Interpretation

Harold N Boris

Interpretation

Harold N. Boris

Table of Contents

Interpretation

At the time I wrote this, on commission for a book on the various sorts of psychotherapeutic interventions described by Edward Bibring (or, Eissler, "parameters"), my grasp of the context for what one can and cannot usefully do had evolved from where it was at the time of "Confrontation" to the point where I could begin to write of it. But in preparing it for republication (the book gasped once and died) I was taken aback by my cordial view that there is a reality from which various distortions depart and, accordingly, to which interpretations return a "Really" (Really!). It is curious how difficult it is to see beyond the boundaries of constraint—how comforting intellectual prisons are; how often one, meaning I, may escape from newfound freedoms by the simple—even a child can do it!—expedient of not noticing there is a there there. Or isn't.

Apart from this sanguine solipsism, the essay says what I want it to say, so I have not revised it. Instead I wrote "Interpretation of Dreams, Interpretation of Facts." That essay (in Part Three) should be read along side the present one.

I don't have, at the moment, a philosophical position on what or where reality is, except that it doesn't return phone calls. I am, however, enduringly fascinated with other people's views—with how they shape, place, define, and nab reality. I attach the view that there is an is and, indeed, an isier, to the pressures of the selection principle, about which more in "Beyond the Reality Principle." (in Part Three.) If people have to make choices, as they do, they seem to prefer to have choicer choices to choose. Real in the sense of absolute, true, so, ideal has great appeal in this regard. Even better are those reals that modestly do not appear unveiled but wreathe themselves as shadows on the cave wall or in phenomena which merely hint at the noumenon.

To interpret other people's experiences it is enough to know the cryptogram by which they have transfigured what was the case. That it needn't ever have been the case doesn't apply. People live histories that never occurred as ardently as they lived those that did, often more so. Freud's constructions, as any good archaeologist's should, searched for what once was but no longer is, for truths among the ruins. But people's inner life has only a peripheral relation to what might be called their actual life, so that as often as reconstructing what happened, one is busied with constructing what almost happened but didn't—what stayed real but never became quite actual and matter-of-factual. The paths not taken are much traveled.

The patient mentioned in this paper diligently continued her work with me, but I cannot say she consolidated it until after her father died. His death seemed to inspire her with a dual sense—of something ended and something completed. She seemed, upon his death, to relinquish her stalwart homoerotic attachment to him, which had only increased with his final illness. She stopped when she felt that my own death was not also necessary, and so grew bored with our meetings. At around that time she found her "own" life surprisingly interesting although it hadn't—actually—changed much.

When, in prehistory, something-in-itself was represented by a thought, a sound, a scratching on a cave wall, humankind realized its capacity to form symbols. When that same process of transformation was reversed, and the actual thing or event reconstructed from its symbol, interpretation was born. Thereafter, anyone who wished either to study humankind or extend our humanity—philosophers, poets, mathematicians, linguists, mystics—had to study

or enhance the transformational processes.

Still it was for Freud to take up and solve a particular aspect of the matter. Symbols that were contrived to reveal—as these words are—can also be used to conceal. Experience can be as readily encoded to repress meaning as to express it. Experiences too painful to be endured can be transformed, also by rules systematic and lawful, into versions of the actual that at once represent and misrepresent the actual. Such transformations, moreover, must resist interpretation in a way transformations meant to convey the truth of the experience represented in them must not.

By 1895 in *Studies in Hysteria*, Freud (with Breuer) had found a way of intuiting from the bizarre symptoms of his patients the actual experiences that were transfigured in them. The interpretation of the symbolic meaning of symptomatology and the (re)construction of the historical events that were contained and ciphered in them were established.

By 1900 a further development had been made. Ego psychology, or the means by which these special transformations occurred, was in place. In the famous Chapter 7 of *The Interpretation of Dreams*, Freud (1900) wrote out the transformational rules by which we come no longer to experience what we experience but to experience some version of the actual experience instead. From a therapeutic standpoint, it was now possible not only to draw patients' attention to the presence of absences (the gaps in their knowledge of their experience) but also to the means (the so-called mechanisms of defense) by which the counterfeit versions of their experience were substituted for the actual ones.

So remarkable was this advance that only two major additions to the transformational/interpretive processes were left to make. Both were arrived at by seeing that there were other transformations needing interpretation.

The first of these has to do with people's propensity for transforming one experience (e.g., that having to do with a patient and a psychotherapist) into another (e.g., one having to do with a child and its parent) and then acting as if the second were as true as, or more true than, the first. This transformation, of course, is what we call the transference; and it, in turn, represents a kind of field of forces that influences the transformations embedded within it. Not only are different things experienced (e.g., remembered) within the sway of the transference, but things are remembered differently. Unless the transference is interpreted, the experiences that also are represented within it cannot be construed accurately.

Interpretations made within the field of forces that is the transference are also affected. At various times the same intervention—even one so otherwise simple as "What did you feel?"—can be experienced as anything from an accusatory attack through an examination question to a benign benediction. Insofar as the therapist hopes to be understood as simply conveying information, the view the patient takes of the interpretation also has to be subject to interpretation.

The second development follows from the increasing understanding of the force of the transference. This is the prodigious power of the person to whom the transference is made—in psychotherapy, the therapist. Earlier in psychodynamic thinking, the transfer of attributes to and from the therapist could be encapsulated by such placid nouns as identification, projection, and displacement. But thanks largely to Melanie Klein (1952), attention shifted from the result of these transformative activities (for example, "he has come to think of his therapist as a father figure") to the activities themselves.

We can now see that to the process of transformation the patient attaches quite specific fantasies. The so-called projection by which the patient imbues the therapist with certain characteristics is thought of by the patient as perhaps an act of evacuation or of gifting, of impregnation or of soiling. Reciprocally in the therapist's seeming reply to this act—that is, in the silence, movement, or speech that follows the patient's activity—the patient will see acts of menace or seduction. To quote Bion (1970, p. iv) on this subject, we must now "attend not only to the meaning of the patient's communication but the use to which it is being put." The topological and structural expositions of Freud's psychodynamics thus have been enriched by a lively sense of the relation of the "objects." This relationship —who is doing what and with which and to whom—accordingly must occupy the participants. For though the amnesias and paramnesias and the host of defensive maneuvers by which these are achieved are but sleights of mind —experiences contrived simply out of selective attention and inattention—they are imagined to be more than that.

