[Tom has now given very rich free associations. He begins by identifying two personal attributes – his smell and his weight – which, in his mind, are associated with other people's rejection of him. But it is more complex than this, since Tom also says that if he had sex he would squash a woman. Through this powerful image Tom is communicating his own rage and murderous feelings and the phantasy that intimacy is impossible because if he gets close to a woman he would squash/kill her.]

To understand the meaning of Tom's communications we need to contextualise what he is saying, that is, we listen to the content of his story bearing in mind that this is the penultimate therapy session. The dominant themes in his narrative are about being neglected/not visited by his parents and a perception of himself as repellent to others thereby preventing any intimacy. I note here that he switches from being angry with his parents to focusing on what it might be about him that makes it impossible for others to get close to him. If we consider these themes in relation to the fact that this is the penultimate session we begin to hear a different story. Tom is angry with me for not seeing him anymore. In his phantasy, I have another non-smelly, non-heavy patient who I would rather see than him and this is why I am stopping the therapy. Behind the initial anger about the therapy ending lies Tom's anxiety that he destroys relationships and that is why people need to get away from him.

The Nature of Psychoanalytic Interpretation

Interpretation is not an exclusively psychoanalytic technique. Cognitive-behavioural therapists also "interpret" when they make explicit to their patients, the links between their thoughts and behaviour. To interpret, in the more strict analytic sense, refers to verbal interventions that make something unconscious[1] (i.e. an aspect of their psychological functioning) conscious.

Jane was a deprived, young single mother who came into therapy because she had become post-natally depressed after the birth of her first child. She told me that her own family had rejected her and the father of her daughter had not shown any interest. She described her daughter as difficult as she cried most of the time. She felt exhausted by her demands and struggled to breastfeed her. She said that her daughter was always hungry, but that her breasts had little milk and it hurt her and that she was going to give her daughter the bottle. She was so exasperated at times that she was contemplating giving the baby up for adoption. She said that her social worker visited her once a week but that this did not help.

Presented with this material, I ask myself what internal experience Jane might be trying to convey through her description of her struggle with her baby. Jane consciously knows that she is depressed, and as the material

[1] I am using the term here in its descriptive sense.

indicates she links her current state with the demands of what she perceives to be a difficult baby. What is missing in her manifest narrative is a sense of why her baby becomes, in her mind, such a voracious, demanding baby that she reaches the stage of contemplating giving her up for adoption. What I know from her history is that Jane has a difficult relationship with her family who have rejected her and with her partner who has also rejected her. She also has a social worker but she does not feel the weekly visit is a good feed. I hypothesise that she is most probably feeling internally deprived and additionally has to contend with the very real demands of a small baby. A dominant theme of the narrative is conveyed by the powerful image of her depleted, aching breasts: she feels she has nothing left to give and that her baby has taken everything from her. In an interpretation we might therefore approach this material as an unconscious communication about a very needy part of Jane that cannot be soothed, just like her daughter who cries and is always hungry. In her own needy state, she experiences her daughter as a rival for limited resources. The fantasy of giving her up for adoption represents a way out in her mind when she feels that her daughter is taking too much away from her.

An interpretation is a hypothesis. It invites the patient to comment on it if he wishes or to ignore it. This is why an interpretation is ideally couched as a tentative statement, question or formulation that conveys to the patient "This might be one way of understanding what you are saying". An interpretation is not a statement of truth where we tell the patient what he is *really* thinking even if he does not yet know it; rather, it is an invitation to consider another perspective that may, or may not, fit.

Interpretation involves an inescapably subjective dimension. Interpretations are neither true nor false, only more or less helpful. It is of course the case that when we know our patients well and have worked with them over a period of months or years, our interpretations will become less hesitant and we can "cut to the chase" when recurring patterns manifest themselves. This may lend to the interpretation, a quality of "certainty", but usually this is not how the patient experiences it. This is why some published case histories are problematic: taken out of the context of the history of the therapeutic relationship, some interpretations may misleadingly come across as unfounded, wild guesses.

The Content, Function and Timing of Interpretations

Three key aspects of interpretations need to be considered, namely, their function, content and timing.

Content

One of the differences between the schools of psychoanalysis can be found at the level of the *content* of the interpretations that dominate the clinical picture.

