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# Amnemonic traces: Traumatic after-effects

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*This article addresses the problem of amnemonic traces. The author considers various effects that traumatic experiences can have on the psychic apparatus and, more specifically, those that give rise to situations in which nothing is remembered and nothing is repeated by the patient. She presents data from the analyses of two patients and explores whether it might be possible to give a more accurate description of factors and processes that accelerate the fading of traumatic experiences from the memory network. As somatic disturbances, or illnesses, often accompany or follow traumatic upheavals, the author examines some examples of how somatic events can be viewed as linked to traumatic turmoil and understood as channels of expression of what remains silent in the mental realm. Some suggestions concerning prerequisites for analytic work with patients who confront the analyst with ruptures and erasures in mental functioning and with reductions in mental processing are discussed. How the analyst's psychic economy is involved while working with such patients is also considered.*

**Keywords:** trauma, memory, amnemonic traces, somatic events, illness, technique

## Introducing the problematic

In *Beyond the Pleasure Principle*, Freud (1920) describes the ego's efforts to moderate excitations, striving to reduce them to zero. The aim is served by repetition compulsion, a process that seeks to control and lessen unpleasant or traumatic experiences.

In his text on *Moses and Monotheism*, Freud (1939) adds that, if an overwhelming situation occurs in a very early period of life, the immature ego is unable to carry out even repetition processes, thus stressing the negative dimension in his theory of trauma. He states that, when nothing is repeated and nothing is remembered, the ego's organization is conditioned by avoidance processes that may develop into inhibitions and phobias (p. 76).

This understanding of the psychic economy, which relates to the development of the second theory of the drives, modifies Freud's views on the constitution and effects of traumatic experiences. Having already replaced his first model of an external traumatic act of seduction with the notion of an internal operator – i.e. unconscious phantasies that emerge in connection with children's sexual theories – Freud is now less preoccupied by the

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nature of the trauma (sexual or other) and refers mainly to its impact. He calls attention to the after-effects of trauma, especially when these take the form of quantitative effractions that paralyse the psychic apparatus, leaving it deficient in elaborative possibilities and exposed to overwhelming anxieties.

In *Inhibitions, Symptoms and Anxiety*, Freud (1926) links anxiety with object loss. But Ferenczi's (1933) understanding of the origins of trauma as relating to primary interactions between subject and object influenced Freud's view of early narcissistic injuries; he then stated that such interactions may assume a traumatic quality, hurting the immature ego in a way that it is left in a state of acute distress and helplessness [*Hilflosigkeit*].

In current psychoanalytic literature, the term 'traumatic' refers to floods of emotional charges that give rise to feelings of helplessness or agonising despair (Roussillon, 1999). Traumas are measured by the quantity and the quality of the disorganization they generate rather than by the nature of the event that precipitated them (Marty, 1990).

Traumatic after-effects have been discussed at length by psychoanalysts of such different orientations as Bion (1965), Winnicott (1971, 1958), Aulagnier (1975), Green (1983, 1993), Roussillon (1999), Botella and Botella (2001), Fonagy *et al.* (2010), Bohleber (2010), Levine *et al.* (2013). Incapacities in representing, symbolizing and mentalizing have been considered. However, I think there are still some specific points that invite further investigation.

One key issue relates to the possibility of describing more accurately the processes and dynamics that contribute to the repudiation of traumatic experiences from the memory network, preventing these experiences from assuming a meaning as part of a patient's historical reality.

One further point concerns somatic events that often accompany or follow phases of traumatic turmoil when patients lose their accustomed frames of reference as diffuse anxieties, fears of breakdown and self-aphanisis dominate the psychic scene. This configuration raises several questions:

1. Given that the orders of the somatic and the psychic are subject to different laws, can somatic disturbances that follow or accompany traumatic upheavals be regarded as their after-effects
2. Can it be argued that somatic events bear some traces of these traumatic experiences
3. If so, how can the situation be understood in terms of the various factors involved

## 'In the absence of memories'

Since 1900 in Chapter VII of the *Interpretation of Dreams* and four years earlier in his 'Letter 52 to Fliess' (6.12.1896), Freud referred to inscriptions of all that an individual experiences in different mnemonic systems, according to different modes of classifications.

After the first year of life early sensory–motor impressions and affective experiences can be reactualized in later life, even if what first stimulated them is no longer present in reality. With the passing of time, due to

 

cathexes and counter-cathexes, the reproductions of early experiences acquire more and more solidity in mental life, relating in complex synchronic and diachronic associations. Any new perceptive stimuli are transformed into representations if they are integrated into the networks of previous memory traces.

In Freud's conception insofar as bindings concern the preconscious system, whatever has been inscribed can be recovered as a memory. This is not the case for the inscriptions in the system of the unconscious, even if at times Freud refers to mnemonic images. Memory traces here do not consist of reproductions of what has caused them; these memory traces act mainly as mediators that facilitate certain trajectories in mental functioning.

When the quantitative magnitude of the perceptive stimuli is such that their excessive weight on the mental apparatus impedes the possibility of it being tamed, the establishment of links with previous memory traces is not possible. These stimuli remain unaltered and are either compulsively repeated with the aim of wearing out their disorganizing effects, or they are negativated through decathexes that lead to their eradication. Both processes suggest that the ego is unable to contain, elaborate and transform the traumatic elements.

In considering situations in which traumatic experiences are kept outside the memory network while the psychic scene is dominated by compulsive repetitions, we are confronted with a paradox: the presence of what is absent. What instigates the reproduction is a 'hold' on whatever asserts its presence in the psychic apparatus, even if it cannot draw on any specific memories. The 'coming back to' that characterizes the process is based on a 'grip' on what is repeated, although what returns cannot find any place within the memory field. Mental and behavioural trajectories that are devoid of recollections[2] discharge excitations caused by the factors that activate the compulsion to repeat, while also indicating an impetus towards specific situations the meaning of which remains inaccessible to the mental apparatus.

Insofar as the absence of memories obstructs inadmissible representations, repetitions also present another paradox: that of a protective procedure that is hooked on to what the ego is seeking to avoid. Through the repetitive procedure, the psychic apparatus holds on to what is unpleasant or traumatic, while keeping it devoid of memories. Thus, an unconscious choice 'not to separate', 'not to lose', prevails and for some analysands even minor changes in their psychic economy are experienced as 'losing pieces of their self'.

