

Biographical truths and their clinical consequences: Understanding ‘embodied memories’ in a third psychoanalysis with a traumatized patient recovered from severe poliomyelitis

Marianne Leuzinger-Bohleber

Sigmund-Freud-Institut, Am Ebelfeld 1°, Myliusstr. 20, Frankfurt D–60488, Germany –
m.leuzinger-bohleber@sigmund-freud-institut.de

(Final version accepted 1 September 2008)

The relationship between ‘narrative’ and ‘historical–biographical truth’ in psychoanalytic treatment has become the subject of many controversial debates in recent years. Findings of contemporary memory research have led to great scepticism as to whether therapists are able objectively and reliably to reconstruct biographical events on the basis of their observations in the therapeutic situation. Some authors even claim that psychoanalysts should concentrate exclusively on observing the here and now of the patient’s behaviour within the transference relationship to the analyst. In this paper it will be discussed whether the baby has been thrown out with the bathwater in this debate. Centred around the insights from a third psychoanalysis with a patient who suffered from a severe case of childhood polio, the hypothesis will be discussed that working through the traumatic experience in the transference with the analyst, as well as the reconstruction of the biographical–historical reality of the trauma suffered, prove to be indispensable for a lasting structural change.

Integration of the trauma into one’s own personal history and identity is and remains one of the main aims of a psychoanalytic treatment with severely traumatized patients. The reconstruction of the original trauma is indispensable in helping the patient to understand the ‘language of the body’ and to connect it with visualizations, images and verbalizations. The irreversible wounds and vulnerability of his body as the ‘signs of his specific traumatic history’ have to be recognized, emotionally accepted and understood in order to live with them and not deny them any longer. Another important aspect in psychoanalysis is to develop the capability to mentalize, in other words, to understand the intentions of central (primary) objects related to the trauma.

The concept of ‘embodied memory’ might be helpful in understanding precisely in what way ‘early trauma is remembered by the body’. Observing in detail the sensory-motor coordinations in the analytic relationship enables one to decode the inappropriate intensity of affects and fantasies which match the original traumatic interaction and are revealed as inappropriate reactions in the present, new relationship to the analyst.

Keywords: Countertransference, embodied memory, historical biographical truth, narrative, poliomyelitis, reconstruction of trauma, transference, trauma

1. Introduction

The highly explosive political ‘false memory debate’ has led to great scepticism as to whether therapists are able objectively and reliably to reconstruct biographical events, for instance, in cases of sexual abuse based purely on observations in the therapeutic situation. As we have discussed in detail in other papers, we share this scepticism (Leuzinger-Bohleber and Pfeifer, 2002, 2006). However, in this paper I would like to discuss whether the baby has been thrown out with the bathwater.

To mention just one example: Fonagy and Target (1997) write provocatively: "... whether there is historical truth and historical reality is not our business as psychoanalysts or psychotherapists ..." (p. 209).

Several trauma researchers have disagreed with this playing down of the therapeutic function of the reconstruction of the reality of early trauma (see also Bohleber, 2000a, 2000b, 2007; Bokanowski, 2005; Fischer and Riedesser, 2006). I agree with their position. According to my clinical experience and the results of a large representative follow-up study on the long-term effects of psychoanalyses and psychoanalytic treatment by the German Psychoanalytical Association, the working through of traumatization in the transference as well as the approach to traumatization that has taken place in reality are indispensable for a lasting effect of the psychoanalytical process (see Leuzinger-Bohleber, Stuhr, Rüger, and Beutel, 2003). Many of the interviewed patients have expressed that the precise understanding of the connection between their psychosomatic reactions and the former trauma has been essential for therapeutic change. A detailed biographical reconstruction of the idiosyncratic traumata also proved indispensable for accepting the childhood traumata and their lasting consequences as part of one's own life and biography. To give just one example. Mrs M said in the interview:

It was essential for me to find out in psychoanalysis that I am not crazy despite all my crazy symptoms. Unfortunately, I cannot change many of them: but at least they now make sense! In my flashbacks and daily nightmares my soul remembers being buried in our burning house in X during the bombings of World War II as a 3 year-old child, smelling the burnt human bodies and all these other terrible things ... These symptoms have become the voices of my very own history. They belong to me, I have to live with them.

In this paper I would like to consider another observation related to this topic: it seemed to me that the thesis just outlined does not apply only to the group of traumatized patients, whose trauma is related to 'man-made disasters' (for instance, the victims of the Shoah; see, among others, Bergmann, Jucovy and Kestenberg, 1982; Cournot, 1988; Faimberg, 1987; Keilson, 1979; Kogan, 2007; Krystal, 1968). I will contend that this topic is also relevant to another group of traumatized patients, namely patients who suffered from a severe physical disease in their early years of life, a rarely discussed problem in the more recent psychoanalytic literature¹. In the context of the follow-up study mentioned above I interviewed four patients who as children had suffered from severe polio infections. All four complained that their experience of suffering from polio had not been processed adequately during their treatment. A couple of years ago, over 20 years after two, so far successful courses of psychoanalysis, a patient began her third psychoanalysis with me. It turned out that her suffering from polio – as a traumatic experience with unconscious long-term effects – had remained largely untreated and still continued to constitute a fundamental source for the massive, frightening dissociations that the patient experienced. This paper will focus on the relatively extensive summary of this treatment as a starting point for discussing the thesis outlined above. In order to understand the dissociative states of the patient it proved indispensable to decode the 'language of her body' and to connect it with visualizations, images

¹At the Congress of the IPA in Copenhagen (1967) a Panel dealt with the effects of physical diseases for mental development (see e.g., Rodrigue, 1968).

and verbalizations in the transference. But this did not seem sufficient for a structural change of her traumatized personality: in addition a precise biographical reconstruction of the specific trauma was necessary in order to integrate the infantile traumata into her core self and identity. This also meant perceiving and accepting the unchangeable vulnerability due to the early traumatization in order to live with it and to deny it no longer – a very painful process as I will attempt to portray.

In this respect the concept of ‘embodied memory’ proved helpful in my understanding of precisely how ‘early trauma is remembered by the body’. Many authors engaged in the above-mentioned discussions claim that observing ‘procedural memories’ in the psychoanalytic situation opens a window for ‘stored knowledge’ of experiences during the first years of life. Procedural memories, defined on a descriptive level as a specific form of long-term memory, cover mechanical and bodily skills (such as eating with a knife and fork). In contrast to ‘procedural memory’, the concept of ‘embodied memories’ is much more specific, and offers a more precise understanding of the so-called sensory–motor coordination of the traumatized patient in the analytic relationship. This unconsciously – in very specific situations – leads to the precise re-construction of the bodily sensations, affects and fantasies which match the original traumatic interaction. Their intensity and quality prove to be inappropriate in the present, new relationship with the analyst. For the patient it is essential to decode in detail the specific (sensory–motor) stimuli which, because of their precise analogies, trigger the ‘embodied memories’ of the traumatic experiences (see Sections 3 and 5). I will try to illustrate that this means more than just ‘understanding procedural memories’ although I can introduce the concept of ‘embodied memories’ only briefly in this paper (see Section 4.). We have discussed it in detail in other papers (see e.g. Leuzinger-Bohleber and Pfeifer, 2002, 2006).

Although polio has become a very rare disease in Western countries, it is suggested that the so-called Post-Polio Syndrome (PPS) is related to Chronic Fatigue Syndrom (see e.g. Dalakas et al., 1995) and can reappear decades after the acute polio infection. It is much more widespread than assumed so far. Therefore it is possible that even today analysts have patients in psychoanalytical treatment, who suffer from Post-Polio Syndrome. Furthermore, I believe that, although the traumatizations due to the polio infection are *specific*, as I will illustrate, we will find and should work on analogous resistance and denial processes among patients who endured other extremely painful and life-threatening diseases in the first years of life. On the basis of a literature survey on ‘Poliomyelitis’ it seems to me that long-term effects of somatic diseases during the first years of life have hardly been considered in conjunction with the state of the art of contemporary trauma research, as I will discuss in the following section (Section 2).

2. Polio in the psychoanalytical literature

At present one can assume that due to widespread immunization during the past decades the viral disease of poliomyelitis has practically disappeared in the industrial nations of the world. The last great epidemic in Germany took place in 1960–1961. Afterwards area-wide immunization was established. So new infections hardly ever occur in Western countries. Conversely, it should be mentioned that the declared goal of the World Health Organization to have poliomyelitis eradicated by 2002 has not yet been achieved.

