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## The Sleeping Analyst, The Waking Dreams

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### Abstract

The discussion applies the basic psychological concepts of emotion schemas and the referential process to the case material presented by Drs. Chefetz and Mark. Emotion schemas are types of memory schemas that develop in an interpersonal field. They include subsymbolic processes, symbolic imagery, and linguistic codes, integrated to varying degrees. In treatment both participants come in with their emotion schemas, developed in the course of their lives, activated in the events of the day; communication between analyst and patient occurs on all levels in subsymbolic somato-sensory and symbolic verbal forms. The discussion of Dr. Chefetz's presentation emphasizes the relationships among multiple schemas of self and others, within the patient and between patient and analyst. The discussion of Dr Mark's three cases focuses on connections and disconnections within the schemas as well as between them, and emphasizes the pivotal role of imagery in connecting subsymbolic experience and words, and in the reconstruction of dissociated schemas in the context of the therapeutic relationship.

It is an honor and a pleasure for me to discuss these presentations by these two gifted clinicians. Working together on this panel has provided us with a special opportunity to examine the basic psychological processes underlying their approaches to clinical work, and to see how the psychological and clinical perspectives can potentially inform one another.

The role of shared imagery was central in different ways in both these presentations. To continue that theme, I want to use a schematic image that represents the concept of emotion schemas and that applies to both papers.

#### Figure 1

Emotion schemas are types of memory schemas that develop in an interpersonal field. They have the specific and unique status of being that part of each individual's internal representational system that is inherently interpersonal. They are representations of one's self in relation to others, built from the beginning of life in interactions with caretakers, then constructed and reconstructed throughout life in all interpersonal contexts – including the interactions between analyst and patient that we characterize as transference or countertransference.

The emotion schemas, like all memory schemas, include all components of the information processing system as characterized by multiple code theory; these are the subsymbolic, symbolic nonverbal, and symbolic verbal codes. They differ from other types of memory schemas in being more heavily dominated by the subsymbolic sensory, somatic and

motoric processes of the affective core; later the words of language are added to some degree. Like all memory schemas, the emotion schemas represent one's knowledge of the world. In the case of the emotion schemas, this is multi-faceted knowledge of the interpersonal world in relation to oneself: what we desire or expect from others, how we expect others to respond to us, and how we are likely to respond to them.

You can also understand emotion schemas as the multiple code version of the notion of *self-states*. Each individual's representational world is made up of multiple schemas, integrated to varying degrees; multiple representations of oneself in relation to others, multiple schemas of others in relation to the self, dominant at certain times, latent or perhaps inaccessible at others.

In integrated schemas, subsymbolic and symbolic experience are connected. It is through the connection of the affective core to representations of things or people in the world that we know their emotional meaning; in the most general terms that is how we can know if something is pleasurable or painful, good or bad for us. The referential process that I have talked about elsewhere (Bucci, 2002) may be understood as the process by which the components of the schema are connected.

Dissociation may occur in many ways among components of the schema. There are two basic kinds of dissociation: **within** the schemas, as disconnections among the subsymbolic and symbolic elements; or **between** schemas, as disconnections among one's various self representations or representations of others.

Both types of dissociation may be normative and adaptive, as I've discussed in detail in two recent papers (Bucci, 2007 a,b). These adaptive dissociations allow us to function in the flow of subsymbolic exploration, and to take on the different personas of one's self, while also

permitting flexible connection of subsymbolic to symbolic processes, or flexible movement among self states, where required in negotiating the demands of life.

In some instances, both types of dissociation may occur as protection against pain that is experienced as unbearable and life-threatening; these are likely to be reinforced, and to become crystallized and rigid. These crystallized dissociations are what bring patients into treatment. I'll talk about these two types of dissociation further in the context of the clinical presentations.

In treatment, both participants come in with their emotion schemas, developed in the course of their lives, activated in the events of the day, playing out in the interpersonal field, integrated and dissociated to varying degrees. Here you can interpret the diagram in Figure 1 as representing the emotion schemas of patient and therapist, as activated in a session. As the diagram indicates, communication between patient and therapist, as between all people, occurs in both directions and on subsymbolic and symbolic levels. On the subsymbolic level, communication occurs in forms such as facial expression, body movements, visceral sounds, or vocal tone. The activation of mirror neurons may be understood as an aspect of such subsymbolic communication. On the symbolic level, communication occurs in treatment as imagery in verbal reports, activating the subsymbolic and symbolic elements of the emotion schema of the other; and in shared reflection on this imagery.

