

**Trauma and the Failure to Mourn:  
A Lacanian Perspective on Serious Acting-Out and  
Passage into Action**

Presentation prepared for the XVIII Annual I.F.P.E Conference

Toronto, Canada, 19-21 October 2007

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Very early into the elaboration of the psychoanalytic theory, Freud addressed the importance of faulty actions, such as parapraxes, slips of the tongue, lapsus and so on, in his remarkable study “ The Psychopathology of Everyday Life.” We know that such mistakes were no mere “ accidents “ and that they were at the core of neurotic formations, obeying a logic that was unconscious and revealing of one’s desire.

I would like to address today a whole spectrum of what we could refer to as “*disturbances in the motor sphere*” , in which we can include serious acting-outs, passage into action, and generalized inhibitions, such as the ones that we encounter in severely traumatized patients and profound melancholias; where the spheres of movement suffers either from a deep sense of delay or an action that is untimely, hastened, or at times, intensely violent. We know that sometimes there is no other way to say something that is not being heard or cannot be heard, than through action. Action is generally used when someone to whom a communication is addressed, is simply not listening. The fact that the action is addressed to this Other, speaks of a need for the Other to listen, and take its place as interlocutor, so that the truth can be said, and the seemingly “crazy and irrational actions”, understood.

As analysts we believe that the more someone can speak about the unsay able, and be listened to, they less they will feel compelled to act it out. The reverse would also hold, the less the offer to listen to something in need to be said, the more someone is in risk of acting. That is why, Psychoanalysis grants such a central place to the function of speech and language, giving someone who comes to see us, the right to speak for themselves.

I will divide my presentation in three parts : 1) I will make an attempt at defining the concepts of Acting-Out and Passage into Action, examining their differences and similarities.

2) We will examine how the understanding of these concepts can be helpful in our clinical work, informing the nature and the difficulties that we face in our work with severe trauma.

3) I will attempt to relate the importance of restoring the mourning process there where the severity of the trauma can prevent its course.

We could claim that severely disturbed patients suggest the existence of unrepressed trauma, a trauma that leaves them prey to its ever present actuality, more prone to impulsive behaviors and thus to the difficulty of entering into the transference. These patients have a predilection for the display of scenes which speak of the mistrust of the power of speech. Thus,

such patients are more inclined to impulsive behaviors, either in the manner of Acting –Out or Passage into Action. It is important to underline that in either cases, just as with “faulty actions”, these type of behaviors carry an important nucleus of “truth”, only that the patient is constricted to the use of these behaviors in instances where words are no longer trustworthy or useful to convey experience, since the symbolic order, which is the one that guarantees an individual’s connection to social relations, language and history, has been crushed, is unsafe or lacks the resources to name and recognize the trauma.

Human beings cannot but experience a feeling of devastation, betrayal and violent rage when the *Other* as keeper of the most basic traits in our daily lives violates the values which hold a community together. What results is always traumatic, a sort of collapse of one’s existence, a pulverization of one’s being. Patients who have gone through such experiences are either deeply depressed or can carry an amount of aggression that often times attack the frame of the treatment in the forms of acting-outs. Still, there is another aspect that I would like to look at when thinking of acting-outs phenomena. Lacan’s view is that all **acting-outs** behaviors, when they take place inside treatment involve a communication to the analyst. A way of hinting at him or her that she has missed the target. Interestingly enough, Lacan refuses to translate this term from English and instead uses the English dictionary to explain it, which states:” ...*to represent (as play story, a story in action, as playing a role on the stage, as opposed to reading).*”

The acting-out would then entail several moments: 1) it’s about the story that has been represented, but has failed on its purpose. As if someone read the scene incorrectly: “ ... *you have read this passage from Shakespeare, but you have read it wrong, you read it in such a detestable voice...*”

2) Thus, the emphasis falls on the second moment, as if someone else would come and say: “... I am going to show you what this is about, we are going to represent it, and we are going to display the scene. “Thus, it is very important to notice that the scene is supported by a text, by a script, that it has a symbolic support.

3) it is a display, as we said, a setting of a scene so that the Other, may, in the best of cases “ read in between the lines and exercise the function of “*intelligere*”, of figuring out what this is about.

