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Basic Psychoanalytic Concepts: X. Interpretations and Other Interventions

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Previous papers in this series have concentrated on concepts which relate to the communications brought by the patient and to the factors, in both patient and therapist, which either facilitate or hinder the free flow and understanding of these communications. However, in the discussion of *working through* (Sandler, Dare and Holder, 1970a) reference was made to those interventions of the analyst which aim at bringing about enduring changes in the patient, and to the need for continual elaboration and reinforcement of the analyst's interventions. Whilst the term 'interpretation' is often used in a general sense to refer to these interventions (at least, to the extent that they are verbal) it seems appropriate to examine the concept in some detail.

Interpretation occupies a special place in the literature on psychoanalytic technique. Thus Bibring (1954) has remarked that '*Interpretation* is the supreme agent in the hierarchy of therapeutic principles characteristic of analysis . . .'. The central role of interpretation is equally stressed by M. Gill (1954) who asserts that 'Psychoanalysis is that technique which, employed by a neutral analyst, results in the development of a regressive transference neurosis and the ultimate resolution of this neurosis by techniques of interpretation alone.'

Because the psychoanalytic technique is predominantly a *verbal* one, and because the psychoanalytic training has become so specialized, it is perhaps natural that a certain mystique has become attached to the analyst's 'interpretations'.* Menninger (1958) has commented 'Interpretation is a rather presumptuous term, loosely applied by (some) analysts to every voluntary verbal participation made by the analyst in the psychoanalytic treatment process. I dislike the word because it gives young analysts the wrong idea about their main function. They need to be reminded that they are not oracles, not wizards, not linguists, not detectives, not great wise men who, like Joseph and Daniel, "interpret" dreams—but quiet observers, listeners, and occasionally commentators. Their participation in a two-party process is predominantly passive . . . their *occasional* active participation is better called intervention. It may or may not "interpret" something. It may or may not be an interruption. But whenever the analyst speaks he contributes to a process . . . .'

In his early writings Freud (1893–5) described the recovery of 'forgotten' memories by his patients. At this time he restricted his own verbal interventions in the therapeutic situation to those required to induce the necessary free expression of the patient's thoughts. He attempted to avoid direct suggestion of the sort which had characterized the hypnotic methods from which the psychoanalytic technique derived. His suggestions were directed only towards *facilitating* the patient's production of verbal material, in the belief that the stream of associations would eventually lead to the recall, more or less spontaneously, of emotionally charged memories surrounding important and significant events of the patient's past. In the early days of psychoanalysis the emotional abreaction which accompanied such recall was regarded as the essential therapeutic agent, for the patient's symptoms were thought to be brought about by the persistence of 'dammed-up' affects. Freud gradually formed the view that the hysterical patient's symptoms also symbolized, unbeknown to the patient, aspects of the assumed traumatic event and

* Some analysts even adopt a special tone of voice when delivering interpretations.

the thoughts and feelings connected with that (now forgotten) event. By 1897 Freud had given up the traumatogenic theory of hysteria, and was devoting himself to a searching examination of processes of symbolic representation, especially as they occurred in dreams. His study of his own and his patients' dreams was published in *The Interpretation of Dreams* (1900).

Freud's first references to interpretation are to dream interpretation, and the concept referred, in this connection, to the analyst's understanding and reconstruction of the hidden sources and meaning of the dream ('latent content'), arrived at by an examination of the free associations of the patient to the conscious memory of the dream itself ('manifest content'). In the early years of psychoanalysis the analyst conveyed and explained *his* interpretation to the patient, but this was a relatively didactic communication to the patient of the interpretation *arrived at by the analyst.*

By the time Freud came to write his papers on psychoanalytic technique (1911, 1912a, 1912b, 1913, 1914, 1915) he commented that there had been changes in the manner of presentation of the psychoanalyst's understanding of the patient's productions. The analyst's interpretation of the patient's dreams and free associations was not to be freely imparted, but might be withheld until resistances appeared. Freud now expressed his 'condemnation of any line of behaviour which would lead us to give the patient a translation of his symptoms as soon as we have guessed it ourselves . . .' (1913). From this time onwards Freud more or less consistently distinguished between the interpretation and the communication of the interpretation. Thus he wrote (1926a): 'When you have found the right interpretation, another task lies ahead. You must wait for the right moment at which you can communicate your interpretation to the patient with some prospect of success. . . . You will be making a bad mistake if . . . you throw your interpretations at the patient's head as soon as you have found them.'

In 1937 Freud differentiated between interpretations and 'constructions' in analysis. ' "Interpretation" applies to something that one does to some single element of the material, such as an association or a parapraxis. But it is a "construction" when one lays before the subject of the analysis a piece of his early history that he has forgotten." A construction (now usually called a 'reconstruction') represents a 'preliminary labour' which facilitates the emergence of memories of the past or their repetition in the transference.