"Content" refers to whether the interpretation relates, for example, to defences, to intrapsychic factors or to the transference. Content is not just determined by what the patient says, but by the level at which the therapist interprets is. For example, a patient may discuss a difficult work situation with a boss whom they are experiencing as hostile towards them. He describes the boss as insensitive, a bully, who always does things his own way. In dealing with the boss, the patient reveals his characteristically passive stance: he will endure the situation while secretly giving expression to his hostile feelings about the boss through his contempt for him. The patient thus presents himself as self-righteous and passively aggressive in the face of a bullying boss. Such a narrative could be taken up in different ways. In a classical Freudian model, the emphasis might be more on interpreting the impulse (e.g. to wish to attack and humiliate the boss) and the defence (e.g. the passivity). More contemporary, object-relational models might place less emphasis on the interpretation of defence and impulse and more on relational and interactional perspectives. For example, they might take up the relationship with the boss as an instance of transference and examine the patient's experience of the therapist as a bully along with his secret contempt for the therapist.

There are no definitive "rules" about how to determine the focus of an interpretation. Nevertheless, if the patient is primarily struggling with the experience of fragmentation and boundary diffusion, this exposes a lack of a sturdy-enough ego structure (i.e. weak ego strength) due to an absence of a constant, defined self-representation; this experience is generally prioritised in the content of an interpretation over issues of subtle meaning, affect and wish (Greenspan, 1977). For example, focusing an interpretation on the patient's conflictual wishes when the patient's main concern is with a sense of inner fragmentation misses the patient's core experience and is thus unlikely to be helpful. With neurotic patients, whose personalities are more integrated, interpretations can afford to focus on the meaning of what the patient says. With more disturbed patients, who have very disorganised object relationships and who cannot regulate their emotional states, interpretations can more helpfully address the patient's affective experience, that is, the focus is on helping them to identify what they feel before meanings are explored.

Psychoanalytic interpretations can focus on a wide range of thoughts, feelings or behaviour:

- They can draw attention to contradictory pictures of people, including the therapist, and the anxieties that lie behind the construction of such contradictory representations.
- They can address specific defensive manoeuvres that compromise the patient's self-awareness and connection to the therapist in the session, that is, transference interpretations (see Chapter 7).
- They can be directed at the patient's self-representations, helping him to explore positive and negative attributes and how these might be linked with particular representations of other people. Such interpretations can be made at different levels, that is, they may invoke unconscious meaning or they may, at first, simply make explicit overt attitudes and feelings the patient has. When working with patients who are more concrete in their thinking, interpretations of this latter kind can provide a gradual entry into a more exploratory mode.
- They can centre on the identification of patterns in the patient's actions, thoughts and feelings, especially in the context of relationships to self and others, including the therapist, highlighting the underlying object relationships and the associated unconscious phantasies that are enacted or implied. We infer the presence of unconscious phantasies[2] from the patient's behaviour or beliefs. For example, the phantasy *"I am filled with badness"* may manifest itself in the transference as a constant vigilance by the patient for critical comments. The phantasy *"I am omnipotent"* may manifest itself as the patient talking about risk-taking behaviour without any sense that he might get hurt.

Function

At its simplest, one of the functions of an interpretation is to convey to the patient that his communications, however incoherent or confused, are meaningful. An interpretation puts into words the patient's experience, focusing in particular on the unconscious aspects of the experience. Many interpretations serve the function of validating the patient's experience; they are essentially sophisticated reflections of empathy that convey to the patient that we have understood his predicament by going one step beyond an acknowledgement of what the patient feels. For example, if the patient is describing a dispute with a friend who disagrees with him over some issue and he tells us that he is upset by the argument, our interpretation would go beyond recognition of the patient's stated distress. We would be, additionally, trying to formulate why a disagreement feels disturbing to the patient, for example, we might hypothesise that the patient experiences any kind of difference as threatening to his internal psychic equilibrium.

When we interpret to our patient his state of mind, we are implicitly communicating our own stance in regard to the patient, that is, we are relating to him as a thinking and feeling being who has a complex mental life that can be understood. This, in turn, includes an element of reflection that will eventually become transmuted into the patient's self-reflective function by a process of internalisation (see Fonagy *et al.*, 2002). An interpretation is thus potentially mutative not only by virtue of its content, but also because it provides the patient with an experience of an external and different object who can think about his experience in addition to validating it (Kernberg, 1997).[3]

[2] Britton (1991) helpfully distinguishes between unconscious phantasy and belief. In his view, *phantasy* exists in the non-experiential realm of implicit memory, whereas a *belief* reflects the mental contents generated by the procedure activated in an object relationship.

