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The language of words, the language of the body and the language of images in the process of change

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In a constructivist perspective, the therapeutic process aims essentially to allow a change in the patient's expectations regarding himself and himself with others. Moreover, it aims to allow a change of the meanings that the person constructs regarding his/her present and past experience. The key instrument of this process is the therapeutic relationship that is built and that evolves through the meanings that the patient and the therapist co-create, mainly implicitly. The interaction develops through multiple and simultaneous communication channels involving at the same time the words, the way of structuring the sentences, the prosodic inflections, the bodily signals, the time of silence; all elements that modify the "felt meanings" that can sometimes, but not always or necessarily, require an explicit narrative reinterpretation. In this paper, we analyse the distinctive characteristics of the different communicative approaches used in the setting that, despite their necessary simultaneity in the patient-therapist interaction, pursue goals and have different effects on the process of change. The implicit and explicit dimension of different languages, and their effectiveness on therapeutic progress, are also analysed by means of some clinical examples and short transcripts of sessions.

Keywords: *constructivism, intersubjectivity, guided imagery, body communication*

F[ather]: […] the notion that language is made of words is all nonsense […] there is no such thing as "mere words." And all the syntax and grammar and all that stuff is nonsense. It's all based on the idea that "mere" words exist… and there are none.
D[aughter]: But, Daddy …
F: I tell you… we have to start all over again from the beginning and assume that language is first and fore-most a system of gestures. Animals after all have only gestures and tones of voice… and words were invented later. Much later. And after that they invented school-masters. […]
D: Would it be a good thing if people gave up words and went back to only using gestures?
F: Hmm… I don't know. Of course we would not be able to have any conversations like this. We could only bark, or mew, and wave our arms about, and laugh and grunt and weep. But it might be fun… it would make life a sort of ballet… with dancers making their own music. (G. Bateson, 1972, pp. 23)

The word "language", when used without any further specifications, has a high rate of indefiniteness. In ordinary usage, when the word "language" is used, we often refer to "language" meant as the words and the set of possible sentences that can be created according to the rules of a specific idiom.

More correctly, the language may be defined as "any system of symbols used to communicate". It is no coincidence that some other words are often added to the word "language" to clarify what we are talking about: the language of words, the language of gestures, the language of animals, the language of cinema, the language of flowers, etc… are just a few examples of a much longer list.

In a perspective of psychotherapy referred to radical constructivist epistemology (von Glasersfeld, 1982, 1984, 1988) and intersubjectivity (Stern, 1985, 2004; The Boston Change Process Study Group, 2010) the change occurs in terms of a *change of meanings* related to self-perception and to the perception of ourselves with others, that is the way of constructing our own experiences (cf. Cionini, 2013). Meanings that, it must be underlined, can be constructed both at the level of our explicit and implicit knowledge.

Implicit knowledge includes everything that occurs in our organism without being able to construct a conscious representation. It is what we *know without knowing that we know it*: it is the knowledge owned by our body that influences our actions, our thoughts and our feelings without awareness. In the process of development, from birth and during the whole life, implicit knowledge is mainly constructed through the interaction with the conspecifics, especially within the attachment bonds or otherwise within the emotionally and affectionally significant relationships. Implicit knowledge is not directly translating into words and represents a different domain compared with the explicit knowledge (Stern, 2004, 2006).

Explicit knowledge, vice versa, operates inside awareness. It includes all that we *know to know* as far as our experience is concerned and what we are potentially able to put into words; therefore, it requires the ability to use a narrative register and, broadly speaking, it is the result of a reflection process, *a posteriori*, carried out on a *first-person experience*.

It is important to consider that the implicit and explicit knowledge influences each other but, at the same time, they are distinct and parallel systems that largely work independently.

The change in psychotherapy occurs especially through the implicit communication between patient and therapist, through the way they interact and implicitly create new dyadic relational experiences, that allow to reconceptualise and give new forms to the intersubjective schemes of the past. The explicit-verbal level is important, but just in so far as it creates the prerequisite to an implicit change; the new elements co-created in the patient/therapist dyad modify the "Pattern of ongoing regulations" (Beebe & Lachmann, 2002) supporting new expectations that can transform those constructed on the basis of the individual-historical experience. The new experiences and meanings felt in the relationship, being explored also verbally, may lead to a subsequent reflection and explicit reinterpretation, in order to create greater coherence between the "felt identity" and the "narrated identity"[1] of the patient (Cionini, 2013).

