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FERENCZI'S REVOLUTIONARY THERAPEUTIC APPROACH*

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Many of the revolutionary principles introduced by Ferenczi in his clinical practice have now been widely accepted especially in the field of trauma and trauma therapy. Examples of these innovative views include his emphasis on empathy as opposed to technical neutrality and his stress on the real conditions of child caring and family environmental deficits and on the consequences of interpersonal violence and abuse that lead to "identification with the aggressor" by the victim thereby resulting in the internalization of both aggressiveness and guilt (the split guilt of the abuser). The resulting "fragmentation" of the personality, which is now considered dissociation (instead of Freud's "repression"), is at the root of several severe disorders, characterized by distortion of reality, loss of touch with one's body and loss of trust in the other. Therefore "abreaction is not enough". A new, positive relational experience must be re-inscribed at the level of implicit memory.

KEY WORDS: trauma; therapy; aggressor; dissociation of personality; body; empathy

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What haunts are not the dead but the gaps left within us by the secrets of others.
Abraham and Torok, *The Shell and the Kernel*

Ferenczi has notably anticipated several aspects of the therapy and clinical treatment of trauma that today have become common practice and are more or less widely accepted. Relational and interpersonal psychoanalysis has legitimated principles that Ferenczi had introduced in his practice decades ago and had illustrated in his *Clinical Diary* (1932a), but which were totally foreign or difficult to accept in his day, since they touched on questions of authority and power, or what we nowadays call the empowerment of the traumatized victim.

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Other fundamental elements of what I would call his revolutionary clinical practice are the empathic attitude of the therapist and the benevolent and committed testimony that he/she has to embody in contrast to the therapeutic hypocrisy of certain analysts of that time, including Freud (Mucci, 2013, 2014).

Crucial in this clinical attitude and in this rewriting of trauma considered as the foundation of future psychopathology for the subject are two concepts: first of all, the reality of trauma versus the fantasy version of it, defended by Freud until the very end of his life, after having abjured so to speak his "neurotica" (i.e., after having decided that the story of abuse recounted by his hysterical patients were indeed stories of fantasy devoid of reality; see Mucci, 2008; Bonomi, 2001). The second crucial concept in the rewriting of trauma is that of identification with the aggressor, profoundly revisited today and given its true political resonance by Frankel (2001, 2002) with the concept of "compliance", among other things. By identification with the aggressor nowadays we mean, thanks to Ferenczi's insight, not simply the defense identified by Freud (1936) following her father's introduction of the concept, but something deeper, a concept similar to that of "incorporation" analyzed by Franco Borgogno in his discussion of "alienating primitive introjection" (Borgogno, 2006, p. 78), a concept also similar to Abraham and Torok's (1994) idea of the "encrypted" meaning of unprocessed traumatic information carried down through generations.

On the reality of trauma and the widespread existence of infantile abuse, in *The Clinical Diary*, Ferenczi writes (August 7th):

> Only a very small proportion of the incestuous seduction of children and abuse by persons in charge of them is ever found out, and even then it is mostly hushed up. The child, deeply shaken by the shock of premature intrusion and by its own efforts of adaptation, does not have sufficient strength of judgement to criticise the behavior of this person of authority. The feeble efforts in this direction are menacingly repudiated by the guilty person with brutality or threats, and the child is accused of lying. Moreover, *the child is intimidated by the threat of the withdrawal of love*. Indeed of physical suffering. *Soon it begins even to doubt the reliability of its own senses,* or, as more frequently happens, it withdraws from the entire conflict-situation by taking refuge in daydreams and *complying with the demands of waking life, from now on, only like an automaton* (…). *The early seduced child adapts itself to its difficult task with the aid of complete identification with the aggressor* (1932a, pp. 189–190). (Italics mine.)

To Freud's objection that the abuse and the seduction were fantasies, Ferenczi protested in his famous essay "Confusion of Tongues" (not published until 1949) that

> The obvious objection that we are dealing with sexual fantasies of the child himself, that is, with hysterical lies, unfortunately is weakened by the multitude of confessions of this kind, on the part of patients in analysis, to assaults on children… They confuse the playfulness of the child with the wishes of a sexually mature person… (Ferenczi, 1932b, p. 297).