Given this historical background, it is understandable that polio often appeared as a topic especially in psychoanalytic work up until the 1960s. Yet it is surprising that the psychological consequences of this severe childhood disease have rarely become an explicit focus of analytical papers. One of the exceptions is the detailed case report of a 6 year-old boy and the aftermath of his polio infection by Bierman, Silverstein and Finesinger (1958), which primarily focuses on the boy's depressive problems. Oral incorporation fantasies, as well as fear of castration, are mentioned as possible triggers for the depression, which the disease additionally stimulated. Limentani (1982) reported an early termination of the therapy by a patient (Mr C), who suffered from visible consequences of polio. Jealousy is seen as a possible cause of the termination, but has not been placed in the context of the patient's physical handicap. Eisnitz (1974) studied the phenomenon of boredom in his discussion of Weinberger and Muller (1974). Here he is referring in detail to a case of polio and points out the presence of a strong fear of castration and diffuse physical fears as well as questions concerning the stability of self-representations as a consequence of polio disease on mental health. Hammermann (1961) analyses the masturbation fantasies of a young man one of whose legs is shortened due to having suffered from polio at the age of 15. The female strivings of the patient are seen as the effect of a mother fixation. The trauma of suffering from polio remains largely unrecognized. On the other hand, Jacobson (1959), referring to Freud's work on 'Exceptions' (Freud, 1916), discusses an interesting, specific processing of the disease in the case of two patients with polio. Both of Jacobson's polio patients had developed an 'exception-self-image', as described by Freud. This among other things led to the fact that neither could accept the reality principle. However, both patients had transcribed an unconscious 'exception fantasy' into their life arrangements in different ways, according to their most central object relationships during their suffering. (For more detailed information, see Appendix.)

I could not find any paper which deals with the effects of traumatization on the patients' subsequent symptom production, and which is dedicated to the specific technical problems that arise in the interaction with this group of patients. The following will focus on such a clinical example.

3. Case study/example

So much pain could have been spared to myself, my husband and my children, if only I had had the courage to take a close look earlier ...

(Mrs B)

(a) Motivation for a third analysis

Mrs B, a 52 year-old, has decided to do another sequence of psychoanalysis because she still suffers from severe sleeping disorders as well as from apparently psychotic 'breakdowns' during conflicts in the relationship with her husband. These unexplainable breakdowns are a heavy burden to herself as well as to the relationship. She has already completed two psychoanalyses, with which by and large she is very content. She initiated the first analysis at the age of 23 after a complete breakdown following the death of her handicapped brother. It lasted almost three years. "As soon as I felt better, I jumped up from the couch and tried to do everything by myself again" She thought of the second analysis as a continuation of the

first because the depression and the severe symptoms of exhaustion kept returning and led to serious suicidal attacks. At age 29 she initiated this second psychoanalysis which lasted almost five years. She gives the treatment the credit for her “having had the courage to settle in a new relationship with (another) man and becoming pregnant. My daughter’s birth (when she was 33) was a turning point in my life – I have definitely buried suicidal tendencies although suicidal thoughts still come to mind once in a while. Unlike previous times, I am now absolutely sure that I am in control of these impulses, because I am not going to do something like this to my children. For this I am grateful to psychoanalysis.” At the age of 38 she has given birth to twins and very much enjoyed experiencing the growing up of her three children. “I was so incredibly thankful that my children were healthy, which in contrast to my husband has never been a given for me. I always reckoned with catastrophe and always reacted with panic if one of the children got sick or had a mild accident ... Because of my psychoanalysis I knew that these events reactivated memories of my childhood catastrophes – I could not do anything about that! Fortunately, my husband was a good counterbalance to those fears, otherwise a lot would have gone wrong ...”

Mrs B has always been employed. She successfully directed a large innovative institution for severely handicapped children, has written several books about her work and is an internationally known expert in her field. “I know that to the outside world I represent a model career. I am much admired because I am able to combine motherhood, marriage and a professional career – but still I cannot get rid of this basic feeling, that I live on the edge of a great abyss. A catastrophe could occur any time ... often at night I am convinced that everything is breaking down around me. I then lie awake, get a panic attack and hallucinate falling into a deep, black hole. I have to get up each time, otherwise I cannot endure it ...” The greatest burden is the “sudden breakdowns”, which Mrs B experiences in conflict situations with her husband:

They occur completely unexpectedly, mostly at times when I feel very relaxed. Often I suddenly experience my husband as emotionally unaccessible and withdrawn, and am then immediately convinced that he wants to leave me. I panic, I rage and attack him physically, just out of control. My entire body is a single wound – everything hurts – an unendurable state, which I only want to bring to an end. Mostly I am acutely suicidal in this situation and would like to get the whole thing over with. In tears and with the feeling of extreme coldness I finally creep away into a dark corner, cowering like an embryo, usually for hours. The whole thing is a nightmare. When it is over, I am not at all able to imagine this state. Then I am terribly ashamed. I am terrified that I can be such a different person. It is like a psychosis and for my husband and me a horror over and over again, unbearable. Often I am afraid that because of this the relationship will fall apart ... neither analysis could change anything about this ...

*(b) Remembering the insights of the former two psychoanalyses:
An attempt at integration?*

In the first months of treatment (4 sessions a week, couch setting), memories of the two psychoanalyses often emerged, with two different analysts, one woman and one man, each of a different theoretical orientation, one with a chiefly modern Anglo-American object-relational approach, the other one seeing himself mainly as a

Neo-Kleinian analyst. Telling me these memories seem to me like an attempt at integration. Unconsciously Mrs B seems to want to inform me about the current state of her unconscious fantasies and conflicts. "It is strange how much is coming to my mind about these former treatments. For years I hardly ever thought of them ...", she once says.

To mention just one example. In the third month of treatment Mrs B's father dies. Mrs B reacts with terrible guilt feelings because she was abroad when he unexpectedly passed away. In the next months she seems to be paralysed in the analytic sessions, unable to feel anything. "I am feeling like a robot – everything has lost its meaning – it is like someone turned off the light." After some months of not being able to reach the mainly silent Mrs B emotionally, I am more and more concerned about the state of her pathological mourning. I finally dream that my patient is lying in a coffin next to a dead person. It is not clear if she is still alive. "You seem to be paralysed here on the couch like a severely ill or even dead person. Could it be that you are sacrificing your own life because you feel so guilty at having given a successful speech in Los Angeles while your father was dying?" I ask my patient in the next session. She now remembers her dreadful feelings of guilt during her first analysis after the suicide of her handicapped brother. "For months I was lying on the couch, silently like a dead person ..." She recalls that she found out in her analysis that the identification with the dead brother was also due to unbearable feelings of hatred and aggression.

For years the four years older, physically visible handicapped brother had been jealous of his younger, healthy and talented sister, who was also the father's favourite child. Many memories had appeared at that time about how her brother had secretly tortured her as an infant, mostly unrecognized by the parents. Mrs B now recalls that it was crucial for calming her own depression during her first analysis to work through her own sadistic and aggressive fantasies, which had been overstimulated through her brother's tortures and had been banished into the unconscious. She didn't allow herself to have such feelings towards her handicapped brother. Instead the only option was to flee from the relationship. Mrs B recalls many scenes of being alone in the woods as a small child, insecure and lonely, occupied with intensive daydreaming.

In the following sessions we are able to understand that the death of her father had reactivated the traumatic loss of her brother. She now releases herself from her silence and recalls many insights of both her former psychoanalyses. I cannot report any details but give only a short summary of her 'life narrative' due to her psychoanalytic insights.

Because of her high achievements and social behaviour she excelled in school. She was considered as the 'integrative element' in her class, mediated conflicts and cared for weak and needy children. As became clear in her first analysis she had formed an altruistic, beaming, warm-hearted personality, which was yet imprinted at its core by profound loneliness, "somehow fundamentally unconnected with the close supporting figures". She only felt loved and respected when she was able to be there for others. These 'truths' had especially become clear in the transference with the first analyst: often she had the fantasy, that the analyst was happy if a session could not take place and she only received the fees.

Her first loving relationship had also followed the same pattern. She unconsciously searched for a needy partner whom she could care for and nurse. Another

central insight of the first analysis evolved around her narcissistic fantasies of omnipotence, of her being able to soothe or heal handicaps. The brother's suicide revealed the omnipotence fantasies, another trigger for the depressive breakdown. The analytic work also dealt with oedipal fantasies and wishes, such as her feelings of guilt, that she had preferred the lively father as opposed to the depressed mother. Three years of analytical work led her out of her depression, and Mrs B was able to take up and successfully complete her studies. The recurring nightmares of being pursued because of a crime, which was unknown to her, disappeared, yet the chronic feelings of exhaustion, as well as the basic feeling of "not really being anchored in this world" remained.

Because she could also profit from psychoanalysis in her professional field, which focused on disability, she decided to continue treatment with another analyst in the city in which she now lived. As she recalls, the analyst soon realized that she was not able to lie still on the couch, but that she constantly had to move. In this context, memories of her polio infection, shortly after her fourth birthday, appeared for the first time. During this illness it remained uncertain for weeks whether she would live or die. Mrs B knew of her infection but mostly had integrated the feeling of how "lucky" she was that she survived the disease without any visible consequences and that she, in contrast to her handicapped brother, was a healthy, talented and handsome child, "everybody's sunshine", as she had often been called within her family. Her enormous fear of passivity had been connected to the experienced fear of death and this realization finally led to coping better with situations of professional overburdening. The hypothesis about the early interaction with the depressive mother played a great role here. The insufficient empathy for her own body and its state was attributed to insufficient introjection of a caring, empathetic maternal primary object. Because, as it was assumed, the mother did not carry out her holding and containing functions sufficiently, the archaic and, above all, aggressive impulses could not be integrated 'well enough' and thus led to a severe weakness in the area of stable representations of the self and of others as well as to her severe suicidality. Mrs B commented:

Together we found a way out of this horrible dark world, the pathological and aggressive seduction of being united with my dead brother, the unconscious anger and revenge, which was primarily directed towards my mother – but also towards my analyst – and similar terrible and embarrassing fantasies. In the relationship with the analyst I gradually thereafter rediscovered many brighter sides of experiences in the early relationship with my father. I sensed that the analyst liked working with me, was truly interested in me and was able to empathize with me and my despair. Thereby I was again able to believe that my father, and possibly my mother in her way, loved me.

