THE SOMATIC EXPERIENCE OF THE WOUNDED THERAPIST

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ABSTRACT

The Somatic Experience of the Wounded Therapist

by

Angela DeVita

Psychotherapists’ somatic responses have largely remained an untapped resource of information and healing potential in the field of psychotherapy. This may be due in part to the difficulty of describing and understanding these experiences as well as an educational gap in teaching therapists to recognize and value them. This dissertation asks: What types of somatic phenomena do psychotherapists experience in the context of therapeutic work with clients, and what therapeutic value can be made of these experiences? This study examines the role of the therapist’s woundedness in his or her experience and understanding of somatic phenomena, with particular reference to the Wounded Healer archetype.

Utilizing interpretive phenomenological analysis as a research methodology, seven psychotherapists to whom the research questions were meaningful and significant were chosen to participate. They shared their somatic experiences and reflections in an interview. Several different categories of somatic phenomena emerged, which included physical sensations, physiological responses, medical conditions, behavioral impulses, postural shifts, emotions, and conceptual images. The images and themes conveyed participants’ conceptual understandings of somatic field dynamics.

The study found that participants unanimously related to the Wounded Healer archetype, agreeing that their wounding experiences played a significant role in their therapeutic work, including but not limited to their vocational call, countertransference,
heightened awareness and understanding, and increased capacity for empathy. The majority of participants made a variety of meaningful connections between their wounding experiences and somatic experiences. Specific types of somatic experiences were related to areas of the body that were either previously injured, ill, or associated with previous emotional traumas. The necessity of self-care was emphasized as it related to their wounds, discernment processes, and perceived demands of the profession.

The findings of this study validate the significance of therapists’ somatic experiences, highlight the presence of both personal and interactive field dynamics, and suggest that the therapist’s own woundedness deepens empathy and thus predisposes one to somatic experiences. Participants used their somatic experiences to further explore and deepen into the psychotherapeutic work.

Keywords: somatic experience, somatic countertransference, embodied countertransference, embodied knowing, Wounded Healer archetype, somatic field dynamics, use of therapist’s somatic responses, empathy, self-knowing, self-care
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DEDICATION

This body of research, a labor of love, is dedicated to my children,

Ryan and Mariah, the lights of my life.

Your presences have given my life meaning, joy, purpose, direction, and the desire to continue growing and individuating so that I, in turn, could better provide loving presence and guidance to each of you, as you discover your own authentic life paths.

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Chapter 1
Introduction

Researcher’s Transference to the Topic

Shortly after I began interning as a therapist, I seemed to be coming down with more illnesses, puzzling symptoms, and health concerns than ever before. I frequented both Eastern and Western doctors’ offices, but relief and physical causes were rarely found. Fueled by frustration, fear, and curiosity, I embarked on a journey of self-inquiry to understand my body’s symptoms and any emotional, mental, or spiritual correlations. I sought guidance from psychotherapy as well as Eastern and alternative healing arts; I pursued classes, trainings, and certifications in various mind-body alternative therapies such as hypnosis, Emotional Freedom Techniques (EMT) (Robins, 2011), Reiki, and Neuro Emotional Technique (Walker, 2011), with the intention of gaining greater relief, understanding, and knowledge to heal myself as well as others. I created art and music from the symptoms and later would invite the symptoms into active imagination. As my understanding increased, the severity and associated fear of experiencing the symptoms decreased.

I have continued to have a variety of frequent somatic experiences both in my professional work and in my personal life. I view them now as opportunities for inquiry, informative messengers rather than enemies, perhaps trying to draw my attention to something outside my conscious awareness. In my psychotherapy practice, I have realized that as possible aspects of countertransference, these somatic experiences, left unchecked and untended, have the potential to be destructive to both the patient and myself, and yet, if investigated and entered into, can open wide a sea of discovery for growth, transformation, and mutual healing. My desire for both better personal health and
fulfillment of my vocational call as a healer has led me to learn to embrace these symptoms as clues pointing to areas in the inter-subjective field, including within myself and within the patient, that may need further exploration and healing.

**Relevance of the Topic for Depth Psychotherapy**

As I was driving up the California coastal highway for a 3-day camping trip, my hip began to ache severely; it was a strange, unfamiliar pain. My mind quickly began to scan through the catalog of possible causes. It just came up blank. Wow, it really hurt! I tried to put it out of my mind, hoping it would go away so that I could enjoy my trip; however, it persisted so strongly into the night that I began considering seeking a doctor the next day. My hip felt as if it was smoldering, disintegrating away in pain. Suddenly, I remembered that my client from the previous day had described a similar aching pain, “red and black—like hot coals,” in her hip, due to necrosis, a condition whereby the bone cells die and decay. I had been planning to take this client’s case in for supervision, as I had often found myself feeling uncharacteristically blank in our sessions. When I realized that the pain I was experiencing was similar to the image my client had described, I was intrigued, yet relieved, and could let go of the pain. I imagined that I was sending it into the ground, and I was thankful that it then subsided immediately.

This occurrence of this specific physical sensation brought up curiosities relating to somatic countertransference: *Why* did I feel that pain? *Why* did I feel that pain? *Why* did I feel that pain? *Why* did I feel *that* pain? How might the emergence of that particular somatic experience be related to my own woundedness?

Somatic experiences, or symptoms, can potentially point to areas within the therapist-patient interactive field that may need further exploration and healing.

“Symptoms, like dreams, are fundamentally attempts at symbolizing, healing in the
psychic domain, although symptoms may then bring new problems of their own” (Bucci, 1997, p. 263). Wilma Bucci, a researcher in the area of psychoanalytic process, made two important points in this statement. First, symptoms, like art and symbols, can serve as the healing bridge between the unconscious and conscious. It has been suggested that effective healers facilitate symbolizing (Miller, 2011). Second, Bucci (1997) cautioned that new problems can arise from symptoms. If symptoms appear, anxiety and fear could result as well as contribute to more symptoms. As archetypal psychologist James Hillman (1975) explained,

> Whenever a symptom appears, or an anxiety about our state of mind or physical welfare, it is immediately carried by fantasy into its worst potential, into the incurable possibility. . . . There is the feeling of something “deeply” wrong, something deeper going on that needs immediate attention. (p. 81)

The something deeper that needs attention is simultaneously the new problem, the old problem, and the potential resolution. The emergence of a symptom raises the difficult question: To whom does the symptom belong: the patient, the therapist, or the shared third—the interactive field? To what might the symptom relate? When the therapist experiences somatic symptoms in conjunction with doing therapy, it is likely a form of somatic countertransference or embodied knowing.

Countertransference, in general, is not only an unavoidable part of the therapeutic process but can also be an essential and integral part of the healing. Pioneering depth psychologist Carl G. Jung (1951/1982) viewed analysis as a process “in which the doctor, as a person, participates just as much as the patient” (p. 116). He asserted, “A good half of every treatment that probes at all deeply consists in the doctor’s examining of himself, for only what he can put right in himself can he hope to put right in the patient” (p. 116). Jung implied that the therapist is able to heal others through the successful healing of his
or her own wounds. This concept is the essence of the Wounded Healer archetype. The therapist must recognize his or her own wounds as separate yet not so different from the patient’s. “Counter-transference, then, has to do with the analyst’s capacity to be wounded,” stated Jungian analyst David Sedgwick (1994, p. 108). Psychological damage can be done to patients when therapists overidentify with the healer archetype and treat the client as the only wounded one (Guggenbühl-Craig, 2009). At the same time, the therapist must also be cautious to avoid overidentifying with the Wounded Healer archetype.

In recent years, with a rise in general consciousness, a body of research, writing, and training has been growing exponentially regarding the mind-body connection in both popular self-help and scholarly spheres (e.g., Duff, 1993; Levine, 2010; Maté, 2003; Osho, 2003; Pert, 1997; Rossi & Cheek, 1988; J. Taylor, 2009). The amount of popular self-help literature, seminars, and audio and visual programming is indicative of progression from the Cartesian split to a widespread acceptance of the wholeness of the mind-body and a general recognition of the psychological component of illness.

A burgeoning amount of research and literature also exists in the fields of health and somatic psychologies. Scholar-practitioners (e.g., Aizenstat & Bosnak, 2009; Beebe, 2004; Corbett, 2011; Costello, 2006; Greene, 2001; Paris, 2007; Woodman, 1987) have been expanding on integrated mind-body concepts that early depth psychologists Jung (1926/1981, 1946/1982, 1951/1982, 1988, 1961/1989), Sigmund Freud (1910/1988, 1912/1990, 1915/2009), and Wilhelm Reich (1942/1973) pioneered a century ago. General countertransference literature is abundant, but until recently, there has been
considerably less available literature regarding the somatic experiences of the therapist.

Analytical psychologist Martin Stone (2006) addressed this concern:

Much of what has been written on this subject has focused on sleepiness, and erotic and sexual feelings, possibly because these are more frequently experienced by analysts. Other bodily sensations such as aches, pains, rumblings, coughing, nausea and suffocation have been less considered. (p. 1)

This disparity could be a reflection of the Eurocentric culture’s tendency to overvalue cognitive processes and devalue or exile the body and soul, especially that of the therapist, as well as its tendency to consider only the patient as wounded.

In this dissertation, I will review pertinent early literature from the pioneers of the depth psychological field, including Jung and Freud as well as the latest available and evolving sources on the following topics: the Wounded Healer archetype, the interactive field, countertransference theories, neuropsychology, and somatic psychology. The current available body of literature provides a contextual backdrop and illuminates the need for further depth psychological exploration of the therapist’s somatic experiences from the archetypal perspective of the Wounded Healer.

The intention of this exploration is to broaden and deepen an understanding of the therapist’s somatic experience, expand general depth psychology scholarship, and more importantly, to improve psychotherapeutic treatment of patients by empowering therapists to acknowledge, understand, and utilize their own woundedness and somatic experiences for the mutual healing and well-being of both. “One danger of psychotherapy is that it becomes too ‘mental’ (wordy) and loses the link with the body. When this happens, psychotherapy loses the psyche also” (Kalsched, 1996, p. 65). If we, as therapists, are to help restore wholeness of mind and body in our patients, we must strive
not only to restore our own wholeness but also to bring wholeness back to the field of psychotherapy by attending to the physical body in the work.
Chapter 2
Literature Review

The Wounded Healer

Only the wounded physician heals.

(Jung, 1961/1989, p. 134)

Psychotherapists are often asked why they chose their profession. The common belief is that they choose this profession to better understand themselves and heal their own wounds. In fact, many research studies have indicated a connection between a therapist’s own acknowledged woundedness and his or her vocational call to the profession (Barnett, 2007; Barr, 2006; Mander, 2004; Norcross & Guy, 1989). Furthermore, some people criticize the reality that therapists’ lives are fraught with difficulties and relational challenges like anyone else’s. The following question is asked: “How can an imperfect, wounded person be a helpful, healing therapist to another?”

Eurocentric society seems to prefer the idealized notion that one in the role of the healer is completely healthy and happy rather than wounded and attempting to heal those who are ill or wounded. Both healers and patients alike easily subscribe to this polarized belief influenced by the culture of scientism. The projections and concerns about what calls therapists to this work may have truth, and yet, a great mystery seems to remain regarding healing.

To start to unravel this mystery, the word heal derives from the Anglo-Saxon word hal, which means “healthy, whole,” and haelen, meaning “to make whole” (“Heal,” 1995, p. 345). Recognition, acceptance, and integration of all one’s parts and polarities are then significant in the process of healing (Miller & Baldwin, 2000). This holistic perspective includes one’s dark and light aspects; conscious and unconscious emotions
and thoughts; and the capacity to wound, be wounded, and heal. Furthermore, professor of mythological classics and ancient religion, Carl Kerényi (1959a), affirmed that “wounding and being wounded are the dark premises of healing; it is they that make the profession possible and indeed a necessity for human existence” (pp. 76-77).

**Wounded Healer in myth.** In times of antiquity, the art of healing was left to the powers of the divine physician. “Classical man saw sickness as the effect of divine action, which could be cured only by a god or another divine action,” explained Swiss psychiatrist and Jungian psychotherapist Carl Alfred Meier (2003, p. 2). The gods were held responsible for both creating sufferable afflictions and healing them. Psychologically speaking, the gods created rupture as well as made repair; however, even the healing gods suffered wounding themselves. The capacity to wound, heal, and be wounded are all interrelated.

This concept of the Wounded Healer is found in early Greek myths, most closely associated with Chiron the centaur and the divine physician Asclepius although also exemplified by Achilles, a student of Chiron as well as Machaon and Podaleirons, sons of Asclepius (Kerényi, 1959a) and illustrated in alternative but less traditional ways by Greek deities such as Hekate (Hillman, 1975; Popovic, 2008), Dionysus (Hillman, 1997; Lopez-Pedraza, 2000), Demeter and Persephone (Downing, 1990), and the medieval myth of Parsifal the Fisher King and the holy grail (Johnson, 1974), as well as by religious figures such as Jesus Christ, Kali, and Lao Tsu. These figures have in common the homeopathic principle of healing and a threefold nature, mediating tension between healing and wounding, life and death, light and dark, temporal and eternal, and flesh and
spirit. This literature review predominantly focuses on the stories of Chiron, Asclepius, and Hekate.

Chiron the wise and gentle centaur, half horse and half human, is a paragon of the archetypal Wounded Healer. According to retellings of the myth based on the works of poet and scholar Apollonius Rhodius (Bonnefoy, 1991; Downing, 1990; Graves, 1960; Kerényi, 1951, 1959b; Kirmayer, 2003; Meier, 2003; Whan, 1987), Chiron’s father Cronos is having an affair with Philyra while married to Rhea, and one day Rhea catches him in the act. At this surprise, he transforms himself into a stallion and gallops off to escape, leaving Philyra behind to bear his child Chiron, half horse and half human. Philyra is so appalled by the hideousness of her half-horse half-human child that she prays and begs the gods to free her from the responsibility of mothering this “monster” and is thus metamorphosed into a linden tree. It is significant to note that Philyra means “linden,” and linden flowers have been used since ancient times as a healing restorative. Chiron later became known as the Son of Philyra and as a famous doctor, scholar, and prophet (Graves, 1960), yet Chiron’s life as a healer began with the emotional wound of his mother’s rejection and abandonment.

As a descendent from the line of the divine god Apollo, Chiron inherited a propensity for healing and was named as such. The name Chiron, in Greek, means “skilled with hands” and is related to the Greek word chirourgos, which means surgeon (Benziman, Kannai, & Ahmad, 2012, p. 3). Though most centaurs were typically seen as drunken, vulgar, and violent, Chiron was peaceful, civilized, and learned. He acquired great skill in the arts, hunting, and medicine and mentored many significant mythological heroes throughout his life, as discussed further on.
The crux of his story is that one day, Chiron is accidently struck in the knee by Herakles’ arrow, which has been dipped in the venom of the Hydra intended for another. The poison is so strong that he cannot recover, yet due to his immortality as a god, he cannot die. He is therefore agonizingly and incurably wounded. He continues to roam the earth using his gifts to heal the sick and injured, all the while suffering tremendously; ironically, he cannot heal his own wound. When Prometheus is sent to Hades for a wrongdoing, Chiron volunteers to take his place in Hades, offering up his immortality to Prometheus in exchange for his own death and a relieving end to his suffering. Zeus offers him a place in the stars as the constellation Sagittarius rather than Hades (Benziman et al., 2012; Bonnefoy, 1991; Downing, 1990; Graves, 1960; Kerényi, 1951, 1959b; Kirmayer, 2003; Meier, 2003; Whan, 1987).

Threefold in nature, as he is part animal, human, and divine, Chiron is most representative of the Wounded Healer archetype. He is deeply connected to instinct, embodiment, and spirit, and he heals others in spite of and because of his incurable woundedness. As part animal, Chiron further exemplifies the shamanic healing tradition in that shamans acquire their healing power from animal spirits (Vitebsky, 2001). Kerényi (1959a) described Chiron as “contradictory” (p. 96) and a union of opposite natures, with the fecundity of a horse, living in dark cave at the entrance to the underworld, yet the lightness of healing, instructing heroes in medicine, arts, and music. As mentioned earlier, Chiron mentored and foster-fathered several notable figures in the healing arts, including Jason and Achilles, who both shared the wound of being deserted by their mothers (Graves, 1960; Kerényi, 1959a); Herakles, who later incurably wounded him; and Asclepius, who suffered the loss of his mother at birth and later became known
as the Greek god of healing. Further, it is of interest to note that Herakles, also known by his Roman name Hercules, is said to represent the heroic ego celebrated in Western culture, acting as an enemy to sickness, death, and the underworld, according to Hillman (1979).

Asclepius is famed throughout Greek mythology and Christian history as a divine healer and also represents aspects of the Wounded Healer archetype. According to the story of Asclepius, as told in Pindar’s Third Pythian Ode (as cited in Bonnefoy, 1991; Downing, 1990; Graves, 1960; Kerényi, 1959a, 1959b; Kirmayer, 2003; Meier, 2003; K. Patton, 2009), his parents are Apollo, a deity and god of healing, and Coronis, a mortal. While Coronis is pregnant, however, it is told that she has fallen in love and committed adultery with another mortal named Ischys. Angered and jilted by both her unfaithfulness and her preference for a mortal, Apollo wants them both killed. He complains to his sister Artemis, and she avenges this act by slaying Coronis with arrows (Bonnefoy, 1991; Graves, 1960). As Coronis’s corpse lies burning in flames on the funeral pyre, Apollo feels sudden remorse, and although he cannot restore her life, he rescues his living, unborn son Asclepius from her burning body. In some tellings (e.g., Bonnefoy, 1991), Apollo himself rescues Asclepius, and in others (e.g., Graves, 1960), he sends Hermes to cut the child from her womb. Apollo proclaims, “He who sent death gave life” (Pindar, as cited in Meier, 2003, p. 24), referring to his own homeopathic healing nature. He then hands Asclepius over to Chiron to raise and mentor in the healing arts.

Asclepius, though born a mortal, becomes a greatly sought-after physician and hero who heals the sick, is exceptionally skilled in surgery and use of drugs, and is revered as the founder of medicine. He learns the art of healing from both his father
Apollo and Chiron. In addition, Athena gives to Asclepius two vials of blood from the Gorgon Medusa’s veins, which gifts him additional abilities. The blood drawn from her left side gives him the ability to raise the dead to life, and the blood from the right bestows the ability to destroy life instantly. When he begins reviving the dead back to life, however, disrupting the natural order of things and taking subjects away from Hades, both Hades and Zeus are angered. Zeus strikes Asclepius down dead with a thunderbolt but later has a change of heart and restores him to life as a constellation in the stars, as he also does for Chiron. This fulfills a prophecy made by Chiron’s daughter that Asclepius would become a god, die, and resume godhead, twice renewing his destiny (Graves, 1960). This elevates his status to deity, God of Healing, and he continues to work miracles at his healing shrines without physical presence.

Psychiatrist Laurence Kirmayer (2003) made some observations of interest about the story of Asclepius. When Asclepius, inflated by his powerful abilities, begins bringing the dead back to life, he suffers resulting deflation at the hands of Zeus. Asclepius’s demise illustrates the ultimate powerlessness of a human being in the natural order as well as the power of decay, destruction, and death, for even the most skillful physician cannot escape death forever. Asclepius, however, is ultimately restored by Zeus as a God, thus experiencing a transcendent renewal.

Asclepius, born of the union of mortal and God, is a transcendent third. He unites opposites and has the ability to heal and wound as well as give life and cause death. His two fathers, Apollo and Chiron, represent the light and dark aspects, spirit and instinct, or intellect and animal intelligence, respectively (Kirmayer, 2003; Meier, 2003). Kirmayer
(2003) further added that Chiron’s darkness connects Asclepius to the underworld and gives him access to the unknown.

The animal forms associated with Asclepius are the dog and the serpent, and Meier (2003) explained that in mythological stories, both the dog and serpent (or snake) guard treasures, have medicinal powers, represent souls of the dead, and can cause or cure illness. Dogs may act as guides into the other world, are often sacrificed for the dead in Greek and Roman mythology, and have strong instincts and ability to follow trails. The snake’s relevant qualities are its keen sight and ability to rejuvenate itself by casting its skin and freeing itself from illness. Because of these attributes, the ancients regarded the serpent (or snake) as a symbol of renovation, renewal of life. The snake also represents humility, crawling on ground in contact with earth. Asclepius is typically portrayed carrying a staff with a serpent on it, symbolizing transcendence and rebirth (Graves, 1960; Meier, 2003; K. Patton, 2009).

Closely related to the symbol of the serpent is the water of life, which is also representative of healing and renewal. Water and springs are associated with healings at Asklepian temples, where people would come to receive healing and healing dreams, often with one of the animal guides present (K. Patton, 2009).

Asclepius also has two sons, Machaon and Podaleirios, who, like their father and grandfathers Apollo and Chiron, both become healers. Notably, Machaon’s name bears a likeness to aristomachus, which means “slaughter,” and its Greek root is “battle” (Kerényi, 1959a, p. 76). A wounding warrior and healing physician, Machaon engages in both external wars and deeply suffers internal battle as well, bearing an incurable wound like Chiron. His wound, however, leads to his death at the hands of Euryplyos.
Machaon’s brother Podaleirios is also a healer, who heals more “invisible ills,” those of the soul (p. 76). Looking at this Wounded Healer lineage from a family systems perspective, we see Wounded Healer Chiron fathering and mentoring significant mythological figures, Achilles, Jason, and Asclepius, in the healing arts. As the son of Apollo and foster son of Chiron, Asclepius passes on to his sons, Machaon and Podaleirios, the gift of healing as well as the wound. In an apparent transgenerational transmission, the sons carry on their family’s legacies of woundedness and the desire to heal the wounds, within and without.

Although Chiron and Asclepius are most often associated with the Wounded Healer archetype, Titanic goddess Hekate bears special mentioning, as she does exemplify significant, though not traditional, aspects of the Wounded Healer archetype and other attributes relevant to this study. This goddess has been associated with a variety of names including “Queen of the Dead” (Apollonius Rhodius, as cited in Popovic, 2008, p. 374), “Mistress of the Underworld” (Popovic, 2008, p. 372), “Goddess of dreams” (Ronan, 1992, p. 108), a “Daughter of night” (Kerényi, 1951, p. 35), “Mistress of the crossroads” (Popovic, 2008, p. 370), “Mistress of Soul” (p. 369) as well as “Trinitarian Goddess” (p. 372) because of her triple form as described by Hillman (1979), Kerényi (1951), and Hesiod (trans. 1973). Hekate, also spelled Hecate, deserves special inclusion in this project in particular because of her association to the body, psyche, and transference/countertransference. She is a mysterious goddess, and many conflicting stories are attributed to her, as her stories of transformation seem to transform through tellings over the years (Farnell, 1992; Hesiod, trans. 1973; Hillman, 1979; Kerényi, 1951,
1959b; Popovic, 2008; Ronan, 1992). Rather than expounding on these various stories, Hekate’s collective essence is the focus as context for this study.

The stories of Hekate’s origins, however, though vastly different, are notable and set the stage for her mythological character. In Hesiod’s Theogony (trans. 1973), for example, Hekate is born to Titan parents Perses, a war god, and Asteria, a star-goddess, which may contribute to Hekate’s association as a daughter of night or Nyx. Titans were seen as more savage, powerful, and primordial than the Olympians, and Hekate inherited these characteristics (Kerényi, 1951). Classics scholar Louis Farnell (1992), citing the work of Greek geographer Strobos (BCE 62-24) and the commentaries of the Alexandrian poet Lycophron (c. BCE 200-300), offered a different story of Thessalian origins: “Hekate was the daughter of Pheraea, and as a newly-born infant was thrown out into the cross-roads, but rescued and brought up by shepherds” (p. 21). This particular story is of interest for two main reasons: Hekate’s strong association to the crossroads in many mythical stories and traditions (Farnell, 1992; Kerényi, 1951, 1959b; Popovic, 2008; Ronan, 1992) as well as the parallel to Chiron and Asclepius, incurring early wounds in infancy due to the loss of their mothers.

Hekate can be described as a homeopathic figure, often feared for inflicting diseases, psychosomatic disturbances, madness, mental trouble, nightmares, and death, yet revered for her abilities to defend and heal and protect against the same “evils” she may inflict. She is often feared and portrayed as a monster. She is also known to have special abilities as midwife and in transitions, moving between darkness and light and over thresholds. The animals she is often associated with include the dog and snake and
the horse (Farnell, 1992; Kerényi, 1951; Popovic, 2008; Ronan, 1992), similarities she shares with Asclepius and Chiron, respectively.

Velimir Popovic (2008), a psychoanalyst and professor of clinical psychology in Serbia, wrote about Hekate from a psychological perspective. He offered that one of her most significant psychological functions is that she takes on and relieves the wounded, discarded, judged, disowned, repressed emotions, impulses, and other unacknowledged contents from humanity’s collective, personal, and bodily shadows and carries them safely within her body. In myth, Hekate makes dinner of uneaten scraps, garbage, and nightmares. She can digest and transform them via imagination into proper food for one’s soul, much like the job of a therapist, helping patients to process, contain, validate, and transform their indigestible issues, experiences, and feelings. Former Catholic monk turned psychotherapist, Thomas Moore (2004), wrote of his appreciation for Hekate: “She redeems many feelings and thoughts that might be undervalued. . . . She validates many aspects of daily life that go into the garbage—because they aren’t valued and approved” (p. 73).

In psychotherapy, Hekate is present as mediator, much like a midwife, between the transference and countertransference, said Popovic (2008). He described Hekate as an agent who stimulates psychic reflection in the analyst and, at the same time, prevents the analysand from becoming the prey of his or her own stereotypic images of psychotherapy which will inevitably rob the client of his or her individuality. (p. 371)

Often depicted as three headed, from Popovic’s perspective, this trinitarian goddess is representative of the transcendent third and the interactive field, binding together and mediating that which was split apart: psyche and matter, day and night, fragments of psyche and body, the underworld and the starry sky, and the shadow and
consciousness. Hekate is an embodiment of the imaginal container for the psychological processes of unfolding, unifying, and coming into being.

The Wounded Healer archetype. In Plato’s Republic (trans. 1992), he remarked that even the most gifted physicians suffered from a variety of ailments, and were not perfect models of health. In 1951, Jung began referring to the concept of the Wounded Healer archetype, reintroducing and popularizing this idea in the field of modern psychotherapy. The Wounded Healer archetype is active throughout Jung’s life work in both theory and lived experience (1951/1982, 1959/1969, 1961/1989, 2009).

To understand the concept of the Wounded Healer archetype more fully, an explanation of archetypes is in order. The etymology of the word archetype is derived originally from the Greek word archetypos, arche meaning “first” and typos meaning “stamp, or mold” (“Archetype,” 1995, p. 36). The current general understanding of archetype is that it is a universal process of meaning-making and pattern generation that gives rise to analogous images and narratives across time and culture and that may reflect any aspect of human experience that is universal, including birth, attachment, desire, imagination, illness, suffering, and death (Jung, 1959/1969; Kirmayer, 2003).

Early on, Freud recognized the presence of archetypes, which he termed “phylogenetically inherited schemata” (1918/1955, p. 119) or “prototypes” (1927/1961, p. 21). The Oedipal complex was an example of an archetypal “schemata” he contributed to the field (Adams, 2008). Jung, however, is credited as the first to employ regularly and popularize use of the term archetype in the psychological field and develop the concept. He described archetypes in a multitude of mystical ways, including “sources of energy” (1961/1989, p. 91); “a priori forms of representation” (1952/1981, p. 457); “pre-existent...
and supraordinate to all phenomena” (1954/1969, p. 75); “types of situations and types of figures that repeat themselves frequently and have a corresponding meaning” (1941/1969, p. 183); and “the numinous, structural elements of the psyche” (1952/1990, p. 232). He explained his perspective on the character of archetypes:

The picture is concrete, clear and subject to no misunderstandings only when it is seen in its habitual context. . . . But as soon as one tries to abstract the ‘real essence’ of the picture, the whole thing becomes cloudy and indistinct. (1941/1969, p. 182)

In another work, he elucidated its reciprocal quality: “the indefiniteness of the archetype with its multitude of meanings, all presenting different facets of a single, simple truth” (1946/1982, p. 288).

Throughout his youth, through his personal struggles and growth, Jung experienced and documented his learning of the power and mystery of archetypes, as portrayed in the Red Book (2009) and in his autobiography, Memories, Dreams, Reflections (1961/1989). Later in his life, he was able to formulate his experiential understanding of archetypes and present this theoretical concept to the psychological world. In Jung’s (1964) essay “Approaching the Unconscious,” he shared his realization that archetypes have always existed, a priori, and will always exist as part of the collective unconscious. He did not believe that new archetypes could develop but rather that existing archetypes could be newly discovered (1952/1981). Additionally, Jung proposed the idea that archetypes exist in both the psyche and matter of the collective world, consciously and unconsciously, including within the biology and physiology of beings and termed this idea psychoid. He saw the psychoid aspect of archetypes as the mediating bridge between psyche and matter (1947/1981).
Others since Jung have further expanded the concept of archetypes. After studying with Jung and training at the Jung Institute, Hillman (1975) later branched off with a revisioning of Jung’s ideas, naming his new approach *archetypal psychology*. He explained that archetypes “tend to be metaphors rather than things. We find ourselves less able to say what an archetype is literally and more inclined to describe them in images” (p. xix). He disliked the word *archetype* as a noun, but preferred it as an adjective, as in *archetypal* images or phenomena, which he imagined as “the deepest patterns of psychic functioning” (p. xix), approaching the concept from an intuitive, image-oriented perspective.

Anthony Stevens (2003), a British Jungian analyst and psychiatrist, integrated archetypal theory with neo-Darwinian evolutionary psychology and postulated that the environment activates archetypes, which, he stated, are “the intermediate between genes and experience: they are the organizing schemata by which the innate becomes personal” (p. xii). In essence, he believed that there is more of an evolving biological component to archetypes, rather than solely an a priori view that they continue to evolve and develop through natural selection. He favored an *archetype-as-such* perspective, meaning that the image that comes forward along with one’s patterned response when thinking of something or someone may not be an archetype in and of itself. Stevens’ contributions broaden as well as ground archetypal theory with neurobiology.

Still another relevant contemporary perspective on archetypes is the emergent/developmental model conceived by psychiatrist and Jungian analyst Jean Knox (2003). Knox, like Stevens, also perceived archetypes to be continually developing, as opposed to the classical view that they are a priori, or innate. Knox, however, proposed a
behavioral model based on current neuroscience research, contending that archetypal experience emerges from developmentally produced brain structures and is activated by affective environmental experiences and interpersonal relationships. Central to Knox’s viewpoint are the concept of image schemas, which she described as the earliest developmental psychic structures that organize one’s experiences, yet contain no content and remain outside of conscious awareness. The image schema concept, as explained by Knox, operates as an archetype-as-such and illustrates that it is “the dynamic pattern of relationships of the objects of our inner world that is archetypal, rather than the specific characteristics of any particular object in inner or outer reality” (p. 66). These archetypal dynamics and structures, such as containment, versus the object itself, such as mother, exemplify a significantly different perspective in the understanding of archetypes.

The Wounded Healer archetype, according to Jung (1946/1982, 1951/1982), implies the recognition of one’s own human suffering as initiation to both individuation and a vocation to healing others. The wounded healer has the capacity “to be at home in the darkness of suffering and there to find germs of light and recovery with which, as though by enchantment, to bring forth Asclepius, the sunlike healer,” said Kerényi (1959a, p. 100).

Across all time and cultures, a pattern of contract exists between a patient seeking healing and a doctor who heals. Jung (1952/1981, 1964) described archetypes as patterned configurations of human behavior; thus, the relationship between patient and doctor constellates this archetypal pattern of transference and countertransference (Groesbeck, 1975; Hillman, 1975). The archetypal patient is wounded or sick in some way and seeks treatment from one who has the knowledge, wisdom, and abilities to heal,
which ultimately rests upon the archetypal Healer. The Wounded Healer archetype integrates both the Healer and Patient/Wounded archetypes within it. The Healer and the Wounded cannot be split apart, as the modern culture of scientism may suggest. The Healer archetype needs its counterpart, the patient (wounded), to fulfill its destiny. Each time one becomes ill/wounded, the *healer-patient archetype* is constellated, suggested Jungian analyst Adolph Guggenbühl-Craig (2009). “The therapy game enacts an archetypal pattern,” stated Hillman (1975, p. 75).

Initially, the ill person identifies with the patient archetype, projecting his or her own inner healer onto the outside healer, and the healer with the authority, knowledge, and abilities identifies with the Healer archetype. The opposite side of each archetypal image is projected on each other, and in this dynamic, “in the doctor, his inner wounded side, his own unresolved illnesses, psychic, somatic or both are activated by his contact with the sick person” (Groesbeck, 1975, p. 128). Hillman (1997) contended that analysts are not actually healers but channel the Healer archetype, appearing as Healer “only to the distorted vision of the ill, because the ill cannot find the source of healing in themselves” (p. 124); therefore, the initial projections are necessary.

Psychiatrist Jess Groesbeck (1975) found that for the healing to occur mutually, the projections must then be withdrawn and the patient must get in touch with his or her inner healer, just as the healer must get in touch with his or her own wounding. Though ill persons seek a healer outside themselves, it is the activation of one’s own inner healer that enables healing to occur. “Psychologically, this means not only that the patient has a physician within himself but also that there is a patient in the doctor” explained
Guggenbühl-Craig (2009, p. 81). The job of the healer is to activate that dormant inner healer within the patient (Guggenbühl-Craig, 2009; Kirmayer, 2003).

Guggenbühl-Craig (2009) further discussed how the attempt to split the healer-patient archetype may actually prevent healing and sustain the patient’s wound. He explains that psychological damage can be done to patients when a therapist overidentifies with the healer archetype, treating the client as the only wounded one and not acknowledging one’s own woundedness. By casting off one’s own woundedness into the shadow, the patient is burdened to carry it unconsciously. Relatedly, Hillman (1975) warned that collusion sometimes occurs between patient and therapist, enabling dependency of the patient on the therapist. Another danger of identifying with the one-sidedness of the healer archetype, as exemplified in the myth of Asclepius, is that the healer can become inflated with power, lose conscious awareness, and then suffer resulting deflation (Kirmayer, 2003). The therapist, with the power to diagnosis pathology, can become God-like in bestowing the illness and simultaneously relieving it, as described by Hillman (1975).

Given the tension of opposites between the archetypal Patient and Healer, and the presence of eros energy within the analytic alchemical vessel, the coniunctio between Patient and Healer gives rise to the Wounded Healer archetype as a third. “The analyst’s insight and the patient’s wound together embody the archetypal figure of the Wounded Healer, another ancient and psychological way of expressing that the illness and the healing are one and the same” (Hillman, 1975, p. 76). The Wounded Healer archetype, in contrast to the split archetypes, represents balance and wholeness in healing.
The Wounded Healer archetype is manifest in all types of healers, shamans, physicians, psychotherapists, across time and culture (Benziman et al., 2012; Kirmayer, 2003; Meier, 2003; Merchant, 2012). The consistent characteristics inherent in this archetype appear to be a vocational call to healing through an initiation of wounding and the homeopathic principle of healing, where the healer and the illness, the antidote and the poison, are one and the same and are divinely inspired and healed, as previously described with regard to Chiron, Apollo, Asclepius, Machaon, and Hekate. As it was in times of antiquity and still is, with adoption of the attitude that all illness is divine, the sickness, *divino afflictio*, actually carries its own healing power (Groesbeck, 1975).

**Wounding as initiation to the vocation of healing.** “The very purpose of the wound is to make us aware of the healing power in us,” proposed Gerhard Adler (as cited in Miller & Baldwin, 2000, p. 257), psychologist and co-editor of Jung’s *Collected Works*. Likewise, British-trained psychiatrist and Jungian analyst Lionel Corbett (2011) echoed Jung in suggesting that learning to heal oneself is the basic training for healing others.

Jung emphasized a shamanic and alchemical model of healing, in which analysts mirror their patients, thus becoming infected by their patients’ illnesses in their psyches. Through suffering the illness, they have personal need to develop a cure for themselves, and thereby heal patients psychically through healing themselves (Jung, 1937/1982, 1946/1982, 1951/1982). “Only the wounded physician heals” (1961/1989, p. 134) because of an understanding and empathy based on experience and need for one’s own healing.
Christine Downing (1990), a scholar and professor of religious and mythological studies, asserted that “woundedness, illness, and suffering are a prerequisite for taking on the role of healer” (p. 59). She added that

initiation into healing comes through falling radically ill of a disease that often cannot be diagnosed and for which there seems to be no cure. Recovery comes only when the patients recognize the illness as a call, only when they agree to become healers. (p. 59)

In ancient and current shamanic practices, all illnesses are seen as divine, even if the psychological component is not recognized, though in the present-day culture of scientism, more often only physical causes are considered and treated.

Romanian spiritual philosopher and professor Mircea Eliade (1951/1964) explained several ways that one can become a shaman, and all involve a call and an initiation, whether it be an accident, illness, or hereditary transmission. He acknowledged the parallel between a shaman’s “sickness vocation” and “rite of passage” as initiatory experiences into the vocation of healing (p. 33). Eliade as well as psychohistorian Marvin Goldwert (1992) discussed the notion of creative illness, whereby psychological disturbance acts as initiation into transformation.

In his recent book Shamans and Analysts: New Insights on the Wounded Healer, Jungian analyst John Merchant (2012) explored in depth the relationship between shamanism in various cultures, psychoanalysis, and Jung’s Wounded Healer concept, concluding that shamanism and wounded healer are aspects of same archetype. Applying Knox’s (2004) emergent/developmental theory of the archetype to the wounded healer aspect of shamanism, Merchant (2012) posed the idea that the early developmental wounding experiences become psychically imbedded and that certain wounding experiences in infancy, such as loss of the mother or nourishment in some capacity, are
more common to people called to shamanism versus the people who are not, which underlies the emergence of the wounded healer component in shamanic phenomena.

Michael Ortiz Hill (2009), a registered nurse and practitioner of traditional African medicine, reported that he felt called to become a healer, or nganga, through his “water spirit illness” (p. 46). He had already become sickened and paralyzed with multiple sclerosis and then additionally began to experience water spirit illness symptoms, which included vivid dreams, waking visions, “an empathy that incapacitates” (p. 47), mood swings, stomach problems, and personal tragedy. The cure for water spirit disease, according to this African cultural tradition, is initiation as a healer and making peace with the afflicting spirits. “Only then can the water spirits be allies in the activity of healing—one’s own healing through perpetuity of initiation, and the healing of others” (p. 47). Hill viewed his illness as a sacred experience:

Sacred illness comes of God and returns to God in this life or through the end of it. Healing can mean either. The essential thing is to listen to the spirit that afflicts, yield to its wisdom, be undone as one will be undone. (p. 46)

Similarly, in African Xhosa culture, the rite of initiation to become a healer or sangoma is Thwasa, which usually includes a state of illness, seen as an occasion of ancestors entering and communicating with the individual (Benziman et al., 2012; Cumes, 2004).

Psychoanalyst Charles Ducey (1976) comprehensively explored the early developmental experiences and psychodynamics of Siberian shaman with the question: “Is the shaman sane?” (p. 175). Though he perceived the shaman to be one who “bridges the gap between the known and the unknown” (p. 175), operating in the liminal/borderline zone, he viewed the vocational call to shamanism as psychopathological. He believed that shamanistic practice may be a defense activity attempting to cure a
preexisting mental disturbance, which has come about from wounds that have occurred in the earliest stages of infant development. Ducey compared this defense to what object relations theorist Melanie Klein (1946) described as the *paranoid schizoid position*.

Like others, Ducey (1976) recognized the existence of pre-initiatory illness in the call to shamanism but proposed three unique stages: (a) spirit possession or hysteria; (b) soul loss, which could be compared to the depressive position identified by Klein (1946); and finally, (c) the experience of a cure. Ducey’s (1976) conclusions were that shamans’ early traumatic woundings were due to the loss of parents on some level, such as death, lack of presence or nourishment, or some disruption in the mother-infant bond. He contended that shamans consistently display schizoid tendencies and suffer from what he called *hysterical psychosis*. Yet he stated, “Healthy and pathological patterns are too deeply interwoven to be meaningfully separate” (p. 177), implying his recognition that the wound can simultaneously be both pathological and beneficial to healing.

The shaman’s initiatory illness is not only the call to vocation but also transforms one to a person of power, according to Eliade (1951/1964). Along the same lines, Jungian analyst Michael Whan (1987) examined the archetypal meaning of one’s woundedness in terms of its initiative role into the vocation of healing as well as the way in which wounds shapes one’s work and how the work, in turn, reshapes the wounds. Similarly, Kirmayer (2003) contended that the healer’s own experience of illness and affliction is the most significant source of clinical authority and effectiveness. He claimed that winning the struggle against disease brings new awareness of what the disease signifies. The general process of initiation into a vocation of healing affects the healer’s attitude towards his own wounds as well as the wounds of others.
Kirmayer (2003) presented five stages in the development of the wounded healer that comprise looking inward at his or her own wounds along with another, parallel set looking outward at the patient’s wounds. The five stages of the inward process (pp. 267-268) are the following:

1. The healer is not fully conscious of his or her own woundedness, is attracted to the apparent power of healing, and feels set apart from patients.
2. Initiation into healing from training or therapy brings the healer’s awareness to his or her own wounds and shadow material.
3. The healer is overwhelmed by shadow and woundedness, loses sight of healing ability, and looks outside his or her self for healing.
4. The healer accepts his or her woundedness and tentatively evokes inner healer, though still hopes for another to come to the rescue.
5. The healer accepts that the wound can be only partly healed and develops power and confidence in returning again to underworld of the inner wound.

