.

The idea of meditation became popular amongst some other participants also. Notably T21 engages his clients in a relaxation process at the commencement of the session and thus encourages a focus on their bodies, he states the following about this process:

In our China, Wu Wei, If we want something happen normally, we do nothing, Just let it go, if you force the therapy process, the anger will be amplified. Let it go, angry is just angry. If you do not set anything to it, there is no meaning. As Freud said, “a cigar is just a cigar. T21
I think what T21 is implementing here is the Taoist principal of non-interference whereby the therapeutic session becomes a free space of allowing whatever to surface without interference from the therapist. This is a Chinese take on a classic non-directive psychotherapeutic process endorsed by most psychodynamic therapies and psychoanalytic modalities. In addition to T21, T17 and T4, other participants reported taking up Buddhist retreats, Tai Qi practice and mediation to enhance their therapeutic sensitivity and in some cases to provide greater protection against exhaustion and psychic infection. This will be explored in more depth in later chapters.

Another approach with somatic countertransference was observed from Guangzhou with the participants that studied at South China Normal University. According to Professor Heyong Shen, this course is one of the three most important Psychology Degrees currently in China. Professor Shen, a Jungian analyst has heavily influenced the teaching style with a strong Jungian and cultural focus. The practice of sand-play and the integration of the work of Robbie Bosnak, a Jungian analyst were evident in the responses given by the participants. For example T22 spoke of working with the patient’s dreams and acting out the dream through sand play whilst observing bodily states. She says the following:

*He will describe a dream and then we will work on the dream, go into the dream, so like the animals, the people that are in the dream. So we direct our body to feel the roles in the dream. The ego and the other people in the dream. Then we will feel our function in our body.*

*Here is not function but feeling as follows. Then, I and the client both feel our feelings of our body, also our feelings of emotion, in our heart. These feelings will be seen as*
the information of messages or energy from the unconscious or the psyche. So the body show the feelings to the conscious ego. And it is like this in the Sand play therapy. T22

It is a particular style of psychotherapy that engages a number of expressive outlets with the main aim to articulate feelings either through dreams or sand play or both in combination. In addition T22 reports that the session involves her observing her own feelings in her body for resonance with the client. A colleague of T22, T23 reports the following:

We work with the clients with sand play, with the miniatures. They put some miniatures in the sand tray, I will ask him or her when he/she look at it how to feel it his body. T23

T23 then explains that she will reveal her bodily experiences to her client if she feels that it is relevant to them, if not she will hold back. Essentially T23 states that the aim of therapy is about orientating the client back to themselves by encouraging them to observe their feelings in their body and her parallel bodily sensations as the session evolves. T23 is adamant that the role of the therapist and client body is essential and says:

Yes, but when the feeling is serious, I can feel it and I am sure it is very important and I will work with patient and if it affects my life I will work with a supervisor. T23
In follow up communications it was established that T22 and T23 combined Bosnak’s embodied dream technique with sand play, therefore creating a Jungian treatment modality approaching symbolic work via sand play together with heightened body awareness. This is a unique take and combination of working with the body of the therapist and client developed in Guangzhou, China.

When thinking about somatic countertransference and how it is worked with from a Western and Chinese perspective there are some similarities, some slight differences and then the occasional unique and highly personal perspectives and approaches. As such, T17 sums it up accordingly and in doing so compares Western and Chinese appraisal of somatic countertransference from his perspective:

Because I practice in China, I know that mainly that western interpretation of somatic countertransference, maybe a negative way, maybe they see it as a regression for the therapist, psychoanalyst or maybe this is a very severe trauma from the patient’s side, or maybe it because the analyst did not receive enough training. Maybe they interpret this phenomenon from a negative side? But for me, I am happy with somatic countertransference every day. It is my inner guide, it is not a regression. Even if it is a regression, it is a healthy regression with the assistance of ego. T17

Concluding Remarks

In conclusion, and returning to the common example of drowsiness, T18 explores sleepiness as a form of somatic countertransference and cautions the tendency to see it
She starts with discussing how she experiences her client then later moves onto the topic of sleepiness.

One of my patients who I have been working with for about two years a female patient. At the beginning of this year when I was meeting with her every week, I mean the feeling of boring and sleepy yes it came out and ran in my body apparently. And I think it is also a good opportunity to help me to better understand her loneliness, as she didn’t get a good care from her mother during childhood.

It depends on where we are and depends on the patient personality and depends on my assumption how to work with different kinds of patients. But usually if I try to do interpretation, maybe I will not speak very directly about my feelings. Maybe I will try to be, I think it depends on the opportunity to test; maybe I will say it more softly. Or try to avoid those very negative words, which may be resisted by the patient. Yes but I will try to and I would like to work with this part with patients in the proper way. T18

T18 is speaking clearly about one of the important findings of this thesis. Somatic countertransference can be many things but it is indeed situational, a co-creation that occurs within the therapeutic space. Connolly, Orbach and Schellinski echo this sentiment in particular in the interviews I conducted with them (Connolly, email, 11 March, 2013, Orbach, Interview, 18 December, 2013, Schellinski, Interview, 16 January, 2013). They agree that it is indeed a co-creation and situational to the therapeutic process emerging at the time. Connolly in particular alludes to the importance of the relationship that is occurring between the analyst and client and that within the relationship lays the potential for cure.
The body of the therapist, according to the findings of this research from both chapter 2 and the current chapter appears to be a cross-culturally viable therapeutic tool. Emerging from the data analysis was the finding that many themes reverberated with Western thinking particularly in the areas of somatic countertransference can be meaningful, uncanny, preverbal unmetabolised expressions or reenactments from the client taken up by the therapist. In addition there were similar ideas about when it occurs in therapy and whether to articulate it to the client for therapeutic process. The body of the therapist was also in some instances seen as a means to gauge therapeutic change and or to progress the therapy. Similar divergence of opinion also existed around ideas of the body acting empathically and or as a container. Where there was an emergence of new ideas occurred with the integration of techniques to facilitate greater sensitivity and protection against psychic infection seen as a by-product of working with deep unconscious material. This suggests that Chinese participants experienced profound affects as a consequence of somatic countertransference, provided some unique ways to work with somatic countertransference to harness its potential as a therapeutic tool and ways to explore how it manifests. Importantly both chapters 2 and 3 articulate that somatic countertransference has many dimensions and ways to work with it. It cannot be solely reduced to be an expression of preverbal material; rather the Chinese participant’s responses suggested a number of dimensions to what somatic countertransference can be seen as and how to work with it clinically. These aspects will be discussed further in the following chapters.
Chapter 4: Psychic Infections and Shared Wounds: a Chinese Perspective.

The wounded places in our own psyches are often the sources of our most creative work with patients. (Greene, 2001, p 565)

The notion of the psychic wound as Green indicates, is at the heart of psychotherapy. Furthermore, if worked with in a thoughtful and conscious way our psychic wounds can provide many creative possibilities for processing both our own and our client’s material. It is also important that as psychotherapists we treat the psychological wounds of others, but in doing so indirectly revisit our own psychic wounding. In the zone of mutual unconsciousness between two people proposed by Jung, it is possible that somatic countertransference may evolve and illuminate similar or otherwise psychic wounds that are uncanny yet deeply meaningful for both therapist and client (Jung, 1954).

Emerging from the data analysis were two important findings that correlated with these ideas. First of all, when working with clients, the Chinese psychotherapists spoke about taking in their client’s material and thereby becoming infected. This can be in the form of an embodiment, a taking in of psychic material both physical and/or psychological in content. This is the idea of the psychic infection mentioned by Jung (Jung, 1937/1993). Secondly, it is the analyst’s and psychotherapist’s personal psychic wounding, captured within the idea of the wounded healer archetype\(^9\), that enables this capacity to be infected by other. This idea has been taken up more

\(^9\) The term wounded healer suggests that people working in the helping professions are drawn to this work because of their previous psychological wounds. Jung wrote about this vulnerability and predisposition in his Collected Works vol. 16 (Jung, 1954). The term ‘the wounded healer archetype’ was further developed by Adolf Guggenbuhl-Craig and C. Jess Groesbeck (Merchant, 2012).
recently by Merchant and Clark in post-Jungian thought and explored in a doctoral thesis by Burda (Merchant, 2012, Clark, 2010, Burda, 2014). Furthermore, in an important book entitled *The Wounded Healer: Countertransference from a Jungian Perspective*, Sedgwick after returning to Jung’s seminal ideas about countertransference and by exploring personal clinical vignettes, also concludes that the analyst and analysand are engaged in a zone of mutual woundedness that is a curative factor in the analytic process. This is consistent with Clark and Merchant’s notion that our prior woundedness as analysts facilities a resonance and capacity to work with our clients (Clark, 1996, Merchant, 2012). Importantly, this susceptibility to psychic infection facilitated by personal wounds warrants greater self-care by the therapist when working with this material.

This chapter commences with a discussion of these two important related concepts of psychic infection and the shared wound. I will reference current thinking and ideas about these concepts from Western psychoanalysts and Jungian analysts. These ideas will then be applied to the data provided by the Chinese participants to determine whether they are cross-culturally relevant. In investigating these examples, it is hoped that a clearer understanding of the presence of the shared wound and its relevance to somatic countertransference is obtained. Finally a discussion on the impact of working with psychic infection and the shared wound will occur with a call for greater self care of the therapist. This will generate some ideas for managing shared wounds and psychic infections suggested by the Chinese participants and Western experts in this area.
What is a Psychic Infection and what is meant by the Shared Wound?

According to Merchant, Jung first introduced the notion of the psychic infection in 1937 and alluded to a ‘zone of mutual unconsciousness’ between analyst and patient that could affect the body and psyche of the analyst (Merchant, 2012, p 4). In Jung’s own words, he says the following:

> For two personalities to meet is like mixing two different chemical substances; if there is any combination at all, both are transformed. In any effective psychological treatment the doctor is bound to influence the patient; but this influence can only take place if the patient has a reciprocal influence on the doctor. You can exert no influence if you are not susceptible to influence.
> (Jung, 1954, p 71)

This sets the stage for understanding both important concepts of psychic infection and the shared wound. What Jung is stating here is that when two people meet in a clinical setting there is a shared zone of mutual influence that is happening both consciously and unconsciously. As such, both participants are affected by the process of psychotherapy and thereby mutually influence each other. This follows on to the idea of countertransference and the role that it plays in this mutual exchange process. Jung says the following:

> One of the best known symptoms of this kind is the counter-transference evoked by the transference. But the effects are often much more subtle, and their nature can best be conveyed by the old idea of the demon of sickness.
According to this, a sufferer can transmit his disease to a healthy person whose powers then subdue the demon— but not without impairing the well-being of the subduer. (Jung, 1954, p 72)

Jung is describing a psychic process that happens within the therapy session and how countertransference can feel like a sickness, taken in by the therapist to somehow tame and heal in the therapeutic process. It is commensurate with the idea of somatic material that is experienced in the body of the therapist, it can be subtle yet poignant about the inner experience of the patient. As Merchant points out, Jung ultimately positioned the idea of psychic infection and by association countertransference as crucial for understanding the inner world of the patient (Merchant, 2008).

Continuing with this theme of mutual influence, Merchant extends our understanding by suggesting that in order to pick up on these somatic experiences, be susceptible to them, there needs to be a predisposition to porosity to this psychic material. Merchant and others suggest that this is only possible because of previous wounding suffered by the analyst or psychotherapist (Merchant, 2012, Sedgwick, 1994). Merchant says the following:

Susceptibility to these kinds of vectors can only come about through the therapist’s own wounds. The therapist MUST be a wounded individual (this is going to be the case in our profession anyhow otherwise why would we go into it in the first place?) But more importantly, the therapist’s wounding must be processed to the point where a kind of third position is attained i.e. the capacity to have emotional experiences whilst observing them at the same
time. It is only from that position that the countertransference can be used as a means of communication and fed back into the therapy. The alternative is to be infectively swamped which can lead to all sorts of actings out. (Merchant, 2008, p 4)

In responding to Samuel’s initial paper on embodied countertransference, Giles Clark, a Jungian analyst extends Samuel’s ideas on how embodied countertransference evolves by integrating Jung’s idea of the ‘psychoid’ (Jung, 1969). Clark implies that Jung’s idea of the deeper layer of the unconscious noted as the psychoid holds the potential of being a place whereby mind and matter are inseparable and therefore able to explain how psychical states relevant to the inner experience of the patient manifest in the body of the analyst for processing. Equally importantly, Clark suggests in agreement with Merchant that it is the therapist’s psychic wounds that enable this picking up or resonance of psychic material. Clark adds that the wounded healer in the analytic relationship is able to contain and process the wound of other because he or she has survived his or her own wounding (Clark, 1996). Clark infers that whilst being wounded facilitates this porosity and ability to take in the inner experience of other, it is not necessary that the therapist be wounded in the same way (Merchant, 2012).

Agreeing with the idea that pre-existing wounds facilitate our porosity as psychotherapists, van der Giessen says the following:

Without the formative experience of being "held", our sense of self never fully establishes its identity; it is continuous with the world around. We have
difficulty distinguishing what is "self" and what is "other". Like a cell whose membrane is, our identity lives in danger of flowing out into the surrounding void. (van der Giessen, 2011, p 4)

In a homage to Winnicott, van der Giessen explains that our early experiences of holding whether they were lacking or impinged by other sets up a capacity within the therapist to take in or feel swamped by other’s psychic material. It is this developmental template or wounding that both Clark and Merchant allude to that allows for psychic infection also manifesting as countertransference in its various forms. As such, this susceptibility in the therapist is what brings about psychic infection and the notion of somatic countertransference which may be familiar or not but most importantly a communication about the inner world of the client. Likewise, Ross expresses his own experience of being wounded and how it enables his ability to perceive body states relative to his client, he says:

   Developing an ability to be attuned to and embracing of my own thin-skinned, narcissistically wounded, psychotic infant leaves me advantageously predisposed to actual physical experiences. (Ross, 2000, p 457)

This strong statement implies that a previous wounding from the original maternal dyad has predisposed Ross to picking up somatic material relevant to the therapeutic relationship and process. Similarly, the experts I interviewed provided different ideas about the shared wound and whether it is a pre-existing necessity to facilitate this experience. Both Orbach and Schellinski from my interviews with them intimated that our ability to pick up somatic countertransference cannot solely be explained by the idea of a shared wound. Indeed, Orbach dismisses any attempts to be formulaic in
understanding how somatic countertransference comes about or how best to work with it in a deliberate move away from a mentalist straightjacketed approach about the body (Orbach, Interview, 18 December, 2013). Schellinski expressed the view that shared wounding could only explain some profound experiences whereby other clinical examples went way beyond wounding to experiences that were very difficult to understand yet equally as moving (Schellinski, Interview, 16 January, 2014). She explains this in reference to a clinical example of stomach gurgling with a client. She says in our interview:

*So the gurgling, I still have that and for me it is a little bit beyond the wound, it is not only when it is a shared wound. It may come totally widely different. I don’t understand what the person says to me, I don’t understand my symptoms but it does speak to the person. So I am sort of…..I am a mirror, I am a blank mirror. I am not just a shared wound mirror, I am blank mirror. It goes, (gurgling), I hear it and I think, “Okay we have got some work and it is there.” And the most exciting, but I can’t prove it but in the course of that analysis of a woman whom I saw, she was in her late 60’s/70’s I think and she had Crônes disease. Crônes disease is a very serious afflict. It is an affliction of the bowel. It is bleeding and it went away after two years of analysis. And it was through gurgling and *(That a lot of the processing and integrating into consciousness took place.)* / I don’t know what I said, yes there were some things that she dreamt and yes we understood. Yes I was empathetic, yes I interpreted, yes we saw some symbols but essentially something in her body processed all the way through, gurgling through and in the end she did not have any more symptoms of Crônes disease. And she said, “I would never have thought of this that it was possible!” and the work was finished. It was fabulous. But of course I don’t have*
a study of 20 people and I can’t prove it. I observed it so that just came to my mind just now. (Schellinski, Interview, 16 January, 2014)

To put this example into context, Schellinski explained that she observed her stomach gurgling in response to her client’s stomach gurgling. It was like a body-to-body communication, a physical conversation that was enacting a processing of sorts that paralleled the verbal interpretative work they were undertaking. For Schellinski, this takes the experience of the therapist’s body in a different direction that cannot be directly linked to previous wounding per se. Yet, consistently with Merchant, van der Giessen and Clark, it is possible that whilst there was not a direct match of personal shared wounding experience, Schellinski, like many psychotherapists has a predisposition to picking up and working in this manner traceable to early developmental experiences (Merchant, 2012, van der Giessen, 2011, Clark, 1996).

Returning to Orbach and Schellinski and the idea that the shared wound is not the only explanation for understanding how somatic material is picked up by therapists, Connolly in our personal communications, expressed the idea of the shared wound /wounded healer archetype was sometimes over stated and emphasized in relation to how an analyst works with their patients. Yet she agreed that it would be difficult for an analyst to work with material that had not been adequately worked through in their personal analysis, thereby suggesting that a thorough reductive analysis is paramount in training. In addition, Connolly suggested that experiencing similar traumas such as seen in the collective experience in Russia could enable an analyst to be more effective in their work with Russian patients for example (Connolly, 2006, Connolly, Email, 11 March, 2014).
Nonetheless, the notion of the psychic infection and the potential for shared woundedness were discussed by the Chinese participants and therefore it warrants further exploration. Importantly, developing our knowledge and conscious awareness of this material is necessary for the psychological well being of both the analyst and patient. In Schellinski’s words:

I believe if the analysand and/or analyst remain unaware over a long time or even block the signals from transference, including somatic transference, either one or both may indeed become ill, in body and/or soul. (Schellinski, 2013, p 15)

It is with warning in mind that the following material provided by the Chinese participants becomes more real and vital for our consideration.

What the Chinese Participants said about these Concepts?

In discussing somatic countertransference with the Chinese participants, frequently without any provocation on my part, they would start to speak of personal material that resonated with their clients and or that the somatic countertransference was deeply meaningful for them in some way. This emerging theme was unexpected and yet common amongst most of the participants. As such, exploring one’s personal material and the potential intersection between client and therapist’s experiences provided the means to understand, unpack the inner experiences, dynamics from the early childhood of the patient in a new and meaningful way. It also suggested that somehow the client had gotten into psyche of the therapist, had penetrated or infected the analyst/psychotherapist within the psychotherapeutic dyad just as Twemlow in our
interview, expressed happens with embodied countertransference over a long psychoanalysis (Twemlow, Interview, 7 December, 2013).

Returning to T2 and his experience of headaches and stomachaches as common somatic countertransference when working with his clients, he ponders whether he uses these somatic expressions as a means to avoid conflict. This example was discussed in Chapter 2 demonstrating T2’s development of meaning around this material and his ability to reflect on these experiences to broaden his understanding of his client. He goes on to say something about the cultural context of his experience of avoidance. He says the following:

Our Chinese cultural [context], we do not like the conflicts, we have [a] saying 靈生財 in Chinese, that means that harmony is good, yes. We do not like the conflict. For me, it can make a headache and that means conflict and I don’t like it. It is the culture and it is mine. When I was a kid, my father usually beat me a lot; I don’t like the conflict at all. Usually the physical touch or something, the conflict, I try avoiding the conflict if it comes in. So I think it is my personal and cultural creation. I am not Christian, only this part effects me. T2

T2 showed no hesitation in sharing this very personal material to explain how much he dislikes conflict from a personal and cultural perspective. Whilst he does not explore this reaction as an indication of his client’s reaction to conflict, it does depict the personal dimension and content that can be activated via bodily reactions and expressions when working psychotherapeutically with other. In addition, this material focusing on conflict avoidance has been explored by Chinese psychotherapists pondering whether conflict avoidance noted with the Chinese can be thought about
psychoanalytically (Ng, 1985, Zhong, 2011)? This will be taken up in chapter 7 when
a discussion about whether the psychoanalytic approach can be applied comfortably
when working with Chinese patients.

In explaining how somatic countertransference could be a tool for understanding the client’s inner world, T3 outlines his approach and finally adds that essentially our own personal complexes will also be activated. He says the following:

_Literally, it may be challenging but when we find a convention or as a therapist to interpret, we therapists actually, it is a kind of, maybe take it as a tool. As an object, it might actually (may be able to) provide for your client an object for resonance. When that resonance occurs, basically the therapist can feel, can respond. For certain training, we try to dampen down this kind of response you know. But not completely, because we are human, you know. We are human; we cannot filter all response. So powerful, those selective from person to person. We can perceive more fully the autonomic system, to enter the therapist and give a particular response, some are somatic, some are not. So I am quite convinced that therapists will respond with this differently, depends on their personal defending system, particular area, the muscles, the headache. Sometimes their chest, actually every part of the body could respond differently for different therapists. That is my summary._

_In general training, I would call it a little be different when I apply the analytical psychology, the Jungian way because the supervision would be a little be different. I think that would be a new experience where you interpret that sort of response. For the analytical psychology approach, it appears to me to become more meaningful as well. Not just a body reaction to your patient’s heavy stuff. Do you see my point? ............_
it might guide you to look at the complex underlying; it might be your client’s complex as well as your own complex. T3

T3, a trainee Jungian analyst articulates how important the role of the body can be when working psychotherapeutically, especially in analytical psychology. He explains that this will vary from therapist to therapist as we all have personal systems of defense enacted in the body and in some cases this can lead to a shared wound experience. More specifically, T3 uses the Jungian term, ‘complex’.

Returning to the idea of psychic infection, which occurs as a result of previous wounding, T4 actually uses the word contagion thereby confirming the idea that the therapist is performing the role of taking in the patient’s infection. He says:

*So most of the time, with the patient that has some prominent character, we talk about some story with strong feelings; I will have some somatic response. I feel it is a direct communication, like a contagious, a contagion, I receive in my body, like my body is a tool to receive it, to feel it and will have a response.* T4

This is an exciting; almost word for word match with Jung’s original idea of the psychic infection that occurs when psychotherapists work closely with their patients. Just as extraordinarily, T4 anticipates that psychic infections can often lead to one’s personal material because of a lack of resistance within the therapist’s psyche to this particular experience. He says:

*If your somatic response was so connected with your own personal material? (your past experience) it can occur again because you have so deep connection with it. We have resistance, we can repress such personal material so it didn’t have a chance to last longer.* T4
In this statement T4 is confirming that there is susceptibility within therapists to certain material as a result of their preexisting personal experiences or wounds. In a follow up interview, he provides a personal example to illustrate this idea:

I received a patient, the first interview; he talked about suffering from stuttering. He couldn’t speak words fluently; he often paused and repeated some words. I found it easy to identify with him and I try to speak fluently but I was easily influenced by him and I also paused some while. It was interesting. So when I talk to some patients that suffer from some problems we can easily be influenced to have the same problem, identification.

Maybe it comes from a deep identification with the patients, when we listen so carefully to the patient, it is easy to be involved in their situation; we try to imitate his response. Or maybe it is a natural response. It is like when people cough, it can make other people cough. When people smile it makes other people want to smile. When we are in a group with people and some one has some gesture, others will have the same gesture. It is an unconscious influence.

Maybe, it evokes the same feelings in me and so I have the same impulse to imitate his response, he felt so inhabited and feared being criticized by other people, so he tends to stutter before other people and repeat words, pause for a while and then begins to talk.

Yes, I was influenced by the same feelings because maybe before I also feared the authority and fear to show myself in public and so I also fear my performance in public. They are the same feelings, we have something in common between us so maybe, and it is like an ability to identify with each other. I became to stutter like him. My body countertransference is a reaction, maybe it discloses a part of myself, so it is easy to be influenced by him. Maybe other people will say it is like the projective
identification, somebody puts something onto you and you take it in. Maybe you can identify with him because you have something in common with him, so it is easy to identify with him. T4

In talking specifically about the concept of the shared wound, T4 is in agreement and says the following:

Yes we vibrate at the same time. It is very interesting when we have a body reaction, it is a good sign for us to know more about the patient because we are influenced and we have the influence. We deduce from some sensations. So I think that the body reaction is very direct communication between the patient and the therapist. T4

T4 is stating a number of aspects to therapeutic work that is important to consider. He mentions the idea that it is easy to identify with the patient and yet goes on to state that more than identification is happening here as if there is a process of mutual influence and vibration that enables two bodies to relate in that moment. T4 also expressed that shared material as a good sign that somehow it enables a direct and deeper communication of inner experience between client and therapist. T4 is in agreement with Jung that in the mix, both client and therapist are mutually influencing each other (Jung, 1954). Furthermore the idea of identifying with a patient’s material fits naturally with the neuro scientific explanation of mirror neurons discussed by Schellinski and others (Schellinski, 2013). This will be explored in more detail in a later chapter.
Another example of the shared wound experienced by the therapist whilst working with a client was provided by T5. T5 spoke about her work with a client she calls Sarah whom she worked with for several months. She described Sarah as anxious especially when she fell pregnant and that she experienced some initial problems with her pregnancy. In addition she originally presented with her partner as they had ongoing difficulty communicating with each other. T5 says the following about her feelings of similarity or identification with Sarah:

*I later took this case to be supervised and one of the reasons I chose this case was because I feel there is a very strong connection between Sarah and me. There are some similarities between our experiences, and I feel that I am very absorbed in this case. After the session, it takes me a long time to write down the record because I don’t do any recording during the session, so usually I try to remember as much as I can about the session and I write this down and also what I feel in the session. There is a lot of after work after the session and also part of the time I also have a headache. T5*

When T5 describes difficulty writing up her clinical notes after the session, this suggests that she is possibly being psychically swamped. In addition, T5 reported experiencing headaches after working with Sarah and that in parallel her personal relationship suffered in that she often stayed up late into the night arguing with her partner, just as Sarah had described was happening in her relationship. T5 reveals the following about Sarah:
Sometimes when they were arguing, sometimes they would stay up the whole night and they would not sleep. They would just argue. I suddenly realized in March and April I had some (issues), the relationship between my boyfriend and I, we had that problem. Sometimes during the night we would argue, we were not really fight or something but we would not be happy and we would not know how to talk with each other. And I don’t know whether this has something to do with the session as well. Because previously when Sarah told me how she and her husband would argue during the night I would sometimes feel that that was what was happening between my partner and me. Because sometimes when we have this experience my boyfriend would just sit there and smoke and would not know how to comfort me and I would feel quite vulnerable. Sarah told me that when she had these problems with the husband, her husband would try and debate with her. Her husband is a lawyer; he is very good at it. And she said, “I just want him to comfort me and he did not comfort me.” So yes it just felt like it hit me and I don’t know whether this has something to do with this case as well. Because we haven’t argued for a long time. T5

This is an astonishing example of a shared experience and possible wound. From supervision conversations about how a client’s life experiences and material can mimic in part our own as therapists is not uncommon. This is at the heart of the shared wound and the therapist’s experience of psychic infection. As T5 reported, her personal life had started to mimic Sarah’s and as importantly she developed insomnia and headaches after and during the period of their work together. It was in reading my recruitment email for this research project, that T5 realized that there was some strong resonance occurring between her and Sarah and prompted her to discuss this in the interview.
In a similar way, T9 revealed how assessing a patient and her mother affected her sufficiently to ponder her own capacity to mother her own daughter. She says the following:

*Yes, once I met a mother and girl, that girl and she was schizoid kind, but not very serious she can talk about her story to me. I saw her mother together in a therapy room. I noticed that the mother and the daughter paid little attention to each other. Especially the mother. It seemed like the mother was all, what is that word in English, I just forgot it. She paid no attention to her daughter, especially when the daughter seemed to be crying out to her mother and her mother didn’t hear her. She didn’t want to visit her when she was in the psychiatric hospital. Her mother just sat there with no emotions, no feelings. Really like wood, a piece of wood. In that session, I can just see how cold the relationship is, it is really cold with no emotions, two separate people. But after that session, I had a really serious headache.*

*I didn’t have the headache in the session but after that and I can’t stop the headache for hours. You know what I can understand about this right now is that I, myself paid much more attention to the relationship between mother and daughter and I also wish my mother give me a lot of attention. So when I saw them, I just tried my best to help the daughter and the mother to look at each other but they did not and so maybe I was so busy with that, that I could not see, feel my headache or something that came from inside. After they left, I only saw them once. So I have a real headache.*
I could see that I paid much attention to this topic, the relationship between daughter and mother and that me feel uncomfortable, when I saw those two. T9

T9 shared that in this one-off assessment treatment session, her own experience of mothering was touched and that she attributed the headache to the session and how it drew her to explore own personal experiences of being mothered. T9 stated that it is common to share the same material in some way with your clients and expressed that this viewpoint was shared by her colleagues. She said:

Yes it is really, how to say I can imagine what kind of patient I would meet as a first patient, the very kind but when she first came in and told me about her problem I just was shocked. Not only me, a lot of my colleagues have the similar feeling that what kind of person you are, you will meet that kind of person, yes. What problem you have, you will have the same kind of background problem, very early. T9

Echoing Merchant’s idea about observing one’s reactions to client material and adopting a third position, T9 agrees and says:

I just think, maybe I can understand the similar part of them was me, myself and I observe this. This is what the therapist should do, observe and have feelings at the same time. So you are in the circle and out of the circle. So this worked. T9

As such, there is an unconscious connection between therapist and client and the therapist needs to equip themselves with the capacity to observe and name what is
happening in the here and now. This is the process of a deepening self-awareness in the session as well as an ability to manage psychic infections.