Such insights finally made it possible for her to free herself from a restrictive relationship with a mathematician, in which she felt very lonesome. After this, Mrs B fell in love with a man, her future husband, with whom for the first time she experienced a satisfying and fulfilling sexuality.

(c) Doubts about the 'untreatable early disorder'

In the following months of psychoanalysis, there appeared, among other things, doubts about the hypothesis of an untreatable early disorder:

- Mrs B depicted her mother's interaction with the three grandchildren in many different versions. In these situations she experienced her as jovial, humorous and with much empathy for the infants. These observations raised doubts about her mother's diagnosis of severe personality disorder. We discussed the question that her former perception of her mother's personality could also have been partially due to her infantile (oedipal) fantasies and projections onto her primary object.
- The 'psychotic states' during Mrs B's breakdowns did not seem to have the character of a psychosis, but rather of a dissociative state as described by recent trauma research. At the time of Mrs B's first two psychoanalyses little psychoanalytic knowledge about trauma was available. Are the 'states' an unconscious enactment of traumatic experiences?
- As an analyst, I often noticed the strange way in which Mrs B talked about her polio infection. The narration almost had something coquettish. It appeared to be some form of a 'wonderful fairy tale of a lucky girl who (just) escaped death', who thanks to a 'lucky star' was able to continue her way of life without restrictions, in contrast to many of her classmates, who bore witness to the epidemic through visible handicaps. In her narration every record of fright, fear of death and physical pain was missing. Does this express denial of the trauma suffered?
- Both psychoanalysts, as recalled by Mrs B, seemed to have shown hardly any interest about details of her polio illness. It came to light that even Mrs B had almost no medical knowledge about polio, e.g. she did not even know how the disease is transmitted, its causes, what types of polio exist, etc. This was extraordinary for an intellectual woman, especially one who is employed in upper management in a home for the handicapped.

Before summarizing our alternative clinical hypotheses (in Section 5), I would like briefly to introduce the concept of 'embodied memory'.

4. Embodied memories: An often neglected key to the unconscious and to early traumatic experiences

The controversy surrounding the relevance of 'narrative' versus 'historical-biographical' truths for the results of psychoanalytic working has been intensified through the present dialogue with the neurosciences, a topic which cannot be discussed within the framework of this paper (see e.g. Kandel, 1998, 2005; Milner, Squire and Kandel, 1998). To summarize one of the main arguments relevant to this paper briefly (see Figure 1). The declarative memory, within the brain areas which are considered to be responsible for accomplishing these memory performances (cerebral cortex: medial temporal regions, limbic system: hippocampus), is only fully developed by the age of 4, a fact which is crucial for memory processes of the traumatizations taking place in the first, vulnerable years of life (cf. among others Koch-Kneidl and Wiese, 2003). Therefore authors, for instance, Peter Fonagy and Mary Target (1997), conclude that explicit, declarative memories can only reach back to the fourth year of life, and that therefore earlier traumatic experiences cannot become conscious or accessible in the therapeutic situation. They plead for psychoanalysts and psychotherapists to restrict themselves to

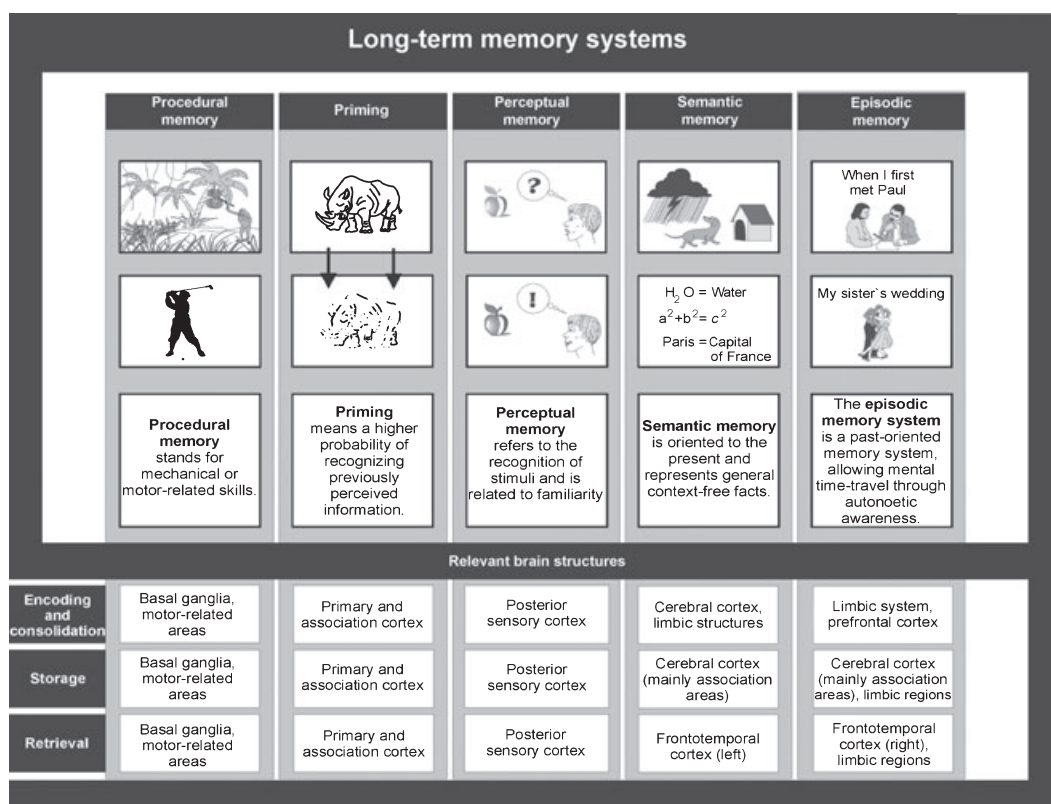


Fig. 1. (see Reinhold and Markowitsch, 2007, p. 87)

observing procedural memory in the here and now of the transference and to comprehend its meaning in the present interaction with the analyst. This advice has had a strong impact on the psychoanalytic technique of treating traumatized patients. Let me try to summarize some critical remarks concerning this unmodified transfer from memory research to the understanding of psychoanalytical treatment techniques:

‘Procedural’/ ‘declarative’ memories are *descriptive* categories of long-term memory, as illustrated by Figure 1. This means that they *describe* which memory functions are observable at a certain age. The fact that one can only observe declarative memories in children after their fourth year of life does not mean that the brain has not been influenced by experiences in a specific way before this date or that it suddenly reaches a certain phase of development at the age of 4. Earlier memories are not only recognizable in the mechanical and motor related skills which are described by “procedural memory”. Therefore it is problematic to claim that the clearly distinguishable descriptive categories of memory indicate clearly distinguishable phases of the brain development as well. This danger can be avoided by the alternative concept of ‘embodiment’.

It is generally agreed that from the very beginning biological–genetic and environmental factors interplay in a complex way. Right from the start (i.e. in the embryo when the hippocampus is not yet fully developed) social experiences leave

their marks on the neuronal network of the brain. Edelman (1992), among others, has described this 'imprint' in detail. He talks about development of the primary and secondary repertoire, followed by the connection of the neuronal maps.

This conceptualization of the development of the neural network also implies a dynamic view of memory. According to Edelman (1992) and other authors in this field (Pfeifer and Bongard, 2007) memory is not to be conceived of as stored structures but as a function of the whole organism, as a complex, dynamic, recategorizing and interactive process, which is always 'embodied' (human memory does not exist in isolation from the body). It is important to note that sensory-motor, 'embodied' co-ordination does not simply mean nonverbal: it implies that there is a *coupling* between the sensory and the motor processes, i.e. that the two mutually influence one another. In particular, through the physical interaction with the environment, patterns of sensory stimulation are induced in different modalities, e.g. visual, tactile and proprioceptive. When I grasp a glass, I induce sensory stimulation in the tactile modality in the fingertips and the hand, in the visual modality by bringing the glass into the range of the visual field, and the proprioceptive one by feeling its weight. Moreover, these patterns contain information structures – correlations – which support processing in the neural system, e.g. for categorization and learning. At the level of the brain, this coupling is implemented via the neural maps which are embedded in the sensory-motor systems of the organism. Clancey (1993) thus defines *memory as the capability to organize neurological processes in such a way that they coordinate – and therefore categorize – sensory and motor processes in an analogous way as in former situations.*

