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PROBLEMS OF PSYCHOANALYTIC TECHNIQUE: PATIENT-CENTERED AND ANALYST-CENTERED INTERPRETATIONS

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The treatment of psychotic and borderline patients presents formidable technical problems for the psychoanalyst, and many of these arise from the uncomfortable countertransference feelings these patients evoke. They are usually aware of the disturbance around them and to which they react, but, they are unable to recognize their role in the creation of the situation and are unaware or unconcerned with their own internal problems. In analysis, the patient in this state of mind is not interested in discovering things about himself, and uses the analysis for a variety of purposes other than that of gaining insight into his problems.

Joseph (1983), who pointed out that many such patients are not interested in understanding, saw this as related to the fact that they are functioning at a paranoid–schizoid level. In these circumstances the patient's main concern is to obtain relief and

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security by establishing a mental equilibrium, and consequently he is unable to direct his interest toward understanding. The priority for the patient is to get rid of unwanted mental contents, which he projects into the analyst. 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 to have 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.

It is important to remember, however, that although he may not be interested in acquiring understanding, that is self-understanding, the patient does 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 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. Such containment depends on the analyst's capacity to recognize and cope with what the patient has projected and with his own countertransference 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. The patient 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 that 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 centered and differentiate them from patient-centered 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.

Of course, the distinction between the two types of transference interpretation is schematic, and in a deeper sense all interpretations are centered 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 the patient 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-centered 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 his or her wording. If the analyst says, "You see me as . . ." and implies that the patient's view is one that 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-centered. To be analyst-centered, in the sense which I intend to use it, the analyst has to have an open mind, be willing to consider the patient's view, and try to understand what the patient means in a spirit of inquiry. 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 interpretation 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 in reaction to them.

Sometimes the patient-centered 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 that is added to an analyst-centered 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 operating at a paranoid–schizoid level. 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. Especially in the early stages of an analysis and particularly with schizoid, borderline, and psychotic patients, it is necessary to recognize the problems that ensue from both types of interpretation and from the links that 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. To examine these issues I will first briefly look at some material from a psychotic patient whose case I have discussed in a previous article (Steiner, 1991).

This patient had recently recovered from a major breakdown, and although just able to return to work was still very paranoid

and concrete in his thinking. He began a session by voicing bitter complaints against his employers, who had been unfair to him, and then against his analyst, who did nothing to rectify this unfairness. He next described a breast infection that his mother had when he was a baby, and moved on to speak with triumph about his ability to hurt the analyst. He then announced his intention to change his job; since this would necessitate a move to another city, it meant the end of his analysis.

The analyst felt sad at the idea of losing his patient and interpreted 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 he began to discuss government policies of nuclear deterrence. He argued these were stupid because they involved total annihilation, but the policies of nuclear disarmament were no better because you could not neutralize existing armaments. He then complained of gastric troubles and diarrhea and said he had been going to the toilet after each session recently. He explained that he had to shit out every word the analyst gave him in order not to be contaminated by infected milk.

In his response to the analyst's interpretation the patient at first appeared to agree that he wanted the analyst to feel the pain of separation and loss in order to effect an "equalization," but a moment later he complained of being poisoned. I believe that he found this interpretation correct but 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 analyst had forced him to take these feelings back into himself and he experienced them concretely as poison and tried to evacuate them in his feces. The patient indicated the catastrophic nature of his anxiety by talking about nuclear disaster. His insistence that no defense was possible against a nuclear

attack may have had its roots in his conviction that his defenses could not protect him against his analyst's words. 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 reasserted 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 feces. 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 the analyst disapproved of these wishes and was himself pushing the distressed feelings back onto the patient.

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 some two years after her analysis began. As a child she habitually withdrew to a fantasy 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 behavior, 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 son, 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.
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> 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 son has run off, and I don't know where he 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, that she decided she had to attend. She knew about this on the weekend and had wondered if she should 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 the friend knows there are disasters all around. Finally, 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 center on the patient's need to get through to the analyst that there is something very seriously wrong that 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 train was not simply a message indicating how she felt, but was 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 behavior. Ultimately the aim of an analysis is to help the patient gain an understanding of herself, and even with 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 me 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.

