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New Perspectives on Symptoms and Symbols in the Case of Clara and Their Role in the Treatment Process[1]

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ABSTRACT. – The treatment of Clara as described by Dr Marina Amore provides new insights into the role of somatic functions in the development of emotional disorders and in the therapeutic communication. According to the theory of the referential process, descriptions of specific bodily experiences may function to build connections to the symbolic and verbal mode when narratives involving people and events of life are not accessible. During the 10 years of treatment, Clara's reports of her severe neuralgic symptoms, and her bodily as well as emotional experience in her interactions with Dr. Amore enabled her eventually to talk about past and present experiences with her parents and others, and to rebuild emotion schemas that had been dissociated. Dr. Amore's own bodily feelings in her interactions with Clara guided her in the therapeutic work, and also opened new understanding of experiences in her own life. The referential process can be seen as playing out in depth between and within the two participants as they recognized Clara's growth, and also worked to resolve their sense of loss in the termination phase.

Key words: Symptoms; symbols; multiple code theory.

The complex story of Clara's treatment, told with sensitivity by Dr. Amore, provides insights into the role of somatic experience in the development of emotional disorders, and in the treatment process. The discussion of this case allows me to return to my earlier paper...' Symptoms and Symbols: A Multiple Code Theory of Somatization…' (Bucci, 1997) and to present new perspectives concerning the interaction of psychic and somatic processes since that time.

In my initial comments on the case, in response to Dr. Amore's presentation in November, 2017 in Milan, I discussed Clara's emotional issues from

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[1]Case material was made available to me by the treating clinician.

the perspective of multiple code theory and also raised several questions concerning the treatment process, including Dr. Amore's own experience. In these comments, I'll present a brief summary of the theory, focusing on the role of bodily experience in the development and treatment of emotional disorders. I'll then apply the model to the case of Clara, as discussed in Dr. Amore's new paper that deepens and elaborates her earlier presentations (also see Amore, 2012). My discussion will include changes in the therapist as well as the patient in the interactive field of the therapy, and as the two together played out the drama of the termination phase. Here I add that this discussion can be seen as involving not only interaction between therapist and patient, but as also involving multi-leveled discussion between Dr. Amore and myself, which has opened new ideas and new pathways for us both.

Concepts of the *Multiple Code Theory*

In this brief theoretical presentation of multiple code theory, I'll focus on three major points: i) organized thought occurs in sensory and bodily forms as well as in verbal language; ii) the processes involved in emotion are also involved in the regulation of physiological functions; iii) bodily experience is shared between people; we *feel* what others *feel*.

The basic concepts of multiple code theory include *subsymbolic* and *symbolic* processing systems; *emotion schemas* that constitute the organization of experience in memory, and the *referential process* by which subsymbolic experience is communicated in verbal form. All these concepts have been discussed elsewhere; I'll outline the basic ideas here.

People think and communicate in both *symbolic* and *subsymbolic* forms. Symbols may be words or images that refer to and represent the experiences of life. They may be combined to represent complex ideas and are central in logical reasoning and in communicating to others. People also have access to a complex world of subsymbolic experience in analogic form, as gradients of experience rather than as discrete representations. These may involve feelings in all sensory modalities, including sight, sound, smell, taste and touch, as well as in bodily and motoric experience. Both symbolic and subsymbolic processes may occur in conscious or unconscious modes. We are accustomed to viewing symbolic processes as conscious thought. We are also aware of the flow of subsymbolic experience that provide the color and music and feel of our lives, but somehow classify experiences that cannot be readily named as not conscious. As I have argued elsewhere, it changes our view of mentation in general, and of therapy in particular, to admit subsymbolic experience to the domain of mature, conscious, rational thought (see for example Bucci, 2002, 2011a, 2011b; Damasio, 1999) .

Emotion schemas. The organization of emotional life and motivation

depends on emotion schemas. These are networks in memory that are formed through repeated interactions with other people and that include patterns of visceral or somatic experience in subsymbolic form - what we feel, or expect to feel when someone acts in a particular way towards us or some particular event occurs; patterns of motoric response associated with such arousal - to attack, to flee, to caress; and representations of the object of the emotion, the person or event that is associated with these patterns of feeling and response.

