

PREFACE

THIS BOOK INVITES the reader to accompany a Kleinian psychoanalyst as he shares the intimate, day-to-day, moment-to-moment clinical experience that unfolds when treating a wide variety of patients in private practice. The author creates a genuine, user-friendly, experience-near atmosphere in which the reader has the chance to see how a modern psychoanalytic practitioner actually conducts Kleinian treatment. The nuts-and-bolts approach of the “he said/she said” dialogue opens a wide window into the actual clinical exchange.

The general public—not to mention students currently studying in the field of psychology—can sometimes have the false impression that Freud is “old hat,” ancient, outdated, or even silly and useless. However, when helping patients maneuver through their complex and painful problems, many of Freud’s discoveries and basic theoretical tenets remain powerful.

Likewise, Melanie Klein’s original thinking in her work with children and adults is sometimes seen as outdated or out of pace with the modern therapeutic climate. Again, when working intensely with neurotic, borderline, narcissistic, and psychotic patients, Klein’s highly original elaboration of Freud’s work still proves vital in the analytic setting. This volume provides a wealth of clinical material to illustrate this point.

Some of the most popular or prevalent perspectives in psychoanalysis today owe a great deal to Klein's discoveries, have compatible aspects of theory and technique, or dovetail in important clinical constructs. The American relational school has embraced such Kleinian concepts as projective identification and, in its own way of conceptualizing and utilizing this idea, has come to make regular clinical use of it. While operating from viewpoints sometimes quite in opposition to the Kleinian approach, relational analysts such as Seligmann, Cooper, Altman, and Aron nevertheless include the Kleinian cornerstone of projective identification in their theoretical and technical methods.

Mitchell (1995) has written extensively about the common ground and contemporary importance of both the interpersonal/relational schools and the Kleinian tradition. He notes that while emerging from quite different starting points, they arrive at perspectives on the concept of analytic interaction that complement each other. He outlines how Klein took Freud's ideas of the life and death instincts seriously, seeing the infant as struggling with biologically rooted, instinctually driven unconscious forces. However, Klein's followers, especially in the last few decades, have emphasized the value of the environment alongside that of the biological, unconscious aspects of the patient's psychology.

Here, Kleinian theory and technique also dovetail with the current interest in attachment theory. Fonagy and Target both espouse a more attachment-based version of Klein's discoveries. Modern Kleinian thinkers value the significance of the internal phantasy interaction between self and object as well as the external environmental interaction between infant and caretaker. This is echoed in the sharp focus that Kleinians place on the interpersonal interaction between analyst and patient.

Melanie Klein focused on both the environment and on the internal landscape of the self and object, but she emphasized the importance of relationships in the mind of the infant and the patient. Fairbairn, Winnicott, and others put the emphasis on actual external interactions with real people in real time, while the Kleinian school considers the unconscious relationship between self and object—as colored by the paranoid-schizoid position and the depressive position—to be the bulk of the individual's subjective experience in life. In looking at these unconscious processes, Klein discovered the dynamics of projective identification, in which aspects of the self are communicated or expelled into the object

for a variety of motives. One mind puts its contents into the mind of another, in the form of a profoundly intense, intimate interaction. For Melanie Klein, this was purely an unconscious phantasy process.

However, my own contemporary Kleinian approach as well as the more modern stance currently held by most Kleinian analysts has been to expand this internal view of projective identification to the more inclusive view of its being both an intrapsychic and an interpersonal, interactional process. This interpersonal expansion of Klein's landmark discoveries began with the work of Bion, evolved from there to my own work, and is now foremost in the current views of Betty Joseph. This more inside/outside, unconscious/interaction view of projective identification has spread from its birth in the Kleinian tradition to become one of the main aspects of many relational, interpersonal, and even modern Freudian approaches.

In fact, Klein's powerful concept of projective identification is now being integrated into most of contemporary psychoanalytic culture. At a 2009 scientific meeting at a psychoanalytic institute, a paper entitled "A Neuropsychanalytic Perspective on Unconscious Communication" was delivered. This presentation included a discussion of how projective identification, from a more Kleinian perspective, is part of an intricate mix of factors colored by elements of neuroscience and attachment theory. Interestingly, a major proponent of the relational school spoke of the "sensational contribution" of the paper—as well as its substantial difference from his own point of view. Betty Joseph's modern Kleinian work was brought up in the audience discussion as pivotal for the argument. The close connection between projective identification and the mirror-neuron system was noted as well.

Enid Young is one of several contemporary Kleinians writing about and lecturing on the elements in neuroscience and brain function that complement original and current Kleinian theory. Studies in infant development are also beginning to confirm Melanie Klein's own work with infants and young children. Klein's ideas about the infant's capacity for strong object-relational connections at an early age have now been proven by observational studies and developmental research.