Moreover, they are imagined to transform subject and object alike. Once a little girl and I watched some other children go for a boat ride after supper. "My name," said the little girl who was deemed too young to join the boat party, "is Galen." When the boat turned and headed back to shore, the little girl confided: "My name isn't really Galen. Her name is. But don't tell her I said I was Galen." One person's transformations are supposed by that person to transform others. My young friend might have imagined that the Galen from whom she borrowed her Galen qualities without permission might react as did the gods to Prometheus. Galen too was transformed by the little girl's act. Sullivan (1953) was alert to these matters, as well. He saw that when we cannot bear to know what

we experience, we cannot bear to know the truth about others: they too are transfigured and continue to be until we can come once again to know ourselves. Interpretation alters not only our experience of ourselves, but also how we experience others and how we experience others' experiences of us. Let us see this process at work in the course of psychotherapy. I shall begin with the essential *structure* of therapy, for on it depends the experience of interpretation.

THE PSYCHODYNAMICS OF INTERPRETATION: BACKDROP

Psychodynamic psychotherapy introduces a person to himself or herself. More precisely, it introduces the person at his or her present age to himself or herself at previous ages, and "previous" here can mean a few moments or years and years ago.

At age 5 one cannot know the 15-year-old one will become. A 5-year-old can extrapolate from 5 to 15 in imagination, but it is only a small child's vision of 15. Likewise, an adolescent can only know 5 from an adolescent's point of view. The adolescent cannot know 30 and so cannot know that 30 will know 5 differently. If only 5, 15, and 30 could meet and talk things over themselves! But surely an interpreter would be needed.

People think that pain can be reduced and pleasure gained by not knowing certain things about themselves and others. Of course, they have to know what they do not want to know, and this plainly presents certain difficulties. They are rather in the position of one of Kipling's characters who was guaranteed access to a great treasure, provided only that, upon encountering it, he did not think of a white rhinoceros.

Freud likened this dilemma to paragraphs excised from a newspaper by censors. The spaces give away the censor's activities. But what if the spaces were filled with false or innocuous typescript? Repression, not knowing, is not sufficient. One must have something else to know instead: a screen, a cover, a myth, a cipher, a code, a symbol, a dream, or a symptom. Perhaps if Kipling's character thought: Purple elephant, purple elephant, purple…

Interpretation is a two-stage process. It has first to identify the instead of. It has then to identify the instead-of-what.

Fortunately there is a pattern to transfigurations of the actual into the fictive. We say: "In acting (thinking, feeling, perceiving, or remembering) as he or she does, this person is behaving *as if* X were true or had once been true." Binstock (1986) writes of this as he imagines: This person is acting as if what we are doing together is not a

psychotherapy in which she is a grown woman and a lawyer and I am a grown man and a psychotherapist. Instead she is acting as if this were a toileting experience and she is my mother. He further imagines: For this transfiguration to have taken place, the little girl to whom I must introduce my grown patient must have had the experiences (which he describes), found them unbearable, is afraid that they will still be unbearable, and has changed them by attending to them in a very constricted or selective way. Later still he confides his surmise to his patient—drawing her attention not only to the experiences, but to the system by which she transformed the experiences.

Freud first thought psychotherapy was a matter of making the unconscious conscious: "Where id is, ego shall be." Later he saw that putting his patients in the picture concerning their systems of transfiguration—analysis of the ego—was also important. Since selective inattention (not knowing) combined with selective overattention (creating the instead-of) is so transparent a device, people need not only—as Laing (1969) puts it—to deny, but to deny that they are denying, and to deny that they are denying that they are denying, and so on. This they can do only by creating an "instead-of" for the fact that they actually are merely using selective attention. Thus if, as the Bible has it, one looks to the mote in the other's eye so not to see the beam in one's own, the whole "projection" collapses if one knows one is doing what one is doing. A projection cannot be known to be a projection if it is to survive. What if a projection is instead experienced as if it were a penetrating missile, and not selective attention? Now we have a version of the evil eye. Much better.

But that is what leaves us with the task of identifying not only the substitution of the substantive fiction for the actual one, but also the substitution of the methodological process for the actual one. This is hard work—so much so that therapist and patient often wish there were another avenue to salvation.

This wish, this hope, is at the core of what we term resistance. Normally both therapist and patient experience this, although for understandably self-serving reasons resistance is normally attributed only to the patient. But what therapist does not shrink at the prospect of bringing a patient's attention to aspects of an experience the patient feels unable to bear knowing?

The patient's resistance is better understood perhaps than the therapist's. The patient has predicated his or her life on fictions, such as that time is coextensive with possibility and that neither ebbs, and is not gratified to discover that efforts to realize this illusion are doomed. But the therapist too has wishes for or from the patient. These are evident when the therapist moves beyond displaying to the patient the instead-ofs and the instead-of-whats

and starts trying to cure the patient. Any attempt to induce a patient to change reflects the therapist's resistance to interpretation and is, as such, an expression either of countertransference or of an identification that goes beyond empathy.

Interpretations grow out of sympathetic imagination of the sort captured in the phrase, "Nothing human is foreign to me." (Fortunately, as Harry Stack Sullivan remarked, "People are more human than otherwise.") This sympathetic imagination is at its most capacious when its owners (therapist *or* patients) feel receptive to the experience they are having. We can conceive, gestate, nourish, be fruitful and multiply, to the degree we can tolerate without loathing knowing what we and others experience. Insofar as we cannot, we will naturally try to change the experience or, failing that, to know as little as possible about it. At these times the therapist will want to speak to the patient in order to change the patient and get some relief for the intolerable (or about to be intolerable) experience the patient is visiting upon the therapist. Therapists are often unaware of this as a motivating factor in their interventions, interpretive or otherwise. Their own experiences as patients in psychotherapy will often have laid bare the heretofore unconscious elements in their transferences and countertransferences. But as Bion (1966) remarked, the conscious elements are often not subject to analysis for the simple reason that membership in the group—the school or orientation—of therapist makes these intentions appear unexceptional and unremarkable, when often they are anything but. As an example one might consider that psychodynamic psychotherapy deals precisely with that: the dynamics of the patient's psyche. Yet often therapists' ideas about patients' lives may stimulate them to make interventions calculated to affect what their patients do, and how, where, or with whom. To some who read this, the thought that such activities are in any sense a blurring of the line between counseling and interpretive psychotherapy will seem to be of no consequence. In their group that is how psychotherapy is done, and they would protest any implication that they were acting out countertransferences or identifications. To my group, however, that is exactly what it looks like. To return to Bion's point, here it is not what we feel for (or against) any given patient—the unconscious element in the countertransference—but that some of us consciously feel that influencing a patient is within, and others feel it is outside of, the precinct of psychodynamic psychotherapy.

