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Affect, somatization, symbolization and the analytic situation[1]

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Resumo

O autor parte de material clínico de análise de um paciente portador de queratocone para discutir factores da técnica analítica favorecedoras de movimento no sentido da mentalização e da simbolização, como por exemplo, a condição de reverie. A mentalização instalar-se-ia no princípio através da aquisição de formas primitivas de consciência, tendo como modo básico de expressão a emoção e os sentimentos, que operam como forma de compreensão da realidade. A consciência afectiva inicialmente é configurada por formas simbólicas não discursivas, não havendo distinção clara entre o signo e o conteúdo de seu significado.

O refazer do elo entre emoção e representação, a partir do paciente se sentir "falado por outrem", propiciará a instalação de um tecido conectivo a funcionar como ponte, que permite a criação do símbolo onde prevalecia a somatização.

The theme will be approached starting from clinical material (discussed in a previous paper from another vertex – Montagna, 1996) from the analysis of a 36- year-old patient who came to me extremely anguished about the third cornea transplant surgery attempt he had to be submitted to. Owing to rejection of transplanted tissue, his first two attempts at surgery had been unsuccessful.

From the material I think it is plausible to make the hypothesis that the emotional experience lived out in the analytic interaction was instrumental to the success of his third operation, and I will try to raise some points about this issue.

The discussion will be centered on a series of meaningful situations that took place in the analytical interaction, and its implications.

Clinical vignette

C., a 36-year-old man, came to me in a state of extreme anxiety about an upcoming cornea transplant operation. He had **keratoconus**, a dilation of the lining of the cornea, of obscure origin, which can cause a very significant and progressive loss of vision. A sufferer from this disease may have

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to undergo surgery when the use of contact lenses fails to cause a significant improvement in vision and when the illness is already at an advanced stage. In such a case, a cornea transplant is recommended. C. had already undergone two unsuccessful attempts at transplant , the transplanted tissue had been rejected. The disease had caused a marked deterioration in his vision such that with his right eye he could only make out outlines and blurs. The likelihood of rejection in new attempts increases with each surgery, as the cornea gets vascularized in the process of rejection, and vascularized tissues tend to reject more than tissues that are not (Allansmith, 1982).

The patient was terrified about the third up coming surgery, convinced that he would die or go blind during the operation. He had put off seeking me out for a long time believing that an analyst could exercise excessive power over an analysand.

Married, two children, an executive with an obvious love for his work, he was also very concerned about the future of his family who depended on him for both their material and emotional well-being.

I take this clinical material from the fifth month of analysis as a starting point for the issues to be discussed.

In the second session of the week, C. arrives punctually, as he usually does. Soon after he lies down, he begins a lively account of his experiences of trips he has been taking for work during his life. He talks about many different countries he visited in Europe, Asia, Africa, all very different from each other. He talks about the diversity of the people and mentions some unusual and exotic habits, customs in some regions. He becomes enthusiastic as he relates details of geography. He seems to feel like a ***pioneer****. He talks about the cuisine of these places and significant people he met. He shows pride at having seen so much. His account involves me, the atmosphere looks strange in a way I can't quite pinpoint.*

His account involves me, engulfs, intrigues me. It's a pleasant description, "I travel along with him", absorbed in what he is saying. I observe myself very curious about it. For a moment, it occurs to me that he is defensively travelling far away from his painful anguish. I drop this idea and continue to accompany him and taking me away with him. I can not "see" anything else, so I go on enjoying the narrative in a slightly dreamlike state, imagining the places and situations. Without realizing, I start to shift the focus of my attention. It isn't deliberate, but gradually I become concerned about the rhythm, sounds, music of the communication. Strangely I start to hear a ***Portuguese (from Portugal) accent*** *in C.'s prosody and intonation,* ***an unusual accent*** *that did not fit to his* ***characteristically Brazilian one.*** *I keep concentrated listening to it and ask myself what importance this could have, what could it mean. The impression vanishes but what comes to mind now is the image of* ***Camões****, the epic Portuguese poet and warrior who wrote about Lusitanian dis-*

*coveries in the work "**Os Lusíadas**", poem about travels and conquests, lands, worlds and people.*

***Camões was blinded in one eye** in a war battle.*

I tell the patient that his account reminds me of Camões, and that by telling me adventures which he prided himself on, he could wish to impress me but also wanted me to understand all his anguish in relation to his sight and surgery.

