INTRODUCTION

Talking cures as we practice them today started with Breuer and Freud’s attempts to make sense of patients’ symptoms by listening to what they said or were asked to say about their symptoms and themselves. It was an extraordinary medical innovation, for until that point only resting cures, physical procedures, and hypnosis had been used to alleviate the incomprehensible suffering of mental patients. Freud had learned to hypnotize in France. Breuer and he had started to use hypnosis in order to relieve their patients’ symptoms. They came upon something that changed their medical practice:

For we found, to our great surprise at first, that each individual hysterical symptom immediately and permanently disappeared when we had succeeded in bringing clearly to light the memory of the event by which it was provoked and in arousing its accompanying affect, and when the patient had described that event in the greatest possible detail and had put the affect into words. Recollection without affect almost invariably produces no result. The psychical process which originally took place must be repeated as vividly as possible; it must be brought back to its status nascendi and then given verbal utterance. (Breuer & Freud, 1893–1895, p. 6)

This quotation marks the birth of psychoanalysis and all talking cures derived from it. To recover from our psychic disturbances, we must find words to affectively express the personal experiences that make us ill. Breuer and Freud had tapped into the therapeutic power of the spoken word, the word spoken to and with the physician.

Breuer and Freud’s technique was marked by the psychiatry of the period in which they practiced. Their focus was on remov-
ing symptoms related to specific and concrete traumatic events from the past. Nonetheless, the freshness of their discovery, the therapeutic power of the affectively expressed description in words of private experiences, was to remain the core of the psychoanalytic approach to help individuals with their psychic suffering. Other aspects of their technique were part of the standard medical practice of the period (rest, physical care) until the work with patients forced Freud to continuously correct, update, and modify his theories and technique and transform them into psychoanalysis, a procedure limited to speaking between analyst and analysand. At that point, all the authority was in the doctor’s knowledge. The therapeutic aim intended only to remove symptoms. The past appeared solely as episodic traumatic moments that had to be singly recollected and abreacted. The listening attitude of the doctor was limited to making sure that the patient had described the traumatic event “in the greatest possible detail” and that the original affect had been put “into words.” Nevertheless, the key elements of all later talking cures were already there: a patient who could get better by talking to a therapist about past privately experienced events, thoughts, and feelings whose pathogenic effect appeared as symptoms, personality disturbances or character traits that interfered with the patient’s desire to live a satisfying life. The foundational technique for all talking cures was also there: a listening analyst capable of paying careful attention to the patient’s words to assure that all had been said with the appropriate affect. The basic intention of all talking cures was already present for both participants: The patient was to talk with true feelings and the analyst was to listen in such a way as to assist the patient to express in words all that had to be said and felt. I believe that we can create a basic theory and technique for all talking cures starting from these premises. Before I elaborate my point, I will take a brief tour to follow the evolution of theory and technique in the 113 years that have elapsed since Breuer and Freud’s “great surprise.”

EVOLUTION OF THE THEORY AND TECHNIQUE OF THE TALKING CURE

Freud’s early theory and technique used hypnosis and suggestion to induce the patient to remember traumatic moments and express them and their affect in words. The underlying theory
supposed that the cathartic discharge of affect in words had a curative effect. Soon Freud (1905) discovered that suggestion and hypnosis did not work: It was like painting, as Leonardo da Vinci had put it, *per via de porre*, placing some color on a blank canvas. It had shown Freud the resistance patients used to keep their symptoms unchanged in spite of the hypnotic suggestions. Freud moved to the way of sculpting, which proceeded as sculpture does *per via de levare*, to reveal hidden forms, to uncover now through analytic therapy “the genesis of hidden symptoms” and understand resistance (p. 261). He was forced to recognize that “it is not so easy to play upon the instrument of the mind” (p. 262). Freud had to postulate that the mind harbored unconscious processes and that “every mental compulsion is rooted in the unconscious” (p. 262) and that the pain and displeasure caused by making the patient aware of what he or she had repressed made the analytic work a continued effort to overcoming resistances (p. 267). Freud (1904) used free association and the interpretation of the unconscious derivatives it revealed in an effort to “mak[e] the unconscious accessible to consciousness, which is done by overcoming the resistances” (p. 253). Most resistances had to do with the unpleasure of remembering and the shame of having to disclose to the analyst unflattering aspects of the patient’s life and mental processes.

