Ricerca Psicoanalitica | pISSN 1827-4625 | Year XXXVI, s1, 2025
doi:10.4081/rp.2025.1039

Traumatic sexuality: a dialogue between neuroscience and psychoanalysis

*Chiara Soligo**

ABSTRACT. – This paper explores the complex relationship between childhood sexual abuse and the development of sexual dysfunctions in adulthood through an integrated lens that brings together psychoanalysis, neuroscience, and sexology. Traumatic experiences of abuse can disrupt the vital connection between mind and body, often resulting in dissociative symptoms and somatic pathologies. Within the sexual domain, these traumas may resurface as painful memories, dissociation, or sexual dysfunctions. Neuroscientific insights – particularly those concerning autonomic dysregulation and implicit memories – highlight how trauma is inscribed in the body, offering clinical guidance that complements psychoanalytic theory. Building on the contributions of Freud, Ferenczi, and contemporary authors such as Mucci, the paper underscores the importance of therapeutic approaches that address both the psychological and bodily dimensions of trauma. The analytic relationship, grounded in safety, empathy, and right-brain mirroring, can help restore a sense of self, agency, and relational intimacy. Ultimately, psychoanalytic therapy can facilitate the integration of dissociated experiences, enabling deep empowerment and a return to a more unified and embodied subjectivity.

Key words: childhood sexual abuse, post-abuse sexual dysfunction, embodiment, psychoanalysis, neuroscience.

Introduction

Childhood sexual abuse constitutes one of the most profoundly disruptive experiences an individual can endure. Owing to the complex and often contradictory psychological messages it conveys, alongside the physical violations endured by a body unprepared for sexuality, such abuse becomes entrenched in the survivor's mind-body system as an implicit memory. These memories are often reactivated during adult sexual experiences. For individuals exposed to such trauma in childhood, sexuality remains a psychologically fraught domain, frequently accompanied by persistent sexual dysfunction.

*SIPRe, Milan, Italy. E-mail: chiara.soligo.1@gmail.com

Understanding the link between early traumatic sexual experiences and adult sexual pathology necessitates an exploration of the mechanisms through which traumatic memory may manifest symptomatically. From a broader theoretical lens, psychoanalysis has long been engaged with the enigmatic relationship between mind and body. How are these two dimensions interwoven? More specifically, how can a somatic symptom lack any physiological basis while originating from psychic conflict?

The etiological debate in psychoanalysis places trauma at the center of symptom formation and maintenance, particularly in the context of hysteria. In parallel, contemporary neuroscience investigates the somatic embedding of traumatic experiences. Thus, the mind-body relationship – or more accurately, the unified mind-body system, transcending Cartesian dualism – is a shared focus across disciplinary boundaries.

This paper aims to foster an interdisciplinary dialogue by integrating insights from psychoanalysis and neuroscience, seeking a multidimensional understanding of trauma that may inform clinical practice. Within the constraints of this brief contribution, the objective is to offer a framework that acknowledges the patient as a psychophysical whole and to outline potential psychotherapeutic approaches. Central to this is the psychological understanding of the symptom as a meaningful response—an expression intimately linked to both physical and existential survival. In this context, the psychoanalytic clinician positions themselves within the broader interdisciplinary exchange between neuroscience and psychoanalysis.

Psychoanalytic perspectives

Early psychoanalysts were primarily concerned with hysteria: they observed many patients presenting with unexplained physical symptoms. It began to be understood that such symptoms were the result of intense emotional states that had no way out and were therefore expressed through the body (Freud, 1892, 1895). While Charcot traced the cause of hysterical symptoms to hereditary transmission, Freud and Breuer began to identify unconscious memories of trauma as the true source (Mucci, 2024; Prela, 2024). In their 1892 work *On the Theory of Hysterical Attacks*, they acknowledged Charcot's view that a particular disposition could affect an individual's ability to discharge excess energy, which would then accumulate in the nervous system and manifest as trauma. Thus, hysterical attacks would be caused not by heredity but by the return of traumatic memories. Faced with such a disorganizing amount of energy, expressed through the body, the idea began to emerge that the psychic apparatus might enact mechanisms to defend itself from this distressing process. This led to the development of the theory of repression, seen as a voluntary act to banish