*Obviously surprised at my interpretation, he tells me his father had always been an admirer of Camões and that one of the things he always wanted to do was to visit the **writer's tomb** in Portugal. He goes on: "This reminds me of **Inês de Castro**", and I add: the one who **became queen after she was dead**. (Camões tells us that, Inês de Castro, the beautiful lover of Pedro, – XIV century – who did not accept to get married to another woman, was murdered by order of Pedro's father, king Afonso IV, in retaliation. This raised the wrath of Pedro, who ordered that she would be enthroned dead in a morbid ceremony). This commentary "reverberates" and he continues: "My mother too. I remember her now. She died when I was a little boy, there was always a certain nostalgia about her at home. She was always remembered". After some minutes in silence, he says that he was remembering his last operation. He had heard people talking in the operating room and couldn't move, couldn't react or do anything. He goes on to telling me that the fear of the operation was mainly the fear of isolation and that during the previous surgery he had felt like he was falling into a deep hole, and that way down to the bottom of the hole he had seen a clearing reappear. When he came round from the anaesthetic the first thing he said was"Fa freddo" an expression that his mother, of Italian descent, used, he thought.*

We go on working with the identification that he makes between his mother and Inês de Castro, his feelings of guilt, fear of retaliation and his feelings of abandonment.

We had touched on a C.´s extremely private area in this session.

As the analysis went on, the atmosphere of the interaction changed. He began to show, in the here and now of the session, the fear of being at the mercy of the analyst due to his previous sensation of a loss of privacy. The analyst-analysand relationship came to the focus.

C. started to reject outright any intervention on my part, regardless of its content, tone, hour. He would arrive late and this attitude of systematic opposition lasted for some weeks. Actings were hatred and retaliation relating to my interventions were present, turning me into a kind of "foreign object".

We went on talking, I showed him that he seemed to treat me like a strange cornea, transplanted, of which he wanted to free himself – because it seemed to him to be intrusive coming from another person and because it made him see painful things. But, on the other hand, just as the cornea was useful, perhaps my observation could also help him to see interesting things. At the same time he could not take in my interpretations as in fantasy I would die.

His associations verbalized his discomfort at having within him someone

who had died. We understood the fantasy he had that someone had died so that he could survive, his feelings of guilt, "survivor's guilt". He seemed to blame himself for having killed someone in order to survive and to see, the guilt for having survived his mother's death, a death he also blamed his father for, the father who adored the dead blind poet but who had only valued his mother after her death.

He was fearful of his' homosexual impulses when observed himself object of his father's love and of his death instinct aimed at reuniting with his mother. With the transplanted cornea, he would see with the eye of a dead man. We talked about his feeling that he had killed his vision out of self-punishment. I stated that the transplant implied preserving life. The fantasy of judgement surrounding the surgery he would undergo also came up. The fear of rejection had increased as a result of two unsuccessful attempts as if his dead mother had rejected and was rejecting him.

It is interesting that he presents himself as Camões, blind and at the same time, someone who went a long way, who showed new things, a sort of Oedipus--Tiresias, blind and clairvoyant. A Camões who also wanted to be recognized by the analyst and who in a certain way, also made him see. Fantasies of matricide were unveiled as did the fantasy of having killed the mother in order to remain with the father. In the transference, he also presented himself as someone who showed a lot to the analyst. Camões too, like his mother, only received recognition after his death.

Another aspect is that he sees himself full of death and thus rejecting himself would mean rejecting the death inside him.

About three months after these sessions, he decided to confront the new surgery, with a successful outcome.

The issues raised in this account continued to be worked on.

Discussion

I think it reasonable to take that the analytic experience of C. with me increased the likelihood that his organism would accept the new cornea on the third attempt. The dilemma the surgery had aroused in C. was the focus of the sessions. Work related to his fantasies went on to include fantasies of castration, death and situations related to sight.

I believe that the content of what we talked about was very important within the field of operational intersubjectivity. In the patient's discourse, the conditions which allowed us to catch a glimpse of a fantasy world linked to psychotic anguish were picked out. Uncontained on a mental level, they are found interposed in a barren space between psyche and body as McDougall describes (McDougall, 1982).

