or justified and shame and guilt are inappropriate. It is indeed the lack of shame which makes these alliances with omnipotent figures so dangerous since normal restraints on destructiveness and cruelty are rendered inoperative.

This kind of alliance arises when something has gone radically wrong in the relationship with primary objects in the nuclear family. It is these figures – chiefly the parents, of course – which make up the normal superego, and because it results from the internalization of human figures, the normal superego is a human one with ordinary human hopes and fears. If these objects are destroyed, or if the parental imagos are too distorted by the projection of primitive sadism, a more primitive, powerful, and cruel superego will result (Klein 1932). If the guilt becomes unbearable, self-mutilating attacks on the perceiving ego may be resorted to and the resulting damage leaves a disability which can only be patched over by means of omnipotence since ordinary human figures are too weak to be of help.

The individual is then possessed by more monstrous forces, and since these contain projected parts of the self a complex structure results. Here too we have a pathological organization of the personality, but one organized at a more primitive level. Whereas all pathological organizations are basically narcissistic in structure, they differ markedly in form. When they take on a paranoid grandiosity, as in *Oedipus at Colonus*, they seem to protect the individual from paranoid-schizoid disintegration and fragmentation. Sometimes the psychotic character of the retreat, and of the organization underlying it, is obvious, but at times of crisis its psychotic nature may be more difficult to recognize. At these times omnipotence is so much sought after by all of us that we are ready to accept as a hero what in normal circumstances we would recognize as a madman.

Vellacott suggests that Sophocles has, throughout the play, separated the *sacred* from the *good*. At times of crisis the good is treated as a weakness which we cannot afford because survival demands a reliance on powerful gods whose sanctity must not be questioned. We are fortunate then if the *good* can be located in a group or an individual where it might survive until it can again be recognized. Near the end of *Colonus*, the Chorus liken Oedipus to 'A rock in a wild north sea at winter's height, fronting the rude assault of all the billows of adversity that break upon his head from every side unceasing'. It is clear that for him *strength* is a priority, and what remains of hope lies in Antigone who pleads to Theseus, 'Then pray you see us safe returned to age-old Thebes. There it may be we can yet stem the tide of blood that dooms our brothers.'

11

Problems of psychoanalytic technique: patient-centred and analyst-centred interpretations

Patients who withdraw excessively to psychic retreats present major problems of technique. The frustration of having a stuck patient, who is at the same time out of reach, challenges the analyst, who has to avoid being driven either to give up in despair or to over-react and try to overcome opposition and resistance in too forceful a way. The situation is one where the patient and analyst can easily be at cross purposes. The patient is interested in regaining or retaining his equilibrium, which is achieved by a withdrawal to a psychic retreat, while the analyst is concerned to help the patient emerge, to help him gain insight into the way his mind works, and to allow development to proceed.

Joseph (1983) has pointed out that the patient, in this state of mind, is not interested in understanding, and uses the analysis for a variety of purposes other than that of gaining insight into his problems. In these circumstances his main concern is to obtain relief and security by establishing a mental equilibrium and in consequence he is unable to direct his interest towards understanding. The priority for the patient is to get rid of unwanted mental contents, which he projects into the analyst, and in these states he is able to take very little back into his mind. He does not have the time or the space to think, and he is afraid to examine his own mental processes. Words are used, not primarily to convey information, but as actions having an effect on the analyst, and the analyst's words are likewise felt as actions indicating something about the analyst's state of mind rather than offering insight to the patient. If the analyst believes his task is to help the patient gain understanding and if the patient is unwilling or unable to tolerate such understanding, then an impasse is likely. Such situations are not uncommon and present distressing problems for patient and analyst alike.

Throughout this book I have discussed different ways in which contact with the analyst, and with reality, can be evaded, distorted, and misrepresented, and I have described how various mechanisms are brought into play when reality is unbearable. When these mechanisms are welded into a pathological organization of the personality which provides a retreat from reality, the analyst may be tolerated only if he submits to the rules imposed by the organization. Pressure is put on him to agree to the limits which the patient sets on what is tolerable, and this may mean that certain types of interpretation are either not permitted or not listened to. If the analyst becomes too insistent that his task is to help the patient gain insight and develop, an even more obstinate withdrawal to the retreat may result and an impasse can materialize which is extremely difficult to negotiate. If, on the other hand, the analyst takes too passive a stance, the patient may feel he has given up, and may see the analyst as defeated or dishonestly caught up in a collusion with a perverse organization.