Therefore, in clinical practice it is important to distinguish what is communicated at an implicit or at explicit level in the interaction between patient and therapist, and so which communications have a greater chance to lead to a reorganization of declarative knowledge (explicit) and which ones have a greater chance to lead to a reorganization of implicit relational knowing.

[1] With the term "narrated identity" we refer to what we can put into words about ourselves and our life experience. With the term "felt identity", *vice versa*, we refer to what we know about ourselves only at implicit level.

In this paper I will examine, also giving some clinical examples, the possible use of three different communication languages in the setting and their different implications for the process of therapeutic change: the language of words, the language of the body and the language of images.

The language of words

As for verbal communication, a first partial but certainly correct distinction, concerns its content and its paralinguistic aspects: the content represents the mainly explicit dimension of communication, while the paralinguistic aspects (such as the rhythm of speech, the tone and the volume of the voice, the micro and macro body movements that inevitably are associated with words) convey the implicit dimensions of meaning.

The relationship between content and paralinguistic aspects may be very different depending on the speaker's aims and it is reflected in the different prosodic forms in which words and sentences are expressed.

In the ordinary conversation, the speakers usually pay prevalent or exclusive attention to the content of their language production, underestimating the form and the implicit meanings. Simultaneously, they are widely affected by the implicit aspects involved in the paralinguistic communication of the other speaker, usually with little or no awareness at all. "To quarrel about dirty socks" is a typical Italian expression: it describes a common attitude to face conflicts in the couple using explicit contents that have little or nothing to do with the core of the conflict.

However, when there is a professional use of the conversation, such as in psychotherapy, the psychotherapist's attention must be paid especially to the implicit dimension. The most relevant meanings of the relationship are communicated through this channel, in which it is possible to achieve a shared intersubjective context that may reorganize the implicit relational knowing when the two minds/bodies meet.

Concerning verbal communication, and its use in psychotherapy, it is appropriate to make a further distinction, even considering only its content. Not the whole content is explicit in itself with reference to the speaker's intentions. Beyond the paralinguistic aspects, it is important to consider that also the choice of the words and especially the way of structuring the sentences convey different meanings and communicative intentions although the contents may seem apparently equal. This is the reason why the speech is often not fluent in the therapeutic conversation; words are chosen and sometimes taken back or revisited, sentences can remain apparently unfinished, depending on the intention they are produced for.

In order to better clarify the above observation, we can try to imagine two hypothetical scenarios of an initial therapeutic conversation to distinguish the differences in terms of communication effects.

Let us imagine being with a patient who has just described the uneasiness he feels when he gets someone's positive attention (especially from a significant other) and claims to have difficulty in understanding the reason for this uneasiness.

Let us assume that the first therapist's question was formulated approximately in this way:

T. "This difficulty that you feel when you realize that someone is looking at you… How would you define it?"

We might expect that this kind of question can drive the person to answer semantically, that is to provide some linguistic labels that define the nature of this uneasiness; for example, the patient might answer:

P. "Well… in these situations I feel a mixture of embarrassment and anger"

These linguistic labels (embarrassment and anger) certainly guide us towards a direction, but they specify in a generic manner what the patient feels, because both anger and embarrassment could have very different experiential content from person to person. Let us assume, instead, that the initial therapist's question has this kind of structure:

T. "How could you describe this uneasiness as… as a feeling… how do you feel it? …You are aware that someone is looking at you…"

In this case the aim or the original intention of the therapist is different. The question may be divided into two parts: the first one is an invitation to describe his own physical experience (sensory) in that relational context, without using semantic labels. The aim of the second sentence, articulated slowly and left unfinished (*You realize that someone is looking at you…*), is to facilitate the patient to return in an imaginary way into one of the situations where the uneasiness usually arises.

P. "It is like a pang… at the body level, as if I was short of breath mmm… as if I was holding it. Physically I have the sensation of holding… something like closing…"

According to the prosody and the linguistic structure of the therapist's question, the patient's answer, in this case, could be oriented towards a more sensory and physical dimension.

From this first interaction, the conversation has already taken two different directions, although the two hypothetical initial questions can be considered equivalent, at least concerning the therapist's intention to get a clearer specification of the nature of the patient's uneasiness.