If nothing else, empirical studies convincingly show that the opportunity to talk to another person about recent or ancient traumas (for example, the death of a close relative, the divorce of parents, sexual traumas) can reduce the statistical occurrence of some diseases and the use of medical services (Pennebaker 1987, 1989,

Pennebaker and Susman, 1988). From the cognitive point of view, the mere act of putting a traumatic experience into words can transform the memory of it, and organize the emotional experience into something coherent. Once it is thus organized, such an experience can be more easily assimilated (Berry and Pennebaker, 1998). Analytical thinking may of course go beyond that point. I tend to see somatization like McDougall, who considers it in the same way as action, substituting thought, "through which the person disperses the emotion instead of thinking about the precipitating event and the feelings related to it". In some way, the phenomenon of **rejection** and the anxieties involving the future surgery serve as an organizing **referential** around which various aspects of the patient's internal world were evident.

In this way, the content of communication and the revealing dimension of the interaction are without a doubt relevant to the valorization of vital and vitalizing aspects of the internal world of the patient accepting the transplant itself. But we must specify that we are working in an area where it's possible that there is no precise limit between ideation and emotion. It's an area where what is at stake is the embodiment of emotion. We could talk of Joyce McDougall 's term "**desaffectation**", and one of the questions which is raised is the possibility of taking advantage of any nuanced manifestation of vitality that can lead the primitive emotion-cognition at a psychic level, with emotion as the functional and operative system of the mind. We can also talk about the **bodily expression of emotion as the first and primary means of comprehending the world**. Emotion can be viewed as a way of perceiving the world, a kind of consciousness of the object and of the subject that gives the world a sense. The emotion present could be a memory arising from previous surgical operations and of suffering, a sensation of eminent death or of total lack of control of the self and the outerworld, of life and death, of destiny that could repeat the mother's death, fantasy of reunion with the mother expressed at a primitive bodily level.

In the material presented, we see that the surgery is experienced by the patient as a judgement. The fear of death is experienced in the context of agression from and towards others. The "bad things that he did in the past" and the current aggression are fundamental elements in the "judgement" in question. The fear is further aggravated by two previous rejections in two previous surgeries leading to the fantasy that the dead mother had rejected him, or would reject him.

The fantasy of alteration of identity as an outcome involves the "acquisition of the identity of the transplant donor". This is also described by other authors, such as Crombez and Lefebvre (Crombez and Lefebvre, 1972a, 1972b, 1973) in work with renal transplants. In the case of C., the possibility of incorporating death

through the cornea of a dead donor was an important fantasy.

These sort of anxieties could be verified in the transference which allowed the development of "live" analytic conversations. The analyst was experienced as an intrusive "foreign object – acquired cornea", a psychological intrusion which meant, for the patient something like an unbearable "transplantation" of the psyche. In fact, the analyst´s interpretation, when it touches the patient, has the power to function as a foreign body to be initially rejected, an intrusive object to be pushed away. This is the violence of the interpretation.

The analyis of this situation undoubtedly allowed the **psychological acceptance** of the transplant. In particular, the breaking down of the fantasy of the psychological transplant in the analytic situation led to a widenig in C's capacity to think for himself, to utilize his own resources and to accept external help, thus making him less pseudo-independent.

This widening of emotional consciousness in relation to the object allows the installation of a reflexive consciousness which helps him to interpret the surgery, the transplant and the transplanted cornea in new ways. This perception detaches the emotion from body, thus allowing for a immunological reorganization to take place. It may alter, I suppose, the result of the surgery. The anxieties are mitigated once the symbolic representation is installed (Segal). This may be the central question that arises from a prior psychological acceptance to the actual physical acceptance of the transplant.

What also has to be taken into account is the context in which this widening of consciousness takes place. On coming to analysis, C., was afraid of the power of the analyst, in particular of the analyst's words. In the beginning, the analyst's interpretations were invested with an almost mythical meaning and this configuration repeated itself frequently.

This dimension is interesting and important. The offering of an object can give meaning to the patient's world in the sense of mentalization, which can facilitate the passage from body to symbol. This recalls **Levi-Strauss'** descriptions (Levi-Strauss 1958), in his classic anthropological articles "Le Sorcier et la magie" and "L' Efficace symbolique", of the importance of faith in the **shaman's power to cure**, the shaman's own faith in his method, the vitality and nature of "the experience lived out" in the story spun by the shaman, in the psychological cure, in the passage from the physiological to the mythical universe and vice-versa. The faith of the person who is ill is fundamental. Cure consists of "making thinkable a situation which was initially experienced emotionally and making the pains which the body refuses to tolerate acceptable to the spirit". He says, "It isn't important that the sha-

man's mythology doesn't correspond to objective reality. The person who is ill believes in it and he is a member of a society which accepts it".

