Generations of analysts, generations of patients: non-symbolizable destructiveness in contemporary patients

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Abstract

This article focuses on contemporary psychological problems, given the frequent difficulties in analytic work with patients and the relevance of contemporary analytical treatments. The author gives a particular attention to destructiveness and provides a working hypothesis with patients that present a deficit in symbolization. It seems important to develop areas of psychic work not only bounded in the relationship between two subjects, but that are also widespread in the mental state of a generation or more generations. It seems also important to identify a group/state of mind that exists between different longitudinal degrees of kinship. In addition, this work takes place in an area that, I imagine, exists before, or around, the psychoanalytic treatment, even if it involves analytical thought, without which it would have no meaning. These themes are treated from the perspective of destructiveness, of desubjectification, and the difficulty of symbolization, as conditions that increase the traumatic dimension of the mind, in which the trauma that the subject encounters can multiply from his own destructiveness not symbolized or containable.

Key-words: trans-generational, group state of mind, destructiveness, lack of symbolization

Theories and Times

When reflecting on contemporaneity, the relationship with theory is crucial, insofar as it is connected to the analysts who once treated us as patients, and today constitutes, perhaps only in part and hopefully not in a rigid manner, non-anonymous areas of the identities of our personas. Certainly, a theory does not cure if it is not supported by a relationship. It is in this sense that more attention is given to the relations of encounter with theory, which often risk giving preference to the conservation of knowledge over the creativity of learning (Kernberg, 1996). Thus, studying treatment methods and reference theories does not imply studying objects that are distant from us, insofar as the link between patient care and an implemented treatment occurs within ourselves. This poses the problem of belonging to different generations, as Chianese (2008) writes when he asks whether psychoanalysis does not contribute to the formation of a type of man in which many in Western culture had recognized themselves in the past, but with whom few identify today.
Interest in periods and in our “grandfather” analysts may also be considered through a reflection on the transformations of psychic suffering that occurred from our

"grandfathers"' times to our own, as Rossi Monti (2008), bears in mind, implying today a greater presence of psychotic areas. Gaddini (1989) also provides an articulation of the type of distress over generations, considering hysteria and phobias as the predominant forms of distress at the end of the First World War, while disturbances of borderline state nature denote the end of the Second World War.
An evident condition of European analysts, who at home had to come to terms with the Totalitarian block on the development of psychoanalysis, is discernible in that those who were unable to reach England or the United States had to remain tied to those first psychoanalytic models, insofar as they were excluded from the evolution of the psychoanalytic process within which the debate of counter-transference was taking shape. Thus is the case of many German analysts who remained in their homeland during the reign of Nazism. They passed from the analyst who aseptically reflects transference intended as pure repetition of an infantile schema, presumed as objective and immutable, to the analyst persona, that is, the manner in which the analyst behaves, as an indispensable element of the bipersonal or groupal field, able to influence a way of living and a specific intimate world within the analysis room.
This type of experience suggests how much psychoanalysts have had to operate partial separations from the primary models of their "grandfathers". The theme of the relationship with separateness is, moreover, one of the themes we often find in so-called contemporary distress, or in so-called contemporary patients, indicating through these terms a perhaps generic abstraction, yet one which corresponds to the attempt to define problematics of common contemporary distress.

Contemporaneity, Mourning and Separateness

A first element connected to contemporaneity is constituted by the internal relation with the areas of anxieties of death, mourning and separation (Comelli, 2010), and of how much, tendentially in the adolescent age range, these are little experimented or managed, to the benefit of an anaesthesia via objects upon which dependence is developed, as well as to the benefit of a narcissistic theme able to keep the shame of one's own internal world under control, avoiding the intimacy of relationships. The "negative", the "bad", can only appear as part of a symptomatology or as a fascination with an otherwise non-experimentable world.
In ethno-psychiatric studies (Coppo, 2000), the mental or internal world elements, scarcely experimented by a social group or by the domestic context, reappear under the form of collective symptoms. In contemporary Western ethnicity, it seems that the anxieties of death and separation that are not tolerated, dealt with, or integrated into the relationship, in the case of anorexic pathologies, reappear presentified in the possible death of the patients or in self-destructive behaviour, like a timely and tragic return of those elements which were not understood, encountered or dealt with in familiar or intrapsychic relationships.

