THE FRAME AS LISTENING AND ACCESSING THE DEEP EMOTIONAL LIFE. THE LENS TO REACH THE SUBCORTICAL BRAIN

EL ENCUADRE COMO ESCUCHA Y ACCESO A LA VIDA EMOCIONAL PROFUNDA. LA ÓPTICA PARA ALCANZAR EL CEREBRO SUBCORTICAL

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Abstract

This article explains how the sense of ourselves is shaped in the deeper layers of our subcortical brain and body, then later coloring our emotional and conscious life. It shows how our conscious life sits on primary emotional systems with which all mammals are equipped. It proposes how an essential psychotherapy should reach the deepest stratum of our psyche in order to promote a process of transformation and consolidation in a new personal narrative and sense of self. It exposes a model to develop the skills for selective listening in the therapist to create a sense of being limbically seen and to organize the frame for the reprocessing of traumatic experience. At the end, it illustrates this process with an excerpt of a psychotherapy session in which the therapist helps the patient to access her own painful history organized on her early life; this history was permeating and organizing the conscious and adult life.

Keywords: *primary emotional systems, subcortical brain, frame, essential psychotherapy*

Resumen

Este artículo explica cómo el sentido de nosotros mismos está conformado en las capas más profundas de nuestro cuerpo y cerebro subcortical y cómo luego influencia y colorea nuestra vida emocional consciente. Muestra cómo la vida consciente se asienta en los sistemas emocionales primarios con los que todos los mamíferos vienen equipados. Propone cómo una psicoterapia esencial debe alcanzar los estratos más profundos de nuestra psique en orden a promover un proceso de transformación y consolidación de una nueva narrativa y sentido del self. Se propone un modelo para desarrollar la habilidad de una escucha selectiva en el terapeuta que cree un sentido de ser límbicamente visto y organizar el encuadre para reprocesar la experiencia traumática. Finalmente, se ilustra el proceso con un estrato de una sesión de terapia en el cual el terapeuta ayuda al paciente a acceder a su historia dolorosa organizada en su vida temprana, historia que estuvo impregnando y organizando la vida adulta consciente.

Palabras clave: *sistemas emocionales primarios, cerebro subcortical, encuadre, psicoterapia esencial*

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This paper addresses the role and function of the therapist in helping the patient to access the deep systems, formed in early life, that organize and determine the perception of self, others and the world. It is proposed how what are referred to here as "core organizing schemes" are rooted in our primary, neurobiologically based emotional systems, and which then color the way we feel and act in life today. A model of therapeutic listening is proposed which, by pointing out the clues of the still active historical material, helps the patient to locate the original interpersonal context where his or her perception was shaped. Framing is presented as a therapeutic tool that helps the access and localization of root experiences to subsequently invite bottom-up reprocessing of the experience (from the body to the higher brain structures), in a way that facilitates that these unmetabolized experiences, encapsulated in our subcortical-somatic system can finally find a conducive environment, the full and radically accepting presence of the therapist, but also of the patient himself/herself on his/her own painful experience, to come to light, to be completed, transformed and ultimately consolidated in a new way of perceiving oneself and the world.

This model of selective listening (limbic listening) and framing is a way to create an attunement with the most unconscious brain, the subcortical one, which stores in implicit format (somatosensory) our ancient history. It is also a tool to promote in the other the experience of feeling limbically seen and understood. At the end of the article, this method of intervention is illustrated with a commented excerpt from a therapy session.

From the Interpersonal to the Intrapersonal

Our brain is a complex life management organ. As multicellular organisms we have needed to develop an organ capable of coordinating and managing the complexity of the different specialized systems that contribute to our life: the cardiocirculatory system, the immune system, the nervous system, etc. On the other hand, the human being is also the most evolved mammalian animal in the species, capable of observing itself, creating and transforming the environment. Intelligence has somehow endowed us with the ability to study the environment and manipulate it. Science and technology have put in our hands a very sophisticated tool to transform nature itself and nature in general; this can be done to aid growth and development or for destruction. Therapy is about creating an interpersonal environment conducive for the healing capacities of the human brain to kick in and process the experiential information that had not been metabolized so far.

Managing one's own life implies the ability to manage one's own ever-changing needs and exchanges with the external world. So our brain has to constantly assess, 24 hours a day, the state of the internal environment, the state of the external environment and how the interaction and exchange between the two occurs. As mammals this exchange with the external world makes us especially dependent on the response of our conspecifics. We depend on each other to regulate our internal

world, most especially in the earliest stages of our development.

Our brain's first and foremost task in managing life is to help us survive. Everything the brain organizes is in function of helping us adapt to the environment in order to survive. We come into the world already equipped with a series of neurobiological programs that are the result of the selection over millions of years of phylogenetic evolution of those reflex programs most necessary to relate to the world at birth and before birth. Because humans need to depend on their caregivers for longer periods of time, they are also more dependent on and vulnerable to the influences of the external environment and their caregivers on them, and at the same time have more capacity for learning and development than any other mammal.