It became clear to Freud that the person of the analyst as the expected judge of the patient was acquiring a significance he had not predicted as a scientist. Soon he realized that patients were also experiencing affectionate, erotic, and sexual feelings for him and wanting favors from him. Freud became aware of the power of the transference upon him of childhood parental imagoes, and of the desires and fears that were experienced in growing up in the relationship with the father and mother. He realized that the transference and its implications in the treatment went beyond what making the unconscious conscious could accomplish. He elaborated the structural theory to account for all the components of the patient’s psychic world manifested in the treatment. There was an ego that was realistic enough to be willing to cooperate with the analyst. There was a superego that did not allow the patient to say what was in his or her mind. There was an id that could not cease to demand satisfaction.

From 1923 on, Freud’s analytic technique aimed at strength-
ening the ego to make it as free as possible from the dominance of the id and the superego. It is the ego that has to summon memories from its past, that has to tolerate the unpleasure of painful affect and assume the responsibility of bringing everything that falls into the patient’s mind into a verbalized association. Once the ego had achieved enough strength, the patient could be entrusted to his or her own care. The strength of the ego emerged from the verbalization, interpretation, and understanding of unconscious material, the working through of the painful transferential and other affects, and the reconstructions that permit the full emergence of what had been repressed, the pathogenic experiences and memories. At the end of his life, Freud (1937) arrived at an astonishing conclusion about those cases in which it was not possible to bring the patient to recollect:

The path that starts from the analyst’s construction ought to end in the patient’s recollection; but it does not always lead so far. Quite often we do not succeed in bringing the patient to recollect what has been repressed. Instead of that, if the analysis is carried out correctly, we produce in him an assured conviction of the truth of the construction which achieves the same therapeutic result as a recaptured memory. (pp. 265–266, my italics)

The word conviction seems out of place in Freud’s vocabulary. It goes beyond scientific discovery to focus on the joint effort of believing that what patient and analyst have done and said together in their exchanges to understand the pathogenic power of the patient’s past is as transformative as the recovery of a repressed memory. Freud had not time before his death to elaborate on his own words and their potential technical consequences. I propose that the change from recollection to the “conviction of the truth of the construction” introduces a new dimension into analytic exchanges. The focus is no longer the recovery of memories lodged in the private reality of the patient’s mind but the analysand and analyst’s belief in the truth of the psychic reality they have spoken about and constructed together as the actual past and present experience of the analysand. The sentence gives priority to the relational component of their speech and the joint belief in the psychical truth of what they have said over the actual revival of memory. Freud did not
seem to have noticed the profound theoretical and technical changes that his remark called forth. I will not attend to all of them, but focus only on the aspects related to the subject of this article. The emphasis had shifted from the exclusively intrapsychic process of remembering to the shared belief in the truth of the construction the patient and analyst had created about the inner experience of the patient. They could have done it only by speaking together about what the patient was saying because the analyst has no privileged access to the analysand’s actual or psychic history. Yet Freud paid limited attention to the power of speech between people as a tool for communication and affective exchanges. As Peller (1996) suggests, “[Freud] did not deal with communication... The function of language which interested Freud was the added consciousness (awareness) it could bestow on mental acts” (p. 465).

Freud’s limited interest in the complex functions of speech in analysis is surprising. In 1891, he had written a magnificent monograph on aphasia, where he described the participation of the perceptual body in the organization of language (Rizzuto, 1993). What is even more surprising is the scant attention paid to the fact that analysis is a spoken cure, a continuous speech act, by the new theories and techniques that emerged in the hundred and more years that followed Freud’s invention of psychoanalysis. Bergmann and Hartman’s (1976) book, The Evolution of Psychoanalytic Technique, which covers the main authors from Karl Abraham to Heinz Hartmann, does not include in the index the words language, speech, verbalization, or communication. The American Psychoanalytic Association’s official Psychoanalytic Terms & Concepts (Moore & Fine, 1990) does not include any term related to speech, not even verbalization.

