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The Body and the Action of Narrating in Psychotherapy: Somatisation, Enactment and Consciousness Processes[1]

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Abstract. – In this work the author explores some recent theoretical-clinical developments in psychoanalysis rendered necessary by a real paradigm shift in the conception of the mind-body relationship. In particular, she highlights how these developments call for a different perspective in our approach to the debate concerning the role that implicit and non-verbal processes play in the flow of dialogue and the development of consciousness. The author's voice is part of this debate. Referring to Wilma Bucci's Multiple Code Model as an observation platform, the author proposes to extend the concept of clinical dialogue to the multiple ways of processing experience, verbal and non-verbal, including sensory experiences and somatisation. This perspective implies the need to revise the analytic method itself, extending the concept of exploration. The illustration of a case shows how clinical dialogue can be structured in the therapeutic process defined by the author as 'somatic enactment', and how one can investigate it and understand it by expanding analytic technique in the direction of the proprioceptive and microanalytic exploration of bodily experience.

Key words: Body; consciousness; enactment; implicit; somatisation.

Introduction

The bodily sensations and somatic symptoms emerging in the here and now of the psychotherapeutic process constitute, for both members of the dyad, embodied expressions of affective experience that draw on the flow of non-conscious dialogue between therapist and patient. Their specificity has its roots in the history of subjective, affective development woven into the complex network of learned implicit relational procedures, and their subsequent re-transcription. As sub-symbolic forms of communication (Bucci, 1997) that orient the conscious and unconscious dialogue of the

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analytic couple, these expressive forms can be defined as specific organizations of enactment.

Although they are normally present in clinical exchanges below the threshold of consciousness, for the therapist who has learned to intercept them among the multiple levels of clinical exchange and to make good use of them, sensory perceptions and somatic symptoms can become powerful engines of change. A dynamic clinical approach that also extends micro-analytical exploration (Stern, 2010) to the somatosensory experience, leverages body sensations and somatic symptoms as natural activators of what Bucci has defined the 'referential process' (1997), that is, capable of promoting processes of integration between the various normally dissociated levels of consciousness, between mental and bodily facts, between oneself and the other.

Therapist and patient can be predisposed to consider bodily sensations and symptoms as 'dreams of the body' which, like dreams of the mind, lend themselves to being explored and investigated together. In the clinical case illustrated here, neuralgia of the trigeminal nerve becomes the somatic expression of the impasse generated by the imminent therapeutic conclusion.

The paradigm is shifting

Psychoanalytic thought, like all contemporary Western thought, is undergoing a fundamental paradigm shift in the de-construction of the meaning originally attributed to the body and its actions. The process is still underway. Wilma Bucci's contribution to the process is formalised in multiple code theory (1997).

The idea that the body and actions are associated with instinctual expression and libidinal satisfaction is gradually declining as research broadens out into a variety of different fields (attachment theory, infant research, cognitive sciences, neuroscience, non-linear dynamic systems). Thus, acknowledgement of the intimate interconnection between bodily experience and the expansion of consciousness has been validated (McClelland & Rumelhart, 1986; Rumelhart & McClelland, 1986). Far from being an obstacle, with its specific structural and functional equipment, the body plays a decisive role in the elaboration of mental content. It is in this perspective that the nature of the mind has what is now termed an 'embodied' quality, drawing closer to the Eastern vision which has existed for millennia. Varela, Thompson, and Rosch (1993) pointed out that in the West knowledge was conceived of as a purely theoretical reflection and the exclusive property of the mind so that the concepts of mind and body travelled along separate paths. As a result, science was separated from experience while, at the same time, the effect of direct experience on knowledge was refuted.

Including the bodily register among the processes of knowledge implies,

on the one hand, freeing the concepts of language, consciousness and knowledge from one another (Jaynes, 1976) and on the other, detaching the concept of motor action from an excitement charge. As Bucci also points out (1997), our perception unfolds in simultaneous sensory-motor, cognitive, affective, organic and visceral representations of meaning. In this framework, from being a mere cradle of instinct, the body becomes the rooting base of the self-reflective experience (Aron, 2004), while the notions of acting-out and acting-in, considered lower forms of memory, are superseded by the concepts of *procedure* and *enactment* which contain the communicative potential of non-verbal exchanges between therapist and patient.

The recognition of the role assumed by direct experience in the process of change should inevitably predispose psychoanalysis to reconsider the theory of technique. In fact, in clinical work, as recognised by several authors, including Hopenwasser (2004), '*...physical sensation is a source of information historically devalued and often clinically trivialised'* (p. 318). I would add that such a position still hinders the development of a psychodynamic clinical practice capable of exploring the direct experience of the body. The inevitable consequence is a narrowing of the spectrum through which experience can be investigated, and a loss of opportunity to develop and integrate important aspects of analytic communication naturally organised in 'enacted' exchanges, *i.e.* in implicit and non-verbal performances.

The experiences which shaped my education as a person, even prior to my clinical education, were delineated in different settings but had in common the centrality of the bodily experience. My first approach to psychotherapy involved the treatment of somatic disorders based on a holistic view of the mind-body relationship. This afforded me the advantage, on undertaking psychoanalytic training, some years later, of appreciating the therapeutic value of including direct bodily manifestations in the observation of clinical dialogue. Much of my work has been devoted to broadening the focus of the multiple forms of interaction in the therapeutic process, focusing with particular attention on non-verbal exchanges. Among these are somatic, dysfunctional and non-somatic states. From the beginning of clinical practice this orientation meant identifying and validating a clinical approach that would be effective in directly intercepting implicit experiences and, at the same time, exploring them analytically.

For an extended perspective of clinical dialogue

Somatisation and relationship

Profound suffering keeps us anchored to painful experiences and tends to smother any reflection on the its meaning. When the body suffers, our

consciousness remains strongly attracted by and bound to the content of the sensory experience.

When a physical symptom enters the here and now of the analytic field it can easily compromise the reflective function of the mind. In an emergency, words - the essential tools for revealing the mind's content in analytic dialogue - cannot be activated to serve reflection and awareness whose nature requires long, slow rhythms hardly reconcilable to the urgency of pain.

