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Trauma, memory and transference

Ordinary People¹

There are patients who appear quite ordinary during the course of the initial consultations and of the first months of the analysis, at least on the surface.

They complain about being depressed, or anxious, unsatisfied with their lives, with their relationships or with their jobs. They tell a story which appears quite ordinary as well. There are no abuses, no tragic losses, no dramatic deaths. However, if we listen carefully to what they say we realize quite soon that something is out of tune.

There are small discrepancies, inconsistencies, incomprehensible dissonances. Sometimes you simply cannot understand the relationship between the normal, biographically detailed story which is told and the deep and repeated unhappiness resulting from it. Sometimes you cannot explain the disproportion between the absolutely *normal* events they tell and the persistent inability to lead a satisfactory life. The traumatophilic² character of the events they describe is intriguing because it doesn't offer a logical explanation. Unlike other patients, these patients do not tell nor present a particularly difficult or wearying family context.

For a while, in the beginning, the analysis seems to develop in a simple and natural way. Patients come willingly, they have gladly made room for the sessions, both in the inner and in the external world. They soon acknowledge a sense of immediate relief and well-being, and they are grateful for it. Analysis seems to be oriented toward a natural and easy development.

Little by little, however, as soon as the analysis gets to the heart of the matter, we notice a few uncommon, out of the ordinary elements, particularly remarkable in the counter transference.

In the transference-counter transference dynamics, we are met with the repetition of those extraordinary protections (Mitrani, 2001), of those extraordinary defences set up at some point in their life, when the awareness of the traumatic event would have been overwhelming for the maintenance of the status-quo or for the psychic survival itself.

I want to describe here the development of an abnormal defensive relational barrier in some patients. This extra-ordinary barrier is characterized by schizoid or maniacal defences and by the constant and protracted misuse of splitting, projection, and denial. These defensive maneuvers start only after the development of an intimate relationship with an object, a relationship which has often

¹ The title refers to the movie *Ordinary People* (1980) directed by Robert Redford.

² With traumatophilic tendency we indicate the concept according to which some patients tend to continuously repeat traumatic experiences in the vain hope to reach different results. So the traumatic experience becomes the organizer of the whole mental life, as well as the source of experiences which repeat themselves ever the same.

been avoided and from which they have often escaped to protect the object and themselves from a possible breakdown.

Those defences are the answer to traumas sustained but not immediately perceived as such by the patients and, what is worst, by the external environment. These traumas are characterized by physical and emotional neglect, separation from the caregivers, repeated verbal violences and abuses, protracted exposure to serious depressions, paranoid features or other major parental pathologies (included serious and disabling physical illnesses), continuing distortions of the emotional and cognitive competences by the primary objects and many others. These traumatic experiences are less striking than the traumas characterized by physical or sexual abuse, or by the exposure to dramatic violent events, and for this reason they developed with little acknowledgement of their traumatic nature by the patient and, worst still, by the external environment. (Meares, 2000) Sometimes these traumas occurred in periods of life when the traumatic experience was not representable, that is when the explicit memory wasn't yet structured. In this case we are dealing with the emotional and affective memory, the *implicit memory*, which communicates its mnemonic images through the perceptive-receptive canals. At times the traumatic experiences started at a very early stage of development, but then went on for a very long time and left clear memories in the patient, who, however, cannot stand the exposure to such memories. Sometimes the traumatic character of the experience completely escaped everybody's notice and the suffering, or, better, the defence from suffering developed mainly through the mechanisms of denial and splitting, early primitive defences reactivated only for this purpose.

The aim of this work is to present, through some clinical material, the emergence of the traumatic elements in the transference, that is their reactivation in the relationship with the analyst, which is a prerequisite for those traumatic elements to be understood and transformed.

What differentiates those patients from others equally traumatized is the development of the analysis in two movements: the first movement is focused on the reception and the comprehension of more superficial factors, whereas the other is focused on deep traumatic elements. These elements become accessible only after the development of an early stage of reception and exposure to a constant and emotionally sympathetic setting, that is precisely what the analytic situation should be. It is possible to differentiate the transference and counter transference elements in the analytic situation of the present from the experiences of the past only after the development of a different relational model, characterized by attention, comprehension and, above all, a careful use of time and space. I want to emphasize this last element, because a steady feature in all those patients seems to have been a continuous unwarranted interference in their time and space.

