Feeling the feelings

Jeanine Connor puts the case for not denying the feelings we have about our clients – particularly those felt in the body

Confession: I experience feelings about clients during their therapy sessions, and I know plenty of respected colleagues who also do. We are human after all, and it's part of the human condition to feel, particularly in relation to another. Our feelings towards clients can include boredom, rage, repulsion, fondness and something akin to love or hate. They can be difficult to bear, but bear them we must because they contain vital information about the dynamics at play between our client and us.

Our feelings might be understood cognitively, for example 'I feel irritated by him', or they could be experienced in the body, perhaps as an ache or a sickness, and can range from subtle to overwhelmingly powerful. I've been encouraged to acknowledge my feeling response to clients from day one of my psychodynamic training, but I'm aware that not everyone is comfortable with this. I've debated with counsellors who argue that it's unscrupulous to have, let alone admit to, feelings about clients. I believe the contrary; that it is disingenuous to deny such feelings, and to do so is to miss a significant therapeutic trick that can lead to a deeper understanding about our clients' worlds. In this article, I present the case for feeling our feelings, with a particular emphasis on those felt in the body. I illustrate my assertion that feelings are communicative, informative and invaluable therapeutic tools through the use of vignettes borrowed and disguised from my clinical experience.

Transference/countertransference

Counsellors and therapists with a psychodynamic training might recognise what I'm talking about as countertransference, and that's a good place to start. Countertransference is our response to the client's transference, a phenomenon first suggested by Freud[1] to describe the way his patient, Dora, transferred her (sexual) feelings onto him. In essence, transference describes the way that clients relocate feelings about other people (unconsciously) onto the therapist. For example, a child client I'll call Dotty presented differently during a recent session. She spoke to me more aggressively, threw a ball at me and walked out of the session early without saying goodbye. Because this was different from how Dotty usually presented, I understood that she was relating to me *in the transference* as if I were someone else. I was attacked verbally, physically and emotionally, most likely because Dotty felt attacking towards someone else. I discovered later that she had been let down by her estranged father, who had failed to take her out as arranged.

Psychodynamically informed therapists believe that real-world relationships get re-enacted in the therapy room. In this way, the transference relationship helps to inform how the client relates to others and can identify patterns in their relationships. If Dotty had presented as aggressive and rejecting in *every* session, she would have illustrated something about her internalised relationships as rejecting and attacking. Usually she didn't present this way, so I was able to recognise the shift as significant. The emphasis we put on transference, as a means of communication is one of the reasons why it is vital to maintain consistent boundaries. If something feels different, when everything else is the same, it is likely to be a transference communication.

Countertransference is therapists' feeling response to clients' transference. This was initially perceived (by Freud) as a hindrance that should be analysed away.

However, it has become recognised as one of the most valuable therapeutic tools that therapists have at their disposal. In the example above, Dotty invited me to re-enact a role by provoking me into feeling attacked. I did feel attacked, and I also felt hurt, confused, and ultimately rejected. It was my role to contain and process those feelings, by remaining thoughtful, and avoid taking up the position Dotty dictated, by either retaliating or trying to make things better. In the following session, I recalled aloud that the previous one had felt different. Dotty told me about her father and I remarked that it feels painful when someone lets us down and we might want to hurt them for hurting us. As therapists, 'we do something like what a mother does, by trying to bear the feelings, and (we) hopefully process them and understand'.[2] Then, when the time is right, we can give those feelings back to our client, as I did with Dotty, in a more processed and manageable form.

When a feeling is aroused during a client session, it's important to determine its origin. For example, is the trigger something personal, such as being tired after a late night, or irritable because of a quibble with a colleague? Does it relate in an obvious way to what's happening in the room, like feeling anxious in response to a client who is at risk? Feelings that cannot be readily explained are the most significant ones to recognise and work through.

Feeling sick

Often, feelings towards clients are located in the body and have no obvious trigger. Nathan made me feel sick. We met weekly in a GP surgery equipped with desk and swivel-type office chair. The smaller-than-average nine year old was mostly nonverbal in his communication, except for expletives that he bandied about indiscriminately. He was described as destructive and unable to learn, and I had been asked to provide a clinical opinion on whether Nathan might meet the criteria for (yes, you guessed it) attention deficit hyperactivity disorder (ADHD). Throughout the six-session psychotherapy assessment, Nathan rejected all play and art materials on offer, choosing instead to bounce up and down and spin around on the chair. I remember struggling to decide how to write up my assessment. I was reluctant to say that Nathan hadn't engaged: he'd presented at every session and stayed for the duration. But all he seemed to do was swear at me and wear out the chair's suspension. When I reflected on Nathan's sessions, I acknowledged that I always felt nauseous and that on more than one occasion I'd felt as if I might actually vomit. I remember thinking that I just had to bear the feeling, which I likened to seasickness or a hangover, and wait for it to pass. It was clear to me that my feeling was a symbolic communication that belonged to Nathan. I wasn't *actually* seasick or hung-over, but the feelings were no less overwhelming than if I was. Our feelings can inform us about the feeling state of clients who are unable or unwilling to put words to their own feelings. McDougall[3] called this 'disaffection' and used the term to describe individuals who have historically experienced overwhelming emotion.

Nathan was a child in care, and I decided to liaise with his social worker to find out more about his developmental history. I learned that his mother was addicted to alcohol and had been using substances throughout her pregnancy. Nathan was premature, with a low birth weight. I assimilated this with what I'd observed: a boy who was small for his age and clumsy, had difficulty with learning, attention and social skills, and who ticked (some of) the boxes for ADHD. But informed by my feeling response, which I'd likened to a hangover, I was able to wonder about Foetal Alcohol Syndrome. If I'd denied or disregarded that Nathan made me feel sick, he could have been well on the way to misdiagnosis and medication.