Consistent with its theoretical-clinical model, analytic practice expects somatic symptomatology itself to testify to a dysfunctional and regressive organisation of the mind. Symptomatic states that alter the clinical dialogue modality are considered and treated as forms of resistance to the advancement of the analytic process and psychological growth. If physical suffering takes centre stage, the basic conditions necessary to promote exploration through free verbal association necessarily default: sessions of this nature are to be commented on and terminated.

Over the course of clinical practice I have been unable to corroborate the principle which draws a close analogy between somatic symptoms and resistance to the consciousness process. I have been struck, if anything, by the commitment of my patients to join me in my consulting room *despite* their physical discomfort. My silent acceptance and extended listening to fragmented words, disoriented by waves of pain and a state of physical incapacity, became the opportunity to explore and understand more intimately what was going on in my patients' bodies, often to the point of tracing their unconscious emotional source. Following the guiding principle of listening, I have always appreciated how somatic symptoms that hijack the patient's attention and clinical dialogue are themselves forms of free association. Under certain conditions, they represent the only path that can be explored, the only road open to promote the process of consciousness and psychic development, and a singular opportunity to establish a link between experience and its affective meaning. In these cases, we see the somatic symptoms acting as a subsymbolic codification which, if taken and explored, can usefully promote the processes of symbolisation. Bucci shares this opinion:

> *"To allow the re-symbolisation process to begin, in even a minimal form, the treatment of patients with trauma or somatisation would require a focus on those entities available to function as organising symbols within the patterns of emotion before they can make connections to other symbolic objects or other people. In this regard, the implications of the multiple code approach diverge from the psychoanalytic ones. Symptoms and actions can operate progressively to implement the symbolisation process, rather than being regressive, as the discharge model implies, and as is generally believed"* (Bucci, 1997, p. 202)

Despite the decisive theoretical change that has sanctioned a true paradigm shift, psychoanalytic practice tends not to explore the intimate expe-

rience that each subject has of their own somatisation. This determines how such experiences are normally destined to remain unknown and not included in the analytic discourse. Historically, psychoanalysis has justified such a procedure in the belief that discomfort and/or somatic illness consume an enormous amount of narcissistic energy, leaving little left for transference and the analytic process. On this theoretical basis lay the conviction that somatisation processes are antagonistic to the processes of consciousness (Freud, 1914; Lefebvre, 1980; Sifneos, 1973). To borrow a metaphor from Robutti (1992) we could say that somatic symptoms keep the internal enemy hidden as does the Trojan horse. It may be the inability to imagine something new, *i.e*., the failure of mentalisation, that causes 'relapse into the body'. Placed outside the world of symbolic meanings, the somatic symptom can *thus* be considered only as, *'(...) the signal that something has got out of hand, that a communicative fracture has occurred and the patient,' weak from past experiences', is lost. With his symptom he seems to say: 'You are no longer the one who can treat me, my body is sick, I need another doctor'* '(Robutti, 1992, p. 199).

As I prefer to think of mental experience as intimately rooted in the body, I find it difficult to share the regressive and narcissistic vision of symptoms and somatic expressions evoked by the image of a 'relapse into the body'. How can one fall into one's roots? Although I share the idea that somatisation is often a sign of the subject's state of difficulty, as it would be for the analytic dyad - on being referred to the dyad - I find it more useful to assume that the difficulty lies in the establishment of analogical correspondences between the sensory experience and a verbal way of rendering its full meaning. When a satisfactory verbal correspondence is identified, the irreducible value of words allows us to overcome the greater distances drawn when the affective significance underlying the intention expressed by the body is not shared - as in implicit communication. The embodied word, saturated in its referential function, flies like an arrow, reaching distant places so quickly that the intimate meanings of the experience can reach otherwise unattainable ones. This may represent the most important function of human verbal communication.

If somatisation enters analysis, I do not necessarily consider that my patient and I have failed to attribute meaning to a fundamental experience. Failure to understand the meaning of events is always a possibility, even in the absence of somatisation. Rather, I wonder if, from the patient's point of view, the passage through a somatic representation of meanings is necessary for the expansion of consciousness; and, again, in what way are we, as an analytic couple, involved in this process of building useful and effective correspondences between the experience of the body and *the* words capable of communicating it in its entire, intimate complexity.

Somatisation, enactment and integrating experience

The concept of enactment in analytic literature, to whose definition Jacobs (1986) was the first to make a fundamental contribution describes a sort of dramatisation in which procedural interaction compensates for the difficulty or impossibility of using verbal codification for affective relational experiences. The enactment procedures, employed in a non-conscious way, develop for each of the interlocutors along the individual historical line of past relational experiences, but are solicited and reorganised in the self-other interaction of the moment, and condense the result of the active contribution of both partners (Lyons-Ruth, 1999). Many authors agree that enactment is the product of traumatic affects experienced in past interaction (Bromberg, 1998). Defensively dissociated from consciousness, these affects would invariably remain registered in the body's memory in the form of sensation-(re)action patterns and would be evoked by similarities between present interaction and the original traumatic experience. This form of interpretation emphasises the correspondence between enactment and difficulty in the mentalisation process, associating the mutual non-verbal and non-conscious influence of the patient and therapist to the dysfunction of the patient's mind and the analyst's unconscious collusion.

Following another line of thought similar to the one proposed for a revisitation of somatisation, we can, by contrast, conceive of a more physiological view of enactment and define it as a functional process that presides over and guarantees the implicit exchange of non-verbalisable meanings (Amore, 2012). It would act in support of the implicit expression of all the meanings that have strong sensorial, though not necessarily traumatic, roots. This view puts enactment at the service of non-verbal intersubjective communication regardless of the mentalising ability of the subjects.

