The loss of symbolic capacity. Implications for a psychoanalytic understanding of traumatic states

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Abstract

Although the history of psychoanalysis had its origins in Freud's study of hysteria and its association with traumatic events, specifically sexual boundary violations in the women he analyzed, its intrapsychic and extra-psychic determinants, as well as behavioral manifestations, remain elusive and often challenging to treat. In this article, I intend to present ways in which the effects of trauma in general, but more so the pervasive impacts of incestuous trauma, could be understood from the point of view of a deficit in symbolizing capacity and the accompanying shifts in the economy of libidinal forces that perpetuate the reenactment of experiences for which the patient at a conscious level will seek help, but will unconsciously strive to refuse it. Some of the associated treatment difficulties will be mentioned, emphasizing sadomasochistic maneuvers employed by patients, with accompanying counter-transferential responses by the analyst. Some examples of technical approaches to managing difficult clinical impasses from the author's clinical experience will be presented. I also offer the concept of the Fear Position as a psychic maneuver that some traumatized patients show, which represents a challenge to developing a symbolizing capacity without which healing from trauma is impossible.

Keywords: *Trauma, Symbolization, Fear Position, Sadomasochism*

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Introduction

Evaluating and treating post-traumatic states are among the most daunting prospects in all behavioral health. Patients with a history of trauma are often resistant to conventional psychiatric and psychotherapeutic treatments (Greenspan & Moretzsohn, 2013; Kaplan & Klinetob, 2000). Those patients who seek treatment for chronic depression, but who have a history of childhood trauma are likely to respond poorly or incompletely to standard trauma-informed therapeutic interventions (Williams et al., 2016). Psychoanalysis provides an alternative viewpoint that looks beyond psychopathological symptom domains, delving into phenomenological, historical, cultural, societal, and, ultimately, unconscious dynamics in the expression and sequelae of traumatic experiences.

For the psychoanalyst who delves into the effects of trauma, symptoms that describe mental states and behaviors do not provide the totality of the story that will ultimately create a foundation for alleviation and cure. Symptoms are just points of interest around which the rest of the patient's life will provide the crucial pieces of the story. The patient's life is examined from two main points of view: one that focuses on the environment (outside of mind) and its effects on the patient's life, and another that focuses on the patient's internal (within mind) understanding of traumatic events that will also include unconscious elements that impact the perpetuation and pervasiveness of the traumatic sequelae. The rule, rather than the exception, is that patients with a history of early-life trauma will live in constant conscious and unconscious fear. Psychic energy investment tends to contradict classic notions of a pleasure principle seen in health. It is better understood as the deviation of these energies toward the purpose of destruction, described by Freud as the death drive (Freud, 1920).

Mourning interrupted by trauma

Experiences become traumatic to the extent that they are unexpected. A traumatic experience is, in the end, a loss. It is the loss of a person, knowledge, body, psychic integrity, or a profound and significant belief. A 'belief' entails the creation of an object outside of the self. When belief is lost, the Object is lost; when it is lost, it is mourned. When the loss of belief is not mourned, an identification with its absence leads to doubt, disbelief, and a sense that nothing can be trusted. Such is the conundrum after trauma.

Invariably, after trauma, time seems to stop. When approached, patients gravitate to periods of time where the course of life dramatically changed in one way or another, and they get "stuck" and unable to participate in life. It is as if life keeps happening as a highlight reel where they don't have any say. Life is dry and colorless because life is no longer lived but survived. In trauma, there is a loss of an Object. Losing an Object requires the subject to mourn it to move on and keep living. When the ego cannot let go of the Object after its loss, it keeps it tight within the mind. In identifying with the lost Object (Freud, 1915), the ego can 'magically' give it life. The Lost object is no longer lost, but the ego surrenders part of itself in the act of bringing it back to life. The ego feels that the only way to survive the Object's loss is never to have lost it in the first place. Therefore, subject and Object blend timelessly, and "...the shadow of the object falls upon the ego" (Freud, 1915). With this beautiful metaphor, Freud alludes to the dryness and artificiality of the griever's way of

attaching to the lost Object. The subject surrenders his capacity to live and instead prefers to exist in a timeless gray limbo if it means that he will keep the Object alive in mind. Freud's writings on object loss have profound implications for the understanding and treatment of traumatic states, for in trauma, as Freud described for melancholia, the psyche can become whole again in the process of letting go (grief). The commonalities between pathological mourning, leading to melancholia, and trauma lie in the subject's refusal to accept the reality of the Object's loss. Therefore, links between the subject and Object at the level of phantasy are sustained at the expense of the reality of the loss and unlived life.