One of the first primary emotional systems, in terms of neuroscientist Jaak Panksepp (1998) is the attachment system. The infant will seek and orient to the mother's body both for nourishment and physical nurturance and for emotional connection and comfort, which is just as important as the former. For the young child, attachment is a matter of survival. We also know that our brain has a sensitive period of learning relational schemas in the first two years of life. So it is at this time that the interaction of our biological programming with caregivers in the environment begins to shape the patterns or schemas of being in relationship with each other. Likewise, it is in the relationship with others that we acquire and shape experiences and meanings of ourselves, others and the world. For the young child, who feels that he or she is loved or not by how he or she is cared for, what Damasio (2010/2018) calls the "proto-self" begins to organize, the bodily experience of who we are for the other; in essence, whether we are worthy or unworthy.

These primary relational schemas will henceforth function as a filter that will organize and determine a predisposition and selective attention to external stimuli and to attribute to them a meaning that fits with what is already known or not. This process corresponds to the ideas put forward by Jean Piaget (1968) of assimilation and accommodation. So the child already faces experiences with "a previous idea" of how things may be; and as humans generally live with the same caregivers for a long period of time, they predict what they are going to find, assimilating what they experience into what is already known or accommodating what is already known to the new nuances. In this way, it shapes the neurological networks that accumulate information on how to feel, react and what to expect. At the same time, these neurological networks shape different senses of self depending on contexts and relationships. Thus, interpersonal life shapes our intrapersonal world, in a way, what is outside is inside.

Let's take an example, a baby was abandoned in its first year of life, then was in institutional care and later adopted. In early life this loss of the primary attachment is a threat to his sense of survival, subcortically we know ourselves to be in danger of death. The instability of bonds in institutional care confirms that bonds are not secure and can be lost at any moment, they cannot be trusted; moreover, later on the adoptive family will never offer a perfectly attuned bonding experience, so he

will be very sensitive already to small signs of rejection-abandonment. This will organize in this child a traumatic relational scheme that will anticipate abandonment in other contexts of life. When he goes to school he will have an increased sensitivity to subtle signs of rejection, being left aside, being ignored, not seen... that he will assimilate in his relational schema as confirmations (retraumatizations) of experiences of abandonment and rejection. The experiences that in the first years have an essentially somatic and emotional nature, will later be the basis for the conformation of limiting beliefs: "I do not deserve love", "I am not important", "I am not worthy", etc. And he will learn to accommodate to what he perceives as the demands and requirements of the relational environment.

Primary Organizers and Primary Emotions

This whole experiential world is occurring in the infant in the early years of development, when the dominant structures are the right hemisphere and the subcortical brain, which is somatosensory and emotional in nature. In the words of Panksepp (2010) "there are still ancient minds within our modern human minds, and we will not understand our higher mental processes unless we seriously address the earliest neural solutions that still influence the complex mental apparatus of highly encephalized mammals".

Panksepp (1998) studied with electrical brain stimulation the subcortical brain areas that trigger primary emotional responses and that are common in all mammals. In essence, our subcortical brain (limbic and reptilian) is shared with the rest of the mammalian species. He thus speaks of "primary emotional systems" or "raw feelings" with which we come already equipped neurobiologically as a legacy of phylogenetic natural selection. These "primary emotional systems" equip us with predetermined responses to specific stimuli or situations without having to think, identify primary threats to survival, and will subsequently inform higher-order mental processes. They immediately inform us what to do. These primary-process emotional affects include, according to his research, SEEKING, FEAR, RAGE, LUST (sexual desire), maternal CARE, PANIC of separation, and PLAY-joy.

Panksepp et al. (2012) and Panksepp (2011) propose a tripartite concept of mental functions (figure 1) that mature hierarchically and continue to influence and color higher-order functions throughout life:

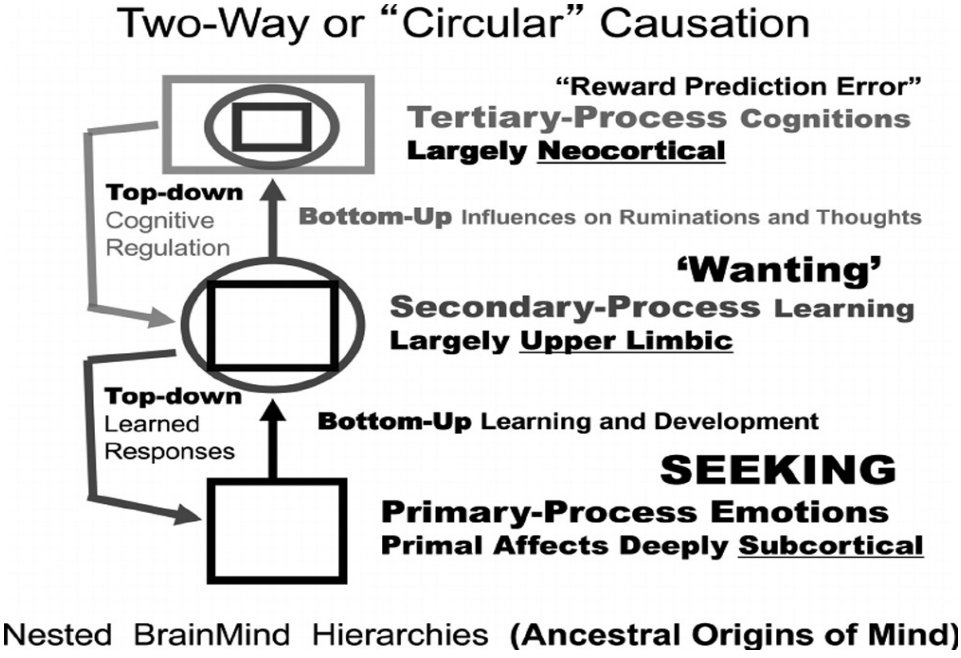
a) Primary-Process functions, which are the result of evolution and contain raw but highly effective vital mechanisms of action. They are usually labeled as "innate" or "instinctive" reactions. They are rooted in neural substrates of the reptilian and limbic brain.
b) Secondary-process functions. These reflect the basic brain capacities to learn through sensitization-habituation. These secondary processes are formed when the individual begins to interact with the environment, trying to respond and adapt to what it requires. Here we would place the social emotions such as empathy, pride, shame, guilt, trust, etc. They would also