[3] Fonagy and Fonagy (1995) suggest that when the mother responds to the baby's distress by giving it a dual-tone message that acknowledges both the child's experience alongside the expression of another emotional state that is incompatible with the baby's, this conveys to the baby that her emotional experience has been contained.

Many interpretations serve the function of linking what the patient experiences internally with external reality. This helps the patient – particularly the more disturbed patient who has blurred ego boundaries – to establish connections between powerful affects or states of mind and perception. Such interpretations provide a gentle introduction to the idea of an unconscious mind that exerts an impact on behaviour.

Interpretations are often said to "contain" the patient's distress. By bringing together disparate aspects of the patient's experience, an interpretation metaphorically "holds" the patient. The mere act of interpreting may be experienced by the patient as a concrete expression of our interest in him and this too may be felt to be very containing. At times, containment may be all that the patient can manage: some patients come to us to be understood but not for understanding (Steiner, 1993). Understanding presumes the patient's active involvement in the process such that he is emotionally sturdy enough to take on responsibility for his own mind and its impact on others. Although the containing function of interpretations is important, and with more disturbed patients it is essential, containment is not an end in itself (Steiner, 1993). As Frosh aptly puts it:

> If containment is all that therapy provides, then the real thing, the existence of contradiction and loss, is never faced.
>
> (1997b: 108)

As we approach any of our patients' communications we always need to be mindful of the ever-present pressure from the patient to relieve him of his suffering. Of course, this is one of the aims of any therapeutic enterprise. But there are different ways of easing psychic pain. One is to engage in some activity, such as giving advice or providing reassurance. Such interventions, while providing short-term relief to the patient, may also communicate to the patient that we cannot bear to stay with his pain and to think about it. Keeping to an interpretative mode conveys to the patient, even if painfully, that unbearable states of mind can be reflected upon with another person who validates the patient's experience. After all, as Frosh suggests, perhaps all that therapy can offer is a "metaphor of interpersonal recognition, a sign of not being alone" (1997a: 98). Interpretation may be one of the means of conveying this kind of recognition. It signals to the patient that he is "not alone", that another mind is grappling with his mind. We should not underestimate this simple, yet powerful, function.

In our work we need to balance an open, receptive, supportive attitude with one of searching and "facing up to". An interpretation may both validate and contain a patient, but it also needs to bring together disparate elements in a way that is ultimately challenging. Ideally an interpretation is more than revelatory: it is also destabilising. The act of interpreting is more than a reflective statement that captures the patient's experience. It also introduces a new perspective on the patient's experience. It is important, therefore, to create the conditions of safety within which the patient can withstand the challenge that is a necessary part of the therapeutic enterprise.

Timing

An interpretation can be resisted if it is felt to threaten an existing internal state or established views of the self or others. Timing is therefore of the essence. Just like a badly timed joke, an interpretation, even if correct, will fall flat, may shame or may alienate the patient if it is offered when the patient is not psychologically ready to hear it. If a particular behaviour is interpreted before the patient can fully grasp its psychological significance, the patient may feel forced into a passive position where our perspective is privileged. Premature interpretations can unhelpfully lend the therapist an omniscient quality that serves to protect both participants in the therapeutic process from core anxieties elicited by "not knowing". The patient's inner sense of the analytic relationship must be stable or be stabilised in order for him to utilise the destabilising impact of interpretations, which, by definition, bring something new to the patient's attention.

The best interpretations are no more than well-timed prompts that enable the patient to arrive at his own interpretation. These prompts are skilled interventions informed by our dynamic understanding of the patient and of the particular transference matrix dominating the relationship at the time. The aim of analytic work is to foster the patient's self-analytic capacity, not to make him reliant on a therapist who delivers clever interpretations. Although we may be tempted to make an interpretation we need to guard against approaching the therapeutic situation as a forum for exposing our analytic prowess. If we always pre-empt the patient's efforts to understand himself, we are like the mother who upon seeing her child reaching out for an object always leaps in and hands it to him, depriving him of an opportunity to experiment with his own abilities. This is why, when it comes to interpreting, less is often more. Tarachow observes:

> An interpretation should rarely go as far as possible. It should by preference fall short even of its intended goal. This gives the patient an opportunity to extend your interpretation, gives him greater share in the proceedings and will mitigate to some extent the trauma of being the victim of your help.
>
> (1963: 49)

A good interpretation is simple, to the point and transparent. By "transparent" I mean that the interpretation shows the patient how we have arrived at our particular understanding. This is especially important in the early stages of therapy when the patient might be unaccustomed to working with the unconscious and may therefore experience an interpretation as "plucked out of the blue" unless it is grounded in the content of what he may have been talking to us about in the session or in the dominant feelings expressed. Importantly, this minimises the patient's experience of us as omniscient and provides a model that the patient can adopt to make sense of his own unconscious.

> During her penultimate session before a two-week break, Sara asked me during the session whether I had seen a programme on television, which dealt with people's attitudes towards death. As she spoke I was aware that

her speech was quicker, her voice brittle. Sara told me that she had found the programme helpful as it validated her own experience of how difficult it is to talk about death. She had lost her own mother to cancer two years previously, and since that time she had painfully struggled to reconcile herself to her death. She did not like the word *death* and actively avoided it in the sessions.

In approaching this material, I had two things in mind: Sara had indeed come into therapy to explore her grief about the loss of her mother on whom she had been very dependent. The session reported here took place a few months before the second anniversary of her mother's death. It felt important, therefore, to respond to her comments both as related to her mother's actual loss as well as to consider the possible latent communication. In this respect, I was mindful of the forthcoming break in the therapy and of Sara's dependency on me. We had explored, on a few previous occasions, her fear that I would not be there for her at the time of her session and how she struggled to allow herself to rely on my being there for her. She was characteristically quick to dismiss her dependency on me while at the same time reassuring me that she valued my input a great deal.

In light of this background history in our relationship and the material in this particular session I made the following intervention, taking into account her conscious preoccupation and linking it to my own understanding of what else it might also mean: "I am aware that we are approaching the anniversary of your mother's death and we both know that this makes you feel very anxious. I wonder too whether our forthcoming break is making you feel anxious but to speak about it feels too dangerous. Just like the people in the TV programme you were telling me about who confirmed your experience that death talk is avoided, I think that you are telling me that 'break talk' is also difficult today."

Our interpretations will serve different functions depending on the developmental level of the patient. This is a crucial consideration in relation to the timing of an interpretation. Whether an interpretation is experienced by the patient as liberating or horrifying has everything to do with the degree to which language is freed from some of its ties to the body and to primitive impulses. Only when language has truly become a system of signifiers will interpretation help. With very disturbed patients, especially psychotic patients whose symbolic capacity may be severely compromised, an interpretation will not necessarily contribute to an experience of validation, containment or understanding.

Knowing when and what to interpret therefore relies on our ongoing assessment of the patient's overall degree of disturbance and his shifting states of mind within a session. There is a distinction between an interpretation that makes the patient conscious of patterns he is unaware of and an interpretation that makes the patient conscious "in the sense of helping the patient acquire a previously non-existent representation" (Edgecumbe 2000: 19). With more damaged patients who may have had little, if any, experience of another person

helping them to make sense of their emotional experiences, our work is often not about uncovering meaning; rather, it is about helping the patient to find or to make meaning. That is, we help the patient discover what he feels before we can begin to explore why he feels in a particular way.

The Interpersonal Context of Interpretation

Before we can consider the type of interpretation we might make, we need to think about the quality of the interpersonal context in which the interpretation is made. If one of the functions of interpreting is to challenge the patient's perspective on a given issue, this is a risky strategy. The pull of the internal psychic status quo can be powerful and an interpretation may therefore be experienced as an unwanted intrusion that threatens to disrupt a fragile equilibrium. This is why it is preferable to interpret in the context of a good therapeutic alliance that can withstand the patient potentially experiencing us as unhelpful, attacking or persecuting. Nevertheless, there will be occasions when the patient will experience us as unsupportive precisely because of the distortions of transference. In these circumstances, it will be important to interpret this as a way of re-establishing a context of support. As with any relationship, the therapeutic relationship will suffer the strains of misunderstandings and mis-attunements. What matters is that such experiences can be thought about and survived constructively. The therapeutic relationship is strengthened by the experience of ruptures that can be repaired.

