

International Review of Psychoanalysis of Couple and Family

N° 2007/2 - The psychoanalytical process

DEVITALIZATION AND INTERSUBJECTIVE DRIVE VICISSITUDES

DAVID MALDAVSKY

The objective of this paper is to describe certain complex clinical situations as well as their clinical approach. The theoretical foundations of this approach have been included in several books (Maldavsky, 1986, 1990, 1995a, 1995b), while the systematic analysis of the clinical material through the application of the David Liberman algorithm, a Freudian-oriented method used to detect drive fixations and defenses (and their state), has been published in yet other works (Maldavsky et al, 2001, 2003, 2005, 2006).

In this paper, however, I shall deliberately leave out all metapsychological ideas as well as all reference to systematic research in order to briefly describe certain clinical problems and attempted solutions. Therefore, I will only make passing reference to both theoretical and methodological problems despite the fact that they constitute the very foundation of the ideas I will be introducing.

Intersubjective drive vicissitudes

A considerable amount of patients in couples and family psychotherapy treatment generally describe extremely violent scenes

which, at best, later awaken feelings of guilt and shame. When we analyze the episodes previous to those scenes, we notice that there is a sequence formed thus: 1) the individual perceives a state of devitalization in the other, and 2) suffers a crisis of automatic anxiety, which is a way of reacting to the identification with the devitalization of the other, and which, in addition, infiltrates the individual's body and behaves as if it were a drive source. The fit of temper appears to be the consequence of the aforementioned anxiety crisis and also constitutes a failed attempt to escape the previous identification and to re-vitalize the other.

It will be noticed that my own perspective of analysis is based upon intersubjective drive vicissitudes. This state of devitalization to which I am making reference has been described in different ways within psychoanalytic literature: *asthenia*, *apathy*, *dépression essentiel*, among others. It seems to be the effect of a defense against Eros that Freud (1923 b) attributed to death drives, and which consists in annihilating all vital tension: the production of energy in reserve is prevented, or else, ruined. We should bear in mind that Freud (1923b) had suggested that the lack of this energy in reserve prevented individuals from performing specific actions, in order to work through either their own drive's demands (be them loving or hostile) or those of the other. It is precisely this impossibility what awakens automatic anxiety in the ego. This automatic anxiety, in turn, appears as consequence of devitalization. From this perspective, the individual's own sexual arousal, or else that of the other, becomes an unpleasant stimulus, impossible to work through, in particular during sleep.

The previous statement allows us to understand the passage from devitalization to anxiety, but not the swerve into violence. Indeed, the latter appears to be an attempt at restitutive invigoration in order to recover (and to recover the other) from the previous feeling of devitalization. Sometimes, the search for invigoration involves explicit violence, whereas at other times, promiscuous practices, alcohol or drugs consumption, lasting hyper-tonicity (which in turn causes back pain), binge eating, or problem gambling can be observed. It is easy to observe that an essential aspect of problem gambling is the "stimulating injection", such as adrenalin secretion for instance. Similar things occur in other attempts at invigoration. They constitute solutions at two separate times: in the first, the desired effect is produced, while in the second a knock-on effect can be appreciated; i.e. increased devitalization both in the individual and his significant

others, which, incidentally, was the starting point of the whole process.

The aforementioned situations are particularly frequent in those couples and families characterized by psychosomatic disorders, drug-addictions, traumatophilias, traumatic neurosis, or by other conditions where physical disorders are a central aspect of the clinical problem. Some of the members of the group tend to behave in an apathetic way, and lack all vitality; others seem to be smothered by panic crises devoid of any symbolic resource, others, still, are constantly assailed by fits of temper. Other members of these groups, however, go through the entire path that connects devitalization with anger, including anxiety. Despite this, and even in the most stereotyped situations, there is a particular combination between the devitalized participant and the irate participant, who tries to rescue himself and the other from inertia by means of the attempts at invigoration we have described above.