The Healer stays in touch with his or her dark side as a counter to the threat of hubris and inflation, as in the myth of Asclepius.

The parallel sequence of development of the wounded healer regarding the healer’s attitude towards others’ wounds consists of the following:

1. The healer is called to vocation through concerns for others or his or her role in the family.
2. Clinical training experience reawakens the healer’s old personal wounds.
3. The apprentice-healer identifies with wounds of others and worries about failing to meet the expectations and responsibilities of being a healer.
4. The healer finds resources within and offers his or her own inner healer to heal patients’ wounds, holding both personal and patient woundedness.

5. Acknowledging and exposing his or her own inner wound, the healer can accept the patient’s healing ability as equal participation. The patient can wound and heal the healer.

6. The healer’s relationship to his or her own wounds conveys power but opens the psychological relationship. Both engaging the patient empathically and being willing to acknowledge his or her own vulnerability fosters the redistribution of power and evokes the patient’s healing resources.

From the literature, there appears to be agreement that those called towards many healing practices of a shamanic nature have experienced sufficient wounding in both infancy as well as a later event, which served as an initiation into the healing practice. A strong similarity seems to exist between the call to shamanism and the vocational call to psychotherapy.

The Wounded Therapist.

When the Wounded Healer archetype is dominant in the soul, one’s own suffering enables one to help others. . . . A Chironic approach to healing makes the therapist profoundly sensitive to the suffering of the other and opens up the therapist’s own vulnerability. One knows the person’s suffering empathically, deeply within oneself.

(Corbett, 2011, p. 178)

Only those who have a “fateful disposition” are led to seek the vocation of psychotherapist, said Jung (1946/1982, p. 177). This profession, explained second-generation Zurich-trained Jungian analyst J. Marvin Spiegelman (1996), is marked by a connection and devotion to an endless confrontation with suffering, wherein one is more likely to feel anxiety and depression than in any other profession. The questions then
arise: What common preconditions exist for the Wounded Healer archetype to become dominant in one’s soul and lead one to become a therapist? What is this “fateful disposition” Jung identified, and to what degree might the acknowledgement of one’s woundedness factor in one’s ability to heal?

Preconditions including personal suffering and childhood wounding act as forms of initiation into the work of psychotherapy, according to Corbett (2011), which parallels the initiation into shamanic healing as discussed in the preceding section and is evidenced in Jung and Freud’s history. Merchant (2012) also explored the essence of these questions, looking for commonalities in the childhoods of both shamans and “true Jungians” (p. 4), a term he borrowed from Groesbeck (1989) to refer specifically to those Jungian-oriented analysts who feel called to operate in shamanistic way by dealing directly with a patient’s illness to bring about a transformative healing experience. He found that in both shamans and true Jungians, their archetypal mind/brain structure seemed to have been affected by particular traumatic early infant experiences of heightened affectivity due to particular vulnerability or disruption of the infant-mother bond. Merchant termed this psychological structure *proto-borderline*, akin to what others call “Borderland” (e.g., Bernstein, 2005; Costello, 2006) or “borderline type” (Winnicott, 1971). According to Merchant’s proto-borderline model, those who are sufficiently wounded at the core of their personality in this way but without enduring significant continued chaos in development, which heightens their level of psychopathology, are able to develop the capacity, or ego strength, to process and self-heal these early traumas and lead a relatively functional life. Their brand of wounding experience calls them to self-heal and then to heal others.
Person-centered therapist Alison Barr (2006) conducted a quantitative self-report study of the relationship between therapists’ psychological wounding experiences and their inspiration to the profession, based on data collected from 253 therapists using an online questionnaire. Among her findings, 73.9% of therapists reported that one or more of their wounding experiences lead to their career path, and these wounding experiences included abuse, family life as a child, their own or family members’ mental or physical ill health, family life as an adult, and bereavement. Directed by a similar question, counselor Marilyn Barnett (2007), who embarked on a detailed qualitative study exploring the unconscious motives calling psychotherapists to the profession, discovered two prevalent themes: early loss and narcissistic needs.

In her article, “The Selection of Candidates for Training in Psychotherapy and Counseling,” psychotherapist Gerturd Mander (2004) described her findings from interviewing prospective therapists. She reported that many candidates described being “summoned by an inner voice” (p. 165) to become therapists due to their desire “to give others what they (or their mother) did not have when they needed it” (p. 163). Often, their wish to help translated to a denied wish to be helped themselves. Mander explained, “The unconscious reparative drive that underlies the desire to help and to revisit with another an area of pain, of unfinished mourning, or of unresolved conflict that resonates with something familiar in oneself” results in mutual healing. The candidates’ statements also suggested that the mother did not have what she needed, which presumably created a disruption in the mother-infant bond or a transgenerational wound in the prospective therapists, resulting in them not having what they needed to some degree. This finding supports pediatrician and psychoanalyst Donald Winnicott’s (1971) theory that the
mother’s mental health or illness, in large part, creates the emotional environmental conditions that directly relate to the mental health of her child.

Also reflecting the theme of transgenerational wounding, Harold Searles (1979a), a pioneer in the psychoanalytic treatment of schizophrenia, proposed the idea that “we may have chosen this profession on the basis of unconscious guilt over having failed to cure our parents” (p. 28; as cited in Sedgwick, 1993, p. 141). Sedgwick further expounded upon Searles’ idea that therapists, as children, acted as therapists to their families, their early lack of success causing them guilt and unconsciously propelling them to become therapists; he proposed that clients become the therapists’ parents in the countertransference, just as therapists are the clients’ parents in the transference.

Sedgwick (1994) noted, “Not just the patient, but the therapist brings his entire ‘self’—neuroses, wounds, needs, soul etc.—to the analysis” (p. 42). He observed that therapists inherently suffer and share “a tragic sense of life, a sense which is no doubt reinforced by working with patients” (1993, p. 132). He said that often, the rewards of this work may not be commensurate with the degree of suffering, in part because of the guilt and dissatisfaction associated with the idea that psychotherapeutic work is not ultimately completed. His description is essentially, in Corbett’s (2011) terms, Chironic. Downing (1990) made a similar point: Wounded Healers are not those who were once wounded and now are healed but instead are still wounded as “an integral part of . . . [their] being” (p. 67). Medical psychologist and Jungian training analyst Gadi Maoz and Jungian-oriented expressive-arts therapist Vered Arbit (2011) acknowledged therapists as people with their own difficult living realities, noting that they will “often react with
physical, emotional and spiritual responses associated with their own personal traumatic memories” (p. 17).

These realities raise the issue of countertransference, which is intrinsically interwoven with the Wounded Healer archetype in psychotherapy. Spiegelman (1996) relayed an experience of countertransference wherein his own feelings were hurt by a patient’s projection of him in a dream, describing it as inducing the archetype of the Wounded Healer in session. He suggested that the analyst’s suffering is “both induced and activated” by the patient, similar to and different from the patient’s, and “finally it is or becomes” the analyst’s own suffering (p. 75). The effects of countertransference, as described by Jung (1929/1982),

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. (p. 72)

Whan (1987) offered this caveat: “To be open empathically is to be open to the other’s shadow and disturbance. . . . Constellation of this archetype can indicate the way the therapist has become profoundly involved with and vulnerable to the patient’s psyche” (p. 202). Jung had coined the term “psychic infection” (1946/1982, pp. 176-177; 1937/1982, pp. 329-330) to define this phenomenon. He further implied that the analyst’s early wounds resonate with those of the presenting patient, which create this susceptibility to psychic infection. In 2012, Merchant reached the same conclusion, backed by his research, which identified those most susceptible as the proto-borderline type.

Another chief danger brought on by “psychic infections” in psychotherapy is the potential for both doctor and patient to become stuck in the same unconscious complex if
the analyst does not step further in his or her own development (Jung, 1961/1989). It is all the more beneficial and necessary, therefore, for both patient and psychotherapist, that the psychotherapist seek out appropriate clinical supervision or personal psychotherapy. “The patient’s treatment begins with the doctor, so to speak. Only if the doctor knows how to cope with himself and his own problems will he be able to teach the patient to do the same” (p. 132).

Jeffrey Satinover (1985), a writer, psychoanalyst, and physicist, questioned Jung’s conception of a Wounded Healer archetype, criticizing Jung’s ideas as born only of his personal experience of pain and psychosis due to his break with Freud and lacking a scientific, objective base. The review of literature found no scientific or objective proof to support the Wounded Healer archetype, or anyone’s emotional pain, for that matter, though Knox’s (2003, 2004) neuroscience-based emergent archetype theory may come closest.

Spiegelman (1996), who authored several essays regarding countertransference and the mutual process of psychotherapy, acknowledged the magnitude of therapists’ sufferings but exhibited ambivalence concerning this archetypal image: “I have never been happy with this image of the ‘wounded healer.’ . . . The image is too dark and heavy, however, and leaves out the healing effects of joy and laughter” (p. 75). Instead, Spiegelman utilized, and perhaps prefers, the phrase “unhealed healer” for the title of his 1992 book. Relatedly, he associated the majority of his countertransference descriptions with patient-induced wounding due to absorption rather than acknowledging his own preexisting psychic material, possibly indicating his reluctance to facing and exploring the heaviness of what this archetype may signify. Nonetheless, building upon Jung’s
concept of psychic infection, Spiegelman (1996) described the way in which the analyst is open to the poisons of the patient as a consequence of the analyst’s own wounds and thus allows them to enter into and be absorbed by his or her Self, which then heals. He specifically noted, “It is the Self that does the healing, evoked by the patient, carried by the therapist, and experienced jointly in the process” (p. 116) that encapsulates the archetypal Wounded Healer in the psychotherapy process.

Many other authors attest to their resonance with the archetypal Wounded Healer concept as means to facilitate greater healing in others through the experience of their own woundings and healings. This concept is evident in Catholic priest and spiritual writer Henri Nouwen’s (1972) approach to spiritual ministry in his book, *Wounded Healer*. Like Jung, Nouwen maintained that an understanding of one’s own woundedness is an essential component of compassion and healing. Psychiatrist Martin Lipp (1980) shared, “My wounds became my spectacles, helping me to see what I encounter with empathy, and with a grateful sense of privilege” (p. 107). Therapists Grant D. Miller and Dewitt C. Baldwin, Jr. (2000) asserted the benefit and necessity of intimately knowing and accepting one’s wounds and vulnerability and applying one’s own personal experience in order to understand and heal patients and help activate their inner healer but also stressed to the responsibility of separating one’s own wounding from the patient’s.

British counseling psychologist Peter Martin (2011) also strongly advocated that an analyst develop deep self-knowledge in order to use the Wounded Healer archetype consciously and responsibly. After sharing his own personal story of depression, he embarked on a research study inviting other therapists to “‘come out’ of the false closet of professional immunity” (p. 18) and share their personal stories of woundedness, the
meaning they make of it, and how it affects their work with patients. The therapists in the study reported their observation that embracing their own humanity and imperfections, drawing on the wisdom gained from an examined life, and bringing their whole selves to the therapy room were worthwhile and valuable to client. Martin suggested that woundedness and humanness are the same thing, indicating a move away from the superficial, detached image of professionalism and scientism.

In The Wounded Healers: Creative Illness in the Pioneers of Depth Psychology, Goldwert (1992) presented case studies of several early depth psychologists, including Freud and Jung, with a focus on childhood traumas, creative illness in adulthood, and a shamanic-like call to the profession. The term creative illness was first conceived of by Novalis in the late 18th century (Goldwert, 1992), and then more recently employed by Ellenberger in 1970, who explicated:

A creative illness succeeds a period of intense preoccupation with an idea and search for a certain truth. It . . . can take the shape of depression, neurosis, psychosomatic ailments, or even psychosis. . . . The subject emerges from his ordeal with a permanent transformation in his personality and the conviction that he has discovered a great truth or a new spiritual world. (as cited in Goldwert, 1992, p. xi)

Goldwert added that creative illness is a significant transformative time, or *kairos*, of breakdown and breakthrough, acts as a catalyst to creativity, and a mission of purpose from which one emerges with new vision and insight.

Depth psychology pioneers Freud and Jung both personify the archetypal Wounded Healer therapist, as evidenced in the literature. Goldwert (1992) related how these psychologists’ own wounds led to insight and transformation, thus resulting in a greater propensity to tolerate, understand, attend to, and heal their patients’ suffering.
Goldwert also speculated that sexual trauma may have contributed to the development of their psychologies and spiritualization. He recounted:

Late in life, each of the “wounded healers” transformed their psychological doctrines, rooted in painful introspection and emotional crises, into cosmic messianic messages to all humankind, . . . having found themselves in creative illness, then having used their hard-won knowledge to help others. (p. 119)

The most significant factor in the ability to heal from the creative illness as in the cases of Freud and Jung, according to Goldwert, is the presence of dual egos, whereby part of the ego is split off, descending deep into the unconscious, while the other part of the ego remains conscious, observing and interpreting the journey into the unconscious. This duality allows for meaning to be made of the experience and an ability to heal others with this new understanding.

Works such as Memories, Dreams, Reflections (Jung, 1961/1989), The Wounded Jung (Smith, 1996) as well as the more recently released Red Book (Jung, 2009) further document Jung’s early wounding experiences; his personal transformative journey through periods of darkness and deep suffering, including his difficult break with Freud; and the accompanying creative, imaginal, and alchemical processes he experienced while becoming one of the most prominent, influential theorists and healers in psychotherapy. Regarding the woundedness and turmoil he confronted, Jung wrote, “There is no other way. All other ways are false paths. I found the right way, it led me to you, to my soul. I return, tempered and purified” (p. 232).

Downing (1990) reiterated the relevance of the Wounded Healer archetype, “The more aware we are of just what this image represents, the more likely we are to recognize its role in our own work” (p. 61). Whan (1987) presented the following image of the Chironian woundedness of the soul:
An “open wound” indicates interiority: the punctured, torn flesh, open to the world; . . . raw, red depths; lacerated feelings, exposed, tender, bruised and swelling; the pierced access to what is within. It signifies an archetypal image of an empathic consciousness which is in its own way a wound; a wound which brings consciousness. (p. 202)

This image of the archetypal Wounded Healer is significant then to those who feel called to become psychotherapists. Jung’s words serve to remind and encourage the wounded healers, that it is one’s “own hurt that gives the measure of his power to heal” (1951/1982, p. 116).

The Interactive Field of Psychotherapy

The interactive field is the physical and psychic space co-created by therapist and client, in which psychotherapy takes place. Most therapists as well as clients can attest to a visceral, tangible experience of this space, but much of what is exchanged in psychotherapy can be difficult to observe as it remains mysterious and elusive, often outside of conscious awareness. Abundant images, emotions, and synchronicities emerge and are experienced from within, seen but mostly unseen, as they belong to a primarily invisible realm.

This section provides context for the dynamics in the interactive field of psychotherapy by first presenting a review of the developing theories of transference and countertransference phenomena occurring within and contributing to the creation of the interactive field. Though transference and countertransference occur simultaneously and may be considered of equal importance, this review focuses more predominantly on countertransference because this research study is mainly concerned with the psychotherapist’s experience. Following this review is a discussion of the historical underpinnings and evolution of field theory, which offers a scientific context for an
explanation of these interactive experiences as well as their occurrence in therapeutic interaction.

**Transference and countertransference.** The original meaning of healing through transference is well illustrated by the ancient Greek Asklepian healing practice of hanging bandages from the trees at the temples. In this ritual, the patients sought healing through transferring the bandages from their wounds to the trees, which they believed could absorb and heal the sickness from their bodies (Meier, 2003).

Fast-forwarding to the 20th century, Freud is credited as the first to recognize and psychologically discuss the phenomenon of transference between patient and doctor and for coining the term *transference neurosis* (Jung, 1946/1982). According to Freud (1912/1990), transference is the most important element in analysis and thus is the cornerstone of Freud’s theory of psychoanalysis. Freud (1905/1953) described the occurrence of transference: “A whole series of psychological experiences is revived, not as belonging to the past, but as applying to the person of the physician at the present moment” (p. 116). In effect, Freud’s theory is that people respond to their doctors as well as their libidinal partners and rivals as if they were children relating to their parents (Singer, 1994, p. 249). Viennese professor and analyst Erwin Singer noted that this concept goes along with Freud’s earlier theory of repetition compulsion, which holds that people revert to previous, familiar states of organization and behaviors. Freud’s approach to transference, says Singer, is based on the assumption of these regressive tendencies and repetition compulsion, Oedipal conflicts/castration anxiety, and death instinct.
Freud (1912/1990) posited the occurrence of both positive and negative transferences. Singer (1994) explained Freud’s transference theory that positive transference occurs when the patient transfers positive, admiring, loving, or sexual feelings for past significant figures onto the therapist, whereas negative transference involves transferring negative, more hostile, angry attitudes onto the therapist. Though he initially believed that positive transference was, in fact, positive, he later revised his perspective, perceiving it as a form of resistance, impeding therapeutic progress. Freud (1912/1990) viewed negative transference reactions, also, as a form of resistance by which to keep Oedipal conflicts repressed by developing reaction formations. An example of the primacy of transference in Freud’s psychoanalytic theory is his stance that psychotic patients are not able to benefit from psychoanalysis. Singer (1994) noted Freud’s assertion that because psychotic patients have not reached the Oedipal stage of personal development, therefore, no Oedipal conflict exists to resolve through transference. Singer noted Freud’s conclusion that because no transference reactions are evident in a psychotic patient, no analysis of the patient is possible.

In 1907, Jung (1946/1982) had originally agreed with Freud’s definition of transference and its significance, calling it “the alpha and the omega of the analytical method” (p. 172); however, after his split with Freud in 1912, Jung (1961/1989) began revising his position, and in his Tavistock lectures in 1935, Jung dismissed transference as having “nothing to do with the cure” (1935/1980, p. 151) and described it as “an awkward hanging-on, an adhesive sort of relationship” (p. 136). In the transcription of his 1937 lecture “The Realities of Practical Psychotherapy” (1937/1982) continuing through his 1946 seminal work “The Psychology of the Transference” (1946/1982), he often used
quotation marks around the word *transference*, another cue implying his ambivalence, which Sedgwick (1994) also suggested about Jung’s position on transference. Jung (1946/1982) argued that the importance of transference in treatment is relative: transference is “a panacea for one and pure poison for another” (p. 164). Jung (1937/1982) criticized the concept of transference, suggesting patients felt they failed in analysis if they could not consciously create one, and described “‘transference’ as *only* [emphasis added] another word for ‘projection’” (p. 328).

Jung nevertheless wrote and spoke a great deal about the transference, despite his ambivalent use of the terminology. He explained that in the transferential projection process, the patient transfers onto the doctor “feeling toned” (1946/1982, p. 172) images of a parent or the like, creating a substitute relationship but with a bond with all the original intensity of the past. The analyst then “quite literally takes over the sufferings of his patient and shares them with him” (p. 172).

Jung (1929/1982) outlined and described four stages of transference in analysis: *confession, elucidation, education,* and *transformation,* which he continued to elaborate upon in subsequent works (e.g., 1935/1980, 1946/1982). Following is an amalgamated summary of these four stages as put forth by Jung as well as several authors (Douglas, 2011; Haule, 2011; Samuels, 1985b; Wiener, 2004) who have contributed distilled interpretations of Jung’s model. Though these stages are theoretically presented in a sequential order, Jung noted that they could overlap and occur in any order. During the confession stage, the patient shares their history, cathartically releasing long held emotions, unconsciously transferring them and any associated projections onto the therapist, and the therapist helps them to acknowledge these projected images. When the
transference has developed, the elucidation stage begins, wherein the therapist brings attention to the transferential relationship. Through dreams and other unconscious material that emerge, the therapist helps the patient connect his or her previously unconscious projections to their early origins, distinguishing between the personal and archetypal. In the education phase, the therapist’s task is to help the patient integrate and apply the understanding of the transference into his or her everyday social life, moving from mostly unconscious work to the ego and persona, translating insights into action. During the final most alchemical phase, transformation, the patient continues to delve deeper into unconscious material while integrating it consciously, towards individuation, self-actualization, and the archetypal image of the whole Self. When the transferenceal projections are recognized for what they are, then a real relationship can begin to form. This is also a time when one becomes less reliant on objects outside oneself and, instead, finds one’s treasure within. The greater portion of Jung’s work on transference and countertransference could be classified as occurring in this fourth stage of transformation, which is discussed from here forward.

Through the years that Jung continued his explanations of transference, describing how “the activated unconscious appears as a flurry of unleashed opposites and calls forth the attempt to reconcile them” (1946/1982, p. 182), it becomes apparent that he is simultaneously talking about countertransference as psychotherapists have come to understand it. His concluding remarks on transference in 1958 came full circle when he proclaimed transference phenomenon as the “crux, or at any rate the crucial experience, in any thoroughgoing analysis” (1958/1982, p. vii).
Freud (1910/1988) was the first to give name to and lay the framework for the conception of counter-transference as well, describing its content as that “which arises in him [the analyst] as a result of the patient’s influence on his unconscious feelings” (p. 16). He suggested that the therapist pay careful attention to his or her own reactions and feelings with evenly hovering attention when listening to the patient. Though Freud strongly believed transference to be a necessary and central component of analysis, he did not feel equivalently about its counterpart, countertransference. He warned against countertransference, considering it a harmful danger of analysis in that it hampered the analyst’s ability to work effectively. Countertransference, according to Freud, was to be eradicated through one’s own personal analysis, though he also believed that countertransference reactions could lend themselves towards the analyst’s increased self-understanding.

With Jung’s ambivalence regarding the concept of transference as put forth by Freud, it is not surprising then that Jung also rarely used the term countertransference explicitly; nonetheless, he discussed the process regularly. Sedgwick (1994) pointed out that it was after his break with Freud when Jung began developing these ideas about the “analyst’s side of the equation (i.e., the countertransference)” (p. 6) and discussed the “reciprocal influence” (Jung, as cited in Sedgwick, 1994, p. 11) of patient and therapist. Sedgwick noted that the majority of Jung’s work addressing the concept of countertransference was expressed through alchemical metaphors and images as well as through his abundant descriptions of the wounded healer dynamic. For example, Jung often employed the alchemical term mixtum compositum (e.g., 1946/1982, p. 171) to refer to the mutual process between analyst and patient. Another alchemical example, which
relates to the very heart of this proposed study, is this explanation: “For two personalities to meet is like mixing two different chemical substances: if there is any combination at all, both are transformed” (1929/1982, p. 71).

Jung, like Freud, recognized the potential risks of countertransference. Jung (1937/1982) theorized that countertransference occurs when the analyst has “a more extensive area of unconsciousness than usual,” (p. 329) meaning an extensive repository of unconsciousness material and explained that the patient’s transfer of unconscious contents onto the analyst activates the corresponding unconscious material in the analyst; the analyst’s psychological state is affected and adopts attitudes in response. The danger of this dynamic, warned Jung (1946/1982), is that “doctor and patient thus find themselves in a relationship founded on mutual unconsciousness” (p. 176). Jungian analyst Murray Stein (1984) later warned that this situation could cause a concerning reversal in the therapy, which he termed “folie a deux” (p. 78). Relatedly, as cited in the previous chapter, Jung (1946/1982) spoke of the potential perils involved in “psychic infections” (p. 177), whereby the analyst takes over the patient’s suffering in order to heal both himself and the patient yet may also get lost in mutual unconsciousness. Sedgwick (1994) similarly offered the explanation that within the analyst’s shadow is the analyst’s “projection ‘hooks’” (p. 108), which are accessible to the patient’s projections, enabling the analyst to be pulled into the countertransference.

Jung’s thinking differed from Freud’s, however, in that he described the countertransference process as a “highly important organ of information” (1929/1982, p. 71) that plays an essential role in healing. Jung strongly believed that the doctor can only influence the patient “if the patient has reciprocal influence on the doctor” (p. 71).
and stated, “You can exert no influence if you are not susceptible to influence” (p. 71). Analogous to Jung’s position, Searles (1965) believed that the effectiveness of therapy coincides with the extent to which therapists allow themselves to be affected, and described a process almost identical to psychic infection: “The therapist . . . introjects the patient’s pathogenic conflicts, and deals with them at an intrapsychic unconscious as well as conscious level bringing to bear upon them the capacities of his own relatively strong ego” (p. 214). Interpreting Jung’s and Searles’s ideas, Sedgwick (1993) clarified that the therapist does not consciously or voluntarily take on the patient’s illness, other than making the decision to engage as a therapist, but that this happens unavoidably, given the power of “unconscious communications” in the field (p. 79).

In his article “The Patient as Therapist to his Analyst,” Searles (1979b) proposed a reciprocal yet complementary rephrase of Jung’s statement, suggesting that it is the therapist’s illness that gives the client the power to heal the therapist and thereby heal himself (the client). Sedgwick (1993) viewed the healing potential of the therapist’s wounds on the patient’s unconscious in that “the therapist’s pathology enables the transference to occur, and the transference in turn facilitates the cure” (p. 83). Jung, Searles, and Sedgwick as well as Jungian analyst Andrew Samuels (1985b, 1989, 2001) all held the conviction that a therapist must be wounded in order to be effective in helping others to heal.

Sedgwick (1993) agreed that the transference of the sickness to a therapist with the capacity and ego strength to handle it is “a key component in the process of psychotherapy” (p. 80); however, this “key component” is two-fold, as two distinct and essential assertions are implied. One is his position that it is the transference that heals,
and another is the precondition that the therapist have the capacity and ego strength to handle the transference, which implies both the therapist’s woundedness as well as relative emotional health or ego-strength. A delicate balance of assumptions is at play between the expectations that therapists have sufficient ego functioning and self-awareness to bear the burden of the sickness of the patient and, at the same time, recognize his or her own inherent woundedness. London-based Jungian analyst Michael Fordham (1978, p. 86) and later Samuels (1985b, p. 175) used the term *asymmetrical mutuality* to clearly delineate these significant differences in roles and responsibilities within the mutual therapeutic relationship.

Relevant to the analyst’s role, although Jung acknowledged the impossibility of eliminating unconsciousness, he advocated that analysts continue working on their own complexes and learning, because they can only help patients as far as they themselves have gone (1929/1982, 1946/1982, 1951/1982, 1961/1989). Sedgwick (1994) similarly advised analysts, though they cannot nor should not attempt to eliminate their own pathology, to develop a familiar understanding of it and use it for therapeutic benefit.

Despite their ambivalences, Jung’s and Freud’s initiation of the discussion concerning transference and countertransference between doctor and patient provided a solid leaping-off point for further inquiry by others in the field. Whereas Freud and many subsequent followers in the psychoanalytic field perceived countertransference as akin to “cardinal sins, evidence of neurotic blind spots in the analyst—and nothing more” (Samuels, 1985a, p. 51), Jung became the first to endorse the positive potential of countertransference as an analytic technique. Since then, numerous schools of thought began developing theories of countertransference, from differentiating and describing
different types of countertransference to distinguishing different foci such as the analyst’s emotionality, symbolic communication, projective processes, empathy, intuition, the imaginal, and embodiment.

An important mid-20th-century contributor to the development of countertransference theory was psychoanalyst Heinrich Racker (1959/1968), a Jewish Argentinean psychoanalyst of Polish-Austrian origin, who differentiated specific forms of countertransference in terms of projective and introjective processes. *Neurotic countertransference*, he said, is the occurrence of the analyst projecting his or her own issues onto the patient, whereas *countertransference proper* was the term Racker applied to the feelings that emerge within the therapist in response to the patient’s transference. He coined the terms *concordant* and *complementary countertransference* as two distinct variations of countertransference proper. *Concordant* refers to the situation when the analyst resonates with and responds empathically to the intuited needs of the patient, perhaps engaging in mimesis or allowing the patient to use or carry the analyst where needed, and *complementary* refers to projective identification, when the analyst identifies with the patient’s projections or inner object, which then become introjected into the analyst’s psyche and behavior.

Fordham (1974b) expanded analytical psychology’s existing countertransference theory by identifying and defining the countertransference differences he observed as *illusory* and *syntonic*. *Illusory countertransference* refers to the analyst’s own projected material getting in the way of seeing the patient clearly, analogous to Racker’s (1959/1968) concept of neurotic countertransference. Fordham (1974b) described the term *syntonic countertransference* as referring to the analyst letting go of ego control,
identifying with and experiencing the patient’s inner objects as if they were his or her own, analogous to Racker’s (1959/1968) concept of complementary countertransference. Fordham (1974b) believed that through this introjection into the analyst’s own psyche, he or she could better understand the patient, which is a premise similar to Jung’s. Fordham (1974a) initially suggested that “almost any unconscious behavior of the analyst” constitutes countertransference, also stating that “all analyses are based on countertransference” (p. 137). Later, Fordham (1979) revised his perspective, proposing that the term *countertransference* (of the illusory sort) be reserved only for problematic occasions when therapeutic interaction is blocked and the analyst has difficulty containing the content presented.

Analytical psychologist Jan Wiener (2004) noted that Fordham’s countertransference ideas developed out of Jung’s concepts of empathy and *participation mystique*. Also similar to Jung, Fordham (1974a, 1974b, 1978) spoke of transference and countertransference as a whole process, rather than as distinct functions, and acknowledged its archetypal dynamics, beyond solely the personal. He noted characteristics of the archetypal dimension often included projections of the self that needed integration, and material useful for individuation. Further, he suggested that it is “the analyst’s archetypal reactions that form the basis of his technique, which without them must lack all true effectiveness” (1974b, p. 112), thus underscoring the significance of archetypal countertransference.

Symbolic communication in the therapeutic process was the focus of psychoanalyst Robert Langs’s (1979) ideas on countertransference. According to Samuels (1985a), Langs worked within an interactional field model, viewing the
psychoanalyst’s countertransference responses as equal to the patient’s transference in contributing to analysis, as each places the contents of his or her psyche within the other. Because Lang’s perceived the patient as an ally rather than an enemy, Samuels noted that this belief allowed the analyst to gain greater access to the patient’s disturbance and therefore lend more effective assistance through the countertransference.

The evolving and expanding inquiry into countertransference led to the emergence and recognition of the essential quality of empathy in psychotherapy, suggested Samuels (1985a). In his 1981 essay on the topic, originator of self psychology Heinz Kohut (2011) defined empathy as “vicarious introspection” (p. 542) and “a mode of observation attuned to the inner life of man” (p. 542) as ways to gain emotional information and understanding of both the patient’s psyche as well as the intense personal relationship.

Building upon the theoretical influences and terminology of Jung, Racker, and Fordham as well as Kohut, Jungian analyst Mario Jacoby (1984) addressed both the value and depth as well as the shadow side of countertransference. He presented case material exemplifying his own syntonic, concordant, and complementary countertransference experiences and detailed their helpfulness in understanding his patients’ unconscious dynamics. Arising within the shadows of countertransference, explained Jacoby, are the analyst’s personal narcissistic and professional needs, which may include money, power, success, and the erotic. Jacoby was among the first to acknowledge that types of countertransference could be mixed, or spectral, rather than classified as strictly neurotic or nonneurotic.
Like Jacoby, Stein (1984) also believed that the types of countertransference that occur are most often mixed. He contended that distinguishing between countertransference originating autonomously from the analyst’s psyche versus occurring directly in response to the patient is difficult, as is determining who is reacting to whom. Both Jacoby and Stein were developing their ideas amid the growing obsession in the field as to question of who initiated the countertransference (Samuels, 1985a; Sedgwick, 1994). Stein (1984) presented descriptions of three types of countertransference: the analyst’s desire for a sense of mastery or power; shamanism, healing through the taking on the patient’s illnesses; and maieutics, acting as midwife by going deep into the unconscious to help birth the Self in the therapeutic process. In addition to these types, he acknowledged the existence of many other types of countertransference and cited the maternal-nurturant type, identified by Harriet Machtiger, and eros-sexual type, identified by Nathan Schwartz-Salant, both Jungian analysts. Another concept Stein proposed is that each type of countertransference can also be further distinguished by attitudes, reactions, and phases. Attitudes he described as long-held “conscious and unconscious images, values, and thought patterns,” typically originating in childhood; reactions are “temporary and fleeting, chiefly rooted in unconscious complexes and not under ego control”; and phases are longer-lasting reactions in response to the patient’s transference (p. 85).

Samuels (1985a) defined two types of “usable” (p. 52) countertransferences: reflexive, when the analyst’s feelings are mirroring the inner state of the patient; and embodied, in which the analyst might feel like a particular inner figure of the patient, or when the patient’s unconscious issue becomes embodied in the analyst as “image”
Based on his research findings in a countertransference study, he proposed further usable countertransference groupings—bodily and behavioral responses, feeling responses, and phantasy responses—and observed, “all [emphasis added] these instances of countertransference may be said to be images” (p. 57) or “visions” (p. 59). It follows then Samuels also believed that some types of countertransference reactions are not “usable,” namely neurotic countertransference, which he denoted as identifying with the patient, idealizing the patient, reactions to the patient’s aggression, self-sabotage of any therapeutic progress, and the analyst’s narcissistic needs being satisfied through the patient (p. 54).

Samuels’s (1985a, 1985b) research into the body’s role in countertransference is significant, as he has been one of few to do so in recent decades. In the process of feeling into the patient’s psyche, Samuels explained, the analyst may take on a presence or operation of a figure in the patient’s psyche. The therapist’s countertransference reaction then may embody the patient’s emotional experience of that particular figure, which symbolically represents an active theme with the patient. This process is what Samuels defined as embodied countertransference. His theory seems to borrow from Langs’s (1979) ideas on feeling into the patient’s psyche and symbolic communication, but Samuels (1985a, 1985b, 1989) took this concept a step further by integrating the somatic counterpart. Samuels’s perspective on embodied countertransference is addressed further in the discussion of somatic psychology.

Though classically psychoanalytic-oriented analysts valued transference positively, many regarded countertransference, especially of the illusory or neurotic type, as a negative occurrence in whole or part. Klein, for example, wrote very little
acknowledging countertransference but did express concern that analysts might use this concept to blame the patient rather than to take responsibility for their own neuroses (Klein, 1952; Spillius, 1992). In a dialogue between Langs and Searles (as cited in Goodheart, 1980), they discussed their observations of the lack of countertransference material addressed in current analytic literature. Langs called it an “absurd picture” (p. 3) that analysts’ presentations of cases related information solely about the patient and not inclusive of the analyst, as if “the analyst has functioned perfectly throughout the analysis” (p. 2). Searles responded, calling it “complete rot” that it is an “incomplete picture” as “the parts that are left out are the most important parts” (p. 3). Stein (1984) also criticized the psychoanalytic field for its often negative or complete lack of interest in countertransference, abandoning it to the shadow of analytic practice, as evidenced by the lack of inquiry in the field, and suggested that this attitude may have been due to analysts’ fear and defense of self-inquiry. It is evidenced in this literature review that even several of the early Jungian-oriented analysts regarded neurotic forms of countertransference negatively or as unusable.

Sedgwick (1994), however, challenged the classification of certain types of countertransference as either useful or not useful, or good or bad; instead, he viewed them more neutrally as elements present in the analysis to be worked with and informed by, agreeing with Jacoby (1984) that countertransference usually consists of a mixture of types on a spectrum somewhere between neurotic and useful. A possible move beyond the ongoing disagreement as to who is inducing whom in the transferential field, or whether countertransference is positive or negative, suggested Sedgwick (1994), is Jung’s (1946/1982) concept of the transcendent function. The transcendent function involves a
third element arising from the tension of opposites, transforming both opposites in the process (pp. 198-199). The third moves out of and above the conflict into a new paradigm, with the focus moving instead to the mutually shared interactive field. This concept is discussed further in a subsequent section.

In addition to comprehensively reviewing the existing countertransference literature, Sedgwick (1994) shared his personal countertransference material in The Wounded Healer, exemplifying a method of acknowledging and constructively utilizing countertransference material for mutual psychotherapeutic benefit. He noted that the “two-way street” between patient and analyst is also a parallel “two-way” process of separating and merging within the analyst himself (p. 148). Working with countertransference within the paradigm of the wounded healer was a natural and meaningful experience, recounted Sedgwick.

The analyst’s typology may also relate to his or her “countertransference vulnerability,” according to Sedgwick (1994), proposing that analysts with superior feeling and intuitive functions may naturally be more sensitive to and inclined towards successfully utilizing countertransference (pp. 135-136). Reikian-trained psychoanalyst Paula Heimann (1950) valued the analyst’s emotional response to the patient as one of the most important tools for understanding the patient’s unconscious, adopting a much more progressive view than her Kleinian cohorts. Searles (1986) similarly “found that the countertransference gives one one’s most reliable approach to the understanding of patients of whatever diagnosis” (p. 190) and believed that “the feelings that the therapist is having are of the very essence” of the therapy (1978, p. 151). Perhaps these theorists’ typologies were either superior feeling or intuitive functions; either way, it is evident that
these theorists placed significant value on their own feeling responses in the therapeutic process.

The emotional involvement of the analyst and continued self-analysis are essential in developing the capacity to work with countertransference enactments, explained Jungian analyst Joseph Cambray (2001). In this work on amplification and enactments, he shared vignettes of his own processes during the clinical workday, and underscored the inevitability of countertransference enactments in therapeutic interventions, equating them as metacommunications. He explained how the analysand unconsciously recreates fundamental pathogenic experiences with the analyst out of necessity to master them and their significance in therapy, utilizing similar imagistic language as he might in an amplified reverie:

In the archeological metaphor, observing the fissures in consciousness opened up by attending to enactments not only offers access to ontological traces, but may also permit glimpses of cultural and archetypal components at play. It is through these “ruptures” that analytical psychology’s belief in an objective psyche with its wellspring in the mythopoetic imagination of the collective unconscious becomes meaningful. (pp. 278-279)

Cambray described the various dimensions occurring within the transferential field as “living language of analytic experience” (p. 277) and suggested that paying attention to and amplifying the nuances and shifts in session, such as voice changes, reveries, behaviors, and somatic cues, which occur in both the patient as well as the analyst oneself, present opportunities for affective attunement and healing response through the enactment. Cambray revered the alive and evolving nature of analytic process models, recognizing the importance of understanding their historical underpinnings while encouraging their continual reconsideration through experience.
Wiener (2004) also acknowledged the complexity of countertransference as a joint creation between patient and analyst, as well as within the analyst as a professional and as a person, plus its progressing contextual nature in the field. “Countertransference now embraces the notion that both the analyst’s professional and personal identity are inevitably involved in the analytic process” (p. 163). The body of work regarding countertransference continues to shift and expand to include further in-depth explorations of transferenceal dynamics within the interactive field as well as somatic aspects.

**Field theory.**

*Historical physics-based underpinnings of field theory.* Cambray (2009, 2011) presented a detailed, historical progression of field theory as contextual backdrop for the interactive field of psychoanalysis, beginning with attempts by 19th-century physicists to study and link electric and magnetic properties of matter and light. Generally speaking, he suggested that field theories have come about through studying interactions. A brief summary of this history, based predominantly upon Cambray’s research, follows.

Cambray (2009) pointed out that Hans Christian Oersted began observing and reporting that electric current could deflect a magnetic compass in 1820. Building on Oersted’s observations, Michael Faraday continued experimentation with these electrical and magnetic phenomena and, in 1845, proposed the first field theory, identifying lines of force, its circular nature, and presence of effect in a vacuum. He witnessed that lines of electromagnetic force could create a field capable of carrying light and account for gravitation, thereby disproving Newton’s ideas that space was empty and absolute. Cambray proposed the arrival of this concept as “a re-emergence of an archetypal idea leading to a vision of a wholly interconnected universe” (p. 40).
A supporter and believer in Faraday’s theories, James Clark Maxwell expanded upon them and ultimately developed mathematical equations expressing the electromagnetic field, which unified electric and magnetic phenomena (Cambray, 2009). His research also proved light to be a form of electromagnetic radiation, possessing a spectral range beyond what is visible. Cambray noted that Maxwell’s work acted as a springboard to further developments of field theory in physics.

Albert Einstein, whom Cambray (2011) considered to be the greatest field theorist of the 20th century, transformed Maxwell’s field equations into relativistic field theory. The theories and associated mathematical equations he developed regarding relativity explained and unified the mechanics of inertia and motion, gravity and acceleration, force, energy, electromagnetics, space, time, and their relative relationships to each other and to objects as well as to the perceiver (Cambray, 2009; Einstein, 1916/1920).