According to the Bucci model, enactment can be included within the frame that defines subsymbolic forms of implicit knowledge, which in this specific case operate by implementing knowledge through the organisation and reorganisation of action schemas. Within this framework, enactment appears as the natural precipitate of the continuous non-verbal elaboration of the lived experience, the result of a cross between the power of suggestion evoked by the present relational context and the reactivation of memories of past experiences placed in some analogic connection with the facts of the present. These experiences may include traumas as well as more generally incongruous states of self that have laid the foundation for dissociative defence activation; and they discover in the unconscious solicitation of the moment, the opportunity for reactivation. In addition to this, enactment can organise implicit and non-verbal communication even in completely new (Amore, 2012; Aron & Atlas, 2015) and consequently not yet organised self-with-other experiences. Furthermore, stimulated by the affectively sig-

nificant exchange of a present interaction, unprecedented procedural schemas are activated. From this moment, following the natural course of elaboration of a lived experience that Bucci defined as a 'referential cycle', the content of sense-motor schemas may at the same time propagate even mental representations which words will now be able to decode.

A perspective that identifies sense-motor schemas among the modes of subsymbolic expression of unconscious communication between subjects, allows us to recognise an organising function of enactment in orienting and regulating exchanges based on the emotional meanings of the interaction. Released from serving only defensively dissociated experiences, the function of enactment can then be repositioned in the natural ambivalence that Galimberti (1983) describes as '*and* this, *and* that'. According to the philosopher, it is ambivalence, not ambiguity, that establishes the nature of the body and human experience in their original plurality of meaning, and which restores a sense of its unity to being.

If enactment can be removed from the bond of dissociative defence, it remains true that dissociated affects have the possibility of expressing themselves only in the subsymbolic way of the body and its functions: motor, sensory, somatic or visceral. In this case, the traumatic quality of the reactivated memory will shape the meaning of the present experience, bringing the relational trauma back onto the scene. And thanks to the updating of the past onto the present through the configurations of enactment, the traumatic experiences become accessible and available to the analyst and the patient, and the subsequent work of joint elaboration and symbolisation becomes possible.

Although the concept of procedure invariably involves activation of the motor system, the concept of enactment could also be usefully released from discrete actions and be extended to all those relational configurations that focus on the intersubjective processes of sensory-motor and visceral self-regulation. Since enactment is articulated on the level of the non-conscious, we can also consider '*enactment*' to be the verbal reference of a non-verbal experience whose meaning is not known: as when a patient signals the emergence of a sudden sensation or physical discomfort during a session. When the non-verbal score organises its narration through sensory configurations and somatisations, we identify this specific form of staging as 'somatic enactment'. Its action is exerted on the body itself, amplifying the subsymbolic procedures that constitute the physiological substrate of emotions until it alters the optimal arousal parameters and, as a consequence activates self-correcting physiological adjustments to these alterations.

Sensory states and somatisation, as well as actions proper, can be considered part of the network of relational procedures influenced and regulated by exchanges in the here and now, and which in their turn will condition this exchange. In this same verbal exchange, we observe words floundering in an

effort to connect the patterns of emotion to their symbolic representation (Bucci, 1997, 2007). To support the need to share the complexity of sensory and somatic experience, we can see a continual flow of enactment (Jacobs, 1986) in the non-verbal score that underlies and embodies verbal discourse, so that even through words we continually act on one another (Bass, 2003).

Procedural interaction in the analysis room

Psychoanalysis has increasingly freed itself from the idea that the analysable patient should have an already organised mind despite being altered by conflict. The principle of psychoanalytic treatment has thus been re-coded to promote the organisation of the mind, a process which is now thought to continue actively throughout the life-cycle and is entrusted mainly to implicit communication (Arnetoli & Pacifici, 2004). In the constant flow of procedural exchange between analyst and patient, dissociated experiences - or simply those that are not yet integrated (Amore, 2012) - can occupy the analytic scene in various forms, including the somatic form (Jacobs, 1986). When the verbal translation of our emotions is challenging, somatic expression can be the most direct way to experience and represent some singular organisations of the states of self (Marty & M'Uzan, 1963). I agree with Bucci (1997) that patients' obsessive attention to their symptoms is the first step towards creating an association between the implicit subsymbolic process and the content of the emotional schema. Thus, it is vitally important in the analytic procedure for therapists to attune themselves, and their practice, to how patients seek to integrate their states of self.

When the symptom is partially the result of a repeated trauma that occurred in a period long past, I would stress that it also assumes the symbolic role of transition between past and present: if on the one hand, it builds on an element which is in some way involved in the original affective experience, on the other, it is stimulated by interaction with the analyst in the moment, as the clinical case will help me illustrate.

Exploring the sensory experience in the consulting room

Clinical practice in line with the new perspectives on psychoanalysis, attention to implicit and procedural functions should include the recognition of bodily processes as manifestations of states of self. These states constantly (re)organise themselves in the course of interaction for both interlocutors during a clinical exchange to support and facilitate re-transcription of implicit and procedural experience in which the sense of one's subjectivity is rooted (Stern, 1985; Edelmann, 1989; Modell, 1990). As stated above, the

clinical experience led me to observe all the symptomatic reactions - psychic and somatic - as forms of enactment. In my mind, the concept of enactment is descriptive of the wide network of action-reaction procedures emerging from the continuous flow of interaction between self and other. Included in this complex network are both discrete motor actions directed towards a purpose, and physiological activation structured in recognisable and observable symptomatic form. Implicit and normally non-conscious, the network is functionally at the service of the subsymbolic modalities of knowing and communicating, inherent to, and necessary for the development of relational skills and an integrated sense of self.

In a situation in which a somatic state saturates the space for subjective experience, the understandable clinical difficulty understandably lies in accessing the reflexive function and the use of free association. I am convinced that very few analysts today would choose to suspend a session in which fluid thinking is impeded by the temporary impairment of self-reflection that accompanies intense somatic discomfort. However, I am equally convinced that, in many cases, the difficulty in integrating states of significant physical suffering with analytical exploration is avoided at its inception by a silent agreement between analysts and patients to keep the physical expressions of malaise out of the consulting room, so that patients avoid coming to sessions when they feel physically unwell. As Jacobs (1986) observed, even how the setting of the consultation room is arranged may be seen as an implicit communication between analyst and patient that suggests the analyst's exploratory predisposition. The patients - also implicitly, adhere, making their own contribution to the co-construction of an enactment in which there is 'agreement' on the avoidance of some areas of exploration in favour of others. Thus, patients adhere to the implicit terms of a 'work contract' where symptomatic, functional, or pathological experiences cannot be validated in clinical dialogue.