The subsymbolic components of feeling and action constitute the *affective core* of the schema; the clusters of memories that form the emotion schemas are based on activation of the affective core with different people and in different places and times. The schema is activated when *something happens* in one's life that activates the affective core. The core of feeling and action - or tendencies to action - that is built when a child is punished or neglected by a parent, may be activated again in an intimate relationship, or in one's work, or in any other day by day context of life. Each episode in which the affective core, or components of the core, are activated constitutes an instantiation adding to the schema - in some cases modifying the schema; in some cases reinforcing the expectations that are incorporated in it. Each such activation of an emotion schema constitutes what we refer to as an experience of emotion. In some cases clusters of such activation, shared by many people, are classified by emotion words such as 'anger', 'fear', or 'shame'; in many cases the clusters are more diffuse, more varied, and specific to an individual's life; people say 'I can't explain how I feel'.

Relation of emotion schemas to other concepts

The construct of the emotion schema builds on the basic notion of the memory schema (Bartlett, 1932). As defined by Bartlett, memory schemas are organized representations of past knowledge and experiences that are activated and altered by new experience and determine interactively how new experience is perceived. As for all memory schemas, we see all experiences of the world through the lens of the emotion schema; there is no other way. Piaget's (1936) concepts of assimilation and accommodation also represent the constantly changing nature of knowledge schemas in the experience of life. The emotion schemas differ from other memory or knowledge schemas in that their organization is based on the subsymbolic sensory, bodily, visceral experiences of the affective core, and they are grounded in interactions with the world of other people from the beginning of life.

Bowlby's (1969) concept of *Internal Working Models* and Stern's (1985) concept of *Representations of Interactions that have been*

Generalized (RIGs) emphasize the developmental and interpersonal nature of emotion schemas, and the role of the caretaker in their development. As defined by Stern, RIGs are based on episodes that include ..'sensations, perceptions, actions, thoughts, affects and goals...', and that occur repeatedly in a particular temporal relationship. (Stern, 1985, p.95). As specific episodes repeat, the infant begins to form the prototypic memory structure, the RIG, which Stern characterizes as: '... 'an individualized, personal expectation of how things are likely to proceed on a moment-to-moment basis...' (p. 95).

The view from psychoanalysis

The formulation of emotions and emotion schemas as defined in multiple code theory are also related to basic psychoanalytic ideas. Freud's 1912 concept of transference involves a similar organization relating objects, actions and somatic satisfaction, in different terms:

> "…Each individual, through the combined operation of his innate disposition and the influences brought to bear on him during his early years, has acquired a specific method of his own in his conduct of his erotic life - This produces what might be described *as a stereotype plate (or several such), which is constantly repeated - constantly reprinted afresh* (emphasis added) in the course of the person's life, so far as external circumstances and the nature of the love-objects accessible to him permit, and which is certainly not entirely insusceptible to change in the face of recent experiences… If someone's need for love is not entirely satisfied by reality, he is bound to approach every new person whom he meets with libidinal anticipatory ideas…" **(**Freud, 1912).

The concepts of the stereotype plate, libidinal anticipatory ideas, the compulsion to repeat, as well as the concepts of internalized object relations, self-states (in the relational approach) and complexes (in Jungian theory), and many others all involve organized representations, built up through life, that determine *how one feels* or *how one expects to feels* in particular situations, with particular people.

The concept of the emotion schema also relates, indirectly, to the psychoanalytic concept of drive and provides a characterization of the fundamental psychoanalytic idea of the interaction of psyche and soma, independent of the energy model. Freud (1905) characterized drives on the basis of their somatic source, their aim, and their object. In the emotion schema, as in the concept of drive, there is a somatic source, a set of bodily functions including sensory, visceral and motoric activation and a pattern of response associated with these functions. There is also an object - something happening in the present or in memory or fantasy - which is the aim towards which the responses are directed.

The interpersonal nature of emotions schemas

A central aspect of emotion schemas concerns their development in an interpersonal context. The new work in social neuroscience and embodied communication has provided a framework for understanding such development. The initial discovery of mirror neurons in monkeys required implanting of electrodes in the brain (Gallese, Fadiga, Fogassi, & Rizzolatti, 1996). Researchers in the field of affective neuroscience have now found noninvasive ways to study mirroring processes in humans in experimental designs, as well as through stimulation of particular brain areas in procedures associated with neurosurgery for epilepsy and related conditions. In studies using functional magnetic resonance imaging (fMRI) or transcranial magnetic stimulation (TMS), researchers have found that some of the same nerve cells fire in a person's brain when he sees a person being touched as when he himself is being touched (Keysers & Gazzola, 2009); when he observes another person showing expressions of disgust or expressions of appreciation as when he experiences disgusting or pleasant smells (Wicker *et al*., 2003); or when he observes pain in another person or receives pain himself (Singer & Frith, 2005).