Einstein was a significant and inspirational contemporary of Jung, noted Cambray (2009). In a 1953 letter, Jung wrote, “It was Einstein who first started me off thinking about a possible relativity of time as well as space, and their psychic conditionality” (as cited in Cambray, 2009, p. 16). In this letter, he also traced both his thesis of synchronicity and relationship with Wolfgang Pauli back to his introduction to Einstein’s theories.

Another field theorist of impact was William James. Influenced by his study of physics, Cambray (2009, 2011) credited James with initially bringing classical field theory concepts into the realm of psychology. A philosopher, physician, and psychologist, James integrated his disciplines, and in 1901-1902, lectured about the field of consciousness and the psychological field:
At present psychologists are tending, first, to admit that the actual unit is more probably the total mental state, the entire wave of consciousness or field of objects present to thought at any time; and, second, to see that it is impossible to outline this wave, this field, with any definiteness. . . . The important fact which this “field” formula commemorates is the indetermination of the margin. Inattentively realized as is the matter which the margin contains, it is nevertheless there, and helps both to guide our behavior and to determine the next movement of our attention. It lies around us like a “magnetic field,” inside of which our center of energy turns like a compass-needle, as the present phase of consciousness alters into its successor. Our whole past store of memories floats beyond this margin, ready at a touch to come in; and the entire mass of residual powers, impulses, and knowledges that constitute our empirical self stretches continuously beyond it. So vaguely drawn are the outlines between what is actual and what is only potential at any moment of our conscious life, that it is always hard to say of certain mental elements whether we are conscious of them or not (1961, pp. 190-191).

Jung integrated James’s ideas, including the above passage and James’s term transmarginal field, where he elucidated that the unconscious is just on the margins of consciousness. James had particular influence on Jung’s subsequent development of psychological field theories, particularly Jung’s formulation of his theory of psychoid processes (1947/1981, pp. 176-184; 1954/1969).

*Psychoid* is the term Jung (1947/1981) used to describe the dual aspect nature of archetype, existing both in psyche and matter and having both objective and subjective as well as quasipsychic and physical presences in the world at large. Cambray (2009, 2011) pointed out that Jung, borrowing from classical physics (notably Maxwell, in this example), used the analogy of the electromagnetic spectrum to illustrate the archetypal field of psychoid processes. Jung explained that the central part of the spectrum of visible light corresponds to the conscious aspects of the archetype, whereas the invisible infrared and ultraviolet ends of the spectrum metaphorically correspond to the unconscious biological/somatic aspects and spiritual aspects of the archetype, respectively (Jung & Pauli, 2001).
Jung’s theories of the psychoid function and the related field of synchronicity fully developed out of his working partnership with Nobel physicist Wolfgang Pauli, with whom he explored the interconnectedness of psyche and matter. It was Pauli who initially brought forward the idea that the psychoid archetype linked physical events to the observing mind (Cambray, 2009; Zabriskie, 1995). In addition to his collaborations with Jung, Pauli made other contributions to field theory. Working along with physicist Werner Heisenberg, in 1929 they presented a physics field theory describing particles of matter and force as manifestations of deeper levels of reality or quantum fields where “all particles are bundles of energy in various fields” (Zabriskie, 2001, p. xxxi). A philosopher by nature, he integrated rather than separated soul and science. Pauli was also an advocate for the quantum uncertainty theory, which highlights the effect of the observer of the reality and perception of the field or subject being observed, noting that when something becomes visible or in focus, something else is simultaneously sacrificed and made invisible at that time (Zabriskie, 1995, 2001).

In a series of lectures presented in Zurich in 1969, Jungian analyst Marie-Louise von Franz (1980) shared that she began letting go of the notion of cause and effect and instead began thinking in fields. A close working associate to Jung, she also incorporated properties from physics and applied them psychologically to field theory. She reported that engineer Lancelot Whyte defined the field as “a network of relations in every situation” (p. 61) and explained that an electro-dynamic field of elementary particles arranges itself, not randomly, but in certain ordered positions. She noted famous physicist John Archibald Wheeler’s explanation that matter is made up of the “excited” high-energy particles within an electrodynamic field. Based on these principles, von Franz
proposed that “the collective unconscious is a field of psychic energy, the excited points of which are the archetypes” (p. 61); therefore, just as relationships are arranged in physical field, so they are in the collective unconscious.

**Analytic field theory.** Many other analysts in addition to Jung began writing their observations of field phenomena and developing ideas about it from a psychological perspective. From an object relations perspective, Winnicott (1971) described “potential space” (p. 100) and “intermediate area of experience” (p. 14) as various relational fields occurring between mother and baby, individuals and their environments, subject and object perceived, the transitional space between one’s subjective and objective perception, and, when applied to analysis, the shared reality between analyst and patient, inclusive of each other’s inner realities. He focused predominantly on relational aspect of the field, as did psychoanalyst Robert Stolorow, who was known for his work on intersubjectivity. Stolorow, Bernard Brandchaft, and George Atwood (1987) proposed that the “intersubjective” field experienced by analyst and patient is “created by the interplay between them” (p. 8) and that the intention of psychoanalysis is to identify phenomena in that field between the two subjectivities of the observer and observed.

Jungian analyst William Goodheart (1980) reviewed conceptions of the interactive field as put forth by Langs and Searles, extrapolating their commonalities, and then proposed three potential fields or “distinct configurations of interaction” (p. 3) from a synthesized Jungian perspective: (a) _persona-restoring_, (b) _complex-discharging_, and (c) _secured symbolizing_. He asserted that “one of these will dominate the field at any particular time and determine most of what occurs” (p. 3), because each affects the
interactions between patient and analyst and requires correspondingly different analytic attitudes and interventions.

Goodheart (1980) equated the *persona-restoring* field to Langs’ *Type C* field and Searles’s *Out of Contact* field, which are erected out of defense against attending to what is meaningful, vulnerable, and authentic in therapy, and could be described as shame-avoidant. Within this field of interaction, explained Goodheart, any communication’s purpose is to avoid real contact and is dominated by the presence of the patient’s or analyst’s persona, or both. Goodheart’s *Complex-Discharging Field*, equivalent to Lang’s *Type B* field and Searles’ *Pathological Symbiosis*, he conceptualized as a field of mutually shared and activated unconscious complexes between patient and analyst, which Jung had described as “a relationship founded upon mutual unconsciousness” (1946/1982, p. 176) and hallmarked by a predominance of mutual anxiety, ambivalence, problematic symbiosis, and projective identification. Goodheart (1980) cautioned that archetypal images arising from either *persona-restoring* or *complex-discharging* fields are not likely to activate a genuine transcendent function experience and instead may be used as a defense measure or interaction description.

According to Goodheart (1980), the *secured-symbolizing* field, equivalent to Langs’s *Type A* field and Searles’s *Therapeutic Symbiosis*, is the most effective field, wherein collaboration facilitates the symbolic transformation processes, active imagination, mutual exploration of fantasy and reality, empathy, and closeness. For a *secured symbolizing* field to exist or continue, stated Goodheart, the analyst must consciously tend to it and take steps to maintain the temenos. He noted that *complex-discharging* and *secured-symbolizing* fields require the analyst to hold opposing
positions. The *complex-discharging* necessitates the analyst maintaining a strong separateness and avoiding collusion with the patient; whereas the *secured-symbolizing* field allows or requires a symbiosis with the patient’s unconscious, as in participation mystique. Goodheart suggested that when analysts discuss interventions and patient material, they consider the relevant field from which the material emerged but also recognized that his propositions could best be used as helpful, rough guidelines rather than reified principles.

In a collection of essays ranging from 1965-1996, Spiegelman (1996) addressed psychotherapy as a mutual process and referred to the therapeutic situation as an analytic field in itself. Though he acknowledged that fields exist and can be activated by one person, he preferred the term *interactive field* be reserved for the interaction between two or more people and observed that this field can be activated by the personal unconscious and collective unconscious autonomously as well as by conscious invitation of the unconscious. He held the belief that ideally, therapy should be a mutual, symmetrical process between two partners, moving from a brief initial asymmetry to symmetry and mutuality, and that the more mutual the process, the greater the interactive field. He disagreed with theorists’ rising preference for asymmetrical analytical relationships. His perspective was that when entering into the unconscious in service of the Self, both parties are equal. This perspective bears some complementarity to the fields Goodheart (1980) proposed, moving from a *persona-restoring* field, indicative of an initial asymmetrical relationship, towards *secured-symbolizing*, the field characteristic of the most mutual process and certainly the most symmetry, though Goodheart would likely prefer to maintain a healthy asymmetrical relationship. Spiegelman (1996), however, did
come to recognize that his ideal of symmetry could only be achieved when both parties are connected with their own inner authority and solid sense of Self, and for the majority of patients, this is not yet the case.

Italian psychoanalysts Antonino Ferro and Roberto Basile (2009) opened the realm of understanding the analytic field to include more possibilities beyond the present moment between two subjectivities. They contextualized existing relational perspectives with the image of

a stream flowing through the field; this river then widens out into a vast lake in which there is time for characters to emerge, to sink into the depths, to return to the background or to take the stage again. (p. 2)

Their view is that the analytic field begins with an asymmetrical therapy dyad and is infinitely inclusive of multiple phenomena, as seen in their image of “The Big Bang” at the beginning of a session and “The Big Crunch” at the end (p. 3). Their imagistic description of the field is illustrative of their field theory.

French philosopher and scholar Henry Corbin (1964/1972, 1981/1983) borrowed from Latin the words *mundus imaginalis* to describe an imaginal, intermediate dimension of reality between sensory impressions, intellect, and spirituality. Corbin’s theory differs from others in that it supposes that this dimension of the field is preexisting and can be accessed by a relationship dyad rather than solely created by a dyad. The *mundus imaginalis* acts as a “central mediating function” of communication through symbolization between all levels of reality (p. 9). Jung (1955-1956/1963) had previously used the term “Unus Mundus” (p. 534) referring to a like concept of a unified realm of integrated inner and outer realities. Perhaps Ferro and Basile’s (2009) image of the stream in the midst of a field widening into a deep lake carries with it the likeness of the
*mundus imaginalis*, or perhaps from the unus mundus, this image emerges. They appear to be complementary.

Samuels (1985a) integrated Corbin’s concept of the *mundus imaginalis* into the field of psychotherapy and countertransference, drawing the parallel that the analyst, by mediating between image and understanding, symbolizes something for the patient. Samuels described the *mundus imaginalis* as the field “in-between patient and analyst, and also in-between the analyst’s conscious and unconscious” (p. 58). Because the *mundus imaginalis* is shared, the countertransference feelings and images, which Samuels referred to as “visions” (p. 59), therefore belong to both. He said the *mundus imaginalis*, which includes internal imagery of each, is the connection linking the two and is “an attempt to express the psychological basis of that mutuality” (1989, p. 123) in analysis.

Samuels’s (1985a) description of the *mundus imaginalis* as an intersection of the interpersonal relationship and the intrapsychic imaginal field, took into account Jung’s (1946/1982) alchemical conception of the mutual transference and individuation processes. Though Samuels (1985a) delineated differences between the interpersonal and intrapsychic as focusing on either the relational or imaginal, respectively, in the spirit of Jung, he simultaneously warned against the paradigm of compartmentalization and promoted integration:

> It is necessary to see our field of reference in analysis as seamless and continuous so that ostensible ‘images’ and ostensible ‘interpersonal communications’ do not get separated, nor one gain ascendancy over the other. . . . The coin is three-sided: to body and image can be added relationship. (p. 68)

Here, again, was another reference to the third, as found in Jung’s theory of the transcendent function.
Jung (1916/1981, 1946/1982) postulated the concept of a transcendent third as that which emerges from the union of opposites, and he translated this idea to the concept of the therapeutic encounter as the analytic third, whereby both analyst and patient are changed through the alchemical process. The third, he explicated, arises in situations of increased interactional complexity, transitional states, and psychic reorganization. Spiegelman (1996) described this phenomenon in practice as “mercurial energy gripping the two participants” (p. 173). Other pertinent aspects comprising Jung’s (1916/1981, 1946/1982) interactive field model are the emergence of archetypes as thirds within therapeutic dyad as well as the context of the dyad within the larger society and culture.

Zurich-trained Jungian analyst Schwartz-Salant (1984, 1995) made valuable contributions to applied field theory in psychoanalysis, proposing his view of the interactive field as an analytic third and the main object of analysis. He explained that two people mutually constellate the unconscious in therapy process, participating in a shared realm outside space, time, or causality. He noted that the interactive field is within the field of the collective unconscious, and the intersubjective realm includes them both. The individuals’ subjectivities also interact simultaneously with the field of the collective unconscious. The interactive field of analysis therefore includes the examining the subjectivities between two people in relationship, the field created between them, plus the intersection of these fields with the field of the collective unconscious. Schwartz-Salant described the field as taking on its own dynamics and compared its rhythm, between union and disorder, to Jung’s description of the alchemical processes. Schwartz-Salant’s explanations resonate with Samuels’s (1985a) work integrating the mundus imaginalis.
Other contributors writing on the concept of the third in the analytic process include Spiegelman (1996), who suggested that the third appears as unconscious content in such forms as shadows, projected content, archetypes, somatic sensations, dreams, and shadow reactions as well as “transpersonal poisons and gifts” (p. 83). Influenced by Winnicott’s (1971) ideas of the third area in the field, psychoanalytic theorist Thomas Ogden (1994, 2004, 2009) became recognized in the field for his conception of a co-constructed analytic third which arises from the interplay between the analyst and patient and, at the same time, influentially shapes their subjective experiences. He advocated the use of reverie as a tool for gathering insight into field dynamics. His analytic-third theory bears similarities to Jung’s (1946/1982) theory of the transcendent third as well as Schwartz-Salant’s (1984, 1995) concept of the interactive field as an analytic third, except that, as Cambray (2011) pointed out, Ogden’s theory did not account for the two participants’ entrenchment within culture and society outside of therapy nor did it address archetypal patterns.

Cambray (2011) expounded on Jung’s conceptions of the analytic third and Ogden’s use of reverie, noting that essential features of a dream often will come into the therapeutic field before the dream has been told. Therapeutic reverie, similar to Jung’s active imagination, can be useful in getting in touch with the emerging third in the interactive field. These occurrences, which Cambray described, are in line with Jung’s conception of synchronicity.

Jung (1952/1981) conceptualized synchronicity as “meaningful coincidences of two or more events” (p. 520) that “connected so meaningfully that their ‘chance’ concurrence would represent a degree of improbability that would have to be expressed
by an astronomical figure” (p. 437). In addition to referring to related events, Jung offered another explanation of synchronicity as “the simultaneous occurrence of a certain psychic state with one or more external events which appear as meaningful parallels to the momentary subjective state—and, in certain cases, vice versa” (p. 441). Jung had postulated that the experiences between the body and soul may also be related by the principle of synchronicity. In essence, he explained that all meaningfully related occurrences between observers, events, psychic states, body, and soul are connected via the psychoid archetype, as they are all originating from the same source, the unus mundus.

Pauli had been collaborating with Jung on his theory of synchronicity, supporting it as scientific, though they held some differing views (Cambray, 2009; Zabriskie, 1995). Pauli, reportedly intrigued with mirror and symmetrical phenomena and the mirror-like relationship between physics and psychology, viewed synchronicity as an attempt to restore symmetry and associated it with restoring the divide between the self and ego. Jung, on the other hand, believed that the archetype was a condition of synchronistic phenomena, and that nature is driven towards the third, asymmetrical thing as a move towards individuation and wholeness rather than viewing symmetry as wholeness. Implied in his last known letter to Pauli, Jung asserted that the deepest levels in psychological development arrived through the breaking of the symmetry (Cambray, 2009; Zabriskie, 1995). Notably, Jung’s own psychological development transpired after the breaking of symmetry with Freud and then later Pauli.

Cambray (2009, 2011) reexamined Jung’s synchronicity theory through the lens of emergence and complexity theory, suggesting that Jung had viewed synchronistic
events as outside of energetic phenomena, because complexity theory had not yet been formulated or articulated. Many of the connected phenomena that Jung was attempting to understand through his theory of synchronicity could now be described and understood better as “emergent phenomena in systems undergoing self-organization,” suggested Cambray (2011, pp. 300-301). Though synchronicity is consistent with paradigm of emergence, Cambray stated they are not exactly the same thing, as some meaningfully connected phenomena do not necessarily have emergent properties and may still be better explained as acausal synchronicities. Emergent phenomena, noted Cambray, are evident from the microcosm to the macrocosm operation of complex systems, as well as seen in the transition between the levels. He explained that complex adaptive systems (CAS) with emergent properties display holistic features and possess self-organizing properties. Emergence of high order phenomena, he said, tends to happen at the edge of order and chaos, at the periphery of consciousness. The emergence of mind arises from the body/brain matrix.

The Boston Change Process Study Group, led by psychiatrist and psychoanalytic theorist Daniel Stern, examined the experience of the therapeutic dyad, acknowledging the asymmetrically mutual process of transformation that occurs within the field (Stern et al. 1998). A key point they proposed was the concept of moments of meeting. During the therapy process, now moments occur when there are shifts in intersubjective field due to unexpected dynamics on the edge of breaking or succeeding in breaking the traditional therapeutic frame boundaries, which then lead to the potentially transformative moments of meeting, or kairos; the now moments are illustrative of the concept of emergence from complexity (Cambray, 2011; Stern et al., 1998, pp. 911-912). Philosopher and cultural
critic with particular interest in technology, Mark C. Taylor (2001) similarly offered the term moments of complexity to distinguish these transformative moments marked by an accelerated rate of change towards “the tipping point” (p. 5) of emergence from complex network culture. The formation of or increase in complexity is accompanied by a breaking of symmetry leading to transformational moments of emergence. Cambray (2011) suggested that complexity theory brought a return to holism back to science. Moments of complexity are significant in broadening the understanding and meaning-making of emergent phenomena, therapeutic boundaries, and transformative moments of decision that occur in the field of analysis.

Regarding complexity theory and emergence, Cambray (2011) stated that empathic resonance leads to attunement (empathy), which then leads to emergence. Viewing empathy in therapy in the context of interactive fields, Cambray suggested that “significant self-organizing properties are operative in which mirror neurons [discussed below] may serve as field resonators” (p. 301), which may have previously been considered synchronistic, but can now be explained as emergent phenomena.

**The body in the interactive field and applied neuroscience.** Samuels (1985a) continued his discussion of the mundus imaginalis, applying it to the subtle body, the place where the concrete and the imagistic are intermingled. The analyst’s body, he explained, serves as the communication link between the corporeal world and soul. Just as countertransference as it occurs within the mundus imaginalis is described as shared, Samuels described the analyst’s body as “not entirely his own and what it says to him is not a message for him alone.” Based on Corbin’s (1964/1972) metaphoric proposal that the “imaginative consciousness” is “the organ which perceives” the mundus imaginalis
(p. 2), Samuels employed the term “bodily visions” (1985a, p. 60) to describe embodied countertransference.

Schwartz-Salant (1984, 1995) believed that the interactive field could be known and experienced through the psychic and somatic unconscious, describing the field as both a “mutually and imaginally experienced coniunctio” (1984, p. 10). This brings to the forefront Jung’s (1946/1982; Jung & Pauli, 2001) conception that the invisible infrared and ultraviolet ends of the light spectrum metaphorically correspond to the somatic unconscious and spiritual aspects of the archetype, respectively. Schwartz-Salant (1984) suggested Jung’s conception of the Self as the structure between two. This construct also can be compared to Samuels’s (1985a) conception of the mundus imaginalis as the shared imaginal realm. Schwartz-Salant (1984) elucidated this concept as

experiences that happen in a realm that is felt to be outside normal time sense and in a space felt to have substance. This space long known as the subtle body exists because of imagination yet it also has autonomy. (pp. 10-11)

Schwartz-Salant and Samuels were among the few at their time to address the presence and importance of both the imaginal and somatic aspects of the countertransferential field.

Advances in the field of neuropsychology offer supportive explanations of the psychic and somatic interactive field dynamics, which analysts have been describing. Leading neuropsychological researcher Alan Schore (2001) explained:

Non-verbal transference-countertransference interactions that take place at preconscious-unconscious levels represent right hemisphere to right hemisphere communications of fast-acting, automatic, regulated and dysregulated emotional states between patient and therapist. . . . In a growth-facilitating therapeutic context, meaning is not singularly discovered, but dyadically created. (pp. 315-319)
Relatedly, Cambray (2009), integrating recent research in neuroscience on mirror neurons (e.g., Chartrand & Bargh, 1999; Decety, 2007; Iacoboni, 2008; Rizzolatti, Craighero, & Fadiga, 2002), explained that phenomena of mind encompass neural processes and somatic experiences and, at the same time, emerge from their joint field. Phenomena of mind are embedded in the body as a whole, not just in the brain. Embodied cognition expresses the interdependent involvement of these processes. Without necessarily being in conscious awareness, emotions are transmitted between people within milliseconds, as has been measured and studied by neuroscientists. People mimic and synchronize with the emotions and emotional cues of others, and the degree to which they do this corresponds to their capacity for empathy. Empathy, in fact, may be the mechanism through which the shared somatic experience occurs.

Alvin Goldman (2006), philosopher and researcher of cognitive science, explored and presented contemporary neuroscientific support for the intuitive idea of empathy, in which people come to understand others by imagining themselves in their position. Goldman’s findings (2006, 2009) showed that when one observes others in pain through mirroring or even imagines others in pain, one’s own pain system becomes activated, which is the basis of simulation theory. Mirroring, as described by Goldman (2009), is a social interaction in which two people share a similar mental or emotional state. Both mirroring and imaginal enactments engage the mirror neurons and exemplify simulation processes used in low-level and high-level mindreading, respectively. Mirror neurons were defined by Goldman as

a class of neurons that discharge both when an individual (monkey, human, etc.) undergoes a certain mental or cognitive event endogenously and when it observes a sign that another individual undergoes or is about to undergo the same type of mental or cognitive event. (2009, “Definitional Issues,” para. 2)
Types of signs that potentially activate an observer’s mirror neuron system, according to Goldman, could include behaviors, facial expressions, and other associative stimulus.

Cambray (2009) agreed that this synchronizing of emotions, from a scientific standpoint, occurs with the function of mirror neurons. Mirror neurons, which he described as “field resonators” (p. 85), help detect the shifts in the intersubjective field, or the analytic third, through empathy, and connect the conscious and unconscious experience. The somatic experience, observed Cambray, is an example of the transcendent function of the field, with the somatic third emerging from the co-construction of mutual experiences, conscious and unconscious, as well as from the archetypal underpinning of the field.

Goldman and his colleague Frederique de Vignemont (2009) reviewed existing literature regarding embodied social cognition, and presented several theses of interest, though they also cautioned that much of the research is difficult to defend. Among the noted theses of relevance: the idea that different parts of one’s anatomy directly affect the type of information perceived and interpreted; one’s body activity, such as posture or facial musculature, also affects perceptual experience; and the most significant, cognitive activities or ideas, including mirroring, can be represented in various processes within the body, playing an important role in embodied social cognition.

Based on neuroscientist Marco Iacoboni’s (2008) pioneering research on mirror neurons, Cambray (2009) discussed the idea that deficits in the mirror neuron systems seem to correlate with the limitations of empathy characteristic of autism. Likewise, other dysfunctions in the mirror neuron systems, such as incomplete integration or activation of neurons in the brain network due to attachment injuries, correlate with the
hypersensitivity common to borderline-type patients who are “perpetually scanning others for microshifts in affective expression” (p. 79).

A 2011 neuropsychological study by Russell Meares, Allan Schore, and Dmitry Melkonian found certain abnormalities in the right brain hemispheres in borderline patients. These abnormalities were found to be consistent with an emotional maturational deficit, including a decreased capacity to inhibit emotional responses in a social context and emotional processing. The study suggested that this deficit may be a consequence of misattunement and lack of “matched” (p. 136) responses in early attachment relationships. The right hemisphere, they explained, is more dominantly utilized in infancy and early childhood and therefore more vulnerable at that time; therefore, treatment recommended for borderline patients is psychotherapy with “matching” or “analogical” responsiveness (p. 136). The implications of this research are significant, for they suggest that the neuropsychological structures can be repaired through conscious, authentic use of empathy and attunement.

These neuropsychological studies’ findings are relevant to this proposed study, which is intended to provide a context of awareness for the potential emotional and neurological experiences within the therapist in response to those of the patient and to suggest how to utilize this knowledge consciously to heal. In addition, previous research in this review has indicated that borderline or borderland characteristics (on the spectrum but not full-blown borderline) are common to those who feel particularly called to this vocation. This point highlights the importance of self-awareness of what the therapist brings to the field and suggests the healing nature of this vocation for the Wounded Therapist: in attuning to others, the therapist is being attuned to and healed as well.
The developments in psychological theory validated through physical and biological sciences play a vital role in helping psychotherapists literally “make sense” of their experiences and facilitate a deeper understanding of the dynamics, seen and unseen, operating within the interactive field. Cambray (2009) drew this conclusion, which links together key subjects discussed in this review:

I believe the emergence of the third in the field was facilitated by the unconscious affective attunement or mirroring that when processed with conscious empathy supported the intensifying constellation and subsequent use of the “wounded healer” pattern in the field—this third is a property of the field not simply in/of the analyst. (p. 85)

With the reviewed theories of the countertransference, the interactive field, empathy, neuroscience and the wounded healer paradigm in mind, the exploration of literature continues with an integration of these theories with thoughts on somatic psychology.

**Somatic Psychology**

The field of somatic psychology was revived and reintegrated into modern culture by certain 19th- and 20th-century philosophers. Friedrich Wilhelm Nietzsche (1885/1976; Saban, 2011) sought to rescue the body and soul from its previous exile by order of the Cartesian split, and restore the lived body to wholeness in human thinking. He purported that knowledge actually comes from the corporeal reality of the body. Edmund Husserl (1950/1969), credited as the founder of the phenomenological movement, similarly believed that intellectualization separates understanding from lived experience and proposed a return to the “things themselves” (p. 86). Maurice Merleau-Ponty (1945/1962; Saban, 2011) concurred with Nietzsche, underscoring the role of the lived body in perception and claiming that one’s experience can only be understood through the lived marriage of mind and body.
Although literature in the field of somatic psychology has focused predominantly on the mind-body relationship in general and with respect to patients’ symptomatic experiences, these philosophical tenets and studies can also be applied to the therapist’s somatic experiences, as a therapist is essentially a patient in life as well. Examining all sides of the whole is relevant for gaining a deeper understanding of the therapist’s somatic experience in psychotherapy, as both the archetypal patient and healer are simultaneously present, affected, and affecting in the same field as well as within each person.

**The psyche-soma relationship.** Jung, Reich, and Winnicott were named among the first to integrate the body significantly into psychological theory and practice, thus acknowledging the body’s relation to psychic function (Conger, 2005; Meier, 1986; Sassenfeld, 2008). With the subsequent accelerating rise of new-age philosophies, general consciousness, and the growing search for and acceptance of alternative medicine practices, literature acknowledging and exploring the mind-body connection has simultaneously flourished.

In the 1920s, psychoanalyist Wilhelm Reich (1942/1973) began developing his integrated psyche-soma theories, finding that the psychic and the somatic operate as two systems that work together and condition each other, with the body as an outward expression of the psychological. The body was Reich’s primary concern in analysis, and he addressed therapeutic resistance on a body level. Reich believed that neurosis was not only due to psychic conflict but also caused by blockages of libidinal energy and would require significant energetic release for the restoration of one’s emotional health.
Reich (1942/1973) described the somatic expressions of the psyche’s secondary layer, which Conger (2005) paralleled to the *shadow* in Jungian terms, as chronic contractions and rigidity in one’s musculature that act as defensive armoring against perceived assaults from within and without, drastically shutting down the energy flow in the body. He offered examples of a variety of facial and body musculature expressions as well as physical symptoms and diseases, proposing corresponding psychological meanings and origins. Reich thus created a practice of energetic somatic intervention based on his theory that psychological healing could be attained through physically working on the musculature armoring of the body to facilitate the release of repressed emotional/libidinal material.

Jung, though not associated with Reich, had also begun similar theorizing and later articulated, “Psyche and matter are two different aspects of one and the same thing” (1947/1981, p. 215). Based on his experiences with patients, Jung theorized that people who live with one-sided convictions are predominantly intuitive, or are out-of-balance in metaphysical thoughts tend to suffer from digestive issues. He suggested observing the body’s reaction to any new metaphysical ideas, noting that if either the body or soul feels amiss, one may trust that something is indeed out of balance. Jung (1988) perceived, “The body is merely the visibility of the soul, the psyche; and the soul is the psychological experience of the body. So it is really one and the same thing” (p. 355). He designated the somatic unconscious, also known as the subtle body, as the place where unconscious manifests in matter (p. 441). He explained, “Symbols of the self arise in the depths of the body and they express its materiality. . . . The symbol is thus a living body” (1940/1969, p. 173). Jung identified the solar plexus as “the brain of the
sympathetic system, a sort of ‘counter brain’” (1984, pp. 333-334) and described it as “an exceedingly emotional centre, and it rules to a great extent the emotional part of our psychology” (p. 335). He noted that the word sympathetic is derived “from the Greek word meaning to suffer, feel compassion, together with” (p. 335), which connects one to the collective rather than solely the personal, as if something else has taken possession of one.

The varied sampling of Jung’s body-inclusive statements reflects the depth and breadth present in his mind-body integrated philosophy, yet very few of Jung’s immediate followers took up these ideas. Stevens (1995) remarked how Jungian analysts had basically ignored the body in practice and literature. Bioenergetic analyst John Conger (2005) reported his initial impression was that Jung only minimally acknowledged the body in his theories, but in studying his work over time, he discovered Jung’s comprehensive inclusion of the body.

Following Jung, psychoanalyst and pediatrician Winnicott (1971) advocated awareness of the body’s important role in psychology. He merged his acquired understandings from his two professional fields in his last written work, where he stated, “The basis of psyche is soma, and in evolution the soma came first” (p. 19). He added, “Human nature . . . is a matter of inter-related psyche and soma” (p. 26). With his recognition of the interrelatedness of physiology and psychology, Winnicott blurred the boundaries of these two fields and applied his theories experimentally in treatment by engaging in controversial direct physical therapeutic interventions (Conger, 2005; Winnicott, 1971).
As the field of somatic psychology progressed, others proposed alternative imaginal and spiritual perspectives in addressing psyche and soma in psychotherapy, beyond direct body intervention or traditional talk psychotherapy. Hillman (1975, 1983) believed that the experience of symptoms or illness occurs on the soul level rather than the physical level, and therefore, treatment of the physical illness requires imagination. Conger (2005) encouraged participation in a “middle path” of body-oriented psychotherapy, involving attention, awareness, and participation in somatic dialogue (p. xxvi). Depth psychotherapist Ginette Paris (2007, 2011) found that calling forth images and metaphors about one’s painful situation creates an opening of imagination, which pushes one beyond the victimhood experience at the level of the limbic system. Corbett (2011) affirmed the spiritual importance of the body as a medium of connection to the sacred and as a value of creation.

Conger (2005) alleged that people have generally become disconnected from their bodies, often since early childhood, and have abandoned attention and care of their bodies to their shadow. He explained that the body is so overloaded with unconscious meanings, drenched with lost emotional memories, that we are ashamed, numb, or ill-at-ease in the physical company of others. We split off in an intellectual defense or find some other way to deny our physicality and ignore the lush body voice of friends and clients. (p. xvi)

A wounded mental health counselor suffering from chronic fatigue and immune dysfunction syndrome, Kat Duff (1993) chronicled her process of inquiry into her illness, the transformation and insights she gained from it, and the meaning she made of it in her life. Based on her experience, she viewed illness as “an attempt to embody the whole truth, to remember ourselves” (p. 9). In a deconstruction of the concept of illness, she explained that the many parts of oneself, realized and unrealized, swirl about in a
turbulent confusion, and, often, an old, established construct of character gives way, while previously hidden, neglected parts of oneself emerge in sudden reversals of mood, thought, or behavior. She warned that these neglected parts, typically one’s unmet authentic soul desires, can become toxic to one’s health if not allowed expression. She claimed her body is her “sure voice” (p. 8), who knows that something is “seriously amiss” (p. 8). Duff said, “I am often reminded that my body knows more than I do, that it has already picked up a disturbance and reacted appropriately before I realize anything is going on” (p. 26).

Beyond the growing popular consensus that mind and body are connected as “two different aspects of one and the same thing” (Jung, 1947/1981, p. 215), the contributions made by psychoanalysts who are also scholars and researchers have illuminated bodily experienced sensations as forms of communication and meaning-making that can potentially elicit healing and transformation.

**Perspectives on patient somatization.** Among those who apply a depth psychological perspective on the body as it relates to patients’ somatic experiences is Jungian specialist in trauma Donald Kalsched. Kalsched (1996) proposed a view of patient somatization as an archetypal defense against unbearable affect and memory. He found somatization to be a protective polarization unconsciously engaged by trauma patients to separate the mind from traumatic bodily experiences and feelings. He differentiated a neurotic patient’s processing of disowned shadow material from that of a trauma patient, finding that the neurotic patient has a place within his or her psyche to store and eventually recognize and integrate shadow material, whereas the trauma patient does not. The repressed, disowned material within the trauma patient is either banished to
the body or stored as fragments in the mind, with amnesia barriers. He explained that within the transferential field, the trauma patient may experience the emergence of vulnerable needs, and intolerable feelings may threaten the links between body and mind “in an effort to cut the affective connections” (p. 17). Perhaps when the patient loses the connection to his or her body, the therapist then complementarily picks up the somatic sensation.

Also applying an archetypal perspective, Jungian child psychotherapist Mara Sidoli (2000) hypothesized that patterns of somatic disturbance are developed in childhood through unregulated affects and archetypes. She further observed that patients were more likely to somaticize when significant insights or changes were imminent.

Examining the relationship between somatic phenomena and insight in psychotherapy, Jungian analyst Melanie Star Costello (2006) approached somatic symptoms from a progressive rather than regressive frame of development. She imagined somatic symptoms as a progressive bridge towards resolution of psychic conflict and as an opportunity for insight rather than a regressive indicator of pathology and defense, as proposed by Kalsched (1996).

Costello (2006) envisaged images rising up from the body in which they reside rather than being pushed down into the body. Her premise was that somatic symptoms express something already known that has not reached complete awareness in the conscious mind but exists instead in a “perceptual borderland” (p. 5), which may involve a distortion of perception rather than a repression of memory. Jungian analyst Jerome Bernstein (2005) wrote about this phenomenon in his book, *Living in the Borderland*. Bernstein also distinguished between personalities that may be vulnerable to borderland
and intuitive types. Because of these borderland perceptions, analysis of the transference and countertransference is crucial with psychosomatic patients, advised Costello (2006).

A variety of conceptions regarding patient somatization have been presented in this review. In terms of the focus of this study, an understanding of patients’ somatic experiences is relevant in further understanding the therapist’s somatic experiences, because the patient archetype is alive within the Wounded Healer archetype and therefore any conception regarding patients can be applied towards the experience of the therapist. Additionally, these understandings of the patient serve to comprehend further what may be happening in the therapist due to mirror resonance.

**Somatic experiences of the Wounded Therapist.** The somatic experiences of the therapist may be related to several valid and relevant possibilities. There may be preexisting circumstances not initially directly related to the psychotherapeutic work causing physical sensations. Perhaps the therapist is hungry, tired, suffering an illness or allergies, injured, or sore from exercise exertion, all of which can affect the interactive field. In addition, as previously discussed, any physical symptom or illness, no matter what the biological cause, could be considered a divine invitation for healing. More significantly, therapists report experiencing physical phenomena that they acknowledge as coinciding meaningfully with their psychotherapeutic work. These experiences are referred variously to as *somatic countertransference, embodied countertransference,* or *embodied cognition.* Exploring somatic countertransference, Merchant (2012) posed one of the essential questions at the very heart of this dissertation inquiry: “Do analysts have these kinds of counter-transferential responses because of their own wounds or are they just taking upon themselves the wounds of the patient?” (p. 10). The perspectives on the
origins, experiences, uses, and meanings of somatic countertransference range by varying degrees of presence or consciousness related to one’s own wounding.

In quantitative studies of Irish female trauma therapists and Irish clinical psychologists, psychologists at NUI Galway and University College Dublin attempted to measure body-centered countertransference through the application of their recently developed “Egan and Carr Body Centered Countertransference Scale,” comparing and contrasting the results between groups (Booth, Trimble, & Egan, 2010; Egan & Carr, 2008). High levels of body-centered countertransference in both groups were reported in both studies, the most frequently reported symptoms being, in order of frequency, sleepiness, muscle tension, yawning, body shifts, tearfulness, headaches, stomach disturbance, and raised voice. Other symptoms reported less frequently overall, but notably, more often among the female trauma therapists, included dizziness, loss of voice, joint achingness, nausea, numbness, sexual arousal, and genital pain. With over 80% of the participants in each study reporting an experience of somatic symptoms, the research validates the necessity to acknowledge, better understand, and utilize somatic countertransference.

When Jung (1937/1982) discussed patients who expressed somatic symptoms, he also stated that patients transfer their symptoms onto the analyst, or sending the “demon of sickness” (1929/1982, p. 72), thereby implying that the analyst’s body is also affected and exemplifying the idea of embodied countertransference. Spiegelman (1996) shared this idea and recounted that he would often experience “symptoms” in session, which he described as “bodily reactions of various kinds such as—headaches, stomach aches, heartaches, shortness of breath, sphincter tension, fatigue, etc.” (p. 114) not necessarily
directly connected to the manifest content. When he shared his somatic responses with
the patient, he would “almost always discover that the patient is having or had in the
recent past, the same symptom or one related to it.” He observed that in such instances,
“most of the time, an underlying symbolic parallel is associated to the psychological
content being discussed” (p. 114). He explained that in sharing with the patient his
awareness and the meaning he made with regard to the symptoms in the field, the
symptom Spiegelman experienced would generally clear up, and he would feel a sense of
relief.

Psychotherapist John Beebe (2004) noted that the tightening of the analyst’s
stomach or other areas of the body could be perceived as a signal that the patient is
possibly feeling uptight. Beebe reported that when he attended to these sensations in
himself, viewing them as feelings that were being introjected, and succeeded in getting
the patient to express the feelings his body picked up, therapy moved forward, and he
was not left with the symptom afterward (p. 97). Both Beebe and Spiegelman (1996)
shared similar somatic countertransference perspectives, suggesting that meaningful
symptoms will often originate with the patient, transfer to and resonate with the analyst,
and then can be relieved through attending to them. However, Spiegelman (1996) brought
this process about through revealing his own symptoms to the patient, in contrast to
Beebe (2004) who found it more important to elicit the patient’s expression of his or her
feelings.

Samuels (1985a, 1985b) is a notable Jungian contributor on embodied
countertransference, in both theory and practice. He suggested that embodied
countertransference is one of the two usable countertransferences: the analyst might feel
like a particular inner figure of the patient; or the patient’s unconscious issue may become a physicalized, unconscious, projective identification embodied in the analyst as “image” (1985a, p. 52). Samuels employed the term “bodily visions” (1985a, p. 60) to describe his understanding of embodied countertransference. He provided a personal example of the positive use of his bodily visions for increased insight when he reported that an increasing awareness of his bodily erotic feelings brought to consciousness his previously denied feelings, which had made him susceptible to his patient’s unconscious needs. Based on his personal experiences as well as a research project on this topic, Samuels came to the conclusion that embodied countertransference could be used to augment the previously unconscious issue, bringing new insights back to consciousness. Samuels’s conclusion augmented Jung’s (1946/1982) conception of the mixtum compositum by including embodiment in the equation regarding analyst and patient.

Samuels’s (1985a, 1985b) conceptions and conclusions of the role of embodied countertransference also bring to mind the image of Hekate (Popovic, 2008) taking the uneaten scraps, digesting them, and turning them into nourishment in the form of insightful dreams. Samuels (1985a) intended his use of the word embodied “to suggest a physical, actual, material, sensual expression in the analyst of something in the patient’s inner world” (p. 52). The analyst’s integration and solidification of this element in the patient’s psyche produces an incarnation by the analyst in line with Jung’s (1959/1969) idea that the psyche tends to personify. Countertransference states are often nonverbal or preverbal, and the therapist’s body may become a medium for these communications. As Samuels (1989) stated, “the analyst’s body is not entirely his own and what it says to him is not a message for him alone” (p. 119).
Psychotherapists Adrienne Harris and Kathy Sinsheimer (2008) also emphasized the therapist’s body as an important instrument in therapy due to its capability for receiving insights about the patient’s experience through sensations experienced. They highlighted the vulnerability of the therapist and the physical impact psychotherapeutic work can have, making the case for the therapist’s necessary attentiveness and care of his or her body in psychotherapy.