Following a youth culture slang that speaks of positive/negative bipolarity, one could say that these two dimensions need containers to guarantee them the sense of experimentability and perceptibility.

Bad, Negative

It is obvious that the ego has much to handle, starting with the trauma of birth, that is, the vast range of anxieties varying from death to separation.
Classically, the alternation between a part of oneself that is good, omnipotent, and solely follows drives of primary gratification, and the so-called "negative" finds hospitality in a maternal container - the mother's breast - triggering a dynamic between two polarities which sets down the bases for a transference and for a future symbolization. In other words, the undesirable and destructive elements of the inner world, including feelings of hate, may or may not (Klein M., 1952), integrate in a singular element with those that are loved, as a sign of mental growth and access to the forming of the symbol.
References to fragmentation or to integration appear important insofar as the angst of the destructive drive is either fixed and contained in an object able to tolerate, or is lived as fear of an uncontrollable, potent and uncontainable object. Such a drive would thus certainly be diverted in the environment and fixed in the maternal container object, but in part, it would remain nonetheless within the subject. If this latter part, which remains bound to itself, is quantitatively or qualitatively excessive, the effect on the internal world will be of a fragmented type, as a defense of the ego, itself faced with an anxiety too strong to be tolerated. Contrarily, the recognition that the maternal object is the target of one's own destructiveness may lead to the terror of its loss and destruction (Klein M., 1946).
The split of the bad object from the primitive ego, through a process of projective identification (Klein M., *ivi*, p. 423), such as displacement of the bad parts of the self to the maternal object which collects destructiveness, has a protective purpose regarding the persecution of the bad destructive object (Klein M., *ivi*, p. 417) and results in the idealization of the good elements that remain, so to say, purified of the destructiveness.
These reconstructions can help us therapists define the areas that our minds may use to theoretically imply the fields in which we can have experience. But we may ask ourselves what the subject experiences in cases where the infantile maternal experience does not allow for an objectual relationship sufficiently protective of the symbolic abilities or the containability of the tormenting objects.
It thus seems important that we question whether the separateness of which we speak addresses a mind that has had sufficiently transformative Oedipal experiences during growth, or a mind that has not had such opportunities for its own inner world. In the case of the latter, the mind finds itself living a condition we therapists may define as pre-egoic. Although as analysts we can define this state, we may ask ourselves how much we can understand the type of separation anxiety experienced by patients

whose minds struggle to symbolize, and whether such patients, precisely because they are equipped with a different language, must be refused in terms of being non-analyzable.
Are we sure that the separation spoken of by adolescent patients of this period is the same separation that we analysts experienced in another time?
Thus, if we are used to observing neuroses based on transference and its symbolic sense in the traditional clinic, in contemporary distress with a prevalence of free anxiety (i.e. panic attacks) or compulsive symptoms (i.e. eating disorders), we must come to terms with an aborted beginning of the symbolizing register and of the sense of separateness, with an induction to a conformist reduction of the value of the subjective identity to the benefit of a dependence on regressive mechanisms of the masses.
All of this is meant to trigger reflections on the sense of different languages, recalling that psychoanalysis, reaching beyond these areas, risks not providing a very useful, even if not immediately expendable, personal knowledge to patients who cannot yet use it.

The Lack of Symbolization and the Significance of the Body as the Container of the Mind

Once again drawing from psychoanalysts, we can make a second reflection, not antiethical to the first, but perhaps more destructuring.
From clinical experiences, I can deduce that the individual mind of the patient with serious dependencies (taken as an example of a widespread form of contemporary distress) cannot organize and tolerate a language and an experience in its inner world, at least in certain phases. The adolescent chooses a dependency that contains and protects from still containerless anxiety. Therefore, in these patients lacking an object upon which to depend, there is no container for inner distressing states.
From this, at least one psychopathological question is raised. In concert with Gaddini's opening considerations, the condition of absence of a container and of representability of anxiety brings this state closer to psychotic schemas than to dependencies that appear only as symptoms. It thus may be hypothesized that, in many of these cases, dependencies keep conditions of lack of container and borders of the ego under control, rather than previously developed neurotic schemas that are closer to psychotic areas.
In many patients, the absence of dependence uncovers conditions of total invasion by anxiety and its non-representability, which is fundamentally different from the neurotic schema capable of symbolizing and representing the anxiety through a symptom-symbol.
In the absence of symbolization of anxiety and with a borderless ego, there is an evident distance from the condition possibly experimented by a therapist, who may instead have come to terms with his or her own separations, even from his or her own first theories. Therefore, there is the risk that an analyst who has done the work of