As the social neuroscientist, Christian Keysers, notes:

> "...the discovery of shared circuits has changed our understanding of the link between the individual mind and the people around us... In light of the new research, people around us are no longer just part of 'the world out there', restricted to sensory brain areas. Through shared circuits, the people around us, their actions and their emotions, permeate into many areas of our brain… our motor system and our feelings. Invisible strings of shared circuits tie our minds together…" (Keysers, 2011, p. 117).

The implication of these findings is enormously significant for our understanding of the organization of emotion schemas in development, and for their playing out in the treatment process. Just as we are not accustomed to recognizing subsymbolic sensory, bodily and motoric processes as systematic thought, so we are not accustomed to recognizing that we are each partially occupied by the perceptions and actions of the people with whom we are in contact - and some parts of us are permanently occupied by the people with whom we were in close and continuous contact in our early years. I note here that the concept of projective identification, which has been seen as somewhat magical and in some cases malevolent, acquires a systematic and neutral basis with these new discoveries.

Dissociation within and between emotion schemas

At some points in life, every child, every person, will find herself in a state that is painful, frightening and may be experienced as life-threatening.

Such states may range from the hunger that turns an infant into a redfaced squalling bundle of frustration and rage, but that is readily resolved by connection to the mother's breast, to the other less readily managed pains and assaults that occur in every child's life. If caretakers are able to recognize the child's distress, to modify the entrained patterns of painful activation, and to redirect the interaction, processes of regulation will eventually be incorporated into the emotion schema, and will play out when new threats occur. Problems arise when caretakers fail to intervene effectively or are overwhelmed, or in extreme cases, when they are themselves the agents of abuse. The child cannot avoid the activation of the painful somatic experience, or the entrained tendency to attack or avoid the source of the pain. What she can do is attempt to escape mentally - or virtually; try to turn attention away from the situation that aroused these feelings by escaping in her mind. In particular, she will attempt to avoid recognizing that it is a parent who has neglected or abused her. Such recognition would add an additional, dire, source of pain and fear; she is not only in pain; but also abandoned or even endangered by those whom she needs to call on for help.

While people are able to direct attention away from some objects and events, they are generally not able to direct and control the bodily systems that make up the affective core - including heart rate, blood pressure, breathing, sweating, and digestive functions. The bodily activation of the affective core of the emotion schema, including sensory and visceral activation, and the tendencies to respond associated with anger or fear or loss remain, to be accounted for and regulated in some way. The child may focus on her somatic experience, she may act out in aggressive or other ways, or find ways to take the responsibility for her state on herself.

The child and then the adult may also seek ways to regulate the painful arousal more directly, by eating or not eating, use of drugs or alcohol, or injuring herself. In some cases, people find more positive means of regulating the surges of painful affect, such as immersing oneself in a career, or in sports, or in care of children, engaging in political action, or scientific exploration, or in the arts, or in doing good works for others. Throughout life, the child and later the adult is likely to confront situations that lead to activation of a painful schema; and to playing out of the response patterns that have worked in the past, to ward off a threat before it is actually realized.

The strategies that have been used to prevent attack may also block the person's opportunity to see that new situations are different from earlier ones. The scope of the dreaded situation, the sense of similarity of new events to early situations of threat are likely to broaden widely, encompassing an increasingly wide range of interpersonal interactions. The fixed responses to an increasingly broad range of situations add to the life problems that bring people to treatment. The psychological roots of dissociative processes and their implications for treatment are discussed in detail elsewhere (see Bucci, 2007a, 2007b).

Emotional disorders and somatization

The emotion schemas are where mind, emotion and bodily functions intersect. In situations of dissociation within the schema, where the threat is not recognized as such, prolonged activation of the affective core is likely to occur. It is not only the external challenge as such, but the body's continuing attempt to manage this that increases vulnerability to physical illness. The generalized stress response (Selye, 1950; McEwen & Seeman, 2003) involves biological and behavioral functions that attempt to maintain internal balance where the external challenge itself cannot be met effectively; these functions may involve hormonal systems, the pituitary-adrenal axis, and the autonomic system, and interactions among these. There is considerable evidence for the effects of such activation on a wide range of illnesses, including inflammatory disorders such as are involved in the neuralgia that afflicted Clara, as well as on disorders involving endocrine, reproductive, growth and immune systems.