In melancholia and trauma, losing the Object is not tolerated and, therefore, refused. When a loss is denied, an unconscious connection *based on an impetus for wish fulfillment* (the need to keep the Object permanently) is made in phantasy with the Object due to refusing to let it go, which keeps it alive in mind (Bott Spillius, 2001; Freud, 1915). The subject forces himself to connect with the lost but *brought-back-to-life* Object, thus preventing the flourishing of healthier object-relatedness. In melancholia and after trauma, identification with the lost Object makes its incorporation by the ego possible. Projective and introjective processes make that possible (Ogden, 2002). Therefore, Freud implicitly stated that identification involved a reciprocal relationship between subject and Object that kept viable, in phantasy, a link between the two. The concept of identification (as a way to hold on to objects after their loss) helps us understand why traumatic experiences leave an indelible mark. In other words, such experiences seem permanent because they are tattooed in the mind with the strongest of inks: identification with the traumatizing entity or identification with the trauma itself. It is then expected that defenses that deny, avoid, and repress the nature of such identification will be deployed to foster the link with the traumatic Object. The central conundrum here is that *identification and symbolization of traumatic experiences are mutually exclusive*. That is, identification with the traumatic event precludes symbolization of such experiences, and vice versa. While symbolization presupposes an integration, by the ego, of all aspects of such a loss, identification with the lost Object (traumatic event) achieves the opposite: *an unintegrated, split-off 'entity' within the mind*.

The loss of the object

In his work, Freud implicitly touched on the demarcation between the inside versus outside origins of trauma (Freud, 1905). In all discussions related to trauma and its effects, a common question revolves around what constitutes trauma and whether it involves an external agent affecting the mind or whether the environment is even necessary as a causative agent. All discussions related to the inside/outside (the mind) dichotomy in trauma should consider Freud's contributions, first described in his studies on the effects of sexual trauma on hysteric presentations. His observed clinical experience led Freud to conclude that something from outside the mind (A sexual event experienced during infancy or childhood) broke something inside (Sigmund Freud, 1896). Psychological barriers were shattered. Freud's seduction theory accounted for the result of an attack on the mind by traumatic elements from the environment. The somatization of traumatic memories by hysterics resulted from sexual abuse at an early age by a paternal figure. Freud would later point out

that the hysteric's memories were fantasies of a sexual nature that the child developed toward her father as part of the oedipal situation (Freud, 1905). Despite the resulting debate on Freud's prioritization of outside trauma, followed by his emphasis on fantasies (Freud, 1904), taking his body of work together and adding what is known today on the nature and sequelae of trauma, it can be concluded that, in essence, *there is no trauma without the environment. Still, there are no sequelae of trauma without the coloring from the inner fantasy world (Sanfelippo & Dagfal, 2020).* For Sandor Ferenczi, a traumatic process initiated outside or inside meant the same: a process of loss of the self due to identification with the motivations of the adult (Ferenczi, 1988); the language of love is confused by the adult, who provokes confusion in the child. Tenderness is mixed with sensuality, and chaos ensues. The limits of the former are lost in the latter; tenderness is spoken in the language of the senses and embraced by the concreteness of sexuality. When the child is exposed to the concreteness of sexuality before she has had a chance to live in the intermediate world of 'make-believe,' there will not be an opportunity for the mind to metabolize experience into manageable substrates that can be incorporated into a sensible, and linear representation of herself and the world. It is therefore expected that after infiltration of the mind by such a traumatic experience, it will be flooded by experiences that will be misunderstood *with no clear demarcation between inside and outside the mind,* which sets the basis for a patient's constant fear that her inside world is concretely representing the outside one. The most critical sequela of this situation entails that what is inside the mind is the same as what is outside for the patient. *This will give rise to an innate fear that if she 'thinks' about what is in her mind, it 'becomes' her tridimensional reality*. In that sense, the patient's internal fantasy world (in this case resulting from her trauma) is projected outwards into the world where it becomes an 'outside-the mind' reality. The patient will be terrified explicitly of putting her thoughts into words, which she sees as akin to opening a cage and letting loose a wild animal that will destroy everything in its path. From the standpoint of psychoanalytic technique, when a developmentally traumatized person who is 'unsure' about outside/inside reality seeks help, the high likelihood is that they will be silent, *for words, as we are beginning to note, become 'weapons of mass destruction.'* The analyst must put aside classic notions regarding the nature of free association as a vehicle to seek the patient's unconscious. Asking the patient what comes to mind is not a question that will make sense to them and will be deemed too 'dangerous' to answer.

The notion of the external and internal worlds (inside vs. outside the mind) when it comes to traumatic experiences can be appreciated in the case of K. Her psychopathological presentation was not appropriately conceptualized for years after her intrusive memories began to dominate her life. At 21 years old, K could not express what bothered her to all that would ask. She would only minimize it to 'depression,' 'anxiety,' and 'panic,' which would dominate her existence. K's inability to 'say' what bothered her and her treaters' failure to help her be ready to share it led to multiple misdiagnoses and unnecessary treatment trials with medications that would often cause side effects but did not free her of her debilitating symptoms. She would eventually do so when the time was right. "What kept you from saying what bothered you?" her analyst asked. "I was afraid that saying it would make it true...I

cannot believe it is...Why did he do that to me!?" she would remark while sobbing, often going into dissociative states while experiencing the terror of observing her words materialize in the real world, the chaos of her inner world. K struggled to bring to life through her words, which had remained dormant for years, that starting at twelve years of age, her father had raped her repeatedly.