New theories and techniques emerged to expand and elaborate on many aspects of analysis. Klein, ego psychologists, object relations theorists, Kohut and self theorists, interpersonalists, social constructivists, intersubjectivists, and others insisted on their particular focus of attention during the psychoanalytic process. None attended to the fact that the talking cure is a continuous speech act between unequal partners. Few noticed some significant aspects of language during analysis, and others resorted to linguistic concepts to illuminate the value of words in analytic
discourse. The exception is Jacques Lacan, who based his body of analytic work on understanding the language of the analysand. Lacan, however, was not interested in the communicative but in the structural function of the analysand’s language. Evans (1996) describes Lacan’s analytic use of what the analysand says: “The analyst must attend to the formal features of the analysand’s speech (the signifiers), and not be sidetracked into an empathic attitude based on the imaginary understanding of the content (the signified)” (p. 98). The person of the analysand is subordinated to the structure of the language he or she speaks to the analyst.

There is, nonetheless, an unavoidable fact: Analysis is a talking cure. I propose that there is another unavoidable fact: The rich structure of human speech between patient and analyst encompasses the essential elements to achieve the psychic changes the analysand requires to have a freer emotional life. In the next section of this article, I will examine the developmental significance of spoken language and its power to access the analysand’s private reality.

DEVELOPMENTAL SIGNIFICANCE OF SPOKEN LANGUAGE

I am intentionally using the expression “spoken language” because I want to make it clear that I am not talking about language as linguists do, as an entity to be studied objectively by the scientific method. Linguistics sciences have made invaluable contributions to the understanding of the structure and function of language. Yet they have so far contributed little to clarify the effectiveness of analytic discourse. Psychoanalysis needs to understand the psychic functions of the spoken language between patient and analyst. I hope to bring some light to this issue.

The capacity to hear develops in the fifth month of gestation, long before the child is able to see his or her parents or be touched by them. The voice brings to the fetus the first maternal sensory stimulation. I have suggested (Rizzuto, 2003) that the maternal voice is the first mirror of the child’s self, even before birth. The affective power of the voice has from the beginning the capacity to “touch” the child viscerally. Early in postnatal life, the maternal voice announcing care precedes the actual satisfac-
tion of the baby’s need. The experience of having been contacted as a self by the maternal voice and her ministrations bestows upon the spoken word a sense of hope about the voice and words of the mother, and later of other people (Rizzuto, 2004), the hope that one can be found psychically when one is lost and can be helped when in need. I believe that this earliest of hopes remains as the foundation for the analysand’s acceptance of the “talking cure.” The contrary experience of having felt neglected as a self by the maternal speech (Rizzuto, 1988) makes the prospective analysand wary that anyone is willing or capable of making spoken contact with him or her. The prosody of the maternal voice impacts babies to the point that after birth they prefer their mother’s voice over any other (Kolata, 1984). Furthermore, babies prefer words over any other sound, including music (Butterfield & Siperstein, 1974). The maternal voice has not yet semantic value for the small child, but it carries powerful affective messages about the child’s relatedness as an engaged individual. The sound, pitch, and melody of the maternal voice indicate to the infant the maternal wish for engagement and the responses of approval, affective relatedness, prohibition, and reprimand. The maternal voice also reveals the affective state of the mother and the moment of speaking to the infant. The communications between mother and child involve their entire bodily being: voice, posture, gestures, closeness of bodies, and ways in which their bodies fit into each other in moments of physical contact.

There are two affectively organized conditions between partners that transform any communication, bodily, gestural, or verbal, into a self-enhancing or self-inhibiting process. The first requires that both partners experience similar affect and the second that they exchange complementary messages in bodily movements, gestures, or words (Rizzuto, 1991). The absence of either component engenders the shame of not having been reciprocated, as when a friendly greeting in adult life finds no response. These conditions are present throughout life beyond the formative years. The person whose affect or gestures are ignored experiences shame and a wish to hide, to disappear or to resort to protective defenses to avoid pain. What is being challenged is the sense of the child or the adult of deserving to be noticed by
the addressed person and given a complementary response as an individual self. Schore (2003) says explicitly: “The human appraisal system, from its very beginnings throughout the rest of the life span, is not just directed toward evaluating the overt behavior of others, but also toward attempting to understand the mind of other humans” (p. 53). What truly matters in human communication is the disposition of the other toward the self, the other person’s well-implemented intention to establish meaningful contact with the partner.

