In connection with controversial IJP articles by Stern et al. and Fonagy on the interpretation of the repressed and the recovery of past memories, the author maintains that the affect that is inherent in positive transference is at the heart of therapeutic action. Points of view put forward in the controversy (based on neurobiological knowledge) are related to Freudian metapsychology, as well as to their precursors whose scope was necessarily limited by a lack of access to more recent scientific discoveries. The author demonstrates metapsychological elements of therapeutic action inherent in the intersubjective relationship, especially identification, manifested in introjection and empathy. He describes cognitive development as spontaneously blossoming from the affective nucleus, and he explains the neuroscientific bases of this step forward. The classic (interpretative) psychoanalytic method makes up the cognitive superstructure necessary for the organisation of the mind that has sprung from the affective substratum. As a primary factor in psychic change, interpretation is limited in effectiveness to pathologies arising from the verbal phase, related to explicit memories, with no effect in the pre-verbal phase where implicit memories are to be found. Interpretation—the method used to the exclusion of all others for a century—is only partial; when used in isolation it does not meet the demands of modern broad-spectrum psychoanalysis, as the clinical material presented illustrates.

**Keywords:** implicit memory, metapsychology, transference, empathy–introjection

dyad

*IJP* papers by Stern et al. (1998) and Fonagy (1999) provoked a controversy which is likely to bode well for the future of psychoanalysis, since, by calling into question the importance of the interpretation of the repressed and the recovery of past memories, these authors open the way to some very fertile thinking on the nature of therapeutic action. By proposing the abolition of the ‘archaeological metaphor’, the papers deprive interpretation of its prerogative as the principal agent of psychic change, transferring this to the intersubjective relationship itself: ‘The removal of repression is no longer considered to be a key to therapeutic action. Psychic change is a function of a shift of emphasis between different mental modes of object relationships’ (Fonagy, 1999, p. 218). There followed various contributions to this debate, both supporting and opposing this revolutionary position. Ryle (2003) refers to Stern et al. preaching the dismantling of the rules that make up the *setting* in order to give greater space to the ‘moment of meeting’—according to Stern et al. this peak of intersubjectivity would justify damaging the analytic situation. Ryle criticises

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1Translated by Daniel Hahn.
them for not replacing the norms they have abolished with others that make up a new method, thus transforming the process of analysis into anarchy. He thus deepens the split by replacing the conventional method by another which he calls **analytic-cognitive therapy**—this takes innovation to such lengths that it is almost impossible to make psychoanalysis out amid so much cognitive-behavioural activity.

Those who began the controversy make their case with support from neurosciences, particularly the existence of two types of memory located in distinct parts of the brain. One, **explicit memory**, passes through the cortex, and is linked to common associative memories, susceptible of becoming conscious ones. The other, **implicit memory**, is found in various subcortical areas, and is irretrievably unconscious without having been repressed—in other words, it cannot be remembered. Among the sorts of memory to be found in this latter category are: (1) those involved in automatic actions (swimming, riding a bicycle) derived from learning by repetition—in this case called **procedural memory**; (2) those underlying **emotional reactions** which do not depend on the conscious remembering of the facts that generated the primary emotion—**emotional memory**.

In view of this knowledge, any therapeutic effect of interpretation would be secondary, as it concerns explicit memory only, without any effect on implicit memory which is considered of primary importance in therapeutic action. As implicit memory governs automatic actions and emotional responses (whose genesis is not only unconscious but cannot be made conscious through interpretation) we can conclude that its origin can be found through repetition in the transference, as the idea that interpretation can make initial motivations conscious is an illusory one.

In spite of the relevance of some of the criticisms of the reforming proposal, the new vision, if it is adapted to the Freudian concept of the mind as a process of development in which all stages are fundamental, including the verbal stage and that of explicit memories, it is marked out as the most striking element of psychoanalysis in recent times, capable of altering its trajectory and dragging it out of its long and worrying period of stagnation.

**The precursors of the new ideas**

Notwithstanding the revolutionary aspect of a confrontation with the hegemonic power of interpretation for the recovery of events lost in time, its motivation (as concerns the primacy of the relationship) is nothing new; for some time people have been pointing out the manifestation in the transference of object relations at a pre-verbal stage, which cannot be captured in words. What is new here is the use of objective scientific knowledge to support long-standing observations, allowing us to develop them now with greater conviction. Since the papers that instigated the controversy omitted any discussion of the steps that preceded them, it would be sensible to offer a brief retrospective of the advances that brought us towards these newly revealed horizons, in preparation for presenting one of the key points of this paper: namely, that Freudian metapsychology is an adequate theoretical system not only to protect past hypotheses but also to accept current and future developments. This swift retrospective becomes necessary above all when one notices that the
papers constituting the debate contain only a partial view of the Freudian concept of the unconscious, erroneously confused with the repressed.

Freud had already questioned the absolute effectiveness of interpretation when he considered positive transference as the irreplaceable emollient for dissolving resistance, stating that psychoanalysis stopped being merely an interpretative art (1920, p. 18). He was then struggling with the limitations of psychoanalysis, which faltered in cases of serious defence neuroses and was harmless at best in narcissistic neuroses (1919, pp. 165–6). He announced the need for a new technique for these latter, hoping to make it feasible when exploring the essence of the ego, the seat of narcissistic pathology. He believed that, when he found the ego-psychotherapy that he was looking for, he would be in a position to carry out the ‘greater task’ of psychoanalysis; under these circumstances he would have a ‘low opinion’ of the knowledge obtained through research into the repressed libido (1916–7, pp. 422–3).

As it turned out, he was unable to create the technique founded in the ego which would enable the ‘greater task’, but he did leave clear indications of the path that ought to be taken: (1) the idea that the ego and the id have a common hereditary origin, becoming distinguished subsequently according to a plan that is genetically defined (1937a, p. 240); (2) the ego presents developmental alterations which have no relationship to its defensive activities (1937a, p. 240); (3) the personality of the analyst plays a part in therapeutic action (1937a, p. 248); (4) identification, a crucial factor in the structuring of the ego, is the first affective relationship, preceding object relations (1921, p. 105, 1923, p. 31). Further, in his final paper on technique (1937b, pp. 261, 265–6) he adds that he drastically reduced the scope of interpretation, saying that he considers the analyst’s most important work to be construction. With this new concept he assumed that the past constructed by the analyst was enough to convey conviction to the patient, even without the patient being able to remember consciously.

These elements, which are so important for the discovery of the appropriate technique, were not articulated by post-Freudians to provide an internal coherence to the metapsychological system and bring it into harmony with intersubjective relations. The object-relations school, although it did start from an observation of the limitations of analysing the repressed, seems not to have noticed that Freud had seen this too, even if his statements on the subject were rather obscured by the emphasis that had previously been put on the erroneous equivalence of the repressed and the unconscious. This explains why the multiple implications of the structural theory on object relations have not been explored, owing to the underestimating of the revolutionary reach of the theories of the ego and narcissism. In turn, the current of thinking on object relations produced no convincing theory to replace Freud’s, leaving a gap that resulted in the maintaining of the technical parameters of the analysis of the repressed whose ultimate aim is interpretation.