I emphasize that the particular physiological expression that occurs is viewed as depending on an individual's areas of organic weakness or vulnerability, not as associated with a specific unconscious conflictual emotional event. This view is held by most writers within the psychoanalytic field. As Auchincloss and Samberg (2012) state, summarizing current views: ..'In recent years, efforts to link specific ailments to specific underlying conflicts have largely been abandoned in favor of a more general use of the term to suggest only a pronounced contribution of psychological factors to the etiology or expression of any medical syndrome...' (p. 215)

To summarize this process, which has sometimes been misunderstood, the bodily activation that manifests as a physical symptom is not a symbol with particular emotional meaning. It is a response to a stressor that exceeds a physiological threshold; the nature of the stressor depends on an individual's life experience; the particular somatic expression depends on an individual's areas of physiological vulnerability. There is increasing agreement, even in medical fields, that such disorders require psychiatric or psychological therapies, as well as medical and in some cases surgical treatment.; there is of course disagreement as to the nature of the psychotherapies that might be useful, and how they work.

The referential process in the therapeutic context

The great mystery of psychotherapy that has intrigued me since I began this work is how do words – ephemeral changes in sound waves - that go back and forth between two people bring about change in physical systems; how can physical as well as emotional disorders be responsive to a talking

cure? Freud addressed this question using concepts of libidinal energy and its conversion between somatic innervation and mental forms; we can now account for these effects without calling on such concepts.

The communication of emotional experience is a multi-leveled process, which I've termed the referential process, and which includes three basic functions: *Arousal; Symbolizing;* and *Reflection/Reorganization.* The multiple levels of thought must occur in therapist as well as patient in order that effective communication can take place. In the optimal playing out of the process, these functions will follow one another as phases of the treatment. The progression may also be interrupted, may loop back on itself, or may be aborted. I've discussed these functions and their operation in treatment elsewhere, and will review them briefly here.

Arousal: The patient knows something is bothering her, something is on her mind as she enters the session. Traces of a problematic dissociated emotion schema are activated within the relationship, in the interaction of the two participants and in different ways in the subjective experience of each. The experience of both participants is largely in subsymbolic form in this phase, involving activation of the affective core of a schema, and their communication occurs primarily on sensory, bodily and motoric levels. The patient, like any person trying to communicate emotional experience, has difficulty in connecting experience to language. The problem is particularly acute for the patient, who is struggling with schemas that are dissociated, and who is trying to avoid connection to the painful experience, rather than seeking to formulate and communicate it.

Symbolizing/Narrative: Images or sequences of images associated with the affective core come to mind, perhaps in fleeting or disconnected form, perhaps in waking fantasies or in events of the treatment relationship, perhaps as they appeared in a dream. The images constitute instantiations of an emotion schema that has been activated - one of the cluster of events that activate a similar set of feelings and involve similar responses. In the optimal operation of the referential process, the patient can then go on to describe the image or event in the kind of vivid and detailed language that indicates connection to emotional experience in the speaker and is capable of evoking corresponding experience in the listener.

Reflection/Reorganization: Once the material is shared, and the affect is present but sufficiently contained, there is opportunity for a reorganizing phase in which the meaning of the events that make up the schema may be further explored, new connections may be discovered, and new schemas constructed.

The functions may occur within sessions, and across periods of the treatment; they may occur in the specified order; or the order may be interrupted. The process will play out differently for different patients, with different presenting problems, and in different treatment forms. As I have argued, the basic process may be identified in all types of psychotherapy (Bucci, 2013).

Transition from arousal to symbolizing phase

Kris outlined the optimal patterning of the treatment process in his description of the good hour:

> "…Many a time the 'good hour' does not start propitiously. It may come gradually into its own, say after the first ten or fifteen minutes. Then, a dream may come, and associations, and all begins to make sense. In particularly fortunate instances a memory from the near or distant past, or, suddenly, one from the dark days may present itself with varying degrees of affective charge. And when the analyst interprets, sometimes all he needs to say can be put into a question. The patient may well do the summing up by himself, and himself arrive at conclusions…" (Kris, 1956, p. 446).

The reality, as clinicians know, is that the first ten or 15 minutes to which Kris refers, which I characterize as the phase of Arousal, may become 10 or 15 weeks or months or even more. In the framework of multiple code theory, this is a phase of subsymbolic activation; much is happening inside the patient, but not much that can be shared in symbolic form. Gestures and body movements contribute to subsymbolic communication; speech rhythms, and vocal tones also carry emotional information.