traumatic memories (Freud, 1985). Treatment, initially hypnosis and later the talking cure, aimed at abreacting the memory (Mucci, 2024). However, in the formulation of an etiological explanation, a divergence emerged between Freud and Breuer, particularly around the role attributed to sexuality. In *Project for a Scientific Psychology* (1895), Freud departed from Breuer, proposing that defense neuroses were caused by sexual trauma suffered before maturity. He reaffirmed this idea the following year in *The Aetiology of Hysteria*: "At the root of every case of hysteria there are one or more episodes of premature sexual experience during early childhood", often perpetrated by close relatives such as the father or brother (p. 344, trad. it. 1968). Freud's etiological theory was first rejected by Breuer, who instead hypothesized a dissociative mechanism, suggesting that patients entered 'hypnoid states' (Prela, 2024). Freud was later frequently criticized and accused of inducing such memories in his patients. By 1925, he abandoned the theory of actual seduction, proposing instead that traumatic experiences might be of a phantasmatic nature. This conceptualization viewed trauma as a psychic event that was voluntarily repressed, without yet recognizing that certain traces could be inscribed in the body, beyond any conscious intent. In other words, the body's capacity to record non-conscious, implicit memories – stored in the temporo-parietal associative areas of the right hemisphere – had not yet been understood. These areas encode memory even before the hippocampal structures responsible for explicit memory are developed. Indeed, certain experiences during early childhood, including sexual or physical violence, occur before the hippocampus is sufficiently mature and therefore cannot be repressed – a defense that is more developmentally advanced (Mancia, 2006). These memories are nonetheless recorded and contribute to what Mancia calls the early non-repressed unconscious (Mancia, 2003).

Ferenczi gave voice to abuse victims and made a fundamental contribution to the study of interpersonal trauma as a real experience. His trauma theory aligns more closely with current neuroscientific research. His studies identified dissociation or fragmentation, rather than repression, as the pathological response to interpersonal trauma. This distinction carries significant clinical implications: repression is a more mature defense, whereas dissociation is more primitive, as also recognized by McWilliams (2011). These two defenses may even involve different brain hemispheres: repression associated with the left hemisphere and dissociation with the right, at a subcortical level (Schore, 2023). The right hemisphere is the first to mature and governs affective, relational, and social dimensions. It is in the right hemisphere that intuitive, emotional, and nonverbal information is encoded (Bear *et al.*, 1996; Mucci, 2020). In children, it is this hemisphere that most actively records events and inscribes implicit traces. A body becomes the target of unconscious attacks and complex identification

dynamics. This is confirmed by Van der Kolk (2015), who shows that the immaturity of the left hemisphere and the hippocampal structures does not diminish the extent to which traumatic experiences affect the mind-body system, but rather affects their cognitive comprehension. A traumatic experience can strike at such a primitive level that it triggers dissociative reactions even in adults – the difference lies in the capacity to understand and make sense of the experience, a capacity children lack. A child may feel such overwhelming and inexplicable affect that they are completely engulfed, unable to comprehend what is happening. They try to give meaning to the experience using whatever internal resources are available. This overwhelming experience creates a sensation akin to death, a surrender that becomes the precursor to tolerating violence. The child not only identifies with the aggressor but also internalizes the aggressor's aggression, guilt, and shame. In trying to make sense of the experience, the child ends up believing they caused it. When confronted with such an atrocious and ambivalent message – such as that of sexual abuse – the only way to regain a semblance of control over the environment without feeling completely at the mercy of cruelty is to assume responsibility and feel bodily shame for having provoked the adult's desire. Thus, the body itself loses credibility, and it becomes difficult to remain in contact with bodily sensations. Dissociation then becomes the only defense mechanism allowing detachment from a body that bears the traces of the aggressor – a body that is at once victim and perpetrator, a target of hatred and attack (Ferenczi, 1932a; Mucci, 2013; Mucci, 2020).

Neuroscientific voices

There is a complex and intricate relationship between the mind – which experiences emotions it cannot recognize or identify, thereby preventing their articulation into words – and the body, which takes on the burden of the same unexpressed pain, channeling it into somatic expression. Neuroscientific research has helped demonstrate how psychological pain can indeed manifest as somatic symptoms. Embodiment theories explain not only how trauma is reflected in the body but also how its memory becomes embedded in the somatosensory cortex (Van der Kolk, 2015).

