

Psychotherapy Guidebook

KLEINIAN TECHNIQUE

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Kleinian Technique

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DEFINITION

Melanie Klein's technique is a psychoanalytic method used in treatment of children as well as adults.

HISTORY

Klein began her therapy first in Budapest in 1917, mainly with children. This work enabled her to study early infantile development at firsthand. From this analytic work she obtained her main insights into the functioning of the human mind. These discoveries also helped to shape her analytic technique.

In 1924 Klein moved to Berlin to undergo analysis with Karl Abraham. She came to England in 1926 through an invitation of the British Psycho-Analytic Society. She settled in London and practiced and taught there until her death in 1960.

Her ideas and methods are widely used in the treatment of both neurotic and psychotic patients, and have greatly influenced the thinking of the British School of Psycho-Analysis.

Klein came to realize that the individual is exposed from birth to a conflict caused by the action of the two opposite impulses: love and aggression. She is an adherent of Freud's view on the life-and-death instincts. An early and rudimentary ego also exists from the start and is capable of experiencing those impulses and anxieties, and of creating defenses necessary to defend itself. The impulses, being of a biological nature, cannot directly be perceived as such by the mind. The ego creates fantasies that are psychological transformations of instinctive impulses as well as representatives of the object that satisfies them. The mechanisms of projection and introjection operative throughout life play a central role in the infant's relations to his objects. All these mental phenomena are perceived and expressed in the mind by unconscious fantasy.

TECHNIQUE

This basic theoretical understanding made Klein and her followers develop certain emphases of analytical technique that are generally thought to distinguish them from other followers of Freud's basic method. First, Kleinian analysts are especially rigorous in using transference as the main basis of formulating interpretations, and they assume that transference operates from the moment the analysis begins rather than as something built up gradually. Second, in evaluating the transference they use not only the verbal contents of what the patient says but also the feelings that he

expresses by his manner of saying it and the feelings he evokes in the analyst. Third, they do not necessarily deal with defenses, rather than anxieties, first, as most of the analytical schools do but refer to the anxiety content together with its defense. Fourth, compared with many analytical schools of thought in the United States and on the Continent they interpret more frequently.

However, Klein and her followers maintained the main points of Freud's classical technique: the analyst works with the patient five times a week in sessions lasting fifty minutes, asks the patient to lie down on the couch, to free associate, uses his understanding of transference, and presents his findings to the patient in the form of interpretations with the aim of achieving therapeutic insight. The Kleinian Technique is thus modeled on Freud's method. In a sense it adheres to it with special strictness, since it avoids making any kind of interventions other than interpretations.

To illustrate some of these points I want to describe some material from the initial sessions with a patient. He was a thirty-year-old man, very handsome, cold and distant. He came to his first session and proceeded to tell me that he did not expect much from analysis. In fact, he did not expect anything at all, but just wanted to see whether it might help him with his problem. He added that his main problem was not just psychological. As it happened he was told by his father that he had to get married or he would be disinherited. (His father wanted to make sure of an heir to the family name.)

He had never had a real girl friend. He had never been in love and he had never had sexual intercourse. All this was said to me in a very superior way. After a short pause he proceeded to say that he was rather surprised that Kleinian analysts treat adult patients; he had thought they worked only with children, but he was pleased to have chosen a Kleinian analyst. Here I pointed out to him, tentatively, that it seemed to me that he had two different feelings: on the one hand, he expects very little from the analysis; but on the other hand, he is somewhat hopeful that I might be able to help him with the problems he felt to have been with him from childhood. This would explain his remark that I was a “Kleinian” and also his notions that Kleinians work only with children.

