

# On the edge of representability: memory, narration and oblivion of trauma in the psychotherapy of young victims of abuse and violence

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*Abstract.* On the basis of metapsychological issues on the representation of trauma, this paper investigates how psychoanalysis supports the re-integration of the traumatic event in minors who, as victims of serious forms of violence, see memory as a threat to their defense strategies and are at risk of psychological collapse. What emerges from the experience of the authors is how the most relevant element in psychotherapy for child and adolescent abuse victims is their potential and ability for representation, as well as the intricate connections between external traumatic factors and internal dispositional factors. From a treatment perspective – referring to some of the arguments involved in the debate on changes to the basic model technique according to the internal organization of the patient – the authors suggest a technique that, by respecting the internal time frame of the patient, the fluctuations of transference and psychological functions, alternates between a supporting and an explorative function (especially in cases in which the Ego remains relatively intact) with different patients, or even with the same patient in different phases of therapy. The therapeutic objective is to rebuild a “sense” of an event, which, having broken any logical order, forces the subject into an existential “non-sense”.

*Keywords.* Victim of Abuse, Memory, Narration, Psychich Trauma, Psychotherapy.

“Woe betide you if you dream:  
the moment of consciousness which accompanies  
the awakening is the most acute suffering”.  
(Primo Levi, 1987)

## 1. Introduction

The above mentioned Primo Levi quote stigmatizes the psychological torment of those suffering from extreme traumatic situations with lucid yet dramatic simplicity. Levi strips the dramatic *échec* the victim is trapped in to the core: shelter from suffering or psychological pain cannot be provided by a dream nor by reality. This “constant” experience of the traumatic scene, that never fully abandons them, is typical of Holocaust survivors – but not unlike many other situations of mass trauma. We believe that this psychological impasse, which paradigmatically defines the existence of victims of extreme traumatic situations, may also be found, *mutatis mutandis*, in the experience of children who are victims of pervasive and cumulative traumatic experiences. Similarly, yet not equally, to situations of massive trauma - in which the greater etiological weight in the development of illness can be only be attributed to the exogenous rather than the endogenous factor - in child sexual abuse, the trauma devastates the existence of the victims, and profoundly subverts their development. Sexual traumas introduce an actual existential paradox in the victims’ lives: an aporia at an individual and collective level. It is a conflict arising from the need to dispose of the memory, to share it – even the ethical and social duty to provide testimony of it – and the need to forget. This irreconcilable nature cannot be alienated from the experience of therapy itself, and raises issues on the relevant purposes and treatment strategies on these patients. We do not wish to promote an ethic based on repression, yet we wonder to what extent, in which cases, and above all how, we can

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reasonably deem it possible to reintegrate and subjectivate the traumatic memory (see Moore, 2009; Rosenblum, 2009), without simultaneously neglecting or mortifying the child's will and need to find shelter from the horror.

An unscrupulous use of memory during therapy puts the child at risk of insidious supplementary traumas bearing additional suffering, a threat posed by an actual ab-use of memory. In this respect, the thoughts of Rosenblum (2009) come to our aid, as she illustrates how Holocaust survivors – often destined to lead a “desiccated existence”, a “death in life” following serious trauma – sometimes run an even higher risk in choosing words over silence. Rosenblum questions if, in psychoanalysis, the analyst is always capable of undertaking the risk of subverting this precarious equilibrium, which the survivor sometimes sees as a form of victory over the trauma – albeit an unsatisfying and sterile one. The use of words and subjectivation – overcoming denial and splitting strategies – may in fact trigger unforeseen reactions. Rosenblum therefore ponders the potential psychoanalytical “poros” that may allow a controlled return of affects, permitting the patient to speak of the catastrophe without feeling newly overwhelmed.

On the other hand, we question whether or not such precautions and wariness could also be necessary for child and adolescent victims of extreme forms of trauma and violence, requiring tools that facilitate the re-integration of the traumatic scenario, without having to re-experience it. For them, to remember, departing from secrecy and silence, means to invert their defensive strategies – sometimes actual permanent coping models, with which to negate, dissociate the trauma – and open up to the risk of collapse. This, beyond the desire and need to relieve the child's pain, faces us with the fact that refusing reality is sometimes more comfortable than fully acknowledging the facts and internal implications of the abuse. It also raises the issue of how many opportunities it is appropriate to provide children to tell of their violent history, and how to identify such opportunities. This is why we deem it our duty, during treatment, to seek emotionally tolerable alternatives for the victim, in the hopes of re-building a “sense” to a story, or an event that has broken every order of logic, forcing the patient into an existential non-sense.

## **2. Trauma: psychiatric classification vs. metapsychological comprehension**

Before any considerations can be made regarding the possible psychotherapeutic strategies with traumatized children, we believe it is crucial to provide some points on the concept of trauma, by comparing the diagnostic and classification model, used in psychiatry and forensic psychiatry, with the psychodynamic one. Our professional practice has allowed us to record the many, complex facets of what, perhaps all too unambiguously, we are accustomed to calling trauma. Trauma and its effects are in fact highly variable, often unspecific, and require the use of composite conceptual categories, which enable us to provide the child with individualized attention and care, by respecting his/her singularity.