Identification in incestuous trauma

Although incest might show itself in the form of non-sexual boundary violations within family members, my discussion will be limited to patients who have come to treatment years or even decades after a sexual boundary violation at the hands of a member or members of their own family. I would also like to distinguish that, more often than not, it is a figure of perceived authority, expected to provide security and nurturance, who abuses the child's trust. In this paper, I refer to sexual boundary violations perpetrated by a father on his daughter. For incestuous trauma sufferers, the attack on the developing ego makes it very difficult to recover and is perhaps the worst type of boundary violation. When the loss of ego boundaries is related to incest, the traumatized patient will *identify with the incestuous act*; that is, libidinal energies will be cathected to the act, first and foremost, at the expense of the actor (the perpetrator). This situation will impede proper ego differentiation and the persistence of primary narcissism. Since there is no demarcation between the developing ego and the primary caregiver, *the boundary violation* (the act itself) provides the core of the ego and its investment of libidinal energy. In other words, the abuse itself (the process, and not the perpetrator) is cathected by death-drive-derived energies, given that it fuels the compulsion to repeat the prior destruction of the ego, or what Shengold calls Soul Murder (Shengold, 2011).

Furthermore, *the cathected Object is not the original perpetrator but the perpetrated action*. In my view, this is a subtle yet critical difference in how incestual trauma is conceptualized. *When the process of identification with the primary caretaker, which fosters the development of object relations, is thwarted, the infant identifies herself with the process whereby primary identification is interrupted*. In the abuse process, a state of 'being' associated in phantasy with the sequence of events leading to 'intrusion' (the boundary violation) is taken in. What Winnicott calls 'going on being' (Winnicott, 1991) seems irreversibly halted, and in its place lies an *'existence within terror'* that, for the patient, becomes an ego ideal in and of itself. The 'process,' therefore, provides ego structure and gravitation toward reenactments. In the details of the act (of abuse) and their accompanying effects (fear), the patient will pursue some degree of ego cohesion. It can be concluded that its opposite, or a sense of inner peace and equilibrium, is unconsciously avoided because it is antinatural and, therefore, unsafe. It could even be proposed that working with a traumatized patient to help them achieve ego cohesion will likely produce a paradoxical effect in the patient of terror associated with the threat of psychic annihilation (Klein, 1930). As a result of incestuous trauma, death drive derivatives will be cathected by processes that entail the repetition of the original traumatic breach. Freud's economic principle dictates that the discharge of libidinal urges will be attained by the principle of the repetition compulsion, which utilizes primitive projective and introjective maneuvers to maintain a union between the abused and the traumatic act. *In essence, it is*

not so much that the perpetrator of the abuse becomes the central pathological object relation but that the 'link' itself, in phantasy, and its investment by libidinal forces seek the original Object to create and recreate that link.

For C, an identification with the incestuous Object fostered a relationship with that [entity], which remained unnamed for years (the act of abuse), which gave her a sense of self, a sense of identity without which life seemed meaningless. For her, nothing came close to the exhilaration that the fantasy of use and abuse by the Other induced in her. She desired to be hurt, for love could be found in pain. To be swallowed by her abuser meant that there was a reason to be alive, a reason for her existence. In one of many sessions with her analyst, C desperately remarked, "I want you to use me as you wish. You can do anything with me. That is what I want. I don't want to be treated with respect. I don't want to be treated with care…." Sadomasochistic fantasies prevailed in the transference as the patient tried to love and be loved by her analyst in a way that made sense to her. The more her analyst attempted to foster a relationship based on respect and appreciation for otherness, the more the patient felt rejected and unloved, which she would clarify in her use of self-harm as a loving substitute. These sessions were challenging because, at this point in her analysis, C was just getting acquainted with play as a mode of expression in her fantasy world. Until then, C had been unable to fantasize in a way that allowed her to live and exist in transition between her desires and concrete reality (Winnicott, 1951). Therefore, there was no difference between thought and action for C, which served as the basis for her prominent omnipotent defenses.

Omnipotent defenses deployed by the death drive induce a displacement of libidinal urges toward the self in the name of destruction. There is a significant difference between incestuous trauma and massive, catastrophic trauma occurring in adulthood. In the former, libidinal cathexis is redirected. In the latter, libido is de-cathected with a resulting break in what Laub calls empathic bonds (Laub & Lee, 2003). For C, ties to the trauma involved an amalgam of love and pain, libidinal urges directed against the Self-involved protection and destruction represented in self-harm to be able to love and protect herself.

Further emphasis is placed between post and pre-oedipal trauma of the sexual type, even when incestuous in its typology. For the pre-oedipally traumatized, the nature/identity of the traumatizing Object is unknown to the extent that two factors are involved: 1. The capacity for biographical (verbal memory) is still in formation. 2. Libidinal aims are displaced, and the abusing Object is 'forgotten' (repressed). For the post-oedipally abused, libidinal aims are de-cathected (no longer invested) on the abusing Object but susceptible to 're-libidinization' due to the preconscious presence of the 'verbal' remnants of the abuse and abuser. Despite the prominence of defenses that impede working through, the verbal memory remnants of trauma make it more amenable to psychoanalytic exploration. Nevertheless, there is often an eventual moment in the treatment where the patient suddenly realizes that what was all along in his memory is now 'meaningful' to the extent that it is now 'clear' that he has been profoundly damaged by it. This is perhaps when the actual working through of the trauma will begin because the patient can now start relating to others economically (Roussillon, 2013), which is a prelude to reestablishing subject-object relatedness.