The awareness of the violence that has occurred is usually dissociated from consciousness because it is unbearable; here is Ferenczi again (5 April 1932), writing "On the long-term consequences of forcibly imposed, 'obligatory' active and passive genital demands on young children":

> *Protection of the personality by loss of consciousness, compensating fantasies of happiness, splitting of the personality*…The child is helpless and confused, should she struggle to prevail over the will of an adult authority, the disbelief of the mother, etc. Naturally she cannot do that, *she is faced with the choice—is it the whole world that is bad, or am I wrong?—and chooses the latter. Thereupon displacements and misinterpretation of sensations, which ultimately produce the above symptoms* (Ferenczi 1932a, p. 80, italics mine).

The "loss of consciousness" and "splitting of the personality" lead to a distortion of cognition, so that having to choose if the world is bad or if he or she is bad, the child chooses the second. In this way, the child has introjected the aggressiveness and the dissociated sense of guilt of the aggressor: the aggressiveness is very often, especially if the child is a girl, directed against herself, which, together with the introjected sense of guilt, becomes the psychological nucleus of the victim. So the child is both the aggressor (becoming aggressive against herself, with self-harm and suicidal behavior), and the victim (sometimes even encouraging more abuse on herself), and this dyad perpetrates aggressiveness, pain and a cycle of re-victimizing. If the child is a male, more often the aggressiveness is acted out externally, on others, in this way perpetrating, once again, the cycle of violence (with the same split from consciousness).

What is very interesting for the theory (and the therapy) of trauma, is that the aggressor changes from external and interpersonal to being intrapsychic, sometimes to the point of obliterating the reality of certain episodes and emotions. As we read in "Confusion of Tongues":

> As a result of the identification with the aggressor, let us call it introjection, the aggressor disappears as external reality and becomes intrapsychic instead of extrapsychic…Yet the most important transformation in the emotional life of the child…is the introjection of the guilt feelings of the adult (1932b, p. 298).

This introjection of negative parts reminds us of what in recent times Fonagy and colleagues have described as the "alien Self" and as a sort of colonization (Fonagy *et al.*, 2002, p. 22) on behalf of an insensitive or

violent caregiver. It is a very important point for severe future pathology and often takes the form of self-harm or destructive behavior of many kinds, and might even become externalized in criminal behavior.

Travelling along the psychological road opened by Janet (1889), Ferenczi was the first in his day, to define real trauma as an extreme experience by which consciousness is overwhelmed and shattered, so that split parts or fragments have to be dissociated. Although Freud had actually spoken of "splitting of consciousness" (which means dissociation) in *Studies on Hysteria* written with Breuer (Breuer and Freud, 1985, p. 123; see also Mucci, 2016), he had explained the formation of hysterical symptoms as the result not of dissociation but of repression, a defense much more evolved/mature and belonging to an Ego better formed, compared to dissociation, which Janet first, and Ferenczi a few decades later, described as the outcome of the traumatic, overwhelming experience for the subject, and that contemporary neuropsychology describes as one effect of traumatization, together with hyperarousal (Schore, 1994, 2012).

So, on the dissociative effects of trauma, that he calls "fragmentation", Ferenczi was a pioneer. Here is the famous entry on "Fragmentation" in his *Clinical Diary* (Ferenczi 1932a), on 21 February, 1932:

> A child is the victim of overwhelming aggression, which results in "giving up the ghost",… with the firm conviction that this self-abandonment (fainting) means death. However, it is precisely this complete relaxation induced by self-abandonment that may create more favorable conditions for him to endure the violence.… Therefore *someone who has "given up the ghost" survives this death physically and with a part of his energy begins to live again*; *he even succeeds in reestablishing unity with the pretraumatic personality, although this is usually accompanied by memory lapses and retroactive amnesia of varying duration*. But this amnesic piece is actually a part of the person, who is still "dead", or exists permanently in the agony of anxiety. *The task of the analysis is to remove this split* (p. 39) (Italics are mine.).