After Freud (1920, p. 18) had pointed out the effectiveness of positive transference as a decisive factor in overcoming those resistances that are not susceptible to interpretation, the role of the affect became transparent, despite the absence of any theoretical conceptualisation to match its transcendence, as it had always been one of psychoanalysis’s blind-spots. Although she did make the role of the object in the formation of the mind explicit, Klein privileged the interpretative
goal, without any exploration of the essentially structuring factor of the relationship, while baby observations (Spitz, 1945) showed the effects of positive affect, a lack of which can damage babies’ development. Winnicott revealed the importance of the relationship itself in the treatment of more badly damaged patients, though he did not support the practical benefits with any all-encompassing theory. Kohut (1971, 1984), taking an unconventional position, drew attention to empathy in the treatment of narcissistic personalities, using it as a structuring tool in its own right rather than as an intermediary phase towards final interpretation. But his technique was compromised by the creation of new psychoanalysis, with which he steamrollered over Freudian metapsychology with the dispensable idea of the structural self, bringing division rather than union.

**Freudian metapsychology as a container for innovation**

One of the obstacles to the realisation of the ‘greater task’ has been the fear of infringing the established technique, a technique whose inadequacies even Freud himself denounced. I believe that neuroscientific knowledge can provide security to those who are aware of the deficiencies in conventional methods, encouraging them to adopt with conviction a position compatible with current science. This position implies an admission that psychoanalysis has kept to the paradigm founded in 19th-century knowledge, even as 21st-century science is opening up for it the most generous new frontiers. This does not mean to make the apology of careless transgression, but of working to build a greater psychoanalysis. Notwithstanding the continuing importance of the repressed libido, it has now become part of something more extensive. The understanding of the body ego and its development as psychological ego, as well as the discovery of a theoretical position for affect, provides the opportunity for an entry into a new dimension, one which must include the possibility of living together with neuroscience. Once affect expresses a bodily discharge (Freud, 1915b, p. 179), felt as a psychic fact encompassing the environmental context related to discharge (Damásio, 1994, p. 159), and the ego emerges from this somatic/psychic event (Freud, 1923, p. 26), the genesis of the affective phenomenon must be considered at the intersection of psychology and biology.

It is worthwhile, then, having some commentary on the omission of the steps that preceded the controversy now under discussion. With regard to the ‘forgetting’ of Freud, I would like to make reference to Ryle’s (2003) critical reflection on Stern et al.’s (1998) claim, supported by Fonagy (1999), that implicit memory has no representational content, that it would only ever exist in the verbal stage. Ryle draws our attention to pre-verbal forms of communication that presume the existence of representation:

> the assumption that the pre-verbal infant is pre-symbolic should be questioned … infants are capable of ‘non-linguistic, symbolic-like transformations, abstract ‘thinking’ and ‘pre-thinking’ … Thus the joint action sequences of mother–infant activity are precursors of sign-mediated communication (2003, p. 111).

It is true that Ryle uses this argument to support the idea that these precursors are the means by which implicit memory can become conscious, which contradicts the heart of the theory that generated this controversy in the first place.
This is where the Gordian knot of this matter is to be found: although in theory Ryle is correct as regards pre-verbal representations, clinical practice demonstrates that there are memories which are unequivocally irretrievable. However, the existence of representation at pre-verbal stages is vital to the understanding of implicit memory in the transference relationship and its contribution to psychic change. To define this phenomenon in a more refined way, it is necessary to go back to what Freud (1937a, p. 225) called *witch metapsychology*, again expressing some regret that this has not been brought into discussions of the controversy.

Affective experiences which register as implicit memory do seem to me to fit into what Freud (1915b, p. 178) called *unconscious affective structure*—which contains representations whose cathexis (quotas of affect) are discharged as affects. In the transference these quotas of affect are moved to other representations (Freud, 1900, 1915a, 1915b). Even if the transference manifestation as repetition makes up the automatism that is characteristic of implicit memory, it is accompanied by an unconscious representation, whose content is concrete in nature (*Sachvorstellung*), and makes up the affective structure. This differs from the affect itself, which is conscious bodily discharge, while the unconscious affective structure is thing-presentation (mnemic register cathected by the quota of affect), the nucleus from which the affective discharge repeated in the transference can arise.

It seems to me that the omission of this point by those who have contributed to this polemic is a result of the inaccurate idea of the unconscious being equated to the repressed, a conception that Freud abandoned when he saw that the ego too can be unconscious, just like the repressed (1923, pp. 18–9). The old formula of ‘making the unconscious conscious’ was superseded, and the ultimate aim became the development of the ego (1933, p. 80). Through concepts of thing-presentation, *primary repression* (a representation which was never conscious), *unconscious affective structure*, *unconscious ego* and *construction without remembering*, Freud seems to have been talking about implicit memory, even if he never used this term nor ever developed the concept of the unconscious affective structure, a subject I have discussed elsewhere (Andrade, 2003).

If we consider the pre-verbal symbolism Ryle refers to as equivalent to Freud’s concrete symbolism, which would fashion an unconscious thought that consciousness is as yet unable to perceive, we can conclude that there is a mind which remains unconscious even after it has overcome the primary process inherent in the regulation by the pleasure–unpleasure automatism (Freud, 1900, p. 574). At this stage of development, the mind works with characteristics of unconscious fantasy—which, even when genuinely unconscious, follows the rules of preconsciousness (1915b, pp. 190–1). So we see that this process begins with feelings of pleasure–unpleasure, whose registers generate concrete representations; after they have been gathered and linked together associatively, these then lead to the overcoming of automatic sensory regulation while remaining unconscious. Such representations are then linked to the ‘mnemonic system of indications of speech’ to form the word-presentation (*Wortvorstellung*), only then becoming conscious (1900, p. 574). The process as a whole makes up a continuum that includes hallucination as an initial step, unconscious, non-verbal thought (including unconscious fantasy) as an
intermediate stage, and ultimately verbal thought. Each stage of this continuum is characterised by the way in which the quota of affect occupies the mnemonic system to make up a representation. At first, occupying the first thing-presentation, the cathetic energy has a marked tendency to be discharged as affect. As the quantity of mnemonic registers increases, so the energy tends to be linked more strongly to multiple representations, and its tendency to be discharged is reduced, leading to the overcoming of automatic sensory regulation.

