The fracture between object and word

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Summary

I explore the relationship between language and experience in the genesis of delusions, adopting a bottom-up perspective according to which a fragmentation of experience is the preparatory field of the emergence of delusions. Delusions are prepared by a 'hallucinatory' state – a change in experience whereby some perceptions detach from the flow of the other perceptions because of their exceeding intensity and sensory power. The detail detaching from the whole elicits an intense emotion that is not fully conscious and may be perceived as a confused state of mind in which attraction and repulsion intermingle in a perplexing way. The hallucinatory object is too powerful, and the emotion it elicits is so overwhelming that no language can express it. In the preparatory field of delusion, sensoriality dominates over language. Delusion is the organisation of this fragmented sensoriality. The patient will have to insert hyper-sensorial details within a frame capable of making it intelligible. Yet these fragments of perception, charged with contradictory emotions, become estranged, mysterious and non-existent, or rather existent in a world apart that is incompatible with the ordinary world. Therapy of delusions is then a matter of deconstructing delusion into its individual building blocks, looking at the linguistic potential of each individual block.

Key words

Delusion • Emotions • Hallucinatory • Language • Psychosis

Introduction

Delusion is such a powerful and pervading trait that it can shadow nearly all the other aspects of psychosis. It appears, in fact, unbeatable and non-modifiable, immediately conveying to the observer its quality of strangeness, the perception of something coming from a parallel and alien world, totally inconsistent with common sense.

Like a stone for the radiologist or a disease-specific marker for the clinician, a delusional event is the clear sign that relieves the therapist from diagnostic uncertainty: the patient is no doubt psychotic.

Moreover, delusion is somewhat persistent and long-lasting, fundamentally self-sufficient as if granting some sort of dark but irreversible fulfilment. When meeting with delusion the patient feels a sort of relief and welcomes it as contributing not only order within disorder, but also pleasure, like a pulsional discharge in which libidic and destructive aspects get irreversibly entangled, resulting in obscure delusional satisfaction [1 2].

In addition, delusion appears totally unquestionable. Every therapist is familiar with the dilemma of choosing whether to immediately face the delusion, partially accept it, or adopt a tangential approach.

In any case, delusion has a nearly religious quality: it is often felt by the patient like a revelation, an enlightenment, sometimes as a message directly coming from the deity. Despite its distressful nature, the mysteriousness of its origin, seemingly so sacred and universal, confers delusion itself the significance of a privileged role the deity has assigned the patient in reward for some special merit, or a promotion from squalid anonymity to superomistic heroism [3].

In addition to strangeness, unquestionability and religiousness, a less apparent (and therefore more dangerous) component of delusion is the deceptive nature of some of the patient's obscure perceptions, such as in hypochondriac delusions in which the false perception, no matter how indistinct, of a badly damaged body develops into firm belief [1].

The underlying assumption that one's body is made of inorganic matter or wood, or rubber, or else ridiculously shaped, passive, flabby, is so penetrating to be more easily recognised by its effects than directly identified as an experience.

I have chosen to start my paper with these remarks because I want to highlight how easily the clinician is led to regard delusion as an alien structure, a mental parasite, or an outgrowth similar to a tumour, to be eradicated through targeted surgery to prevent further invasion of the healthy part of the mind. The specific traits of delusion, its strangeness, undefined nature, unquestionability and powerful penetrance can hardly elicit a different attitude [4].

The development of delusions

That being stated, I would like to focus on a somewhat different approach, taking into consideration other aspects of delusion. I will start by posing two central questions to which I would like to explore possible answers.