#### *Discussion of Rich Chefetz's Presentation; The First Phase.*

Rich Chefetz is talking about work with a patient whose presenting problems he experienced as on the edge of unbearable, certainly excruciatingly painful. He shares with us, most generously, the emotional communication between his patient and himself, in his complex and nuanced description. He talks about feelings and physical responses that are coming up

inside him; describes how he responds to his patient, based on his own physical and emotional state in the present as well as memories of the past.

This is a clear illustration of the kind of bidirectional emotional communication in multiple modalities that I am describing. Some clinicians argue that they need the term projective identification to account for the ineffable, subjective, intimate, quality of this communication, and that a psychological term such as emotional communication does not carry the clinical meaning of the process. I think that is a discussion that needs to go on. I believe the concept of projective identification carries the implication of the analyst feeling the **patient's** unbearable disavowed feelings; that is an oversimplification that serves to mask rather than explain the complex nature of the interpersonal communication. Rich takes the responsibility for generating his own painful or unpleasant feelings. The example shows that what he, the analyst, feels is a complex product of what he comes into the session with, and the communication on all levels between the two of them, including particularly the subsymbolic. The emotion schemas that are aroused, like all emotion schemas, are internal to each individual, while also representing the interpersonal field. The feelings emerge from the interactions between the two of them, each individual's response to the other. I think people agree with this formulation of the process, I worry that the term projective identification oversimplifies and misleads in certain respects.

Rich struggles with the problem of falling asleep in sessions with this patient – most often with the patient as Joey rather than as A. (I'll return later to the role of the alters - Joey vs. A – for the patient and for the treatment.) There are a few comments in his paper that show that Rich is trying to put his sleepiness into a normative context – he knows it is after lunch, he knows it happens to other analysts – but he's not convinced; he knows there is something more.

In the central incident that Rich describes, the alter Joey is telling a horrendous story of vicious abuse by Mr. X. Joey speaks in a dissociative, depersonalized manner; her body is stiff, her voice is flat, her speech is slow, all that is in the domain of subsymbolic communication. In the image she describes, she has fallen on the floor, she has no clothes on, she sees her body, she has an image of her legs stretched in front of her with blood on them.

As she talks, Rich becomes more and more drowsy, he is fighting to stay awake, can't do it, falls asleep, jerks himself awake. The patient, as A again, takes charge when he nods off, as she has done before; the roles shift in a dramatic way. Rich notes that he is struck by the absence of the shame and humiliation that he might expect to feel in this situation. That movement away from expected affect may be part of his – perhaps adaptive – dissociation from aspects of his response to the patient; it might also be, in part, a product of the basic field of trust that is shared between the two of them. He tells her he will work on this problem privately; he will explore the meaning of his responses within his own emotion schemas and in the context of his relationship with her.

They agree to continue with the session. She is able to bring back Joey. Rich says he becomes explicitly aware for the first time of what must have been the depersonalized deadness in Joey. Then Rich has a memory from when he was about 20, his father dying of cancer; he has an image of his father's legs sticking out from his pajamas as he lay in his hospital bed, the translucent scaly skin of a wasting body. In the terms of the referential process, Rich is connecting his diffuse experience of depersonalized deadness, communicated subsymbolically between them, to a symbolic image from his own past, the horrendous vision of his dying father's legs.

Now he knows his own horror from his own life that he feels is vibrating in tune with her; he has a feeling connected to an image that can be shared. The patient as Joey has the image, the memory, without the feeling, dissociated from the feeling.

As the referential process operates and Rich's own emotion schema opens up further for him, the image connects to or activates feelings not previously acknowledged, in particular feelings of anger. We can note that there is no explicit expression of anger, only horror, in Rich's story of his father; yet what seems to turn the treatment around at this point is his association to his patient's anger. There's a gap here as to what is going on in his explorations during the 15 minutes of "letting his thoughts cook". He attributes feelings of anger to Joey; Joey acknowledges, owns the feelings.