This conceptualization of memory is central to the discussion of the controversy mentioned here, i.e. the role of 'historical' versus 'narrative–biographical' truth. To summarize our considerations, which we have elaborated in detail in various papers (Leuzinger-Bohleber and Pfeifer, 2002, 2006; Leuzinger-Bohleber, Henningsen and Pfeifer, 2008): memory always consists of new and constructive processes in the 'here and now' of a current interactional situation (system – environment – interaction in the case discussed here; in the transference situation with the analyst or an important person in the current reality of the patient) which is essential for constituting memories. At the same time this constitution of memories is not arbitrary because the way the current system-environment interaction is structured and the way sensory-motor patterns are interpreted are determined by the individual's history. Memories are constructed by analogy to previous situations with similar sensory-motor patterns. Although this physical stimulation is always subject to interpretation, depending on the individual's history, the sensory stimulation itself is still 'objective' and not arbitrary. This is a consequence of embodiment: sensory-motor states are, at least theoretically, measurable physical processes; the sensory-motor coordination is given by the way the neural maps are integrated in the organism, which is again objective. In this sense memories result from constructive processes on the one hand, but on the other hand they are influenced by the 'historical truth', which means, for example, the historically first constituted processes dealing with a (traumatic) situation, which constrain the recategorization of the new analogous situation. In this sense recategorizations in later interactional situations are related to the original trauma. *Metaphorically we could therefore postulate that memory is always based on new and idiosyncratic narratives taking place in current interactional situations, but at the same time containing traces of the 'historical*

truth'. This is the main argument addressed in the hypothesis of this paper: to produce structural changes in the bodily reactions, emotions and fantasies it seems essential that the analysand should understand precisely the analogies between a current interactional situation (e.g. the stimuli in the interaction with Mrs B's husband or her analyst which trigger her 'breakdowns'), and the original traumatic situation (during her polio infection). As I will discuss in the next section, this means much more than just trying to 'comprehend procedural memories' (e.g. the way Mrs B gets up from the couch, see Figure 1). *Analysing 'embodied memories' means analysing the specific sensory-motor coordinations in a very specific interactional situation, including understanding the precise analogies to the original (traumatic) situation.*

In other words, traumatic experiences have left their marks on the organism, even when experienced before the age of 4, and can therefore also be remembered in the form of bodily reactions (sensory-motor coordinations). Of course, it must be considered that such traumatic experiences (biographical-historical realities) are never preserved in memory in a one-to-one manner, but have been subject to many subsequent re-writings (see Freud's concept of *Nachträglichkeit*, see Section 6). Still the 'historical-biographical reality' is always preserved as the core of these re-writings. Moreover, traumatized patients during their flashbacks often recall precise details of the events that have taken place in reality, even from their first years of life. Amnesia for the trauma does indeed occur, however it is by no means common. Often recollections of the trauma are present (as with Mrs B), but are dissociated from the overwhelming emotions and unbearable experiences. According to the aforementioned clinical experiences, it is the exact reconstruction of the traumatic experiences which patients aim to obtain when interrogating surviving witnesses or historical studies, which make a minimal psychological integration of the suffering possible (for details, see Bohleber, 2007; Leuzinger-Bohleber and Pfeifer, 2002, 2006).

This interdisciplinary conceptualization of memory corresponds to Freud's view that 'the ego is primarily a bodily one': the sensory-motor coordinations are a new *via regia* to understanding early traumatizations, because the body does not forget anything. All early traumatization is preserved in the unconscious (see also Melanie Klein's concept of 'memories in feelings' [Klein, 1957]). In Cooper's (1986) well-known definition, traumatic experiences, due to their unbearable qualities, could not be endured and 'worked through'. Banned to the unconscious they influence current thinking, feeling and behaviour. Tutté (2004) refers to the 'archaic dimension', Hartke (2005) to the alpha-function (Bion) of the determining traumatization during early infancy. Such traumatizations are therefore often an important unconscious source for inadequate behaviour. Subsequently, the decoding of such reactions (e.g. the appearance of a dissociative state when Mrs B experiences a situation which unconsciously reminds her of a traumatic memory) is essential in order to diminish the unconscious influence of past traumatization (in detail, cf. also Leuzinger-Bohleber, in press; Leuzinger-Bohleber, Roth and Buchheim, 2008). As already mentioned, this calls for understanding the 'embodied memories' of the trauma in the bodily reactions on the one hand, and precise historical reconstruction of the traumatic event (as a precondition for accepting it as part of one's idiosyncratic biography and thus as part of one's identity) on the other.

Now, which ‘historical–biographical truths’ could be encoded in Mrs B’s unconscious enactments in the psychoanalytic process?

5. Approaching the specific ‘embodied’ trauma of the polio infection in the transference: Indispensable for structural change?

“Suddenly everything is different ...”: Dissociation and trauma

The following sessions took place around one year after the beginning of psychoanalysis. After a weekend Mrs B comes to the session in a warm woollen sweater, in spite of the sunny weather. She looks pale and tired with a frozen expression on her face. ‘Is she ill?’, I ask myself. I notice that she stops several times while walking up the stairs, breathing heavily. This is uncommon behaviour for her. I am thinking that I myself had trouble climbing the stairs last week while suffering from a slight infection. Lying on the couch Mrs B is silent for a long time. She lies there in a stiff and frozen position. The longer she is silent the more intensive my depressive feelings become ... Suddenly my dream with the two people lying in a coffin comes to my mind (see Section 3[b]). I panic because I suddenly fantasize that someone could close the lid of the coffin in spite of the fact that it is not clear if the people are really dead. Now I make the association that both of us are wearing warm woollen sweaters in spite of the sunny weather outside. Are we the dying people in the coffin? Mrs B does not know that I myself have suffered from polio in my childhood and that I share with her one of the generally unknown long-term symptoms – the difficulty of regulating bodily temperature. I ask myself if my dream contains not only the issue of the death of Mrs B’s father and brother as mentioned above, but also our shared experience of being paralysed and threatened by death during the polio infection.

Mrs B is still silent. Finally, after about half an hour, I break the silence: “Is it difficult for you to talk today? – Where are you with your thoughts?”

Mrs B: “I did not want to tell you what happened during the weekend. I do not want to burden you ... and, well, psychoanalysis does not change anything anyway ...”

“Are you afraid I would not be able to cope with your experiences?”, I comment (thinking of Mrs B’s fantasies about her mother during her polio infection). Finally Mrs B slowly starts to talk.

She had spent the weekend in a holiday house with her husband and their adolescent children. She had looked forward to this event for months because it would be the first time that the whole family would be reunited again. The ‘catastrophe’ happened during a walk through the sunny meadows. She felt very relaxed and happy, and joked with her husband and the children. She then told her husband about her plans to celebrate his coming birthday in an idyllic little restaurant close to a lake, which she had already reserved. Her husband did not react with enjoyment as she had expected but withdrew, seemingly somehow angry (he told her many days later that he felt overwhelmed and excluded by her plans). Immediately everything changed: the positive mood collapsed, her body became stiff and “dead”, she seemed hardly able to breathe. At the same time she had terrible headaches and a strong impulse to vomit. Her entire body was hurting. Because she was not capable of coping with these painful changes she started – in front of her chil-

dren – to attack her husband, verbally and even physically. Finally her husband and her children were angry. The children went back to their homes. She was in a desperate state. For hours she sat in a corner of her bedroom in the dark, freezing and in a curled up position like an embryo. “I could almost not bear it – the terrible pains in every part of my body. I only wished that everything would come to an end ...” Her husband found her in this state when he returned in the middle of the night. He tried to talk with her and to take her into his arms. For hours she could not bear the bodily contact and continued to attack him violently. Finally, after many hours cowering in the dark corner in his presence but silent she calmed down a little and the extreme pains diminished. In the morning she could finally allow her husband to touch her and to bring her to bed. Exhausted she fell asleep

...

Mrs B is deeply ashamed and shocked. She suffers from heavy feelings of guilt and fears of having finally destroyed her relationship with her children. “It is like a nightmare – in this state I am like a different person. Am I crazy or psychotic?” While listening to the patient I had realized that the topic ‘polio’ had disappeared from our psychoanalytic sessions for about nine months. I comment:

I can imagine how painful and degrading this is for you. You had hoped that the breakdowns would not appear anymore after all these psychoanalytic sessions. It is understandable that you feel doubts whether psychoanalysis will be able to change these terrible states of mind. I was just thinking that polio as an subject of our work here has disappeared for a long time. Could it be that your ‘breakdown’ unconsciously wants to remind us of this topic? Perhaps your body is expressing some unconscious memories of unbearable physical and emotional pain during the polio infection in this ‘crazy way’, memories which are normally not accessible to you as today in this session.

Mrs B seems to be touched and starts to cry. “Yes, I have forgotten about all this for a long time again ...,” she says.

After this session she surfs the Internet. While reading the medical information, she recognizes that she had suffered from “*paralytic poliomyelitis with typical symptoms, above all, symptoms of palsy*”. She remembers that she was playing with her cousin in the garden, feeling relaxed and happy in the middle of her summer holiday. All of sudden she felt very ill, and had to throw up. “From that moment on I felt absolutely miserable – my entire body hurt, particularly my head”. She telephones her mother to request more details. Her mother tells her that she [Mrs B] had high fever with attacks of shivering. She screamed with pain and would not let anyone touch her, because every single touch hurt. Both legs were paralysed. She was close to death for several weeks.

In the following sessions we discover the analogies between her psychic and bodily sensations during her “breakdown” and the beginning of her polio infection. It now seems probable to us that the extreme emotional and physical states during her “breakdown” are specific ‘embodied memories’: the triggering experience of her husband’s “sudden”, “unexpected” and “abrupt” withdrawal in the trustful, happy situation on the walk, the experience “that from one moment to the next everything is different ...” as well as the unbearable pain of the entire body bear a striking analogy to her experience at the outbreak of polio.