For cases in which nothing is repeated and nothing is remembered we can say that 'there is nothing to hold on to' and form the hypothesis of an absence of, or deficiencies in an internal containing setting that preserves and sustains the stability of cathexes on certain psychic morphemes,[3] i.e. on constellations of representations and affects.

[2]A.Green (2000) has used the term 'amnesic recollection' to describe actualizations of a past that are not recognized as such (p. 108).

[3]The term comes from the Greek verb 'morphono', which means 'to provide a form' and it refers to elements that have taken form in various connections.

 

The concept of an encompassing structure that Green (1993) proposed as the positive outcome in the work of the negative specifies, I believe, Bion's (1963) notion of the container and Winnicott's (1958) holding function.

Green stressed that in the period following the post-natal mother–child separation, the imperative of the mother's real presence slowly subsides. When the mother–child relationship gives the child the assurance that the mother's containing capacity is not lost, the presence of the primal object is negativized in the child's psychic life by the operation of its negative hallucination. What remains are traces of the contours of a space empty of the mother's presence, which correspond to an impression left by the maternal hands embracing the child's body. The empty containing scheme thus leaves room for a number of substitutes that thought processes can install and use in place of the mother's presence. But, for this to happen, the encompassing structure must be internalized. The modes of activating the turning-upon-the-self mechanism, in my view, provide indications both of the maternal cathexis and of its acceptance by the child, leading to the organization of the young ego's capacity to hallucinate the satisfaction of desires.

Winnicott (1956, p. 303) indicated an even earlier setting provided to the child before the establishment of drive patterns. He called it "primary maternal preoccupation" and considered that this covering setting is needed for developmental tendencies to start to unfold and for the child to feel as the owner of sensations appropriate to this very early phase of life, which he called the phase of "going on being". Winnicott: As said there is no value whatever in describing babies in the earliest stages except in relation to the mother's functioning.

If the mother–child relationship encounters obstacles – for example, when separation and differentiation of inner–outer are impeded – the inner setting either cannot be established or, if it has been partly internalized, lacks stability. The child remains dependent on the external object, while the unfolding of object- and self-representations, of emotional unfolding and of symbolic thinking shows various defects.

The meaning of Bion's -C finds one of its applications here.

Deficiencies in the establishment of an inner setting involve insufficiencies in mental boundaries. However, these boundaries are necessary for the emergence of differentiations, which are the precondition for complexification in human mental development, even if we keep in mind that the syntax of the preconscious is subject to oscillations in binding and unbinding procedures.

A defective mental setting also has a negative impact on the capacity to watch over the self, a functional process related to the internalization of maternal preoccupation as expressed in attitudes of vigilance (Potamianou, 1992). Internalization of maternal vigilance is an indispensable factor for orientating cathexes on the self and, consequently, also on thinking.

In the realm of processes that favour the fading of mnemonic traces, the failures of a primary object that is felt by the subject as being a duplicate of the self must be taken into consideration. When tendencies towards non-differentiation remain strong, the object's deficiencies cause fissures and gaps into which the subject's ego itself is drawn. In such cases, the mental field

 

may remain clear of the painful and anxiety-inducing experience of the object's failings, but violent repetitive impulses of turning against the self can be regarded as traces of a fusional functioning of the subject with the maternal object. Aulagnier's work (1975) with psychotic patients has shown that if subject and object are not differentiated some sensory impressions can be figurated, but they cannot be transformed into memory traces or signs. The inscription of perceptions remains untranslated.

When fading of memories breaks the continuity and the unity of the ego, a further factor to consider is the intensity of emotional turmoil that has to be negativated because of the pain involved. What must also be taken into account is the persistence of situations that produce emotional charges. Their tenacity renders the flux of excitations intrinsically traumatic, perforating the protective shield and disrupting the subject's network of feelings and thoughts. The traumatic vein can long remain concealed behind various defensive configurations, as even a tormented ego, unless it abandons itself, may assemble whatever forces are at its disposal in order to find ways of dealing with damaging tensions. Various strategies are deployed to limit the traumatic impact, including splitting, exclusion of parts of psychic reality, narcissistic encapsulations, decathexes and so on, but in some cases the ego remains open to fissures and its unity is broken under the primacy of raw excitations. The traumatic potential manifests itself with a violence that shatters mental life, damaging representations and affective configurations and leaving the psychic field devoid of positive experiences. Patients refer to such situations as experiences that crush or trap them. They complain about gaps in memory and breaks in the continuity of thinking. When such experiences occur, either momentarily or more persistently, counter-cathexes and dream activity become inoperative.

Often various somatic events and disorders are concurrent with psychic defects; in cases where nothing is remembered and nothing is repeated, they introduce the idea of the body as the only channel through which what cannot otherwise be elaborated becomes manifest.

## Concerning two analytic cases

### *The case of Mrs A*

During the first period of her treatment – an analysis four times weekly – Mrs A, aged 38, spoke about her tempestuous, vituperative clashes with her husband. After what she called the "battles", she would fall asleep exhausted. However, she rejected the idea of a divorce because, as she put it, the idea made her "lose the ground from under her feet". Mrs A felt she would then sink into nebulousness and confusion.

Connections with her childhood and severe tensions she had experienced very early due to her parents' constant quarrelling, cries of hatred and violence, were either rejected or suppressed. Links could not be established. The patient complained about a void in her head and difficulties in thinking. She was despairing and doubted whether she would continue her work with me.

 

After this initial period, she fell into persistent silences during the sessions. The only matter she referred to was her suffering from intestinal spasms. She said these symptoms had started when she was still a child and had initially been diagnosed as irritable bowel syndrome and later as colitis.

During one of the sessions, I connected her silence with the restrictive impact of the spasms, as well as her retreat into sleep. I suggested that her spasms could be related to being here with me while she wanted to keep her distance and abstain from our communication. The patient answered by referring to an image which, as she said, sprang up: "an embryo that is calm as long as the outside world does not intervene". She added: "When I feel your presence, I lose all sense of calm because I imagine a clash. Yet, when I leave here, it is as if I sink into non-being."

I understood this reference to the repeated abolition of representations and perceptions whenever she left me as a loss of all her inner bearings when the object ceased to be present. She was lost when contact with the object was not perceptually available to her. Under these conditions, the intestinal spasms were an affirmation of her "being", while also serving her retreat from an object which was not at her disposal. But these somatic manifestations could also pin down energy that was in danger of draining outflows.

