Luigi Solano[1]

Beyond symptoms: towards an assessment based on level of integration

Abstract

The paper starts from criticism of a clinical assessment based on the presence/absence of psychiatric symptoms. This modality show strong limits namely in the case of sudden and unexpected violent behaviours, of adhesion to terrorist groups or to criminal regimes, of somatic pathologies. Utilizing psychoanalytic – or psychoanalytically inspired – literature, including work on the above situations, a different assessment modality is proposed, both of baseline conditions and of the outcome of treatment, based on levels of connection between different systems of the organisms. Psychic, but also somatic symptoms appear in this view as useful alarm signals and forms of communication, and should anyway be considered in interaction with the proposed dimension.
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Main psychological theories – deriving from psychoanalysis, cognitive science, clinical cognitivism, systemic-relational orientations, neuroscience, developmental psychology – after many years of mutual discrediting **are today showing a substantial convergence**, though not officially declared and often covered by the use of different terms. Differently from thirty years ago, nobody questions the existence of unconscious processes or of an internal world; on the other hand, nobody questions the importance of present, real relationships. Only organicist psychiatry and radical behaviourism remain outside this convergence.

At the same time we witness full correspondence (with rare exceptions) of data deriving from the clinical setting with data deriving from empirical research (Westen, 1998; Bornstein, 2005; Solano, 2005; Lingiardi e Ponsi, 2013). Psychology, including psychoanalysis, has reached a scientific level which, though it cannot be compared with the level of natural sciences such as classical physics (an ambition I believe we should definitely dismiss), makes it susceptible to empirical investigation to a degree with is much higher than in widely respected disciplines, such as economy or history, and comparable to that attainable in natural science in its more recent developments, such as quantum physics or caos theories, where statements may only be probabilistic.

For these reasons I find difficult to understand why we should abdicate to our assessment tools in “official” scientific communications and continue using in many cases a classification based on the presence/absence of symptoms, such as the Diagnostic and Statistical Manual (DSM) in its various versions: a classification essentially based on agreement among “experts” (an agreement which changes on some points at every edition), irrespective of individuals’ subjectivity, of their more general features (such as resources and achievements), of their relational world, of the meaning of symptoms themselves for a specific person; a classification which discards 120 years of psychological science, psychometrics included. All this was justified in a search for “atheoretical” criteria, motivated in its turn by a postulated “babel” of psychological theories, described as discordant one from the other and void of scientific foundations. As discussed above, these assumptions hold true no more.

I will not have time to dwell on the problems inherent to categorial diagnosis, posing a definite distinction between “healthy” and “ill” individuals. The subject I wish to address is

[1] Full member of Italian Psychoanalytic Society, Associate Professor of Psychosomatics at the Department of Dynamic and Clinical Psychology, Sapienza University of Rome.

the *total insufficiency of a diagnostic system based only on the presence or absence of psychiatric symptoms*, as is employed not only by psychiatry, but also by common people.

When **unexpected violence** takes place in a family, the most usual phrase we hear repeated by friends, relatives, acquaintances is *"He (or she) seemed to be such a nice person".* In a recent occasion words of this kind were reported in the press as used by several people in describing a man who had just confessed slaughtering his wife and children with a kitchen knife (La Repubblica, 20-6-2014).

I need to admit that until some time ago I tended to consider this kind of statements as coming from naive people, uncapable of grasping anything in their fellow human beings beyond the most explicit appearance; I tended to think that any psychologist, even not particularly skilled, would have easily understood that something was wrong in that person.

If we stop and think for a minute, however, we discover that our naive people are in good company: even *after* this kind of events have taken place, a large part of psychology, of psychiatry and of public opinion start discussing whether the killer was sane or not, and delegates this assessment to a psychiatric evalutation, which will commonly be based on the presence of apparent symptoms. As if this latter kind of assessment could be more reliable than the presence of a gesture which from a different viewpoint we could consider the prototypical expression of insanity, with no need of confirmation, and not liable to confutation through different data.

Obviously another question is possible and important, from a legal point of view, that is whether a capacity of discernment was present at the moment of the crime; but I wish to emphasize that the two aspects are not the same thing: a mentally sane person may be uncapable of discernment in a given moment under the effects of drugs or alcohol, of recent trauma, of prolonged sleep deprivation; on the other hand no mental pathology, except maybe deteriorated schizofrenia, definitely and permanently alters the capacity to be aware of the consequences of one's actions.