The stages of the continuum are repeated in the analysis, with the respective quotas of affect being transferred to the analyst. A patient with very intense transference affects is probably repeating experiences from the pre-verbal phase regulated by the pleasure–unpleasure automatism. The action manifested by concrete symbolism (picking secretions from his nose as an expression of coprophilia and anal auto-erotism) can also be repeating the pre-verbal stage, but no longer under the aegis of primary automatic regulation. In such cases, the concrete content of the original registers cannot be recovered by consciousness, but its quotas of affect cathect other representations that are susceptible to consciousness. It is cathetic mobility that makes the necessary space for psychic change, the essential engine of which is the transference—so the primary element of change is not interpretation but the analyst’s attitude when faced with the transference. His position involves not merely listening in an understanding way, but also providing a dialogue that provokes the construction of new affective structures. Previous representations are not transformed into new ones; they are just emptied of their quotas of affect, transported to new representations that have emerged from the analyst’s behaviour. It is an economic factor, not a topographical one, that reveals itself as the agent of change: the representation stays where it is; it is the quota of affect that changes. Or to put it another way, implicit memory does not become explicit, as Ryle suggests, but its quota of affect is linked through a new representation that makes up explicit memory.

**Demonstrations that affect is the primary factor for change**

It is possible to deduce that psychic change is not carried out by the ideational content of representation, but by the affective content, hence the idea that it is the transference that is the key factor in analysis, with interpretation complementing it. The correctness of this conclusion can be demonstrated by the existence of different theories in very diverse regions, occasionally making it difficult for colleagues from different schools to understand each other.

In spite of such stark differences between distinct theoretical lines, there is no apparent difference between their practical results, whether positive or negative, a fact which seems to be common whatever country or continent you may choose to examine. What is more, analysts at the start of their careers sometimes meet with greater success when dealing with severe pathologies than their more senior, more experienced colleagues. Strictly speaking, one cannot say that on average any one region is better than any other in terms of clinical successes. And, if this is indeed the case, the results should not be attributed to the theories, but rather to the way in which the transference is managed—in other words, the affective part of the
relationship. The theoretical content of interpretation, while important, is secondary. More crucial are the key components of the method: the setting, the fundamental rule and the attitude of the analyst, this latter including empathy, wisdom in knowing how to deal with the transference, a skill in ‘good timing’, the exposing of clear and coherent ideas at a suitable level for the patient’s concrete understanding, and behaviour that is transparent and honest.

For this reason, whatever the evidence that implicit memories cannot be retrieved into consciousness, it is still common for adult patients to be told that they want to devour the analyst’s breast, which can easily sound like so much unhelpful nonsense. Yet, if the patient is in a positive transference, this nonsense might contribute towards his wellbeing. However, this result should not be confused with the patient’s consciousness of a desire to devour the analyst’s breast, as we are dealing here with material that cannot be evoked. In truth, the content of the interpretation per se is totally innocuous, just producing wellbeing through the positive affective context of intersubjective relations. In such circumstances, what the analyst says is immaterial, just as a baby can happily fall asleep being gently rocked by its mother, even if the lullaby warns, very alarmingly, that ‘When the bough breaks,/The cradle will fall;/Down will come baby,/Cradle and all’.

Once again is it worth drawing on neuroscience to explain this phenomenon by means of priming memory, which is one kind of implicit memory. This relates to shapes and appearances, which can include words and sounds that are totally free of semantic connotation (Pally, 1997). In this case, it is the affective content of the analyst’s voice—and not the semantic content—that has an impact on the patient’s store of implicit memories.

A metapsychological description of psychic change

It is beyond doubt that method should be rooted in scientific theory. That is why I stated that the controversy cited above, if adapted to the Freudian theoretical system, could revolutionise psychoanalysis. If we already have metapsychological concepts covering clinical experience, then when we bring in neurobiological knowledge it is preferable that we incorporate it into the pre-existing system, especially when this system was originally assembled as a natural science that one day could be held up alongside biology. This theoretical reference point attributes identity to psychoanalysis as an autonomous science, a necessary condition for it not to become depersonalised, that is, becoming a cultural science attached to philosophy or, as now, an appendix to neuroscience. With its own identity, it can receive contributions from all sides, but it is necessary that its psychological premises are defined—until now, it seems, this has not been possible outside Freudian metapsychology.

Once we have pointed out the error in treating implicit memory using the interpretative method, we can understand in metapsychological terms what happens when we have to direct our focus to affective reliving. In the analytic setting, where the patient acts out his affective history, the analyst participates in the repetitive enactment using a part of his ego which is capable of accompanying the patient in his regressive transference immersion while at the same time remaining an observer of the double
regression: his own, and that of the patient. The two people in regression come together for a common primary identification that in the analyst is manifested as empathy that is capable of tuning in to the patient’s feelings, while in the patient it appears as the introjection of the empathetic analyst, which leads to the patient’s ego being changed.

When dealing with phenomena that occur in affective structures with no access to consciousness, we must acknowledge that changes take place as a result of affective factors and not cognitive ones. If we then reach the conclusion that the restructuring of the mind springs from the affective empathy–introjection dyad, what, then, is the role of the non-regressed ego of the analyst observing the process?

In fact, its functions are various: (1) it supplies the solidity necessary for the regression which leads to the capacity for empathetic identification; (2) it recognises the nature of the autoregressive process and integrates it to its synthesising function; (3) it communicates verbally with the non-regressed ego of the patient (the absence in the patient of an intact part of the ego would make analysis impossible). The dialogue between the non-regressed egos creates the conditions that allow the affective change to become integrated with cognition, even if the affects of implicit memory never do become conscious.

Metapsychology and its interface with neuroscience

This is a metapsychological description of therapeutic action. But, just as we make use of objective scientific knowledge to demonstrate the limitations of the interpretative technique, do we then use these same means to show that the affective relationship is at the root of therapeutic action? Can we justify the hypothesis that the empathy–introjection dyad is at the heart of psychic change? I believe we can. Experiments described by Hofer (1995) show that baby rats which have strayed from their mother react with anxiety, with significant physiological change similar to those in a human baby in the same situation, then revert to their normal state when the mother is near again. According to Shanberg (quoted in Barnes, 1988), rats that are not licked by their mother experience stunted growth. Hofer (1995) states that separations between adult humans have relevant somatic effects. Schore (1994, 1997) writes that when babies interact with adults (especially at ages 6–12 months) the production of dopamine in their mesencephalic region increases (this is the neurotransmitter that is given off in the orbitofrontal cortex where it results in an enlargement of the neural circuits related to cognition and the regulation of emotions). Thus, an affective factor (such as interaction with an adult) helps to develop cognition and regulate emotion; this in turn suggests that a lack of adequate affective stimuli can have a negative effect on cognition and the control of emotion. In fact, Teicher (2002) describes how victims of abuse in infancy show a reduced left cerebral hemisphere compared to a control group who have been treated normally. Kandel and Hawkins (1992) and Kempermann and Gage (1999) show that damaged nervous tissue can be restored with the appropriate stimuli.