Types of Interpretation

There are two main types of analytic interpretations: *reconstructive or genetic interpretations*[4] and *transference or here-and-now interpretations*. A reconstructive interpretation draws attention to the patient's feelings or thoughts, for example, by linking them to their developmental origins (e.g. "*I think that you feel angry when your husband does not share his work with you just as you felt when your parents excluded you from their discussions*"). Until Kleinian thinking established itself in mainstream analytic practice, reconstructive interpretations had been the quiet staple of analytic work (Brenneis, 1999). As we saw earlier in Chapter 2, some contemporary approaches now stress the importance of understanding childhood events as being shaped into procedures based on early experiences that may never be retrieved. This position has challenged the function and prominence of reconstructive interpretations.

In our work, we need to pay attention to the very psychic structures that organise our behaviour. It is through addressing these structures – not the experiences that have contributed to these structures in the first place – that therapeutic change will take place.[5] The interpretative focus is on the patient's

[4] These are also sometimes referred to as extra-transference interpretations. The latter effectively covers any intervention that is not transference interpretation.

[5] I am describing here what I consider to be important, rather than a definitive, psychoanalytic stance.

patterns or procedures as they manifest themselves in the transference relationship. These interpretations are often referred to as "here-and-now" or transference. Although they can include links to figures from the patient's past, they retain their primary focus in the present relationship with the therapist as it unfolds in the consulting room (see Chapter 7).

We infer the transference from the patient's associations, affect and behaviour that recreate or re-enact the past. Nowadays this is mostly regarded as a new experience influenced by the past rather than an exact replica of it. A transference interpretation makes explicit reference to the patient-therapist relationship and is intended to expose, elucidate and encourage an exploration of the patient's conflict(s) as it makes itself known in the relationship. Although the emphasis of the interpretation is not on the patient's past, work in the transference leads to an understanding of the past, as Roys points out:

> It is the experiencing of the live interaction with the therapist, rather than an intellectual explanation from the therapist that leads to the reconstruction of infantile anxieties and defences.
>
> (1999: 37)

The aim, in many contemporary approaches, is not to arrive at the truth in terms of what really happened to a patient but to reach an understanding of the patient's affective experience (Flax, 1981). Consequently, many contemporary therapists concentrate their therapeutic efforts on the formulation and interpretation of the patient's *current* representations of himself in relationship with other people. This focus reflects a move away from the illusion that there is an objective truth to be found in reconstructing the patient's past.

In practice, few therapists restrict themselves exclusively to either transference or reconstructive interpretations though there are differences in emphasis typically associated with different schools. The respective use of these two types of interpretation produces quite different experiences within the consulting room. A reconstructive interpretation locates the origins of the patient's behaviour firmly in the past. As such the patient's current feeling of anger, say, can be redirected by the therapist back to a past significant figure, thereby protecting the therapist and patient from a potentially too immediate emotional experience in the room. By contrast, a transference interpretation is bolder: it invites the patient to examine his emotional reaction, however uncomfortable or distressing, in the immediacy of the therapeutic relationship. In this sense, a transference interpretation involves more direct exposure to the affect that the patient might want to avoid. By implication, it involves the therapist directly as a protagonist in the patient's unfolding narrative. It renders the therapist the target of emotions that may also feel uncomfortable to the therapist. Indeed, Waska observes that:

> Many patients and analysts use genetic reconstruction, free association and dream recall to defend against the exploration of transference fantasies. The ability of both the patient and analyst to keep returning to the centrality of the patient's fantasy life and the intricacies of that internal motion as it plays out in the treatment relationship is what defines the treatment as psychoanalytic.
>
> (2000: 28)

Another common distinction is drawn between surface interpretations and depth interpretations. A *surface interpretation* restricts itself to material that is very close to the patient's consciousness, that is, a more manifest level of communication. Generally speaking, in response to such an interpretation the patient is unlikely to feel bemused; rather the patient is likely to more readily recognise that which the therapist points out even if he had not himself consciously made the connection. When in doubt as to what the patient can tolerate, it is best to avoid starting with interpretations that are potentially too threatening or farthest removed from what the patient is consciously aware of, such as interpretations relating to the patient's destructive feelings or phantasies.