These issues are always present in the discussion of analytic cure and are expressed conceptually in the theory of **transference**. One way of looking at this theory is to consider transference as a slightly hypnoid state which somehow charms the analysand (Roustang,1991), a relation that permeates the field of transferential manifestations. It is the presence of and interaction with this external linking object, an emotionally charged relation, which will set up conditions favourable to passage from body to symbol. The presence of affect can't be underestimated (Rezende, 1998).

In this field, we can imagine that the fine tuning with the feelings of the patient, the harmony of the subject with the human condition confers the shaman the power of a sorcerer who, in fact, like a primary object, will facilitate the comprehension of the experience at an increasingly abstract level, decodifying communication, at first, of the expressions of the body. Then the psyche will be constituted and the reflection on the symbolic world amplified.

Here I approach, as Melsohn did (Melsohn, 1995), the experience of being spoken by the other, the experience of being recognized and being inside the other. Creating a liberating fusion which will reignite the first union of the two halves that are separated. This fusion will take place through an emotional encounter, in the fine tuning of the emotion, once again meaning, emotion-cognition.

In such a way, the symbolic action of Psychoanalysis, its route from the body to the symbol, also would continue within the shaman's field. The initial experience which Meltzer refers to as the aesthetic experience may be similar to the experience of religious fascination. This may be one of the manners in which the shaman's power is manifested.

On the other hand, differently from psychoanalyst, the shaman exercises his power within a shared culture of certain institutionalized beliefs, within a belief system shared by both, "a frozen knowledge". By other hand, the analyst points out exactly the freezing existent in the symptom, whether it is psychic or psychosomatic and, instead of adhering to institutionalized beliefs, he breaks them down, "opens wounds up".

I think that the necessary instrument for the escalation to the symbolic, even in psychosomatic situations, is **rêverie**.

The condition of **rêverie**, which facilitates the decoding of anguish, giving meaning to the components of the "theatre" of the mind, naming and giving back the disintoxicated anguish, is the centre of the subject-object interaction which leads to the

creation of the symbol. As a component, for Bion (Bion, 1962), of the mother's alpha function, this "dream state", expansion of floating attention, takes up once again a functional unit with the mother, a personal and intersubjective process (Ogden, 1997), fueled by the impact of stimuli from the analysand on the analyst. This will allow the reorganization of the field in which emotion is a connecting element. When the analysand feels recognized by the analyst, when he feels himself to be alive in the analyst's mind, able to observe the analyst's perception of his feeling of rejection, things work as if the analysand and analyst are joined for a moment in the joint battle for the assimilation of the implant, against rejection.

Rêverie, whether in ordinary level or strange conditions, manifested in bodily sensations, perceptions, images, tones, phrases, is always, in my understanding, a state in which the life instinct predominates, in other words, **love.**

Gradually, the body which stimulates the development of mental functions in the state of rêverie, through the creation of the possibility of containment and representation, "will be eclipsed" to use Ferrari's term (its light is dimmed and refocussed on the psychic dimension). This allows for the creation of a mental space, of the necessary alpha function for the process of thought and consequently, symbolism.

Love thus becomes the central emotional mode, forming the benign figure over which emotional life and symbolization are organized. This is also consequence of the capacity to recognize and put up with the absence of the object, which allows the experience of oneself as a distinct entity.

In the example in question, we observe **metaphors** for mental states which are represented bodily, thus losing the very dimension of the metaphor. This concreteness is explicited in the concrete tissue rejection. In my view, the reinstalation of the metaphoric dimension began with the instalation of the **dreamlike state of rêverie.** At the same time, however, concrete bodily states are presented at a psychic level as evidenced in the "dramatization", in the transference, of immunological rejection of the transplant. In such a way, in this case, we can consider the communication of mind and body as, in fact, two sides of the same coin.

In my understanding of the state of rêverie with its fine tuning, we also have a two-sided coin. As Souza Mello (Souza Mello, 1995) says, in the words of poet Fernando Pessoa, on trying "to fake the pain that should be felt (the poet is so good at faking that he fakes to feel the the pain that he feels indeed) the truth of this pain will be felt in another space where faking is not efficient in spite of its expression".