I would like to introduce a brief example of a case that is being studied at present by two different teams of colleagues: one of them formed by six members of the Argentine Psychoanalytic Association, and the other, by sixteen members, all of them Professors at USES (Universidad de Ciencias Empresariales y Sociales), many of whom take part as well of the Couples and Families Psychoanalysis Lab. This clinical material, which was provided by JC Perry, is about a man (Catulo) who had made a serious suicide attempt, and who was in addition an alcoholic and drug addict and prone to sudden outbursts of violent temper. The analysis performed by both teams focused upon the sequence of events previous to the patient's fits of temper, and the comparison between their respective results demonstrated that they were very similar (interjudge reliability was thus tested). We were able to notice a sequence of scenes which included two antecedents: 1) the feeling of being trapped within a hopeless situation where he was deceived by a liar woman and there was nothing he could do to remedy this situation; 2) the economical crisis he experienced while he was away from his family home, which was an object of longing to him. After these events, the patient tried to kill himself with pills, and then flew into a temper when he noticed that "if he was in any luck" he would soon die. The sequence from the attempted suicide to the fit of temper corresponds, in our opinion, to two different mental states: one was a reaction to the other. However, at other times these scenes appeared separately in the relationships he had. When he was a child,

for instance, Catulo was unable to connect with his father, as he always seemed to be asleep and used to turn his back on the patient. During his adulthood, however, the exact opposite situation happened: the patient had agreed to spend Christmas with his girlfriend, but he fell asleep in his flat. The girl knocked at the door several times, but all to no avail. When the patient finally woke up, he felt wanted to die. In these two last episodes one of the characters manifested apathy, while the other was in a fury, however, in the episode of the suicide attempt both states (devitalization and fury) were manifest in the same person.

Freud approached these conditions with actual neuroses, as opposed to psycho-neurosis, in mind. In fact, in actual neuroses a "toxic condition", as it were, the clinical evidence of which is automatic anxiety, appears to predominate. Therefore, the therapeutic approach of actual neuroses does not seem to be centered on the interpretation of the derivatives of repressed wishes. It is not identical to the analysis of narcissistic pathologies (such as depressions) or of psychoses, although it bears some resemblance to the clinical approach of the latter.

In my opinion, the most appropriate thing to do when we face these clinical situations is to focus on the actual episodes that took place immediately before each of the fits of violent behavior. I am not trying to suggest here that these recent episodes lack historical roots; rather, they tend to repeat themselves again and again as if they were always actual episodes. The clinical consequence of this is that the analytic contract should include not only free association during the session, but also the focus upon these episodes and the events that happened immediately before. I do not believe that giving up the classic analytic contract would be convenient, as free association, which is more frequent in the cases of neuroses, could also take place when treating these other non-neurotic conditions. Despite this, we should be very careful to find out whether these "neurotic" occurrences are ways of masking a state of devitalization or not. What is more, when we are faced with couples who cannot recall any anecdotes, who express themselves erratically, and whose description of episodes constitutes an incessant expulsive attempt, it is convenient to actively organize the series of occurrences in their daily life: we should therefore enquire about their relationship with their respective parents, with work, their bodily complaints and, within this particular area, if there are sleep disorders, digestive complaints, allergies, skin conditions, respiratory or circulatory conditions, drug abuse and so on, as each of

these elements is characterized by a particular psychic constellation which, in turn, has certain specificity. For instance, in Catulo drug addiction and sleep perturbations predominated.

Prototypical actual scenes

Beyond these considerations, when during the sessions our clinical work is focused upon the episodes that took place immediately before the outbursts of fury, we are able to observe a group of scenes which frequently appear in a sequence, as I have been able to observe while systematically analyzing the speaker's discourse with the David Liberman algorithm. The first thing we notice is that there are a number of episodes which make the speaker feel he has been unfairly treated, and make him want to take revenge. Secondly, feelings of unrequited love and disappointment tend to appear, while in the third place reference is made to insincere relationships, where words contradict facts and with which cognitive efforts fail. Finally, there are allusions to situations where the speaker is an object of "speculation" for others, who are trying to gain something (money, physical pleasure) at his expense. The consequence of all this is that the longing for an internal balance of tensions, such as the one that allows us to sleep, remains unfulfilled.