And a bit further on:

> A completely limp body will sustain less damage from the thrust of a dagger than one that is defending itself. If the body is as dead, with the muscles slack and virtually without any circulation, then a stab wound will draw less blood, or perhaps none at all (pp. 104–105).

The extraordinary accuracy of the above description of the dissociative traumatic reaction resulting even in a fainting of the body, a freezing response, has been confirmed by neurophysiological findings as in the research of Porges (2011) and Schore (2012) describing the vagal response leading to blunting and

analgesia (compatible with the "shrinking of the field of consciousness" as defined by Janet (*L'Automatisme psychologique,* 2005, p. 38).

In this passive hypometabolic state, heart rate, blood pressure, and respiration are decreased, resulting in a numbing of the pain and in the elevation of endogenous opiates that contribute to the feeling of blunting. As Schore writes: "It is this energy-conserving parasympathetic (vagal) mechanism that mediates the 'profound detachment' of dissociation" (Schore, 2011, in Bromberg, 2011, Preface, p. xvii).

The splitting in personality as a result of trauma and also the twist in the subject's personality once he/she has been "defiled", was described by Ferenczi on March 25, 1932 ("Psychic Bandage"), in a passage that is remarkable for its explanation of how the violence from interpersonal and real, in the environment, becomes intrapsychic, ending up menacing the differentiation between what is external and objective and what is internal and not so clearly distinguishable from internal reality, therefore blurring what is remembered consciously:

> From the moment when bitter experience teaches us to lose faith in the benevolence of the environment, *a permanent split in the personality occurs*.... Actual trauma is experienced by children in situations where no immediate remedy is provided *and where adaptation, that is, a change in their own behavior, is forced on them—the first step forwards establishing the differentiation between inner and outer world, subject and object. From then on, neither subjective nor objective experience alone will be perceived as an integral emotional unit*... (Ferenczi, 1932a, p. 69, emphasis mine).

This passage also hints at another major turning point that has lead to the present therapy of trauma: the link that several theoreticians and clinicians trace between abuse in childhood, (especially of the kind of complex trauma involving repeated abuse perpetrated for years in the silence of a home), and the development of personality disorders, which imply a problem in the individual response to reality and in the "differentiation between inner and outer world, subject and object", following the "adaptation" to repeated relational trauma, which causes, according to Ferenczi, a "change in their behavior" (see quote above, 1932a, p. 69) in order to adjust to the distortions of the environment, a distortion created by the perpetration of the violence covered over with silence and disavowal.

The child feels "the duty to remain silent", both for the father (most often the offender) and the mother (on 10 June, *Diary*, p. 118); sometimes the mother even hates the child as a rival (Ibid.).

As Judith Herman has pointed out "the child trapped in an abusive environment is faced with formidable tasks of adaptation" (1992, p. 96), to trust somebody who is the least unreliable, meaning not only the abuser but

his/her companion, often the other caregiver, and to survive in a hostile environment which should be instead the caring and protective place of his/her development.

And here is also another point where Ferenczi is very clear and certainly alone in his time: what is traumatic, in addition to the traumatic event or traumatic relationship itself, and what therefore results in a real distortion and an additional traumatic pain, is the fact that in his environment the child does not receive the support of the other caregiver, the "third" in the family, who probably knows but remains silent or does not believe the child. In "Confusion of Tongues" we read:

> Usually the relationship to a second person of trust, in the chosen example the mother, is not intimate enough either to provide help. Timid attempts of this kind [on the part of the child] are rejected by the mother as nonsense. *The abused child turns into a mechanical obedient being or becomes defiant*, but can no longer account for the reason for the defiance, even to himself; *his sexual life remains undeveloped or takes on perverse forms* (Ferenczi, 1932b, p. 299).

Finally trauma is assimilated to a total dissolution, a form of death for "the most refined parts of the personality":

> *Trauma is a process of dissolution that moves toward total dissolution, that is to say, death*. The body, the cruder part of the personality, withstands destructive processes longer, but unconsciousness and the *fragmentation of the mind already are signs of the death of the more refined parts of the personality* (1932a, pp. 130–131).