separation may be faced with a youth who cannot directly use the inner language that the analyst has developed with him or herself: a so-called generational conflict.
One of the difficulties resides in the diversity of inner languages between two subjects. One understands the sense and frustration connected to separation, while the other is crushed by undifferentiated mental states in which the terms of identification with the masses, seriality and de-subjectivation describe a condition of disappearance of the ego and a regression toward pre-egoic states. There would not manifestly be a dynamic of transference, through the annihilation, as much as an implosion of the borders of the ego, which would disappear before differentiating itself.
Here again, perhaps it is not the case that psychoanalysis remains silent until the subject is able to symbolize. We would find ourselves faced with the need to continue being psychoanalysts, and to help the patient who may need a thought –container able to provide borders and sense to situations that appear without the possibility of a reading of the very sense of the distress.
In these scenarios, the patients desperately search for borders: existing without borders is the equivalent of being exposed to psychotic anxieties and to having an impellent need to identify a container that is most often in the body and in its sensoriality.

Body - Container of the Mind

In many cases, there is a precise alternation between phases that are more unequivocally psychotic, delirious, or without productive symptoms, and phases with a strong presence of the dependence, with the direct effect of the dependence on the body. This produces intense somatic absorption both in the need and in its fulfillment, inducing an effect of container in the body and in rhythm. The container-body thus assumes a preverbal function of limit and of rhythm, so as to provide a rudimentary response to the absence of a mental border and of other tools for feeling pain.
However, in this sense, the symptom of depending foresees that the object on which one depends becomes essential for the finding of one's container. The implication is that the object of dependence creates and determines the container.
One can thus verify a correspondence between the absence of borders of the ego, exposure to non-symbolizable or truly incommunicable psychotic anxiety, and the locating of the body as container.
But again, in reconstructive terms and through the use of a familiar language, this regards those who have developed psychoanalytic knowledge. In real clinical experience with patients presenting these areas of non-symbolization, we can consider that the therapist with analytic knowledge must appeal to more primitive elements of his or her own experience, not only psychoanalytic, without immediately being able to use a psychoanalytic language.
In many cases, even among adolescents, this is often very well known by "expert" patients in periods of adaptation or who are constrained to a concretization of their own inner experiences, such as those who have experienced traumatic disorders of

the psychosoma during a stage in which the self was not yet formed (Williams, 2003).
In these cases the ego-body and the sensory bodily image are unable to support traumatic disorders exceeding the subject's ability to tolerate them. A rudimentary representation of the other thus inserts itself into the mind of an infant before a coherent sense of self is developed.
With "incorporation of an invasive object" Williams (2003) intended a rudimentary and premature identification with the object in early infancy that has precipitated from a precocious and crushing interaction with the object itself. In absence of the psychological ability to symbolize or mentally represent the impact of the experience of being invaded, the premature identification registers itself in *the body* as an incorporated state that remains unavailable for metabolization through the normal forms of symbolization.
In these cases the mind would experiment a state *not* part of itself, nevertheless superimposed in part *with* the sense of self, creating an area of psychotic conflict or of a "heterogeneous inner state" (Quinodoz, 2001, p. 235-248).

Implications on the Encounter and on the Beginning of a Therapeutic Relationship

Bringing this argument to the traditional setting of the "talking cure", one may ask how the patient with a symbolization deficit may perceive reference to our interpretative codes and to therapeutic processes. On the part of patients and even of colleagues with non-psychoanalytic orientations, the psychoanalytic claim of treating many patients is increasingly viewed as a colonial and culturally assimilating behaviour.
Often the dependent adolescent with a deficit of symbolization has his or her own apical expression in a word caricaturing expertise, insidiously confident with the self-reflexive and technical aspects of the treatment (in the case of anorexic patients, familiarization with pharmacology and support of a will to abuse, mostly of psychopharmaceuticals prescribed by the treating psychiatrist, as well as laxatives and diuretics, with the tools for measuring and controlling the physiological and bodily parameters with the diagnostic labels) (Faucitano, 2010).
I would like to again underline how dependencies (including that on psychoanalytic language) would cover, in subjects with symbolization deficit, an absence of mental borders that bring these schemas close to defectual psychotic states of the mind.
The issue of mutual understanding between contemporary analysts and patients therefore mainly plays itself out at the beginning of the relationship, when gazes and languages meet for the first time, even without the full use of words. The beginning, the encounter with a so-called "grave" patient, through the rhetorical figure of the analogy, may reproduce the wordless encounter between the caregiver and the newborn.

