On Interpretation

Talk by Donald Meltzer at the University of Oslo, 1987
Clinical material has been redacted

Introduction: dialogue with the presenter

Presenter: I wish to welcome you all to this evening's Red Wine Seminar. We are so fortunate to have Doctor Donald Meltzer as our guest and lecturer this evening.

Some of us have had the pleasure to get to know you through your books and through your previous lectures in Norway, and you even hospitably welcomed some of us in your home some years ago. It is therefore a very special pleasure to have you here among us in this room at this established institution where we all try to learn psychoanalytically oriented psychotherapy. As the Kleinian tradition is not very well known to most of us, I will ask you if you could give a short introduction in that way of thinking.

Since there are so many here that yet do not know you, I will first shortly introduce you and you just correct me if something I say is not right or there is something you would like to add. There are just a few facts that I know about you. That you are an American and that you arrived in England in London in 1954 to have an analysis with Melanie Klein and to become a child analyst. You have lived in England since then and you are now living in Oxford, where you have your own private practice. In addition to your practice, you give extensive supervision in several countries, such as Italy, France, Argentina, India. And Norway.

D.M.: Germany. Spain [*with a smile].* So it's been.

P: And you have been coming to Norway for ten years?

D.M.: Since 1975.

P: And the place where you usually teach is the Nick Waals Institute.

D.M.: Mentalhygienisk. Gaustad. And the Majorforening. And now for the first time at the University.

P: You are one of the leading figures developing the Kleinian tradition and so I thought I would like to mention the books that

you have written as I've indicated your field of interest. The first one was *The Psychoanalytical Process*. And then *Sexual States of Mind, Explorations in Autism, The Kleinian Development, Dream Life* and *Studies in Extended Metapsychology*. That is the last one.

DM: There's a new one called *The Apprehension of Beauty*. On aesthetics.

P: Looking very much forward to that.

DM: Thank you.

P: Your interests and thoughts have gone in the direction of clarifying Melanie Klein's theories in contrast to Freud, investigating the practical clinical application or implications of Bion's theories and developing your own new ideas. Especially in the areas of early infancy and psychosis. How to think about the newborn baby's experience coming into this world and what you call the aesthetic conflict.

D.M.: That's right.

P: In the practice of psychoanalysis, you're not especially concerned with what group of patients this method is specially suited for.

D.M.: No, not particularly.

P: No, and you have had good experiences treating even psychotics lying down on the couch.

D.M.: Schizophrenics, for instance. Hmm.

P: The most significant contribution is maybe your view on emotional meaning as the fundamental fact. That is the starting point of psychoanalysis. Not only the clinical work with patients, but also the theory. This evening, you have been asked to give a talk about interpretation and we all look very much forward to this.

The practical arrangement around it will be that you will talk until you are finished. [*Laughter.]*

D.M.: Or thrown out?

P: And then then there will be a break were people can buy red wine, and then we will open for discussion and questions after that.

Talk: On Interpretation

D.M. Doctor Hartmann asked me to speak about interpretation and I do welcome the opportunity to talk at the university, as I am not so accustomed to be invited to universities, as you know.

Although to my amazement, I'm now a visiting professor in Milan University. What I'm supposed to do, I haven't discovered yet.

My training really is in two parts because I was trained in psychiatry, in child psychiatry, in the States, and did my first analytic training there and then went to England to work with Mrs Klein and her group. Mainly because I was fundamentally a child psychiatrist and interested in children. And I just stayed there because it was a nice country. And I had made good friends.

Now, I'm not accustomed to write about interpretation as a thing apart, but I welcome the opportunity to think about it and talk to you about it. Because I know that my views on it keep changing and developing and I have not very orthodox views about it. So you must realise that you're hearing very personal, and in a sense, idiosyncratic views. But I'll try to explain them to you and it's necessary of course always to start with the history of things.

So. In Freud's terms interpretation was the therapeutic instrument, and its aim was really primarily reconstructive, to reconstruct the history of the infantile neurosis. And the therapy was felt to reside in the revelation of that history and the relieving of the amnesia related to it when he discovered – when Dora discovered – the transference. He rather marvellously grasped that it was an instrument of investigation. But he saw it primarily as transference resistance. On the one hand, it gave information about the infantile history – because he saw the transference as a repetition of the infantile experience. But did it function in the analytic relationship as primarily a resistance to investigation? That is, interfering with the patient's ability to free associate and so on.

Now under that view, of course, there was no question but that the interpretation had to be correct. And that has remained really as the orthodox psychoanalytic view. That there is such a thing as a correct interpretation.

Now, Freud was disappointed initially in the clinical results of psychoanalysis and realised from his practice that the reconstruction itself did not bring about the therapeutic results that he had hoped for. With hysteria it worked quite well, but then he broadened the spectrum of his patients and treated obsessionals, neurotics and so on … because a lot of his so-called hysterics were not hysterics at all,

but what we would now call borderline patients like Emmy von N. So he decided that the reconstruction itself was not sufficient, but that it had to be what he called 'worked through', and that meant repeated and repeated in its various dimensions and facets.