Feeling dead

Stanley was 13 and selectively mute when we worked together over a period of 18 weeks. He spoke not one word, yet the feelings he provoked in me were overwhelming. Every week, Stanley arrived on time under his own steam. He sat in the chair opposite me, his head dropped to his chest and his arms flopped to the sides. In the early sessions, I attempted to cajole him into engaging with art materials, music or clay, but this was my agenda not his. Like Nathan (like *all* clients), Stanley needed to engage in his own way. His breathing was slow and heavy, and often he slept. Once or twice he seemed to soil himself. I was struck by his capacity to wake himself up in the final minutes of each session, as if he'd developed a physiological timer, and certainly suggesting he had internalised the rhythm of the sessions. Stanley's commitment to therapy was evident, but what was less apparent was what he needed from me. Being alongside Stanley was akin to the experience of being with a nonverbal infant. I was reminded of Bion's concept of 'maternal reverie',[4] which is the capacity to sense and make sense of what is going on inside the infant. With Stanley, I felt a heaviness in my chest that dragged down through my abdomen. I experienced pins and needles in my hands, which felt cold. I felt sleepy and sometimes struggled to keep my eyes open or my chin raised. And at the end of every session, when it was time to stand up

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and leave, I had difficulty doing so because my legs felt dead. As with a preverbal infant, Stanley lacked the capacity to verbalise his feeling state, nor could it be directly observed. *But I felt it.* In our ending review with Stanley and his adoptive parents, I shared something of my powerful experience of feeling heavy and dead. I pondered aloud about cold hands, pins and needles and numb legs being symptomatic of poor circulation, as if the blood had been drained from me. I contemplated also about the preverbal baby who finds alternative ways to communicate their bodily state and needs. I was mindful of the anal/potty-training stage of development but was careful too not to shame the adolescent in the room who, I was sure, had soiled. I wanted to share how powerfully Stanley had communicated with me through feeling states, which I interpreted as symbolic representations of an internal world made up of dead/murderous objects and the reality of his lived experience.[5] I wanted him to know that I had understood something about what it might have felt like when, at 18 months old, he had witnessed his father stab his mother dead.

Feeling the feelings

Many clients come to therapy with a sense of not-knowing – why they're here, what they want, what the point is – in relation to therapy, as well as existentially. A good place to begin making sense of things with them is by helping to make sense of their feelings. Often when I wonder how my client feels in relation to something that's happened, they tell me what they think. I asked Joni, aged 14: 'I wonder what it felt like when she walked away from you.' And she responded with: 'I don't think she could handle being in a relationship.' So I asked again: 'I wonder how that *felt* for you.' And she recounted the break-up of her relationship with Laura. The story provoked painful recollections of adolescent break-ups, and the associated feelings of not being good enough, pretty enough, sexy enough. I felt my throat constricting as I persisted with wondering about Joni's feelings until she finally told me: 'I don't know what you mean, how did I feel!' This isn't uncommon. Often clients don't know how they feel. Often, they've never been asked, or learnt the emotional language to verbalise it. I asked Joni if maybe she felt something in her body when she spoke about Laura. She told me she felt her chest tightening and her throat constricting like she couldn't breathe properly. She said she hadn't realised that until I'd asked. I commented that it *is* hard to take a breath when we feel in pain or panicky. And then Joni began to feel understood and to understand her own feelings of abandonment and rejection. There is an interesting theory that any stimulus leads initially to a physiological feeling (such as increased heart rate, sweating, shortness of breath) and that our emotional feeling (such as joy, sadness, fear) is a secondary response.[6] In other words, the physical feeling comes first and the 'feeling-feeling' comes afterwards. This idea reminds me again of the preverbal baby, whose entire experience resides in its physical sensations and how they are understood and responded to by their caregiver. For infants whose emotional needs have been neglected, it is difficult to differentiate between physical and emotional sensations.[7] The body acts as a container in which individuals, quite literally, feel their feelings. In the therapy room, this can manifest most noticeably in clients who present with psychosomatic characteristics, which can be interpreted as the body's way of 'speaking' emotion.[7]

Formulations

When we engage in a dynamic relationship with another person, we can't *not* be triggered to feel something. But it's one thing to acknowledge the feeling response we experience towards our client and quite another to know what to do with it. Sometimes, my feeling informs what I say, as it did with Dotty and Joni. Other times, I might use it as a cue to gather more information, like with Nathan. Or, I might share my feeling response with the client and/or their family as I did with Stanley. The most important thing, always, is to process the feeling first, by reflecting in session, post session and/or in supervision. That way, whatever we decide to do will be thoughtful rather than reactive. I also use my feelings to inform formulations. A psychodynamic formulation is a hypothesis about what might be going on for a client, based on their presentation, behaviour, history and environmental influences, as well as their impact on me in the room. It's what guides my work and informs what the young person might need. A formulation is *not* a diagnosis; I'd go as far as to say it's much more than that. It's not scientific or empirical, pragmatic or measurable. It's a holistic interpretation, based on my felt sense of the client in the room. My feeling response is integral to my work as a psychotherapist. It's how I sense and make sense of what is going on through the act of 'reverie', which, as Bion stated, is an act of faith in the unconscious process.[4] I think that sums up the process of psychotherapy quite well.

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