Even the most sensitively-tuned analytic couple whose verbal exchanges include the extended exploration of non-verbal experiences may struggle to understand the meanings organised in somatic states. Careful listening alone will not be enough, in many circumstances, to grasp and share the meaning of the somatic experience, an essential step in proceeding with the clinical work of reorganising the mind. In any event, an impasse is reached. In such circumstances, a knowledge of alternative routes by which to reach patients where they are becomes a clinical resource for therapists who need to be as close as possible to their patient's somatic experience. An initial intervention in this direction should enable our patients to draw an ever clearer map of the sensory experience in the here and now. I consider such a therapeutic choice consistent with what Antonino Ferro (1996) defined as 'respecting the patient's text': somatic expression can be considered one of the possible texts that the analytic process may need to explore.

My own way of intervening clinically to promote exploration of intense somatic expressions, as a means of intercepting their implicit content, is influenced by the conviction that the analyst is not required to resort to any techniques other than conscious observation of the content of the experience - a characteristic which is already part of analytic technique. However, I believe that practising using a variety of specifically-dedicated techniques can teach the analyst a great deal about the nature and complexity of mind-body interconnection processes. This is especially true if the processes are investigated from one's own experience.

In line with ideas expressed by Jacobs (2013), I firmly believe that as in any field of knowledge, the development of the proprioceptive skills needed to observe and recognise one's own non-verbal, sensory, procedural and physiological experiences, calls for specific learning consistent with the object of knowledge. I also agree with Jacobs that the acquisition of such a specific skill should be included in the training of every future clinical professional: the ability to tune in, with the utmost attention, to one's own somatic experiences is often a necessary prerequisite for picking up on and sharing the sensory experience of patients more intimately.

If the non-verbal is the object of direct observation analysts must have the sensitivity to intercept - from among the many forms of implicit expression acting during the meeting – the ones that are most useful in understanding the process taking place, beginning with their own. Therefore, to better grasp the patient's often subtle bodily manifestations, the analyst must be trained to intercept the echoes of his sensoriality and to use them as probes to initiate the exploration of the patient's experience of his own body. Sometimes, the analysts' sensory channel is also the main tool by which it is possible to intimately access and identify the non-verbalisable meaning of the patient's experience to initiate processing. In a disciplined frame of self-observation and self-reflection, the sensory track that informs the analysts' mind during interactions with a patient is made up of somatic states that belong intimately to them, and which are therefore also imbued with their emotional history. Equally important is the choice of *how* to use this sensory information in a clinical session, and I trust there will be an opportunity in the future to discuss this aspect which is no less important for the observation of somatic co-transference.

As with other areas of analytic exploration, the analysts' direct experience of interacting with their own and others' body signals is essential in developing and communicating the confidence and solidity required to gain patients' confidence in the relevance and usefulness of the process that they are preparing to undertake. Sometimes this process means that patients are faced with having to withstand the anxiety generated by a sense of extraneousness from their own body that often follows the amplification of proprioceptive sensations. As with mental content, the direction of attention pre-

disposes the patient and analyst to observe the implicit emerging in the here and now. Intercepting somatic states, recognising them, and reporting them to explore meanings, is certainly a more difficult task than handling thoughts or other mental content such as images or dreams since the sensations are much more fleeting. For this reason, attention to the non-verbal may mean that the analyst and the patient agree on a temporary renunciation of the more usual verbal exchange modality, to orient themselves towards a free focal perception of sensations, and only subsequently seek the best verbal coding to describe them effectively.

In my clinical experience, during an analytic encounter the directing of attention to present or emerging bodily sensations has often constituted an effective tool for detailed exploration, thus promoting the elaboration of an affective experience and, as a result, the organisation and re-organisation of the mind in individual subjects and the dyad. When patient and analyst concentrate their attention on somatic states and symptoms in the here and now of the encounter, and explore sensory representations pausing on the phenomenology of the experience without necessarily attributing any symbolic meaning to them, and mentioning only the phenomenology of the experience, analytic discourse evolves along the thread of a non-verbal score, anchored to those schemas of emotion which tend towards their organisation. When a sensory experience becomes the object of shared attention, the patient can be invited to stay in contact with the sensation to explore it in detail. Simply by observing, it will be possible to perceive the sensation with ever greater clarity. Often, this will tend to integrate spontaneously into the wider proprioceptive context, reclaiming, as if it were a sort of gravitational centre, the well-structured representation of bodily unity, highlighting its sensory solids and voids. Often, it will progressively change in intensity and amplitude until, at the end of the process, it is transformed into a sensation of a different nature.

The analytic dyad can agree on the merits of exploring sensory experiences - including physical symptoms - as if they were body dreams that can be investigated and understood on a par with mind dreams. Even in the initial phase of the therapy agreement I will usually inform my patients of the possibility of a focus on bodily sensations during analytic exploration. I introduce this point of technique by likening it to exploratory work on dreams where the focus is on eliciting details that are not clearly remembered on awakening. Just as a careful exploration of dream images can spontaneously promote access to emotion schemas (Fosshage, 1989) even the exploration of a sensation may of itself be a non-interpretative clinical intervention able to promote the activation of the referential function (Bucci, 1997), and thus favouring the integration of the sub-symbolic and the non-verbal symbolic systems leading to a mental representation of the experience.

Exploring symptoms as dreams implies that an elaborative rather than a

defensive process is at play. If we talk about the *embodied mind,* we implicitly associate it with a *thinking body.* Thus, it is helpful but also inevitable that we go beyond the representation of somatic symptoms as the expression of an attack on the relationship, or the difficulty of the dyad in identifying meanings, and evaluate the process as spontaneously oriented towards integration and connection between the parts. As in dream analysis one may witness a spontaneous organisation of meanings from apparently disturbing and non-significant elements; often the descriptive-perceptive observation of a sensation can implicitly and spontaneously modify the body's organisation, determining a transformation of state - just as it can help the patient overcome the acute phase of a disabling migraine during a session. At the same time, exploring sensations introduces to one's sense of self a new, shared experience which will be the context for an expansion of consciousness in a subsequent circumstance. Under different circumstances, however, thanks to meticulously descriptive language which is more easily supported by metaphorical associations, the sensorial focus will activate the emergence of non-verbal symbolic representations. Among them are images capable of embodying current emotions, or memories of lived experiences that share the quality of present emotions, in whole or in part. These images can set in motion conscious processing of the experience and can go as far as identifying the missing link to something that has not yet been integrated.