The formidable technical problems which arise from this situation are, in part, therefore, due to the uncomfortable counter-transference feelings which are evoked in the analyst. The patient is usually acutely aware of the discomfort in the analyst but is unable to recognize his role in the creation of the situation and is unaware or unconcerned with his own internal problems. The analyst's interpretations are felt as intrusions threatening his place in the retreat, and he fears that if he emerges from its protection he faces either persecutory disintegration or unbearable depressive pain.

In this chapter I want to make a distinction between *understanding* and *being understood*, and point out that the patient who is not interested in acquiring understanding – that is, understanding about himself – may yet have a pressing need to be understood by the analyst. Sometimes this is consciously experienced as a wish to be understood, and sometimes it is unconsciously communicated. A few patients appear to hate the whole idea of being understood and try to disavow it and get rid of all meaningful contact. Even this kind of patient, however, needs the analyst to register what is happening and to have his situation and his predicament recognized.

The transference is often loaded with anxiety which the patient is unable to contend with but which has to be contained in the analytic situation, and such containment depends on the analyst's capacity to recognize and cope with what the patient has projected and with his own counter-transference reactions to it. Experience suggests that such containment is weakened if the analyst perseveres in interpreting or explaining to the patient what he is thinking, feeling, or doing. The patient experiences such interpretations as a lack of containment and

feels that the analyst is pushing the projected elements back into him. He has projected these precisely because he could not cope with them and his immediate need is for them to continue to reside in the analyst and to be understood in their projected state.

Some analysts, in these circumstances, tend to phrase their interpretations in a form which recognizes that the patient is more interested in what is going on in the *analyst's* mind than in his own. At these times the patient's most immediate concern is his experience of the analyst, and this can be addressed by saying something like, 'You experience me as . . .', or 'You are afraid that I . . .', or 'You were relieved when I . . .', or 'You became anxious a moment ago when I . . .'. I think of such interpretations as *analyst-centred* and differentiate them from *patient-centred* interpretations, which are of the classical kind in which something the patient is doing, thinking, or wishing is interpreted, often together with the motive and the anxiety associated with it. In general, patient-centred interpretations are more concerned with conveying understanding, whereas analyst-centred interpretations are more likely to give the patient a sense of being understood.

Of course, the distinction between the two types of transference interpretation is schematic, and in a deeper sense all interpretations are centred on the patient and reflect the analyst's attempt to understand the patient's experience. The problem is to recognize where the patient's anxieties and preoccupations are focused. In practice, most interpretations take into account both what the patient feels and what he thinks the analyst feels and include a reference to both patient and analyst. When we say, 'You experience me as . . .' or 'You are afraid that I . . .', a *patient-centred* element is present because we are talking about the patient's 'experience' and 'fear'. Moreover, it is clear that the distinction depends more on the analyst's attitude and state of mind than on the wording he uses. If the analyst says, 'You see me as . . .' and implies that the patient's view is one which is in error, or hurtful, or in some other way undesirable, then the emphasis is on what is going on in the patient and the interpretation is primarily patient-centred. To be analyst-centred, in the sense which I intend to use it, the analyst has to have an open mind and be willing to consider the patient's view and try to understand what the patient means in a spirit of enquiry. Although these considerations complicate the distinction between the two types of interpretation and suggest gradations between them I will consider them to be distinct for the sake of clarity. Both types of interpretations are necessary for the patient's total situation to be understood and both types have dangers attached to them if they are used excessively and without due attention to the feedback the patient gives about his reaction to them.

Sometimes the *patient-centred* element is elaborated further, and we may say something like 'You are *trying* to get me to feel . . . such and such', or, 'Your attack on me just now gave rise to such and such a result'. The interpretation then involves a *link* between what the patient does, thinks, or wishes, and the state of the analyst. Sometimes these links take the form of a *because* clause which is added to an *analyst-centred* interpretation. We may say, 'You are afraid that I am upset *because* of the fact that you did such and such.' Such links are the essence of deep analytic work but are particularly difficult for the patient who is caught up in a pathological organization of the personality. They imply that he is not only capable of taking an interest in his own actions but able to accept responsibility for them as well, and this implies a degree of independence which challenges the dominance of the organization. It is especially in these patients and in the early stages of an analysis that it is necessary to recognize the problems which ensue from both types of interpretation and from the links which arise between them.