But by the end of his life, he was still very disappointed in the clinical results of psychoanalysis. And with his colleagues, who didn't practice it with the same marvellous intelligence that he did. Psychoanalysts in the 1930s and 40s – particularly in the 40s, after the migration of the German analysts in the face of the Nazi persecution – mainly moved to the United States and a bit to Great Britain, and the major developments in psychoanalysis in the 40s were certainly in the United States. And the theory of the therapy tended to bifurcate and go in two different directions. One was the orthodox Freudian direction of reconstruction and working through, and the other was the development of what came to be known as the 'corrective emotional experience'.

This, of course, made for a very great difference in the ways in which analysts behaved with their patients. Those who were following the orthodox Freudian line behaved in a very austere way. They talked very little. They talked only when they had a reconstructive interpretation to make, and it became part of the American tradition that analysts talked or said something maybe once a week [*laughter*] … with the result, of course, that they're with a patient who was talking away and waiting and waiting and waiting for interpretation. When it did come, it had an Olympian voice [*laughter*], it became a pronouncement that carried a tremendous weight with it, and had of course a very great effect on the transference, and it encouraged idealisation.

And encouraged a passivity and submission, and brought about changes in the patient which were not always actually so desirable. It also seemed at that time to have an adverse effect on people's other relationships, particularly their marriages, which tended to suffer.

However, that was happening in unanalysed people as well, so they couldn't really be laid at the at the feet of psychoanalysis.

On the other hand, the analysts who began to move in this direction of corrective emotional experience began to behave in a very parental way. It was a bit encouraged by the experiments of Ferenczi in a more active technique. And certainly it produced more

favourable and faster results, in spite of the fact that it had a very infantilising, at least temporarily infantilising effect on the patients, who became extremely dependent, and the analyst's life under that method was often unbearable, because he was getting telephone calls from his patients and he hardly dared to take holidays because they were so extremely dependent. They were really like small children, and having 10 or 12 small children, doesn't leave one free to have much of a life of one's own, so it had its drawbacks as well. Although I think generally from the point of view of its therapeutic achievements, with neurotic patients, it was better.

But strange things began to happen to the population of people that came for analysis. Hysteria seemed to disappear, I don't know what happened to it. But probably with the changing sexual morality, hysteria seemed to sort of evaporate, and obsessional neurosis and character disorders and psychotic patients began to fill the analysts' consulting rooms, and life became even more difficult.

Now, the idea of the correct interpretation persevered and was sort of given its definitive form by James Strachey in what he called the 'mutative interpretation'. That is it. It was the idea that when the interpretation was really correct, it did something inside the patient's mind. Really it was a slightly mechanical view – that it got into the patient's mind and did something to his thinking and his feelings and his attitudes and his anxieties.

And that concept of the mutative interpretation has persevered. Now, in England in the 1950s, where the controversies between Anna Freud and Melanie Klein had sort of seized and split the society into very combative but very interesting and active groups, there begin to appear papers about the countertransference. Now, the countertransference, as defined by Freud, had been viewed almost purely as a phenomenon that was a manifestation of the limitations of the analyst, of his being – to that extent – inadequately analysed. And somebody like Winnicott could even say that the answer to the countertransference was go back to analysis. And indeed, many analysts did go back to analysis, and in the 40s and 50s, there was even quite a strong tendency for analysts to feel that they ought to go back to analysis periodically.

The concept of self-analysis as a continuation of analysis was very little developed, in spite of the fact, that of course, everybody

knew that analysis started with Freud's self-analysis, but that somehow never became part of the orthodoxy of what analysts thought they did. Or thought they ought to do. But in the 50s, these papers on countertransference by people like Winnicott and Paula Heimann and Mrs Klein herself, and others, Money-Kyrle, began to establish the concept of the countertransference as a tool of analysis. Just as Freud had established the transference and the observation of the transference as a tool.

And it became clear to people, and I think was fairly quickly, quite universally accepted, that the analyst's field of observation was really in two directions. That he was observing his patient, but also observing himself in his own emotional response to the situation all the time, and that he really had two sets of data – his internal observations and his external observations.

Now, in the early days of Mrs Klein's work – which can really can be divided in half by the famous paper in 1946 on schizoid mechanisms – she was really, in her theory of technique and in her theory of the therapy, absolutely orthodox Freudian. But there was this subtle difference that really grew out of her work with children. That is, that she was not so interested in the psychopathology, in elucidating and curing the psychopathology, as she was interested in promoting the development of the child's personality. And this gradually sort of subtly extended itself into her work with adult patients and quite took hold of the whole Kleinian group. That they were more interested in promoting development, than in investigating and curing psychopathology, either character or symptoms.

This forward-looking view of promoting development had a very big effect on the ideals within the Klein group about what sort of patients were suitable for analysis. Because under the orthodox Freudian, psychotics were not suitable for analysis. Character really could not be altered by psychoanalysis. Certainly, the schizophrenic was absolutely outside the range of any psychotherapeutic, psychoanalytic approach, but a developmental attitude, or a developmental interest, seemed to imply that there was no basis for excluding anybody. That if one was intent on promoting development rather than curing symptoms, we might do a patient some good developmentally, even if it didn't cure his symptoms, and so on.