4) this display of a scene sustains a speech that was not articulated , a verbalization that was not spelled out, but one that begs, and we underline this, begs for interpretation in a far more urgent way than a symptom does, due to a variety of reasons.: a) the degree of depersonalization that severe

acting –outs entail b) the gestures of self destruction c) the impulsive handling of time in which the patient experiences an urgency that forces him to go to the edge and do desperate things d) the request to the analyst to help him re- introduce to the field of speech that which had been cast out and left unspoken.

5) It is reversible: acting –out leaves open the possibility of a return to the symbolic dimension, where it was expelled from (a hope structurally unavailable when a passage into action has been accomplished).

Severe acting-outs could be understood as a hint, as an unspoken message that both masks but also begins to communicate an experience of such devastation that the sole process of articulating it through speech would cause enormous psychic pain. Thus, such un-symbolized traumas, real psychic catastrophes that precipitate someone into the place of the Real, are generally acted- out repetitively, without memory or words which can contain it, until the analytic work can restore the social link through the dialectic of symbolic speech in a human relationship, where the trauma can be both spoken and remembered and as Gorney reminds us, even usefully repressed or forgotten for long periods of time. ( 2004)

Lacan proposed a structural distinction between “acting- out “and “passage a l’ acte.” ( see Seminar 10 on Anxiety, 1962/63). While the former implies that the patient “acts- out “because she is subjected to a puzzling question and seeks an answer, the latter is described as an attempted solution, a flight from the scene of phantasy, which aims at a final solution ( generally under the form of suicide or a criminal action). Yet, even if in both cases there is a reference to scenes, which entail a certain amount of activity on the part of the patient, where things are done that involve the display of a scene; in the case of the passage into action, the scene no longer holds itself together, there is no more display, and the scene concludes.

However, one can distinguish two moments in the structure of the passage into action: 1) the period in which the scene begins to develop, and progressively begins to include more and more aspects of the life of the patient, becoming wider and wider, Now, what type of scenes are we referring to? It is a scene in which the patient begins to drift more and more into the place of the unspeakable catastrophe and becomes increasingly identified with a state of despair, worthlessness or nothingness, where he no longer matters or counts. We can say that at first, we begin to notice this in very small episodes, which are isolated at the beginning, but then become more and more frequent. The patient begins to withdraw more and more, or begins to feel less and less important, his self esteem begins to crush, to fall

apart, and the patient begins to place himself increasingly in situations where he is unimportant, where he has no place, not even a little corner that he can call his own in all the scenes of life that he is part of. Such cases in which the narcissistic supports begin to crumble and disappear, necessarily involve a deepening identification with a devalued and worthless object, with the entrance into a zone where there is no way out and someone is more at risk in trying to “do” something to make this stop.

2) The moment when the scene suddenly, irreversibly, and irremediably stops. The scene is terminated by the patient. This second stage is the one that is usually understood as “passage into action”, whereas the first one is the one in which the conditions are developed, and the one with which, hopefully, we can still operate with.

So, how can we operate clinically with such situations when faced with the risk of a passage into action? Iunger and Nadel ‘s work on this matter (1981,1993,) has provided the clinician with useful and important guidelines.

1) The first parameter to consider is the transference, and we are reminded that any possibility of efficacy has to do with being able to have a strong transferential allegiance, or to develop one as a first priority.

2) In cases when the patient begins to experience suicidal or criminal ideation, with a strong affective component, we know that we have to take the patient seriously and a sign that this is registered in the analyst is when we begin to feel concerned and worried. Worried does not mean terrified (or it shouldn’t), fearful or impotent, but it does mean the acknowledgment of these countertransferential feelings in the analyst. As we said before, we can’t wait for the structure of the passage into action to become complete so that we can begin to operate on it, although there are times in which it is not preventable. In every treatment and this is such a delicate balance that is related to the question of timing, the patient’s phantasies have to unfold before the analysis can attempt any shift. Due to a sort of natural desire to help someone remove themselves from a painful scene, therapists are at the risk of attempting to do this too soon, while hopefully we don’t get there too late. We know of the extreme difficulty therapists and the community are faced with when they have to intervene in situations of life and death.