In this sense, from a medical and psychiatric point of view, we believe that the etymology “trauma” has progressively taken on its current meaning. This tends to reduce a complex phenomenon to an all too nosographically defined and unitary etiology and semeiotic. One risk we observe in limiting our knowledge to the sole comprehension of its classification is limiting our focus to the exogenous aspects of trauma. Another risk is that of quite unvaryingly establishing an inferential link between the cause and the manifestations of the illness, thereby eclipsing any specificities of the person's way of functioning.

Contrarily to psychiatric nosography, psychoanalysis provides an explanatory model of trauma based on the individual's metapsychological way of functioning, providing us with illuminating arguments for treatment. In the psychodynamic model the relevant element is not only the qualitative and quantitative characteristics of the stressor, as much as the individual's development: the child's structure and mechanisms, and the intricate network of relationships between external traumatic factors and internal dispositional factors, which contribute to the determination of the actual results of the trauma. The structure and mechanisms of the Ego, the failure to translate the event into a symbolic register, the psyche's *impasse* in facing the *après-coup*, and the experience generated by the enigmatic correspondence between various elements of the complementary series,

are all crucial issues bearing equally complex economic, dynamic and structural issues between them. These are all crucial for a valid strategy in treatment. “*External traumas*”, Anna Freud (1967) explains, “*are turned into internal ones if they latch on to, or coincide with, or symbolize the fulfillment of either deep-seated anxieties or wishes or fantasies*”. It is because of this affective contiguity (between different areas of the psyche, instances and affective experiences) that traumas, when the event fulfils an inappropriate fantasy at the time, may produce a dangerous “*disruption of the developmental sequence*” (A. Freud, 1967) or generate explosions of panic, dreams of anxiety, nightmares, re-experiencing phenomena. However, the issue that most requires our attention, is the fact that the psychoanalytical model allows us to recognize the specific theoretical and clinical structure of the trauma: it is not only a “breaking and entering wound”, but above all an elision at a representational level, a hole (as claimed by Gerzi, 2005), “*trou-matisme*” (according to the effective neologism of Lacan<sup>1</sup>), a “*lacuna*” (see also Moore, 2009), which corresponds to specific metapsychological effects even before symptomatic ones appear.

### 3. Trauma: representation, memory and narration

According to Freud, trauma, representation and mnemonic functions have always been key concepts in his model of the mind. According to Freud, memory –intended as a continuously reviewed complex and dynamic system – does not have one single, but rather a multiple, form, fixed in different types of signs (Freud, 1896) according to the “re-writing” process it is subject to. In Freudian doctrine, memory is not a simple “impression” regarding the likeness with the represented object, but a sign that is “*co-ordinated with other signs and not bound to any particular sensory quality*” (Laplanche and Pontalis, 1973). The function of remembering is the effect of the representation (*Vorstellung*), or what is “transcribed” from the object in the different  $\psi$  systems that make up the psychic apparatus (see Laplanche & Pontalis, 1973). Representations (*Vorstellungen*) are not simple and slavish unchanging traces, nor are they passive and weakened reproductions of perceptions, but signs that take on meaning as they are connected, coordinated with each other over the becoming of time. Freud makes a distinction between *thing-presentation* (*Ding-Sachvorstellung*; Dv) and *word-presentation* (*Wortvorstellung*; Wv). The *thing-presentation*, which is essentially visual, derives from the object (*Ding*) – of which moreover it is not the mental analogy, seeing as the object is present in different associative systems and complexes – and is the representational subject of the unconscious (Ub). Thing-presentation “*is made up of a mnemonic trace as well as a pulsional link. This mnemonic trace is not a global image of the object, rather an associative series, a “shadow” of the original experience of the object: it is more similar to the ideas of the object than to the object itself, because it has lost its sensory vivacity, and is devoid of specific qualities, which can be recovered through language*” (Giaconia & Racalbutto, 1990). On the other hand, the word-presentation is acoustic and derives from the word, a psychic trace of a sound testified by the senses. In this model – in which the preconscious-conscious system (Vb-Bews) is characterized by the conjunction between Dv and Wv - the mnemonic image acquires the specific sign of quality of the conscious by associating itself to a verbal image (secondary process), so that the conscious representation includes the Dv plus the corresponding Wv (Freud, 1915).

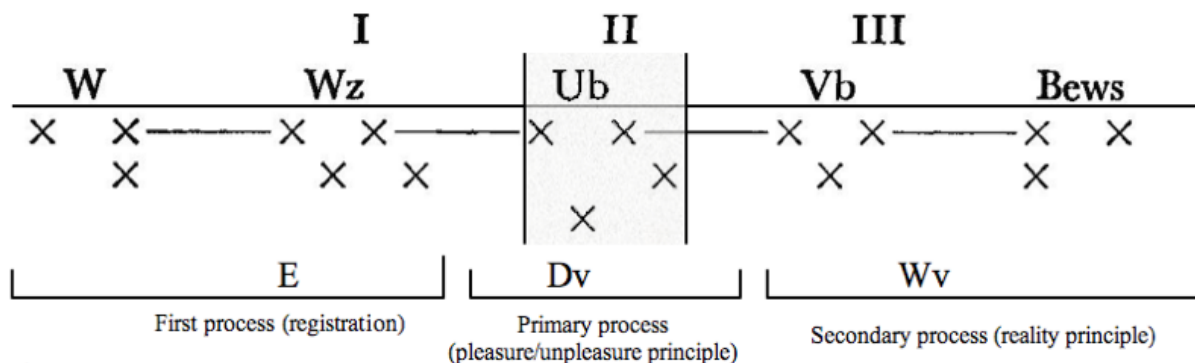
In this perspective, traumas are all excitations that cannot be assimilated by the psychic apparatus, and interfere with the formation of the (symbolic) word representation of the fact, producing an enormous disturbance in the energetic economy of the organism (Freud, 1920). Because of the unsuccessful transcription from one system of the psychic apparatus to another (from perceptive system I to system III as illustrated in letter 52 to Fliess) (see Fig. 1), the traumatic experience settles into a “psychic province”, in which “anachronistic” arousing processes persist and cannot be processed (Freud, 1896). These are “pre-symbolic” areas that Freud compares to medieval Spanish city-states regulated by statutes and special laws (*fueros*) that do not apply to other provinces, as they are excluded from the secondary process. Thus, the traumatic event, excluded from secondary processing due to its qualitative and quantitative characteristics and the