However, my patient's compulsive acts of participation in conflicts and clashes indicated to me that, at another level of functioning, repetitive processes were not devoid of erotic and aggressive strivings, which related to moments when Mrs A felt excluded from the parental relationship, which she found immensely exciting because of its violence. Elements of her phantasy life were present here although memories were lacking.

I told her: "You mentioned sinking into non-being when you leave here. Could we say that for you 'feeling alive' is related to clashes with me, as well as with your husband, as long as we are with you?" In using this intervention, I definitely placed myself on a level far away from the attempts to destroy the object and the self that became evident when the patient mentioned sinking into non-being in my absence. At this point in the therapeutic process, I also refrained from relating our present exchange to her past, as I felt that it was important for the patient to make contact with what was actually happening in our relationship.

The patient said she could not understand what I was telling her. And anyhow what was the use?

I intervened again: "Is it possible that whenever you witnessed your parents' quarrels as a child you wanted to withdraw by snuggling into bed, away from what was disturbing you, but at the same time you were far from happy to be restricting yourself from taking part in their conflict? In your current relationship with your husband, participation is achieved. The same applies when you think about your relationship with me. As if the actual quarrelling keeps alive the time when you imagined you could take the place of one or other of your parents in what was happening between them."

"Ringing no bells" was the answer I got from the patient, in a sad tone. But a few weeks later, she spoke of "some thoughts … like a memory that

 

suddenly had come back". She remembered listening to her parents' "atrocious quarrels and swearing", while imagining what she would have said or done if she had been in either of their places. She would then start feeling dizzy and felt as if her head were about to explode. She would find refuge under her bedclothes, pressing her head with both hands. Despite finding the experience uncomfortable and painful, she admitted that she would wait every evening for the shouting to start.

My construction – which was a proposal attempting a synthesis of what was actualized between patient and analyst, as well as between Mrs A and her husband – was first met with negation: "Rings no bells". Later came the recollection that gave 'flesh' to the intervention and included past body sensations, like feeling dizzy, feeling that her head would explode.

If what 'was remembered' following what I had said is considered as a reconstruction by the patient of her own past, then my intervention, which attempted to reconstitute part of the infantile history in its reality and fantasy aspects, was not passively accepted. Mrs A integrated it in a production of her own, speaking of "a memory that suddenly came back". The scenario sheds new light on Freud's account of conviction (1937b, p. 266), as far from staying "an incomplete substitute" conviction here produced a complete result[4] : a recollection.

Gradually, we were able to review the history of how, during the years of her marriage, the quarrels with her husband kept beyond memory and consciousness the quest of the Oedipal adventure and the phallic claims, but also, and, especially, the destructiveness towards present and past objects that was then turned against the self. Falling asleep after the quarrels provided protection through a mode of distancing and closing up to the external world, but also to the inner world, as for a long time the patient would say that she was "closed to dreams". Narcissistic implications of the 'closing up' were elaborated and worked through.

In the meantime I thought that her recollection of the scene with her parents indicated that Mrs A was taking possession of her inner space in which representations and affects had a place. But it was clear that the functional disorders, i.e. the range of intestinal spasms, were not integrated into mental life. Therefore, it was up to the analyst to try and give a psychic status to the raw energy charges by means of constructions aimed at establishing a link between somatic discomfort, pain and psychic suffering. In this optic I thought the spasms could eventually be a trace left by a non-integrated traumatic relationship. I chose to interpret them as an analogue of the psychic restrictions that resulted from the patient's attempts to retreat from object-relating and identifications. The emptying of the bowels and the emptiness of ideas and affects were linked to impulses to reject objects and to their final aphanisis, which led to motions of turning against the self.

[4]Neuroscientists nowadays agree that external stimulations are submitted to internal connotations which are anchored in our memory. The external stimulus is an essential component in the process of perception, but subjective choices concerning what is perceived, and what will be made of it, are even more decisive. Perception and memory are in constant cooperation (Delorme and Flückiger, 2003). This is what Winnicott (1971) showed when he combined finding and creating.

 

Mrs A associated by referring to something her mother and grandmother had talked about – the fact that when her mother was feeding her, she, as a baby, would push her away with her hands and feet. This behaviour, inexplicable to the two women, reminded the patient of her childhood conviction that her mother had never recovered from the loss of a previous child, a still-born boy. "Was I pushing her away because I felt she did not really want me as I was a girl?" asked Mrs A, crying. "Did she ever want another child? … I never thought about our relationship from this perspective. I always thought she was hostile towards me because of my relationship with my father."

In the following sessions, Mrs A spoke about her tears that "dragged out" her sorrow and despair about the "Mummy" she never had: the caring, all-embracing ideal mother for which she had hoped. But at the same time she felt as if her whole body were shrinking away from something frightening and dangerous: a mother alien to her.

## *The case of Mrs B*

Opening the door to a patient who had requested an appointment, I found myself facing a slender woman who said: "Good morning" in a low, flat voice, and looked at me in a distant and reserved way. After while she said that she had come because some friends had given her my name.

Then there was a silence. After waiting a little, I said: "Yes?"

A few seconds passed, and then the patient said that she was, as always, feeling ill at ease. Silence again. I asked: "Do you mean you never feel well?"

The patient replied: "Yes, somehow … I don't know. Everywhere …"

There was another silence as I wondered whether "everywhere" meant in every place, under any circumstances, or everywhere in her body and her mind. I decided to ask: "Everywhere refers to where?"

The patient said that she did not know how to "speak" about things. "I don't have a very good sense of things, I'm not really interested. I do things but they feel like heavy loads I have to bear … I always feel tired. Perhaps because of my hole." When I asked about this, Mrs B explained that a few years ago she had had a peptic ulcer: "It's not active any more … Actually I smoke and I eat too much." Then she asked: "Have we finished? May I go?"

I told her that I would actually like to spend some more time with her in order to understand better why she always felt unwell. Mrs B answered: "Well, what can I say…? Okay, I'll call you."

A few days later she called, and we began to work together face-to-face twice a week for the next two years, in a way I thought about as a therapy devoid of tonus, except for around holiday periods, which seemed to distress Mrs B. But again she did her best to avoid the subject. Throughout this first period of work the patient's discourse was impoverished and elliptical, with contradictory elements of which she seemed to be unaware. She sometimes referred to the ulcer, always calling it "my hole". If I asked a question, she would reply: "I haven't thought about it" or "I don't

 

understand". She went on relating details of everyday events or activities, or simply remained silent as if she had lost interest in what was going on around her. If asked how she felt about something, she would reply: "I'm not sure" or "I can't say … There are no thoughts. I don't feel anything".