First question: how does delusion develop? Which psychic

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elements have combined to result in such a tightly impenetrable and omni-comprehensive structure? And when has this happened?
As previously remarked, the patient often feels delusion as an enlightenment, a sudden flash of discovery, but this is in fact prepared by a number of sporadic but recurrent fragments of perceptions that slowly, through many different narrow paths, make their way to converge into the imposing synthesis we name delusion. They consist in moments of depersonalisation, transient feelings of unreality, automatic actions, the feeling of one's body as a stranger, mechanic or unreal and empty. In addition, prior to the outburst of delusion, hallucinatory sensory experiences have occurred, characterised by hyper-clarity, exceeding sensory intensity, decontextualisation, like a detail detaching itself from the whole and acquiring autonomous life.
Through which process hallucinatory sensory experiences, depersonalising moments, feelings of unreality are slowly brought together to give birth to a powerful and seemingly highly organised structure resistant to any questioning, that transforms disorder into order, uncertainty into satisfaction and makes anxiety and terror nearly pleasant?
We know that from its very start psychoanalysis has interpreted the preparation to delusion as a catastrophic rupture of the apparatus of thought containment and synthesis, of mental elements. Freud himself spoke of reality disinvestment threatening to develop into loss of contact with reality [5]; Bion later spoke of a catastrophic change [6], as a rupture of the apparatus that allows thoughts to be thought, and Winnicott [7] described primary agonies as the experience of a catastrophe that has already occurred but fails to be remembered.
In this view, delusion would represent an attempt to rebuild a different kind of container, strange and alien but nonetheless functioning, to re-establish the synthesis or continuity that the catastrophic rupture has destroyed.
In this perspective, the emersion of powerfully sensory and concrete mental elements would be consequent to catastrophic fragmentation, and this would account for the strange and illogical nature of delusion.
This is certainly a clearly defined view, but not easily reconciled with clinical experience showing that the outburst of delusion is preceded by a variety of preliminary symptoms which, though not indicative of an actual catastrophic change, are essentially hallucinatory, depersonalising and automatic. These symptoms are experienced by the future psychotic patient during her/his entire life and it is highly presumable that they were relevant in the early stages of life, first in the relation with her/his mother and then with other primary subjects [8]. The problem is therefore the following: truly enough, when the catastrophic change takes place, delusion represents an attempt to overcome a condition of unbearable fragmentation, so concrete and hypersensorial, but when the catastrophe is more in the background, as meant by Winnicott, or even never occurred, how is delusion generated?
Could it possibly result from an attempt to organise a sensoriality of such intensity and penetrance that it cannot be expressed in words, or might delusion itself represent an experimental field of communication for experiences that cannot be translated into language?
This is the point I would like to discuss here, and this is why in the title I introduce delusion as a form of hypersensoriality.

Truth in delusions

The second point deals with a crucial and debated question, still open and relevant not only on theoretical ground but also in clinical practice: is there any element of truth in delusion? Does the delusional patient seek refuge in a totally alien world out of a sort of psychic self-centrism, nearly a kind of perversion? Or rather is there, in delusion, an effort to communicate something real which hyper-sensorialilty has utterly deformed to be by no means credible?
After all, at first sight, delusion appears as something absolute, allowing no questioning; it is out of time and out of ordinary space; communication follows fantastic paths, e.g. transoceanic, interstellar, in any case magical, while time is static, motionless: perhaps these very traits make delusion unapproachable, as if driven by a high though mysterious logic. But when closely inspected, delusion reveals a wealth of meaningful components.
First of all, the patient's tale invariably refers to specific elements, single objects, body parts, sensory perceptions: in short, delusion is undoubtedly a rigid self-referring structure, but it is composed of particulars, of single relevant details.
Why has the patient chosen that single specific detail? If a body part, i.e. mouth or eyes, appears in the delusion, what does this suggest about the specific patient's experience of her/his own mouth or eyes? Are these body parts witnessing something relevant in the patient's history, which should not be overlooked? What does delusion communicate, in relational terms?
We all know very well, after years of family therapies, also psychoanalytical, how the maternal figure predominates in psychosis, being at one time idealised and felt as upsetting. But of course the peculiarity of psychosis is elsewhere. The peculiarity of psychosis is in the way in which the tale is told, in the particular type of symbolisation used by the patient.
For instance, the story of the patient's relation with her/his mother is not narrated as such, none of the innumerable possible patterns of narration seems suitable to the patient, who will rather start by reporting some particular sensory details, which the therapist will identify as typical of the maternal relation, while the patient has lost sight of this, as though the tale had taken autonomy from the facts it should tell.