Perhaps he hoped that I might be able to help a part of him that might feel like a child and that this might allow him to feel friendly toward a woman and eventually to move toward marriage. The patient mocked a bit, scorned the interpretation, and said that he could not comprehend my point. Then he proceeded to tell me that he had often been out with women; some he found very pleasant but he always felt distant toward them. Usually what happened was that they were very interested in him, and then he dropped them. He proceeded to recount in some detail a particular episode that puzzled him. He was going out with a girl who seemed to be getting more and more attached to him and then, for no reason he could account for, he suddenly left her in the middle of a dinner party. This situation had always made him feel rather

uncomfortable and strange. He could not understand it. He said that often he daydreamed about becoming a bishop and building an enormous church. He suddenly asked me when I took my vacations. I suggested that perhaps his attitude played a part in producing his feeling that nothing is to be expected from the analysis. I went on to say that he might fear that were he to allow himself any hope from the analysis this would make him feel unsafe, and that this insecurity would be a torture to him. For example, he might be exposed to the disruption of my going on vacations. I also pointed out that this would explain his question about vacations which otherwise seemed premature, since we were in the beginning of the year. In this interpretation I tried to connect his cold, superior attitude with his attempts to make me feel unwanted. He wanted me to know that he could walk out on me and thus could avoid the bad feelings that he might have if he were placed in the same situation that the girl whom he had left had been placed in.

The patient's response to this interpretation was slightly different from his response to the previous one. He proceeded to dismiss what I said, but he sounded 'more thoughtful and not so patronizing. In the following session he said that he had had a dream where he was sitting in a train feeling terribly frightened; he felt he might lose his way and his belongings. He could not understand this at all. He associated with this a time when he was very young — under seven — and was sent to boarding school. He had felt utterly desolate there, and he tried to phone his parents, but they just would not

listen and told him to be a man. Here I was able to interpret how if he did not express his usual coldness and contempt and wasn't patronizing he might feel like this terribly desolate child. I reminded him of the previous day's session, about the vacations, and said how he feared that I might send him away as he had been sent away to school and that led him to put all these vulnerable and frightened parts of himself and his feelings into me, and then he looked down at me as he felt he had been looked down on when he was small and he treated my interpretations as though they were noises from a child who was making too much fuss. Here, for the first time, the patient laughed. He tried to dismiss the interpretation by saying, "Oh, it's quite interesting. I think I understand what you say. Of course it is a parallel, just a parallel, and anyhow, I don't know how it would solve my problem."

In the following day's session he began to tell a dream. In the dream he woke up and tried to recall his dream, but he was interrupted all the time by a very gay, mocking, handsome young man who looked a bit like himself and who kept singing opera very loudly. The moment he tried to speak, the singing grew louder and louder. Here I made the following interpretation with the aid of an association he had given me, namely, that through the dream we could see that there seemed to be a big split between two aspects of himself in his relation to me and to the analysis, and that those aspects were in conflict. Also, I suggested a connection with his saying the day before "... I think I understand what you say. Of course, it is a parallel..." I remarked

that this division in him makes him see things in parallels.

I have brought some instances from the beginning of this patient's analysis to illustrate my mode of interpretation, which is conditioned both by one's understanding of the transference and content of the patient's material, and by one's theoretical conceptions. In his comprehension of the transference and the central role it plays in the analytical work, the Kleinian analyst is much influenced by the idea that object relations exist from birth and by the concepts of the paranoid-schizoid and depressive positions, each with its characteristic pattern of anxieties and defenses. The understanding of the processes that underlie the formation of the transference — that is, repetitive compulsion — and its meanings make a Kleinian analyst watchful for manifestations of it from the very first session, and the analyst tries to understand how the patient first relates to his analyst — what expectations he has, what anxieties he feels, what methods he uses to defend himself. In evaluating the patient's material the analyst takes into account, together with his verbal communications, the total of the patient's behavior; his movements from the moment he enters the room, his tone of voice, the form he speaks in, the way he responds to the analyst's interventions.

Interpretations are given frequently and are formulated as soon as some understanding of what is happening has been reached. They are then modulated and shaped according to the patient's response. To be therapeutic