In clinical practice, not all patients are willing to connect with the proprioceptive sensation for the time necessary to observe it with meticulous attention. Since focused attention hyperbolically amplifies the sensation observed it is not easy for some patients to withstand the intensity without the fear of being overwhelmed by perception and the often automatic emotional reaction**.** In this case, the time required for the sensation to become clear enough to be described is not sufficient. In my experience, the analyst who has had the opportunity to experience the process himself is usually also able to support patients in tolerating the anxiety generated by the task. This result may be obtained over repeated sessions thanks to the analyst's progressive interventions which enable patients to acquire the confidence they need to orient their proprioceptive sensations, and to rest for a few seconds on the somatic state which surfaces to one's conscious attention during the flow of verbal discourse. We see the increasing ability of patients to acquire a clear and precise sensorial focus, testifying to a greater constancy in maintaining self-observation skills. At the same time, although conscious proprioception causes patients to witness unexpected changes in their body image, they gain a greater sense of security in the recognition of self-generated by the conscious integration of the changing, continuous, and not normally conscious flow of affect.

On their first visit to our consulting rooms, patients may already present chronic or acute somatic states, or the condition may emerge during the

clinical dialogue. In either case, dysfunctional somatic conditions which emerge during the hourly sessions should alert the analyst to the fact that an implicit appeal may be underway and that the analyst is the elected recipient. This appeal may mean we need to intercept the dissociated aspects necessary for the development of the sense of self, or the clinical process; or it may be that there is some difficulty in integrating the new procedural schemas, co-constructed with the analyst, with the former and more familiar representation of self. In both cases, we can expect some problems when drawing on the past or recent affective experiences deposited in implicit consciousness but not yet integrated into the self-image.

In these moments one may wonder whether the intensity of sensations or the patients' symptoms, in bringing into play specific, characteristic sensory impressions, also function as implicit relational procedures to promote contact between the analytic dyad and otherwise unintelligible unconscious content. Somatisation may also signal the urgent need to give priority to mind-body integration in the precise time window of the development of the sense of self. Whether we are dealing with dissociated memories that find echoes in transference, or new experiences for which therapeutic interaction urges the assimilation to the already known sense of self, we may find it necessary to manage an impasse with respect to the more usual procedures of narration through verbal clinical dialogue. This is the analyst's opportunity to validate narrative's different linguistic codes to accomplish the task of keeping as close as possible to the patient's experience in the ongoing dialogue. A rushed attempt to shift the experience to the verbal symbolic level usually turns out to be unprofitable and often risks weakening the meaning of the sensory or somatic representation, invalidating the only expression that can be accessed by the patient at that given instant of the clinical process.

The case of Clara

Clara, a young woman aged thirty, contacted me because she was having episodes of severe perceptual dysmorphism, including the sensation of 'emitting air from the eyes' as if they were two holes through which the air flows in and out of the body giving rise to the sensation of dispersing its vital essence. These episodes trigger violent emotional reactions which Clara calls 'panic attacks' during which she experiences the profound terror of losing the integrity of her body and dying. Given the severity of the symptoms at this early stage, I seek the collaboration of a psychiatrist colleague. The drug prescribed manage to control the frequency and intensity of the episodes and means that Clara can reach my consulting room. Reluctantly, she agrees to take the drug for no more than about three months but continues to carry it with her for more than a year.

The symptoms had first appeared the previous year after a second failed attempt to obtain a degree in humanities. Clara recounts that on both occasions she passed all the exams successfully but floundered during the writing of her dissertation. As far as the first course was concerned she states clearly that she lost interest in the qualification when the social opportunity to apply these specific skills to the world of work declined. As for the second attempt, her tone and vagueness in supplying the details of the story made it difficult for me to fully comprehend. Clara, stammering, told of an increasing reluctance on the part of her supervisor to follow her progress in the chosen subject with sufficient attention and care, and of her difficulty in continuing the work alone. Based on this information my theory is that the expectation of a grand ideal of perfection may have played a central role in the repeated failures. I seem to recognise the same organising principle emerging in Clara's other life stories where the underlying motif is a goal unfulfilled due to her severe and always unsatisfactory self-evaluation. This leads me to conclude that Clara needs a great deal of attention, approval, and confirmation to maintain an active, robust sense of self and that her relationship with the supervisor may have been distorted precisely by these affective conditions, which constitute optimal terrain to induce a dramatic and annihilating experience of abandonment.

At a later stage in our work, however, the narrative and the motivational framework are complicated by an episode of abuse. Clara's deep need for approval and acceptance meant that she could not escape from the sexual attentions that her professor - known for his questionable manner with students - had pressed upon her with increasing insistence in a period when he had wanted her collaboration on an academic project. The attention was unexpected and unwelcome and Clara had tried to brush him off minimising her embarrassment and hoping in her heart that the man would desist from his intentions. On the contrary, the time came when the man went a step further. Now, as she recounts this she states clearly and firmly her sense of shame at having been the passive object of the man's sexual pleasure, but when it happened Clara only remembers feeling a generally confused numbness. She had remained motionless for the duration of the act and took her leave at the proper time as if nothing significant had happened. The following day she duly turned up at the Department to discuss researching the material for her dissertation.

The strategy that Clara unwittingly puts into action to distance herself emotionally and to normalise what happened with her dissertation supervisor, however, is not sustainable because the man is cold and detached and becomes less and less approachable. Clara interprets this as contempt towards her for having been in some way sexually disappointing; she begins to feel obsessed and anguished by this thought. The first episode of dysmorphism occurs in this period. This deeply erratic affective state is reinforced

in the professor's presence and Clara limits her contact with him to a minimum in an attempt to regain control. Inevitably, the situation compromises the writing of the dissertation progressively, but definitively. Nonetheless, Clara continues to pay her university tuition fees in the hope that she might sooner or later pick up where she left off. In analysis, the possibility of simply asking another professor to supervise the dissertation comes up, but this is not feasible as far as Clara is concerned: how could she possibly justify this request after having been supervised by another for so long? Clara imagines this would mean laying bare her responsibility for the failure and revealing her shameful flaw.