What is interesting here is that the traumatic is assimilated to dissolution and death: split parts of the Self are dead, unless they find a place for reparation and restoration in the living experience of therapy. Only a few lines earlier, Ferenczi had written: "*No analysis can succeed if we do not succeed in really loving the patient.* Every patient has the right to be regarded and cared for as an ill-treated, unhappy child" (1932a, p. 130, emphasis mine).

In some ways, these reflections go back to what he had written in 1929 in the essay on "The unwelcome child and his death instinct"; this is a turning point in his theory I think, if we see his theorization as a (courageous) response to Freud: the so-called death instinct, introduced by Freud in his, in its own way, revolutionary writing *Beyond the Pleasure Principle* (1920), is not innate or intrapsychic, but relational and interpersonal, as I have explained in my previous work (Mucci, 2013, 2014), or in any case becomes intrapsychic as a consequence of a relationship with an adult who is not available or even violent, and, instead of being life-enforcing, becomes, most of the time unconsciously, death-enforcing.

Survival in this death-enforcing relationship is a sign of the implacable resilience of the spirit. In other words, even the death instinct is not innate (as Freud maintained) but is learned in a relationship between parent and child, transferred intergenerationally (Faimberg, 2006). And to put it very synthetically, the introjection of the negative feelings and dynamics of the identification with the aggression is at the (relational) root of the death instinct, aggressiveness and destruction towards self and other.

A similar position was taken by Ferenczi on what we may consider the bedrock of Freudian psychoanalysis, the Oedipal complex: in the *Diary* as well as in "Confusion of Tongues" the Oedipus complex is indeed a violent desire and an implicitly sexual request projected by the adult onto the child, who on the contrary desires only tenderness. And Ferenczi concludes that "the antitraumatic in Freud (i.e., his aversion to consider trauma a real event perpetrated mostly within the family and by a supposed caregiver), is a protective device against insight into his own weaknesses" (1932a, p. 186); as he says on the page before, "Freud as the son really wants to kill his father. Instead of admitting this, he founded the theory of the parricidal Oedipus, but obviously applied only to others, not to himself" (p. 185).

The inherited interpersonal nature of the death instinct, was also theorized by Fairnbairn when, in the 1950s, he insightfully redefined the so-called death instinct as a masochistic relationship with internal or interiorized bad objects (1952, p. 106). In more recent times Grotstein (2009, p. 114) would call this "depressive organization", (not to be confused with Klein's theorization of the depressive position, see Segal, 1973), which defines a relation with an internalized aspect of a sadistic and aggressive Self which attacks another aspect of the Self, and through identification, takes the place of a lost object. To some extent his theorization is similar to the already mentioned concept of the Alien Self as explained by Fonagy and colleagues (Fonagy *et al.*, 2002), a pathological basis of Self-organization. Since the child cannot introject a coherent view of the caregiver, he/she has to distort reality, both external and internal reality through pre-mentalizing modalities of thought called "psychic equivalence" and "pretend mode" (Fonagy *et al.*, 2002, pp. 13–14); while usually, when there is appropriate and consistent affect-mirroring and marking on the part of the caregiver, these modalities leave place to mentalization by the child is four or five years old. Again, it is evident how lack of mentalization results in the dysregulation, impulsivity and destructiveness typical of personality disorders and borderline pathologies.

On the absolute importance of good primary relations for future mental health, of an environment capable of sustaining, supporting, and nurturing life with love, from which a fundamentally good narcissism stems, Ferenczi writes in several passages:

> Expressed in physical or geometric terms, one could claim on the basis of similar experiences that the narcissism that is indispensable as the basis of the personality—that is to say the recognition and assertion of one's own self as a genuinely existing, a valuable entity of a given size, shape, and significance—is attainable only when the positive interest of the environment, let us say its libido, guarantees the stability of that form of personality by means of external pressure, so to speak. *Without such a counterpressure, let us say counterlove (Gegenliebe), the individual tends to explode, to dissolve itself in the universe, perhaps to die.* (1932a, pp. 128–129, emphasis mine).