If we think that we can reach such processes of transformation that can break the traumatophilic chain only through the reactivation of the early traumatic experience in the transference, we must pay careful attention to *all* the elements developed in the analysis, that is also to the psychosensorial elements and generally speaking to the extra-verbal moments and not only to the verbal elements.

The deep work of the analysis with these patients should be carried out with careful attention to the micro-phenomena, to the micro-fractures of time and space in the setting during the analytic hour.

Betty Joseph (1985) stresses that "If we work only with the part that is verbalised, we do not take into account the object relationships being acted out in the transference... We need to understand the patient's current internal state in term of the total interpersonal situation the patient creates in the transference with the analyst".

Trauma

The history of psychoanalysis coincides with the theory of trauma. From Freud until today trauma has always maintained a central position in understanding the psychic pain even in the different theoretic positions. In this paper, following a theoretic line which starts from Freud and goes

through Ferenczi to more recent authors ((McDougall, 1982, 1989; Giaconia e Racalbuto, 1990) I consider traumatic those events which cannot be integrated nor worked out, and which persist like leaks in the continuum of mental functioning.

They remain like silent areas of the mind, and they damage both the thinking process and the very thoughts, preventing the symbol formation. In these situations the body may become a representational area and realize the concrete representation of primitive phantoms through coenaesthetic perceptions.

Memory

The philosopher Paolo Rossi in his book “The past, the memory and the oblivion” (1991) says that in the philosophical tradition, memory refers to a persistence, a reality somehow continuous and untouched, whereas the reminiscence or recalling refers to the capability of retrieving something that one had in the past and has forgotten. For Aristotle remembering implies a deliberate effort of the conscious mind, an excavation or a voluntary search. Whereas for the Platonic tradition memory is a form of knowledge connected to the true knowledge that the soul can reach.

So we have memory/ oblivion on one hand and remembrance /forgetfulness on the other. So we can have memories which we will never remember and that nevertheless constitute the most intimate and profound identity of the person. We know very well that patients in analysis will not necessarily get to remember those events or traumatic experiences from which their symptoms or their pains originate. Those past events may have happened before the development of the memory system which is able to encode and retain the past experience in a way that can be represented, consciously or unconsciously, as a story. Also Ricoeur’s philosophical reflection on time and memory (1998) is helpful in suggesting the analyst to be considered as a historian whose work enables the patient to acquire a *historical consciousness of his unconscious*.

Peter Fonagy (1999) underlines that : “The only way we can know what goes on in our patient’s mind , what might have happened to them, is how they are with us in the transference... Therapeutic action lies in the conscious elaboration of preconscious representations, principally through the analyst attention to transference.”

During the course of an attentive and empathic analysis we can, in my view, restore the patient to a good enough memory of the Self, even without the development of proper memories from his past. The patient may testify to his experience, without being constantly forced to remember the traumatic elements. Actually I do think that through the experience of the transference-counter transference dynamics the analysis can restore the human beings to the dignity of their memory and their witnessing, freeing them from persecutory recollections of the past or from the residual tracks of those recollections.³

Transference and counter transference

As Freud emphasized in his early writings, transference is central in analytic work. He discovers that *the work of analysis revolves and depends upon the handlings of transference* (1912) and this statement remains for every analyst the basic element of any clinical experience with every patient. Whatever are the troubles and the suffering of the patient, these must be reactivated in the transference in order to be understood and transformed.

Following Freud’s lead, Melanie Klein (1952) further developed the analytic thinking about the transference and proposed that the transference situation encompasses a whole constellation of past experiences, emotions, defences, and object relations. For Melanie Klein and her followers the transference is at the centre of a movement which goes from the past through the present time toward the psychic change. Therefore transference is eminently the place of psychic change.

³In Latin the word *supertestes* (the witness), is different from *testis* (the third party), and indicates the person who has lived an event from start to finish and is therefore entitled to give evidence of that event.

Betty Joseph (1989) for example takes into account all the minute shifts in transference, and stresses the unconscious need for the patient to maintain a psychic equilibrium which resists his conscious desire for psychic change. A constant setting facilitates this process of psychic change.

In the last few years in psychoanalytic literature special attention has been given to the analyst's subjectivity and to the influence of countertransference on the analysis. The attention previously given to the intrapsychic level of the patient is now focused on the intrapsychic level of the interaction between patient and analyst. (O'Shaughnessy, 1983).

Luciana Nissim Momigliano has been a creative and original interpreter of this school of thought in Italy. In *Shared Experience: the Psychoanalytic Dialogue* (1992) the dominant theme was the hope that these two people in a room (the patient and the analyst) will be able to communicate with each other and share their experience.