If we try to continue with these two hypothetical conversational sequences, the two directions, hereafter, may further differentiate involving not just the linguistic structure, but also the specific explicit contents.

Let us imagine that in the first case the therapist continues asking a further question in order to get a specification of the linguistic label "embarrassment":

T: "What do you mean by the term embarrassment?"

Getting an answer like this:

P. "That gaze puts me in the centre… and I have the feeling of taking space in that relational situation"

The therapist may continue this sequence aiming to verify which explanation of his own uneasiness could be constructed by the patient:

T. "Can you imagine the reason why taking space in a relationship may make you feel embarrassed?"

But the patient may not be able to give an explanation at the moment.

P. "I don't know… I only have the feeling that I have to find out something else to put into that space"

In the second case the therapist, trying to get into the embodied metaphor of the patient (*Physically I have the sensation of holding… something like closing…*) and to make it his own, might be interested, instead, to share and develop the possible implicit meanings. Starting from the sensations felt in an attempt to put himself into the image given by the patient, he could repeat his last words (*Something like closing…*) and, as if he was musing over, he continues to offer the patient his sensory/iconic image of the situation:

T. "Something like closing…… as if the other person looking at you was an attempt to go right through you?"

Getting an answer:

P. "Yes, it is as if it reached me deeply…"

Then, continuing on the same imaginative dimension, the therapist could ask:

T. "A request for contact…?"

And after an affirmative response, the therapist tries to attune to the patient's feelings through his own feelings. Let us assume that the patient's words have led the therapist to visu-

alize/associate the image of an open tridacna[2] that as soon as it is touched closes very quickly. So, inspired by this image, the therapist could offer, in hypothetical terms, and using what I call the Ego language, the sensations that came out through his own association.

T. "And the fact that it touches me leads me to withdraw into myself... Does it scare me?"

The patient confirms the therapist's sensation, but at the same time he defines it like a meaningless sensation:

P. "I have the feeling of danger... It is not logical... But..."

T. "But... actually what you feel is a contact... I would say... I don't know if it makes sense... too intense?!... And for that dangerous!?..."

The last therapist's sentence has two different aims: first of all, to validate the person about the sensations that he feels and that he has defined as "meaningless". Then, starting from the assumption that personal experience has always got its own "inner coherence", even when this may not appear evident on the basis of external criteria, to help the patient integrate and give meaning to his feelings using the question "*too intense?!*" that is linked to the sense of danger.

Personally, I feel that this second way to use the language is more consistent with my idea of the aims of the therapeutic conversation. A language that, thanks to the way of constructing and structuring the sentences and to the paralinguistics adopted, favours the analogical and evocative communication starting from the idea that, as I have already said at the beginning, the therapeutic "moving along" process takes place most probably and deeply through a sharing of implicit meanings and affective attunement.

The body and its language

In our culture, the body tends to be considered mainly as "physical body" (in terms of health/disease) or in relation to its aesthetic aspects (thin/fat, nice/ugly, etc.). But the body is much more.

The body forms and defines the boundaries of Self; everyone is in his/her body, it *is* one's own body, with its history, its experience, in the Mind-Body unity.

The body has got hands, arms, legs, trunk, face… and especially eyes. Thanks to the body we get in contact with the world. Through our body we always communicate with others, whether we want it or not. Through our body we always communicate with ourselves, whether we listen to it or not.

In the therapeutic setting the bodies are two; they move away, they get closer also through micromovements; sometimes they touch each other even without touching, sometimes (less frequently) they may decide to really touch each other.

However, the bodies speak and they do not need any words. When words are spoken, the bodies define their "deep" meanings, because they convey implicit meanings, even those that we may be aware of only partially or not at all.

The patient's body is always a possible object of observation for the therapist, but it becomes "real" only, and when, it is a privileged object of attention. It becomes "real" only when the therapist's mind is not completely (or mostly) busy to think, to reflect, to make assumptions, and it is not completely focused on what he should do/say at that time to "be good", to

[2] Marine mollusc with a bivalve shell that has symbiotic algae inside giving it an intense colour, from blue to green. During the day, the shell is open but, when it perceives the possibility of a "dangerous contact", it closes to protect itself and keeps closed even for a long time.

resolve, to help the patient. It becomes "real" only when the therapist's body is open and receptive to the messages of the patient's body, allowing himself to feel the feelings and the emotions that the patient's messages arouse in him, giving them value and meaning.