Clinical material

I believe that the distinction between these two types of transference interpretation can help the analyst to examine the technical problems he has been struggling with and may allow him to shift from one type of interpretation to the other when it appears to be appropriate. In order to examine these issues I will first briefly look again at the material from a psychotic patient (Mr C) which I have discussed in greater detail in Chapter 6.

This patient was very paranoid and concrete in his thinking, and spoke with triumph about his ability to hurt the analyst which he connected with the way he hurt his mother when she had a breast infection when he was a baby. He then announced his intention to change his job, which meant ending his analysis, which made the analyst feel sad at the idea of losing his patient. This led the analyst to make a patient-centred interpretation, saying that the patient wanted to get rid of his own sadness and wanted *him*, the analyst, to feel the pain of separation and loss. The patient said, 'Yes, I can do to you what you do to me. You are in my hands. There is an equalization.' A moment later he started to complain that he was being poisoned, and after discussing government policies of nuclear deterrence he complained of gastric troubles and diarrhoea and explained that he had to shit out every word the analyst gave him in order not to be contaminated by infected milk.

It seems to me that the patient found the patient-centred interpretation to be threatening because it exposed him to experiences such as grief, anxiety, and guilt, which were associated with the loss of his analyst. He felt that the interpretation had forced him to take these feelings back into himself and he experienced them concretely as poison and tried to evacuate them in his faeces. The patient indicated the catastrophic nature of his anxiety by talking about nuclear disaster. He needed the analyst to recognize that he could maintain a relationship with him only if the analyst agreed to hold the experiences associated with loss in his own mind and to refrain from trying to return these prematurely to the patient. After a transient contact with the experience of loss the psychotic process re-asserted itself in the patient's assertion that he would shit out every word the analyst said.

This is a situation where the interpretation may be unbearable even when it is correct. The psychotic process has made experience so concrete that insight is poison and has to be evacuated in faeces. When the analyst suggested that the patient wanted to get rid of his sadness and wanted the analyst to feel the pain of separation and loss, he was making a link between the patient's wishes and the analyst's state of mind. The patient felt that the analyst disapproved of these wishes and was himself pushing the distressed feelings back into the patient, and this led him to withdraw once more to the protection of the psychotic organization which asserted that disturbing insight was poison.

A different situation is seen when the patient is not psychotic and has a greater capacity to tolerate understanding and insight. This was the case in the material I will next discuss taken from the analysis of a 40-year-old academic woman (Mrs G) some two years after her analysis began. As a child she habitually withdrew to a phantasy world in which she joined figures from books or television to escape from the distress and anxiety going on in the family around her. The history contained many reports of extremely disturbed, wild, and even violent behaviour, and she often found herself in situations where she seemed to invite exploitation, mistreatment, and even danger. This was particularly true in her adolescence and was now being repeated by her 14-year-old daughter who created enormous problems for her.

After missing a Monday session she began on Tuesday by saying, 'I wondered if you would get the message. I spoke to a girl who said that she would put it in your drawer. I know what happens to messages like that. On Sunday I had wondered about ringing you at home.

'On the train I imagined meeting someone I know who would ask, "How are you?" I would reply, "Fine, only my department is collapsing, my daughter has run off and I don't know where she is, my husband is fed up and helpless and otherwise I am fine."'

She continued by explaining that she had missed Monday because of an important meeting with the university bursar to discuss finance which she decided she had to attend. She knew about this on the weekend and had wondered if she would phone to see if I could offer a different time. Instead she phoned my secretary early on Monday morning and, suspecting that the message would not reach me, had phoned again during her session time to explain that she was not coming. In fact it turned out that just before going into the meeting she was told it would be better if she did not attend and she said that they implied that she would be a liability. She added that there was something theatrical about the way her colleagues were behaving and that, as a result, the negotiation with the bursar was not straightforward.