be rooted in the paleomammalian or limbic brain.

c) Tertiary-Process functions. They include all those "reflective" processes of the higher BrainMind, in Panksepp's words, that we refer to as thinking, decision-making, planning, the higher forms of intentionality (i.e., intentions-to-act), and other neocortical processes such as reflection, metareflection, etc.

Panksepp's idea, as well as that of other neuroscientists such as MacLean (1990), Damasio (2003/2005), is that each stratum of the higher order system builds on the adequate or inadequate maturation of the lower strata. In other words, an individual will not be able to effectively perform tasks of the tertiary order when there is alteration or damage in the lower strata.

Figure 1. *Nesting of the Affective Mind* (image extracted from Jaak Pankseep, 2011)



While the functions of the primary process (primordial affects) are common to all mammals, as we ascend to the secondary and tertiary levels of the Brain-Mind, the complexity of functioning increases enormously, shaping idiosyncratic manifestations, which are individual and dependent on family, social, national, ... culture.

The primary emotional systems have a "natural wisdom" and provide us with immediate responses programmed by evolution, they do not require the cognitive process or learning.

What is of interest here is to see that the emotional lives of adult subjects are

as strongly linked to the higher cognitive capacities as to the lower emotional networks. But the higher capacities (of tertiary order) do not have a "life of their own". We can say that everything upstairs is still linked to the many emotional networks of the lower regions of the Brain-Mind and that these subcortical systems have a "life of their own" (Panksepp, 2011; Panksepp et al., 2012). Ancestral affects can control and regulate higher cognitive processes. Figure 1 shows how the square of primary processes is included in the circle of secondary processes and the latter are included in the square of tertiary processes. Deep therapy will have to access these deep layers, still embedded in our tertiary and secondary processes, which continue to condition perception in order to help its actualization.

In this sense, we consider the "sense of self" primarily as a matrix of conscious and unconscious memories organized in episodes, stories and narratives; the most determinant of them recorded in our corporeality in an implicit and procedural form -in somatosensory code- (Salvador, 2008). Non-conscious decision making continuously permeates and shapes the construction of the "sense of self", the hidden layers of our neural processing pre-digest and organize our experience before it emerges into our consciousness. Somehow, in our older, subcortical brain, the information from our painful history remains unprocessed. This is the nature of trauma, it remains frozen in time in our neurobiology, not yet metabolized and integrated.

A deep and transformative psychotherapy has to detect, understand and correct the content and organization of these hidden layers. The hidden layers - as a matrix of implicit, procedural, cognitive, cognitive and sensorimotor memories - create our reality milliseconds before reaching our conscious self (Salvador, 2009). What we call INTUITION is the result of quick, unconscious decisions that guide our thoughts, feelings and actions without our conscious knowledge (Damasio, 1999/2001). The therapist has to help his patient to access this implicit world "forgotten", "rejected" and therefore "abandoned also by oneself".

Antonio Damasio (2010/2018) expresses in other words this same idea of the importance of our ancient world still alive in our sensations and our corporeality:

> ...the hidden knowledge of the management of life precedes the experience of being aware of any such knowledge. I also assert that hidden knowledge is quite sophisticated and should not be considered primitive. The complexity of this knowledge is enormous and its apparent intelligence remarkable... While in making this claim I do not degrade the position of consciousness, I do place a higher value on the non-conscious management of life, suggesting that it constitutes the organizing plane that structures the attitudes and intentions found in the conscious mind. (p. 69)

The therapist practicing an essential therapy has to be attentive to how the clues of the old life still alive are determining the attitudes and reactions in the patient's present life. This still-living old life continues to permeate our sense of self and of the world marked by the perception elaborated and fixed in the early stages of our development. We can consider therapy as a continuous process of

updating information that was fixed and trapped in time and that in the compulsion to repetition seeks how to show itself, complete itself and finally transform itself. This requires the presence of someone who knows how to listen to us limbically.