We can begin this intricate journey with the work of Bessel Van der Kolk, who, in *The Body Keeps the Score* (2015), carefully outlines these mechanisms. He shows how trauma leads to alterations in both the central and peripheral nervous systems, which in turn have numerous psychological repercussions, affecting the sense of self, sensory and emotional processing, the ability to assess danger, and the perception of time (Mitchell *et al.*, 2005; Porges, 2003; Williams *et al.*, 2006). Baldwin (2013) confirms

what early psychoanalysts had already observed clinically: trauma survivors often present with a wide variety of medically unexplained symptoms and high comorbidity with other illnesses. This naturally raises questions: What is the purpose of this symptomatic activation? Why does the body react so intensely? Why do all these symptoms appear?

We humans often forget how deeply we are tied to our *bios*, yet we exhibit reactions that are profoundly rooted in species survival (Darwin, 1859; Van der Kolk, 2015). When we are exposed to abuse or violence, the entire body is mobilized – from limbs and pupils to the heart and even the most primitive brain structures in the brainstem, inherited from reptiles through evolutionary history. To survive, we activate animal-like mechanisms that are initially adaptive responses. These survival responses recruit all the body's defense systems: neurophysiological, neuroendocrine, pain-related, and even the immune system (Basson, 2012; Danese, 2020). Thus, the body becomes a powerful tool of self-protection. However, restoring the original baseline is not always easy, and what begins as an adaptive response may persist over time, ultimately incurring a cost (McEwen & Stellar, 1993).

From a neurophysiological standpoint, responses to traumatic events fall into two evolutionarily distinct categories. Faced with danger, mammals typically fight or flee, while reptiles freeze. Despite millions of years of evolution, humans still display these reactions. In the former, blood moves away from the core toward the limbs, which contract in preparation for action, heart rate increases, pupils dilate – indicative of sympathetic nervous system dominance and a fight-or-flight response. In the latter, derived from reptiles, the parasympathetic nervous system predominates, causing lowered blood pressure and muscle relaxation. Crucially, areas of the brainstem responsible for life-preserving responses become active when fight-or-flight proves ineffective. Consider the freezing behavior of mice, descendants of reptiles themselves. Sometimes, one does not pretend to be dead; the body simply mimics death without any conscious control (Baldwin, 2013; Porges, 2003; Van der Kolk, 2015). In individuals who develop post-traumatic stress disorder (PTSD), symptoms may stem from the first type of response. For example, flashbacks reflect hyperactivation of the right hemisphere – responsible for visual and emotional processing – alongside deactivation of the left hemisphere, which constructs meaning, and the dorsolateral prefrontal cortex, involved in executive functioning. This results in a sense of being trapped in a traumatic past that invades the present (Koenigs & Grafman, 2009; Williams *et al.*, 2006). Then come freezing, numbing, and depersonalization: functional MRI scans of individuals recalling traumatic experiences show reduced brain activity. There is no capacity to feel, to assign meaning to what is happening (Van der Kolk, 2015). We thus see how trauma can become so

deeply inscribed in the brain that it directly impacts the most primitive neural core that defines us as living beings.

At the neuroendocrine level, the limbic system – also known as the 'emotional brain' – shows differentiated activation in response to trauma: the thalamus is deactivated, impairing the filtering of threatening information. As a result, all stimuli are perceived as salient and dangerous (Lanius *et al.*, 2001; Van der Kolk, 2015). The amygdala becomes hyperactive, as though the traumatic event were occurring in the present moment (Rauch *et al.*, 2000; Williams *et al.*, 2006). When the amygdala encodes a threat, it activates the production of cortisol and adrenaline – the stress hormones (Bear *et al.*, 1996; LeDoux, 2012). The body prepares to fight or flee. The problem is that this occurs even in the absence of real danger, and the defensive response becomes chronic (Bear *et al.*, 1996; Lanius *et al.*, 2001; Williams *et al.*, 2006). For the organism to function optimally, a balance between sympathetic and parasympathetic activity is essential. The physiological mediators involved – such as adrenaline, cortisol, and immune system cytokines – act on receptors across organs and tissues, producing short-term adaptive effects. But if they are not deactivated after the stressor has passed, these same adaptive mechanisms become harmful, taxing the body. Chronic stress, in fact, dysregulates pain neuromodulation by altering the sensitivity of neural circuits, which contributes to pain chronification and affects autoimmune processes (McEwen & Kalia, 2010; McEwen & Stellar, 1993).