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<sup>1</sup> Lacan makes a play on the French word for gap (“*Trou*”) and traumatism (“*traumatisme*”).

subject's condition of helplessness (*Hilflosigkeit*), remains, unavailable to the preconscious-conscious system (Vb-Bews), in systems I and II in the graph reproduced here segregated on this side of the unconscious (Ub) as a repressed (or non-repressed) content. Should, on the other hand, the relevant mnestic traces be invested and subsequently counter-invested - it becomes a repressed unconscious representation. The event, enclosed in traces, signs (Wz) or thing representations (without its corresponding word representation), may therefore look for re-signification in a deferred action (*Nachträglichkeit*), by expressing itself in an almost hallucinatory form (similarly to productive psychotic symptoms), through enactment or by erupting into the conscious in the form of fragments of memory from sensory impressions that are associated to one another (such as in Proust's well-known Madeleines).

**Figure 1** (modified from: Freud, 1896):



**Fig. 1**

*Legenda:*

- W: [Wahrnehmungen (perceptions)]
- Wz: [Wahrnehmungszeichen (indication of perception)]
- Ub: (Unbewusstsein [unconsciousness])
- Vb: (Vorbewusstsein [preconsciousness])
- Bews: (Bewusstsein [consciousness])
- E: [Erinnerungsspur (memory trace)]
- Dv: [Dingvorstellung/Sachvorstellung (thing-presentation)]
- Wv: [Wortvorstellung (word-presentation)]

If the latter is a case of recovery of repressed mental content, thanks to the association with word representations, in the first two cases – when the trauma produces a morbid, psychopathological and diffused process – the event, without the structuring logic of language, can be materialized by acting-out or realization in linguistic formations, like word-representations treated like thing-presentations (Freud, 1915). One example may be found the “Great Camp” chapter in “The Truce” by Primo Levi (1987), depicting a child in the concentration camp, on which Giorgio Agamben (1999) bases a model to explain his perspective on the possibility of providing testimony of trauma: “*Hurbinek was a nobody, a child of death, a child of Auschwitz. He looked about three years old, no one knew anything of him, he could not speak and he had no name(...) The speech he lacked, which no one had bothered to teach him, the need of speech charged his stare with explosive urgency...After a week, Henek announced seriously, but without a shadow of self-consciousness, that Hurbinek ‘could say a word’. What word? He did not know, a difficult word, not Hungarian: something like ‘mas-klo’, ‘matisklo’. During the night we listened carefully: it was true, from Hurbinek’s corner there occasionally came a sound, a word. It was not, admittedly, always exactly the same word, but it was certainly an articulated word; or better, several slightly different articulated words, experimental variations on a theme, on a root, perhaps on a name.*

*Hurbinek continued in his stubborn experiments for as long as he lived. In the following days everybody listened to him in silence, anxious to understand, and among us there were speakers of*

*all languages of Europe; but Hurbinek's word remained secret.*" Mass-klo is a secret word, devoid of its symbolic and communicative potential "... a sound that comes from the lacuna, the non-language one speaks to oneself" (Agamben, 1998). It is this non-language that we believe Freud would define as words "treated like things" (Freud, 1915). It is a word that has not been emancipated to the level of language, which is subject to the primary process, and that is not unlike dissociated memories, flashbacks of PTSD patients, or manifestations of illness that we can postulate as being representations subtracted from the secondary process: those which have not received *hypercathexis* (Freud, 1915) and that can become explicit, a hallucinatory expression in the real world, an expulsion of unprocessed mental content (see Freud, 1925). These metapsychological observations, which have important implications in treatment strategies, are supported by recent neuroscientific discoveries (see Mancina, 2006): the division between thing and word representations reminding us of the modern division between implicit and explicit memory. Furthermore, there is ample evidence of an *impasse* in the representative function (memory and narration) in traumatic situations, and that the accuracy of memory, varies on the basis of the emotional value of the event.