The days go by, and for Clara with no goal to aim for, the affective states of anguish and panic alternate with states of emotional and sensory numbness - similar to those she experienced during the abuse - predispose her to fairly frequent promiscuous sexual relations, devoid of desire and pleasure. About a year after the abusive event, the first panic attack occurs following an episode of dysmorphism. Together, over time, we were able to piece together how the agitated, terrifying excitement of panic was totally fitting as a means to express Clara's erratic reaction to the complex dissociated emotions that had a tendency to resurface into consciousness; it was there that the more recent memory of the abuse was spontaneously interwoven with early childhood memories.

Clara told me at our first meeting about the disabling trigeminal neuralgia attacks which she had had since she was six years old. The symptom recurs regularly and seriously disrupts her life. However, it never affected our sessions during the entire course of analysis until, as we will see, the final phase. Rather, the neuralgia attacks afflict Clara between one session and another. When the symptom appears it can take more than twenty-four hours and repeated painkillers for the condition to resolve itself, and so there is little choice but to spend most of the day lying down waiting for the pain to pass. She says that even as a child during these attacks she lay on the sofa in the living room of the family home waiting for the drug her parents gave her to take effect. The spontaneous association with this childhood memory prompted me to ask her if she could tell me something more about how she experienced the pain in those moments and how she reacted to it. Without hesitation, but in a detached tone, Clara replies that it was not her habit to complain or cry; mostly she waited in silence, and in vain, for someone to come and comfort her. This is the first, but not the only time that during our exchanges I am aware of the consistency of a sense of annihilating loneliness that has marked and compromised the life of this young woman.

Clara is the second daughter of a couple who took an active part in the events of 1968. Both parents were very involved in their respective social projects and engaged little with their daughters and with each other, to the point that the couple were soon hit by a declared emotional and relational

crisis, never resolved in a *de facto* separation. From Clara's description, her mother appears to be unable to establish an empathic relationship with her younger daughter; she is easily unsettled by even the slightest physical suffering that Clara, like every child, happens to experience. One day Clara cut herself badly in a fall but her mother's reaction at the sight of her blood was so severe that her father and older sister had to resuscitate her, leaving Clara stunned, confused and lonely spectator of the family drama, while the blood trickled down her face. Very soon she learnt to minimise any discomfort in the presence of her mother. Her father, for his part, was intolerant of any requests made by his daughter for reassurance; such as to keep a small light on in his room during the night. In one of Clara's recurring dreams, in the early phase of our work together, she is a child lying on a sofa pretending to be asleep while being sexually abused by a couple of unknown adults who claimed to be her parents to the third parties present in the dream and to observers and witnesses outside the scene. During our dialogue the connection between the dream state and the feelings of insensitivity and strangeness that Clara experiences initially, during the abuse, and subsequently, in promiscuous sexual relationships, is evident to both of us.

Clara, an intelligent, alert, and cognitively bright child, was prematurely forced into an autonomy that defied all common sense. For a long time she perceived herself as stable, strong and courageous, and even a little presumptuous, thanks to her precocious skill in use words wisely. Since childhood, she resorted to linguistic categories such as 'enterprising', 'courageous', 'uninhibited', 'intellectual' to reconstruct a self-image in her mind and describe herself to others. Now Clara can no longer intercept such states and the effort to reconstruct an image of herself consistent with the linguistic categories of the past induces a sense of de-realisation. The first panic attack takes her by surprise as she observes the television image of two lovers kissing passionately**.** The intensity of the passion that she watches in an emotionally frozen state suddenly appears to her to be such a strange and inconceivable phenomenon that it triggers the first terrifying sensation of the interior crumbling of her sense of reality.

Ever since the consultation phase, although we speak in low tones and at a slow pace, the flow of words at our meetings is continuous and there are rarely any silences between us. Clara tries to regulate the strong internal pressure of sensations and emotions through intense verbal discourse, however, the verbal resource seems to have lost its power and potency for her. Words are never quite adequate to grasp and describe the 'dark' experiences that pervade her inner world. She experiences this limitation as if it were evidence of her being incomplete and flawed, and she fears that I may be so disappointed in her that I will decide to discontinue treatment.

After about a year of twice-weekly meetings, Clara is becoming aware of the traumatic nature of many of the interactions she experienced with her

parents. The consciousness of this increases her sense of fragility and emotional pain. There and then, in the meetings, we manage to regulate the tension but her anguish grows in intensity between one meeting and the next and becomes unsustainable at the weekends. Clara does not explicitly ask me to prolong our time together but I am alarmed at the desperate expression on her face when I see her out - it seems to implore more closeness and continuity of contact. We both know that the time between sessions seems too long for her and I propose intensifying the frequency from two to three times a week. As part of our new arrangement she may call me even at weekends if she has serious difficulty in self-regulating her emotional state. Clara did call me on occasion but with great parsimony and discretion.

The introduction of a third session helps us to better regulate her affective states. The rhythm of three meetings a week characterised the longest phase of the clinical process and also the most fertile for the emergence of traumatic memories and the deconstruction and reconstruction of the sense of self. More than ever, in this phase, I felt I needed to take particular care to keep my subjective self in the shadows as far as possible. Since the consultation phase, the inhibitory influence of even my facial expressions had been evident to both of us. Sharing this awareness meant that we set up our first twice-weekly setting agreeing to use the couch as the instrument which would allow Clara to feel less influenced and inhibited by my presence.

Indeed, as we had hoped the couch helps Clara in her effort to maintain more lucid contact with her multifaceted, intense, but at the same time - thanks to the dissociative defence - volatile inner experience. Clara is always attentive to every word that I utter and to the way I utter it, but the advantage of not being visible to her gaze is helpful in our clinical work and is often the subject of exploration and discussion in our dialogue. The couch provides Clara with a private space in which to feel protected in my presence - sheltered from the fear of severe judgment that, for a long time, she feared she would discern in my verbal and non-verbal expressions. During this phase, the most intense moments of our sessions are the welcome and the farewell: in the space and time between the threshold and the couch, and vice versa, I feel Clara's gaze inspecting my person in an almost feverish way as if it were a map with which to orient herself to intercept the point of access into acceptance. Sometimes, in our sessions' most distressing moments when she feels lost and without a border, I may be her only anchor to reality and then Clara turns her head as if looking for proof that I'm always sitting in my place, next to her.