But in fact, it seemed to turn out that when analysts concentrated on the developmental process and the development proceeded, the symptoms rather mysteriously seemed to melt away and disappear, So that was very encouraging: that the clinical results seemed to improve and people were very heartened and I can remember when I first came to England in the early 50s, there was a kind of euphoria about the therapeutic potentialities of analysis and people were – almost everybody in the Klein group – were treating schizophrenics.

It was absolute optimism, of course. The results were very disappointing: the schizophrenics, and analysts who had undertaken such patients with a kind of naivety, took a terrible beating from their patients, who were in and out of hospital and committing suicide and taking drugs and assaulting the analysts. And by the time of Mrs Klein's death in 1960 it had already calmed down. Uh. Those of us who had worked with psychotic children, of course, were in a much better position because we knew what we were in for, and I would never have dared to have more than one schizophrenic in my practice because I knew some colleagues who had three or four schizophrenics in their practice and this made their lives hell.

Now, as I said, Mrs Klein's work can be divided into two parts by this paper in 1946 in which she described these two mechanisms of projective identification and splitting processes, because that completely altered the view of what analysts were observing in the consulting room, and what they were demonstrating to the patient. It placed a new emphasis on the description of those mechanisms. And later the elaboration of the concept of the countertransference as a tool, really made the most extraordinary difference to what the analyst thought he was observing in the consulting room. It became a place to lay the emphasis on observation, as against information. So the analyst became aware that the information he got from the patient was not the data with which his mind was working. He was trying to elucidate a process of transference and countertransference that was hopefully evolving a forward movement in the patient's development.

What he was observing was almost independent of the information content of what the patient was saying. He was really observing the whole of the events in the consulting room in the same way that he observed the patient's report of a dream. When a patient

tells you a dream it doesn't have any information content in it at all. It's a picture. It's a moving picture, a film. It's like a television programme. It's something you are looking at in your mind. As you listen to the patient, it makes a picture in your mind and you're following that picture, and it either means something to you, or it doesn't mean something to you. Where analysts discovered that that's really what they were doing in the consulting room with their adult patient, it became almost identical with what one was doing in the playroom with children when watching their play. And their play was indistinguishable from the dreams of adult patients.

And only very late in the analysis of a child, does the child really begin to talk to you in the sense of giving you any information content. He's mostly playing and doing things and involving you in doing things, and there's an event going on in the consulting room.

What analysts in the 50s discovered was that that's what was happening in the consulting room: that an event was going on. And that what they were doing was trying to discern what that event was, between the patient and himself: between the patient's emotional and mental state, and his own emotional mental state. And the two of them were interacting with one another.

Well, under that point of view, of course, the interpretation turned into a description. It lost its explanatory significance. The word because tended to drop out of the vocabulary. The reconstruction became an object of very little interest to analysts, although it might be interesting to the patient and the patient often talked about the past in associations, but the reconstruction of the past became an utterly secondary and almost redundant aspect of the work that the two of them were doing together.

And this, of course, was heightened by the recognition that the history kept changing.That as the patient developed, the patient's account of his history kept changing. You know, when the patient comes to you for his first consultation, he had a beast of a mother, and his father was a drunkard and didn't work and so on. By the time they get to the end of a successful analysis, his mother was rather beautiful and was always at home and available and only occasionally was she a little bit bad tempered. Yes, father drank a little bit, but he was very successful in his work… The whole thing changes.

Well, it was realised that this account of the history again has very little reliable information content as far as the actual events of a patient's childhood go. It was really a story about the patient's internal situation. As his internal situation evolved and developed through the analytic method, the story changed and it was a story about his inner world, and had only a problematic and in a sense anecdotal relationship to his actual developmental history.

Well, it was under the sway of those recognitions that that I wrote *The Psychoanalytical Process.* Which certainly is a statement of what we were all experiencing at that time. And I think generally the members of the Kleinian group were enthusiastic about it. It was almost a kind of manifesto with which my colleagues at that time were in great agreement. And it presented the analysis in an entirely different framework. That is, it presented the analysis as something that takes place in a particular setting that the analyst constructs. That within that setting, which the analyst tries to manage and contain, the patient's unconscious begins to evolve a process of development. And this process of development turns out to have a certain sequence of events with an internal logic in it.

It isn't an internal logic that is an absolute recapitulation of what happens in childhood. You can't say that 'Oh yes, in the first year you're recapitulating year one, and the second year …'. It doesn't seem to work like that. It has an internal logic that has to do with the formation of the internal world and the waxing and waning of splitting processes and processes of integration. It has to do with the evolution of the Oedipus complex from more part-object and what Mrs Klein called the paranoid-schizoid position into depressive and more whole-object and back again. A very oscillating, circular sort of spiral process. It probably has, you know, very little resemblance to the way a child actually grows.

But it seemed to be a process of mental development. Now, within that picture where the analyst views himself not as doing anything definitive to the patient, but as creating a situation and enabling a situation where something can happen within the patient, the function of interpretation loses its mechanical, definitive, mutative significance and becomes really a kind of running commentary by the analyst about what he thinks is happening, but stating it in

terms of infantile and childhood development.