There is a sketch in a Monty Python Show in which a Something-English dictionary is mischievously translated: the poor foreigner laboriously thumbing through it to make a purchase at a tobacconist ends up asking for a kiss and getting belted for his pains. We take it as an article of faith that the interpreter interjects nothing of his or her own into the process, but with the greatest fidelity makes the meaning of one person's communication known to the other. The therapist's job is to be translucent.

This is not a happy point of view to those who wish to be psychoactive. Even capsules and pills are permitted more potency than therapist as translator, therapist as fiberoptic conductor! Indeed, it is not to be wondered at that so many psychotherapists find the work unendurable and wish to go back to being proper physicians, counselors, nurses, and social workers.

All the same, the efficacy of interpretation, as Freud himself counseled, depends more on the position of the therapist vis-à-vis the patient than on the brilliance, or even accuracy, of the interpretation itself. Accordingly, I shall now develop my thinking on this matter.

The patient ordinarily does not make use of interpretations until three conditions are satisfied. First, he or she must be disillusioned about salvation through means other than "systematically understanding his self-deceptions and their motivations" (Hartmann 1953). Second, he or she has to feel convinced by the data. Third, he or she has to detach the giving of interpretations by the therapist from the belief that the therapist is engaging is lascivious acts in the guise of giving interpretation.

Fulfilling these conditions is at once a matter of technique (to which I will come presently) and a matter having to do with the therapist as a person.

If the therapist does not value interpretive psychotherapy, why should the patient? If the therapist cannot wait for (as Bion [1961] put it) interpretations to become obvious, and remarkable only in that the patient has not reached them on his or her own, how can the patient feel convinced? If the therapist is engaged in changing the patient, how can the patient distinguish the communication of bits of knowledge from expressions of love and hate, lust and yearning? Freud speaks of "sticking coolly to the rules."

Perhaps the single greatest distinction between the psychotherapeutic encounter and other human encounters is the capacity of the therapist to limit (through an act of continuous mourning preceding and during each therapy) what he or she needs from the transaction. As so often happens, this delimitation opens up other possibilities that might otherwise be latent—but of that, more later. People receive information from others all of their lives. Something, after all, has to make the giving of interpretations distinguishable from the welter of other information people are given about themselves. As I have been trying to demonstrate, much of this distinction lies in the patient's experience of the therapist's motives.

Parents, not unnaturally, give information to their children in order to make themselves or the children more lovable. The more urgent this need, the fewer chances the parent (later, perhaps, the lover) can take with a considered, empirical approach; "Because I say so!" is the unspoken, or sometimes spoken, attribution of authority for the information.

The therapist needs to eschew these claims to omniscience, the more so since many who become our patients have in their helplessness turned to omnipotent thinking as a comfort. Instead, the therapist must allow experience to cumulate and evolve until its interpretation can be assessed by the patient. Patients who complain of being treated as a case out of a book often have a good point. It is understandable that a patient will resist giving out precious or painful material if he or she feels it to be unnecessary to the interpretation. And insofar as the interpretation is based on material the therapist has about the patient (such as the life-history or some rumor, contrived perhaps by the referring agent or a supervisor or a recently read paper), the patient will feel irrelevant and supernumerary. Interpretations have to provide meaning and dimension to what the experience consists of. If they do not, the patient can only become more and more like himself or herself; he or she cannot become more and more himself or herself. As a patient of mine once put what I am trying to say, "I have a way of thinking of myself as if I were myself, which is like thinking of today not as Thursday but as if it were Thursday."

How intolerably boring it is when patients go and on about something we have heard a dozen times if we heard it once! But we may not have heard it once, which is why we are hearing it a dozen times. We may have heard it and interpreted it and in doing so closed it off from further consideration. Yet for the patient it needs to evolve. And if it cannot evolve in the patient's mind, the patient needs it to evolve in the therapist's. Consider a patient who might wish to find out how to go to Bar Harbor, Maine, but since he cannot bear to know that is where he wishes to go, asks the directions to Providence, Rhode Island. Given these, he will know they are wrong without quite knowing what to ask instead, except directions to Providence, again. Anyone who has hung around with 4-year-olds who keep asking "But why?" will know what I mean. Both the patient and the child may have to be asked whether they are asking what they really want to know.

Much of the information concerning what the patient is being comes from the impulses being with the patient generates in the therapist. Acting on those impulses relieves the tension but loses the information. The therapists who ask themselves *why* they want to nod or speak or yawn or look at the clock or remember that the patient lost his or her mother a year ago have a chance of knowing more of what the patient is experiencing then if they yield to

these impulses.[1]

Between the instant that dice leave the roller's hand and the time they show their dots on the green baize of the gambling table lies either the mysterious workings of chance—or a series of activities that, if closely observed and repeatedly studied, make the outcome understandable, predictable, and controllable. Patients eavesdrop upon themselves; and the more details they provide the therapist, the more they learn directly from themselves. What seems mad, random, meaningless, purposeless can be seen by them to have pattern, design, coherence, intent. The therapist's patience is the patient's best friend. Provided therapists do not have too often to give themselves relief from waiting, patients become more and more obvious to themselves.

Now, of course, few if any of us can interpret so well that only interpretation need serve. Nor does every patient who enters psychotherapy intend to accept a strictly interpretive approach. Preliminary caution on both sides should be exercised: grandiosity afflicts all who have once felt impotent to affect their fates. And, as I indicated earlier, there is bound to be turbulence and upheaval in the course of a psychotherapy that will be difficult for both parties to stand —and still stick "coolly to the rules." "Parameters," in Eissler's (1958) phrase, are useful, but, as Eissler indicates, when these are no longer used as a means to make interpretation possible, they become the means to make interpretation impossible. Since the object of the psychotherapy is to enable patients to feel and understand the full reality of their experiences so that they can recover what they have taken pains no longer to experience, the task of the therapist is to become self-effacing. Time and energy are limited and limiting; if the patient's attention is to be drawn to himself or herself, past and present, it is not helpful for the therapist to draw attention to himself or herself. And yet insofar as the therapist wants something for or from the patient (fees perhaps expected), the patient understandably will become even more preoccupied with influencing his or her therapist than he or she ordinarily would be—and "ordinarily" is. Thus interpretations often are spoiled by the teaching or preaching that surrounds them. Winnicott observed that he could tell when he left off making interpretations: it was when he started saying "moreover." (For his fuller treatment of this, see Winnicott 1958.)