The therapist's body speaks in any case and always like the patient's body; it speaks in silence, during the conversation, in wait, even beyond any explicit intention but, because of his different role in the relationship, his body can be (or better should be) used, as far as possible, with more awareness regarding what it is conveying to the patient.

Since the messages coming from the body are more implicit, usually what they communicate is more important than the explicit meaning of words. The body messages are more directly conveyed, they are perceived as more authentic, and they are falsified with more difficulty.

The contact between the therapist and the patient's bodies does not usually take place, apart from the formal greeting of shaking hands (that can be meaningful, despite the formalities). Anyway, the contact can be an important instrument to be used, if and when the quality and the features of the relationship and of the present moment allow and suggest it.

Apart from more technical uses of the body contact, hugging may be an important moment that can happen both with just a contact of the hands and "hugging tightly" the patient's body. This is possible with some patients, not with others; this is possible only in particular moments of the therapeutic relationship, not in others; it is the tangible sign of a sharing constructed in that therapy session or in that moment of the therapeutic process, that allows to give/offer/get a strong, and strongly felt, confirmation of the attunement that they have created together, that they have experienced together, in a "shared emotional journey".

In most cases the messages exchanged through the bodies are not translated into words. Sometimes, however, the patient or the therapist may be feel the need and/or the usefulness to communicate what they have felt coming from the body of the other also by means of words.

First clinical example

The following transcript is the final part of the first session of psychotherapy (after the first session and the three following sessions dedicated to the collection of her life narration) with a young woman of about thirty who had presented her problem in terms of a general feeling of inner chaos, loss of interest in life, lack of internal and external reference points and, above all, in terms of distancing herself from the world because of a generalized distrust both in everybody and in herself.

She was on her third attempt to go to psychotherapy after having stopped the previous two for a feeling of uselessness.

Despite this declared sense of unreliability towards the others, from the very start I had felt a deep intersubjective contact and a flowing sharing of the heightened affective moments passing through a mutual recognition of bodily states and of feelings that were beyond words.

At the end of this first session, the patient told me about her strain of working on herself asking me, at the same time, if I was having the feeling that we had already begun to do so. My positive response was followed by a moment of silence a bit longer than usual, during which our bodies apparently had continued to talk.

At that point, the patient said:

P. "No! Don't let me keep silent please!"

And as in a previous moment of the session she had referred to her difficulties in abandoning herself to pain, at the same time she also said, "you are looking at me in that way!" pointing out that she had caught something peculiar in my eyes, I asked her:

T. (…) "'you are looking at me in that way!'... How… How do you feel from my gaze?"

P. "..Um…..hem…… no I feel ashamed to say it, it's strange… eehm… sweetness!?"

T. "Um…"

P. "Um……. Um…. That is, there is silence but you are speaking to me with your eyes and… and there is no… reaching some points that I don't want to… no!"
T. "As if I were touching you!"
P. "Um, yes! No"
T. "Eh, maybe this was what I meant… when we were talking about the other meaning… no?... about…"
P. (Overlapping and anticipating me) "Um... I understand now"
T. // "…compassion"
P. "Um! And how is it possible to look like this?... Um…eh… actually yes I can… but…"
T. "How is it possible? In words, you know, the answer is simple, but… as in most cases, it is easier to say than…"
P. "Of course!"
T. "I would say you feel it!"
P. "Um yes!... turning off the mind, and nothing else"
T. "Um"

"Your eyes talk" is a phrase that sometimes some patients had said to me. In some cases, my eyes had expressed the conscious intention to share a feeling, a message having more chance of being "caught" by the patient without using words. Actually, the eyes, as well as the rest of the body, always communicate implicitly: they can create moments of intersubjective contact, shared at the same time by both patient and therapist, that often allow changes in the "implicit relational knowing" and a "moving along" of the therapeutic process (The Boston Change Process Study Group, 2010).

In this specific and very peculiar case, the fact that this event occurred, and was also put into words, from the very first session represented an important indicator of the probability of working profitably together. Actually, the therapeutic process with this patient has gone on very quickly, also considering the heaviness of the person's life experiences emerged later on during the therapy. This is a confirmation of what reported in literature (cf. Lingiardi, 2002) about the fact that the quality of the therapeutic relationship in the very first meetings represents a good predictor of the psychotherapy outcome.