I often wondered if I was not in danger of being completely immobilized, trapped under the heavy load of an operative type of thinking. I had the phantasy of my patient as a compact mass that might engulf me.

One day, when the atmosphere was particularly heavy, Mrs B complained of having difficulty breathing. I reacted with an intervention that surprised me for both its immediacy and its content. I said: "Like somebody who is imprisoned, or perhaps like an embryo trapped in a mother's womb, as if no opening is available?"

While I was thinking about my countertransference reaction, the patient murmured: "Perhaps", but in the next session she referred to herself as a citadel with no exit. She added that huge blocks were holding the citadel together. "Talking to you or describing feelings means separating the blocks. But then some of them may be lost." A few sessions later Mrs B spoke about the dermatitis she had suffered from during the earlier years of her life. She had no memory of it, only her sisters' comments about it.

I invited her to comment on the Greek word 'derma', which means 'skin'. The patient reacted by saying that the skin covers and protects the body. Then she added: "I am thinking that when my skin was ill, I could not bear to be touched."

Deciding to leave aside all the other aspects to which her answer might refer, I said: "Something was missing, then, in terms of protection and contact, as when I disrupt the continuity of our sessions. Perhaps you feel that I am responsible for the painful feeling that there is a void in the place of my presence? And therefore you think better that nothing here should touch you, as before with the dermatitis."

Mrs B's eyes were full of tears: "I couldn't sleep; I couldn't play. My body was itching. And mother was always after me with medicines and creams … No room for peace. She was devouring my space and my time. And yet there was no peace if she was not there either."

From that point onwards, we were able to work on what "separating" meant to her. It was never an absence or putting things aside. It was only a terrifying loss.

Two series of associations followed. One concerned her difficult labour with her baby daughter. This related to what her two elder sisters had told her about her own very difficult birth. Her mother had been in labour for many hours with terrible pains, but the gynaecologist had refused to perform a Caesarean section, insisting on a natural birth. Both mother and baby were in a very bad condition when the baby was delivered. (The patient used the word "liberated").

The second sequence of associations concerned what was reported – again by her sisters – about the period immediately after her birth. For the first few months her cradle had been placed in a room next to the kitchen. The door of the room was always closed and the baby was left alone, crying

 

throughout most of the day and night. A few weeks later, after this exchange, came the patient's demand for an analysis.

For a long time Mrs B kept asking herself what her mother's wish had been: not to let go during birth because separation was unacceptable? Or to cover the reality of not caring for the baby, as when it was left alone crying? Moreover, why was the birth of her own daughter so difficult?

"Unbearable, tormenting thoughts," said the patient, "which I can't get rid of." During that phase of analysis, the patient reported dreaming about dismembered bodies and wounds that kept spurting black blood.

The ulcer's "hole in me", as the patient said, was further worked on, as gradually it became evident that under certain conditions the absence of the external object erased any inner reference to it, thus creating images and feelings of a void.

Towards the end of her analysis, the patient said: "Whenever my thoughts are stuck, I ask myself: why this self-mutilation? It took me a long time to accept that it was my choice not to let myself sail on the sea of my thinking … Murderous self-lacerating thoughts about keeping in touch or turning away and abandoning."

## On gaps and breaks

There is certainly a great deal to be said about both cases. But for the purpose of this presentation, I will restrict my comments to two points: compulsive repetition and somatic symptomatology.

In the case of Mrs A, the difficulties in making connections, as well as the voids and the gaps in thought processes, indicated that the representational tissue was not at all firmly woven and that symbolic substitutions were scarcely available. The quarrels and clashes with her husband – followed by strategies of retreat – gave evidence of compulsive repetitions that actualized situations and object relations from the past with parallel appearance of some somatic symptomatology. Such repetitions were not present in the case of Mrs B. Her thinking processes suggested the image of a frozen land while the patient was engulfed in suffering and despair. On the somatic level, her earlier dermatitis and the more recent ulcer seemed to have acted as axes of somatic bindings that prevented any further disorganization.

Following the configuration presented by the two cases, what we know about compulsive repetition processes becomes more evident: they necessarily refer to what remains active psychically, even if it is absent from consciousness. Links between thought and action are broken and what becomes important to verify are the circumstances and modes of intervention under which links can be revived, making it possible to work on the repetitive actualizations so as to transform them into 'agents of change' (Potamianou, 1995).

In cases where, as Freud indicated, even repetitions are absent, the question arises as to whether not only certain representations, but also the memory traces that support them, are disorganized or have never been constituted, in which case the psychic apparatus can only retain the raw

 

excitations in the form of tensions. These tensions affect the psychosomatic unity, and the soma often becomes the channel of their outflow.

One more point to consider is that, in spite of their differences, the two cases mentioned have a common denominator: the difficulty in forming representations that can transform and manage excitations along the mental line.

In recent years, psychoanalytic publications have increasingly drawn attention to the problem of the unrepresented or the unrepresentable[5] that result from an event when the patient's psychic apparatus was unable to encompass it, or when cathexes had to be withdrawn because of emotional factors that imposed unmanageable excitations leading to the failure of the axis of representations.

In a recent publication (Levine *et al*., 2013) in honour of A. Green – the pioneer who worked on manifestations of negative dimensions in psychic functioning – it is evident that all authors, in one way or another, refer to gaps, breaks and 'states of absence' on the lines of the perceptible and the representable, verified during clinical praxis. In my view, the issue relates to the problematic of mnemonic traces as the constitution of representations requires the mutation of elements provided by perception through their connection with networks of traces already present in the different memory systems.

In the *Language of Psychoanalysis,* Laplanche and Pontalis (1973) note the specificity of the term 'memory traces' as conceived by Freud. They point out that, although Freud sometimes uses the term 'mnemonic image' as a synonym, traces are not reproductions of the thing because they undergo modifications by virtue of being linked with other traces of memorized elements. Moreover, traces can be reactualized in one context[6] while remaining inaccessible to consciousness in another. Therefore we are not dealing with inscriptions in the sense of precise registrations or impressions in the sense used in empirical theory.

Obviously, the dynamism of memory traces presents characteristics that help to explain (a) why Freud held that recovered memories have fewer sensory qualities than perceptions, and (b) why he refers to traces as arrangements of facilitating pathways (Freud, 1895b), which, I think, confers on them the value of attractors in psychic functioning.