According to the concept of ‘embodied memory’ as summarized above we can explain the ‘automatically reconstructed’ memory of the traumatic experiences in

the following way. The perceptions of informations in different sensory channels in the triggering situation (the sudden, unexpected changes in her husband's facial expressions, his gesture and bodily position, his withdrawal, his resistance to hold her hand any longer (when angry he does not want to hold her hand) lead to analogous sensory-motor coordinations as in the situation of the sudden breakout of polio in the sunny garden. These sensory-motor coordinations 'construct' the 'embodied memories' on the bodily state (headaches and pains in the entire body, throwing up, despair, changes in the perceptions of the surrounding persons, etc.).

'The catastrophe': Fear of death and panic

In one of the following sessions Mrs B tells me one of the few conscious memories of the polio infection. Mrs B is lying in the darkened room, all by herself, peaceful and wishing her beloved God take her with him to heaven... In this scene Mrs B does not feel any physical pain, she is lying there entirely calmly. To us, the picture of peaceful solitude and the childlike wish "that the dear God may take her to him" seem to be an expression of massive denial of the extreme physical pain which accompanies every bodily movement in acute polio, as well as a denial of the perception of being paralysed and of the massive fear of death.

We finally find the analogies to the traumatic situation in infancy triggering her 'embodied memories'. In her dissociated states Mrs B tries to get herself into a paralysed and cringing position in a corner of the (bed)room; she tries not to move at all in order to 'freeze' the unbearable storms of affect, the panic and the pain of the entire body. Hours later, she successfully reaches a state of motionless calmness, freedom from pain, and 'paralysis of the feelings', which give enormous relief. Only when she is able to get herself into this state of emotional peace, can she endure her husband to physically touch and relieve her. Here she also seems to construct an 'embodied memory', an attempt to manage the overwhelming with unbearable pain and vehement affects by 'freezing herself'.

"It is most bearable, when I am by myself ..."

In her dissociative state, as just described, Mrs B attacks her husband vigorously and sends him away, she cannot bear his physical presence, least of all "his angry-perplexed-fearful face", although simultaneously she panics when he leaves her. To us, another detail of the memory of the darkened room just described seems to offer the key to understanding this part of the enactment.

Mrs B remembers her mother's fearful face. To see her in this state is far more unbearable than lying alone in the darkened room. According to Mrs B's (oedipal) fantasies her mother probably could hardly contain the fear that her child might die, or survive even more severely handicapped than the elder son. "For years she told me over and over again how many children had died in the village during the epidemic. On Saturdays she often took me with her, and placed flowers on the graves of the polio children." Mrs B recalls how she imagined lying in one of these graves herself.

In the session we assume that Mrs B identified with her mother's fantasized wish for death in this situation, perhaps another aspect of her later suicidal tendencies. In any case, she developed a central unconscious conviction that when ill and needy she would become a heavy burden to others so that she had to hide it and "cure

herself'. I assume that a seed of Mrs B's profound loneliness lies within this unconscious conviction – only her husband, a very much loved child of a physically ill mother, could again and again reach out to her emotionally in her loneliness.

Probably the comforting bodily contact, which each time finally gets her out of her states, is also connected to embodied memories. She recalls that in the evenings her father used to sit down on her bed and hold her hand – for her a pleasant (maybe also psychologically life-saving) experience. Apparently, it was he who was able to control his fears for the child, and was therefore also able to communicate to his ill daughter a hopeful, positive bodily experience.

Because of these memories it is easier for Mrs B to understand why the very empathetic analyst in the second treatment could lead her out of the severe depressive crisis: presumably she unconsciously connected in the transference such experiences of good object relationship with her father.

Denial of the horror: Flight into health as a "sunshine child"

In the following months Mrs B, having survived the life-threatening disease, fled into healthiness in an impressive way and reinterpreted the fear she had suffered as a remarkable "lucky stroke of fate". Perhaps she had not received enough support from her parents² in order to deal with the traumatizations. Understandably both were probably happy and relieved that they had their healthy, uncomplicated and talented child back. Unconsciously, Mrs B experienced herself as positively selected by fate, as a chosen one, who because of her remarkable talent or because of being especially loved by "almighty God" had now received the existential assignment to be there for others, especially for handicapped individuals like her brother, in the form of a "sunshine child". She developed into an altruistic personality (see also Anna Freud [1936]). However the suffered trauma remained unconsciously present, influencing, for example, the basic feeling of being alone and lonely, of not deserving her own existence, feeling guilty for the tragic fates of her brother and her polio, and therefore being allowed to exist only as the "Siamese twin of a handicapped sibling". The severe depressions and states of exhaustion in her late adolescence seem to be connected to the repressed and not unassimilated fear from the trauma.³

The struggle for memory (Leuzinger-Bohleber): The integration of the trauma and its therapeutic effect

The struggle for understanding of the 'embodied memories' lasted months and was characterized by renewed denial and the wish to re-establish the old, seemingly

²Trying to understand her parents' behaviour during her polio was essential for her increasing capacity for understanding more profoundly the intentions and motives of her primary objects. This had an observable effect on her social relationships.

³After having studied the medical literature Mrs B also asked herself whether the unusual symptoms of exhaustion, which had been the main reason for her earnest suicidal intentions during the second analysis, were related to a post-polio syndrome (26 years after the polio infection). The main hypothesis was hardly to be tested *a posteriori*, mainly because medical information, which assumes episodic but also progressive development of PPS, bore contradictions. Yet it seemed important to her that the analytical treatment, without knowledge of PPS, had made possible better coping with her body: avoidance of extreme muscle exertion, as in the movement and dance groups during the previous years, good phases of relaxation with the infants, less stress etc. These are all recommendations which are given to patients of PPS today.

manic, contraphobic defence of the suffered pain and despair. Attempts at flight set in again and again, including thoughts about terminating the analysis before completion. To mention just one example: after being confronted with her renewed denial of her polio traumatization in again not taking notice of her exhaustion and falling into depression, she angrily jumps off the couch and shouts at me: “You want to keep me little. You are envious because of all my activities and successes.” In the next session she reports a dream: *A little girl completely dressed in white, with fine white shoes, was climbing up a large mountain of shit. As she arrived at the top she began to sing beautifully ...* We both have to smile: “Yes, it really is a mountain of shit, this polio. The little girl just does not care about it and is even capable of bringing happiness to the whole world by singing so beautifully ...”

We can talk about the temptation of denying the trauma again and again, in order not to have to confront oneself with the horror of the trauma and one's own vulnerabilities. Again and again Mrs B tries to prove to herself, that “everything is fine – polio has gone away for ever ...” It is a very painful process for her that she – physically and emotionally – is still suffering from the consequences of the traumatizations and that she will never be able to completely overcome them or to delete all traces of the traumatic memories. She constantly experiences her physical vulnerability as narcissistic defects. She often expresses her sadness because, judging by her dreams, the early traumatizations (growing up with a depressed mother and a handicapped brother, her polio infection, etc.) have influenced her unconscious fantasies so much – a topic which I cannot elaborate further here.⁴

As far as psychoanalytic technique is concerned it was difficult not to be blind to Mrs B's repeated denial of the trauma (during the first year of psychoanalysis, see above). She often tried to seduce me with her wish to hear that the trauma – compared, for example, with the Shoah – had not been so severe and would not have any long-term consequences for her. On the other hand, as we now know, I had to cope with the risk of a re-traumatization if the reactivation of the traumatic experiences in the analytical relationship became too intensive. Many psychoanalytical authors have described that coping with the intensity of the reactivation of trauma in the psychoanalytic process is one of the main difficulties in analytical work with traumatized patients. The successful navigation of these risks must be linked to a continual processing of the difficult feelings in the countertransference, which is often difficult to manage without supervision. Therefore I just want to mention how important the containing function of the psychoanalytic relationship was in the psychoanalysis with Mrs B. I have no doubt that working through the trauma

⁴To mention just one example: apparently during the polio infection age-related oedipal, sexual fantasies had been mixed with a magical processing of the respiratory complaints. She had repeated infantile dreams of anacondas suffocating her (see danger of suffocation during polio) or about poisonous snakes: the venom destroying the body from the inside – this also possibly being a processing of oral fantasies in connection with polio (see case descriptions of Bierman, Silverstein & Finesinger [1958]). Mrs B narrates that unconscious body fantasies played a great role in her second psychoanalysis, triggered by the pregnancy. “That I had such an easy birth and that I could experience my body in a new way as healthy and functioning had also to do with the important processing of my fears that something destructive could be hiding in my body.” But apparently the connection to polio was not explicitly recognized back then. In our psychoanalytic work we still came across more body fantasies: Mrs B attributed surviving polio to her “very special body”, a body that could defeat a deadly disease and therefore was immortal, invincible and without boundaries. These body fantasies were probably in part the basis for the aforementioned extraordinary dissimulation of physical states (such as pneumonia) or her pronounced contraphobic behaviour (see also Jacobson [1959]).

(e.g. the state of extreme helplessness, of despair and unbearable pain, the panic connected with fear of death, etc.) in the transference was essential for the gradual structural change in Mrs B's personality.