Another experience of being psychically infected and taken to an experience of previous wounding occurred with T11 and her group ‘debriefing’ for a corporation where an employee committed suicide. T11 was called in to pre-form a group debrief and thereby facilitate a group discussion to enable the group to process their feelings. T11 says the following:

'I can’t remember which patients, but I feel that my heart is cold and it is really sad but I can not allow this to happen but to speak out I had to control myself very tightly I had to work for a whole day with these people as a professional. I can still feel that in my heart, it is cold; it is like a very sad stone? T11

T11 explains her reaction as such:

'I think that they were sad and so close and there were so many people, their fear cause my reaction. On the other hand, I think it is related to my own experience. Although they are a lot of losses in my family, but I was always outside of the town. so when there are grandparent?passed away, my parents will say “it is okay, you don’t need to come back. ”. So I didn’t really attend many funerals and this meant that I am not experienced.

Yes, I didn’t attend too many funerals and [have not] seen dead bodies, so maybe I have fear, I don’t know if I didn’t have so much fear I wouldn’t feel so scared. T11
T11 explains that her reaction was fuelled by her own lack of experience of dealing
with multiple losses and her own pent up unexpressed feelings of loss. She describes
being effected so deeply to the point that it was almost unbearable. She further
acknowledged that there were many people in the room, which intensified the
experience for her. Again, it is a clear indication of feeling psychically infected or
swamped by intense grief and moved to revisit the unexpressed grief of many past
family losses.

Likewise in discussing her work with her patient Jason, the patient with whom
she experienced severe sleepiness and wanting to avoid direct discussion, T12 said
this material led to a shared wound. She felt that this material was shared because of
the intense somatic reactions she experienced. She says the following:

Yes, the interaction with Jason is, you know, I am too much involved with him but we
kind of became one, I was really afraid of his feelings. Also, he evoked feelings in me
like when I was very young, you know like a little girl. I used to have the feelings, I
was not aware of until I was working with him. Sometimes I felt strange, so self-
conscious, like an animal…very strange feelings. Scary, kind of. T12

In this testimony, T12 alludes to regressing to previous feeling states when working
with Jason, which illustrates the idea of returning to a shared or similar wound. In this
case she is taken to previous experiences she had either forgotten or was not
conscious of. In addition in a follow up interview, T12 spoke of feeling psychically
infected when working with her other patient WJ. She described how she developed
physical ailments such as hemorrhoids and that she felt like she looked older than her
actual age. T12 reveals that these same physical symptoms were shared by WJ’s girlfriend at the same time, who recently moved to Shanghai. T12 expressed deep concern about the parallel timing of these physical conditions and was sufficiently worried about this experience that she spoke about it in her analysis for 6 months\(^\text{10}\). In my interview with Schellinski, she echoed this same concern and provided personal examples of becoming physically sick with parallel symptoms when working with some of her patients. Anecdotally, she spoke of a Jungian analyst in Switzerland who was so worried about her propensity for becoming physically ill due to psychic infection from the analytic experience that she has since retired and has ceased feeling unwell as a consequence (Schellinski, Interview, 16 January, 2014). The capacity for psychic infection is at times alarming and must be handled with due care and thoughtful consideration. This opinion was further stated by Iannaco after attending numerous conferences papers at the Freud Museum in 2000 on the therapist’s body: due care must be taken when somatic countertransference is experienced in the therapeutic process (Iannaco, 2000).

Another Chinese participant T15, experienced in somatic experiencing technique of psychotherapy, spoke plainly about the idea of the shared wound. She notes the following:

I think before how come I got so severe shoulder pain, it is because I am really absorbed in what the client is saying and taking the energy and being influenced. I have one experience when working with an obese client. In that time, I not only dream

\(^\text{10}\) This example expressed by T12 in which she starts to develop the same physical symptoms as WJ’s girlfriend at first appearance, may not seem like somatic countertransference. It is in my opinion, an excellent example of psychic infection enacted via the unconscious-to-unconscious communication in the session. The hypothesis is that it is possible that some aspect of WJ drives his women to illness. As such, it seems to be like a toxic form of projective identification.
of her and of her family members and then the next day and the weeks following, I got very severe shoulder pain. I noticed that it must be something from that client because otherwise, I am not doing manual work. I shouldn’t have that pain. I sit in an office and I see clients, how come I have that pain? T15

I think this example expresses the deeply symbolic and uncanny way in which embodied countertransference, in somatic form, can manifest (Samuels, 1985, Zabrieski, 2006). It is as if T15’s shoulder pain is saying something about her role in shouldering the client, her taking in of the client’s feelings. T15 reported that she used Reiki to alleviate her shoulder pain and thought about how the pain also symbolized her tendency to take on too much responsibility. As such, T15 was very clear that she felt infected by her client’s material, which moved her sufficiently to discuss it in supervision and seek out a means to remove her physical pain.

In the case of T18, her male patient led her to contemplate her own experience of being mothered and how she is presently parenting her daughter. Furthermore, she states that the whole process of being emotionally moved in the therapy by the client’s material and reflecting upon it for the personal meaning, led her to experience a form of personal healing. T18 explains that with one client she has worked with for one and a half years, in one session her client described to her three words that exemplify his parent’s experience of him. At the time, T18 could only recall two of the three words, that being ‘disappointed’ and ‘scorn’. T18 relates that these words affected her. She says:
Yes scorn by the parents yes. The last one is disappointed. I forgot the middle one, but very strong words and we had a very long silence after these three words but I know that he was very sad at that moment because me too. I could feel that my, something was stuck in my throat.

I want to sit in the sofa tightly, like lie on the sofa tightly. After the session, I stayed with myself for a while. I think that there is something about myself in the countertransference. He let me, to me go through how I work with my daughters. Also at the same time, I feel like I could better understand his deeper emotions instead of his weakness or his useless as before. Yes. I would like to tell you that after the session when I went back home, I had a conversation with my daughter. It was quite constructive.

………..Yes, so we help the patient and also the patient helps us. They help us to get into human. I don’t know if I am using the correct words in English. It is like they help us to better understand ourselves and the humans, others and ourselves. So the body we could use the body to stay with the patient to feel, that there is something real but maybe the patient didn’t realize it before. T18

I think this example demonstrates how the therapist’s bodily experiences in the session provides a connection and insight into personal material that potentially resonates with the clients. It is the very vector that Merchant speaks of when discussing the role and importance of prior wounding for the therapist’s capacity to work therapeutically (Merchant, 2008). In addition, T18 touches on the possibility that both client and therapist are mutually affecting each other in the session. This affirms Jung’s original position of mutual influence in psychotherapy and the
potential for healing and transformation of both therapist and patient in the analytic process (Jung, 1954).

With a case presented by T21, T21 reveals that he felt a familiarity with his client’s material, in a way suggesting a zone of shared wounding. The client in question was a young student who felt depressed after the suicide of his friend. In particular his young client felt that no one took his concerns about his friend seriously before his death. T21 says the following:

_I can remember at that time, I didn’t feel very well because I was very confused that, yes but maybe there is something related to me. I remembered that it was my countertransference because in my life I grew up in a very poor family, I had to do a lot of work to draw other people’s attention and maybe most of them are not necessary to other people. From a Jungian psychological perspective, the boy is like me, also introverted intuitive._ T21

T21 reported that he felt really affected by his client’s case and revealed that they shared a number of interests including helping others and studying philosophy. T21 specified that he felt ‘unwell’ which I suspect is both physical and emotional in content. Once more, this example was presented freely and in relation to experiences of somatic countertransference and what meaning they can hold for the therapeutic process. This is commensurate with Sedgwick, Clark and Merchant’s ideas about pre-existing wounds that enable porosity to experiencing and being affected by this material (Sedgwick, 1994, Clark, 1996, Merchant, 2008).
This susceptibility is discussed further by Merchant in his more recent publication “Shamans and Analysts, new Insights on the Wounded Healing” (Merchant, 2012). An important warning is issued in this work that in training analysis a through reductive analysis is necessary so that the trainee analyst or in the broader context, trainee psychotherapist is able to process personal material so that it does not impinge upon work with their clients (Merchant, 2012, Sedgwick, 1994). This was also articulated by Gelso and Hayes accordingly:

The therapist’s wounds need to be sufficiently healed to be drawn from usefully. We would argue that one’s vulnerabilities and conflicts are never fully resolved, nor do they need to be. In fact, a therapist’s issues probably need to be alive enough so that they are available to be drawn upon in the work. Conflicts that are dormant or sealed off cannot be used to relate to the patient. The ideal, then, would be for therapists to be more healed than wounded, to be able to empathize with patients’ woundedness and to offer patients a lived sense of potential healing. (Gelso & Hayes, 2007 pp. 110-111)

This implies if a balance of woundedness and sufficient healing has occurred, the psychotherapist can operate from a third position of observing the material without being so affected by it which could result in collusion or avoidance with the client’s material (Merchant, 2012). In Burda’s recent doctoral thesis, he contends after interviewing six Jungian analysts that there was a connection between personal wounds and the experience of countertransference. His argument is that greater self-awareness of countertransference facilitated better management of it, which further influenced therapeutic outcome. Conversely poor management of countertransference
could lead to withdrawal and disengagement by the analyst in the therapeutic alliance (Burda, 2014). As such, there is consensus here from diverse sources of the importance of attending to personal wounds and that they allow a greater capacity for undertaking analytic work with clients.

To demonstrate the importance of sufficient healing and self-awareness necessary for the psychotherapist, the following examples from the Chinese participants will be explored. With T26, an intern psychotherapist, she openly acknowledged that she required further assistance to process material that she was picking up in her work as it was negatively affecting her. T26 presented a case of a child she saw who appeared to suffer from OCD. From her assessment of the child together with the child’s mother she observed that the mother was not forthcoming about her child. T26 says the following about the mother:

_A really constricted woman who suppresses/denies her negative experience, which means that it is quite possible that a lot of stress and negative energies are locked up inside her, and she might be infecting me in that way and my body became stressed, as if her body was communicating with my body and passing along her stress. When I started to work with her and her family closely, my body became so stressed. Usually I sleep OK, but when I started to work with them intensively my body and sleep pattern changed. When I started to fall asleep my body would jerk awake, with recurring muscle spasms, and so I thought to myself “my body must be so stressed.” That interrupted my rest pattern, as I would be about to fall asleep and jerk wide awake (at times it startled me), and wait to fall asleep again, and then jerk awake_
again. This change only started to occur after I started working with them intensively. T26

T26 astutely observes that something is happening between herself and the family she is treating. As we discuss the case, I mention the idea of psychic infection and pre-existing shared wounds enabling her to be so infected in this instance. She says the following in response:

There might be more to it. Similar to this really constricted mother, my own mother was using her children to meet her needs. This OCD client’s (i.e., the son’s) childhood certainly reminded certain aspects of my own childhood. This mother and my own mother were both in denial of what they are doing to their children. They are both too blinded/preoccupied by their needs to use their children to heal themselves, to see the reality of the damage they are doing to their children. At one point I was angry with this mother, until I saw how her fears were driving her dysfunctional parenting. My muscle spasms could also be my suppressed anger making it self known. T26

In an update following our interview, T26 says the following, which further illustrates the potential effect of psychic infections in psychotherapy.

I just wanted to give you an update that I thought is very interesting. Remember I told you about my sleep twitches (jerking awake when I was about to fall asleep) after I started working with a family intensively. I gave the son an OCD (diagnosis) and I thought I had those sleep twitches on days following sessions because I was
picking up on the family's stress. A few weeks ago, mum told that that son had been suffering from night terrors consistently for about 1 year. But as son acted out his aggression (with sexual content) in session, son's night terrors subsided. (She didn't know about the acting out in session, but she told me about the night terrors and their remission right after son "took me to town" in therapy.) Not long ago I woke up during a nap gasping for air, and a rush of terror came over me. The son has asthma. T26

This follow up information confirms for T26 and I that she had experienced a psychic infection, a taking in of parallel material that was likely to be possible because of her own experience of similar mothering patterns. In T26’s case, it was specifically the manifestation of asthma and jerking awake at night. For T26, this processing of information was profound for her development as a psychotherapist and a warning to take greater care post sessions with clients. Furthermore it encouraged T26 to undertake a personal reductive analysis post participation in this research project.

Similarly the topic of exhaustion is closely related to the idea of psychic infection and has been investigated empirically in some of the aforementioned studies on somatic countertransference (Forester, 2007, Egan & Carr, 2008). As I have written previously, it was surprisingly under-reported in comparison with Western studies, yet this underreporting is consistent with the fact that most of the interviewed Chinese psychotherapists expressed that they experienced support when discussing somatic countertransference in supervision. Nonetheless T27, a recently graduated psychotherapist was one psychotherapist who complained of exhaustion.
He says the following:

*Yes, I think so because one of my concerns when I was counseling, when I working with my client, I feel upset, I feel down. When my clients are upset and down, I will also feel upset and down. Less energetic than before. I also asked these questions with some people, maybe there was something wrong with me? Why do I feel so upset, so less energetic when I do the counseling with someone, with one of them. T27*

T27 reported that his feelings and exhaustion could be related to his lack of clinical experience. In returning to Merchant’s warning about the necessity of undertaking a reductive analysis when pursuing analytic training, I would agree that supervision on a regular basis would also facilitate a discussion about all experiences of countertransference physical or otherwise and this is imperative (Merchant, 2012). This view was also suggested by Forester, who in personal communications with fellow colleagues acknowledged that heightened body awareness lessened the negative impact of somatic countertransference of psychotherapists (Forester, 2007). More recently Sletvold, a Norwegian psychoanalyst has argued for the necessity for training analysts and psychotherapists to become more body-focused and cognizant of bodily monitoring approaches for better understanding somatic countertransference and the effect of it on the psychotherapy process (Sletvold, 2014). This idea is well known and practiced in Kyoto Japan in clinical psychology according to Professor Oyama whom I interviewed for his ideas on somatic countertransference from a Japanese perspective. He confirmed that all clinical psychology students were taught to observe

---

11 In addition, I discovered that T27 only received about 15 sessions of supervision over a period of a year which he expressed was inadequate for his needs whilst developing his therapeutic style and practice.
their physical experiences before engaging with verbal psychotherapy techniques (Oyama, Interview, 5 December, 2013). In my interview with Susie Orbach, she further encouraged an awareness of somatic material for further enriching the therapeutic process for both client and psychotherapist (Orbach, Interview, 18 December, 2013).

Whilst the majority of the Chinese psychotherapists were familiar and experienced with the term of countertransference and by association somatic countertransference, others were less so. In the case of T28, a Buddhist psychotherapist, he presented as a practitioner that relied less on these terms in his reflection on his practice. In spite of this, T28 revealed that in working with a client, he was also aware that he experienced a familiar or psychic wounding. He says the following:

*Of course there are some cases where I do experience counter-transferences. There was a case of an old - an elderly man. He was contemplating ending his life because he was in poverty and he suspected that he has contracted cancer. But on the part about cancer, I managed convince him that it was all in his mind and that there was no cancer. The thing I did after that was reminiscence therapy with him when he described the Japanese war period and how he had suffered, I shared those feeling also because my father and mother had gone through the Japanese occupation period also. They told me similar stories about the bombs and all that and I felt it because my father died there as a result of the war. Not a direct result of the war but because of malnutrition and you know there wasn’t enough food and he passed away, so and I …at that moment you know, it was not a comfortable feeling. Of course, my eyes*
began to be a bit wet but then I couldn’t cry in front of him, I mean, I thought that I was supposed to do the therapy on him and not him on me. Then I collected myself and we went on, so there is one instance. T28

T28 alludes to another aspect of working with somatic countertransference that intersects with our own material, that is, that it can be deeply moving. In looking back to the previous examples of this chapter that illustrate psychic infection and shared wounding, there is a profound sense of being moved in the moment in the session. As importantly these somatic experiences in our work with others can return us to our wounds and as stated by T18, we are able to work on our own material as a consequence if we are conscious of what is happening within us at the time.

In light of this, T22 says the following in a follow-up interview:

*In my work, usually, what the client said and the image he/ she showed, can moved me, let me think more about myself or the whole human……. When I am touched, I will think it much, some time will talk about it with my analyst. Yes, something come from the client can help me to deal with my own material. T22*

This statement also affirms the necessity of continuing to work on our material whilst we work with others and the importance of staying psychologically healthy and conscious of what is occurring in psychotherapy with our clients. Working with our psychic infections and wounds as Greene alludes to can provide us with many creative possibilities (Greene, 2001). It can simultaneously heal us as suggested by T22 but we must operate in the third position suggested by Merchant and articulated by T9 (Merchant, 2008). The following section explores these ideas in more depth.
Self-care and Management of Psychic Infection

I think it is hard to take the difference between the feeling is mine or the client’s.

Which parts? And another important things is in the way we take our body as a container like a trash can. The patient puts something in it and we must focus on our health problems. I think it is very important as a therapist. T23

In contemplating the importance of acknowledging and understanding how we can become infected during psychotherapy with our client’s material as a consequence of our previous wounding from childhood, it is further essential to consider the impact of this on our physical well being. T23 succinctly states just how important it is as therapists to take care of our physical and psychological health in our work. This sentiment is shared by many, namely Schellinski in her previous warning about both therapist and client becoming physically sick if the somatic dimension of psychotherapy and analysis is not acknowledged and worked with (Schellinski, 2013). This section will commence with a few examples of the ill effects of psychic infection for intern psychotherapists. It will then progress onto exploring what Western empirical research reports about the importance of self care and conclude with looking what both Chinese and Western psychotherapists suggest for taking better care of the therapist’s psyche to mitigate against the negative impact of psychic infection.

To commence, I would like to explore in more depth what was reported by two Chinese new psychotherapists struggling with working with this material. I think this is essential to consider as it confirms the importance of regular, supportive clinical supervision, the development of other practices to affirm one’s separateness
and wellbeing and personal rituals for self-protection when working with depth
psychic material.

A recently graduated psychotherapist, T27 reported feeling infected by his
clients and having only 15 sessions of supervision in one-year period only provided
some assistance. As such, there was a sense that T27 needed more guidance in being
able to process his countertransferential material after working with his clients. He
explained the following about his experience of somatic countertransference:

*How about tired or exhausted? When you feel like you are powerless, it seems like
you don’t have any power to move. You just jump into a swamp. You cannot move out
from that. Your legs are totally drowned by the pull ….something like that.* T27

When we explored his reactions further T27 said the following about his techniques
of self-management in and after the session:

*When I do the next session, I would remind myself to relax, to be confident and I just
make myself relax. So I would talk slowly in order that I can explain myself clearly. I
also try to observe the reactions of the clients.*

*I just move my concern onto something, like when I finish my session, when I come
back to my own dorm, maybe I will watch a movie or listen to music. I just want to
get out of that session, the environment, the words and the sound of my clients.*
Yes, such feelings when I did counseling with clients, yes. Hurting in my body for half a year. Especially in the consulting room but in my normal life when I was not doing counseling, I would feel better. T27

I think these three statements illustrate the importance of specific training in the area of somatic countertransference for the developing psychotherapist. The idea that T27 felt that he was ‘hurting in my body’ for half a year is alarming and illustrative of the negative effects of working with somatic countertransference that is that either unacknowledged and or unprocessed with sufficient supervision.

Similarly when speaking with T26, an intern psychotherapist other examples of the concerning affects of working with psychic infection emerged. T26 says the following:

In the very beginning when I saw this client suffering from trauma. I thought that something was following me home. It was almost like there were spirits in my room, in my bedroom. In the middle of the night, I felt them and I said, “Get out” I said, “I am trying to help her, why are you bothering me?” T26

In a follow up interview, T26 reported more material about this case which supported the experiences she had of feeling haunted or followed by her client post the session. She says the following:

Now I remember, when I first saw her (first few sessions), she talked about heart problems, being easily startled by noise or sudden movement, being scared of fast-
moving traffic, and being followed. She felt that something was following her, attached to her, clung to her back, especially at night. Then I started to have weird dreams of experiences that weren’t mine, with people I didn’t know, I never saw. The dreams were very chaotic and fragmented. The dreams eventually stopped, and I think around that time I started to feel a presence in my bedroom. T26

The experiences reported by T26 are deeply concerning and frightening for a developing psychotherapist. Returning to the work of Forester and others who have explored the effects of working with trauma patients, it is clear that the client T26 is working with a patient who is deeply traumatized and T26 is taking in symptoms of trauma such as exaggerated startle response, nightmares and hyper-vigilance from the transference (Forester, 2007). If we follow the literature further, it is paramount that T26 be provided with supervision that allows her to explore these sensations safely and concurrently enable her to leverage from this heightened sensitivity to develop her psychotherapy practice. It is also noteworthy that T26 was one of the two Chinese psychotherapists that stated that they did not discuss somatic countertransference in supervision for fear of ridicule.

In returning to the empirical research from the United States and the United Kingdom, in general there is the overall finding that many psychotherapists report experiencing somatic countertransference (Booth et al, 2010, Shaw, 2003, 2004, Loughran, 2003, Egan & Carr, 2008, King, 2011). In a more recent study conducted by Athanasiadou and Halewood in 2011, they made the following statement:

Our grounded theory analysis indicated how the therapist’s body may function as a means of empathic and intuitive connection to the client’s internal world
within the realm of Inter-subjectivity, through the unconscious mechanisms of identification and projective identification. (Athanasiadou & Halewood, 2011, p 257)

Like previous studies, they support the idea that somatic countertransference is an essential tool that enables a greater understanding and acknowledgment of underlying dynamics within the therapeutic alliance. They suggest that it operates via a process of identification and or projective identification. They further noted that somatic countertransference could be defended against which indicated an inability on behalf of the therapist to contain and process this vital material. In addition, they emphasized the importance of supervision and training to equip psychotherapists with the ability to work with somatic countertransference (Athanasiadou & Halewood, 2011). Prior to this significant research, Booth, Trimble and Egan in 2010 claimed that therapeutic outcome was affected by the psychotherapist’s ability to manage somatic countertransference. Whilst not replicated in Booth, Trimble and Egan’s research, Egan and Carr in 2008, determined that supervision played a positive and necessary role in managing the negative aspects of somatic countertransference and correlating sick days undertaken (Booth, Trimble & Egan et al, 2010, Egan & Carr, 2008). In Loughran’s study, she suggested that for many psychotherapists it was embarrassing to discuss somatic countertransference and that the more skilled and trained a therapist was, the more likely they were able to manage and work effectively with somatic countertransference (Loughran, 2002). Likewise in Shaw’s work, whilst he positions somatic countertransference as an empathic form of resonance rather than consistent with the psychoanalytic ideas of countertransference, he agrees that understanding the role of the therapist’s body is essential for the future training of
psychotherapists because of the impact it has on the therapist and the information it can provide to enrich therapeutic process (Shaw, 2003). As expressed previously, Forester is a strong advocate of acknowledging somatic countertransference because of the potential illness it can create on those specifically working with trauma patients (Forester, 2007). In summary, there is an emerging consensus that it is essential to notice and process when the therapist’s body is affected in psychotherapy because it can be harmful if not explored.