The introduction of the (at once) deceived and deceiving self to what it experiences requires that experiences evolve. This evolution must take place in both patient and therapist. Neither should "head it off" by analyzing it. Only in so far as the patient and therapist have an experience in common to advert to can either feel convinced. Recognizing the "truth" of an interpretation is only partially mutative. At this stage it is, if shocking, akin to a confrontation, or if intellectually assimilated, akin to a clarification. Only when the "truth" takes on an air of

inevitability does an interpretation do its work.

Repression is hard work. It is easier to know what one knows but to detach significance from it. Patients ordinarily know far more about themselves than they ever use. Sometimes they seem to know everything there is to know—except how the proliferation of knowledge mitigates any single insight.

Therapists must, therefore, husband their additions charily. They will need to be careful lest their contributions only add to patients' profligacy of understandings. Only the fullness and intensity of experiencing can truly inform a patient, can help him or her rescue conviction from mere insight.

The dynamic tension in psychotherapy takes place between the patient's need to reveal and need to conceal. Much of this has to do with a wish to influence the therapist's disposition toward the patient in a direction the patient imagines would be favorable. But part of it reflects the fear of certainty. If the patient is the only one who knows what he or she experiences, that knowledge can be forever doubted or be denuded of significance. The same is true so long as the therapist is the only one who knows something. The danger lies in the exponential leap to certainty when something is known to both of them. In this conjunction also lies the immense power of an interpretation.

After some years of work, a patient confided the following:

> She wished she could be dressed in a gray pinafore and a white turtleneck and that the therapist would take her onto his lap, put his hand under her skirt, discover she was not wearing anything, and touch and fondle her to orgasm.
>
> She remembered, as a child of 6, standing with her back to a mirror and bending forward peering between her legs to see what she looked like. If her father should chance to pass on the way to his dinner with her mother, he would laugh.
>
> Once, before her menarche, she tried an experiment with her rowdy pal. He tried to put his you-know-what into her. His sister was present and they were all laughing. Some months later she felt very bad and isolated. She feared she was pregnant but couldn't tell anyone, not even her own dear sister. That winter she had her first menstrual period. She felt awful and didn't tell any of her friends. Two years later her rowdy pal's good friend and her own good friend asked her to show him how she put a tampon in. She showed him with pleasure. The good feelings associated with the experiment and previous times briefly returned. Her pal liked to look at and touch her breasts, but she hated that. She hated her breasts.
>
> With the exception of the fantasy concerning the therapist, the patient had mentioned all of these experiences over a span of months. The incidents were scattered over time as wreckage might be strewn over a landscape. Except for the solace of confiding personal and private pleasures and agonies, the patient, a woman now in her

thirties, saw no special reason for telling her therapist of the incidents. They were things that happened.

From time to time the patient allowed herself to have intercourse. She liked the men's excitement, but hated the act itself, though she felt that to be fair she must submit. In response to a question, she said that she did not have orgasms except to her own masturbation. Later she added that as she touched herself she frequently imagined a man and woman discussing her: "How can we make her come? Is there anything we can do? Nothing. There is nothing we can do. Nothing at all."

She did not look at men she found attractive, except when they could not notice she was looking. Ordinarily she fastened her gaze at a point to one or another side of the therapist. She talked falteringly with many stops: "I-uh-uh-so-um...." Someone in her therapy group called that manner of talking hostile. Later it was understood to be an enactment of the "nothing" fantasy: "There is nothing we (you) can do to make me go/come. When you have no-thing I will come/go, which will be something!" When she was 6, her parents, who always vacationed with the three girls on Cape Cod, went to Europe, leaving them with the measles and a nurse. Constipation, which may have started as adjunctive to the illness, became, in response to hounding by the nurse, a lifelong misery. Whether she was defying the nurse or holding on to her parents, or both, of course, matters, as does the question of earlier struggles with ownership and loss. But of no less moment is the series of symbolic transformations: breast = feces = penis = go = stay = come. Quite an achievement, the more so, perhaps, in that her own misery draws her attention from the pain inflicted upon others, on which the member of her therapy group commented (no doubt feeling-fully). As do artists with "found" objects, we, all of us, seize upon the adventitious in life to craft and shape our transformations.

This material—both in the way it was communicated, implying at once strewn wreckage and a hostile attack on the therapist's deductive powers, and in itself a content in a life—tells a story of yearning, defect, fury, and a love in danger of being obliterated by envy. The material may be thought to say: Once I discovered I did not have a penis, I soothed my anguish first by believing the condition was temporary, then by forgetting the fact. Finally I had almost to rediscover it. Now all I want is to return to the days when there were no differences, and to feel alive and all of a piece and one of the guys.

An interpretation along those lines might (in fact did) produce a flock of additional memories, further elaboration of the patient's current experience, a sense of the absolute rightness of the construction of the child's experience to the grown-up patient. But what changes for the patient? The little pink "moosh" of the 6-year-old's genital is still the mushy, smushy "crotch" of the 36-year-old. Both are unconsoled. The 6-year-old is still heartbroken because her 36-year-old self has done no better for her than she herself could. What is the use of being 36? The 36-year-old weeps profusely at her current and her earlier plight. She thinks 6 might do better than she can at 36—6 has her whole life in front of her. Six had her mother, which 36 lost. Six could watch her daddy in the bath; 36 doesn't even get a phone call.

What is happening here? If anything, it has been in whatever 36 had to endure to make the interpretation possible. The interpretation reflects the experience back to the experiences. This augments, intensifies, and amplifies the experience, which, when communicated, makes the interpretation more exact, more vivid, more detailed, more inclusive. Akin to a laser, the interpretation can now further amplify the experience, which then further infuses the interpretation, and so on.