If I made patient-centered interpretations, 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 that 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 thought that she hoped that I would see that beneath this composure things were very far from fine. However, I found myself adding 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 thought 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. I also knew from past experience that a critical comment could lead to the enactment of a sadomasochistic relationship in which she would feel the victim of an unfair attack.

She was silent for a while and then spoke about her fraught relationship with her son. She described the way he wound everyone up, and how he had screamed that he could not bear to live with her, and had stormed out. At first he said it was for good, but later he phoned and said he would be back for school on Monday. In fact he failed to turn up, and she had to ring the school and explain because they were also at the end of their tether with him and 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 that 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 son 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 that 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 son 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, and did try to reach me and get through to me.

After a silence she continued with more material about her son and the dangerous company of older criminal youths he was associating with. She described how she had tried to trace him by phoning his friends and their parents, and that when he had

discovered this he was furious, abusing her, and accusing her of spying on him and controlling him. She had also tried to get her ex-husband, his adoptive father, to go and bring him home, but he said he was busy and had no car. He thought the boy should be allowed to find his own way back in his own time.

This made a direct connection with my own experience of her behavior 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 whether I should try to pursue her or wait for her to return.

I interpreted that she saw me as helpless when she withdrew and that I left 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. However, she also made it clear that when she felt disturbed, violent, and out of control, she would be angry and feel intruded on and controlled if I tried to reach her with interpretations.

The remainder of the session continued in a 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 state, but that with applicants and colleagues from other universities the problem was exactly the opposite—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 staff cutbacks to avoid this. I had a strong impression of her insecurity, and because of numerous recent hints that she may not be able to continue her analysis, of my own possible redundancy.

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-centered* interpretations, she felt intruded upon and experienced it as my failure to cope with the anxiety, which led to me blaming her and pushing the anxiety back onto her. I thought she tolerated *analyst-centered* 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 one hand, and of the analyst's countertransference difficulties on the other. Our understanding of both of these has been enhanced as we have learned more about the mechanism of projective identification (Klein, 1946; Rosenfeld, 1971), and about containment (Bion, 1959, 1962, 1963), and countertransference (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 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, the analyst has to have a "free-floating responsiveness," and that the analyst's reactions, as well as thoughts and feelings, contribute to the countertransference. Joseph shows how through such "enactments" the analyst is drawn into playing a role in the patient's fantasy and as a result is used as part of the patient's 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 fantasy.

We have come to use "countertransference" to refer to the totality of the analyst's reactions in the relationship with the patient. The recognition of the importance of projective identification in creating these reactions led naturally to the idea that countertransference is an important source of information about the patient's state of mind. 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.

But countertransference 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 countertransference reactions remain unconscious. Self-deception and unconscious collusion with the patient to evade reality makes countertransference unreliable without additional corroboration. Here a third point of view can help the analyst to recognize his blind spots and fortify his judgments (Britton, 1989; Segal, 1991). He may use colleagues and supervisors between sessions and to some degree internalize them. Most of all an analyst can use the help the patient gives, sometimes through a direct criticism of his work, but more often through reactions to 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 countertransference 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 countertransference 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, including 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 the analyst can stand the pressure, he can use this understanding to formulate an interpretation that allows the patient to feel understood and contained. When this is convincing the patient feels that the analyst can contain those elements the patient 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 to help him cope.

If the analyst is unable to contain the projections and closes himself off or counterprojects, 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 that 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 to illustrate how such a development depends on the experience of separateness and loss.

A few months following the sessions already described, the patient was told that I was taking an extra week's break in midterm. 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 onto me. This time she began a session by describing how she had walked to work as usual with her husband and passed a neighbor'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 she imagined one of the parents attending to the baby as they passed. 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 gynecological problems that would have to be overcome and that 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 I was able to go on to interpret that she had previously 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-centered 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 threatened loss of the object leads to panic and to the deployment of omnipotent fantasy 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 fantasies 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 the 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 behavior 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 son. When I was able to contain her anxiety about my ability to cope with such responsibility she seemed relieved. But this relief needed my 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 neighbor 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 that 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 (Steiner, 1990, 1993) have argued elsewhere that it is through the work of mourning that the patient is able to regain those parts of herself that she previously got rid of through projective identification, and that with further work these projected fragments can be reintegrated into the ego.

It is at these times that the patient can take a true interest in her own mind and begin to differentiate what belongs to the