The Work in the Therapeutic Relationship

The first task of the therapist in an essential psychotherapy is to provide an experience of deep connection to his patient, so that he can feel "limbically felt". This involves co-creating the experience of being with someone who now sees and responds with respect and kindness what in previous relationships they failed to see or even rejected or threatened. This task involves several factors:

a) Create an atmosphere of safety. As Stephen Porges (2001) shows in his Polyvagal Theory, we heal in secure relationships, the neural pathways of social connection coincide with those of healing and growth. Porges discovers that our vagus nerve, involved in emotional regulation and connecting our reptilian brain with the enteric brain (the viscera) also follows a hierarchical model: the first way we seek protection and calm is by turning to our fellow humans, if in turning for help we feel safe and comforted, the whole system returns to homeostasis and well-being. If the caring relationships fail to provide safety and affective support, a second system is triggered, the sympathetic system, responsible for activating our active defense responses: flight or fight; if it is effective in avoiding danger or resolving it, the organism returns to homeostasis. If this second system also fails, then we have to activate an older and more extreme system, the parasympathetic immobility system (dorsal vagal branch); this implies that the organism tries to inhibit its active defense responses in order to appear immobile, invisible and not to attract attention. The latter implies a shutdown of energy to enter a state of lethargy which if maintained enters "the freeze response". Individuals who have had to resort to this system to defend themselves from environmental threats experience this state as dissociation. As Janet (1889) says "when the body cannot escape, the mind seeks how not to be". The correlation between this sustained freezing response and traumatization is well known, which is why it is said that trauma is information frozen in time in the same implicit code in which it was experienced.

b) 'Convince the subcortical brain', involved in survival, that it is now in a new context. With many of our patients, the first therapeutic task is to help them return to the relationship, and to differentiate that the traumatic transference reactions to the therapist actually come from another relational context, and that they are now in a present and safe relationship. Neurobiologically it is a way to calm the alarm and pain reaction triggered by the subcortical structures so that the patient acquires an experience of being in a new present context free of danger.

c) Help the patient to gradually place his or her center of identity in a mind of self-study and self-observation (the state of mindfulness) from which he or she can now compassionately contemplate his or her own previously forgotten, disowned or dissociated experience ('I am not me'). This will allow activation of the prefrontal

areas of the brain involved in meta-reflection, regulation and mindfulness, which will enable the patient to "feel an experience" but "not be being his experience". In this way he will be able to remain a compassionate and welcoming observer of his remembered experience and listen to his forgotten painful history. It is here that the capacity of the system to heal itself is awakened and to be able to process information that still needed to tell that old story in the presence of someone (now the therapist present but also the patient present about his own experience) in order to come to light, to be finally completed to acquire a new transformed meaning and consolidated as a vital resource acquired from the lived experience.

This initial task is built with the attuned presence of the therapist.

The Therapist as Detective: The Inquiry

In the first part of the therapy, part of the therapist's active work is to elaborate a broad inquiry into the experience and difficulties referred to by the client. The therapist "does detective work" to help the client clarify the nature of the difficulty, find its root and the context in which it was adaptive, and gradually elaborate the framing that exposes in the light of consciousness the core organizing scheme of the painful or limiting experience.

Inquiry is a powerful tool in the hands of the therapist to propel the healing process. It is through respectful inquiry that the therapist helps the client's brain to delve deeper into the nature of the problem, the search for its root (the organizing schemas) and the impetus to its resolution. Inquiry guides the brain's attention to turn on itself -when directed at intrapsychic processing- and to awaken the capacity for reflection or meta-reflection: a brain that begins to observe itself. It is through attuned inquiry and in a therapeutic relationship in full presence that we help the client's mind to adopt a self-study approach. This is the state of mindfulness or mindful presence of the client in his or her own experience, without judgment, without expectations or assumptions or definitions about the experience. The ultimate purpose of the inquiry is to help the client come into more intimate and friendly contact with his or her experience, and to develop a sense of natural and compassionate curiosity about how he or she adapted intelligently to survive.

The purpose of inquiry then is not to obtain information but to promote the very process of reflection and looking internally and in perspective towards the client's intrapsychic phenomenological-experiential world; since our life system on autopilot trains us to function in a more habitually reactive way towards the external world and does not give room for the meta-reflective process.

Asking questions and crafting interventions that stimulate and support this type of internal search, in respect for the intelligence and courage with which the client has built his or her defenses, is the essence of good inquiry (Erskine et al. 1999/2012). Effective inquiry helps the person elicit her unique answers by inviting her to look in places and ways she had never considered (or dared) on her own. The therapist does not have the answers, but must have developed highly

selective observation in detecting the clues to the still-living traumatic experience that emerges and colors the patient's verbal and somatic account. The therapist's interventions offer the patient a different direction from his usual one in which to search and look, accessing the subcortical world.

In the same sense, the aim of the inquiry is not for the therapist to get an answer, but essentially for the client to find, re-appropriate and inhabit the parts of his experience that he had dissociated, denied or disowned. It is also a way of placing the center of healing within the client. The answers are more for the client than for the therapist, although the therapist also learns from the answers and helps to organize and formulate the frame on which the client's brain has to focus and process.

