The irrepresentable, the repetition and the death instinct: psychoanalysis and neurologic illness

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The psychoanalytical treatment of defense neuroses has classically consisted of the analysand's free association in combination with the analyst's floating attention and interpretation of the unconscious desire. Transference refers to both the context in which this process unfolds and the reason why it happens. In other words, the theoretical standards guiding the technical and metapsychological approaches to such cases usually revolve around repression, with hysteria as the model. However, patients whose top layer of suffering is related to their narcissistic identity demonstrate as little tolerance to that approach as they do benefit from it. Such clinical types have several different designations and are classified by terminologies pertaining to a wide variety of clinical configurations. Among other nomenclatures, these clinical types have been designated as current pathologies, borderline states, non-neurotic structures or narcissistic pathologies. They present, among other, false selves, *as if* personalities, blank or empty selves, basic failures etc. Regardless of the term chosen or the characteristic highlighted, and considering the metapsychological peculiarities of each nomenclature, these forms of psychological suffering generally present important limitations in terms of symbolizing, representing and elaborating capabilities and are thus considered refractory to analyses. Clinical practice involving these patients usually addresses the triumph of the act over the word, hence being designated pathologies of the act, difficult cases, or pathologies of emptiness.

Although the etiology of such cases have been attributed to events involving the (non)consolidation of primary narcissistic processes in childhood, we believe it is possible to apply the same metapsychological understanding to another type of subjective suffering in which threats to the sense of identity may also be recognized as some sort of a posteriori attacks to primary narcissism. We observed that psychopathological conditions established after experiencing cognitive impairment derived from neurological illness consist of clinical configurations that impose limits on the classical psychoanalytical treatment similarly to the phenomena that can be observed in narcissistic identity disorder.

If we assume, as proposed by Green (1966-1967/1988), that primary narcissism is a structure and not only a specific state within psychological development, whose maintenance must be guaranteed in order to function as a narcissistic support, we can think of cases in which that structure becomes fragile not while it is being built but rather because of later problems that radically affect the possibilities of individuation and symbolization. Just as in narcissistic pathologies with early etiologies, the possibility of the elaboration of anxiety, which is far different from neurotic castration anxiety, is expressed as the fear of the annihilation and collapse of the ego, who, paradoxically, is no longer consistent or cohesive.

Thus, we present the hypothesis that the psychopathological condition that develops after the perception and experience of cognitive impairment demonstrates similarities with both narcissistic identity pathologies and traumatic neurosis. This hypothesis was developed based on the studies "Do cérebro à palavra: a clínica com pacientes neurológicos" ("From the brain to the word: practice with neurological patients") and "Aspectos subjetivos do adoecimento neurológico" ("Subjective aspects of neurological illness"), which were both performed in PUC-Rio, with support from FAPERJ (processes number E-26/101.498/2010 and E.26/102.784/2011) and CNPq (process number 305175/2012-2), and were approved by the PUC-Rio research ethics committee. Each patient gave his/her informed consent for all the clinical sessions.

Among the reasons supporting our hypothesis, two aspects are essential. Firstly, clinical practice has shown that a patient's perception and experience of impairment, especially when it affects important cognitive functions, destabilize the feeling of identity and continuity of subjective existence, dissolving the egoic cohesion that is supported by both primary narcissism and the functions of the ego sustained by cognition. Secondly, we have observed that the impossibility of the elaboration of the perception and of the experience of cognitive impairment, due to their very existence, freezes those subjects permanently in the present time, engendering repetition compulsion processes in an effort to perform elaboration and symbolization, and, at the same time, discharge (Winograd, Klautau & Sollero-de-Campos, 2014).

The brain injuries in question here, which result in severe cognitive impairments, occur either after specific abrupt injuries, as with strokes or traumatic brain injury, or in gradual events, as with degenerative disease (Alzheimer's disease or primary progressive aphasia). It is important to highlight the traumatic impact of these neurologic events, and not only the neurological problems, since it will affect the whole identity and further radically disorganize the psychic economy of the patient.

Freud (1923) identified and described a few egoic functions, positing that the general function of the ego involves intrapsychic moderation (antinomic function), as well as moderation between the psyche and the environment. For him, the ego's essential functions are as follows: (1) induction to the secondary process; (2) motility control; (3) perception; (4) reality check; (5) anticipation; (6) temporal organization of psychic processes; (7) rational thinking (synthesis); and (8) inhibitory functions, especially rationalization, pretermitting, postponement and defenses against instinctual demands, such as censorship and repression. Undeniably, almost all of these egoic functions are internally supported by cognitive functions (perception, attention, memory, language, and executive functions), and help to maintain intra- and intersubjective limits. Alterations in these functions (cognitive and, consequently, egoic) result in variations and disturbances in the relationship of the subject with both him/herself and with the environment. These may include important difficulties in the inhibition of primary processes and in the management of instinctual demands, temporal disorganization of psychic processes, loosening of reality checks, difficulty in synthesis, differentiation, and, more specifically, important limitations in the capabilities of symbolization and representation. In cases of patients presenting brain injuries or neurological diseases, we have observed that, after realizing that they have one or more egoic functions impaired by cognitive dysfunctions, they undergo a violent disorganization of the whole psyche rather than just of the ego. A traumatic neurosis blended with some sort of posterior early trauma seems to become triggered as if the ego, in particular, and the intrasubjective limits were gradually decomposed.

Therefore, the clinical and metapsychological issues raised by cases such as these have been posing challenges for contemporary psychoanalysis. As stated by Malabou (2007), the study of the impact of neurological illness on the continuity of the psychic life and the study of the subject's vulnerability to such impacts reveal that the fundamental problem here is also the incidence of trauma, which has recently become a central issue in modern psychopathology.