Regarding the articulation of the image of an event (Dv) and its semantic representation (Wv), neurosciences have identified physiological mechanisms and memory processes, also providing neuro-biological descriptions of the critical points in the formation of declarative, narrative, memory in trauma victims. For example, identification has been provided for how early traumas have large scale effects on the individual psyche of children: by altering the development of their psycho-physiological regulation, as well as in the establishment of stable bonds. Such alterations are deemed to be at the origin of long-term deficits in the ability of the individual to assimilate an experience in a narrative form. In fact, these kinds of trauma victims appear to be unable to integrate traumatic memories and lose the ability to adapt to new experiences. The act of narration sometimes generates confused, disorganized and incomplete accounts, and re-activates the trauma-related anxiety. Neurobiological evidence suggests that stressful situations reduce the functions in the hippocampus and activate the amygdala, a fact which explains the state of suspension, between body and consciousness, of trauma victims. One study (Rauch et al., 1996) using the PET technique on PTSD patients, revealed that triggering the memory of the trauma leads to an increase of activity in the paralymbic regions linked to the amygdala, and the Broca area "switching of". For trauma victims, the event is mainly recorded in the form of affect states or in sensorimotor form, as timeless physical sensations or visual images (nightmares, flashbacks), instead of being encoded and stored in the memory in a semantic form. Even subsequent memory is difficult for these patients, for whom "*the traumatic image is encoded as a "thing" representation than as a "word" representation*" (Person & Klar, 1994).

#### **4. Pietro**

Pietro and his family, long-known to the system, are in precarious social, economic and residential conditions, and present serious psychiatric issues: his mother suffers from manic-depressive psychosis, and his father, a psychologically unstable person, an alcoholic, passed away when Pietro was twelve years old.

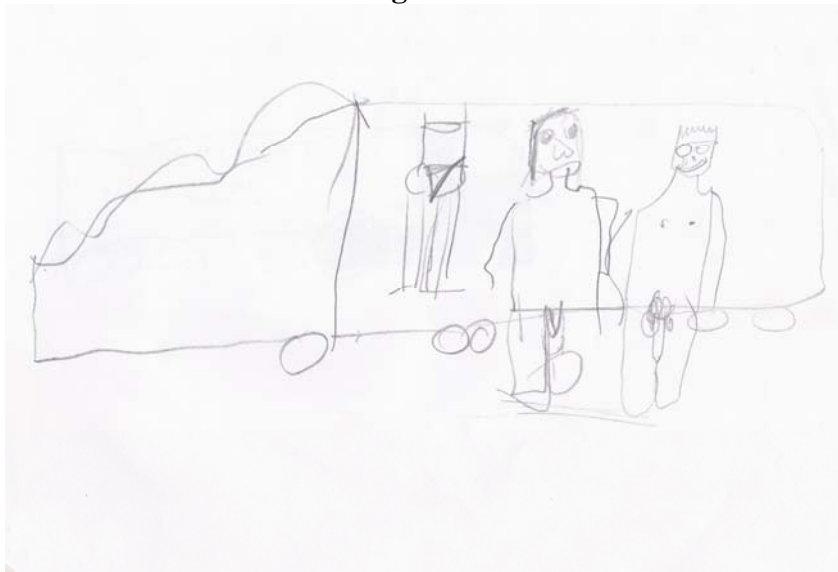
Pietro, whose case history reveals the presence of many previous neuro-psychiatric issues (generalized epileptic crises at age 4-5, repeated episodes of *jactatio capitis*, language difficulties in a more general context of slight mental retardation), was entrusted to Social Services and sent to a facility for minors at the age of ten, following physical abuse and sexual abuse (masturbation by his mother) in the family. At age 13, the boy was a victim of sexual abuse by a slightly older boy.

Institutional psychotherapy began on a weekly basis when Pietro was 15 years old. The overall psychotherapeutic journey has been characterized by moments of relative compensation and exacerbation of substantially psychotic phenomena. During the first months of therapy, the re-emerging aspects of the experience that had not yet been integrated appear to have accompanied (albeit small) positive symptoms and an increase of states of excitation and confusion. During these moments of greater decompensation, which occasionally triggered some fugues and required

temporary increases in session frequency; however, no actual deconstruction in the field of the experience took place, nor any psychological fragmentation episodes.

Pietro is generally involved in therapy and establishes a good bond with the therapist right from the beginning. Communication, during the first few sessions, is mainly focused on the topic of trucks, with which he describes scenarios that are imbued with strong violence and expresses experiences of intense anxiety: he questions their technical characteristics, the power of the engines and their speed, the speed limits, braking difficulties, contents of the trailers), and the possible results of a wide variety of accidents, in which he imagines that the victims are children (squashed and “reduced to meat”). He fantasizes on a fictional truck driver who kidnaps a child and locks him in the trailer, then he asks the therapist, in the hopes of a reassuring answer: “what would you do if a trucker kidnapped a child and wanted to hurt him?” (see Fig. 2 and 3).

**Figure 2:**



**Figure 3:**



In rare occasions – during the same period of time – he appears to be driven by the need to understand what happened to him when he was abused by his peer, giving the impression that he is looking for support because he has been involved in an activity that triggers an actual tumult of

guilt, shame, disgust, and a profound sense of identity confusion. During the description of the facts, he alternates moments of manic excitement to others in which he appears more anxious. He seems to be declaring his sense of confusion for something that for him, beyond the constraint with which he sustains that the fact occurred, might have been accompanied by a degree of arousal.