As soon as the child is capable of saying some words, mother, father, and family continuously encourage the child to communicate verbally, to give semantic meaning to what they are asking for or expressing. Such involvement and the multiple levels of emotional engagement present in them bestows on all the components of human speech from prosody to syntax a complex emotional and object-related meaning. It gives words an emotional history.

The capacity for semantic communication introduces several new dimensions to the developing child’s mind’s organization. Language is a culturally organized system that must be learned from the parents and in the family to obtain entrance into social life. The semantic components of the mother tongue give the child the Weltanshauung of the local society and involve imperceptibly the young person in particular modes of being and identity. After the second year of life, parents progressively help the child to name objects, wishes, affects, and internal experiences. They offer the child a model to follow in structuring language. Shapiro (1970) sums up this process:

Brown and Bellugi (1964) showed that although children at an early level speak telegraphic syntax, their parents always answer them in an expanded syntactic form and that the interchange goes on until it is finalized by the parents’ reiteration. Thus the child comes to expect that in order to end an exchange the mother must naturally repeat what has been said. In this sense the development of naming is keenly attached to the relaxation of tension through affirmation by repetition. (P. 414)

The emergence of the semantic function of language interposes both the external and the internal world between the mother and the child, thus facilitating separation and differentia-
tion. This process occurs at the visible level of the child and members of the family collaborating to integrate the new person into the world of spoken discourse and interactions.

There is another level of equal significance for the organization of the child’s psychic life, the referential function of words. Early in his career, Freud (1891) described the structure of a meaningful word as composed of an “object-presentation” and a “word-presentation” linked to each other in the mind, more frequently than not, by the auditory components they share. Strachey, Freud’s translator, found such similarity between Freud’s description of the functions of “things-presentations” and “word-presentations” in his paper on *The Unconscious* (1915) and the earlier monograph that he decided to add that sector of the monograph to it as Appendix C. There Freud said:

A word, however, acquires its meaning by being linked to an ‘object-presentation’ [‘thing-presentation’ in *The Unconscious*]. . . . The object-presentation itself is . . . a complex of associations made up of the greatest variety of visual, acoustic, tactile, kinaesthetic and other presentations. (p. 213)

It is clear that in Freud’s conception of representation of things (material objects and human objects), we must include some acoustic sound-image. Probably, it became integrated into the thing representation by the way in which the child learned to name and to experience the actual object in verbal and dialogical exchanges with the parents speaking with him or her.

The expression *thing-representation* refers, in my understanding, to (1) actual objects in the external world as perceived by the child and named by the mother tongue; (2) very complex representations of human objects; (3) self-representations of the child as the subject who experiences his or her body in relationships with others; (4) representational fantasies formed by the child in its effort to make sense of the world; and (5) real or constructed scenic representations of relationships between people, such as the oedipal scene. The elaboration of these representations conditions the emergence of concepts and symbols as soon as the child acquires the capacity to form them. Some of these representations have never been conscious. Some have been briefly conscious and have been repressed because they
created conflicts for the child. Others have never been fully articulated to make them personal possessions of the experiencing self. Some bodily sensations and affects might never have been named. What is essential for psychoanalysis is that all these representations, which have contributed to the organization of a particular person’s self and which are the foundation of all of his or her mentation, as Freud preannounced it in 1891 (Rizzuto, 1990, 1993), result from perceptual experiences of bodily external and internal sensations, states, and affects elicited by interactions with others and the world. The human mind is a bodily mind (Rizzuto, 2001). In that early monograph and throughout his work, Freud defined the word as the psychological unit of speech. The phonetic word needs mental representations to become a meaningful psychological word. Freud (1891) said: “A word acquires its meaning through the connection with the object-representation at least if we restrict our considerations to substantives” (pp. 77–78). If we follow Freud’s reasoning and integrate it with our contemporary knowledge of the the structure of the speech act and affect, we can suggest that a person who wishes to speak to another organizes the meaning of the utterance by preconsciously scanning a multitude of affect-colored representations and their associations to find in his or her reservoir of affectively significant words those that seem fit to communicate not only a specific content but also the person’s state of being and wishes to a particular person. The words said to the other have the richness and the limitations of what the speaker is able to say to that person at that particular moment. The selection of words and representations is favored and limited by wishes and defenses against them in the context of the relationship. Yet they are the spoken words available for that singular moment of the dialogue with the other. What the person has not said but is frequently insinuated or clearly audible in the pronunciation of the communication and the type of words selected points to other representational realms and feelings that cannot be explicitly revealed, but that are nonetheless present nonconsciously in the speaker’s mind. Thus, paradoxically, the spoken words between people manage to insinuate what cannot yet be put into words.

