The therapist may use interpretations for a variety of purposes. He may use them to pass the patient’s tests, to help the patient feel more secure in therapy, and to help the patient see himself more sympathetically. Also, the therapist may use interpretations to help the patient become conscious of his pathogenic beliefs and goals, and thus to work more effectively at disproving these beliefs and pursuing these goals.

Interpretations may provide the patient with explanations (Bibring, 1954) that help him to understand his development and his psychopathology. For example, he may learn that he developed maladaptive beliefs in his attempts to maintain his ties to his parents, and that these beliefs require him, for example, to maintain his psychopathology out of loyalty to his parents. Such explanations may be demystifying and normalizing. They may help the patient to realize that he is not inherently bad, perverse, crazy, or borderline, and that the symptoms that make him ashamed and guilty are readily understood in terms of his childhood experiences and his attempts to cope with them.

The value of the therapist’s interpretations depends not simply on the knowledge they convey, but on the authority of the therapist who conveys this knowledge. A patient may have considerable understanding of his psychopathology, yet be unable to use this self-knowledge constructively. However, the same knowledge conveyed by the therapist may be quite helpful. For example, a patient may know that he is not protecting himself from certain dangers, but be unable to give himself the
protection he needs. However, he may be helped if told by his therapist that he deserves to be protected, especially if he becomes convinced that the therapist wants him to avoid taking unnecessary risks. In this case, as in all instances of the successful use of interpretation, the patient relies on the therapist’s authority to help him do what he unconsciously wants to do. It is one thing for a patient to know that he wants to go in a certain direction; it is another thing for him to realize that a person whom he endows with considerable authority wants him to go in that direction and will help him to do so.

THE THERAPIST’S FIRST PRIORITY: HELPING THE PATIENT FEEL SAFE

The therapist’s concern for helping the patient to feel safe takes precedence over his attempts to give the patient insight by interpretation. In those instances in which the patient is threatened by any interpretation, the therapist should refrain from interpreting until the patient can safely tolerate his doing so. This applies to the patient who likens the therapist’s interpretations to his parents’ lecturing him, pulling rank, or giving unsolicited advice.

If the therapist succeeds by noninterpretative means in providing the patient with a sense of safety, the patient may begin to develop insights on his own. He may remember more about his childhood traumas and become more aware of his pathogenic beliefs and goals. At this point, the therapist may add to the patient’s developing self-knowledge by providing explanations that the patient can use to organize this knowledge and to fit it into a comprehensive picture of his personality and development. This may be illustrated by the example of Thomas C. (see Chapter 4).

Thomas E. (Continued)

As noted in Chapter 4, Thomas C.’s parents were critical, allowed him little or no freedom, and insisted that he work most of the time. At the beginning of treatment, almost any interpretation
made the patient feel uncomfortable. He would experience an interpretation as an infringement on his freedom. He wanted unconsciously to feel free with the therapist and to be accepted by him, and the therapist tried to help him to feel these ways by treating him noninterpretatively. The therapist chatted informally with Thomas about almost any topic that Thomas introduced.

After only several weeks of therapy, the patient began to feel safe enough to produce new memories and insights. After a number of months, the patient was talking easily about how he valued a sense of freedom and how he felt confined by even a loose schedule. He also linked his need for freedom to the constraints his parents had imposed on him. At this point, the therapist demonstrated sympathy with the patient’s striving for freedom and offered the patient a conceptual framework for understanding how he came to feel constrained. The therapist pointed out that the patient had complied with his parents’ restrictions. He had come to believe that his parents were right to restrict him, and thus that he was not supposed to feel free.

As a consequence of these and other comments, the patient became less averse to interpretation. Though the therapist continued to treat the patient mainly by his attitude, he made a number of comments designed to help the patient to fit his memories and ideas into a broad explanatory framework, thereby helping the patient to understand himself better and to see himself more sympathetically.

**CHARACTERISTICS OF GOOD INTERPRETATIONS**

**Good Interpretations Are Not Neutral**

The patient is always in psychic conflict. He wants to work at disproving his pathogenic beliefs and pursuing his goals, but in order to do this, he must defy his pathogenic beliefs and thus experience anxiety. In this conflict the therapist is never neutral. He is always on the side of the patient’s attempts to solve his problems. Moreover, even if the therapist tries to be neutral, the patient does not experience him this way. The patient relates everything the therapist says to his efforts to disprove his pathogenic beliefs; therefore, he experiences the therapist’s comments either as sympathetic to his goals, as opposed to them, or as irrelevant to them.
Sometimes an interpretation may be true but anti-plan because it sends the wrong message to the patient. In such instances, the addition of a new element may make the interpretation compatible with the patient’s plan. This may be illustrated by comparing the interpretation “You are critical of me” with the interpretation “You are uncomfortable about being critical of me.” If the second interpretation is true, so is the first. Yet the two interpretations may carry quite different messages. The first interpretation implies that the patient should become aware that he is being critical and should stop being that way; the second implies that he should become aware that he is uncomfortable about being critical and should permit himself to be critical.