In the writings I've done about dissociative processes, I've emphasized the spectrum, from normative dissociation, the kind that enables all of us to negotiate the different roles and functions of our lives, to the condition that would be diagnosed as DID. We all have different schemas of ourselves, accessible to varying degrees: for example, Rich as clinician or scientist (or fisherman); also as husband, parent, child - the son who lost his father and had a not fully specified, perhaps not fully explored relationship with each of his parents.

In an integrated system, the various self-schemas are potentially connectable, happening in the space of the same bodily structure, linked on the time line of autobiographical memory, thus part of the overall schema of the self (Bucci, 2002). Rich explicitly placed his memory on the time line of autobiographical memory; it happened in his 20<sup>th</sup> year.

The core of psychodynamic therapy or psychoanalysis is that a range of personas come into the room inside of the analyst, as of the patient, waiting there in the wings to be activated, and that is of course the great potential and great danger for the kind of therapy that people like

Rich and David do. The more of these personas the therapist has some access to within himself, the more he can let in, the better he can work. For the therapist to respond in a genuine way, the response must emerge from a schema that is activated in him; otherwise the danger is that the patient's dissociations will be reinforced rather than new connections built.

Rich seems to have several schemas activated alternately in the session: the dedicated and experienced therapist, the young man with his dying father, as well as other schemas incorporating affects that he has not as yet acknowledged or owned, such as feelings of resentment towards his mother and father. There was some degree of flexibility for him, in moving among his various states and schemas. While part of the affective core of the hospital image was accessible, there were also elements that were disconnected, that he worked on and struggled with, in his own thinking and in the joint work of the treatment.

For the patient, whom Rich diagnoses as having DID, we know of two schemas, two personas: the competent A, and the victim Joey who is immersed in the painful memories of abuse. We see that the Joey schema is dissociated from the A schema; Joey has his own set of controls. The experience was so unbearable in relation to the patient's capacity for endurance that she can access it only by disowning it; if she calls on Joey she can let the experience in, but she can access it only partially, even then. The schema of being Joey is not only externally dissociated from the A who goes about daily life; Joey is also dissociated internally within him/herself. Joey has the memory of abuse without the associated affect; a feeling of deadness, the numbness of shock, rather than the unbearable activation of horror in his/her body.

What is the psychological difference associated with encapsulating the schema in such a way as to give it a distinct persona with a name; is it on a spectrum with the dissociative processes that Rich (and all of us) experience at some points in ourselves, and that the analyst

may call on to do his work; or is it qualitatively different? Putting aside this complex question for the moment, it is clear the the alternate persona did enable Rich's patient to access the unbearable emotion schema at least to some extent. Were the analyst, at this point, to emphasize that Joey is really part of A, which the patient may be capable of acknowledging, that access route might be blocked. This is a specific example of the general question: how much to invite affect; in what form; how much to develop capacity to see reality; when and how.

A comes a long way in this treatment; she eventually can feel the horror when she can feel the anger – toward her abuser, later towards the therapist. We don't know what happens to Joey.

The therapist has come a long way too, as he acknowledges. As the treatment goes on we see that there are feelings of rage all over the place; not only in the patient towards her abuser, but also in the patient (victim) towards her therapist (rescuer), who draws her to experience her pain and sometimes in his sleepiness is not there for her; and in the therapist towards the patient's abuser. They both move on to acknowledge deeper anger towards their mothers; then the anger of the therapist towards the patient becomes dominant in his feelings.

Then comes the opting out of Medicare; what is the subtext of that, its meaning for him, for example as part of the Karpman drama triangle and each of their roles in this? In my initial discussion in the panel, I mentioned that in presenting the triangle as it played out in this treatment, Rich referred to attacker, protector, rescuer. I knew that the triangle, as observed in the treatments of dissociative patients, has been defined as attacker (or persecutor), rescuer, victim (Davies and Frawley, 1994; Liotti, 1995). I knew that Rich knew it too, since he in fact had introduced this scenario to me through Giovanni Liotti's work. So I thought it might be of interest that somehow, in the retelling, the victim was lost. Knowing Rich, I was pretty sure

that he would not say “Oh, yes, I meant victim”, and continue on; but I did not foresee how far he would take the implications of this slip and how interesting it would be.