A male patient might report that he fears the cannibal witch, hidden in every woman, while stating that his own mother is an angel. Only the therapist will understand and find the way to tactfully and prudently let the patient realise he is deceiving himself.
The two issues, delusion as organisation of sensoriality and as expression of something true, but profoundly modified in the process of telling, will be addressed in the following paragraphs.

The hallucinatory

Clinical experience very clearly demonstrates the importance and frequency of the hallucinatory phenomenon in the psychotic mind. When closely inspected this phenomenon will be apparent, not only in the current time, but also as a massive and penetrating component of the patient's past, strongly suggesting that it has been particularly relevant in the first phases of the infant's relationship with her/his mother.
In a previous article entitled *The hallucinatory and psychosis* [9], I have tried to describe as accurately as possible what I mean by the term 'hallucinatory', and in what respect it has to be attentively distinguished from hallucination proper. By the term 'hallucinatory', I mean a specific trait of some perceptions, that qualitatively detach from the flow of the other perceptions, because of their exceeding intensity and sensory power.
These perceptions, being too elaborate, too dense, too delimited and focal, do fall within the frame of reality, being neither invented nor imagined, but gain autonomy from the unity of the overall picture as though endowed with partially autonomous life. In other terms, one could say that the detail detaches from the whole to develop its own life.
Thus, looking at a face, a wrinkle around the eyes, or a rebel tuft of hair, or spiky moustaches or a tooth more yellow than the others may appear as particularly prominent. But the process does not stop here, the detail detaching from the whole elicits an intense emotion, either disgust and rejection, dislike or else attraction, seduction and excitement. This emotion is not fully conscious and may perhaps be perceived as a confused state of mind in which attraction and repulsion intermingle in a contradictory and highly disorienting way.
The outcome of this particular situation can be described as a feeling of perplexity and doubt, like an enigma: what is this I am looking at? Is it what I think it is, or something else? Why does that eye wrinkle appear in my mother, whom I know for sure as an angel and an heroic or anyway wonderful being so devoted to me and my family, and raises in me doubts and questions?
We cannot rule out the possibility that in many experiences of depersonalisation the experience of strangeness or unreality starts with an enigmatic perception, a mysterious detail, a doubt that makes the whole picture uncertain in the absence of any tool to evaluate more precisely [10].
What are the characteristics of hallucinatory perception? By which means do such perceptions, detaching from the rest, gain such priority in the observer's mind as to totally absorb her/his attention? A first aspect deals with the figure-background relation: in the hallucinatory perception this is altered so that the figure becomes totally predominant. The background becomes hazy, fading away or discordant with the figure, resulting in the perception of a shape lacking a container, as if having a kind of autonomous life, as mentioned above [11]. The outcome of this phenomenon, which the patient feels as strange and worrying, is that the shape becomes wobbly and like floating on its own, against a vanishing background. The very popular and much quoted smile of Alice's Cheshire cat is an appropriate representation of this.
A second aspect deals with the lack of a definite light source. The detail perceived as hallucinatory lacks an oriented illumination, e.g. from a window or a lamp, or a fire: it appears in a cold, neutral light having no direction, no life of its own, just homogeneously diffused in the apparent absence of a source [11].
A third aspect, connected to the latter, deals with the lack of a view point. The hallucinatory detail lacks a definite location, from which somebody could see it from a different place. It appears in a wide horizontal space without any perspective, or reference point, so to say an absolute rather than relative spatiality.
The lack of a light source and the lack of a view point endow hallucinatory perception with an "absolute" character. By this term I mean something deprived of any position in time and space, but rather existing in a still world, lacking reference coordinates.
These data, which I have briefly recalled, help us to understand why the hallucinatory represents an alien world, unrelated to the rules of the ordinary world, hence enigmatic and mysterious. In a way, this bears resemblance to the theme of the sacred, if by this term we mean something completely different, not following any rule of actual life and appearing as the expression of a different dimension of existence [12].
We should now consider the following questions: 1) How does the subject react to this kind of experience? and 2) Which psychoanalytical explanation can help us to account for such an impressing phenomenon as what we might define "decontextualisation of the detail"?
1) The subject faced with such enigmatic experiences almost invariably feels bewildered and somewhat paralysed. The flow of thought stops and the mind concentrates on that single particular detail, as if interrogating it.
In many instances, when a psychotic patient suddenly looses attention this is due to the appearance of a hallucinatory detail into her/his perception field, which monopolises the attention taking it away from the general picture.