From nothingness to symbols

While contemporary psychiatric discourse emphasizes the description of symptoms resulting from an 'outside' source of trauma bringing about fixed memories, psychoanalytic phenomenology describes trauma not in terms of faulty memories but resulting from a distorted understanding of the traumatic experience. The process of understanding is made possible by the mind's use of symbolization, which involves representations through symbols. Symbols are, to the mind, transitional objects that serve as links between the outside situation, event, or circumstance and their recognition by the mind. These transitional symbolic objects serve as a buffer against the flood of experiences that can overwhelm the psyche after traumatic experiences. From a technical standpoint, in deciding how to help the patient, the analyst will work through the traumatic experience by assisting the patient in giving meaning to his traumatic past.

Giving meaning to the traumatic experience entails analyzing the pre-traumatic period, what it was like to live their life up to the time of the trauma and beyond. Those are only a few potential questions delving into the phenomenology of the traumatic experience. Without a transitional symbolic object or link, memories of traumatic events will be understood as outside persecutors from which the patient has to hide. Because the patient lacks the transitional symbolic link, she will misjudge potential external threats as actual ones because there is no bridge between her traumatic memories and her environment. For her mind, memories and reality are the same; if memories are horrifying, so will her reality. This is confusing for both the patient and analyst to the extent that they will show up for consultation with a sense of acuity that seems to indicate a concrete threat from which the patient is trying to protect herself. More often than not, current outside circumstances are average, and it is not clear what the sense of urgency is about. "I am anxious," a 22-year-old female repeated to her clinician. With a fearful expression and a sense of impending doom, she continued to insist that she did not "feel safe!" She was diagnosed with post-traumatic stress disorder and deemed to be having a 'flashback.' Yet her clinician was perplexed because she was unresponsive to repeated attempts at reassurance. To name something (a flashback) does not mean it is understood. Had her clinician understood the nature of the transitional symbolic Object, they would have been able to abstain from reassurances that fell on deaf ears.

The transitional symbolic object and the fear position

In the first stages of the treatment of incestuous trauma, the first hurdle will be to achieve and then surpass the Fear Position, a preamble to symbolization. The constant conscious and unconscious avoidance of the outside threat that predates the Transitional Symbolic Object renders the beginning stages of the analysis of trauma almost an impossibility. I consider the following clinical example (from a patient previously described in this manuscript) an appropriate representation of the concept of the Fear Position in trauma. It depicts how far the avoidance of the outside threat can go in the service of safety. K began treatment with her analyst serendipitously in a psychiatric inpatient unit due to chronic anxiety and depression. At 21, K was unaware of what was perpetuating her dysphoria. Despite

apparent attempts to avoid and reject therapeutic work, throughout the next few weeks, K began to develop trust in her analyst, which led to her sharing a horrible history of parental incest starting at the age of twelve. After a few weeks of inpatient psychoanalytic work, K was discharged to continue analytic psychotherapy in the inpatient analyst's private practice office. Her improvement was almost miraculous. She felt far less depressed, applied to and obtained a job, and began considering college applications.

Over the next year, K's improvement, although welcomed, was extreme. Although very happy about her progress, K's analyst was highly suspicious and concerned, although he didn't know why. Eventually, while in the context of a traumatic re-experience, K regressed, got depressed, and necessitated an inpatient level of care. While in the psychiatric unit, she experienced severe nightmares, persistent insomnia, agitation, and extreme anger. Her attending, also her analyst in the office setting, continued the work there but realized that K was relating to him in a way he had not experienced before, exhibiting rage that showed in the transference that led to multiple impasses and painful confusion in her analyst. It was clear that K's analyst was experiencing her confusion and pain. This erratic course of events set the stage for transitioning from the Fear Position (her prior miraculous recovery) to the paranoid-schizoid one. After extensive self-study and consultation, her analyst understood that K needed to transcend the objectless realm where her traumatic experience had taken her to begin working through the horrors of her past. Upon the occurrence of incest, first at the age of twelve years old and regularly after that, K's trust in a 'life possible' was shattered. With that, a reversion back to an earlier developmental state that Guntrip has described as returning to the maternal womb, and by Bick as a chaotic, unintegrated state in the infant, made cohesive by the integrative function of the skin (Bick, 1968; Guntrip, 1962).

Further considerations on the fear position

The Fear Position represents a state devoid of object relations in the interest of safety and protection. Ch, a 23-year-old female with a history of chronic severe physical and psychological abuse in her early childhood, commented after a long pause, "I have so much inside…but I do not know how to say it…." Ch wanted to talk. She needed to talk. Yet, she could not. Ideas, images, sensations, and snapshots of an oppressed life kept bubbling up in her mind; none of it was part of a sensical narrative. It can certainly be understood that if the patient must choose, they will try to get as far away from the traumatic experience as her mind would allow.

