ISSN: 2318-8413 DOI: 10.18554/refacs.v9i2.5422 REFACS

Active transference: a clinical management in the treatment of psychoses

Transferência ativa: um manejo clínico no tratamento das psicoses

Transferencia activa: una gestión clínica en el tratamiento de las psicosis

Received: 05/07/2020
Approved: 22/01 /2021
Published: 18/04/2021

Araceli Albino[1]

This is a narrative review about the management of the psychoanalytic technical element of transference in the clinic of psychosis. It was developed in 2020, with clippings from the classic Freudian, Kleinian, Lacanian perspectives, and also other contemporary theoretical approaches, with the aim of presenting the concept of active transference as a possibility applied to the clinic of psychosis. It addressed the following thematic areas: *Transference: Freud's technical invention*, *Transference according to Melanie Klein*, *Transference according to Lacan*, *The differential of transference in the clinic of psychoses*, *Transference in psychosis and contemporaries* and *Active transference - the acting of Love*. In psychosis, active transference is direct, massive, objectal, it is an acting of love. The direction of treatment supported by active transference, integrated with other areas of knowledge, such as psychiatry, creative and projective techniques of psychology, and individual and group psychoanalytic listening, can help to significantly improve the quality of life of people in psychotic structure.
Descriptors: Psychotic disorders; Therapeutics, Transference (Psychology); Psychoanalysis.

Esta é uma revisão narrativa sobre o manejo do elemento técnico psicanalítico da transferência na clínica da psicose, desenvolvida em 2020, com recortes das perspectivas clássicas *freudiana, kleiniana, lacaniana* e também outras abordagens teóricas contemporâneas, com o objetivo de apresentar o conceito de transferência ativa como possibilidade aplicada a clínica da psicose. Abordou as seguintes áreas temáticas: *Transferência: a invenção técnica de Freud*, *Transferência na visão de Melanie Klein*, *Transferência na visão de Lacan*, *O diferencial da transferência na clínica das psicoses*, *Transferência na psicose e os contemporâneos e*,*Transferência ativa – o acting do Amor*. Na psicose, a transferência ativa é direta, maciça, objetal, é um *acting* de amor. A direção de tratamento sustentada pela transferência ativa, integrada com outras áreas do conhecimento, como a psiquiatria, técnicas criativas e projetivas da psicologia, e a escuta psicanalítica individual e grupal, pode ajudar a melhorar, de maneira significativa, a qualidade de vida de pessoas em estrutura psicótica.
Descritores: Transtornos psicóticos; Terapêutica; Transferência (Psicologia), Psicanálise.

Esta es una revisión narrativa sobre la gestión del elemento técnico psicoanalítico de la transferencia en la clínica de la psicosis, desarrollada en el año 2020, con recortes de las perspectivas clásicas *freudiana*, *kleiniana, lacaniana*, y también de otros enfoques teóricos contemporáneos, con el objetivo de presentar el concepto de transferencia activa como una posibilidad aplicada a la clínica de la psicosis. Abordó las siguientes áreas temáticas: *Transferencia: la invención técnica de Freud, Transferencia en la visión de Melanie Klein, Transferencia en la visión de Lacan, El diferencial de la transferencia en la clínica de las psicosis, Transferencia en la psicosis y los contemporáneos,* y *Transferencia activa - el acting del Amor*. En la psicosis, la transferencia activa es directa, masiva, de objeto, es un *acting* de amor. La dirección del tratamiento sustentada en la transferencia activa, integrada con otras áreas del conocimiento, como la psiquiatría, las técnicas creativas y proyectivas de la psicología y la escucha psicoanalítica individual y grupal, puede ayudar a mejorar significativamente la calidad de vida de las personas con estructura psicótica.
Descriptores: Trantornos psicóticos;Terapéutica; Transferencia (Psicología); Psicoanálisis.

1. Psychologist. Psychoanalyst. PhD in Psychology. TechnicalCoordinatorand Professor atthe Núcleo Brasileiro de Pesquisas Psicanalíticas (NPP), São Paulo, SP, Brazil. ORCID: 0000-0002-1391-8553 E-mail: araceli.albino@uol.com.br

INTRODUCTION

Transference is a psychoanalytic term, used to express the relationship established between patient and analyst in clinical practice. It is a fundamental concept, which drives the analysis. Without transference, there is no analysis, an indisputable point among classical and contemporary psychoanalysts, when it comes to neuroses.

During treatment, transference is explained by the combined action of innate dispositions and influences suffered by the child during the first years of life. This produces a stereotype, that is, a predisposition to falling in love[1]. These childhood experiences are reissued in the relationship between analyst and patient.

In the contemporary view, transference allows the patient to represent their story to the analyst, not only reporting what they live, but reliving the affections felt in the previous phase, as a way to update hidden erotic impulses[2].

Since Freud's time until the present moment, transference has been used as one of the fundamental procedures in the applicability of psychoanalytic technique, there are no disagreements between psychoanalysts from different currents. This instrument is managed to place the patient in infantile conditions and the analyst comes in as a kind of substitute for parental authority[3].

In psychosis, transference is controversial, it is a little explored topic, since there are few analysts who dedicate themselves to studying it.

The concept of active transference addresses the idea that the analyst leads the direction of the treatment of psychoses through the act of love, it is what moves the relationship between analyst and psychotic patient[4].