From the clinical literature, as already stated, Schellinski is adamant that our physical health may be threatened if we do not stop and reflect on physical sensations that emerge in therapy when we are working with others (Schellinski, 2013). In agreement, Connolly in our personal communications stated that if somatic countertransference was not adequately acknowledged and processed, this could be harmful to the psychological and physical health of the therapist (Connolly, Email, 11 March, 2014). Whilst not to the same level of caution, Orbach also acknowledged potential ill harm as a side effect of not attending to somatic intrusions in psychotherapy (Orbach, Interview, 18 December, 2013). In my interview with Stuart Twemlow however, another aspect of embodied countertransference came to light with the following statement:

"It is a somatic one when I suddenly become voraciously hungry or I develop a blinding headache. Or on one occasion, I forgot how many children a patient had, fundamental things about their life and this is someone I have been analyzing for years. In other words I acted as if I was mentally retarded. Another patient, the only reason I knew there was something was because my secretary said that every time you come out from that patient, you are very bad tempered for about half an hour."
I did not know that it was going on. I didn’t make the connection until after the session. It remained entirely somatic. So that is what I meant by somatic countertransference in a very specific way. If you catch it in advance as an anxiety reaction or an angry reaction or a sad reaction then you can analyze it. It is less primitive, put it that way. (Twemlow, Interview, 7 December, 2013)

What Twemlow draws our attention to in the above statement is that somatic countertransference can happen without our awareness. This was also noted by Joyce McDougall in 1989 when she recounted how material could be out of the therapist’s and client’s awareness for some time or in some cases indefinitely (McDougall, 1989). This adds another dimension to the importance of acknowledging and working with the body in psychotherapy, that is whether it is within our conscious awareness or not. As Forester contended, with greater self-awareness of one’s body there may be less somatic intrusions and illnesses in the therapist (Forester, 2007). Harris and Sinsheimer in 2007 wrote about the analyst’s vulnerability in the dimension of the psyche soma. In agreement with van der Giessen, they allude to the parentified child within the analyst, whereby there will be a natural fit for taking in material at a preverbal level often experienced as somatic countertransference. Harris and Sinsheimer therefore emphasize that analysts are rendered vulnerable to burnout and by implication psychic infection and need to work through the shame associated with this by taking greater self-care (van der Giessen, 2011). In gest, Harris reveals that at times she had felt like the Paris Hilton of the psychoanalytic world with her strong promotion of massages and pedicures for analysts undertaking analytic work (Harris & Sinsheimer, 2007).
In my interviews with the experts, Orbach was unable to nominate specific ideas for greater self care other than embracing one’s physicality by taking a walk after a long day in the clinic (Orbach, Interview, 18 December, 2013). Connolly commented that suggesting specific techniques seemed too concert or prescriptive, however agreed that physical exercise, knowing one’s personal limits in psychotherapy work and having a fulfilling personal life outside of the clinic was essential (Connolly, Email, 11 March, 2014). This exact sentiment was written about by Jacoby in 1984 in his seminal work *The Analytic Encounter* (Jacoby, 1984). He emphasized the significance of a full and well balanced life for the analyst undertaking depth psychotherapy practice. Schellinski in her research spoke about some ideas for self-protection and psychic cleansing suggested to her via her reading and discussions with colleagues (Schellinski, Interview, 16 January, 2014). As such, she recommended massage, saunas, taking a blanket or hot pad to recreate support and protection for the analyst’s body when working through intense material. In my interview with Professor Oyama from Kyoto, as discussed previously, he supported the idea of fortnightly massages for maintaining a healthy and in-tune body ready to pick up somatic material after moving out any residue that had remained (Margarian, in press, Oyama, Interview, 5 December, 2013). He also spoke about attending the bathroom between sessions to open the window and undertake toiletry needs as a way of creating a space and distance from the intensity of working with the body during analytic sessions.

The Chinese psychotherapists also presented personal ways of working with their body for heightened sensitivity to be able to pick up somatic material and for greater protection against psychic infection. This will now be explored in some detail.
How the Chinese Participants manage their Psychic Infections?

In discussing becoming infected with client material, it became apparent that some Chinese psychotherapists with more clinical experience drew upon mediation, Buddhism and mindfulness practice for their well-being after working with clients. T4 during the course of this research, developed an interest in meditation in order to facilitate greater awareness of the psyche of his patient. Indeed, he spent time at a retreat to further refine his meditative practice. Both T26 and T27, the newer psychotherapists who revealed struggling with somatic countertransference and exhaustion have both attended Vipassanā retreats in the past as a means to understand their psychic attunement and for greater separation and protection from the psyche of other. T17 and T28 are both practicing Buddhists with considerable experience and belief that regular meditative practice on a daily basis and before seeing patients specifically with T17, enables greater self-awareness, capacity to pick up on material relevant to others and for a degree of self-protection and ability to remove infective material out of one’s system. T18 sought the teaching of a Taiwanese Zen Master for the technique of mindfulness. She stated this really added to her development as a therapist in her capacity to pick up on bodily states and reflect on them in a thoughtful and separate manner. T28, a well known Singaporean Buddhist Psychotherapist, was scathing in our discussion about separating out mindfulness practices without a thorough understanding of the underpinning Buddhist practices such as the implied Middle path that puts the practice of mindfulness in context. T24 drew upon her interest and practice of Yoga, specifically breathe work to provide a means to pick up material and remain centered and relaxed in her work with others. This practice of focusing and centering implies that the psychotherapists are enlisting techniques to separate out what material belongs to the client or therapist and therefore enabling
greater self-awareness and consciousness when working with somatic intrusions. Similarly both T7 and T15 employed the Japanese practice of Reiki for self-healing post working with clients. T15, a Somatic Experiencing practitioner specifically has applied this technique to remove a somatic illness of a sore shoulder she felt was related to a client she was working with. T7 was also very clear that Reiki was only for her personal use and was a means to keep herself psychologically healthy and free from her client’s psychic material or infections. Others like T10, simply made a point of integrating time for physical exercise and relaxation that is urged by Connolly and Orbach in our discussions (Connolly, Email, 11 March, 2014, Orbach, Interview, 18 December, 2013).

Whilst not a specific technique, both T22 and T6 spoke of the need to rest and sleep post-sessions due the amount of exhaustion experienced and energy expended in the session. I think this is a natural extension of the practice of remaining quiet and reflective post a session. In addition, it calls to mind the work of Michael Fordham, Jungian Analyst who theorized about the process of de-integration and re-integration that occurs with babies when they have internalized some experience the result of engaging with their environment (Fordham, 1976). He positions these processes in the context of the primary self and in proposing a developmental model of Jungian analysis. Like with a baby after a good feed given by mother, the act of sleeping indeed enables the taking in and processing of something that has occurred with our interaction with other in the environment. Is it possible that sleeping after a difficult session is a similar reparative act that enables processing at a deeper level just as proposed by Fordham with re-integration following de-integration? Whilst sleepiness classically is thought of as a defense against the emergence of psychic material, in this instance it implies an act of processing material at a deep level (Orbach, 2004). It
further suggests that for some, sleeping after a session is the only means they have to process material not adequately provided in supervision. I imagine that this is only one explanation of what may be occurring and calls to mind Orbach’s recommendation that it is essential to stay with the body and within the context of the relationship that exists between the psychotherapist and client (Orbach, Interview, 18 December, 2013). This is in preference to relying on theories that start from the mind and apply ideas broadly and prescriptively.

The idea of becoming psychically infected when working with our clients is an important aspect of psychotherapy worthy of serious consideration. It further urges psychotherapists to consider that when a psychic infection occurs, something has gotten into us and it is not surprising that it is through our own experience of wounding that this becomes possible. By understanding these concepts it is possible to increase our conscious awareness in our work with others and to become more bodily focused. As a caution however, it is essential to know that on occasion, this material can happen without our awareness as suggested by Twemlow and McDougall (Twemlow, 2013, McDougall, 1989). These ideas were supported in the data provided by the Chinese psychotherapists and numerous ideas for managing and working with psychic infections were put forward by the Chinese psychotherapists and the Western experts I interviewed. In addition, the younger and less experienced psychotherapists demonstrated the importance of paying attention to these aspects for developing sound clinical practice and attending to their psychological wellbeing.

In the next chapter I will explore new material provided from the interviews with the Chinese psychotherapists pertaining to how to understand somatic countertransference from a Chinese perspective. This discussion of new material
makes reference to the mind-body continuum implicit in Chinese holistic approaches to healing and within their language. I also explore how somatic countertransference is understood differently by the Chinese as they conflate feeling and physical states naturally when compared to their Western counterparts. This next chapter also commences the process of understanding how somatic countertransference evolves and how best to work with in relation to Buddhism, I Ching, The Tao and TCM healing practices.
Chapter 5: Somatic Countertransference; the Relevance of the Mind-body Continuum, Traditional Chinese Medicine (TCM), Taoism and Buddhist Spiritual Practices

Whilst the previous chapter explored Chinese experiences of psychic infections and the shared wound, this chapter will commence the examination of what Chinese healing practices, spiritual and philosophical beliefs can bring to our understanding and working with somatic countertransference. First of all, I will focus on the presence of mind-body continuum in Chinese psychotherapy and how this manifests in language and linguistic use of metaphor in clinical descriptions. Then I will discuss what the Chinese psychotherapists revealed about their understanding of somatic countertransference according to their spiritual, medical and philosophical beliefs. In addition, data provided by several experts in Qi Gong, Traditional Chinese Medicine (TCM) and Martial Arts will be incorporated to provide further insight and material to enrich this analysis. As such, practices involving TCM and Buddhism will be examined to determine whether they may provide any understanding into how somatic countertransference evolves and accordingly how to best work and manage it.

In assessing the data provided, several issues emerged such as the loss of this ancient knowledge and how Chinese practitioners integrate their cultural influences into their psychotherapeutic style, however this relevant material will be explored in chapter 7.

At the most general level, this chapter commences the investigation of how Chinese psychotherapists would explain how somatic countertransference comes about according to their cultural background. So that a cross-cultural comparison is present, Western ideas provided by the interviewed experts working and thinking about the process of somatic countertransference will also be investigated and
contrasted. As such, this chapter will be divided into several sections commencing with a discussion of the presence of the mind-body continuum in Chinese psychotherapy. This will be followed by personal explanations of somatic countertransference. The next two sections on Chinese philosophies and spiritual practices such as the *Tao, I Ching* and Buddhism will be investigated with reference to somatic countertransference. In the following chapter 6 I will complete this process by examining the concept and relevance of *qi* and Qi Gong practice for Skype psychotherapy and psychoanalysis. Additionally a short study of Japanese perspectives on the role of the therapist’s body and final a discussion on Western ideas on somatic countertransference for a cross-cultural comparison will be undertaken. In essence, by exploring these ideas provided by the Chinese participants and interviewed experts, it is hoped that a new understanding and original knowledge about how somatic countertransference occurs will emerge. Additionally ways to work with and manage somatic countertransference clinically will be developed.

**The Mind-body Continuum in Chinese Psychotherapy**

In approaching the complex topic of mind-body dualism and the apparent divide between Eastern and Western thinking, I will commence with a brief comment on the concept of mind and body unification underpinning Traditional Chinese Medicine and how this permeates psychotherapeutic approaches in China, Hong Kong and Singapore. I will further consider how the Chinese participants conflated feeling and somatic states when discussing countertransference and how the Chinese language enabled this fusion of physical with feeling states. These ideas are taken up in further depth later in this chapter and chapter 6 that explore Chinese ideas about somatic
countertransference and other cultural influences on psychotherapeutic style and practice.

_A Holistic Approach to Mind and Body_

When approaching contemporary psychotherapy from a Chinese perspective, it is apparent that is has been strongly influenced by Traditional Chinese Medicine (TCM) and the inherent notion of mind and body existing in union and the idea of resonance between human, heaven and earth. In Sun’s _Themes in Chinese Psychology_, she explores how TCM embraces body, mind and spirit and states this in the following way:

In traditional Chinese societies, the practitioners of traditional Chinese Medicine (TCM) take a holistic view and assume responsibility for all three aspects, as their frame of reference, a problem is not defined as being purely physical, psychological or spiritual. Indeed TCM has always been characterized by the absence of a Cartesian dualistic model of mind and body in which it is posited that emotions arise from two sources, namely the intellect (Passion of the soul) and the body (Passion of the body). (Sun, 2013, p 202)

In this statement, I think Sun is emphasizing the full breadth of how TCM influences and permeates healing practices in China. Chen and Swartzman echoed the same sentiments. They stress that when working with Chinese patients it would be necessary to understand the strong influence of Taoist and Confucian belief systems
and that the idea that mind and body are deemed united (Chen & Swartzman, 2001). This idea of mind-body unification was affirmed in some of the statements reported by the Chinese participants. For example, T3 states the following about Chinese people:

They take the whole person. The whole person when he encounters another person, there is a feeling of resonance in between the heaven and the earth. T3

Whilst T3 is hinting at a Chinese explanation for somatic countertransference and the potential transmission between therapist and client, what is noteworthy is the emphasis on taking ‘the whole person’. This theme emerged many times during the interviews, that being that in appraising people and patients, a Chinese approach is to look at body and mind on a continuum in that mind and body exist in a state of wholeness and balance. The idea of balance noted in the concepts of yin and yang further imply internal balancing of yin and yang energies and yin and yang energies between people within the environment. This concept is well known and explicated in the teachings of TCM (Zhang and Chi, 2013). In agreement, T7 stated:

Chinese medicine is totally the whole philosophy of China T7.

12 Sun defines yin and yang as such: A Taoist concept that in nature, events and matters always exist in pairs of contrasting states. Within the context of health, disequilibrium between yin and yang is deemed to be responsible for feelings and sensations of distress and discomfort (Sun, 2013, p 254).
Likewise, T9 expressed the common opinion that Chinese people are more somatically inclined and able to feel and experience their body as a consequence of their cultural heritage. She says:

*Yes, you know this makes me think of something about Chinese culture that I should say. Chinese people are used to feeling their body. T9*

These quotes imply and emphasize a way of thinking that the body and mind exist as one and that they mutually influence each other and are integral in traditional medical practices and by extension psychological approaches. As an illustrative example of this style of thinking, T13 reveals that when she discovers her leader has cancer she immediately assumes a psychological cause, thereby suggesting mind-body fusion and or mutual state of influence.

Perhaps the most compelling statement from my research was made by T17. He states:

*In Chinese we do not separate somatic from pure psyche process, I experience somatic countertransference every year, every month and every day and nearly every second. Yes. Countertransference has the somatic dimension whether you are aware of it or not, or sensitive enough to it or not. You regarded it as trash or regard it as treasure. Yes, they are the same ontologically but they are two dimensions. They are granted in the sum total of experience as a whole. T17*
Until my interview with T17, I had observed the preceding participants to report feeling states when asked about somatic countertransference and I had wrongly assumed that they had misunderstood my question. This statement clearly established a unique cultural difference that was implied in my initial research questions that suggested a cultural division between Chinese and Western psychotherapists. This was an exciting finding that allowed me to appreciate the complexity of the material I was exploring.

Additionally from this important research finding, both T18 and T20 added to this notion that there is an implied wholeness of body and mind underlying psychological approaches in Chinese culture. T18 states the following:

Yes we Chinese always say that the body, the mind and the soul, they are connected, there is an integrated thing for a person. Even in the dreams, we have feelings, emotions, the body reactions yes. T18

In agreement, T20 echoes the same sentiment by stating:

I think that when the Chinese person looks at something or says something, they always do so in an integrated way, they do not separate things; it is like a big circle. So we think things and deal with things in a circle. T20

In essence there is an implied wholeness, continuum, never ending loop or circle integral in the mind, body and soul of all humans that permeates Chinese thinking that
was observed in the responses provided by the participants about their experiences of somatic countertransference.

*Conflation of Physical and Feeling States*

Returning to Sun’s seminal text, Sun states that the holistic approach in healing and spiritual practices in China is further heightened and promoted by Chinese linguistic structure. She provides the example that all psychological expressions appear to contain a reference to the word ‘heart’, thereby bringing together a body part and psychological state (Sun, 2013). This idea that feeling and physical states were fused was noted when the participants were asked the simple question: ‘can you give me an example of somatic countertransference?’ Many diverse examples were provided with an emphasis on body parts and feelings in a state of fusion. Such examples included: ‘the heart feels nervous’, ‘heavy heart’ and ‘nervous in shoulders’. These clinical examples illustrate that body parts and feeling states easily fuse when the participants spoke about their somatic experiences when working with clients. Furthermore, consistent with Sun’s observation, the heart is often referenced when feeling states are discussed.

Another interesting observation was that commonly feeling states were reported in place of somatic countertransference. When I asked T21 to provide me with an example of somatic countertransference from his clinical practice, he explored a particular case in which he felt rage when his client revealed that she had been sexually active with her boyfriend and used the morning after pill many times thereby severely compromising her health. He stated:
I am very angry, I cannot control myself. So my body is very hot. Also because she told me the first time she didn’t want to make love with the boy, this boy compelled her. T21

In short, T21’s body expresses emotion and his language freely captures this fusion. For T21, it is as if his feeling state of anger is equal to the hot sensation in his body. There are a number of other rich examples were provided by the participants to illustrate this point. For example, after asking T16 about her experience of somatic countertransference, she immediately provided an example in which she experienced depression thereby identifying a feeling state rather than a physical sensation. Equally, T2 in revealing his experiences of headaches and stomach aches as his two most common somatic experiences when working with his clients explained that they were about expressing anger and nerves therefore employing his body to hold and express these emotions. T15, a Somatic Experiencing Practitioner, well versed in bodily states related that she experienced ‘heaviness of the heart’ and ‘heaviness of the stomach’, thereby conflating a feeling and body part. In her somatic reactions to a patient she reported the following:

Yes, not much with sleepiness but some heaviness in the heart, and some heaviness in the stomach. Sometimes also some backache but not lasting long, just lasts for a few seconds maybe. When you are talking about something really heavy. T15

To add to the idea that mind and body exist in a state of fusion, T29 raises the interesting question of whether visions and images seen in the mind during a
treatment session and treated as countertransferential clues are indeed somatic as they are formed in the mind and associated with the act of seeing. This conundrum embraces the very essence of mind-body dualism, which was less problematic with the examples provided by the Chinese participants. This sentiment was expressed in my interview with Susie Orbach when we discussed the finding that that Chinese psychotherapists, when reporting somatic countertransference, seemed not to notice the mind-body divide. After providing the same examples noted above when feeling states were reported instead of body states, Orbach responded with the following:

*So I think the fact that anger is a physical as well as an emotional, in a way I don’t believe in the divide either but I have to divide it because we are so mentalist in psychotherapy and psychoanalysis in the West and in order to emphasis the physical nature or the corporeal nature, I want to call it somatic countertransference. But of course I don’t think anger is simply a mental construct. I think it is very much a physical feeling, just as sadness is, just as speech is a physical production, isn’t it? It is a physical, mental production. So I am with them, but it is not a very useful concept in the West because we are so mentalist.* (Orbach, Interview, 18 December 2013)

Orbach expresses that the body and mind are one and yet in the West we employ terms such as somatic countertransference in order to make sense of these physical manifestations of emotional states according to our propensity for mental constructs. As such, emotions and bodily states are entwined and intermingled. Anger can be experienced physically and emotionally to provide one example from many. This aspect of mind-body division endorsed in Western thinking was indeed challenged by the examples provided by the Chinese participants.
Returning to the conundrum expressed by T29, the idea that mind and body exist in unison was explored with reference to his experience of visual imagery. He recounted the following:

*I actually experience things in my body all the time. Of course in terms of the body we categorize it all the time, different categories. One would be the emotions, one is the physical sensations, then I would say there is a category I will call it, it is sort of leading to the second category, it has images, pictures, visions you could call it but then ….. most of the time, there could be images in my body. T29*

In this instance, T29 articulates that the body not only provides various sensations and feelings but also symbolic expressions in the form of images. He reported that these images could be deeply meaningful and relevant to the therapy. I think visual imagery formed and seen in the mind adds another dimension to the ideas circulating around this phenomenon thus far. I believe this heightens the symbolic potential that can occur with countertransference whether seen in a pictorial representation as an image or vision or as a physical sensation in the body. Kristina Schellinski, in explaining the relevance of somatic countertransference has articulated the idea that a symbol\(^\text{13}\) can manifest in the body of the analyst or analysand and that it is the role of the analyst to make sense of it (Schellinski, 2013). The symbol is therefore an image that articulates something unknown and it can be known through the various senses of the body. This addition of the visual image as a possible form of somatic countertransference adds further dimension and depth to our understanding of this phenomenon.

\(^{13}\) Symbol is an expression for something unknown. Jung stated: “Every psychological expression is a symbol if we assume that it states or signifies something more and other than itself which eludes our present knowledge”. (Jung, 1971/1989 p 457.)
Furthermore, it continues the notion that it presents in uncanny and strange ways in the clinical setting.

The Impact of the Chinese Language

When discussing somatic countertransference, the effect of the Chinese language and how it is structured and utilized to explore emotional states cannot be dismissed. Equally this is further complicated by the fact that 28 of the 29 participants were interviewed in English, their second language with various degrees of fluency. This topic has been explored extensively and in relation to the hotly debated clinical finding that Chinese people somatize more than their Western counterparts (Sun, 2013). In an investigation of the symbolic meanings within the Chinese language, Tung challenges the notion that Chinese somatize their psychological illnesses by demonstrating that when a Chinese person is speaking, they employ a deeply symbolic language that freely employs body parts imbued with feeling states. What Tung is stating is that it is not that the Chinese somatize their psychological states rather, the expressions they use freely conflate feelings and body parts (Tung, 1994). In short, the idea that Chinese people somatize more so than Western people is deeply flawed when considering the structural nature of their language. What this means for investigating somatic countertransference is that the Chinese participants are likely to conflate body parts and feeling states when discussing this material. As previously discussed this was noted with numerous accounts of somatic countertransference.

The participants interviewed for this research on occasion expressed an opinion about the impact of language on the Chinese capacity to express emotion. For
example, T1 claimed that the Chinese people do not possess a language that reflects their emotions like in the West so the body is experienced and spoken about easily in preference to articulating an emotion. She states it as such:

As a Chinese we do have minimal words/language to express our emotional state. Or what happened inside us. So there may also be the reason that we react, perceive and also respond bodily, we don’t have the terms and language to express it. So it may come into the body or I am not sure maybe everybody even western, eastern we have the bodily reactions. It is just that we don’t have the language to put it into words so that is why tend to….., actually we tend to ignore it actually. T1

In terms of the language actually employed to express an emotion, there was often a fusion of a body part and a feeling state or a mixture of metaphors as previously stated. This is consistent with the idea put forward by Tung’s research on Chinese language. One unusual example that shows how a spoken expression about a feeling state can be very different from a Western equivalent is demonstrated when T11 spoke about a group debrief she attended. She explains it as such:

I think there is another time, it was last year in August. There was a man, he committed suicide, he threw himself out of the window of his office and his colleagues were panicked, they were afraid, shocked. So the company invited me to do, actually I had to write a proposal for them. For some people, you can do group therapy and for some people who are very distressed, they can attend but if they are more serious and have symptoms such as nightmares, flashbacks or highly avoiding the work place, they can get some help individually. So I worked for these people for a whole day and
I worked with these people from morning until 5pm. When they talked about the
death, their fear and maybe their somatic experiences triggered by this man’s death, I
had to isolate my feelings, just like a professional although I am empathic, I had to
isolate myself very much just so that I am not affected I can’t remember which
patients, but I feel that my heart is cold and it is really sad but I can not allow this to
happen but to speak out I had to control myself very tightly I had to work for a whole
day with these people as a professional. I can still feel that in my heart, it is cold; it is
like a very sad stone? T11

This is a strange but highly evocative expression that captures the heaviness, the
coldness and the sadness of the emotionally charged atmosphere within the group
debrief. This demonstrates the complexity yet poetic style of the Chinese language in
conveying a feeling state experienced in a therapeutic process. Metaphoric expression
inherent in the Chinese language according to Bollas is commensurate with the
Eastern style of thinking which he considers to be largely, nonverbal and maternal
contrasted with the verbal, paternal and literal style of thinking and expression
employed in the West (Bollas, 2013). What this implies is that there is a cultural
difference in the way Chinese people think and express themselves when compared
with their Western counterparts. This cultural variation is evident in the data provided
by the Chinese participants that freely conflated feeling and physical states and
alluded to them in symbolic and metaphoric ways.

Finally, in an interview with Stuart Twemlow an eminent psychoanalyst,
psychiatrist and Martial Arts and Zen Buddhism practitioner, he states the following
about the Chinese language and what must be considered when thinking about how
Chinese people experience and express feeling:
Chinese is basically 50,000 characters, each of which may mean several different things but none of them mean a letter or a complete sentence necessarily. So they are structured initially from pictures. Whatever it is, it is not like English, you cannot specifically say “a, b, c” or “the” or “and”. So the upshot of it is, if you undergo psychiatric training in China or Japan prior to psychoanalytic work, which came about 30 years ago with the Norwegians and Germans. If you had a problem with feelings and you wanted to speak to a psychotherapist about feelings, you would have to leave China. I have a really interesting example of that, a man who spent 30 years of his life and he became a Taoist priest and he had gone through 20 years of training. He had a problem, an emotional problem that he wanted to speak to someone about but he couldn’t find anyone he could talk to. He came back to America to see a therapist because everybody he saw in China, would get him to do something like some important healing aphorism or give him acupuncture or give him medicines. But nobody wanted to hear what he was feeling or thinking. Within the Taoist experience, the whole idea of feeling, was really not acknowledged simply not the way we do when we treat feelings as clues to underlying unconscious thinking. It is thus quite unsurprising to me that first that any Chinese therapist might have trouble understanding is what a somatic thing is. (Twemlow, Interview, 7 December, 2013).

I think Twemlow’s example of the Taoist Priest exemplifies the inherent difficulties of expressing and distilling emotion culturally in China, which is further complicated by the underlying pictorial and structurally diverse nature of their language. Additionally, it alludes to how mental illness and emotions are dealt with in China, that being in a holistic way that is endorsed by Traditional Chinese Medicine. In short, endeavoring to explore cultural difference in relation to somatic
countertransference is complicated and yet enhanced by these underlying divergent aspects.

In terms of the mind-body continuum, it was illustrated that underpinning Chinese ways of working psychotherapeutically was the notion of wholeness not articulated in the West. This was further explored in terms of how somatic countertransference was a concept often expressed in reference to body parts and or feelings therefore illustrating how feelings and physical sensations are conflated consistent with this idea of implied wholeness and their holistic approach to healing. Furthermore, the impact of the Chinese language and how body parts and feelings states are often expressed together metaphorically was further shown to confirm this idea of implied union of mind and body not freely expressed in Western psychotherapy practices.

**Chinese perceptions of Somatic Countertransference**

*Some Personal Explanations of Somatic Countertransference*

In asking the Chinese participants about how somatic countertransference occurs according to their cultural backgrounds, it became immediately clear that this was a murky terrain to investigate. First of all a number of Chinese participants claimed that knowledge from Confucian, Taoism and TCM was in the process of being lost due to previous political and historical events that attempted to dispense with these indigenous practices and also due to the rapid modernization of China. This will be
discussed in chapter 7. Nonetheless, on occasion, a few participants revealed personal explanations of how somatic countertransference comes about.