The speaker's feeling of being unfairly treated usually appears in situations where someone who is in a position of power ill-treats him to such an extent that the speaker angrily experiences the need to "eject" from the relationship. The feelings of unrequited love tend to appear connected with ideas of self-sacrifice: one of the patients has given everything to the other and all he gets in return is (indifferent, mean) ingratitude. On the other hand, the feeling that the relationship in which the speaker is involved is insincere appears in the description of scenes where he depends on untruthful, sly or ambiguous people. And finally, the speaker's feeling of being the object of speculation for others becomes manifest when he claims that others tend to "solve" their own shortcomings at his expense (he feels he is being "robbed" of his energy or his money).

When we analyze these scenes, we notice that the first two (connected to feelings of injustice or unrequited love) tend to go together, as the object of the speaker's love sacrifice gradually reveals himself as

revengeful and abusive. In addition, these two scenes usually express the “passionate” component of the relationship, which incidentally constitutes the core of the couples’ or the families’ suffering.

However, the other two scenes that sometimes characterize a relationship could indeed be even more painful, as they transform it into something mendacious, insincere, filled more with “numbers and calculations”, as it were, than with symbolic resources.

In consequence, it is my view that, while the first two scenes to which we were making reference allow us to understand the rage that fills relationships with “noise”, as it were, the latter (linked to the lack of credibility and to speculation) could well explain the states of devitalization and terror.

In our clinical experience we notice that those patients who express the kinds of scenes we were describing are usually haunted by incurable nostalgia. Indeed, the feeling of being haunted is connected to the feelings of being unfairly treated, while nostalgia expresses unrequited love, but at the same time manifests an attachment to untrue situations, as nostalgia is above all a longing for a situation that has never happened (Freud, 1933a), but which is considered as if it had: this is precisely what constitutes the basis for fictitious relationships, and for the urgency manifested by the patient to find someone who will lie to him. The clinical example to which we made reference above allows us to notice the patient’s hopeless nostalgia, the feeling of being trapped in the deceit of others and the economic breakdown, which all underlie the suicide attempt and the consequent outburst.

With regard to the defense mechanisms present in these kinds of relationships, there is usually a blend between: 1) disavowal or foreclosure of reality and the ideal, and 2) foreclosure of the affect. These defenses are implemented in the external world and require the presence of others: indeed, the other becomes the object of revenge, of sacrifice, of untrue expressions, of speculation (at the expense of whom money and/or physical pleasure will be gained). It is frequently observed that one of the members of the relationship manifests disavowal, while in the other foreclosure of the affect becomes manifest. It can be easily noticed that I am making reference here to the intersubjective distribution of two groups of defenses. This intersubjective defensive “scaffolding” appears to be successful for a

while but in the end fails and therefore, automatic anxiety and “invigorating” violence become evident.

It should be emphasized that, from a theoretical perspective, these defenses constitute an expression of death drives and their effect on psychic life. Among them, the most powerful is foreclosure of the affect due to its ability to introduce psychic disruption, which attacks the very foundations of subjectivity and prevents the individual from perceiving the psychic qualities of affective relationships. In my view, this defense is a testimony to the way in which the death drives hinder the progressive development of vital tension, leading to devitalization. In consequence, the predominance of foreclosure of affects constitutes not only an indicator of the predominance of states of devitalization, but also “represents” as it were, this devitalization as a defense mechanism within the ego. More precisely, the state of the defense appears to have decisive importance. All defense mechanisms can have three possible states: successful, failed, or both. When the foreclosure of the affect is successful, the “invigoration” we were describing predominates; when it fails, automatic anxiety predominates, and when success and failure are blended, devitalization can in turn be appreciated.