In this view countertransference is no longer considered a disturbing element in the analytic work, a plain expression of the analyst's difficulties or a pure product of the patient's projective identification, but rather a specific emotional context that originates from the encounter of *that patient with that analyst*.

In every analytic treatment we meet some countertransference and transference somatic elements that represent the Ps-D dialectic, and the narcissistic-object transference dialectic.

In this work I particularly insist on the sensory-somatic experiences as a privileged area of transmission of those imperceptible elements of communication, whose reception and awarding of meaning allow the analytic work to develop along paths that would remain otherwise unknown.

The concept of countertransference becomes quite amplified: we are dealing with the area defined by Gaddini *psycho sensory area*, in which fantasies are expressed by means of bodily functioning. Gaddini calls them *fantasies in the body*. *"A primitive fantasy expressed in the body can hardly be further elaborated in the course of development. In the infant's mind, before fantasy can be associated with an image, thus becoming a visual fantasy, it is experienced in the body – namely, a particular physical function is enacted and altered according to its mental significance. These fantasies in the body remain usually enclosed in a primitive and exclusive body-mind circuit and are not available to further mental elaboration, as visual fantasies are instead."* (Gaddini, 1982)

Lucy

Lucy is 39 at the beginning of her analysis. She originates from a small town in Northern Italy, where her family owns a farm and still lives in a big house. During the initial consultations Lucy presents herself as a simple, naïve girl, rather depressed, disheartened by a clerical work of little interest, with a narrow circle of friend. She doesn't recall a particularly difficult or wearying story, nor do I see anything suspicious in that sense.

Her father had died two years before. He was a rather authoritarian and aggressive figure especially in the family context, but for a long time she'll present him as a severe but fair man, basically good and beloved by all family. The mother instead is presented from the very beginning as a weak figure, querulous and complaining. She would often be sick and unable to react to the frequent outbursts of anger of her husband and to his verbal and physical aggressions. Lucy is the rebellious daughter who mostly incurs her father's furies, especially because she demands more freedom and independence. As an extreme concession she obtains to come and live in Milan to attend University. She doesn't say very much of the 20 years she has spent in Milan ever since, thus suggesting a slight disillusion compared to the initial expectations.

For the first six months the analysis seems to develop quite well following the initial consultation's tracks. Lucy seems very interested in the functioning of the analysis, and extremely grateful for the attention that her loneliness and depression at last can receive.

Then I slowly realize I have unexpected and incomprehensible fits of drowsiness during her sessions. The sessions are at different time every day and I cannot understand the cause of my drowsiness. I get to dread these sessions with Lucy, because I fall into a heavy sleepiness, a kind of more and more incomprehensible black-out. In the meantime new and really bizarre elements of

her story sift through my numbness. Lucy is talking about her maternal grandmother, an almost mythological figure, living representation of persecutory ghosts, who tells her stories of local superstitions, of flower wreaths put on the windowsill to calm down the witches, of spells cast by wizards and witches. Lucy is also often repeating: “She’s ugly! She’s ugly!” referring this time to her paternal grandmother, that seems to embody a kind of witch too. I have trouble to disentangle myself between old mountain legends, and present time fears, between phantasy and reality. I start to suspect the presence of a delusional core in this patient, well hidden, but very well organized.

Little by little Lucy is able to describe the phenomena of physical depersonalization, of coenaesthetic misperceptions, that assault her on the couch. She feels she is floating in the air, or she is sticking to the couch, she feels she is petrified and cannot move, and I understand she is as terrified as I am.

I received these communications with great difficulty, because in the meantime my sleepiness was getting worse. One day I suddenly wake up, perfectly clear minded. I had the impression I was dreaming, and that in my dream someone was uncovering a grave, and that I was free to get out. At this point I hear Lucy say: “It seems to me they just uncovered a grave, I feel freer now.” The nightmare is over, for both of us, and I won’t have those weird phenomena anymore, true spells cast by the witches.