For Freud (1920), a traumatic event necessarily presents two faces, one of which is exogenous and the other of which is endogenous. The exogenous one results from its sudden and surprising occurrence. The endogenous one refers to how this exteriority is elaborated by the psyche so that it becomes integrated (or not) in the subject's history. The traumatic aspect

of the subjective experience of a neurological illness with cognitive impairment implies both faces. It is the occurrence of something that, because of its virulence and violence, belongs in the realm of the meaninglessness, being unrepresented, unthinkable, derived from discontinuous transformation, frequently sudden, and something through which the identity gets dissolved. It is an event that, despite surely having an endogenous face, is felt as exogenous by the psyche. Indeed, as highlighted by Malabou (2007), when a neurological illness with cognitive impairment affects the psychic identity of a subject, some level of articulation of the exogenous and endogenous contents is revealed. In addition, their specificity is refractory to any symbolization attempt. The extraneous character of the accident remains extraneous to the psyche, as something exterior inside the interior, not assimilable, which demands the subject to face the narcissistic wounds that untwist the thread of his/her history and suspend its course. That is, why the accident may be understood as an unfortunate encounter with the Real, i.e., with some intimate exteriority (Porge, 2000) or with some radical internal exteriority (Cardoso, 2011) which, not being assimilable for or by the subject, and, therefore, not representative, promotes the intensification of the death instinct and the amplification of its effects.

Thus, clinical practice involving patients who suffer from cognitive impairments derived from neurological illness reminds us that the conceptual investigation involved in psychoanalysis must always acknowledge a relationship of "dependent concomitance" between the brain and subjectivity, as proposed by Freud (1891), conversely from a relationship of contraposition, juxtaposition, or causality (Winograd, 2013). It is indeed possible to observe several common characteristics in the destructive effects of trauma on the psyche, irrespective of whether its triggering cause is organic or psychic (as if separating them were possible). In every case, some unexpected event, also impossible to elaborate on, happens.

The actual, the unrepresentable and repetition compulsion

If it is correct to state that the occurrence of a sudden or a degenerative brain injury with cognitive impairment disorganizes the functioning of neural systems and structures, it is also correct to say that subjective experience as a whole is profoundly affected as well. In general, subjects with neurological diseases can no longer count on the subjective coordinates that have usually structured the cohesion of their ego since the cognitive impairment have imposed more or less radical limits on their representational capabilities.

In many cases, it is possible to observe some sort of conviction that lost and inaccessible memories must be recovered to restore the subjective impairment caused by forgetting words, names, people, places, and situations that compose a past that is no longer recognized as their own. Such references are supplied by cognitive functions and its loss is experienced as a traumatic wound that divides the subjective experience into before and after the unhealthy event, convulsing the whole of the psychic organization and destabilizing the feeling of identity and continuity of existence. When the subject experiences the sensation of an ego in ruins, he/she searches for cohesion through the belief that it is possible to recover what was lost, returning to the way things were before. The nostalgic feeling derived from the subjective experience of having lost a part of themselves drives the desire to return to their lost identity. The project is actually a protective measure to address the anxiety provoked by the ongoing disease process.

One of the patients in our study, who had suffered from a stroke a few years before and still faces impairments because of the disease, confessed to the analyst as follows: "I wanted an answer; if I will be cured of this or not. I don't know if I am handicapped or not (...). I have a problem, but if I get on a bus no one gives up the seat for me because no one can see anything wrong with me. No one knows I had a stroke. Sometimes I need to get a seat but I just have to keep standing. Therefore, it seems that we, who had strokes, don't exist. There is no free pass, there's nothing… let's say, no help". The patient complained about the fact that her limitations could not be visually recognized and expressed her anguishes referred to her feeling of non-existence.

The same fragility of the feeling of existence is implicit in the visible satisfaction of another patient when showing to the analyst an identification badge with his name and a short description of his clinical diagnosis. The badge, manufactured by the speech therapy sector where he was undergoing treatment, was used by him in social circumstances in which he faced challenges in communicating with strangers. To avoid any misunderstandings about his health condition, the badge said: "I am aphasic. I had a stroke. I'm facing difficulty in speaking and understanding. I need time and your help to communicate. I do not have a mental disorder". This badge seemed to provide him with some identification elements that guaranteed, though precariously, the feeling of continuous existence.

We verified through our research that the feeling of the loss of part of oneself reenacts the repertoire of defenses against the helplessness experienced in previous traumas. Although the perception of cognitive impairment is unequivocally a traumatic blow to the psyche, its psychopathological effects do not always result from a single trauma. Initially, many patients nurture the hope that their cognitive impairment will be overcome. That does not always occur even though speech therapy and neurocognitive rehabilitation treatments do provide significant improvement. In these specific cases, the relevant issue is that the perception that the cognitive impairment derived from the neurological injury remains over time leads to the insidious installation of a series of little traumas. As these little traumas accumulate, they disrupt the unity of the ego and damage the whole of the psychic organization, solving its internal and external limits.

The concept of cumulative trauma, elaborated by Masud Khan (1963), gives us resources that help to understand the idea. Khan (1963) assumes that failures of the function responsible for protecting the developing psyche provoke little fissures in the ego during development and acquire traumatic value both cumulatively and retrospectively. That is, the traumatic effects of these fissures is not caused by the events at the very moment they occur, i.e., when the fissures are oppened, but rather silently and invisibly by repetition and accumulation of such cracks. In other words, over the duration of the illness, the subject gradually accumulates wounds which are initially imprinted by the realization of the cognitive impairment and the damage to the egoic functions, followed by the perception of the permanence of the losses. This gradual collection of wounds affects the consistency and the solidity of the primary narcissism, resulting in the impossibility of recognizing the self as being whole and continuous, as well as in the impossibility of finding support in one's own perceptions and representations of him/herself and the world.