Nevertheless, as Freud clearly exposed, identification achieves quite the opposite; the farther she retreats, the closer to fear she gets. The fear position is an alternate realm where no clear demarcations exist. By this, I'm referring to the mind's tendency to organize reality in 'absolutes' to achieve predictability, order, and safety. The Kleinian paranoid-schizoid position presupposes a dichotomizing, by the mind, of opposites. It entails the presence of an outside environment/Object with which the subject is interacting and from which they are persecuted; an outside environment is required in the act of running away or hiding. In the fear position, all options are present as possibilities; the depressive, paranoid-schizoid (Klein, 1930), primal (Eekhoff, 2019), and

autistic position (Tustin, 2013) are all present because of their absence.

Fear, love, and hate are undifferentiated. Therefore, there is nothing to run to or away from. This situation is seen in the patient's confusion, which precludes the expression of apparent idealization or devaluation. In this sense, Klein's description of a split in evaluating the world is, in this context, undoubtedly, a developmental achievement. In the psychoanalytic treatment of developmental trauma, the expression of split-off aspects of the self should not be seen as a technical inconvenience but as a desired step in transcending the Fear Position. Ch would need to transcend the Fear position to be able to hate. Real reparative work can begin once she can 'hate' her therapist. For Ch to start the reparation process, she must tell her story under the careful guidance of the empathic and compassionate therapist, relieving every emotion associated with those frightening memories. The initial challenge is that the nonsensical traumatic event she experienced has been internalized and made a part of her ego. There is no difference or clear demarcation between the ego and the traumatic event; they are two sides of the same coin. It might be concluded that as the ego organizes under the shadow of trauma, the objective world (outside Object/environment) is decathected in what Green calls de-objectilization (Green, 2005; Green, 1999).

Helping a patient transcend the Fear Position is a challenging task. During this stage of the therapeutic process, some patients might stop their analysis prematurely and never resume again. Transcending the Fear Position might take a few months or even years. Once the nonsensical traumatic set of events and internalized experiences acquire the coherence needed to become a spoken word, libidinization of 'something outside of the self' begins, and trauma can become a 'not-a-part-of-me (NAPOM)' entity. Although terrifying and now a reality outside of the self, this new entity is *nevertheless a coherent narrative that can be understood and cognitively reappraised and, with that, a transition to the paranoid, schizoid position*. At this point, the analyst will see (and experience) intense countertransference due to the prominence of projective identification, which was not the patient's preferred mode of communication used in the Fear Position but gains prominence in the paranoid-schizoid realm.

The Fear Position is fueled by the Death Drive, which is itself a vehicle for self-annihilation. Such a state is seen in the traumatized as a relentless pursuit of self-destruction in the interest of safety. This is contradictory when seen from the point of view of the pleasure principle, but such a discrepancy is one of the hallmarks of severe trauma. The result of intense trauma is a nonsensical psychic structure that seems as such when understood from the point of view of the non-traumatized. In K's case, death drive derivatives led to what Green calls the work of the negative, where the unbinding of life-promoting drives toward the Object is decathected, and internal representations turn into representations of the unrepresented (Green, 1999). For K, life occurrences led to the destabilization of defensive maneuvers to preserve the fear position. Returning to the inpatient unit in what is usually a re-traumatizing experience but being able to keep working with her analyst now in a different frame led to re-libidinization and 'outside-of-self' directed object cathexis (K to her analyst). The following sections will describe how the re-establishment of drive investment as a function of the working dyad serves as a preamble to the beginning stages of symbol formation.

Re-libidinization and symbol formation

Traumatic circumstances that disturb normal development in the preverbal/preoedipal period might result in an incapacity by the self to recognize its separation from the outside Other. In other words, the elements whereby *Phantasy* leads to object-relatedness are interrupted, ultimately halting any capacity for *fantasy* (lower-case f) and resultant symbol formation. The first objective in working with those who have been traumatized in the preverbal period is to resist the patient's attempts to inhabit the therapist's inner psychic realm. Just as the astronaut must inhabit the spacesuit to survive in space, the patient will use violent projective identification maneuvers to survive her analyst's attempts at relatedness. Projective identification will show key features. The analyst might feel controlled and used disturbingly and might feel as if all power has been lost. As the patient projects those bad/hated elements she is trying to disown onto her analyst, they will eventually return to her as originating from the analyst who, if not careful enough, will identify with those disavowed harmful elements from the patient.

For instance, in the case of Ch, the analyst felt the urge to extend the usual fifty minutes by an extra half an hour because he considered the patient's story to be remarkable and did not want to interrupt her stream of consciousness because he knew, given this patient's traumatic history, that she found it difficult to talk, let alone engage in what seemed like an interminable account of her teenage years. The analyst felt confused because of how out of character his decision to extend the hour was. Further self-analysis and discussion with his supervisor and own analyst revealed that his decision was the product of a constellation of details, both on his developmental past and unconscious projections from the patient's part. Further sessions showed a tendency that the patient slowly began to recognize in herself to control the extent of her information sharing with her parents as there was a way in which she felt she could gather more attention to herself if she was measured and calculated in providing, or not, information about herself to them. She felt, omnipotently, that she could control her parent's responses with the availability, or not, of her words. Her analyst felt the urge to give more of himself to this patient who suddenly was doing something she usually didn't do: talk. However, the analyst's history with his mother, who was inconsistent with her demonstrations of affection, predisposed him to be exquisitely sensitive in recognizing an opportunity to be provided with "words" as a representation of maternal affection.