Active transference is the engine that moves the analysis of patients with psychotic structure, enabling the improvement of the subject's quality of life. Thus, this study aims to present the concept of active transference as a possibility applied to the clinic of psychosis.

METHODS

This is a narrative review on the handling of the psychoanalytic technical element of transference in the clinic of psychosis, carried out in 2020, with clippings from the classic Freudian, Kleinian, Lacanian perspectives and also other contemporary theoretical approaches.

Psychoanalysis, understood as a scientific discipline, has epistemological and ethical bases for conducting research[5].

It is proposed to work on the concept of active transference4 as the drive pole, which helps to build an analytical process capable of improving the quality of life of patients who have a psychotic structure.

RESULTS

24 psychoanalytical references were used. And, for a better understanding, the following thematic areas were addressed:*Transference: Freud's technical invention, Transference according to Melanie Klein, Transference according to Lacan, The differential of transference in the clinic of psychoses, Transference in psychosis and contemporaries and Active transference - the acting of Love*

DISCUSSION

Transference: Freud's technical invention

The term transference is not specific to psychoanalytic vocabulary; it is used by several areas of knowledge. Its origin is from Latin and etymologically means '*trans*' (to pass through) and '*feros*' (to drive). It covers some meanings, such as transportation, displacement of values, rights, exchange, exchange, crossing borders and barriers[6].

In the psychoanalytic clinic, Freud used the expression transference (al. *Ubertragung*)[1], to explain the relationship established between patient and analyst in the treatment of neuroses.

In "*Studies on hysteria*", from 1893-1895, Freud talks about the patient's love, which turns to the analyst as a transference process[7]. In 1900, in Chapter VII of "*The Interpretation of Dreams*", the idea about transference is consolidated as a concept specifically related to the relationship of the analytical pair (analyst-patient). The transference is the phenomenon constituted from the repressed desire, which will manifest itself through any object that is represented in the unconscious symbolic chain, for which there is no possible direct translation[8]. In other words, the repressed desire cannot be recognized is ineffable, the impossible to be said and, it will be present in dreams, lapses, repetitions, jokes, flawed acts and symptoms.

Transference is a process of repetition of childhood experiences, those that determine the subject's form of relating to objects, specifically in the analytical process. The children's experiences related to the parental figures will be displaced and relived in the relationship with the analyst, under the command of the pulsional ambivalences of love and hate. In other words, there is an unconscious transfer of archaic childhood affections to the analyst.

The concept of transference gains greater relevance from the Dora case, from which there was no good management and the patient abandons treatment. In the period from 1909 to 1915, Freudian thinking on the subject had important evolutions[9]. He considered transference as a therapeutic agent, being a process suffered by the patient, but necessary for treatment[9]. Technically, the analyst tries to adjust the unconscious impulses to the patient's life history, facilitating the understanding of the impulses and the action, and works the resistances that appear in the form of transference, the transferential relationship.

Resistance appears to avoid children's sexual desires, that is, it appears when the analyst approaches pathogenic contents related to parental figures[10]. In this case, the transfer, as a process of resistance, was considered an obstacle to the analytical process.

The transfer as a powerful technical instrument arises when two types of transfer are conceptualized, the positive and the negative[11]. The positive is related to the loving feelings for the person of the analyst, who moves the analysis forward. The negative transference is related to the erotic and aggressive feelings towards the analyst.

The analyst needs to endure the feelings the patient has for them, they must not depart from the love of transference, but must treat them as unreal. Parental images are unconsciously transferred to the analyst, who must deal with neutrality and abstinence to help the patient to elaborate and heal such affections.

The love that the patient directs to the analyst is an authentic demand for love felt as real, and the analyst must invoke and treat it as a transferential fantasy. The analyst's first challenge is to support the transfer and, still, to find a way to analyze it, for which there is no model in real life.

Otherwise, the transference love is consolidated through the analytical listening about lack, desire, suffering, through which the analyst can direct the love.

The patient longs to live this love to its fullest and the analyst needs to differentiate, clarify that it is not directed at the person of the analyst, but at introjected parental figures[11].

Through the Freudian writings on the technique, the concept of transference was based on the use of clinical practice and is handled by psychoanalysts as an essential instrument in the analytical process.

Transference according to Melanie Klein

Melanie Klein's contribution is fundamental to psychoanalysis, as it emphasizes the "primitive elements of the psyche". She is a pioneer in child psychoanalytic clinic through the technique of playing and has greatly contributed to the understanding of the transference process applied to patients who do not respond to the transference neurosis proposed by Freud[12].

The transference process from the existence of an internal world, or world of objects, is internalized by the child from birth, through introjection mechanisms and, later, returned to the external world as a projection[12].

The internal world would be the result of unconscious fantasies, the introjections of good and bad objects, which are revived in the analytical situation. The projection and introjection processes are initiated in the first object relations (mother-breast), originating in the phase called schizoparanoid. Objects are divided into good and bad; the affections, in love and hate and, in this way, are transferred to the Other. In the Kleinian view, the transfer:

> *It originates from the same processes that, in the initial stages, determine object relations. In this way, in the analysis one has to return repeatedly to the fluctuations between loved objects, external and internal, that dominate since the beginning of childhood* [12].