I can mention several examples of this. A psychotic male patient found it impossible to talk to women because some details of their body, in particular their breasts, trapped his attention in a spasmodic and paralysing way. To defend himself from this he used a technique, which he defined as voyeuristic: he would use coarse humour, focusing the conversation on nearly pornographic themes, so that the girl would invariably feel disgusted and retract. In the long run, this patient developed an erotic delusion, according to which all girls were irresistibly attracted by his extraordinary impressive virility.
Another patient reported that he could not read, since at the second or third line a word would detach from the text and started hammering in his brain, flashing like a shop's neon light. It is easily understood how hard any human situation becomes, when the hallucinatory blocks one's thought and captures one's attention in such a paralysing way.
2) Coming to our second question, we all know the psychoanalytic explanation proposed by Bion: a very powerful projective identification would infiltrate the object making it hallucinatory [13]. Another way to explain the phenomenon deals with the ability to conceptualise, in turn linked to the ability to symbolise. The hallucinatory object is too real, too intense, too powerful and the emotion it elicits is so overwhelming that no language can express it. Sensoriality dominates over language, which is unable to translate its meaning into any form of verbal communication. Thus, the patient will have to insert this hyper-real hyper-sensoriality within a frame capable of making it intelligible and "human". This is where delusion is born.
Delusion is an attempt to symbolise, to find a tale telling what is impossible to tell, to find a frame capable of containing something continuously shifting out of frame. How can one communicate what is so powerful as to escape verbal communication? One needs a story with such bizarre and unusual characteristics as to link and accommodate facts into a logic that appears possible though not recognisable as such by others. The psychotic mind exceedingly and frantically symbolises, but does this using, instead of a narrative logic, a paradoxical logic, which must explain the unexplainable. It uses the building blocks (the hallucinatory perceptions) to shape a building no way resembling the starting project, often developing into something totally unpredictable. Let's think of Schreber [14], who, in order to justify his desire to feel like a woman, got to the point of conceiving a gigantic metaphysical system. Delusion is thus made of hallucinatory building blocks arranged in an impressive defensive structure. The specificity of the psychosis is perhaps in these two traits: the tendency to hyper-sensoriality and the tendency to insert this mode into big delirious constructions, capable of giving a meaning to it. The delirious mode then often gains autonomous life and supports itself through a kind of a self-sufficient automatism.
I would like to very briefly introduce two distinctions. The hallucinatory should not be confused with the screen memory [15]. In the latter, a specific desire is transferred to a detail and fixes it in hyper-clarity. But this phenomenon, the yellow flowers in Freud's attraction for his cousin's beauty, has no enigmatic feature, its scope seems to just fix a memory transferring it to a different particular. No enigma here, just a process of fixation. Moreover, the screen memory does not monopolise attention and does not block the ability to think, but rather results in curiosity and nearly a feeling of pleasure and nostalgia.
Psychotic hallucinatory should also be distinguished from traumatic hallucinatory, so well described by the Botellas [16], as for psychic figurability. In this case, the fragments of the traumatic scene gain autonomous power and appear invasive and persistent: the handle of the analyst's door, a coat-hanger, the light of the car that ran over me, the bush into which the bomb that wounded me fell. But in post-traumatic depersonalisation described by the Botellas and so well known to researchers studying borderline disorder, there is no enigma, no need for explanations. Trauma activates images but does not suggest explanations, in any case not of the universal or cosmic kind: it is in connection with the evil of life or with our wishes or faults, but bears no reference to any sublime or hidden reality.
I would like to add one more concept before moving to the next paragraph. Very often the hallucinatory deals with the body and is experienced as a hypochondriac doubt. This may occur primarily, when the body informs that something strange is happening inside and secondarily as a somatic state accompanying a hallucinatory experience [17]. But no psychotic is free from the hypochondriac dimension, a mysterious sensation that something is missing, or of housing some source of inorganic or non-biological material. Often delusion results from an attempt to explain this lack of vitality of the body, both as perception of the external world and as a fault of the subject. Once again, deconstructing delusion down to its single constituents can show how it might have developed.
But now we have to ask a crucial question. Within which primary relationship does such a pattern develop? No doubt in psychosis there is a basic biological component favouring this type of development, but it is just as true that some basic relational configurations can be found with astounding frequency in psychotic experience.