In summary: The spoken word can do nothing but reveal
the inner world of a subject that speaks to another, if the other intends to listen to the speaking person and not to partial aspects of the communication. The representations evoked by the words during the speaking moment tell of aspects of the person’s life history; the words selected indirectly disclose their previous use or avoidance; the affect present in the representational referent as well as in the prosody of the enunciation communicates the feelings experienced at the moment when the words are said to another. As I have written (Rizzuto, 2003) paraphrasing Freud (1905): “No one who speaks can keep secret major portions of his or her life from the ears of a good listener” (p. 293). Today I add: That is the case when the hearer truly intends to know the other person.

Analysands arrive for treatment carrying with them the emotional history of the way they have been spoken to and they have spoken with their parents and family. Unknown to them, they would assume soon enough that the analyst would speak to them as he or she has been used to. They would try to ascertain how the analyst addresses them. Patients develop transferential and nontransferential feelings for their analyst’s speaking style, tone of voice, and manner of speaking. Analysands afraid of separation or in need of reassurance or consolation may call the analyst’s answering machine with the sole purpose of hearing the voice in the message.

THE COMPLEX FUNCTIONS OF SPOKEN EXCHANGES IN THE ANALYTIC SITUATION

The analytic situation is a prolonged speech act of a very peculiar type. In ordinary dialogue, people face each other, take turns talking, and define the subject matter they agree to talk about. In the analytic setting, the partners do not look at each other, agree that they will not take the usual turns to talk, and, most specifically, change the subject matter. They agree not to have a subject matter. Instead, the analysand is invited to express as freely as possible what he or she has in mind and to avoid trying to keep to a particular subject. In this manner the analyst can hear what the patient says as an expression of his or her psychic world in the analytic situation. When Freud (1912a) es-
tablished the “fundamental rule of psycho-analysis” (p. 107), he intended to reawaken the repressed representations and desires that he postulated were at the roots of the patients’ problems. He (1913) was aware that the ordinary face-to-face situation would interfere with the task of accessing the patient’s inner world: “I do not wish my expression of face to give the patient material for interpretation or to influence him in what he tells me” (p. 134). Freud’s analytic work, and in particular his study of dreams, had convinced him that the power of human pathology lies in the unmastered and unconscious representations, affects, and thoughts that cannot be articulated in conscious words.

The patient’s suffering stems from the inability to elaborate and tolerate representations, affects, imaginings, fantasies, convictions, and relational beliefs stemming from past experiences and to place them at the service of a functioning self. Some components of the representational world function in the patient’s life like a record stuck in a groove: The analysand repeats a theme over and over again in actual life circumstances that somehow match the unmodified representations. In normal circumstances, representations are continuously updated by nonconscious and conscious experiences in everyday life that evoke them directly or indirectly. In pathology, they are segregated and fixed as a result of nonconscious defensive operations that block their access to the transformative mediation of mental and actual activities of quotidian life. In other words, they are repressed or have never become conscious and found articulation as part of the individual’s experiential life. A similar process occurs with affects that are constantly reawakened in real or imagined scenes of interactions with others, only to be repressed or acted out again. Also, the unconscious activation by internal or environmental stimuli of representations of unfulfilled scenes of desire that are defended against keeps the patient in a state of anxious turmoil. Preconscious reawakening of frightful scenes of actual or imaginary traumatic events brings the patient to an ill-defined state of fearful expectation of unavoidable harm. These and other unconscious representations and anticipated scenes of painful human exchanges are the foundation of most pathogenic conditions that bring the patient to analysis.