A *depth interpretation* typically involves bringing to the surface those elements that are most historic and so farthest from awareness. Busch (2000) helpfully suggests that by the time we make a depth interpretation, this should ideally not seem very deep at all to the patient. Ross argues further that:

> interpretation of conflicts that are still unconscious and that therefore can only be inferred [are] violations of the analysand's mental autonomy – as premature schematisations to which the analyst resorts when a patient requires some kind of frame or guidepost to assuage terror of the unknown.
>
> (1999: 98)

Busch and Ross both advocate an approach that follows the patient's pace warning us against the perils of over-interpreting and ascribing meaning prematurely as a defence against uncertainty.

The most helpful interpretations are those that help the patient understand himself in a way that is emotionally meaningful, not intellectually seductive. An approach that relies on frequent so-called depth interpretations privileges our agenda whilst remaining distant from what the patient may be capable of at any given point.

Another clinically helpful distinction is drawn by Steiner (1993) between "patient-centred" and "therapist-centred" interpretations. This distinction reflects Steiner's view that some patients, whilst wanting to be understood, cannot bear understanding. The patient who wants understanding is actively engaged in a process of self-exploration. This kind of patient can make use of *patient-centred interpretations*. These interpretations focus on what the patient is doing or thinking, revealing to the patient his projections into the therapist. These kinds of interpretations invite the patient to assume responsibility for having an effect on the therapist:

> Responsibility is a key trigger for depressive anxiety and some degree of working through of that position may have to be achieved before the patient's role in phantasy can be interpreted. That is to say, the patient's responsibility for the

analyst's mind brings on feelings of guilt and blame which may involve a sense of deserving punishment.

(Hinshelwood, 1999: 804)

By contrast, the patient who simply wants to be understood, according to Steiner, uses the therapist to evacuate unwanted thoughts and feelings but is not able to take back these projections in the form of interpretations. If the patient cannot tolerate self-understanding, Steiner advocates using *therapist-centred interpretations* that focus on the patient's view/phantasy of what might be going on in the mind of the therapist (e.g. *"You experience me as ..."* and *"You are afraid that I will feel ..."*). Such interpretations have a more containing function.

Table 6.3 summarises the main considerations for how to approach making an interpretation. At the risk of repeating myself, our primary concern, when we interpret, is to make an assessment of the patient's state of mind at the time of the interpretation and the implications of this for his receptivity to what we have to say. A patient in the grip of paranoid anxieties will struggle with a so-called patient-centred interpretation, but this same patient, when in touch with more depressive anxieties may be able to make use of such an interpretation.

Interpretation: The Patient's Experience

Asking for help is a complex psychological process: it requires an acknowledgement that we need help, that we are therefore vulnerable and hence that we are in some important respects dependent on those who help us and who are not within our omnipotent sphere of control. Being understood by another person before we can understand ourselves is not universally experienced as supportive. For some patients, it is evidence that they are a failure or that they are weak or dependent, and hence it is at its core a potentially humiliating experience (Mollon, 2002). Being in therapy can therefore be experienced as shameful by the patient who may view it as an admission of weakness or inadequacy that threatens a fragile psychic equilibrium. The patient's experience of an interpretation will most likely reflect his state of mind and dominant self-representation at the time of the interpretation.

Analysing means breaking things into their component parts. The interpretation tries to make sense of what emerges through this process. It is therefore an exposing experience for the patient who is being presented with a version of himself that he may not like and may indeed feel very ashamed of. Shame experiences result from sudden awareness that we are being viewed differently than we anticipated. In a shame experience, there is a split in awareness (Spiegel *et al.*, 2000): the self is experienced as deficient, helpless, confused and exposed, and the shaming other is experienced as if inside the self, judging and overpowering.

When we make an interpretation, our intention is to help the patient to understand something about himself that will be of help to him. Nevertheless, when we speak we can never know what the patient hears and whether it is what we intended. Just as we listen to the patient's non-verbal behaviour, so does the patient listen to ours. Sometimes the patient may "mishear" intentions, or at other times he may "hear" accurately intentions we are not even aware of but that may in fact hold a degree of truth. Our patients often turn out to be our best supervisors. Even if we are sitting out of sight, what the patient hears happening behind the couch, such as our possible restlessness or our tone of voice can be interpreted rightly or wrongly as signs of boredom, lack of concern or critical judgement.