Another field where symptom-based psychiatric diagnosis appears to fail miserably is that of **terrorists and war criminals**. A paper published on the IJPsa by Carol Beebe Tarantelli (2010), "The Italian Red Brigades and the structure and dynamics of terrorist groups", reminds us of the repeated failure to find macroscopic signs of manifest psychopathology, or of a particular level of aggression, not only in the members of the Red Brigades, but also in suicide bombers (Silke, 2003) and even in nazi criminals tried at Nurnberg: people who had directed the planning and functioning of extermination camps where millions of innocent people were killed. This finding appeared from the beginning so disquieting that it was published only 35 years later (Borofsky e Brand, 1980).

What reliability is offered by a type of assessment which records nothing, or almost nothing, in subjects we may consider as the most highly selected sample, the "gold standard" of psychopathology? Were nazi criminals mentally sane or our instruments inadequate?

First of all, we have to recognize that we are not confronted with a generalized propensity to violence, but with an altered vision of the world, where most cherished values are felt as strongly threatened by somebody: by Jews, in the case of nazi criminals; by the "International State of Multinationals", in the case of the Red Brigades. A loss of reality sense appears implied: but then, wasn't this the clearest indicator of psychopathology? Except here we are not confronted with grossly deluded or hallucinated individuals, but with a loss of reality sense which appears "focal", limited to a very specific area, so that it may remain unapparent unless this area comes to the fore.

Group dynamics may certainly be involved: but there must be something also on an individual level differentiating those fifteen hundred or so individuals who joined terrorist

groups in Italy from the millions of people who shared a strongly leftist ideology at the time but who, when the moment of choice came, took a different route? Beebe Tarantelli in her paper (2010) reminds us of the bionian term *valency,* taken from chemistry to indicate an individual's capacity for spontaneous and instinctive emotional combination with other individuals. We are confronted, therefore, with something far less apparent than what we are used to name psychopathology, something having to do with areas of the mind which in different theoretical systems we may call *split off* (Freud, 1927), *dissociated* (Bromberg, 1998; Bucci, 2009), *alexithymic* (Taylor et al., 1997; Solano, 2013, 267-318), or *unresolved* (Main e Solomon, 1986); these areas send very faint signals to the outside, unless the "valency" combines with other "free radicals" in the social environment, generating terribly explosive compounds. Areas which may be revealed through instruments capable of exploring not contents – which are more or less inaccessible – but modalities of functioning: I am thinking of the Attachment Interview (George et al., 1996), capable of detecting "unresolved" mental states or a low mental "coherence"; of the Interview for Alexithymia (Bagby et al., 2006; Taylor et al., 2014), capable of detecting difficulties in contact with emotion, as a witness of disconnection among systems in the organism (Bucci, 1997a, 2009); of the Scale for Dissociative Experiences (Bernstein e Putnam, 1986).

We should remember that in Red Brigades members and nazi criminals *macroscopic* signs of mental disease were not found, but something was found; what possibly we need to recognize is that in particular contexts a faint signal may be indicative of *specific and limited* dissociated areas, which are difficult to access and may not give any external manifestations for a long time, until encounter with a complementary valency in the environment, or possibly a new stimulus, produce explosion. Niels Peter Nielsen, an Italian psychoanalyst of Danish origin, in his book on "The nazi mental universe" (2004) speaks of "intermittent" perverse areas (p.136). "A part of the mental apparatus prevails temporarily on another, which is ready to prevail in its turn when environmental and existential coordinates become favourable" (p.161).

Careful revision of Rorchach protocols collected from nazi officials while they were standing trial in Nurnberg (Nielsen e Zizolfi, 2005) confirmed the paucity (again, not the absence) of signals of "psychopathology" as could be derived from the classical formal interpretation; but it did in fact find, through an exquisitely psychoanalytic analysis of contents - which was also put in relation with the historical and biographical context - a series of specific features which could very appropriately be connected with the actions for which subjects were under trial: denial of difference between life and death; denial of differences between sexes and between species; devitalization, affective detachment; splitting, ambiguity, copresence of opposite truths; omnipotence, focal disavowal of reality; masked aggression.