It becomes clear how a real external event can be registered by the body independently of any interpretation or conscious meaning. In many cases, years may pass before adverse childhood experiences manifest as illness. This deep imprint on the body is facilitated by the particular plasticity of the developing brain and immune system (Danese *et al.*, 2007). When stressful experiences – both physical and psychological – are cumulative, chronic symptoms and illness may be viewed as the product of these repeated encounters. The earlier such experiences occur, the more their effects become integrated into the body's regulatory systems, including those governing sexuality (Shonkoff *et al.*, 2009).

Sexological developments: post-abuse sexual dysfunction

Sexuality itself becomes deeply affected by emotional, relational, and physical distortions, to the extent that Gewirtz-Meydan and colleagues propose the term 'traumatic sexuality' to more accurately describe the phenomenon (Gewirtz-Meydan & Goodbout, 2023; Gewirtz-Meydan & Opuda, 2022). Like all bodily functions, sexual functioning is regulated by the balance between the sympathetic and parasympathetic nervous systems, with

optimal functioning depending on their equilibrium. Sexual abuse, when considered in its traumatic dimension, disrupts this balance.

Drawing on the two evolutionary pathways outlined by Van der Kolk (2015), parallels can be identified: on one hand, any sexual experience may serve as a trigger for flashbacks – such as touch, semen, nudity, *etc.* – leading to hyperarousal that interferes with sexual functioning; on the other hand, dissociative reactions may emerge, causing individuals to feel disconnected or to observe themselves from the outside during sexual activity. This disconnection from bodily sensations impairs the ability to experience pleasure (Gewirtz-Meydan & Ofir-Lavee, 2021; O'Driscoll & Flanagan, 2016). Although various forms of sexual dysfunction are fairly evenly distributed among survivors, the most prevalent in women with histories of childhood sexual abuse are arousal disorders (84%) and desire disorders (53%), while among men, erectile dysfunction (33%) and hypoactive sexual desire disorder (24%) are most common (Gewirtz-Meydan & Opuda, 2022; Westerlund, 1992). An inverse relationship appears to be confirmed: the greater the impact of trauma on the body, the more difficult it becomes to connect with genital sensations (Meston *et al.*, 2006). Traumatic experiences are stored as implicit memories in the body, thereby influencing the capacity to feel sexual pleasure.

Given the symptomatology primarily associated with sympathetic activation, it is also evident that hypervigilance during sexual interactions may prevent focus on bodily sensations (Gewirtz-Meydan & Goodbout, 2023). Studies have demonstrated an overlap between orgasmic and pain responses: whether a stimulus is perceived as pleasurable or painful depends on the balance between excitation and inhibition at the level of the central nervous system. To achieve an orgasmic response, excitation must slightly outweigh inhibition – enough for the experience not to be perceived as aversive (Komisaruk *et al.*, 2023). When sympathetic activation is excessive, the sexual response is inhibited (Bradford & Meston, 2006). Considering dysfunctions driven by excessive sympathetic activity, neuromodulation mechanisms alter pain perception, resulting in the genital area becoming chronically tense and hypersensitive to pain, as though in a state of constant threat (Basson, 2012; Graziottin *et al.*, 2020). Chronic pelvic pain is associated with numerous male and female sexual dysfunctions, including genitopelvic pain disorders, dyspareunia, vulvodynia, prostatitis, and penile pain (Chaitow, 2007). In such cases, sexuality evokes traumatic memories and is thus avoided through symptomatic expression. When sexuality becomes a reminder of the original danger, the body itself activates survival mechanisms that protect against or mitigate the traumatic impact. In this context, sexual dysfunction takes on a significant psychological function: it serves to prevent further traumatic experiences, restore a positive sense of self, and reestablish a sense of control over one's sexuality (Gewirtz-Meydan, 2022).