Not only the body: the language of images

During the psychotherapy's interactions there is always, in some way, the emotive-affective dimension. Actually, what the patient experiences in telling emotionally significant events and in reflecting on them, that is always a "third-person" experience, it is qualitatively different from being able to feel and to relive the same emotions into the "here and now" of the setting, that is a "first-person" experience.

The use of imagery techniques can sometimes facilitate the patient to focus on what he/she feels, to get in touch with his/her own sensations, to relive them in real time and later on, possibly, to try to express them also with words (Cionini, 1994).

Imaginative codes are closer to the affective and emotional ones, compared to linguistic codes.

For example, Frijda (1986) affirms that cognitions are emotionally effective only translating them in an appropriate code; this translation does not seem to be accessible to the intentionality and can be facilitated only through the voluntary imagination. Greenberg and Safran assert that "focusing on spontaneously occurring images can be an important medium for accessing complex, affective based meanings" (1987, p. 217).

The images are similar to the metaphors; they are strongly expressive and evocative, they do not have univocal meanings; on the contrary, they can be constructed and re-constructed inside different frames of meaning not necessarily incompatible with each other. The images, like the metaphors, can be sometimes suggested by the patient, as well as sometimes by the therapist, to "help each other" to share meanings that are difficult to express because they mainly belong to implicit dimensions.

The language of images may be revealed within the psychotherapy session both by telling night dreams, and also by using different kinds of guided imaginary techniques. In this context, it is not possible to examine deeply how to conduct these experiences and the techniques used to help the patient in constructing, exclusively through associative processes, a personal interpretation of the meanings of his/her own imaginative creation (night or guided creation) (cf. Cionini, 2013). Therefore, I will present only a brief second clinical example in which the use of guided imagery process, together with the use of the body and of a temporary change of the setting (compared to the usual vis-à-vis setting), helped to interrupt an *impasse* of the therapeutic process, that lasted about a month. The patient (that I will call Giorgio) was about thirty-five years old and he had been in therapy for a little longer than a year.

Second clinical example

Giorgio's early experience seemed to have been marked by precocious and multiple relational micro-traumas which, during the assessment, he was able to narrate but with an absolute emotional detachment, so to make me think about the phenomenology of a dissociative disorder of consciousness. During the therapy, many of the problematic events of his childhood in the family life had been reviewed and analysed. This had allowed Giorgio to "realise", at least in words, of the pain that those events "could" have given him, and of the implications that they "could" have also in his current behaviour, in the relational situations that he had presented as a "problem" in the request of help. This path, even if it has increased its theoretical awareness about the effects of his early experiences, did not seem to have led to substantial changes in his way of feeling and acting within his current relationships. As I said before, for about a month I had felt a temporary *impasse* of the therapeutic process. The patient and I, in the last session, had shared this feeling; the patient had talked about it in these terms:

> *P. "I feel blocked… there is the will to go on with this path, but at the same time I feel held back and this kind of conflict goes with a feeling of discomfort that I feel as a knot in my stomach"*

Thinking I could use this body image, at the end of the session I proposed the patient, for the first time, a temporary change of setting for the next session. The new setting required that the patient was lying on a chaise longue while I would be sitting next to him, by his side (cf. Cionini & Ranfagni, 2009).

The following session, in this new spatial arrangement, after asking Giorgio how he felt in our different proximity and on the chaise longue, I carried out a brief indirect trance induction (Erickson, 1986), then I asked the patient to close his eyes, to concentrate first on his whole body and on the sensations that he felt coming from it. Furthermore, I asked him to let me know from which parts of the body he felt the most significant "signals". He showed me the part where he had felt the sensation of the "knot" in the previous session:

> *P. (…) "The stomach that is rebelling"*

Hearing that the patient's stomach started gurgling and after having shared this consideration with him, I said to him:

> *T. "The stomach that is rebelling… as if it had something to say……. You could try to put this sensation into words… as if the stomach was speaking through your mouth…… taking all the time you need"*

Due to the difficulty expressed by the patient to make his stomach speak "*without intercepting it, without inhibiting it*", I carried out a further deeper *trance* induction suggesting him that in that part of the body, where he had felt the sensation of the "*knot*", some images might take shape that he could gradually visualize more and more sharply and clearly.