I said, at the time of the panel, that we did not know whether and how he will use this drama triangle, whether and how he will share the complexity of his feelings about that scenario in working with A. We certainly know more about that now, in Rich’s description of the phase of treatment following our panel. The slip was a very small trigger that turned out to open up a very large area of self-exploration for Rich and an apparently productive turn in the treatment. In the interchange he describes, he struggles over whether to disclose the feelings of anger towards his own father that have opened up for him, and finally decides to do so. A’s emotional response was very strong, indicated by autonomic signs as well as words, but she was able to tolerate the affect; and the interaction then led to a discussion about the death of her husband five years previously.

The productivity buzzer sounded for me at this point; I don’t know if it did for the patient or for Rich. Having read in her initial description that she was a widow, I had been waiting for her feelings about this loss to emerge in Rich’s report. He alluded to her husband’s illness in relation to his image of his own father, but she is not reported as responding emotionally at that time. I kept wondering (and still wonder) what her emotional reaction had been to the loss of her husband; whether she may have been angry with him as well; whether and how this adult trauma added to the childhood traumas and losses that were presented as pivotal in her emotional organization. This pivotal loss in adulthood seemed to be a missing piece in the case report; its emergence at this point, in response to Rich’s disclosure, seems worthy of note.

Rich is telling a very powerful story about abuse, horror and anger, much of it unformulated at the time of the panel. I said at that time that there was a lot of anger and pain all

over the place, a lot of material left unexplored - in the treatment, in Rich himself, as well as in my discussion of his presentation. I feel privileged that Rich was willing to share these explorations following the panel, and to have a chance to respond to them. This second phase of the work is so multi-leveled, concerning interactions of emotion schemas of analyst and patient, as to be a topic for a presentation in itself. Rich characterized the treatment as “a kind of mutual analysis”, and explored his considerations about when, how and for what purposes to disclose. His report raised the question for me of the extent to which all treatment are necessarily mutual analyses, to different degrees and in different ways. I expect to return to a discussion of this part of the work at another time.

*Discussion of David Mark's presentation; The “waking lucid-dreams”.*

In talking about Rich's presentation, I emphasized the relationships among multiple schemas of self and schemas of others – within the patient, between patient and analyst. In talking about David's case, we focus on connections and disconnections within the schemas as well as between them.

A major premise of multiple code theory is that imagery is the pivotal connector between subsymbolic experience and words. Images, like perceptions, may occur in all sensory modalities, as sights and sounds and smells, although visual images may be dominant for many sighted people. Images may occur in subsymbolic form, as representations of music, or smells, or movements or sights with global and analogic properties; or they may be entities with discrete features that can be described in words. The role of metaphor is to use language to activate connections to imagery, and to the visceral and motoric and sensory processes of the affective core.

The poet doesn't say "you are beautiful, I love you"; Solomon's words make love rather than naming it:

Behold, thou art fair, my love; behold, thou art fair; thou hast doves' eyes within thy locks.

Thy two breasts are like two young roes that are twins, which feed among the lilies.

Thy lips, O my spouse, drop as the honeycomb: honey and milk are under thy tongue; and the smell of thy garments is like the smell of Lebanon.

A garden inclosed is my sister, my spouse; a spring shut up, a fountain sealed.

(Song of Solomon, 1:15)

The power of such metaphor is to carry meaning well beyond the specific image itself. Such language has the capacity to evoke complex experience in the listener, including aspects of an emotion schema that are experienced subsymbolically but not explicated or formulated. The field of literary criticism is aimed at explicating the meanings that are unformulated in the metaphor, that the poet may or may not have intended to put there.

How do people in general, patients in a session, connect strong feelings to language – open the spring, unseal the fountain; they do it by telling stories of events of their lives, telling dreams, and fantasies; in the associative context of the relationship. All of these narratives are metaphors as well; the stories, fantasies and dreams that the patient tells are metaphors of the emotion schemas and can be understood that way. As in poetry, aspects of emotion schemas that have been aroused, that are known subsymbolically but not explicated or formulated, can be shared and communicated in an image or an episode, in the patient's associations. In treatment as in poetry, the complex connections and emotional meanings of the image that are likely not to

be known to the speaker, are out there then in the image that is described, to be explicated and to be shared. We saw that in Joey's image of abuse and Rich's image of his father in the hospital.