Anthropologist and Jungian analyst Barbara Helen Miller (2011) also agreed that healing practitioners could use their own body experiences and somatic registrations effectively to aid in the process of healing. Miller embarked on a rare opportunity to receive healing and regularly visit and train with the shamanic Coastal Sami healers in Norway. In Sami practice, Miller explained that the healer began with feeling a patient’s left arm and pulse in order to enter “‘in’ the body of the patient” and then would feel in his or her “own body the location of the patient’s affliction” (p. 147), viewing the symptom as a “ghost” of “an untold story,” (p. 151). Comparing her experience of traditional Sami to psychoanalysis, she discovered that both groups use embodied countertransference to diagnose and investigate that which is incomplete and unconnected, as well as to dialogue with the symptom, seeing it as an implicitly shared communication. Integrating her experiences with the Sami tradition, she asserted the physical body acts and communicates symbolically, and that through this process, a connection is made to God or a “larger narrative” (p. 158).

Working with trauma survivors in Israel, Maoz and Arbit (2011) offered the image of the psychotherapist as a bridge, helping the trauma patient to reconnect and reunify fragmented parts of the self. They proposed that healing reintegration occurs
when the patient’s trauma, imprisoned and contained within his or her symptomatic body, is metabolized through the therapist’s psyche and body. Again, the image of Goddess Hekate is called forth.

To describe embodied countertransference, Stone (2006) offered up the image of the resonance of an analyst’s tuning fork vibrating with the patient’s psychic unconscious material. In his article, “Analyst’s Body as Tuning Fork,” he addressed the commonly asked question of why the analyst’s body seems to resonate or somatically experience along with some patients and not others or only at certain times. He found that when sensations and symptoms are experienced in the body, emotions may not be clear, and the analyst must be able to tolerate and contain the confusion of the unknown.

Three concurrent conditions that Stone (2006) identified as most likely to result in embodied resonance are “the pathology of the patient; the patient’s inhibition to express strong emotions directly and consciously; and the typology of the analyst” (p. 15). He expanded upon previous research regarding increased vulnerability, childhood trauma, and the borderland/borderline-type qualities in the patient (e.g., Bernstein, 2005; Costello, 2006; Ducey, 1976; Winnicott, 1971) and concluded that for the therapist, “somatic reactions are more frequent with patients exhibiting borderline, psychotic or severe narcissistic elements; where there are basic instinctual problems (sex, aggression, eating disorders); or where there has been early severe childhood trauma” (p. 15). In addition to these conditions related to the patient, Stone mentioned that occurrences of embodied countertransference also indicate the analyst’s own personal experiences “and thus the neurotic countertransference” (p. 15), an observation that acknowledged the possibility of the therapist’s own material resonating with the patient’s material.
Stone (2006) was not the only one to suggest that the analyst’s typology may be a factor in experiencing somatic countertransference. Previously, Sedgwick (1994) had indicated a strong relationship between superior feeling and intuitive function types and heightened effects and utilization of general countertransference. Spiegelman (1996) denoted himself as a superior intuitive type with an inferior sensation function, and focused a great deal of his analytical work and writing on somatic experiences in the body. Cambray (2001), in discussing his experience attending to somatic cues in enactments, reported that his own typology includes introverted sensation as his third function (p. 293). John Beebe (2004) had applied Jung’s theory of psychological types, suggesting a connection between the psychological types of the patient, the therapist, and countertransference experiences, and had specifically pointed out that frequent somatic responses of the analyst were related to introverted sensation function within the body. Conger (2005) also implied typology’s relevance to somatic experiences in psychotherapy in sharing that his own inferior sensate function may have contributed to his research interest in somatic psychology. Regarding typology, Stone (2006) made these observations:

The particular typology of superior introverted intuition, with auxiliary feeling or thinking, and inferior extraverted sensation, is much more frequent among Jungian analysts than among the general population . . . and explains why the phenomenon of somatic countertransference may be more common than analytic discourse has so far acknowledged. (p. 15)

Without delving into a discussion on the specifics of Jungian typology, the general consensus among the researchers cited here regarding the relationship between typology and the regular occurrence of somatic countertransference appears to be that the sensation function is involved as either an inferior (third or fourth) or introverted function and not the superior or dominant function, and its corresponding opposite, the intuitive
function, is deemed as a superior function connected to somatic transference. Basing her observations on Jung’s typology theory, von Franz (von Franz & Hillman, 1971) noted that superior intuitive/inferior sensation types are often “sensitive to the atmosphere of a place. Probably intuition is a kind of sense perception via the unconscious or a sort of subliminal sense perception” (p. 45). She observed that unconscious contents appear most strongly through the inferior function, which “makes the bridge to consciousness” (p. 10). The majority of Jungian-oriented analysts could thus be experiencing and processing their most unconscious vulnerable material via their bodies.

Other literature presented earlier in this review indicated that certain groups of people, including true Jungians, may have been called to the healing professions due, in part, to their developmental histories and tend to be more empathically open and therefore more vulnerable to “psychic infections” (Jung, 1946/1982, p. 177) and “others’ shadow and disturbance” (Whan, 1987, p. 202). The significant point with respect to typology and those who are called to the profession of psychotherapy is that the therapist’s vulnerabilities, in both psyche and soma, play an important role in experiencing unconscious contents somatically.

Groesbeck (1975) was one of those who fully acknowledged the therapist’s vulnerability and woundedness in relationship to somatic experiences. He wrote, “In the doctor, his inner wounded side, his own unresolved illnesses, psychic, somatic or both are activated by his contact with the sick person” (p. 128). Psychiatrist and psychoanalyst Regina Pally (2000) recognized both the analyst and patient in the somatic experience equation, suggesting that “how the analyst feels, both ‘in the body’ and ‘in the mind,’ may be as important an indicator of what is going on in the patient as whatever the
analyst is thinking” (p. 99). Analytical psychologist Giles Clark (2006) made the significant proposal that an analyst’s own areas of psychic and somatic vulnerabilities are the places that are most open, sensitive, affected by, and potentially reactive to the patient’s material; however, he underscored that those areas within the analyst are not necessarily the same areas of emotional or physical symptomatology within the patient. “Counter-transferential information is received through my psychosomatically ‘weakest’ and most problematic areas” (p. 81), remarked Clark.

Spiegelman (1996) spoke of suffering persistent tensions from a buildup of toxins taken on from patients, which resulted in aggressive feeling responses that he could not express or act upon naturally in sessions. He exclaimed, “When one speaks of the ‘wounded healer’ I think of it as residing in my tense muscles, rather than in the unhealed complexes. . . . Perhaps the muscles are where the complexes reside!” (p. 83). Perhaps his tense muscles were his weakest areas.

In a recent exploration into how and why somatic effects are evoked in the analyst, Merchant (2012) concluded that although therapist and patient do not necessarily share the same wound or symptomatology, they were both “wounded in the same zone, that is, early infancy—which underpins the porosity required to experience the embodied countertransference” (p. 163). He applied Jung’s (1946/1982) conception of “psychic infection” (p. 177) in a somatic way to describe embodied countertransference. Merchant (2012) advocated that analysts in training give attention to processing their early infancy complexes at the root of their embodied countertransference porosities, establishing a dialogue with them, so that rather than becoming possessed by them, they can be utilized as a trusted information source regarding the patient’s unconscious experience. Lacking
this relationship to their complexes, cautioned Merchant, analysts are at risk of the negative effects of the psychic infection.

This discussion of somatic countertransference has implied its connection to the therapist’s woundedness through explanations of the therapist’s susceptibility, vulnerability, and, as noted by Stone (2006), the therapist’s own material. However, the review of literature found sparse recognition of a relationship between somatic countertransference and the therapist’s woundedness, which may hint at a conscious or unconscious attempt to protect the vulnerability of the therapist.

Conclusions in the literature included connections between frequent somatic countertransference and certain typology elements as well as early experiences of trauma. Although many instances of somatic symptoms experienced by the therapist were found to be similar to those reported by the patient, this was not always the case, and the therapist’s areas of woundedness may certainly be different than the patient’s as well. Nonetheless, the somatic psychology literature presented general agreement that the information the body provides is of value and that somatic countertransference can be used as an opportunity to gain greater communication, insight, and healing in psychotherapy. Finally, as a collage of images presented by the various contributors in the field, the Wounded Therapist’s body in psychotherapy could be imagined as Hekate, a bridge, an instrument, a tuning fork, a porosity, expressing an inner figure, communicating, becoming infected, metabolizing, empathizing, resonating, visioning, personifying, healing, and symbolizing.

**Statement of the Research Question**

The proposed research study is an attempt to enter into the mystery of psychotherapeutic healing through the somatic experiences of the therapist by pursuing
this inquiry: What types of somatic phenomena do psychotherapists experience, and what meaning and potential therapeutic use can be made of their somatic experiences?

Through the lens of the Wounded Healer archetype, assuming that suffering is part of the human condition and therefore every therapist is in some way wounded, further questions arise: What role might the therapist’s woundedness play in his or her experience of somatic phenomena? How might the specific varieties of the therapist’s somatic experiences in psychotherapy be related to his or her personal wound, the client’s wound, and the dynamics of the interactive field?

The term *somatic experience* is employed consciously and preferentially to other similar terms such as *embodied countertransference, somatic countertransference, embodied cognition*, and *somatic symptoms* in order to support the intention of remaining as open minded and least assumptive as possible as to the meaning the interview subjects attribute to their bodily felt experiences.
Chapter 3  
Research Methodology and Procedures

A method is a way into one’s work.

(Romanynshyn, 2007, p. 215)

Research Approach

The purpose of the proposed study is to enter into the mystery of psychotherapeutic healing through somatic experiences of the Wounded Therapist, inquiring deeply into these phenomena as well as any associated physical, emotional, spiritual, and psychological meanings and usable understandings attributed to them. A phenomenological research approach, therefore, is most suitable.

The phenomenological movement was founded by philosopher and mathematician Husserl (1859-1938). Husserl proposed “a return to things in themselves” (1950/1969, p. 86) meaning he wished to develop a method to allow phenomena to be described as they appear, as well as to apprehend understanding and knowledge through intuition or inner evidence. Merleau-Ponty (1908-1961) joined with Husserl in trailblazing Western thinking, reigniting the concept of the lived body and nonduality and thereby initiating the healing of the centuries-old Cartesian mind-body split.

Both Husserl (1950/1969) and Merleau-Ponty (1945/1962) also made the important acknowledgement that complete reduction to the subject, or being truly objective, is not possible because the observer is observing within the observing field, which is an essential consideration for researchers. Within the field, the researcher also encounters reciprocity of perception, an exchange between the body and environment, and the fact that from any one perspective, something is revealed and something else concealed.
Phenomenological research requires that the researcher aim to describe, as accurately as possible, the lived experience, or phenomenon, of the research participants (Kvale & Brinkman, 2009). The operative word in phenomenological research is *describe*, according to Amedeo Giorgi (1985), who has led the use of phenomenological methods for psychological research. Michael Quinn Patton (1990), an independent evaluation consultant, offered, “A phenomenological study . . . is one that focuses on descriptions of what people experience and how it is that they experience what they experience” (p. 71).

In his book, *The Wounded Researcher*, Jungian psychotherapist Robert Romanyszyn (2007) proposed using a research method as a metaphor for one’s engagement with the subject matter, whereby the design of the research reveals what the researcher is imagining about the subject. He stated, “In their symptomatic character, methods are to epistemologies what symptoms are to individuals” (p. 213). As both a wounded healer and wounded researcher, it is my intention to honor the soul of the wounded participants and all others for whom this work might benefit, through a reverent, metaphorical, and methodological process. With this in mind, I therefore have elected to implement interpretive phenomenological analysis (IPA) as the methodology for conducting this research study.

Interpretive phenomenological analysis (IPA) is a phenomenological approach consisting of interviews that aims to explore in detail participants’ lived experiences and the meanings the participants attribute to them (Smith & Osborn, 2008). Jonathan Smith, a professor of psychology specializing in qualitative research methodologies, and his colleague, psychologist Mike Osborn, consider IPA a sound approach to use to inquire
about how people perceive particular situations and experiences they encounter. M. Patton (1990) stated the purpose of interviewing is specifically “to find out what is in and on someone else’s mind” (p. 278). Steinar Kvale, a former director of the Center for Qualitative Research, along with colleague Svend Brinkmann (2009) remarked with regard to data capturing during the qualitative interview that it “is literally an *inter view*, an interchange of views between two persons conversing about a theme of mutual interest” (p. 2).

As an embodied therapist and researcher inquiring into the somatic phenomena of other therapists through phenomenological method of IPA, I, too, become a participant therapist of the study. The phenomenological inquiry and interview process mimics a therapy session. The research process reinforms the method and further honors the subject matter being studied. This method, engaging one experientially, is a way into the work, as Romanysyn (2007) suggested. Both the image of the *ouroboros*, a symbol that represents self-reflexivity or cyclicality (Jung, 1988, p. 1310), and a mirror-reflected-in-a-mirror appear to me as symbolizing the recursive nature of using this methodological approach.

**Research Participant Selection**

The suggested number of participants for IPA case studies, is about five or six (Smith & Osborn, 2008). As this is a depth psychological study rather than a broad quantitative study, the intention is to explore in as intimate detail as possible the depth of the experience and perspectives of the participants, yet it is also necessary to have enough participants to be able to discern themes; therefore, six or seven participants will be chosen to interview.
IPA typically works best with a purposive sampling of participants for whom the research question will be meaningful and significant (Smith & Osborn, 2008). In this study, the sample sought will be comprised of psychotherapists who report an awareness of somatic experiences they feel are at least partially connected to the psychotherapeutic work. Invitations to participate will be sent to reach a variety of therapists of different backgrounds and orientations who are most likely to relate to the research question, which may include therapists who are affiliated with the Jungian Institutes, alumni from depth psychology programs, practicing depth psychotherapists, body or somatically oriented psychotherapists, shamanic therapists, authentic movement therapists, and senior therapists in practice over 20 years.

**Procedures for Gathering Data**

Research data will be collected via semi-structured interviews, which allow both the participants and me to engage in free-flowing dialogue, wherein certain open-ended questions are asked. Depending on the participants’ responses, as the researcher, I may follow other directions of questioning to explore those responses in more depth. This style of research interview most closely resembles the therapeutic process.

In order to glean the phenomenological information sought from the interviews most effectively, the participants will be prepared with general questions prior to the interviews. They will be asked to begin recalling and reflecting upon their past and present somatic experiences they perceive as connected to therapeutic work with patients, paying closer attention to any somatic experiences occurring before, during, and after sessions until the time of the interview and noting any perceived relevance attributable to their sessions as well as any potential connection to their patients’ and their own wounds. I may also ask them to reflect upon the types of wounds they themselves experienced and
the types of wounds they most often encounter in patients. The participants will be encouraged but not required to jot down notes, make journal entries, or create art in connection to these experiences in preparation for the interview.

In audiorecorded interviews of approximately 60 minutes each, the participants will be asked to share their lived bodily experience as therapists, discussing examples of physical sensations or symptoms they experience before, during, and after sessions and any meaning they attribute to them. They will be invited to discuss perceived correlations and synchronicities between their somatic experiences, the patients’ woundedness, and their own woundedness. Without asking for detail, I will ask them about the general types of wounding they personally experienced and the types of wounds they most often encounter in patients.

Because the interview process is similar to a psychotherapy session, and the nature of the research subject matter will likely bring up unconscious and preconscious material, potential exists for enactments and, therefore, somatic experiences to occur in both the research participants as well as in me, the researcher, during the interviews. With awareness of this potential, I will invite participants to discuss any somatic experiences occurring within the interviews as well as make note of any somatic experiences I have. Other aspects of interest to explore within the interview hour, time permitting, will be participants’ typologies, with specific note made regarding their sensation or intuitive functions, as suggested in Stone’s (2006) study, for a possible correlation with their somatic experience descriptions and meaning associated with them.

The interviews will be conducted at each participant’s choice of location, preferably his or her psychotherapy office, if the participant is comfortable with this
arrangement. The possibility of conducting interviews via Skype will be offered if the participant’s location is a great distance outside of the researcher’s geographical area. The primary rationale to maximize the participants’ comfort and ease in the interview process and maintain confidentiality. Secondarily, conducting an IPA interview in the participant’s own therapy office mimics the therapy process and may support relevant somatic experience recall.

**Procedures for Analyzing Data**

The interviews will be audiorecorded and transcribed verbatim, including pauses, repeated words, and other vocalizations and expressions in order to capture the essence of the participants’ responses as fully as possible. While engaging in an embodied, empathic, and intuitive style of inquiry and observation, I will take note of what emerges during the interview, potentially including but not limited to noticeable physical gestures and body language of the participant, perceived shifts in the energy of the interactive field, personal somatic experiences, and any symbolic or imaginal images that may come up. These notes will be included along with the interview transcriptions for IPA data analysis and coding methods (Saldana, 2009; Smith & Osborn, 2008). If the participants voluntarily offer additional notes or journal entries relevant to the research, those will be included as supporting material for analysis. Analysis consists of repeated readings of the transcript, notes, and supporting material, annotating what is interesting, reoccurring, or poignant, until themes, associations, and relationships emerge. This process culminates in a distillation of meaning.

**Ethical Considerations**

The utmost reverence to both the letter and the spirit of ethical codes is imperative throughout the process and final published product of this research. A preliminary
assessment of issues to be considered includes informed consent, confidentiality, consequences, and the role of the researcher (Kvale & Brinkman, 2009).

All of the selected potential participants will receive a brief summary of the topic, preparation questions, and process of this study before committing to participate in the study and will receive, review, and sign an informed consent form before the interview. The participants will be informed both verbally and in writing on the consent form that their participation is voluntary and there will be no remuneration. Additionally, they will be assured that their confidentiality will be protected to the degree they wish and that they may choose their own alias.

Confidentiality is an especially important issue to consider because this study involves personal, intimate aspects of the both participant therapists’ lives as well as their patients’. Special care and attention will be taken toward allowing the participants the freedom to omit or disguise any potentially identifying information about them or their patients, while maintaining the truth and integrity of the research study.

The research questions have the potential to bring up sensitive and emotionally charged issues. Awareness and sensitivity on the researcher’s part is necessary, as contemplation and exploration of the subject could potentially cause a participant psychological or emotional stress as well as somatic symptoms. A consideration that will be held throughout the duration of this research is how the nature and topic of this study might affect, for better or worse, the interview participant, the patient, me as a researcher/participant, the depth psychological field, and beyond. The participants will be assured that in the event of distress or any other reason, they may elect not to answer the question and are free to terminate the interview at any point. In case of participants’ report or my
observation of any distress, I will be prepared to ask them if they currently have psychotherapeutic support in place to process it, and if not, will be prepared to provide additional referral resources as needed.

Finally, my role as an ethical researcher is to be mindful and aware of interviewing with respect; transcribing, analyzing, and interpreting as accurately as possible; and remaining as true and loyal as possible to the interview participants’ statements, intentions, and essence. As a wounded researcher re-searching with soul in mind, I am also ethically bound to be aware of and accept responsibility for the shadow I inevitably cast upon the work (Romanyszyn, 2007).
Chapter 4
Findings

Overview

Seven licensed psychotherapists of varying theoretical orientations were interviewed for this study. The participant group was composed of four women and three men, ranging in age from 29 to 85, with five based in the United States and two from European countries. Participants were selected who reported having somatic experiences in connection with their work as a psychotherapist. An attempt was made to gather a sample comprised of a range of ages and therapeutic experience and with a balance of both men and women and persons in and outside of the United States. Because four of the participants’ locations were out of my geographical area, those interviews were conducted via Skype. Two of the interviews were conducted at the participants’ offices, and one was conducted at my own office location. All participants chose their own aliases and are referred to in this study from here forward as Peter, Eve, Lisa, Howard, Adrienne, Samantha, and Eddie.

Participants were invited to participate through an announcement (see Appendix) posted to several psychotherapy-related Facebook pages and online groups and forums, e-mail solicitations to groups of psychotherapists including somatically oriented psychotherapists and depth psychotherapists, and by word-of-mouth. When candidates expressed their interest in participating in this study, I e-mailed them three documents for their review: an Informed Consent form (see Appendix), Participant Instructions (see Appendix), and a Participant Information form (see Appendix). Interested candidates emailed the signed consent forms and completed information forms back to me, and if an individual met the basic criteria relating to the topic, an interview was scheduled.
Notably, women responded immediately and enthusiastically to the opportunity to participate, and they played a key role in passing my invitation on to other potential participants they knew. In contrast, it was challenging to find enthusiastic and willing male participants, especially from the United States. A few men responded through e-mail with some interest but then became unavailable or unresponsive, and a few actually scheduled an interview but canceled at the last minute. Each of the three men who did participate in this study was enthusiastic, willing, and helpful from the moment they were invited; two of them were from European countries.

Though I had prepared a list of questions for the interview, once the interview process began, it felt more natural and true to allow the conversation primarily to free flow and to expand upon and deepen into the material presented rather than adhere to the original list of questions. I began to feel that the material offered freely the responses I truly sought. Often, once participants began sharing their experiences, many of the subsequent questions I had prepared either did not fit conversationally, felt slightly leading, or had already been answered in some way. The first two interviews I began by asking the participants, “In general, what are some of the types of somatic experiences you have?” By the third interview, however, I began with the question, “How often are you aware of having somatic experiences?” or “How often do you experience somatically?” and then followed up with asking about types of experiences. I found that when asking about the frequency before moving into the phenomena of the experiences, the flow felt more organized and natural.

Based on my experiences and the rich information they were gleaning, I simplified my general list of questions on hand and used it more as a reference to myself
to ensure the core topics were addressed; however, many of the questions asked were spontaneous, based upon the information offered. The new list of interview questions addressed in varying ways and orders included (but were not limited to) these:

- Are there certain types of somatic experiences that you have regularly or more often than others?
- When do you seem to experience them?
- At what point in your profession did you begin noticing your somatic experiences?
- Could you share a particular example of a somatic experience that stands out? Where did you feel that ____ in your body? How did it feel in your body/what was the sensation like in your body?
- What brought you into the work of psychotherapy?
- How do you relate to the concept of the Wounded Healer archetype?
- In what ways, if any does this archetype make sense to you in your work as a therapist?
- How might your own life challenges—past or present—relate to your work as a therapist?
- Do you think there is any correlation between your own wounds and your somatic experiences?
- Do you know your Jungian or Meyers-Briggs typology?
- Were you aware of having any somatic experiences during this interview?

The typologies of the participants varied, and not all could identify all of their typology elements. The participants reported known aspects of their typologies as
follows: Peter, ISFJ, though he felt that his intuitive and sensation functions have now become more balanced; Adrienne, ENFP, reporting fairly balanced perceiving and judging functions; Samantha, ENFJ; Lisa, INFJ; Howard, ESF; Eddie, EST; and Eve, INFJ, who also felt that her intuitive and sensing functions had become more balanced. In summary, four of the seven participants are extroverted, including two males and two females, four of seven participants have more dominant intuitive functions than sensing. All of the intuitive types in the study are women and the three sensing types are men, though one of each reported that they felt their intuiting and sensing functions had come closer to balance now, and six of seven participants have dominant feeling functions.

Six of the seven participants were also trained in adjunct complementary healing modalities. Two female participants were trained in Somatic Experiencing, two males practiced hands-on or energy healing techniques, both European males were trained and theoretically oriented in body psychotherapy modalities, and one female practiced new-age spiritual work with integrated kinesiology techniques including muscle testing. Additionally, three participants identified their theoretical orientations as including Jungian or depth psychology approaches, two identified psychodynamic, two identified spiritual, and one included cognitive-behavioral.

The majority of participants reported that they regularly and frequently had somatic experiences; only one practitioner reported infrequent occurrences. The majority also reported that paying attention to their bodies’ feelings and sensations throughout each session had been regularly interwoven into their practice of psychotherapy, and some indicated that the very practice of psychotherapy was a continual somatic experience for them. Most participants recounted that they had originally begun noticing
somatic symptoms in their psychotherapeutic work after some form of education or training that called their attention to it.

**Major Themes**

Many themes and patterns of significance emerged through the data analysis process. Thematic material is addressed in three main sections: “Centrality of the Wounded Healer Archetype,” “Somatic Experience Phenomena,” and “Discernment and Use of Somatic Experiences.” The first section explores the contextual central theme of the Wounded Healer archetype throughout this study, examining the role each participant’s wounding experiences have played in their vocation and somatic experiences as a psychotherapist; the second section explores the wide variety of somatic phenomena the participants reported, the ways in which they were experienced, the meanings they made of them, and the most commonly reported situations associated with the occurrence of somatic phenomena; the third section addresses participants’ discernment processes and therapeutic use of the somatic experience, considering to whom or what the somatic experiences may be related. Although the nature of the material presented is interrelated, complex, and not in any way linear, an attempt was made to address these themes here in a categorical fashion while taking care to indicate the meaningful connections between them.

**Centrality of Wounded Healer archetype.** All of the therapists who participated in this study unanimously agreed that their own wounding experiences played a significant role in their therapeutic work and that they could relate to the Wounded Healer archetype. They all explained ways in which their wounds in some way affected their pursuit of the vocation of psychotherapist as well as how their wounds empathically opened and connected them to their clients, both emotionally and somatically. The
majority perceived some degree of correlation and meaning between their personal wounding experiences and somatic experiences.

Role of therapists’ wounds in vocation. As an overview of the therapists’ significant wounding experiences, four participants (Eve, Lisa, Samantha, and Peter) implicated attachment issues, including emotional abuse, neglect, or the emotional availability of a parent. Three participants identified some form of bullying or physical abuse as an initial wounding experience, including two who reported bullying from peers (Samantha and Eddie) and two indicated bullying/physical abuse from family members (Peter from his father and Eddie from his brother). Though Howard made mention in his narrative that his father spanked hard, he did not identify it as abuse or a wounding experience. Divorce was another wounding experience presented, with two participants (Howard and Adrienne) directly acknowledging their own divorces as a significant wounding experiences. Eddie discussed his parents’ divorce in the context of its resulting circumstances eventually leading to his vocational call but did not expressly identify their divorce as a wounding experience. Cancer was identified as a significant wound for two participants as well. Adrienne endured breast cancer personally, and Howard was deeply affected by losing a loved one to cancer. Broken dreams of the future were significant wounds of both Howard and Eddie.

Peter. Peter described his early woundings as a combination of attachment issues and emotional and physical abuse. He related that he formed an ambivalent attachment with his mother, feeling “insecure about her constancy,” and described himself as a “preoccupied baby.” Growing up, he suffered emotional abuse from his mother, who he says used him against his father, “abusing this early preoccupation of mine.” He also
reported enduring physical abuse when his father would lose his temper and regularly
beat him and his siblings when he was between the ages of seven and 11. He noted that
he became identified with the aggressor for some time. Overall, he experienced a lack of
connection and availability from his parents.

Reflecting upon the calling to become a healer, Peter stated, “There was an early
choice to try to prevent violence and abuse in others, and in me, and a deep compassion
for those who have suffered.” Additionally, he was influenced by a grandmother who
taught him traditional massage and a system of hands-on healing when he was a teenager.
From there, he moved on to study acupressure, reiki, and other kinds of energy and body
healing. While he was doing bodywork with clients, however, he observed that many
were regressing to their early childhoods, and he was not sure how to handle those
situations effectively. This led him to study attachment, which he said took him “to a
different level of working, where the preverbal is and where the trauma is.” He stated that
he decided to become a psychologist when he entered his own psychotherapy process and
realized this was his path. He therefore embarked on a journey to study psychology,
attachment psychotherapy, and body psychotherapy. He said, “I entered my own body
and my own processes. I touched my own traumas—my early childhood attachment
trauma, preverbal traumas.” He underscored that engaging in his personal work and
learning to understand his process has prepared him to be present and helpful for others.

It’s a very painful journey. . . . It’s not easy. I feel that for . . . a good 25 years of
my life, I’ve been in ranging painful situations. Yes, it’s been very painful. I
think, I mean, the gift and spiritual growth and the spiritual path of service is very
great, and of course, you need to give up any expectations of—(laughs) any
infantile hopes of an easy life or a loving life before embark[ing] on the journey.
Of course, when you allow the journey to unfold then you can find those
childhood dreams being fulfilled in a different moment, but you certainly discover
that if you have this archetype, you are here to serve others. And that’s the
journey of selflessness. And how to embrace that in a world that embraces exactly the opposite. How to value and honor this journey of the wounded healer in honor and service of what it really means and the priceless gifts it brings to others in this dark, shadowy area of which—(laughs). It’s a dark shadowy area; it is not superficial.

Peter strongly related to the Wounded Healer archetype, recognizing its presence in both his vocational call to become a healer and psychologist as well as in his ongoing work in psychotherapeutic practice.

_Eve_. Eve categorized her early wounds as attachment and developmental in nature, elaborating that at times she is aware of current patterns in her life with family, former partners, friends, or authority figures that stem from these early childhood wounds. She noted that often, just as she “unsticks” herself from a pattern or issue, a client seems to show up in therapy with a similar pattern to which she can relate. When asked how she personally relates to the Wounded Healer archetype, she responded,

Well, it—I think it’s true. I mean, I think there’s a lot of wounded healers out there, and we are all always growing and healing and kind of learning ourselves. And so, I actually would go as far as feeling like it’s an ethical issue to do our own work so that we can hold the space for our clients. Also, that we can’t allow the clients to go to the depth that they’re able to . . . if we don’t do it ourselves.

Eve added that without a working awareness of one’s wounds, “we’re just blind in a way,” and stated her belief that becoming familiar with her own wounds, history, and healing process was an important part of therapeutic work with others. When asked further about how she felt the Wounded Healer archetype may be present and related to her work with clients, she responded,

I feel like—I mean, almost 100% of the time. If I’ve had an opening of my own or I’ve done my own piece of work on something myself, then in the next week or two it would show up in my clients, 100% of the time. Somebody is going to come in with that same thing.
Eve reported a challenging occasion when a client’s issues felt “a little too fresh,” meaning they were similar to difficult issues Eve herself had recently confronted and worked through in her personal life, in which case she had to make a conscious effort to stay present and grounded. At the same time, she emphasized, “It feels very rewarding.” She explained, “Now I’ve cleared the way, and they can then step in to this part of themselves also. Because it’s healing through me, and then they get permission because I’m not blocked in that place or something.”

Eve became curious about pursuing somatic-oriented work after going through a period of anxiety post graduate school when she felt physically unwell and exhibited much symptomatology, but she would go to the doctor and find “nothing is wrong.” This experience led her to pursue mindfulness and becoming aware of the body. This new direction coincided with colleagues introducing her to somatic experiencing, piquing her curiosity, and impressing upon her a sense that including the body was important in therapeutic work.

Lisa. “Massive mis-attunement” by her mother and Liza’s associated sense of “being invisible” were the primary wounding experiences she identified in her life. She recounted that this wounding began from day one and became worse over time, because her mother became “even more shut down and depressed,” and that “it was still pretty extreme growing up.” She said that although she has always been an introvert, all of the members of her family were extroverts, which caused her to feel like she “stood out like a sore thumb.” She reported, “People looked at me like I was weird, and [they] didn’t really have the curiosity to understand me, so I often just felt invisible.” She stated she felt “unseen on so many levels.”
When asked about how she related to the concept of the Wounded Healer archetype, Lisa replied,

Oh, it’s so true for myself as well as a lot, if not all, of my friends who are therapists... My wounds were the driving force, although I didn’t really realize it at the time, but were the driving force that caused me to be so fascinated with this work and that caused me to really want to get the answers—to really want to figure out, okay how do you heal somebody? How do I heal myself? Like it was just a big mystery to me.

She expounded that the drive to learn to heal herself and others led her to explore “every treatment model out there.” She added, “[I was] basically trying to find the answer for both me and for the people that I work with.” Finally, she discovered and integrated two models: Intensive Short-Term Dynamic Psychotherapy (ISTDP) and Somatic Experiencing. “This is the ticket,” she said, “this is what works; the healing is in the body. And that notion has just been reinforced for me again and again and again in different ways.” She explained that she feels most comfortable, confident, and “a believer” in using these modalities only because she personally experienced their power and effectiveness in her own healing process. Because of Lisa’s wounding and healing experiences, she now asks her clients, “How do you experience that physically?” because she feels strongly that the body is a necessary area of focus in her personal and professional work.

Lisa also described occasions of her unresolved grief or unresolved anger coming up in sessions and said, “I’m very aware of it when it’s happening.” Reflecting on these occurrences, she said,

I think it’s definitely really helpful that it’s there, and it can also at moments be unhelpful... It’s helpful because I’m really attuned, I feel like I’m really attuned to the depth of what she’s [the client] experiencing, at least emotionally or maybe even physically, too, in the moment, and she’s not fully attuned to herself yet, so I can kind of use that to kind of guide her. So there’s moments that it’s really helpful, but then there’s moments where, for me, it’s intense, and the intensity of
that grief, for example—that’s my own unresolved grief—and then, like I was saying before, it can then prompt me to work harder than she is because . . . the desire to rescue . . . comes up.

Howard. Howard reported, “I have a heavy wounding. A heavy one—I was expelled from medical school when I was 24 because I was trying to change the system.” Howard continued describing the situation, which included a conflict with the dean. He emphasized, “That trauma is—when I finally got into therapy—that trauma was the trauma of my life,” and further detailed the difficulty in telling his father about it and the suicidal feelings he experienced in this life-altering event. “That was a major wound,” said Howard. “I wanted to be a healer-doctor. I ended up being a healer.” He added that wanted to be a doctor because he thought that he would be good at it, as he described himself as very empathetic.

Howard chronicled his life path following the loss of his dream of becoming a doctor. Eventually, he became a pharmacist and got married, which pleased his parents. While he working as a pharmacist, he took a healing class and learned that he had healing capabilities. He began to try his skills out with people he knew at work and found he had remarkable successes with hands-on healing. Recalling that he would touch painful areas of people’s body and hear from them that their pain had ceased, he explained,

That propelled me to go into healing. I studied it professionally for 2 years, which propelled me to being a therapist, because you can do all you want to fix the body, but if you don’t fix the life, there’s no change.

Howard also talked about his struggle with depression, which occurred most severely for the first time with close succession of losses when his home and boat were destroyed in a fire, his neighbor passed away, and he lost his job. “That was a lot of trauma,” he stated and yet attributed the deeper roots of the depression to the trauma of getting expelled from medical school and losing his dream of becoming a doctor. When
asked if he felt that going through a depression helped him to understand his clients better, Howard responded, “By far. By far. Unless you’ve been depressed, the way I was, you don’t know what depression has been about. . . . I was disabled.”

Five years after the onset of his severe depression, after considerable psychotherapy experience and close to 30 years of doing healing work, Howard began his studies to become a licensed psychotherapist. He alluded to several synchronicities and chance encounters encouraging him to pursue this path. During this period, however, he also separated from his wife. “The other trauma of my life was my divorce,” Howard stated. Expressing his deep regrets and “the pain of having damaged someone,” he admitted he had not completely forgiven himself. He acknowledged that the wound of his divorce definitely affects the work he does and said that he cautions and thoroughly questions his clients who are considering divorce. At the same time, he values the direction his life eventually took because of the divorce. “All these situations change you” he stated. He shared a metaphor—”pick up the pearls”—explaining, “The idea of the pearls is things happen in our life: . . . a force that lines things up, . . . the coincidences that shape our lives,” and for him, those pearls led him to become a healer and psychotherapist as well as make other personal life changes.

Adrienne. Responding to the question as to whether she related to the concept of the wounded healer archetype and if so, how might it make sense to her in her work, Adrienne emphasized that when “you’ve had the experience of the pain in the heart and the sweet relief that can come when you heal from that, then you want to help other people.” When asked if she if felt that her own wounds affect her abilities to heal other
people, she replied, “Definitely yes.” Identifying her initiating wound as “the cancer,” she explained,

That was what opened me up to learning how to love myself. Up until that point, . . . I could give but I couldn’t receive love. I just had to get over that and start loving myself and forgiving myself and healing. There was just such deep healing that came through that process. It brought me to my knees.

She had already been studying and training in Jungian-oriented psychology at this point, but she described her work becoming more spiritual after her cancer experience.

Several contributing factors initially led Adrienne to pursue Jungian analytical studies. She identified her first divorce as a significant wounding experience, which led her to the vocation of psychotherapist, and noted being drawn toward this path by her powerful dreams as a child and the familial influences of both her grandfather, who was a healer, and her mother, who worked a counselor and had undergone Jungian analysis. She reflected,

My grandfather was a healer, and the way that worked for him was that when somebody else had a physical problem, if he would get near them, and if he would touch them, the pain would leave them and go into him. I’m not sure this is a gift, you know, but it’s just how it was. I didn’t know I was that way too until I separated from my first husband and my back pain disappeared, and he had it. I didn’t know that I took in the pains and also the emotional states of other people. But its something I’ve figured out. . . . [My grandfather] didn’t really have recourse to figure out how to ground and release and work with it, but probably one reason I went into the counseling field is so I could deal with the onslaught of stuff I get from everybody.

She clarified that the pain of her first divorce was what drove her into her own analysis. As she was beginning to understand herself and her gifts, she realized that her current profession did not use her strengths and intuitive nature but instead required sensation, which she acknowledged as the weakest pole for an intuitive person. Her analyst suggested that she find a profession using her intuition, so she studied and underwent a great deal of analysis at the Jung Institute in Zurich. When she returned, she began
practicing psychotherapy and understood her own system better, including how to manage better the physical feelings she takes on from people.

*Samantha.* Samantha reported several wounding situations in her childhood, which included being “constantly bullied in school” as well as familial issues such as the emotional absence of her father, her mother’s depression, and her family’s high expectations of her. When asked how she related to the concept of the Wounded Healer archetype, she responded, “Extremely, um, (laughs) intimately,” explaining that her early experiences such as being bullied as a child in an affluent environment contributed to her desire to go into this work. She said, “I knew it from a young age,” which she identified as 13. She continued, explaining the role of the bullying in her vocation call:

If you didn’t have what they had, they made you feel less than. So I knew what it was like, and I was in my counselor’s office, like, every single day. . . . So I decided I can either keep on feeling this way, or I can decide to actually help other people who might have felt as down as me, you know, going to school and whatever. So . . . from that wounding is how I chose to do my life’s work.

She added that when she was a child, all her friends confided in her, because she listened and gave them perspective. Having been a patient in various types of counseling since she was 13, she felt comfortable and acquainted with both sides of the couch.

The messages that Samantha internalized from being bullied at school as well as the expectations and family relationship dynamics she experienced at home included, “I’m not good enough, I have to be perfect at all times, I can’t make mistakes.” The expectations of her felt “high, high, high, high,” and she attributed some portion of this to her mother’s Eastern European familial heritage. Her parents took her to a therapist early on, she said, because she was the “identified black sheep patient in the family” and an only child, and her parents thought that she was “an angry teenager” and “depressed,” in part because she would raid the refrigerator after hours of cheerleading practice. She
laughed, saying that after the psychiatrist interviewed both her and her mother, her mother was the one who left the appointment with a prescription for her own medication. Growing up with a depressed mother and an emotionally absent father, however, was no laughing matter:

He [Samantha’s father] was physically in the picture, but emotionally he was checked out. . . . We had a good relationship up until I was probably 10, and then he just stopped kinda having interest, and I was always having to chase him, like, “Dad, let’s hang out,” and he would, but it would just take a lot of coaxing. And then, by the time I was a teenager, he’s like, “I’ve had it with you, forget you, you’re nothing, your ugly, you’re never gonna get a boyfriend,” blah, blah, blah, . . . a lot of hurt from the male, and then criticism from mom. and then being the only child. . . . How do I take some of the pressure off here?

Samantha recounted that she has recognized and worked with many parallel situations with clients with similar issues:

Absent father, nonexistent father, emotionally distant father, being criticized either by partner, by mother, by father, by family, the high expectations, the black sheep, a lot of that. So, yeah, I can relate to all those, (laughing) ‘cause they were me.

Samantha believed that her own woundings and her experiences as a therapist “definitely correlate” and stated, “I think that I couldn’t be doing the type of work that I do, and I couldn’t be calling myself a depth psychotherapist, if I hadn’t gone through purging my own wounds and processing a lot of it.” She explained that her own healing process of moving through pain can serve as a model to her patients who suffer from deep pain and do not know what to do with it.

*Eddie.* Eddie described his significant early wounding experiences as a combination of bullying and an unfortunate injury, which destroyed his future aspirations and took away what he enjoyed most in his life. First, his described his foray through being bullied:
It was throughout my life. So, I had an older brother that was a bit abusive, and then, in my neighborhood, all my friends were older, so they kind of picked on the young guy, and then in school, it was just that on a bigger scale. So, I had to learn to toughen up. And I, curiously enough, I toughened up while playing football. So then I would run faster than they would, I would dribble better than they would, I would do sneaky stuff on the pitch and win over them. So that was kind of a streetwise way at getting back at the bullies, so to say. And I guess that that is— that has been with me since. And I’ve been able to outsmart the bullies, in a way.

Sports were not only something Eddie enjoyed but they also provided him a way to rise above the experience of being bullied and find his own strength and empowerment. He detailed how football and athletics became the area of his life he enjoyed most, because he felt strong and confident as a “top athlete.” He said that did not care about academics, only about sports.