These themes have their own legitimacy precisely in order to avoid indulgence or imitation of therapeutic relationships based on the maintenance of untruthful zones. Thus, I believe the beginning of a relationship to be an establishing element of contact with the patient, through an attempt to suspend every prejudice or precognition, even psychoanalytical, while leaving the function of preconception unbound. This is why an analytic mentality and training are required for the process, without immediately giving way to *tout court* analytic treatments, in light of the fragility of contemporary patients and not only of their presumed "resistances".

We can thus consider the beginnings of the patient-analyst relationship as an encounter in which at least the following questions surface:

What is the relationship between the patient's need and the "analyst-container" and, hence, what kind of container can the analyst be for this patient?

Can the analyst contain the containers of the patient even before developing an observation of the contents?

How can we organize and consider the family container and its relationship with the patient-analyst couple?

We are therefore speaking of phenomena that occur even before words become the conscious containers of representation, or are crossed by the most differentiated, adult, and Oedipal aspects. What follows is a brief description of a clinical case of precocious mental areas and their containers. An anorexic newborn (two months old) does not eat, risks dying, is in distressing conditions, and furthermore, is tortured by medical investigations. A sitting with the mother allows for the reconstruction of the latter's own childhood, dominated by the terror of suffocation induced by the forced feedings of her own mother, that is, the child's grandmother. Listened to and engaged, the mother greatly changes her approach to the nourishment of her daughter, who gradually and more readily begins to ingest food.

These experiences refer to the child's preverbal reception of basic states, such as precocious prohibitions and the mother-baby unit (McDougall, 1989). Only in a second moment then will psychoanalysis translate into words and into linguistic experience all that occurs so precociously during our infancy.

And again drawing from psychoanalysts, we likewise return to the beginnings of the relationship and to the paradoxical state occurring in the encounter with the patient, between being without speech and without questions, on the part of the latter, before his or her elements of serious need.

Upon first contact with a gravely psychotic - in the sense of extreme auto-aggressiveness - and perhaps "hopeless" patient (that is, after the refusal of any help or cure), beyond alarm for his or her condition and image, I am instilled with the sense of a strong need for authority. This makes me move within the relationship in a very "strong" and decided direction. I understand that this corresponds with the patient's need and, over time, I discover the absolute absence of containers in his or her infancy. I also understand that the patient perceives him or herself as the conveyer of terrifying events and he or she is thus afraid of hurting and wounding the mother.

Over time, I also understand his or her terror in rupturing the mother-baby unit, though manifesting a need to be distinct from this.
The quality of the relationship in the mother-baby unit and the relative psychic and somatic disturbances are therefore of absolute interest. McDougall also indicates that if the child loses his or her own maternal object, he or she fears death, that is, the subject pre-verbally experiences states of total loss of the mother-baby unit. The subject would thus lose the container of which he or she is part and in which he or she is contained. This amalgamating dimension of the first transitional phases presupposes that a part of the mother also merges with the baby, resulting in a mother-baby unit which also holds true for the former.
In the mother-baby unit, the primary identification with the mother, that is, with the object upon which one's very survival depends, also presupposes identifying oneself or de-identifying oneself with the themes of the maternal unconscious, as well as with an unelaborated family state there stored.
In these and in other cases, we may recall Badoni's observations (2008) of how the agents of the patients' grandparents can be relived as unelaborated subconscious states in the minds of the patients' parents. And furthermore, of how our patients bear traits of unconscious infra-generational violence (Riva, 2010). Therefore, we can say that within the mother-baby unit a baby-maternal containers unit may be identified, inclusive of the third generation in cases of still unelaborated generational agents. Despite the fact that the newborn does not possess verbal tools, his or her mind knows these issues very well. Thus, the intolerable and incompatible difficulties with the maternal container unit are rejected - excluded - precisely to impede the rupture with the container. The negative or the intolerable for the mother-baby couple produces what Bion (1954) calls a cancellation of the perceptive qualities (p.45).
Contrarily, the rupture of the mother-baby unit may be suffered as guilt due to the destruction and subsequent loss of the lifesaving object. It is a primary guilt, due to its own potentially disruptive elements for the mother-baby unit, including third-generation elements that have never been transformed.
Thus, one of the possible areas to take into consideration is connected to the relationship with the homogenous objects of the unconscious or untreated family group and to the positions of the subject with respect to this homogeneous lifesaving container which includes elements of three generations.
At the core there is always the concept of the tolerability or intolerability of the precocious representations, as in the case of exclusion, where the refusal of representations that are impossible to tolerate occurs in a mind that is not yet differentiated.
As with therapeutic groups, the possibility of observing a phenomenon from a different vertex, over time, may construct an alternative to a monochromatic and non-transformable vision. Likewise, in family groups this theme appears to be important through the mechanism of heredity.