As I will discuss in the next paragraph, all this may be viewed in the superordinate dimension of severe *disconnection*. Another thought I wish to anticipate is that subjects who are capable of producing psychiatric symptoms, which in some way give expression to dissociated areas, may end up being less "pathological", and above all less dangerous for self and others, than subjects who harbour "silent" dissociated areas.

My proposal is therefore to give fundamental importance in assessment to **levels of connection/disconnection, or dissociation**. This concept may be considered implicit in most psychoanalytic models of mental functioning, where contact with experience, or with emotion, or with the internal world are considered central.

Bion (1962a, b) describes his theory of thinking as the progressive translation in images (alfa elements) and words of an experience of reality which in the beginning is gross,

formless, imbued with physical sensations, with confuse emotions (beta elements). This capacity of translation/elaboration is considered at the basis of mental health.

Bromberg (1998, 2006), starting back from Janet and continuing Sullivan's and Mitchell's perpective, strongly emphasized the multiple nature of self states and the ensuing need for their integration, therefore positing a link between (trauma-originated) dissociation and psychopathology. Ogden (e.g. 2005) sees the aim of analytic work in helping the patient "dream undreamt dreams and interrupted cries". Donnel Stern (1989) speaks of "unformulated experience", which analysis may help in formulating.

The construct of *alexithymia* (see Taylor et al., 1997, 2014; Solano, 2013, 267-318), derived from that of *pensée opératoire* of the Paris psychosomatic school (Marty et al., 1963) is focused on the capacity to identify and communicate one's own emotional experience. Connection of physiological levels of emotion (comparable to Bion's beta elements) with visual and verbal symbols allows reaching a conscious, specifically identifiable form of contents (joy, fear, anger) which at this point may be named *feelings*. Feelings may be managed, regulated, decided upon. Quotas of physiologic emotions which remain untranslated (Grotstein, 1997) are felt as dangerous for the individual, and activate defenses against their emergence, contributing to the alexithymic condition. Failure of these defenses may bring to *sudden, uncontrolled emergence of non-symbolized emotion*, as in panic attacks or pavor nocturnus, or to similarly *uncontrolled acting*, such as unexpected domestic violence. A less sudden emergence may bring to somatic disorders.

Similarly and in a more articulate way Wilma Bucci (Bucci, 1997a, 2009; Solano, 2010; 2013, 29-66) in her Multiple Code Theory defined health, both mental and physical, as based on *sufficient connections* between a non-symbolic system[2] and symbolic systems (verbal and non verbal)[3], all defined as inseparably comprising "mental" and somatic aspects, in a unitarian body/mind perspective. In this theory as well non symbolic emotion needs to find a representation in images and words, so that it can be elaborated and regulated.

This connection is neither automatic nor innate, but develops in the relationship with caretakers, through functions that were postulated as in all relational psychoanalytic theories (reverie in Bion, holding in Winnicott, attunement in Infant Research etc.).

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[2] The Nonverbal Nonsymbolic (Subsymbolic) System includes functions we are used to calling bodily functioning, procedural memory, implicit memory and physiological levels of emotion. This system coordinates motor actions, from the simplest to the most refined, such as driving a car or playing tennis or football, and may therefore be viewed as endowed with a capability for organized thought, albeit non-symbolic and generally non-conscious thought . From the anatomical–physiological perspective, it corresponds to what is commonly called "body", including brain areas involved in involuntary movements, the autonomic nervous system, the amygdala, and other centres linked to nonsymbolic aspects of emotion.

[3] The *Nonverbal Symbolic System* appears to be rather similar to Bion's alpha function since it generates or processes images, generally visual, that can be directly assembled in dreams or connected to verbal, symbolic representations. It may also be likened to the ''oneiric thought of wakefulness'' as described by Antonino Ferro (2002), pp. 59–69) along Bionian lines. Its anatomo-physiologic counterparts are the hippocampus and cortical visual areas. The *Verbal Symbolic System* includes verbal thought and language; it functions more or less according to the rules described by Freud as pertaining to the secondary process. It allows reflection on one's experience, identification and regulation of emotion experienced at other levels. It is based on superior cortical areas.