In *Beyond the pleasure principle* (Freud, 1920), trauma was described as an experience that could not be processed psychically at the moment it occurs since its high intensity bursts the psyche's protective shield, tearing apart the psychic fabric that is totally unprepared to address

it. In the text, Freud developed the idea that an exterior trauma may provoke an enormous disturbance in the psyche's energetic economy, activating all the possible defensive measures and temporarily suspending regulation according to the pleasure principle. Since the protective shield is damaged and is no longer able to prevent the psychic apparatus from being flooded with large amounts of stimuli, another issue arises: namely, the control of the intensity of stimuli flowing inside and its psychic binding so it can be adequately discharged. That is the very function of traumatic dreams: to repeatedly bring the subjects back to the situation when the trauma occurred to help them retrospectively master the excessive stimuli through the development of anxiety, which absence allowed the deflagration of the traumatic neurosis. In this way, we can understand the anxious remarks of a severely aphasic patient in almost all his sessions of the period he designated "postsurgical", which consisted of a repeated recall, a rumination, taking him back to the traumatic experience of realizing he had lost part of his cognitive capabilities. His reference to "postsurgical" could be explained by the fact that his neurological impairment had occurred a few days after he had underwent cardiac surgery, which resulted in the occurrence of an ischemic stroke and the development of severe aphasia.

Therefore, if, on the one hand, the continuous perception of a neurological impairment works as some sort of dissolution of primary narcissism, on the other hand, its psychopathological effects are similar to the ones of a traumatic neurosis. Simone Korff-Sausse (2001), in dealing with trauma in parents of children with physical disabilities, highlighted the following elements, which can also be detected here: (1) unpreparedness of the psyche, (2) experience of terror and agony (more than fear and anxiety), (3) failure of the symbolization capability, (4) consequent predominance of the unrepresentable, and (5) psychic sideration or fragmentation without the possibility of mourning. In other words, the experience goes beyond the metabolizing capability of the ego because of both its intensity and its consequences. As if the sudden intimacy with death were not enough and excessive in itself (Barrois, 1998), patients with cognitive impairments derived from neurological illness can no longer count on the skills that enabled proper functioning of the ego and, namely, necessary elaboration. Taken by illness and captured by trauma, these patients freeze in time, astounded at the presence of their impairment and facing a moment of rupture between a lost past and a rejected future.

The psychic experience of time being frozen reveals a psychic functioning characterized by immobility and suffocation of the psychic life. One of our patients revealed this exact type of psychic organization as she mainly resorted to repetition compulsion mechanism. Having had a stroke that provoked some motor impairment several years before, the patient was fixated in a position of total displeasure with life, presenting traces of pessimism and hopelessness. She lived with her elderly mother, who became the main object of the patient's hatred and resentment and the depositary of the responsibility for the patient's stagnation, although the patient herself showed signs of intense dependence on her mother. The patient resented the fact that her physical difficulties, seen as a true absence of any capability, prevented her from doing manual tasks that would have been a source of pleasure in the past. She viewed herself as someone completely incapable of doing any professional or leisure activity, which inhibited her from imagining modes of existence that could bring any vitality or pleasure into her psychic world. The narrative of her childhood brought up the traumatic relationship with her primary objects, allowing the assumption that her symptomatology dated from earlier stages. That did not stop us from realizing the essential role played by the illness in the intensification of her defenses.

The beginning of her analytical work seemed initially fruitful. She then started to develop themes linked to sexuality and to express the desire for a love relationship, imagining the possibility of investing new objects libidinally. At fifty, she had very few intimate experiences with men. Nevertheless, she decided to join a dating website and was able to arrange a few dates. Those attempts of psychic movement soon showed failures because the struggle to establish a love relationship frustrated her intensely, thus confirming her idea that life would only bring her sorrow and dissatisfaction. It is relevant to say that, among the impairments of the stroke, the patient later started to have isolated convulsive crises, which provoked great insecurity and made her prefer to stay alone more often, doomed to stay home with her mother. This clinical circumstance led to some stagnation in the analytical process coupled by her repeated efforts in keeping herself in a frozen and immovable position. It was as if the patient performed, in a repetition compulsion movement, her fantasy of "non-modification of the actual," (Aulagnier, 1979, p. 122), which was maintained through the complaints about her mother and the impairment derived from the illness.

However, if a sideration regarding a traumatic event expresses a tendency toward psychic immobility, given the impossibility of symbolization, it also reveals an effort towards symbolization. Therefore, as we will see, when a repetition compulsion arrives on the scene being driven by death instinct, that may and should be understood certainly as what is keeping the subject in a deadly movement but, at the same time, as the act of gathering the necessary forces for the subjectivation process in order to reestablish intra- and intersubjective limits. According to Freud (1920), the purpose of a repetition compulsion is to dominate the excess stimuli and to be involved in the process of linkage of free energy. In other words, since stimuli cannot be metabolized psychically due to its intensity, thus dissolving the logic of the pleasure principle, the mechanism of repetition compulsion becomes active in an effort at the same time paralyzing and willing to evacuate and manage the energy that cannot be metabolized yet. Green (2000) refers to this as a paradox, that is, the same energy that is repeatedly needed in the attempts to elaborate is, at each discharge, temporarily emptied from the psyche, liberating it from the tensions that would permit the enrichment of its organization, the improvement of its functioning, the enlargement of its field of activity, and the diversification of its investments, grading its answers.

This sort of fixation engendered by a trauma differs, in essence, from a libidinal fixation. That is, while the latter classically expresses a connection of the libido to certain ways of obtaining satisfaction, namely, to certain characteristic organizations of its developmental phases, the first reveals, on the contrary, a disorganizing and undifferentiating movement that is a side effect of the intensification of the death instinct. Therefore, because of the impossibility of psychic inscription and transcription, a repetition compulsion is equivalent to time becoming dead (Green, 2000). What the discharge does not cease to evacuate, without being able to do it once and for all, can not be transformed nor assimilated. It becomes fixated and impossible to be articulated in a representational grid, thus unable to construct historicity. The consequences of this are the freezing and paralyzing of time, the suspension of the pleasure principle and, more significantly, the failure of the attempts for its implementation, all of which are characteristics that can also be found in cases in which psychic suffering are caused by very early traumas.