The sessions during the first two years of treatment progress, between activities, fantastical games, adventure games, involving the child and the therapist, in the role of travel companion. During play, Pietro fantasizes, quite immaturely, about entering unreal worlds, sea depths, sidereal spaces aboard a ship. The therapist is responsible for reading maps, messages, written by evil entities, and driving the shuttle in a faraway and mysterious world, populated by monstrous creatures, as if it were, as he himself remarks “a journey inside himself”. The fact the therapist-patient couple remains solid appears to warrant a greater degree of safety in his fantasies, in the process of exploring and facing the insidious presences that populate his internal world. In these adventures, Pietro, with a suggestive, cavernous, tone of voice, reproduces his father’s voice, which, with a malignant tone, threatens the boy and the therapist, forcing the latter to actively participate in a perception, a persecutory experience that, beyond the space of the session, takes on the form of “shinings” (as defined by Pietro, referring to the film *Shining*) or hallucinatory apparitions of traumatic scenarios that will only disappear after a few months. During this period, Pietro continues to play and enact “the shining that wants to take him over by killing him or turning him into a monster”, or question himself on the ship and on the need for repairs, in the attempt to get rid of these oppressive presences.

These appear as actual traces of memory that can be referred to tormenting objectual relationships, which seem to disorient him and that require the therapist to take on the role of an active witness to the scene, naming the affect states that emerge from time to time and comment – mostly with non-interpretative interventions and with a modulation of the tone of voice in his communications (almost to balance the specific prosody of the child’s voice when playing the persecutory voice) – in the attempt to clear a universe populated by fragmented, undigested, “things” (on one of these occasions, Pietro says: “we have to take the bad things out of the brain”). After a few months, Pietro, whose productive symptoms seem to have subsided, enters a more frankly depressive area: he repeatedly brings up death-related topics regarding his father and complaints – sometimes more theatrical than real – regarding his distance away from home and the limitations on his meetings with his mother. In an even later period of time he spends the sessions inventing plots for horror films with bizarre titles and stories, in which he appears to express the attempt to differentiate the past, which returns in a hallucinatory form (“the shinings”) or in the form of dreams, from objective reality. During one of these sessions, describing the “different phases of the shining”, he confusingly explains “what you see aren’t real things... they’re the things that have happened...they’re the same things”.

As treatment proceeds, Pietro seems to recover more contact with reality, through the supportive attitude of the therapist. Although the global organization of his personality remains problematic, Pietro shows the encouraging ability to organize experiences into more stable and coherent internal representations, albeit in a simple manner, and forms plans for greater independence and to complete middle school.

One day, during his final year of school, Pietro - who has a small scar on his wrist, barely visible – arrives to the session and, as soon as he is seated, begins talking about death, his father and himself, concluding that he wants to commit suicide. In reality, communications on this topic seem dramatic, instrumental, almost an attempt to reassure himself, through the alarm his remarks may provoke in the listener, on the reliability of his attachment figures. In particular, he wonders if Maria, a girl from school he sporadically exchanges conversation with, is worried about the scar on his wrist: “she sees that I’m down – he comments – then sees the scar...she’s worried about the pain!”. Then, sustaining that he did not get the cut voluntarily, adds: “I didn’t explain the truth to her... I was mad, some things had happened to me...Maria takes the pain away...after I got the cut I thought about dad, about mom getting mad...I was blind with rage, I was washing the dishes and I broke the glass...Maria doesn’t want me to kill myself”. At this point, Pietro takes a sheet of paper

and starts drawing: a drawing with a completely different quality compared to his usual chaotic and bizarre graphic productions. An unusually colorful drawing, which also communicates an unsettling sense of cold, flat calm. He says: "...I'm doing the sea, the sand ...if you draw you unload the anger" (he is actually neither drawing the sea nor the sand, but a landscape with a tree). The therapist therefore comments that maybe he feels the need to unload something to avoid being misunderstood by Maria, to make sure she doesn't worry about him, and Pietro adds: "I unload it here...is Maria scared if I hurt myself?!?". The therapist answers that he is also obviously afraid, maybe he is afraid of pain, of something slipping like the glass that cut him when it slipped from his hand. At this point Pietro says: "yes, anger doesn't let you think, I didn't think and I smashed the glass...this thing is hard you know!! It's hard to stand these situations...I didn't cry, but I suffered...I feel like drawing these things...life isn't easy, yes, I wasn't expecting the glass to cut me. Sometimes I think that there are good and bad moments in life, it's like having the devil inside you...what I'm saying doesn't make sense, I feel empty inside and I'm unloading the anger with the drawing". Once provided with the suggestion that drawing is a way of feeling that things can take form from emptiness, like - when he talks to Maria - he feels like he is filling a bit of that emptiness of his, Pietro replies: "it's true, I hadn't thought about that...sometimes some words are missing when you talk and it happens to me a lot...". Then, once he has finished his drawing, he comments: "it's a masterpiece...even if it's more important for it to have a meaning! ...can you keep it? (referring to the therapist)... that way you can discover the situation....the meaning!".

## **5. Therapeutic factors and therapeutic action in the care of child abuse trauma victims**

Based on these considerations regarding the possibility of representation, and persuaded that psychoanalytical psychotherapy provides great scope for transformation in the support of personality coherence (see McQueen et al., 2008), we investigate the existence of specific therapeutic factors for children and adolescents who are victims of abusive trauma. Although establishing or re-establishing connections between unconscious representations and verbal images remains the principle behind the psychoanalytical *talking cure*, this objective often proves to be a dangerous or impossible operation. Producing the specific quality of consciousness, eluding defenses built against the sense of confusion and anxiety, entails the risk of triggering the dangerous exacerbation of the symptoms. Gaensbauer (1995; 2004), for example, describes how traumatic stress symptoms can flare-up – in the form of mood swings between hyper-vigilant and avoiding states – when treating traumatized children, potentially compromising the therapeutic alliance. Moreover, Trowel et al. (2002), in a study conducted on the effectiveness of psychoanalytical treatment on a group of sexually abused girls (aged 6-14 years), observed that a small part of their young patients became more symptomatic – probably inclined towards dissociation, in need of a more long-term treatment.