It is clear that we already have a complex communication and enactment between patient and analyst. There is a patient who wants to get a message through to her analyst and various obstacles come in the way. There is a woman who tells a friend that everything is fine but makes sure that she knows there are disasters all round, and there is a professor who tries to attend an important meeting but is told she is not wanted because she is a liability. These stories all have powerful transference implications which I believe centre on the patient's need to get through to the analyst that there is something very seriously wrong which needs attention. This need to get a message through is central to the interactions in the session but it is complicated by other motives. For example, it was possible to recognize a perverse side of her, which hated being understood, and which hindered or sabotaged communication, making everything far from straightforward. The imagined comment to the friend on the tube is not simply a message indicating how she feels, but is likely to make the person hearing it very uneasy, guilty, and confused.

In this situation I believe it is possible to concentrate our attention on either the patient's or the analyst's state of mind, mental mechanisms, and behaviour. Ultimately, the aim of an analysis is to help the patient gain an understanding of herself, and even in this material interpretations could have been used to explore the way she reacted and behaved. However, in this instance, I believe the patient was primarily concerned with the way her objects behaved. She felt that I did not make it easy for her to make contact with me on the weekend, and she had to overcome a feeling that she was a liability and unwanted if she intruded. Consciously she felt that she did her best and tried to get through to my secretary but she knew what happened to messages which are supposed to be left. When she imagined saying everything was fine she was partly being ironic, and partly trying to

make me uncomfortable. Moreover, she left open the possibility that she was being theatrical, so that it was not clear what her inner reality was. I thought there were elements of despair and helplessness in the way she felt obliged to say she was fine and to go on coping somehow. The statement, although clearly a negation of feeling fine, left it open to the analyst to choose to ignore the irony and against all the evidence to hear her to mean that she *was* actually fine. She herself was sometimes convinced that this was the case and that it was other people who were making an unnecessary fuss. These thoughts led me to feel that despite the fact that she was not always able to carry out a straightforward negotiation she needed me to recognize her desperation and she feared that I would prefer to agree that everything was fine even though I knew very well that the contrary was true.

It would have been quite possible to use *patient-centred* interpretations and, for example, discuss the way she used irony, provocation, and passivity to create a situation where she was misunderstood, but I thought she would experience this as an attempt to make her responsible for her failure to get through to me, and that it would indicate my reluctance to accept responsibility for my contribution to the obstacles which stood in her way. In fact, it was probably true that her passivity and inability to fight for her needs helped to achieve the projection into me of guilt, pain, and responsibility. If so she would, in principle, benefit from an understanding of these mechanisms, which no doubt contributed to her difficulties, but I feared that she was in no state to be interested in understanding issues such as this. What she wanted was that I recognize that something was terribly wrong with her and that I accept the feelings this aroused in me and refrain from projecting them back into her. She was afraid that I was not going to be able to cope with these feelings because they would disturb *my* mental equilibrium.

I interpreted that she feared I was not able to create a setting where messages would get through to me, and I drew her attention to the atmosphere of the current session where she seemed relatively composed. I said that she hoped that I would see that beneath this composure things were very far from fine. However, I found myself saying that she also hinted that something theatrical was going on and I wondered if this was expressed in the way she tried to make contact. I suggested that this left her unsure if I could see through the theatricality to what she really felt.

After I had spoken I realized that this additional comment had a somewhat critical tone to it which I suspected arose from my difficulty in containing feelings, including those of anxiety, about her and possibly my annoyance that she made me feel responsible, guilty, and helpless. It is an example of a 'double-barrelled' interpretation in which

the analyst is not content to make a single point but adds a second which is nearly always unnecessary and often unhelpful. In this instance I knew from past experience that a comment with a critical tinge could lead to the enactment of a sado-masochistic relationship in which she would feel the victim of an unfair attack and withdraw in silence.

She was silent for a while and then spoke of the fraught relationship she was having with her daughter. She described the way she wound everyone up and how she had screamed that she could not bear to live with them and had stormed out. At first she said it was for good, but later she phoned and said she would be back for school on Monday. In fact, she failed to turn up, and Mrs G had to ring the school and explain because they were also at the end of their tether with her and had threatened expulsion. She told them she knew it was terrible, but what could she do?

I considered this to be a comment on the interaction which had just taken place and a reaction to the interpretation I had made. At one level I thought she felt I had been critical, and like her daughter she had the impulse to withdraw in anger. It was difficult to know how to respond, but I thought it was probably better to refrain from emphasizing this side of the relationship. I did not think she would be able to take responsibility for her contribution to the difficulties in communication between us, and that interpreting them would probably feed a view of herself as an abused victim. I thought she disowned these feelings in the session and identified with me as a parent who could not cope.