The role of somatic symptoms in transition to the symbolizing function

For some patients, and at some points of treatment, when access to instantiations of an emotion schema in dreams or fantasies, or narratives of life events are not available, descriptions of physical symptoms may serve as protosymbols, providing entry to a shared symbolic mode. Somatic symptoms, as they are experienced, or are reported in a session, are components of the affective core of a dissociated emotion schema that has been activated in the context of the relationship; talking about these bodily events may enable connection to components of schemas that have been dissociated when other elements of the schema are avoided. Through the shared circuitry of emotional communication, activation of such bodily components of the schema may occur in therapist as well as patient. We may see this interactive process play out in the case of Clara, as described by Dr. Amore.

Clara's history and the treatment process

As Dr Amore writes, Clara came to treatment at the age of 30, suffering from severe '…episodes of perceptual dimorphism, as 'releasing air from her eyes,' as if her eyes were two holes from which the air moves inside and outside her body, dispersing her vital energy. These episodes trigger violent affective reactions, which Clara calls 'panic attacks'. Dr. Amore works in

collaboration with a psychiatrist who prescribes medication to enable Clara to come to treatment. Clara continues to take the medication for only three months, but carries it with her for over a year.

In the first session, Clara also talks about the recurrent trigeminal neuralgia from which she has suffered since the age of 6. The symptom recurred regularly and heavily affected her life, but did not occur in the sessions during Clara's analysis until the termination phase, as will be discussed further.

Clara describes her mother as being unable to establish an empathic relationship with her, and as easily disorganized by minor problems, including physical ones. She tells a memory of an incident in which she cut herself severely during a fall. Her mother's reaction was such as to require the family to care for her, while Clara looked on, confused and alone, her blood running down her face.

Through repeated occurrences of such events, from early in life, in many contexts, Clara learned that her mother was not available, in fact not capable of comforting or caring for her. She also learned that calling for help made things worse. Her father did not tolerate requests for reassurance and coldly rationalized emotional experience. It seems likely that early in life Clara recognized her parents as unavailable or destructive. It also seems likely that she attempted to avoid this recognition, to maintain whatever relationship to her parents was available for her. That is an example of dissociation within the emotion schema. Clara as a very young child experienced painful activation of the bodily core of the emotion schema, while avoiding connection to the events that caused the activation. Her body and her mind would then swing into action to account for these feelings and to manage them. Part of this reaction would involve prolonged activation of adaptational responses, as in the generalized stress response as discussed above.

Facial pain, an aspect of the trigeminal neuralgia from which Clara suffered, is known to be associated with such stress responses. When the symptoms of neuralgia came, she lay on the sofa in the family home, not complaining or crying, waiting in silence for the effects of the painkillers that her parents gave her. Her intelligence and competence enabled her to care for herself sufficiently to avoid the more painful and devastating experience of her parents' emotional abuse and neglect. She strived to function so as to see herself as 'consistent, strong and brave'; also as 'uninhibited', 'brave', 'intellectual'. Expressing emotional or physical needs carried great dangers for her. Not only would she lose her connection to her parents by calling on them for the help that they would not or could not give, but she would also lose her construction of her competent self that had supported her from early in her life. Her attempts to maintain this image of herself would be likely to intensify the stress response.

Repair of dissociated schemas in Clara's treatment

Clara comes to treatment as this construction of herself as consistent and brave is breaking down. While she needs and seeks help, she also retains her expectations of others as potential sources of danger, and her strategies of response through avoidance of connection to her own needs. The treatment begins with two sessions a week, on the couch. As Marina[2] describes their interaction, 'the flow of words is continuous' between them, but 'words are never enough to grasp and describe the 'dark' experiences that pervade her inner world...' In the treatment, Clara talks about herself, but is frustrated by a sense of not being able to understand what she really feels; she has the impression that her speech is always incomplete, that she is incomplete. She is not able to describe the horror she feels that leads to the panic attacks; not able to connect to the specific experiences that distress her.

After a year, Marina suggests that they increase the frequency of the sessions from two to three times a week, and includes the possibility of calling on the weekend. The new setting changes the patterns of communication in the session and provides a stronger foundation in their relationship. Here we can begin to see the playing out of the phases of the referential process in the session and in the treatment. This period of the treatment is dominated by functions of *arousal* of experience in the context of the new relationship. Clara is constantly testing her experience of Marina in small incremental ways; seeing that Marina does not react in ways that she learned in her childhood to expect. Yet Marina senses that Clara continues to keep her at a distance from important aspects of her experience.