By bringing together these data, we can deduce that: (1) inadequate object relations can lead to neurophysiological changes; (2) adequate analytic relations lead to psychic changes that correspond to neuronal changes. In an attempt to include
these links in the context of an inclusive psychoanalytic theory, I will sketch a brief description to illustrate the key role played by metapsychology in harmonising the languages of psychoanalysis and neuroscience.

Freud may have been thinking about something like these links described above when he claimed that psychoanalysis is a natural science, one whose hypotheses would one day be able to be explained in biological terms (1895, 1914, 1920, 1938a, 1938b). When he carried out his study of the ego and showed its physical origins, he also noticed the limitations of the psychology of the repressed. His redefinition of the ultimate goal of psychoanalysis was categorical: this goal ceased to be making the unconscious conscious and became instead the development of the ego (1933). Structural psychology suggests that (given its physical nature) the ego can have its natural development damaged by the object’s failure to supply the necessary conditions for this development (1937a). Beyond its genetically inherited origin, the development of the ego is based on perceptions, mainly from the body and its sensations; from these come the primary identifications that suggest the presence of affective links that precede object relations (1923). So structural faults in the ego are a result of the incapacity of the object to provide for the baby’s affective needs, resulting in the introjection of a deficient (bad) object. The transference-replication of this primitive atmosphere creates conditions in which the analyst becomes a good object, leading to his being internalised with this characteristic; and it is there that his capacity to exert the desirable influence on the patient’s psychic structure resides.

From the evidence brought to us by neuroscience that the mind is the operational manifestation of the brain, we can conclude that when we talk of psychic change we are also referring to a corresponding somatic change. In this sense, the concept of the body ego is vital. When we say that the introjection of the analyst modifies the patient’s ego, discoveries in neuroscience let us assume that when he becomes a good object affective interaction can promote the development of new neural circuits which in turn—although they spring from neurotransmitters secreted as a result of emotional responses—develop cognition and regulate emotions. If we consider what happens in the brain during affective interactions, it is not unreasonable to presume that the psychoanalytic method can act upon the cerebral tissue associated with failures of development. When we talk of introjection and psychic change we are simply describing in metapsychological terms what is taking place neurochemically. It is appropriate to reason in this way if you believe in a brain–mind continuum, where the existence of psychic phenomena which are not an expression of some activity in the brain is inconceivable. As regards the basis of therapeutic action, I believe that there are good reasons for accepting what I have been describing. Even at worst this way of examining psychoanalysis allows objective research to put these perspectives to the test.

**Illustrations from clinical practice**

**Patient A**

Although the factors described above may reflect the day-to-day experience of any psychoanalyst, I would like to offer a couple of specific case studies to illustrate
the concepts discussed. Notwithstanding the fact that neuroscientific data have contributed to substantiating these concepts, in the clinical accounts I limit myself to psychoanalytic terminology; I am thus aiming to show that seeking recourse to elements from other sciences does not imply relinquishing hold of our method, but, on the contrary, perfecting it.

A patient presented diffuse feelings of identity and a florid range of pathological symptoms, which did not individually suggest any particular diagnosis. Besides immature behaviour, he could just as easily be hysterical, with passing conversions, histrionic behaviour and inconsistent identifications; or obsessive, with tyrannical control, manifestations of anal sadism and superstitious and omnipotent behaviour. His impulses were excessive; although they were usually encysted in the ego as character traits—an ability to work hard, dynamism, determination, a taste for adventure—his impulses frequently led him astray from there, expressing themselves as conversion, projective mechanisms or reckless and destructive acts. Persistent feelings of self-pity and paranoid self-referent ideation led him to feel himself a victim of the world, which became the reason he gave for his subsequent antisocial behaviour. During a self-referent phase, his ideas were sometimes delirious, usually associated with feelings of rejection, a state in which he often reacted with narcissistic rage (Kohut, 1972). Envy made him predisposed to stubborn aggressiveness, with ‘paranoid micropsychotic episodes’, self-destructiveness as a triumph over the analyst and dishonesty in the transference, characterising what Kernberg (1984, p. 290) called ‘malignant narcissism’. Faced with the lack of a defined psychotic diagnosis into which he could fit, and considering the instability of his multiple pathological symptoms, his pathology could be classified as a severe narcissistic personality disorder, borderline in nature.

His father, a chronic psychotic—that was how he remembered him, as far back as his memories stretched—soon became demented. His mother had a significant narcissistic personality disorder, but she looked after her son as best she could, giving him support and education, in spite of the precariousness of the affective relationship that she was in a position to offer. In his childhood he felt humiliated by his mother, who treated him coldly and strictly; he was ashamed of his father—being quite elderly he was more like a grandfather than a father, quite apart from the fact that he was frequently interned in psychiatric institutions.

He would always arrive at his sessions full of complaints—about people (the analyst in particular), about life in general, with feelings of hatred and desires for revenge, talking about both murder and suicide equally naturally as practicable actions without any associated conflict. He received any observation related to his state with hostility. At the beginning, I was given the impression that he was trying to transform the setting into the chaotic atmosphere familiar to him, provoking me to mistreat him as his parents had done. He behaved like this in all situations, which explains why he did not maintain lasting relationships. He had had four analytic experiences in the past, which had probably been interrupted by countertransference feelings on the part of the analyst. I soon realised the futility of what I was saying to the patient. There was abundant oral, anal and phallic-oedipal material, but interpretations were received with hostility and scorn. References to the transferential nature of
his attitudes were met with derision or fury. He could not bear to be told things he had not expected to hear, and reacted with rage, attempting to exercise tyrannical, suffocating power. In truth, he was seeking to suppress my very existence, as though I should be his echo. It was painful for him to admit my existence as a separate person, since his experiences with primary objects had been so catastrophic. That was why I would have to be careful not to appear different—though it was of course difficult to handle a situation in which I could not manifest myself as a distinct person, which was what generated negative countertransference. In fact, this indicated the need for establishing a primary identification with me, in which there was neither subject nor object. Notwithstanding the negative countertransference, which decreased as I came to know the patient better, I was fascinated by the fact that someone with such a pathology, born amid madness and having spent childhood and adolescence in an atmosphere of insanity, should have managed to get to university, to graduate and get married, without ever experiencing a lasting psychotic outbreak, albeit his lifestyle was a chaotic one. Taking the initiative to go into analysis indicates the existence of a portion of the ego sufficiently healthy to establish a therapeutic alliance and to develop from it. It was a challenge to discover a friendly access to that ego which was so full of bad objects, which was so mistrustful and hostile as a defence to allow it to survive. I was able to confirm that the interpretative method was no longer useful, as a severely damaged ego is unable to make use of interpretations—in fact, rather than thinking (in the sense of ‘reflecting’), his ego needed first to be dressed (in the sense of dressing a wound) in order to acquire the capacity for reflection and elaboration. It was not enough simply to support the ego as one does in superficial psychotherapies, but actually to treat it, to restructure it and develop it, as a really profound psychoanalysis should do.