Therapeutic resonances

What, then, is the role of psychoanalysis? Contributions from neuroscientific and sexological literature can certainly inform fundamental considerations when working with patients who present this clinical configuration. These include the importance of creating a safe therapeutic setting and strictly respecting the timing of interventions, especially given that their sense of safety and trust has been fundamentally undermined. Sexological exercises, such as sensate focus techniques, may prove disorganizing for these patients if not preceded by substantial work on trauma. Breaking the chain of silence surrounding the unspeakability of abuse is also crucial; otherwise, the patient's internal working models are inadvertently validated, and the therapeutic space risks becoming yet another place where one must hide (Binik & Hall, 2014; Gewirtz-Meydan, 2022; Gewirtz-Meydan & Ofir-Lavee, 2021). According to Gabbard (2014), there are always four individuals present in the therapy room: the victim, the therapist, the aggressor, and the silent witness. The patient will enact these identifications, along with dissociated affects. For this reason, working with survivors of abuse is profoundly complex and requires the therapist to engage in deep personal work. It is essential for the therapist to avoid identifying as the savior, as the patient needs to feel they have the internal resources to rescue themselves. Identification with the silent witness or the aggressor would be equally damaging, as these stances risk re-traumatization. The therapist must therefore maintain an ethical stance, carefully modulating their own affects to allow for reparative processes while safeguarding the boundaries of the therapeutic setting (Mucci, 2024).

Given the centrality of the mind-body connection discussed earlier, Van der Kolk (2015) suggests that therapy must help the patient approach the body and its feared sensations, integrating them through practices such as mindfulness and yoga. However, the dialogue between psychoanalysis and neuroscience allows for further advancements. While Freud believed that the talking cure could abreact affects linked to trauma, Ferenczi understood that when trauma has deeply marked the body, verbal therapy at a purely intellectual level is insufficient. According to Mucci, who has developed a psychoanalytic technique for trauma that gives special attention to the body, it becomes essential to establish a form of analysis that helps repair what has been torn: namely, the relationship between mind and body, as well as between past and present (Mucci, 2014, 2020, 2024).

To move beyond a merely intellectual level – taking into account recent neuroscientific findings that support Ferenczi's theory – therapy can be based on the right hemisphere (Schore, 2019). Indeed, not only is the patient a mind-body system, but so is the therapist. In the context of empathic listening, the therapist can offer an embodied witnessing that allows the

patient to feel heard and held, and to understand that, through the therapist's gaze and presence, trauma can be narrated and relived together in a wholly safe space – sustained, as Ferenczi (1932b) taught, by the analyst's love for the patient. In this way, psychoanalysis can serve a powerful function: helping the patient feel that, despite their painful agony, life is still worth living – using as antidotes not only interpretation but also authentic tenderness. This lays the groundwork for building a sense of trust, overcoming psychic splitting, and integrating fragmented parts within the therapeutic relationship (Mucci, 2024; Ferenczi, 1932b). A *vis-à-vis* therapeutic relationship allows for deep right-hemispheric connection through mirroring processes, making co-transferential experiences possible. Such attuned relating supports not only cognitive processes but also allows the analyst's body to be used by the patient to reinscribe into the self and body those dissociated elements, making them reintegrable. These dissociated parts, processed *via* right-hemispheric mirroring, are then elaborated by the patient's left hemisphere, which creates both meaning and the possibility of expression through language – language that, in turn, is reintegrated into the right hemisphere, enabling a more profound and holistic understanding (Gallese, 2009; Mucci, 2020).

Moreover, considering the prior discussion of identification with the aggressor and the related emotional experiences, a fundamental task of analysis is to support the patient in disidentifying from both the position of the victim and that of the persecutor, guiding them toward reclaiming their agency beyond the trauma (Gewirtz-Meydan & Ofir-Lavee, 2021; Mucci, 2013). In *Essere e divenire* (2015), Michele Minolli writes that the inherent tendency of every 'I-subject' is to realize itself – that is, to assert itself through a dynamic act of will. Others, including the therapist, exist and play a fundamental role, but it must never be forgotten that it is the patient who actualizes themselves. Indeed, all therapeutic approaches agree on the essential goal of patient empowerment. Since trauma fosters a sense of helplessness, healing must involve restoring a sense of self as capable of acting in the world – an appropriation of one's identity that enables the emergence of an 'I-subject'. Through this, the patient can recover initiative, competence, and identity, as well as the capacity to trust and form intimate connections with others (Gayford, 1975; Minolli, 2015; Mucci, 2020). Therapy also provides a vital experience of connectedness, helping individuals feel human, part of a community, and thus able to assert themselves in the world. Psychoanalysis, then, can enable the patient – understood as an 'I-subject' – to face and rework the 'there and then' of trauma, but more importantly, to relocate themselves in the here and now, reclaiming not only their body, but also their time and unique mode of self-assertion – inhabiting the world and their own becoming (Minolli, 2015; Mucci, 2013). Psychoanalytic psychotherapy thus fosters deep empowerment and reestab-

lishes the connection between mind and body. Healing from symptoms will reflect broader transformation across multiple domains of functioning, including relational and sexual dimensions. With significant analytic work, the patient may eventually be ready for more specific sexological integration to address sexual dysfunctions, where necessary, grounded in a body that is fully integrated and ready for further therapeutic stimulation (Gewirtz-Meydan & Ofir-Lavee, 2021).