Now, of course it's problematic whether that statement made in terms of babies and breasts and penises, and sibling rivalries, is correct to state it that way as if it were a recapitulation. Because it obviously is not a recapitulation in terms of the chronology of childhood. Nonetheless, it seems to have a certain psychic reality: that is, that the structure of the mind does seem to have a kind of stratification, not so much the Freudian topographic stratification of conscious, preconscious and unconscious, but a chronological age group sort of stratification. And the different parts of the personality seem to relate to one another in a kind of social way.

And the analyst finds himself really describing both the process in the consulting room and what he is able to discern of its implications for the internal organisation of the patient, parts of the patient's own personality, the adult part of his personality and how it relates to the child parts, how they relate to one another and so on. Like a kind of football commentary. Yes, it has a certain element of editorial comment about what's going in the wrong direction, and what has to be rethought, and it has a certain – what would you say – quality of opinion in it: that the analyst is giving his opinion, not only about what he thinks is going on, but what he thinks is the value of it.

Now that introduction of 'value' is not of social value. It's purely a developmental value: whether a particular move that is going on in the patient's mind and in the organisation of his personality has developmental potentialities, or whether it seems to be tangential or regressive and so on. So the analyst's commentary has this value judgement aspect to it, but it is about developmental value.

Now, of course, in the early days of the Kleinian group, everybody treated children. It was just taken for granted that anybody who trained in the Kleinian group would also train as a child analyst, even if they never treated another child in their lives. And at that time, if you looked through the roster for the star that said 'child analyst', you could almost pick out which were the Kleinians, because they all had stars. And this experience with children, augmented by people's experience of course with their own children at home, developed a kind of vocabulary which has sometimes cruelly

been called baby talk. And it is a kind of baby talk. It added a certain dimension to the art of interpretation: that is, the content of the interpretation changed from definitive statements about mental mechanisms and their reconstructive significance with the aim of making a correct interpretation. Not only did that change to a running commentary on the transference-countertransference process, but the art of interpretation changed. Because when you became aware that you were watching in yourself and in the patient a complicated social organisation of different parts of the personality in both of you, you also became aware that there were different parts that you wanted to talk to.

It was like running a nursery school or family with a lot of children, you know. You sometimes talk to the child who is making the most trouble at the moment. Or you sometimes talk to the adult who wasn't looking after the children and noticing what was going on. And you find yourself in this orientation of talking in different voices, really in a different vocabulary: that you are talking kind of baby talk to a very infantile part of the personality at times, and at other times discussing in the children with the adult part of the personality in a perfectly adult to adult way.

So, it wasn't simply a matter of commentary like a football commentary. It also lent itself to an unconscious development of a technique of communication that had a sort of social structure to it. It all grew out of work with children. I mean, the whole Kleinian technique grew out of the work with children. Now, for some reason, after Mrs Klein's death, the training in child analysis seemed somehow to disappear from the training and the people coming into the group to train. The Child Department, which Winnicott had constructed with 10 consulting rooms for treating children in the expectation that this wave of interest in child analysis and its training significance would continue, simply dried up. In the late 60s and 70s these rooms remained absolutely empty and gradually began to be used for the overflow of adult patients. Then the secretary moved down, and the child department disappeared.

They all moved to the Tavistock Clinic. That is, the whole interest in child analysis moved to theTavistock Clinic. Because what started there in 1948 under Mrs Esther Bick, and later devel-

oped by my wife, Martha Harris, was the training in psychoanalytic child psychotherapy, and that blossomed. It blossomed in an incredible and unexpected way. As it was drying up at the Institute, it blossomed at the Tavistock. And other changes occurred accordingly. That is, as the interest in child analysis dried up, the Kleinian method as it had been practised began to lose this childish, childhood vibrancy. It became more didactic and began to approximate more to the Freudian work, with the result that the Institute and the British Society became a more unified but more orthodox society. What had been three groups fighting with one another and presenting combative and interesting papers, turned into a rather boring situation.

But the Tavistock became full of life and what started out with three child psychotherapists being trained every other year, within 10 years developed into 25 students a year. And child psychotherapy became established as a separate profession within the National Health Service. The child guidance clinics began to be peopled with child psychotherapists, and then in the late 70s, interest in Europe began to awaken and my wife and I and other people from the Tavistock training began travelling in Europe and helping groups to form – a Tavistock training was established in Rome and so on.

So, the interest in children moved out of the society in London. Because it's never been a very integrated part of psychoanalytic training anywhere. It's always developed from the outside and in a kind of – you know – déclassé attitude. Partly because you can't make much money treating children, because parents won't pay for the children like they will pay for themselves, but also because, just as teachers are poorly paid, child analysts, people who treat children, are looked upon as if they were giving Kitty portions and not the real thing. They should charge half price because it's only fish fingers.