Other more perverse ways in which PI can be deployed involve the projection of wishes to destroy the therapist, who might then identify himself with those destructive aspects of the patient, engaging himself in harmful acts toward her. Therefore, projective identification can result in an unending cycle akin to a boomerang thrown forward with force, only to see it return with equal violence. The patient will feel persecuted by the same disowned elements she tries to get rid of in the first place. The analyst might have a sense that he has lost himself. He has become a spacesuit for his patient. His mind doesn't move his body. His body is now possessed by the patient, who cannot use hers. Therefore, projective identification is the primary defense used by patients who lack a sense of their existence because of developmental trauma. As formu-

lated by Melanie Klein (Klein, 1946), projective identification described a process that was more of a hindrance to the analytic process and which the analyst needed to resist. Klein understood projective identification as an attempt by the patient to get inside the analyst's psyche with no useful purpose other than as a disruption of the analytic process that needed to be resisted if the analyst was to be successful. Neo-Kleinian thinking now understands PI to be an archaic attempt at communication that the analyst needs to interpret. In trauma, PI is often the primary mode of communication by patients. In the countertransference, the analyst will sense that he is walking around land mines with no easy way to navigate the patient's constant projections.

After trauma, PI is deployed because the ego has lost itself in an amalgam of split-offs that create a confusional state of sadomasochistic part-object relations (Eekhoff, 2021). This confusional state gets in the way of whole object relations between analyst and analysand. The fear position is purported to represent a more primitive state preceding Klein's paranoid-schizoid position. For K, described above, the fear position halted all possibilities for developing object relations and symbolization. While K was in the unit, her analyst noticed a more pronounced use of projections, leading to impasses in analyst-analysand communication. Her analyst understood K was trying to communicate erratically, employing sadomasochistic defenses. Sensing an opportunity for growth, her analyst decided to modify his technical approach and decided to confront her, mostly refusing to accept her projections. What followed was a challenging period of days where K showed prominent paranoid anxiety and a clear display of rage that her analyst could contain, albeit with tremendous difficulty. Suddenly, K was able to truly begin the process of re-libidinization and cathexes to the person of the analyst. In K's case, she needed to transcend the fear position to experience the paranoid-schizoid realm and enter the earliest stages of object-relatedness to be able to symbolize ultimately.

Symbolization presupposes the patient's recognition of the Object outside of herself, whereby sadomasochistic defenses, including PI and omnipotent approaches, are no longer used as a primary way of communication. The traumatized patient lives in a world of sensory overload, where, to survive, he will need to make sense of concrete experiences. The outside world, filled with the concrete, is intrinsically meaningless. For instance, a rock exists in time and space as a composite of minerals held together by chemical bonds. When they think of a rock, most people try to make sense of it by thinking about what it represents to them. For instance, for some of us, a rock might signify strength, solid core values, something with which we accidentally hit our head while in a playground when we were little, or the many cobblestones with which a fire pit is built with a loved parent with whom we spent many hours of pure joy. Innumerable meanings can be assigned to a rock, but it is unlikely that most of us will only think of it for what it truly is: a dense cluster of chemically connected atoms. Our world experience does something to it, and the world does something to us. Our minds and brains transform the experiences gathered from the world into digestible bits and thinkable meanings. Symbolization provides meaning to meaninglessness. To symbolize is to transform something that intrinsically means nothing into an entity we can carry in our minds. What is held

in mind is not what is out there in reality but a substitute or representation.

A, an early 50's divorced female patient with three adult children, related in session how desperate she was that she felt she had "this ball inside" while pointing to her abdominal area, which she felt was a tumor since it did not feel that it was part of her. For A, that Object inside of her felt like an alien given to her from outside that she needed to get rid of. A had been molested at eight years old and was struggling with intense shame outside of conscious memory. A had come close to recognizing the extent to which her trauma had negatively impacted her life and how it perpetuated her chronic depression and anxiety. However, she still struggled to mourn the loss of her psychic equilibrium at an early age. What A still struggled with was letting go of her connection to trauma. To do that, she would have to allow herself to grieve. But to do that, she would have to be able to first symbolize her traumatic experience in order to let it go.

The most significant outcome after trauma is the loss of symbolic capacity. The centrality of symbolism to cognitive or mental flexibility is integral to understanding catastrophic trauma on the psyche. The mind's ability to symbolize experience allows it to coexist within a rich and constantly changing environment. The mind must represent experience to metabolize it onto a more sensical substrate to understand the world around us. The product of this metabolism allows for the richness of Phantasy and, therefore, object-relatedness.