Later on, on August 24, in "On being alone", he writes:

> The childish personality, as yet barely consolidated, does not have the capacity to exist, so to speak, without being supported by the environment. Without this support the psychic and organic components of mechanism diverge, explode, as it were; … the analysis should be able to provide the patient the previously missing favorable milieu for building up the ego…A new couvade, so to speak, and a new taking flight (1932a, pp. 210–211).

If what becomes pathological is this lack of care and love in primary relationships, therapy needs to restore some kind of basic trust and needs to be a form of reparative love. (I would note here that Herman, 1992, posits reparative love as essential for the restoration of healing after trauma for the victim).

In the entry on 30 July 1932, writing on "What is trauma?", Ferenczi (1932a) includes, among the "new elements present in the analysis" (p. 182), *the "[p]resence of a helpful person (understanding and wanting to help)" as a fundamental element for the "alleviation of pain"* (p. 182).The importance of "love" in therapy is stressed several times in the *Diary*, (pp. 128–129, emphasis mine).

The therapist needs to offer, in contrast to a certain tendency for hypocrisy or even "cruelty" (as he writes on p. 178 of *The Diary*), "real conviction of the reality of the construction (of the traumatic memory)" and "a genuine interest, a real desire to help, or more precisely an all-conquering love for each and every one of them, which alone constitutes a counterweight to the traumatic situation" (p. 129, "A new stage in mutuality").

The hypocrisy of a certain form of psychoanalysis is clearly described in "Cruel game with patients":

> The way in which psychoanalysis operates in the relationship between doctor and patient in a friendly manner, works to establish transference securely, and then, while the patient is going through agonies, one sits calmly in the armchair, smoking a cigar and making seemingly conventional and hackneyed remarks in a bored tone; occasionally one falls asleep (1932a, p. 178).

On the necessity for a caring therapist, who is not intellectual, nor cold nor unemotional, in order for the patient to get in touch with the emotional side that has been erased from consciousness thereby creating the fragmentation, Ferenczi is clear (January 19, 1932):

> The analyst is able, for the first time, to link emotions with the above primal event and thus endow that event with the feeling of a real experience. Simultaneously the patient succeeds in gaining insight. Far more penetrating than before, into the reality of these events that have been repeated so often on an intellectual level (Ferenczi, 1932a, pp. 13–14).

From the therapist's empathy and from his/her capacity to be in harmony and to resonate emotionally with past trauma as if it were present trauma (something Freud considered impossible), the patient derives the possibility of recovering the emotional unity that had been lost in fragmentation. If memory is a collection of scars of shocks in the ego, (1932a, p. 11), the presence of a committed benevolent and sympathetic therapist allows the recollection or reconciliation of the split parts. It is even more than this: without the presence of this sensitive and committed-to-truth analyst the patient cannot believe what has happened (consistent with Ferenczi's conviction that the traumatized patient loses the sense of the reality of his/her experience).

This is exactly what expert theoreticians and clinicians of traumatized patients state today: there needs to be a testimony, totally committed and involved empathically, to reconstruct the empathic dyad that has been destroyed, the internal good object obliterated by trauma, which has become an "event without a witness" (Laub, 1992; Mucci, 2014), for the simple fact that when the traumatic event happens it destroys the subject and deletes consciousness, in other words it destroys the possibility of keeping it within the conscious experience, so that it has the paradoxical status (Laub and Auerhahn, 1993) of "knowing and not knowing", the event is split from consciousness but embedded in implicit memory or what has been called "unrepressed unconscious" by Mancia (2006, in Craparo and Mucci, 2016, p. 34), from where it returns to haunt the behavior and to direct unconsciously or implicitly the life and the future relationship of the subject. The presence of a sensitive and committed testimony makes the reconnections of the fragmented pieces of consciousness possible, it is a channel of life in opposition to the erasure and the annihilation of death, the death instinct at work (as Laub again has magisterially written) (Laub and Lee, 2003).