It was thoughts like these which made me interpret that she needed me to accept the sense of helplessness when my patient disappears which may be something like her feeling when her daughter disappears. She needed me to cope with the anxiety associated with her not coming to her session and not being able to get in touch with me. She felt I blamed her for this just as she now feared I was too critical and defensive to understand her anger and disappointment with me and to recognize that she also wanted to make contact, she had not in fact withdrawn and did try to reach me and get through to me.

After a silence, she continued with more material about her daughter and the dangerous company of older criminal youths she was associating with. She described how she had tried to trace her by phoning her friends and their parents, and that when she had discovered this she was furious, abusing Mrs G and accusing her of spying on her and controlling her. She had also tried to get her ex-husband, her adoptive father, to go and bring her home but he said he was busy and had no car. He thought the girl should be allowed to find her own way back in her own time.

This made a direct connection with my own experience of her behaviour in the session. I thought that she was identified with her role

as a helpless mother but that the angry, disturbed patient who was furious with me, who could not bear to be with me, and who had such difficulties in getting through to me was not directly available. This was a familiar problem and left me uncertain if I should try to pursue her or wait for her to return.

I interpreted that she saw me as helpless when she withdrew and was afraid that I would leave it to her to find her way back to the session. This made her fear that I did not take the danger she was in seriously. I did, however, add a patient-centred element when I said that, if I did try to reach her when she felt disturbed, violent, and out of control, she made it clear that, like her daughter, she would be angry and feel intruded on and controlled.

The remainder of the session continued in similar vein. She described how her colleagues had to put on an act with the bursar to persuade him that the department was in a terrible financial state but that with applicants and colleagues from other universities the problem was exactly the opposite since *they* had to be convinced that the department was viable. There were references to the real possibility of being closed down and to the necessity of making staff redundant in order to avoid this. I had a strong impression of her insecurity, and because of numerous recent hints that she might not be able to continue her analysis, of my own possible redundancy. These themes linked with her need to fit in with the way her colleagues worked even when she disapproved of their methods. It corresponded to an internal situation where she felt trapped in an organization she hated but at the same time felt she needed and could not extricate herself from.

This session was fairly typical in terms of the anxiety she generated, and also showed both the problems she had in staying in touch with it and the problems she generated in me. If I tried to make contact with a very disturbed patient who found it difficult to come to the session, she felt that I pursued her and she made it clear that she would not tolerate that. If, on the other hand, I was too passive, if I seemed to throw up my hands as she did and claim that there was nothing more I could do, she was afraid that I would give up and see the analysis as bankrupt and hopeless. If I made *patient-centred* interpretations, she felt intruded upon and experienced it as my failure to cope with the anxiety which led to my blaming her and pushing the anxiety back into her. I thought she tolerated *analyst-centred* interpretations better, but she sometimes saw them as a confession that I was not coping and as an admission that I was afraid to tackle her difficulties and face the consequences.

Discussion

Technical problems such as those I encountered in this material can be thought of as expressions of the patient's resistance, on the one hand, and of the analyst's counter-transference difficulties, on the other. Our understanding of both of these has been enhanced as we learn more about the mechanism of projective identification (Klein 1946; Rosenfeld 1971b), and about *containment* (Bion 1959, 1962a, 1963) and *counter-transference* (Heimann 1950, 1960; Money-Kyrle 1956; Racker 1957; Sandler 1976), which are closely related to it.

Both Sandler (1976) and Joseph (1981) have recognized the way in which patients nudge and prod the analyst in order to create a particular situation in the transference. Sandler describes how an internal relationship between the self and an object becomes *actualized* in the relationship with the analyst, who is led to enact an *infantile role-relationship*. As a counterpart to Freud's *free-floating attention*, he points out that the analyst has to have a *free-floating responsiveness* and that the analyst's reactions as well as his thoughts and feelings contribute to his counter-transference. Joseph shows how it is through such *enactments* that the analyst is drawn into playing a role in the patient's phantasy and as a result is used as part of his defensive system. The patient may of course interpret such actualizations and infantile role-relationships in a delusional way and come to believe that they were achieved not by natural means but by omnipotent phantasy.