In this setting, the analyst takes the place of original objects and the patient relives the feelings and conflicts, with the same defenses that they used in the original situation. The patient's associations are related to current objects, which express anxiety, guilt, envy and reparation.

The transference process is a reproduction of all primitive objects and object relations internalized by the subject in early childhood, which are directed to the analyst. They are impulsive representations, fantasies and anxieties, which are closely related to the representations of ego, primitive superego and early Oedipus Complex[13]. There is an interconnection of positive and negative transference, an interplay between love and hate.

The transference is seen as a phenomenon of projective identification, giving rise to the Kleinian concept of primitive transference[12], which opened the field for thinking about another type of transference, other than neurotic. This treatment requires a sufficiently stable technical management, whereby the analytical scenario must sustain the difficult relationship with the analyst.

Kleinian ideas about the existence of another technical management of transference have encouraged work in the psychosis clinic today.

Transference according to Lacan

In Lacan's conception, transference is an unconscious and universal phenomenon, governed by the primary process, and is determined by libido and desire, in which there is no possible word. The impossible to be said, the ineffable, will be present in the analysis through repetitions, lapses, jokes, dreams and symptoms.

Desire is the desire of the Other (Great Other) and, in the case of analysis, it would be the analyst's desire, and the analyst must recognize the instinctual movements of love and hate itself, so as not to enter the traps of the charm of transference[14].

The fact that the human being places themself as a being of language already implies the existence of transference, it is a permeable mechanism to the action of speech. Speaking in the analytical situation is different from talking to your fellow man. In the analysis, the patient speaks to the Other who imaginaryly knows about them, and who called themself the Supposed Subject of Knowledge[14].

Lacan admits that: “it seems impossible to eliminate the phenomenon of transference from the fact that it manifests itself in the relationship with someone to whom it is spoken”[14].

The neurotic patient establishes an imaginary relationship with the analyst, attributing to them the knowledge about themself and what happens to them. It is a way of symbiotically joining the analyst, who interprets knowledge, and the patient puts them in the place of truth, of savior, leaving them in the position of the Other. However, the analyst, in turn, does not occupy this place, as they know that they are not the Other, but recognizes that it is what guarantees the analytical situation. The analyst is the Other One in symbolic transference[14].

There is no symmetry between the position of the analyst and that of the analyzed, as the former does not act as a subject, they transfer knowledge to the patient, which is not theoretical knowledge, but ethical knowledge, provoking and sustaining a place over the

subject. The love of transference is directed to knowledge. The transference is based on a failure to know in the Other, in this case, the analyst, who responds to the subject who desires their love, absent themself as the subject. The analyst's imposture enables the emergence of desire, the truth of the subject of the unconscious[14]. The transfer would be the updating of the reality of the unconscious, it is the mobilization of the subject of the supposed knowledge in the free association, which is equivalent to the appeal to the Name-of-the-Father[15].

In the Lacanian view, the transference process, as a technical management, is similar to the Freudian proposal, an effective and essential technical instrument in conducting an analysis, arising from the unconscious representations that are updated in the analytical field, being an important reframing factor.

The differential of transference in the clinic of psychoses

The transference as a concept was theoretically established, as well as the clinical management. Initially, it was related to the clinic of neuroses and, little by little, it was applied in conducting a treatment direction for patients with psychotic structure.

Freud started thinking about psychosis as a dissociation of psychic functions, and not as a mental deficit; when he did Schereber's biographical study, he recognized that the transfer made to the person of their doctor was a precipitating factor of their psychosis, which means that the persecution and the appearance of persecutory figures that were already an effect of the transfer[16]. Another significant point in Freudian studies is delirium as a possibility for the reframing of the imaginary experience[16].

The analyst has, as an ethical principle, respect for what the patient says, it is in this transference relationship that the direction of treatment is conducted. The analyst supports the subject's signifiers, seeing delirium and hallucination as their particular way of dealing with their own castration.

Melanie Klein treated the first case of psychosis (Dick's case) through the psychoanalytic interpretation of playing, considering the analysis of projective introjection[12] essential, which she transferred to the analyst and toys in a real way. The analyst needed to have a maneuver to deal with the impoverished world of subjectivity. This form of management paved the way for her followers to work with psychosis.

In turn, Lacan begins his psychoanalytic training with the thesis that the analyst should not retreat in the face of psychosis[17]. The psychoanalytic view of the existence of a subject, who has an unconscious, a language and occupies a place in the world, gives way to the clinic of psychosis. The psychotic, like the neurotic, is a subject who has been constituted psychically in a different way.

Another relevant point is that the psychoanalytic treatment recommends the subject to their organizations of the psyche, constituted by mechanisms that are psychic defenses, not diseases. The psychoanalytic technique is articulated according to the constituted structure and the defenses associated with it. It does not treat the subject with a psychotic structure in a stereotype of mental illness.

The handling of transference in the treatment is the analyst's, they are the patient's witness, who sustains and secretariats the delusion, since it is in them that the subject are[17].

Lacan's theory on psychoses points out that the outbreak can be triggered in a pre-psychotic state, or in the first analysis sessions, since the analyst starts from the attempt to link the core of psychosis to a relationship between the subject and the pure signifier and their relationships of affection[17].