The symbolic function as a mathematical notation

A symbol in mind is the portrayal of reality linked to the concrete outside Object. It is, in consequence, not the real Object but its metabolic product. A way to visualize these relationships is to borrow the *function* notation $Fi = fi(x1, x2,...xn)$ from the field of mathematics. In mathematics, a function fi is used to denote the relationship "i" between 'n" variables "x" (i.e. "x1", "x2",… and "xn"), whereby an output "Fi" is obtained from this relationship. In the case of the mind's symbolization, we need to assume, for the purposes of this discussion, that symbolization by the mind will entail a function $f2$ (a relationship between two variables "x1" and "x2"), where one of the variables, "x1", is another function $f1$. Here is the explanation as to why function $f2$ is named before function $f1$: The first relationship (Binary Relationship #1 or BR1) will be that of the sensorial stimuli with the mind's primary processing of such stimuli.

In other words, the binary relationship #1 (BR1) between the senses (our mind's understanding of sensory stimuli) and reality is a function $f1$ with the following mathematical notation: BR1 = $f1$(s,p). Where the first variable, "x1" is "s" and implies the sensorial aspect of experience and the second variable "x2" is "p" and implies the primary processing of stimuli in mind. The Symbolic Function (SF) is the binary relationship #2 (BR2), which, for the purposes of clarity, will be labeled as "$f2$" and will be described with the following mathematical notation: SF = BR2 = $f2$(BR1,RO). Where "BR1" is the binary relationship mentioned above and "RO" signifies the Real (concrete) Object.

In summary, the mathematical relationship to depict the symbolic function in mind includes a *relationship within a relationship*

or a function of a function. It is as if, in order to symbolize experience, the mind needs to first grasp and understand stimuli, which will include the concrete Object (as the rock was used in the example above) and how we feel it, see it, and, in some cases, taste it. The mind then takes that relationship (concrete + senses) and further processes it, creating unconscious (Phantasy) and preconscious (fantasy) links with the Object (outside world/environment).

$$BR1 = f1(s,p)$$

$$SF = BR2 = f2(BR1,RO)$$

Trauma as a disruptor of symbolic capacity

Freud alluded to the mind's capacity to symbolize with his description of trauma as "…any excitations from the outside which are powerful enough to break through the protective shield [so that] there is no longer any possibility of preventing the mental apparatus from being flooded with large amounts of stimulus which have broken in…" (Freud, 1920). Implicit in Freud's writings is that trauma produces some form of interruption in the process whereby experience is filtered and made into manageable substrates. In other words, symbolization keeps that 'protective shield' intact in mind. It prevents flooding by excessive experience.

This idea could also be written as a mathematical function where "s," which implies the sensorial aspect of experience, is a function of trauma (the traumatic experience).

The mathematical notation would be:

$s = f3(t)$, where "s" is a function "$f3$" and the only variable is "t" which implies the trauma (traumatic experience).

After severe developmental trauma, the real and concrete outside the mind becomes the real and concrete inside it. There is no modification of the concrete from the outside into an abstract understanding of that outside reality. In essence, extreme fear shatters the mind/brain's ability to create tolerable representations of the world. Without such representations, the mind is left with an 'unfiltered' reality of the traumatic experience. In other words, trauma breaks apart the mind's ability to symbolize experience. Without symbolization, the psyche is rendered naked, and there is no longer a clear demarcation between what is real and what is not. It is as if watching a horror movie, after which it is unclear whether what was watched was fictional. Under normal (non-traumatic) circumstances, although one is terrified of the chasing monster in the movie, it is understood that once outside the movie theater, no monster truly exists, and we are safe. To switch from the more concrete movie experience (the monster on the movie screen is 'real') to the more abstract (It looks real, but it is just a movie), the mind must convert reality into a manageable representation. The efficacy of analytic work resides in its ability to implicitly facilitate creating symbolic processes using the 'frame' (the theories and within-session technical applications that define psychoanalysis) and creating the 'as if' experience between analyst and analysand. In other words, in the analytic situation, an 'alternate reality' is lived in the transference-countertransference enactment whereby unconscious processes are explored within the safety of the frame. The frame, akin to the movie theater, provides an opportunity for experiencing the horror movie of trauma in '3D' within the safe confines of the office/movie theater. It is as close as the patient will come to experiencing her trauma, 'as if' it was once

again occurring for them—the 'as if' experience is, therefore, one of *unreal reality*. *Recreating the horror of trauma within the movie theater of the office creates an opportunity for a remodeling experience within the safety of the 'Unreal-Reality' scenario that transforms unfiltered, raw memory into symbolic representations*. This transformation is mediated using words. Words are powerful entities that, in trauma, hold the key to healing; despite their power, or perhaps because of it, words are rarely pronounced by the traumatized. The patient with a history of trauma is most of the time silent. The patient is quiet because words reveal her presence and the presence of the Other.

With her silence, the patient is too close to what Lacan calls The Real (Lacan, 2018). The Real has no name, state, or temporality and is now at the forefront of the patient's experience. The Real reveals itself in the patient's chronic unsayable fear, her relentless nightmares, and her vision of an unlivable world. Words are powerful to the extent that they transform signifiers into signifieds en route to the symbolic order. In other words, for Lacan, language is the medium whereby something is transformed into something with meaning (a representation in mind). Transforming traumatic experiences into words is taken for granted but can prove almost impossible for the traumatized. As previously described, for patients with a history of severe trauma, naming the event, experience, or perpetrator is akin to a complete audiovisual transformation of reality to the traumatic one. The analyst must be patient and compassionate, as the patient's silence will be her only defense before she can begin to trust the process.