In a small passage from 1939, in "Moses and monotheism", Freud briefly indicated the influence of early trauma in early infancy (until approximately the fifth year of age) on the

development of neuroses as follows: "The impressions we experienced at an early age and forgot later, to which I have ascribed such great importance for the etiology of the neuroses, are called traumata" (1939, p. 91). He complemented later with the following: "The traumata are either bodily experiences or perceptions, especially something heard or seen; that is to say, they are either experiences or impressions" (p.93). However, the terms "impressions", "bodily perceptions" and, to a certain extent, "experiences", although relatively impossible to be precisely defined, mean that something that has been experienced left marks which became fixated as traces from a period before language acquisition, before its transcription into some representation.

We should remember that the beginning of the construction of the psyche is based on the first bodily sensations associated with the pleasure or displeasure, which leave psychic impressions. In his famous "Letter 52" (1896/1994), Freud posited the occurrence of three basic levels of inscriptions *(Niederschrift)* for the organization of the psychic apparatus as follows:
0. The first inscription consists of perceptual signs (Wahrnehmungzeichen), which are formed by psychic impressions derived from perception (Wahrnehmungen) and are simultaneously associated, being entirely accessible to consciousness.

1. The second inscription consists of unconsciousness (Unbewusstsein), composed of mnemonic traces organized, no longer by simultaneity, but possibly also by causality.
2. The third inscription is preconsciousness (Vorbewusstsein), which involves word-representations. That register would correspond to our official self, that is, what will later constitute the ego.

The assumption of the inscription of something beyond representation is easily recognizable, though roughly formulated, being the basis upon which the ego is formed, through retranscription of one layer into another. As Freud himself taught (1896), we should not suppose that, in passing from one level to another, that the initial inscription would disappear. Conversely, the three levels coexist and, in the same way that not all of the unconscious content reaches consciousness, not all of the content of one of the inscriptions will reach another.

In 1900, in chapter VII of "Interpretation of dreams" (Freud, 1900), Freud, revisiting the theme of psychic inscriptions, developed the idea that the first representations would be composed of mnemonic traces of pleasure and displeasure associated with bodily sensations. These representations would gradually evolve from the primary process, which is characteristic of unconscious processes, into the secondary process, which is typical of the ego, through the growing possibility of simultaneous and contiguous associations. Here, an approximation with Letter 52 is possible as follows: from the inscription of perception signs to the subsequent inscription (still unconscious) and from there to the third inscription of conscious marks. Dependency on the automatic discharge of bodily sensations would diminish as available representations are augmented. In other words, a repetition compulsion would lose its intensity as the availability of the representations that are prone to convey excitement increased.

Early traumas and, to a certain extent, present traumas, would then be inscribed on the first level of inscription, that is, the level regarding the perceptual signs. They would be registered but not yet established as traces and not organized into representations of any kind. Although we can already speak of impressions and, therefore, of mnemonic marks that are

inscribed, we are still operating at the level of the non-representable or, better yet, the unrepresented. If we assume the idea that a repetition compulsion is a natural and necessary process for psychic constitution, as its function is to manage the excitation that reaches the psychic apparatus through its articulation on the representational grid (Freud, 1920), it is possible to understand that, in cases of both early trauma and traumatic neurosis, the effort for the representational metabolization of excitation (including the instinctual ones) is the relevant mechanism. It is also possible to understand that the psychic apparatus could not perform the process at the very moment it was reached by the excitation, when the trauma was produced.

As stated above, the more there are representations available, the less there is automatic discharge, and thus, the shorter the reach of a repetition compulsion. In cases of neurological illness with cognitive impairment, we observe some sort of reversed mechanism; neurologic damage operates the dissolution of variable portions of the representational grid until the realm of the first inscription (perception signs). It would be as if the psyche became discontinuous, undifferentiated, and non-integrated psychic zones, far beyond the pleasure principle, were gradually developed, disconnecting the previous connections. Such are the *fueros* that Freud mentioned in the "Project" (Freud, 1895) and recalled in his book on Moses (Freud, 1939) as follows: "They are as a state within a state, an inaccessible party, useless for the common weal; yet they can succeed in overcoming the other, the so-called normal, component and forcing it into their service" (Freud, 1939, p. 95). Of course, there are important differences among the subjects who have had just a few cognitive functions impaired and those with degenerative diseases whose functions deteriorate continuously. We could formulate the hypothesis that, regarding the first ones, the *fueros* are circumscribed, as if there were walls around them and, with respect to the second ones, the territory of the *fueros* is in continuous expansion, suffocating psychic life both literally and metaphorically. The fact that the *fueros* are in expansion in cases in which the process of neurological deterioration is gradual seems to provoke the feeling of the loss of the self as even more significant. In these cases, before the condition deteriorates drastically, the subject follows the insidious and uninterrupted loss of his/her cognitive skills and, in this way, experiences a more radical feeling of the impoverishment of the ego.

This is what we could observe in the case of a patient in our study who was diagnosed with progressive primary aphasia and whose psychic pain included the anguish of disintegration and psychic death. Sometimes the patient would come to the point of expressing suicidal ideas as a last resort for facing the imminence of psychic death and annihilation of the ego. Her psychic suffering was closely articulated with the perception that the continuity of her existence was broken. This perception was repeated every time she missed words when she was making an effort to communicate her thoughts. The cognitive impairment made the patient experience a feeling of extreme impotence, causing her to react with frequent self-recriminations and offenses. In repeated situations, when she unsuccessfully tried to recall a certain word or even mixed syllables, she would get intensely frustrated and would cover her face with her hands, complaining and lightly hitting her own head. The experience of deadly horror was reenacted in each event of forgetfulness and would place her in the realm of a repetition compulsion, fixated on the search for *that specific* lost word. Fortunately, the psychoanalytical treatment helped her to start inventing new ways to address these events of forgetfulness, namely, resorting to other

strategies to communicate her thoughts, be it trying to express ideas close to the one initially thought through drawings on paper or even using bodily gestures during the session.