If, on the one hand, heredity is a function of physiological reliance on transmission of content, on the other, we note that it, in part, intensely uses a transfer of preverbal aspects.
Pichon Rivière[1] considers the family as conceptually analogous to the group (for example, the vertex of the arrival or disappearance of its members). He believes that the treatment of mental illness cannot be abstracted from work on the family group, since the patient is the spokesperson of the group's phenomenon.
The implicit levels of the family group, segregated and silent, would imply a pact of disavowal, as occurs in institutions, in order for the group to avoid destruction, even at the expense of tolerating a neurotic symptom. Very often, the problem of segregation and of the storage of non-elaborated contents is accompanied by generativity and the birth of a child, who is connoted with stored aspects of the family group. This is also true in the case of transmission of narcissistically sane contents.
Such aspects either may be treatable and sustainable for the family group or may store themselves as problems unresolved by preceding generations. In the latter case, the last-born finds him or herself with aspects that are not understood by the family group and is delegated to treat them in some way. The patient who contains the most serious aspects of a family group often takes on the role of scapegoat, remedy, or drug, and therefore his or her psychic system may find itself faced with quite a difficult task. With respect to a group's vertex, all of this may correspond to a fundamental presumption of coupling in hopes that by entrusting everything to the new arrival - to a messiah - the group's own internal problems will be resolved.

The case of R.: An Existence without Mental Borders and its Relation to Destructiveness - Brief Clinical Notes and a Possible Method of Analytical Development

I must specify that the person in question, R., would not accept any form of intervention and that the path I initially pursued was not that of an analytically followed case. Nonetheless, in the early phases I appealed to inner concepts, something that would never have been possible without my analytic training (i.e. the concept of "container"), even in the presence of a patient very far from an analytic understanding.
On the other hand, while treating this case, I often thought of toiling to prepare favourable grounds for the development of a work of an analytical nature.
The extreme gravity of the situation seemed to not allow for any kind of solution.
This case presented itself as "untreatable", or rather the patient, aside from having attempted suicide in anamnesis, had tried every kind of private and public therapy and was consuming substantial quantities of cocaine. She describes herself as an adolescent though she is 27 years old.
I see her privately because the transfer came through specific request from the public system.

Only the mother, E., came to the preliminary meetings. She explained that R.'s symptom is the destruction of everything, that is, objects, herself, and most of all, the mother and grandmother. I listened to the mother who seemed to be, herself, completely dependent on her daughter. All of the previous therapists had tried to separate the two, but the pair resulted too strong. I immediately listened to a series of my associations and my oniric waking thoughts that suggested: a) that the mother still contained the daughter within herself; b) that the mother was the patient; c) that the mother was, herself, very implicated and paired with her own mother; d) that R., the patient, was the daughter of the mother-grandmother pair; e) last but not least, that they spoke of very distant times. The mother spoke of elements deep in the past, pertaining to herself and the grandmother, as if they occurred yesterday, as if they were current facts, perhaps internally present.

By now R. had an extremely strong distrust in doctors and psychologists, as well as every kind of treatment structure and technique. The father, a violent man, left home when R. was 4 years old and now lives with another woman. The mother asserts that R. feels guilty for her father's flight and for her parents' separation. R. had always chased after her father while becoming a doormat for every man she encountered. Gradually, however, one begins to understand that the mother and grandmother, always suffering the violence of R.'s father, failed to defend themselves from him, maintaining with R. an improbable goodness of the father, salvaging and justifying him, and never connoting his destructiveness, which was very evident even to R. (who was nevertheless raised in a confusion of what is good and what is bad).