Limitations, strengths, and future perspectives

A significant strength of this work lies in its integrative approach and the attempt to foster dialogue between different disciplines and therapeutic frameworks. To the best of my knowledge, there are no other works quite like this one. A major limitation, however, is the restricted word count – further reduced from the original version presented at the IFPS Forum 2024 – which has hindered a more in-depth exploration of the concepts discussed. Indeed, the multidisciplinary nature of the work is both a strength and a limitation, particularly where precision may have been lacking. Given that few studies to date have investigated the relationship between childhood sexual abuse and sexual dysfunctions, there is a clear need for further research into this phenomenon.

Conclusions

In conclusion, childhood sexual abuse has the potential to devastate an individual both psychologically and physically, profoundly disrupting the possibility of connection between mind and body. Dissociated affects often find expression through the body, which becomes particularly detached from the mind and may develop genuine somatic pathologies through neurophysiological, neuroendocrine, pain-related, and autoimmune processes. Within the sphere of sexuality, the phantoms of such traumatic pasts resurface in the present through painful memories, dangerous identifications, or as symptoms, such as sexual dysfunctions. Neuroscientific discoveries provide key insights that not only help guide psychoanalytic work with patients, but also support certain psychoanalytic contributions, especially those of Ferenczi. In such a symptomatic configuration, analysis can enable the patient to work through trauma by reclaiming and integrating dissociated parts of the self, bringing together not only past and present, but also mind and body, thereby yielding a consequent benefit in the symptomatology observed within the sexual domain. This process fosters a renewed sense of trust in others and in the world, enabling profound empowerment.

REFERENCES

Baldwin, D. V. (2013). Primitive mechanisms of trauma response: An evolutionary perspective on trauma-related disorders. *Neuroscience & Biobehavioral Reviews*, *37*(8), 1549-1566.

Basson, R. (2012). The recurrent pain and sexual sequelae of provoked vestibulodynia: A perpetuating cycle. *The Journal of Sexual Medicine*, *9*(8), 2043-2051.

Bear, M.F., Connors, B.W. & Paraiso, M.A. (1996). Williams &Wilkins (Trad. it.: Neuroscienze. Esplorando il cervello. 4ª ed. Traduzione e adattamento a cura di A. Angrilli et al., Edra LSWR S.p.A. 2016).

Binik, Y. M., & Hall, K. S. K. (2014). *Principles and Practice of Sex Therapy*, Fifth Edition. Guilford Publications.

Bradford, A., & Meston, C. M. (2006). The impact of anxiety on sexual arousal in women. *Behaviour Research and Therapy*, *44*(8), 1067-1077.

Chaitow, L. (2007). Chronic pelvic pain: Pelvic floor problems, sacro-iliac dysfunction and the trigger point connection. *Journal of Bodywork and Movement Therapies*, *11*(4), 327-339.

Danese, A. (2020). Annual research review: Rethinking childhood trauma–new research directions for measurement, study design and analytical strategies. *Journal of Child Psychology and Psychiatry*, *61*(3), 236-250.

Danese, A., Pariante, C. M., Caspi, A., Taylor, A., & Poulton, R. (2007). Childhood maltreatment predicts adult inflammation in a life-course study. *Proceedings of the National Academy of Sciences*, *104*(4), 1319-1324.

Darwin, C. (1859). *On the origin of species by means of natural selection.* John Murray.

Ferenczi, S. (1932a). *The Clinical Diary of Sándor Ferenczi* (J. Dupont, Ed.; M. Balint & N. Jackson, Trans.). Harvard University Press (Trad. it.: Diario clinico. Gennaio-ottobre 1932 [G. Carloni, Ed.; 1a ed.] Cortina, 1988).

Ferenczi, S. (1932b). *Confusion of tongues between adults and the child*. In J. M. Masson (Ed.), The Assault on Truth: Freud's Suppression of the Seduction Theory (Appendix C, pp. 231-236). Faber & Faber (Trad. it.: Confusione delle lingue tra adulti e bambini. In J. M. Masson [Ed.], Assalto alla verità. La rinuncia di Freud alla teoria della seduzione [Appendice C]. Mondadori, 1984).