It is therefore a case of understanding whether or not it may be more appropriate to devise possible variations to the setting or to specific parameters of technique (see Eissler, 1953), instead of idealistically aiming for a "standard of care", for example by adjusting to the different potential metapsychological profiles of patients (as well their age, development phase, etc.), corresponding to as many possible levels of integration and subjectivation of the experience. As a matter of fact, if we look at the extreme variability of trauma and its effects, and if we consider that each patient requires specific attention and care, we cannot only refer to one model of the technique and apply it indistinctly to everyone. Based on the therapeutic and treatment suggestions advanced by the debate on psychoanalytical technique, the medical analogy illustrated by Loewenstein (1958) seems appropriate in the fact that, speaking of interpretation as the psychoanalyst's specific tool, it states: "*...we might imagine an intestinal ailment requiring treatment by an antibiotic that can be carried to the diseased portion of the intestine only by certain vehicles having no specific curative effect in themselves. In this analogy the antibiotic represents the interpretations; or rather, the insights resulting from interpretations. The vehicles stand for the various other steps which the analyst must take in order that he can interpret correctly, i.e., understand his patient and enable him to benefit from it; in other words, so as to make interpretation effective*". In response to Lowenstein's



statement, Eissler (1958) discusses the antibiotic's vehicle: "*In my estimation what determines whether or not a psycho-analytic technique is classical depends on what vehicle carries the interpretation to its locus operandi in order to effect a change in the patient's personality structure. In the cathartic treatment it was hypnosis, later it was suggestion and its equivalents. It was a real triumph of Freud's ingenuity that he developed a technique in which the therapeutic agent and vehicle were of the same kind and interpretation became in principle the exclusive tool. The vast differences between the techniques necessary with delinquent and schizo-phrenic patients depend on the technical vehicle necessary to carry the interpretation to the places where it applies*". In fact, according to Eissler – it is not the structure of the symptom, but the structure of the Ego (its alterations or deformities) in which the symptom is inserted, that requires the use of the *parameter of technique*. In 1953, he had already stated the need to use parameters (intended as variations of the basic model technique) in a variety of situations and disorders, in which the free association technique or insights with verbal interpretations do not apply, due to the risk of precipitate regressions in the patient.

Regarding the patients considered in this study, we believe the technique issue can once again be compared to the therapeutic action of antibiotics, and in particular to the difficulties implied in the choice of the most appropriate and effective compound and dosage in order to minimize side effects. In the past, some authors have suggested technical changes in the treatment of sexual abuse victims, for example recommending particular care in working on resistance – which may be a necessary form of defense against the sense of narcissistic vulnerability (Raphling, 1990) – or suggesting a supportive and active attitude, especially with the more disturbed patients (Marcus, 1989; Margolis, 1977). In such cases, others criticize and warn against neutrality or the abstinence of the analyst, because silences – especially for those who have had early relational trauma – may activate or intensify the conflicts and anxieties deriving from the abusive experience (see Dewald, 1989). When working with less compromised patients, some analysts on the other hand stress the need to provide clear boundaries and limits, as well as clarify not only the multiple facets of fantasy and reality, but also the intra-psychic justifications that support this confusion (see Krimendahl & Alpert, 1991). Regarding therapy for children, Kramer (1983) recommends a cautious attitude when following play therapy sessions, due to the fact that these children have a low tolerance for verbalizations of the analyst regarding play.

As far as we are concerned, considering the techniques, its instruments and our clinical cases – which, in different ways from one case to another, present recurring pre-genital issues, damages to the representation and borders of the Self, compromise to objectual relations, experiences of fragmentation and narcissistic issues – we believe we can make a first basic distinction between two types of patients: those that may benefit from a "classic" technical structure, due to their age and/or metapsychological presentation – in particular, the integrity of the Ego, the ability to bond and representation abilities; and those for which there is an ever-present risk of triggering dangerous regressions. Obviously, whereas in the case of very small children the limits of representation and subjectivation can easily be attributed to cognitive, linguistic and neuro-functional immaturity, before that of the Ego, in the case of children in a latent, pre-pubescent, or adolescent age, the limits of therapeutic action are imposed by a particular weakness of the Ego. On the basis of these observations, we deem it reasonable and useful to use a technique that can switch from a supportive to an explorative function on the basis of the relevant structure and psychic mechanisms, in different patients or in different phases of therapy with the same patient – according to internal timing, transference fluctuations and on the basis of the structure and mechanisms of the psychic apparatus.