Over the years, I witnessed the situations I have described. In order to make the analysis possible it was necessary for me to realise that he did not want to drive me crazy, nor did he want to transform the analytic setting into the chaotic atmosphere of his parents’ house as a form of sado-masochistic repetition. It is clear that repetition involves reproducing the original environment, but this does not appear to be its ultimate aim. The environment in which the patient repeats his pre-verbal history systematically rejects him, which explains why he is drawn to people with similar characteristics with whom he is able to interact (albeit in an anarchic way). In an attempt to break this vicious circle it was necessary for him to repeat his affective history in such a way that I would understand it, that is, understand it without rejecting him or reproducing the environments in which he has always lived. In order for me to treat his crazier aspects, the patient needed to bring them as an expression of his shattered ego, but he had to have confidence in his analyst’s capacity to remain undisturbed by his madness, not replacing empathetic identification with introjective identification. This replacement would involve an internalising of the patient’s material, rather than an empathetic understanding of it. Contrary to what I had first supposed, he was not trying to put his bad objects in me in order to attack or control me, but to perform his madness on the analytic stage, taking part in a play in which I would be the director and co-protagonist—corresponding to the analyst’s dual role of understanding the patient and helping
him. The repetition was to result in working through, like the repetitive dreams of unexpected traumatic accidents (Freud, 1920). His need for binding had to be understood if he was to stop compulsively repeating for the rest of his life.

I do not think that the negative countertransference was caused by projective identification (understood as an initiative on the part of the patient to introduce parts of himself into the analyst). Contrary to what I had believed previously, influenced by Klein (1946, 1955), the patient projects in order to rid himself of something uncomfortable. The fantasy that the thing projected belongs to the analyst and not to him shows how his perception is distorted: it remains within the patient’s sphere, in fact, and has no direct impact on the analyst. The countertransference feeling is the responsibility of the analyst, who is identified with the projected material.

In dealing with a most important technical detail, I would like to return to the point where I examined identification in the analytic process in metapsychological terms. The analyst’s feelings of discomfort in cases like this can be explained by his regression in the service of the analysis. What happens is that in order to understand the patient’s affective state the analyst has to identify with him empathetically, which can lead to suffering when faced with psychotic states. Exposing himself to this risk is a part of his job, which means that he must have a sufficiently strong ego that can be divided into one part that regresses to primary identification and another that stays outside the regression. The regressed parts of the egos of analyst and patient come together in a reciprocal double primary identification: in the first, it manifests itself as empathy, making it possible to understand the patient’s state; in the second, as introjection, allowing the internalisation of the analyst as a good object that will alter his internal world. Empathetic identification is a result of the analyst’s capacity to regress in the service of the analysis; the introjective identification from the patient’s regression in service of the ego. The two processes are similar, but distinct: empathetic identification is exclusively perceptive in nature, while introjective identification has a structuring function, storing away the new primary identification as implicit memory. This is the key point of the theory of technique: the structuring described here comes across as implicit knowledge, which remains unconscious (in the ego) just like the original experience with primary objects. In empathetic identification, the ego of the analyst is capable of working over and neutralising what is perceived. When he replaces empathy with introjective identification, the analyst demonstrates his inability to work over the perceived material, and in these circumstances tends to internalise the patient’s madness. In order to protect himself he mobilises various defence mechanisms, some of them radical, which diverts the analysis from its goal. One of these defences consists in a kind of counterprojection, which makes the patient responsible for the countertransferenceal discomfort. This distortion perverts the usual progress of the analysis, as it reveals the analyst’s difficulty in taking on the vulnerability of his ego; under such circumstances the analysis tends to reach an impasse, or becomes superficial. The ego of the analyst is a key part of the therapeutic action; so in this case the cornerstone of the patient’s recovery is pulled away.

I think the patient would pick up in me an attitude that revealed my inclination to ascribe responsibility for the countertransferenceal discomfort to him, since his
aim was not to harm me but to relieve his own suffering. Or at least, if he did want to attack me, the real target was not really me but an object which had been internalised as a bad object, projected in me. It is through this understanding of the state of things that the analyst is able to offer a new model of relationships, one with which the patient is able to identify to change the previous paradigm. In the past the patient’s unusual envy led to offensive behaviour towards me on his part, including threats of legal action—since he belonged to the legal world, when delirious he would accuse me of harming him by charging inflated fees and fraudulently prolonging the course of treatment. His envy made it hard for him to develop social relations, as it led to heightened curiosity that made him interfere clumsily in other people’s privacy. It also led him to belittle people who showed any qualities; this was a serious obstacle to his analysis, as for him to get better he would have to recognise some value in me, which he would ardently deny.

He would sometimes arrive at his session in an altered state, as if possessed, complaining about me and making insolent threats. When I became aware of how ineffective my initial interpretative attitude was in the face of this dissociative state, I could see that it was the manifestation of an epileptoid discharge that had to run its course, at which point he would calm down and could hear me. I understood that my role in such situations was that of a sort of silent exorcist, capable of showing myself to be stronger than the demon to be expelled (‘strength’, here, being the capacity for comprehension). After this stormy discharge, it became possible to have a clarifying dialogue at the end of which the patient felt calmed. One might attribute the calming to the interpretations, the constructions and clarifications that became possible in these circumstances, but I think that in fact they are only partly responsible for it. The principal factor was the confidence placed in the analyst following his demonstration of the understanding of the patient’s need to free himself of his demons. This understanding was empathetic and provided the opportunity for a juxtaposition of the patient’s introjective identification. Each time he acted out his madness without making me go mad he felt trust in the analyst, which allowed him to internalise the welcoming object and modify the structure overwhelmed by the psychotic objects. It should be pointed out that, although all this took place on the level of implicit knowledge of the unconscious ego, without access to the patient’s consciousness, the observing ego of the analyst could follow the entire process, and could thus convey it to the patient in such a way as to build explicit knowledge.

It should be noted that during his earlier analytic experience the patient was simultaneously receiving psychiatric treatment, because of a non-specific alteration of the EEG. When he began his analysis with me, he was still on medication, and complained of its effects that made his daily life difficult. I offered no opinion on this treatment, which was probably interrupted with the consent of the psychiatrist about one year after the beginning of the analysis.