T6, when asked about her understanding of somatic countertransference, naturally referred to the importance of the emerging relationship between therapist and client and how that will bring about a unique mix of both good and bad aspects for exploration in its interaction. T6 then goes on to reveal her confusion and therefore difficulty applying the Western term ‘transference’, she commences this statement with indicating what is important for Chinese psychotherapists. She says:

Possibly they really care about relationships. So they are very aware of reaction, so when you put two people together, they will interact whether in which way, a good way or a bad way, as in some way. So a lot of talking through our own experiences, our own way of noticing things. So that’s the way I see things, of course I will use my way to interpret you and the things that you say. …..I remember when I first saw the word ‘transference’ in Chinese, it was interpreted into Chinese, I was totally stunned. I said what does that mean I have never heard this word before? I have never seen transference interpreted into those two words. And now we say this is not correct, you’re not supposed to translate this. It has nothing to do with that, one word is ‘transfer’ and the other word is ‘feeling’. So it is ‘transfer feeling’. But actually they say that it has nothing to do with feeling. So maybe something to do with the relation, I don’t know? But nowadays a lot of people have been using this term for several years now. China is changing. T6
T6 raises an important point about the fundamental differences between the English and Chinese languages. When bringing to China concepts such as ‘transference’ and ‘countertransference’, there has been a lot of confusion and yet ultimately an embracing of these terms in a unique way (Scharff, Sehon, Wei & Wanlass, 2011, Plaenkers, 2011). As T6 says, ‘China is changing’. As importantly, T6 hints at an essential aspect of understanding what somatic countertransference is, that it is somehow understood within the context of a relationship. This idea has been strongly argued by Orbach, Connolly, Schellinski and others in the West (Orbach, 2004, Schellinski 2013, Connolly, Email, 11 March, 2013). It has further been taken up by relational psychoanalysis, recently with the concept of the ‘embodied third’ whereby the relationship between analyst leads to an inter subjective space which in part is embodied (Rappaport, 2015).

Likewise T17, a practicing Buddhist, with a strong interest in integrating TCM and Buddhism into his psychoanalytic practice, also points to the importance of the relationship between therapist and client when understanding how somatic countertransference evolves. In addition, he suggests that this relationship is cemented through the presence of the bodies in the room. T17 explains:

*When people are together, their body also builds a relationship. The body is a temple. Even though they have not shaken hands, do not kiss each other, did not have sex. But the first thing is two bodies are together. This is the most primordial one. Your bodies are together. So they must be a lot of communications between the two bodies, whether you are aware of it or not. The bodies are the root for all the experiences. Because the so-called advanced communications were based on soma. Mostly I am*
Bionian, Bion speaks about beta and alpha elements. So once the communications starts with beta element. The beta element starts between the boundary between somatic and psychic surfaces, it is where our-communications start………T17

As previously stated, T17 has developed a particular style of psychotherapy that draws upon the role of the body never separate from mind. Like T6, T17 is acutely aware of the fundamental role the relationship plays in allowing somatic countertransference and other forms of communication to surface. This same idea is echoed by T12 who says the following:

*I don’t know, but when two people are together we communicate with words, like verbal, we use words but there are many ways for communication, those ways for communication are more direct even unconscious. Some of that even unconscious. Also I mean I believe that we human beings but there other ways to get information, like animals, they are more sensitive but sometimes because we have so much intellectual… Right, so much intellectual thoughts and things, we ignore that those ways of communicating, if we could pay attention to that and understand that it would be very helpful. Those ways of communication. I don’t know, I cannot make it better. T12

Like T17, T12 is expressing that there is a way to communicate between people that is beyond words and that this involves the unconscious and the body. These ideas have been taken up previously clearly in the work of Jung, Freud and Bion as mentioned by T17. These above explanations demonstrate thoughtfulness about how somatic countertransference evolves and that the relationship between two people is
the crucial factor, which is enhanced by the unconscious. Furthermore the Chinese participants explain, in cultural terms, the notion that the relationship and the bodies in the room form part of this relationship, which has recently been taken up in relational psychoanalysis (Rappaport, 2015). Ultimately what is expressed here from a Chinese and Western perspective is that relationship, bodies and the unconscious are central to our understanding of how somatic countertransference emerges in psychotherapy (Margarian, 2015).

**The Influence of Traditional Chinese Medicine (TCM)**

Whilst some Chinese participants expressed concern and sadness about the loss of Chinese cultural practices, others readily embraced and integrated ideas, especially from the practice of TCM. As such, ideas from TCM were readily referenced when discussing somatic countertransference. John Dolic, TCM practitioner in our interview explained that TCM treats $qì$ blockages within the individual and these blockages underpin all physical and psychological illnesses. Sun establishes the vast difference between Chinese and Western medicine as such:

> In Euro-American societies, an individual’s body, mind, and spirit are generally taken care of by medical doctors, human services workers, and the clergy respectively. In traditional Chinese societies, the practitioners of traditional Chinese medicine (TCM) take a holistic view and assume responsibility for all three aspects, as in their frame of reference, a problem is

---

$^{14}$According to Professor Sun, she defines it as “The vital force in the body, which is the synergy of yin and yang” (Sun, 2013, p 252).
not defined as being purely physical, psychological, or spiritual. (Sun, 2013, p 202)

It is this underlying philosophy of mind-body fusion that underpins a Chinese approach to life, illness and wellness. This was noted with some of the responses given by the Chinese participants. An obvious but interesting idea was that body parts, according to TCM correspond to feeling states. This idea was considered core for some Chinese psychotherapists in the study. To commence with T25 says the following:

Yes, I think we are influenced by a lot of meaningful things from Chinese Traditional Medicine (TCM) because in TCM, our bodies is just like, not so material but has some spiritual aspect of our body, or each response, or each phenomenon in our body has connections with spiritual things, for example. In TCM, we think for example, our heart and our liver or our kidneys are related to different kinds of emotions. For example our heart is related to joy and our liver is related to anger and our kidney is related to fear. If we have a lot of fear experiences, our kidneys will be weak or will be destroyed or have poor function. Also we have some symptoms related to our kidney and if we need to go to the washroom every hour, that is related to some anxiety or some emotional state of our unconscious I think. I think TCM, has a lot of things that talk about this……. Yes I didn’t study it but I have some connections with it. For example I have some friends who have studied this and when I have some response I will share my experience with them and they will share some information or theory, their philosophy so I can use it. Maybe it is an amplification of my experience…….
I think in TCM, bodies contain very rich information of our unconscious. I think because Jung and Freud said dream is the most important material of our unconscious but we can’t have the dream when we do the therapy, we can just talk about the dream or work with the dream. I think we also need to know the unconscious process in right in the moment of the therapy. So I think body response is very important index of ours that connects us to our unconscious in the moment. T25

T25 expresses the many varied ways TCM can be applied to thinking about somatic countertransference and how to work with it. First of all she establishes that the body and mind are intricately connected and that each body part carries within it a psychological expression or aspect. As such, she goes on to reveal that she consults friends who practice TCM to ‘amplify’ her somatic countertransference from her clinical practice. In addition, she states that the body can be accessed in the session whilst looking to a reported dream is somehow rooted in the past and less readily accessible. She presents many interesting ways of working with somatic countertransference and concurrently positions it as a tool that is more immediate for clinical application.

Similarly T14 related the following about TCM and how it informs and applies to her clinical practice:

Yes, now it makes me think of the Chinese Medicine actually, this is apart of Chinese culture. In the Chinese traditional medicine, we talk more about the emotions and affect and the body, the connections between them and the different organs related to different emotions. We say “wu xing” (a word in Chinese), the five elements…….
The metal, the wood, the earth, the water and fire, the five elements. The five different organs and they are related to five different emotions. So actually in the Chinese traditional culture we do have this process, the body is related to the mind. T14

In relation to bodily organs, the idea that the ache of certain bodily parts can be meaningful was expressed by other Chinese participants. Similarly, in the important work of Marie Louise von Franz, Jungian analyst she explores the notion of the body parts and their archetypal nature:

The idea that individual parts of the body can be coordinated with certain gods (archetypes) is very richly developed in the Far East. In the Chinese Taoistic view of the world, for instance, man is a microcosm (as in Western astrology) whose subdivisions correspond exactly with the “floors” of Heaven and with its constellations. A subtle psychophysical life energy called ch’i circulates through this physical cosmos. Every organ, indeed every smallest part of the body, has it deity, and this deity is described as the “highest officer” or the “highest function” of that part. If the deity should abandon its organ, the latter then ceases to function and decays. Such divinities of the body must, therefore, be taken care of through meditation, through one’s diet, etc. One must “unify them through the body,” in order to attain long life, even immortality. (von Franz, 1998, p 96)

In this instance von Franz is bringing together Chinese knowledge with Jungian thinking in terms of archetypal theory, thereby alleviating the importance of the body and further its role for longevity. It supports the emphasis that T22, T23 and T25 have
all given to the integration of TCM into psychotherapy practice and in extending our understanding of somatic countertransference.

An integral aspect of TCM’s philosophy is the idea of yin and yang. As clearly explained by Sun, the concept of yin and yang underpins Chinese thinking and approaches to life and wellness. She says the following:

TCM is rooted in Taoism, which sees the Universe as a macrocosm perfectly reflected and represented in Man, the microcosm. In other words, the structures of the Universe and the human body reflect each other perfectly, and human life is a miniature form of the cosmos existing within the infinitely larger cosmos of heaven. Health is perceived as a state where there is harmonious equilibrium between yin and yang, the five elements (metal, wood, water, fire, and earth), the six environmental conditions (dry, wet, cold, hot, wind, and flame), and the seven emotions (joy, sorrow, anger, worry, panic, anxiety, and fear. In The Yellow Emperor’s Classic of Internal Medicine, it is said that the natural order of the Universe can be located in the law of yin and yang, which is the foundation of all matters and the root of all changes, including life and death. (Sun, 2013, p 204)

Sun clearly states the importance of the role of yin and yang and the notion of balance that is required for good health. T6 in thinking about how somatic countertransference comes about and cultural difference she says the following:

---

35 As expressed by Professor Sun, “A Taoist concept that in nature, events and matters always exist in pairs of contrasting states. Within the context of health, disequilibrium between yin and yang is deemed to be responsible for feelings and sensations of distress and discomfort” (Sun, 2013, p 254).
Chinese medicine is totally the whole philosophy of China. They look at Yin and Yang, the balance, yes. So in your balance it is directly both physical and psychological. So if your body has for example we say you have the heat, you might have a sore throat, a toothache, spots on your face. That means that you have a lot of heat. So the Yang principle is too much, that has caused that, so Chinese medicine will bring down the Yang and to stimulate the Yin. So it will go up, and that is how you get better. So all this toothache is in your body that it is caused by psychological meaning. So maybe recently you were worried about something, stressed about something and that will come through in the physical. So they will always ask you, Chinese medical practitioners not only about your physical problems, but what happens with your life and even about your personality. You start to experience some attitude, some teachings, they may say, “don’t worry it is all this stress, to feel stronger, let go.” It is like a crisis, in Chinese crisis means danger and opportunity. It can go either way; if you go through your crisis you will get an opportunity. But if you fail, that part it will be a true crisis. If you couldn’t overcome it. So they often give you this kind of attitude where they will say, “okay, next time it will be good”, and then you let go a little bit and you start getting better. Because psychologically yourself is in crisis. T6

T6 is expressing how Chinese people take into consideration the concept of yin and yang and their balance when living life. She further implies that it permeates all areas of life in China. Following on T21 clearly expresses how the concept of yin and yang apply to the therapeutic dyad which is an important notion for extending our thinking on somatic countertransference from a Chinese perspective:
Even when the person enters the room, you and the person you will be one, this is tai chi. It is the Yin and the Yang. You are the wholeness, you and the patient find a balance point, and the tai chi will stable, even if you are not in a balanced point your patient will turn around, that it is not stable. T21

In my interview with John Dolic, a TCM practitioner, he affirms this idea of how yin and yang is played out between two people. He says the following:

So if have more yin, you have less yang, that is how they work. If you have more darkness, you have less brightness, more heat, less cold, so that is how they work. Ah you have positive energy and you have negative energy. Positive energy is the one that protects us, you have your positive energy, I have mine. Everybody has positive energy, as along as we are alive. If your positive energy has gone, you die. Negative energy would be a disease of any kind, that is seen as yin, yang is protective. If you are suffering from a lot of negative energy like patients of any kind then they deal with it in their own way but you also deal with their energy.

They come with their problems that is seen as negative energy that I am exposed to and then as my positive energy was building, I was able to keep the balance but maybe this is my explanation.

So when my positive energy was stronger, then I was protected, so it could not harm me, so it was like you have this darkness and then you have light. So if my light was not very strong, then it is really dark. But when the light becomes strong the darkness
is smaller and it is gone. As I say, that is just how I explain it but in truth that what was happening. I could take their problem and I would be protected but it only worked I guess because I have had a lot of experience dealing with patients and also I practice Qi Gong. (Dolic, Interview, 17 January, 2014)

Dolic is making several important statements here. First of all, that when two people are in a room, there is a combination of yin and yang taking place. Secondly in the process of treatment the imbalance of the patient can be altered; affirming Jung’s idea of mutual influence (Jung, 1954). As importantly, Dolic states that via his regular practice of Qi Gong he is able to assist others whilst remaining protected. This will be taken up further in the following chapter on Qi Gong, however essentially what Dolic is stating here is that whilst yin and yang play a balancing act individually, it also occurs when two people meet. Therefore this implies that there is a transmission of unconscious energy or qi, which takes place in the consulting room. In returning to this idea taken up by Jung, indeed it was Murray Stein who suggested that Jung was influenced more so by his collaboration with Richard Wilhelm on the Taoist text, The Secret of the Golden flower, than by Freud (Stein, 2005). In looking towards Taoism and TCM it is clear that Jung’s ideas about the transcendent function, synchronicity were greatly influenced and enriched by Chinese philosophy. As such, Jung’s idea of the mutual zone of unconscious to unconscious communication intersects neatly with the Chinese idea that qi between people exists in a state of yin and yang balance therefore inferring that people unconsciously influence each other.

Continuing on with this theme of yin and yang balance, an interesting correlation existed between T17 and T16 when applying the teaching of TCM to
psychotherapy. T17, as previously mentioned, has developed his unique style of psychotherapy freely applying TCM and Buddhism to his clinical approach. He suggests that like the practice of acupuncture in unblocking qi, words and interpretations in psychoanalysis are like acupuncture. He says the following:

Yes, I think it would be a good beginning, the talking acupuncture because acupuncture can’t be used with the metal needle, it can be applied with other needle, you can use your words. Like Winnicott’s ideas, the holding environment is not only provided by arms with blanket, it can also be provided by words by the speech of the therapist, of the analyst........

With the patient’s free association you can also find the blockage. There are a lot of blockages. Your interpretations are like acupuncture. T17

This idea was echoed by T16 in the following manner:

This is something from my own experience. Therapy is very much like a massage. You find a point or several points of the patient which they feel sour but the therapist is doing the work to massage this painful point which is not really existent but you can find several points where the patient cannot really ….. how can I say this? Which is not exactly painful but that kind of a feeling of sour, this is like the relationship between the one who works the massage and the one who is being massaged is very close, because you can really feel…. T16

T16 speaks about therapy as if it is a form of massage that actively works on blockages in the psyche. Therapy as a massage closely parallels T17’s
aforementioned ideas and TCM’s concept of acupuncture and massage for removing blockages in qi. In addition, T16 alludes to the importance of the relationship in the room.

In returning to the concepts of yin and yang and their rebalancing in TCM practice and their correlation with psychotherapy, Zhang and Chi point out further compelling alignments between psychoanalysis and TCM (Zhang & Chi, 2013). They suggest that that a potential ‘talking acupuncture’ could evolve by integrating the knowledge from TCM and Tao with psychoanalysis. They explain that both the treatment styles of TCM and psychoanalysis are underpinned by the shared notion of ‘reducing’ or removing negative symptomology and ‘reinforcing’ or strengthening new insight and knowledge as a result of the treatment process (Zhang & Chi, 2013, p 1). In summary they state:

Everything exists together in a delicate balance. These span mind and body, qi and its other forms, man and nature, normality and abnormality, past and present, patient and analyst, East and West. (Zhang & Chi, 2013, p 6)

Accordingly, Zhang and Chi are writing about what T17 and T16 have intuitively picked up from their practices as psychotherapists. Interestingly, this intersection between Chinese TCM and its underpinning philosophies of Taoism and Confucianism is taken up in current psychoanalytic thinking. In a recent book, Bollas likewise makes this same link that Eastern thinking converges with psychoanalysis (Bollas, 2013). Specifically, Bollas suggests that Eastern thinking is far more in tune with preverbal communication, which is where contemporary psychoanalysis and

216
analytical psychology have recently shifted their focus to in conjunction with current neuroscience findings relating to right hemisphere to right hemisphere communication enacted in psychotherapy (Schore, 2014). This confirms that there is much to glean from exploring these underlying Chinese philosophies when exploring psychotherapy practice.

Another application of TCM to our assessment of somatic countertransference was provided by T27, a younger psychotherapist interested in meditation and Buddhism. He says the following:

Yes, the first idea, the first explanation I could tell is our body has relationships with our unconsciousness. Something we are not aware of with our consciousness, maybe we are aware by the unconsciousness. So the therapist always have some training how to feel our unconscious, or how to feel the unconscious, the analyst or therapist has a better ability to listen to the unconscious, to expand their consciousness by integrating the unconsciousness. So when they are doing counseling with clients, such ability just occurs unconsciously. Maybe the therapist is not aware of it but they did, that is one explanation I get. From Chinese culture, in Chinese Medicine it is quite special and unbelievable. A doctor can feel the pain of the patients. T27

T27 goes to explain in great detail the process by which a TCM practitioner will collect information about his patient from his senses, taking their pulse and by targeted questions. What T27 is suggesting is that the TCM practitioner is reliant on his/her senses for diagnosis and that there is a parallel with the psychotherapist in that through their senses, unconsciously he/she is able to pick up what is happening for the
client. T27 adds that this process is greatly enhanced by meditation practices that increase one’s capacity to tune in to others. This idea brings to mind the work of Barbara Miller and her investigation of the shamanic practices of the Norwegian Sami. What she discovered was that the Sami had a heightened capacity to pick up in their body (via their senses) what was either physically or psychologically wrong with their patient (Miller, 2011). It is precisely this skill that Merchant discusses in his work entitled *Shamans and Analysts: New insights on the Wounded Healer* (Merchant, 2012). It is the capacity of the therapist to listen to their somatic states for further information about what is emerging from the therapeutic alliance and from the psyche of the client. This important focus on one’s somatic states and senses is further emphasized in the work of Giles Clark, Jungian analyst (Clark, 1996, 2010). Furthermore, there appears to be a strong parallel drawn here between the TCM practitioner, the shaman and the psychotherapist.

In summary, TCM brings to the discussion and understanding of somatic countertransference, information about body parts and their meaning and that the therapist/practitioner can glean specific and important information from his/her senses. In addition, the concept of yin and yang and the notion of balance is not only played out within the individual’s psyche but also with the analytic dyad, at an unconscious level thereby suggesting a process of energetic transmission and mutual influence. This notion strongly correlates with Jung’s idea of the mutual zone of unconscious communication and contemporary ideas regarding inter subjectivity from a relational psychoanalysis perspective (Jung, 1954, Stolorow, Atwood & Orange, 2002). Furthermore the process of psychotherapy closely parallels the removal of *qi*
blockage through acupuncture and massage in TCM (Zhang & Chi, 2013, Margarian, 2015).

*The Tao, i Ching and Buddhism*

In trying to unearth a unique Chinese assessment of how somatic countertransference emerges, on several occasions Taoism, and Buddhism were spoken about to various degrees by a number of Chinese participants. At times, as is expected, TCM was discussed together with Taoism indicating and confirming that it is difficult to separate out the medical practices and philosophies in China as they are well integrated (Sun, 2013). Alluded to but largely avoided was Confucian knowledge when compared with Taoism and Buddhism. As such, rarely were Confucian ideas provided in this research project.

Nonetheless, T3, a Jungian training candidate, psychiatrist and recent practitioner of the i Ching suggested several interesting ideas for potential Chinese explanations of somatic countertransference. T3 provided the idea that within the Chinese language, an important character exists that demonstrates that the human is taken as a whole not separated into mind and body and furthermore exists in a state of balance between heaven and earth. This balance is further experienced in relation to meeting someone else. This was explained by Dolic during our interview, in his application of how yin and yang can be experienced as a state of balance or in balance between two people (Dolic, Interview, 17 January, 2014). T3 explains further:
In the Tao, they said that there is a sort of heaven and human resonance. Heaven and human. As human to human there is a resonance, this is the basic idea. And the part of unconscious is deeply under the earth that could also be there. …..T3

T3 then draws a diagram as such:

人 denotes human; 天 denotes human between heaven and earth.

T3 explains:

This picture gives you the impression that humans are something in between the sky and the earth and it is a being that can respond to the other in between the sky and the earth. So human actions will give this sort of resonance and that is my understanding of the i Ching. It is a system of inaction. So why do we have this sort of response? The whole i Ching is talking about the synchronicity, this kind of response, so if you ask me is this something with the culture then I think of that um, the main feeling in the i Ching is the kind of synchronous response between the humans. It is also compatible, connectedly to the sort of sympathy response that has provided to my understanding on that. T3

I think T3 is providing an example here of the energetic levels that exist between people, humans located between heaven and earth; and how these levels may be enacted in the psychotherapy setting when resonance occurs between patient and analyst. This multi-dimensional thinking about human, earth, heaven and interaction is expressed in the character drawn by T3 to explain this concept. This pictorial
representation of resonance that explains somatic countertransference was also spoken about by T17. T17 commences by talking about ancient Chinese wisdom that can explain mind-body interconnectivity and the overall connectivity between people. T17 says the following:

*I think for Westerners, mostly they have forgotten this wisdom. I am not mentioning one, but every one of them. But for India, for Ancient India, Ancient Chinese they never separate these experiences from cogitations The yoga practice, it is all the channels; they are connecting to the body. You have special cultural provision, they have special breathing techniques, all of them are connected with the body. For Chinese the philosophy itself is based on soma. Chinese philosophy is mostly based on soma rather than thinking. We have a lot of characters, which show this tradition. It is very natural because I was a boy in this cultural matrix and I was immersed in this without cognitive learning and I also learnt from the body. For me, it is very natural. I think that psychoanalysis and the method for this training only helped me to discover it, maybe not teach, but helped me to discover the inner supervisor, or inner guru, your body. T17*  

T17 is stating how influenced he is by his culture enriched by the ancient ideas of Taoism, TCM and Buddhism. He explains that the cultural idea of mind-body connectivity is articulated in Chinese characters. He clearly states that the body, closely integrated with mind, has an alleviated status in providing important information in the psychotherapy setting. Additionally, T17 implies that the introspective exploration encouraged by psychoanalytic practice has enabled him to reconnect with the Chinese cultural notions of mind and body interconnectivity.
In terms of the broader philosophy of the Tao, little information was forthcoming from the Chinese participants. There was a general consensus that whilst Taoism underpinned the Chinese mind set, it was an esoteric text that was difficult to access directly. Yet whilst it was mentioned sparingly, it was T21, a psychotherapist who had previously studied philosophy, who succinctly said the following in relation to his work as a psychotherapist:

*In our China, Wu Wei, if we want something happen normally, we do nothing.* T21

T21 mentions the Taoist concept of ‘wu wei’, or non-interference in relation to his processing of a strong countertransference reaction. He states that by doing nothing, something will come forth naturally that will be client directed rather than from a style driven psychotherapy approach. This brings to mind, Jung’s analytic approach that is client driven, so that the psyche of the client can emerge naturally towards self-healing (Samuels, Shorter & Plaut, 1986). Accordingly, when confronted with an impasse in psychotherapy, it is a wise solution to do nothing; this is an essential Taoist premise. Whilst the concept of wu wei does not explain how somatic countertransference evolves, I sense T21 is interested in highlighting this concept as a Chinese equal to a non-directive psychotherapeutic approach.