In this perspective, psychoanalytically speaking, the issue concerning memory traces is not whether reference is made "to a less complex level than that of representations, or whether there are pre-psychic inscriptions" (Levine *et al*., 2013, p. 5), given that traces always participate in mental dynamism and in shaping representations. Their disorganization or non-organization is of paramount importance in the development of mental life.

[5]Of course we have to bear in mind that an event, that could not be understood when it happened, may become understandable retrospectively because its inscription is drawn into a network of thoughts that allow its representation, giving it the quality of something 'virtually possible' to be understood and elaborated.

[6]One example may be what happens during an analysis where traces are actualized in scenarios and in linguistic constellations determined by the particular conditions of the analytic situation.

 

Recently, S. Botella (2010) introduced the idea of the memory of the id conceived as concerning a very primitive layer of traces that do not constitute inscriptions that can be recalled.

Following this line of thought, we can accept the metaphor of the id – conceived by Freud as open to the soma – as the basic psychic 'topos' in which sensations and impressions stemming from various sources accumulate. If the insertions occur at very early periods of life, they leave deep marks due to the action of raw urges. But though active in ways that condition the economy of the psychosoma, these marks escape mutation into more evolved forms that can assume the quality of recollections. Mrs A's early and persistent intestinal disorders, as well as Mrs B's dermatitis, bear the marks of sensations and impressions that an immature ego could not cathect so as to form elements that could be integrated and used in the patient's mental life. Of course, in other cases somatic symptomatology is the result of a regressive current that develops later following drive defusion and degradation of the primary masochistic kernel.

Be that as it may, and taking into account the fact that hypotheses concerning very primitive levels of our psychic organization retain an important unverified and possibly unverifiable potential, what can be said with certainty is that, whenever a traumatic situation acts as an operator submerging the mental field, it can also act as a facilitating agent for the course of somatic disturbances.

## Sounds of the soma

In thinking about somatic involvement in conflictual and traumatic situations, it is clear that in early childhood the immediacy of somatic and psychic interaction is strongly apparent. The colic of the first three months of life, the insomnia of the first six months, regurgitation, as well as the anorexia of the second six-month period have provided ample evidence of this (Kreisler *et al*., 1974).

When emotional turmoil occurs before speech has developed, somatic reactions are consonant with psychic upheaval. With time, the consonance diminishes. However, whenever during the course of life distressing upheavals, resulting from failures, frustrations, disappointments, prohibitions etc., disrupt the protective shield against excitations and the barrier of psychic defences, a variety of somatic reactions and disorders can occur alongside the forceful vibrations in mental processing and/or behavioural disorders. Biochemical changes, the malfunctioning of mechanisms that regulate appetite, sleep and body temperature, breaks in the equilibrium of the immune system, are some examples of somatic manifestations that generate debates concerning to what extent and in what ways somatic events can be conceived as related to mental turmoil, i.e. to conflictual or traumatic situations. Under what conditions can they be understood as equivalents of mental occurrences, for example, of crises of anxiety as Freud (1895a)stated? Given the differences in organization and functioning between the psychic and the somatic orders, would it not be more logical to consider mental and organic symptomatology as randomly converging elements?

 

Certainly the interactions between the mental and the organic require further study. In 1928, writing on Dostoyevsky, Freud presented his difficulties as an abnormal organic discharge of mass of excitations that could not be treated mentally. Nowadays, neurobiologists (Vincent, 1986) and psychoanalysts have agreed that anything experienced by a living being has an inscription[7] on the psychosomatic unity. Modes of inscription vary within the orders of the mental and the somatic, but the dynamics and the economy of both domains are influenced by them. The observation of very young children, as well as the treatment of adult patients, verifies the participation of both orders in emotional and affective manifestations. After all, the characteristics of the two orders may differ, but both have been issued from the transformational continuity of the psychosomatic unity, even if this continuity is not linear, but allows for oscillations and variations in time according to the narcissistic equipment and the early developmental history of each patient.

When the soma stops being silent, repeatedly and under conditions that present similarities, even if it may seem excessive to speak of a 'memory of the body' as some do, it would certainly not be inordinate to call attention to sensitivities that become manifest following psychic commotions in a body libidinally cathected, or in a soma mainly determined by the biological and estranged from the activity of the drives.

Even if the differences in level and the specificities in functioning make it difficult to adhere to the thesis of a direct and inevitable cause–effect relationship between psychic events and somatic dysfunction, the impact of intense emotional states on the 'body/soma' configuration cannot be ignored. Drive defusion and degradation of the primary masochistic kernel, which are often their result, lead either to massive fixations of the libido on objects or to their abandonment, while destructivity is running free. Under these conditions mental anti-traumatic strategies become shaky or fail, and drive economy is altered as energy charges may lose all their qualifying denominators. In that case the activity of crude disqualified excitations on the organic level can be also understood in terms of the process Bion (1962) conceived as psychic evacuation.

Much earlier Freud had announced that, when drive defusion prevails, the desintricated forces do not stop operating in non-specified fields.[8] By introducing the notion of a psychic apparatus open to the body on the level of the id, Freud gave us the possibility to reflect on the possible consonance of conflicts and turmoil on both levels: somatic and psychic. He spoke (Freud, 1915) of processes that start in the soma and produce stimulations which can be 'taken up' by mental formations, but in 1920 he noted that we know very little about their modifications on the psychic level. Years later, P. Marty one of the founders of the Paris School of Psychosomatics, repeated the statement, saying (1976, p. 151) that we know very little concerning the question: "how is the somatic transformed into psychic". But with the passing of time, the work of psychoanalysts and of psychosomati-

[7]An analyst would add: In counteraction to tendencies towards extinction.

[8]See Freud, 1937, p. 243.

 

cians, based mainly on clinical data, confirmed that excitations are metabolized through representativity and meaning. Both relate to what can be bound between ego and objects, as well as in the ego itself when psychic morphemes come under the organization of the primary masochistic kernel and under the aegis of the pleasure/displeasure principle.

On the opposite when quantums of energy cannot be attached to an object – be it the ego itself or the body – so as to acquire or hold the status of drives, i.e. of movements of desire or retreat which sustain autoerotic and alloerotic cathexes, the road of regression is open, eventually leading to somatic implications that may take the form of organic disturbances. Somatic experiences are, then, usually registered as free of psychic meaning. But their marks can be found in tensions and sensations induced by their emotional repercussions. The turmoil they often entail affects the psychosomatic unity as a whole, running through its different orders.