An interpretation is a hypothesis, but it can be experienced by the patient as an action (i.e. the therapist doing something to the patient). Interpretations can thus be experienced as attacks or invasions that must be warded off. When working with patients who have been in some way abused it will be crucially important to bear this in mind. Because interpretation involves externalising, and thereby exposing, the contents of the patient's mind at a given point in time, this can be experienced as the therapist entering the patient's mind. In more disturbed patients this can provoke a violent reaction, not necessarily directly towards the therapist but possibly displaced onto someone else.

In part at least, the patient's experience of an interpretation will be determined by what he is seeking from us. As Steiner (1993) points out, for those patients who are not looking for self-understanding, the therapist's role is to carry the burden of knowing. Interpretations that put back to the patient his disturbing state of mind – that is, patient-centred interpretations – may be experienced as a burden rather than feel containing. Disturbed patients, such as

Table 6.3 Guidelines on how to approach the task of interpretation

- The first stage of an interpretation is the clarification of the patient's subjective experience.
- The second stage involves interpreting what the patient may not yet be aware of and/or may be avoiding becoming aware of.
- The patient's state of mind is an important consideration when making an interpretation: ask yourself what he can bear to know.
- The interpretation needs to reach the patient: it must take into account his level of personality organisation.
- The interpretative focus should be on material infused with the most affect, whether it is a transference or extra-transference interpretation.
- Consider the interpersonal context: it is less risky to interpret in the context of a good therapeutic alliance.
- Interpretations early on in therapy need to be delivered cautiously and in the context of some evidence, not pure guesswork.
- As a rule, refrain from making elaborate genetic reconstructions about matters outside a patient's awareness and usually outside of your own knowledge. It is far more reliable and productive to stay focused on the here-and-now conflicts and patterns as they arise in the therapeutic relationship.
- Monitor how you are using both transference and reconstructive interpretations. Historical reconstruction may be used defensively to avoid the present situation.

those with more borderline personality organisations, alert us to the importance of the interpersonal dimension of the act of interpreting. This kind of patient lacks trust in his objects. He has little or no confidence that his objects will understand him and may therefore feel defensively hostile to a therapist who tries to understand him. Where shame-based experiences dominate the patient's internal world, an interpretation may be destabilising – a potential threat to a fragile self. The safety and consistency of the setting are key aspects of the intervention that such a patient needs. For a long time, turning up for the session at the same time each week may be all these patients are able to manage.

The act of interpreting itself communicates to the patient that we have a separate mind, capable of entertaining different thoughts from those held by the patient. This reminder of difference may be intolerable for some patients. Britton (1998) suggests that as the therapist produces interpretations this may be experienced by the patient as a painful, even unbearable, separateness that challenges the illusion of being one and the same with the therapist. Britton is referring here to the difficulties some patients experience with triadic relationships where the interpretation is experienced as the therapist being engaged with her own thoughts – in a couple as it were – that excludes the patient. When we introduce our thoughts, we may be experienced as:

> a father who is either intruding into the patient's innermost self or pulling the patient out of his or her subjective psychic context into one of the analyst's own.
>
> (Britton, 1998: 49)

A transference interpretation, in particular, introduces us as an external object, separate from the patient and therefore is a reminder to the patient that we are not within the patient's omnipotent sphere of control. Along very similar lines, Kernberg (2000) understands the therapist's interpretative function as representing "the excluded third party". In giving an interpretation, Kernberg suggests that the therapist replicates the role of the Oedipal father in disrupting the pre-Oedipal, symbiotic relationship between infant and mother. The therapist's interpretation is a reflection of the third position, introducing triangulation into the symbiotic nature of transference and countertransference entanglements between patient and therapist:

> When the analysand reflects on his communications and the analyst provides an interpretation, he always bears the name of the father: the outside who breaks the unhindered movement of desire and defence.
>
> (Bollas, 1996: 3)

Interpretation does not always assist the therapeutic process. It can also be used defensively by both patient and therapist. The therapist's interpretation and the patient's response to it may be no more than "a means of joint disposal" (Britton, 1998: 94), an intellectual way of reassuring both parties that they are doing the work of therapy when they are, in fact, avoiding something unsettling in the transference. The illusion of understanding may be pursued to defend against the pain of not understanding. Ideas or the construction of a narrative may be used to reassure:

> An interpretation can become a means of seeking security rather than enquiry and its constancy may be more highly valued than its truth.
>
> (Britton, 1998: 106)

Britton is making a very important observation because it is all too easy to forget the potentially defensive function of the search for understanding.