It was when he was playing football, however, that Eddie experienced an unfortunate event that would, in retrospect, serve as his initiation into the psychotherapeutic profession:

When I was 14, my world was shattered because I had this knee injury . . . and because of that surgery, I had to say goodbye to that which gave me most pleasure, which was sports. Any dreams of ever becoming really, you know, successful, and then having to rethink my whole life. . . . Where else can I be a top athlete? . . . Because . . . [of] the body, . . . [it wouldn’t be] in this lifetime, so it needs to be in other sectors of reality or, you know, maybe I need to turn into an intellectual, which up to that [time], I had total disdain for. It didn’t make any sense to study, for me. The pleasure was in the body. Running and jumping and footballing and cycling and all that stuff. So, and I think from that moment on, a lot of wounds took place. And all about my vitality, my manhood, about my regret for overly investing into the sports arena. . . . And that all coincided with the outburst of puberty, so I guess it was a troubled period for me, in terms of defining my identity and finding new stages where I could come out as a top athlete. . . . I had a lot of pride and prestige for being so fast and strong and athletic and agile, and all of a sudden, I had to put all that drive and energy into something else, and I guess, I never found a true match for that, so . . . I think part of my wound comes from there.
This injury affected Eddie in terms of his core identity and how he saw himself in the world, the ways in which he had learned to empower and enjoy himself, and the future he envisioned.

Addressing the question about what led him to pursue the vocational path of a therapist, Eddie stated that several of his family members are therapists, including his mother, who also practiced body psychotherapy. He reported,

My mom was divorced when I was 7, so she’d come home and discuss her work and her cases with me. And I was a young kid trying to keep up with her, and I kind of got pretty well versed into that world.

Then he chronicled his initial career path of studying engineering, working as an engineer, and working in the corporate world, including a few years of “yuppie life.” He recalled, however, feeling that his work was “pointless” and that it “had no deep meaning” to him. He therefore decided to pursue a second career and go back to school to study Jungian-oriented psychology.

When asked how he related to the concept of the Wounded Healer archetype, Eddie replied,

Terribly, terribly. I that is a universal—almost a universal motivation for one to become a therapist. I think—if we are to show anyone with any sort of authority that our weaknesses can become our strength, we need to have walked that walk. . . . It’s a form of authority that emanates from your personal path. It’s not a lot of technical know-how and knowledge—you know, it’s good to know techniques and stuff, but when you are dealing with a wounded soul, you need to approach it also as a soul, so you can’t really hide behind the therapeutic or the technical or the technique that you are using as a mask. You still need to deal with the real pain and the real being that is in front of you, so . . . anyone who is doing therapy without that sensibility will be doing an incomplete job.

This response beautifully and comprehensively summarizes the heart of the research question, powerfully relating how one’s wounds can be transformed into one’s strength and ability to heal others.
Eddie addressed the ways in which his own wounds had affected his therapeutic work with clients both negatively and positively. He explained that earlier in his practice, when he had young clients about to begin college, who were seeking clarifying guidance as to whether to follow sports or economics or the like, he had difficulty remaining neutral and impartial. He reported feeling “too biased,” and “too blurred to help them” and admitted, “My wounded teenager kick[ed] in,” wanting to push them towards sports, when he recognized “the twinkle in their eyes” and “how much they live and breathe and dream about sports.” He said he wanted to encourage them to “follow their true self” and, at the same time, recognized the needs of transitioning into adult life and the “need to look at the parts of themselves that don’t want to grow up.” Now, when he has teenage clients who need vocational orientation and it has to do with sports, he tells them that he is not the best person for that kind of advice.

Eddie’s wounding experiences have more often beneficially affected his therapeutic work, especially with regard to bullying. Regarding his clients presenting cases of bullying at work, bullying in the family, or bullying at school, he stated, “I can really help people gear up, to man up to those aggressors” by drawing on his past experiences of bullying and his reflections on his process of working through it. He stated,

I invite the clients to get at the core of their emotions of humiliation and of fear and get them to convert those feelings as fuel to fight back, to be successful, to have an effective counterback measure against them so that they can defend their own territory.

He explained that he also has had psychodrama training, which guides helping his clients rehearse those situations and prepare them to face their aggressors. “In that sense,” he
reflected, “I feel that my personal history has been of added value to both me as a therapist and what I can offer in the session.”

In summary, though the participants described a varying range of wounding experiences and different paths towards the vocation of psychotherapy, all participants agreed that their experiences of woundedness in some way led them towards the vocation of psychotherapeutic work and greatly continue to impact the work that they do. Most of the participants also associated some degree of their somatic experiences to previous wounding experiences.

**Relationship between personal wounds and somatic experiences.** In the somatic experiences section of this chapter, correlations participants made between specific somatic experiences and personal wounds are noted. This section addresses the general perceptions and meanings participants related between their personal wounds and somatic experiences. Howard offered no responses relevant to this theme.

*Peter.* Peter affirmed that his childhood woundings increased his sensitivity and receptiveness to somatic experiences in the body. He explained, “I received a lot—in the good and bad sense of receiving a lot (laughs)—but when you receive a lot in terms of affection and care, you can give that back.” He referred to the abuse he suffered as negative and to the love and affection he received as positive. He also reflected that he had always been “empathic,” “sensitive,” and “caring” towards others, even as a young child. He indicated that his somatic experiences that feel connected to his own wounds generally last longer, usually until he is able to recognize or work through them, and that he feels them more intensely.
He described several somatic experiences, which are explored in the somatic experience section, that he related directly to his childhood wounds, and that were most often experienced as somatically felt emotions as well as behavioral postures and impulses. One example is a somatic experience he had when he felt threatened by a client. He connected his response to an early childhood wound due to his father’s “harsh and domineering” manner with him, and said he responded to the client in a similar fashion. He related that often the clients’ issues can trigger his own wounds, in which case their experiences, in the first moments, seem “confused or fused together.” He added, “It’s part of an assumption that what I’ve been feeling has been . . . magnetically attracted by something similar in me,” and described the concept of synchronicity at play, acknowledging also that the client has something to teach the therapist.

_Eve._ Eve noticed that when her attachment woundings are touched upon during a psychotherapy session, she most often experiences certain somatic responses that she feels are directly related, such as a sense of “clenching, bracing, or the collapsing” in her posture, a desire to protect heart, and fidgetiness. Though she experiences somatically in many circumstances, she noticed that her somatic experiences are of “a different level” with “the people who have that same kind of patterning” as her early attachment patterns. Another example regarding this type of response was having a tight jaw for a month or so and seeing clients who also had tight jaws. She said, “I can often feel my own jaw tightening more intensively with those clients. And so it can be that it’s my own vulnerability, but then it’s also happening with them and it gets tighter.” Eve made the significant point that one’s own vulnerabilities are more likely to feel amplified and affected by client material.
Lisa. In response to being asked if she perceived any correlation between the types of somatic experiences she has and her own history of woundedness or present challenges, Lisa responded, “Yeah, there’s a 100% correlation,” and described her own healing coming about through focusing on her body and “specifically the feelings that have been buried and feeling them on a physical level.” Lisa observed that when she and a client share a similar wound, her somatic experience is stronger, and more intense. She said that her somatic experience can be helpful in that she feels especially emotionally and physically attuned to her clients in these situations, and when the clients are not attuned to themselves, she can use her somatic experience to guide them. She also shared, “There’s moments where for me it’s intense, and the intensity of that grief, for example—that’s my own unresolved grief—it can then prompt me to work harder than . . . [the client] is because it’s the desire to rescue.”

The types of somatic experiences Lisa most frequently reported and associated with her childhood wounding included a postural component, or physicalized projective identification. She reported, for example, that when feelings of invisibility and attachment issues get activated, she often feels a collapsing posture and an impulse to “crawl up and hide” or “just turn away.” She admitted, “I can feel it right now even as I think about it; it’s kind of these wounds . . . and the collapse.” She noted that similar somatic experiences occur when she has clients with narcissistic traits, because they trigger her wounds of feeling invisible, unsafe in being present and seen, less important, and feeling like she does not matter as well as the need to caretake.
Adrienne. When asked if she noticed any correlations between the somatic experiences that she felt and her own wounding experiences, Adrienne responded with a personal example:

Yeah, I’ve talked about the somatic thing of the tumor growing in my left breast. I had a dream in which I saw the breast as a faucet, as in giving and nurturing other people and, in the dream, the faucet got turned off. It’s like my psychology was—I give to everybody else, but I didn’t get what I needed. And that the tumor in the breast of overgiving and not being in balance with my needs and the needs of others . . . and then it manifested as the tumor there.

She emphasized the need for self-care and noted some somatic experiences that indicated when she was needing more.

Adrienne laughed when sharing some somatic experiences related to her own wounds while working with clients, as in this example:

The first client that ever walked into my therapy office when I got my first job as a counselor had the same issue that was the issue that broke up my marriage. It was like, oh boy, there it is. I felt my own feelings.

In presenting examples, Adrienne tended to report first the emotional aspect of her somatic experience. When asked if she felt any additional somatic responses in the above situation, she replied, “Pain! Yeah they’ve got some of the pain that I had,” adding, “I feel it in my body. A squeezing of the pericardium. . . . There’s like a constriction of the heart energy, and it physically hurts.” She noted that she would feel this type of somatic experience whenever someone was going through something similar to what she has been through herself or someone felt close to her or her experience. The sensations she described were an “aching” and “raw pain in the heart,” which she recognized as the pain of divorce from both her marriages.

Samantha. Samantha believed it was probable that her own past experiences affect the types of somatic experiences she has as a therapist, because she is “more in
tune” with them. The most common somatic experiences she had relative to the early wounding experiences she described were stomach symptoms such as “feeling punched in the gut.” Regarding several instances, she said, “[I was] feeling an overwhelming sense, like I was identifying with my clients pain.” Offering an example of working with a client who was constantly bullied like she was, Samantha stated, “[Being] able to resonate and have the same kind of (makes sound) like gut, uh, explosion going on in my stomach made me feel like I was able to join with them.” Further describing these types of sensations as “constricting,” and “clenched up,” she said that when clients’ situations were similar to what she had been through before, she found that she tended to notice somatic symptoms more.

Another way Samantha interpreted her somatic experiences as related to the wounded healer archetype was through being wounded by the work. Her descriptions of feeling like she was “stabbed with a knife” or “like somebody punched” her not only implied her identification with both the pain of her client and her own but also feeling wounded by the work of a psychotherapist. She explained,

I’m feeling like people are beating me up (laughs) and they don’t mean to, because I know (a) that I’m sensitive and (b) that it’s a consequence of our work, right? And so yeah, when that archetype comes to mind, we’re being beat up, but then, at the same time, we’re supposed to be the healer and help the people that are beating us up so that they can take—here’s your punch. You got to give it back to ‘em. Here’s your punch, and this is what you need to process now, ‘cause I’ve now metabolized it, now it’s your turn.

Samantha also noted that, physically, she commonly suffered from digestion and stomach issues, including IBS, and therefore related, “My stomach area is where I tend to get the most gut reactions, like literally gut reactions, to what people are saying and it definitely drives how I do my therapy.”
**Eddie.** Eddie often referred to the concept of resonance when discussing his somatic experiences and relating them to his own history of wounds as well as other previous experiences. The somatic experiences that he reported as related to his wounds were most often sensations. He spoke of being able to “recognize the signature” of particular somatic experiences as they related to his past histories of drinking coffee, substance abuse, familial history, and his own wounds. He explained,

The fact that I have a resonance with the client, it’s a sign that I’m in tune with the client, and that I’m more sensitive to those wounds because I have similar wounds, but that doesn’t mean that those wounds are the most significant wounds or the ones that need priority or focus.

In this statement, he clarified that his somatic experiences were not necessarily reflective of the client’s major issues at hand but were “indicators” of other client material and were likely experienced because of their similar histories. “It’s equal injuries,” he stated.

“When the theme touches upon a similar injury, I resonate louder, so to say.”

A few of the most notable examples of the somatic experiences Eddie directly related to his own personal or familial history included his stuttering when he saw a certain client, which he described as “definitely very physical” and very much touching on his own personal history. Also, when he worked with clients who bullied others, he would experience pain, shivering, and shaking in his previously injured knee and leg, and with clients who were being seriously bullied, he would experience the addition of stomach cramps, which indicated to him that there was a significant threat. His ability to process the resonance he feels with the client in these situations he attributed to his personal therapy:

That’s the personal work I did with it so now I know exactly what kind of vibration I’m getting from that person and—I was victim of bullying myself in school so, then it’s always something to work on that personal front.
Eddie, like several of the other participants, highlighted the importance of doing one’s own personal work, including personal psychotherapy or supervision, in learning to recognize and understand one’s somatic experiences and any relationship to personal wounds that may become activated.

**Somatic experience phenomena.** Because a primary purpose of this study was to explore the phenomenology of therapists’ somatic experiences, my first line of questioning was to ask the participants to describe their somatic experiences: specifically, what do they experience in their bodies, where, how often, and when? Initially I expected sensation-language descriptions of the phenomena; therefore, when they led with an emotion word or seemed to have trouble clearly describing their experience, I often restated the question specifically to ask, “And where did you feel that in your body?” and “Can you tell me what that felt like? Can you tell me more about the quality of that sensation?” I began noticing different modes in which the individual participants described their experiences, and categories of somatically experienced phenomena emerged. Participants described their somatic experiences not only as physical sensations but also in terms of physiological responses, medical conditions, behavioral impulses, body movement and postural changes, emotional feelings, and conceptual images. I created a spreadsheet for each participant and wrote each somatic experience description they shared in the column(s) of the matching category or categories, the part of the body affected, the timing of when the experience occurred, and any meaning they made of it.

The focus of this report on somatic experience phenomena is on the types and varieties of somatic experiences, though contextual information, associations, and meanings made are also included to foster a more comprehensive understanding. It is
important to keep in mind that the somatic phenomena reported were often experienced through several modes of experiencing simultaneously within the whole narrative. In order to highlight and discuss these different modes of somatic experience perception, I have artificially separated elements of the somatic experience, resulting in some repetition.

One of the main intentions of this study was to explore therapist’s somatic experiences in connection with their therapeutic work; however, in the interviews, many participants also shared personal somatic experiences of their own that were not directly related to their work as a psychotherapist. It quickly became obvious that these experiences are equally pertinent and related, and therefore, they are included in the data. This aspect of the participants’ responses exemplified how the personal self cannot be separated out from the therapist self and how the personal is brought into the therapy room. Any reported somatic experiences occurring during the interviews are also included in the data.

**Part of body affected.** The number of times each participant mentioned a particular body area was counted to detect areas of the body that are the focus of the most attention and somatic effect. I was surprised to find that a “body area” that people referred to the most was “energy” and its derivative, “energetic,” which had a total of 64 mentions, with six out of seven participants naming it. In second place, also with six out of seven participants identifying it, was the heart (which included heart chakra), with 45 total mentions; relatedly, the chest was referenced an additional nine times, which brings that body area up to 54 references. In third place, the identification of “stomach,” “intestine,” “gut,” and “belly,” comprised a total of 43 mentions. In fourth place was the
legs, including leg, knee, and calf, at 35 mentions; however, including “heel,” “feet,” and “foot,” at an additional 11 mentions, would bring the total to 46 and thus move this whole limb of the body into third place. In fifth place, “eye” and “eyes” were mentioned a total of 27 times.

As I compiled the data and recorded each somatic description from the transcripts, I also recorded the area of the body affected. Originally, “energy” was not documented as a body area but instead included as a concept or physiological response; however, as my reading of the interview transcripts progressed, it became clear that many somatic experiences were being assigned to the area of “energy,” and truthfully, it is an area which the esoteric traditions refer to as the ethereal body, of which our physical body is a part. When I performed a word searched on each transcript, I was amazed at the frequency of the mention of “energy.”

Each participant quantifiably spoke of certain body regions more than others. Eddie made the most mentions of his leg and stomach/intestinal region; Lisa, her energy, leg, chest; Samantha, her stomach/intestinal region; Eve, her eyes, heart, jaw, and feet; Howard, his heart chakra and his hands; and Peter and Adrienne, both their energy and heart.

Additionally, on occasions where a symptom was reported on only one side of the body, it most often occurred on the left. Eddie experienced his left eye twitching and sinking, and his left leg had been previously injured and subsequently hosted several of his significant somatic experiences. Adrienne had been diagnosed with breast cancer affecting her left breast. Howard reported feeling a specific somatic pain in his body on the left side in the same region as his client’s cancer. Eve discussed a somatic pain she
felt in her feet but more predominantly in the left one. The theme of the left bears significance for the therapists, as it is considered to be the receptive, yin side of the body.

**Physical sensations and physiological responses.** “The body speaks in terms of ease and disease, comfort and discomfort. The body is very honest and very basic. Like and dislike,” explained Peter. He was not alone in addressing the most basic, elemental, way of describing how the body feels. Howard spoke of some somatic sensations as feeling “comfortable” or “very uncomfortable” as well as “at ease” or “ill at ease.” Likewise, Eve discussed an “uncomfortableness” in the body, Adrienne also spoke of “an extremely uncomfortable feeling,” and Samantha talked about “feeling uneasy.”

More of the somatic sensations discussed are of the discomfort, dis-ease, and painful variety, as those are the ones that tend to attract more attention. Adrienne noted that at times she would experience “a sudden onset of a sharp pain or an extremely uncomfortable feeling,” which would lead her to ask her client if he or she had something going on in the area where she was having pain. Howard shared, “At the end of the session and when I got home, I hurt in the same place as . . . [his client], like I had cancer,” describing his pain in the same side as his client’s non-Hodgkins lymphoma.

Eddie simply stated that when he works with “people with obesity,” he gets “lumbar pain” and clarified that though he does have his own back issue due to leg problem, he experiences a distinctly different pain when working with this population.

Eve reported a personal somatic experience that included a variety of unpleasant sensations and physiological responses:

In the first 5 years after graduate school, . . . I did go through a period of anxiety, . . . I didn’t like take in food well. . . . I would get nauseous or wasn’t hungry or my stomach would tighten up or I felt tired and, actually, that is what sort of led me to mindfulness. I was, in general, not feeling well, tired, kind of depressed,
low energy, just not feeling well but nothing wrong with me actually. Well, you know, I’d go to the doctor and nothing is wrong.

This somatic experience was a puzzle of meaning, which would eventually lead her, like others, to pursue training in somatic psychological work and learn to explore her own somatic experiences in order to understand herself and her clients better.

*Effects in stomach and digestion.* Many of the participants experienced sensations affecting their stomachs and digestive systems, especially Samantha, whose somatic sensations as well as physiological responses occurred predominantly in this area of the body. Similar to Eve’s account of not taking in food well, Samantha shared many occasions where she physically felt “I’m really full . . . and my body’s [saying] . . . I cannot take food right now,” even if she had not eaten, an effect that also exemplifies the common accompaniment of a physiological response with a somatic sensation. These responses typically occurred for Samantha when she saw many clients back to back without breaks.

Samantha encountered many clients who were dealing with experiences that were “parallel” to her own childhood wounds, such as emotional distance, receiving criticism, being bullied, or being subjected to others’ high expectations. She explained,

I feel for them . . . in the solar plexus, that’s where I FEEL a lot of my instinctual reactions like a tightening of the stomach of the solar plexus when I’m like, ooh yeah, that triggers me, or I can relate to that.

Regarding her work with clients who suffered from being bullied, she described similar sensations similar to theirs affecting her stomach, “It was constricting . . . clenched . . . clenched up.”

Samantha described sensations that occurred frequently when she would see a client who had a very traumatic history of sexual abuse: “It just felt like . . . my insides
were collapsing . . . like everything was being constricted, like all my intestines and all my stomach was just constricting,” and its duration varied “anywhere from just a pain, a couple seconds, to 15-20 minutes, a half an hour after the session.” Another physiological response that Samantha experience occasionally was “the sensation of needing to go to the bathroom” due to diarrhea and irritable bowl syndrome, which she said occurred when she felt “really stressed,” particularly when conducting her practice in a negative work environment. She felt her ability to contain and her own personal health were negatively impacted by her work environment.

Adrienne relayed sensations that occasionally are felt when she is in the physical presence of clients: “I can feel like sometimes my belly will kinda be tight and then I know that there’s some agitation in them.” Another example she provided was a personal interaction she had wherein her “stomach got so upset,” when talking with a woman that she came to believe the woman had a malevolent presence around her. She continued,

When I would be around that person, my belly would get upset and my stomach would just . . . my intestines would rumble and, um, (laughs) during this woman’s talk, I was passing gas like crazy. I just got bloated, and then I saw her later and talked to her, and while I was talking my stomach started getting really agitated . . . and then I went to the bathroom and I had diarrhea, so it was like there was something in me that was extremely agitated.

Eddie shared that he sometimes experienced “intestinal derangement,” which he described as “sort of colics and cramps” in his stomach. Though he qualified that it could be difficult to discern the reason this symptom came on, he did say that it usually coincided “with passive aggressives” and people with “repressed anger” and further explained, “There is a lot of acidity within them, but its very . . . camouflaged, and when it comes out, it’s very . . . very subtle. There’s a slight sadism in their discourse. Their narrative is slightly—and I start to get this colic sense and stomach cramps.”
Howard’s stomach-affecting sensations were reportedly related to feeling nervous. He recounted, “There are times when I’m anticipating, I’m ill at ease with—my stomach churns,” adding that whenever he would see a client for the first time, he felt somatically nervous “in the gut” and felt it “churning.”

*Physiological responses of anxiety and stress.* Several other participants reported somatic responses, mostly in the form of physiological responses, related to varying degrees of anxiety, panic, or distress. Both Samantha and Eddie actually shared somatic experiences associated with anxiety occurring during this research interview. Samantha described, “I’m feeling like a little bit of fluttering, you know, in my chest” and explained that she felt “good anxiety” about being “put on the spot” as well as reminded of difficult client material. Eddie observed that he felt “slight anxiety” along with “a bit of a dry throat” in anticipation of speaking English for a full hour during the interview, being that it is not his primary language and he had not spoken it in a long time.

Peter shared a variety of physiologically based somatic responses related to feeling anxious or to anticipation anxiety, including “hand sweat” and noticed “bodily perceptions such as tension,” as well as “a slight excitement” when “female favorite clients are about to show up.” A specific physiological experience he recounted concerned the incidence of a new client telling him a painful story about being choked by her father. He said, “I went into an autonomic nervous system reaction, I went into distress, my hands were sweating.” He experienced intense somatic responses to her situation through other modes as well, which are discussed further on in this chapter.

Samantha observed that her heart “starts racing,” and “beats a lot” when she feels very anxious or feels dread. Eve also reported experiencing “a racing heart kind of
sensation,” which she connected with “stepping into a new comfort zone” in her life; she reported, “My heart would get a little panicky.” Howard noted, “When I’m stressed, I get short of breath,” and, noticeably, he sighed several times during the interview.

Eddie reported that when a client has some combination of high anxiety, phobias, strong coffee drinking habits, and poor kidney functioning (which, in Chinese medicine, is related to the emotion of fear on the water meridian), he tends to feel thirsty. He explained, “I was [once] a strong coffee drinker myself, so I also can recognize the signature of that,” and said he would therefore use these somatic experiences as cues to inquire into the client’s vitality levels, coffee consumption, anxiety, and other related aspects, often finding they corresponded.

*Effects on the eyes and sleepiness.* Eddie reported a physiological response in his eyes: “When I’m dealing with people that have some sort of addictions or . . . clearly obsessive compulsive behavior, . . . I get my left eye to twitch, it starts . . . it kind of closes halfway.” He further explained,

> It’s not an immediate effect. It’s sort of a transferential effect that after 5-10 minutes, I’ve noticed that my left eye is sinking and . . . that’s for me a trigger then to probe into those questions and quite often they are on target.

Eve also described somatic sensations affecting her eyes: “My eyes get really tired, and then it can be really hard to keep the eyes open.” She explained that these somatic experiences with her eyes were often more difficult to deal with because the duration of the symptoms lasts longer, and the pressure she felt “to be the attendant therapist” could make the symptoms even worse. She noted that these somatic symptoms occur “if somebody is really spacey or [had] surgical trauma or they’re a pot smoker or something like that” and also mentioned clients who had experienced being put under anesthesia. Particular client situations came to her mind where she could feel her eyes
“working really hard to stay present, to stay focused,” in which cases she felt and tried to fight against

the eye tiredness or the, the glazing over of the eyes or the fogginess, that sometimes can go more mental into the whole head but, but the eyes in particular may get harder because they want to just close or rest but they’re just working hard.

She also indicated that she detected some level of disassociation in the client that accompanied her “spacey” eye sensations. Another eye-related sensation Eve discussed was feeling “some pre-tears or tears behind” her eyes when clients were not reporting or connecting to any sadness or any emotion but were speaking concretely and appearing visibly depressed, numb, or tense.

Adrienne discussed a case of a particular client with whom her eyes would be affected during their sessions:

In the session, my eyes would get so heavy, I’d feel like I wanted to fall asleep. And I came to realize that was a part of her that was trying to put me to sleep, because that part of her didn’t want me to talk about painful things and figured, if I were sleeping, then I couldn’t make her talk. If that sensation, a real heaviness in the eyes and the sleep chemicals start to circulate, then I have started asking clients “Is there something that’s really on your mind that you haven’t mentioned yet?” And usually then that’s enough to break through, and they tell me the real thing. Sometimes I think there’s a dark force entity that tries to put me to sleep to avoid getting detected, but usually I can figure that out and ask for help.

Participants also reported feeling fatigued or tired, referring to their energy levels in some cases rather than their eyes. Peter shared, for example, a reaction he has sometimes when clients arrive: “I’m really fatigued, I’m really tired, like all my energy goes down [makes expressive vocalization], and I feel like I want to go to sleep, but I was not like that before the client.” Samantha talked about feeling occasionally “tired” and “exhausted” the last session of the day or of a long week as well as at times when she felt overwhelmed by the combination of personal and professional life stresses.
Adrienne spoke of feeling tired after a session: “If I’m in the physical presence of someone who is really down, . . . it might be a couple hours before I totally shake that. . . . I just have to go and rest.” She said that she also feels tired after phone sessions or after traveling home from conducting several sessions in a row. She explained, “My energies reserves are just depleted, not from necessarily the content of the material but just from the amount of sustained concentration and the energy it takes to do the work I do.” Participants reported feeling tired and sleepy due to tuning in to client content as well as their own personal energy depletions from the requirements of this work and from life stress.

*Sensations affecting the legs and feet.* Eve focused much of her attention on a peculiar foot pain, beginning most prominently in the heel of her left foot, that she had been experiencing to some degree for over a year, around the time she “left the stability of the old job.” She described the pain as “kind of an ache” and a “throbbing” in both feet, and said, “It tends to be at the end the session when I stand up and walk someone out that maybe it’s stiffened up or it’s a little like untrustworthy to step on.” She related that this somatic experience was more personal in nature and related to her work situation in general, but she did not connect this experience to client material.

Similar to Eve, Lisa also described a personal somatic experience that she had been experiencing in her legs for an extended period of time. She described it as “relentless” and said,

It’s always difficult to describe this. It’s kind of in between like a—like intense vibration that’s running up and down my legs and also like a lethargy, like my legs—when it’s at its worst, my legs feel like dead weight. And I think it’s somewhat similar to restless leg syndrome.
She, too, attached meaning to this experience with regard to her personal life, unrelated to client material, and said she included consideration of her regular experience of this sensation into her normal “baseline” of how she feels before seeing clients. Lisa further described this ongoing somatic experience as “stuck anger in my legs with always an impulse to kick” (also a behavioral impulse) and mentioned her own somatic experiencing work she did to process and understand this experience, which has, in turn, helped her to help her clients.

Eddie discussed how he would occasionally have somatic experiences in his left leg, which was the site of a significant sports injury:

Sometimes my left leg starts to get a bit edgy, . . . shaking a bit as if . . . sort of nervous shake, almost as if it was shivering of cold . . . but, um, I’ve had surgery on that leg, on my knee, so that’s always been a weak spot . . . and that’s usually a sign for me that I’m scared of something . . . so that my anxiety and fear express themselves . . . And there’s been a number of cases where I’ve felt insecure and afraid of the person itself or for what they have told me or for what they threaten to do once they would leave the office, and that’s for me a clear sign that I don’t have total access to the real fear that I’m experiencing, and its only when my leg and my left knee start to shiver that I get to recognize its true dimension.

These particular experiences he associated with working with “bullying types.” He said that when he saw clients who were facing a significant threat from a bullying type, he would experience a similar leg shiver along with stomach cramps.

Effects in heart and chest. In addition to felt sensations such as a racing heart, addressed in the previous section on physiological responses of anxiety, participants discussed feeling other sensations in the heart area and chest region. Themes that came up were sensations of contraction and heaviness. Eve described the sense of a “contraction” that she sometimes felt “come around heart” as a part of a postural body pattern she experienced often in session. Likewise, Lisa’s descriptions also included “tension” in her chest as a part of a postural body pattern. She described another
experience she sometimes had, “a tightness in my chest and it’s like a heat that kind of rises up from my abdomen,” which she said accompanied feelings of anger and associated impulses in her body when clients had anger but did not express it.

Additionally, Lisa spoke of somatic experiences while seeing a client who had similar issues as those involved in Lisa’s wounds regarding her own mother, which brought up considerable grief. Describing the sensation, she said,

> It was in the chest; it’s kind of this fullness. Often for me the grief is kind of like a pain or like a tender feeling in my heart and then just kind of this heavy feeling in my chest with kind of a little bit of collapse and then the tears.

Touching his chest, Howard reported feeling the “despair” of cancer patients in “the heart chakra.” He said, “I feel their despair in the form of a heaviness.” Though the reasons were different, Lisa’s and Howard’s sensations of heaviness and associated emotions of grief or despair were similar.

Adrienne, like Lisa, also recounted somatic pain she felt while helping a client through an issue with which Lisa could personally relate regarding the breakup of her marriage: “Yeah, I feel [the pain] in my body. A squeezing of the pericardium. . . . There’s like a constriction of the heart energy and it physically hurts.” She explained that she feels “raw pain,” or a “raw aching pain in the heart” when a client is sharing a similar wounding experience or a person close to her is in pain.

*Other bodily sensations of contracting and tightening.* As discussed previously, several participants described sensations of contracting or tightening in the leg, chest, and stomach areas; however, these sensations were also identified in other body regions and in general. Peter noted that he experienced a “contraction in muscles when facing an
angry client” as well as various other “muscle tension” sensations, depending on client material.

Eve chronicled that for the past month or two, she had felt “tension” in her jaw, which she further expounded on as “a lot of just tightening in the jaw and then also in the neck and shoulders and kind of a holding on feeling and a little like clenching—a little holding-on-for-dear-life kind of feeling.” Though the jaw tension appeared most prominent, she also experienced these tightening sensations throughout her body: “I might feel my jaw tighten or my stomach tighten or my heart tighten or I might feel openness and expansion.” She described the sensations as primarily personal in nature, particularly those affecting the jaw, yet noticed that their intensity amplified in sessions with clients who had specifically similar body tensions. She revealed, “I kind of know who has a jaw situation, like in my clients, and so I often will feel my own jaw tightening more intensively with those clients.” She added, “A similar type of thing can also happen in my neck and shoulders.” Eve noted that strength of the jaw sensation had recently begun to diminish and was “kind of going in and out now.”

Other somatic sensations. A variety of other significant somatic sensations were described by the participants, such as the sensation of itching and irritation, that merited inclusion in this report but did not fit with other thematic categories that emerged. Eddie reported, “I get sometimes itching on my scalp when I know that somebody is clearly, clearly, clearly lying. So if it’s a succession of lies, I start itching as if I’m getting irritated. My skin is getting irritated.” He acknowledged the possibility of other rational reasons for itching and that he used this sensation to check-in with himself but commented that “more often than not” his assessment of this reaction as related to the
client was accurate. He observed, “There’s some deceit going on, there’s some distortion
taking place,” further clarifying that the itching occurred in association with
“premeditated lying, and “when their persona is way too active—they are really trying to
sell an image that doesn’t fit the reality and they know it.” Another example of somatic
itching that Eddie shared was while working with a client suffering from alopecia, whose
symptoms included missing bits of facial hair, beard, and hair on his head as well as
rashes on his body. Eddie reported, “During the session, I would start feeling—itching on
my body, especially so around my face or around my head, in the very same places where
his hair was missing” and further described the “irritations of his skin” as “very
[un]comfortable” and “very unpleasant.”

Peter shared a variety of different somatic experiences. He discovered, for
example, “If I was very, very sad and refrained myself from crying I would immediately
get liquid retention.” He discussed an occasion in where he experienced his mind “go
blank” when doing touch body psychotherapy with a client who had a past similar to his
own. Other somatic sensations he reported included occasions of “bodily heaviness” or
“lightness,” as well as feeling “cold,” “hard,” and “rigid” when he felt threatened by a
client’s stature and accompanying dissociative nature. Peter as well as Eve and Lisa
reported specific situations where they felt “strong” or “stronger” in their muscles,
coupled with certain postures of standing taller, bigger, or elevated.

Energetic sensations. Both Howard and Adrienne integrate spiritually based,
ergetic healing work with their psychotherapy practices and offer both in-person and
distance healing sessions. They therefore reported some physical-energetic somatic
sensations that are of a different essential quality than the others.
When Howard engages in his energetic healing practices, he uses his hands to feel his client’s energy body. He explained, “When I put my hands over [his client’s] hands, I feel everything. I can tell where the energy is.” He further elucidated how he could feel the client’s pain with his hands, send healing energy, and then feel when the pain was gone. “Also,” he said, “if I have someone on the table, I can pass my hand over the table and . . . ooh, that’s where the pain is.” Demonstrating with his hands first and then my hands, he said,

It’s very tactile. . . . If I do this . . . there’s a place where—oop, it goes kerplunk. Oh, there’s a kerplunk. Put your hands out, I’ll show you. [I put my hands out] There’s a certain place. . . . There’s a kerplunk! Do you feel the kerplunk? [I feel it, nod, and agree] There’s a click right there. There’s some places more sensitive than others, and often I will put my hand over their heart chakra, and they feel it, and I know where it is because . . . right there . . . it’s my desire . . . oops, there it is . . . for me. . . . Do you feel it there?

I did, in fact, strongly feel the sensations in both my hands and in my heart chakra during our interaction, heightened, perhaps, because I also have training in energetic healing modalities. A majority of Howard’s somatic experiences are the sensations he feels in his hands, and their subtle differences in heat, sensation, and strength are difficult to describe.

Adrienne, like Howard, also has a developed ability to sense energy with her body; in fact, she has sensed energetic presences of others near or in her personal energetic field, in both positive and negative encounters. She shared a personal somatic experience that occurred while she was praying when she was first diagnosed with breast cancer:

Jesus came . . . and stood right in front of me. I had my eyes closed, but I sensed his presence, and I felt a tap on right my sternum, and with that tap—it was a physical tap over my heart—there was complete thought: “I now heal your soul.” And with that little tap, a wound in my soul healed up.
Adrienne’s somatic experience involved the energetic sensing of a presence, the physical sensation of the tap, as well as an emotional response. She explained why this experience was particularly significant to her: “Just with that tap, just something *so deep* healed, and I was *flooded* with joy, and I *absolutely knew* that I would survive the cancer, because I knew that with my soul healed, my body would follow suit.” This description illustrated her understanding of the intimate relationship and oneness of body and soul and the meaning she made of her somatic experience.

Adrienne offered a few other examples of somatic experiences related to sensing presences. A client had been discussing her worries concerning a malevolent individual in her life, and later that night Adrienne reported, “I experienced the energetic presence of this . . . [person] trying to get into my energy field. It was a horrible feeling.” When I asked what it felt like, Adrienne described the experience with vivid metaphorical images (explored in “Images of somatic field dynamics,” a later section of this study). I followed up by asking if she had a physical feeling as well, and she answered, “It was just *there* . . . a sense of something extremely menacing.”

Another example of Adrienne’s energetic sensations is that at times in session or otherwise she feels extremely cold and may simultaneously feel like falling asleep, despite drinking coffee. She learned that these sensations occur when there is a presence of an earthbound spirit. She described an early impactful experience:

One day, . . . [the client] came into my room and the room got *really* cold. I was chilled. I put on my winter coat and I was still chilled to the bone. I couldn’t get my hands warm. And she tells me, “My father’s spirit is in me today. It’s attached to me.” . . . I could feel it—it was *so* cold. So I knew it wasn’t just her unresolved grief from the trauma in that relationship. I could *physically feel* the presence of something that was taking all the chi out of the room. That convinced me that it was real, and I’ve noticed since then that if I’m in session with the client, and I
can’t get my hands warm, to check out whether there’s an earthbound spirit present.

She indicated that on occasions, she engaged in the spiritual work of assisting these earthbound spirits to cross to the other side. She explained, “Once the spirit crosses into the light, then the room would get normal temperature again, and my hands would be instantly warm.”

Furthermore, Adrienne noted that she often burps or yawns when utilizing a specialized form of energy tapping (tapping with fingertips on an energy meridian point) with clients. “When they get a relief, I will yawn. They’ll yawn, and I’ll yawn,” she said, further explicating that yawning resets the energy in the liver meridian, and noting cases where clients are releasing darker energy, she and the client will often both burp. “I do get those two kinds of somatic releases,” she said, “and then I know that something’s going on, ‘cause there’s an energetic shift.” She perceived this somatic experience as an involuntary shamanic technique of release.

Pleasant sensations. Not all somatic experiences reported by the participants were painful or unpleasant. The most pleasant sensations seemed to occur most often in cases of perceived positive transference and, relatedly, when the therapist felt successful in helping as well as engaging in conscious self-care. Notably, more often, this category of somatic experience was described primarily through modes other than sensation. Samantha, Peter, Howard, and Adrienne expressed a few sensation experiences in this regard. Samantha stated she experienced a “rush of adrenaline” in a positive transference. Peter noted sensations of “open breathing, open heartedness, [and a] sense of grounding and peace” and also disclosed feeling a few instances of excitement and/or sexual stimulation with certain female clients. Samantha and Adrienne both referred to the more
pleasant somatic sensations they experience when they engage in self-care and well-balanced living. Samantha said she felt “more open” and “lighter,” and Adrienne said that after recharging in her favorite way, an Epsom salt soak, she feels “clean inside . . . ’cause the magnesium sulfate pulls out the impurities.” She added, “My insides are like buzzing” and that she experienced “a sense of well being” in her “central core.”

*Health conditions.* A few participants discussed an illness or health condition to which they also attributed meaning. One way of viewing a health condition or injury is as dis-ease, or deeper chronic manifestations of disruption of the mind-body connections. As previously mentioned, Adrienne was diagnosed with cancer in her left breast, which she took as a signal that she was overgiving and not receiving or engaging in sufficient self-care as well as not expressing her feelings enough. She explained what she also learned through taking kirlian photographs of herself throughout her healing journey:

> When I went through radiation, I got really depressed. The radiation poisoned me and really did a number on my body. And so I took a kirlian photographs, and the energy was all low and spotty, and then I just started crying my heart out, and then I took another photograph. . . . The one I took while I was crying was *better,* and one of the things I found out is that—the cancer profile is that people *don’t* express their feelings. They’re very nice, and they don’t tell anybody what they’re going through. . . . So . . . I had to learn to express my feelings more.

Samantha suffered from irritable bowel syndrome, frequent bronchitis, strep throat, and colds while unhappily working at a stressful agency with a hostile work environment, and she reported she was not participating in sufficient self-care during that time. In both Adrienne’s and Samantha’s cases, their energy spent was out of balance with the care and energy they were taking in. Howard suffered from a severe depression in his life. Eve, Lisa, and Eddie each have had a chronic leg or foot issues to varying degrees, and though their initial causes may differ from each other, they have continued to experience unpleasant sensations.
**Behavioral/postural impulses.** This category refers to behavioral or physical impulses do something (or not do), or that involve some physical movement or posture change. This category was among the most predominant with Eve and Lisa, both trained in somatic experiencing and both INFJs, though other participants provided examples as well.

*Impulse to move or take action.* When Eve was using somatic experiencing techniques to help release a client’s trauma and working with the client’s physical impulse to protect herself, Eve experienced her own physical impulses, which began with strength and energy building up in her arms and legs to the point where they felt “fidgety” and “like something needs to move.” Another example Eve offered was when she would be working with clients with developmental traumas and responses that matched her own patterning, she would notice she would begin to “get in this eye-and-mental kind of place.” She described an unconscious trance-like state, which included “spaciness,” and then when she would realize it, she would react: “I’ll be like, ‘Whoah! Okay, I need to just like close my eyes’ or ‘I need to move my body’” in order to shift out of the pattern and space.

Along with the sensations Lisa described as “somewhat similar to restless leg syndrome,” she experienced a strong “impulse to kick,” which she explained: “I think it is this kind of stuck anger in my legs.” She revealed a personal situation with her mother, which, “brought up a lot of rage and then there was more activation” in her legs. She related that the anger has felt old and stuck for a long time, and somatic experiencing techniques in her own therapy helped her. She advocated the use of props, such as a pilates ball, to help in this endeavor: “I feel like . . . [the anger] is still in me, and then, as
soon as I use the props, it’s like . . . that was the missing piece.” She clarified, “It was almost like I needed to have that resistance, something to press up against that enabled me to get fully in contact with all the physical sensations of the anger.” She explained that her feeling when following her body’s impulse to kick and to press: “[I felt] totally in touch with the anger, pressing as hard as I could to just really kind of get it all out,” which, she said, resulted in feeling more integrated, empowered, and confident, emotionally and physically. This significant personal somatic experience helps guide her and provides perspective when working with clients with similar issues.