3) We have to allow the patient to be able to unfold his phantasies, allowing the phantasies “to speak”, as it were, that they find their text and display themselves in a scene (which means that often times, the therapist has to bear some things which are quite dramatic in the transference), so that eventually the patient can do something else with it. The analyst must try to find ways to enhance speech, to allow the patient to speak, because often

times the patient gives us some clues, says a little phrase here and there, a metaphor, refers to a movie or a book ; etc, but does not speak clearly and openly to us about his phantasy of “ passage into action “. The patient can insinuate it, allude to it, but the analyst has to promote in every way that the patient speaks about it. Particularly when what is not spoken about is some unbearable trauma, objectified position or a mourning process that the patient is going through, in order for the patient to be able “to *articulate which are the scenes that take him to the edge of the abyss.*” In order to help this process, it is so important to try to preserve the *continuity* in the narrative of the scene, to allow the patient to bring it to the session so that the analyst can be inside the scene and become part of it.

4)The analyst needs to attempt to produce a cleavage and allow the patient, if possible, to de-identify from this worthless, dead/ rejected object, so that the self can be rescued, together with the self esteem and any threads of the desire to live.

5) Another important indicator is the relationship to time; anxiety, anguish and desperation are part of a dialectics of affects in relationship to the patient’s capacity to wait without falling apart. In the case of anxiety, the patient seems placed in a “longing for the missing object”, anxiously waiting for it, at times unable not to overeat, over drink or medicate himself. In the case of desperation, we can concern ourselves that a patient might be on the edge of an act that could expel him from the scene of the world. Desperation is defined both as a state of great recklessness brought about by a sense of urgency and anxiety, but also, a state of hopelessness. In cases where there is no more hope, no more attempts for the other to listen, or rectify its position, because the game has been lost, even before it has been played, the risk of a passage into action is imminent. When someone is caught at a place where there is no way out, no light at the end of the tunnel; one can be dominated by this impervious urgency that will precipitate the end.

We can claim that in such cases, where the end is accomplished in a suicidal passage into action, there is a maximum effect of loss of self, which takes place in one’s own self- annihilation, as the effect of a trauma that has been impossible to mourn, and therefore has crushed all subjectivity and hope.

Most probably this was the case with so many talented writers, who after having survived the *Shoah*, and bearing witness to it, succumbed nonetheless to suicide. One can arguably claim that in the end, they were unable to overcome a core of radical opaqueness, left by the *Shoah*, which for P. Levi was “incurable.” In his case, this ferocious, implacable experience , where he doesn’t want to return to Auschwitz, and yet

discovers, that *in truth, this experience has never ceased to take place, as it is always already repeating itself*, appeared to Levi, as we know, as a dream. A dream within a dream, where the aspect of peace and tranquility of the dream, which represented his life prior to the camp, dissolves, and a well known voice, that of the dawn command of the camp is uttered: “get up, *Wstawach*. “For some authors, the un-mourn able inhumanity of this command had never been able to relinquish its incurable destructiveness and had finally pushed Levi to suicide. For E. Wiesel, as for many others, P. Levi had already died at Auschwitz forty years later.

We know that some “ traumas “ may be impossible to mourn , or all the more difficult if the death or crime has been repudiated by the social order, thus preventing the subject or a people , from ever being able to forget it. The death or crime that is un-acknowledged by society prevents the mourning process and the possibility of working through the trauma. A process that would allow for the trauma to be recorded in the social order, so that the mourning process would not be aborted ahead of time and the dead could be mourned.

And yet, was P. Levi’s suicide an effect of such a un-mourn able trauma that had ultimately destroyed his subjectivity and hope? It is a question to wonder about, not only because Levi was already 87 years old, and through his writing and through his life, had left a lasting testament to the indestructibility of the human spirit, but also because the arguments pointing to an accidental death are as powerful as the ones which claim that it was a suicide. There were no witnesses to his death, no note and no direct physical evidence. Still, we shall probably never know for a fact whether he committed suicide or not. What we do know, or at least, chose to believe, is that Levi’s last moments were not an act of delayed resignation before the inhumanity of Nazism. For us, he seems more someone who never yielded, at most, on that tragic Saturday morning of April 11, 1987, P. Levi snapped and fell from that narrow stairwell of his Turin apartment, where only his body, but not his spirit, came to an end.

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