In spite of all the defence manoeuvres a gradually increasing integration of the trauma takes place, which manifests itself primarily in Mrs B's altered basic feeling of self, for me an indicator of structural change in her personality. In daily life she experiences herself as more fearful, more careful and less permanently capable of working intensively, at first experiencing these changes as a threat and as a loss of narcissistic satisfaction. She feels increasingly dependent on interactions with others and on their support in solving problems. At the same time more confidence in others is gradually appearing and with it a basic feeling of connectedness, of shared responsibility. These emotions are a completely new kind of experience for her. She continues to work a lot, but at the end of the second year of the treatment she notices: "Already for quite some time now my nightmares have disappeared, the expectation of catastrophe has decreased ... I don't seem to be continuously standing on the edge any more ..." It is also important to her that she has a better feeling for her body, especially for reactions of tiredness, and that she pays attention to these signals, presumably a reason for her reduced feelings of chronic exhaustion. "I feel more grounded in myself and less absent from reality than before this analysis," she once says. However, it is most important for her that the breakdowns during the conflicts in her marriage rarely reoccur. "For my husband and me it is very important that we increasingly understand what these breakdowns mean and what triggers them. Most of the time I can detect when panic appears and then directly ask my husband if and why he is emotionally withdrawing. I am still incredibly frightened in such situations and I have to deal with the expectation of catastrophes, but I don't break down entirely any more ... You probably can't imagine how relieved I am ..."

In many psychoanalytical sessions Mrs B occupies herself with mourning. Reproaches towards her two former analysts appear. She formulates these very clearly, even harshly, without however destroying the aforementioned gratitude that her two psychoanalyses, despite their limitations, had opened many doors for transforming her life.

6. Conclusion

Centred around the insights from the third psychoanalysis with Mrs B, I made attempts to verify the hypothesis that the working through in the transference with the analyst of the traumatic experiences and the reconstruction of the biographical-historical reality of the trauma suffered (emotional as well as cognitive) both proved essential for lasting structural change in this severely traumatized patient. As I have tried to illustrate with the clinical material, the traumatic experience had been integrated into Mrs B's basic feeling of identity as an unrecognized source which had largely determined her personality development. Convinced of her selection by the Almighty as a "chosen one" and of her "eternal guilt as one who is preferred by fate", she was equally convinced of being under the obligation of sacrificing her own life to the handicapped and to others less privileged. She thus developed a 'false self' and a life-style of constant exhaustion. Understanding the details of her biographical trauma helped her to modify her core identity and to

accept the hidden vulnerabilities of her own body and her dependency on others, particularly her husband. These changes are connected to the disappearance of her nightly panic, her constant "waiting for catastrophe" and her breakdowns which is a great relief for her and her family. "*So much pain could have been spared to myself, my husband and my children if only I had had the courage to take a close look at my trauma earlier*", she had once said in an analytic session.

I hope that this communication about my patient might contribute to the discussion of some technical issues in the treatment of other severely traumatized patients. Many questions still seem to be open for me: should we modify our techniques according to the different kinds of early trauma of our patients? Compared with victims of man-made disasters it seems to me that patients traumatized through illness develop different kinds of unconscious phantasies in order to explain their survival. As mentioned above, Mrs B was unconsciously convinced that she was a "chosen one" who had been positively singled out by God or fate. She also developed specific unconscious body phantasies (being invulnerable, etc.). These unconscious phantasies could be connected to the difficulties seen in the *Auserwählten* (Freud, 1916) in really accepting the reality principle (Jacobson, 1959). I therefore think that former polio patients could be considered as a specific nosological group from many points of view. They share specific characteristics of the unconscious long-term effects of polio infection, for instance, 'embodied memories' of the experience of extreme, sudden pain, of being paralysed, of approaching death, but also of the helplessness of the primary objects and of the doctors who had no possibility of treating the illness. Their only hope was that the child's body might be successful in its fight against the illness. It seems most likely that a child suffering from polio would have perceived all these factors, integrating them into the unconscious fantasies of its own body being immortal and no longer vulnerable. Within the framework of this paper I was unable to deal with the question of whether patients from other nosological groups, for example, having suffered from other severe illnesses in their first years of life, show different kinds of long-term effects (e.g. a patient of mine from former East Germany with its rigid medical system who suffered from severe encephalitis in her first year of life). I also think that further clinical research on this question is necessary. However, I assume that for these other groups of patients severely traumatized through illness it would also prove essential to work on the chronic denial of the traumatization again and again in the psychoanalytic process if structural change is to be achieved.

Another topic which needs further discussion is the relationship between 'narrative' and 'biographical' truth in psychoanalytic treatment. As I hope I was able to illustrate, it seems clear that a largely intellectual reconstruction of biographical facts does not lead to therapeutic change. Only detailed (emotional and cognitive) understanding of the enactment of traumatic events in the therapeutic relationship and in close object relationships (Mrs B's breakdowns) including the scarcely bearable emotional intensity leads to structural change. Without the holding and containing function of the analyst and the empathetic attitude of trying to understand the incomprehensible Mrs B would not have had the courage to look at and to withstand the horror of the traumatic events of her life. Without this courage in a sustaining therapeutic relationship neither understanding of nor working through the trauma would have been possible.

I have tried to illustrate that the concept of 'embodied memory' might be helpful in understanding that early trauma is remembered by the body in a more specific way than in merely understanding procedural memories (meaning mechanical or bodily skills) in the transference. Trying to understand 'embodied memories' means observing in detail the sensory-motor coordinations in the analytic relationship. This enables one finally to decode the inappropriate intensity of affects and fantasies which match the original traumatic interaction and not the present, new relationship to the analyst. The reconstruction of the original trauma then helps to understand the 'language of the body' and to connect it with visualizations, images and verbalizations.

I was able to mention only briefly that the reconstruction of the trauma supported the process of conceptualization, for example, by empathizing with the intentions of the primary objects during the polio infection. These processes improved the current relationship with the Mrs B's parents, particularly with her mother, because for years the relationship had been dominated by unconscious feelings of revenge and hatred.

Therefore, the discovery of the 'biographical-historical truth' of the traumatic experiences as well as their working through in the psychoanalytic relationship helped to integrate the trauma into the self and the identity of the patient, which remains one of the main aims of a psychoanalytic treatment with severely traumatized patients.

Appendix

Further remarks on the literature on polio (see Section 2)

Conn (1955) studied 14 severely ill patients, ranging in age from 14 to 35 years, in the Respirator Unit of the Children's Hospital School in Baltimore. A characteristic personality was delineated and correlations attempted between this and the course of the poliomyelitis. The typical patient showed marked inhibition in aggression and self-assertiveness, a compulsive need to please others, and a pronounced fear of failure, all resulting in a tendency to compulsive overactivity and over-exertion in an effort to secure approval. This character type helps to explain the over-exertion and over-fatigue that frequently precede the attack of poliomyelitis. These patients are deprived of the safeguard against extreme exertion normally provided by a sense of fatigue. This is one of several factors that may contribute to the breakdown of the protective mechanisms against illness. Prugh and Tagiuri (1954) found out, that patients with respiratory paralysis resulting from poliomyelitis, cared for in a special respiratory unit, are fundamentally alike in their reaction to the illness. A marked regression is fostered by the almost absolute dependence of the patients. Denial, projection and primitive fantasy are used to cope with anxiety. With normal sexual outlets abolished, pre-genital forms of gratification assume prominence. Patients go through one or several periods of depression, often followed by irritable or demanding behaviour. Attitudes of families and staff are especially important at these times as the patients tend to interpret illness as a punishment for primitive instinctual impulses. The ease of separating a patient from the respirator or from any other form of respiratory aid appears to be intimately

connected with the patient's current emotional state, his personality, and the attitudes of the ward personnel. Psychotherapeutic procedures seem to be of value in helping the patient to handle his anxiety, in fostering his acceptance of his illness, and in promoting his striving toward independence within the limits of his disease. Families of patients may be helped by discussions with the psychiatrist about feelings of guilt and resentment towards the patient.

In many of the following psychoanalytic papers suffering from polio is mentioned as an aside and thus does not play a critical part in the psychoanalytic considerations:

1. It is mentioned in case examples that the patient had suffered from polio (Bing and Marburg, 1962; Buxbaum, 1954; Fraiberg, 1952; Heilpern, 1941; Holzman, 1971; James, 1975; Kafka, 1979; Oremland, 1973; Pines, 1994; Reich, 1951; Reider, 1961; Segel, 1961; Tolpin, 1970; Wallerstein, 1967; Weinberger and Muller, 1974; Weiss, 1986).
2. It is mentioned that a patient's sibling suffered from polio and that his death or enduring handicap was of great importance for the development of the patient (Jacobson, 1959; Stern et al., 1998).
3. One can find important biographical hints that the patient's father or mother either suffered or died from the consequences of polio (Aragno and Schlachtel, 1996; Beratis, 1984; Beres, 1958; Friedman, 1996; Karme, 1979; Lester, 1985; Lester and Notman, 1996).
4. It is often mentioned that the patients as children or their parents suffered from phobic fears of polio infections. In most cases the phobic anxieties were triggered by an epidemic or a polio infections in a child living nearby (see also Arlow, 1972; Eisenbud, 1965; Grinker, 1955; Hellmann, 1960; Keiser, 1954, McDougall, 1974; Meyer, 1983; Ogden, 1996; Seidenberg, 1963 (the patient developed a hypochondrial fear of polio after his wife left him); Tolpin, 1970)

Some authors have mentioned polio in other contexts, for example, in connection with general questions (Winnicott, 1965), depictions of polio in art etc. (see among others Castelnovo-Tedesco, 1981; Mahon, 1998; Lieberman, 1996 [Frida Kahlo's polio infection]). Lipton (1962) discusses the medical findings which indicate a common and unrecognized correlation between poliomyelitis and tonsillectomy. Miller (1962) mentions intensive day-dreaming and in extreme cases the development of hallucinations among paralysed polio patients. Rodrigue (1968) discusses polio infections with life-long damage as a paradigmatic example of a group of somatic diseases with severe psychological aftermaths (consequences to the psychic situation).