Peter also expressed a “body restlessness” and a compressed rage in his body that activated an impulse to move that energy after he saw a client that he perceived wanted to “squish” him and triggered his anger. He chronicled his somatic experience and his process of understanding it:

My rage was squished . . . and compressed. So by the time . . . [the client] left, I offered myself a body psychotherapy session where I could mooove that energy through my body and bring it out through expression. And I did all the protocol of grounding, discharging, expressing all of the aggression, verbalizing and releasing all the waves of feeling. Once I’d done that, I went into supervision session . . . The supervision session was about how painful it is for me to try to connect with somebody who is not connected to their feelings, and that’s part of my story, in my childhood with my parents (laughs) and how angry I am when I don’t feel like I make a heart-to-heart connection with somebody (laughs).

Both Peter and Lisa’s examples highlight the connection with residual anger in their bodies from old childhood wounds as well as the significance of participating in one’s own psychotherapeutic work or supervision to maximize one’s understanding of somatic experiences as an opportunity for growth and healing.

Howard acknowledged feeling so angry at times that felt as if he wanted to “slam things around,” or “I want to choke somebody.” Along the same lines, Lisa expressed an “impulse is to strangle,” on behalf of her clients, “whoever . . . [the client] might be
talking about that she’s really angry at, but she’s not yet fully aware that she’s angry at.”

Though both Howard and Lisa had experienced a similar impulse, Howard’s impulse was based on his own personal feelings of anger, and Lisa’s was directed towards the person causing her client pain. If Adrienne sensed a dark force or destructive energy around or attached to a person, she honored her “desire to repel it,” and stated, “I want to get away from that. I want to push it away. I don’t want to hug somebody if they’ve got a dark force attached to them.”

Eddie mentioned a few somatic experiences, behavioral in nature. He noticed, “When I’m dealing with somebody with a strong narcissistic trait, I find myself rolling my hair with my fingers.” Another example he offered was that he begins to stutter when working with a particular client who stuttered in childhood due to the trauma of repression as well as her reconciliation confessions being shared and used against her. He made an additional association to his mother, who began stuttering after a trauma in her youth, though he reported having no other history of stuttering himself.

Both Samantha and Howard expressed an impulse to cheer and vocalize a “Woo hoo!” and a “Wee haa!” respectively, after a “good” session where they felt helpful or experienced positive transference. Samantha admitted that when a client responded with something like “Well, I never thought of it that way” or “You really helped me with that insight,” she felt the impulse to make the cheer movement with her hands. She said, “Inside me I’m like ‘Woo hoo . . . that was a really good session’ and, you know, pat on the back, ‘cause we don’t get too many of those.”
Posture. Posture shifts were a significant thematic somatic experience that emerged from Peter, Lisa, and Eve’s responses. Notably, these experiences were more physically demonstrated than explained in detail.

Peter chronicled three different situations, offering rich insight and understanding into each. The first occurred when he was leading a therapeutic training group, and a particular student was going to give a demonstration of his work in the group. Peter confessed that he felt threatened by both the student’s good work and his display of grandiosity. He disclosed, “I responded aggressively, and I dismissed his work, and I wounded this person with my reaction.” He realized he created fear in the therapeutic learning relationship, which continued on for a couple of years. He said he came to understand that their dual process had become stuck because of his initial rejection of the student’s presentation. He discussed his reflections and physically demonstrated his responses within their sessions, including his somatic experiences, which prominently featured shifts in body posture:

The whole time I felt that I had to be bigger and stronger than him [puffs up body] and literally feel like, you know, “Beware because I’m after you” (laughs). There was some kind of this [demonstrates puffing up chest, making arms and shoulders broader, sitting taller] in my body—body language with this guy, and, and he was, he was defending being distant, and I hated him being like that, and it was not until I processed how, how I felt threatened by his presentation, that and how I responded to him, that I connected to an early childhood wound, like my Dad was harsh and domineering with me, and I responded to him like my dad responded to me . . . so I was . . . that was my own drama . . . so I unhooked myself from that . . . and I could relax myself.

Peter continued, explaining, “I really felt threatened,” and said, instead of giving the student positive affirmations or valuing his work,

I really went into a, a very aggressive stance and didn’t give him any room to be who he is. And that’s where we got tangled, but all the time there was a somatic experience of being alert, of having to be on the top, of having to match his own
demands and standards instead of really listening to his needs which was “See me, value me, and look how much effort I put into things.”

Peter described some somatic posture shifts that occurred in this instance: “I felt my shoulders pumping up. And my head had to be bigger, and I had to know more and . . . appear more threatening to him.” He felt these had emerged as a compensation for feeling threatened by his own fears of appearing smaller or less knowledgeable than the client in some way and an unconscious attempt to defend against those feelings activated within himself. He acted out familiar scenarios between his father and himself, taking on his father’s role and projectively identifying his student as his younger self.

Peter offered another similar example of a somatic experience as a reactive posture:

I had a client who was very dissociated . . . but a similar type of person [as in the above situation] . . . a big . . . uh, medical doctor who came into my office, and, uh, he is like this kind of guy who knows it all, and he’s quicker than me, and—but he was emotionally dissociated, and I felt threatened by his position, by his title, by—and I thought something’s going to go wrong, so I became cold, and hard, and confrontive.

[Researcher: when you felt cold and hard and confrontive? How did you feel that in your body?]

Rigid, rigid. I went into a very rigid place, and I remember I had to say, Well, I don’t care if you are a psychiatrist. If you are going to work with me, you need be in supervision, and you need to do this, and you need to do that . . . (laughs) and that’s what was my defensive stance.

In this situation, though he again felt threatened by the client’s position, he responded differently in the session in terms of his posture. Rather than enlarging and puffing up, he took on a defensive stance, which he described as cold, hard, and rigid. He said the trigger to this situation was that this client was not connected to his own emotions, and therefore Peter felt unable to connect with him, which again, he identified as reminiscent
of his early wounding. Further on in this chapter are references to the rage Peter felt with this same client.

A third somatic experience reported by Peter that involved a shift in posture occurred during an initial consultation with client who was recalling the trauma of being choked and strangled by her father. As she gave the account of her story, Peter had physiological reactions of distress, emotional reactions of fear and panic, and shifts in his body posture. “I was frozen. I couldn’t move,” he said and further detailed, “All my body and energy was moving to the back of my body. I was not in present in the front. . . . I could see my whole self retreating.” He described feeling afraid of being pulled into projective identification: “She’s going to pull me in to reenact that killer dad.” He reported that before agreeing to work with her regularly, he confronted his reaction in supervision, calling it “that part of the destructiveness or the violence I face in myself before I could work with somebody who has been a victim of violence through a relative.”

Though a very different situation, Samantha described a retreating posture along the same lines: “I’m just like—leanin’ back in my chair,” when feeling “detached” and tired, usually when she feels she has reached her “limit for the day or the week.” As she described this to me during the interview, her body followed, sitting back and continuing to lean herself further back in her chair. Other postures she noted were “slouching” and “sinking,” in conjunction with a feelings of “dread” and “anxiety” and a rapid heart beat that occur in situations such as realizing she needs to write a Child Protective Services [CPS] child abuse report.
Eve noticed a “collapsing” posture, which she described in part as a “contraction” she feels around her heart. She added, “Maybe my belly pooches out, and I collapse so like my spine is kind of like you know, slumpy.” Through reflection, she came to understand this posture as a self-protective response—”to protect my heart”—associated with situations that trigger her own attachment vulnerabilities. Furthermore, she reported that when she becomes aware of sitting in this posture, she consciously makes the shift to change the body pattern and sit up straight, which elicits the further somatic responses of rapid heartbeat and feelings of panic. “It’s more like then, if I notice that, and then I come out of it, then its more exposing for the heart, and so then the heart gets a little bit more racy around that sometime.” She explained,

So like my body pattern might be around that slouch, and then to straighten up the spine and still like really stand up and show up in the world and, you know, be open, and then that can be a little bit more heart panicky.

The meaning she made of this experience was “I’m at my own growth edge of something. . . . I’m stepping into a new comfort zone straightening up.”

Lisa shared several different scenarios of somatic experiences primarily involving body movement and posture. Similarly to Eve, Lisa reported experiencing “a collapse” in her posture at times. This occurred when she felt grief while empathizing with a client who shared similar wounds and familial history; simultaneously, she felt an impulse to rescue the client and push her to advocate for herself. At other times, Lisa experienced a “collapsing” when working with clients who exhibited narcissistic characteristics. The collapse would be followed by a compensatory shift in posture, comparable to aspects of what both Eve and Peter described. Lisa reported,

I’ve had a few clients with narcissistic traits where it’s been difficult because they’re such a strong pull on me to collapse in that way, and then once I do come out of the collapse, they don’t like it. Like I can just feel energetically, because
then they they’ll kind of sit up taller, becomes like this competition almost, like who’s going to be the more dominant, and then that’s where it gets a little tricky.

The sitting-up-taller posture, exemplified by Lisa, Eve, and Peter, signified a compensation to the participants’ previous feeling and associated posture and exhibited a sense of dominance. She explained the trigger for these posture shifts: “So . . . [the clients will] talk over me, they take up a lot of energy in the room and are dominant, and that’s when I noticed that [the collapsing] gets triggered. They’re more important than me, that feeling.” She noted that she easily feels pulled into the role of caretaker—”being overly empathic or overly supportive,” setting herself aside, feeling as if she is not important, and not asserting herself. She feels she loses her “clarity of mind” in these situations.

It’s more like once I become aware of [being in the collapse posture], then it’s like I’m not—I don’t want to go to that place, that’s not helpful for the client, it’s not going to be helpful for me or this relationship so I try—I might even shift my posture, so I’m just kind of sitting more upright or something that can help me to get out of that collapse

She associated the collapsing posture and countertransference feelings to her childhood wounding experience of feeling invisible, emotionally neglected, and misunderstood. She said, “I know for me the place that it’s coming from is more of not feeling like it’s safe for me to be visible and fully present” and further related an impulse to “shrink up,” “protect” herself and “hide.”

Another example of somatic body movement and posture Lisa experienced was when working with young college students who were generally more unconscious and less aware of their anger. In such situations, she perceived that she “started to get more animated,” moving around in her chair, and “kind of leaning in more.” She described “feeling this energetic pull,” accompanying an inner urge to express to her clients, “Come
on, get on board, feel it,” meaning she wanted her clients to feel and acknowledge their feelings. She said she noticed “when they’re not feeling their anger.”

The third scenario Lisa reported regarding somatic body movement and posture was when she noticed herself responding to a situation with specific client that reminded her of a similar dynamic with a significant ex-boyfriend. Lisa essentially described being pulled into a countertransference projective identification, finding herself acting somewhat “critical,” “oppressing,” and “challenging him [the client] more than what he could handle.” She noticed, “it was like I was leaning in more, I was—I could just feel myself like wanting to press—it was almost like that. Just pushed up against him.” She reported that her client acted “very detached and kind of like this,” physically demonstrating his posture, which she described as “slouched and leaning back in the chair, not facing me head on but instead at an angle, creating more distance.” The client’s behaviors and postures elicited a response in Lisa which, she admitted, caused her “to press even more, like, to try to reach him.”

These particular postural somatic experiences were notably prominent with Peter, Lisa, and Eve and directly related to each of their early wounding experiences. Also significant was that these postural shifts were often in direct response to the postures of their clients.

Emerotional feelings in the body. There were some times when the first or primary somatic description participants offered was an emotion felt in their body, and other times, after describing other types of somatic experiences, they reported an emotion. For several feeling-type participants, especially Peter and Howard, who are both dominant feeling-sensation types, descriptions of emotions often seemed to come first. These
participants’ descriptions of their empathic natures is notable. Peter began his interview explaining,

I have been more empathic than a somatizer. I can empathize to a degree that I get somatic reactions but that does not mean that I am a psychosomatic person. I mean, I am very open to my feelings and very well connected to my body.

Howard said of himself, “I’m very empathetic. . . . I can feel sadness and others’ pain. I get upset. Not everybody does.” He mentioned that world events, tragedies, racism and the like deeply upset him: “I get so fuckin’ angry and sad. I really get involved.” Samantha considered herself “a very sensitive person,” and Lisa indicated that she has a tendency to be “overly empathic.” Adrienne did not explicitly use the words “empathic” but identified herself as an “extremely feeling” typology and, throughout the interview, implied her empathic nature by expressing, “I feel their feelings.”

On repeated occasions, when asked about his somatic experience or what he felt in his body, Howard described an emotion. In one instance, he responded, “Sometimes after a session, I might be angry. I notice anger.” He expounded, “Anger to me is a somatic sensation. Oh god, I’m pissed. . . . The cortisol is flowing,” indicating that he felt the emotion all throughout his body and sometimes had an physical impulse that accompanied the emotion. He recounted a session where a client was constantly putting him down and explained his reaction:

I’m human, and sometimes I can sit there and be a therapist, and sometimes I get pissed, and that’s a very . . . I guess that’s kind of somatic, like I’m friggin’ angry. He’s putting me down. Like when this lady knocked me over with her anger. That was a real knockover.”

He also communicated that in situations where a client yelled at and berated him, he would experience depression, anxiety, and fear along with feeling fragile and assaulted. He observed that when a client was not making progress, or he felt that he could not help
the client, he would feel “frustration” and “helpless[ness],” which he found “unpleasant.” Regarding the first time he sees a client for the first time, he admitted, “I’m always nervous—in-the-stomach nervous, and that, somatically, is nervous.”

Though he said that he experienced heavy feelings at times, Howard reported, “It doesn’t seem to affect me as the joy of someone getting healed does.” Fortunately, he said he often felt a great deal of “joy” and “delight” in his work, which he associated with feeling “lighter” and “feeling good” physically. He shared stories of his use of imagery and energy work in helping heal or extending the lives of people dying of cancer and related witnessing their lab results change almost immediately. “It was delicious!” and “joyful,” he exclaimed, adding, “That was a win, and I get excited.” Also, when working with a difficult couple, he found satisfaction and joy in being thanked each time by the woman. He described his reaction when she asked to give him a hug: “That felt good, because I’m succeeding in some level of helping these people.” He said that half the people whom he and his colleagues treated in this way “feel less worse,” and he commented, “That’s success in the business.”

Samantha also reported feeling “euphoria” after a “good session” and receiving positive feedback from clients that she was helpful in some way. Adrienne shared how she feels when she assists in the process of helping an earthbound spirit cross over to the light: “This indescribably happy feeling . . . [electronic interference] comes over me and it’s like, ‘Oh I think that worked!’” Another example of a positive emotion Adrienne shared was the occasion described above, when she felt the presence of Jesus and experienced a soul healing and a “joy” that assured her of her body’s healing. In these
cases, the emotion seemed predominant, though other related somatic experiences were reported as well.

Samantha reported feeling anxiety when caseloads were high, when dealing with clients with trauma, when completing CPS reports, and during her interview with me. When I asked Eve to describe further her somatic response of feeling energy in the arms and the legs when working with a client, she responded, “It felt like anger.”

In his interview, Peter tended to express his emotions first before describing his other somatic experiences. Emotional somatic experiences he reported included excitement, rage, anger, sadness, fear and anxiety. In one situation, he described feeling “compressed anger” localized in his lower back and pelvic area and then feeling “rage,” when the client left. Peter explained that in supervision, he was able to make meaning of this emotional somatic experience, as described above, by identifying it with the lack of “heart-to-heart connection” with his parents in childhood. He added,

This guy, this doctor, he was insecure of his feelings but he was not insecure of his intellectual achievement or his position or whatever, but he was insecure in his feelings. . . . [It seemed that it] would be too much of a risk for him to be open in his heart. But when I felt that, I said, “No I don’t trust you. You know, I don’t feel you. But in your heart, I cannot trust you,” so I went into that place. That happens somatically.

Like Howard, Peter emphasized that he felt these emotions in a somatic way and that his emotional experiences were in part a response to the emotional energy of the client. He also noted feeling “death anxiety” immediately when he sees AIDS and cancer patients, and relatedly, experiencing the feeling of fear in his body associated with the idea of contracting a client’s pain or illness.

**Localized conceptual images.** Several of the participants at times expressed their somatic experiences as conceptual ideas and metaphorical images, some which focused
more on the personal and localized somatic experience and others on the perceived therapeutic field dynamics. Though there is cross-over in these experiences, this section focuses on the images and concepts participants used to describe their personal, localized somatic experience, and the metaphorical images pertaining to the perceived somatic field dynamics are addressed at length in a later section. Participants who consistently expressed their somatic experiences in this way were Samantha, Lisa, and Eve.

Samantha described the majority of her somatic experiences with conceptual images, similes, and metaphors: for example, “like I can’t digest it all,” “literally gut reactions,” and “like the world is coming in on top of me.” Repeatedly, she referred to “feeling punched in the stomach” and “like a knife is going in my gut.” Further conveying the nature of the onset of these feelings that would come on suddenly when a client would begin to discuss experiences of rape, trauma, or sexual abuse, she said, “That’s how that hits me.” When asked to elaborate further on the timing and experience of the sensation, she responded, “I would feel like . . . someone had stabbed me, and I don’t know what that feels like, I just, that’s the only way I can describe it to you,” thus highlighting conceptual imagery as her primary mode of expressing somatic sensations. She perceived that her “insides were collapsing and constricting” when empathizing with the client. When she described the physical sensation of “feeling really full,” and not being able to eat after working, she expressed it as similar to having “been to a buffet.” Finally, when describing pleasant somatic experiences including positive transference and acknowledgement, she offered the following: “like I just had a great workout,” “I feel like I’m on top of the world!” “Like, Yay, I won! . . . And in a sense like, I’ve got this,” “like a weight has been lifted off,” as well as “like I just lost 15 pounds.”
The somatic experiences Lisa felt in her legs were illustrated through conceptual images such as “My legs feel like dead weight” and her perception of “stuck anger” in her legs. In addition, when describing her somatic experience of working with a client who shared a history of being wounded similar to Lisa’s, which elicited tremendous empathy and grief in her, she expressed emotional concepts and images such as “a tender feeling in the heart” as well as “it’s more just this kind of experience of being forgotten or left” and added, “I’ll be undermined basically.” Regarding a variety of other circumstances, she reported images and concepts such as feeling “stirred up” and “activated,” both emotionally and physically. The most notable conceptual image she presented came along with the collapsing posture she experienced when working with narcissistic traits:

I think of those little animals—you see people holding them in their hands, and you touch them, and they shrivel up—kind of an amoeba that you see at the beach on the rocks. But that’s the image that comes to mind as I think about it. Just shrivel up and protect yourself and hide. Don’t let anybody see you.

On the other hand, referring to when she felt confident and standing taller, the concept of feeling “integrated” was expressed.

When discussing her ongoing foot pain that began around the time she left the stability of a previous job to venture into private practice, Eve associated meaning with the sensations in the form of concepts and images: “I just kind of left the stability, and now the ground is moving and it doesn’t feel stable or it doesn’t feel safe and secure so I mean my feet are gripping a little bit.” She detailed her report further with the concept of “round movement, kind of like plates moving, or like things are constantly in motion and the ground isn’t level.”
Another image Eve offered was that of a lotus flower and a tree, in response to a direct question I had asked about any images that arose around being a somatically experiencing psychotherapist. The question was asked spontaneously, and she was the only person to whom I specifically asked it. She said,

The lotus flower often comes to me very easily because it just—it opens and it closes, and it’s in mud and then it’s out and free. . . . But I also get a tree when you ask that question. There’s some kind of grounding and roots that can grow, or that maybe sometimes don’t feel as rooted or that the tree feels more life or less life or—or sometimes maybe I’m too much in the leaves, branches, and then that’s when then it’s like, oh yeah, I could float around the wind a little bit more than just like if I can feel the base and the trunk and the roots and the earth.

When asked about what sensations she felt when considering this image, she responded that it depended:

Like right now I feel more of like an alive tree and so that feels good. That feels like there’s space and air and life as opposed to, like a tree that’s dying or dried up or doesn’t have leaves or more brittle, but that there’s more moisture in it now . . . so right now it feels more like an alive kind of tree.

She noted that the life of the tree and how it felt could change depending on the client and their situation: “It feels like there’s aliveness, and it feels like there’s no aliveness . . . or that, yeah, someone is coming to life and that, like, oh, okay, it’s blossoming versus oh, it’s contracting.” She continued to explain the nature of tracking, expansion, contraction, and going with the flow in sessions. It seemed as though it was easier for her to communicate detailed somatic experiences and connect with her body through the language of imagery, feeling through the imaginal body, branches, and leaves of the tree.

Images of the somatic field dynamics. In addition to the use of images to describe the somatic experience itself, thematic images emerged as metaphorical understandings and meaning made of the therapeutic encounter encompassing the somatic experience. These images were spontaneously offered by the participants as they described their
somatic experiences, often in response to the question of how their somatic experience may relate to their own woundedness or in response to questions regarding discernment or meaning. The images and their implications range from positive to negative with respect to the perceived level of impact on a therapist’s body as well as the boundary dynamics in a given situation. An attempt was made to group similar images together into categories, which include attunement, lending one’s body and containment, fusion, catching pain, and assault. Though the somatic symptoms experienced may physically feel similar across image categories, and crossover exists among them, each category of images conveys a slightly different quality and implies a different meaning. Depending on the imagistic way each somatic experience is perceived, different interventions and ways of proceeding with both treatment or self-care may be warranted.

**Attunement.** The conceptual image of attunement was popular a theme, shared by six out of seven participants in some way, through descriptive terms such as “tuned in,” or “in tune,” “attuned,” “resonance,” “a vibe,” and “in sync” as well as the image of a mirror. This conceptual image grouping was the most positive expression of the perception of the therapist’s body in the therapeutic process, where the body is depicted as a helpful instrument such as a “sounding board” resonating with the client’s material. The essence or quality of these images is a sense of neutrality causing little to no detriment to the therapist, even in cases where the therapist reported feeling the client’s pain. The images as described instead reflect a harmonious “attunement” of the therapist’s body with the client’s, while, at the same time, the boundaries between the therapist and client remain relatively clear and intact.
Regarding the experience of being “tuned in,” Adrienne explained, “As I’m tuned in to somebody that I’m working with, I’ll get the emotional feelings they are going through, and if they have a big physical issue, I may start to get a physical pain.”

Reporting, however, that she now conducts most of her therapy on the telephone and via Skype, she clarified the experiential difference when outside of a shared physical field: “I don’t take on nearly as much of the physical impact when it’s the telephone thing because I’m not in the physical field of that person. I can tune in so I know what’s going on.”

Eddie referred to a particular occasional response he would have in therapy sessions as the “Jungian jukebox,” describing it as “sort of an inner melody” and “a subconscious tuning.” He explained,

I get sort of music during the therapy so I get a little beat going on, and . . . I allow myself to take that beat on and then get the lyrics, and then when I get the lyrics, they have to do with what’s not being said between the client and myself. . . . They are very illustrative. . . . So, quite often, I get this sound intuition.”

Eddie suggested that these “subconscious tunings” usually come to him in the early stages of therapy, before rapport has been developed, and they give him access to “the hidden stuff” that is “not being communicated.” Along the same lines, Peter felt attunement to disassociated feelings not communicated or acknowledged by the client: “I think when clients are disassociated from some kind of feeling, it’s very likely I’m going to have somatic response, because I feel I’m in tune with that part that’s disassociated.”

Images of attunement were also associated with the relationship between participants’ past experiences of being wounded and their somatic experiences. Samantha, for example, explained she experienced certain somatic experiences with clients with a similar wound because she is “more in tune with it.” Similarly, in
discussing a clinical case where her client shared many similarities to her own personal history of woundedness including “misattunement,” Lisa related,

I feel like I’m really attuned to the depth of what she’s experiencing at least emotionally or maybe even physically too in the moment and she’s not fully attuned to herself yet, so I can kind of use that to kind of guide her.

Using frequent variations of the word resonance, Eddie explained why he believes he has certain somatic experiences in relation to elements of a client’s history: “It’s a resonance with . . . my own personal history.” Regarding the client’s similar wounds, he said, “[They] can resonate with my own anatomy.” He added, “It’s equal injuries. When the theme touches upon a similar injury, I resonate louder. . . . The fact that I have a resonance with the client . . . [is] a sign that I’m in tune with the client.” Eddie stated that much of his training background in body-oriented psychotherapies “focused on recognizing in our body the resonance points with what is going on” with the client.

When asked about what meaning she made of a particular painful somatic experience in her stomach, Samantha responded, “It just meant like her pain I was resonating with, or I was joining with her and how disgusting it must’ve felt for her and how painful it was. . . . So that was my way of feeling like I was joining with her.” Her explanation combined the image of resonance with another slightly different image, that of joining, which is further discussed in a following section. This description of her experience, however, is a significant bridging of the terms, because it indicates that in resonating together with similar pains, a joining in that pain may occur, which can further blur the differentiation of boundaries between patient and therapist and increase the likelihood of fusion or mutual unconsciousness.
Lisa also used variations of the word *resonance* to discuss a situation where she believed that the client was not acknowledging or feeling her own feelings of anger and associated somatic response. Lisa said, “I’m feeling angry but she’s not. So, . . . I’m aware of . . . the impulse in my body that I think is resonating with the impulse in her body that she’s just not aware of.” In another example, Lisa integrated several additional attunement images to describe the dynamic and healing potential this field of resonance can bring:

I’m thinking about . . . mental telepathy as it relates. . . . I feel like it comes out of the resonance like when . . . with clients, I’ve been really, really attuned, like we’re totally in sync in that moment. It’s almost like I can read their mind or they can read my mind, which is even scarier, . . . but just in terms of . . . being in that resonance in this very visceral kind of energetic way, . . . when you’re kind of on that same energetic level or vibration level, really profound things can happen.

Also presenting the images of vibration and syncing, Howard relayed a case where he was administering a distance-healing session by phone with a regular client. As usual, he instructed his client to lie down, hold her hands out, and expect to feel his energy meet her hands. (He physically demonstrated this in the interview, describing the sensation as a “kerplunk,” which I felt as well.) He explained, however, that this session was different, with his client reporting to him that she felt her entire body throbbing to a rhythmic beat. He asked her to speak the rhythm she was feeling. He recounted,

I started to check . . . and she was totally synced with my heart . . . We checked it, and I said, “let’s start over again.” De dut, de dut, de dut, . . . Did I get her heart, or did she get my heart? We were absolutely synced. We did this for 20 minutes. . . . It was clearly a somatic link. I would tell her, “Sometimes I hear my heartbeat, older people do, . . . okay, here we go,” and she would tell me her heart beat rhythm, and it was the same as mine.

I followed up by asking Howard what he thought about the idea of this occurrence as a third thing, at which point in the audiorecording, a loud electrical interference came
through, then took on a rhythm similar to that of a heartbeat. I did not hear this until I was transcribing this portion of the interview:

It was a syncing. Every so often in the world in the world that we live in, something comes along that reinforces your belief that there’s more going on (loud interference, and the beating continues)... I call it the connection between people’ (electrical interference). The vibe between people... (much more interference).

He neither attributed nor excluded the meaning of this occurrence to unacknowledged or unexpressed feelings of the client, his own personal history of wounding, or the client’s physical pain, but associated his experience to the concept of connection and vibe between people that exist.

Eddie spoke about the “vibe in the air” in the context of discussing the resonance between therapist and client and the presence of both the client’s disassociated state and the therapist’s history and familiarity with a given state:

When I was a bit younger, around my 20s, I consumed cannabis quite often, and when I’m listening to people—and I know its something about the vibe in the air is related to slightly disassociated moments... [my] left eye... close[s] halfway, so I know that what they are talking about has some interference with that field, so then I pay more attention to it.

Eddie suggested that this somatic experience was “one of the indicators... [or] a trigger to probe into those questions.” His descriptions evoked an image of his body as an instrument used to pick up on vibrations. In another example, he stated, “My knee is my barometer,” offering this metaphorical image of how his own physical and emotional wounding often connected him with clients’ material. He said, “It makes me sync in with a client. It reinforces the therapeutic relationship because there is a lot of mutual congruence.” Relatedly, Lisa presented the image of using her body as an instrument: “(I’m) kind of using my body intuitively or... maybe... as a sounding board when I’m working with clients or I’m just talking to different people.”
The image of the body as mirror was also presented by a few participants and could likewise be considered an instrument of attunement. Although the image of the mirror initially appears different than the image of “tuning in” per se, it carries a similar essence in meaning and function. Where the “tuning in” images are associated with sound-wave frequency resonance between people, the “mirror” image reflects the concept of visual light-wave frequencies transferred between people. The mirror concept is similar to attunement, because the therapist is feeling a significant degree of what the client often reports to be feeling in the same areas. The therapist is thus often mirroring a client’s pains, symptoms, or feelings.

Adrienne simply stated, “My body is a mirror of what’s going on in other people.” Peter shared a similar general perspective, chronicling that often, just before a client would show up, he might begin experiencing a range of somatic effects such as fatigue, sleepiness, low energy, or pain and tension in various body areas, when previously, he was feeling “normal.” He added,

Then when the client shows up and complains and . . . they confirm that “I have pain here and I have pain here, and I’m so tired,” . . . it’s like in a mirror, you know? I could have the symptom they have, but I could have it in the opposite side of my body as they have, but I still have (it). It’s like I’m gonna have the same thing as you have, so that I will know what you are going through.

Peter suggested he was being notified of what the client was experiencing through his own body “or the mirror neurons or the energy field or whatever you want to call it.” He reported that he often felt these experiences most acutely when the client was “sick or depressed, severely, or close to psychosis” or had a life-threatening illness.

Eddie discussed how he felt irritation on his body, head, and face in the same exact places where a client with alopecia had rashes and hair missing. He said, “[It was]
as if his skin jacket was put on top of my own skin jacket. And I was mirroring his own skin rashes.”

*Lending one’s body and containment.* Images associated with lending one’s body or body functions and containment were well-represented among the participants and encompassed several variants such as digesting, metabolizing, holding, and carrying as well as feeling burdened and clogged. These conceptual images, though distinct, are closely related, often appearing together in the participants’ statements.

The image of lending one’s own body, although a combination of an attunement and a containment image, conveys its own unique essence and psychological gesture. Whereas the image of attunement might bring to mind two separate tuning forks resonating at the same frequency, the image of lending one’s body involves the concept of an active, purposeful use of one’s body, temporarily surrendering some degree of one’s boundaries metaphorically and somatically, and stepping in to the client’s situation and taking it in for the purposes of empathically relating and facilitating the healing process. The subtle difference lies in the image’s perceivable level of involvement with another as an instrument to pick up frequencies of pain in the other, versus allowing the use of the body to feel or actively process client material in order to help the client to do something they are not able to do themselves, while there still remains a distinction between therapist and patient. Ultimately, this may be an image that best represents the idea asymmetrical mutuality. It also exemplifies traditional shamanic practices.

An example of lending one’s body is Eddie’s description of his own somatic experience of the lumbar pain he often felt when treating people with obesity. He presented this powerful image: “I’m lending my own body to understand what kind of
sensations they are denying to themselves.” He clarified that though the issue of obesity was not familiar to him personally, he did suffer from low back problems, with a different quality of sensation, and that his own vulnerability allowed him to feel and empathize more with others’ pains centered in a similar area.

Among images of lending one’s body that included “digesting” and “metabolizing,” Eddie discussed taking time to digest a session in order to provide thoughtful and meaningful feedback or interventions. Samantha relayed the occasional difficulty when she has had many clients back to back or was processing heavy material with clients and felt “really full” to the extent that she “just can’t even digest it all.” Also, she explained,

[Sometimes] I’m able to metabolize it and deal with it and get it out of my system through exercise or sleeping or doing something fun. Or the opposite happens, where . . . I can’t metabolize it and it just keeps building and building. Then I think that I tend to get sick.

She reported that after a long day, it took her about “an hour to debrief, distress after, . . . metabolizing it a little bit.” Synchronistically, at that moment during the Skype interview, the transmission became slow and frozen for a few moments, as if the computer program was having a difficult time metabolizing the incoming information as well.

Adrienne recounted somatic experiences of burping and yawning that occurred “pretty much every time” she utilized a specialized form of energy tapping on meridian points:

When they get a relief, I will yawn. They’ll yawn, and I’ll yawn. I might start yawning first, or they might start yawning first. And sometimes when they’re releasing . . . a dark program or something, I’ll burp. They often burp too. But I do get those two kinds of somatic releases, and then I know that something’s going on. ‘Cause there’s an energetic shift. And I feel their feelings. My emotional body is linked to theirs when I set up sacred space.

She compared these somatic experiences in her body to shamanic technique.
In shamans, in the way they deal with stuff that’s not supposed to be there is they extract it from the client, from the client’s body into their body—it’s like my grandfather did but without knowing what to do next—and then they will go and either vomit it out or burp it out, or they have another shaman pull it out of them. So, I see that as a shamanic technique, . . . it’s a release, and I would prefer to burp rather than vomit.

Evident in these examples is the meaningful nature of these somatic experiences: a sense of purpose in using one’s own body to provide the service of healing for the client.

Additionally, these images highlight a conscious need for self-care and the benefit to the therapist in the processing of the therapist’s material.

The central essence of containment images is that within the therapist’s energy and/or physical body, in some manner, he or she is containing, carrying, or in temporary possession of content belonging to the client. Though images of containing are quite similar to lending one’s body, they can be differentiated in that containing is not necessarily actively processing or digesting the material but, instead, more passively or even unconsciously taking on and carrying the transference of client material. Some of the participants’ responses regarding containing and carrying exhibited a more “weighty” impact on the therapist than in previously discussed image groupings, perhaps due, in part, to the perceived obligations inherent in the role of the therapist.

Participants used the words holding and carrying interchangeably to describe their understanding of somatic encounters in situations where clients either had difficulty acknowledging or expressing their emotion or could not contain it themselves. Lisa explained, for example, “It’s like I’m holding the feeling for them until they can feel it themselves.” Likewise, Peter offered, “I’m carrying the symptom for them until they can take it back.” Peter also relayed the importance of discerning and working through his
own similar issues: “Then I can really hold the client to go through their issues.” These examples of carrying and holding convey a general sense of good will and nurturance.

Like Peter and Lisa, Samantha perceived that her somatic experiences were often indicative of content a client had not yet acknowledged or communicated, and regarding occasions where she mentioned her somatic symptom to a client, she said, “[The symptom] gets less severe because then we can share it together. I’m not having to carry it for them.” She continued, explaining the nature of this situation with some clients: “I feel like they would probably break if I talked to them about their somatic experiences. . . . That’s one [instance] where I feel like ‘Oh, I have to hold this.’” Samantha suggested that clients indirectly “are asking us to possibly contain some of their material.”

When asked if he felt that his own wounding experiences helped him to help others, Peter shared this account of a Buddhist story meaningful to him:

It’s about two guys about to cross a river, and . . . they find a scorpion trying to cross the river as well, and one of the Buddhist monks grabs the scorpion in its hand and the other tells him, “Watch out! That animal is going to sting you and can kill you” . . . because that’s his nature—to sting you. And the other says, “Well, I carry it because that’s my nature too.” So, it’s kinda this meeting. . . . The wounded healer is that person that you can go with across a river, risking to be stung.

Peter’s story highlighted his view that his nature as a therapist and wounded healer is also to “carry” and “to serve others.”

In some situations, however, the conceptual act of holding and carrying may be perceived as a more burdensome obligation impacting the therapist. Samantha shared her view:

The impact on us is huge and . . . I think, as therapists who work primarily with adolescents and kids, . . . we have to hold that, a lot of that for them, so . . . that’s why I think I feel full, like emotionally full. . . . I feel like I can’t eat for . . . an hour after I’m done. I want to, but physically, I feel like I’m really full, and my body’s like “I cannot take food right now.” It’s like I’ve been to a buffet.
She said this feeling of fullness occurred most often on her busy days with back-to-back clients or at other times of cumulative life stress. “We can only contain so much for people and for everything,” she added. In a vein similar to Samantha’s imagistic expression, Adrienne reported occasions of feeling “clogged up” and said, “When I get clogged up with other people’s stuff or my own stuff, it feels like you’re trying to drive through the mud, and there’s cars all around, and it’s hard to make headway.”

Samantha also shared somatic experiences of feeling like she literally could not contain what was occurring in the therapeutic setting. These incidents involved stomach and intestinal upsets that came on strongly, necessitating an emergency excusal from the session. She reported,

I’m thinking of like particular sessions where I couldn’t even—where I . . . had to excuse myself and go to the bathroom because I couldn’t . . . um . . . like I couldn’t _contain_. You know what I mean? Yeah, like I couldn’t, um . . . I’ve had both where (sighs) the client had to use the bathroom because _they_ couldn’t contain what _they_ were talking about, and then there’s been times where I had to.

These experiences were not attributed to client material per se but to intense stress in her work environment due to a tense relationship with a critical supervisor, resulting in Samantha’s feeling of anxiety and general overwhelm and sacrificing her own needs. All the examples the participants shared highlight the reality that therapists can be holding, carrying, containing, and becoming clogged with not only patients’ material but their own as well, and trying to contain it all sometimes creates overwhelm.

Eve associated somatic experiences such as tension and tightness in her shoulders with her own attachment wounds. She related, “It’s like the weight of the world is on my shoulders, and it’s like, oh my God, they’re—I’m so tired and tensed, I’m tired of carrying everyone else’s weight,” indicating other people’s burdens as well as the posture involved in protecting her own heart. Peter, too, described an image of “a burden” in his
shoulder when listing different somatic sensations he may feel before a client arrives and said that that he can feel “burdened” or “drained” when the client is sick or severely depressed or close to psychosis. Adrienne also talked of feeling “drained of energy” when working with others who have lower energy. The image of being “burdened” conveys the extra heaviness of a load one is carrying, and the image of “drained” conveys the loss of life force energy from the container, perhaps displaced by the load.

*Fusion.* Images of fusion emerged in regard to situations where the boundaries and wounds between therapist and client combine and become less differentiated. These images may best represent the caution Jung (1946/1982) expressed about such an occurrence: “Doctor and patient thus find themselves in a relationship founded on mutual unconsciousness” (p. 176).

Samantha discussed an instance where, in supervision, she made meaning of a somatic experience of intestinal collapse and constriction as a “joining with” the client, who suffered from pain due to previous abuse. Eve shared the example of an instance when she recognized a client’s presented a “fresh” issue to which Eve personally related. Eve felt she could easily “go to the ceiling with the client” or “float away with them,” and had the impulse to hang onto her chair, “holding on for dear life,” in order to stay grounded and avoid getting lost in mutual unconsciousness. Peter used the words “tangled,” “confused,” and “fused together” to describe a variety of his countertransferenceal somatic experiences occurring when his clients’ issues and his own were similar.

Peter also described a particular experience as a “consciousness lagoon,” which occurred at an earlier time when he was still practicing hands-on healing and noticed that
as he touched a part of his client’s body, he would “just drift away.” He said that he was well practiced in meditating, martial arts, and maintaining his focus but explained,

“When I touch this person’s leg, I go into an empty place. In my mind I just go blank. I don’t know what the hell’s going on there.” Bringing this case to his own psychotherapy for guidance helped give him insight and understanding for how to work with these situations, and he shared the meaningful connections he made regarding this consciousness lagoon:

As I would stay with that empty place, voices would come at my head: “Oh, the reason that there’s nothing here is because you’re dumb, because you’re no good, because you’re a fool.” . . . [These] damaging critical voices would come through my head, . . . and then, as I allow[ed] those voices to happen, then the energy would flow into the [client’s] leg, and I could continue the healing. And then by the end of the healing, I said, “You know, what a funny thing...” This I would [ask the client], “How were you treated in your childhood by your father or your mother?” “They said I was no good. They said I was a fool.”

As he attended to the experience and the voices in his head, he discovered that his client and he shared very similar wounds, so close that for a time they became part of the same “lagoon” of unconsciousness. Both Peter and Samantha indicated supervision as an important support in their ability to make meaning, be effective, and work toward differentiating in their experiences of fusion with clients.

*Catching illness or pain.* Participants’ image of *catching another’s illness or pain* could be considered an accidental or unconscious transference involving a therapist’s receptivity resulting in the carrying another person’s contents, exemplifying Jung’s (1946/1982) conception of “psychic infections” (p. 177). This image falls between the containment and assault groupings in the category of somatic field dynamics. Peter, Howard, and Adrienne, who each practice hands-on or energetic healing work, expressed
concerns regarding this concept. The following is a short section of the interview with Peter:

Peter: So let’s say if a person comes and has some kind of pain and maybe some illness, and I, in my countertransference, become really fearful, and I say “Oh, if I touch this person, then I will get sick.”

Researcher: Like afraid you’re going to catch it.