There are different perspectives on defense mechanisms, such as those put forward by Kernberg (1996) and the Kleinian School, which usually stresses the importance of projective and introjective processes. Other authors, Green for instance (1993), emphasize the significance of disavowal. Despite the fact that we certainly agree with many of these ideas, we nevertheless consider that they lack the necessary specificity in order to account for the processes of the individual’s disengagement with his own affective and libidinal-aggressive life. We therefore believe that the term “foreclosure of the affect” is more appropriate. This particular mechanism could blend with disavowal or even with psychotic foreclosure. The constant use of these kinds of defense usually places the patient in a position of hopelessness, which means that the others completely give up on him. The way Catulo’s session ended allows us to infer that the patient managed to induce this feeling of hopelessness in the therapist. Indeed, the therapist saw him off telling him that he “wished him the best of luck”, which blends with the previous remark made by the patient, that with luck he would soon die. The hypothesis on projective and introjective mechanisms could allow us to explain mostly their effects on others, as well as the way in which the patient was affected

by certain familiar scenes, which in turn promoted certain intra-psycho processes. However, we need another hypothesis, such as the one on foreclosure of the affect, in order to explain the specific characteristic of these intrapsychic processes.

In clinical work, focusing on the scenes we were describing not necessarily means leaving out symbolic links. However, we very soon notice that it is better to point to the repetition of certain situations in the history of the relationship and/or the life of each of the patients, where differences are merely certain circumstances that could either alleviate or worsen devitalization states.

Transmission, conscience, mnemonic traces

I have referred to intersubjective processes, following other authors that study social or family relationships, including inter-generational transmission. I believe that these processes constitute clinical facts which have become increasingly noticeable: it has been more than fifteen years since I started to describe their mechanisms (Maldavsky, 1991) from a Freudian perspective. In this paper, however, I am interested above all, in considering the mechanisms that make inter-generational transmission possible. It is my view that these mechanisms are forms of communication and interchange that, far from being typical of the "official ego", not always require spoken language in order to be transmitted. Rather, they tend to include the paraverbal components of language, such as timbre or the languid intensity of the voice. Patients might also cough, burp, or yawn and this, combined with certain unfinished phrases, or with stereotyped remarks, repeated again and again as a litany, or else with a snigger, made while the patient is referring to painful occurrences (such as a miscarriage) can sometimes cause surprise in others. We should point out that this first perspective of transmission in situations where intersubjective drive vicissitudes predominate is merely descriptive.

From a theoretical point of view, these kinds of exchange are characterized by a lack of awareness, a lack of qualification of the stimulus, be it motor, visual, verbal, olfactory and so on, because sensory organs have an adhesive – and not diacritic – function. Exchanges usually take place in situations where a combination between disinvestment and physical intrusion is produced; for

instance, in cases of terror-induced hypnoses, perceptions within somnolence crises, or traumatic episodes.

To this we should add a discourse characterized by banalities and inconsistencies, which in addition appears to be histrionic as well as avoidant. This banal discourse shows that the individual is identified with a disappointing object and further, is a testimony to the disinvestment of the interlocutor who, in consequence, shows no interest whatsoever in what he hears. This disinvestment is the expression of a state of devitalization and, therefore, the qualifying function exercised by the primal conscience is stopped. In situations such as these economic exchanges usually take place within the relationship.

It is my opinion that the significance of sensory influence upon psychic life requires further consideration. The assumption that perception plus conscience leads to the creation of mnemonic traces is well-known. However, something similar could occur when perception is not accompanied by conscience. This issue has been lately studied by neurologists, who claim that the difference between both kinds of memory lies in the sense of familiarity which is absent every time perception has taken place without conscience. Perhaps we could establish a connection between this description made by neurologists and a form of the uncanny, of the herald of death drives. However, beyond these considerations, it is my view that we should closely study the way in which these “unfamiliar” inscriptions return. Indeed, among the most frequent clinical manifestations we might observe the appearance of unacknowledged affects, bodily disorders and unconscious hallucinations. Unacknowledged affects usually manifest themselves by the lack of affective nuances, which is in turn frequently accompanied by bodily disorders. Unconscious hallucinations appear as subtle and/or fleeting images which overlap with sensory reality. Freud (1922a) made reference to un-invested delusions, which are ignored by the patient. Something similar happens with these kinds of hallucinations: when the investment they receive increases, the patient might give them credit and they might even obtain clearer figurability. There is yet another way in which these un-familiar mnemonic traces could return: those scenes where the patient is surprised by the behavior of others, despite the fact that, for the analyst at least, these have become predictable. The patient, however, finds this behavior unexpected and hard to bear.