Other aspects of Kleinian theory and technique that stand the test of time and now fortify many other contemporary psychoanalytic schools are the concepts of countertransference, enactment, and interpretation.

Joseph (1989) is among many of the contemporary Kleinians (Schafer 1997) to have shown the value of the countertransference as a specialized tool in locating and understanding the nature of the patient's anxiety and the immediate transference situation. In addition, much of the current thinking regarding enactments in the relational, interpersonal, self psychology, and modern Freudian schools is an outgrowth of the pioneering work of the contemporary Kleinian school.

My own work is grounded in the classic Kleinian school but is certainly deeply influenced by the contemporary movement of such modern Kleinian thinkers as Betty Joseph, John Steiner, Hanna Segal, Ron Britton, Elizabeth Spillius, and others. I place pivotal clinical importance in the ongoing interplay between transference, countertransference, projective identification, and the interpretive process. The foundation of Melanie Klein's work and that of her followers is the view that the moment-to-moment, here-and-now interpretation of both positive and negative transference and the unconscious phantasy state are essential to the steady work of building and maintaining a psychoanalytic process. In turn, this process gradually assists the patient to work through his or her core conflicts, resulting in a more stable emotional foundation and a higher degree of psychological integration. This Kleinian emphasis on the importance and value of the consistent interpretation of the transference in the context of the object-relational realm has been proven clinically effective by current research. Probably the most robust of this emerging research are the recent AMA findings. In a 2008 *JAMA* article (Leichsenring and Rabung 2008), the researchers demonstrated the successful outcome of psychodynamic therapy lasting longer than a year, noting it to be superior to other forms of therapy and clinically more effective than treatments of shorter duration. The researchers defined this mode of therapy to be as the same as Gunderson and Babbards's (1999) findings of "a therapy that involves careful attention to the therapist-patient interaction, with thoughtfully timed interpretations of transference and resistance embedded in a sophisticated appreciation of the therapist's contribution to the two-person field." This definition certainly describes the essence of all Kleinian treatments as well as my own Kleinian approach to what I have termed "analytic contact."

In psychoanalytic treatment, we strive to identify, understand, and work with the core unconscious phantasies that shape, distort, or con-

strict patients' experience of themselves, others, and their day-to-day existence. We seek to analyze the phantasies that create imbalance or anxiety in the patient's internal and external world. In order to do this work, we strive to create the best conditions to learn about and then transform these psychological conflicts. When successful, this clinical situation is best described as the establishment of analytic contact (Waska 2007).

This is a therapeutic process that holds transference as the primary vehicle of change, but it also considers the elements of containment, projective identification, countertransference, and interpretation to be critical to therapeutic success. Dreamwork, genetic reconstruction, analysis of conflict and defense, and extratransference work are all seen as valuable and essential. The concept of analytic contact is tied not so much to external factors, such as the use of a couch or the frequency of visits, as it is to building a clinical forum for the understanding and modification of the patient's deepest phantasies. Analytic contact is about finding a foothold into transference and into the core phantasy states that have the greatest effect on the patient's feelings, thoughts, and actions.

In working to establish analytic contact, I employ a combination of classical and contemporary Kleinian approaches to reach the patient at his current internal experience of self and object. Again, this involves the consistent exploration and interpretation of all conflictual self↔object relational states and the struggle between love and hate within them. Countertransference is vital to untangling the jumbled threads of transference and to understanding the nature of the projective-identification communications or attacks that are so frequent in most treatments.

Just as Joseph (1985) spoke of the total transference situation, I think we also need to be clinically aware of the complete countertransference situation. By this, I mean an awareness of not just the basic "I feel *x*, so patient must be projecting that feeling into me" method of understanding countertransference. Instead, we must be alert to the overall atmosphere of mood, action, thought, sensation, urge, and emotional climate that exists within the treatment setting. The complete countertransference situation is elusive and fleeting in most treatments and is not something easily formulated. But if the analyst is paying equal attention to the countertransference and transference and the dynamics of projective

identification, analytic contact is possible. With this therapeutic contact, a clinical process in which the patient's core phantasies will be revealed, understood, interpreted, and worked through is possible.