Conclusion

With this manuscript, I have attempted to delineate some of the salient psychodynamics of the traumatized patient, emphasizing developmental trauma in the form of incest. Based on my clinical observations, I have described that the main obstacle in the psychoanalysis of victims of incest is their stunted capacity to symbolize experience. Victims of incest, if in the preoedipal stage, will show an alteration in the economics of drives with resultant libidinal decathexis, impacting the flourishing of Phantasy and ultimate object relatedness. The fear position is proposed as a defensive preamble to the paranoid-schizoid phase that must be confronted in session to redirect libidinal drives outside of the ego and onto the other. Only if the investment of drives is externally redirected will the initial stages of symbolization be viable. It is then that traumatic working- thought can be achieved.

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References

Bick, E. (1968). The experience of the skin in early object-relations. *The International Journal of Psycho-Analysis*, *49*(2), 484–486. https://www.ncbi.nlm.nih.gov/pubmed/5698219

Bott Spillius, E. (2001). Freud and Klein on the concept of phantasy. *The International Journal of Psychoanalysis*, *82*(2), 361–373. https://doi.org/10.1516/5PWR-57TK-VT2U-3XU8

Eekhoff, J. K. (2019). *Trauma and Primitive Mental States: An Object Relations Perspective*. Routledge.

Eekhoff, J. K. (2021). No words to say it: Trauma and its aftermath. *American Journal of Psychoanalysis*, *81*(2), 186–206.

Ferenczi, S. (1988). Confusion of tongues between adults and the child: The language of tenderness and of passion (1932). *Contemporary psychoanalysis*, *24*(2), 196-206.

Freud, S. (1896). The aetiology of hysteria. In The Standard Edition of the Complete Psychological Works of Sigmund Freud, Volume III. The Hogarth Press.

Freud, S. (1904). Letter from Freud to Fliess, September 21, 1897. *The Complete Letters of Sigmund Freud to Wilhelm Fliess.*

Freud, S. (1905). Three essays on the theory of sexuality. In The Standard Edition of the Complete Psychological Works of Sigmund Freud, Volume VII. The Hogarth Press.

Freud, S. (1915). Mourning and melancholia. In The Standard Edition of the Complete Psychological Works of Sigmund Freud, Volume XVI. The Hogarth Press.

Freud, S. (1920). Beyond the Pleasure Principle. In The Standard Edition of the Complete Psychological Works of Sigmund Freud, Volume XVIII. The Hogarth Press.

Green, A. (2005). *The Dead Mother in On Private Madness Pub*. Karnac Books.

Green, A. (1999). *The work of the negative*. Free Association Books.

Greenspan, F., & Moretzsohn, A. G. (2013). What Treatments are Available for Childhood Sexual Abuse, and How do They Compare? *International Journal of Advances in Psychology*, *2*(4), 232–241.

Guntrip, H. (1962). The manic-depressive problem in the light of the schizoid process. *The International Journal of Psychoanalysis*, *43*, 98–112.

Kaplan, M. J., & Klinetob, N. A. (2000). Childhood emotional trauma and chronic posttraumatic stress disorder in adult outpatients with treatment-resistant depression. *The Journal of Nervous and Mental Disease*, *188*(9), 596–601.

Klein, M. (1930). The importance of symbol-formation in the development of the ego. *The International Journal of Psychoanalysis*, *11*, 24.

Klein, M. (1946). Notes on some schizoid mechanisms. *The International Journal of Psychoanalysis, 27*, 99–110.

Lacan, J. (2018). *The Four Fundamental Concepts of Psycho-Analysis*. Routledge.

Laub, D., & Lee, S. (2003). Thanatos and massive psychic trauma: the impact of the death instinct on knowing, remembering, and forgetting. *Journal of the American Psychoanalytic Association*, *51*(2), 433–464.

Ogden, T. H. (2002). A new reading of the origins of object-relations theory. *The International Journal of Psychonalysis*, *83*(4), 767–782.

Roussillon, R. (2013). The function of the object in the binding and unbinding of the drives. *The International Journal of Psycho-Analysis*, *94*(2), 257–276.

Sanfelippo, L. C., & Dagfal, A. A. (2020). The Debate Between Janet and Freud Revisited: Trauma and Memory (1892-1895/1913-1914). *The Psychoanalytic Quarterly*, *89*(1), 119-141.

Shengold, L. (2011). Trauma, soul murder, and change. *The Psychoanalytic Quarterly*, *80*(1), 121–138. https://doi.org/10.1002/j.2167-4086.2011.tb00080.x

Tustin, F. (2013). *Autistic States in Children*. Routledge.

Williams, L. M., Debattista, C., Duchemin, A. M., Schatzberg, A. F., & Nemeroff, C. B. (2016). Childhood trauma predicts antidepressant response in adults with major depression: data from the randomized international study to predict optimized treatment for depression. *Translational Psychiatry*, *6*(5), e799.

Winnicott, D. W. (1991). *Playing and Reality*. Psychology Press.

Winnicott, D. W. (1951). *Transitional objects and transitional phenomena.* Tavistock.