During this period, Clara reports a dream in which they are climbing a high mountain together, 'as in a pilgrimage, to reach a sacred place where an uncovered sarcophagus rests'. As they near the edge of the sarcophagus, Clara puts her hand on Marina's eyes. As Marina reports:

> ..'For both of us, the exploration of the dream makes explicit the thought that the vision of what is her most intimate feeling, experienced fearfully as shapeless and unrepresentable, can somehow be intolerable and harmful to me. If this happened as it happened when the mother saw her blood, she would find herself alone again...'

To enable Clara to make some connection to the painful experience that is 'shapeless and unrepresentable', in the context of the session, Marina invites Clara to 'focus the conscious attention on the bodily sensations matched with feelings of inadequacy' and to explore them. As discussed

[2]In presentation of the case material, following current procedures for reports of interpersonal and relational treatments, I refer to therapist as well as patient by first name.

above, patients may be able to focus on and talk about bodily experience, while narratives involving other people or events are not accessible to her; such reports of specific bodily and sensory experience *may begin to build connections to the symbolic and verbal* mode.

The analyst's presence and the responses to that may also be symbols or protosymbols of this sort (Bucci, 2001).

Clara talks about the cracks that distort her voice, her rigid posture and movements; she also talks about her experience of Marina. In the movement from the Arousal to the Symbolic mode, the subsymbolic interaction that has been going on continuously between them begins to be articulated as well; now Clara is able to focus on Marina's expressions and is able to talk about how they make her feel.

Clara's comments also lead Marina to focus on her own bodily experience. In some situations, Marina feels that her leg muscles are contracted '…as if prepared for a sudden jump forward…'; she associates that with her fear that because of the intensity and tension of their interaction, Clara may experience a sudden psychotic break. In other instances, when they focus on aspects of their shared womanhood, Marina is able to experience her own body in a stronger way and to convey this strength to Clara.

By three years into the work, Clara no longer suffers from the symptoms of neuralgia or the panic attacks. She becomes increasingly able to talk about life experiences that had previously been felt as unbearable, as these now emerge in memories and dreams. She connects the occurrence of the attacks of neuralgia to a painful and annihilating sense of loneliness in her childhood. She reports re-experiencing these feelings as an adult, while lying on the sofa in her living room, waiting in vain for someone to come and reassure and comfort her.

Movement into a symbolic narrative phase appears to be occurring more consistently in the sessions during this long period of treatment, and Clara is more able to report fantasies, dreams and narratives of past and future events. As Clara is building new connections between her somatic and sensory experiences and her representations of others in the treatment, the therapist is becoming a new 'other' connected to her self-representation. During this process, Clara is also building new connections to the figures who appear in her memories, as well as new connections in her current relationships to others; she forms a relationship of love and become a mother.

After about ten years, they agree to change the treatment setting to twice a week, face to face. In the initial phases of the treatment, the use of the couch had proven effective in helping Clara to maintain a closer contact with her own volatile and intense inner experience. As the treatment progressed, the couch and its implications themselves became objects of their exploration, serving as indicators of changes within each of them and in their relationship. As they discovered together, the use of the couch initially

functioned for Clara to preserve Marina as a supportive presence. As Marina observes: '…In this way, not even I could see, reflected by the frightened-frightening expression on her face, her frailties. Clara needed to preserve me, as we had also seen in the sarcophagus's dream in which she covered my eyes from something that could not be looked at…'. The shift from the couch to face-to-face reflected their shared observation that Clara had over time come to feel more confident of Marina's emotional solidity in the face of her frailties, and more safe and confident in their relationship. As Marina has described: 'This awareness now made her eager to look at me; defying the risk of seeing the negative responses that she had fantasized for so long a time. Now she could meet my gaze where finally she could see herself being seen in her frailties. This shift in setting made possible a long phase of comparison and mirroring that followed…'. This can be seen as a time of some *reflection and reorganization;* Clara was more able to talk about her experience and its emotional meaning for her, and more lasting changes in her emotion schemas may be seen.

The referential process in the termination phase

The therapist's experience

Although the shift in the nature of their interaction was apparent, Marina is surprised when, after they had worked together for about 10 years, Clara expresses her feeling that it is time to end the treatment. Marina is aware of the considerable gains that Clara has made but also recognizes significant areas of fragility that remain. As they explore the prospect of termination, Marina becomes more aware of her strong feelings of emotional connection to Clara. She also explores parallel feelings that she is experiencing in the process, ongoing at the time, of weaning her daughter. Clara, like Marina's child, was growing and separating. For Marina as analyst and also as mother, both situations, to different degrees, involve the complex feelings associated with such separations: mourning a loss; pleasure and pride in the growth of a person whom she has nurtured; the fears that one has when a patient - or child - must confront the world on her own. Marina believes that it is time for Clara to meet life on her own but remains concerned that she may not be ready, and also concerned that her worry may be undermining Clara's faith in her own capacity to function independently. We may see this as a version of the referential process in the analyst's experience: Marina's increasingly strong feelings and her awareness of them; her association to the process of weaning her daughter; followed by her exploration of the pain of separation, and the conflicting meanings of pride in the growth of the other and fear for the other's capability.