The images that David talked about are different in some respects from those that Rich presented. They came up as islands of imagery, like fantasies or dreams - waking dreams as David calls them - rather than as part of the flow of associations on the time line of one's life; but of course they didn't emerge "out of the blue" any more than dreams do. They are metaphors of the patient's life, and metaphors of the ongoing relationship; they potentially work as pivots connecting the subsymbolic experiences that are aroused in the moment to language, in a way that can be shared.

***The case of Ron:*** I would say that Ron existed and communicated in the session primarily in the subsymbolic zone. He mumbled severely, we can say he was paying a kind of lip service to being in the talking cure but outside of it, working on the edge of it. David describes him as existing in a cloudy, half awake, half asleep state of consciousness. David's sense of the encounter with him is fuzzy and cottony, weird, isolated, drifting. Ron's words and his affective state were severely dissociated; the intervening imagery - in narratives, dreams, or fantasies - that was needed to connect these formats was sparse. The major or only experiential domain that worked at first to connect subsymbolic experience to elements of images that could be spoken and shared was food. I would agree with what David seems to be recognizing here - the value of using any symbolizing function you can get that might serve to connect subsymbolic experience to language and connect the self to the other, for patients who can't do it any other way.

Later the phenomenon of visual imagery, which occurred several times, opened up the treatment in a more sustained and meaningful way. David reports Ron's image of the

decapitated deer, that changes to a deer caught in the headlights (now perhaps blinded rather than decapitated). In the playing out of the referential process, connecting the components of an emotion schema, as represented in Figure 1, we see Ron moving from his primary isolation in a subsymbolic mode, his feeling frozen with terror about the prospect of a party, and his inability to describe this, to suddenly seeing a decapitated deer, feeling his legs go numb, then describing himself, apparently with feeling as “a deer caught in the headlights”. David also moves to the image of himself as a car, barreling ahead with his questions, regardless of how Ron felt about them. Through reports of such shared imagery, resonating between them, they move from being two isolated individuals and become real to one another.

***The case of Fred:*** Ron’s images were of a terribly vulnerable self in danger from a powerful other; Fred’s image of his face and David’s, peeling like a banana skin, appears to concern the process of revealing an underlying structure that is precisely delineated. The patient initially describes this as a self-mutilation fantasy, (perhaps associated with mutilation of the analyst). The therapist represented his own image of himself as “needy, greedy David”, at the beginning of the treatment, and also in a different way at the end.

Fred’s image is, however, not simply associated with anger or self harm; he said he felt reassured, calmed by the image. Maybe Fred truly wanted to see beneath the peel; maybe he felt enabled to do this by the collaboration with someone who understood and made sense. Fred seems to be getting a hint of the possibility of closeness with sympathy and understanding. Maybe Fred was also reassured that he (a scientist) saw solid manageable underlying structures rather than spools unraveling.

Aside from the specific contents of Fred’s imagery, this example makes the strong general point that Fred, like most people, had difficulty in accepting nonverbal processes as

thought. The experience of having spontaneous visual images was disturbing in itself for Fred; he prided himself on how he was able to use language to keep the intensity of his experience within a reasonable, limited range; he worried that the images were a sign that he was losing his mind. Maybe it would be helpful for the associative process in general if people – therapists as well as patients - were more able to recognize that imaging is thinking. Images are thoughts, that, like verbal thoughts, may or may not be lucid, may or may not carry rational contents, even before we explicate them. They carry more and different information than we are able to formulate in words; they are valuable and useful as guides and organizers in themselves. Many scientists, notably including Einstein, report that they think visually, as Hadamard (1945) has discussed. When Fred feels like he is unraveling, his image of their two faces, with the underlying solid three-dimensional graph paper cubes, carries complex meaning that he can bring in to ground him; considerably more meaning than he is able to explicate as yet. Fred doesn't bring in an alter, he brings in an image; it's another way of accessing affect and allowing it into the shared emotional space of the session. (Perhaps we may say a more adaptive way, with different implications for personality organization, but that is another question.) Will the image or the power of the image dissipate when all the associations are worked through, as Freud suggested? I do not believe it will. The connection to the subsymbolic persists and the image is a way to evoke and share it.

***The case of Kurt:***

This case seems to have features of Rich Chefetz's case of A. Kurt doesn't have the explicit DID diagnosis but David describes him as fragmenting into rapidly shifting dissociated self states, and David struggles with his response to Kurt's nearly bottomless despair and pain. Kurt responds to this with a pure sense of hatred of David and being injured by him.