The fragmentation of the subject, when approaching the true word, places its entrance and its slide in psychosis. The transference, in its dimension of loving deception, reveals the closing time of the unconscious that Lacan defines as: "*updating the sexual reality of the unconscious*" and introduces the category of the Supposed Subject to Know, as the true pivot of the transference[14].

Due to the ideas presented by the primary authors, psychosis has come to occupy a relevant place in the scope of psychoanalytic treatment, a process that has been developing until today.

The possibility of stabilizing the psychotic structure by means of psychoanalytic treatment, the transference being the differential in the treatment of psychosis, does not imply that it is the only possibility, nor the best method of treatment, but it is possible to consider it as scientific knowledge, which can add something in an area so lacking in alternatives.

Transference in psychosis and contemporaries

Freud[18] does not explain the possibility of establishing transference in the treatment of psychosis, nor does it completely rule out this possibility, as can be seen:

> *The persecuted paranoid* […] *cannot see anything in other people as indifferent and take insignificant indications that these other unknown people present to them and use them in their delusions of reference. The meaning of their reference delusion is that they expect something similar to love from all strangers*[18]*.*

The transference, then, is constituted under the *aegis* of love in analysis, of libidinal investment. It can have different features, in the neurosis of transference, erotization, sublimation, idealization, erotomania, projective identification, in the symbolic, as well as in the imaginary. There are several facets, which can be transferred to the analyst in different ways, and the analyst needs to analyze and interpret them.

The transference in psychosis requires a greater libidinal investment on the part of the analyst, they are a living presence, which calls for the responsibility of building a loving bond capable, step by step, of creating an atmosphere of reliability and persistence, which can strengthen the fragile ego that characterizes the psychotic[4].

Hanna Segal[19] notes that "[...] *the psychotic does not stop developing a transference; effect an almost immediate and generally violent transfer to the analyst "*[19].

The difficulty in the treatment is not the absence of transference, but its character; what is difficult for the analyst is to support the transfer, which occurs in a primitive way through the projective identification mechanism. The patient's omnipotent fantasy is placed on the analyst, so that they can get rid of their undesirable fragmented parts, so that the transfer is massive, violent and fragile[19].

Segal[19] was the first analyst who actually worked with a patient whose diagnosis was schizophrenia, using purely the psychoanalytic method. His patient was in the military and, during the officer training course, he had his first crises and was admitted to the military hospital. Treatment began, which lasted 3 years, with 5 weekly sessions. Despite the difficulties in using the technique, it was through the observation of significant differences in treatment that it was possible to initiate a direction of transference in the treatment of psychosis.

The patient did not symbolize the neurotic, the object was used as real. When he lay down on the couch, he remembered the hospital bed and was very nervous. His ideas were purely unconscious, which made the analytical relationship difficult. Interpretations were isolated or abolished from consciousness[19].

Segal pointed out that the ideas needed to be put carefully, so as not to invade him. She noticed that the interpretations of delusions and hallucinations gave them greater relief, dreams had sexual connotations and were related to the ideal object of love, which, in this case, was the analyst, that is, transfer[19]. These observations were interpreted whenever possible. As well as links between thoughts and fantasies, fantasy and reality, believing that the archaic and primitive fantasies of the psychotic suffer repression, but the return happens in collapse and, they need to be analyzed and linked to delusions[19].

As for the transfer process, it was found that the difference was in the management: "[...] *it proved to be the only way to attack the roots of a mental illness, that is, not strengthening the patient's defense mechanisms, but bringing it for the transfer and analyze it "*[19].

This case of schizophrenia, in which the patient achieved significant improvements through the interpretation of defenses, positive or negative contents, are indicators of the possibility of working with transference in psychosis[19].

In the 1950s, Herbert Rosenfeld devoted himself to the study of psychosis, taking advantage of Kleinian ideas on the investigation of very primitive infantile situations in the analytical transference, which compared the treatment of psychotic patients to that of a child, who depends on someone's care for them; they do not lie down on the couch and usually presents difficulties to express themself in words[20]. This leads the analyst to have to communicate through action and gesture, it was suggested to interpret psychoanalytically, through words, the patient's meager gestures and attitudes, in order to understand the terrible anxieties and manifestations of the omnipotent defenses of psychotics[20].

In the transferential manifestations of a schizophrenic patient, the analyst's major problem is to recognize and interpret the transference manifestations in possible poles - negative or positive. If the patient is unable to establish contact with interpretations, the error is not with the patient, but in understanding what was happening in the transference situation. The analyst must interpret transference, to which the psychotic manifestations are linked, developing what Rosenfeld[20] called "transference psychosis", similar to the neurotic transference neurosis.

The transference psychosis presents itself in the analytical situation with psychotic patients or in the psychotic manifestations of the very regressed neurotics. It is a process that aggregates the projective identifications that are directed to the analyst. The patient throws their destructive and threatening part at the analyst, in an attempt to expel it from within themself, it is a way of showing the analyst the emotions and anxieties they cannot manage put in the word[20].

In the same decade, Bion[21], also a follower of Kleinian perspectives, proposed a comprehensive theory of schizophrenia, based on the language of schizophrenics. He points out that the psychotic lives in a fragmented world, without differentiation between themself and objects, which provokes feelings of terror, because they threatened by bizarre objects. This form of psychic construction prevents the symbolization process, making it difficult to articulate and integrate language. The psychotic cannot synthesize, words acquire a dimension of concreteness. Communication takes place through acting, a primitive communication that, due to the absence of symbols, produces massive effects on the other, in the case of transference to the analyst.