As the inquiry progresses, the therapist increases his or her level of attunement to the client's process and the client will feel deeply understood by someone who is involved and interested, someone who is able to see his or her denied and hitherto misunderstood world. One of the reasons that inquiry itself is part of healing is that it is done within an authentic relationship between therapist and client; it provides the safe context in which the client can discover, know and heal him or herself. In fact, the therapeutic relationship can and often must be a cause for inquiry in itself; it involves the activation of a new neurological network in the client, that of this time being accompanied by someone safe, present and interested. Helping the client to compare the new relational schema, experienced in the relationship with the therapist, with the old, traumatic relational schema, in which there was no one or whoever was was also the source of the threat, is a powerful way to help integrate new material into the old schemas (Hebb's principle, 1949: neurons that activate together connect together).

In attuned inquiry there is no hidden agenda in the therapist, the therapist is open to whatever emerges on its own. Each intervention of the therapist will be based on the client's response to the previous one. Thus it is a co-constructed and unpredictable process. The therapist embraces "the uncertainty principle" and assumes that "he does not know about the patient's meanings", he is open to welcome the patient's experience as it is and as it emerges, with no prior plan.

Framing, "The Optics for looking into the deep brain"

The therapist's inquiry orients the patient's gaze to his inner world, guides "where to look for" the rejected information, to locate it in the original context in which it was shaped (organizing scheme) and subsequently give space so that this experience, and usually the child who lived it, can tell its original truth to the dimension of the Loving Observer (state of mindfulness) which is where the patient has been placing himself.

The therapist's detective work is based on a very selective listening, knowing that beneath the surface of the story there is still active and living historical core material that limits the patient's perception and action. This selective listening has to pay attention to the clues of this nuclear material that is emerging in the story

("organizers" and "emotional markers"). By pointing out the significant information, the therapist returns a formula that offers "a frame" through which to look more deeply; in a way the frame acts as a 'magnifying glass' that directs the client where to look in a more focused and deeper way. The framing also provides the brain with a framework in which to hold processing.

Figure 2 contains the key elements for training the therapist's selective listening and organizing the frame that orients and focuses the gaze on the patient's painful inner world, the deep layers of the subcortical world. The framing also provides a powerful tool to promote a sense of being "limbically listen". In the first phase, the therapist thus helps the patient to go beyond the rationally (neocortically) told story in order to access the nuclear organizing schemes, the core material, and the original scenes where the traumatic story was being lived in an interpersonal context. In a second phase, once the old experiential context is accessed (which is already facilitating a differentiation between the present moment of now and an experience coming from the past), the patient will be helped to listen to this old story found from the bottom-up (from the subcortical-somatic world to the neocortical world, now in its function of non-judgmental and compassionate observing consciousness).

The Organizers and Emotional Markers of the Emerging Subcortical Material

The following are the key concepts used in the funnel model for framing in order to clarify the key elements used to which the therapist has to pay attention masked in the patient's verbal and non-verbal account.

The psychoanalyst Joseph Blegler (1967) defines the frame as a set of constants, what he calls the non-process, and in front of that, coexisting, would be the process, which would be the mobile and variable. The frame as a constant support will operate as a background against which the figure will emerge, that is, everything that has to do with the mobile, the variable and the experiential process.

The frame organizes and is at the service of the processing of the experience; it performs a function of support and containment in the same way as the constants that a mother provides for the growth of her child (of care, of protection), which allow the child's ego to develop since it shelters and contains, but also supports the limits, contains and limits the intense emotions that may arise during the processing, by transmitting that the other is seeing and accompanying the child's own internal world. The frame is offered as a framework that provides psychological security.

The "organizers" constitute underlying schemas that organize (in the sense in which we speak of organizers in embryology) the behavior of a group and, for example, guide choice and decisions. In the field of psychology, René Spitz (1959) uses the term "organizer" by analogy with its embryological antecedent and defines it as the result of complete integration, i.e. the formation of a new psychic structure on a higher level of complexity. For example, the patient can organize his experience in certain experiences with a common denominator of helplessness, abandonment, helplessness... or around his hope or resources to get out of a situation, let's say