The advantage of the couch as a safe place where Clara can feel protected in my presence is clear to both of us from the first session in the new setting. That is not all. In the course of our work, we find that the couch allows Clara to effectively protect me from her so that even I cannot see her face, and the frightened and frightening expression aroused by

her inner feeling of profound fragility. As we will see in a subsequent dream Clara is convinced she needs to save me from contact with her internal world.

Indeed, aalthough the three-times-a-week rhythm reinforces in both of us a sense of confidence in our analytic work and its chance of success, I still have the impression that an unidentified feeling of caution holds us back. It seems to me that I am being led firmly towards some as yet unexplored places, but as Clara - trusting in my presence - is preparing to enter, an intense and impalpable fear stops us on the brink. Clara's implicit awareness of this shared process takes shape in a dream in which we ascend a high mountain together as if on a pilgrimage, to reach a sacred place with an imposing uncovered sarcophagus. Together we move closer to observe its contents, but as we draw nearer to the edge, Clara puts her hand over my eyes as if to protect me**.** It becomes clear for both of us during our exploration of the dream that Clara intimately experiences her inner world as a place which is not approachable and, therefore, not representable. She believes I may not tolerate seeing it, and may react as her mother did on seeing her blood. And if that were to happen Clara would find herself alone once again.

For a long time, during our sessions, we explore Clara's feelings of inadequacy. In this phase, I am aware that she has a strong need to reconnect with her body and when I feel she is sufficiently receptive to tolerating this contact with discomfort, I invite her to focus conscious attention on the bodily sensations co-present with her sense of inadequacy and to explore them. Accompanied by my voiced indications during the exploration, Clara directs her attention first towards one, then towards another part of her body, focusing on the areas where she perceives a disturbance - pain, contraction, cold, or isolation from adjoining areas - for the time it takes to clarify the nature of each sensation. As often happens with patients when they direct and focus attention on their bodies in my presence, Clara, too, observes the progressive reduction of the distance generally perceived between the awareness of self and the discomfort she experiences in her body. At the same time, this shared experience supports the containment of anguish generated by episodes of sensory dysmorphism that could emerge even during our explorations.

Clara becomes increasingly confident with the technique over time, so that in the course of an ordinary verbal exchange when her perceptions are confused, she automatically focuses on the bodily sensations she feels and explores them. She is now better able to maintain prolonged contact with unpleasant perceptions and observes with less distress the cracks that affect her tone of voice, her posture and rigidly controlled, restrained movements - the general awkwardness she feels when she becomes aware that she is *also* a body. At the same time, she wins the freedom to observe my body,

reflect on it and make observations, but also to point out to me how some of my expressions or postures intimidate her or make her suddenly feel insecure in her beliefs. In their turn, Clara's comments about the way she perceives my body and its expressions reconnect me to my corporality. In moments of great emotional intensity my leg muscles are often strongly contracted as if to ready me for a sudden leap forward: they are signals that connect me to my more or less constant state of alertness brought on by the intensity of the tension that I perceive to be Clara's underlying state, and which makes me fear the ever-present risk of a sudden psychotic breakdown**.** At other times, when the discussion concerns femininity, I perceive that my body is more solid - similar to how I felt during my first pregnancy. On these occasions, I know that Clara also perceives that I own more strength and solidity to protect her vulnerability.

After three years of our work Clara no longer has panic attacks, and even the neuralgia ceases to recur. She is not yet sufficiently sure of our emotional stability, however, and with each meeting the old fear of opening up and seeing her inadequacy confirmed in my gaze somehow still rears its head. However, we proceed steadily towards the goal of making unthinkable thoughts thinkable through the exploration of feelings, emotions and sensations emerging from awareness, or from the rich and agonising dream life that animates Clara's nights. We cautiously identify new representations of self that are closer to her more current life experience, and together we witness the gradual transformation of an isolated, insensitive and incommunicable sense of self into a self that is desirous and capable of establishing meaningful relationships. One Christmas she gives me a book by Clarissa Pinkola Estès (1992), *Women Who Run with the Wolves*, in which she writes: '*Thank you for giving me to life.*' She settles into a stable romantic relationship and becomes a mother.

Nearly ten years on, at this point in our journey we both feel the need to reorganise our meetings to biweekly, and to sit facing each other. The transition is certainly partly conditioned by the advent of parenthood to which Clara dedicates her time with absolute devotion, but for the most part, it is related simply to the renewal of a more secure sense of self. She has become firmly confident in our relationship and confident in my emotional availability concerning her fragility. This awareness means that she is now eager to look at me, defying fears of seeing reflected in my face the negative judgments which she imagined and dreaded for so long. Now she can meet my gaze and finally tolerate seeing the reflection of her fragility and mine.

This latest setting change allows us to enter an intense phase of discussion and mirroring during which we appreciate the extent to which Clara has achieved an acceptable sense of integrity. Thus, against the distant background of my private thoughts, the idea that analytic work can begin to conclude emerges. Nonetheless, I am surprised when, finally, it is Clara who

says she is ready to set a possible ending date. Although Clara fears losing the benefit of my presence in her life, the desire for emancipation from our work, and to experience the effectiveness of having completed it, seems to be stronger. I am aware that she has achieved a level of cohesion that makes the planning of a conclusion completely realistic, however, the persistence of recurrent nocturnal episodes of sleep paralysis with their sinister and threatening atmospheres indicate that there is still some significant fragility at play which disturbs her sleep. When this occurs she has difficulty in regulating her affective state throughout the day and from the moment she wakes is in a state of confusion and insecurity about her future life plans, such as that of resuming and completing her university studies, which continue to remain on standby.