Many Chinese psychotherapists however spoke freely about their interest and practice in Buddhism, meditation and mindfulness. As explored previously, some deliberately followed Buddhism to enhance their psychotherapeutic practices through mindfulness and meditation. T28 noted himself to be a Buddhist psychotherapist and
explained in great detail his style of practice and the underlying tenets of Buddhism and their applicability to psychotherapy. T28 described that by following and integrating Buddhism into his psychotherapy practice increased self-awareness that allowed him to become more sensitive in his body and therefore more able to perceive the inner state of his clients. He reported the following:

*I usually do so in the morning, once a day, for about 45 minutes and I start at about 5 o’clock in the morning. As one meditates for a period of time - after a number of months or years, what can happen to the person or the meditator is that he develops a sort of sensitivity to his surroundings. He picks up other peoples aura or other people’s bio field, and it becomes very useful to him then. Being able to pick-up the vibrations of other’s bio field is more than expressions of body language. You have known that between verbal expression and the body language – the latter is more accurate than the former. So when sensitivities to the psychic or auric expression the information received is more subtle and more accurate. For instance I may sense that a guy is trying to irritate me. I may be thinking, “Why is he trying to irritate me? Rather than answering the question he seems to be beating about the bush.” With that feeling I then am no longer angry about the situation. I could just play around and be more relaxed and allow the client to lead me on and see how it goes. T28*

As such, T28 describes a capacity to observe his feelings rather than act on them which is what Merchant alluded to in being able to manage psychic infections or client material that the therapist picks up either consciously or consciously from a third position (Merchant, 2008). T28 spoke about the necessity of greater self-awareness and space for reflection that he attributes to his practice of Buddhist
In Buddhist terms they would have called it telepathy because in Buddhism also a topic they call Abinna (higher powers). Abinna is supposed to be psychic abilities. You may be aware that psychic phenomena exist in the world of everyday experiences itself. So as you and I are conversing now, we are only communicating verbally? You are looking at my lips, you are looking into my eyes - eye contact but there is this other unseen transmission of messages that goes on between you and me. Carl Jung would have called it synchronicity. In quantum physics they call it interconnectedness between the particle and the waveform...Yes I use this material but it is unconscious process. You see because and through the practice of meditation the process becomes embedded into my psyche. T28

T28 alludes to an unconscious-to-unconscious transmission between people that enables the therapist/Buddhist practitioner to pick up material unconsciously and from a position of heightened sensitivity. T28 goes into greater detail to explain the machinations of Buddhist practices that enables greater focus and concentration for example the practice of vedanupassanna, which facilitates a focusing on the skin’s surface. As such, he outlines intricately designed micro-practices that are aimed at greater self-awareness and sensitivity to other. In addition, he explains that the body plays a central role in Buddhism via breathing and focusing techniques. He says:

The body - we focus on the various body parts first. You start with the breathing and then after the breathing you then move your focusing to the various body parts and as
time goes on (not immediate) you are able to consciously feel your heart beating. You then continue to visualize the movement of the heart - the contraction and the expansion of the heart. Do it for a few moments and then proceed to the stomach and the spleen, and liver and so forth. The focusing on the internal organs makes one aware of their uncontrollable nature. Then the excellent part is that the surface of the skin, you feel your skin first, feel the hairs of the skin and feel what is beyond the hair, for skin, the hair roots and all that and you can feel below your scalp, you can feel some sensations, some vibrations that are below your scalp. So when you begin to be sensitive to that then you know that all our skin - they are all living organisms - they are all living things, made of cells. So there is a lot of vibrations that are being generated there. Yes that is right and this is interesting because sometimes you can pick up the vibrations of your clients. so when a client walks in you can get a sort of a feeling that it is going to be a good session or it will be a bad session. But of course, again as counselors we have been taught not to prejudge and to be non judgmental. T28

T28 points out that the body is integral to Buddhism and by association psychotherapy practice. He suggests that by practicing Buddhism and namely meditation practice, it facilitates an increased awareness to other which is further possible via unconscious transmissions or communications. Of note is the close attention paid to body parts in meditative practice, which enables greater sensitivity to other. T28 also spoke scathingly about the Western uptake of Buddhism without a thorough appreciation of the breadth and intricate practices employed. For example the latest trend in Western psychotherapy to integrate mindfulness techniques he expressed was ill-informed as it was divorced from a full understanding of the
Buddhist approach. In addition he expressed the opinion that many singled out practices for example Vipassana mediation and Kundalini yoga embraced a heightened state of innerness without understanding the dangers of doing so. In short, he felt that many Westerners incorporated split off facets of Buddhism, adapted them freely whilst largely ignoring the hazards that could occur. In summary, T28 states;

Without strong moral foundation and without a trained and knowledgeable meditation teacher one can easily get into emotional and mental difficulties. The world is excited by Vipassana meditation – but therein lurks many dangers. But Vipassana mediation is very dangerous. It is just like Kundalini yoga is quite dangerous. Vipassana ultimately directs the practitioner to a state of “impermanence, suffering and non-self”. In Kundalini yoga one starts to move the primordial energy inside the body. When misdirected mental and emotional issues result because in Vipassana mediation you are supposed to meditate and look deeply into the concept of impermanence and suffering and selflessness - there is no self in you. So if a person reaches that stage and says nothing is permanent, I am not me, I am not real, the table is not real, and you are not real – what happens then? When the practitioner emotionally experiences “emptiness” and that everything is devoid of substance – what happens then? Yes, and yet there is a Buddhist teaching that instructs one to realize that everything is a mental construction – we are living in a phenomenological world. You construct the world around you; this is actually what quantum physics is also. It is the observer that observes when the waves collapse to become particles. That is why it becomes dangerous, that is why you need to develop your morality before proceeding to engaging meditation as a spiritual path. T28
Whilst acknowledging that Buddhism is an imported philosophy and spiritual practice to China, it has greatly influenced and melded with many Chinese philosophies prior to the Western introduction of Christianity. What T28 suggests is that it can explain to some extent how somatic countertransference comes about and more importantly that by practicing mediation one aspect of the Buddhist practice, greater sensitivity to other’s inner psychological state is possible. T28 cautions strongly however that it is essential to practice mediation from a complete understanding of Buddhism so that one does not endanger one’s self psychologically.

Also addressed by T3, T21 and T17 were Chinese ideas regarding the interconnectivity and resonance of humans between heaven and earth. These are distinctly Taoist concepts that were employed to explain the zone of unconscious communication between client and therapist from a Chinese perspective. These ideas from Chinese culture intersect with Jung’s notion of the zone of mutual unconsciousness and contemporary relational psychoanalysis focus on intersubjectivity between client and therapist (Jung, 1954, Stolorow, Atwood & Orange, 2002).

From what has been presented thus far in this chapter, it is apparent that the Chinese participants were able to actively reference their cultural practices for understanding somatic countertransference. Specifically the idea of the mind-body continuum, TCM and Chinese philosophical and spiritual practices such as the i Ching and Buddhism provided rich sources of understanding unconscious processes. A continuation of this exploration will occur in the following chapter as I will now investigate qi, Qi Gong practice, a Japanese perspective as well as conduct an Eastern and Western comparison of understanding somatic countertransference.
Chapter 6: Somatic Countertransference: exploring Qi, Qi Gong Practice, Skype and a Japanese Perspective

In Chapter 6, I will continue our investigation of what Chinese spiritual practices can add to our understanding of somatic countertransference and our capacity to work and manage the potential negative effects of it. Specifically I will focus on the practice of working with qi and the corresponding practice of Qi Gong. Additionally, a short examination of working with somatic countertransference on Skype will be undertaken in a section entitled Qi and Skype. All sections will integrate ideas for best practice with somatic countertransference from a Chinese perspective. Following on from this, two final sections explore a Japanese perspective from Kyoto and Western perspectives on somatic countertransference to complete our cross-cultural analysis. This chapter concludes our exploration of a Chinese understanding of how somatic countertransference manifests and their perspective on how best to work with it for increased clinical efficacy.

Qi and the Practice of Qi Gong

For many of the Chinese psychotherapists when grappling with how somatic countertransference manifests in the body of the therapist, qi was considered to play a central role. Generally speaking qi was thought to equate with the Western construct of the unconscious and by extension the phenomena of transference and countertransference. As explained by both Chunyi Lin, Qi Gong Master and John Dolic, TCM and Qi Gong practitioner, qi equates with energy (Lin, Interview, 21 November, 2013, Dolic, Interview, 17 January, 2014, Dolic, 2011). Specifically, qi is
energy that is within the individual and flowing between human beings, partly known but mostly outside of our awareness. It is the idea that it is occurring with minimal awareness that equates with the Western concept of the unconscious, at least on some figurations of this idea. The idea that qi can also flow between individuals and therefore affect people will be explored with data from the Chinese participants. Following on from this initial exploration of qi, the practice of Qi Gong will be investigated to provide further richness to understanding somatic countertransference from a Chinese viewpoint.

In exploring how the therapist’s body can pick up the inner unconscious state of the client via his/her body T3 says the following:

*It is potentially [useful], maybe it is useful in a sense in a more comprehensive way for your body to pick up and catch all those underlying issues and material rather than verbal. So when you become more fully aware of that, it might be a valuable truth. Just like the thermometer or detector, that is picking up the sense. What if the therapist can produce a response back in to the kind I am thinking of, through this way? Because when you mentioned about the culture, in Chinese, there is qi. The qi, now it may sound a little bit far-fetched but I think it could be explained too, that is the somatic, that is exactly the somatic. Through your qi and then you transmit it back to your client.*

*In is a sense, it is possible I think. But probably not me, not my experience. I am talking about some theoretical things. In another way, the somatic countertransference could be interpreted for the qi principal. T3*
Early on in my interviewing of the 29 Chinese Psychotherapists, T3 was the first participant to truly grasp the possible parallel between \textit{qi} and the unconscious, that \textit{qi} could manifest in the body of other as a result of the process of mutual influence and that the psychotherapy encapsulated this idea of shared effect outlined by Jung (Jung, 1954). In agreement, another Chinese participant T14 also declared the following:

\textit{I never thought of it before in a cultural way, I mean from the Chinese culture can explain this. I never thought of this before. In Chinese culture, we have a word, it is qi.}

\textit{It is another definition of unconsciousness. It is a term, we call it in that way but maybe it is the same thing. T14}

As such, this suggests that \textit{qi} is an unconscious energy within each person that can also affect others. This sentiment was also picked up by T4. He says the following:

\textit{You have a qi area, you have some qi around you and other people will be influenced by your qi and they can feel your qi and it can control other people this qi. It can influence other people. So some people who are powerful, we can feel the energies are powerful, the qi is stronger and intense and peaceful or passionate, qi is different from other people. It is qi. Maybe some substance or some description but from China we call it the qi. T4}

T4 went onto explain how the concept of \textit{qi} is essential in Chinese thinking and way of life and taught early in their education. He adds that \textit{qi} is harnessed and refined through (Qi Gong) practice and it can be transmitted by people to help others. He says:
It is like the air, the qi is like the air. I think people from other cultures couldn’t understand the Chinese knowledge about the qi. When it is a substance or a subjective description or like the Chinese Medicine, we think that the patient have different cure (acupuncture point), even the traditional Chinese people didn’t have a machine to detect where it is, we can describe it and find it, where it is and how it flows from one place to another place. They can use some needle to push it, to push the flow. Later when some research about it they find the place, exactly, it is very right place for something that has happened. So I actually think that qi is like a substance and it can influence other people like an energy, even when they didn’t have machine to detect it, but we can feel it, like our traditional Chinese medicine. The Chinese Doctor, we can find such place. T4

In terms of working with clients, I asked T4 if he worked with qi in some way when working psychotherapeutically, he replied:

Yes, somebody with depression, you can feel down. Yes, when someone is seductive, you can feel sexually aroused and when someone is angry you can feel the atmosphere will become nervous, intense. So you can feel the atmosphere, you can feel the Qi come from the patient. T4

As such, it would seem that qi energy can be seen to be infectious. As explored in Chapter 4 on psychic infections and the notion of the shared wound, this suggests that there is a Chinese explanation for how we can pick up on the energy of others and therefore be affected by it. T5, in agreement with this idea, says the following:
It is just like they believe that every person has their own mental aura. So that is why they say when we study in the college, we girls live in the same dormitory, and usually after a period of time all the girls will have their menstrual period around the same time. And that is because it is like a magnet or something like that. It will influence each other. So that is why sometimes in China we think when we see somebody that we have never seen, for the first time we have seen them, I feel very comfortable to be with them. Or I don’t feel very comfortable. And sometimes they say that when we do feel comfortable it is because we have a very nice mental aura. They produce a very comfortable, and to some people they have a very uneasy one. So when we’re close with them we may feel uneasy. So that is what Chinese people say according to Tao, each person has their own aura. And we can connect that information unconsciously, to our body. It is called a magnetic field. T5

In this case, T5 avoids the term qi but instead alludes to the Tao therefore suggesting that TCM, Tao and Qi Gong are interrelated practices with shared concepts. In greater detail T5 in relation to her client Sarah explains the potential for mutual influence at an unconscious level.

You know there is a term; we call it resonance, yes. When we see the magnetic field, we see whether we are resonant, and I can just feel when I work with Sarah that we do have that resonance. So maybe that is one of the reasons that I can pick up the unconscious, I don’t know whether it is information or whether it is something from her, I just can pick up those things, from her body to my body. Other than that I haven’t really thought more about this kind of thing. But I do have that sort of feeling when I work with her. So sometimes I think when we are working longer we build up
the therapeutic alliance, I wonder whether this is just something about alliance. You know we have the resonance with the patient. And we can pick up the information consciously and unconsciously and reply back to them. T5

In true poetic form, when discussing what qi is, the Chinese are likely to describe it metaphorically, in many different ways and imbued with diverse qualities consistent with their thinking and expressive styles (Bollas, 2013). For example, T6 says the following:

Chinese qi, yes? Like gas? But it is not really gas it is like breath, yes? So Chinese say if you die, you have lost the qi. You are out of breath then. It is like that you have to keep the flow. You know Tai Qi; it is all about that you transfer the whole thing into a flow. You never let it get stuck in one place. You know they do this thing, it looks really simple but you have to take the qi from here to here, naturally it comes back, you mustn’t let it get stuck. You have to make it flow. It never stops; it creates so much energy and health. So that actually becomes the philosophy for life, the attitude. So life get stuck by crisis, but you have to keep going no matter how hard it is you have to keep going. So that is kind of following the flow, I guess. T6

Like the image of gas or breath, other poetic descriptions of qi emerged from T16 and T17 respectively:

Sometimes I feel like the boundary between the therapist and the patient is not that, how to say this? Sometimes it is not very clear because you can feel something like water, like a river and how to say that? It is moving between you and the patient and
this is where the somatic response comes from and also I think that I quite agree that
the therapist doesn’t have enough time to reflect every feeling and it is kind of the
space….how do you say? It is going together but when you think back it is just like a
flower blossom and you can see very detail things where they come from, what
happened during the sessions. Yes. T16

Similarly T17 says the following:

People are like waves and sprays above the sea, though they seem separated, but they
are all parts of ocean with the same nature----water.

As such, qi is perceived to be acting as a substance between people equated with
various physical qualities like the five elements of wood, fire, water, air and metal
alluded to in TCM. Furthermore whilst qi is seen to flow within and between people
there is another dimension addressed with T17, that is that all humans exist in a
connected state. This concept of interconnectivity was also spoken by other Chinese
participants when discussing Buddhism.

In speaking about the ebb and flow of qi and whether this can be picked up in
the therapist’s body when working with clients, T6 immediately agrees and say:

Yes, I talked earlier about that I felt so exhausted after seeing some patients. It is like
their qi, their negative qi, they gave to me and they took a lot of my positive qi away,
so I felt exhausted. like I feel constantly stretched. Sometimes it feels like a battle, they
can see win their qi over mine. I consciously or unconsciously, I will not let them
In talking about qi with T7 however, she introduces her practice of Reiki for her own comfort and cleansing post-session. She states that she can feel the energy in her hands and that it is like ‘wind’. Furthermore she states that by being attuned to qi, it is possible to intuit the feelings of another and that ‘it is like a flow’, she says:

Reiki makes me flow with Qi and I can feel something, lots of feelings. T7

In China some people practice Qi Gong and work with qi. I think that Reiki is a way to work with this sort of thing. We just use different approach to feel these kinds of thing. And I think that it is the same thing but just that we use different ways to explore qi, approach qi. And I think I can feel the feelings of another, something like the flow. At that moment I had already learnt Reiki and I think maybe I can feel the other because I know Reiki. Reiki makes me flow with qi and I can feel something, lots of feelings. T7

Yet, in speaking with T15, another Chinese practitioner who practices Reiki, she outlines the difference between Qi Gong and Reiki. T15 says the following:

It is different, because the qi, Reiki the qi is from outside of a person (energy just pass from the one who apply Reiki to the target person or object) but for most Chinese Qi Gong, people need to accumulate the qi inside (after using, it takes time to
accumulate enough qi). The source of the qi, I am not an expert in that area, but the source is different. T15

As such, qi in Qi Gong practice is distinctively different from what is taking place in Reiki undertaken by T7 according to T15.

Qi Gong Practice

The practice of Qi Gong in Western psychotherapeutic treatment programs at both a group and individual level is not a new development (Dougherty, 2007). It has been practiced in psychiatric hospitals to enhance wellness with trauma patients (Potik & Schreiber, 2013). By extension, attempting to explain the concept of somatic countertransference with reference to Qi Gong practice was therefore possible. As such, when discussing somatic countertransference as a form of qi, Qi Gong practice was a necessary consideration as it provided ideas for how to manage and work with qi. Chunyi Lin and John Dolic, provided the historical context of this ancient practice spanning over 5000 years (Dolic, 2011). According to Chunyi Lin:

*Qi Gong, qi means energy and Gong means work, working with the body’s energy, is what Qi Gong is all about. (Lin, Interview, 21 November, 2013)*

Chunyi Lin further explained that there are many different varieties of Qi Gong practice involving physical exercise, breathing techniques, meditation and that it can be applied to many illnesses for healing. John Dolic expanded that Qi Gong can be tailor made for many applications such as study, wellness and creativity to name a
few (Dolic, Interview, 17 January, 2014). According to Chunyi Lin, it differs from Tai Qi and martial arts and yet there are many points of similarity and intersection. Specifically Chunyi Lin revealed that he practices a personal style of Qi Gong focused on self-healing and healing others physically and emotionally often from a distance. He says explicitly about Qi Gong:

Qi Gong means working with the body’s energy. In Qi Gong practice, qi is energy. Everything actually is energy from a star, to a rock to a tree, to every emotion such as anger, frustration. It is just the energy in different forms. So Einstein said energy couldn’t be created, it has always been. Energy cannot be destroyed, it will always be but energy can be transformed. So literally our body’s energy and every form of energy in the universe including in our body is in the process of transformation in very minute so a person can transform for better or for worse but in Qi Gong practice by putting your mind, your spirit and your heart together by activating the unconditional love from your heart you consider the most powerful energy in the entire universe. You can help yourself to heal, to transform something already good into better and something like illnesses into healing so that is what Qi Gong is about. (Lin, Interview, 21 November, 2013)

In essence, Chunyi Lin is positioning qi as an energy that can be transformed. This energy, as previously stated, is likened by many Chinese practitioners to the unconscious and it can be harnessed, picked up and moved on or transformed. Furthermore, he explains that qi connects all people and therefore one is able to pick up on the qi of others, to send qi to heal others or indeed focus essentially on one’s own qi for self-healing. Some of these ideas about transmission and how it can be changed via intervention were in alignment with what the Chinese participants spoke
about when discussing *qi* as an equivalent for somatic countertransference. Chunyi Lin also detailed an elaborate process for preparing one self to work with *qi* and that *qi* can be picked up across the internet without actual contact with the person who is wishing to receive treatment with Qi Gong (*Lin, Interview, 21 November, 2013*).

Chunyi Lin articulated that sensitivity to and capacity to work with *qi* requires great self-care. In agreement Dolic, implied that working with other people’s *qi* can weaken the beginner and therefore he undertakes regular Qi Gong practice to remain healthy, strong and separate so that he can work in his clinic with his patients. This is in accord with the notion that when working with somatic countertransference, a manifestation or form of *qi*, regular supervision, personal rituals for clearing and self-protection are necessary for the wellbeing of the psychotherapist (Margarian, in press). As such, Chunyi advises that the novice Qi Gong practitioner can be prone to taking in another person’s *qi*, which can weaken them. Specifically he advises the following:

*First of all you don’t allow that information to stay in your body otherwise you will weaken your body or weaken your qi and sooner or later you are going to get sick too. This is a technique I tell people, listen after you finish detecting the healing, you take three gentle deep breathes inhale and visualize energy coming in through the skin, every pore of the body and collect in the lower Dantian, which is behind the navel, that is the centre of vitality, when you exhale all the information, all the stress, all the negative thoughts the aches and pains in the body changing into smoke shooting out from very part of the body to the end of the universe and do breathe like that three times and then you say in your system, my body, is my body and your body is your body and I appreciate you and I leave my body and go back to the universe and take a moment to feel all the information, leaving your body and your body is back to*
normal and then you focus on the lower Dantian and which is behind the navel and you take three deep breathes again and then can help to clear all these messages you pick up. (Lin, Interview, 21 November, 2013)

Chunyi Lin is providing a specific Qi Gong technique for self-protection that enables the practitioner and psychotherapist to separate post session and therefore not take in and suffer from residual left over qi from others. Agreeing with this idea, Dolic provided an anecdote of a fellow practitioner who became ill because they had little self-awareness about the negative effects of working with qi (Dolic, Interview, 17 January, 2014). In essence both Chunyi Lin and Dolic outline knowledge and a method for working with qi whilst articulating the pitfalls of working with qi and advocating for increased self-awareness and practical methods for removing and separating from working with qi. These ideas equally apply to the psychotherapist experiencing somatic countertransference in both its negative and positive forms. As suggested by empirical research and anecdotal evidence, working with such material can weaken and harm psychotherapists, therefore it is strongly advised that great care be taken (Egan & Carr, 2008, Forester, 2007).

In summary, the Chinese psychotherapists interviewed for this research could equate qi with the unconscious and therefore from a Chinese cultural perspective provide an explanation for somatic countertransference. With this description came further ideas about how qi like somatic countertransference can manifest in psychotherapy in the body of the therapist. Like Jung’s ideas of a zone of mutual unconsciousness between people, the Chinese participants that understood qi as a Chinese equal to the unconscious, intuitively sensed that mutual influence was occurring at an unconscious level which could present in bodily sensations in the
psychotherapist (Jung, 1954). Moreover, they described qi metaphorically and pictorially, which is commensurate with their expressive and thinking styles. Importantly, as somatic countertransference was likened to the transmission of qi, there was a sense that it could be infectious, potentially overwhelm people and therefore recommended appropriate practices for achieving greater clinical skill, self-protection and self-care.

Qi and Skype

When discussing somatic countertransference often the question of whether it was possible to experience physical sensations when working on Skype emerged? This was an important question given the efficacy of psychoanalysis and psychotherapy via Skype is currently being researched by CAPA and others such as Jill Scharff (Scharff, 2013, 2015). Understandably, Skype is a hot and contentious topic given the expansion of psychoanalytic training and provision into China and the reliance on Skype for reaching patients and students located across China. Often the efficacy of Skype is questioned, in terms of whether the therapeutic alliance and by extension transference and countertransference can develop via this disembodied medium. In relation to this research, the question posed is if somatic countertransference is positioned as a form of qi, is it possible to experience qi via Skype? If so, what can this add to our understanding and working with somatic countertransference via the medium of Skype?

T4 was the first to raise concern about this and expressed the opinion that if qi was an equal to the unconscious and the conduit for countertransference and
transference per se, then it would be necessary to be within the same room of the other to pick up qi. T4 revealed a personal example of this as he has undertaken psychoanalysis via Skype with his analyst who resides in New York. He said the following about his experience:

*I think it is different when we are in the same room; it is not so strong as when on Skype. I think when we are on Skype I can learn from experience, from her words are powerful but when she was present in the same room I feel it was not so influential like on Skype, because I can touch her reality, the real person, have some features. I can directly feel her. That is my analysis. I have different feelings about different situations… Yes, the image, I think we tend to idealize or because we only see her upper half of body. Not the rest of the body/the whole body? Only the face and shoulders. T4*

I think T4 is revealing his own personal experience of working on Skype and contrasting it with an embodied session and how the two experiences were vastly different. I think this is an important consideration because it infers that different individuals experience various things under diverse circumstances. I believe this must be always considered and trialed when working with patients on Skype when assessing suitability with this medium. Yet both Dolic and Chunyi Lin suggest that with Qi Gong practice it is possible to work with qi via distance and via the medium of Skype and the telephone effectively (Lin, Interview, 21 November, 2013, Dolic, Interview, 17 January, 2014). Chunyi Lin said the following about working with qi on Skype:
Yes, because this energy, energy healing is a message healing, it is information healing, no matter where you are as long as you are an energy being, and then this message, this qi can find you. In my mind, the qi flow, in the interaction, it is like a telephone, so we are here on the Skype, no matter where we are we find each other’s code and the cell phone number or whatever, then we can connect with each other, so it is like we are talking face to face. So that is the distance healing and even we have global healing room on the website and people just give put in the names in the global healing room and we tune in, people from all over the world tune in, to send energy to people and it helps, lots of people have had amazing stories from the global healing website. (Lin, Interview, 21 November, 2013)

If we follow what Chunyi Lin is stating about qi and Skype, this would suggest that countertransference, somatic or otherwise would be possible to access on Skype. As such, whilst Skype offers a process of engaging with psychotherapy remotely, the unconscious, qi energy, countertransference and transference is still possible. Some analysts however remain guarded about its application to treatment. In my discussion with Angela Connolly, a Jungian analyst, she suggested that she would be unlikely to encourage Skype for personal analysis because it is difficult to pick up clearly on the non-verbal communications that occur in the room between analyst and client (Connolly, 2013). Others such as Scharff suggest that ‘the future is here’ and given that Skype is a new technology quickly assimilated by younger generations, it is necessary to explore both the benefits and the pitfalls of utilizing Skype for analysis and psychotherapy (Scharff, 2013, 2015). Importantly, she suggests that it is necessary to know and discuss its limitations whilst keeping an open mind for utilizing it for psychoanalysis. Furthermore from her review of analytic literature
exploring teleanalysis, she concludes that the various components of psychoanalytic process including transference and countertransference are observable (Scharff, 2013).

In summary, working with energy such as qi nominally an equivalent to unconscious processes, according to experts in the field of Qi Gong it is possible to work with it via the medium of Skype. In its application to psychotherapy, if qi equates with energetic transmission commensurate with the notions of transference and countertransference it is likely that it can be experienced and worked with in this form. As suggested by Scharff if we continue to work psychotherapeutically via Skype, we must continue to research it and promote consciousness about its implementation for increased efficacy and skill (Scharff, 2013). Whilst not solely focusing on Skype practice, this research project is touching on the underlying process of somatic countertransference and whether it can be worked with and managed via Skype.

A Japanese Perspective on Somatic Countertransference from Kyoto

In exploring the important question of how do we explain somatic countertransference, interesting ideas were provided by Professor Yasuhiro Oyama from Kyoto University. First of all, he provided an explanation from a Japanese perspective that like T3’s reference to a Chinese character, explained somatic countertransference pictorially. As such there was a strong parallel between the Japanese and Chinese understanding of resonance between human beings. Secondly, Professor Oyama positioned the capacity for greater self-awareness of the body as
crucial in undertaking clinical work and that he taught this skill to his students before they engage in verbal interpretations.

In explaining somatic countertransference and its relation to the self and other, Professor Oyama said the following:

Yes in Japanese, the vocabulary that corresponds to self is jibun. 自分.

So 自(ji) means ‘me’ and 分(bun) means ‘my part’

So Jibun corresponds to the ‘self’ in English and at the same time jibun means that the phenomena of ‘myself’ is possible only when I have the other.

I can say ‘my part’ because there is the other part...... so in oriental or especially in Japanese self-construction, our self-construe is only possible with the other.

Okay, then I would like to refer to the Japanese vocabulary 気分 (ki-bun). Ki-bun means ‘my feeling’, 気(Ki) means ‘atmosphere’, 分(bun) means ‘shared my part’ as I mentioned. So my feeling may be a part of an atmosphere. (Oyama, Interview, 5 December, 2013)

If we piece this all together, Professor Oyama explains that people can only know themselves in relation to another person. In addition, the experience of ki (which he confirms is the Japanese equal to the Chinese qi) enables people to know others via the atmosphere or energy exchange that occurs between people when they meet. As such, there is some correlation between Japanese and Chinese thinking here and furthermore an explanation of how somatic countertransference occurs. What is explained here according to these two cultures is that the psychotherapist and client
will be affected by each other in the atmosphere of the psychotherapy room. There is an implied energetic exchange that facilitates self-knowledge for both participants. These oriental ideas strongly parallel Jung’s seminal work about how we mutually influence each other in psychotherapy practice (Jung, 1954).