Although it is possible to differentiate between conditions with localized neurological loss and those with degenerative disease, we observe an intensification of the death instinct in both cases, certainly as a psychopathological effect of unbinding. However, the work of the death instinct may be understood, even more radically, as some recruitment of forces to engender the reconstitution and reintegration of what was deconstructed and disintegrated.

Death instinct and subjective constitution

The binding function mentioned by Freud in (1920) "Beyond the pleasure principle" as being the essential function of the psychic apparatus is, indeed, the action of coating and covering, that is, the production of representations that are able to organize the world through the capture and management of excitation. This binding work is a function of the ego, which is responsible, as we have seen, for the synthesis, the integration, and the inhibition processes, among others, in some sort of returning movement to the same, of searching what is familiar and of covering everything that seems to be a threat to its structural permanence (Scarfone, 2013). In other words, the ego welcomes what is new only if it can assimilate, bind, or make the content similar to what it already knows and place it in its established representational universe. It is classically said that the ego renews and transforms itself, becoming an effect of the binding processes fed by the life instinct. However, if it is correct to say that the maintenance of the limits of the ego depends on the life instinct, it is equally correct to say that there would be no limits without the work of the death instinct, in a continuous resume of the subjective constitution processes. Deepening our understanding, we could say that, on the same time that the individuation of the ego is related to the activities of integration, synthesis, and objectification, it significantly depends on the death instinct and its effects of unbinding, non-objectification, and negation (Green, 1988).

As taught by Garcia-Roza (1986), although the concept of the death instinct was elaborated in 1920, it was only in 1925, in the article on negation, that this concept would have suffered its deepest and most definitive theoretical transformation. In a comment made during one of Lacan's seminaries, Hyppolite ([1955]1966) highlighted the fact that what Freud offered in his article were hypotheses on the genesis of thought based on negation. The following two passages of the Freudian text deserve mention: "Negation is a way of taking cognizance of what is repressed; indeed, it is already suspending of repression, though not, of course, an acceptance of what is repressed. We can see how this intellectual function is separated here from the affective process" (Freud, 1925, p. 254) and "Affirmation – as a substitute for uniting – belongs to Eros; negation – the successor to expulsion – belongs to the instincts of destruction" (Freud, 1925, p. 256).

The first passage expresses the idea that the intellectual results of the suspension present in the function of negation, from which repression is not totally eliminated, since what was denied remains as such. When the analyst reveals what was denied to a patient and the patient accepts it rationally, says Freud (1925), he denies his negation, but the repressed is not integrated into the ego because of that. Green (2011) explains that, here, the same operation allows something to reach the conscious ego and reinforces the refusal to admit it as part of the ego.

Because of that, the resulting affirmation (as a negation of a negation) is purely intellectual and is far different from the original affective affirmation.

If we go back to the moment the ego was constituted, we will be able to acknowledge that before the acquisition of language (and the possibility of saying "no"), the baby was dominated by a "yes", by a sort of primitive affect, without the possibility, provided by language, of being apart from the experience (Garcia-Roza, 1986). Based on that, as in the second passage mentioned above, Freud (1925) articulated the act of judging with the mechanisms of introjection and expulsion. In addition, these were respectively articulated with the sexual and the death instincts. He explains that, despite the fact that the mechanisms of expulsion and introjection obey the pleasure principle, the judgment of negation escapes that principle, being its very condition of possibility.

The judgment of affirmation or negation may be configured as a judgment of attribution (affirms or denies possessing something) or existence (affirms or denies the real existence of a representation that belongs to the ego). The first case is about the incorporation of something experienced as good into the ego because of the action of the life instinct or the expulsion from the ego of something experienced as bad as a consequence and an action of the death instinct. Similarly, the second case is about the internal and external contents not in terms of what is good or bad but of what is real or unreal. In the latter case, the pleasure principle is not determining. Freud (1925) wrote that the original ego-pleasure wants to introject all that is good and expel whatever is bad. Contents that are bad, strange, or exterior to the ego are initially identical among themselves.

Indeed, those formulations relate to the process of the formation of the ego and the object. They result from the action of the life instinct (union/introjection) but also from the death instinct (disunity/ expulsion). Hyppolite ([1955]1966) states that "the primitive affirmation is nothing else but affirming; but denying is more than wanting to destroy" (p. 391). In other words, there would be a primitive affirmation corresponding to the initial form of the relationship between a baby and his/her mother, an affective relationship *par excellence* which is purely affirmative for being the direct expression of the instinctual, previous to any repression, previous to any individuation or constitution of subjective limits. Then, there would be a negation of that primitive affirmation, under the form of the original repression, that is, not operated by the subject because he is its result and not its agent. It produces inscriptions which fix the instinct onto the representative-representational. Thus, the condition of the possibility of the establishment of the differentiation between the ego and the non-ego is as follows: what is bad is denied and expelled, and what is good can now be introjected in a movement of weaving the fabric of the egoic limits.

If we consider the intrinsic relationship between introjection, affirmation and the sexual instinct, as well as between expulsion, negation, and the death instinct, we will be able to state that the death instinct is what performs the separation between the ego/non-ego, the constitution of the object and, consequently, the structuring of the psyche. In other words, negation, which is deeply linked to the action of the death instinct, is necessary for the construction and structuring of the psychic space. We cannot say, however, that the life instinct is unimportant in this process. On the contrary, without its processes there would be no psychic constitution. But, without the very processes operated by the death instinct, inter- and intrasubjective limits could not be established as well. Therefore, we may say that the

intensification and amplification of the death instinct in cases in which the subjective limits are undefined are an act of recruitment of constitutive forces. Their psychopathological effects are, then, side effects, which, many times, cannot be neutralized.