A series of recent papers dealing with the interface between Psychoa-

nalysis and the development of the Neurosciences (Pally, 1997a, 1997b, 1998) point to the fundamental **emotion's integrating role** as co-ordinator of mind and body of the individual, as well as a connector of minds and bodies between individuals. Unconsciously processed , they form a non--verbal system of communication which, through small non-verbal signals, will or will not favour "attachment" and "rapport" between people. Beebe and Lachmann(1988) propose that when an individual "matches" with the emotional hints from the other person such as posture, accent or facial expression, this recreates within this person, the alterations associated with the emotional state of the other (Pally, 1998). We literally feel, she says, "exactly what the other feels". This is important for the transferential field and the situation of rêverie and takes account of the profound nature of mind-body relations involved and emotion as an organizer.

The apprehension of the same situation in another emotional state organizes the memory in another way, even anatomically, pathing the way for the psychic dimension where only body had existed before, opening up space for new perceptions and for the "availability of representations".

One of the analyst's tasks will be, taking into account McDougall's studies (McDougalll, 1989), the differentiation of what was repressed from the fantasies which haven't yet been constructed, so that this space must be created. In other words, this involves (and at times this can be particularly difficult in the management of psychosomatic issues) discerning when the symbolization of a situation, which is being facilitated, is closer to a **re-symbolization**.

If emotion is a central issue in somatization, as its lack blocks symbol formation, (if the sorrow that has not vent in tears makes other organs weep, as Henry Maudskey suggested) it is fundamental that we take into account this cognitive vertex of emotion as communicative and which can also be manifested through **body language**. The issue is the deciphering of the code through which it is expressed (Montagna, 1996). In this sense, emotions related to rejection can be experienced by the body as concrete, like rejection.

The process of incorporation of a transplant is gradual, like the escalation to symbolization mediated by emotion. What is initially manifested in the body, in body language, will cross various levels of sub-symbolic abstraction before the instalation of the real symbol. Bion's nameless terror will substitute the somatic phenomena at a psychotic level, when the anxiety has found this way of expressing itself . This is shown in the analysis of C., initially as a nameless terror, which the patient must have experienced before. On a neurotic level, the predominant fantasy is that of the judgement, of the punishment or ab-

solution of the prior wrongdoing. In my view, the experience also shows how the neurotic level of the fantasy was verbalized in the emergence of the fantasy of rebirth. In such a way, the emotions as functions of the coordination between mind and body (Pally, 1998), organize the perception, memory, thought, behaviour and social interaction, body and mind, allowing a gradual mentalization. It is the appearance of this verbalization of the contents accompanied by emotions that will allow, perhaps, the transformation of the signic option, into symbolic option, which will free the symbol of its concreteness.

Emde (Emde, 1999) also stressed the integrating role of the emotional experience as embracing two aspects: the incorporation of changes in development and the maintenance of individual continuity and coherence in the midst of these changes. This role is fundamental to the "liberation" of the body from the psychosomatic symptoms through its fundamental role, both in the formation of symbols and in the formation of identity. This can take place through emotions which in my view are, using Emde's terminology, self-enhancing and self--maintaining. In the case I describe in this paper, living out (in the transferential here and now) the emotional experience, facilitated in C.'s mental functioning the emergence of alpha elements in the place of somatic expressions and beta evacuation.

The possibility of creating **representations** of mnemonic registers and of turning unavailable representations into available ones will depend on emotional organization which regulates and connects the various sensory impression…

The situation experienced in the analytic session will allow the patient to transpose the concrete meaning and change his *modus operandi* into that of symbolic abstraction. The state of rêverie may be the counterpart of the patient's necessity to feel immersed in a field where there is an opportunity to feel what the other feels.

In the case presented, a movement in the direction of mentalization – symbolization, takes place initially through the acquisition of primitive forms of consciousness in which basic mode of expression are feelings, working as the form of comprehension of reality. The hatred of the intrusive and rejecting analyst is the first mental level of comprehension of a state that will eventually appear as a symbol. In the beginning, the consciousness is an affective consciousness made up of non-discursive symbolic forms, where there is no clear separation between the sign and the content of its meaning.

The patient feels that there is someone speaking for him, that he exists in the other's mind and he feels himself within the other one's mind. A certain fusion takes place, which allows for the recovery of what was lost, the link between emotion and representation, or the fostering of the es-

tablishment of a connective tissue which will bridge emotion and representation, permitting the creation of representation where somatization had prevailed.

Abstract

The author presents clinical material from the analysis of a patient suffering from keratoconous in order to discuss factors of the analytical technique that may favour the path to symbolization.

Mentalization manifests itself, firstly, as affective consciousness, composed of non discursive forms, having feelings and emotions as its tools to aprehend reality.

The remaking of a link between emotion and ideas allows the occurrence of symbol where somatization prevailed.

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