Pathology, both mental and physical, is seen in Multiple Code Theory as deriving from different levels of disconnection, close to the clinical concept of dissociation. Connections may fail to form from the beginning, for traumatic reasons or anyhow for a deficit in primary relationships, or be interrupted later, on a conflictual basis (as described in the concepts of attacks on linking in Bion, or inhibition of reflective function in Fonagy). At a physiological level the disconnection may be conceptualized as between amygdala and hippocampus (episodic memory) and between amygdala and cortical areas. Disconnection leads to non-symbolic activation in the absence of identification of the object who is or was the source of activation: a *nameless activation*, or, if we prefer, an unconscious activation.

As in alexithymia theory, *direct emergence of this activation* to consciousness, without the mediation of symbolic systems, will generate panic attacks or other disorders involving nameless anxiety, such as pavor nocturnus.

Efforts on part of the subject *to find a* (spurious) *meaning* to activation will give origin to the different *mental disorders*: attribution of activation to an external persecutor will give rise to paranoid disorders; attribution to a somatic disease, to hypocondria; to an inanimate external object, to phobias; to subject's guilt, to depression, etc.

Efforts on part of the subjects to *sedate activation* may give rise to:

- identification with the author of trauma which was responsible for the disconnection, assuming the identity of a terrorist, warmonger, serial killer, ideologist and/or wilful agent of criminal governments. In Nielsen's (2004) description of the nazi mind we find many elements which may be ascribed to disconnection: detachment from one's affective experience and more authentic self (Winnicott, 1960); a "soul-less life style; a lifeless language (alexithymia); an ambigous personality (Bléger, 1967); disavowal not of reality but of its meaning (disconnection from symbolic systems); identification with the aggressor.
- substance abuse, gambling, sexual promiscuity, disordered eating behaviours, paraphilias, addictive use of work (workaholics) or of physical activity.

An effort on part of the subject to *avoid activation* will bring to generalized avoidance of any experience entailing a risk of activation: this implies giving up any personal achievement, either totally (no job, no couple, no children) or partially (low committment in work, passionless couple relationships, low interest in children. The concept is strongly remindful of that of *vie opératoire* (Smadja, 2001), a conceptual enlargement of the former pensée opératoire of the French school.

Non symbolic activation which finds neither a connection – either adequate or spurious – nor a form of sedation, may cause *somatic disorders* which will be proportional in severity to the degree of disconnection and of non symbolic activation. I wish to emphasize, however, that this form of expression *may be estremely valuable* (at least when the disorder does not appear fatal from the beginning) when compared to a total lack of expression. A somatic symptom may have the role of a *non symbolic first communication* of an item of content which until then had not found any possibility of expression, a *first attempt at connection*, which also favours seeking help from the outside (Bucci, 1997b). An adaptive and progressive value of somatic symptoms was also advocated by Winnicott (1949) and Smadja (2001). I have more extensively considered this aspect elsewhere (Solano, 2010).

In this framework one of the most maladaptive and most dangerous situations is when non symbolic activation finds no way of expression, not even on a somatic level: in these conditions an explosion may take the form of a *sudden and fatal somatic disease or of a sudden, uncontrolled, acting*, to the point of violent gestures against self and/or others, which appear unexpected and incomprehensible ("He was such a nice guy…."). It is well known that most gestures of this kind are committed by people who had never had any contact with mental health professionals. A recent paper, by the evocative title "Do bodies

need to talk?" (Kotowicz, 2013) presented the case of a woman with a "frozen body" who had never produced in her life any kind of somatic symptom or illness, not even a cold or flu: until her sudden, "inexplicable" suicide.

Symptoms, either psychic or somatic, appear therefore not as the essence of pathology but as *safety valves, alarm signals*, possibilities to communicate a condition of distress to oneself and to others. The most unfavourable situation appears instead, in the presence of dissociated non-symbolic activation, *a total absence of symptoms*, since this implies either the definite sacrifice of life in order to avoid activation, or a totally unstable balance with the constant risk of violent explosion.