While, early on, interpretation was regarded as a process occurring in the mind of the analyst, no great confusion could arise if the term was also applied to what the analyst said to the patient, for (apart from restrictions imposed by the need for 'analytic tact') the content of the two was the same. With the increasing realization that resistances and defences had also to be pointed out to the patient, more emphasis began to be placed on the form in which the analyst gave his comments and explanations to the patient. This has led to a use of the term 'interpretation' in the psychoanalytic literature after Freud which emphasizes what the analyst says to the patient rather than being restricted to the analyst's understanding of the patient's productions. The term is now regularly employed to describe one or other aspect of the analyst's comments. The 'art of interpretation' demanded of the analyst has come to mean the art of making a successful verbal intervention of a particular sort rather than the art of understanding the unconscious meaning of the patient's material. Thus, Fenichel (1945) refers to interpretation as 'helping something unconscious to become conscious by naming it at the moment it is striving to break through'.

It would seem that the change in the concept was an inevitable result of the introduction of the structural theory by Freud (1923, 1926a), and the move away from the previous 'topographical' conception. More and more stress came to be laid, in the area of psychoanalytic technique, on formulating interpretations which were acceptable to the patient, or which would be particularly effective at a given time. Stress was laid on *what* the analyst chooses to relay to the patient, *when* he chooses to do it, and on the *form* in which he does it (Reich, 1928; Anna Freud, 1936; Fenichel, 1941, 1945;

Hartmann, 1939, 1951; Kris, 1951; Loewenstein, 1951; Greenson, 1967).

It should be noted that from 1897 to 1923 the patient's free associations were regarded as being surface derivatives of unconscious wishes and impulses 'forcing their way to the surface from the depths'. The problem of interpretation was seen predominantly as one of understanding 'deeper' unconscious material from conscious productions. The structural viewpoint emphasized the role of the organized part of the personality (*ego*) in finding compromises between instinctual urges (*id*), dictates of conscience (*superego*) and external reality. Interpretations were seen as being addressed to the ego of the patient, and its strengths and weaknesses had to be taken into account. The analyst was forced to consider the *effect* of what he wanted to say. This is exemplified by Fenichel's anecdote of the analyst who unsuccessfully interpreted, for weeks on end, the patient's wish to kill him. While the analyst's understanding of the patient's unconscious wish appeared to be correct, what the analyst said to the patient did not appear to be so. 'Such an interpretation in that sort of situation *augments* the anxiety and with it the ego's defence, instead of diminishing it. The correct interpretation would have been: "You cannot talk because you are *afraid* that thoughts and impulses might come to you which would be directed against me" ' (1941).*

The situation at present appears to be that the term 'interpretation' is used both as a synonym for nearly all the analyst's verbal (and even occasionally non-verbal) interventions on the one hand, and as a *particular variety* of verbal intervention on the other.

There has been relatively little attempt in the literature to distinguish, at a descriptive level, between the various components of the analyst's verbal interventions. Loewenstein (1951) considers that those comments of the analyst which 'create conditions without which the analytic procedure would be impossible' are not interpretations, but rather comments which aim at freeing the patient's associations. Interpretations proper are verbal interventions which produce 'those dynamic changes which we call insight'. He thus excludes instructions and explanations from the concept of interpretation, considering the latter to be a term 'applied to those explanations, given to patients by the analyst, which add to their knowledge about themselves. Such knowledge is drawn by the analyst from elements contained and expressed in the patient's own thoughts, feelings, words and behaviour.'

Loewenstein also draws attention to interventions which could be called 'preparations for interpretation', as, for example, the analyst's pointing out similar patterns in experiences thought by the patient to be quite unconnected.

Eissler (1953) adds that certain verbal interventions other than interpretations are also essential to the 'basic model of psychoanalytic technique'. These include instructions (e.g. about the basic rule of free association) and questions aimed at elucidating the material. He takes the view that 'the question as a type of communication is a basic and therefore indispensable tool of analysis, and one essentially different from interpretation'.

Greenson has dissected some of the verbal components of analytic techniques (1967). He considers that 'The term "analysing" is a shorthand expression which refers to . . . (certain) . . . insight-furthering techniques.' Among these he includes:

Confrontation. This is regarded as a process of drawing the patient's attention to a particular phenomenon, making it explicit, and getting him to recognize something which he has been avoiding and which will have to be further understood.