Months later the story will clear up a little more. During a session Lucy brings a dream. She has a doll in her lap. To her deep horror the doll starts to move and drags herself about the room. Then the doll loses her bits, one by one, and Lucy, with growing horror, is forced to follow her and to pick up these bits, one by one, realizing that the doll is alive, but at the same time inanimate. Nothing comes to her mind, in association, but something comes to *my* mind. I ask her, with great caution, if, by chance, she ever had an abortion. Terrified, she confesses that, as soon as she had arrived to Milan she had gone out with a boy, whom she wasn’t really involved with, and immediately had become pregnant. She had to undergo an abortion, hidden from her very sex phobic family. She had never told this story to anybody, not even to her friends, and she had spent every single day after that episode thinking of it with deep guilt and sorrow. “I think of that abortion every day.” I say that it seems to me that with the abortion she had killed and buried also a part of herself. Maybe it’s for this reason that she has been feeling for a long time as if she was buried in a grave. She answers that it has been really like this for a long time, and that ever since she has perceived herself like “someone no longer alive”. After the abortion she has never had a relationship with a man. She adds that in these recent months, however, she had the impression to be no longer alone and that: “If I was buried in a grave you were with me for sure.” I confirm her that I had the impression of having gone through a very choking period too.

Bollas in his book *The shadow of the object* (1987) speaking of the *unthought known*, emphasizes the relevance of the evocative mental process, through which important information on the self state emerge from the deepest part of the Self. During the psychoanalytic dialogue the analyst too can be in a state of not-knowing-yet-experiencing-one (Bollas). These experiences can often be bodily experiences, like drowsiness, or stiffening, as widely described in psychoanalytic literature.

Also Thomas Ogden in his book *The primitive edge of experience* (1989) termed the psychological organisation generating the most primitive state of being *the autistic contiguous position*. He described briefly some possible countertransference responses to the analytic experience in an autistic contiguous mode: “*More specific to the autistic contiguous mode of experience is countertransference experience in which bodily sensations dominate... Very frequently the countertransference experience is associated with skin sensation such as feelings of warm and coldness ... as well as tingling, numbness*”. The contact between the patient psychic primitive state of mind and the analyst psychic primitive state of mind produces a countertransference characterized by sensory-somatic experiences, especially when we are dealing with those traumatic events which cannot be integrated nor worked out.

I want to comment briefly on the memory/trauma relation regarding this episode. In the associations Lucy brought up to the doll’s dream, there was no memory of early traumatic

experiences, and the only association was with the abortion experience. That episode had taken the shape of a highly dramatic experience inside the patient, the repetition, in my view, of previous early traumatic experiences she couldn't recall. She had never talked about the abortion with anybody for twenty years. A friend she was living with at those times (and who knew the story) had soon become a constant persecutory object in her nightmares. The abortion following a casual sexual experience had in fact confirmed her worst sex phobic fears and her persecutory suspects connected with the relationships with other people.

Actually Lucy's dream refers not only to the abortion. Lucy represents with great efficacy the perception of a growing and dramatic fragmentation of the Self, which goes together with the transformation into an inanimate object. We are deep into that condition defined by Gaddini as psycho-physical syndrome (1982) which is typically fragmentary and representative of a mental functioning which precedes the integrative process. The *non-integration* is the first functional organization of the Self, a fragmentary organization which must be distinguished from the *disintegration* resulting from the anxiety of loss of the Self. The latter presupposes the existence of a certain degree of integration, therefore a phenomenon which has regressed from a more advanced state. In the first case, according to Gaddini, we must proceed for the first time from a non-integrated functioning to integration, implying the integration of parts which had never been previously integrated. Thus the analysis becomes the means through which we can restore the never born, aborted parts of the Self, which are at risk of living a life of their own as inanimate and critically persecutory objects.

The experience lived by Lucy is absolutely terrifying. It's an experience that can be communicated only through contagion (projective identification), and which cannot have meaningful and communicable ideational representations. The anxiety for the experience of the abortion mirrors in analysis the anxiety for a possible abortive failure of the analytical experience. If the analyst goes on sleeping he won't be able to modify the barrier of unreality and lack of significance of the patient.

Analysis in two movements, as I was saying in the introduction, meaning that only establishing a really relational analytical modality one can develop the identification and counter identification necessary to penetrate into the deepest layers of the unconscious and receive the primitive non-integration anxiety of the patient.

"The deep work of the analysis with these patients should be carried out with careful attention to the micro-phenomena, to the micro-fractures of time and space in the setting during the analytical hour." I was saying in the introduction.

I want to bring two fragments from two sessions, as an example of the micro-processes. They are interesting because they evidence the remembering of the traumatic experience and its subsequent transformation.

When Lucy starts the session she is particularly tense and nervous. She seems to fall into one of her introspection states, absent and retreated from the background. She doesn't speak and remains indifferent to my attempts to stimulate her.

Slowly, without losing control, I become silent too, and I realize how the external environment seems particularly noisy that evening.