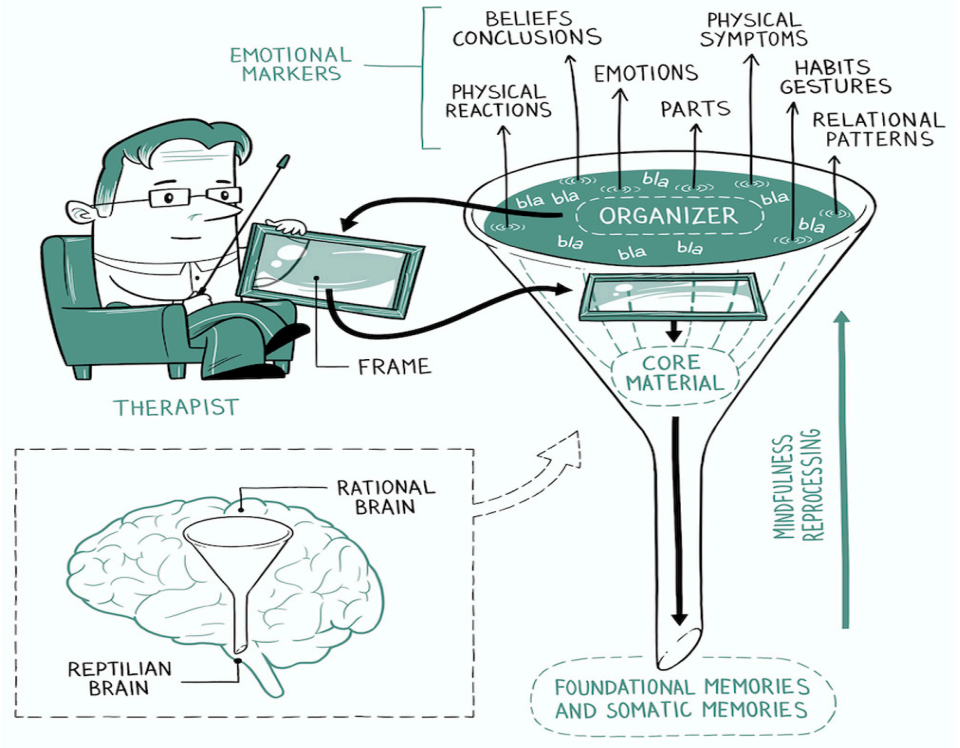
a resource of freedom and tranquility. These organizers thus serve to classify and organize those experiences that share a similar emotional quality.

The term "emotional marker" is used on the basis of the somatic marker proposal (Damasio, 1994/2011), which proposes that decision making is a process guided by emotional signals related to homeostasis, emotions and feelings. The emotional markers in this model refer to those indications of the core material: the phenomenological experience that took place in the old experiences that led to the elaboration of the limiting decisions and conclusions, the physical sensations, the associated painful emotions, the reference to internal parts that refer to a differentiated experience and, when the experience is dissociated, the physical symptoms that give it away. The therapist will be able to listen in the patient's account to these markers that determine not only their ways of perceiving but also drive their decisions and actions in managing their current situation. We can listen for reminiscences of ancient history in beliefs such as "crying is useless", "no one is there for me", etc. (which speak of a context in which this was a reality and what the person concluded to manage it). Likewise, we can observe patterns of gestures (e.g., covering the legs with the skirt repeatedly as a marker of when at an earlier time someone sexually touched the client), behavioral patterns such as isolating and not asking, we can observe cues in physiological reactions that contain the somatic account of what was experienced in the past context, or even in the language of differentiated parts or states of the self (e.g., "a part of me feels afraid of..."). Finally, as noted above, signs of active, unprocessed traumatic experience can be seen in physical symptoms; it occurs when the dissociation defenses have had to engage in extreme denial.

Developing the model in figure 2 (own elaboration), framing refers to how the therapist, at some point in the process of inquiry, can detect the organizing schema that shapes the way of perceiving, thinking and feeling that the client experiences in her current circumstances or situation. In the therapy excerpt below the experience of not having had a good enough mother was what agglutinated her actions for her determination to "be a good mother" ("organizer"). In the verbal and nonverbal narrative the client is expressing her way of perceiving and experiencing the problem, this is wrapped in many nuances and words describing what she experiences (her "blah, blah, blah"). Sometimes the "blah, blah, blah" is also a distractor from the more painful material; and, in either case, it is the explanation that the conscious mind and rational brain has given itself about the problem. The therapist in his selective listening detects the "organizers" and "emotional markers" around which the patterns of perception-emotion-somatic experience-behavior are shaped. These "organizers" and "emotional markers" come from early relational experiences that were the cause of pain and/or trauma. At some point in the problem narrative, aspects of the client's old material from the deep and subcortical-somatic system will emerge from the client's deep and subcortical-somatic system, these emerge among the contents of the client's narrative. These emerging clues reveal "aspects

of the core material" and may act as "windows of entry" into the deep experience. We may hear conclusions such as "impossibility to attend to me", "there is no space for me" - in the therapy excerpt below -, "crying is useless".

Figure 2. *Funnel Model for Framing*



The emotional markers -emergent cues- give intensity to the story and are manifestations of the early history still alive in the client's subcortical brain and body. The therapist by observing and pointing out these emotional markers helps the client's brain to focus, search and locate the context of the early history (therapy excerpt: *"when I was born my mother was depressed, stressed and had nothing to give"*) not updated, and access the "core material" that influences the way of living in the current context (the struggle to be a good mother). The therapist in detecting these emotional markers and "organizers" can offer a "frame" (therapist: *"it seems that being a good mother is a whole issue in your life"*) by which to look at the deepest level, so that the brain can be placed in a mode of compassionate self-study and self-observation (mindfulness) and can sustain and focus the inner gaze on the painful experience in a state of self-regulation in which reprocessing and healing is possible. The frame thus acts as a "peephole", "window" or "lens" with which to help the client's brain to focus and go to the bottom - it fits the image of a funnel

that narrows its focus to become more and more concentrated - to access the core material and the foundational experiences and historical context; and at the same time it acts as a support and container for processing so that the person keeps looking at what is coming from the subcortical and somatic world. Now the client can more easily remain in a state of dual consciousness (the Observing Self and the Experiential Self) in which the subcortical brain and the body tell a long held truth.