To end this section I would like to present the clinical evolution of a patient in treatment, where the therapist was forced to change his clinical strategy. This patient consulted due to a marriage crisis; his wife said she didn't love him and he could not bring himself to put an end to it. The patient described his wife as a cold person who was only interested in attending religious seminaries which took all her time, but which required her husband's financial assistance. This situation was hardly new: his wife's attitude had always been like that, but in the beginning he had reacted with violence and intrusive sexual advances. However, this behavior of his had lately stopped. Now the patient felt disheartened, and did not know what to do. During treatment, the patient manifested histrionic resources, as well as a remarkable expressive ability to describe his problems, which revolved around his marriage crisis and problems at work. In addition, he mentioned he used to binge at night, and feel precordial pain whenever he felt overwhelmed by the feeling of being trapped in his problems.

The patient was in charge of an Intensive Care Unit and he sometimes spoke with anxiety about the impotence he felt when he faced extremely serious cases. As the treatment progressed, the therapist became aware that he was unable to analyze in detail the scenes described by the patient because the patient did not provide any enlightening associations, and rather, used to change subject in a sudden. This is how the patient's discourse progressively became repetitive and evasive. In addition, it transpired that the patient every now and then consulted with a clairvoyant or else with spiritual and religious advisors in search of advice which he then failed to follow, and which appeared to point to the convenience of separating from his wife. The patient chose an alternative solution: he moved to another room, distant from the one he used to share with his wife. It did not have a window and he used to sleep on a couch. During this period, the therapist intervened as follows: he asked the patient to provide associations to the scenes he narrated, and then, in turn, offered interpretations on their symbolic meaning. These interpretations emphasized how the patient took refuge from his immediate reality in a fantasy world and then remained paralyzed. In the beginning the therapist emphasized the patient's repressed wishes, as well as his castration anxiety and feelings of guilt. Then, the therapist pointed out that the patient, with his histrionic-evasive discourse, was trying to

disavow his wife's indifference to him, as well as his own dependence on a person who disinvested him and only cared about his money.

The therapist added that, by the way the patient expressed himself in the sessions, he could see he was trying to bring treatment into an impasse and avoid change: in this way, the relationship they had was similar to the one the patient had with the seriously ill in Intensive Care. However, these interventions failed to bring about clinical change in the patient, who went on to behave in a histrionic-evasive way. The therapist therefore deduced that the patient's discourse was mainly cathartic: he used it in order to get rid of his own unbearable affective states.

These ideas finally led the therapist to change his clinical orientation. He therefore went on to point out that, when the patient tried to get rid of his feelings, he was in fact expressing an identification with terminal patients, whose condition was hopeless and who could only get palliative care. In this context an infantile memory became important: as a child, the patient used to sit in a park near the cemetery and he could see the dead being moved in order to be buried. Many other memories about his irate, violent father, who frequently hit both him and his mother, also emerged. These memories allowed the therapist to establish a connection between two characters, one was disheartened, lacking vitality, and the other was violent. The therapist interpreted that in the beginning, when the patient was trying to paralyze treatment with his histrionic-evasive discourse, he was in fact trying to induce a scene in which he ended up receiving more and more violent interventions, which were like blows, while the patient abandoned himself to inertia.

In a session after holidays from analysis, the patient made reference to his suicidal ideas, and the therapist established a connection between object-loss (the therapist himself) and the tendency to let himself go. The therapist added that, in the beginning, when the patient had developed histrionic-evasive resources in order to paralyze treatment, he had been showing, as well as evading, these suicidal ideas. The therapist was also able to establish a connection between these ideas and the trips his father used to take when the patient was a child and which left him in a state of inert paralysis and terror. Some time later, supported by his therapist, the patient told the history of his father: when he was about a year, his mother committed suicide after taking cockroach poison and a few months later his father (the