In analytical practice, attention is drawn to the countertransference process, negative therapeutic reactions that the analyst may have when faced with the chaotic contents of the psychotic; the destructive attacks that the patient directs to the analyst are strong, as an effect of excessive projective identifications[21].

In psychosis, as in any structure, there are psychotic and non-psychotic parts[21], this makes it possible to establish transference in any structure, what will differentiate is technical management.

In Zimerman[22], "[...] *every psychotic patient has a part of a neurotic nature, every neurotic patient has an underlying and hidden" psychotic part*". And yet, it shows that, in the psychotic, not only are projective identifications used as a way of discharging intolerable feelings and ideas. The form of non-verbal language triggers in the analyst the effects of what they cannot speak verbally, promoting psychotic transference[22]. The analyst-patient relationship can be installed in a primitive way, being fragile and unstable[22].

The analyst is constantly subjected to idealization and degradation, oscillating between savior and destroyer, being accused by the patient for all their sufferings and indifference[22].

It is a difficult process, which requires the analyst's effort to be able to withstand the patient's endless attacks and, for that, the establishment of a sedimented bond is extremely important to sustain the transfer.

Soler[23] states that "the analyst is called to fill with their predications the emptiness suddenly perceived by foreclosure" *(our translation)*, it is that who guides the patient's enjoyment in psychosis, using a saying by which the analyst becomes guardian of limit of enjoyment, without which horror can be absolute.

The analyst operates between the position of witness and orientation of jouissance, unlike the Lacanian proposal in which the analyst is silent[23]. The psychotic patient demands that the analyst be their oracle and legislate for them, the analyst becomes the voice of the psychotic. They take their speech as truth, and the transfer maneuver can prevent outbreaks from emerging.

In the clinic of psychosis, jouissanceis not interpreted, as it can only be repressed; in the case of the psychotic, it is only necessary to elaborate their delusions[23]. In this way, the transference maneuver in psychosis teaches that it is necessary to operate an emptying, avoiding offering psychotics elements that make them put the analyst in the place of the absolute Other, in which he becomes purely an object.

The psychotic, due to the structural lack of mechanisms to symbolize the separation, is linked to the concrete presence of the object. It is as if, in the physical absence of the object, it was difficult to continue knowing about its existence. The psychotic will carry this characteristic for their "relationship" with people, including the analyst. Therefore, the physical presence of the analyst and the establishment of a "active transfer" relationship[4] are significant points, which corroborate with the clinic of psychosis.

The need for the presence of the Other implies an enlargement of the setting, that is, the analyst needs to provide a contact resource for the patient's moments of anguish, which is usually done by telephone contact outside the session. They need to know that they can use it, that there is someone who listens to it.

The transference in psychosis is direct and, in cases of severe crises, it can be extremely destructive, as the patient offers the analyst all its fragments, so that they can use themself and make their enjoyment, its completeness. This is how the patient puts the analyst in the transfer.

The work with patients with psychotic structure, called "*Grupo Vida*", gave rise to a psychoanalytical research on a treatment direction managed by active transfer[4].

The management of transference in the clinic of psychoses is directly related to knowledge about the conduct of treatment, which is not knowledge about the patient. It is essential that the analyst knows how to locate the subject's position in case of absence, to measure the weight of their intervention. Intervention by the word of the psychotic patient is fundamental, in order to help to recover some distance between subject and passage to act, ensuring the presence of the symbolic through verbalization[4].

The word can allow the psychotic to articulate what is real, imaginary and symbolic; the use of the word has an organizing function. The analyst must support the patient to speak. When accepting the speech of the psychotic, the unconscious that is in the open is welcomed, enabling the transference. Taking as an example the speech of Pardal, a member of*Grupo Vida*[4]:
... I need to speak not to do it "[committing a crime, killing the rapist's family or anyone, as it appears in his fantasies], speech recorded in the session of January 5, 2011. He managed to take another step by bringing his destructive impulse in the form of a nightmare: "Tonight I had a nightmare. I was on a bus raping and doing bad things. I can't remember anything else, he deleted it". Then he commented: "The thought of revenge still comes."

For there to be a transfer, it is important to think that one has to bet on the emergence of a subject and that from there a transfer can be inscribed, so that in a second moment there is some subjectivity. It means that, if it is in the field of the Other that the subject is constituted, when the psychotic speaks to the analyst, there is a possibility that the testimony of the analyst allows the subject some subjectivity about their life, about the meaning that the patient can find in their productions[4].

The analyst's presence and discourse can guarantee the psychotic their place as a subject in the transference relationship. It is necessary that psychoanalysts have the courage to continue to explore and plow the arid and artful terrain of psychosis.

Active transference - the acting of Love

The idea of active transference is supported by classic and contemporary approaches, which admit the existence of transference in the analytical relationship with psychotic patients; it is a different transfer from the neurotic.

The psychotic structure is split, does not form an associative chain, has no defense mechanisms, which causes a strangulation of the Ego. This is literally taken over by the phenomena of the unconscious, dragging the subject into the emptiness of psychosis. In order to support this emptiness, the psychotic uses delusional and hallucinatory productions to build an imaginary world and not be swallowed up by emptiness.