The position I have illustrated up to this point entails that **phenomena taking place on a somatic level should be given a place in a global assessment,** and given sense in the context of the individual's past and/or present relational and lifecycle situation. We may recognize that division of health between "mental" and "somatic" is an artifact which was introduced by Positivist Medicine in the second half of the 19th century. To put it simply, any physician before that period would have endorsed the conclusion that la Dame aux camélias – Violetta, in Verdi's La Traviata – died of tuberculosis mainly due to the unfortunate course of her love relationship with Armand/Alfredo. This truth, which appears so evident to audiences in the whole world who still weep on Violetta's fate, has been thoroughly denied by medicine (particularly by academic and specialist medicine), which would nowdays blame everything on the mycobacterium and possibly on some family predisposition. On the psychiatric side, the new DSM-5 has eliminated any reference to a psychosocial origin of somatic disorders, which was contained in terms such as "Somatization disorders" or "Somatoform disorders" of the preceding edition. We are left only with "Somatic Symptom Disorder", referring essentially to mental distress deriving from somatic symptoms.

Disregard of psychosocial, relational contributions to somatic disease (and, of course, viceversa) brings to great flaws in assessment and treatment. In an emblematic situation I reported elsewhere (Solano, 2013, pp.439-440), a physician in charge of a patient who had gone through *14 episodes of acute pancreatitis* in the last 3 years, far from thinking that this man might benefit from psychological help, sent me the man's wife for anxiety problems. The notion that deep distress may subsume severe somatic illness appears difficult to accept.

If on the contrary we wish to follow a unitary body-mind position coherently (as expressed in my country most completely by Carla De Toffoli, 2011, 2014), we should *assign somatic symptoms an importance as a signal of distress equal to that of psychic symptoms*; keeping in mind that a somatic signal is more remote from consciousness and therefore is witness to a lower level of connection, of contact with oneself.

In order to illustrate my position, not certainly to elaborate a definite diagnostic system, I wish to propose **a classification of levels of health** (with no distinction between psychic and somatic) **based on the extent of connection/disconnection between systems**. It may not of course be easy to place all possible situations in one of the levels proposed, while intermediate situations may be present.

Level 1 *(Minimal Health)* = maximal disconnection of the non-symbolic from symbolic systems. This may give rise to:

° Vie opératoire

° Sacrifice of life, generalized avoidance of any experience capable of activating dissociated contents
° Schizofrenia with prevalence of negative or catatonic symptoms

No "positive" symptom is present. Except possibly in the case of schizofrenia, which implies deterioration, the risk of a sudden, massive emergence of non-symbolic activation is constantly present: suicide; murder either "passionate" or "senseless" (serial or mass killers); adhesion to terrorist organizations or extreme political groups; sudden appearance of fatal somatic diseases without any anticipation. In any case it appears impossible to find satisfaction in life, relationships, work.

Level 2 = higher degree of connection than in level 1.

Possibility of expressing distress mainly through:
° somatic pathologies, before irreversible damage
° thoughtless acting, though non-murderous: drug or alcohol dependence, sexual promiscuity, gambling, self injuring.

Level 3 = higher degree of connection than in level 2

Possibility of expressing distress through different psychic symptoms, which may be viewed as an expression of dissociated non-symbolic activation, a spurious symbolization. Distress may be more easily recognized both by subject and by others, and a help request more easily activated. Final fate of the problem is highly dependent on appropriate timing of intervention, and on the adequacy of help available.

Level 4 (*Optimal health*) = full contact with non-symbolic (or emotional, or drive-related) activation.

The presence of this condition is more of an ideal of sanity: in actual reality, event-related activation in some moments of life overcomes our capacity for connection (for mentalization, or our alpha function), and we will develop psychic or somatic symptoms or acting.

Level of connection/disconnection may be assessed clinically and/or with instruments listed in the initial paragraphs of this paper. Capacity for connection, which we may consider a superordinate function, may also be assessed through evalutation of subordinate functions, such as reflection, affect regulation, dreaming, self-soothing etc.

To conclude: this paper proposes in fact no substantial modification of psychoanalytic theory or technique. It tries to state clearly, and with firm belief, what we already are and do: in the field of assessment, utilizing our instruments, and not those of academic, neo-kraepelinian psychiatry; in the field of treatment, defining our work as analysts as aimed not at elimination of symptoms (which we well know are alarm signals and not the problem) but at promoting the development of functions, in particular the capacity of connection between parts of the self, in whatever way we prefer to call these parts, and in whatever way we prefer to call this promotion: awakening the dreamer, developing alfa function, connecting basic sensory and emotional levels with verbal and non verbal representations, and many others.

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