patient's grandfather) abandoned him. The boy was left to his aunt's care, a sister of his mother's, whose name was the feminine version of that of the patient. The therapist pointed out that the patient appeared to fulfill a protective function with regard to his father, a function that was secretly linked to the tragic fate of his paternal grandmother. In the sessions, a connection was established between the patient's father fits of temper and the need for someone who could work through certain scenes for him, scenes he found unbearable, such as his own mother's suicide. In this way, the suicidal ideas of the son appeared to be ways of working through scenes that were unbearable for his father. The patient also said that, when his father went away on a trip, he remained terrified by the sight of enormous cockroaches that scampered about the garbage cans. This memory was considered to be a way of providing figurability to a thought that was unthinkable for his father, for whom his own mother, killed with cockroach poison, came back to haunt their home. The result of this clinical work, which took about a year, was that the patient stopped using his histrionic-evasive discourse in the sessions, and was able to move on and focus on his grief and on the possibility of separating his home from that of his wife.

It is evident that in this case the therapist progressively changed his clinical strategy. In the beginning, he thought that repression predominated in his patient, that is why he requested associations and offered interpretations which pointed to the symbolic element in the clinical material. Then, he supposed that the predominating defense mechanism in his patient was disavowal, and he therefore tried to make the patient connect with his conflictive marriage, as well as with his secret wish to bring treatment into an impasse. Finally, the therapist was able to consider another clinical hypothesis and emphasized the foreclosure of the affect, stressing the importance of the cathartic proneness in the patient, as well as his search for "palliative care". This last clinical orientation allowed the therapist to consider things from another perspective and to find great similarities between many scenes centered upon the combination between devitalization-violence. These involved: the history of his father, the father-son relationship, the relationship with his wife, his work and the exchanges during the sessions. I do not think that the therapist disregarded the symbolic value of certain scenes, or that his hypothesis on disavowal was groundless. The thing is that they were insufficient to explain the whole situation. We could not say that the

scenes finally described by the patient (about the history of his father, and the connection between his father and his own suicidal ideas) were repressed, either, or that disavowal predominated in all of them. Rather, it is my view that all this clinical material was always there, available at preconscious level. What is more, the patient manifested no resistance whatsoever to the therapist's new clinical approach; rather, he volunteered memories, remarks, and so on. Therefore, we believe that all that was needed was a change in the clinical orientation, a change that could offer new coherence to the material and, in addition, another perspective which included inter-subjectivity and the work-thought of unbearable experiences between generations.

Drive vicissitudes and relationships within the session

The approach to clinical facts that I am trying to describe not only focuses upon the intersubjective drive vicissitudes in couples and families, but also upon those that take place within the session itself. Within this context, there are a number of symptoms that the analyst could experience: drowsiness while in the sessions, insomnia, tachycardia, sudden outbursts of allergy, as well as sheer exhaustion, dizziness, angry outbursts against one of the members of the family, a surprising incredulous indifference to the description of painful situations, banal interventions that involve giving up on one of the patients as if he were a hopeless case, and so on. Many of these symptoms point to the fact that the condition of a patient, or of a whole group, has "crossed the boundaries" and slipped under the therapist's very skin: the therapist is immersed in a hypnotic state.

In contrast, other symptoms point to the anxiety felt by the therapist when he becomes aware of his own devitalization, while other symptoms show an attempt at restitutive invigoration. Many other symptoms could be named; however, they can be easily distributed into a few categories. The therapist frequently tries to understand these occurrences within the context of his own neurosis, and he might make some progress. However, I believe that it would be more adequate, both from a theoretical and a clinical perspective, to consider these phenomena within the context of the relationship, where the therapist has unknowingly taken up the role of one of the characters in the patient's traumatic scenes.

I believe that this particular issue requires further elaboration.