The process—as a wide-ranging analysis—lasted just over 10 years, with the patient subsequently returning for short periods to rethink things in particular situations. The analytic process—in its earliest stages and also subsequently—followed the path described, with the observing parts of the two egos maintaining a dialogue about the experience of the parts that were regressing. The empathetic
understanding and the dialogue on the events of the here-and-now made a great deal of progress possible, with transformations to the patient’s mental state and triumphs in everyday life, even though there did remain some vestiges of structural faults, which did no serious harm to the patient or anyone else. I consider it almost a psychoanalytic miracle that it was possible to maintain such a stormy process for almost two decades without external help—there was no recourse to hospitalisation, and no medication except in the initial period described above. It would have been regrettable if it had been necessary to draw on extra-analytical resources, as they would have compromised the depth of the intersubjective relationship necessary for the achieving of profound changes. The mutative process tends to be diminished when changes are made to the setting, as this is the crucial factor in inducing the transference. In cases such as this, maintaining the constant setting can be a tough challenge, as the patient tends to destroy it as a manifestation of his psychotic states, making it necessary to be both rigorous (if it is to be maintained) and at the same time sufficiently flexible to allow and accompany transferential repetition. I believe that the breaking up of the setting praised by Stern et al. (1998) in order to make room for what they call the ‘moment of meeting’ would make any development of the analysis unlikely.

**Patient B**

A second case, presented elsewhere (Andrade, 1993), is described here to illustrate a wide-ranging analysis rooted in a neuroscientific basis. This patient also experienced a personality disorder, demonstrating behaviour similar to that of patient A, but of a lesser intensity. He complained of vagueness of feeling, of not finding space in his life. He had low self-esteem and feelings of social rejection, which he disguised with an apparent air of superiority which led him to make disparaging criticisms of people with whom he did not get along, generally as a manifestation of envy. In spite of his intense participation in social activities, his mood was depressed, with a history of suicide attempts. Within a few months he presented material related to his main complaint: (1) he left his papers in a taxi on the way to his analysis; (2) he dreamed of losing his ID card, which had been sent on to the university where it was meant to be delivered to his mother, but it was in fact him who received the card, noting with alarm that the photo on it was of his mother’s face—she was him; (3) in another dream, he fell from some high place and his body crashed to the ground, fracturing in many places; passers-by gathered around his broken body, and he could hear what they were saying although he was dead; the analyst approached him, taking his hand without a word; but now his body was intact as though nothing had happened.

This material is interpreted as being related to the patient’s diffused identity. However, it contains some aspects that are easily quite intelligible whose interpretation does not serve to make them any more conscious. I believe these dreams refer to experiences of birth which were displaced by subsequent experiences. The primal trauma which was stored somewhere re-emerged as repetition in search of being bound (Freud, 1920), all mixed in with later experiences. The binding does not result from working through arising from interpretation. The material of one of the dreams itself shows how the binding occurs. The talking crowd that takes the inert body for
dead suggests objects incapable of understanding the needs of the baby at birth, who was maintained in a state of catastrophic anxiety for a long period. The attitude of the analyst, whose gesture of taking the patient’s hand reintegrated his body, shows that the restoration of the ego will be achieved through empathy rather than through interpretation. In the other dream (which is related to the oral stage of (pre-verbal) primary interpretation), in which mother and son are indistinguishable, the patient reveals himself to be unable to acquire his own identity, making it necessary that the analyst identify with him and thus—by taking the role of the fused ego—confer on him a sense of himself.

Another episode took place in the analytic setting. The patient would arrive late systematically, and then remain in silence for some minutes. On several occasions I interpreted this as resistance, without any resulting change in his behaviour, so I decided to remain in silence too, attempting to understand the significance of what was happening. One day the silence was unusually long, and there was a difference: his body remained absolutely immobile. I remained silent, trying to understand what was happening. After about 20 minutes, he got up, sat on the couch with his head hung over his knees, resting in his hands. He got up, and still in silence went over to an armchair. His first words were a request to be allowed to smoke. Without waiting for my assent or contradiction, he lit up a cigarette and began to smoke. After drawing on the cigarette two or three times he put it out and thanked me—apparently quite moved—for allowing him to smoke. Then, gently tearful with relief and calm, he told me that he was feeling an intense pressure in his chest, as though his whole body was in a cast and he was unable to move. He felt dead, while still aware that he was alive.

This patient, whose father was an alcoholic who beat his family and broke furniture and household objects during his frequent periods of drunkenness, experienced a dystocic birth, having survived the tumultuous pregnancy during which his mother was pressured to use backstreet methods to abort the unwanted foetus. His childhood was full of dramatic incidents in which his mother had to protect herself and her children from the father’s drunken episodes. He also learned to defend himself as best he could, developing an ego with significant flaws. He had feelings of social exclusion, always positioning himself on the fringes of a group, struggling to be accepted, sometimes using antisocial methods to make himself feel more appreciated. With the silence, the pressure in his chest and the smoking he was acting out the episode of the abnormal delivery. As well as the perinatal hypoxia, the cigarette smoke also seemed to indicate his need to live with the destructive behaviour of his father, with whom he had to identify in order to survive, with some of the antisocial actions being manifestations of this identification. The existential discomfort that led him to seek me out showed that he wanted to change the repetitive behaviour paradigm but was unable to do it on his own. He had to go back over his life, reliving it with someone who could understand it without judging him, to introject a good object and acquire a new model of behaviour. Here we find a part of what Fonagy demonstrated in relation to the procedural memory, attributing the change effected by psychoanalysis to a modification of the previously existing automatism through a new experience with a new object. This certainly does
happen, but it is not just this. To my mind, the affective link that leads to the change in the behavioural automatism also acts on the development of the ego through introjective identification. Looking more deeply in metapsychological terms, we can see that the psychic ego has its bodily aspect too, where we can catch a glimpse of some sort of correspondence between the act of internalisation and the emission of the neurotransmitter of the mesencephalus in the pre-frontal cortex, just as Schore (1994) says. Moreover, this does not occur only as repetitive automatism, but also as an expression of emotion. Furthermore, it would be a narrowly unilateral approach to consider these emotions exclusively from the point of view of an experience stored subcortically. It is necessary to consider the negative influence of inadequate affective experiences on (cortical) cognitive development. The psychoanalytic method would seek to compensate for these negative experiences by encouraging positive relations. As has already been shown, the affective relationship seems to have a real part to play in expanding neural circuits in the cognitive area, with an increase of its regulation of affects. In psychoanalytic terms, we can call this a restructuring of what is properly termed the psychic ego through the body ego, by means of an introjection of a good object.

The current analyst–patient relationship and the analytical setting

The clinical episodes described above refer to experiences of the pre-verbal phase that are not susceptible to remembering. The impossibility of attaining conscious memory does not prevent the analyst—in a favourable transference situation—from discussing with the patient his impressions of events that took place at times no longer capable of recall that may be manifesting themselves in current behaviour. This dialogue would include interpretations and, above all, constructions from repressions that emerge in dreams, verbal associations and correlated phenomena, but is not restricted to these. It would also include talking directly about the analytical relationship, sometimes pedagogically, with commentary on the history gathered through the transference material or external actions. It would not seek to recover irrecoverable memories, but simply to transmit adequate knowledge about the patient’s development. Based on the fundamental trust the analyst has earned, the knowledge conveyed by the analyst is incorporated into the collection of explicit memories, structuring the cognitive aspect of the personality, developing a capacity to regulate emotions, as well as strengthening self-esteem while bit by bit new implicit memories begin to alter the previously existing pattern of repetition. This cognitive stage is the consummation of the psychoanalytic process, serving to organise the turnaround caused by the dyadic and reciprocal primary identification that put into action the ‘moment of meeting’ so praised by Stern et al. (1998).