Concerning the convergence between traumatic situations and somatic illness, an important factor to be taken into account is that a somatic illness may act as a binding process,[9] ultimately leading to ego reorganization, whereas in other cases a progressively disorganizing evolution becomes evident (Fain, 1992, 1994; Marty, 1976, 1980). Of course illnesses are relevant to a great variety of factors. They involve bio-organic processes, the exact impact of which across the psychosomatic spectrum has often yet to be identified. But psychosomatic praxis leaves little doubt as to the fact that, when the mental constellation proves unable to assume the charge of transforming raw charges, the activity of charges that escape mentalization may invade the valley of the organic.

Ferenczi recognized the tragedy inherent to this situation when he stated that: "Instead of falling ill mentally, I cannot but destroy or be destroyed in the depths of the organic[10] ."

## Some thoughts concerning technique

Confronted with a wide range of disorders that are nowadays no longer centred around desires and prohibitions, but include voids in objects, gaps in identity formation, compulsive repetition of elements of reality in daily life or in dreams, analysts have to consider a broader horizon of psychoanalytic praxis[11] that corresponds with inevitable changes in the use of the classic psychoanalytic technique. They have to work not only on repressed material, but on obliterations, erasures and ruptures that indicate defects in mental functioning and massive reductions in mental processing.

As the conditions required for the application of the traditional method are lacking, much has been written about new approaches to be developed concerning the analytic setting and the analyst's interventions and attitudes.

[9]See Potamianou, 2002.

[10]Referred to by Pragier, 2012, p. 749.

[11]I am using the term analytic 'praxis' because it covers both the classic psychoanalytical method of work and parameters introduced in the treatment of non-neurotic patients.

 

I do not intend to review here the many techniques that are actually used. I only wish to point out some modes of approach I consider to be necessary prerequisites for the therapeutic endeavours with patients whose psychic space is exposed to overwhelming excitations and whose mental life excludes the pleasure principle due to the activation of primary defences that alter the psychic organization. With such patients, questions pertaining to resexualization and reobjectalization become crucial, as libidinal disqualification and decathexes characterize their psychic processing.

Under such conditions, an approach for which I have introduced the term 'optimal seduction' (Potamianou, 1992, 2001) is anticipated to reintroduce an erotic tonality into the patient's mental processing and object relating.[12] The analyst invites the patient to reflect on some of his/her psychosomatic experiences and actions, exploring whatever is felt as unbearable, to be excluded from the psychic scene. Attempts are made to prompt the patient's interest[13] in his own psychic functioning by underlining some aspects of the patient's references to what he is living through; for example, by showing a patient that the cohesion and continuity he feels he is lacking can be found in what he/she compulsively repeats. Such interventions by the analyst may produce uneasiness and negative feelings for the analysand as they are unfamiliar, but these reactions are counterbalanced by the familiarity acquired by the analytic setting through the regularity of the work and the analyst's presence. Thus, optimal seduction in analysis combines familiarity and strangeness.

The situation can be compared to the early life period described by J. Laplanche (1987) when some messages of the mother sound as enigmatic and unfamiliar to the very young child. The child's immature ego cannot interpret them but, as they are emitted in the familiar maternal context, their effects are not disruptive for the child. Excitations due to what is not known are registered in a setting that maintains intimacy. Therefore, on the condition that the mother figure and the maternal representations do not induce over-excitation, the unfamiliar messages are solicitations to the opening of thinking and experiencing.

In the framework of optimal seduction analysis may reveal and explore what was never encountered, never known before. Anxieties raised by what was previously unknown – barred from psychic reality despite being present in patterns of compulsive repetitions or in certain character traits – abate when pleasure is found in the processual flexibility and the flow of associations. Desires can emerge.

It can be argued that the solicitations introduced by this approach may constitute invitations to subtle enactments whose unconscious meaning may escape the analyst's awareness. Such a possibility cannot be excluded.

[12]In the *Three Essays on the Theory of Sexuality* (1905, p. 223) as well as in *the New Introductory Lecture* 33 (1933, p. 120) and in the *Outline of Psychoanalysis* (1940, p. 188) Freud refers to the first seductress, usually the mother, as the person who arouses the child to life and to desires, preparing it for the later intensity of drive urges. Similar solicitations that change the traditional attitude of analytic neutrality are necessary when diserotizing processes prevail in the patient's psychic field.

[13]This approach differs from the active technique by which Ferenczi (1924, p. 237) urged his patients to produce fantasies.

 

However, with an ongoing self-questioning, it is hoped that the analyst's understanding of possible countertransference implications will safeguard against this danger.

The optimal seduction approach is, I think, particularly useful with patients who keep the pathway of somatizations wide open. Here the analytic work is often impeded by severe restrictions of the patient in the capacity to represent, by anaemia of feelings and fierce opposition to regression. The patient's discourse usually stays close to narrations of somatic events that are viewed as accidents or as simple occurrences in the course of life.

The analyst is then called to focus his efforts on weaving a web with filaments that can stretch over the splittings, extending over the divided parts. As one patient said: "Until now I couldn't join together the aspects of my experiences. I couldn't see where I was standing. Now my dreams show sectors that are no longer separated; spaces in which I can move around ... I believe I was keeping things apart because one of my eyes was looking in despair at what the other eye saw as marks of a victory."

Through 'combining' and 'connecting' interventions, the analyst brings together elements that the patient is keeping apart, trying to transform opposed and mutually alien pressures (experienced by the patient as unavoidable constraints) into the recognition of a process in which the patient is involved, both as an active agent and as someone activated by the drive forces.

What must be taken into account here is the necessity for a thorough evaluation of the dynamics active in each patient.[14] Cases that present somatic symptomatology do not always remain estranged to verbal signifiers. As a matter of fact our psychoanalytic horizon is full of patients that run on two lines: the line of mental formations – which can be more or less precarious, but are not missing – and the line of somatizations which are solutions (Smadja, 2008) for excitations the mental line cannot elaborate. Somatic symptomatology *per se* – with the exception of hysterical conversion phenomena – is devoid of symbolic meaning. It may though have a heavy affective tonality for the patient and may acquire meaning through the analyst's interpretations and/or constructions.

Of course, it is clear that neutrality is replaced here by more active attitudes that generate dynamic oscillations in the analyst's way of thinking, as well as moments of alternation between free-floating attention and vigilance.