By elaborating an appropriate framing, we enable the brain to process the "core material" that makes up the experience (the limiting conclusions, the beliefs, the emotions that respond to frustrated needs, the accompanying bodily experience, the survival decisions). The client is now able to take in and process the story told by his body in its language of sensations, emotions, images, conclusions and decisions that express the way he survived. This is the process that holds a space for self-healing, which Salvador (2017) calls "The Healing Bubble." The space in which the unmetabolized story awakens and begins to tell itself in a sequential mode: beginning, plot development, denouement, and resolution. This story goes from the contact and the story of defenses to the access and discharge of the painful story of our vulnerable nature and to the emergence and experience of our natural qualities of joy, creativity, love, freedom, spontaneity, courage... (the transformation). It is in this telling and unloading of the buried story that the process of transformation that involves reprocessing occurs: the story now welcomed and accepted by the dimension of the Observer Self or Essential Self (Salvador, 2017) that appropriates and inhabits its own experience in a new way.

Therapy Excerpt: Putting it into Practice

Let's look at an excerpt from therapy with Constanza, who began by dealing with her guilt of "not being the good mother she wants to be". In the time leading up to this transcript she is exposing her experience of a lot of pain in giving birth to her two children and her depression afterwards.

T: *What was going on in your life or what was your life like when this second child was born* (the therapist chooses to take the client back to the context prior to the birth of the second child)?

Cl: *Well, it was fine. When is he born?*

T: *Yes.*

Cl: *I had a very hard postpartum of the second child. A very hard labor and postpartum*.

T: *What made it hard* (phenomenological inquiry; therapist shows interest in knowing more about the experience).

Cl: *A lot of pain. A lot of pain in childbirth. A lot of endurance for an idea of natural childbirth, of giving birth at home. A lot of pain. The first one was also like that.*

T: *The first one was also like that* (repeating the question is an elegant way of saying "tell me more about it", without abusing the interrogation).

Cl: *The first one was a very painful labor, with a lot of endurance that ended in an emergency cesarean section and after the second one I was in a lot of pain, worn out and very physically exhausted and with 2 small children. A newborn baby and another one... I was breastfeeding both of them at the same time.*
T: *Wow, what was it like to be so tired, in pain and have two children who still need you so much?* (the exclamation is a way of recognizing and validating the intensity of the experience; then you continue inviting to reveal more of the phenomenological experience).
Cl: *Difficult, difficult because since the second one grew up I have felt like this* (stretches out her arms and sways) *as if pulled. Like... by one and the other... with a difficulty of integration really. And I still feel that way. Like I keep feeling like they're both claiming me for themselves or something, right?*
T: *They kind of pull you each from one side.* (This intervention expresses the therapist's involvement, which again reflects recognition and validation of the experience. The intervention condenses the experience "*I see how hard it is and there is something important in your experience"*).
Cl: *Powerless, of not being able to give them what they want, what they need.*
T: *And I have the impression that this touches a very fundamental issue in you*. (The therapist takes the opportunity to return to something that had come up at the beginning of the session, the client's concern about being a good mother. This intervention tries to focus the framing on the importance of being a good mother and the powerlessness as an "organizer" of the experience. At the same time, the way of asking does not impose any content, but only emphasizes the importance of the issue of "being a mother" as an "organizing scheme" of the experience -see Figure 3.)
Cl: *yes* (the client's "*yes"* confirms that the therapist's intervention is a successful framing).
T: *I heard that you suffered to have two natural births and I understand this as the desire to be the best mother and give them the best possible experience.* (Here again the therapist acknowledges and validates the effort and suffering to have a natural birth as the desire to "be a good mother", it is a confirmation. "Being the best mother" sets a frame to further focus the search. Interventions narrow the funnel of experience to help her go deeper and sharpen the focus.)
Cl: (Nods his head)
T: *So your frustration is already born there at least. Wanting to give them that experience, different and natural that you could not.* (The attunement here is expressed in the recognition -I see it- and the validation -I see that it is important- of the effort as the attempt to be a good mother; at the same time the seed is placed that maybe this attempt comes from a time

further back "it is already born here at least"; the affective bridge to the old experience is stimulated).

Cl: *Yes, now I don't live it that way so much. I've been able to turn the matter around and take some of the blame off myself, at least a little bit. But there was a thing of Why can't I?*

T: *Observe what you answered yourself to that question?* (The therapist in this intervention encourages the client to become aware of the conclusions and survival decisions adopted by the client).

Cl: *I had no answer* (starts to cry). (Emotion is itself an answer)

T: *We have to stop at this because now I am seeing this suffering of yours.* (This intervention contains acknowledgement - "I see your pain" - and validation "and it is important". The therapist with this intervention invites to give time, focus and deepen by listening to the story expressed by the tears, the funnel narrows -Figure 3).