Are they playing out together the Karpman triangle that Rich talks about – abuser, victim, rescuer? Yes, a version of this.

As the treatment proceeds, as it seems to go well, they reach the expectable point that the treatment is increasing the patient's experience of pain, more than the patient can contain. Following a session with vivid imagery, a small, indeterminate animal disappearing through "a black hole", the patient wishes to quit; the treatment is making him crazy; but he agrees to come back one more time.

From here on, Kurt experiences many images – he experiences them in the session, not outside. I think they can be understood best as waking nightmares rather than waking dreams; they happen in the session, when Kurt is in a period of relative calm, feeling an increase of relaxation, an increase even of safety that lets him relax. But the images do not help him to connect to experience within himself or to share experience with the therapist; they feel like meaningless, sadistic intrusions. I would suggest that this is the quality of a dissociated memory schema, developed in response to an event that was unbearable at the time of occurrence, in which the memory is laid down in fragments rather than in a time and space context, not associated with the source of the abuse, not owned by the self. Kurt wanted David to cure him of the images, to eradicate them. At a turning point in the treatment David recognizes explicitly and communicates to Kurt that the goal cannot be to make the images disappear but to imagine himself into them. Once Kurt can do that, the path is open for development of emotional meaning and eventual integration of emotion schemas in the therapeutic relationship, as illustrated in the session of the Popeye dream.

In this session, Kurt became silent and appeared to look off in a way that David had come to understand as indicating that he was involved in a waking dream. At such times, as David

reports, he typically had a general feeling that he describes as “something between eerie amazement, interest and mild anxiety”. In some instances, however, David has a more focused affect; in this session, a deep inexplicable sense of loss, but without specific content. The patient then describes the image of Popeye, who was proud and defiant, but then lay down with an implement – a sword – through his heart. As David reports, the image was a symbolic expression of the dissociated affect that Kurt did not have access to within himself, but that was playing out in the session, between the two of them.

We do not know what were the subsymbolic contents of Kurt’s emotional communication that evoked the focused sense of loss in David. It could be a matter of direct operation of mirror neurons; it could also be a product of shared associations built up in the course of their work together that directed David’s responses to Kurt’s words or tone of voice. We cannot explain away the complexity of the interactions in the interpersonal field by saying Kurt is projecting an image or an experience onto David. Rather, the emotional communication in the session, and the shared experience of the past led to arousal of the affective cores of both participants. The patient told a narrative of an image; the emotional meanings of the symbolic image lay in the connections between the subsymbolic and symbolic components of the emotion schemas of each participant and in the connections between them.

In both Rich Chefetz’s case of A as the alter Joey, and David Mark’s case of Kurt, the patient brings an image that is vivid and evocative, but disconnected from subsymbolic, affective experience. The affective experience that is aroused but dissociated is communicated to the analyst; the analyst then is able to work from his own arousal to symbolic meaning and further associations within the emotion schema that has been activated in him. This can be seen as an

interpersonal version of the referential process, operating between the aroused emotion schemas of the two of them.

In previous characterizations of the referential process, I have recognized the role of subsymbolic communication in activating emotion schemas for both participants in the shared interpersonal context of the treatment, and recognized the role of the analyst in generating interventions based on his own self-exploration, but have focused on how the intervention activated connections between arousal and imagery **within the patient**. We can see in these examples, in which the analysts explicate their own schemas, how the operation of the referential process in the context of the relationship moves back and forth between the components of the emotion schemas that have been aroused in the two of them, in an intricate and complex way.

Here we move away, perhaps radically, and in several ways, from the jewel in the psychoanalytic crown, the notion of the interpretation of dreams as Freud formulated this. The notion of interpretation implies that there is a latent formulated meaning of the image, that has been repressed, and that can be uncovered through interpretation. The process that David and Rich illustrate is radically different from this in two ways: the underlying emotional meaning, the underlying nature of the schema has to be explored, recognized and discovered, not simply interpreted and uncovered; and the meaning emerges from the interpersonal field, the affect that is communicated, not from the experience of a single dreamer – or imager - alone.

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Figure 1

## Development of Emotion Schemas in an Interpersonal Field