Peter: (Laughs) Yeah, like I’m going to catch. And then I hold that fear and that feeling. I have the feeling in my body, but as I hold that in my consciousness, the feeling leaves, and when I finally touch the client in this place, I’m totally free from this engagement with whatever feeling in me.

Peter had previously used the image of a mirror when reporting feeling similar physical feelings as his clients. Perhaps his fear comes from having the experience of so easily feeling another’s feelings. In this case, though, the somatic experience he reported is more of the feeling of fear within his body related to the conceptual idea of catching an illness. Here, he reported that by attending with consciousness to the feeling in his body, the feeling dissipated, rendering him ready to proceed with treatment.

Howard experienced not only associated fear but also a body pain in his left side, the same location in his body as his client with cancer, as documented above. He explained his interpretation of this somatic experience:

Howard: Well, an opinion of mine is . . . we catch emotions. We catch ‘em. And that’s what we’re talking about—feeling someone’s depression . . . or something like that, or sadness. . . . And I really was going through the craziness: “I must’ve caught cancer,” which makes no sense, but I believed it. I’ve heard other healers say they hurt, they catch stuff, but I’ve never “caught” pain like that before. And then the interesting thing was that it was gone the next day, but I was frightened that night, and he [the client] was clear the next week when he went to see the doctor. So it was kind of remarkable. But it’s the most somatic thing I’ve ever felt.

Researcher: What meaning did you make of that that you felt the pain in the same place and then his tumor was gone . . . the whole chain of events?
Howard: Well initially, I’ve heard of other healers who are therapists, . . . who say they catch people’s pain, and I’ve never had it happen before . . . that I can remember, and . . . this time I was frightened. I caught cancer. That was what was in my brain. And that was frightening that I caught a non-Hodgkins lymphoma. That was my emotions about that, and then the frosting on the cake was that the next week he was clear. . . . I’ve dealt with many cancer patients over the years with many things. I don’t think I’ve ever felt their pain. I feel their despair.

Like Peter, Howard’s somatic experience was temporary and was released after being present with his emotion. In addition, both their somatic experience accounts were dominated by their experience of feelings of fear regarding catching pain or illness and both are feeling types. Howard’s account of taking on a pain in the same area as his client’s cancer along with the subsequent doctor’s report of his client’s tumor being gone brings up the shamanic role the therapist often plays taking on the patient’s illness and is a reminder of the mystery of healing.

Adrienne shared that her grandfather was a healer, and when he touched or was near to people, their pain went into him, but he did not know how to ground or release it. She later realized that she was like her grandfather and that she, too, “took in the pains and also the emotional states of other people.” She added, “Probably one reason I went into the counseling field is so I could deal with the onslaught of stuff I get from everybody.” For Adrienne, taking on of other people’s material could be so burdensome that she equated it to an onslaught, as described further in the following category. As illustrated, often the somatic experiences are perceived in a multitude of ways.

Assault. The last thematic category of images emerging from participants’ descriptions of somatic interaction is assault, which also includes onslaught, energy invasion, impact, rage pack, and being knocked-over, pushed, stabbed, and punched. These images convey an active, undesirable infliction of sensations onto the therapist,
resulting in a negative impact. In these cases, the therapists perceived the somatic experience as happening to them rather than occurring due to their choice to participate in the somatic experience.

Among the terms Adrienne had used in her description of taking on other people’s physical and emotional pain was “onslaught,” perceiving it initially as something negative happening to her and not knowing how to protect herself from the impact. Later, among other self-care and energetic techniques, she began to have preference for distance therapy via telephone or Skype. She explained, “I don’t take on nearly as much of the physical impact when it’s the telephone thing, because I’m not in the physical field of that person.” Another example she shared was a somatic experience outside of the physical presence of the client. While in a hypnagogic state at home, Adrienne felt the presence of a malevolent “menacing” person, whom her client had spoken about, trying to invade her personal energy field. Adrienne reported, “[It felt] like energy invasion, like something else was gonna just get inside of me. Something very dark and awful was going to try to take over my body.”

Assault is among several words Harold used to define a situation where he was working with a couple, and the woman began berating and screaming at him. He described in physical language the assault-like impact the interaction had upon him: “This lady knocked me over with her anger. That was a real knockover.” He continued, conveying its lasting impact: “But that event, that event, the screaming . . . pushed me into a depression. That was the beginning. Then from that, for the next few months, I was like up and down and up and down . . . anxiety and depression.”
Peter also reported a somatic experience related to anger, although, in this case, his response was due to the client’s disassociation from his feelings. Peter related, “When he left, I get like an energetic experience, like as if he had dropped some killer rage pack in my office, but that was my own.” He also shared that he felt as if the client wanted to “squish” him. Through the somatic reaction he described as feeling like an assaultive “killer rage pack,” which initially he experienced as his client’s unexpressed rage, Peter was also able to identify his own rage, past and present, ignited by the situation.

Samantha discussed her somatic experiences on multiple occasions when meeting with clients who suffered from tremendous trauma as feeling “like a knife is going in my gut,” and referring to particular clients who shared the details of trauma in session, she said, “I would feel like, continually like stabbing me in the stomach.” She clarified that she would be feeling well before the session, “then all of a sudden I feel like somebody stabbed me.” Similarly, Samantha also reported, “[I felt] like I was punched in the stomach . . . sporadically, out of nowhere, . . . while I’m sitting with them, and they’re telling me about, you know, uh, being raped, or being tortured or being abused . . . and how that hits me . . . [is that] I feel like it just kinda comes like somebody punched me.” Samantha’s descriptions of these experiences certainly have an assaultive quality to them, but, notably, she had also associated these same terms with images of attunement and fusion with the client. In this instance and others with the participants’ reports, each experience is not confined to one category or one way of making meaning of it. A variety of dynamics can be experienced simultaneously, and the subjective nature of perception and meaning-making is evident.
**Other images.** A few other images were presented by the participants that did not fit into the stated categories but nevertheless are significant. Adrienne previously viewed herself as “a faucet,” giving and nurturing other people, but said that the faucet turned off when she was diagnosed with breast cancer. She reported that it was her “psychology”: “I was giving to everyone else—too many people—overgiving and not being in balance with my own needs. I didn’t get what I needed.” Another image was of “feeling the pull,” which Lisa discussed regarding a few different situations of projective identification.

**Most frequently reported occasions of somatic experiences.** Based on the reported somatic experience phenomena, this section is an analysis of themes emerging from the most commonly reported situations and meanings participants associated with somatic experiences. Participants most often noted somatic experiences in the following scenarios: the therapist’s own wounds were activated, the therapist felt threatened, the client had not communicated or acknowledged significant material or emotions, the client expressed trauma or endangerment, the client had a health condition, the therapist had a Herculean desire to rescue the client, positive transference was experienced, and the therapist had a need for self-care. A few notable examples are given to illustrate these themes. Multiple themes apply simultaneously.

*Activation of therapists’ wounds.* Frequently, therapists reported somatic experiences associated with their own wounds being activated by (a) a client’s case material, spoken or unspoken, resonating consciously or subconsciously with the wounds of the therapist; or (b) the therapist’s personal life events other than client material. This theme was previously described in the subsection “Relationship between personal wounds and somatic experiences.”
Therapists’ feeling of threat. Therapists’ somatic experiences were sometimes associated with feeling threatened by a client due to (a) the therapist’s prior wounds being activated, (b) the therapist’s current fear of being wounded by the client, or (c) some combination of both. Included in this category are Peter’s combined emotional-postural somatic experiences that occurred when he said he “felt threatened” by clients and, after a period of reflection, realized that his responses were due to his own childhood woundings. Notably, he described being triggered clients with traits such as “grandiosity,” “a guy who knows it all,” and “emotionally disassociated,” which could be perceived as narcissistic personality traits of the client. Lisa also reported similar emotional-postural somatic responses as a projective identification with clients she identified as having narcissistic traits, when she was “not feeling like it’s safe . . . to be visible and fully present,” and felt “a strong pull . . . to collapse,” which she related to her early woundings. Both Peter’s and Lisa’s cases were alike in that they were both triggered by clients with seemingly narcissistic personality traits, and they each responded with both emotional and postural somatic experiences.

Eddie discussed experiencing a shivering and shaking in his left leg, sometimes combined with stomach cramps, when he detected “a threat in the air” while working with clients who either bullied or were being bullied. About this occurrence, he stated,

That’s usually a sign for me that I’m scared of something. So that’s my anxiety and fear express[ing] themselves, and there’s been a number of cases where I’ve felt insecure and afraid of the person itself or for what they have told me or for what they threaten to do once they would leave the office, and that’s, for me, a clear sign—that I don’t have total access to the real fear that I’m experiencing, and its only when my leg and my left knee start to shiver that I get to recognize its true dimension.

The somatic experiences in his leg he related to the physical and emotional woundings from his leg injury as well as his experience of being bullied himself. The threat he
experienced was an empathic feeling and concern for the person who may be potentially threatened by the bullying.

Howard described feeling threatened, somatically angry, and upset by a client who was screaming at him and berating him and called the experience “a real knockover” that sent him into another depression. He feared that the depression would become worse, like the one he had suffered years before. In the interview, Adrienne spoke with me about feeling threatened by the presence of a malevolent person in her psychic space and having the energetic sense of its presence:

Adrienne: I was seeing this client at an agency, and the head of the cult came to work at the agency—[it] was extremely disturbing. Extremely disturbing. It is a tactic they use to try to scare people out therapy, like to make it totally unsafe to go there. And [when] I was lying in my bed . . . one time when I was in a hypnagogic state, I experienced the energetic presence of this cult member trying to get into my energy field. It was a horrible feeling.

Researcher: What did it feel like?

Adrienne: Like energy invasion, like something else was gonna just get inside of me. Something very dark and awful was going to try to take over my body.

Although the possibility is that the participants may have had previous wounding experiences associated with these somatic responses, neither Howard nor Adrienne specifically related any previous experiences to these incidents; these were present threats. Whereas Howard’s somatic experience was felt primarily as an emotion, Adrienne’s also involved an energetic sensation as well as conceptual images. All the reported instances of somatic experiences associated with feeling threatened included an emotional component.

Clients’ unacknowledged or unexpressed material. Most participants noticed that they frequently had somatic experiences relating to unacknowledged, unexpressed, or
overly intellectualized client material that was dissociated from emotion, and they observed that the somatic symptom would lessen or dissipate after it was acknowledged in some way by either party. Eve explained that somatic experiences such as sadness in her heart area, face, or behind her eyes often occurred “where the client is not reporting any emotion whatsoever,” adding, “There’s just no emotional content in what they—in their face or their body or their story, and then I feel just sadness.”

Lisa observed that when a client would intellectualize a situation and not acknowledge or express any appropriate emotion, she felt the emotions physically along with an impulse. In one case, before the client was able to identify and feel her own anger, Lisa felt angry on the client’s behalf and felt an impulse to want to “strangle” the person causing her client pain and anger. She particularly noticed somatic experiences related to unexpressed emotions when she worked with young college students:

When they’re not feeling their anger, when it’s even more unconscious, I started to get more animated. . . . I just . . . notice myself shifting in my chair more and kind of leaning in more and kind of feeling this energetic pull of like, “Come on, get on board, feel it.”

Referring to occasions when she could see in the clients’ body language or hear in the affect in their voices that they were finally feeling their previously unacknowledged emotion, Lisa said, “I can feel that they’re feeling it, then I notice the anger subsides in me.”

Peter observed, “I think when clients are disassociated from some kind of feeling, it’s very likely that I’m going to have a somatic response, because I feel I’m in tune with that part that has been disassociated.” These somatic experiences often come for Peter in the form of emotions and somatic sensations at the beginning of a session, either before a client shares pain or feelings or when a client remains disassociated from emotions.
The connection between somatic experiences and unexpressed client material was implied by Adrienne with a conceptual image: “My body is a mirror of what’s going on in other people.” She learned that she continually takes in “the pains and also the emotional states of other people.” Additionally, she reported that when she finds herself experiencing the sensation of “a real heaviness in the eyes,” with “sleep chemicals start[ing] to circulate,” she has started asking clients, “Is there something that’s really on your mind that you haven’t mentioned yet?” which, she has found, usually prompts her clients to share “the real thing”—the material that she was feeling but they had not yet expressed.

In Eddie’s experience, he would often feel “colics and cramps” in his stomach and “intestinal derangement” when he was with a client he described as having some combination of repressed or unexpressed anger, passive aggressive behavior, and an “acidity within them,” which he described as “very camouflaged” and “very subtle,” and with “a slight sadism in their discourse.” Though these somatic experiences seemed associated with these situations in clients, he also emphasized that he did not rely upon the stomach sensations as an indicator, because “it’s difficult to discern.”

Another example Eddie presented was his “Jungian Jukebox” experience, which he said tended to occur when “there’s no therapeutic bond yet, no alliance formed, . . . [in] the early stages of therapy.” He stated, “That’s how I get access to the hidden stuff, . . . what’s not being communicated,” essentially describing receiving intuitive information in this manner. Along the same lines, Samantha noted, “My somatic experiences have helped me, along with my intuitions about patients to ‘get it,’ aka formulate already in my head what they may be experiencing and tap into it.”
Clients’ trauma. With clients who had suffered trauma of some kind, participants noticed corresponding somatic experiences, both when the trauma and associated feelings were initially not expressed (such as the category above) as well as during the client’s report of the trauma. Samantha experienced sensations “like a knife was going in [her] gut” or “constricting” and “collapsing” feelings in her stomach and intestines when working with victims of trauma, especially when working with a particular adolescent, who suffered “a pretty extreme case” of trauma. Samantha and Eddie also discussed frequent somatic experiences when they worked with clients who experienced the trauma of being bullied.

Peter described experiencing physiological somatic responses as he listened to a new client describe the trauma of being strangled by her father. He said, “I went into autonomic nervous system reaction, I went into distress, my hands were sweating” and added, “I was frozen. I couldn’t move. . . . I could see my whole self retreating.” He clarified that a major part of his experience of panic was the fear of the projective identification that would make him “that strangling father” in the therapeutic dynamic. Only after a supervision session and working through the destructiveness and the violence he faced within himself did he feel that he could commit to working with a client who had suffered the trauma of violence by a relative.

Clients’ health condition. Participants reported somatic experiences coinciding with clients’ health conditions including chronic and acute pain, injuries, and serious mental or physical illnesses. Peter noticed that when he works with clients who have life-threatening diagnoses such as cancer or AIDS, he feels death anxiety, and when the client is sick, severely depressed, or close to psychosis, he feels the “most acute” body
sensations, including feeling “burdened” or “drained.” He said he felt the somatic experiences “immediately” when the clients arrived, and he felt “okay” when the clients left. He likened his experience to being a “mirror” of how the clients feel.

Howard reported that when he has seen clients who have a serious illness such as cancer, he has felt “despair” and, on one occasion, experienced an alarming pain in his body in the same location as his client’s cancer. Because of his energy healing training, he also feels illness and dis-ease in clients’ energy bodies through sensations in his hands.

Adrienne said, “I still will take on the physical things of people,” such as their pain, and she noted that she is cautious as to whom she spends time with in close proximity, including partners. She revealed, “If I’m in the physical presence of someone who is really down, it might be a couple hours before I totally shake that. . . . I’m tired after session and I just have to go and rest, take a little nap.” Doing distance therapy is easier for her, because her somatic experiences related to taking on others physical conditions are much less intense and less frequent. She explained, “I don’t take on nearly as much of the physical impact when it’s the telephone thing, because I’m not in the physical field of that person.”

Eve observed that her existing jaw pain and neck and shoulder tightness became more intense when clients who also had similar physical issues were present in session. Also, she connected clients’ experience of medical trauma or anesthesia with feeling a sense of spaciness and fogginess in her eyes. Eddie reported many somatic experiences in relation to clients’ physical or mental health issues. When he saw a client who suffered from alopecia, Eddie’s skin itched in the same places as the client’s rashes and missing hair. With clients are dealing with OCD or addictions, his eye will begin to close
halfway. When he works with clients who have kidney dysfunction, dehydration, or are strong coffee drinkers, he finds himself thirsty. In addition, when seeing clients who struggle with obesity, he has lumbar pain.

*The Herculean desire to rescue the client.* Though the theme of desiring to rescue clients was not commonly reported among the participants in this study, it was reported by one participant and is included because it represents a significant archetypal theme that may be more common in the psychological field than is discussed both in this study and the field at large. As mentioned in the literature review, Chiron had been accidentally wounded by the poison arrow of Herakles, also known as the Roman Hercules, who, according to Hillman (1979), represents the heroic ego with the desire to eliminate sickness, death, and the underworld. For Chiron, the Herculean arrow ironically caused an incurable wound, which reflects the concept: “That which we resist, persists.” The influence of this Herculean heroic ego on our society wounds us all by creating unrealistic expectations of healing and eliminating sickness and death, though for deeper, lasting healing at the soul level, the incurable wound brings us to confront and work through the emotions and wounds at our depths.

Illustrating this archetypal theme, Lisa shared her awareness of working with certain clients who elicit in her an impulse to rescue them. When she worked with young college students, many of who had never been in therapy before and still lived at home with their parents, she viewed them as “more innocent” and “not able to be independent,” and she observed that, therefore, she felt prompted to “work harder” than the client. She acknowledged that the presence of her own unresolved grief contributed to the intensity
of her emotionally driven somatic experiences and noted that it was sometimes difficult to be fully present with her college-age clients’ grief without the impulse to rescue.

One client in particular whom Lisa discussed had childhood wounding experiences similar to Lisa’s, which triggered somatically felt emotions of grief and anger in Lisa that she attributed to feeling both the client’s unexpressed feelings as well as her own. She observed, “I just kind of well up, and I have to catch myself. And . . . my protective countertransference comes out, and then I kind of notice . . . wanting to rescue her or protect her or . . . push to help her to advocate herself.” She further described the somatic feelings of grief as “in the chest, it’s kind of this fullness” and added,

> Often, for me, the grief is kind of like a pain or like a tender feeling in my heart and then just kind of this heavy feeling in my chest with kind of a little bit of collapse and then the tears with her. That’s happened a few times, and then tears come to my eyes.

Although Lisa is the only participant who spoke at length about the desire to rescue a client from pain in connection with her somatic experiences, others hinted at this through discussing their somatic experiences in association with positive transference. As wounded healers who came into this work as a result of being wounded, it follows that a desire exists to heal others’ pain because of their own struggles with the personal experience of pain.

*Positive transference.* Participant therapists reported having more pleasant somatic experiences when they feel successful in helping clients heal or they receive positive feedback from their clients. Samantha stated she experienced a “rush of adrenaline” and a feeling of “euphoria” when she received acknowledgement from a client that she had been helpful. She further explained her feelings: “like I just had a great
workout,” “like I’m on top of the world!” “like a weight has been lifted off” as well as “like I just lost 15 pounds.”

With regard to receiving expressions of praise or gratitude from his clients or hearing the good news of a client’s condition improving, Howard described feeling “excited,” and a great deal of “joy” and “delight,” which, somatically, he associated with feeling “lighter” and “feeling good.” Similar to Samantha, Howard described it feeling like “a win” when he receives positive feedback about his work. He commented about receiving a hug from a challenging client: “That felt good, because I’m succeeding in some level of helping these people.” Adrienne also reported having positive emotionally based somatic experiences when she successfully helped an earthbound spirit cross over to the light, which, in turn, helped her client from whom the earthbound spirit was drawing energy and negatively affecting her. Adrienne said, “This indescribably happy feeling . . . [electronic interference] comes over me and it’s like, ‘Oh I think that worked!’” These positive experiences can be especially rewarding and encouraging to the therapist, considering the high level of emotional and energetic requirements of the profession.

Therapists’ need for self-care. The need for self-care on a regular basis was a significant point made by several of the participants, and some reported that when they were providing themselves with less than sufficient self-care, they had somatic experiences. Lisa noticed the occasions when she would feel the impulse to retreat into the “collapsing” posture and the associated role of “being too much of a caretaker,” being unable to assert herself and feeling that she did not matter, because the client was more important. With increasing awareness of that dynamic, however, she began to realize
when it was happening and consciously try to shift out of it, adjust her posture, and take care of herself. She explained, “I don’t want to go to that place. That’s not helpful for the client, it’s not going to be helpful for me or this relationship.”

Samantha reported periods of time when she was getting sick frequently, including recurring bronchitis and strep throat, and having more intense somatic experiences, which included the increased sensations of feeling stabbed and feeling full. She attributed these effects to the combination of several stressful life events and losses and working as an intern in a clinic where she had a heavy workload and a tense and hostile relationship with her supervisor. In addition, she described her perception of the therapist’s roles and responsibilities as having “to metabolize” and “contain” client material and said that if she does not engage in sufficient self-care to process it, she becomes “really full.” She explained, “It just keeps building and building then I think that I tend to get sick.” Exercise, sleeping, doing something fun, practicing yoga and meditation, and receiving reflexology are some ways of self-care that help her metabolizes the material she takes in from others.

As a working psychotherapist, Peter emphasized the importance of engaging in regular process work in one’s own personal psychotherapy, body psychotherapy, or supervision as self-care. He not only recognized these activities’ helpful role in his life and work, but he observed the unfortunate difference in colleagues who were not engaging in regular process work: “They accumulate these reactions in their body and then they become sick.” He was saddened to have had lost a few of colleagues because of this, and he noted, “They were not working with the shadow issues on the body
countertransference with their clients, and it was very painful to see that.” This experience, however, reinforced his commitment to continue his personal work.

Adrienne had been diagnosed with a cancerous tumor in her left breast, and she shared a dream she had wherein she saw her “breast as a faucet, as in giving and nurturing other people,” and it “got turned off.” She, in turn, made meaning of the dream’s message that her tumor was about “overgiving” and being out of balance because of giving love and energy to everyone else but not taking care of having her own needs met or allowing herself to receive love. Since that time, she said, she has learned to love, forgive, and take better care of herself and her needs, which also includes taking naps, gardening, being in nature, taking salt-baths to recharge, and doing more of her work through Skype and the telephone.

In this study, the left side of the body was more often identified in reports of somatic experiences than the right was, and the types of associated conditions reported were more serious, chronic, and personal in nature. The left side is our receptive side, and as therapists who are in the business of receiving our clients’ troubles and giving nurturance to them, it is essential to have a sufficient balance of self-care to maintain our health and have energy available to give to oneself, one’s loved ones, and one’s clients. Unless we also receive nurturance and self-care for ourselves, not only are we not as effective for our clients, but we can also become more vulnerable to sickness and disease.

**Discernment and use of somatic experiences.** This section addresses the following questions: To whom does the somatic symptom belong, and how might this information be used for therapeutic benefit? With two wounded beings in the therapy
room, it becomes an important endeavor to identify whether the somatic experience is more indicative of the therapist’s own personal material, the client’s material, or the shared field so that the therapist can better understand how to interpret and utilize the information to facilitate healing and for whom.

**Process of differentiation.** Though one’s wounds may create an empathic opening, not every somatic symptom “belongs” to the therapist. If one is self-aware, it is easier to notice when something changes and therefore follow a process to discern to what or whom the somatic symptom may be associated. Several participants including Adrienne, Peter, and Eddie stated that they find their somatic symptoms more often indicative of what is going on with the client than themselves. Acknowledging the difficulty of this discernment, Adrienne said, “That’s always a question,” and yet reported finding that as frequently as nine out of 10 times, her somatic experience seemed more related to the client. Participants discussed various processes of discernment—emphasizing self-knowing, self-care factors, continual reflection and inquiry, noting the timing of the onset and duration of somatic experiences, tracking symptoms, and how their discernment processes evolved over time.

**Importance of knowing thyself:** Knowing oneself and one’s wounds intimately is the essential precondition of discernment, as discussed by the participants. They stressed the importance of maintaining awareness of the presence of their own wounds and how they are expressed somatically so that they can integrate them into their contextual “baseline,” which makes it easier to discern any other somatic changes that come about. These wounds may also serve as an opening through which the therapist experiences other somatic symptoms as well.
All of the participants expressed that psychotherapy or supervision has been useful to them in becoming familiar with and working through their wounds as well as serving a role in their vocation call to psychotherapy. Working through these experiences gave them opportunities to understand themselves and their bodies’ responses to their own issues. Most also discussed the significant role of psychotherapy/supervision in developing discernment and exploring the meaning of somatic experiences. Personal psychotherapy and supervision were helpful to the participants in knowing and understanding these somatic experiences so that they could better sort out their material from the client’s. Lisa explained, “In my own therapy, . . . I feel like I’ve gotten to the point where now I’m pretty clear most of the time what’s mine and what’s theirs . . . [including] knowing . . . what’s unresolved in me.” She described times when she felt a combination of emotional and somatic responses that she could identify as both the clients’ grief and her own. She added, “I just kind of know that from . . . knowing myself long enough.”

Mindfulness practices such as yoga and meditation were also underscored by the participants as a significant contributing factor in the development of their somatic awareness. Samantha stated, for example,

I’m really into being present. I’m really into meditation and yoga and, you know, appreciating the moment and living in the moment, so I think that probably, like I said, has to do a lot with why I feel so many things going on with my body.

Lisa explained, “I’ve done a lot of meditation over the years, so that’s really kind of helped me to have a body focus, as well as doing the SE work.” Peter also noted that he meditates regularly to center and quiet himself in order to be able to listen to himself and be in a place of openness and receptivity with a client. For Eve, puzzling personal
somatic experiences led her to pursue mindfulness, and mindfulness practices brought her attention to her body and onto the path of integrating body and mind in psychotherapeutic practice.

In one way or another, all the participants communicated the concept of becoming familiar with their baseline—their body state at the beginning of the day or beginning of the session—noting that the baseline may change from day to day or even throughout the day depending on eating, sleeping, or working habits. Being familiar with one’s body helps one know what is normal and what feels different when a shift occurs. The shifts are explored further in the section on the timing of somatic responses.

Participants emphasized the importance of being aware of their own vulnerabilities, on both emotional and physical levels. Most had become familiar with certain recurring somatic experiences, especially those that were associated with their personal wounds, having done their own process work to understand them. Eve suggested that her stiff neck and tight jaw had recently been vulnerabilities, as they were familiar pains that could be further activated when working with clients. Eddie also identified several of his vulnerabilities that become activated with clients, the most prominent being his left leg and knee plus lumbar pain associated with his leg injury. He explained that when he worked with someone who had obesity, he would often have lumbar pain, not because he himself had ever had a weight problem but because of the preexisting vulnerability in his back. He reported these as very distinct pains, which he can discern because of his attentiveness and familiarity with his body. He said, “I can differentiate between the pain that I experience when I’m dealing with somebody with obesity and just wrong posture. And that’s my own wrong posture. I can differentiate that.”
Physical health and self-care factors. In association with knowing oneself, basic self-care and lifestyle factors are pertinent to consider in the discernment of somatic symptoms before needing to explore any deeper. Eddie, for example, discussed times when he has felt stomach discomfort: “Sometimes I can even explain it physiologically. Umm . . . I had no breakfast, or I drank too much coffee. Then, that’s a no brainer.” Peter similarly offered,

If I look at that pain and . . . it doesn’t disappear, then I say, oh yes, this is mine, because such and such—I’ve been working too many hours or I overexercised the other day, or I slept in the wrong position—this kind of thing.

Peter mentioned other somatic experiences he related to disregarding his self-care. He said, “In times of stress, I disregard my self-care and just not eat what’s right for me and immediately get soreness . . . [and] very strong pain,” which he interpreted as neglecting to nurture himself and added, “It’s an experience of not being mindful of me.” He also shared that on occasions when he felt very sad and did not allow himself to cry, he physically experienced “liquid retention.” He emphasized the importance of a healer to engage in self-care in order to continue doing this type of work. Adrienne also made important connections between communication of emotion as self-care and somatic experiences related to her cancer experience. She found that her kirlian photographs showed clearer, more vibrant energy after crying than before her emotional expression and related that she associated her dis-ease of cancer with her previous lack of self-care, nurturance, and communication of her feelings.

Samantha emphasized the importance of regular self-care as a psychotherapist because of the demanding nature of the work and the toll that it can take. She offered examples of times when she was not exercising sufficient self-care and working long
hours, especially when she was working at a clinic where the environment greatly contributed to her stress and her somatic experiences were much more intense and severe. When considering the meaning she made of her somatic symptoms, Samantha, therefore factored into the discernment equation her overall work environment, personal life, and related degree of self-care measures.

Eve also made reference to self-care issues in considering her somatic symptoms. She said she is sometimes aware of factors like not sleeping well, or doing “a cleanse” and therefore not having had a “grounded” meal and feeling like she “could just float away,” and added that these self-care elements could contribute to the likelihood of her becoming anxious right along with an anxious client. Engaging in an ongoing self-care process and grounding exercises had become part of Eve’s practice, which she said included checking in with her breathing, grounding, feeling her “bones in her chair,” or pushing into the floor with her legs. This could help her discern and get clearer if the somatic experience was related to her self-care needs or some other factor.

*Self-reflective questioning.* Self-reflective questioning involves a process of continued exploration of the self in new circumstances rather than focusing on what is already known. Participants frequently described checking in with themselves and querying the meaning of their somatic experiences. Eve discussed an example of what occurs in her discernment process: “If the intuition is there and the somatic experience of something I’m being drawn towards doesn’t fit, . . . I will take time and pause and check in and see what is going on with my body while I think about this.”

Peter shared how his self-reflective questions played a role in his discernment process with regard to the ownership of his somatic experiences.
Once there is ownership, then there’s no other feelings, there’s no fear . . . or unconscious response to the client, or . . . collusion with the client, because you’re ready to say, . . . “What is really, really mine?” and “What is true for me?”—from every angle I can see myself—or I can have a supervision session, for somebody else to be there with me, and . . . ask, “Why have I responded to this in this way? Where did I feel triggered? Where did I feel threatened? Why did the client make me feel threatened? And why did I . . . [go] there?” . . . Once I’m really grounded . . . , then the somatic experience is totally different. And then I can really hold the client to go through their issues.

Peter’s explanation exemplifies the complexity of a somatic experience. Often, part of it reflects the therapist’s own issues, projective identifications, and countertransferential reactions, while at the same time those somatic symptoms may also be giving information about the client to the therapist. His self-reflective questioning process helped him to sort through the complexities and discern the ways in which the somatic experience belonged to him as well as the client.

Some participants described using recognition of a certain symptom to engage in reflective questioning. Eddie, for instance, referred to somatic experiences such as his leg twitching or his eye closing “as a trigger” to “probe deeper” and ask more questions. He learned that his eye (or thirst or leg) symptoms primarily became an indicator of what was going on with his client, even though it had “a resonance” with his “own personal history.”

Despite the fact that he frequently found his somatic experiences to be client related, he said he could not rely on them. Sometimes he would experience “intestinal derangement—sort of colics and cramps” in his stomach, which he said were often related to characteristics of passive aggressive behavior in clients. Because this correlation is often “difficult to discern,” Eddie said he begins with an initial assumption—“I always assume I am wrong. I always assume it’s mine first”—and then checks in with himself:
I’ll always put it on the table and I try to investigate whether it’s relevant or not. So, I’m not so sure that the fact that it’s coming is necessarily relevant. Part of it is just my own curiosity, you know—I’m just going to investigate this just to make sure this isn’t a missed opportunity.

Sometimes this self-reflective process can take weeks or remain ongoing for him, and he often brings these queries into his own therapy and, at times, takes his familial history into account to find a meaningful connection to the somatic experience, as in the case of his stuttering with a certain client. He further explained,

Sometimes it’s just my own unworked issues that start to surface, and I might have the tendency to take the high ground and think that this has something to do with the client, and it has nothing to do with my own history—and in those moments, I take a step back and . . . I write that down after the session and then discuss it with my own therapist, . . . try[ing] to do some sort of follow up. And more often than not, if I go deep enough into those symptoms and bring some sort of meaning and closure to them, they don’t seem to reoccur. . . . If they come back again, it’s because I somehow didn’t really work on them enough, and then they keep on cropping up and cropping up, and then I know . . . this is still a glass roof. This can break, anytime.

When Eddie referenced the “glass roof,” he was referring to ongoing issues or wounds that have not been fully processed and that can break through at anytime. He alluded that the somatic symptoms that persist usually require more self-reflective questioning and indicate unworked issues within himself, the therapist.

**Timing: Onset and duration.** A commonly considered factor in the discernment process is the timing of the somatic experience with regard to the onset of a symptom and what it may coincide with as well as the duration of the somatic experience. Several of the participants observed that when the onset of the somatic experience was sudden and in the presence of the client, such as Adrienne reported—“a sudden onset of a sharp pain or an extremely uncomfortable feeling”—it seemed more often to reflect the client’s material. Timing as a method for discernment is directly interrelated with the precondition of knowing oneself and one’s baseline, as the following examples illustrate.
In describing how she differentiated to whom the somatic experience seemed most related, Eve explained,

The most obvious way is just if something changes when the client comes in the room, or changes when the client leaves the room. And so that it wasn’t there before, and now they’re here, and it’s there, and all of a sudden I’m like, whoah, I cannot stay awake. Ten minutes ago I had lots of energy, and I was feeling fine. So, so that’s more of an obvious—it’s probably the client.

Her explanation demonstrates the combined use of knowing oneself and one’s baseline and timing as discernment strategies. Peter exemplified this same reasoning in his discernment process:

Sometimes before clients arrive—some clients—I get bodily feelings, and I say, “How strange—I was not feeling like that. Now I feel a burden in my shoulder or a tension in my leg, and I’m really fatigued, I’m really tired,” like all my energy goes down (makes expressive vocalization), and I feel like I want to go to sleep, but I was not like that before the client. In the beginning of my day, I was perfectly normal perfectly good. And then when the client shows up and complains, and I just wait for that, and they confirm that “I have pain here and I have pain here, and I’m so tired.”

Peter’s account illustrates receiving direct feedback from the client, validating his sense that his somatic experiences were reflective of the client rather than this own. He also noted that his symptoms would promptly disappear in those cases. Relatedly, Lisa noted that as clients reported their symptoms, hers would fade: “As soon as they feel it, then it subsides in me.”

Samantha also primarily associated to client material those somatic experiences that came on suddenly with the arrival of a client. She reported, “I’ll be feeling you know, like a baseline,” which she said included taking into account whatever else she had going on in her personal life. She explained,

If there’s something that’s completely—like, I wasn’t feeling sick or I didn’t feel like I had to rush up to the bathroom or whatever—and then all of a sudden I feel like somebody stabbed me or I have a mess of intestines in my stomach and
they’re constricting, . . . and that wasn’t happening before, . . . it makes me feel like it’s something more to do with the client than me.

At the same time, she did not preclude the experience as associated to her own wounds but rather was noting that she perceived a significant correlation between the arrival of her somatic experience and client material.

On the other hand, Samantha found that if a somatic experience came on gradually, “built up towards the end of the session,” and continued afterwards, she would be more likely to inquire as to what part of that experience or symptom might belong to her. Peter said something similar: “If I look at that pain and, say, it doesn’t disappear, then I say, oh, yes, this is mine because such and such.” In the cases where a pain came on suddenly with the arrival of a client, as he described above, Peter similarly offered, “If they don’t say anything, and the symptom in the body doesn’t get relief or disappear within the very first moments of the session, I just say, well, it’s probably mine and I have to look at it.” In the last example in the previous section, Eddie noted that the ongoing duration of some somatic experiences generally point to his own issues and that once they have been worked all the way through to the point of closure, “they don’t seem to reoccur,” but if he does not “somehow really work on them enough,” then “they keep on cropping up and cropping up.”

Tracking. The concept of tracking was discussed by several of the participants as a way to discern the source of somatic experience by simultaneously following the state of their clients and as well as their own inner state and noting any shifts, including somatic symptoms. This practice is similar to and used along with self-reflective questioning, but it involves a dual-channeled observation of both self and other. Adrienne described the process with a certain client: “There was one part of me that was
monitoring my feelings . . . [as well as] another part of me that was staying present with her story, and hearing how that was for her.” Samantha explained that when a somatic experience occurs, she will “follow” it throughout the session, watching for any shifts, changes, and associations within herself and her client.

When I asked Peter how he discerns the difference between what he feels is related to his patient that he feels he is taking on versus what felt related to an old wound of his own, he responded, “It’s both/and: both the reason and experience of other layers (pause). It’s the client’s issue impacting my own wound. [The] experience of the very first moments are, like, confused or fused or together.” Peter described what he does when notices fusion or confusion between him and a client at the beginning of a session: “As I process through awareness, I track the client and I track myself at the same time.”

Both Lisa and Eve, who practice the Somatic Experiencing technique, often used the term tracking. Lisa stated that, at times, she would “track” countertransference feelings she became aware of in session and was beginning to “track” somatic responses more often. Eve used the term tracking in conjunction with awareness of her baseline, “tracking” the patient and herself. When she begins noticing her eyes feeling tired, for example, she will “track” when they shift to becoming spacey along with any disassociation simultaneously happening with a particular client. After tracking and processing her somatic experiences and countertransference feelings, she came to the discerning conclusion, “This doesn’t mean I’m a tired therapist, this means something is going on with this person.”

Energetic and spiritually based differentiation techniques. Adrienne reported using a combination of kinesiology-based muscle-testing and spiritual guidance at times
to discern to whom the somatic symptom was more related. She said, “When I have a
sensation come up, I go inside, and I ask of my own guidance—like I’ll muscle test
internally—‘this is my issue’ versus ‘this is their issue.’” When Howard was engaged in
energy healing, it seemed that his somatic sensations were more clearly discernable. In
those cases, the sensations he felt were usually in direct response to the area of the
client’s energy field with which he was in contact. He noted, however, that some
sensations he experienced, such as his pain in the same body location as his client’s
cancer and the syncing of his client’s and his heartbeats, remain a mystery.

*Shifts in discernment processes occurring with experience.* A few participants
indicated greater time and experience in the psychotherapeutic field have helped to
increase their ability to distinguish when somatic experiences are more indicative of the
client’s material or their own. Peter, in particular, shared extensively about the
development of his discernment processes. He expressed his initial confusion: “If I talked
to you from 10 years ago, I would be really in collusion with my clients with their
somatic symptoms.” He said,

> In the very beginning of my practice I thought all those issues were mine. But slowly through practice I learned to discern what was mine what was a client’s, and, of course, eventually, as I moved through the process, some clients did trigger old wounds from early childhood or from teenage years—and then those were subjects for lengthy therapy sessions and supervision as well.

> Peter had learned to distinguish the difference or to check it out with the client, more often finding out that the somatic occurrence was informative of the client’s experience. In contrast, he described examples from his earlier years when he
misattributed some somatic experiences as related to the client, and after later reflection,
he realized he was not aware of or owning his own feelings, as in the case of the
previously described “rage pack” and the “puffed up” posture. These examples illustrate
the difficulty and complexity in discernment, especially as a beginning therapist. Now, with more experience, Peter said he “receives the impact ahead,” meaning that he feels that he can anticipate which types of client material potentially could trigger his issues. He added that since he has done much deep personal work, he knows how to stay with a feeling, recognizing how he feels affected by a client, and continues to utilize his own therapy and supervision to be in a clear place in sessions.

Eddie explained how experience has affected his process:

I always assume that it’s something that is going on with myself. I always assume that I’m wrong. . . . I assume that it’s something going on with me. But, for the sake of ruling that out, then I probe those questions. And there’s been a number of times that it was clearly my own stuff and not having to do with the person. So I exercise, I would say, a good deal of caution . . . [regarding] making any assumptions.

He added, “But I still have to test it.” Over time, he has found, “The majority of times . . . I would say that it is not my own history,” meaning that it was more to do with the client than his personal wound, even if the location of his somatic experience was related to his personal history. “It confirms that my resonance is right,” he said.

Adrienne also observed that in the beginning, even before she began psychotherapeutic work, she often felt the emotional and physical feelings of others but misattributed those feelings as her own. As she began to understand about her nature of empathically taking on the feelings of others, she began to recognize it and find ways to better protect herself. Now, she finds that nine out of 10 occurrences of somatic experiences seem more related to her clients than to herself, whereas in the beginning, she felt that it was the opposite.

*Therapeutic use of somatic experiences.* This study’s primary focus has been to explore phenomenologically the experience of therapists’ somatic experiences and the
meaning and understandings they make of them, especially regarding connections made to their own wounding experiences. The question that follows is: In what ways can a therapist use this information to facilitate the healing process? The section “Images of the somatic field dynamics” touched upon the use of somatic experiences for conceptual understanding, essentially indicating a depth psychological perspective. This section, in contrast, considers the ways in which participants made therapeutic use of their somatic experiences in psychotherapy sessions in terms of the therapeutic action they took, in the form of decisions, statements, and questions. Participants generally described using their somatic experiences and understandings thereof as an informational guide from which to ask their clients further questions and gather additional information.

Adrienne shared, “If I feel a sudden onset of a sharp pain or an extremely uncomfortable feeling, I will ask them,” posing questions to client’s such as “Is there anything going on in your back?” She found that in most cases, her clients validated that they were, in fact, experiencing an emotion that she asked them about.