And another bifurcation was established when a new Kleinian orthodoxy developed, while the people treating children took up the work of Wilfred Bion with an interest because it was so applicable to what one observes with children, whose capacity to think and talk and transform their emotions into play and into language is right there in front of you. Whereas when you're working only with adult patients, unless you have a patient who has a clear-cut

thought disorder, you don't see these phenomena very much, and therefore people only treating adults didn't take the same kind of interest in Bion, except for the theoretical interest in his theory of thinking and his theory about groups and the internal group structure of the personality. It didn't work its way into their clinical practice. Whereas the people working with children absolutely seized upon it hungrily, because it threw such a light on what you were observing, particularly with young children or with children whose development was seriously retarded for emotional reasons. I worked with autistic children where in their process of their developing you could really see their capacity to think, their capacity for symbol formation, their capacity to use language and so on, absolutely developing under your eyes.

So that the result has been that this, what I consider the third great step in psychoanalytic history, Wilfred Bion's theory of thinking, has attracted only a sort of intellectual interest in the psychoanalytic world, but has become a tremendously important tool for thought and observation amongst the people working with children.

So that's the story – my view of the story – of the history of interpretation as a psychoanalytic tool. The orthodox position I think is still that the interpretation, if it is correct, has a mutative effect on the patient's ways of thinking and feeling, and his fantasy life and attitudes, and so on. And I think that the psychoanalytical process, or the psychoanalytic method, is still in the orthodox sense largely a process for eliciting the information that enables a reconstruction and elucidation of the patient's life history and so on. The Kleinian development has gone beyond that, or is tacked on to it, in a different dimension, and the development from Bion's work goes still further or in a slightly different direction. And so on.

You know, when one is using Bion's theory of thinking, one is not only observing the transference-countertransference, but also observing much more acutely the ways in which the thought processes are shaping themselves. With children, it's seen in the techniques that they use in play – the minutiae of those techniques. With adult patients, it's largely linguistic: one has a tool for observing the linguistic processes and so on. And of describing them as part of the evolution of the patient's ego functions.

[*Clinical material omitted*]

We will have a little break and after that a discussion. Now I'll have a glass of red wine.

Discussion

DM: I'll go back a bit and describe to you the way of working, my way of working, which I think has a certain general Kleinian relevancy. First of all, you can see that exploration of the material and asking questions and getting an enriched material, is a terribly important part of the Kleinian technique. It's a very active technique in that sense of assisting the patient to observe more closely, report more accurately. To notice what's going on in his mind and so on. That's terribly important. A lot of what the analyst says in working this way is not interpretation at all but is exploration.

When it comes to interpretation, there are again two very different categories of interpretive comments. One is frequently making little interpretive comments that also have the aim of stimulating the patient to think and to produce more and richer material. Now the idea behind this is that the analyst works largely intuitively and then checks his intuitions intellectually against the material. And that his intuition operates best when it has rich material, rich data to operate on. One is always waiting for intuitions to take and compare with the data. And when you get an intuition that you think has relevance, then you're in a position to make something that could reasonably be called an interpretation.

Now in this material that I've given you, the first thing that could possibly be called an interpretation was my saying to her that it seems to me that [the patient] experiences both her sexual life and her professional life as if she were operating as a prostitute in a brothel. Now that interpretation was later brought into the transference towards the end when I described to her that this man who [in a dream] sold her this cheap briefcase seemed also to represent me as a father who prepares her to be a prostitute by his inability to value the female genital. That was a transference interpretation.

So, in this hour there were two interpretations. One was a for-

mulation of the material, and the second was a transference interpretation. So, there are these three categories of activity, well, really four. One is exploration of the material. The other is interpretive comment to enrich the material. The third is definitive interpretations of a formulating variety to organise the material and impose a formulation upon it. And the fourth is a definitive transference interpretation.

It's a complicated way of working. But on the other hand, it's an artistic way of working, and it's the sort of thing that you do really at your fingertips, and you can talk about it later when you write your notes and realise what has happened. But when you're doing it, it's absolutely at your fingertips and you're hoping that you don't do anything stupid or hurtful and so on. Now you can imagine that my saying to her that she experiences both her sexual and her professional life as if she were a prostitute in a brothel, is potentially a very hurtful interpretation.

Q: Did she accept it?

D.M.: Well, she didn't jump off the couch and run out of the room. It was followed by only a very brief silence before she brought further material. She didn't say yes, that's right, or no, that's wrong. But my patients don't usually say anything like that, except for argumentative patients who are always saying it's wrong. Generally, patients understand by the time they've been in analysis for a while that neither they nor I know whether an interpretation is of any value until we see its consequences, and we just have to wait and see the consequences.

Now I don't know whether this was a valuable hour until I see what happens next week. But I think probably it was a valuable hour, because I thought that I understood something that I hadn't grasped before.

Q: What had you not grasped?

D.M.: The link between her professional life and her sexual life. I hadn't grasped that at all, and I knew that she was at loggerheads with the organisation that she worked for, but I knew nothing about the politics.

Q: Did you know about her relationship with her father?

D.M.: I knew enough to know that she experiences him as a very egocentric man who has the gift of the gab and he can talk

persuasively, but does not have any original ideas. So I had that background for recognising the man in the shop.

Q: You said it wasn't a psychotic idea but something she brought from her childhood, she had to be on the winning side. Would you say all psychotic ideas are like that? Because it wasn't an accurate perception…

D.M.: Well it was an *infantile* idea, that remained active and operative in what should be her adult life.