How is an analyst to proceed to help the patient to trans-
form his or her unmastered representations, affects, fantasies, and anticipated harmful interpersonal scenes into good-enough acceptable and ego-syntonic personal possessions he or she can live with while keeping the personal integrity of the self? The capacity to participate effectively in the talking cure is the analyst’s only tool. This simple sentence encompasses extraordinarily complex processes that require the personal engagement of the analyst as a listening and speaking participant in the talking cure he or she has invited the patient to start. It is certain that the analysand will not be able to truly free associate, to really talk about what comes into his or her mind. Instead, the analysand will talk and say something of what comes to mind with a particular tone of voice and a manner of speaking that cannot fail to indicate in a direct and indirect manner where the patient stands in relation to what he or she is saying to the analyst as an expected type of listener. It also will give hints about where the analysand stands in relation to what comes out of his or her mouth. This complicated sentence suggests in Jakobson’s words (1971) that “we speak to be heard and need to be heard in order to be understood” (p. 47) and “[that] the whole structure of language is built on this evident fact” (Waugh, 1976, p. 26). Analysands, however, are people who do not want anybody to hear significant aspects of what they think and feel but are afraid of knowing it themselves. Nonetheless, by the very act of speaking, each of the analysand’s sentences carries a message to the analyst, a hope to establish some communicative contact, and a conative suggestion for some expected response. The words used cannot fail to represent some aspect, some derivative of the analysand’s defended representational reality while the prosody of the patient’s words cannot hide the complexities of the desired and feared emotional contact with the analyst. The convolutions of each single sentence, even when considered only as a speech act, defy any simple understanding. The sentence becomes even more intricate when the reality to be disclosed is the mental life of the analysand. The content of the sentence is multifaceted because many competing representations have been concretized in a sentence as a compromise formation (Brenner, 1999) to make acceptable to the speaking patient what he or she is saying.¹ The message to the analyst is multifaceted because the patient who
wishes and fears to be heard is afraid of his or her own inner realities. The effort to establish emotional contact is ambivalent because the patient fears to repeat failed communications of the past. Nothing is simple in the words the analysand is saying except that he or she is there, on the couch, and is talking to and with the analyst.

How is the analyst to listen to make sense of the staggering complexity of the analysand’s communications? Today the technical options are many: to listen to the content of the communication, to the conflicts they point to, to the affective state of the analysand, to the derivatives of unconscious fantasies, to the state of the self, to the interpersonal communication, to the intersubjective encounter, to the transferential appeal, to the defenses that hide the true communication, and other technical variations. I do not discount the theoretical foundation and value of each option. Instead, I suggest that each technical alternative runs the risk of distracting the analyst from the central task of analysis, which consists in hearing the patient as the unique self he or she is. The question the patient has been asking all along from meaningful people in his or her life is, “Can you hear me? I am confused, I cannot hear myself.” The person has lost the compass to guide significant aspects of his or her internal and relational life. To respond to this unspoken question, I propose a very simple approach that is very difficult to implement: The analyst’s task in listening to the patient’s communications is to muster all that analytic training has offered him or her in the service of a unique function: the full intention to listen to the analysand as a very unique self that cannot be fitted into preconceived ideas.

How do I conceptualize this intention? I must return to Schore’s (2003) assertion: “The human appraisal system, from its very beginnings throughout the rest of the life span, is not just directed toward evaluating the overt behavior of others, but also toward attempting to understand the mind of other humans” (p. 53). Fonagy and Target (1998) describe one developmental aspect of the appraisal system:

Mentalization or reflective function is the developmental acquisition that permits children to respond not only to another per-
son’s behavior, but to the child’s conception of others’ attitudes, intentions, or plans. Mentalization enables children to “read” other people’s minds. By attributing mental states to others, children make people’s behavior meaningful and predictable. (p. 92)

They continue:

Exploring the meaning of others’ actions, in turn, is crucially linked with the child’s ability to label and find meaningful his own psychic experiences, an ability that we suggest underlies affect regulation, impulse control, self-monitoring, and the experience of self-agency. (p. 92)