From the Freudian legacy, the practice of psychoanalysis is inherited through the method of free association, the interpretive technique of the unconscious, resistance and transference. Lacan demonstrated that the subject is constituted in the structure of language through the S/s algorithm, to say that the signifier induces the effects of the signified. He says that "*the symptom is a metaphor*". The metaphor is a function of the signifier, which replaces another signifier that is repressed, generating an effect of signification, always unprecedented[24].

So, how then is the psychotic who has a language, but stays out of the discourse? If the symptom is a metaphor and the psychotic does not have a symbolic system? How is the transference relationship between patient and analyst? This means that when it is said that all roads lead to Rome, for the psychotic all roads lead anywhere else, it is complete dispersion.

For the psychotic, all paths lead to the non-existence of the primordial lack, this is the indicator of the existence of love. Thus, the psychotic is constantly affected by bizarre situations that feel like real, they live an eternal nightmare, which leaves them suspended in the abyss of psychosis.

Psychosis is a void, a context that cannot be seen from the edge or the bottom, the subject is always in free fall. It is in this place that the analyst enters, with the active transference that they can build a bridge that takes them somewhere; sometimes they throw it to the bottom, sometimes it takes it to the edge[4].

The relationship established with the analyst also occurs in a bizarre way, the patient desperately seeks a way to live. The psychotic does not seek knowledge about themself as the neurotic does, but a way of being able to live, and the relationship with the analyst takes place in this field, of living and not of knowledge.

It is the analyst who will promote a kind of transferential relationship, which will support the subject's existence and, thus, concrete paradigms can be created in the tasteless unconscious. It would be a restoration, but in theory, the question of how it is possible to place the psychotic in a subject connection persists. It is precisely at this point that the establishment of active transference is proposed, an operation that is inverse to neurosis, which would be the rectification of the Other[24], of the subjective, initiated by the transference with the analyst.

In psychosis, the subject's composition with its symptom occurs between living and the lack of the object; in this sense, the transfer comes to occupy another place in the clinic, the possible relationship with the analyst is in the field of living and not of knowledge.

Active transfer makes it possible to establish a meaningful object connection, that is, the analyst causes the transfer, presenting an object bordered with affection, for the psychotic subject to establish a relationship. The patient experiences the symptom through the active transference relationship promoted by the analyst, in order to first have a significant object and, later, introject as a good object[4].

It is questioned about: *What place does the analyst speak of, what position? According to Albino[4]:*

> *"It is not from the mothering position, it does not interpose itself as the lost mother, but as a successor to the Name-of-the-Father, as an Other who speaks, but from an interdicted position, as from an Other that means for the subject the your place in the world"[4].*

What use does the analyst make of speech? It is the one that makes the rule work, for example: "*if you don't take the medicine, I won't help you; you have to follow the treatment with your psychiatrist; you cannot stop coming to the group, you need to hear your colleague speak*". A pact is promoted through speech, a pact that symbolizes your absences, presence, limits of your actions and behaviors, such as, "*I will wait for you on your schedule*", "*you can call me if you are in crisis*".

The analyst does not base their intervention on maternal attitudes, placing themself as pure desire is an impulse of love. It attracts to itself the fragmented parts of the psychotic unconscious, bordering them with loving affection and meaning. It is the pure representation of love that redirects the fragments to the psychotic of the psychotic, now, with a representation of order, with a look, with a word or just a letter. This force gradually attracts other objects to its surroundings, giving them other acceptable and bearable meanings.

Pure desire is a power marked by the puncture of the love drive, which indicates a direction, which can inscribe a letter, a sign there. It is not an experienced desire, but a singular field, a point within the structure of the analytical relationship. It is an attractive field, where the psychotic can encrypt and be encrypted and communication will take place through the split parts of the structure.

In the analyst's situation, tgeir unconscious, which went through the inscription of the Other's desire, desire for pure "*thing*", attracts the unconscious unconscious of the psychotic. It makes a suture, a joint, forming a closed set.

In this set, the patient can be taken to the edge, leaves the suspension time, can feel the drive power, without being destroyed by it. The analyst returns to the patient the power associated with an object, with a letter, essential elements in the articulation and meaning of the word and objects[4].

It can often seem strange, as it is something new, but not shattered. The analyst enters the patient into the game of fragments, whose pieces are loose, isolated, mixed and disparate and, together, they will work towards forming a mosaic. The cracks remain, but with an image, with a history that allows you to get out of the suspension time. The form of relationship established in this field is what is being called active transfer[4]:

> *... active transference is a voice that includes itself, that speaks, punctures, leaves a mark and has a name (psychoanalyst, psychiatrist, medicine, group, family, contact, telephone, listening, understanding, support, limit, no, yes , and others.) that the patient calls when they evoke. It is a summons that happens, not by chance, but through something that can be called love. It is a love that is built, conquered and that remains unshakable. It is able to listen, to position itself, to interdict or to validate, without invading. It creates an edge, sustains the passage through the hole and is reunited on the other side, stating that it is possible to enter and leave the emptiness of psychosis. It leaves a mark that has no name, a mnemic mark that indicates the presence, the existence of a love called "analyst". This mark is what allows the construction of a bridge between the internal and the external, between the present and the past, helping the connection of the two worlds; thus, the psychotic can come out of the darkness of not existing. He can manifest himself, learn to organize himself, put the pieces of himself together and start living*[4].