Clarification. While this may follow confrontation, and blend with it, it represents more the process of bringing the psychological phenomena with which the patient has been confronted (and which he is now more willing to consider) into sharp focus. It involves the 'digging out' of significant details which have to be separated from extraneous matter.

Interpretation. This means 'to make conscious the unconscious meaning, source, history, mode or cause of a given psychic event.

* There are analysts who still regard their task as that of continually interpreting deeply unconscious material to the patient, and who apparently take the view 'the deeper the better'.

This usually requires more than a single intervention'.

In addition to these three (often interwoven) procedures, *working through* is added by Greenson as the fourth component of the procedure of analysis (*see* Sandler, Dare and Holder, 1970a).

To sum up, the term *interpretation* has been used in the psychoanalytic literature to mean the following:

1. The analyst's inferences and conclusions regarding the unconscious meaning and significance of the patient's communications and behaviour.

2. The communication by the analyst of his inferences and conclusions to the patient.

3. All comments made by the analyst. This is a common colloquial usage of the term.

4. Verbal interventions which are specifically aimed at bringing about 'dynamic change' through the medium of insight.

Some authors have differentiated the following from interpretation:

(a) Instructions given to the patient about analytic procedures in order to create and maintain the analytic setting.

(b) Constructions (or reconstructions) of aspects of the patient's early life and experiences, derived from material brought or enacted during the analysis.

(c) Questions aimed at eliciting and elucidating material.

(d) Preparations for interpretation (for example the demonstration of recurring patterns in the patient's life).

(e) Confrontations, as described by Greenson (1967).

(f) Clarifications, as described by Greenson (1967).

The degree of arbitrariness in many of these distinctions is striking. It is fairly generally accepted in the psychoanalytic literature that no interpretation can ever be complete and perhaps the most practical use of the concept would be to include within it all comments and other verbal interventions which have the aim of making the patient aware of some aspect of his psychological functioning of which he was not previously conscious. This would *include* much of what has been referred to as 'preparations for interpretation', confrontations, clarifications, reconstructions, etc. It would *exclude* the normal and inevitable verbal social interchanges and instructions as to analytic procedure. While these may nonetheless have an effect on the patient (e.g. the reassurance gained through the arrangement of regular appointments), we would suggest that an interpretation should be seen from the point of view of the analyst's intention of providing insight rather than on the basis of the effect of the analyst's remarks on the patient. Rycroft has elegantly described what could, from this point of view, be regarded as the central element in interpretation. He says (1958): 'The analyst invites the patient to talk to him, listens, and from time to time talks himself. When he talks, he talks neither to himself nor about himself *qua* himself, but to the patient about the patient. His purpose in doing so is to enlarge the patient's self-awareness by drawing his attention to certain ideas and feelings which the patient has not explicitly communicated but which are nonetheless part of and relevant to his present psychological state. These ideas, which the analyst is able to observe and formulate because they are implicit in what the patient has said or in the way in which he has said it, have either been unconscious, or, if they have been conscious, it has been without any awareness of their present and immediate relevance.' Rycroft adds 'In other words, the analyst seeks to widen the patient's endopsychic perceptual field by informing him of details and relations within the total configuration of his present mental activity which for defensive reasons he is unable to perceive or communicate himself.'

Attempts to narrow the concept of interpretation have a secondary effect on interpretative technique, particularly if certain interpretations are thought to be the only 'good' interventions. Such an effect has been evident in regard to the value put on transference interpretations, which, because they have been regarded by some analysts as the only 'proper' form of interpretation, have become the only interpretations given by some analysts. Consequently, all interpretations may be forced into a 'transference' mould (*see* Sandler, Dare and Holder,

1970b, c, and the comment on 'mutative' interpretations made below).

The content of interpretations has received a considerable degree of attention in the literature, particularly from the point of view of the relative effectiveness of different types of interpretation. In what follows we shall list some of the varieties of interpretation which have been described.

Content interpretation is an expression used to denote the 'translation' of the manifest or surface material into what the psychoanalyst understands to be its deeper meaning, usually with particular emphasis on childhood sexual and aggressive wishes and fantasies. This was the predominant type of interpretation given in the first decades of psychoanalysis. Such interpretations are concerned only with the meaning (unconscious content) of what has been thought to have been repressed rather than with the conflict which has led to the memories and fantasies being kept unconscious. Together with *symbolic* interpretations, which are the translation of symbolic meanings as they appear in dreams, slips of the tongue, etc. content interpretations are popularly regarded as constituting the bulk of the psychoanalyst's activity, a misconception which dates from Freud's early work.