Translations of summary

Biographische Wahrheiten und ihre klinischen Konsequenzen. Das Verstehen von "Embodied-Erinnerungen" in der dritten Psychoanalyse einer traumatisierten Patientin mit überstandener schwerer Poliomyelitis. Die Beziehung zwischen "narrativer" und "historisch-biographischer Wahrheit" in der psychoanalytischen Behandlung ist seit einigen Jahren Gegenstand zahlreicher kontroverser Debatten. Aufgrund der Ergebnisse der modernen Gedächtnisforschung wird die Frage, ob Therapeuten objektiv und zuverlässig biographische Ereignisse auf der Grundlage ihrer Beobachtungen in der therapeutischen Situation zu rekonstruieren vermögen, sehr skeptisch beurteilt. Manche Autoren behaupten sogar, dass Psychoanalytiker sich ausschließlich auf die Beobachtung des Verhaltens konzentrieren sollten, das der Patient in der Übertragungsbeziehung zum Analytiker im Hier und Jetzt zeigt. Der vorliegende Beitrag diskutiert, ob in dieser Debatte womöglich das Kind mit dem Bade ausgeschüttet wurde. Gestützt auf die Einsichten, die in der dritten Psychoanalyse einer Patientin gewonnen wurden, die als Kind unter einer schweren Polio gelitten hatte, wird die Hypothese diskutiert, dass eine dauerhafte

strukturelle Veränderung unabdingbar voraussetzt, dass die traumatische Erfahrung in der Übertragung gemeinsam mit der Analytikerin durchgearbeitet und die biographisch-historische Realität des erlittenen Traumas rekonstruiert wird.

Las verdades biográficas y sus consecuencias clínicas. La comprensión de los “recuerdos encarnados” en el tercer psicoanálisis de un paciente traumatizado, recuperado de una poliomielitis severa. En los últimos años, la relación entre “verdad narrativa” y “verdad histórico-biográfica” en el tratamiento psicoanalítico se ha vuelto tema de numerosos debates controvertidos. Los hallazgos de las investigaciones contemporáneas sobre la memoria han suscitado gran escepticismo respecto a si los terapeutas pueden reconstruir de manera objetiva y confiable los acontecimientos biográficos a partir de sus observaciones en la situación terapéutica. Algunos autores incluso sostienen que los psicoanalistas deberían concentrarse exclusivamente en la observación del aquí y el ahora del comportamiento del paciente dentro de la relación transferencial con el analista. En este trabajo se discute si en dicho debate se ha arrojado al bebé junto con el agua de la bañera. Centrándose en los *insights* provenientes de un tercer psicoanálisis con un paciente que padeció un caso severo de polio infantil, se discute la hipótesis de que tanto la elaboración de la experiencia traumática en la transferencia con el analista, como la reconstrucción de la realidad histórico-biográfica del trauma sufrido, resultan indispensables para un cambio estructural duradero.

Les vérités biographiques et leurs conséquences cliniques. Comprendre les «souvenir incorporés» au cours d'une troisième analyse avec une patiente traumatisée, remis d'une poliomyélite sévère. La relation entre vérité « narrative » et vérité « historique-biographique » dans le traitement analytique a fait l'objet de plusieurs débats et controverses ces dernières années. Les données de la recherche contemporaine sur la mémoire ont conduit à des doutes importants quant à la capacité des thérapeutes à reconstituer de façon objective et fiable les événements biographiques sur la base de leurs observations en situation thérapeutique. Certains auteurs prétendent même que les psychanalystes devraient se concentrer exclusivement sur l'observation du « ici et maintenant » du comportement du patient à travers la relation transférentielle à l'analyste. Dans le présent article, nous abordons la question de savoir si, dans ce débat, le bébé n'a pas été jeté avec l'eau du bain. À partir des « insights » issus d'une troisième analyse d'une patiente qui a présenté une sévère poliomyélite au cours de son enfance, nous discutons l'hypothèse, selon laquelle aussi bien l'élaboration de l'expérience traumatique dans le transfert avec l'analyste, que la reconstruction de la réalité biographique et historique du trauma subi, sont indispensables pour un changement structural durable.

Realità degli eventi biografici e relative conseguenze cliniche. La comprensione delle ‘memorie nel corpo’ nella terza analisi di un paziente traumatizzato da un grave caso di poliomenite. Il rapporto fra narrativa e realtà storico-biografica nella cura psicoanalitica è stato, in questi ultimi anni, al centro di molte controversie. I risultati di recenti ricerche sulla memoria hanno portato a un grande scetticismo sulla capacità da parte dell'analista di ricostruire eventi biografici in modo affidabile e oggettivo sulla base di osservazioni nella situazione terapeutica. Certi autori hanno perfino stabilito che una psicoanalisi dovrebbe concentrarsi esclusivamente sull'*hic et nunc* del comportamento del paziente nel rapporto transferale con l'analista. In questo articolo ci si chiede se, in tale dibattito, non si sia “buttato il bambino con l'acqua sporca”. Partendo dalle osservazioni ottenute nel corso della terza analisi di un paziente affetto nell'infanzia da un grave caso di poliomenite, si avanza l'ipotesi che, ai fini di un durevole cambiamento strutturale, siano indispensabili e l'elaborazione dell'esperienza traumatica nel transfert con l'analista e una ricostruzione della realtà storico-biografica del trauma subito.

References

- Aragno A, Schlachtel PJ (1996). Accessibility of early experience through the language of origin: Three case examples. *Psychoanal Psychol* 13:23–34.
- Arlow JA (1972). The only child. *Psychoanal Q* 41:507–36.
- Beratis S (1984). The first analytic dream: Mirror of the patient's neurotic conflict and subsequent analytic process. *Int J Psychoanal* 65:461–9.
- Beres D (1958). Vicissitudes of superego functions and superego precursors in childhood. *Psychoanal Stud Child* 13:324–51.
- Bergmann MS, Jucovy ME, Kestenberg JS (1982). *Kinder der Opfer. Kinder der Täter. Psychoanalyse und Holocaust*. [Überarbeitete Fassung: 1990; deutsche Übersetzung] Frankfurt a. M: Fischer, 1995.
- Bierman JS, Silverstein AB, Finesinger JE (1958). A depression in a six-year-old boy with acute poliomyelitis. *Psychoanal Stud Child* 13:430–50.
- Bing JF, Marburg RO (1962). Narcissism. *J Am Psychoanal Assoc* 10:593–606.
- Bohleber W (2000a). Editorial. *Psyche – Z Psychoanal* 54:795–6.
- Bohleber W (2000b). Die Entwicklung der Traumatheorie in der Psychoanalyse. *Psyche – Z Psychoanal* 54:797–839.
- Bohleber W (2007). Remembrance, trauma and collective memory: The ballet for memory in psychoanalysis. *Int J Psychoanal* 88:329–52.