Freud, S. (1892). *Letter to Josef Breuer* [Lettera non pubblicata]. Unpublished manuscript, Freud Archives, London (Trad. it.: Lettera a Josef Breuer, 29 giugno 1892. In Abbozzi per la Comunicazione preliminare [Opere 1]. Bollati Boringhieri, 2003).

Freud, S. (1896). *The aetiology of hysteria* [Über die Ätiologie der Hysterie]. Wiener klinische Rundschau (Trad. it.: Etiologia dell'isteria. In Opere 2 [pp. 331-360]. Bollati Boringhieri, 1968).

Freud, S. (1925). *Selbstdarstellung* [Autobiographical study]. In L. R. R. Grote (Ed.), *Die Medizin der Gegenwart in Selbstdarstellungen* (Vol. 4, pp. 1-52). Leipzig: Felix Meiner Verlag.

Freud, S. (1985). *Minute K: Die Abwehrneurosen* (Weihnachtsgeschichte) [Minute K: The Defense Neuroses (Christmas Tale)] [Manoscritto inedito]. Freud Archives, London (Trad. it.: Minuta K: Le nevrosi da difesa [Favola di Natale] [Opere 2, Progetto di una psicologia e altri scritti 1892-1899]. Bollati Boringhieri, 2002).

Gabbard, G. O. (2014). *Psychodynamic psychiatry in clinical practice*. American Psychiatric Pub.

Gallese, V. (2009). We-ness, embodied simulation, and psychoanalysis: Reply to commentaries. *Psychoanalytic Dialogues*, *19*(5), 580-584.

Gayford, J. J. (1975). Battered wives. *Medicine, Science and the Law*, *15*(4), 237-245.

Gewirtz-Meydan, A. (2022). Sexual dysfunction among childhood sexual abuse survivors: The "functional" dysfunction? *Journal of Sex & Marital Therapy*, *48*(7), 694–705.

Gewirtz-Meydan, A., & Godbout, N. (2023). Between pleasure, guilt, and dissociation: How

trauma unfolds in the sexuality of childhood sexual abuse survivors. *Child Abuse & Neglect*, *141*, 106195.

Gewirtz-Meydan, A., & Ofir-Lavee, S. (2021). Addressing sexual dysfunction after childhood sexual abuse: A clinical approach from an attachment perspective. *Journal of Sex & Marital Therapy*, *47*(1), 43-59.

Gewirtz-Meydan, A., & Opuda, E. (2022). The impact of child sexual abuse on men's sexual function: A systematic review. *Trauma, Violence, & Abuse*, *23*(1), 265-277.

Graziottin, A., Murina, F., Gambini, D., Taraborrelli, S., Gardella, B., & Campo, M. (2020). Vulvar pain: The revealing scenario of leading comorbidities in 1183 cases. *European Journal of Obstetrics & Gynecology and Reproductive Biology*, *252*, 50-55.

Koenigs, M., & Grafman, J. (2009). Posttraumatic stress disorder: The role of medial prefrontal cortex and amygdala. *The Neuroscientist*, *15*(5), 540-548.

Komisaruk, B. R., Del Cerro, M. C. R., & Goldstein, I. (2023). Orgasm utilizes the pain pathway: Is orgasm "nonaversive pain"? *Sexual Medicine Reviews*, qead037.

Lanius, R. A., Williamson, P. C., Densmore, M., Boksman, K., Gupta, M. A., Neufeld, R. W., Gati, J. S., & Menon, R. S. (2001). Neural correlates of traumatic memories in posttraumatic stress disorder: A functional MRI investigation. *American Journal of Psychiatry*, *158*(11), 1920-1922.

LeDoux, J. (2012). Rethinking the emotional brain. *Neuron*, *73*(4), 653-676.

Mancia, M. (2006). Implicit memory and early unrepressed unconscious: Their role in the therapeutic process (How the neurosciences can contribute to psychoanalysis). *The International Journal of Psychoanalysis*, *87*(1), 83-103.

Mancia, M. (2003). Dream actors in the theatre of memory: Their role in the psychoanalytic process. *The International Journal of Psychoanalysis*, *84*, 945-52.

McEwen, B. (2002). Sex, stress, and the hippocampus: Allostasis, allostatic load, and the aging process. *Neurobiology of Aging*, *23*(5), 921-939.