As Robert Jay Lifton, another leading theorist and practitioner with traumatized patients, has argued, "I was never doing therapy with survivors of Hiroshima or Auschwitz. It was a dialogue with them, and it was very powerful" (Lifton 2014 in Caruth, 2014, p. 18). The absolute relevance of the stance of the therapist as a witness who believes in what has happened

and therefore allows what is recorded in the implicit memory to become alive so that the patient herself can trust in that memory, is clearly expressed in this revealing passage from 31 January 1932:

> *It appears that patients cannot believe that an event really took place, or cannot fully believe it, if the analyst, as the sole witness of the events, persists in his cool, unemotional, and, as patients are fond of stating, purely intellectual attitude, while the events are of a kind that must evoke, in anyone present, emotions of revulsion, anxiety, terror, vengeance, grief, and the urge to render immediate help*. One therefore has a choice: to take really seriously the role one assumes, of *the benevolent and helpful observer*, that is, actually to transport oneself with the patient into that period of the past (*a practice Freud reproached me for, as not being possible*). With the result that we ourselves and the patient believe in its reality, that is, a present reality which has not been momentarily transposed into the past. (Ferenczi, 1932a, p. 24, emphasis mine)

This empathic process of reconnection makes the dead or dissociated parts become alive, as episodes that can become narrated in explicit memory:

> I know from other analyses that a part of our personality can "die", and if the remaining part does survive the trauma, it wakes up with a gap in memory, actually with a gap in the personality, since it is not just the memory of the death struggle that has selectively disappeared or perhaps has been destroyed, but all the associations connected with it as well (Ferenczi, 1932a, p. 179).

And it is really the true emotional response on the part of the therapist that, "like a kind of glue, binds together permanently the intellectually assembled fragments, surrounding even the personality thus repaired with an aura of vitality and optimism" (1932a, p. 65). Ferenczi even compares this special bond between patient and therapist to the mother–child relationship (Ibid.), exactly what we believe in today as a fundamental element for the cure to be effective, in so far as the good mother–child attunement allows the emotional self-regulation that has to be reestablished in therapy (see Stern, 1985; Schore, 2012). Against "psychoanalysis as usual", which is in his mind a form of cruelty, a retraumatization, Ferenczi is convinced that "abreaction is not enough". Here is the complete passage:

> What is fundamentally significant in all this is the fact that an *abreaction of quantities of the trauma [as Freud would maintain] is not enough*; the situation must be different from the actually traumatic one in order to make possible a different, favorable outcome. The most essential aspect of the altered repetition is the relinquishing of one's rigid authority and the hostility hidden in it. The relief that is obtained thereby is then not transient, and the convictions derived in this way are also more deeply rooted. (1932a, p. 108)

In fact if the trauma must be relived in some way emotionally (thanks to the contribution of the analyst) this experience needs to rewrite a new implicit course even at the level of neural circuits, As we would say nowadays, in order to be truly healing.

Again Ferenczi is very lucid:

> Experiences with neocatharsis seem to oblige me very often to give up the strict observance of this analytic principle toward the end of an analysis… Relaxation, on the other hand, requires unifying the personality completely and allowing all perceptions to register on the self in an unfragmented way: that is, *a kind of re-experiencing*. … The repetition has succeeded all too well, they say; what is the use of [repeating] the trauma word for word, to have the same disillusionment with the whole world and the whole of humanity? (Ferenczi, 1932a, pp. 54–55).

To summarize (17 August 1932):

> *In addition to the capacity to integrate the fragments intellectually, there must also be kindness, as this alone makes the integration permanent. Analysis in its own is intellectual anatomical dissection.* A child cannot be healed with understanding alone. It must be helped first in real terms and then with comfort and the awakening of hope. (Ferenczi, 1932a, p. 207, emphasis mine).

Consistent with what we understand today about therapeutic change, the healing aspect of the process lies precisely in transforming the affective experience, through a different (Borgogno, 2007, 2011, 2014, 2016) and positive relationship. We need to repair the capacity of the patient for trust and hope.

As he writes towards the end of the *Diary*, (24 August):

> The patient's confidence, which we have thereby earned, now makes it possible for us to present to him as reality what he has experienced in the trance, and by means of countersuggestion to put an end to infantile, posthypnotically fixed command-automatisms; with real determination and its verbal expression we can prevent unnecessary repetitions of suffering for the patient…. (p. 210).