There is more to be learned for both parties, having perhaps to do with earlier disparagements of the mother

and the horror of becoming a mother disparaged. But that too will have to be experienced to be communicated; and it is in the dawning realization that the experience need not be so cataclysmic now as it was then that the development takes place. Interpretation is retrospective; before it is mutative, the patient must have already changed. The adult must be able to stand being 36 and the 6-year-old must also stand it. If they cannot stand being in the same room together, there is no way of effecting an introduction. The interpretation makes them fathomable and comprehensible to one another, but that is only important if they have already decided to coexist—and to coexist in the presence of the therapist.

Much, perhaps most, of the work of the therapy lies in providing the conditions that make such a conjoining seem endurable. The child in people does not want to know of grown-up limitations. Its helplessness demands omnipotence of its elders. The elder does not want to know of its helplessness either, especially in conjunction with the passions of youth.

Bibring saw this, of course, and knew that while interpretation could put everyone on speaking terms, much else had to pave the way: abreaction, confrontation, clarification, and the like. But perhaps more than anything, it is the capacity of the therapist to stand his or her own helplessness, and the patient's, to make do with a good deal less than omnipotence, and to know a lot about passions, that keeps psychotherapy from being a refined sadomasochistic exercise and interpretation a tutorial.

THE PSYCHOACTIVE INGREDIENT AND THE NATURE OF DEVELOPMENT

Well-being depends on outer options and inner possibilities. To some extent each conditions the other; and to some extent each has a life of its own. Psychotherapy allows people to experience what they experience, bear it, learn from it, and apply what they have learned to their sojourn in the personal and material world. But, as Freud himself knew, "neurotic misery" is all too often replaced by nothing better than "common unhappiness." Outer options do not surrender their constraints to the well-analyzed person.

Still there is something to be said for expanding inner possibility: for understanding that one's experience of past, present, and future are extrapolations from inaccurate appraisals of what is so. These inaccuracies are, of course, not products of faulty cognition. They are the result of wishful thinking. The future is often feared because it is unknown. But there is no special reason the unknown should be feared, or not feared. In fact, when the future is

feared (or not), it is because it represents an extrapolation from the past or present. The only unknown thing in this is that it *is* an extrapolation.

Such extrapolations are at once necessary and unreasonable. It is (for most of us) necessary to act as if the sun will rise tomorrow. Some of us can see, however, that the fact that it has risen faithfully in the past holds no inevitable power over the future. Transference is compounded of the same wish-propelled, hopeful extrapolations. The transference, after all, requires a rather optimistic indifference to certain otherwise compelling facts: that time passes, that people differ, that things change. It is a testament to hope that such a thing as the transference exists (Boris 1976).

Development occurs insofar as one can stand the disillusionment of such wishes and hopes. Why some people can stand disillusionment—can grieve, mourn, and relinquish—and others cannot is not well understood, at least by me. Often we think that as people test reality in the course of psychotherapy, they get on more cordial terms with what is so. But is there any technique or approach in the world that can induce people to take a step that they are convinced will lead to calamity?

Many patients, for example, tell their psychotherapists that they simply cannot "say" something. ("Say" may at other times or in other therapies be "think," "feel," "try," "do," etc.) Their therapists can understand this as a situation needing interpretation ("You are acting as if to say this to me is tantamount to saying *x* to so and so"), confrontation ("Say it anyway!"), manipulation ("A bright person like you?"), clarification ("Is saying the same as doing?"), catharsis ("What does the thought of saying it *feel* like?"), and so on. Experienced therapists have shown the power of these interventions for nudging patients beyond the impasse and for taking the next step.

But what if the patient does not? What if the helpful nudges contained in the various interventions only frighten the patient more and stiffen resistance? Now there really is an impasse! Experienced therapists have a repertoire; there is more than one arrow in their quivers. They try, as they should, to see what will help when first one interpretation and then another does not.

But as important as trying is the capacity of the therapist to *stop* trying. It is the patient who has to take the plunge—who has to summon the courage to risk calamity—or what is perhaps the greater courage to give up the wish-driven extrapolation that conjured up calamity. For any intervention to be useful, the patient has to use it.

Take the widely known example of Freud and his patient, the Wolf Man (Freud 1918). For reasons not clear to Freud, at a given point in treatment, the Wolf Man froze progress. Nothing was happening. Interpretation after interpretation failed. The ever-pragmatic Freud finally imposed an ultimatum: six months more of treatment, and termination—no matter what.

The treatment unfroze enough to reveal that the causes of the freezing lay in the patient's observations of and reactions to the primal scene, and the extrapolations of these to the transference. For us there is this question: Was it the ultimatum, or Freud's relinquishment of hope, that freed the patient? Was it the active intervention, or Freud's mourning for his own therapeutic potency, that constituted the psychoactive ingredient?

The answer is probably both. But surely the patient simply had finally to take the next step, had to give up the thrall of past and future and attend to the present Freud, the Freud who was primarily Freud. It is the patient who conduces the treatment.

Viewed in this light, the psychoactive ingredient is not the intervention. It is rather the therapist's capacity to be in the treatment in the same way the patient is. Both parties have to develop. Each has to suffer disillusionment. Each has to mourn. Each has to learn from their common experience. When this happens each is as fundamentally necessary to the other as the other is. There is an equality, a jointness, a commensalism. Psychotherapy inevitably imposes a process of mourning upon both therapist and patient. This is not a matter of weaning, with which it is sometimes confused. It means that both therapist and patient must come to stand the limits in their relationship—that they cannot use each other in every kind of way, but must use each other up in the way of work. When, however, longings for different and additional pleasure are renounced and the therapist becomes resigned to the patient as a source of only some good experiences, those now delimited experiences become invigorated. For instance, when the therapist is resigned to learning what the patient has to teach, the sessions become less tedious; often the therapist feels bored when listening for things, such as those that make much of him or her, which are all too slow in coming. If the therapist is senior enough to do supervision, the therapists in training may be obliged to hear tales of wonder and woe, as the more senior therapist palliates the wounds to his or her narcissism delivered by his patients.