In 1911, Freud had already approached those issues, although he had not yet coined the concept of the death instinct. In his article on the two principles of psychic functioning (Freud, 1911), he declared that a psychic apparatus that was ruled exclusively by the pleasure principle and, therefore, ignorant of reality would probably be doomed to death for being unable to perform the judgment of existence. In the case of a baby, however, we know that the absence derived from the hallucinatory satisfaction is usually overcome by the offering of the mother's breast. However, if that was so all the time, it would be impossible for the baby to create the distinction between his mother's breast and his own body, mixing the fantasized and the real breasts. It means that it is necessary for the baby to lose the object and to separate himself/herself minimally from the mother to individuate and to be able to operate the reality check or the judgment of existence. We have mentioned above that this individuation results from the death instinct processes, such as disunion, because while the baby cannot distinguish his own body from the mother's breast, he is still a closed system in which it is not possible to separate the subject from an object (Green, 2011). This situation will only be dismantled and the closed system will be opened when an absence of satisfaction occurs, provoking a deception that leads to the renouncement of the hallucinatory satisfaction. With that, the pleasure principle will be transformed into the reality principle and the kind of judgment in operation will no longer be the one distinguishing between good and bad but rather the one distinguishing between what is real and what is hallucinatory.

Such changes in the psychic functioning result from the loss of the primary object, the separation, and the disjunction that is operated particularly by the death instinct, which necessarily involves movements of repetition. That is why Green (1979) could affirm that if, on the one hand, the function of the primary object in constituting the psyche involves protecting, containing, binding the instinct discharge; on the other hand, the primary object needs to let itself efface, since its absence is essential for the consolidation of an individuated psychic apparatus opened and capable of other investments. In other words, that separation is necessary so that the primary object may be internalized and transformed into a framing structure, necessary space of absence. Evidently, such structuring loss cannot be abrupt but must be gradual enough not to be experienced as such. In other words, the quality of the relationship with the primary object is the condition in which the absence may be established in a positive way: it is a function of the object to stimulate and awaken the instinct as much as it is to contain it and make it tolerable.

All this enables us to realize that the death instinct, far from being a (self) destructive principle inherent to the organism, can and should be regarded as accomplishing a mission in psychic survival with respect to traumatic flooding. As posed by Ferenczi (1934), it is unacceptable that there is no resistance regarding psychic commotion. That is, the following is how we understand the death instinct in trauma: "in a relationship of forces with no way out, only some resistance born from its own death instinct sources is able to confront the threat of a mortal danger" (Zaltzman, 1994, p. 64). Therefore, in cases of neurological illness with cognitive impairment, as well as in cases in which the main psychic functioning is in "traumatic mode" (Janin, 2005), we certainly witness an increase in the death instinct as a result of trauma.

However, instead of this being only a psychopathological expression of failure in symbolizing and elaborating the unrepresented, it is some kind of gathering of forces, a vital protest and a necessary resistance for psychic structuring and for the reestablishment of the limits that were more or less dissolved as a consequence of the lack of cognitive functions support.

It is not hard to come to the conclusion that situations such as those demand some adaptation of the psychoanalytical technique usually structured upon free association, floating attention and interpretation of repressed contents. As we will see, clinical practice with these patients differs from the classical psychoanalytical one in considerably important aspects.

Psychoanalysis as a therapeutic device for patients with neurological issues

Until recently, clinical care for neurological patients was centered on neurology and neuropsychology (Sury & Sano, 1999 e Miller, 1993). The treatment focused on brain, cognitive and motor losses suffered by the subject because of his illness, neglecting the psychotherapeutic approaches and prioritizing rehabilitation of the cognitive functions. In turn, the traditional psychoanalytic practice did not accept this type of case for having specialized in treating problems of psychological etiology, having left the spectrum of pathologies of neurological etiologies to the fields of neurology and neuropsychology. According to our experience, and taking into account the possible enormous cognitive limitations, the biggest challenge was building a narrative from which it would be possible to establish an elaboration path for the traumatic blow. Because of the limitations, it is evident that the analyst cannot count on the recovery of memories that the mind can no longer access. As in narcissistic identity disorders, the material available to the analytical work scarcely belongs to the representation realm. Therefore, we understand that only through affect will a path for subjective elaboration and reconstruction be established.

We have observed a growing appreciation for the affective aspects of analytical function in the present psychoanalytical literature as being detrimental to an attitude in which the analyst's neutrality is mostly demanded. The capability and availability of the analyst to be psychically affected by the encounter with the analysand has been emphasized so that the analyst takes a more active role in face of the affects produced in the transferential relationship.

However, it is important to remark that the opinion that is in favor of the analyst's affects in practice does not reflect the Freudian position on the theme. As is known, Freud expressed objections with respect to the affective responses on the part of the analyst during treatment and recommended caution and explicit effort to refrain from them. His opinion on the subject can be seen in his considerations on the concept of countertransference. Although passages in which the topic of countertransference are directly approached are rare, Freud clearly states that he thinks that countertransference jeopardizes the treatment, being necessary to be overcome (Freud, 1915 [1914]).

Nevertheless, post-Freudian analysts turned countertransference into a theme of increasing attention, especially since psychoanalytical treatment has been gradually evaluated regarding its relational dimension, that is, as a "dialogue situation" (Green, 2008), wherein both the analyst and the analysand are immersed.

Laplanche and Pontalis (1982) very briefly reminded that the limits of the concept have been extremely varied. While some have understood that all the aspects of the analyst's

personality would intervene in clinical practice, others have restricted countertransference to the psychic processes (conscious or unconscious) that the patient's transference engenders in the analyst. Still, regarding the delimitation of the concept, opinions vary with respect to the terminological distinctions between the pair transference and countertransference, distinctions that were established and emphasized by Freud himself, being sometimes revisited and other times refused by psychoanalytic authors. Refusal of this distinction would be justified by the fact that transference and countertransference are not understood as distinguished or separated processes, with one relating to the patient and the other to the analyst. It would, though, compose the analytical field as a whole, as a broader phenomenon that is the transferential relationship. In this way, as was defined by Green, "the relationship between the two concepts is something else than the sum of attributes of each object composing the relationship" (Green, 2008, p. 77).