Professor Oyama outlined his personal view of somatic countertransference by stating that from his clinical experience and observation there are two types. He stated the following:

*Because somatic countertransference is very important to know what is going on in the interpersonal field. I think we have two types of somatic countertransference, salient countertransference and much more subtle one.*

Okay, *salient countertransference is very obvious body states or feelings. For example, stiff shoulder, or a pain in the back or a migraine headache, nausea, and sleepiness and sometimes stomach ache and desire to urinate.*

The *subtle type of somatic countertransference is the continuous process of body feeling during a session. During listening to the patient’s talk, I pay attention to my feelings, to my body feelings. For example when I listen to the talk of clients, for example, I sometimes feel tension with my heart or feel my stomach moving.* (Oyama, Interview, 5 December 2014).

This was a fascinating discussion that determined the importance of incorporating the body into clinical practice and furthermore that there could be additional nuance to somatic countertransference. As such, this suggests that specialized training to ensure that future psychotherapists become aware of the different types of somatic expression would be advisable.
Accordingly, Professor Oyama stated that with his Masters and Doctoral Clinical Psychology students he integrates an exercise early in their training to endorse a bodily focus in psychotherapy practice. He explains it as such:

When I train my students or candidates for Clinical Psychology, I often refer to somatic countertransference and I tell them that somatic countertransference is very essential. It is an essential one.

Yes, I ask students to sit, face to face, and ask them to report their body feelings respectively. For example they report, “I am starting to pay attention to my stomach” or “I had a pain in my back.” And the pair, the person sitting in front, reports their somatic feelings too. Students often find that they report almost at the same time, the same somatic feeling. They are very, very surprised to find this synchronicity and says “Oh you feel that feeling as well!” Then I ask them to change their partner and pay attention to their body feeling again. Then, they find that their body feeling has changed with different partner……..

If we change our pair, the body feelings of ourselves change.

When I teach counseling to students I put this program at the beginning before students experience the training of the therapeutic way of words, I mean before they train verbal therapy, I teach them how to exist with their body as a therapist. So I teach students the importance of posture, posture and gestures, every non-verbal aspect. I also say to them, “You should monitor and manage your body feelings. Pay attention how your body works when you are with a patient in order to know what is going on between you and the client, and at the same time in order to keep you as a
In speaking with Professor Oyama, it became immediately clear that Japanese psychotherapy practices had much to contribute to Western psychotherapy. First of all, how they perceived self and other within the atmosphere with the counseling room articulated and reinforced the notion that when two people meet they affect each at an unconscious and conscious level. In addition, by observing the body, unknown, unacknowledged material is able to surface and be worked with. As importantly, Professor Oyama advocated for the understanding and working with somatic countertransference to occur early in psychotherapy training so that the body as a tool for psychotherapy is developed and reinforced before the inclusion of verbal psychotherapy techniques.

This is fascinating, insofar as similar creative ideas have also been integrated in Norway, where supervision is practiced with a similar method of closely observing the body of other by a process of re-enacting the client patient sessions in supervision (Sletvold, 2012, 2014). In summary, there is much to be learnt from other cultures such as Chinese, Japanese and Norwegian which can be applied to psychotherapy practice.

**Western Perspective on the Origins of Somatic Countertransference**

In undertaking a cross-cultural investigation into somatic countertransference, it is essential to contrast the ideas generated by Qi Gong, TCM, Buddhism and the
contribution from Japan with what is currently being thought about in the West. As somatic countertransference has been alluded to in neuroscience with the work of Allan Schore and others, this suggests that it is being investigated and discussed in relation to the development of self and ego and conceived of within the relational context (Schore, 2012, Carroll, 2006). In my discussion with Kristina Schellinksi, a Jungian analyst who has thought about and researched somatic countertransference for 15 years, together we developed a number of possible explanations based on current research and conceptual ideas from the West.

Schellinksi revealed that her research into somatic countertransference first commenced with her own experience of being physically affected by her clients and by observing her colleagues also similarly become unwell. She states the following:

*So if I look back I came this close to be infected which then manifested in his body as a symptom which was going to carry unconscious suffering. So that is how I started and I thought, “Oh my God, what am I going to do?” and I started in it from….first I went at it from a compassionate angle and I thought, this is compassion, this is at the very bottom of where you are empathic with the other person and then I came across something from here in Geneva from Cern, the nuclear research facility and they had run an experiment where they had sent electrons. I hope I am saying this right. Electrons in a circle. Exactly and in another circle, it was 20 kilometres away, the electrons aligned itself in a circle and mirrored the movement. So I looked at what had happened to me with this mentor/patient as this kind of alignment of where the electron was spinning in a similar way and where my body was tuning in, in an empathic link in a compassionate link to mirror what this person was dealing with. But it was very, very dark stuff. As I was kind of alluding to and it took me about….*
was seriously afraid at that time that I would feel ill. And a colleague of mine had fallen ill with similar symptoms. She was a very famous colleague from Zurich during my training and she had given up the profession because of this, because she could not keep being in the profession with her body being in and getting into this kind of mirroring loop and empathic link. (Schellinski, Interview, 16 January 2014)

This important observation of the electron experiment in Cern inspired Schellinski to think broadly about how the body of the therapist can pick up physical sensations that were meaningful to her analysands. Following on from empirical science, the idea of mimicry at a subliminal level occurred even before conscious recognition has been suggested with the presence of mirror neurons. Schellinski reports that Rizzolatti via his experiments with macaque monkeys established a biological basis for mimicry and empathy (Schellinski, 2013). As mirror neurons have now been discovered in humans, it suggests that humans unconsciously will mimic others and therefore experience a form of empathic resonance that equates with somatic countertransference (Rizzolatti cited in Schellinski, 2013). For Schellinski, this explains how we can experience empathy and or somatic countertransference when we work on Skype as well as during embodied sessions. When interviewing the Chinese participants T4 also mentioned mirror neurons as a possible explanation for how we can empathize with our clients when working with them remotely via Skype.

In Schellinski’s article that articulates her research and thinking to date on somatic countertransference, Schellinski further suggests the role of the synchronicity, the subtle body\textsuperscript{16} and even typology as providing some answers as to how somatic

\textsuperscript{16} The subtle body according to Tibetan medicine suggests a network of energy channels that parallels the physiology of the body. It is thought to be accessed through meditation practices.
countertransference is picked up by the therapist (Schellinski, 2013). In terms of typology this is not new material with Stone previously suggesting that introverted intuitive types are more likely to experience somatic countertransference as they will unconsciously take in sensations that can be overwhelming at an unconscious level (Stone, 2006). Whilst this research did not investigate the typology of the Chinese participants, my sense is that it is highly unlikely that all the participants were introverted intuitive types; yet all participants reported some form of somatic countertransference. As such, I find this explanation limiting when applied to our understanding of somatic countertransference. Schellinski in our discussion has agreed. However, the idea that somatic countertransference could be explained by synchronicity is interesting but difficult to conceptualize. Schellinski points out that in a footnote in his book on synchronicity, Jung suggests that there is an alignment between body and mind like ‘two synchronized clocks’, implying that both exist in some form of acausal relationship (Schellinski, 2013, p 21). Schellinski suggests that the occurrence of:

Somatic countertransference, as body and soul phenomena, can be understood as being ‘caused’ by mirror neurons, or as an acausal experience of synchronicity, pointing towards a connection in the service of Self; it is therefore not necessarily a function of unconscious projection on the part of the analyst, in the inter-dependent dynamic with the analysand, but rather accedes to an experience of that deeper layer, to which both psyche and soma can tune in (Schellinski, 2013, p1).

Schellinski in speaking about the potential for the role of synchronicity is also directing our attention to another idea proposed by Jung, that of the psychoid. The
The concept of the psychoid is complex yet implies a level within the psyche whereby mind and body unite and communicate. Jung says the following about the psychoid:

Since psyche and matter are contained in one and the same world, and moreover are in continuous contact with one another and ultimately rest on irrepresentable, transcendental factors, it is not only possible but fairly probable even that psyche and matter are two different aspects of one and the same thing. (Jung, 1969 p 125)

It is this idea that suggests a fusion between psyche and mind somewhere within the unconscious that is applicable to our understanding of somatic countertransference. It provides the possibility that within the relationship between therapist and client and the implied zone of mutual unconsciousness, physical sensations relating psychic material can occur (Clarke, 2010). A Western concept that nonetheless applies to the conflation of feeling and physical states expressed by the Chinese psychotherapists.

In proposing embodied countertransference in his seminal paper in 1985, Samuels wrote about the Mundus Imaginalis as it ‘refers to a precise order or reality, located somewhere between primary sense impressions and more developed cognition or spirituality’ to elucidate where embodied countertransference may evolve from (Samuels, 1985, p 58). As Samuels goes onto to explain, embodied countertransference occurs from an in between state, between analyst and patient, between consciousness and unconsciousness, an imaginal space (Samuels, 1985). As such, he boldly asserts:

My suggestion is that there is a two person or shared mundus imaginalis which is constellated in analysis (Samuels, 1985, p 59).
Clark adds to Samuels’s idea of the constellated mundus imaginalis between analyst and analysand by including the possibility that the psychoid state, whereby soma and psyche meet is operational in this space therefore allowing a transmission of psychic states known as somatic countertransference (Clark, 2010). The role of the psychoid state is also considered by Zabriskie as active when uncanny presentations of embodied countertransference occurs in analysis (Zabriskie, 2006). Clark explores the psychoid process in-depth and proposes that it is a primitive, preverbal part of the unconscious where psyche and soma meet and are a consubstantiating substance (Clark, 1996). He describes how these embodied and largely somatic counter-transferential experiences are experienced as such:

For me mind and body, fantasy and reality, inner and outer, my mind and your mind, my body and your body, you and me are and must always be fused as one....(but you must not simultaneously sort out this confusion). I shall get into and possess your separate body-mind by disturbing and infecting you psychosomatically. I shall confuse your thinking, attack your linking, and somatize your symbolizing function....as mine is.” (Clark, 2010, p 92-93).

This is the very essence of psychic infection that was written about in chapter 4. The data collected from the research of 29 Chinese psychotherapists clearly demonstrated on occasion this interplay of psyche and soma and psychic infection. Clark goes onto explain that somatic countertransference is likely to occur with regressed borderline patients and enabled by a previous wounding in the analyst (Clark, 1996). Angela Connolly in our interview confirmed that her understanding of somatic countertransference was that it does indeed manifest from unconscious-to-unconscious level between analyst and analysand, when there has been a profound
split between mind and body evident with dissociation of traumatic material with the patient. She asserts that with this inability to symbolize, it is the role of the analyst to work with the somatic countertransferential material and through reverie at some point make meaning of the experience that is palatable for the analysand (Connolly, Email, 11 March, 2014). This idea of reverie by the analyst and the capacity to hold and survive the influx of psychic material that can manifest as somatic countertransference in the therapist has also been written about by Clark in relation to his difficult cases of Jim, Rose and Pat (Clark, 1996, Clarke 2010).

In a recent article, Connolly returns to synchronistic events between analyst and client that can happen in somatic form and provides an excellent clinical example, Veronica, an analysand who experienced somatic countertransference associated with choking. Connolly surmises that this material is dissociative in nature and that synchronicity between analyst and patient occurs because of the analyst’s capacity for reverie (Connolly, 2015). Whilst synchronicity is a complex concept to understand at the best of times, I sense that both Connolly and Schellinski agree that it plays a role in the manifestation of somatic countertransference in psychotherapy (Connolly, 2015, Schellinski, 2013).

In an alternative interpretive perspective, Schellinski embraces the Jungian concept of the symbol and the Self17 in order to propose the following analysis of somatic countertransference:

The embodied symbolic approach goes further: I feel and sense what is happening in my body, I embody the symbol which expresses what is

---

17 The Self, denoted with a capital S, aligns with the Jungian notion of the archetype of the Self. This is experienced to be a pre-existing archetype that guides the individual in the process of individuation.
happening in my body as a reflection of what is happening in the body of the 
analysand, or what was stimulated by the other in my own unconscious. The 
embodied symbolic approach has the potential to lead to body-and-soul-
healing, to an experience of wholeness, of the Self in a palpable and 
symbolical way. For the analysand, the effect of being understood and 
contained to that level can be a healing experience (Schellinski, 2013, p 18).

This is Schellinski’s current and still-evolving position on what is happening for the 
analyst when somatic countertransference occurs. She names it as ‘an embodied 
symbolic approach’ (Schellinski, 2013, p 18). I think it is a uniquely Jungian position 
born from her clinical experiences but not necessarily shared by other Jungian 
analysts who speak of and work with somatic countertransference such as Clark, 
Connolly and Weiner (Clark, 1996, 2010, Weiner, 2012, Connolly, Email 11 March, 
2014).

When I interviewed Susie Orbach, a relational psychoanalyst, and asked for 
her understanding on how somatic countertransference can be explained and 
understood, she said the following:

Well I don’t think we understand anything about how we transmit anything to 
anybody else. We just know these things as a phenomenon. That's why we call it 
countertransference but we don’t actually know how a feeling or an affect or when we 
walk into a room, or how we convey a good mood, or a bad mood. We feel this stuff in 
normal life, let alone in the clinic and we don’t have a way of talking about it except 
to say these phenomena happen, people communicate to each other. I don’t want to 
say...we don’t have a way to say it. We could look at baby tapes, mother baby tapes,
Beatrix Beebe’s work and we can look exactly at how the baby and the mother makes an invitation and the other responds and we look at proto conversations, but that is all we can say about it. And that is all physically, the mother smiles and then the baby smiles and then the baby does this, so I am not sure what you mean, how do we explain it? That is how we explain. It is not that I think it is happening at a molecular level and that is going to help me understand it better than I do as a psychoanalyst, I don’t need to reduce it to something else to go, right brain to right brain. I haven’t understood anything in saying that. (Orbach, Interview, 18 December, 2013)

Whilst Jungian depth psychology has proposed some conceptual ideas about what happens between analyst and analysand and how this manifests as transference and countertransference, Orbach on the hand does not want to define it. Rather, she expresses a desire to remain liberated from such explanations. In her earlier work, Orbach argued that in the West we are too mentalist and bound by the mind that in order to work more effectively with the body it is essential to start with the body, thereby freeing it from unnecessary mental constraints (Orbach, 2004). I am sympathetic to Orbach’s wanting to free up our thinking about somatic countertransference and the body. Yet I sense that her ideas focused on relational psychoanalysis are more pertinent. From our interview, Orbach reinforced the idea that the body happens in the session and it comes about through the relationship that is occurring at that time. This sentiment was echoed by Connolly in our personal communication when she expressed the idea that through the relationship somatic countertransference may occur and therefore through the dyad, this material will be processed (Connolly, Email, 11March, 2014). This was further taken and spoken about by a number of Chinese psychotherapists that highlighted the role of the relationship for understanding the body and somatic countertransference (Margarian,
One theoretical question raised in the West by Gubb but not taken up in this research project is whether somatic countertransference comes from within the therapist as a form of resonance or is it a direct transmission from the unconscious of the client (Gubb, 2014)? Whilst Gubb presents theoretically and clinically as a relational psychotherapist, I am surprised that she is concerned with this question, as relational psychoanalysis would suggest that this material is in the zone of co-creation rather than belonging to one part of the dyad. I also acknowledge that this area of consideration has been omitted from this research project as my focus has been more about increasing our understanding and capacity to work with somatic countertransference.

A recent overview of contemporary thinking on countertransference written by Zachrisson echoes comparable sentiments espoused by this thesis. In his review of past and current ideas on countertransference and projective identification he suggests that there is a potential co-creation of material, a capacity for infection by both parties and that what is paramount is that the analyst/psychotherapist retain the capacity to observe and process this material (Zachrisson, 2009). Increasingly noted with the numerous clinicians quoted thus far, there is the sense that contemporary psychoanalytic thinking has finally embraced the relationship that occurs at both conscious and unconscious levels. I think this was what Jung meant when he wrote about the mutual zone of unconscious communication that manifests in the therapeutic dyad (Jung, 1954).

In comparing the aforementioned Western ideas with the theories from Qi Gong TCM and Buddhism, there is a strong sense of agreement, that being that
energy or *qi* is likened to transference and countertransference or largely unconscious processes. That the mind-body connectivity endorsed by TCM, Taoism and expressed in both the Japanese and Chinese pictorial language systems is considered relevant to the work of Jung and his ideas regarding the psychoid and the process of unconscious-to-unconscious communications in analysis. The application of yin and yang was described as the relationship that evolves in the psychotherapy session, whereby a balancing act occurs between patient and psychotherapist, I suggest this equates to a degree with the importance of the evolving relationship in psychotherapy as mentioned by Orbach and Connolly respectively (Orbach, 2013, Connolly, Email, 11 March, 2014).

After exploring both Western and Chinese explanations of somatic countertransference the position where I have arrived at takes into consideration many ideas from both cultures. I acknowledge that there is an unconscious-to-unconscious process occurring in the session that is largely out of our awareness as suggested by Jung, taken up in relational psychoanalysis and spoken about by the Chinese psychotherapists (Jung, 1954, Stolorow, Atwood & Orange, 2002). This is consistent with the important work of McDougall that posited that unconscious transmissions even if they manifest in the body of the therapist, can remain out of our conscious awareness (McDougall, 1989). I sense that the process of psychotherapy acts as a vessel or container whereby there is a mutual unconscious zone of communication occurring between analysand and analyst and that in this process, there is a co-creation of material manifesting. This diverges greatly from Gubb’s concerns about where somatic countertransference comes from, the body of the therapist or the patient (Gubb, 2014). As such, it is specific to the relationship at that time and furthermore enabled by previous wounding that has occurred for the analyst. This
point has been explained by both Merchant and Clark therefore suggesting that therapists are able to pick up somatic countertransference because of their porosity to this material from their developmental personal experiences (Merchant, 2012, Clarke, 2010).

From the West, we have ideas of mutual zones of unconsciousness, the psychoid whereby mind and body are inseparable, synchronicity as an acausal facilitator between analyst and patient and more recently the inclusion of inter subjectivity. All these Western conceptualizations suggest that mind and body act in union and that in relationship analysts and patients can mutually affect and infect each other. From a Chinese perspective similar ideas evolved namely that mind and body are intricately connected with respect to TCM. Body parts according to TCM are noted to correspond to feeling states thereby suggesting a state of union with mind and psyche. The notion of \( q\) was likened to the unconscious and by association transference and countertransference within psychotherapy alliance. In applying TCM principals, psyche and body can be unblocked via working with \( q\) energy in psychotherapy practice. Qi understood with reference to Qi Gong practice, flows between people and balances itself out according to yin and yang principals. Furthermore, Buddhist and Qi Gong practices imply connectivity amongst people that further affirms the idea that energy \((q)\) and therefore somatic countertransference can occur across psychotherapy relationships.

These cultural practices further provided warnings and ideas for protecting the practitioner against the negative effects of working with \( q\). The idea that \( q\) can be worked with in Qi Gong practice via the Internet further implied that somatic countertransference is possible in Skype psychotherapy. In summary, the ideas
provided by Qi Gong, TCM and Buddhism affirm many contemporary ideas discussed in analytical psychology and psychoanalysis in relation to somatic countertransference and how to work with it from a Western perspective. By considering and integrating Chinese cultural knowledge both a validation of Western considerations of somatic countertransference occurred as well as new material for contemplation.
Chapter 7: Cross-Cultural Considerations

To complete the process of exploring the phenomenon of somatic countertransference cross-culturally this final chapter will tie up the loose ends that surfaced during the data analysis. It will explore a number of findings that do not fit neatly within the parameters of the research questions, yet in surfacing add to the completion of this research project.

Specifically it will explore the notion that for some Chinese participants cultural knowledge has been lost due to political challenges in recent Chinese history. This stood in contrast to the finding that for other Chinese psychotherapists cultural knowledge was freely adapted into psychotherapy practice. Additionally this chapter will explore how for some Chinese psychotherapists Western psychotherapy was considered a last resort for the Chinese population. This idea led to the final consideration of whether psychotherapy is indeed relevant to the Chinese in their pursuit of psychological treatment? It is these disparate considerations that emerged from this study that provide additional detail into the vast terrain of this research project. In examining these areas it will be established that the Chinese can indeed enrich and extend our thinking on psychotherapeutic practice; an idea, which has immediate implications for understanding somatic countertransference.

The loss of Cultural Knowledge in China, Hong Kong and Singapore

When designing this research project, I assumed that it would be reasonably easy to access information from Chinese philosophy, medical and spiritual practices from the Chinese participants themselves in the process of our interviews. What emerged
However as I proceeded was the sense that China, and the Chinese whom I was speaking to, had moved on from the more traditional beliefs of the culture. China has undergone significant cultural, economic and political changes in the past century that have on the one hand brought progress and on the other hand substantial trauma (Markert, 2011, Chu, 1985, Plankers, 2011). There were slight cultural differences to be had with the Hong Kong and Singapore participants adamant that as they resided in Westernized cities it was in their interest to dispense with folk law knowledge in preference for Western psychiatry and psychotherapy. Moreover, some Chinese participants from the mainland cited political and historical issues that dismissed spiritual beliefs commensurate with Confucianism, Taoism, TCM and Buddhism. Whilst a number of interviewees were able to cite important texts that held knowledge of the Tao or TCM, many had little contact or experience with these actual texts. Yet on the other hand, some participants spoke as if TCM ideas and Tao were largely common knowledge inherent in their education and family upbringing. Their diverse responses will be explored accordingly.

To commence, T2 bleakly comments about the rapid modernization and expansion that has been observed in China recently:

*Actually, our main land, I don’t know Hong Kong and Taiwan as well, but after our cultural revolution, lots of our traditional things have gone. It is a very big trauma too. So we have no faith, religions. One thing we need in our country is GDP. (I have to say that not all people like this) To people, housing, cars, this kind of thing. Material things. We will pay, we are paying now.* T2

T2 is expressing concern and great sadness about this rapid movement towards modernization and economic growth in China presently. T13 echoed similar concerns
but implied that whilst the West could take time to explore such conceptual notions such as somatic countertransference, in China there is an immediate preoccupation with basic survival. I think that T13 is expressing an important consideration here, that in light of the rapid economic expansion coupled with the recent earthquakes that T13 personally survived, the loss of indigenous knowledge is not a specific focus at present.

Commensurate with the sadness that T2 is expressing, T6 an older woman observes the economic and family structural changes in China and says:

I remember a Professor gave a talk at a University and he said, “We are no more like what the Western people see, the Chinese are changing, sadly.” I relate it back to what you were saying, what is happening in China now, we are losing the older ways now; it is best for me to challenge this. Because I am not so young and I am still drawn to traditional, the past China. But I am right in the middle of this. The old thing and the new thing, I am right in the middle. The society has changed now with the single child policy and the affect on the family, like the west. We have changed also to the nuclear family. T6

T2, T13 and T6 are all clearly alluding to the Westernization of China in the recent past, which has had an enormous impact on families and their adherence or not to traditions inherent in their culture. Consistent with the views expressed by Chu, T6, identifies that there is a split between the generations, those that are embracing the new materialism and those healing from the catastrophic effects of the Cultural Revolution (Chu, 1985).
Similarly T13 also comments that in contemporary China indigenous knowledge is not studied. She says:

*Compared to nowadays with the ancient China, I guess it is true that we have lost a lot. In my understanding and in my imagination, in ancient China, we know these kinds of knowledge if we go to the school but now I feel that this is kind of lost. You know in some school we can go and learn these ancient books again but actually we have lost a lot. Maybe it looks like we are going back but I don’t know about that.* T13

Indicative of this loss of knowledge or lack of access to texts on the Tao and TCM, T15 suggests that accordingly, the Chinese have become less unified with their mind-body as one, in their approach to addressing illness and health. It is noteworthy that T15 is from Hong Kong. She states:

*I think even for people in China, actually they are not...because of modernization, actually we are all place more emphasis on our mind than our body. I think that that is a trend and we forget about wisdom from our bodies, whether we realize it or not we rely on our thinking and what we believe. I think both people in Hong Kong and China, we are both like that. We pay more and more emphasis on our mind and ignore our body...Yes, we may have the idea that these things are important but we may not be really integrating into our daily. We know how to talk about it but whether we are really practicing it in our daily life, I doubt it.* T15

This same idea was confirmed by T1, a psychiatrist in Hong Kong who felt that the Hong Kong Chinese were very Westernized and more educated than their mainland Chinese counterparts. Likewise, Sun reports that the acceptance and assimilation of Western psychiatry methods for treating psychological illnesses are bringing about a
movement towards Cartesian dualism, therefore Chinese holistic approaches are considered less desirable and viable (Sun, 2013).

Strangely one Chinese participant, T29 both mourned and welcomed the loss of his cultural heritage. He explains:

Yes that is right and I think for most Chinese, in China and Taiwan when the term first came up, it was derogatory. But now it is accepted, there are bananas and I am really a banana where I am Chinese on the outside but white on the inside. Everything that I say, my culture is very Western. So in a sense there is one part of me that rejects the Chinese heritage but there is also another part of me where I recognize that.....because my Mum is still alive she is 79 years old this year and she is very Chinese. She is Chinese to a certain extent. About 30 years ago she was a very, very stanch follower of Buddhism, Buddhism, Taoism and a bit of a mix with a bit of animalistic practices of China. Okay so individuals who left China before the Cultural Revolution may have a strong sense of religiousness. During the Cultural Revolution, all those things were wiped out so individuals who were born after the Cultural Revolution have very little understanding of religious practices but for my Mum, she was born in China in 1935, so that was before the Cultural Revolution. So for the duration of the individuals who came down to China to Malaysia and Singapore in those early years, they brought with them the cultural practices, the Taoism and all that. So for her, about 30 years ago she became Christian, so she starting giving up all those Chinese practices, all those linked to Buddhism and all that...... Because when I speak to her in the dialect, she always brings me back all those spiritual practices, those things she used to do etc. So that is where my connection is with my
past. I have been thinking, when she passes away, when she passes on, that is all the
connection I have with my Chinese roots. T29

To position this within a personal context, T29 is a Chinese psychotherapist who
resides in Singapore and has become disgruntled with the political situation within his
homeland. He expressed deep concern about the division between the expatriate
community and native Singaporeans and the treatment they receive in relation to
goods and services. As such, this explains his desire to leave Singapore, reside
elsewhere and to embrace all that is Western, renouncing his Chinese cultural roots.