The theme of the excess

In her fundamental book from many years ago *The violence of interpretation*, Piera Aulagnier [18] states with great clarity and strength that psychotics, from the beginning of their life, suffer from excess. Let's try understand what this might mean.
I would like to approach this theme of the excess from two points of view. First, i would like to try and better define

what this term means, as it is evocative, but at the same time vague or even generic. Second, I would like to describe the passages, the phases, in other words the path, through which the excess becomes hallucinatory and then, in the case of dramatic and catastrophic experiences, actual delusion.

I will start saying that with 'excess', I mean a particularly powerful emotion, an emotion that cannot be verbalised and that therefore tends to be discharged in a different form (acting, somatisation), and also an exceptionally powerful sensorial input, that presents itself as irreducible from the relational context in which it happened.

To summarise in one formula what said so far, I could say that the excess is an emotion or a perception that is in contrast with the relational form in which it happens and that therefore creates a contrast, a contradiction, a fracture in the mental and somatic world of the subject.

When it comes to the emotion, clinical experience shows very often a particularly high emotional sensitivity of the future psychotic.

Criticism, a negative comment, excitement, an outburst, all determines a fear of inability to contain. This fear can be experienced as loneliness, as loss of contact, as lack of protection, but it surely is connected with the loss or the non-creation of a language container for the emotional experience.

We know that there will never be a linguistic container that will be all-encompassing and part of the emotion will always remain an excess. But in the psychotic, this part remains as a frightening question mark, as a contradictory point and a sign that something doesn't add up.

Also, the emotion is always on the border between two movements. On one hand, there is the desiring impulse, the violent and passionate affection towards the reference figure. On the other, there is a space of opposing movement, an anti-desire, that tends towards blocking the desire itself [18].

This second component is more powerful, the more the relationship is rigid and the more it lacks a third- party dimension, introduced by certain figures. The result of this difficult synthesis is the appearance, in the framework of the form of the relationship, of moments of swerve, of difference, a break, almost an enigma that claims space in a framework, that we would like to be clear and harmonic.

I think that the specificity of psychosis is the fact that this emotion that is contradictory and difficult to bear becomes an object sensorially overcharged.

The sensory detail, in other words, becomes the container for an emotion that is unspeakable and pervasive, and that finds a maybe temporary, localisation in the individual hallucinatory object. Here we can recall the Bionian theme of the excessive projective identification as a matrix for the hallucinatory [13]. The hallucinatory object is, so to speak, violated by the power of the projection and it becomes overcharged with terrifying and paralising meanings.

However, this explanation needs an integration. On one hand, the process is similar to an evacuation. The emotion does not get expelled, but it rather finds a vector, like a localisation, and the choice of the vector is not indifferent to the reconstruction of the process. Secondly, we need to take into account the theme of the forclusion, the fact that the sensorial datum moves outside of the linguistic weave [19].

The term 'forclusion' is known to have been coined by Lacan to extend and reinterpret the Freudian term 'rejection' (*Verwerfung*).

Rejection was introduced by Freud into the much debated issue of the meaning and usage of negation, meant not just as negative assertion, but as refusal to admit the existence of something in a definite context.

Here, far from engaging in such complex and ongoing debate, I would like to highlight a particular aspect of the term forclusion, i.e., the concept that by forclusion the object becomes dramatically detached from its verbal definition. The object is denied admittance to the mutually intersubjective linguistic world, becomes estranged, mysterious and non-existent, or rather existent in a different context, in a world apart, remote and incompatible with the ordinary world, and hence impossible to share.