Lacan (1958) is even more vehement when he defends the "conceptual impropriety" of the concept of countertransference. He thinks that the concept of countertransference is included in the conceptual fabric of the concept of transference and that they are one single phenomenon in the sense that they conjugate the same experience, though they are usually understood separately (Lacan, 1964).

Despite ferocious criticism, the concept has been developed throughout history and inspired contemporaneous authors such as Thomas Ogden (1994), for whom there is an intersubjective dialectic relationship between the analyst and the analysand that engenders what he called the analytical third, that is, a shared creation of the analyst-patient pair, a transferential-countertransferential field composed of, among others, the associative production of both.

Authors who defend referring to the analyst's affectivity as a clinical tool emphasize the importance of psychical openness on the part of the analyst to allow himself to become affectively disturbed by the analytical process. That is the analyst's skill in emptying him/herself through the process of encountering the patient, thus, becoming psychically open, poriferous and permeable to the analysand's transference (Thompson, 2002).

A case of frontal aphasia treated as part of our research allows a brief demonstration of some of the specificities of clinical practice involving patients with neurological issues. Let us see how the analyst, from the transferential relationship, can use affective communication as a clinical tool. Our patient was diagnosed with frontal aphasia. His clinical condition had developed after the removal of a bone tumor from the left frontal region of his brain and was characterized by disorganization in speech production and limitations in reasoning flexibility, coupled with difficulties regarding initiative, programming and planning.

The patient was referred to treatment because of depressive symptoms as a consequence not only from severe cognitive loss but also, according to him, from the recent rupture of a love relationship. He reported that his girlfriend, whom he had started dating a few months before the surgery for the removal of the tumor, broke up with him after he was released from the hospital. The sequence of losses made him feel that his "world and heart were broken". Regarding his cognitive limitations, he declared the following with sorrow: "I think about something and at the moment I am going to say it the thing is not in my mind anymore. The same occurs when I am writing". However, though he had difficulty communicating, the aphasia was not an obstacle when he talked about the end of his relationship. He used several long sessions

to speak of the pain he felt because of the loss of his girlfriend. "The words don't disappear when I talk about her because they are inside my heart. How am I going to be able to take her out of here inside?"

Initially, the analytical work involved creating subtitles and shades for the feelings of loss and abandonment he was experiencing during the sessions. Throughout the treatment, the recent experiences of loss started to update his earlier feelings of anguish regarding his first object relationships. He asserted the following in a certain session: "my world was never made of bright colors, although it was once colorful. But now everything is colorless. It is gray everywhere". These patient's words were followed by a continuous crying, while he cringed on the armchair, holding his feet and folding over himself, such as a baby in the fetal position. In that moment, the sensation provoked in the analyst was that of facing a vulnerable child, reminding her of an episode from the childhood of the patient, marked by his mother's daily commuting to work when he was left babysitting his younger brother. "I have the sensation that the gray hue everywhere did not start after the surgery, nor when your girlfriend broke up the relationship", says the analyst. "I have the impression that this gray hue has been there since when your mother stayed out the whole day". He cries and confirms that his childhood time was also gray. "My mother did similar to her [ex-girlfriend]. When she returned she would only take care of my brother. He was little and needed her more, but I also needed her". In this way, he was able to assess the traumatic memories he experienced in his childhood. Updating the feeling of vulnerability allowed the patient to start mourning, which occurred not only in regard to his brain impairment but also as an attempt to elaborate on early traumas, which would have fixated him in the position of a helpless child.

The analyst, in allowing himself to be touched by the affective modulations of the patient, uses his perceptual and cognitive processes to name the affective contents aroused by the countertransference. When dealing with patients whose skills of recall and representation are limited due to brain injury, it is up to the analyst to use affective experiences as a construction tool in analysis. In this way, the analyst's role would be to establish a transferential field with these patients in order to create privileged access to affect as a clinical tool. When possible, this type of work allows some sort of psychic management of the experienced ruptures and issues prior to the disease, as well as their elaboration and the consequent opening to new psychic investments.

For patients with neurologic impairment, this non-interpretational handling may cooperate for the reestablishment of a state of unity, ie, of me-world coherence. Therefore, in these cases, the *setting* is in first plan as what matters here are constancy, support and the analyst's empathic adaptation to the needs of the still not integrated patient (Winnicott, 1969). This includes the totality of the elements composing the analytical relationship, among which countertransference, as mentioned above, deserves highlighting. From a broader perspective, countertransference is not limited to the positive or negative aspects produced by transference. It goes beyond, comprehending the analyst's whole mental functioning.

In other words, the conduction of analyses of patients with neurological impairments demands that the analyst detach from a position primarily based on listening to repressed unconscious material. The analyst should adopt a more active attitude, taking part in the analytical process with his/her sensitive presence and offering him/herself as some kind of

representational prosthesis for someone who no longer has the necessary cognitive skills to sustain a minimally consistent representation grid.

Facing with such clinical impasses, we suppose that the essential challenge for the direction of the analytical work with those patients is, as suggested by Fédida (2009) regarding cases refractory to analysis, that the analyst asks him/herself about "his power to discover for him a original language" (p.156). Using the same diapason as the not yet integrated patient, in an empathic encounter, the analyst participates in the session with his own psychic, perceptual, and cognitive processes, thus becoming part of the integrative process. In these cases, it is necessary that the analyst is not restricted to free-floating listening but, inversely, is carefully open to all the little clinical details so that, with his/her sensitive presence, he/she may participate in the integration process. Therefore, higher flexibility on the part of the analyst matters the most here not only to address verbal representations but also to address other forms of psychic movement, be it through the eyes, voice tone, gestures, or images available to the analyst's psyche as an effect of the transferential encounter in the analytical context. By making available some of him/herself through his/her physical and psychical presence, the analyst lends cognitive and perceptual elements that may gradually enable the rehabilitation of the not yet integrated subject's potentialities and stimulate the construction of new psychical functioning patterns other than the repetition compulsion imposed by the experience of becoming ill.