In our eagerness to restore coherence in our patient's confused and distressing life story, we may use interpretations to fill the gaps in understanding and to foreclose the open-ended, at times tormenting, nature of exploration.

Conclusion: The Limits of Interpretation

As I have repeatedly stressed throughout this chapter, an interpretation is a hypothesis. As such it is our best guess, in light of the knowledge we have, about a patient at any given point in time. I am using the term *knowledge* to provoke since we filter what we hear of the patient's narrative and therefore the knowledge we arrive at through our own personalities, with our own blind spots and no-go areas and through our theoretical allegiances. Meissner suggests that:

> Listening is limited by the conditions of hearing – namely, that our access to the mental life of another is constrained by audible expressions of that subjective experience conveyed by external behaviour. We have no direct or immediate access to the subjectivity of another: we can only read that subjectivity by way of inferring from its external expressions.
>
> (2000: 326)

Interpretation is a subjective act. It is easy to forget this. We can all get "married to a hypothesis" trying to fit the patient into our ideational mould.

> A good Skinnerian will remind us that the interpreter of psychoanalytic material is on an intermittent reinforcement schedule and that therefore his verbal behaviour and his belief system will be maintained, despite numerous trials, that constitute potential refuters.
>
> (Meehl, 1994: 31, quoted in Pine, 1998)

In analytic work, the scope for misunderstanding or faulty inferences and hence conclusions is impressive. The more we engage in psychoanalytic work, the more we learn to appreciate that when it comes to matters of the mind nothing

can be stated with absolute certainty and that exploration only reveals further questions.

If interpretations are inevitably subjective acts, then how do we know whether our interpretations are correct? Do we assess correctness in relation to whether the interpretation reflects the truth or, as Frosh (1997b) suggests, does its value lie in its effects and not necessarily in its truthfulness? Such questions inevitably lead us to consider whether interpretations lead to a revelation of facts or the creation of a new narrative.

Traditionally the validation of an interpretation has been thought to require the generation of new memories or affects in the patient's free associations thereby amplifying his exploration: the patient runs with the interpretation, as it were. A deepening of affect after an interpretation is often taken as a good indicator that the interpretation is "on the right track" and strikes an emotional chord. If the interpretation falls flat and the patient does not elaborate on it we would note this and remain open to the possibility that we are either on the wrong track or that the patient may not be ready to hear the interpretation.

In analytic work what we take as evidence of confirmation of an interpretation leaves room for considerable debate. The fact that the patient can make use of what we have said is not necessarily evidence of the accuracy of an interpretation. In some cases it may reflect no more than the patient's compliance and wish to please us:

> When there is a desire for agreement from the primary object with a dread of misunderstanding there is an insistent, desperate need for agreement in the analysis and the annihilation of disagreement.
>
> (Britton, 1998: 57)

It is beyond the scope of this chapter to enter into the kind of debate these questions deserve. They are eloquently discussed by Frosh (1997b). In raising the question, my aim is simply to reiterate that because interpretation is by definition a subjective act, we must proceed cautiously and remain open to the possibility that the patient's agreement or disagreement with it may tell us very little about its correctness and/or helpfulness. It is worth noting that this is a problem shared by all therapeutic approaches, not just psychoanalytic ones.

Not only do we need to be concerned with how we evaluate our interpretations, but we will also do well to ask ourselves whether interpretations are the main vehicle for change. If psychic change is not solely related to the verbal articulation of procedures that have become implicit – as suggested in Chapter 2 – interpretations, whether of a reconstructive or a transference kind, are unlikely to be either the sole, or indeed primary tool, at our disposal to help our patients. Our ways of being with our patients, which are so often implicit and perhaps can never be adequately captured by language, may present the patient with a new experience of being with another that contributes to a reworking of internal expectations of self and other and may lead to subtle, yet ultimately significant, changes at the level of implicit relational procedures. These unquantifiable, hard-to-teach qualitative aspects of the therapeutic process, owing as much to therapeutic style and personality as to technique, may prove to be important variables determining outcome.

Further Reading

Casement, P. (1985) *On Learning from the Patient*. London: Routledge.