We have come to use counter-transference to refer to the totality of the analyst's reactions in his relationship with the patient. The recognition of the importance of projective identification in creating these reactions led naturally to the idea that counter-transference is an important source of information about the state of mind of the patient. The analyst can try to observe his own reactions to the patient and to the totality of the situation in the session and to use them to understand what the patient is projecting into him.

But counter-transference also has its problems when we come to try to use it in practice, perhaps most of all because the analyst's introspection is complicated by his own defensive needs so that many important counter-transference reactions remain unconscious. Self-deception and unconscious collusion with the patient to evade reality makes counter-transference unreliable without additional corroboration. Here a third point of view can help the analyst to recognize his blind spots and fortify his judgements (Segal 1991; Britton 1989). The analyst may use colleagues and supervisors whom he can consult between sessions and whose presence he can to some degree internalize. Most of all he can use the help which his patient gives,

sometimes through a direct criticism of his work, but more often through his reactions to the interpretations he has given.

Because of the propensity to be nudged into enactments with the patient it is often impossible to understand exactly what has been happening at the moment when it is taking place. Sandler (1976) suggests that the analyst may catch a counter-transference reaction within himself, particularly if it is in the direction of being inappropriate, but he recognizes that such self-awareness may only occur after the responses have been carried over into action. In either case it is clear that immediate counter-transference reactions have to be reviewed a few minutes later when the patient's reaction is available, and this may have to be repeated as further understanding develops later in the session or in subsequent sessions. Using all the means available to him, including his self-observation, the observation of his actions, the responses of the patient and the overall atmosphere of the session, the analyst can arrive at some kind of understanding of his patient and of his interaction with him. If he can stand the pressure he is put under, he can use this understanding to formulate an interpretation which allows the patient to feel understood and contained. When this is convincing, the patient feels that the analyst can contain those elements he has projected into him and as a result the projected elements become more bearable. The patient feels relief and is able to use the analyst's capacity to think, feel, and experience, in order to help him cope.

If the analyst is *unable* to contain the projections and closes himself off or counter-projects, the patient feels attacked and misunderstood and is likely to become increasingly disturbed and to intensify the splitting and the projective mechanisms he has been using. On the other hand, successful containment leads to integration, and the experience of being understood may then provide a context where further development can take place.

Such further development is necessary for lasting psychic change to occur, and, in my view, it does not automatically follow containment but depends on the acquisition of insight and understanding by the patient. Successful containment, which is associated with being understood rather than with acquiring understanding, is a necessary but not a sufficient condition for these developments. Containment requires that the projected elements have been able to enter the analyst's mind, where they can be registered and given meaning which is convincing. It does not require that the patient himself is available or interested in achieving understanding. If the patient is to develop further, he must make a fundamental shift, and develop an interest in understanding, no matter how small or fleeting. This kind of shift, which reflects the

beginning of a capacity to tolerate insight and mental pain, is associated with a move from the paranoid-schizoid to the depressive position. I will try and illustrate how such a development depends on the experience of separateness and loss in a further fragment of clinical material.

A further clinical fragment

A few months following the sessions described above, the patient was told that I was taking an extra week's break in mid-term. She usually dealt with such disruptions in routine by missing a few sessions, partly in revenge but mostly, I thought, to serve as a means of projecting the experience of being left, into me. This time she began a session by describing how she had walked to work as usual with her husband and passed a neighbour's house where she saw that a light was on in an attic room. She knew that this room had been recently converted to house the family's new baby and as they passed she imagined one of the parents attending to the baby. This made her wonder if it really was too late for her to have a baby with her present husband, and she shuddered as she thought of all the gynaecological problems which would have to be overcome and which had led to so many complications and to endless painful investigations in her first pregnancy. They turned a corner and she passed the street where her colleague and chief rival lived. She had a very difficult relationship with this woman whom she admired but also felt controlled by, and she described how, normally, when she passed she would look right into the house and would often see her colleague moving around choosing what she was going to wear that day. On this occasion, however, she could not see into the house clearly because tears were in her eyes.

I interpreted that while she reacted to my week off in various ways she seemed today to associate this with the idea that I had other things to attend to, like a baby, and that this put her in touch with her grief and made her feel more separate and tearful. Her mood was quiet and thoughtful and we could use the session to explore how previously she dealt with separations by entering my mind just as she used to enter her colleague's house, her family and her department.