This crowning point of psychoanalysis can be explained by Freudian metapsychology to which I would like to refer one last time. Indeed the transferential enactment represents the dislocation of the quota of affect of the representations no longer capable of recall to current behaviour. The enactment per se does not lead to psychic change since, when the behaviour has stopped, the quota of affect contained in it returns to the thing-presentation to which it was originally linked, and from there
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goesto repeattitselfin themostdiverse range of lifesituations. Since the analysis itselfis amongthese situations, the repetition in the analytic process—unlike what happensoutside it—can be understood by the analyst who, faced with the patient’s actions, behaves differently to other objects; that is, the quota of affect is linked to the relationship with the analyst. The analyst’s understanding attitude, besides giving rise to new implicit memories as shown above, makes it possible for the pre-existing implicit memories (unconscious affective structures) to be emptied of their quotas of affect, losing the force that requires repetition, once they have been transferred to the analytic relationship—a new affective pattern of object relations is established, the current model being responsible for the changes in behaviour. Part of the transferred quotas of affect is destined for primary identification, forming new implicit memories, but another part is situated in the current (non-transference) relationship with the analyst. The strength of this quota of affect brought to bear on the analyst means that his explanations of what happens in the early stages of development—and not only the major traumas, like birth, but also the subsequent mini-traumas of day-to-day life—are incorporated by the patient as explicit memories through which he can develop greater certainties about facts that will remain beyond his capacity for remembering.

It is possible to confirm that the analytic relationship is not limited to the transference, which we can assume from the fact of there being part of the ego (both the analyst’s and the patient’s) that remains outside the regression inherent in the analytic process. The analytic dialogue runs between these two parts on which the therapeutic alliance depends. The fundamental trust in the analyst which makes the therapeutic alliance possible demands that the analyst does not confuse the transference with the current relationship, which implies treating the patient as an adult interlocutor and not as a child. In turn, the analytic relationship presupposes a cordial encounter that should not be confused with a normal affective relationship that the patient may have with anyone—the analytic relationship is no less unique than that between parent and child. Confusion between the two kinds of relationship is a compromise of the analytic setting, so the right attitude from the analyst when dealing with the transference is a *sine qua non* of structural change.

Thus the *moments of meeting*, if they are taken as representing the break-up of the analytic situation and the dissolution of the *setting*, as Stern et al. would like them to be, seem to me to be rather everyday affective relationships than analytic ones. The ‘moments of meeting’ that these authors conceived so ingeniously may be an accurate description of what takes place in the analytic relationship, but the failure to place them within the context of a broader theory of the mind means ignoring the fact that the ego of the analyst—regressed to allow it to tune in with the patient’s—is the same as that which remains outside the regression and maintains a dialogue with the non-regressed part of the patient. The functional dissociation of the ego should therefore not be confused with a real dissociation that would be pathological. Once the setting has become indispensable for the transference enactment, it is crucial that the analyst maintain the analytic situation, preventing it from becoming simply a meeting between just any two people, since maintaining it is a guarantee of new moments of meeting which occur through the whole course of the analysis.
Conclusion

The clinical illustrations seem to me to reinforce the idea that therapeutic action arises from the reconstruction of the environment in which the most distant and significant emotional experiences took place, causing a spontaneous blossoming of awareness out from this affective base, in which the analyst shows himself to be a different object to the original one. The classic psychoanalytic method based on interpretation and construction, in order to position itself on the cognitive verbal plane, constitutes the indispensable complement to the organisation of the mind that emerged from the affective nucleus. As has already been seen, it is crucial not to lose sight of the importance of this integrating role of the analytic dialogue, because the emphasis I have been placing on the transference might give the misleading impression that that is the only important factor. In truth, the transference is not an end in itself, but a transitional stage for the empathetic—introjective reciprocal identification—this is the factor inducing the change—which is completed by the verbal dialogue. Used as an exclusive or principal therapeutic resource, the interpretative method can be useful when working with pathologies that involve verbal stages of development that correspond to explicit memories. Although it has been used exclusively for almost a century, this method is partial and does not deal in isolation with the necessities of a wide-ranging analysis, as well as not keeping up with current scientific thinking. Without it, on the other hand, all we are able to obtain from the affective part of the process alone remains incomplete. So either of these two factors, taken in isolation, constitutes what I have termed elsewhere ‘limited range psychoanalysis’ (Andrade, 1993). Complete psychoanalysis should encompass both factors: (1) the prioritising of the affective factor of the intersubjective relationship in order to restore pre-verbal structures; (2) the use of verbal dialogue as a factor for recovering structures from the verbal phase and integrating earlier phases.

To conclude, I would like to refer to the observation with which Fonagy ends his article, wondering whether psychoanalysis really has a therapeutic effect. I believe that psychoanalysis has lost the therapeutic goals of its earliest days when it was still interested in the elimination of symptoms, and has been transformed into a theory of psychic development. Once he had completed his metapsychology, Freud said that the aim of psychoanalysis was to develop the ego, making it more independent of the superego and enabling it to annex parts of the id. If we are aware of the physical bases of the ego, and taking into account what neuroscience teaches us, we can assume that structural faults in the ego correspond to compromises on a cerebral level; as a result, recovery from basic flaws in the ego should correspond to modifications to cerebral tissue, even if these modifications are not perceptible. Thus, when we develop the ego we can only partially correct those flaws resulting from very serious errors in the behaviour of primary objects that occurred during a period of maturation and structuring, just as the possible recomposition of cerebral tissue as described by neuroscientists is itself only ever partial. With this in mind, we cannot maintain great therapeutic ambitions, since our regressive method is a virtual one—old relations are not revived in any real sense, as the reconstitution of the original environment is now dealing with an adult psyche and brain. So, when
faced with serious disturbances, like those described here, our method resembles the physiotherapy that one uses to improve muscles affected by vascular accidents, or collateral circulation attempted in cases of cardiac ischaemia. In any case, the possibility of a virtual reconstitution of the original environment can lead to our methods obtaining results that are probably far more profound than any other method yet known. Although the scientific knowledge on which the hypothesis was based was still in its infancy, I believe that clinical experience with patients experiencing severe narcissistic personality disorders, enhanced by recent neuroscientific discoveries, justifies this conjecture, a conjecture which I think could be the subject of future research.