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The irrepresentable, the repetition and the death instinct: psychoanalysis and neurologic illness

Abstract

Clinical practice involving the treatment of neurological patients with cognitive impairments has usually had neurology and neuropsychology as its main axes, neglecting psychotherapeutic approaches and prioritizing the rehabilitation of cognitive functions. This essay aims at exploring what may be learned about the psychic organization of neurological patients from the perspective of psychoanalytical treatment, as opposed to evaluating the validity of this method. We introduce the argument that the psychopathological scene developed after the experience and perception of cognitive impairment is placed at the intersection of narcissistic identity pathologies and classic traumatic neuroses, since the traumatic blow established by the disease destabilizes the sense of identity and the continuity of the subjective existence, thus dissolving the cohesion of the ego and both intensifying the action of and amplifying the effects of the death instinct. Consequently, we assume that the concept of the death instinct, far from being a (self) destructive principle, should be understood as having a fulfilling role in psychic survival in the face of a traumatic flood. Finally, we approach a variety of technical considerations and offer a few observations on the aspects of countertransference.

Keywords: Traumatic neurosis. Narcissistic identity disorder. Neurologic illness.

O irrepresentável, a repetição e o instinto de morte: psicanálise e doença neurológica.

Resumo

A prática clínica envolvendo o tratamento de pacientes neurológicos com deficiências cognitivas usualmente teve na neurologia e na neuropsicologia seus eixos principais, negligenciando abordagens psicoterapêuticas e priorizando a reabilitação de funções cognitivas. Este ensaio pretende explorar o que pode ser aprendido sobre a organização psíquica de pacientes neurológicos na perspectiva do tratamento psicanalítico, em vez de avaliar a validade desse método. Apresentamos o argumento de que o cenário psicopatológico desenvolvido após a experiência e a percepção de comprometimento cognitivo se situa na interseção entre as patologias narcísico-identitárias e as neuroses traumáticas clássicas, uma vez que o golpe traumático estabelecido pela doença desestabiliza o sentimento de identidade e de continuidade na existência, dissolvendo a coesão do ego, intensificando a ação e ampliando os efeitos da pulsão de morte. Consequentemente, entendemos que o conceito de pulsão de morte, longe de ser um princípio (auto) destrutivo, deve ser entendido como cumprindo um papel na sobrevivência psíquica em face de uma inundação traumática. Finalmente, abordamos uma variedade de considerações técnicas e oferecemos algumas observações sobre os aspectos da contratransferência.

Palavras-chave: Neurose traumática. Patologia narcísico-identitária. Adoecimento neurológico.

L'irrepresentable, la repetition et l'instinct de la mort: psychanalyse et maladie neurologique.

Résumé

La pratique clinique impliquant le traitement des patients neurologiques ayant une déficience cognitive avait habituellement sur la neurologie et neuropsychologie ses axes principaux, en négligeant les approches psychothérapeutiques et en priorisant la réhabilitation des fonctions cognitives. Cet essai vise à explorer ce qui peut être appris sur l'organisation psychique des patients neurologiques du point de vue du traitement psychanalytique, au lieu d'évaluer la validité de cette méthode. Nous présentons l'argument selon lequel le scénario psychopathologique développé après l'expérience et la perception de la déficience cognitive est situé à l'intersection des troubles identitaires et narcissiques et des névroses traumatiques classiques, puisque le coup traumatique établi par la maladie déstabilise le sens de l'identité et de la continuité dans l'existence, dissolvant la cohésion du moi, intensifiant l'action et amplifiant les effets de la pulsion de mort. Par conséquent, nous comprenons que le concept de pulsion de mort, loin d'être un principe (auto) destructeur, doit être compris comme jouant un rôle dans la survie psychique face à un déluge traumatique. Enfin, nous couvrons une variété de considérations techniques et offrons quelques observations sur les aspects du contre-transfert.

Mots-clés: Névrose traumatique. Pathologies narcissique-identitaires. Maladie neurologique.

El irrepresentable, la repetición y el instinto de muerte: psicanálisis y enfermedad neurológica.

Resumen

La práctica clínica que involucra el tratamiento de pacientes neurológicos con deficiencias cognitivas usualmente tuvo en la neurología y en la neuropsicología sus ejes principales, descuidando de abordajes psicoterapéuticos y priorizando la rehabilitación de funciones cognitivas. Este ensayo pretende explorar lo que puede ser aprendido sobre la organización psíquica de pacientes neurológicos en la perspectiva del tratamiento psicoanalítico, en lugar de evaluar la validez de ese método. Presentamos el argumento de que el escenario psicopatológico desarrollado después de la experiencia y la percepción de deficiencias cognitivas se sitúa en la intersección entre las patologías narcísico-identitarias y las neurosis traumáticas clásicas, una vez que el golpe traumático establecido por la enfermedad desestabiliza el sentimiento de identidad y de continuidad en la existencia, disolviendo la cohesión del ego, intensificando la acción y ampliando los efectos de la pulsión de muerte. En consecuencia, entendemos que el concepto de pulsión de muerte, lejos de ser un principio (auto) destructivo, debe ser entendido como cumpliendo un papel en la supervivencia psíquica frente a una inundación traumática. Finalmente, abordamos una variedad de consideraciones técnicas y ofrecemos algunas observaciones sobre los aspectos de la contratransferencia.

Palabras clave: Neurosis traumática. Patología narcísico-identitaria. Enfermedad neurológica.