When Eve experienced sensations of spaciness with her eyes in a particular client situation, it prompted her to shift her approach in session. She shared, “For me, then that’s a clue that we need to slow down . . . or check in with the person, like—’What are you experiencing right now? . . . Do you feel yourself spacing out? . . . Are you leaving? . . . Are you staying here?’” Eve indicated that with increased experience and maturation as a therapist, she has begun to trust herself more and feels “more bold” and comfortable using her somatic experiences as information to act upon, especially when she has strong rapport with a client. She added that she would help the client to “name the patterns” and would suggest to the client, “Just notice what’s happening in your eyes,” because she felt
the client was onto something “overwhelming” and need to stay with the sensation to explore its meaning and associations more deeply.

Eddie frequently referred to his somatic experiences as “triggers” or “indicators” associated with certain familiar situations, alerting him to “pay more attention” and “probe into” further questions. He noted, for example, that when he would notice his left eye twitching and beginning to close half way in a session, based on his past experience, he often saw it as an “indicator” of addictions, substance abuse, or obsessive compulsive behavior in his client. He added, “That’s for me a trigger then to probe into those questions, and quite often they are on target.” Another example he presented was that when he would feel thirsty, he would also probe into that and question the client’s “vitality levels and their coffee consumption,” often finding some combination of high coffee consumption, high anxiety, many phobias, or kidney dysfunction. Sharing many somatic experiences along with his overall philosophy, Eddie said that although every somatic experience may not be relevant to the client, either way, he will “always put it on the table . . . to investigate this, just to make sure this isn’t a missed opportunity.” He also viewed each somatic experience as useful in helping him to “sink in with a client” and said that this “reinforces the therapeutic relationship, because there is a lot of mutual congruence.”

Peter had come to trust that he could use his body as a mirror. He had perceived that when somatic feelings came to him before a client arrived, there would be a strong chance that the client would be experiencing the same thing. For Peter, the somatic experience served as a useful empathic tool: “It’s like, I’m gonna have the same thing as you have, so that I will know what you are going through. And we will start our session
from there.” When asked if he shared his somatic experience with the client, he replied that he did not and explained, “Because that would sound very magical, or that I know it all, and know all these things. And I don’t want to bring this element to my practice.” He said he uses the information privately as a guide for himself. He clarified that if the client did not mention anything about the symptom and if his own bodily symptoms did not dissipate, he would examine it further and assume that it was more related to him personally. Sometimes he found it challenging to relax and be patient, “just be[ing] with the person,” sitting with the anxiety of wondering how long it might take a client to reach recognition or acceptance of an issue or feeling “and not . . . feed it into them or anything” but instead be able to use his experiences somehow to make suggestions and artfully “bring it into the room.”

Some participants reported that, at times, they would share their somatic experiences in sessions with clients to explore if they connected with it, and if so, help them identify and connect with their own feelings. Eve said that in situations when she experienced tension or strong emotional feelings in her body, she often would ask clients if they were aware of any emotions or feelings in their bodies; for example, she would identify what she was experiencing by saying, “I’m feeling a lot of sadness,” or she might say, “I’ll just throw this out there, and you can see if it fits with your experience or not, but I feel just there’s tension in my jaw.” She noted that her somatic experience would dissipate when she acknowledged it in someway rather than being dependent on whether or not a client acknowledged a connection with the feeling.

Samantha also reported that she shared her somatic sensations with her clients in some situations, depending on the client’s maturity and fragility. She described telling a
particular client who had an abusive boyfriend, “You know, as you’re telling me this, my stomach is just tightening, and I’m feeling like constant—like I can’t take anymore and I’m wondering if you were feeling anything similar when you guys were fighting and he had you pinned down?” Samantha observed that when she shared her somatic experiences with clients, they felt “less severe” because then they could “share it together,” and she would not have to “carry it for them.”

Lisa discussed experiencing frequent somatic responses when a client was not acknowledging his or her emotional feeling and said she used her somatic experiences as a prompt to ask questions to help the client to identify and express those feelings. She explained,

I usually am silent about it, but there’s been times when I’ve brought it up. . . . It’s usually when I feel like I’ve tried everything else and nothing else is working, then I’ll say, “You know, I’m not sure what this is about exactly. I don’t know if this is me, mine or yours, but this is what I’m feeling.”

Her approach was usually to keep the somatic experience to herself, but in the select times that she shared it, she had generally found it to be helpful to the clients.

The somatic sensations that Howard mentioned utilizing were those he felt in his hands, which helped him to discern the location of the physical or energetic issue in a client’s energy body and then send healing energy to that area. He often discussed these types of sensations with the client as well as the occurrence of synced heartbeats, perhaps to demonstrate his ability to empathize and be “in sync” with the client.

**Researcher’s Reflections on Somatic experiences and Synchronicities in the Research Process**

Because this research topic was born out of my curiosity and experience with my own frequent somatic experiences in both personal and professional life, it comes as no surprise that I continued to have somatic experiences throughout the various stages of the
dissertation process, including conducting interviews. In this section I note a few of the most recent somatic experiences and synchronicities that reflect a parallel process.

During the interview process, I observed several instances of somatic experience. When I interviewed Eve, my eyes began to feel hazy and unclear, as if there was a smoke in the room. This sensation became noticeably pronounced when she spoke about her own somatic experiences with her eyes. To my knowledge, neither she nor I outwardly matched Eve’s description of the types of clients that would typically bring on that symptom in her eyes. I wondered if I was perhaps experiencing an empathic response to her somatic experience with clients. When I was interviewing Samantha, I began to notice an anxious feeling in my chest and then asked her if she was having any somatic feelings during the interview. I usually asked participants this question at the end of the interview, but because the somatic experience caught my attention, I asked her early on in the process. She responded that she was feeling “good anxiety” because she felt put “on the spot,” and she reporting a fluttering sensation in her chest, which matched my own somatic sensation. In both cases, my somatic sensations dissipated shortly after discussing the associated topics.

The most notable somatic experience I had in connection with the dissertation process was personal in nature, beginning in the time period of awaiting the approval of proposal and continuing for a couple of months, through six of the seven interviews with participant. A weighty pressure and heaviness square in the middle of my chest had come on strongly and abruptly. Initially, I thought it was anxiety—perhaps the anxiety of waiting for the proposal approval, the pressure I felt to complete the dissertation on time, the stress of multitasking my life. I am quite familiar with the many faces of my anxiety
and its frequent somatic appearances, but when the sensation did not dissipate after a week and instead became more intense, affecting my left side, it began to concern me. It felt almost like a foreign presence. I engaged in several rounds of active imagination and creative work and discussed it in therapy and, still, no movement. My anxiety increased and the symptoms increased, eventually leading me to pursue consultations with both allopathic and naturopathic medical doctors.

Meanwhile, I interviewed Howard. As he was demonstrating his method of energy healing and feeling the energy fields, he waved his hand slowly through the air across from me, saying,

I’ll do it from here. . . . I’ll show you. . . . But if I do this (puts his hand up, in his own chair across from me, demonstrates quietly). . . . That’s the place for me (points to an area of my body). You may not feel that, but that’s the place.

The frightening truth was that I did feel it, I felt the energy sensation in my chest and in my energy body and saw his hand exactly across from the area of my concern. I had not shared with him that I had any health concerns, or confirmed with him that I felt it, or indicated that I had concerns in the area he identified. I felt frightened that something seriously may have been wrong with me if he was able to zoom into that area so quickly and casually.

A few days later, I interviewed Adrienne, who shared with me her story of having cancer in her left breast and the significant lessons she learned from her experience, at the heart of which was her need for better self-care and the regular expression of her feelings and needs. As Adrienne spoke about her story, her lesson, and other aspects of her spiritual work, I had a powerful somatic experience of chills, hair standing on end, and a feeling of both warmth and excitement flushing through my energy field. It was a positive experience, another one of those that I feel frequently in circumstances when I
resonate strongly with something; hit upon a core issue of mine or a client’s; have a
numinous, synchronistic, or archetypal experience; or experience being “right on” about
something important. I had been reflecting on my ongoing somatic experience and was
concerned that I was being called to increase significantly the level and
comprehensiveness of my self-care. After hearing this message from all the participants,
especially Adrienne, I hoped I could learn the lesson of improving my self-care without
having to suffer from cancer or any other serious health condition. Shortly thereafter, I
made some other connections and was able to clear myself of personal and collective
issues as well nonpersonal spiritual issues in addition to receiving health care. Doctors
concluded that I was experiencing an emotionally driven physical health issue, and
diagnostics showed I was clear of any serious health conditions. I am thankful for this
somatic warning sign giving me the realization and opportunity to begin engaging in
more thorough self-care practices. As self-care was also a major theme communicated by
the majority of research participants, it is indicated to be a point of concern for all who
engage in practicing psychotherapy. My personal somatic experiences paralleling the
research process further demonstrated the mystery and value of somatic experiences and
the timing of their occurrences.
Chapter 5
Discussion and Conclusion

Overview

This study sought to investigate the types of somatic phenomena experienced by psychotherapists in the context of their psychotherapeutic work with clients. This study also investigates the meaning, connections, and therapeutic use the therapist makes of these experiences, with a particular emphasis on the therapist’s relationship with the Wounded Healer archetype in the therapeutic work. Interpretive phenomenological analysis (IPA) developed by Giorgi (1985), which qualitatively focuses on participants’ descriptions of phenomena, offered the most compatibility as a research method for this particular study. Seven psychotherapists to whom the research question was meaningful and significant were chosen to participate and share their somatic experiences. They described the meaningful connections they made to understand these phenomena with regard to their relationship to their personal wounds, their processes of discernment, and the utilization of these experiences in the therapeutic process.

A phenomenological analysis of the transcribed interviews resulted in the identification of themes and subthemes addressed in three categories presented in the preceding chapter: The Centrality of the Wounded Healer Archetype, Somatic Experiences, and Discernment and Use of Somatic Experiences in Psychotherapy. This chapter presents a summary discussion of these findings from a depth psychological perspective consistent with the research approach, followed by a review of the study’s limitations and delimitations, and concluding with the implications of the research.
Discussion of the Findings

The intention of this study was to bring attention to the therapist’s somatic experiences in the psychotherapy process and glean a more comprehensive understanding of these phenomena, which has too often been left out of the literature. Somatic experiences are often ignored in supervisory discussions of the countertransference, and in formal psychological education. Accordingly, somatic experiences can be difficult to understand and relate to, because the majority of therapists have not been trained to pay attention to or reflect upon them.

Participants in this study seemed to exhibit some difficulty describing their somatic experiences, as evidenced by their responses, which originally included many pauses, false starts, and the use of words such as “like,” and “um” that were largely edited out for the sake of readability. Furthermore, when study participants noticed somatic experiences, rather than solely noting them as somatic sensations or physiological responses, they described these experiences in various other ways. I categorize these as bodily felt emotions, behavioral impulses and postural shifts, and/or metaphorical concepts and images. These types of variance in the descriptions that emerged reflect the diverse ways in which somatic phenomena were experienced, processed, and understood.

Somatic phenomena were most often reported to affect participants’ “energy,” the heart and chest areas, and the stomach and intestinal areas. The surprisingly high frequency with which energy was discussed underscored the elusive, difficult-to-describe qualities common to somatic experiences as well as the participants’ implicit recognition of what is usually described as the ethereal or subtle body as part of their physically felt experience. Participants described somatic sensations in terms of ease and dis-ease,
comfort and discomfort, pleasure and pain, although more often the experiences that
gained the participants’ attention and concern were those of the dis-ease, discomfort, and
painful varieties. Sometimes a somatic experience was identified as an emotion felt in the
body. When bodily felt emotions were noted in conjunction with other somatic
experiences, the emotion was often reported first, preceding descriptions of other somatic
phenomena. Also, when postural shifts were reported, they were almost always
accompanied by an emotional experience as well.

Conceptual images also emerged from participants’ descriptions, representing
both localized experiences within their bodies as well as perceptions of somatic field
dynamics, with some crossover between groupings. The images emerging from
participants’ descriptions were significant as they illuminated ways of experiencing,
understanding, making meaning of somatic phenomena. The occurrence of these types of
responses also supports the premise that somatic phenomena can be difficult to describe
without the assistance of images and metaphorical language. The metaphorical
descriptions are consistent with a depth perspective and reflect conceptual and intuitive
understandings as to what participants perceive is happening in the field. The images are
supportive of Corbin’s (1964/1972) proposal that the “imaginative consciousness” is “the
organ which perceives” the mundus imaginalis (p. 2), and Samuels’ (1985a) conception
that all instances of embodied countertransference may be considered images or “bodily
visions” (1985a, p. 60). The emerging conceptual themes representing the somatic field
included images of attunement, lending one’s body, containment, fusion, catching illness
or pain, and assault.
Some of the thematic images that emerged from the participants’ descriptions have been previously discussed in the literature. Images of attunement spontaneously offered by the majority of participants, for example, were in alignment with the image Stone (2006) presented within his article, “Analyst’s Body as Tuning Fork.” Images of lending one’s body and containing were reminiscent of Popovic’s (2008) understanding of the Goddess Hekate, who personifies these images through the psychological functions of taking on and carrying the wounded, discarded, judged, disowned, repressed emotions, impulses, and other unacknowledged contents from humanity’s collective, personal, and bodily shadows and digesting them within her body. Further, Hekate is said to eat the garbage, nightmares, and discarded scraps of others, receiving them as offerings. She then digests and transforms them into suitable food for the soul, much like the role of a therapist, helping patients to contain, process, contain, and transform their indigestible feelings, issues, and experiences. This process is similar to Moore’s (2004) rendition of Hekate redeeming and validating the thoughts and feelings that are undervalued and unapproved in daily life. Based on these perspectives, the mythological image of Hekate is an embodiment of the imaginal container for the psychological processes of unfolding, unifying, and coming into being. Images of lending one’s body and catching illness also can be likened to the practices of shamanic healing, as described by Eliade (1951/1964) and Jung (1946/1982) with his concept of “psychic infection” (p. 177).

Another conceptual image, not specifically mentioned by participants but one that I have personally experienced, is that of a sponge, soaking in the energy, emotions, and physical pains of those in the room, which can be felt somatically. This image could be categorized either as containment or as catching pain/illness. Moreover, the implications
of this image and others in similar categories suggest the need for the therapist to engage in self-protection practices and heightened awareness. This might include visualizations or rituals borrowed from meditation, spiritual, energy, or shamanic practices to both protect one’s energy field and to cleanse and release whatever one may have taken on in the therapeutic process.

The data were also examined for possible correlations between the various modes of somatic experience and participants’ typology, and occurrences were noted where there was speculation that a participant’s typology may have been potentially meaningful to the situation. I observed, for example, that most of the somatic experiences described first or primarily as a bodily felt emotion were from those for whom feeling is dominant. Feeling types seemed to notice the emotions in their body before the other sensations registered. Emotionally felt somatic experiences often seemed to coincide with postural shift experiences. A higher percentage of concrete sensation descriptions were offered by sensation-types. Eddie, the only participant with a combined sensation-thinking typology, expressed his somatic experiences as sensations, noticeably more predominantly than others. He exhibited an outstanding ability to express clearly, through sensation language, his somatic experiences and make meaningful associations to them. I am curious whether the dominant thinking trait assists in the process of translating the sensations into language. Though I made some observations and speculations and raised questions that could prompt future studies, I was not able to make any definitive conclusions regarding the effects of typology with a small study size of only seven participants.

An assumption I hold from which I began this investigation is that all psychotherapists have experienced some level of painful, wounding experiences in their
lives. I therefore sought to investigate if and how therapists’ wounding experiences might relate to their somatic experiences. I was also curious to explore the relationship between wounding experiences and a therapist’s style of therapeutic practice, because the nature of one’s relational style might offer some clues that could better help understand therapists’ somatic experiences.

Reflecting back on the myth at the heart of the Wounded Healer archetype, Chiron the centaur is incurably wounded by being struck with Herakles’ poison arrow. Hillman (1979) noted that Herakles, or Hercules, could be a metaphorical representation of the Western ego and its desire to eliminate the shadow side of life, including pain, suffering, sickness, and death. Yet the attempt to repress and eliminate pain and suffering, ironically, perpetuates it, as suggested by the familiar adage, “what we resist persists.” The silencing of and failure to attend to pain contributes to its pestilence. It has become common practice for medical and psychological practitioners to advocate a type of care aimed at eliminating symptoms and pain rather than a wholistic treatment of the individual. Rather than treating the person and addressing the deeper meanings and sources of pain, pharmaceutical prescriptions are often the proffered solutions for physical and emotional pain.

The Chironian wound that leads one to the vocation of psychotherapy often creates empathy and desire to relieve others’ pain. Sometimes, however, a client’s pain can seem “too hot” or “too fresh” and thus difficult for the psychotherapist to tolerate and to remain present to it, which may drive him or her to want to rescue the client from the pain. The Herculean desire to rescue clients may also arise from the psychotherapist’s own incurable suffering, with the often unconscious hope that ending another’s pain will
end or give one a sense of mastery over one’s own; however, it is through the Chirionic attending to others rather than rescuing them that psychotherapists are simultaneously able to attend to their own pain and allow for the process of mutual healing. Chiron and Hercules therefore must be considered together in discussions regarding Wounded Therapists’ desire to heal clients’ wounds.

The study found that all participants related to the Wounded Healer archetype. They expressed this relationship through sharing their experiences of being wounded and relating ways in which these experiences significantly affected their call to the profession, their countertransference, capacity for empathy, awareness, and framework for working with patients. Participants detailed ways in which their wounding and subsequent healing experiences became their strength. As Eddie stated, “if we are to show anyone with any sort of authority that our weaknesses can become our strength, we need to have walked that walk. . . . It’s a form of authority that emanates from your personal path.” Wounding experiences shared by participants included attachment issues with parents, bullying, divorce, broken dreams, cancer, and depression. As somatic experiences could, in part, be considered an extended, physicalized function of empathy, these relationships appear relevant to the study.

The majority of participants, six of seven, made a variety of meaningful connections between their wounding experiences and somatic experiences. Specific types of somatic experiences were directly related to an area of the body that was either previously injured or was the location of a familiar emotionally related physical pain—a pain that, in certain emotionally toned experiences, has been felt consistently in that area of the body. In attempting to make sense of the complexities of therapists’ somatic
experiences and the potential connection to their own wounds, Eddie articulated that his somatic experiences are physical resonances to clients that he feels in his body due to his own wounds, especially in places of previous injuries and bodily weaknesses. He noted, however, that his physical and emotional wounds are not necessarily the same wounds as his clients. He was suggesting that one’s own weakened points or vulnerabilities, due to previous injuries and/or emotional wounds, may make one more susceptible to feeling one’s own and others’ pain in those areas.

Eddie’s experiential observations are consistent with Clark’s (2006) proposal that the analyst’s “‘weakest’ and most problematic areas” (p. 81) are the places most open, sensitive, and potentially affected by the patient’s material but are not necessarily the same locations of symptomatology within the patient. Merchant (2012) arrived at the conclusion that although both therapist and patient do not necessarily share the same wound or symptomatology, they were likely both “wounded in the same zone, that is, early infancy— which underpins the porosity required to experience the embodied countertransference” (p. 163). Even if a particular somatic experience is reflective of a patient’s material and not associated with the therapists’ wounds, the literature and data suggest that the therapist’s own woundedness and associated empathic nature, at the earliest time of life, open and predispose one to somatic experiences.

The most frequently reported conditions in which somatic experience occur included situations involving the activation of the therapist’s wound, the therapist feeling threatened, the patient’s lack of expression of emotional material, patient trauma, and the patient’s emotional and/or physical health condition. Other notable thematic occurrences of somatic experiences included the Herculean desire to rescue the client, positive
transference, and the therapist’s need for self-care. These findings bear many similarities to the findings of Stone (2006) in which he identified three concurrent conditions that most likely result in embodied resonance: “the pathology of the patient; the patient’s inhibition to express strong emotions directly and consciously; and the typology of the analyst” (p. 15). Elaborating on his finding, Stone stated, “Somatic reactions are more frequent with patients exhibiting borderline, psychotic or severe narcissistic elements; where there are basic instinctual problems (sex, aggression, eating disorders); or where there has been early severe childhood trauma” (p. 15). Finally, he added the condition of the analyst’s own personal experiences “and thus the neurotic countertransference” (p. 15) as a contributing factor to somatic experiences.

Data reported in this study are supportive of Stone’s (2006) findings, though his conclusions included both typology, which was mentioned in this study but was not a primary focus, and the category of patient pathology. Regarding the latter, many of Stone’s findings and those of this current study were similar but were categorized differently. Trauma and aggression were subcategories of patient pathology in Stone’s study, whereas trauma and threats were emergent categories in this study. In addition, though it was not named as a category, two participants noted somatic experiences connected with patient substance abuse, which would also support Stone’s patient pathology condition. Patient pathology was not selected as a category occurring within this study, not because it did not exist but because the participants often did not use pathologizing language, and the occurrences could be more specifically categorized in other ways. Several of the participants, for example, did identify narcissistic or bipolar traits in clients as triggers involved in the onset of their somatic experiences, though I had
often categorized these triggers in terms of the therapist feeling threatened, which in most cases related to their preexisting wounds. However, some instances of these somatic experiences related solely to the therapist’s perceptions of these pathological characteristics without triggering the therapist’s wound or feeling of threat.

The literature refers to somatic experiences as somatic countertransference, embodied countertransference, and embodied cognition. Although the terms *somatic* and *embodied* are used interchangeably, it could be surmised that countertransference involves the psychotherapist’s wounds becoming activated through the interpersonal dynamic, whereas cognition implies the psychotherapist receiving and “knowing” client material through the interactive field as a function of empathy. Yet, I would also suggest that one can have an embodied cognition regarding oneself, and further, that one’s initial wounds may create an empathic opening increasing the likelihood of embodied cognition. Participants did not explicitly employ these terms often when describing their somatic experiences or discernment processes, though their descriptions strongly indicated conceptions of both somatic countertransference and embodied cognition, often co-occurring and affecting each other, and difficult to separate.

Alternatively, participants described their discernment practices in terms of the ways in which they attempt to identify to whom the symptom seems most reflective and, accordingly, the ways in which they might utilize the somatic experience for further healing, either for themselves, the client, or both. The most important factor noted by the participants was the necessity of knowing themselves—becoming familiar with their woundings, emotional issues, and physical bodies. It was important for the therapists to become aware of their neutral “baseline” as a basis for comparing and contrasting the
shifts they might notice during the therapeutic process. Martin (2011) advocated that an analyst develop deep self-knowledge in order to use the Wounded Healer archetype consciously and responsibly. Participants identified ongoing personal psychotherapy, supervision, or mindfulness practices (or a combination thereof) as the most significant ways of knowing themselves. For some, these measures were mentioned as crucial aspects of their regular self-care practices, which were also emphasized by participants as a vocational necessity. Participants also discussed other processes of somatic experience discernment, which included ongoing reflection and inquiry, observing the timing of the onset and duration of somatic experiences, and tracking symptoms.

All participants used their somatic experiences in some way to further the psychotherapeutic work. Most used the experiences as a source from which to inquire more deeply and ask questions. Some participants shared their somatic experiences with clients at times, and others kept the information to themselves for further reflection or guidance. Eddie noted that although somatic experiences that seem to indicate a client’s pain, injury, or wound may prove to be valid, they may not be the most important issue at hand or the focus of clinical attention. The implication is that the therapist should proceed with caution and not necessarily make the somatic experience the focus of treatment.

Although not discussed previously in this study, another possible way of therapeutically utilizing somatic experience emerges from the depth psychological tradition of dreamwork. The entry of the somatic experience into the shared field is not unlike a dream, and asking Stephen Aizenstat’s (2004) classic dream-tending questions could be relevant. One could consider the emergence of the somatic experience as a third thing or a dream image arising in the session asking to be acknowledged and explored in
some way, even if it is not considered to be the focus of clinical attention. Inquiring “Who is visiting now?” and “What is happening here?” (p. 125) acknowledges the therapist’s somatic experience speaking through the field, and may represent an opportunistic link leading to a well of significant information and mutual healing potential.

**Limitations and Delimitations**

The limitations of this study are primarily the result of the nature of the methodology, which includes an exploration of self-reported phenomenological experiences of a select group of participants for whom the question is meaningful. Thus, the resulting data is subjective and may not be generalizable. In order to restrict the study to participants for whom the question was meaningful, licensed psychotherapists integrating somatic awareness or body-oriented practices in their therapeutic work were sought, a sample that is not necessarily representative of the psychotherapeutic community at large. The findings of this study might not hold true with, for example, a group of cognitive-behavioral or psychoanalytically oriented psychotherapists or with a random sample of psychotherapists.

Though typology was not a primary focus of the research question, it was my desire to incorporate mention of it as a possible relevant factor and explore the concept of any relationship it may have with therapists’ somatic experiences or the way in which they were described or understood. In this study, however, participants’ typologies were self-reported rather than substantiated by validated assessment measures such as the Myers-Briggs Type Indicator® (MBTI®) (Myers & Briggs Foundation, n.d.), and therefore, the inclusion of typology in the study presented a limitation. The associated typology data could only be used speculatively rather than conclusively. More reliable
and consistent typology assessment data would be needed in order to draw meaningful conclusions.

Some features of the study made possible a deeper and more detailed look into somatic phenomena and the meanings associated with them. The study’s main delimitations involve the specific sample and the sample size. Delimitations were made by screening participants on the basis of their having somatic experiences, understanding the relevance of the research question, and seeking out participants within subgroups of the psychological community that were likely to practice with some level of somatic awareness. A sample size of seven participants was small enough to allow for in-depth interviews and analysis processes but large enough to exhibit both interesting variations as well as common themes. The group of participants included both men and women with a variety of ages, different levels of therapeutic experience, multicultural backgrounds, different geographical locations, and different typology. On one hand, these variables can strengthen the validity of thematic commonalities found in a study such as this; conversely, they can limit a study because it becomes difficult to understand which variables affect the findings. Overall, the findings that resulted from delimiting the study in this way provided a meaningful and detailed portrait of these therapists’ somatic experiences.

The limitations and delimitations are congruent with intention of this study, which was not to generalize or establish precise definitions of the meaning of somatic experiences but rather to highlight the variety of experiences and the unique personal ways that they are experienced by psychotherapists and possibly connected to their histories, client material, or both. The research succeeded in yielding richly detailed
descriptions of the somatic experiences and some important themes, and thus offers the profession a deeper understanding of these experiences that underscores the value of somatic awareness. In this regard, this study has provided valuable new phenomenological data for future research.

**Implications of the Research**

The findings of this study contribute to and expand the existing literature in the field by exploring the varied phenomena of psychotherapists’ somatic experiences, the conditions in which they most often seem to occur, and the meaningful associations made to them. Even though there has been a considerable increase in somatic focus in body-oriented practices and literature, the lived body of the psychotherapist has received scant attention in the field at large. This study opens and explores psychotherapists’ experience of somatic phenomena more deeply and with more detail than past studies, especially with regard to the connection between somatic experiences and experiences of wounding. The participants’ responses revealed a range of complex dimensions and relationships beyond those that have been empirically studied so far, although the rapidly accelerating developments in the field of neurobiology are continuing to provide scientific explanations of the mirror-neuron processes involved in empathy and somatic responses.

The therapeutic implications of these findings is that, as psychotherapists comprehensively familiarize themselves with their own wounds and the expression of those experiences of wounding in their bodies, they may learn to utilize more fully their own bodily experiences as a trustworthy guide to the unconscious contents in the interactive field. These experiences become a medium for mutual healing. These implications highlight the need for the psychotherapeutic training and our professional community continually to encourage the development of somatic awareness. Even among
the participant psychotherapists who regularly practice and integrate somatic awareness and reflection, this study revealed some difficulty in describing, explaining, and discerning their somatic experiences. Participants reported that engaging in practices such as personal psychotherapy and mindfulness assists in developing discernment and self-knowledge, which is a foundation of meaning-making and utilizing somatic experiences. More guidance and education in therapeutic education is needed to encourage somatic awareness and to aid in the understanding and responsible use of these experiences.

Based on the descriptions and understandings shared by the participants, the experiences felt within the physical and energy body often appear to be an extension of the therapist’s own emotions, those of the clients, or most often, a simultaneous expression of both. Psychotherapists’ somatic experiences that were attributed primarily to client material, both emotional and physical, are most likely a function of empathy and the neurobiological phenomena of mirror neurons. Both individual and empathic responses may be occurring simultaneously and may affect each other, which can make the experience difficult to sort out who originates a particular experience. If one party in a dyad is having a somatic experience due to his or her own wounds being activated, the other may have an empathic somatic experience in response, and the somatic effect could reverberate between the two through the function of empathy as well as potentially trigger their wounds.

This somatic dynamic in the shared field, along with the participants’ descriptions of somatic experiences, suggest a need for increased awareness and self-protection practices as a function of self-care to minimize the intensity and duration of somatic and psychic effects. These self-protection practices could be in the form of visualizations,
spiritual practices, or any other meaningful rituals utilized with the conscious intention of protecting and clearing one’s energy field. It could be fruitful to explore potential differences in the types and intensity of somatic phenomena experienced when one engages in certain varieties of self-care practices or none at all.

The research findings raise questions for further studies regarding thematic varieties of somatic experiences that may be correlated with factors such as specific typologies, psychotherapeutic orientations and practices, cultural differences, or personal wounding experiences. Further study is needed to examine the presence of potential associations between specific typologies and particular types of somatic experiences, the ways in which they are described, and the situations with which they are associated.

Reflecting on the data presented by participants Howard and Adrienne, who, respectively, integrate energy and spiritual work, it also could be productive to explore whether somatic experiences occurring when practicing energy or spiritually related psychotherapeutic work are different in quality and type than in mainstream psychotherapeutic work. It would be interesting to discover whether thematic differences can be found in somatic experiences across different theoretical orientations or practices.

Building on both this current study and Merchant’s (2012) research, further inquiry might be made regarding the various types of wounding experiences psychotherapists identify and what similarities and differences may be found between the intensity, location, and variety of their somatic experiences.

Other possible research studies might include larger-scale approaches utilizing questionnaires, asking participants to note the various factors with which they identify on lists, including a wide variety of somatic sensations, physiological responses, parts of
body affected, bodily felt emotions, postures, and impulses as well as wounding
experience categories, frequencies, typology, and theoretical orientations and practices.
Alternative qualitative approaches might involve long-term case studies in which
participants journal their somatic experiences, recording their reflective processes and
insights gathered through their own personal work, psychotherapy, or supervision, and
the subsequent use they may make of these experiences based on the meaning they
attribute to them.

Somatic experiences can serve as an indicator of something that needs one’s
attention. The therapist’s somatic experience and associated wounds may be similar to or
different than the client’s, but by attending to a somatic experience and investigating that
which it may reflect, one is also attending to aspects in need of healing in either oneself
or other, which may have remained previously unidentified. Even if one does not
necessarily understand the somatic experience, its presence implicitly asks of the
psychotherapist to honor, attend, and engage it in dialog with care and awareness. The
mystery and intangibility of these experiences, along with the treasure trove of possible
healing benefits to be discovered, merit continued exploration of this topic in both
breadth and depth.

**Conclusion**

This study has verified the existence and significance of psychotherapists’
somatic experiences in the therapeutic process. It has also has provided a rare, detailed
glimpse into both the internal and external experiences of these somatic phenomena and
the associated meanings, conceptions, and therapeutic use made of them. The somatic
experience presents a vehicle for deepening into psychotherapeutic material. When
consistent attention and reflection are given to one’s somatic experiences, much potential
insight and healing can be gained on the part of both the therapist and client. The psychotherapist’s somatic response has been a largely untapped resource of potentially useful information, associations, and access to archetypal themes in the psychotherapeutic field at large.

A key role of the psychotherapist is to assist with psychological individuation, which involves familiarizing themselves with and integrating their shadow parts, including their wounds as well as their bodies, which have too often remained cast off in the personal, collective, and psychology community’s shadow. As individual psychotherapists and members of a professional community, in order to assist clients with integrating their shadows and thus support growth and individuation, we must attend to the work of acknowledging, valuing, and integrating our personal and collective shadows—our wounds and our bodies—into our personal and psychotherapeutic work. In this way, our wounds and our somatic experiences can become our strength.
References


Appendix
Ethics Committee Application
for Approval for the Use of Human Participants

I. Researcher: Angela DeVita		Today’s Date: September 2, 2013
Address: (address)

Home/Business/Cell Phone: 805.304.5705 Email address: adevita@sbcglobal.net

Title of Activity: The Somatic Experience of the Wounded Therapist
Sponsoring Organization Contact Person: Lionel Corbett, PhD, dissertation chair

II. Affix appropriate signatures

I will conduct the study identified in the attached application. If I decide to make any changes in the procedures, or if a participant is injured, or if any problems arise which involve risk or the possibility of risk to the participants or others, including adverse reaction to the study, I will immediately report such occurrences or contemplated changes to the Institutional Review Board.

Investigator Signature: ___________________________ Date: ____________

I have read and approve this protocol, and I believe that the investigator is competent to conduct the activity as described in this application.

Dissertation Chair: ___________________________ Date: ____________

III. Notice of Approval

The signature of the representative of the Institutional Review Board (IRB), when affixed below, indicates that the activity identified above and described in the attached pages has been approved with the conditions and restrictions noted here:

Restrictions and Conditions: ____________________________

______________________________

Institutional Review Board Representative: __________________ Date: ______
1. PARTICIPANTS
I will select and interview 4-6 qualified mental health professionals who report awareness of somatic experiences in correlation to their professional therapeutic work. Invitations to participate will be presented to professional therapists who are most likely to relate to the research question, which may include analysts affiliated with the Jungian institutes and depth psychotherapy, credentialed art therapists, shamanic or Native American therapists, somatic-oriented therapists, and seasoned therapists of other theoretical backgrounds. If possible, I would like to find a candidate or two whose training, upbringing, and/or current practice are from another country besides the U.S. I will distribute a flyer (Attachment 3) via email and online networking platforms, which announces this study to these targeted groups. Interested therapists will be invited to contact me. I will explain the study, its procedures, and confidentiality issues.

2. PROCEDURES
After initial contact and screening, participants deemed suitable will be e-mailed or mailed an informed consent form (Attachment 1), interview instructions (Attachment 2), and an information form (Attachment 4) to be completed and sent back to me. Selected participants will participate in one recorded interview 50-60 minute duration. The interviews will take place at a mutually agreed upon location, in either the participant’s or my office location or through online camera communication such as Skype or by telephone depending on the logistical availability of the participant. The interviews will be transcribed and analyzed. The participants will be assured about the maintenance of their confidentiality throughout the process.

3. CONSENT
Informed consent forms (Attachment 1) will be e-mailed or mailed to participants as noted above. I will request that the completed and signed informed consent form be returned to me prior to the scheduled interview date. Alternatively, I will provide an additional consent form, obtain the participant’s signature and answer any questions before the start of the interview.

4. RISKS
The research questions may bring up sensitive and emotionally charged issues. Contemplation and exploration of the subjects could potentially cause or exacerbate a participant’s psychological or emotional stress as well as somatic symptoms.

5. SAFEGUARDS
Awareness and sensitivity on the researcher’s part is necessary throughout the research process. Participants will initially be screened for their suitability through initial information gathering and phone or email contact. These steps will most likely result in a group of emotionally stable, professional, somatically aware participants who can participate safely and meaningfully in the discussion of their present and past experiences. Informed consent acknowledges that either the participant or the researcher may discontinue the interview process at any stage. This option is available in case of unforeseen instability or lack of suitability. The participants will be assured that in the event of distress or any other reason, they may elect not to answer the question and are
free to terminate the interview at any point. If any distress is reported or observable, I will ask if they currently have psychotherapeutic support in place to process it, and if not, will be prepared to provide additional referral resources as needed.

Confidentiality will be maintained at all times: participants will be provided with a pseudonym or may elect to choose one themselves; recorded and transcribed materials will not carry identifying information. No other party will be aware of the individual’s possible involvement. Aside from myself, no other party will have access to identifying information.

6. BENEFITS
An in-depth phenomenological exploration of therapist’s somatic experiences will hopefully lead to a deeper and more comprehensive understanding of the varieties of therapists’ somatic experiences and any associated correlations, plus ways in which meanings attributed to these experiences may translate into usable approaches for healing in psychotherapy

7. ATTACHMENTS INCLUDED:
Attachment 1- Informed Consent Form
Attachment 2- Instructions to Participant
Attachment 3- Flyer inviting participation
Attachment 4- Participant Information Form
Attachment 1: Informed Consent Form for an Interview Project

TITLE OF THE STUDY: The Somatic Experience of the Wounded Therapist

1. I agree to allow Angela DeVita ask me a series of questions on the topic of my somatic experiences and any meaning or use I may make of them in the context of my vocation as a therapist as well as any personal wounding and trauma that I may have experienced.

2. The interview questions will be asked in a mutually agreed location, in either the participant’s office location, the investigator’s office location, through online camera communication such as Skype or by telephone depending on the logistical availability of the participant, and the interview will take approximately 50-60 minutes.

3. The purpose of asking these questions is to: phenomenologically explore the varieties and depths of therapist’s somatic experiences, any meanings one attributes to them, and any possible relationships to the therapist’s own personal material.

4. I understand that some of these questions may be of a sensitive nature and may cause stress or psychological discomfort. I may take a break or discontinue the interview at any time. If necessary, Angela DeVita will provide me with referrals for psychotherapy, the cost of which will be my own responsibility. I understand that a pseudonym will be provided to insure my confidentiality and that my answers will only be used by the researcher and her committee for data analysis.

5. I realize that the value of this research, which is intended to result in a deeper and more comprehensive understanding of the varieties and meanings made of therapists’ somatic experiences, and ways in which understandings of and meanings attributed to these experience may translate into usable approaches for healing in psychotherapy, may or may not be of immediate value to me personally.

6. Information about this study, the place, time and location of my interview, and my contribution to the study was discussed with me by Angela DeVita. I am aware that I may contact her any time I have questions by calling +1 (805) 304-5705 or e-mailing adevita@sbcglobal.net.

7. This research is part of a dissertation study at Pacifica Graduate Institute and is conducted under the supervision of Dr. Lionel Corbett, who can be reached at LCorbett@pacific.edu.

8. Participation in this study is voluntary. I understand that I can refuse to answer any question and can withdraw from this study without any negative consequence to myself. I also acknowledge that the researcher can eliminate me from the study at any point.

9. I am not receiving any monetary compensation for participating in this study.

Signature: _____________________________ Date: ___________________________
Attachment 2: Sample Instructions to Participant

Interviews will take place in a mutually agreed upon location, or via Skype or telephone if an in-person interview is not logistically possible, at a mutually agreed upon date and time.

The interviews will be recorded and then transcribed into a written format. Your confidentiality will be respected at all times. The transcriber, if other than myself, will not know your identity.

You will be asked to answer a series of open-ended questions about your somatic experiences, any reflections, synchronicities, meanings, or use you may have made with regard to those experiences, including the nature of the therapeutic work you may have been involved in or any concurrent personal concerns, as well as any relevant wounding experiences you feel comfortable enough sharing. I will also ask your Jungian or Meyers-Briggs typology. Although I will initiate discussion with these questions, the dialogue will be open, and you are free to comment on anything that seems significant to you.

Art materials will be provided if you feel inspired to express the experiences creatively, and any art expressions you create regarding this topic prior to the closure of my data collection process are welcome but not required.

For optimal interview preparation, please take the opportunity to notice any additional somatic experiences that you may encounter in your work as the interview approaches, considering the qualities, sensations, locations, frequency, intensity, as well as the context of the therapy the somatic phenomena may have been associated with. Also reflect upon any potential relationship or correlations between your somatic experiences and your own wounding experiences, past traumas, or current life challenges. Any notations you make are welcome but not required.

During the course of the interviews, it is possible that strong emotions, memories, and somatic symptoms may surface. You may feel psychological or somatic discomfort. You are free to take a break from the interview or discontinue the interview at any point. If following the interview you feel the need for psychological counseling, referrals will be provided.
Attachment 3: Sample Call for Research Participants

The Somatic Experience of the Wounded Therapist

If you would be willing to share about your somatic experiences as a professionally credentialed or licensed therapist in the mental health field, please consider the following study:

I am searching for suitable persons to interview on the topic of somatic experiences, exploring the phenomenon of these experiences, any factors that may relate to their presence, including the therapist’s own personal material, and any possible meanings and use therapists make of their somatic experiences. My research is designed to increase awareness of the therapist’s experience of somatic phenomena as well as contribute towards a deeper and more comprehensive understanding of these experiences, including any associated meanings, use, and healing potential.

If you are interested in participating, please contact Angela DeVita, MFT, ATR at (805) 304-5705 or adevita@sbcglobal.net
Attachment 4: Sample Participant Information Form

Name: ___________________________________________ Age: __________________

Address: __________________________________________________________________

Phone: ____________________________________________________________________

E-mail: ___________________________________________________________________

Type of mental health professional: _____________ Years in practice: _____________

Theoretical orientation: _________________ Typology (if known): ______________

Briefly describe an example of a personal somatic experience during, before, or after a therapy session:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Most frequent types of somatic symptoms you experience and when: ______________
________________________________________________________________________