In the most optimistic cases, where we do not stray too far from the *parameter of zero* situation, in which we can rely on more evolved cognitive and linguistic functions (not only on the basis of age), a sufficiently intact Ego structure, and a good basic narcissistic organization, we can predict that session work will enable us to reduce the gap between what the patient has appropriated in his psychological reality and what, although it has existed, has been lost, excluded from symbolic representation. On the other hand, should the Ego be damaged, the narcissistic wound being larger

and deeper, our therapeutic organization will change: in these cases, because the prolonged trauma and stress have collapsed the thought-thinking apparatus, and produced permanent effects on the representative and mnemonic abilities of the subject, we must design a technique that enables the subject to provide an account of the story without telling it. It is a case of taking on the simple and docile role of container, witnesses who share the pain and affects, and thereby provide a new relational opportunity to support the developmental process through the use of new possibilities. This function translates into maintaining the continuity and regulation of emotions, which are so strongly compromised, participating as an actor (not as a spectator or interpreter) in the dramatization of the emerging ideal and affective experience in the therapeutic relationship. If on one side of the traumatic spectrum we have subjects that use the opportunities provided to them to represent the traumatic scene who benefit from the role of words, on the other we have subjects who, when they come to therapy, especially in the first phases, are indisposed to establish a therapeutic alliance, to participate in play, and even more unable to investigate or expose the meanings of the events that have happened to them (Gabbard, 1997; Killingmo, 1989). With these patients, the therapist must be able to switch between the most appropriate strategies – both on the basis of the individual characteristics of the patient, and on the activation (if any) of deep-set affects, which are topologically closer to the traumatic nucleus (see Holinger, 1999). Whereas the exploration in the internal world through observation, the interpretation of the child’s play and fantasies and insights remain the preferable tools to untie the trauma from the fantasmatic dimension (Freud A., 1967) in the more favorable cases, in the more serious cases – in which the non-integrated trauma is repeated beyond the principle of pleasure and the traumatic representations appear to be devoid of their symbolic powers, the therapist must remain as close as possible to the developmental stage of the child, and be available as a supportive presence<sup>2</sup>. This is the case, for example, of those children whose play, as an attribute of the urgency to expel mental content, takes on entirely peculiar characteristics. Here, the content of play, excluded from the secondary process, appears to have the same role as word representations that are treated as representations of things. Play loses its metaphoric function and appears to be an unvarying group of unprocessed fragments of reality, which evoke a traumatic experience based on a deficitary relationship with the primary object (see also Yanof, 2005; Greenspan & Lieberman, 1994; Slade, 1994). In such cases, according to the theories of Bibring (1943) regarding the implicit potential of repetitive processing, we believe that providing an anchor for the impulses that operate beyond the pleasure principle is essential in therapy, in order to promote or sustain the Ego of the patient in the repetition of an experience with variations that allow it to be assimilated. Using play during the session, beyond actual narration and exploring the meaning of behavior using techniques that aren’t directly interpretative, we believe it is possible to provide the subject with a place to attempt a figuration of the trauma from the variety of the relevant affects. We believe that the therapist’s presence, his/her function of being an additional witness and thinking apparatus for the patient, can support the functions that are necessary to re-write the event so that it ceases to be a “constant” presence and can be made more tolerable. For this to occur, and for the images of the trauma to be allowed to re-surface for these patients – constantly at risk of serious regressions – it is first and foremost important for the basic characteristics of the setting to be perceived as safe (Gabbard, 1997), to guarantee the containment of the affects and mitigate the sense of powerlessness and solitude. The flexibility of the therapist, the ability to adapt and to be used as a transference object or as a *real and developmental object*<sup>2</sup> must allow for a different change of register from time to time: from a semantic register, to a declarative, “procedural” one to recover material from the experience at an implicit level (see Fonagy, 1999; Mancina, 2006).

For these reasons, we believe, with these kinds of patients, in addition to the interpretations and insights of the classic technique, that a few technical recommendations are relevant to highlight the importance of the non verbal experience in the change (de Jonghe et al., 1992), the regulation and

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<sup>2</sup> In this perspective, the British tradition of Object Relations appears to be making progress regarding the active role of the analyst when dealing with regression in cases of serious neurotic, borderline or psychotic disturbances (see Rachman, 2009).

synchronization with the affect states of the patient (intended in Winnicott's sense of "fitting in"). In these cases, the inter-subjective experience can prove useful to support the process of "naming the affect states" (Katan, 1961) and produce more internal cohesion and coherence in preparation for any subsequent processing phases. The presence of the therapist, the safe bonding experience in the setting, the inter-subjective interaction, the self-regulating function (see Stern et al., 1998), accompanied by the modulation of the tone of voice (Killingmo 1989), can constitute important variations, actual active measures (see Kirshner, 1994), to contain strongly traumatized patients and even make important neuro-functional changes. In this respect, Solms & Turnbull (2002) sustain that psychotherapy is able to extend the inhibitory influence of the pre-frontal cortex on the underlying limbic structures in charge of emotionality and impulsivity. Functional neuroimaging studies confirm that specific sub-cortical areas are activated in the setting (which mediates affective processes and which is deemed to contain the first affective footprint of a mother's voice), which are responsible for affective mediation and regulation. This evidence could explain how sound, prosodic features of the therapist's voice (see Etchegoyen & Amati Mehler, 2004), are effective tools to tune in to and regulate emotions when treating patients with serious early relational traumas (McQueen et al., 2008).