McEwen, B. S., & Kalia, M. (2010). The role of corticosteroids and stress in chronic pain conditions. *Metabolism*, *59*, S9-S15.

McEwen, B. S., & Stellar, E. (1993). Stress and the individual: Mechanisms leading to disease. *Archives of Internal Medicine*, *153*(18), 2093-2101.

McWilliams, N. (2011). Psychoanalytic diagnosis: Understanding personality structure in the clinical process (2nd ed.). Guilford Press (Trad. it.: La diagnosi psicoanalitica [2ª ed.]. Astrolabio, 2012).

Meston, C. M., Rellini, A. H., & Heiman, J. R. (2006). Women's history of sexual abuse, their sexuality, and sexual self-schemas. *Journal of Consulting and Clinical Psychology*, *74*(2), 229-236.

Minolli, M. (2015). *Essere e divenire. La sofferenza dell'individualismo*. Franco Angeli Editore.

Mitchell, J. P., Banaji, M. R., & Macrae, C. N. (2005). The link between social cognition and self-referential thought in the medial prefrontal cortex. *Journal of Cognitive Neuroscience*, *17*(8), 1306-1315.

Mucci, C. (2013). *Trauma e perdono. Una prospettiva psicoanalitica intergenerazionale*. Raffaello Cortina Editore, 2014.

Mucci, C. (2014). Trauma, healing and the reconstruction of truth. *The American Journal of Psychoanalysis*, *74*(1), 31-47.

Mucci, C. (2020). *Corpi borderline. Regolazione affettiva e clinica dei disturbi di personalità*. Raffaello Cortina Editore.

Mucci, C. (2024). *Psicoanalisi come testimonianza. Il trauma da Freud a Ferenczi ai contemporanei*. Luigi Guerriero Editore.

O'Driscoll, C., & Flanagan, E. (2016). Sexual problems and post-traumatic stress disorder following sexual trauma: A meta-analytic review. *Psychology and Psychotherapy: Theory, Research and Practice*, *89*(3), 351-367.

Porges, S. W. (2003). The polyvagal theory: Phylogenetic contributions to social behavior. *Physiology & Behavior*, *79*(3), 503-513.

Prela, A. (2024). Il mondo dell'isteria. *Ricerca Psicoanalitica*, *2*, 535-552.

Rauch, S. L., Whalen, P. J., Shin, L. M., McInerney, S. C., Macklin, M. L., Lasko, N. B., Orr, S. P., & Pitman, R. K. (2000). Exaggerated amygdala response to masked facial stimuli in posttraumatic stress disorder: A functional MRI study. *Biological Psychiatry*, *47*(9), 769-776.

Schore, A. N. (2019). *Psicoterapia con l'emisfero destro* (C. Mucci & A. Greco, Trans.). Raffaello Cortina Editore (Original work published in 2019).

Schore, A. N. (2023). *Il sé implicito basato sull'emisfero destro: Un meccanismo centrale del processo di cambiamento in psicoterapia*. In C. Mucci (Ed.), Psicoanalisi come testimonianza. Il trauma da Freud a Ferenczi ai contemporanei (pp. xx-xx). Luigi Guerriero Editore.

Shonkoff, J. P., Boyce, W. T., & McEwen, B. S. (2009). Neuroscience, molecular biology, and the childhood roots of health disparities: Building a new framework for health promotion and disease prevention. *Journal of the American Medical Association*, *301*(21), 2252-2259.

Van der Kolk, B. (2015). *Il corpo accusa il colpo*. Raffaello Cortina Editore.

Westerlund, E. (1992). *Women's sexuality after childhood incest* (pp. xii, 241). W.W. Norton & Co.

Williams, L. M., Kemp, A. H., Felmingham, K., Barton, M., Olivieri, G., Peduto, A., Gordon, E., & Bryant, R. A. (2006). Trauma modulates amygdala and medial prefrontal responses to consciously attended fear. *NeuroImage*, *29*(2), 347-357.

Conflict of interests: the author declares no potential conflict of interests.

Ethics approval and consent to participate: not required.

Further information: the original version of this paper was presented at the IFPS Forum on October 26, 2024, in Bergamo, Italy.

Received: 1 May 2025.
Accepted: 27 May 2025.

Licensee PAGEPress, Italy
Ricerca Psicoanalitica 2025; XXXVI(s1):1039
doi:10.4081/rp.2025.1039