However, cautiously and at length we explore the costs and benefits of concluding analysis at this stage of the journey. Exploring my feelings it strikes me that this sense of alarm could be in part due to the schema of interaction that has long pervaded my relations with Clara with whom I have an affective connection; on the other hand, I am dealing with separation difficulties of my own in this period - the contemporary weaning from breastfeeding of my second daughter. I am faced with the prospect - desired but not without reluctant nostalgic overtones - of leaving behind forever an experience that represented for me a guarantee of intensity and deep emotional intimacy with both my daughters.

Taking a year's breathing space we finally fix a date (presumed) for our last meeting. We agree that if we are wrong Clara will always know where to find me. From that moment Clara is beset by a deep fear of leaving me, and the disruptive feeling of being the *bluff,* that she experienced for many years, resurfaces, albeit mildly. The neuralgia flares up between one session and another, as disabling as it was in the past, and drives Clara to despair. We are both aware of the link between the return of the neuralgia and the plan to conclude analysis. I feel awkward and struggle to understand: I imagine that there must be some aspect of her experience that we have not shared and/or understood, and I tell her so. It is evident, I say, that we have missed something important.

One day Clara arrives at the session in the throes of a severe neuralgia attack, and I register the exceptional nature of this fact. She sits in the armchair with her eyes closed and the fingers of her left hand resting on her temple. The tears flow as she communicates to me her sense of helplessness for the pain. I ask her to stay in the position she is in and to focus all her attention on the sensation of pain. Clara brings into focus the impression of '*a nail stuck in her temple*' as her fingers automatically press the point of contact. I urge her to maintain that pressure as she continues to observe the sensation in more detail. She then perceives more clearly that the sense of pressure is like a force that pushes outward from the inside, while the fin-

gers pressing against her temple are actually wanting to counter this force. While under observation the sensation of pressure progressively intensifies until it reaches a climax that Clara calls '*an explosion*' in her head, followed by '*a flash of blinding, white light*'. The flash of light gradually takes the form of '*a white box imprisoning my head*'. At this last image the sensation of internal pressure and pain fade away.

Now Clara moves between images. The box becomes a '*white room, empty and isolated from the rest of the world*'. She sees herself from behind, standing, child, in front of an old radio that she recognises as belonging to her grandparents. She is surprised by the memory. She is sorry while she wonders why her parents wanted to get rid of her. She observes herself turning the knob in search of frequencies. Then her attention falls on something that little Clara in the image is holding with her free hand abandoned along her side. '*Oh, my God... I didn't remember anymore! ... He's a little dog... my stuffed dog! I never parted with him... How did I forget him all these years?*' It is still there, with closed eyes, a hand on the temple that is now moving in a light massage. She smiles as she tells me emotionally how much comfort this object was able to give her in the many situations in which she felt, as a child, alone, scared and in danger. While she tries to reconstruct what happened to it, she suddenly remembers like the radio, one day she simply never found it. Her parents had taken the initiative to give it to her cousin because they considered her too old to play with the stuffed animal. She has no memory of mourning the loss of her soft toy at the time. To be sure, Clara did finally manage to cry when the memory surfaced in the consultation room.

By the end of the session the feeling of having reclaimed possession of an important part of her life replaced her neuralgic pain. I am deeply touched by the shared experience, and moved. Clara can surely see this from my wet eyes.

In subsequent elaborations of memory we reconstructed how her parents' removal of an object so fundamentally important for the regulation of Clara's sense of cohesion and security was experienced by her as a real violation of her body, a sort of amputation, which threatened its integrity, progressively compromising the development of the affective self-regulation function.

Conclusions

Within a theoretical framework that sees knowledge as integrally and synchronously distributed among mental and bodily processes, I propose a theoretical-clinical perspective in which intense sensory states and somatisation are considered and observed, on the one hand, as inherent to the non-

verbal mode of knowing of, and/or recognising experience; on the other hand, as *also* belonging to the network of relational procedures and the enactment process. When intense sensory states and/or somatic dysfunction emerges from the intersubjective body-mind system constituted by the analytic dyad, focusing on sensory impressions is a fertile opportunity to explore and integrate the emotional schemas which emerge into verbal discourse. Conveyed by these emotional schemas the meaningful relational experiences associated with them, at the time confined to elaboration at a sub-symbolic level, tend to surface into consciousness. The flow of process, in the end, automatically promotes the referential function and the integration to consciousness of the dissociated experiences.

The process is clearly delineated in Clara's shared clinical journey, and terminates with the emergence of a memory dissociated from the central value in the unconscious organisational processes of this young woman.

The neuralgic symptom, which, on the one hand, implicitly conserves memory of both the object and the sense of subjective integrity associated with it, on the other, keeps emotionally alive in Clara the pain and sense of helplessness that originally accompanied the trauma of loss, thus allowing for its possible subsequent integration. At the same time, the symptom safeguards the sufficiently satisfactory image of an adult able to manage pain in solitude, in line with the adultomorphic behaviour that Clara, as a child, was implicitly invited by her parents to conform to.

In childhood, Clara's soft toy acted as a transitional object to guarantee a connection between herself and the world (Winnicoucht, 1974). During analysis I acted for the most part as Clara's Self-object (Kohut, 1976), a concept that shares with the transitional object some basic principles relative to the development of the sense of self. During the elaboration phase that accompanied the end of analysis, Clara was finally able to integrate the function of Self-object more consistently. I had my own resistences to overcome in this process: the idea of leaving Clara to handle, alone, the vivid, harsh difficulties she continued to experience with the regulation of her emotions. I was restrained on the one hand, by the still powerful transference invested in developing Clara's capacity for self-regulation; on the other, by subconscious affects conditioned by a subjective, daily struggle to part from a model of motherhood that was congenial to me. In this phase, which called for complete confidence in my patient's capacity for autonomy and her acquired ability to develop autonomy in my absence, the ambivalence of my feelings were implicitly transmitted to Clara fuelling her sense of inadequacy and fear of loneliness and abandonment. At the same time, the processing of the symptom and the effect of a rediscovered memory made a fundamental contribution to completing the deconstruction of the tenacious affective connection between 'growth' and 'loss' evoked by the termination of analysis, and that the dissociated memory represented so emblematically.

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