Evenly suspended attention favours formal regression, which facilitates access to unconscious processes. But, when the analyst is faced with fixations to traumatic and disorganizing excitations, with compulsive acting against the self, repetitive situations of seeking out danger, or

[14]The preparation of analysts able to acknowledge the complexities of the psychosomatic approach should, I think, become one of the main preoccupations in the elaboration of psychoanalytic training programs, as analysts are expected to deal with problems that concern the psychosomatic unity. The fact that psychosomaticians often present their work by referring to extreme situations must not obscure the everyday realities of our work: most often we are faced with somatizations that accompany, or follow, psychic work.

 

representational voids and ruptures of the psychic texture, he has to oscillate between moments when he keeps open the regredient path – thus staying on the path of free-floating attention – while at other times evenly suspended attention is replaced by attitudes of vigilance. I have considered (Potamianou, 1992) the analyst's vigilance as relating to the protective function envisaged by Freud when he referred to the ego's considerations for safety (1940, p. 193).

Usually the 'watching over' function is thought to belong to the superego that oversees the ego from which it hasint separated. But as Freud stated (1940, p. 206), as long as the ego works in harmony with the superego it is not easy to distinguish between their manifestations. I think this concurrence between the two agencies corresponds to moments of strong drive intrication, when the ego in concordance with the superego watches over what it can do for itself to avoid being invaded by anxieties or self-destructive impulses, while at the same time supporting its creative capacities. As a patient said: "Now, I know how to protect my joy."

In opting for the need to oscillate between evenly suspended attention and moments of vigilance while working on certain cases, the analyst introduces differentiating elements into his/her way of hearing and interpreting, hoping to establish a reciprocity of exchanges in which differentiations will have a resonance in the patient's psychic functioning.

As concerns prerequisites for the development of analytic work, another point relates to the analyst's endeavours to prepare the way for the establishment of links between somatic symptomatology, psychic processes and relational exchanges. Somatic symptoms or sensations can then be used in the analyst's interventions (Potamianou, 2008) as attractors of images and as preforms of phantasies that the patient has yet to develop in order to discover his desires and whatever is driving compulsive repetitions. Somatic fixations and processes that are outside the psychic texture can then be inserted into a representational and affective stream, brought under the aegis of the pleasure–unpleasure principle. A surplus of meaning is given to somatic manifestations that are taken into the texture of the patient's linguistic productions marking a progress in mentalization.

By converting energy charges that evade figuration, the analyst's constructions disengage the patient's thinking from encapsulations and open the way to the recovery of memories or to the emergence of convictions that concern a newly constructed past. Sensations and somatic events become part of a psychic text that is integrated into a myth–historical narration[15] woven during analytic work. The process changes the destiny of quantities of raw charges both in the domain of self-preservation and in that of sexuality. Moreover, in following paths that unveil desires and resistances, the 'encounter' with memories and with choices in transference and in dreams reveals the meaning each subject gives to his own life.

[15]The narration a patient develops during analysis about his/her life may correspond to experiences and events that have really taken place, but these are always coloured and highlighted by underlying phantasies (Potamianou, 1985).

 

This was illustrated by a patient of mine who referred to an infection in her genitals, repeating: "It itches,[16] it hurts." The patient had consulted her gynaecologist, but day after day she postponed starting the prescribed treatment, although she went on complaining about her infection over series of sessions.

At this time in our therapeutic work I thought it would make no sense to refer to the erotic invitation the patient was addressing me, or to the aggressive components relating to her husband, her mother and the analyst, or to refer to her resistance to freeing herself of her symptoms through treatment. So I chose simply to say to her: "It is itching – eating."

After a silence, the patient replied: "Mother used to say that I was eating my guts [a Greek expression that means 'eating myself up'], because I was always complaining ... But I had to do it in order to get her attention."

I said: "And perhaps ... even more?", thus opening other possibilities concerning the relation with her mother and with me.

Silence again. Then the patient said that thinking about relationships made her feel as if she were opening her house to strangers. It frightened her. As she sat opposite me, she opened her hands, showing me that she was actually sweating, and said a headache had started. Thus, I was warned to proceed carefully as the somatic manifestations indicated how unprepared this patient still was to tolerate the introduction of new images and representations, entailing the risk of revealing unknown and denied desires that would be traumatic for her psychic reality.

Some weeks later, the patient had a nightmare. She saw herself swallowing large pieces of meat. She awoke in terror. She felt like suffocating. Slowly, we could then start to work on her fears and her repeated negative reactions to "opening up" to others as having to do with her own greedy fantasies and envious feelings.

At this phase of our work I could call the patient's attention to the 'ananke' which imposes the constraints, thus making of the compulsion to repeat an object of thought, cathected as to its functioning and aims. This entails that the analyst focuses his interventions mostly on the process and less on the content (Potamianou, 1995). If the analyst succeeds in giving to the compulsive repetitions the meaning of an enactment in the transference, as well as that of a wish rooted in the past/present relationship of the analytic couple, then this fatal destiny in human history may serve as an agent of change. Patients become aware that their processuality is infiltrated by the unconscious tendency to avoid transformations of their psychic economy.

Concerning the working on fissures that have to do with various modalities of *splitting*, Freud (1940 , p. 276) referred to ruptures that will only grow wider with the passing of time. But I have chosen to stay close to the old text of *Remembering, repeating and working through* (Freud, 1914) which advises the analyst to direct the patients' attention on the processuality of splittings, trying to keep in the psychic sphere whatever tends to exceed it.

[16]The Greek expression for itching is 'me troi', literally meaning 'it is eating me'.

 

I conceive the work on the various splittings and divisions as the weaving of filaments, which stretch over the splitted psychic area or extend over the divisions between the mental and the somatic.

## A final comment

In tackling the question of certain parameters that have to be introduced in working with patients such as those presented, I fully agree with J.-C. Rolland (2006) who said that often, nowadays, it is the analyst's presence, his hearing and his own internal formulations that take precedence over interpreting. But as much as I believe that this is sometimes necessary to the analyst's endeavours, I also consider that we have to keep in mind the dark zones of omnipotence that may underlie our wishes to do more and more in the belief that this extends the scope of psychoanalysis.

Staying open to new propositions certainly meets the needs of our time. However, it may also correspond to a lessening of insight concerning an obscure core that often determines choices and decisions.