Yet amidst the concern about the loss of cultural knowledge another voice
tentatively emerged. T9 expressed that interest in Tao and other Chinese cultural
practices were being revived. She states:

*I think it is alive and in the history especially to me. You know when I was young, a
teenager, a university student I didn’t know anything about this I just grow up every
day with everyday life and worried about my future, but when I am here now, more
than 40 years old I start to think of this and I start to find books to read and I started
to understand a lot of things, I can be quiet, and start to observe and accept
everything. So I think that is culture and it has a little bit disappeared, it is in the
history of this country. In the whole nation. T9*

T9 is expressing that there is a resurgence of interest in this material for her
personally especially as she matures and revisits her cultural heritage retrospectively.
Consistent with this idea T17 expressed the opinion that when treating Chinese
patients they naturally drew upon their cultural heritage therefore implying that there
was no loss of such material apparent. He states the following:
Lots of patients understand their somatic symptoms from psychological reasons, it is not difficult to help them understand their problems carry with psychological and relational reasons. I believe this comes from the long tradition of TCM practice and I-Ching Philosophy. T17

In agreement with T9, T17 suggests that it is impossible to lose this knowledge per se because it has a long established tradition held within the collective psyche.

The literature on whether it is possible to apply and integrate psychoanalysis into China provides a different viewpoint. Consistently reported was the idea that in order to apply psychoanalytic concepts for treatment with Chinese people it is essential to consider, integrate and assess critically the underlying Confucianism, Taoist and Buddhist ideas that inform their culture, education and political systems (Shi & Scharff, 2011, Zhong, 2011, Ng, 1985, Chen & Swartzman, 2001, Markert, 2011, Hwang, 2003, Sun, 2013). What this implies is that in spite of some expression that this cultural knowledge is lost, it remains deeply embedded in the collective Chinese psyche. This is precisely what T17 has expressed and T9 is reconnecting with. Therefore it is essential to be appraised of this knowledge before any potential cross-fertilization and comparison between Eastern and Chinese psychological treatment ideas are undertaken. From the responses provided from the Chinese participants it is apparent that for some the cultural knowledge has been lost yet for others it is inherent and accessible. This suggests a variation in the experience of whether inherent Chinese cultural knowledge is available.
The Integration of Chinese Culture into Psychotherapy Practice

As noted by Hsuan, there is a current ‘psycho boom’ in the last decade in main land China commensurate with the rapid expansion of modern China (Hsuan, 2015). Hsuan notes that there has been an increasing uptake of psychoanalytic psychotherapy training. He suggests that this largely driven by a passion for entrepreneurial pursuits and accumulation of training qualifications. Despite this sobering appraisal, it is apparent that from the interviews with all 29 Chinese participants there is an enthusiasm for practicing psychotherapy in private practice and in community services attached to university institutions. Strikingly, some Chinese participants revealed ways of integrating cultural practices into their therapeutic style. For example T1 stated the following:

*I am interested in Jungian psychology so yes I am interested the fairy tales, the Chinese poems, the Chinese myths. And also the Chinese Classic, the I Ching and the Tao Te Ching, to use those kind of concepts to engage the patient, to align with the patient and also to talk about our tribal collectives, our tribal unconscious. Our cultural unconscious, yes and the kind of challenge we as the Chinese or as a Chinese woman. I like to use these kinds of materials to engage my patients into a deeper kind of exploration. T1*

T1 is developing a psychotherapeutic style that connects with fairytales and cultural practices like the I Ching that she believes will more actively engage and resonate with her clients. Similarly T3 revealed that on occasion he utilizes the I Ching in his psychotherapy practice. Whilst I attended a conference in Macau in 2012, in the formative stages of my research, I met with a young Clinical Psychologist from mainland China that spoke freely about integrating I Ching readings into her
psychotherapy sessions. She suggested that the readings could provide options for her patients. This practice speaks of a therapeutic approach imbued with underlying spiritual knowledge and practice.

As discussed in the previous chapter, T16 and T17 expressed a shared idea that psychotherapy was like a massage that released blockages in *qi* that had become built up in the body. As such, mind-body unification is employed as a metaphor and a creative way to explain psychotherapy from a uniquely Chinese perspective. This idea was independently echoed and taken up by T17 who positioned psychotherapy from a Chinese perspective as a form of acupuncture that is able to dissolve blockages in the body by the Western psychotherapy methods of free association and interpretation. What T17 does in addition is integrate mindfulness techniques from his practice as a Buddhist so that he can become more acutely aware of his body sensations and therefore able to amplify body parts when activated in the transference for further contemplation and meaning. Specifically he says:

*Every time when I have those body experiences I will keep special mindfulness on this part. I may keep it silence to feel all my right hand or left hand you are explaining about without any kind of language, feel it. Or I might amplify this response and also with keep mindfulness on it, I will not amplify this language to speak, what words are shattering down from this, feel it, amplify. You can call it active imagination from the Jungian side or you can make it free association side. Go along with it because right now your hand is your supervisor. T17*

Importantly both T17 and T16 confirm the idea that it is highly probable that China will make their psychoanalysis their own, thereby fashioning and modifying it in a way that is commensurate with their cultural beliefs and practices (Scharff, Sehon,
Wei & Wanlass, 2011). It is a fascinating connection established between T16 and T17, that they have a shared understanding of how psychotherapy can be conceived from a Chinese perspective and furthermore how the notion of somatic countertransference could be applicable to clinical practice.

Whilst not a direct example of integrating Chinese culture into clinical practice, the following demonstrates ingenuity and adaption in China at present. An innovative psychotherapy style emerged from Guangzhou with T22, T23 and T25. All three Chinese psychotherapists studied under Professor Heyong Shen and therefore expressed great interest in Jungian ideas. Additionally they had all studied Robbie Bosnak, Jungian analyst’s embodied approach to dream work. From their collective initiative, all three participants have integrated Bosnak’s embodied dream approach with sand play. As such they have developed a unique therapeutic style of facilitating an embodiment of the sand play imagery and dream imagery presented by their clients. Importantly, they claim that image and body are central to their clinical style. An example of this approach is as follows:

Yes I have a very impressive experience with somatic experiences and I think it is related to the countertransference. My clients bring me dreams and sand play and we talk about….we do the dream in the sand tray and we talk about it and we experience it and work with it very carefully and very deeply. And that sand play, a very powerful image is about a serpent, a very big snake and both of us had somatic experiences in the therapy. In the session and he was tense, and uncomfortable in his body and I also have some somatic responses in the same time. I feel very hurt in my legs. We also talked about our somatic responses at that time. T25
In our interview, T25 outlines a therapeutic process whereby the image of the serpent first apparent in a dream is brought to sand play and together T25 and her client explore the meanings both intellectually and from observing their body sensations in regard to the serpent image. I think this a highly personalized style and approach to analytical psychology that is currently being developed in Guangzhou, China.

In discussing how China is embracing psychotherapy and psychoanalysis it is necessary to acknowledge for some of the Chinese participants, there was no need to modify or make Chinese these Western practices. T2 and T13 both expressed great admiration for psychoanalytic ideas and how they transcend culture as they were largely applicable to all humankind. Thus they both implied that it not desirable to alter or make more ‘Chinese’ psychotherapy practice in China. In summing up, for some participants it seemed natural to bring to their therapeutic style their cultural heritage and personal ideas whilst for others not as essential to undertake.

**Western Psychotherapy as a Last Resort**

One interesting finding that emerged from the data analysis was that some Chinese participants expressed the opinion that undertaking psychotherapy was a last resort for Chinese people because they are still attached to their indigenous methods of healing. This finding appeared naturally in the course of exploring whether Chinese cultural, spiritual and medical practices could explain how somatic countertransference occurs. T25 says the following about how Chinese people seek out help for psychological problems.
Just now I just had some image in my mind. I think with the Chinese, there is an interesting phenomenon, if they feel they have terrible emotions or they feel very tired, or if they feel very anxious. They will prefer to have the massage the first time before psychotherapy or counseling. Yes, to deal with their body. Working with their body. So I think my mother and most of my family, most of my friends I have seen this. So I understand this phenomenon, to do massage, they feel very relaxed and they didn’t have to do the psychotherapy and they didn’t have to talk about their emotions. Emotions are just gone with their bodies, their symptoms. T25

This finding affirms the idea of the mind and body perceived on a continuum given a body based intervention such as massage is thought to assist with psychological problems. It further highlights a potential body orientation less noticeable in the West. Likewise when discussing how Tai Qi works, T9 says quite simply the following:

Yes, so that means most Chinese people don’t need therapy. They can cure by themselves. ……

Yes, we have not enough patients. They do not go to see us not unless they are very much serious; they are going to be mad. Before that, they just try everything to calm down. T9

Both T25 and T9 clearly state that before seeking out a Western treatment modality in the form of counseling, psychology or psychiatry, Chinese people will employ other cultural practices such as TCM and Tai Qi for healing. In an article about the difficulties of translating Freud into Chinese, Plaenkers suggests that the Chinese embrace suffering which is encouraged by the collective teachings of Buddhism, Taoism and Confucianism (Plaenkers, 2013). This further implies that embracing
psychotherapy practices in China will not be a straightforward process further evident in the problematic issue of formulating the correct translations of Freudian terms in the Chinese language from the original German expression. Yet in spite of this idea of embracing suffering, some participants expressed that the Chinese have their indigenous methods for self cure. For example T9 is of the belief that every Chinese person knows from a young age some important techniques for self-healing, as such she affirms this by stating:

*Yes and even the little girl knows how to breathe.* T9

In exploring the territory of indigenous healing techniques, often surprising material emerged. T9 once more alluded to the idea that Chinese people no matter how quick to embrace Western treatment modalities and the modernization of China, still there were exceptions whereby people would seek the old ways of healing and managing physical and psychological issues. T9 shares this fascinating anecdote as relayed by her husband:

*I heard from my husband there is a really old man and he is more than 90 years old right now. He is very healthy and his thoughts and beliefs is a term called Daoism from Laozi. There are three very important cultural beliefs in China. One is Daoism that means, “nothing is everything”. This older man is after this thought, in his own life, he believes this very much. And what surprises me is that my husband told me that a lot of people went to visit him. When they think they have some strange issues like when someone cannot walk, someone cannot speak and they will, the whole family will go and visit him. You know this older man is not a psychologist; he has never studied from a foreigner. He just*
learns everything from ancient Chinese culture. Do you know how he cured this family? There was a girl and she cannot walk, she has a disability and she cannot walk. The old man just criticized very loudly and harshly to the parents first and everything you can imagine, he just criticized loudly for half an hour and turned to them. Then he turned back to the little girl and started criticizing this little girl for another half an hour. And after that all of the family members were shocked. But immediately the girl stood up and ran away.

This older man didn’t know how to treat; he didn’t know what is psychology. But he has his own way. But what I can imagine is maybe he can just feel something that she is blocked somewhere. Maybe, I just imagine, that is a very fantasy old man and other people have been to see him because they don’t believe us. Maybe they do believe in this older man. T9

Whilst the family sought out the revered elder for assistance with a physical condition, it is noteworthy that he approaches the issue psychologically thereby confirming the unification of mind-body in Chinese treatment modalities. Interestingly, T9 implies that the little girl who cannot walk is somehow ‘blocked’ and that his harsh verbal tirade unblocked her in some way, which affirms the importance of removing qi blockages according to TCM. Additionally, it speaks of the faith the Chinese people hold for these practices. This was noted by John Dolic who spoke about the importance of faith underpinning Qi Gong and TCM healing techniques (Dolic, Interview, 17 January, 2014). It is this idea that indigenous methods of healing are employed first before attempting Western psychotherapy that is essential to consider. First of all it questions whether Western psychotherapy practices should be encouraged in China and if so are they indeed relevant for
Chinese well-being? Furthermore in considering the relevance of Western psychotherapy for China, is there any common ground between Chinese and Western methods of treating psychological issues? These questions will be addressed in the following section.

**Is Western Psychotherapy relevant to the Chinese?**

As explored in the proceeding Chapters, for some Chinese participants Western psychotherapy was well received and combined with some Chinese indigenous practices derived from TCM and Chinese philosophy and spiritual practices. Yet questions about the relevancy of psychoanalysis and psychotherapy often surface in the clinical literature. Zhong for example, provides an analysis and exploration of the philosophical and psychological differences between Chinese culture and the Western practice of psychoanalysis. In presenting two case studies and exploring his own experience of psychoanalysis he comes to an understanding that what is more meaningful is:

> … to see things from inside the gap between them in order to develop deeper insight into each unique psychoanalytic situation with my patients. (Zhong, 2011, p 225)

What Zhong is saying here is that it is important to know the underlying culture of the Chinese client and be creative when applying psychoanalytic thinking. To illustrate this point he explores the notion of remaining harmonious with the environment, a Taoist and Confucian ideal. He suggests that in accordance with psychoanalysis, remaining harmonious is seen as a defense, a form of conflict avoidance. Zhong
suggests that this is a simplistic appraisal and needs to be explored with greater sensitivity and creativity for clinical application to Chinese individuals (Zhong, 2011). Ng, on the other hand, is immediately cautious about the applicability of psychoanalysis for Chinese patients and suggests that there is little common ground between Taoism and psychoanalysis and therefore it is difficult to treat Chinese patients with Western psychotherapy approach. Yet strangely he suggests that the object relations style may be a best fit as it explores the role of the individual in association with his family and community more so than other psychoanalytic schools (Ng, 85). Importantly for my thesis, Chen and Swartzman not only advocate understanding Confucian and Taoist belief systems is essential for consideration when treating the Chinese, they further state that it is absolutely necessary to acknowledge the role of the body and how it is perceived as a unification of mind and body (Chen & Swartzman, 2001).

This theme of the inherent need to remain harmonious with the environment indicative of collective versus individualistic societies has also been taken up by Zhong (Zhong, 2011). Like others he critiques psychoanalysis as having divergent cultural values with Chinese society that honors social over individual interests. This idea is supported by other clinicians thinking about whether psychoanalysis and Western psychotherapy practices as a whole are applicable when treating the Chinese population (Markert, 2011, Scharff, Sehon, Wei & Wanlass, 2011). Other Westerners teaching psychoanalytic psychotherapy in China however, have remarked how quickly Chinese practitioners have grasped group process and complex terms such as countertransference (Wanlass, 2011, Markert, 2011). Whilst Wanlass ponders how much of analytic thinking is actually new to Chinese people, Scharff intuits that China will make psychoanalysis its own and that psychoanalytic thinking will undergo a
transformation as a consequence of being taken up in China at present (Scharff, Sehon, Wei & Wanlass, 2011). For Gao Jun she considers whether psychoanalysis can provide a healing space for the intergenerational trauma experienced by the Chinese. She wonders if it has been set up as the great promise and whether it can actually provide this. She sums it up accordingly:

Finally, I remember two teachings, one psychoanalytic, one Chinese. Freud once said that the aim of psychoanalysis “is to replace neurotic misery with ordinary unhappiness.” A famous Chinese Taoist once said, “Once something happened and you don’t know why it happened. That’s life.” Both of these sayings speak for acceptance that despite all our efforts, suffering remains. The Taoist saying speaks merely of acceptance, but Freud’s says that there are things we can do to improve our situation. That is not a magical outcome, but it seems to me it is worth working for. (Scharff, Sehon, Wei & Wanlass, 2011, p 281)

I think Gao Jun is pointing to some commonality and differences between psychoanalysis and Taoism. Essentially she suggests Taoism promotes acceptance whilst psychoanalysis encourages both acceptance and hope. I think Gao Jun is hopeful that a bridge can be built between these two positions and that the Chinese can benefit from the psychoanalytic treatment approach. So what is being presented here is the idea that there is not an entirely comfortable fit between psychoanalytic and Chinese thinking and yet some indication that it is being taken up with great enthusiasm and largely relevant to China currently (Scharff, Sehon, Wei & Wanlass, 2011, Hsuan, 2015).
In my interview with Stuart Twemlow he told the following anecdote that illustrates a historical disconnect between psychoanalysis and Chinese society. This story was stated in a previous chapter and in this context provides further relevance for my research. It is important to consider that he is speaking retrospectively of a case prior to the recent ‘Freud fever’ of 2000’s (Osnos, 2011). Twemlow says:

*If you had a problem with feelings and you wanted to speak to a psychotherapist about feelings, you would have to leave China. I have a really interesting example of that, a man who spent 30 years of his life and he became a Taoist priest and he had gone through 20 years of training. He had a problem, an emotional problem that he wanted to speak to someone about but he couldn’t find anyone he could talk to. He came back to America to see a therapist because everybody he saw in China, would get him to do something like some important healing aphorism or give him acupuncture or give him medicines. But nobody wanted to hear what he was feeling or thinking. Within the Taoist experience, the whole idea of feeling, was really not acknowledged simply not the way we do when we treat feelings as clues to underlying unconscious thinking.* (Twemlow, Interview, 7 December, 2013)

Twemlow in reflecting on this story is reporting several aspects for our consideration. First of all, that there is not an immediate and comfortable fit between being Chinese and undertaking psychological treatment. Secondly, that other methods of treatment are traditionally taken up and encouraged prior to exploring Western treatment approaches, a sentiment echoed by T25 and T9 in the previous section. Finally, this story illustrates how far psychoanalytic treatment styles have been integrated in Chinese society, given that presently in 2015 the Taoist priest would have had no difficulty seeking out a psychotherapist in China via the CAPA website. Clearly
China is undergoing enormous transformation not only economically but psychologically.

In thinking about the relevance of psychotherapy to China however it is important to finally explore the intersection between analytical psychology and China. As stated previously, according to Stein, Jung was far more influenced by his work on the Taoist text with Richard Wilhelm than by Freud (Stein, 2005). I think that this applies to some degree in that Jung’s ideas about synchronicity and the transcendent function can be traced back to this pursuit of Chinese culture in the form of the I Ching and Taoism. Another important Jungian thinker Heuer agrees with Stein in stating the following:

Jung himself, for most part of the second part of his life, immersed himself in the hermetic countercultural traditions of alchemy. From these studies, Jung developed some of his most important theoretical and clinical contributions- I am thinking here of his The Psychology of The Transference (1945), his concept of the psychoid, the subtle body, synchronicity, the ultraviolet/infrared spectrum from energy to matter et al. All of these studies are only thinkable from the assumptions of a basic connectedness of body and mind, matter and spirit. (Heuer, 2005, p 106)

The point in drawing attention to the influence China has had on Jung and analytical psychology is twofold. First of all, it suggests that it could be a more comfortable fit in applying analytical psychology to the Chinese population for psychological treatment. The Chinese participants form Guangzhou and T1 and T3, all actively practice a form of analytical psychology and report that it is well respected in China as an approach to psychological wellness. As Jung drew from Chinese alchemy, I
Ching and Taosim there is a sense that there will be some commonality between the population treated and the treatment modality undertaken. Secondly, it suggests that by attending to Chinese healing and energy practices, as explored in the proceeding chapter and overall exploring somatic countertransference from a Chinese perspective, the possibility exists for rich fertilization and development of a new psychotherapy approaches inspired by China, rather than the other way around.

Another example unrelated to analytical psychology is the influence and integration into psychoanalysis of Zen Buddhism practice. Twemlow suggests that Zen Buddhism has much to teach to the Western psychotherapist about embodying the mind and deepening one’s capacity for reflection in the session (Twemlow, 2009). These ideas are fully supported by Christensen and Rudnick who extensively and cleverly paralleled Zen Buddhism with psychotherapeutic practice (Christensen and Rudnick, 1999). In particular, they detailed a process of observation that echoes Western ideas of engaging in reverie and inhabiting a third position as mentioned by Merchant (Merchant, 2008). What these psychoanalytic thinkers are doing in this instance is enriching clinical practice by referencing and applying Eastern thinking.

In summary, the exploration of cultural difference in respect to psychotherapy, the application of psychotherapy to China, the inspiration drawn from China for the development of psychotherapeutic approach are relevant. In addition, psychotherapy can be utilized by the Chinese providing they are able to make it their own and therefore culturally relevant for their people. This chapter, in exploring phenomena surfacing from the data, such as the notion of the lost cultural knowledge, integrating cultural practices into psychotherapy practice and investigating the intersection between Western psychotherapy and Chinese spiritual and healing practices highlights the importance of cross-cultural research. Chinese cultural ideas can inform
and enrich Western psychotherapy. In relation to this research project investigating the clinical relevance of somatic countertransference, it was established that it is experienced by Chinese psychotherapists and explicable in Chinese cultural terms. As such, this research has brought to contemporary thinking on somatic countertransference new ideas for understanding and managing it from a culture underpinned by a holistic approach to mind and body.
Chapter 8: Concluding Remarks

This thesis has laid out interview material reflecting on the clinical experiences of our sample of Chinese psychotherapists. It demonstrates how the therapist’s body can communicate important material about the therapeutic process and the psyche of the client.

In these concluding remarks, I will sum up the key findings of my research that has explored clinical examples and ideas provided by 29 Chinese psychotherapists and several interviewed experts. Importantly key differences and similarities between Western and Chinese ways of approaching and understanding somatic countertransference will be investigated with a restatement and examination of the proposed hypotheses from Chapter 1. Finally, recommendations for future research will be discussed.

Key Findings

This research posed two core questions to orientate the exploration of somatic countertransference from a cross-cultural perspective:

1. Do Chinese psychotherapists experience somatic countertransference?

2. If somatic countertransference was experienced by Chinese psychotherapists, how do they account for it from their healing, spiritual, cultural and philosophical practices?
Emerging out of the research process were two further questions:

3. How should psychotherapists work with somatic countertransference clinically?
4. How should analysts manage the negative effects of psychic infections associated with somatic countertransference?

The key findings of this research will be examined in accordance with the questions posed.

1. **Do Chinese Psychotherapists experience Somatic Countertransference?**

There were five core findings in response to this question.

i. First, somatic countertransference was established as a cross-culturally viable term because all 29 Chinese psychotherapists provided clinical examples of it.

ii. Second, consistent with participants from a culture wherein mind and body are considered to be on a continuum, rather than a split or dualism, the material illustrated a conflation of feeling and physical states not evident with Western psychotherapists. This was further explored in relation to the notion of implied wholeness derived from Chinese healing practices such as TCM and as a result of Chinese language employed. The Chinese language was noted to enhance conflation of mind and body states, and this was often expressed metaphorically (Sun, 2013, Tung, 1994).
iii. The third notable finding from the rich and candid clinical examples provided was the various ways to work with somatic countertransference. Methods employed in some instances reflected Western psychotherapy practices and in others appeared influenced by the Chinese culture.

iv. Fourth, another finding acknowledged that Chinese psychotherapists spoke of the shared wound, whereby they experienced personal resonance with the issues presented by their clients. This further affirmed the validity of Jung’s idea of the psychic infection whereby psychotherapists can become infected by their clients (Jung, 1937/1993). Again, this finding generated creative and individual ways of managing somatic countertransference for greater clinician health.

v. Fifth and finally, what this research demonstrated was that the body of the therapist is activated in many different ways and harnessed by numerous individual approaches. This implies that we should not limit our understanding of somatic countertransference. For example, to state that somatic countertransference is solely the remnant of preverbal dissociated material limits what possible clinical meanings can be generated. As Orbach and others attest, it is essential to start with the body rather than dictate our understanding of it from analytic processes that further promote the Cartesian dualism split (Orbach, 2004, Interview, 18 December, 2013). The idea is that when we work with somatic countertransference, we need to experience it first rather than analyse it intellectually. This opens up multiple possibilities for creative therapeutic process that the Chinese psychotherapy cohort demonstrated. These five core findings will be discussed in turn.
From the analysis of the responses given by the 29 participants currently practicing psychotherapy in China, Hong Kong and Singapore unsurprisingly somatic countertransference was discovered to be a cross-culturally relevant tool in clinical practice. All 29 participants provided clinical examples of somatic countertransference from their clinical practice. The rate of prevalence of somatic countertransference ranged from 2-100% of their clinical time. Prevalence was defined according to how often the participants experienced examples of somatic countertransference in their clinical work. This rate was provided by 2/3rds of the sample, who each nominated how often they experienced such material. Compared with Western empirical studies into somatic countertransference, this study assessed an overall rate of prevalence of somatic countertransference. Booth, Trimble and Egan established from their research that 80% of their 32 participants reported muscle tension within the last six months of their clinical practice (Booth, Trimble & Egan, 2010). Whilst the current study did not measure this example of muscle tension specifically, the variable prevalence rate established from this study further affirms that the Chinese psychotherapists are frequently experiencing somatic countertransference in their clinical practice. As such, it is therefore considered to be cross-culturally relevant and worthy of further investigation. These findings were predominately discussed in chapter 1.

When investigating the responses provided by the 29 Chinese psychotherapists in closer detail it became clear that in reference to the question about whether they experienced somatic countertransference often evoked examples that fused feeling and physical states. In chapter 5 various examples were provided that bring together feeling states with specific body parts. Additionally, the Chinese language was noted
to employ descriptive metaphors, so that feeling states would be explained in a creative way. This was an important finding because it suggests that underpinning Chinese culture and healing practices is the idea of implied wholeness between mind and body. More specifically that the mind and body exist as one. This point became particularly clear when interviewing numerous participants that expressed the idea that mind and body existed on a continuum and not separately; therefore to delineate the term somatic countertransference was, for them, already a foreign or Western construct.

This was further affirmed in my interview with Susie Orbach, who agreed that feeling states are felt and experienced physically in the first instance (Orbach, Interview, 18 December, 2013). In this instance Orbach implied that in the West we tend to separate mind and body but when somatic countertransference is explored closely it is clear that there is no clear such distinction. As such, the Chinese participants provided sophisticated and clinically astute examples of somatic countertransference, which illustrated the idea that psyche/soma exist on a continuum. It is this very idea that contemporary neurobiology is demonstrating with studies illustrating unconscious to unconscious communication noted with right hemisphere to right hemisphere resonance in mother and infant research and evident in psychotherapy practice (Schore, 2014). Importantly, the role of the psychotherapist’s body facilitates this line of communication (Schore, 2014).

Bringing this testimony together, our research confirms the idea that mind and body exist on a continuum, and therefore within the psychotherapy process, feeling and physical states manifest as a part of a complex clinical matrix and are not so
easily separated out from each other. Moreover, in alignment with Jung’s seminal idea of the zone of mutual unconsciousness, client and therapists are actively enlivened and engaged with this material (Jung, 1954).

The third important finding obtained was the rich clinical data demonstrating somatic countertransference. A deeper analysis of the responses provided an extensive list of experiences commensurate with previous empirical research conducted in the West. These findings were discussed in both chapters 2 and 3. In exploring the clinical examples further, interesting themes emerged that reflected both difference and similarity with responses provided in Western studies. These themes included that somatic countertransference holds meaning, that it can be a reenactment of an earlier developmental experience from the client’s past, that the therapist’s body expresses emotion and that it does not lie, that it can be used as a defense, that the presence of somatic experiences can move the therapy along and that somatic countertransference holds intense emotions and the therapist’s body therefore acts as a container.