Cl: *Yes, when he was born he was not well. I felt depressed for a while, I knew what postpartum depression was, I didn't feel depressed for a long time, but yes, at the beginning yes until the physical pain went away. But then the intensity of the experience with the two little ones was very stressful and still is.* (This response reveals that the framework offered of "being a good mother" has come at a high and personal cost to the client).

T: *Let's look at it...* (This expression conveys "there is something very important in this, let's stay here and give it time. It is a way of inviting to narrow the focus, to close the funnel).

Cl: (Cries. Signal that the therapist's intervention is effective.)

T: *It's okay to be in your emotions, you don't have to drown them out. Let's listen to them as far as they need to be heard.* (Again the therapist validates the emotions - emotions are implicit memories - implicitly stating that they have importance and a story to tell while stating his attitude of being present and interested and inviting the client's Observer).

Cl: (Cries)

T: *Let's see a little more what happens in you when you are in that depression. What is it like to be in depression?* (this validation gives way to focus more on the experience of being depressed and narrows the frame of the experience by placing the gaze further down the funnel to access the core material -Figure 3).

Cl: *Well, tiredness, and like an impossibility to attend to me. There is no room for me*. (Here the oldest root of the organizing scheme is revealed: "there is no room for me"; the client is reaching the core material. This painful belief is a survival conclusion and a "window of entry" into the deeper, older experience).

T: *Listen to that conclusion: "There is no room for me". Stay in it and listen to what else it contains...* (Now the therapist points to a piece of informa-

tion and holds the process so that the client can observe more focusedly all the importance of this old conclusion: emotional marker revealing the core material. Note that in the formulas employed by the therapist he is repeatedly addressing both the Observing Self and the Self that holds the experience "listen to that conclusion". Let's see where this pointing and the proposed framework leads to).

Cl: *There is no room for me. For my needs, for some of my needs.*

T: *It sounds like a very old conclusion in your life: "there is no space for me". Because others occupy that space. When you resonate with that emotion I feel you are connecting with even deeper emotions.* (Now the framing is trying to make a leap from the more current phenomenological experiences to the historical root, the foundational memories that organized the experience. In terms of attunement this is the right moment to make the affective bridge to the past, here we have a "window of entry" that shows ancient history. It is the right moment since up to this point the client has expressed her current experience).

Cl: *Yes, yes... well, I go to my childhood and the parallel of my mother's experience, when I was born. That she was depressed, stressed and nothing to give.* (The framing is successful and the client accesses her early foundational experience).

T: *Wow, nothing to give* (this pointing and validation conveys the importance of pain for a girl).

Cl: *very little, very little.*

From here the client accesses the childhood memory that her mother was also very depressed when she was born, and how she had to develop a toughness defense of "living with little". In the excerpt we can see how the therapist's interventions are aimed at getting the client in deeper contact with her experience, to get to know it, to express it and to invite deeper emotions to tell the story that was encapsulated. All the interventions are aimed at orienting the search towards her internal process, pointing out the indications of the nuclear material and elaborating frames. Throughout the process the therapist invites the client to dwell on her intense emotions so that they can express part of the story they have. We can also observe how each intervention of the therapist builds on the response the client has just given. This is the way to keep the attunement, not to open new paths, but to invite to go deeper and to get in touch with what was silenced. The therapist's involvement is constantly shown through genuine interest - manifested both in exclamations that signal the importance of something - and in interventions of validation and acknowledgement.

In this excerpt we see how the therapist's task has gone from exploration and awareness about psychological phenomena (sensations, emotions, cognitions) lived in the present context, what is manifesting itself at the time of the session and which is connected with the desire to try to be "a good mother" and "helplessness"

(organizers), to being able to get to the historical context, how the client lived the neglect of her own mother because she was also depressed (founding or root experience) . Likewise, in the research process the survival decisions are made explicit: "there is no room for my needs; there is nothing to give" (and later "I have to be hard not to need"); this is the core material that has to be reprocessed now. We see how to the extent that the therapist remains present and involved, he can elaborate his interventions according to the material that is awakening, he simply waits for it and welcomes it in tune. In the course of the inquiry, the client's capacity to be present in her own experience -self-study mode-, to observe it, to know it, to accept it... Interpersonal contact is the bridge to internal contact (Bollas, 1979; Orange et al., 1997; cited in Erskine, 1999/2012) is also trained; thus gradually building an internal link between the patient's Observer and her Experiential Self.

During this session time, the organizing schema of the experience "to be a good mother" (figure 2) became evident. The foundational experience "as a newborn child I did not have an available and nurturing mother" formed the organizing schema of how to perceive and feel the mother-child relationship that later shaped her determination to "be a good mother". With all this we have an optimal framing and the necessary activation to move to the phase of reprocessing, of listening from the somatosensory language, and to promote a transformative healing. Now the client has discovered the original context of her experience and has developed an observing attitude that will facilitate reprocessing in mindfulness and a consolidated relational attunement.

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