In a recent book written in collaboration with a number of colleagues (Maldavsky et al, 2006) I analyzed the first session of ten different patients with their respective therapists. Three levels of analysis were taken into account: 1) the patients' narrations, which referred to their extra-session relationships, 2) the scenes displayed by the patient in the sessions, 3) the scenes displayed by the patient and the therapist. We were able to notice that the scenes narrated by the patient offered a global perspective that allowed us to understand the ones he displayed within the session, which, in turn, emphasized significant aspects of the former. With regard to one of the aspects we are interested in analyzing in this particular paper, we were able to detect, in the patients who presented the abovementioned problem, certain scenes that were connected to feelings of unfair treatment, unrequited love, untruthfulness and speculation, such as the ones described above. In addition, when these scenes were considered in detail, we observed that they blended with other scenes, to which the patient had made reference. Therefore, we could infer that, despite the neurotic aspects the therapist might have, it was the patient who induced the therapist to behave as one of the characters in his internal world, and the therapist responded either temporarily or otherwise. On these occasions, both the patient and the therapist suffered from a clinical "trapping" as it were, something they were familiar with, as the scene in question was very similar to some of the episodes to which the patient had made reference.

At other times, however, the therapist was unconsciously led to take the place of a character that surprised him greatly, as it did not "fit", as it were, into the scenes the patient had narrated. Therefore, we could say that the therapist was led to contribute to the enactment, in the session, of an episode that belonged to the patient's unfamiliar memories, which went on to gain an enigmatic first expression and which awaited further analytic work. Among these unfamiliar scenes, the most significant were those which revolved around the following: the patient felt he had been disinvested by his own parents, or that his therapist had given up on him long ago, or else he tried to distort all these facts and expressed himself inconsistently.

In this other kind of clinical trapping that affects both the patient and the analyst we can appreciate the significance of the patient's unfamiliar mnemonic traces (and perhaps, even those of the

therapist), that derive from perceptions that have taken place in a state of terror-induced hypnosis and have therefore remained unacknowledged.

In a more recent paper, written in collaboration with a number of colleagues (Maldavsky et al, 2007) about a couple in psychotherapy, I came to similar conclusions. I noticed then that the therapist could experience a double clinical trapping: on the one hand, he could unknowingly take the place of a character in a traumatic scene suffered by one of the members of the couple, which was frequently induced by the discourse of the other member, while at the same time he became immersed in a resistance alliance implemented by both members of the couple, and was trapped by their fictitious relationship and speculations. In this situations, it is relevant the perspective of the intersubjectivity involving two series: 1) the psychic process of each participant and 2) the intersubjective exchange, going to the increasing complexity or, inversely, to the complexity lost. The second serie can be blended with the constructivist focus, while the first corresponds to the subject's contribution to the bonds. This double focus allows investigating the enacted situations and the psychic processes of each patient.

Devitalization in patients who take part of complex intersubjective relationships

The dynamics I have described frequently constitute the most important processes of both members of the couple. These processes frequently involve the therapist, and this is the reason why he can sometimes feel exhausted, drowsy, anxious, or even suffer from almost imperceptible hallucinations, among other symptoms, when the session is over.

However, these processes most frequently take up only an aspect of the psychic and intersubjective dynamics. Therefore, other kinds of psychic currents, such as those seen in non-psychotic narcissistic pathologies (i.e., schizoid patients, patients with anti-social tendencies), or similar to those seen in transference neurosis (hysteria, obsessional neurosis) or even psychic currents where non-pathogenic, functional mechanisms predominate, could also become manifest in the members of the couple. In addition, these psychic

currents could also coexist. For instance, in one of the members of the couple the devitalized components could become manifest, above all, in the para-verbal components (such as the timbre, the melody of the voice, the rhythm of speech) while the discourse expresses mainly histrionic, seductive components. The other member of the couple might in turn become banal and inexpressive at the discourse level, while the paraverbal components might express tenderness. The therapist could, for instance, suffer a fit of coughing while at the same time he continues to provide pertinent clinical interventions. What I am trying to express by means of these examples is that we should not reduce the whole psychic functioning to an only current (such as the devitalized aspect); rather, we should be prepared to find a complex intertwining of different psychic currents in each of our patients, which has an influence upon several simultaneous aspects of others, including the therapist, some of which could temporarily predominate.