From all these themes, examples were provided to illustrate their meaning. Essentially all themes intersected with Western thinking on somatic countertransference, particularly with reference to the ideas of preverbal expressions and or dissociated content (Field, 1989, Dosamantes-Beaudry, 1992, 2007, Bloom, 2006, Petrucelli, 2007, Forester, 2007, Sidoli, 2000, McDougall, 1989, Ross, 2000, Greene, 2001, Connolly, Email, 11 March, 2013). One uniquely Chinese contribution was that actual body parts activated via somatic countertransference could be further understood according to TCM knowledge which indicates that body parts are imbued
with certain feeling states. Furthermore this Chinese knowledge implies that mind and body are once more not separate entities per se.. This was taken up particularly by Chinese psychotherapists practicing in Guangzhou in China.

From the emerging themes, various ways to work with and manage somatic countertransference were discussed revealing both novel and tried and true means to process the material provided by the body of the psychotherapist to enrich clinical practice. These ideas were discussed in chapters 2, 3, 5 and 6. These findings responded to the emerging two questions about how to work with somatic countertransference clinically and how to manage potential negativity effects of this physically invasive material. What was found was that some ways of addressing and working with somatic material paralleled Western techniques of naming the experience or enduring it to techniques that were inspired by Chinese methods of healing. These included integrating knowledge from TCM in relation to body parts and applying mindfulness reflection on the body and an appreciation of yin and yang dynamics between therapist and client. These ideas are consistent with Orbach’s call for making the body primary and thereby working beyond the mind-body split endorsed by Western psychotherapy practices (Orbach, 2004, Interview, 18 December, 2013). Additionally it was revealed that the Chinese participants actively seek out supervision to process their experiences of somatic countertransference, which is deemed best practice from the previous empirical research (Forester, 2007, Egan and Carr, 2008). As such, the Chinese participants demonstrated sophistication and openness to this material not always witnessed amongst their Western counterparts in the general psychotherapy community.
The fourth core finding is about the concept of shared woundedness. This spontaneous finding from the Chinese psychotherapists spoke to the notion of psychic infection espoused by Jung and the idea of previous psychic wounding enabling a susceptibility to psychic infections discussed by post-Jungians (Jung, 1937/1993, Sedgwick, 1994, Merchant, 2012, Clark, 2010, Burda, 2014). This notion was the major focus of chapter 4. This finding encourages that all psychotherapists and psychoanalysts either experienced or in training need to be cognizant of the ill effects of one’s susceptibility to shared wounds and therefore the infectious nature of somatic countertransference. In light of this finding, some ideas about self-management of this material were discussed to include distinctly Chinese methods such as meditation and mindfulness techniques from Buddhist practices. Importantly self care to prevent psychotherapist burnout and illness is an essential warning provided by this research. Furthermore consistent with Western thinking, the findings from this thesis supports the idea that awareness of and ways to work with somatic countertransference be integrated into training of future psychotherapists (Merchant, 2012, Sletvold, 2012, 2014, Burda, 2014). These ideas responded to the question that emerged from the research process about how best to manage the negative effects of somatic countertransference.

Finally, the clinical data confirmed that somatic countertransference is acknowledged and worked with in diverse ways by Chinese psychotherapists. Whilst there were numerous points of connection with Western thinking and psychotherapy practices particularly in perceiving somatic countertransference to be of the pre symbolic and pre verbal level of communication, this thesis supports an opening up or extension of how we look at and work with somatic countertransference. This finding
was mostly explored in chapter 6 when a comparison between Western and Chinese explanations of somatic countertransference is conducted. Perhaps by both affirming what has been developed in Western psychotherapy and adding to it with Chinese contributions this has been enabled by exploring the territory from a mind-body continuum. This could be considered more in keeping with Orbach’s suggestion of making the body primary rather than secondary when meeting somatic manifestations in the therapist’s body in clinical practice (Orbach, Interview, 18 December 2013). Ultimately this implies that cross-cultural research in this instance is extending our knowledge base whilst also affirming ideas taught by Western psychotherapy practice in relation to somatic countertransference in clinical practice.

2. If Chinese Psychotherapists Experience Somatic Countertransference, how would they Account for it according to their Beliefs and Cultural Practices?

In order to build upon what has been thought about in relation to somatic countertransference, this thesis looked to China. As set out in the introduction and chapter 1, this choice of culture was deliberate due to the underpinning philosophical influences of the mind-body continuum. It was hoped that in interviewing Chinese psychotherapists, they would be able to draw from their cultural, healing and spiritual practices to provide an understanding of how somatic countertransference evolves. From the literature review in the introduction, Jung’s seminal ideas of the zone of mutual unconscious communication, the role of synchronicity between analyst and patient, his concept of the psychoid process whereby mind and body are indivisible and the process of psychic infection in psychotherapy practice laid the terrain for
Chinese explanations (Jung, 1937/1993, Jung, 1954, Jung, 1969). From interviewing 29 Chinese psychotherapists, a TCM practitioner, a Qi Gong Master and a Japanese psychotherapist who trains body monitoring as a technique for psychotherapy trainees, numerous ideas were provided that demonstrated both intersection with Jung’s seminal ideas as well as new concepts for consideration. For example, the role of qi as an equivalent to the unconscious, TCM’s concept of yin and yang and how that manifests between people and the concept of psychic blockages ameliorated by psychotherapy were all explored (Margarian, 2015). Furthermore, the TCM practice of equating body parts with feeling states provided further richness and avenues for therapeutic exploration for somatic countertransference. This new material was explored in depth in chapters 5 and 6.

A closer exploration of Qi Gong practice provided more ideas about how qi can be harnessed and flow between therapist and client, which equates with Jung’s concept of the unconscious-to-unconscious line of communication (Jung, 1954). It endorsed the idea that people can infect and affect each other and therefore as Jung surmised as two people come together there is a transformative process occurring unconsciously (Jung, 1954). In terms of Buddhism, knowledge about meditation practice and the subset of mindfulness gave the means for which greater reflection upon somatic experiences could be enabled. Returning to the idea that somatic countertransference, if not reflected upon and processed, can be harmful for the therapist, again such spiritual practices suggested by Qi Gong and Buddhism provided the tools for greater self-care and removal of harmful effects of infective material. Finally, the concept that qi could be worked with effectively via long distance on Skype opened up the possibility that analytic process on Skype is plausible.
Contemporary Western ideas drawing from post-Jungian thinking and to a lesser extent neuroscience, provide ways of explaining and thereby enriching our comprehension of how somatic countertransference surfaces. These distinctly Chinese cultural contributions affirmed previous intuitions. This thesis, in entering cross-cultural territory, I believe validates Jung’s seminal concepts of the mutual unconscious zones of communication, the possibility of a point of intersection of mind-body known as the psychoid and the synchronic ways in which the body can pick up material emerging from the psychotherapy relationship.

In interviewing experts in the field currently thinking about the body and its integration into psychoanalysis and analytical psychology, the unifying idea that somatic countertransference evolves from the relationship contained within the psychotherapeutic dyad emerged as a strong and persistent theme. This very idea is currently being explained with neuroscience research confirming the pivotal role of the body, in enabling unconscious-to-unconscious communication during infancy and thought about in relational psychoanalysis in terms of the inter subjective space and its effects on psychotherapeutic process (Schore, 2014). Simply put, the cross-cultural research data provided by this research process, supported current ideas generated in contemporary Western psychotherapy practice and neurobiology about how somatic countertransference occurs relationally in clinical practice.

3. How do you Work with Somatic Countertransference when it presents in the Clinic?
As expressed previously, in chapters 2 and 3 many accounts of somatic countertransference from clinical practice were presented with specific ways to work with this material. The ideas generated from the clinical data ranging from methods greatly informed by Western psychotherapy methodology and theory to processes that integrated Eastern spiritual and healing practices such as TCM knowledge.

4. **How to manage the Negative Effects of Somatic Countertransference that manifests as Psychic Infections?**

In chapter 4, Chinese participants provided highly personal examples of somatic countertransference that at times intersected with personal wounds and overall noted to be psychic infections. Commensurate with cross-cultural research, ideas for managing psychic infections were gleaned from both Western and Chinese psychotherapy practice. As such, personal rituals for analysts’ remaining separate and healthy from the ‘infections’ or neuroses of their analysands were nominated as practical prescriptions, as well as new cultural ideas pertaining to spiritual and healing practices such as meditation and Qi Gong Practice. These concepts and methods were also discussed in chapters 5 and 6.

**Hypotheses emerging from the Research**

In tying all this together and revisiting my initial hypotheses stated in chapter 1, I think overall the notion of somatic countertransference is clinically relevant and therefore as useful in Chinese psychotherapy practice as it is in Western psychotherapy practice. My initial hypotheses were that the Chinese psychotherapists,
unlike their Western counterparts, were likely to experience somatic countertransference commensurate with their underlying beliefs informed by the idea of mind-body existing on a continuum. Additionally, in relation to my second hypothesis, I considered that the Chinese participants were likely to explain somatic countertransference with reference to their inherent cultural, philosophical and spiritual beliefs and practices.

In relation to the first hypothesis, I discovered that the Chinese psychotherapists interviewed all reported clinical examples of somatic countertransference that were meaningful and clinically pertinent. By extension, they acknowledged and worked with it in various ways. As such, in agreement with Wanlass, my observations and findings suggest that the Chinese participants had grasped the complexity of countertransference and freely applied it to their clinical practice (Scharff, Sehon, Wei & Wanlass, 2011). Consistent with the underlying notion of mind-body unification, somatic countertransference at times was spoken about as if feeling and somatic states were fused. Therefore, it was established that the Chinese psychotherapists interviewed for this research understood and utilized somatic countertransference well in their clinical practice.

As many have suggested before me, to understand how and whether psychoanalysis and psychotherapy is applicable to the Chinese, it must be understood in the context of their underlying belief systems informed by TCM, Confucianism, Taoism and Buddhism (Zhong, 2011, Chen & Swartzman, 2001). This implies that in order to understand how Chinese psychotherapists conceptualize somatic countertransference needs to be done so with respect to their inherent cultural ideas.
and practices. As such my second question endeavored to do this and my hypothesis was supported by the wealth of ideas and information provided by the Chinese participants and interviewed experts, who explained how somatic countertransference functions from a Chinese perspective. In this thesis, whilst somatic countertransference was assessed as a clinically viable concept for Chinese psychotherapeutic practices, just as importantly, we have seen how it was explained in cultural terms drawn from the interviewees’ collective spiritual, philosophical and medical practices.

Commensurate with Twemlow, Christensen and Rudnick’s application of Zen Buddhism to extend and enrich Western clinical practice, I believe that by researching somatic countertransference from a Chinese perspective, this thesis has provided some new and interesting ideas about somatic countertransference and how to work with it and manage it for greater self-care of the psychotherapist in mind and body (Christensen & Rudnick, 1999, Twemlow, 2009). This was particularly evident with the recommendations made with Buddhist, TCM and Qi Gong practices for facilitating greater sensitivity to psychotherapy practice and for enhanced self care of the psychotherapist.

**Recommendations for Future Research**

In looking over the core research findings and the broader territory of working with the therapist’s body in psychotherapy cross-culturally, it became apparent to me that whilst some answers were provided, many new questions or areas for further investigation emerged.
One important finding for me personally was a greater understanding of the ill effects and infectious nature of somatic countertransference, and therefore I sense that it would be essential to continue the exploration of that aspect of somatic countertransference in greater depth. How debilitating is unprocessed somatic countertransference for both client and therapist? What effects are the therapists having on the body of the client as a consequence of the zone of mutual unconscious processes?

As Booth, Trimble and Egan suggested in 2010, both therapeutic outcome and the psychotherapist’s health are affected by how well they manage their somatic countertransference (Booth, Trimble & Egan, 2010). This suggests that we need to take psychic infection in the form of somatic countertransference seriously for both the well being of both therapist and client. As encouraged by this research and by Egan and Carr and Forester, the role of supervision is considered essential for processing and acknowledging somatic states in therapists (Egan & Carr, 2008, Forester, 2007). This could be investigated further by establishing how effective supervisory process is and specifically what methods are suggested for best practice. This is in addition to the idea that in order to manage psychic infections a thorough reductive analysis be undertaken during training of psychotherapists and psychoanalysts (Merchant, 2012). Extending this line of enquiry further, what practices provided by Qi Gong or otherwise really help to recalibrate potentially burnout and psychically infected psychotherapists could be looked at?

This kind of inquiry has further implications for the future training of analysts and psychotherapists. As such, what needs to be implemented in the training of future analysts and psychotherapists to assist them with processing and managing somatic
countertransference could be researched further. These questions I sense could encourage important research for our future understanding and capacity to work with somatic countertransference effectively.

Additionally, new ideas may be provided by ongoing cross-cultural research. This recommendation is made on the strength of my interview with Professor Oyama from Kyoto (Oyama, Interview, 5 December, 2013). Although several attempts were made to recruit additional experts from Japan, no further opportunities arose. Given the level of importance that monitoring somatic states is given in Clinical Psychology training in Kyoto, this suggests a sophisticated approach to a holistic style of psychotherapy not tapped into in the West. It is also noteworthy that Japan and China have taken up psychoanalytic and Jungian analytical psychology at different rates. Whilst Freud was first introduced to China in the 1920’s, psychoanalytic training programs are a very recent introduction (Plaenkers, 2013, Varvin & Gerlach, 2011, Kirsner & Snyder, 2009). Thus it is suggested that Japanese psychotherapists may possess knowledge and be advanced in their thinking about somatic countertransference compared with their Western and Chinese cohort. This was further evident in the proliferation of recent body synchrony studies between therapist and client in Japan (Nagaoka & Kimori, 2008).

Aside from suggesting Japan, it is noteworthy that supervision practices in Norway have provided new techniques for accessing the therapist’s somatic experiences for greater clinical insight (Sletvold, 2012, 2014). As such, further cross-cultural studies could further enrich clinical practice in the west with respect to somatic countertransference as a clinical tool.
In drawing this research to a close, I would like to return to a statement provided by T9. He stated:

*Yes, you know this makes me think of something about Chinese culture that I should say. Chinese people are used to feeling their body.* T9

For me, this was an apparent difference noted with the 29 Chinese participants. They all freely explored and spoke of their bodies with great sensitivity and command. This I believe parallel’s Bollas’ notion of the difference between the Eastern and Western mind. As mind and body are indivisible in Chinese culture in accordance with TCM, this implies that as the Eastern mind is nonverbal, maternal and metaphorlic, it is further likely that the Chinese experience of the body is different from that of the Western body (Bollas, 2013). As such, in investigating the Chinese psychotherapist’s body, this thesis has provided some new ideas for exploring, understanding and managing somatic countertransference in psychotherapy practice from a Chinese perspective. The cultural comparisons we have ventured have also illustrated some commonality between China and the West in clinical practice.

Finally, I believe that the cross-cultural exploration of somatic countertransference with Chinese participants and Western experts provided some interesting and affirmative insights that can now be integrated into contemporary psychotherapy practice. The body of the therapist is now recognised as a vital tool that speaks within the vessel of the clinical room, within the relationship that is emerging between psychotherapist and patient.
Bibliography


Dougherty, P 2007, *Qigong in Psychotherapy: you can do so much by doing so little*, Wuwei Press, US.


Loughran, E 2003, 'The therapist's use of body as a medium for transference and countertransference communication', Doctor of Psychology dissertation, Wright Institute Graduate School of Psychology, retrieved 1 June 2011, Pro Quest Dissertations and Theses database.


Orbach, S 2004, ‘What can we learn from the therapist’s body?’, Attachment and Human Development, vol. 6, no. 2, pp. 141-150.


Pines, D 1993, A woman's unconscious use of her body. A psychoanalytical perspective.


Potik, D & Schreiber, S 2013 ‘Carrying body and soul and embracing the one: Qigong group in a day-care psychiatric department’ *Body, Movement and Dance in Psychotherapy*, vol. 8, no. 2, pp. 108-120.


Ross, M 2000, ‘Body talk: Somatic countertransference’ *Psychodynamic Counselling*, vol. 6, no. 4, pp. 451-467.


Urbano, R & Pantesco, V 2011, Body of Knowledge: Somatic Countertransference and Trauma, American Psychological Association (APA), Washington, District of Columbia, US.


Von Franz, M L 1998, On Dreams and Death,: A Jungian interpretation, Open Court, Chicago, US.


Zachrisson, A 2009, ‘Countertransference and Changes in the Conception of the Psychoanalytic Relationship’, *International Forum of Psychoanalysis*, vol. 18, pp. 177-188.


**Interviews**

Dr. Angela Connolly, Email, 11 March 2014

Chunyi Lin, Interview, 21 November 2013

Mr. John Dolic, Interview, 17 January 2014
Dr. Susie Orbach, Interview, 18 December 2013
Ms. Kristina Schellinski, Interview 16 January 2014
Professor Yashiro Oyama, Interview, 5 December 2013
Dr. Stuart Twemlow, Interview, 7 December 2013
PLAIN LANGUAGE STATEMENT AND CONSENT FORM

TO: Participants

Plain Language Statement

Date: 25 June 2012
Full Project Title: A Cross Cultural Study of Somatic Countertransference.
Principal Researcher: Prof Doug Kirsner
Student Researcher: Adrienne Margarian
Associate Researcher(s):

Aim of the study
The purpose of this study is to investigate whether Chinese psychotherapists experience somatic countertransference. Somatic countertransference is defined as any countertransference experiences felt by the psychotherapist in their body during a psychotherapy session. Such phenomena include headaches, nausea, aches and pains in the therapist’s body are thought to be unconscious communications from the client to the therapist during the process of psychotherapy.

How it will be conducted
Participants will be invited to attend in a voluntary capacity, an interview to discuss their experiences of somatic countertransference. In instances whereby the participant cannot speak English, an interpreter will be provided. The interview is expected to last about one to two hours at the participant’s practice and will result in a transcript of the interview that the participant will be asked to sight and edit if necessary so that it meets their approval of being a correct representation of the interview that occurred. This data will then be collected and analyzed and form the basis of this study.

Risks and benefits
The topic of somatic countertransference is considered to be highly personal in that the therapist will be asked about their physical reactions to their clients when working psychotherapeutically. This may cause some discomfort for
participants. On a personal and professional note, participants will be able to share their experiences with a psychotherapist knowledgeable and experienced in working with somatic countertransference. As the literature suggests therapists are at risk for burnout and distress if they are not encouraged to share and work through the potential negative effects of countertransference which has been noted in the area of working with traumatized patients. Therefore is it hoped that by discussing these experiences greater knowledge and awareness of this area of psychotherapy will occur.

The benefits expected from conducting this study for the greater community is that it will add to the already growing research on somatic countertransference. Furthermore it will be the first cross-cultural study conducted which will provide new ideas and material about somatic countertransference and how it occurs. It is an important study in that will include and explore the work of Chinese psychotherapists who are thought to possess unique and different ways of working psychotherapeutically.

**Duty of Care**

To ensure that duty of care, all participants will be provided with contact details of a person in their country so they can seek debriefing or counselling should they experience distress or discomfort associated with the material discussed in the interview or by the process of the interview itself.

Privacy and confidentiality will be protected by ensuring that all participants given a pseudonym. The participants will be asked to check their level of privacy and confidentiality again when they review the transcript of the interview they are provided with post the interview. All transcripts kept during the write up of the research and for the five years post publication will remain in this de identified state therefore ensuring that confidentiality and privacy is maintained.

**Withdrawal of Consent**

The participant is able to withdraw from the study up until the point of signing and agreeing that the transcript of the interview they sight is a true representation of the interview they had. Post this time, given all identifying features will be removed from the data, the researcher would be unable to determine which participant had contributed what material. As such, at this point in time, the data is deemed available for analysis and publication.

**Results of the Study**

At time of consent, the participants can register their interest in receiving a summary of the results. These results will be a brief summary of the findings determined from the research. Furthermore it is expected that the thesis will be made available publically as well as journal articles published about the research.
In all instances of publication, confidentiality and privacy of the participants will be maintained.

**Other aspects of the Study**

The research will be monitored by the principal researcher on a regular basis via Skype or telephone when the student researcher is on site undertaking the research in China and Hong Kong.

The participant’s involvement in the project is voluntary and therefore there will be no payments or incentives to be issued other than to contribute their knowledge to this area of research.

The total amount of funding available to conduct field research is $3500. No other financial contributions or sponsorship will occur in relation to this project.

*Additional information is required for research involving Chinese participants from China and Hong Kong:*

In the design of this project, local advice was sought about any potential cultural issues that could impede the project. In discussion with researchers from Hong Kong University who are well versed in research in both Hong Kong and China it was determined that the topic investigated would pose no real issues or concerns. This is because the material is not culturally or politically sensitive. In terms of whether participants would be reluctant to discuss countertransference and personal material of this kind, it was suggested that this would be unlikely given that the participant group, trained psychotherapists, are likely to be open and well versed in discussing personal information in a way that would maintain appropriate personal boundaries and confidentiality.

In terms of meeting ethical standards and processes in both Hong Kong and China, advice was sought from Hong Kong University regarding this matter. In relation to undertaking this research in Hong Kong, it was confirmed that additional ethical clearance for conducting research in Hong Kong was not necessary providing clearance was granted from the country of origin where the research project was developed. It was also established that the research was considered lawful to conduct in Hong Kong.

In relation to undertaking this research in China it was encouraged that sponsorship of a non commercial nature be sought from a local university. This sponsorship would enable the student researcher to enter China as a visitor of the university and conduct the interviews in abidance with their ethical processes. It was further expressed that it was unlikely that additional ethical clearance in China would be necessary as this would be covered by undertaking the research via the process of being invited by a university. In accordance with this information it was also expressed that it was likely that the research would
be considered lawful especially as it was not politically sensitive in orientation and conducted under the guidance of the university.

The following contact details are available;

To participate contact:
Adrienne Margarian (student researcher) amar@deakin.edu.au or alm11@bigpond.net.au

Mobile numbers- In China/Hong Kong +37257162938 and in Australia 0412 040 534.

For Counselling/debrief contact;

China:
Roshanak Vahdani
BA (Psych, Phil), MA (Psych) Assoc APS Registered Psychologist/Psychotherapist
roshanakvahdani@yahoo.com.au
Skype name: roshanakkhanoom
Tele: +61431017990

Hong Kong:
Dr. Teresa Chan Psychiatrist
chansft@ha.org.hk

Complaints
If you have any complaints about any aspect of the project, the way it is being conducted, the debriefing process or any questions about your rights as a research participant, then you may contact:

The Manager, Research Integrity, Deakin University, 221 Burwood Highway, Burwood Victoria 3125, Telephone: 9251 7129, Facsimile: 9244 6581; research-ethics@deakin.edu.au

Please quote project number [2012-223].
PLAIN LANGUAGE STATEMENT AND CONSENT FORM

TO: Chinese Psychotherapists

Consent Form

Date: 25 June 2012

Full Project Title: A Cross Cultural study of Somatic Countertransference.

Reference Number:

I have read, or have had read to me in my first language, and I understand the attached Plain Language Statement.

I freely agree to participate in this project according to the conditions in the Plain Language Statement.

I have been given a copy of the Plain Language Statement and Consent Form to keep.

The researcher has agreed not to reveal my identity and personal details, including where information about this project is published, or presented in any public form.

I also agree to the interview being audio taped for the purpose of transcription. I understand that the audiotape will be destroyed post transcription.

Should I require an interpreter, I understand that the interpreter will agree to keep confidential the material discussed during the interview.

I am aware that I will be provided with a transcript of the interview and will be invited to check it to confirm whether it is a true representation of what was discussed and able to amend it if I believe it to be incorrect. At the point of returning this transcript to the student researcher I understand that I am unable to withdraw from the study from that point in time.

I would like to receive a summary of the research findings post completion of the research project. Please Circle

YES       NO

317
PLAIN LANGUAGE STATEMENT AND CONSENT FORM

TO: Chinese Psychotherapists

Withdrawal of Consent Form

(To be used for participants who wish to withdraw from the project)

Date: 25 June 2012

Full Project Title: A Cross Cultural Study of Somatic Countertransference

Reference Number:

I hereby wish to WITHDRAW my consent to participate in the above research project and understand that such withdrawal WILL NOT jeopardize my relationship with Deakin University.

Participant’s Name (printed) .................................................................

Signature .........................................................................................Date .................

Please email this form to:

Adrienne Margarian

amar@deakin.edu.au
alm11@bigpond.net.au
A Cross Cultural Study of Somatic Countertransference
Adrienne Margarian
Interview Questions

• Can you tell me about your style of practice, years of practice, types of clients/issues that you work with? Your age and qualifications? Your profession? Location?

• Do you experience somatic experiences within your current clinical practice?

• Can you approximate how frequently this occurs or nominate a percentage of your clients that you experience somatic countertransference with?

• Can you give examples of it and its relevancy for the therapy that you have conducted?

• In considering these examples, how did somatic countertransference enable or impede the therapy process?

• What is your understanding of somatic countertransference?

• How would you account for it? How do you think this process occurs?

• Can you provide a clinical example of somatic countertransference to describe the above?

• From your training and background i.e. personal, cultural and religious, are you able to explain this process?

• What are your thoughts regarding the effect of somatic countertransference has on you and your practice?

• Do you think that somatic countertransference is important/useful for your work as a therapist?

• If yes, how and why do you think it is relevant? If no, explain why?

• Do you discuss somatic countertransference with your supervisor or colleagues?

• Anything else you want to add or comment on that has come to mind from this discussion?
July 27, 2012

To: Adrienne Margarian  
Consultant Psychologist  
187 Johnston St, Annandale  
NSW 2038, AUSTRALIA  
Mob: 0412 040 534

As the president of the Chinese Federation for Analytical Psychology, the chair professor of the Ph.D. program for Analytical Psychology and Chinese Culture at the South China Normal University, director of the Research Center for Analytical Psychology, it's my honor and pleasure to invite you to come Guangzhou China, South China Normal University, to give lectures and seminars to our graduate students and candidates of analytical psychology, and join the cooperate research program.

The South China Normal University has a long history and friendship with the International Association of Analytical Psychology (IAAP). We have worked with the IAAP for the five international conferences of Analytical Psychology and Chinese Culture (1998/2012). I appreciate of your contribution. Your participation is great support to the development of analytical psychology in China.

I am looking forward to your visiting. I hope you will find beautiful experience in China.

With the best wishes,

Heyong Shen, Ph.D.,  
Jungian Analyst/IAAP  
President of the Chinese Federation of Analytical Psychology  
Chair Professor of Ph.D. program of Analytical Psychology and Chinese Culture at the South China Normal University