Insofar as such wishes are taken out of the therapy (even into the supervision), the therapist can treasure what in fact is abundant: One learns a great deal from one's patients—about them individually, about humankind

generally, about (by comparison and contrast) oneself, about what helps and what does not, about how things get the way they are and how they change. If one does not have to make the patient help one be good at doing therapy, all this learning feels enriching and unfrightening. People who, as I do, have left over from childhood a certain dread about being inaccurately perceived or wrongly attributed, can have that experience happen again and again, and yet, with time, have it become progressively undone until one is able to feel freely and fully one's self. A lovely instance of this appears in Winnicott's (1977) *The Piggle*, an account of his analysis of a little girl with that nickname. At one point, some years after the analysis began, Winnicott greeted her at his doorstep by her real name, Gabrielle. Somehow, he intuited that he had grown from being Greedy Baby and Bad Mummy into being Dr. Winnicott, who of course greets a young woman by her own grown-up name! (Interpretations do not need to smell of antiseptic!) Szasz (1956) and Winnicott (1977) make helpful additions to the bounty of benefits a therapist may uncoercively draw from a patient.

There is at once much and little to be said for training. Anna Freud was an experienced psychoanalyst of children, a teacher and supervisor to others, when she learned that the person many took to be her rival was proceeding with children in a way Miss Freud had not thought possible. Melanie Klein was not troubling to educate the child's parents, or even the child. Indeed she thought this alliance-making tended to obscure the very transformations she wished to interpret. More to the point, she found a line of interpretation that made the entire prologue unnecessary. Anna Freud (1954) altered her technique.

Such a person, one can imagine, can learn equally well from her patients. In this case she had not. So she learned instead from Klein. But what of those who learn mainly from books, from teachers and supervisors, from tradition? Here is the analogue to the extrapolations from the past that earlier we had identified as the impediment to patients' development.

Freud, fortunately, had no such impediment. Once he broke with his tradition, there were few but his patients to teach him. He knew his luck. What he wanted to send on down through time were a spare few discoveries: infantile sexuality, the unconscious, the transference—two more. "*Je ne suis pas un Freudian*," he said.

We are not quite so fortunate. There are even texts like this to teach us! But, of course, as in the instance of Melanie Klein and Anna Freud, tradition, comprised as it is of the experience of others, can be of great value. But only, I think, if we learn the spirit as well as the letter of it.

The letter is in each word of this and other books. The spirit is what made the letter possible. The letter has to do with finding, the spirit with seeking; the letter with the known, the spirit with the undiscovered; the letter with conveying, the spirit with inquiry; the letter with technique, the spirit with risk.

Above all, the spirit of psychodynamic psychotherapy requires us to remember whose treatment it is. And, in difference to that, to doing only what the patient cannot yet do for himself or herself when he or she is ready to do it. We put the patient back in possession of *him*self or *her*self by showing him or her how he or she lost it. We introduce the selves, but do not shape or direct them. Throughout, we efface ourselves so that the patient can do what he or she has to do about himself or herself. When the time comes that we can be entirely self-effacing, we politely withdraw from the process. We will not have completed our development with this patient as he or she will not with us, but there is something in the nature of development that requires the catalysis of the new.

MAKING INTERPRETATIONS

There are several rather useful rules of thumb for offering interpretations to a patient, when (and this is the first) it turns out that the patient's efforts to know what he or she is experiencing absolutely requires offering them.

These are as follows:

Interpret

- patterns before specifics
- anxieties before defenses
- defenses before wishes
- derivatives before deeper material
- there before here
- now before then

and how the patient is interpreting each of the psychotherapist's interpretations.

The "grammar" of transformation is intricate but not really complicated. It is economical in the extreme. It

has to be simple and economical because babies and young children need to be able to use it. Thus generalization ("I'm mad at everybody") and specification ("I've only my self to blame") are both "defenses." One, generalization, loses the true target in the crowd. Like Ali Baba, whose hideout was marked with an ineradicable X, and who therefore painted X's on every other door, generalization obscures what is so. But so can simple substitution, as self for other.

Since people come to psychotherapy with most of their transformations intact, their "chief complaint" is often a transformation of their actual complaint. If the complaint is overly specific, the therapist may have to expand it; if overly general, to contract it. The essence of the work here is the effort to display to the patient the role in the countless situations that cause the patient pain of a constant, repetitive factor that originates with him or her. The patient has to a degree to become alienated from himself or herself. In that measure the patient becomes allied with the psychotherapist. If the world causes the pain (which it well might), there is no cure in psychotherapy. Only insofar as by actual or transformational action the patient contributes to his or her own fate can therapy help. A survey of each situation is necessary so that the patient can see among the variables the constant factor brought by himself or herself. Patterns, then, before specifics.

This display generates anxiety. *Transformations* are initially effected to avert intolerable frustration and helplessness. The impact of the actual on the fictive threatens to reinvoke that original pain. It is, therefore, frightening and greatly to be resisted. The patient has to know from the therapist that the therapist knows of the anxiety. The patient who does not discover this may believe that the therapist is unaware of the anxiety, and this is as frightening as being with a dentist who does not know that drilling can hurt. Still, no matter how bad the patient feels now, once it was worse.

Reasonable people do not stand around being frightened; they take countermeasures. These are the defenses by which experience is transformed. Perhaps the simplest of these is evasion. As the patient's patterns are being identified, the anxiety that is generated will, in turn, stimulate countermeasures. The patient may feel reluctant to talk, may come late, may forget an appointment. He or she is trying to transform the experience itself. If this cannot be done, the patient will have to resort to transforming what he or she experiences of the experience. As a last resort, the patient will have to direct his or her efforts to transforming the very experiencing apparatus itself—destroying ego to save the self.[2]

These maneuvers happen so quickly (the patient, after all, has had years of practice) that the psychotherapist needs to link the brief experience of anxiety to the defensive responses that almost instantaneously follow upon it—relieving it, or obscuring it. Since the patient believes the security gained in using his or her defenses is reinforced by severing the connections between experience and transformation (e.g., anxiety and defense), he or she will generally not "know" of the link between, for example, his or her fright in one session and late arrival to the next. A patient who did might remember the anxiety, reexperience the pain of it, and be in danger of experiencing more of the particular experience of which the anxiety was only a foretaste. So, prudently, the patient will not only come late to shorten the session, altering the perturbing experience itself, but will also attribute the lateness to some other cause, some instead-of reason, thus altering the patient's experience of the experience.

"I am sorry I'm late, but the traffic…"

"Perhaps there was something in our last meeting."

Oh-oh!