Q: Would you say it is not just persecution fantasies?

D.M.: Well, this is an important diagnostic differentiation between psychotics whose psychosis is a manifestation of an identification with a psychotic parent, as against the psychotics who have evolved their psychosis within the economics of their own development. And of course, that although they may look clinically identical, the prognosis of the first group in therapy is hugely better than the prognosis of the second group. This is one of the reasons that the literature on the therapeutic achievement with psychotics is so confusing because most of the therapeutic successes are in fact with that first group whose psychotic manifestations are really manifestations of identification with the psychotic parent – they're usually going through childhood in a state of *folie* à *deux* with a psychotic parent.

The other thing that is worth saying about this way of working, is that it has a lot of stress in it because you never know what you're doing. And you never know really what you're achieving. Because you cannot rely on the patient's reports of external data about improvements in their relationships or whether they're happy or this or that. One has to depend on one's own evaluation of the evolution of the psychic structure, and that's always tremendously uncertain. So, it has it has a much greater stress in it than the more orthodox way of working analytically, in which analytic success is measured in terms of the patient's reports of their life situation and their symptomatology, and so on. Now, of course, those reports are in fact extremely misleading: partly because symptoms disappear into character, others disappear into psychosomatic disturbance, others disappear into forms of social adjustment, into groups, and so on.

So that in fact the whole business of the evaluation of therapeutic achievement in psychotherapy is extremely difficult. In the field of psychoanalysis, there is virtually no literature on therapeutic achievement, because there's hardly any way of describing it that carries conviction with it. I mean, psychoanalysts are often accused of being secretive about their therapeutic success, and perhaps they are secretive, but the great trouble is that one really doesn't know how to describe it in a way that would carry conviction for anybody else, since it doesn't even carry conviction for oneself. You never know with any certainty that you aren't wasting your time and perpetrating a fraud. That's the simple truth of it. That you're never sure you aren't perpetrating a fraud. The only thing I can say is that my patients enjoy at least getting the entertainment value. [*laughter*]

The other thing that makes it problematic is that patients have extreme difficulty in leaving bad analysis. Terrific difficulty. By the time you get to my level of professional development and two-thirds of your patients have had previous unsuccessful analyses, sometimes three and four of them, it's terrible, it's grim. And I don't always mean analysis, because I don't know how it is here, but in England and in America the practice of psychotherapy is utterly unregulated.

Q: I wondered: it was mentioned before you started the lecture that you didn't select your patients, who were included for analysis and who weren't suited. I wondered about these four levels of interpretation: Do you mould or choose the level or how far in the levels you are going in your interpretation in connection with what sort of patient you have? I mean, do you stay with enriching the material with more borderline or schizophrenic ones, or do you go to the end with the transference interpretation with all sorts of patients. How do you choose what sort of interpretations, or interventions, you do?

D.M.: Now, that's an important question. I was brought up, of course, in the medical tradition of diagnosis and decision about suitability for analysis. It didn't take me many years to discover that my evaluations were utterly inaccurate and that my predictions had no statistical value of any sort. So, I gave that up and I stopped doing diagnosis and selection so that I just do take anybody who comes along.

The other great tradition is what is called 'timing': that one doesn't make this interpretation at this time. One has to make a decision. Such decisions were really based on timidity: that one was afraid to say this to the patient. And so I abandoned that, and my policy now is to just say what I think, and to say it in a manner that communicates the degree of tentativeness with which I'm holding this idea in my mind. The result is, of course, I talk a lot. [*laughter*] But it makes for a very active and spirited communication.

So, I think part of the problem in practising psychoanalytic work is this one. You have to gradually come to rely on your experience as against that of your teachers. When you're young, you have to stay within the boundaries of what you've been taught. Then as you develop your own experience, you have to form your own way of working. And psychoanalysis is highly individual. I mean, I would never particularly recommend my way of working to anybody.

But of course, when you supervise somebody, you can't help communicating to them your way of working, your way of thinking and so on. And it has an influence on them. I suppose that the people who study with me tend to operate the way I do, with a certain rigidity added to it. Which is unfortunate… for instance, they may not select their patients in a way that doesn't take account (as I would for instance) of certain indications. That is, that I always start analysis with the understanding of the patient that it's experimental, that we'll work together for a few months until we have a basis for deciding whether anything that might be useful seems to be happening. And I know that after a period of three or four months, if I can't stand this person, and it happens sometimes for reasons that are utterly unjustifiable that you can't stand this person, well it's wrong, it seems to me, to continue being the therapist of somebody whom you can't stand for utterly idiosyncratic reasons of your own. Or in the case of some people – I mean some women analysts – really can become frightened of some male patients who are aggressive and threatening, and they probably should not treat such patients. If after a period of weeks or months, they find that they're really frightened of this man, they probably should not continue with them, and so on.