The patient's experience of the termination phase

When Marina has agreed to the termination, and they have set a date for the last meeting, Clara's attacks of neuralgia return, as crippling as in the past. The planning for termination has replayed the situation of early stress; Clara's body has responded with the pattern of physiological activation to which she had been vulnerable for much of her life.

One day Clara comes to the session suffering from an attack of neuralgia. This is an exceptional event; she has not previously had the symptom in Marina's presence. The work of the treatment has brought about a change in Clara's emotion schema; she is now able to show her pain directly. In contrast to the expression in the early dream, Clara no longer needs to cover Marina's eyes to prevent her seeing into the darkness of the sarcophagus - but she is not yet confident of the potential effects of the revelation. Clara's expression of need is presented in the context of the impending termination of the treatment that she herself has chosen; as if she is testing whether she can now be independent in a different and sustainable way, whether she will lose the gains she has made in her life when the separation from Marina occurs.

In the terms of the referential process, as it played out in this session, the activation of the symptom is part of the phase of arousal, activation of the affective core of an emotion schema of pain and loss in the context of the relationship**.** Marina encourages her to focus on her bodily feelings and communicate them to her, as she has done many times in the course of treatment. As Clara experiences the pain and talks about it, she then describes '…an explosion…' inside her head, generating '…a beam of blinding white light...' (Here I note that an aura that may involve light flashes is associated with migraine - different from the neuralgia that had been diagnosed, but possibly related in this instance).

The beam of light gradually forms the shape of a white box trapping her head. This is movement into the symbolizing phase, from proto-symbol to symbol. She moves on from talking about the pain to visual imagery and then to images retrieved from the past.

As Marina describes in her paper:

> Now Clara moves among images. The white box becomes a white room, empty and isolated from the rest of the world. She sees herself as a little girl, with her back turned, standing in front of an old radio that used to belong to her grandparents. She is surprised by the memory. She wonders why her parents gave it away; she is sorry they did. She watches herself turn the knob trying to tune into a station. Then her attention is caught by something little Clara is holding in her hand. '…Oh my God ...I forgot all about it ...It's a dog ...my stuffed animal! I never parted with it ...How could I have forgotten about it all these years?...'

This enables her to enter a *reflection/reorganization* phase. She smiles as she tells Marina how much comfort this stuffed animal had given her when she felt frightened and in danger. She remembers that 'like the radio, one day it was simply gone: her parents had given it to a younger cousin because, as they later explained, she had outgrown it'. She has no recollection of how she felt at that moment, or whether she cried, but now she is able to mourn the loss of this object that was so important to her. Marina writes:

At the end of the session Clara's neuralgia is gone and she feels she has recovered an important part of her experience. I feel the same and am deeply moved by the process I have witnessed and shared. I'm touched by this unexpected finding, Clara can see it by my wet eyes.

The referential process may involve recovery of memories, as in this example, but also takes place though fantasies, dreams, and repeated interactions with the therapist. The memory as recovered here is a new connection, a new instantiation, continuing the process of shared self-exploration in the context of an accepting relationship. She experiences her pain in the presence of another person, who cares for her, and is able to mourn with her. This has presumably happened repeatedly in the treatment, building new schemas involving new representation of herself in relation to others. Marina's emphasis on activating bodily components of their shared experience was central in allowing the new connections to be built.

Here I want to point out a connection between the process I've described here and Freud's (1899) characterization of a screen memory, as a recollection whose value lies in that it represents thoughts of a later date, whose content is connected with the earlier event by symbolic or similar links…' Whenever in a memory the subject himself appears as an object among other objects, this may be taken as evidence that the original impression has been worked over...'[3] Clara's memory vividly included such a representation of herself. As in the interpretation of a dream, she is not recovering latent organized memories that have been repressed, she is building new meanings, organizing new schemas, making new connections, in the context of the new relationship. Freud's comments in 1899 are compatible with this point.