My office is in a private street, where usually there is a big silence, but that evening, instead, we can hear quarrels on the street, children crying, boys playing noisily. Furthermore my entry phone is ringing, but nobody answers it. Lucy appears more and more irritated and annoyed, almost panicky. At the end of the session, which she has passed almost completely silent, having said only: "I don't know what to say tonight, I don't feel too well", she gets up abruptly and goes out, clearly in distress.

Next session Lucy seems happy and relaxed. She speaks of different episodes, but I understand I cannot avoid talking about the previous session atmosphere. I tell her that the day before she looked deeply disturbed by the external noises.

Lucy looks surprised, but also relieved: “Yes, I felt a peculiar annoyance yesterday, the noises seemed to prevent me from concentrating on myself. Sometimes it happens to me, to be particularly disturbed by the external world.”

I ask if this had happened also in the past, and if she remembers anything in particular.

Lucy has no doubts: “My father, of course. He was always shouting, there never was a moment of peace when he was home. I was literally scared, because his furies were violent and incomprehensible. Everything made him furious. I cannot stand noisy situations now. There was no respect for me, for the fact I was studying or for any other thing I was doing. On Sundays he decided to go to church and if we were late he would immediately shout. And if I wanted to go out by myself he would shout again, because he disagreed. We couldn’t do anything, never.”

I tell her: “It seems to me that the most traumatic element was the lack of respect, the continuous humiliation. Maybe yesterday here you felt the noises from the street and especially the entry phone as an intrusion in your private time and space, totally similar to your father’s intrusions.”

Lucy: “It’s something that happens all the time, not only here. I always have the impression that the others have no regards for me, that they have no consideration for me. Sometimes I’m afraid to exaggerate, that it’s impossible that everybody is cross with me, but then I must give in and put up with it.”

Analyst: “I think that yesterday you felt invaded in a particular tiring and needy moment of introspection, and you felt you were being abused also in the analysis, thus repeating the same situation of abuse and lack of consideration you experienced at home.”

In the transference repetition Lucy relives the intrusive noisiness of her father in the episode of the noisy office and the entry phone disturbance, and in that situation the analyst becomes the persecutory figure of her father. This experience, however, wouldn’t have been recalled, and so much the less remembered by the patient, if the external noisiness wouldn’t have suddenly become disturbing for the analyst as well.

What I want to say is that through the projective identification of the patient, and the empathic sharing of the analyst, a minimal episode, a small micro trauma in the session could be taken back into analysis and connected to a precise mnemonic image. As I said in the introduction, it was possible to differentiate the present transference and counter transference elements of the analytical situation from the past experiences only after we were able to recreate a different relational model, characterized by attention, comprehension, and, above all, consideration for the other.

Starting from this episode we were able to activate a path of significance and mentalization (i.e. the capability to elaborate sensorial and bodily sensations into accurate mental representations) of all the frequent episodes of depersonalization and coenaesthetic misperceptions that she had experienced on the couch. We found out that they were nothing but the activation of primitive defensive somatic barriers toward the continuous family intrusion. Actually her mother also showed a relational model based on intrusion and lack of consideration, although different from her father’s.

In the next session Lucy says: “Yesterday I had a dream. I was here, in the session, lying across the couch, and I was asking myself: “Would the analyst realize that there is something strange in my position? That I’m lying in the wrong way? Then the entry phone rang and you went to open the door, and it seemed to me that you were trying to stop a person from getting into the office. I got up from the couch, to help you, and I saw a shadow on the stairs, who seemed very threatening. You were trying to protect me and prevent this person from entering the room.” She then adds that she was feeling better now and thought she was more confident and daring, with higher hopes toward the future, compared to the last days.

I remark that the dream looks like a representation of what had happened in the previous session: “You heard the noises as a threatening intrusion in your time and space, and you feared these noises could penetrate into the analyst’s mind, and you were scared they could divert me from thinking of you. The entry phone, more than anything else, was probably interpreted like another patient, trying

to occupy your time and your space.⁴ On the other hand the analyst was perceived like your father, who disturbed you with a complete disregard toward your intimacy. In the following session there this experience had been recovered.”

This had allowed her to have a visual representation of the confuse and nameless terrors which so often populated her fantasies and produced dramatic sensorial experiences of fragmentation and depersonalization. The man at the door (the following patient?) appeared like an explicit threat seen and shared by the analyst although perceived like a shadow by the patient. The implicit sexual meaning of the terror experience was immediately recognized by Lucy, thanks also to the previous work done together on her difficulties to have sexual relationships after the traumatic experience of an abusive and violent father.