Therefore what we take for granted nowadays, that therapy not only makes the patient relive and restore his emotions trapped in dissociation or in psychosomatic disorders but that it also needs to inscribe a different relational and emotional experience, was already understood and practiced by Ferenczi in the 1920s and 30s. The Boston Change Process Study Group (2007) defines the intrapsychic as interpersonal experience that is implicitly incorporated, starting with internal working models and mental representations of primary relationships. Therapy needs to mark a change in the internal representations of the patient, and this change is achieved only if an interpersonal relationship has successfully changed the internal working

models at work up to that point, which were dysfunctional and painful or destructive for the Self. Linking therapeutic change with neuroscience, Andrade (2005) writes that "inadequate object relations can lead to neuron-physiological changes and that adequate analytic relations lead to psychic changes that correspond to neuronal changes" (p. 684). The brain's neural plasticity, described so thoroughly by contemporary neuroscience when it analyzes mechanisms of change through learning and repetition (for example Schore 2010), are studied nowadays with reference to therapeutic change. This kind of change requires time, consistency through ruptures and affect for the right reparatory relation to be re-inscribed but it leads to a permanent, positive rewriting of one's story.

The last and most extraordinary contribution to contemporary understanding of the resolution of traumatic cumulative experiences contained in the *Diary* touches on the importance of reconciliation for effective therapy (reconciliation with figures of the past and with oneself, with the internal split parts) and forgiveness. I will just hint at them here, but I refer to my previous work on forgiveness (see Mucci 2013) for the appropriate connections.

Here Ferenczi foreshadowed a series of eminent philosophers and psychoanalysts of our time, from Jacques Derrida (2001) to Vladimir Jankélévitch (2005), to Julia Kristeva (2002), Paul Ricoeur (2004) and Desmond Tutu (1999), discussing the revolution and the rebirth that forgiveness marks and opens up within relationships and within ourselves:

> If we succeed in refocusing the traumatic accent, as is justified, from the present to the infantile, there will be sufficient positive elements left over to lead the relationship away from a breach in the direction of reconciliation and understanding (1932a, p. 53).

On 28 June:

> The patient is now more capable of regarding the traumatic events of her own childhood in the spirit of understanding and forgiveness, rather than that of despair, rage, and revenge. A genuine recovery from traumatic shock is perhaps conceivable only when the events are not only understood but also forgiven (1932a, p. 146).

On 13 August:

> Patient: in a position to forgive. That the first step could be taken toward forgiveness for causing the trauma indicates that they have attained insight. That it was at all possible to arrive at insight and communion with oneself spells the end of general misanthropy. Finally it is also possible to view and remember the trauma with feelings of forgiveness and consequently understanding (p. 201).

Strikingly, the very last pages of the Diary *present* the term "forgiveness" and "to forgive" three times: "I released R.N. from her torments by repeating the sins of her father, which then I confessed and for which I obtained forgiveness." (p. 214). Again: "They must be forgiven (…) (Ibid.)".

It is as if the very last thoughts on the resolution of trauma for the subject were for forgiveness, the internal reconciliation.

Recent practices of the therapeutic process with severely traumatized patients (see Mucci, 2013) link the going beyond trauma to a new understanding of self and other and to a liberation from the internalized dyad of victim-persecutor, so that split parts are integrated in a new, regenerated form. Split parts, *non-Me* parts as Bromberg (1998) would call them, which had been operating within the self as alien parts and introjected aggressors can now be released and a rebirth and liberation achieved and experienced.

What the child has not experienced in the encounter with a caregiver needs to be replaced and restored in therapy and in the new encounter between minds and bodies, as in the right hemisphere of both participants to the therapeutic dialogues (for example Schore's ART therapy), (Schore, 2012) through projective identifications and enactments. To conclude, I hope that my reading of Ferenczi's *Diary* will provide some insight into how Bromberg's trauma therapy (1998, 2014), Schore's ART therapy, Judith Herman's contemporary psychodynamic approaches to the cure of trauma (Herman, 1992) nowadays make use of implicit theoretical concepts of the pioneer practice initiated by Sandor Ferenczi.

NOTE

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