From a therapeutic point of view, the fact that precocious and severe trauma freezes the interaction between cognition and language, preventing the mentalization process and stocking the experience in the form of somatic memory, suggests that the field of non-interpretative techniques should be broadened (see Rachman et al., 2009). This could, in fact, be an appropriate technical adjustment to reach the split, pre-cognitive and somatic aspects of trauma (Rachman et al., 2009). Killingmo (1989) uses empathic confirmation and other secondary strategies (such as facilitating techniques) in this sense to treat patients who have experienced serious childhood trauma. Holinger (1999) – in light of Infant Research progress in particular – sustains the effectiveness of non-interpretative intervention such as validation, confirmation, mirroring, clarification, and holding. Even past studies (Akhtar, 1992) suggest the use of affirmative intervention in case of particularly severe illnesses, and Gabbard et al. (1994) and Horwitz et al. (1996) suggest the use of supportive intervention to create a favorable climate for interpretation and as useful therapeutic tools.

If we look at the technique issues more closely, as well as the therapeutic factors in the treatment of children, Yanof (2005) points out that childhood therapists have long accepted the importance of enactment in therapy and that the relationship with the therapist is an essential part of the therapeutic action. Often, as child therapists, we are used to working without basing ourselves on reconstruction, self-reflection or verbal interpretation, as many small patients have not yet developed enough cognitive abilities to benefit from these techniques. We also know that, regardless of the fact that the ability to verbalize feelings progresses with age, the age factor is not always a reliable indicator of auto-reflexive capacity. This is why Yanof – also based on neuroscientific evidence, according to which implicit associative memory operates and is influenced by mechanisms that operate beyond consciousness (see Gabbard and Westen, 2003) – claims to be persuaded that the change can take place both with "wording" and without. Lenore Terr (1989), for example, is of the opinion that, in the treatment of traumatized children, particular stress must be placed on the use of play over verbalizations and interpretations provided by the therapist. Furthermore, evidence reported by Terr herself, according to which traumatized children prefer play even at an older age compared to non-traumatized children, provides an important suggestion for treatment, confirming how play can be a preferable tool to "build" the plot of the event, which remains beyond the realm of language. In all these cases, implicit change appears to occur through codes and techniques – such as play and drawing – in which the procedural patterns of interactions with others (Stern et al., 1998) can change without directly leading the conceptual ideas into consciousness. Implicit and explicit change are obviously not mutually exclusive, but are often complementary (Gabbard and Westen, 2003). This is why the degree and stability of therapeutic change may be improved by making the child aware of the factors that are initially beyond awareness by verbalizing what occurs during play, however bearing in mind that direct words and comments on the game can potentially constitute undue intrusions. Interventions – which are mostly

unsaturated – must facilitate the progress of and in the game and (as well as providing a meaning) support new coping abilities. Non-interpretative interventions (Yanof, 2005), also in these cases, may be more suited to the abilities or extent of development, linguistic functions and the thoughts of the child, and be particularly effective.

## 6. Conclusions

On the basis of psychoanalytic and neurophysiological knowledge, trauma is represented by an event that, trapped in wordless representations, remains impossible to process, and seeks *a posteriori* resignification by breaking into consciousness in the form of fragments of memory that begin from somatic-sensory or associative phenomena or through an expression in a hallucinatory form or by acting-out. If, in some cases, we can count on a sufficiently intact Ego to carry out processing tasks and to tolerate, in a controlled setting, the accessional movement of the repressed content (if there has been an investment and a subsequent counterinvestment of representational content); in other cases, where the trauma has produced a profound alteration in the circuits of explicit memory (Mancia, 2006), the event is a source of torment for the subject, ever present, continuously repeated, enacted, expelled from the psychological apparatus as if it were an unprocessed agglomerate of “things”. With the first type of patient, the structure in and of treatment does not differ too much from the “classical” technique, albeit requiring the therapist’s ability to adapt and synchronize with the internal modulations of the patient, in which the work during therapy aims at reducing the gap between what has been absorbed in the psychological reality and what has foregone symbolic representation even though it has existed. On the other hand, in cases in which the prolonged trauma and stress have determined the collapse of thought and the subversion of the process of transcription of the experience, and the patient appears to be constantly exposed to the risk of dangerous regressions, our role is to provide – instead of a “corrective emotional experience” – our presence as participative witnesses and the function of a supplementary thought apparatus. With these patients, for whom representation of the event is beyond the capacity of language, and the mnestic trace occupies the place of the unrepressed unconscious, “a past event that has yet to be experienced”, our work must promote the transformation of mental content (traces that stagnate, free, “split” in the psyche) beyond their narrative capacity, using as much of the trauma that is expressed implicitly. With this statement, we do not wish to say that our structure and our technique should be alternatively (in a binary logic) or mainly aimed at procedural memories to the expense of autobiographic ones, such as in Blum’s (2003) reproach to Fonagy (2003) in the abovementioned controversy. Instead, we mean to point out that with trauma victims, especially the most destructuring ones, the priority of our work must be changeable in order to be able to provoke real change, not only in the alternations on the basis of the patient’s structure, but also in the adaptation according to how defenses, resources and processing potential change in the same patient at different times during therapy. Procedural memories and declarative ones must find an analytical articulation via the use of elaborative work methods (in the sense of being put into words, should the structure and the functions of the patient allow it), but also of supportive strategies, non-interpretative techniques, which, instead of representing a setting aside of the analytical method, may generate intermediate functioning and working areas, “potential spaces” of figuration in preparation for the representation itself in the form of words, the promotion and consolidation of the secondary process, so that the patient may recompose a more bearable historical plot.

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