When attempting to establish analytic contact, I am, of course, still examining and addressing the patient's current external problems and symptoms, but within a wider, deeper, and more comprehensive context. In this sense, I offer the patient two ways of achieving growth, change, and conflict resolution. The patient may accept, because of his or her transference, phantasy, and defense response, only the external problem-solving potential of psychoanalytic treatment. We would still have had the opportunity for more, but the patient may resist accepting or creating more. If nothing else, the attempt to establish analytic contact may give the patient a lingering taste of what he or she might want to try later on in his or her life. Sometimes, I think that because of transference↔countertransference issues many analysts give up too soon on offering, establishing, and maintaining an atmosphere of analytic contact with patients. The recommendation of supportive counseling over psychoanalytic work is therefore often a collusion with unexplored transference climates in which analytic contact is avoided, attacked, and devalued by both parties.

In the moment-to-moment transference, the patient either is actively engaged or actively disengaged with the psychoanalyst on many levels. This aliveness or deadness of the total transference situation (Joseph 1985) and the interpretation or noninterpretation of it is what can define a treatment as either analytic or nonanalytic. The interpretation of the current state of the transference and the patient's phantasy experience of the object world (rather than interpretation of the past or external matters) is critical in general (Joseph 1989) but even more so when the patient's phantasies, transference stance, and defenses have begun to shift the treatment into something less than analytic. Certainly, the analyst's own countertransference enactment of projective-identification dynamics or personal conflict can escalate this problem. Overall, the resulting loss of analytic contact often occurs within the more interpersonal realm of the analytic relationship. Feldman (1997) has stressed the idea of how a patient's projective-identification process can organize or disorganize the analyst by pushing him into a pathological re-enactment of certain object-relational patterns. I would add that these

projective-identification attacks include attempts to disable, distort, or destroy the analytic contact between patient and analyst, shifting the treatment into more of a supportive counseling situation. This often has multiple motives, including control of the object, hiding out in the non-exploratory pseudoparenting mode of supportive friendship, manipulation of who in phantasy is the authority or parent and who is the child, and, finally, the wish to merely evacuate conflict rather than own and process it. Mourning is avoided and growth or change is aborted. The psychoanalyst must contain, translate, and interpret these psychological maneuvers in order to restore the analytic contact. Otherwise, pathological, collusive enactments will create a perversion of healing rather than a genuine opportunity for psychic change.

Melanie Klein's pioneering work with children and adults expanded Freud's clinical work and is now the leading worldwide influence in current psychoanalytic practice. The key Kleinian concepts include the total transference, projective identification, the importance of countertransference, psychic retreats, the container/contained function, enactment, splitting, the paranoid-schizoid and depressive positions, unconscious phantasy, and the value of interpreting both anxiety and defense. The components of the Kleinian approach have become so commonplace in the literature and adopted by so many other schools of practice that it is easy to forget that object-relations theory and technique was Melanie Klein's discovery.

In broadening Klein's work to match today's clinical climate, my approach of analytic contact makes use of Kleinian technique in all aspects of clinical practice, with all patients, in all settings. In this contemporary therapeutic modality, the analyst is always attempting to engage the patient in an exploration of his or her unconscious phantasies, transference patterns, defenses, and internal experience of the world. Regardless of frequency, the use of the couch, length of treatment, and style of termination, the goal of psychoanalytic treatment is always the same: the understanding of unconscious phantasy, the resolution of intrapsychic conflict, and the integration of self↔object relations, both internally and externally. Psychoanalysts use interpretation as their principal tool, and transference, countertransference, and projective identification are the three clinical guideposts for those interpretive efforts. Viewed from the Kleinian perspective, most patients use projective identification as a

psychic cornerstone for defense, communication, attachment, learning, loving, and aggression. Therefore, projective identification constantly shapes and colors both the transference and countertransference.

By attending to the interpersonal, transactional, and intrapsychic levels of transference and phantasy with consistent here-and-now and in-the-moment interpretation, the Kleinian method can be therapeutically successful with neurotic, borderline, narcissistic, or psychotic patients, whether seen as individuals, couples, or families and at varied frequencies and duration.

The Kleinian method of analytic contact strives to illuminate the patient's unconscious object-relational world, gradually providing the patient with a way to understand, express, translate, and master his or her previously unbearable thoughts and feelings. We make analytic contact with patients' deepest experiences so they can make personal and lasting contact with their full potential.

Successful analytic contact involves not only psychic change but also a corresponding sense of loss and mourning. At every moment, analytic contact is an experience of hope and transformation as well as dread and despair, as the patient struggles with change and a new way of being with him- or herself and others. Successful analytic work always involves a cycle of fearful risk taking, hasty retreats, retaliatory attacks, anxious detours, and attempts to shift the treatment into something less than analytic, something less painful. The analyst interprets these reactions to the precarious journey of growth as a way of steering the treatment back to something more analytic, something that contains more meaningful contact with self and other. The support that we give our patients includes the implicit vow that we will help them survive this painful contact and walk with them into the unknown.