Insofar as the patient discovers that anxiety evaporates when he or she dares to know of what he or she experiences, the patient will less "automatically" use the defensive transfigurations he or she can identify as such. Consequently, more and more of the constituents of the experiencings will become available, though still in the form they took as a result of transformations effected by earlier versions of himself or herself. These constituent elements are, in this sense, derivatives. We may know that the experience the patient is now describing or remembering was not ever thus, but the patient does not. To the patient it is so. And, if the patient's same-self forebears have done their job well, what the patient knows and remembers will have such verisimilitude that the counterfeiting can hardly be spotted—and certainly not by the patient who has so much reason to maintain his or her revisionisms.

Perhaps the most fundamental of the original transformations is this "*She would if she could*" into "*She could if she would*." With it sorrow transforms into anger; resignation converts to hopefulness, and despair and helplessness blossom into a thousand possibilities concerning what I can do to induce her to do what she *can* (now!) do—if *she wants to*. The possibility that she does not do it because/therefore she is bad, leads to one whole branching of the tree (as the twig is bent). Alternatively there is the possibility that she does not do it because/therefore I am bad, leads to another. "Bad" may be in terms of wicked ("I must reform"), size ("I must act big"), gender ("I must change"), and so on: each is fateful. A third transformation is "*She could if she would but will not*

because (or therefore) someone else is bad and coercive." This leads toward a "manic" view, as the previous ("I am bad") leads toward a "depressive" view and the first ("She is bad") to a "paranoid" view.

Perceived and remembered experience will be derivatives of this fundamental transformation and the various ones that followed upon it. From them one can infer what the patient cannot and could not bear to experience. These form the basis of working from the derivatives, here and now, to the deeper experiences, then and there. The rules of thumb follow the order in which the transformations were established: the last is first.

In the spirit of dynamic psychotherapy, however, rules are made to be broken. Early in the history of psychoanalysis, people experimented with saying such things as: "You wish to kill your father and lie with your mother, no?" The patient, visualizing the plump, dowdy, middle-aged woman who was his fairly irritating mother, thought it was perhaps his newfound therapist who could do with help of a rather urgent kind. If he confided this thought, it would be "interpreted" as hostile and castrating. "I am the father of whom you are afraid because of your wish to get rid of me and take the mother for yourself, *hein*?" If, at this, the patient got really angry, the therapist might be heard to give a little grunt of satisfaction. All the same, wild interpretations of this sort did not seem to help much, and the rules of thumb were given respectful development.

Wild "interpretations" of the sort I have parodied did not work, not because they leapfrogged where the patient was in his or her transformations, but because they drew from the books and not from the patient. The assumption behind wild interpretations was that experience is layered, with fictions overlaying the actual experience, but not really replacing them. The recognition that people have to remember what to forget if they are to repress the right bit of knowledge is part of this. We more or less express this when we speak of "at some level…" or "somewhere he must have known…" or "part of me...." The transformed and the original experience are both present, simultaneously.

Actually, however, experience is not layered vertically or horizontally, but continually, being at once experienced and transformed, with the former in fleeting glimpses of the actual. It can be reached for and found by interpretations that do not follow the rules of thumb.

The breaking of these rules involves interpretations of a rather different sort. The experience to which they allude is what patients are continually doing to, with, and about their therapists: the transformation that is the transference. Everything the patients do has this element in it—what they say, how they say it, what they do not

say, why they do not say it. Patients are continually acting upon their therapists—whom they do not know—as if therapists were people or some thing they know and must deal with in ways designed to avert a catastrophic experience and foment a good one. Accordingly, in Bion's (1970) phrase, the therapist listens not only for the meaning in what the patient is communicating, but for the use to which those communications are being put. No patient simply communicates information regarding his or her experiences—and certainly not for a long time. Patients speak for effect.

Let us say that a patient speaks in such a way as to seek to draw from his or her therapist a kind word. If we are lucky as therapists, we can sense this, intuit it. But even if we cannot intuit it from our responses to what the patient is doing, it will presently become possible to infer it from what the patient is telling us. If we still cannot tell, some patients will lose patience with us and overtly demand "feedback" or "some response." Some patients will even stipulate that warmth and caring are wanted.

In this, as in the figure in the carpet, the therapist may imagine he or she discerns the configurations of the patient's relationship to the therapist as mother or, equally likely, as breast, from whom the milk of human kindness is being drawn. What sort of breast is it that the patient conjures when he or she proceeds in this way? Where does goodness lie; where is catastrophic frustration? If the therapist can bear to experience himself or herself as breast being dealt with in a number of quite particular ways, why does not the patient tolerate the experience in such graphically precise terms? What factors has the patient to contend with that the therapist is spared? In whom, breast or mouth, are these factors located by the patient, that he or she proceeds in such a fashion? What early experiences can have accounted for this patient's particular re-creation?

All the information necessary to answer these questions is available to the therapist whose intuitive, inferential, and imaginative faculties are unimpaired. That information is in both what the patient communicates and in the effects he or she seeks. "Why am I being told this?" joins "What am I being told?" as coequal in the therapist's own interpretive meditations. When the therapist finds something to say, he or she will, of course, be aware that what is said is being experienced as emanating from the breast (or the space where the breast is supposed to be but is not, or the mouth, if the patient imagines that he or she possesses the breast and has been giving the therapist food for thought) and that his or her interpretations are at once being experienced as further information about the breast, feedings, and incitements to envy.

"Do you see what I mean?"

"Yes, I think so. Your wife didn't understand that…" (of the rules-of-thumb procedure becomes perhaps): "The breast needs to be primed, as if one can't be sure it knows it's needed."

All the good rules of thumb are violated, as they should be when the spirit of the enterprise takes precedence over the letter of it. We need the rules because we need to do something while we learn from the patient what his or her plight is and how, with our interpretations, we can help the patient retrace any transformations and be able to experience at 30 what the patient could not endure at 3 months of age.

In a lovely paper, Guntrip (1975) speaks of his first analytic session with Winnicott. Guntrip lies on the couch, and Winnicott sits in a wooden chair behind him, sipping tea. Guntrip has done all the talking and now the session is at its end. The analyst, Winnicott, has nothing helpful to say as yet. All he knows is that he is Guntrip's Mummy and that Guntrip, who is also an analyst, is likely to experience Winnicott's continued silence as if it were a nonfeeding from a bad mother with no-thing to offer him. Since that is the most and the least Winnicott can say, he says: "I have nothing particular to say yet, but if I don't say something, you may begin to feel I'm not here."