Something else was interesting in the dream: the first representation. Lucy sees herself lying across the couch, obliquely, and asks herself if the analyst can notice how she is out of place. Also in this case it seems to me that the perception that there is something deeply abnormal in her position is activated and communicated. What I want to say is that in the dream a feeling, an emotion that up to that moment had only been expressed through somatic misperceptions is now represented and communicated through a visual representation. Very often, in the session Lucy seemed to fall in a condition of trance, almost hypnotic, and she complained she could feel nothing of her body, no legs, no arms, no trunk. In her past she had had some episodes of hysterical paralysis, which brought her to the hospital, and all the episodes had occurred after particularly depressing and humiliating events.

Discussion

Lucy presents herself to the analysis with an *ordinary unhappiness*, which until that moment she had not considered a condition requiring help and change. She reveals a lot of faith in the mutative possibilities of the analytical work, and finding a better job, more consistent with her social and artistic expectations, is set as the main objective of the analysis. However those elements represented only one aspect of Lucy personality, pathology and suffering.

In the movie *Ordinary people*, in the idyllic scenario of a rich suburban family we could soon perceive a dramatic reality, encapsulated in the aseptic treatment by a psychiatrist who was supposed to keep away the persecutory phantoms of the past.

Also Lucy's problem soon appeared to be very little *ordinary*, charged as it was with anxieties and pains unconceivable both by the analyst, in the beginning, and by the patient herself at a conscious level.

The idyllic representation of the life in the small original agricultural community was shaken by progressive disclosures of tragedies that had piled up in the years and in the generations.

Lucy's father appeared to be the only survivor among seven brothers, who had died all in their childhood because of various illnesses. The paternal grandfather had withdrawn the surviving child from school, though he was very talented, and had called him back to work in the farm. The paternal grandmother had then closed herself into a deep and furious resentment toward her husband first and her daughter-in-law later, and kept herself removed from any human relationship besides her only surviving son.

Lucy's mother, on the other hand, had lost her father soon after her birth (he had died during the war when he was not even 20), and had been left with her grandparents in Africa by her adolescent mother.

Marriage had been for both the first love experience inside an affective life characterized for both by aridity, inexperience, and above all a terrible loneliness. The birth of three children didn't improve too much the affective quality of their life. Father and mother seemed always soaked in a kind of perennial mistrust (on the father's side) and fear (on the mother's side).

⁴ The continuous disturbance of the entry phone was in fact due to the next patient, (a first appointment), a very anxious person who had arrived half an hour earlier and couldn't speak on the entry phone.

The experience of loneliness, carelessness and continuous emotional and physical neglect, the repeated paternal verbal aggressions and abuses, the protracted exposures to the periodical maternal depressions, the continuous distortions of the cognitive and emotional competences by the primary objects, all this had been the warp and the weft of Lucy's childhood. All these past experiences were prolonged into the mistrust, into the suspiciousness, and into the non-integration anxieties of her present life.

I think that in this phase of Lucy's analysis I had needed the patience and the ability not only to reconstruct the past traumatic experiences, but above all to transform in the transference the emotional quality of the reception and of the listening as to the early (and not-early) traumas she had experienced in her life. Only through the recognition of the unpleasant feelings, only through the possibility of a true empathic sharing of these unpleasant feelings (where it is possible) we can reach the deep level of the traumatic experience and underline the different quality of the present experience.

I couldn't had really understood the level of deep desolation and suffocation experienced by Lucy in the intimate relationship with an absent object (her mother either depressed or engaged elsewhere with the sister), if, on my turn, if I had not experienced myself for such a long time that feeling of drowsiness and numbness which made me feel like a victim of a magic spell. As a child, too often Lucy had perceived herself as a victim of some weird witchcraft, a prisoner of insurmountable evil forces. The possibility to share these weird experiences with the analyst had allowed her to have access to a visual representation (in this form communicable) of the absolutely terrifying incorporeal phantoms of her past.

The following step of signification and mentalization (i.e. the elaboration into precise mental representations of bodily and sensory experiences) of all the frequent episodes of depersonalization and coenaesthetic misperceptions made them disappear in and out of the analysis and transformed them into verbal communications, specific memories of past experiences, significative dream representations (at first her dreams were populated only by persecutory figures, constant and steady, with no past history or meaning). In conclusion, we were able to gain access to an analytical path that was *ordinary* at last both for the patient and for the analyst.

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