Translations of summary

**Affekt und therapeutische Wirkung der Psychoanalyse.** In Verbindung mit kontroversen IJP-Beiträgen von Stern et al. und Fonagy über die Deutung des Verdrängten und den Wiedergewinn vergessener Erinnerungen vertritt der Autor die These, dass der Affekt, welcher der positiven Übertragung inhärent ist, der Wirkung der Therapie zugrunde liegt. Gesichtspunkte, die in der (auf neurobiologischen Kenntnissen basierenden) Kontroverse vertreten werden, hängen mit der freudianischen Metapsychologie ebenso zusammen wie mit ihren Vorläufern, deren Reichweite zwangsläufig durch einen fehlenden Zugang zu aktueller wissenschaftlicher Entdeckungen begrenzt ist. Der Autor demonstriert metapsychologische Elemente der therapeutischen Wirkung, die der intersubjektiven Beziehung inhärent sind, insbesondere die Identifizierung, die in Introjektion und Empathie manifest wird. Die kognitive Entwicklung geht dieser Beschreibung zufolge spontan aus dem affektiven Nukleus hervor; die neurowissenschaftlichen Grundlagen für diese Weiterentwicklung werden erklärt. Die klassische (deutende) psychoanalytische Methode bildet die kognitive Superstruktur, die für die Organisation der Psyche notwendig ist, die aus der affektiven Substruktur hervorgegangen ist. Als primärer Faktor psychischer Veränderung ist die Deutung in ihrer Effizienz auf Pathologien begrenzt, die aus der verbalen Phase stammen und mit expliziten Erinnerungen zusammenhängen, und bleibt ohne Effekt auf die prä-verbale Phase, in der sich implizite Erinnerungen finden. Die Deutung - die Methode, die ein Jahrhundert lang praktisch ausschließlich verwendet wurde —, ist lediglich ein Bestandteil; in Isolation benutzt, wird sie den Anforderungen einer modernen Breitband-Psychoanalyse nicht gerecht, wie das vorgestellte klinische Material illustriert.

**Afecto y acción terapéutica del psicoanálisis.** A propósito de los controvertidos artículos presentados en esta revista por Stern et al y por Fonagy sobre la interpretación de lo reprimido y la recuperación del recuerdo, el autor sostiene que el afecto inherente a la transferencia positiva desempeña un papel central en la acción terapéutica. El autor relaciona los puntos de vista planteados en la controversia (basados en conocimientos neurobiológicos) con la metapsicología freudiana, como también con sus antecedentes teóricos inevitablemente limitados por la inaccesibilidad a los descubrimientos científicos más recientes. El autor muestra los elementos metapsicológicos de la acción terapéutica inherentes a la relación intersubjetiva, en especial la identificación, manifestada en la introyección y en la empatía. Se describe el desarrollo cognitivo como algo que brota espontáneamente del núcleo afectivo y se explican las bases neurocientíficas de este paso adelante. El método psicoanalítico clásico (el interpretativo) establece la superestructura cognitiva necesaria para la organización de la mente que ha surgido de la subestructura afectiva. La interpretación, como factor esencial para el cambio psíquico, tiene una efectividad que se limita a las patologías que surgen en la fase verbal y están relacionadas con la memoria explícita, pero no tiene efecto alguno en la fase preverbal donde predomina la memoria implícita. La interpretación -el método utilizado con la exclusión de todos los demás durante un siglo- es solo parcial; cuando se usa aisladamente no responde a las exigencias del psicoanálisis moderno de amplio espectro, como lo ilustra el material clínico presentado.

**L’affect et l’action thérapeutique de l’analyse.** En lien avec le débat autour des articles de Stern et col. et de Fonagy parus dans l’IJP au sujet de l’interprétation du refoulé et du rétablissement des souvenirs passés, l’auteur soutient que l’affect qui est inhérent au transfert positif est au cœur de l’action thérapeutique. Les points de vue mis en avant dans ce débat (basé sur des données neurobiologiques) sont en rapport avec la métapsychologie freudienne, tout comme à ce qui l’avait précédée, dont la
pertinence est forcément limitée par le manque des découvertes scientifiques récentes. L'auteur montre certains éléments métapsychologiques de l'action thérapeutique inhérents à la relation intersubjective, en particulier l’identification, qui se manifeste en introjection et empathie. Le développement cognitif est décrit comme s’épanouissant spontanément à partir du noyau affectif ; les bases neuroscientifiques de cette étape sont exposées. La méthode psychanalytique classique (interprétative) compose la superstructure cognitive nécessaire à l’organisation de l’esprit, lequel est issu de la substructure affective. L’efficacité de l’interprétation en tant que facteur primordial de changement psychique se limite aux pathologies issues de la phase verbale, en relation avec les souvenirs explicites, et reste sans effet dans les phases préverbales, où les souvenirs implicites demandent à être retrouvés. L’interprétation, méthode utilisée à l’exclusion de toute autre durant un siècle, est seulement partielle ; utilisée de façon isolée, elle ne correspond pas aux besoins de la psychanalyse contemporaine, à spectre large, comme le montre le matériel clinique présenté.

L’affetto e l’azione terapeutica della psicoanalisi. A proposito dei recenti articoli controversi di Stern e Fonagy apparso sull’IJP circa l’interpretazione del rimosso e il recupero dei ricordi, l’autore sostiene che l’affetto inerente al transfert positivo è al centro dell’azione terapeutica. I punti di vista avanzati nella discussione (e che si basano sulla neurobiologia) sono collegati alla metapsicologia freudiana, oltre che ai suoi precursori, il cui campo d’azione era necessariamente limitato dalla mancanza d’accesso alle più recenti scoperte scientifiche. L’autore mostra gli elementi metapsicologici dell’azione terapeutica inerenti al rapporto intersoggettivo, soprattutto l’identificazione, che si manifesta nell’introiezione e nell’empatia. Egli descrive lo sviluppo cognitivo come qualcosa che sboccia spontaneamente dal nucleo affectivo e spiega le basi neuroscientifiche di questo passo in avanti. Il metodo psicoanalitico classico (interpretativo) organizza la sovrastruzione cognitiva necessaria per l’organizzazione della mente che è scaturita dalla sottostruzione affettiva. Come elemento primario del cambiamento psichico, l’interpretazione si limita a essere efficace nei confronti delle patologie che si sviluppano nella fase verbale, collegate a ricordi espliciti, senza alcun effetto sulla fase preverbale, dove si trovano i ricordi impliciti. Il metodo dell’interpretazione – utilizzato con l’esclusione di tutti gli altri per più di cento anni – è soltanto parziale; se usato isolatamente, non risponde alle richieste della moderna psicoanalisi a largo spettro, come illustra il materiale clinico presentato.

References

Freud S (1915a), Repression. SE 14, p. 146–58.
Freud S (1915b), The unconscious. SE 14, p. 166–204.
Freud S (1920). Beyond the pleasure principle. SE 18, p. 7–64.
Freud S (1921). Group psychology and the analysis of the ego. SE 18, p. 69–143.