The mostly nonconscious appraisal system is not optional. It never ceases to work. It is indispensable to us to figure out people’s intentions if we are to relate to them. The capacity to mentalize, on the other hand, may have failed in several aspects of the patient’s life and, as a result, the analysand is unable to understand others and frequently misreads them. Furthermore, there are many areas of his or her mental life that remain foggy, compulsory, frightening, unable to be placed under the control of the conscious self. It is not only repression that might have brought the patient to such a condition. Failed or disturbed primary relationships, actual trauma, miscommunications, unfulfillable desires, narcissistic injury, and other interferences may have disturbed the ability to understand the intentions of others and his or her own. As a result of these difficulties during development, the patient’s psychic organization does not have the adequate tools to handle significant aspects of life, be it affects, thought processes, impulses, relationships, or agency. Anxiety emerges as a signal of danger and interferes each time the analysand attempts to face his or her difficulties. Now when the analysand attempts to follow the analyst’s injunction to verbalize what occurs to him or her, the defenses’ warning and filtering processes interfere and prompt the patient to find a sentence that expresses as much as it suppresses. It is at this junction that the analyst’s intention to hear the whole patient enters the analytic field. Freud (1912b) warned against any deliberate attention on the analyst’s part, because “he is in danger of never finding anything but what he already knows” (p. 112). He recommended that the analyst maintain “evenly-suspended attention” (p. 111)
or that the analyst “should simply listen” (p. 112). Freud’s (1923) listening, however, attended to the content of the patient’s words and intended to uncover the representations hidden in them:

It was found that . . . the patient’s associations emerged like allusions, as it were, to one particular theme and that it was only necessary for the physician to go a step further in order to guess the material which was concealed from the patient himself and to be able to communicate it to him. (p. 239)

Freud’s listening did not include the other components of any spoken communication: the affective message, the conative plea for some activity or feeling on the analyst’s part, the secret hope to be heard as a person and the fear of it. Yet Freud’s (1912b) technical recommendation about “evenly-suspended attention” has all that is needed for the analyst to fully hear the patient: “He should withhold all conscious influences from his capacity to attend, and give himself completely to his ‘unconscious memory’ (p. 112). Unconscious memory includes affective memory with its atemporal register of a great variety of emotional states and its exquisite capacity to tune in to the sound and the whispers of the human voice. It encompasses the ability to hear not only allusions to a theme in the analysand’s words, but also the emotional history of the words he or she uses to approach it and to reveal it to the analyst. The only change in Freud’s recommendation is in the analyst’s attitude. Freud’s “unconscious memory” expected to find some theme. I suggest that the analyst listens with his or her entire unconscious memory as a tool, that is, an affective, relational, and representational memory to be able to hear the whole patient. Why do I claim that it is so important that the analyst listens to the whole patient in his or her words?

In ordinary conversation, the interlocutors ably select themes and levels of affective engagement to restrict it to what the nature and occasion of the encounter with another calls forth. In analysis, there is no theme. In a broad sense the whole patient is the theme. There are no guidelines to modulate what is to be said except that the analysand must talk. It is the patient who sets the level and the style of the affective engagement in verbalizing aspects of what is in his or her mind. It is the analy-
sand who cannot help but try to influence the analyst to obtain some type of response.

The analyst immersed in listening unconsciously to the patient’s preconsciously orchestrated communication of the moment frequently hears the affective, communicative, and thematic dissonance present in them. The analyst’s appraisal system is alerted, the ability to mentalize the obscure meanings of the patient’s communications gets its gears going. The analyst begins to hear and sense in what the patient is saying other intentions, other feelings, wishes, subjects. It will not take long before the patient’s words pressure the analyst to respond, point to a particular concern, reveal fears and wishes, give a particular form to the analysand’s words and feelings. The listening analyst has been associating spontaneously to what he or she is hearing and has been experiencing some insight about what in fact the patient is saying and experiencing. Unlike Freud, I suggest not “to communicate it to him” but to use the associations and emerging insight to invite the patient to elaborate on some aspects of the communication, indicating mostly in the manner of doing it that the analyst is convinced that he or she can only assist the patient to understand his or her inner world: Only the analysand has the key to open the meanings of his or her communications, fears, and desires. I am aware that the analyst has to select something to ask for such elaboration and that in doing so other aspects of what the analysand has said may be also important. This an unavoidable limitation of any act of speech: There is always more in any sentence or discourse than what can be attended to. What matters, from my point of view, is that the analysand realizes that the analyst truly intends to hear what the analysand is saying and will not settle for a superficial understanding.