the interpretation has to refer to the patient's feelings, anxieties, and defenses. It has to take into account the external stimuli, the transference situation, as well as the links with the past. It should refer to the role of the internal object as well as the interplay between fantasy and reality. All this would make an interpretation very long. Interpretations are often given in part at first and then gradually completed, generally enlarged by the new material the patient brings and which corrects and enriches the initial approach. The time it takes to complete an interpretation is irrelevant, but it should be completed to be of therapeutic value. Interpretations are not first directed to the defenses, as in many techniques following Freud, but they refer directly to the unconscious conflict. Here, Klein's use of the concept of fantasy plays a very central role as fantasies represent at the same time impulses and their objects, defenses and mental mechanisms, and they are intrinsically connected with feelings. Following these ideas, the Kleinian analyst does not have a preconceived idea of what to interpret first. He will try to direct his interpretation to where the conflict is felt to be more acute and therefore where the anxiety is stronger. The understanding brought by the interpretation usually allows for some modification of the immediate anxiety, which alters the relationship and allows it to proceed for further examination and working through the existing fantasies. As I have said, interpretations in Kleinian Technique are generally frequent and the analytical session has the characteristics of an active dialogue. The Kleinian

view is that analytical insight is gained through the modification of misconceptions and faulty relationships and that such modification can be achieved only by active searching for causes and communicated verbally to achieve the understanding of them. The continual projection on to the analyst of the patient's relationship with his internal objects permits the analyst to understand his internal world, which, by being communicated verbally through interpretations, allows the patient to modify his object relations by new introjections and therefore to free the ego from enslavement by continuous conflict.

The conception of projective identification and its different functions has played a very central role in Kleinian Technique. It shapes both the understanding of the patient's projections as well as the formulation of the interpretations. The interpretation of projective identification allows the patient slowly to modify and reintegrate the parts of himself he has projected. A step in this process was made by the patient in the example cited above, when he began to accept at least the idea of a small, frightened part of himself instead of projecting it into the analyst. The understanding of the material in the transference is helped by the analyst's own perceptions of the responses to the patient's that he feels in himself. This counter-transference, though having its roots in the unconscious of the analyst, is greatly influenced and shaped by the patient's projections. To illustrate this process I want to give some material from another patient, a woman.

She was feeling that she had a “rather good relationship” with me; no matter what happened, and despite anything I said, she perceived me as a very good, friendly analyst, and believed she was my favorite patient. At the same time she totally ignored my interpretations. Not only did she not discuss them, she also showed subsequently that she was completely untouched by them. She would say something either long or short and then she would politely stop talking, expecting me to speak. She appeared to listen to me, paused for a moment, and then continued with whatever she had been thinking of before, or during, my talk. While this was taking place, I felt awkward and increasingly more restricted while experiencing a sense of pressure to enlarge my interpretation, to explain things in more detail, or to find different or more elaborate ways to present it to the patient. As I became aware of this I took special care to scrutinize the detail of the patient’s responses, coming to the conclusion that she not only had not listened, but that she spoke in an attitude that conveyed her belief that what I said was futile, while her explanations were felt to be fascinating. Slowly I was able to say that while I was speaking she may have heard my words, possibly only my voice, but at the same time she went on thinking her own thoughts. I said that the whole situation did not seem to bother her much and she felt that the most important thing was to tell me what was in her mind. It then emerged that she had been enacting a strong fantasy in which she was inside me and was identified with me as an ideal object that provided everything. She

herself became this object. My role as an external object, on the other hand, was to be a place where she could get rid of her trouble and bad feelings. Slowly, the patient began to explain that she was afraid that she would be expelled from the job she held in a research institution. She thought that her employers might already have discovered that she did not care much for the research she was doing and that what she wanted was for them to like and admire her and find her very extraordinary.

I have quoted this example to illustrate the way in which the patient in the transference relationship was responding to me in two ways. First, she was regarding me as an ideal object, inhabited and totally possessed by her. But second, insofar as I was independent of her, she felt me to be bad and persecuting. This “bad me” was quickly split off into an external situation, the place where she worked.

The understanding of splitting processes in early development, both formative as well as defensive, also helps us to understand the appearance and coexistence in analysis of different parts of the personality, feelings and anxieties that originate in different phases of development but which can coexist and certainly do appear in the treatment in no specific order other than that given in the patient’s personal history. In my view it is important to maintain flexibility in the understanding of the anxieties with their shift from object to object and defense to defense so that one can take them up as they

show themselves in each session or period of work. It is only by dealing step by step that one can help to try to bring the different parts of the patient's personality together and help toward integration through insight into earlier anxieties.