I decided to see R. together with the mother and the grandmother in order to evaluate a background that seemed increasingly more significant. This choice, which may seem like a renunciation of listening to the patient, or a procedure very far from psychoanalysis, originated from the patient's unwillingness, from a request that I felt was being expressed by the family, and from the fact that gradually a very important family-based "common sense" emerged, so much as to overstretch the contents of the patient. The patient, R., though dependent and passive, seemed inserted into the female family group, constituted by the generational line of the mother and the grandmother, from which she had not yet assumed her own identification. This female group had always had a shared consideration of the male, fearing and being subjected to his many vexations in order to avoid his violence. Furthermore, this group had expelled the destructiveness and the "negative", by not dealing with it, with the result of leaving the daughter the arduous task of coming to terms with the destructive elements. After a sufficient period of understanding of these generational dynamics, I hypothesized that the "common sense" of the matrilineal family group (mother-grandmother-patient) consisted in not connoting and not encountering the destructiveness, if not in suffering it or evacuating it in the daughter. R. realizes this when she speaks of her solitude in understanding within herself how to live, how to consider badness, violence - that which explodes within herself – and most of all, how to ethically and internally orient herself between a perception of a subjective nature (the father is violent) and another of a family nature (the father is good). Thus,

R. is left alone before themes of destructiveness, violence, the good/bad dichotomy, and last but not least, the problems that the family group was unable to deal with over the precedent generations.

After an initial phase of accusations against R., regarding her inability to defend herself against the men she meets, the mother and grandmother began telling of how they were never able to relate to men, to defend themselves from them, or to say no. Nonetheless, an awareness of a family-group problem emerges. At first, the mother and daughter narrated the events as if they were the same person, through a twinning and a defensive conformism. This, however, gradually subdued, most of all after R. began to become aware of her own internal differences with what her mother was saying. R. now has a better understanding of her difficulties with men. The differentiating feature of R., with respect to the family group, is the destructiveness that she wreaks on them, as well as on herself, while the mother and grandmother have always avoided contact with destructive and violent elements. What is striking in her story is how the problems of one may very well be the problems and the contents of the other, with the exception of R.'s destructive symptom which marks the separation from the family-group. R's destructiveness is a sort of great divide between the family repetition and having one's own mind. R. finds herself full of destructiveness without the possibility of managing it, desperately trying to bring it back to the place of origin, or rather, to the family-group.

Terror does not pertain to the destructive element, but on the contrary, to its non-signification.

E., the mother, may take into consideration that she is the principal patient and understand that she herself must do something and begin an analysis. R's cocaine consumption has now become occasional. Over the course of the analysis, begun about a year ago, the mother said that she had always protected R. from the evils of the world and from her father's harm, hiding the truth from her. The lack of recognition of the destructiveness in the male figure, more than being a real fact, constitutes a psychic element that the mother was never able to represent within herself.

The destructiveness was without container and the male as element was not symbolized or elaborated by R.'s mother.

E.'s tales in particular narrate scenes of domestic sexual violence on the part of the second husband of E's mother to the detriment of the latter. At the same time, one understands how E. was a drug for her mother's pain, the latter being the victim of violence.

In fact, the mother confirms that it is like she is waking from a coma, unaware of what is good and what is bad with respect to the male figure and to life in general.

Conclusions

In this work, I was strongly impressed by the grandparents' role. The patient was followed for too many years without the presence of a psychoanalytic purpose that

could address the most appropriate member of the family-group. Furthermore, it must be clarified how for contemporary pathologies, characterized by desymbolization and de-subjectivation, long pre-treatment preliminary phases are important which, however, presuppose an analytic mind and not only a psychiatric management.
This type of consideration would open up another examination of the historic dimensions of generational violent objects which may be relived in the inner experiences that are not symbolized or metabolized by the subject.
In the case of R., the unresolved terror of the father is transmitted without being lived or transformed into an inner conflict within the grandmother and mother. R.'s destructive symptom would have the aim of representing this unresolved and unelaborated conflict. I believe that the traumatic dimension of the mind in many analogous cases may result from the trauma that the subject has with his or her own misunderstood or non-symbolizable destructiveness.

Notes

[1] Pichon Rivière E., *The group process from the psychoanalysis to the social psychology*, original texts property of the author.

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