Gaps, ruptures, fading of images and representations as well as compulsive repetitions are not only to be found in patients. Negative countertransference movements often become manifest in connection with movements of negativation of transference in patients. It is certainly not easy to accept that a patient's unconscious demand may be for his analyst just to be there, without any ideas, without the liveliness of reflective questioning. Nor is it easy to acknowledge that patients may long for the analyst's aphanisis as much as they desire the perenniality of his life. But it may be even more difficult to recognize that the incessant activity of our own unconscious cannot be controlled.

Coming to grips with our own fears and phantasies and with our own failings entails the question: how deep is our acceptance of being incomplete and lacking the ability to meet all possible requirements?

"Obscurity is the genius of the night", wrote Christian David (2007, p. 95). I would add that half-light, and at times even darkness, is inevitably related to the complexity of analytic work, which besides the pleasure of the quest includes the trauma of many uncertainties due to elements that will always be missing.[17]

During the extensive work – sometimes arid and barren, sometimes engulfing and overwhelming – with our patients, at times when our own tissue of phantasies and associations seems dangerously close to becoming fragmented, the inner persistence in not giving up the search for the 'alien' in ourselves is, I believe, our only hope of maintaining our psychic mobility. It is also the only chance we have to favour mobility in the patient's psychic life.

To continue the journey until the story of our course in life acquires a meaning is, after all, one of the main requests of the psychoanalytic logos.

[17]After all, each one of us came from a primal scene in which we were not present. The image and the memory of it is something we can never 'possess'.

 

# Translations of summary

**A-mnemonische Spuren — traumatische Nachwirkungen.** Thema dieses Beitrags ist das Problem der a-mnemonischen Spuren. Die Autorin untersucht verschiedenartige Auswirkungen traumatischer Erfahrungen auf den psychischen Apparat, und zwar insbesondere traumatische Nachwirkungen, die Situationen entstehen lassen, in denen vom Patienten nichts erinnert und nichts wiederholt wird. Sie stellt Material aus den Analysen zweier Patienten vor und untersucht, ob es möglich ist, Faktoren und Prozesse präziser zu beschreiben, die das Entschwinden traumatischer Erfahrungen aus dem Gedächtnisnetzwerk beschleunigen. Da Traumatisierungen häufig mit somatischen Störungen oder Erkrankungen einhergehen oder solche nach sich ziehen, untersucht die Autorin anhand von Beispielen, wie somatische Vorgänge mit der traumatischen Verstörung verbunden sein und als Möglichkeiten verstanden werden können, das auszudrücken, was im mentalen Bereich stumm bleibt. Sie formuliert Überlegungen zu den Voraussetzungen der analytischen Arbeit mit Patienten, die den Analytiker mit Rupturen und Lücken im mentalen Funktionieren und eingeschränkten psychischen Verarbeitungsmöglichkeiten konfrontieren. Ein weiteres Thema ist die psychische Ökonomie der Analytikerin im Kontext der Arbeit mit solchen Patienten.

**Huellas amnémicas. Efectos secundarios del trauma.** Este artículo aborda el problema de las huellas amnémicas. La autora considera distintos efectos posibles de las experiencias traumáticas sobre el aparato psíquico y, más específicamente, aquellas experiencias que generan situaciones en las que el paciente no recuerda ni repite nada. Se presentan datos del análisis de dos pacientes, y se explora la posibilidad de ofrecer una descripción más precisa de los factores y procesos que aceleran la desaparición de las experiencias traumáticas de la red mnémica. Dado que, a menudo, estas experiencias se ven acompañadas o seguidas de trastornos somáticos o enfermedades, se examinan algunos ejemplos en los que se considera que los acontecimientos somáticos están vinculados con la conmoción traumática, y se los entiende como canales de expresión de aquello que permanece en silencio en el ámbito psíquico. Se analizan algunas sugerencias respecto de los prerrequisitos para el trabajo analítico con pacientes que presentan quiebres y borraduras en su funcionamiento mental y reducciones de su capacidad de procesamiento. Además, se tiene en cuenta el compromiso de la economía psíquica del analista en el trabajo con este tipo de pacientes.

**Traces amnémoniques – effets traumatiques.** Ce texte est une tentative de traiter la problématique des traces de certaines expériences qui restent hors mémoire. L'auteur pose la question de savoir s'il est possible de formuler avec une plus grande précision quelques idées concernant les facteurs qui favorisent l'effacement de souvenirs, laissant dépourvu le réseau de la mémoire. Les effets que les traumas peuvent avoir sur l'appareil psychique, sont discutés par rapport aux analyses de deux patientes. Est discutée également la question concernant les troubles ou les maladies somatiques qui coïncident, ou suivent, les tourments du mental. Peut-on considérer les événements somatiques comme porteurs de traces d'expériences traumatiques ? Si oui, par quel biais le soma devient-il moyen d'expression de ce qui reste silencieux sur le plan du mental? Quelques propositions concernant les préconditions d'un travail analytique avec les patients qui confrontent l'analyste avec des réductions ou des ruptures de leur fonctionnement mental sont présentées. Sont envisagés aussi certains aspects de l'économie psychique de l'analyste lors du travail avec ces patients.

**Tracce amnestiche: le conseguenze del trauma.** L'articolo affronta il problema delle tracce amnestiche. L'autrice prende in considerazione una serie di effetti che le esperienze traumatiche possono avere sull'apparato psichico, focalizzandosi più nello specifico su quelli che danno luogo a situazioni in cui nulla è ricordato o ripetuto dal paziente. Dopo aver presentato del materiale clinico tratto dalle analisi di due suoi pazienti, l'autrice procede a indagare la possibilità di fornire una descrizione più accurata dei fattori e dei processi che accelerano la scomparsa delle esperienze traumatiche dalla rete della memoria. Considerato poi che gli episodi traumatici sono spesso accompagnati dall'insorgere di disturbi somatici e malattie, l'autrice passa quindi in rassegna alcuni esempi del modo in cui certe manifestazioni di natura somatica possono essere messe in relazione allo sconvolgimento causato da un trauma, e dunque intese come canali di espressione di qualcosa che rimane silente a livello psichico. Vengono infine discussi alcuni suggerimenti relativi ai prerequisiti necessari per lavorare analiticamente con pazienti che presentano fratture e cancellature nel funzionamento mentale, oltre che una ridotta funzionalità dei processi psichici. Tra i fattori considerati a questo proposito sono i diversi modi in cui l'economia psichica dell'analista viene chiamata in causa durante il lavoro con questo tipo di pazienti.

 

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