Periods of contact like this were not frequent and were not sustained, but they did give rise to moments when she seemed genuinely interested in the way her mind worked and was consequently able to accept *patient-centred* interpretations. On this occasion the shift was associated with the patient's sadness when she feared that she no longer had the mental and physical capacity to have a baby of her own. She felt more separate from me, and her tears enabled her to accept a

momentary contact with a psychic reality. This small and transient shift to the depressive position allowed her to become interested in her own mind and her own mental processes.

Further discussion

In psychotic and borderline patients, as well as others functioning at a paranoid-schizoid level, containment brings relief but does not necessarily lead to growth and development. One of the reasons for this is that the relief depends on the continuing presence of the containing object since, at this level of organization, true separateness from the object cannot be tolerated and, as a result, the capacity to contain cannot yet be internalized. The object has been incorporated into the organization so that the threat of its loss leads to panic and to the deployment of omnipotent phantasy to create the illusion that the object is possessed and controlled. The patient internalizes an object containing the projected elements and does not truly face the experience of separateness. Sometimes such omnipotent phantasies are delusional and survive all evidence to the contrary, but in most cases contrary evidence is more subtly evaded and experiences such as the regular timing of sessions fuel the patient's illusion that his analyst is not free to act independently and unexpectedly.

This was illustrated by the way my patient ordinarily dealt with separations by projective identification, which she experienced as entering my mind and body where she was able to control me but where she also saw herself as inside me and hence as my responsibility. In the first section of the clinical material, I tried to show how difficult she was to contain when this happened. Her wild, dangerous, and aggressive behaviour was subtly hidden behind her composure but was apparent when I had such trouble finding and reaching her. My worries about her were paralleled in the terrible worries she had about her daughter. When I was able to contain her anxiety about my ability to cope with such responsibility she seemed relieved. But this relief needed the analyst's presence to act as a container and could survive beyond the end of the session only through a denial of separateness. Such denial was associated with a possessive hold of her objects which remained under her omnipotent control.

Inevitably, occasions arise when the analyst temporarily steps outside the patient's omnipotent control and a degree of separateness is achieved. This seemed to take place in the session I reported soon after I announced an unexpected break in the analysis, and was connected with a recognition that it was her neighbour and not herself who had

the baby she so much wanted. My freedom to act was associated with a lessening of omnipotent control and led to an experience of loss which enabled her to feel more separate and in the process to express some of her sadness and grief which, I think, made up part of the work of mourning her lost objects and lost opportunities. I have argued elsewhere (Chapters 4 and 5, in particular) that it is through the work of mourning that the patient is able to regain those parts of herself which she previously got rid of through projective identification, and that with further work these projected fragments can be reintegrated in the ego (Steiner 1990a).

It is at these times that the patient could take a true interest into her own mind and begin to differentiate what belonged to the analyst and what belonged to her. Such moves towards the depressive position are clearly more frequent in less disturbed patients and at later stages of an analysis, but they may occur at any time even if only for brief and isolated moments. They require a prior capacity on the part of the analyst to contain and integrate the projected elements, but I believe that they also demand that the analyst have the courage to take risks and, when appropriate, give a *patient-centred* interpretation even if this may lead to a persecuted patient.

Shifting between the two types of interpretation

In the clinical material I presented I tried to be sensitive to the need to shift between the two types of interpretation, and I encountered problems with both. When I focused on the patient's behaviour and, for example, interpreted her theatricality or her withdrawal into silence, she felt intruded upon and blamed for the failure to make contact with me. It was when *patient-centred* interpretations implied that she was responsible for what happened between us that she became most persecuted and tended to withdraw. It was particularly over the question of responsibility that she felt I sometimes adopted a righteous tone which made her feel that I was refusing to examine my own contribution to the problem and unwilling to accept responsibility myself. In the counter-transference this issue created serious problems for me, since, when the patient projected feelings with such intensity, I often felt that I was being made responsible for the patient's problems as well as my own.

It is in such situations that I believe it may be better to be sparing with the *patient-centred* elements in the interpretation, to concentrate on the patient's view of the analyst, and to avoid making premature links between the two. Of course this is not a formula which can be

used to solve technical problems, and, as we have seen, *analyst-centred* interpretations have their own difficulties. They too can fail to offer containment, sometimes because they are simply wrong and out of touch and sometimes because the patient feels the analyst is interpreting to cover up his situation rather than to confront it. Too many *analyst-centred* interpretations make the patient feel that the analyst is preoccupied with himself and unable to observe and respond to the patient and his problems. Moreover, sometimes this view of the analyst is justified. The patient is always listening for information about the analyst's state of mind, and whatever form of interpretation he uses, verbal and non-verbal clues give the patient information about him. The patient can use these to see if what the analyst says matches how he expresses himself, and this is important in his view of the analyst's character and trustworthiness.