So, I sometimes find that my students are being brave, when being brave is really foolhardy in analysis, because you cannot function properly with a patient that you're very frightened of. And I know you cannot function properly with somebody that you detest and there's no justification for it. But it's just a fact of your own idiosyncratic mentality that there are occasionally people that you just detest. Other people may love them, but you detest them. It sometimes happens, and it's inexplicable. Absolutely inexplicable. I know it's mostly men that I detest, but that's my psychopathology. [*laughter*] So, generally speaking, I don't select my patients, and I start the analysis on an experimental basis. Probably because I don't want to waste my time or the patient's time if the process between analyst and patient does depend on this ineffable thing of rapport, some kind of meeting of minds, and there are patients with whom it just doesn't happen. You couldn't say whether they don't like you or you don't like them, but nothing happens between you. Your minds aren't attracted to one another in some way. And such a patient should go and try with somebody else. And they do. And then they have a successful analysis, and you feel a fool, but you are a fool. Does that answer your question? Or did you have something else in mind?

Q: I don't know if I quite got that about what sort of interpretation you do. You said something about your intuition. And you said also something about not diagnosing people. Still, I feel somewhat confused because in my mental map there are some diagnoses. There are some ego structures that one should take into consideration. I'm still curious about the sort of transference interpretation you do with people that have a very loose ego structure. But how do you judge what the patient can take …

D.M.: Well, all I can say is that I'm convinced I have no way of judging. I have no way of judging what a person can take, so I better say what I have in my mind and try to say it as politely, as tactfully and in as friendly a way as possible, like with this girl. I mean, interpreting to her about the brothel - that's potentially very hurtful. But I feel that I can say it to her in a way that is not an accusation, that it's not unfriendly. That I can put it with a music in my voice that is not caustic or punitive and so on, and that that makes it possible for her to take it.

And the tact is better than timing because I don't know how to time. But I do know how to be tactful.

Q: Would you say it in a certain way…

D.M.: Yes, my tone of voice always reflects the degree of certainty that I feel or the degree of tentativeness, and so on. And most of the interpretations one makes are tentative and exploratory. They have a big question mark at the end, yes.

Q: And I somehow got the feeling that that was where you divided from the Freudian, where there is a correct interpretation that is the ideal.

D.M: Well, there comes a time when things have been worked out in such detail, and the evidence is so convincing, that you really do feel convinced that this is a true picture of something. But on the other hand, one knows that people are so complicated that what one learns about a person in five years of analysis is just a fragment of the full complexity. I mean you live with someone for 30 years and you're just beginning to know them, and so on. People are complicated. And the more intelligent they are, the more complicated they are. Yes.

Anyhow, where's the necessity of being certain? It doesn't seem to have any heuristic value really, being certain, except it's comforting, but…

One of the great contributions of Mrs Klein to the theory of development was that a certain level of anxiety, and therefore mental pain, is necessary for development, and that's true of analysts. One has to be in pain to a certain degree, if you are to develop as an analyst. But that's quite easy to do. [*laughter]* So, it's not something you have to look around for.

No, if this work weren't so incredibly interesting, most people wouldn't tolerate it for very long – I mean, in terms of pleasure and pain. But so much of the pleasure comes from the interest.

Q: I wonder what kind of relationship you have towards more gratifying techniques like holding, containing, giving advice, positive meaning and so on?

D.M.: Well, it's easy not to give advice if you realise you don't know what advice to give. So that's no problem. I'm convinced from work with children that physical contact is always a mistake, with the exception in my experience of very autistic children with whom

you can't make contact at all without some physical contact. So, I'm fairly immune to that kind of seduction.

Containment is a matter really of containing in your mind. Which means attention when the patient is with you, and the capacity really to worry about them when they're not. The families of analysts complain, and rightly, that their parent tends to be preoccupied. This profession is very difficult for one's family. Because your patients fill you up and push your children out and things of that sort. They fill up your mind and you'll find yourself preoccupied with them in a way that does interfere with your availability for other relationships. It's one of the industrial hazards in this work. You can always think, in my experience, in my various marriages, that being married to a fellow psychoanalyst is the best solution, as you can talk to one another about your patients. [*laughter*] And it's very interesting how many psychoanalysts are couples. In South America it's almost the rule, for some reason. Because it's like talking about the children. Yes.

Psychoanalysts seem to live a long time and to go on practising for a long time. Many psychoanalysts practise into their 80s. And what they lose in memory, they gain in wisdom. [*laughter*] The memory is gone. So, I hope my wisdom is increasing. I know my memory is gone, because if I don't write notes almost immediately, I can't recall the session. I used to be able to sit down at night and write out sessions. I can't do that anymore.

Q: Thinking about – coming back to the Kleinian school – about the interpretations being so deep that there's also… What I understood of this… I don't know if you know Kernberg.

D.M.: Yes, I know Otto Kernberg.

Q: That they don't really relate. And that the analyst and patient get into some sort of play, as I understood it. I don't know if you have any comments.

D.M: Otto Kernberg is a Kleinian. Really. He really has taken the Kleinian ideas to his bosom. And so was Winnicott. But both of them suffer from resentment of not having had a Kleinian training, and it makes them critical of their siblings, like siblings are critical of the ones who are breastfed when they hadn't been breastfed. I know face to face he's not like that at all. But he can't help sniping at his breastfed sib-

lings. [*laughter*] I don't take it seriously because face to face he is not like that at all.