Shame, affiliation and sexual desire

Part of Clara's management of her ongoing difficulties involve construction of a competent, brave, intellectual self who did not need to call out for help. Each time a painful experience occurred that Clara was able to manage adequately, this construction of herself would be supported. Conversely,

[3]Cited from Abstracts of the Standard Edition, International Universities Press, p.89.

a failure to manage the situation could be devastating - leaving her in a state of pain and danger, perhaps expecting criticism or punishment, but also with a devastating failure of her competent self-image. It seems likely that such experiences of shame and humiliation would have contributed to Clara's early withdrawal from expressing emotional need. Such expression would leave her not only with a loss of connection to her caretakers, but also to her sense of self.

The emergence of the memory of the transitional object, the stuffed dog, at the very end of treatment, is centrally related to the change that has occurred during Clara's treatment. The object presumably played a supportive role in her schema of how to survive as a child; there was perhaps some shame associated with that as well. Her parents took it away; she could do without it; she did not need it. As the end of the treatment and as the new relationship with Marina has been internalized, she could let the memory and the sense of need return. She now has an 'object' that she can keep with her, while still being a competent, brave self.

An explicit reference to shame in Dr. Amore's paper emerges with respect to the sexual advances from the professor who apparently raped her; she is ashamed to have been a passive object of a man's sexual pleasure, ashamed to have been sexually disappointing to him. Her strategy of distancing and normalizing the event doesn't work; the teacher becomes cold and detached. The first episode of dysmorphism happens in this period; she also begins to engage in promiscuous sexual encounters without desire or pleasure. Her attempt to write a thesis is compromised and she withdraws from the work, although maintaining some connection to her university.

A recurring dream that Clara reports of a child pretending to be asleep while being abused by an unknown adult couple who claimed to be her parents seems relevant here; this is associated with the total numbness of her body during her sexual encounters. I would be interested in the relationship of this and other dreams to the avoidance of shame in her early self-representation. I would also be interested in an association between her relationship to her father, whom she might have hoped to please by being strong, brave and intellectual, and her later self-abnegating submission to her professor, who uses and then abandons her. Presumably the working through of the bodily numbness and associated fantasies, perhaps involving her father, could be a topic for another paper.

Conclusions

Some main ideas I've presented here, as illustrated in the case of Clara.

Emotion schemas are inherently *mind-body constellations* connecting the sensory, physiological and motoric processes of the affective core to the

experiences of life; an experience of emotion involves an activation of a schema with its bodily core. This view of emotions is compatible with current views of emotion systems in affective neuroscience and related fields. As the neurologist Pessoa has explained:

> "…there are no truly separate systems for emotion and cognition because complex cognitive-emotional behaviour emerges from the rich, dynamic interactions between brain networks. Indeed, I propose that emotion and cognition not only strongly interact in the brain, but that they are often integrated so that they jointly contribute to behaviour. Moreover, I propose that emotion and cognition are only minimally decomposable in the brain, and that the neural basis of emotion and cognition should be viewed as strongly non-modular" (Pessoa, 2008, p. 148).

Emotional difficulties involve disconnection between the subsymbolic bodily and sensory components of the affective core of a schema and the events that activate it. For Clara, a dreaded schema involved her parents' coldness and rejection, her experience of this, and her expectation of abandonment or abuse. Throughout Clara's life, situations occurred, in many contexts with many people that activated this schema, and her painful and frequently unsuccessful response, without her recognition of these stimuli.

Rather than recovering unconscious memories that have been repressed, we can account for Clara's experience as reconstructing schemas that have been dissociated. Such reconstruction occurs through *repeated activation of the referential process in the context of the therapeutic relationship*. In very early years of treatment, trace activation of events associated with a dissociated schema, within and outside of the session, bring with it repetitions of the painful affective core, with its dangers and threats; the connections are quickly closed down. As the therapeutic relationship builds, and the patient becomes more aware of her own powers, instances of events associated with the dreaded schema may occur, but now with somewhat reduced activation of pain and danger. The patient can begin to recognize the meaning of these events, and eventually to recognize that her expectations of distress are not realized in her new interactions. It is necessary for some degree of activation of the affective core to occur in the session itself in order for the emotional change in the schema to occur.

During the phase of termination, Clara experienced her neuralgia in the session itself for the first time, and Marina helped her to work with it. The termination of the treatment is a potent source of activation of the emotion schemas for both participants, particularly for such long and intense treatments and raises important questions concerning the therapeutic process. As this case has illustrated, therapists as well as patients need to work through the painful but desired process of separation, in the contexts of their own lives.

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