The clinical example we presented clearly shows, in my opinion, that three different currents coexisted in this patient and one predominated. One of these aspects was characterized by histrionic-evasive characterologic traits, the other, by a proneness to disavow reality (i.e., his wife indifference towards him) and the third was characterized by foreclosure of the affect, catharsis, states of devitalization, and behaving as a "hopeless case", who can only expect to get palliative care. While the first two aspects introduced certain nuances to the whole personality, the third revealed itself as predominant.

Bibliografía

Freud, S. (1922b) Sobre algunos mecanismos neuróticos en los celos, la paranoia y la homosexualidad, en SE, vol. 18.

(1923b) *El yo y el ello*, en SE, vol. 19.

(1933a) *Nuevas conferencias de introducción al psicoanálisis*, en SE, vol. 22.

Green, A., (1993) *El trabajo de lo negativo*. Amorrortu Editores. Bs. As. 1993
Kernberg, O., (1996) A psychoanalytic theory of

personality disorders, en J.F. Clarking y M. Lenzenweger (Eds.), *Major theories of personality disorder*, pp. 160-137, New York, Guilford Press.

Maldavsky, D. (1986) *Estructuras narcisistas. Constitución y transformaciones*,

Buenos Aires, Amorrortu Editores, 1988.

(1990) *Procesos y estructuras vinculares*, Buenos Aires, Nueva Visión, 1991.

(1995a) *Pesadillas en vigilia. Sobre neurosis tóxicas y traumáticas*, Buenos Aires, Amorrortu Editores, 1996; 1995, *Névrose toxique et traumatique*, París, L'Harmattan, 1999

(1995b) *Linajes abúlicos*, Buenos Aires, Paidós, 1996. *Lignages abouliques: Processus toxiques et traumatiques dans des structures intersubjectives*, L'Harmattan, Paris, 2000 2003) A contribution to the development of a psychoanalytical methodology for research into language. A systematic study of narration as an expression of sexuality, *International Journal of Psychoanalysis*, 2, 2003, 607-636.

Maldavsky, D., Aguirre, A., Alvarez, L., Bodni, O., Britti, A.M., Buceta, C., Bustamante, B., Cantis, J., Cusien, I., de Durán, R., Follmann, A., García Grigera, H., Garzoli, E., Goldberg, J., Iusim, M., Kazez, R., Legaspi, L., Manson, M., Miceli, G., Neves, N., Rembado, J.M., Rodríguez Calo, M., Roitman, C.R., Romano, E., Tarrab, E., Tate de Stanley, C., Widder, F. (2005) *Systematic research on psychoanalytic concepts and clinical practice: the David Liberman algorithm (DLA)*, UCES ed. Buenos Aires.

Maldavsky, D., Aguirre, A., Alvarez, L., Bodni, O., Britti, A. Ma., Buceta, C., Cantis, J., de Durán, R., Cusien, I., Falise, C., Frigerio, R., García, K., García Grigera, H., Garzoli, E., Iusim, M., Jarast, G., Kazmierski, J., Lacher, G., Manson, M., Neves, N., Plut, S., Rodríguez Calo, M., Roitman, C., Romanisio, O., Scilleta, D., Sloin de Berenstein, R., Tarrab, E., Tate de Stanley, C., Varela, R. (2006) *La intersubjetividad en la clínica psicoanalítica. Investigación sistemática con el algoritmo David Liberman (ADL)*, Editorial Lugar, Buenos Aires, en prensa.

Maldavsky, D. , Bodni, O., Cusien, I., Lambersky de Widder, F.,
Roitman, C.,

Tamburi, E., Tarrab de Sucari, E., Tate de Stanley, C. y Truscello de

Manson, M. (2001) Investigaciones en procesos psicoanalíticos. Teoría
y método: *secuencias narrativas*, Nueva Visión.

Maldavsky, D., Britti, A. M., Alvarez, L., Neves, N., Roitman, C. R. y
Tate de Stanley, C. (2007) Exigencias de amor, presiones y chasquidos
de lengua en una sesión de pareja, estudiada con el algoritmo David
Lieberman, *Actualidad psicológica*, año 32, N° 352, 10-16.