Now, Winnicott never recovered from Mrs Klein's refusal to take him into analysis, she took his wife instead. [*laughter*] No, psychoanalysis has all the defects organisationally of a family on the one hand and a monolithic political system on the other. It's very complicated really. And reading the literature, people's criticisms of one another are so political. They're hardly worth reading. The literature that's worth reading is the clinical contributions that come out of people's clinical experiences. The polemics are not worth reading at all.

Q: If I understood you right, when you're giving an interpretation, you just found it in the data you're collecting in the process, in your mind.

D.M.: Yes, it comes to you as a fantasy, as an intuitive fantasy, which you then compare with the data that's been presented to you from observation and the patient's material to see if that idea has congruence and if it covers. Those two things, *congruence* and *cover*. It's what makes you decide if it's worth saying. And then you say it with the degree of certainty with which you hold it, or tentativeness with which you hold it.

Q: Yes, yes. And I wonder if this was connected to the state of mind Bion called without memory and desire.

D.M.: Yes, yes. One really tries to stay in the session and to make an effort not to think about previous sessions, but to just wait until they just come to you as associations. I never read over notes before a session. I never think to myself; now what was the dream I had last time and what was this? I just wait for it to come. But of course, it's all there. And that's what he means by it. The bit about desire, is about goals. You know that, that in this way of working one does not set goals, because it's simply isn't possible. Because your aim is development. Not to lead the patient, but to follow them. And to help them to go where they are going. And not to have any place in mind.

Q: When you say that, I'm thinking about that sort of intuitive interpretation that you're talking about. Is that something that's exclusively for the experienced therapist?

D.M.: No, no! I don't really think that this kind of work is possible for somebody who hasn't had some analysis. Because there are

very few people whose contact with their imagination is sufficiently at their fingertips to be able to operate fast enough in the session. When you're a young analyst you have a lot of what's called the wisdom of the stairs. As you're climbing up the stairs to go to bed at night, you think, oh, I should have said so and so … But we've got to operate in this session. Now of course it is true that when you do recognise something that you haven't recognised before, you can then think back to previous materials … oh my God, that's been there for weeks or months and I didn't see it. But nonetheless, you have to be there to operate fast enough with the material that's in hand in that session. You can go back in the next session and say: I was thinking about the dream we had last time. I mean that's permissible. But you can't do it very often without the patient saying shut up: wait until next time and you can tell me what you think. Like children who may let you see their drawing, let's say take it home and think about it and tell me about it tomorrow. But mostly one has to operate at a fast speed, really. So that it requires the kind of contact with one's ongoing imagination to be able to do it, and I don't think many people who haven't had at least a year or two of analysis are likely to be able to do that. I personally think it's no use for a person to even think seriously of being a psychoanalyst or psychotherapist until they have had evidence from their own experience that it's useful. But you might be too old by then … till you have really had benefit from your own experience of being a patient in analysis or psychotherapy, then you have firsthand evidence that it's useful and not fraudulent.

Have I exhausted you?

Q: Do you think there is a big difference between psychoanalysis and psychotherapy if you are going just once a week? Is it a big difference?

D.M.: Because my idiot society, the British Society, has said that anything less than five times a week is not psychoanalysis – that's crazy. That's quite crazy. I mean, I've conducted analysis, certainly with children, once a week. With adult patients, you can certainly conduct an analysis with many adult patients twice a week, but less than three times a week is not really very nice. It lacks the continuity, the close continuity, and the division between the week and the

weekend, which is such an important part of the experience. If you are working with your eye on the transference-countertransference as your primary data, you are doing psychoanalysis. Whether you do it well or do it badly, you're doing psychoanalysis, and that is the essence of this method. The observation and description – that is psychoanalysis, as I practise it, and I think as every analyst practises it now. But the essence is the observation of the phenomenology of the transference-countertransference. And if you're doing that, you're doing psychoanalysis. If you're not doing that, even if you're a qualified analyst and you're seeing your patient five times a week, it's not analysis.

Now, of course, there are patients who seem incapable of forming the transference, but that is not true. It's just that the transference takes forms that the analyst, that particular analyst, cannot manage to perceive. And it can be so incredibly subtle that it's not surprising that it's difficult to perceive.

In my way of working, if an adult patient doesn't ever bring dreams, I'm in difficulty. I never really know where I'm at if I don't get an occasional dream. Because a dream is really a road map to the unconscious process. My patients all dream. They wouldn't dare not to. [*laughter*] But it varies of course. If you work well with dreams, your patients dream. If you're clumsy and inept with dreams, they don't. And then you have to work with the data that you work well with. And some people work well with dreams, and others work better with anecdotal material, historical material – fantasies and so on.

Q: [A question about whether a dream should preferably be rather fresh.]

D.M.: That's right. I mean, it may be interesting, but it's not much use. The dream has to be recent to throw up both the description and associations that are relevant to the moment in the analytic session. That's absolutely true. The patient tells me, oh, I didn't have a dream last night, but I remembered a dream from two weeks ago. I sort of groan, because I know I won't be able to do much with it, really.

So, let's call it a night. Thank you very much!