At the end of the trance induction, the patient told me that, while I was talking, some "*sharp*" images of some people's faces, including his "relatives", appeared. He briefly described these to me. Now, I am going to relate some passages of the conversational shifts that followed:

P. (...) "I wonder why I visualized those people (...) I do not understand why (...) so I stopped them flowing and I tried to frame them in reasoning"

T. "As if... either your stomach is talking or your head is talking!?"

P. (...) "There is not much dialogue between the parties... I put limits that hold me back a lot... I don't understand what is holding me back... but I feel that I am holding me back"

T. "Do not stop too much, in this moment, in understanding (...) Today the stomach has been allowed to speak although the head has not completely understood"

And after a few more conversational shifts I asked:

T. "How do you feel right now?"

The patient initially told me he felt "*angry*" related to what he had visualized especially because he did not understand the meaning of that, adding immediately "*I feel disappointed*".

I pointed out that there is a difference between "*It makes me angry*" and "*I feel disappointed*" and I asked him to try to focus again on the image of his stomach in knots, in order to enter deeply in touch with the sensations of that moment:

P. "Actually… I said anger but I am not particularly angry, I would say that I am disappointed, embittered, but…"

T. "Sadder?"

P. "Yes, sadder… but I can't say that I'm sad"

His eyes filled with tears while he was saying these words, and when I pointed this out Giorgio started to cry evidently, saying a bit angrily:

P. "Even this… sorry… but I don't understand it… why I have to be sad right now… I don't know"

The experience lived in this new kind of setting had left the door "half-opened" to the possibility, which came true in one of the next sessions, to start keeping in touch with the avoidance or dissociated feelings connected with Giorgio's early intra-family experiences. During the previous months, a hypothetical relationship between anger and sadness/sorrow had already been constructed, on the level of explicit knowledge. We observed that frequently displays of violent anger occurred especially in relation with his closest friends, when he had the sensation of being "*on the side lines*" and/or of "*being unseen*". But this theoretical awareness was split from the family early experienced sensations, although in other moments he had said that he had felt himself as "*invisible*" to his parents and his older sister, and not able to express, both to them and to himself, his own opinions and his own desires.

I think that the *impasse* that we had shared could depend not only on the difficulty in connecting dissociated parts of himself through mainly conceptual acquisitions but, paradoxically, that exactly these acquisitions - perceived by Giorgio as a threat for the equilibrium of his own system – could be a contributory cause of the *impasse*.

In this first session "on the chaise longue", Giorgio had not described the images while he was visualizing them, but he had briefly reported them only later, underlining also in such a way, as well as with the words, the difficulty both in "*giving words to his stomach without intercepting it*" and in living with his feelings.

During the following month, what had happened in the "chaise longue", had been reconstructed and analysed again in this session and in the following one. We decided to use the "chaise longue setting" again for the third time. In this case, after the *trance* induction and the proposal to visualize an image suggested by Giorgio himself, the imaginative production had been much richer and reported "directly", as it generally happens. His stomach had been left free to express itself. At some point images of the house where he had lived at the age of 6-7 had arisen, as well as memories of early infancy lived scenes, initially presented as "*pleasant moments to remember… scenes of ordinary life lived at that time with people living in that house*". Little by little the images had taken a different emotional connotation: the "adult" Giorgio was in the kitchen doorway, he could see all his relatives around the table but not the "little" Giorgio, "*as if he did not exist*". After a while, he could see him seated with the others around the table while he was playing alone. Nobody was taking care of him. This time he could no longer hold back his crying. In the following images, the "adult" Giorgio approached the "little" Giorgio; first he started to play with him, then, taking him by the hand, the "adult" Giorgio moved with the "little" Giorgio into a cone of light. Now, they were both "*lost in observing the sky… almost lost in the vision of the blue of the sky (…) a pleasant feeling… it almost seems we may start walking in the sky (…) and he is fine, I asked him about it… yes, he is glad*".

It was as if the "adult" Giorgio had finally found out a way to offer "little" Giorgio the attention, the "right to exist", that he had not perceived in his childhood relationships, achieving a first integration between his past feelings and his present possibilities.

The different use of the setting, of the verbal language, and the direct access to the bodily/sensory dimension through guided imagery techniques, has allowed Giorgio to reconnect the implicit feelings of the present with those of the past during these sessions. A "heartfelt" integration, probably difficult to achieve in any other way, that allowed the reactivation of a "movement" and made it possible for Giorgio, starting just from the weeks thereafter, to perceive different possibilities related to himself, to himself with another, and to start acting differently in his current relationships.

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