Active transference opens the way for an also active interpretation, which occurs through the analyst's unquestionable word, it is pure living, not supposed to know, as in the interpretation with the neurotic. It is a word that leaves no doubt or exit, unless the one given by the analyst. It is, therefore, called active, it is an acting of love, a symbolic action, directed exclusively at the psychotic patient's unconscious.

The interpretative action allows the patient to visualize and accept their imaginary universe and, thus, to be able to understand and differentiate them from the real world, which makes them remain in reality most of the time, away from delusions, hallucinations and institutional admissions.

The analyst's active intervention puts the patient in the place of responding to one of the Father-Names, the "*analyst*". It is the "*one*" that desires you, gives you a limit, makes a contour, even if miserable, but it is a place. Thus, they can anchor and stop floating in the unconscious infinite. They come into existence and has someone to answer to, from the hole left by the analyst's pure desire.

The analyst's active word allows the psychotic patient to have a truth to support their existence, the acting of love allows them to believe in a truth: that the analyst is able to help them live. This imaginary becomes an attracting and organizing pole of the fragmented drives of the psychotic.

The analyst's image will be introjected as the only figure capable of making them live. It is a very difficult condition, as the analyst must endure the emptiness of psychosis and, above all, believe in the possibility of helping the psychotic to live better. This place, occupied by the analyst who is willing to work with the psychotic structure, can only be of pure desire, so that the void occupies the whole setting and mind of the analyst. It is pure detachment from itself, only then can it move through the world of psychosis without psychotizing, and bring from the heart of the unconscious the subject who strives to live.

These reflections do not mean that the psychotic will constitute a neurotic ego, but that, through active transference, they can join the innumerable fragments, tying them together, forming a mesh, like a fisherman's net. The fish is spotted, not tied, it does not escape because it only goes forward, following the flow of the current, this is how the fisherman catches it[4].

In the case of psychosis, the unconscious is, as Soler[23] says, "*out in the open*", which leaves the subject in the eternal void. Returning to the metaphor of the fisherman's net, it outlines them, makes them perceive a dimension of reality. Between the nodes, there is a space that the subject "gets spotted", in a place, in a space that gives them a limit, supporting them from the void. They are trapped by the hole left by the analyst's pure desire.

From this field, the psychotic can begin to glimpse a subjective world, where the active transference, which is a symbolic action, allows them to make a differentiating limit between imaginary and real. Thus, they can perceive themself as a subject, as a body marked by loving affection, as a name. They may have an answer for themself, an answer for living.

Active transference is a fundamental analytical act towards the treatment of psychoses. It is a management applied both in personal analysis and in groups of patients with psychotic structure.

CONCLUSION

Active transference supports the group and individual analytical process, so that the analyst establishes a strong connection with the psychotic patient, who desperately seeks a way to be able to live better.

This type of transference places the analyst face to face with the unconscious in the open, it has no bars, no limits, no edge.

The analyst, using active interpretation, puts the law to work. It is the thrust of love, exercised by active transference, that will keep the psychotic subject minimally in the temporal, chronological reality and, above all, will keep the fragmented parts of the psyche and the fragmented own body together. The analyst enters as a contour, giving an edge, limits, establishing a link that sustains them, in the sense of creating a rudimentary symbolic.

In this article, the limitation is the possible view of other types of approaches, in academic productions such as integrative or systematic reviews on the theme, and it has not yet intended to exhaust the theme, nor to state that active transference will "cure" psychosis, and that will manage to keep the fragmented psyche of the psychotic integrated. Thus, academic studies in other types of reviews are suggested to better understand the perspective of the clinic for patients with psychotic structure.

In turn, the direction of treatment supported by active transference, integrated with other areas of knowledge, such as psychiatry, creative and projective techniques of psychology, and individual and group psychoanalytic listening, can help to significantly improve quality of life of these people who are plagued by the intense suffering imputed by psychosis.