In this respect, hallucinations and psychosis deeply affect verbal expression. Adherence to reality is lost from language and reality, deprived of the shielding function of language, transforms itself into a mysterious certainty, somehow sacred and terrifying, absolute and irreducible.

In other words it is not just a simple evacuation, but a desperate attempt at using the object as language, in front of an excessive violence of the emotion and its tendency to look for a sensorial container.

I believe that this is a point where psychoanalysis and neuroscience could possibly meet: the tendency, surely facilitated by biological factors, to show emotion through the use of hyper-real or hyper-concrete hallucinatory elements, that paralise mental activity, but at the same time become a possible vector of experience.

I want to state again that the hallucinatory can concern both a datum form the outside world or, more sneakily, a datum of the body, with the creation of hypochondriac experiences of the psychotic kind.

The mechanism we have described must anyway be located within a relationship, often characterised by elements of rigidity. The psychotic wants to safeguard the maternal figure at all costs and then, in succession, the other members of the family. However, he does this through a rigid and unchangeable idealisation, which has its basis on parental figures that are devoted and passionate, but that also have traits of intolerance and scarce fluidity. The result is that, as we saw, within an idealised relationship, foreign elements appear, alien sensorial experiences, such as mysterious and bizarre figures that sneak into the bedroom.

Many moments of paralysis, of hyper-concentration on in-

dividual facts, of viscosity, of distraction, can be explained as efforts from the psychotic patient to somehow place an alien experience in a known and familiar context. The disinvestment Freud [5] talked about could be interpreted as a retreat from the external reality to focus on these alien sensorial data, whose presence poses to the psychotic a question without an answer.

If this phenomenon meets experiences of important relational ruptures (the catastrophic change, the primitive anxiety), delusion can be the only way to give order again to a familiar world that has become messy.

Therefore, there is a turning towards the sacred, the magical and, more simply, to prosecutions and the bad will of the enemies, to explain what cannot be explained. The difficulty is that often the starting point gets out of sight. The moment when the hallucinatory appears, in turn expressing an important relational difficulty, is inaccessible for two reasons.

First, the emotion does not stay attached to the object. This is a very old theme in psychoanalysis, dear to Freud, who thought that the object is the most variable part of the drive [20]. The emotion (or the affection, if we prefer to call it this way) shifted from the initial object to a different one and the psychotic, and often also the people taking care of them, becomes convinced that the reason behind the emotion is not the original one, but the one that took its place. Also, more or less fantastic constructions can alter the frame.

Secondly, the sensorial footprint (what Lacan would call the significant) [21] does not coincide with the object in its entirety. Some sensorial details are more suitable than others to become containers of the emotion and often we see episodes of shifting of the emotion from one sensorial sign (the footprint) to another. We could say that the work to be done on delusion is to give it relativity, when it becomes a self centred and almost perverted object, but also to start a patient work of reconstruction of its origins or of parts of its building blocks, that are its hallucinatory data. The utility of the approach that I have succinctly tried to present is exactly this.

In the therapy of psychotics, it is a matter of building first a basis of trust, of possible narrative, of openness to meaning, of curiosity, of doubt. This is a long phase, but one that is necessary to create a transfert that is conducive to the discoveries, possibly shocking, that will be encountered.

Slowly it is then a matter of deconstructing delusion into its individual building blocks, looking at the linguistic potential of each individual block, as Freud suggested should be done for the interpretation of dreams: not the whole of the dream, but the sum of its components [22].

Finally, the inclusion of the blocks within a relational framework, where it is possible, without fear, to start and see some flaws, some dis-harmonic element, some possible criticism of the idealised figures. These are slow, laborious processes, but it is possible to think that this work on the origin of the delusion can provide the psychotic with some ability to control her/his delirious ideas, that the mere fight against the autoerotic and self-centering components of the delusion cannot alone provide.

Conflict of interests

The Author declares that the present work has not received any financial support. No product is mentioned in the article.

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