In that, one can see references to anxiety, defense, and so forth. The rules of thumb are not wholly absent. But there is the leapfrogging to the heart of the matter—the use to which Guntrip was putting his communication and so the meaning that silence would have. The original and actual are directly culled from the transfigured and fictive. Dr. Guntrip is introduced to himself at an early age. They meet and can stand each other, which is really rather nice, as things go.

SUMMARY

The line "Lady, three white leopards sat under a juniper tree," from Eliot's "Ash Wednesday" can be read as is or as a line intended at once to evoke sensuous images and to convey the beginnings of a prayer to the Virgin concerning the mysteries of death and the intimations of hope and resurrection. Eliot, I believe, intends for the reader to interpret the line in the direction I have suggested; the image contains these meanings; they are not meant to be concealed.

The little boy lying still as can be in his bedroom for fear of disturbing the leopard in the night-shrouded

corner has also created an imagaic fragment. Unlike the poet, however, who can interpret his own symbols, the little boy no longer knows what the leopard is meant to represent. The leopard contains meanings that are meant to conceal, not reveal, an aspect of experience. Bad as his fear of disturbing the beast is, worse, we can surmise, would be the opening out of the contained experience: a powerful, lithe leopard, ravenous with desire, unsuspectedly springing, throwing its weight upon a dear soft creature, turning it upon its back and plunging its fangs into the soft underbelly, while other, equally hungry, leopards stalk and skulk, jealous and furious, amid the sweet sickly smell of blood and heat.

Meanings meant to be revealed through interpretation and those meant to be concealed from interpretation require rather different treatment. Accordingly, much of this chapter is devoted to the conditions under which interpretive insights can be transmitted to a patient, who, like the little boy of my example, might rightly believe that his or her cure, the phobia, is better than the therapist's, psychodynamic psychotherapy.

Alone in his room, the little boy has only the configuration of his clothes heaped on the chair to sculpt his leopard from and himself to enact the other role in the couple—the victim. In a two-person psychotherapy, there are two people, and if the adult in one's consulting room is to realize what his then 4-year-old forebear was like, he or she has to realize that the leopard in the shadows was to the child the patient once was as his therapist is to the current self—that the dynamics of the transfigurations are the same and that these dynamics are similarly motivated. The decrease in the self-deceptions of the adult have to be accompanied by a counterpart decrease in the self-deceptions of the child. Memories from childhood can then give way to memories of childhood.

Interpretation is, as such, an activity within a process. Since interpretations given by leopards differ in intent, and so (one hopes) in effect, from those offered by psychotherapists, the patient's natural wish and lifelong habit of confusing the two needs continual attention. The utterly essential condition is that the psychotherapist not be predatory, at least toward his or her patients. Given that essential, the ways by which the patient transforms the therapist, the purposes these transformations continue to serve, and the dangers averted by containment and concealment can all become subject to interpretation.

The means by which the data are displayed to the patient for affirmation or refutation are considered in the last portion of the chapter. The main thing here, of course, is that two minds are hard at work with equal access to the raw material of experience, with the entire research project done with great consideration.

REFERENCES

Binstock, W. A. (1986). Clarification: clinical application. In *Basic Techniques of Psychodynamic Psychotherapy*, ed. M. Nichols and T. J. Paolino, pp. 265-286. New York: Gardner.

Bion, W. R. (1961). *Experiences in Groups*. New York: Basic Books.

_____ (1966). Book review: Eissler's Medical Orthodoxy and the Future of Psychoanalysis. *International Journal of Psycho-Analysis* 43:575-581.

_____ (1970). *Attention and Interpretation*. New York: Basic Books.

Boris, H. N. (1976). On hope: its nature and psychotherapy. *International Review of Psycho-Analysis* 3:139-150.

_____ (1984a). The problem of anorexia nervosa. *International Journal of Psycho-Analysis* 65:315-322.

_____ (1984b). The treatment of anorexia nervosa. *International Journal of Psycho-Analysis* 65:435-442.

Breuer, J., and Freud, S. (1895). Studies on hysteria. *Standard Edition* 2:1-305.

Eissler, K. R. (1958). Notes on problems of technique in the psychoanalytic treatment of adolescents. *Psychoanalytic Study of the Child* 13:223-254. New York: International Universities Press.

Freud, A. (1954). Problems of technique in adult analysis. *Bulletin of the Philadelphia Association for Psychoanalysis* 4:44-46.

Freud, S. (1900). The interpretation of dreams. *Standard Edition* 4, 5.

_____ (1918). From the history of an infantile neurosis. *Standard Edition* 17:7-122.

Gardner, H. (1983). *Frames of Mind*. New York: Basic Books.

Guntrip, H. (1975). My experience of analysis with Fairbairn and Winnicott. *International Review of Psycho-Analysis* 2:145-156.

Hartmann, H. (1959). Psychoanalysis as a scientific theory. In *Psychoanalysis, Scientific Method and Philosophy*, pp. 3-27. New York: International Universities Press.

Klein, M. (1952). The origins of the transference. *International Journal of Psycho-Analysis* 33:433-438.

Laing, R. D. (1969). *Self and Others*. New York: Pantheon.

Miller, J. (1983). *States of Mind*. New York: Basic Books.

Sullivan, H. S. (1953). *The Interpersonal Theory of Psychiatry*. New York: W. W. Norton.

Szasz, T. (1956). On the experience of the analyst in the psychoanalytic situation. *Journal of the American Psychoanalytic Association* 4:197-223.

Winnicott, D. W. (1958). Hate in the counter-transference. In *Collected Papers*, pp. 194-203. New York: Basic Books.

_____ (1977). *The Piggle: An Account of the Psychoanalytic Treatment of a Little Girl*, ed. I. Ramzy. New York: International Universities Press.

Notes

1 This is true particularly in work with patients who devote great energy and skill to stimulating reactive impulses in the therapist—patients such as anorectics. (See, in this regard, Boris 1984a, 1984b.)

2 Increasingly, current research into infants' cognitive, perceptual and memory functions, and skills shows that what Freud called ego functions are well established at an early age (cf. Gardner 1983, Miller 1983 for reviews and speculations on these matters). Perhaps Melanie Klein was correct in ascribing to infants and young children the mental sophistication she did. In any case, it is now clear that psychosis involves a systematic and ordered destruction of ego function rather than a developmental failure.