REFERENCES

1. Freud S. A dinâmica da transferência (1912). In: Freud S. O caso Schreber, artigos sobre técnica e outros trabalhos (1911/1913). Rio de Janeiro: Imago; 1996.p. 60-73. (Edição Standard Brasileira das Obras Completas de Sigmund Freud; 12).
2. Moreira FB. A transferência na relação analítica: um retorno a Freud e Ferenczi. Semina, CiêncSoc Hum. [Internet]. 2018 [cited in 09 Mar 2021]; 39(1):85-94. Available from: http://pepsic.bvsalud.org/pdf/sem/v39n1/a08.pdf
3. Ferreira DD, Carrijo C. O manejo transferencial em Freud: uma análise da relação entre transferência e sugestão. Ágora [Internet]. 2016 [cited in 09 Mar 2021]; 19(3):393-424. Available from: https://www.scielo.br/pdf/agora/v19n3/1809-4414-agora-19-03-00393.pdf
4. Albino A. Encontros e desencontros na clínica da psicose: uma reflexão psicanalítica. São Paulo: Instituto Langage; 2015. 128p.
5. Silva CM, Macedo MMK. O método psicanalítico de pesquisa e a potencialidade dos fatos clínicos. PsicolCiênc Prof. [Internet]. 2016 [cited in 09 Mar 2021]; 36(3):520-33. Available from: https://www.scielo.br/pdf/pcp/v36n3/1982-3703-pcp-36-3-0520.pdf
6. Roudinesco E, Plon M. Dicionário de psicanálise. Rio de Janeiro: Jorge Zahar; 1998. 878p.
7. Freud S. Estudos sobre a histeria (1893-1895). Barreto L, tradutora. São Paulo: Companhia das Letras; 2010. 220p. (Obras completas; 2).
8. Freud S. A psicologia dos processos oníricos. In: Freud S. A interpretação dos sonhos (II) e sobre os sonhos (1900-1901). Rio de Janeiro: Imago; 1996. p. 115-86. (Edição Standard Brasileira das Obras Completas de Sigmund Freud; 5).
9. Freud S. Fragmento da análise de um caso de histeria (1905[1901]). In: Freud S. Um caso de histeria, três ensaios sobre sexualidade e outros trabalhos (1901-1905). Rio de Janeiro: Imago; 1996. p. 3-150. (Edição Standard Brasileira das Obras Completas de Sigmund Freud; 7).
10. Freud S. Recordar, repetir e elaborar (Novas recomendações sobre a técnica da psicanálise II) (1914). In: Freud S. O caso Schreber, artigos sobre técnica e outros trabalhos (1911/1913). Rio de Janeiro: Imago; 1996. p. 163-71. (Edição Standard Brasileira das Obras Completas de Sigmund Freud; 12).
11. Freud S. Observações sobre o amor transferencial (Novas Recomendações sobre a técnica da psicanálise III) (1915 [1914]). In: Freud S. O caso Schreber, artigos sobre técnica e outros trabalhos (1911/1913). Rio de Janeiro: Imago; 1996. p. 177-88. (Edição Standard Brasileira das Obras Completas de Sigmund Freud; 12).
12. Klein M. As origens da transferência. In: Klein M. Inveja e gratidão e outros trabalhos (1946-1963). Rio de Janeiro: Imago; 1991. p. 70-9. (Obras completas de Melanie Klein; 3).
13. Klein M. A técnica da análise infantil. In: Klein M. Psicanálise da criança. 2a ed. São Paulo: Mestre Jou; 1975. p. 25-170.
14. Lacan J. A transferência no presente. In: Lacan J. O seminário, livro 8: a transferência 1960-1961. Rio de Janeiro: Jorge Zahar; 2010. p. 169-81.
15. Lacan J. Presença do analista. In: Lacan J. O seminário, livro 11: os quatros conceitos fundamentais da psicanálise. Rio de Janeiro: Jorge Zahar; 1988. p. 119-29.
16. Freud S. A perda da realidade na neurose e na psicose (1924). In: Freud S. Um caso de histeria, três ensaios sobre sexualidade e outros trabalhos (1901-1905). Rio de Janeiro: Imago; 1996. p. 107-10. (Edição Standard Brasileira das Obras Completas de Sigmund Freud; 19).
17. Lacan J. De uma questão preliminar a todo tratamento possível da psicose. In: Lacan J. Escritos. Rio de Janeiro: Jorge Zahar; 1998. p. 537-90.

18. Freud S. Notas psicanalíticas sobre um relato autobiográfico de um caso de paranóia (dementia paranoides) (1911).In: Freud S. O caso Schreber, artigos sobre técnica e outros trabalhos (1911/1913). Rio de Janeiro: Imago; 1996. p. 3-51. (Edição Standard Brasileira das Obras Completas de Sigmund Freud; 12).
19. Segal H. A obra de Hanna Segal: uma abordagem kleiniana à prática clínica. Rio de Janeiro: Imago; 1983. 313p.
20. Rosenfeld HA. Os estados psicóticos. Rio de Janeiro: Zahar Editores; 1968. 293p.
21. Bion WR. As transformações: a mudança do aprender para o crescer. Corrêa PD, tradutor. Rio de Janeiro: Imago; 1991. 194p.
22. Zimerman D. Manual da técnica psicanalítica. Porto Alegre: Artmed; 2004. 472p.
23. Soler C. Estudios sobre laspsicosis. Buenos Aires: Manantial; 2008. 170p.
24. Lacan J. O seminário, livro 3: as psicoses. Rio de Janeiro: Jorge Zahar; 1985. 366p.

Associate Editor: Fernanda Carolina Camargo

CONTRIBUTIONS
Araceli Albinowas responsible for the study design, data analysis, writing and reviewing.

How to cite this article (Vancouver)
Albino A. Active transference: a clinical management in the treatment of psychoses. REFACS [Internet]. 2021 [cited in*insert day, month and year of access*]; 9(2):450-62. Available from: *insert access link*. DOI: *insert DOI link*

How to cite this article (ABNT)
ALBINO, A. Active transference: a clinical management in the treatment of psychoses. **REFACS**, Uberaba, MG, v. 9, n. 2, p. 450-62, 2021. DOI: *insert DOI link.*Available from: *insert access link*. Access in: *insert day, month and year of access*.

How to cite this article (APA)
Albino, A. (2021). Active transference: a clinical management in the treatment of psychoses. *REFACS*, *9*(2), 450-62. Retrieved in*insert day, month and year of access*from*insert access link*. DOI: *insert DOI link*.