Sometimes interpreting the patient's view of the analyst helps the patient recognize that he has projected an archaic internal figure into him and is expecting the analyst to behave, say, as his mother would have behaved. The interpretation may clarify this and enable the patient to see the analyst subsequently in a different light. Sometimes, however, the interpretation simply confirms the patient's fears. To be effective, it must neither be a confession which simply makes the patient anxious, nor a denial, which the patient sees as defensive and false. Even when analyst-centred interpretations are successful in creating a sense of containment they leave one with a sense of achievement which is partial and temporary. An impasse may have been evaded, a more friendly relationship with the patient may prevail, but the real work of analysis remains to be done.

The technical challenge is to find an appropriate balance of *patient-centred* and *analyst-centred* interpretations. Interpretations may temporarily have to emphasize containment but ultimately must be concerned with helping the patient gain insight, and an analyst who is perceived as reluctant to pursue this fundamental aim is not experienced as providing containment. Indeed, these two aspects of interpretation can be thought of as feminine and masculine symbols of the analyst's work. Both are required, and insight, which is so often disturbing, is only acceptable to the patient who is held in a containing setting. If the analyst remains sensitive to the patient's reaction to his interpretation and listens to the next piece of material partly as a comment on what has preceded it, then it is possible to shift from one type of interpretation to the other sensitively and flexibly. As development proceeds further, the distinction becomes less important and many interpretations of an intermediate kind become possible, often showing the links between the activity of the patient and the resultant

view of the analyst. Such links are impossible to make when the patient is functioning at a more primitive level where containment and being understood take priority over understanding.

Analytic work with borderline and psychotic patients who present such formidable technical problems is always slow and often disheartening but can lead to significant development. Shifts towards the depressive position which are associated with transient emergence from psychic retreats are by no means absent, and if the analyst makes use of these opportunities the patient can use them to gain insight into his use of the retreats and the pathological organizations which underlie them.

References

Abraham, K. (1919) 'A particular form of neurotic resistance against the psychoanalytic method', in *Selected Papers of Karl Abraham*, London: Hogarth Press (1927), 303–11.

—— (1924) 'A short study of the development of the libido, viewed in the light of mental disorders', in *Selected Papers of Karl Abraham*, London: Hogarth Press (1927), 418–501.

Balint, M. (1968) *The Basic Fault: Therapeutic Aspects of Regression*, London: Tavistock.

Berner, P. (1991) 'Delusional atmosphere', *British Journal of Psychiatry*, 159: 88–93.

Bion, W.R. (1957) 'Differentiation of the psychotic from the non-psychotic personalities', *International Journal of Psycho-Analysis*, 38: 266–75; reprinted in *Second Thoughts*, London: Heinemann (1967).

—— (1959) 'Attacks on linking', *International Journal of Psycho-Analysis*, 40: 308–15; reprinted in *Second Thoughts*, London: Heinemann (1967), 93–109.

—— (1962a) *Learning from Experience*, London: Heinemann.

—— (1962b) 'A theory of thinking', *International Journal of Psycho-Analysis*, 43: 306–10; reprinted in *Second Thoughts*, London: Heinemann (1967), 110–19.

—— (1963) *Elements of Psycho-analysis*, London: Heinemann.

—— (1970) *Attention and Interpretation*, London: Tavistock.

Bowlby, J. (1980) *Attachment and Loss*, vol. 3, *Loss, Sadness and Depression*, London: Hogarth Press.

Brenman, E. (1985) 'Cruelty and narrow-mindedness', *International Journal of Psycho-Analysis*, 66: 273–81; reprinted in E. Bott Spillius (1988) *Melanie Klein Today*, vol. 1, *Mainly Theory*, London: Routledge.

Britton, R.S. (1989) 'The missing link: parental sexuality in the Oedipus complex', in *The Oedipus Complex Today*, R.S. Britton, M. Feldman and E. O'Shaughnessy, London: Karnac Books.