Obviously, tact and timing are required to help the patient grasp that such elaborations are needed but not imposed by the analyst. The analyst’s communications indicate that nothing can be done without the patient’s active and autonomous participation. Such an attitude and the analyst’s persistent invitation to the patient’s self-exploration deliver a very significant affective and relational message: The analyst is not afraid of the “horrors” that terrify the patient, can tolerate what the patient cannot, and has no qualms about being invited to visit the darkest secrets of
the patient’s life. There is nothing the analyst cannot hear and help the patient describe, feel, acknowledge, name, and place in the context of its earlier or present happening. Progressively, the analyst’s acceptance and help to give meaning to what appears meaningless, absurd, or crazy convince the patient that there is no great danger in being curious about his or her inner world. The patient will not do this type of exploration without feeling pain, fear, horror, disgust, shame, and other negative feelings. The pain becomes tolerable because the patient is no longer alone with his or her suffering and the analyst accepts and helps the patient to understand the full range and meaning of the feelings and frightful thoughts. The conscious, spoken elaboration of what has been previously unintegrated or repressed makes it possible for the analysand to transform it into experiences that he or she can own as part of the self he or she is.

When the analysand, frequently in the middle phase of analysis, begins to feel that it is safe to talk freely to the analyst, usually something dialogically new emerges. The patients feels that he or she wants to communicate past or present aspects of his or her life. The analyst knows they have arrived there when the patient says spontaneously, “I want to tell you...”. It is at this moment that they start together the process of construction or reconstruction of the psychic history of the patient.

Spence (1982b) created a significant debate about reconstruction in psychoanalysis:

Although Freud was inclined to believe that every effective reconstruction contained a “kernel of truth,” it is by no means clear how this kernel can be identified and separated from the set of equally likely fabrications which make up a good part of the patient’s life story. (p. 43)

Spence (1982a) suggested that we should renounce knowing “historical truth” and accept the “narrative truth” linked to the analyst’s work of interpretation. “Narrative truth creates a ‘plausible’ construct that offers a ‘narrative fit’” (p. 179) suitable to elicit conviction and change in the patient. I believe that Spence errs because he places the emphasis on the analyst’s interpretation. My focus on the analyst’s intention to fully listen to the patient as a total self and the technical suggestion that the analyst
assist the patient to explore his or her inner world obviates the need to have to choose between historical or narrative truth. The analyst’s aim is to help the patient find a way of exploring inner reality in order to grasp the type of experiences evoked by actual events, the need to create some fictive narratives that in analysis appear as ways of tolerating pain and making sense of the unbearable. Yet neither the historical event nor the manner of narrating it are the focus of attention. What matters is the analysand’s evolving capacity to hear himself or herself, to articulate inner experience, and finally to reach a point in which there is a conviction that what has been constructed and articulated through this assisted self-exploration reflects accurately enough his or her psychic experience in the past and in the present. Concomitantly, the patient has developed a solid awareness of his or her capacity for self-deception and the need for revisiting convictions to understand even more fully his or her hard-won conditions. This approach sees the analyst’s interpretative activity as an exploratory tool to help the patient articulate as fully as possible past and present psychical experiences. In the end, it shares much with the description of naming by Shapiro (1970) mentioned above: “Thus the child comes to expect that in order to end an exchange the mother must naturally repeat what has been said. In this sense the development of naming is keenly attached to the relaxation of tension through affirmation by repetition” (p. 414). After most of the work is done, the analyst might repeat what has been said in order to give full form to Freud’s (1937) “assured conviction of the truth of the construction which achieves the same therapeutic result as a recaptured memory” (p. 266). The conviction in the approach I am suggesting is that the patient has come to know well enough his or her emotional personal itinerary in life as an experiencing self who became derailed from some of its aims. The analysand was unable without the analyst’s assistance to remove the psychical obstacles that interfered with a satisfying life. The aim of the talking cure is to give the patient access to his or her inner world and a way of naming, thinking, and organizing as meaningful psychical experiences the disturbing historical and psychic events of the past and the present.
NOTE

1. Brenner (1999) describes his understanding of the concept: "To say that everything in mental functioning that is of interest to us in our work as analysts is a compromise formation means that the mind regularly functions in such a way as to achieve as much pleasure. . . . Freud (1894) discovered very early that this statement is correct as far as psychogenic symptoms are concerned. What I have emphasized is that it is correct not only for those aspects of mental functioning that are called pathological, but also for the ones that are customarily called normal" (p. 875).

REFERENCES