- Bokanowski T (2005). Variations on the concept of traumatism: Traumatism, traumatic, trauma. *Int J Psychoanal* **86**:251–65.
- Buxbaum E (1954). Technique of child therapy: A critical evaluation. *Psychoanal Stud Child* **9**:297–333.
- Castelnuovo-Tedesco P (1981). Psychological consequences of physical defects: A psychoanalytic perspective. *Int Rev Psychoanal* **8**:146–54.
- Clancey WJ (1993). The biology of consciousness: Comparative review of Israel Rosenfield, *The strange, familiar; and forgotten: An anatomy of consciousness* and Gerald M. Edelman, *Bright air, brilliant fire: On the matter of the mind. Artificial Intelligence* **60**:313–56.
- Conn JH (1955). Relation between personality factors and fatigue in severe poliomyelitis. *Arch Neurol Psychiatry* **70**:310–16.
- Cooper A (1986). Toward a limited definition of psychic trauma. In: Rothstein A, editor. *The reconstruction of trauma* 41–56. Madison, CT: International UP.
- Cournut J (1988). Ein Rest, der verbindet. Das unbewußte Schuldgefühl, das Entlehnte betreffend. *Jahrb Psychoanal* **22**:67–99.
- Dalakas MC, et al., editors (1995). The post-polio syndrome: Advances in the pathogenesis treatment. *Ann NY Acad Sci* **753**:1–409.
- Edelman GM (1992). *Bright air, brilliant fire: On the matter of the mind*. New York, NY: Basic Books.
- Eisenbud J (1965). The hand and the breast with special reference to obsessional neurosis. *Psychoanal Q* **34**:219–47.
- Eisnitz AJ (1974). A discussion of the paper by JL Weinberger and JJ Muller on *The American Icarus revisited: Phallic narcissism and boredom*. *Int J Psychoanal* **55**:587–90.
- Faimberg H (1987). Das Ineinanderrücken der Generationen. Zur Genealogie gewisser Identifizierungen. *Jahrb Psychoanal* **20**:114–43.
- Fischer G, Riedesser P (2006). Psychotraumatologie und Psychoanalyse. *Forum Psychoanal* **22**:103–6.
- Fonagy P, Target M (1997). The recovered memory debate. In: Sandler J, Fonagy P, editors. *Recovered memories of abuse. True or false?* 183–217. London: Karnac.
- Fraiberg S (1952). A critical neurosis in a two-and-a-half year-old girl. *Psychoanal Stud Child* **7**:173–215.
- Freud A (1936). *The ego and the mechanisms of defense*. New York, NY: International UP.
- Freud S (1916). Some character-types met with in psycho-analytic work. *SE* **14**, 311–33.
- Friedman ME (1996). Mother's milk. *Psychoanal Stud Child* **51**:475–90.
- zGrinker RR (1955). Growth inertia and shame: The therapeutic implications and dangers. *Int J Psychoanal* **36**:242–53.
- Hammermann S (1961). Masturbation and character. *J Am Psychoanal Assoc* **9**:287–311.
- Hartke R (2005). The basic traumatic situation in the analytic relationship. *Int J Psychoanal* **86**:267–90.
- Heilpern E (1941). A case of stuttering. *Psychoanal Q* **10**:95–115.
- Hellmann I (1960). Simultaneous analysis of mother and child. *Psychoanal Stud Child* **15**:359–77.
- Holzman PS (1971). Follow-up. *J Am Psychoanal Assoc* **19**:110–21.
- Jacobson E (1959). The 'exceptions': An elaboration of Freud's character study. *Psychoanal Stud Child* **14**:135–53.
- James M (1975). Autism and childhood psychosis. *Int J Psychoanal* **56**:106–11.
- Kafka E (1979). On examination dreams. *Psychoanal Q* **48**:426–47.
- Kandel ER (1998). A new intellectual framework for psychiatry. *Am J Psychiatry* **155**:457–69.
- Kandel ER (2005). *Psychiatry, psychoanalysis, and the new biology of mind*. Washington, DC: American Psychiatric.
- Karme L (1979). The analysis of a male patient by a female analyst: The problem of the negative oedipal transference. *Int J Psychoanal* **60**:253–61.
- Keilson H (1979). *Sequentielle Traumatisierung bei Kindern*. Stuttgart: Enke.
- Keiser S (1954). Orality displaced to the urethra. *J Am Psychoanal Assoc* **2**:263–79.
- Klein M (1957). *Envy and gratitude: A study of unconscious sources*. New York, NY: Basic Books.
- Koch-Kneidl L, Wiese J, editors (2003). *Entwicklung nach früher Traumatisierung*. Göttingen: Vandenhoeck & Ruprecht.
- Kogan I (2007). *The struggle against mourning*. Lanham, MD: Aronson.
- Krystal H, editor (1968). *Massive psychic trauma*. New York, NY: International UP.
- Lester EP (1985). The female analyst and the eroticized transference. *Int J Psychoanal* **66**:283–93.
- Lester EP, Notman MT (1996). Pregnancy, developmental crisis and object relationships: Psychoanalytic considerations. *Int J Psychoanal* **67**:357–65.
- Leuzinger-Bohleber M (in press). Trauma. In: Gehrig G, Pfarr U, editors. *Psychoanalytische Begriffe für die Kunstwissenschaft*. Gießen: Psychosozial Verlag.
- Leuzinger-Bohleber M, Pfeifer R (2002). Remembering a depressive primary object? Psychoanalysis and embodied cognitive science: A dialogue on memory. *Int J Psychoanal* **83**:3–33.
- Leuzinger-Bohleber M, Pfeifer R (2006). Recollecting the past in the present: Memory in the dialogue between psychoanalysis and cognitive science. In: Mancia M, editor. *Psychoanalysis and neuroscience* 63–95. Milan: Springer.

- Leuzinger-Bohleber M, Henningsen P, Pfeifer R (2008a). Psychoanalytische Konzeptforschung zum Trauma: Ein Integrationsversuch mit Perspektiven der Gedächtnisforschung der Embodied Cognitive Science und neurobiologischer Studien. In: Leuzinger-Bohleber M, Roth G, Buchheim A, editors. *Psychoanalyse – Neurobiologie – Trauma* 157–69. Stuttgart: Schattauer.
- Leuzinger-Bohleber M, Roth G, Buchheim A, editors (2008b). *Trauma im Fokus von Psychoanalyse und Neurowissenschaften*. Stuttgart: Schattauer.
- Leuzinger-Bohleber M, Stühr U, Rüger B, Beutel M (2003). How to study the 'quality of psychoanalytic treatments' and their long-term effects on patients' well-being: A representative, multi-perspective follow-up study. *Int J Psychoanal* **84**:263–90.
- Lieberman JS (1996). Contemporary images of women in contemporary women's art: Concurrent trends in art and psyche. *J Am Psychoanal Assoc* **44**:xi–xii.
- Limentani A (1982). On the 'unexpected' termination of psychoanalytic therapy. *Psychoanal Inq* **2**:419–40.
- Lipton SD (1962). On the psychology of childhood tonsillectomy. *Psychoanal Stud Child* **17**:363–417.
- Mahon EJ (1998). *The remarkable Beatrix Potter* by Alexander Grinstein. *Psychoanal Q* **67**:730–2.
- McDougall J (1974). The psychosoma and the psychoanalytic process. *Int Rev Psychoanal* **14**:37–49.
- Meyer BC (1983). Notes on flying and dying. *Psychoanal Q* **52**:327–52.
- Miller SC (1962). Ego-autonomy in sensory deprivation, isolation and stress. *Int J Psychoanal* **43**:1–20.
- Milner B, Squire LR, Kandel ER (1998). Cognitive neuroscience and the study of memory. *Neuron* **20**:445–68.
- Ogden TH (1996). The perverse subject of analysis. *J Am Psychoanal Assoc* **44**:1121–46.
- Oremland JD (1973). A specific dream during the termination phase of successful psychoanalyses. *J Am Psychoanal Assoc* **21**:285–302.
- Pfeifer R, Bongard J (2007). *How the body shapes the way we think: A new view of intelligence*. Cambridge, MA: MIT Press.
- Pines D (1994). *A woman's unconscious use of her body*. New Haven, CT: Yale UP.
- Prugh DG, Tagiuri CK (1954). Emotional aspects of the respiratory care of patients with poliomyelitis. *Psychosom Med* **16**:10–128.
- Reerink G (2003). Traumatisierte Patienten in der Katamnesestudie der DPV. Beobachtungen und Fragen zur Behandlungstechnik. *Psyche – Z Psychoanal* **57**:125–40.
- Reich A (1951). On counter-transference. *Int J Psychoanal* **32**:25–31.
- Reider N (1961). Abstract. *New York State Journal of Medicine* LXI, 1961. *Psychoanal Q* **30**:610–11.
- Reinhold N, Markowitsch HJ (2007). Stress und Trauma als Auslöser für Gedächtnisstörungen: Da mnestiche Blockadensyndrom. In: Leuzinger-Bohleber M, Roth G, Buchheim A, editors. *Trauma in Fokus von Psychoanalyse und Neurowissenschaften* 80–101. Stuttgart: Schattauer.
- Rodrigue E (1968). Severe bodily illness in childhood. *Int J Psychoanal* **49**:290–3.
- Segel NP (1961). The psychoanalytic theory of the symbolic process. *J Am Psychoanal Assoc* **9**:146–57.
- Seidenberg R (1963). For this woman's sake: Notes on the 'mother' superego with reflections on Shakespeare's Coriolanus and Sophocles' Ajax. *Int J Psychoanal* **44**:7–82.
- Stern DN, Sander LW, Nahum JP, Harrison AM, Lyons-Ruth K, Morgan AC, Bruschweiler-Stern N, Tronick EZ (1998). Non-interpretive mechanisms in psychoanalytic therapy: The 'something more' than interpretation. *Int J Psychoanal* **79**:903–21.
- Tolpin M (1970). The infantile neurosis: A metapsychological concept and a paradigmatic case history. *Psychoanal Stud Child* **25**:273–305.
- Tutté JC (2004). The concept of psychological trauma: A bridge in interdisciplinary space. *Int J Psychoanal* **85**:897–921.
- Wallerstein RS (1967). Reconstruction and mastery in the transference psychosis. *J Am Psychoanal Assoc* **15**:551–83.
- Weinberger JL, Muller JJ (1974). The American Icarus revisited: Phallic narcissism and boredom. *Int J Psychoanal* **55**:581–6.
- Weiss SS (1986). Three visits to eternity: Freud, Wiesel, and Patient X. *J Am Psychoanal Assoc* **34**:69–91.
- Winnicott DW (1965). *The maturational processes and the facilitating environment*. New York, NY: International UP.