Defence interpretation is a particular form of the analysis of resistances (*see* Sandler, Holder and Dare, 1970). Such interpretations are aimed at showing the patient the mechanisms and manoeuvres which he uses to deal with the painful feelings involved in a particular conflict, and, if possible, the origins of these operations. Defence interpretations are thought to be an indispensable complement to content interpretations, as the latter are thought to be insufficient unless the patient is also shown the way in which he copes with infantile impulses in himself. Anna Freud (1936) remarks that 'a technique which confined itself too exclusively to translating symbols would be in danger of bringing to light material which consisted, also too exclusively, of id-contents. . . . One might seek to justify such a technique by saying that there was really no need for it to take the circuitous route by way of the ego. . . . Nevertheless, its results would still be incomplete.'

Defence interpretations are also believed to be of special importance in the neurotic patient, as his psychopathology is considered to be rooted, in part, in his particular defensive organization, i.e. in his particular method of coping with conflict. Changes in this organization are considered to be an essential part of the therapeutic process (*see* Sandler, Holder and Dare, 1970).

The idea that some interpretations are more effective than others is embodied in the concept of the *mutative* interpretation. Strachey (1934) suggested that the crucial changes in the patient brought about by interpretation are those which affect his superego. Interpretations which have this effect are considered to be 'mutative', and in order to be effective must be concerned with processes occurring in the immediate 'here-and-now' of the analytic situation (as, in Strachey's view, only interpretations of such immediate processes, especially transference processes, have sufficient urgency and impact to bring about fundamental change). This idea has contributed, as has been mentioned earlier, to the view that only *transference* interpretations (*see* Sandler, Dare and Holder, 1970b, c) should be given by the analyst, as these are the only interpretations which can be effective (mutative). This does not appear to have been Strachey's belief, and does not accord with the practice of the majority of analysts, who make use of *extra-transference* interpretations (or *non-transference* interpretations) as well.

Direct interpretations are those given as an immediate response to the patient's material, without waiting for further associations or clarification. They are often a form of symbolic interpretation (Rosen, 1953).

The relation of therapeutic success to the making of 'correct' interpretations has occupied a number of authors. For example, Glover (1931) has suggested that inexact, inaccurate and incomplete interpretations may still result, in certain circumstances, in therapeutic progress. He regards this effect as coming about through the provision for the patient of an alternative system or organization which can act as a 'new substitute product' (in place of the previous symptom) which 'is now accepted by the patient's ego'.

Susan Isaacs (1939), in discussing the process of interpretation, took the view that the good analyst, by virtue of his training, used interpretations as scientific hypotheses concerning the patient's functioning. She says 'this becoming aware of the deeper meaning of the patient's material is sometimes described as an intuition. I prefer to avoid this term because of its mystical connotation. The process of understanding may be largely unconscious, but it is not mystical. It is better described as a *perception*. We perceive the unconscious meaning of the patient's words and conduct as an objective process. Our ability to see it depends... on a wealth of processes in ourselves, partly conscious and partly unconscious. But it is an objective perception of what is in the patient, and it is based upon actual data.' The emphasis of the 'objective perception of objective data' has been disputed by Rycroft, who suggests that what Freud did was not to explain a phenomenon 'causally, but to understand it and give it meaning, and the procedure he engaged in was not the scientific one of elucidating causes but the semantic one of making sense of it. It can indeed by argued that much of Freud's work was really semantic and that he made a revolutionary discovery in semantics, viz. that neurotic symptoms are meaningful disguised communications, but that, owing to his scientific training and allegience, he formulated his findings in the conceptual framework of the physical scientist.'

An intermediate view appears to be that of Kris (1956), who refers to 'the well-known fact that the reconstruction of childhood events may well be, and I believe regularly is, concerned with some thought processes and feelings which did not necessarily "exist" at the time the "event" took place. They may either never have reached consciousness or may have emerged at a later time, during "the chain of events" to which the original experience became attached. Through reconstructive interpretations they tend to become part of the selected set of experiences constituting the biographical picture which in favourable cases emerges in the course of analytic therapy.'

Balint (1968) has pointed out that the particular analytic language and frame of reference of a psychoanalyst must inevitably determine the way a patient comes to understand himself. From this point of view it would appear that therapeutic change as a consequence of analysis depends, to a large degree, on the provision of a structured and organized conceptual and affective framework within which the patient can effectively place himself and his subjective experience of himself and others (Novey, 1968; Yorke, 1965).

The concept of interpretation is obviously not limited to the psychoanalytic treatment setting or to various forms of psychodynamic psychotherapy. The verbalization by a general practitioner of a patient's unformulated fears about his health can be conceptualized as an interpretation, as it has the intention of conveying new insight by presenting to the patient some aspect of his feelings and behaviour of which he was not previously aware. It does not follow, of course, that the type of interpretation appropriate in one setting is always appropriate in others.

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