Whether one of these interpretations helps or hinders a particular patient or seems irrelevant to him depends on the nature of the patient’s plan. If the patient is attempting to overcome his fear of criticizing others lest he hurt them, he may experience the interpretation “You are being critical” as a complaint, and so may assume that he has hurt the therapist. If so, he may experience the interpretation as confirming his pathogenic belief. On the other hand, he may experience the comment “You are uncomfortable about being critical” as helping him to disprove the pathogenic belief, for he may assume from it that he has not hurt the therapist by criticizing him.

However, if the patient is struggling to face the fact of his aggression, he may find the interpretation “You are being critical” to be pro-plan. This was the case in the therapy of a patient whose Pollyanna parents failed to confront the patient’s aggression. They never spoke about it and appeared not to notice it. The patient had inferred from this that his aggressive behavior was so unacceptable that it could not be talked about. The patient was therefore relieved at the therapist’s blunt reference to his being critical.

The point that two interpretations, although both true, may carry different messages may also be illustrated by comparing the following interpretations: “You feel guilty about wanting to be independent of your parents” and “You are uncomfortable about being dependent on your parents.” If the first interpretation is true, so is the second. Yet a patient may react quite
differently to them. A patient who unconsciously is working to overcome separation guilt may be helped if told that he feels guilty about wanting to be more independent of his parents. However, he may be set back if told he is uncomfortable about depending on them, for he may experience this interpretation as telling him he should not try to be more independent.

In contrast, a patient who suffers from his fear of burdening others by needing them may benefit from an interpretation about his fear of dependency. This was the case in the therapy of a patient who wanted to rely on the therapist, but was afraid that the therapist would be burdened by his dependency. The patient was relieved when the therapist told him, “You are afraid of relying on me.” The patient took the therapist’s comment as evidence that the therapist would not feel drained by the patient’s depending on him.

**Good Interpretations Give the Patient Something He Wants to Receive**

An interpretation is rarely helpful (pro-plan) unless it gives the patient something he unconsciously wants to receive. A good interpretation usually reduces the patient’s level of anxiety, guilt, or shame. It may answer a question the patient is unconsciously asking. It may provide the patient with greater perspective on the course of his life or on the nature of his difficulties. It may help him to understand and forgive himself for behavior about which he feels ashamed or guilty. It may help him in his struggle to disprove a pathogenic belief. Unless the patient unconsciously wants to accept an interpretation, the interpretation will not be useful. If the interpretation is anti-plan, the patient will either ignore it, in which case it is ineffective, or comply with it, in which case it may be harmful.

The therapist cannot always assess the value (planfulness) of an interpretation by noting the patient’s conscious reactions to it. A patient may consciously resist an interpretation that he unconsciously wants to accept; in doing this, he may hope to demonstrate to himself that the therapist has the courage of his convictions and so will stick with it.

This may be illustrated by the example of a patient who con-
sciously resisted the therapist’s efforts to show the patient that he was behaving provocatively. The patient was unconsciously identifying with his parents who characteristically denied their mistreatment of him. The patient would insult the therapist, misquote him, or underpay him, then deny that he had done such a thing. The patient was giving the therapist passive-into-active tests. He wanted the therapist to challenge his denials and to persist in challenging them despite his protests, so that he (the patient) could learn from the therapist how to challenge his parents' denials and to persist in challenging them.

In another case, too, a patient consciously resisted the therapist’s efforts to confront him with his denials. However, he unconsciously welcomed the confrontations. The patient’s parents had been unable to face their problems. They denied their poverty; they borrowed large sums of money and spent it as though they were rich. Also, the patient’s father denied the severity of his chronic bronchitis: Though it was life-threatening he refused to go to a doctor. The patient unconsciously wanted to face his problems, but believed that by doing so he would be disloyal to his parents. He resisted the therapist’s efforts to confront him with his poor management of his finances and his failure to take care of himself. However, he was unconsciously relieved when the therapist persisted, and over a period of time he benefited.

The Therapist Should Help the Patient Develop a Broad Perspective

The patient has a strong wish to develop a broad, coherent picture of his psychopathology and development, for such a picture helps him to see himself sympathetically and to increase his mastery over his problems and his personality. The therapist should help the patient to acquire such a picture. The therapist should help the patient to understand where he came from, where he wants to go, and how he plans to get there. Once the therapist has helped the patient develop a broad picture of himself, the therapist should try to relate the patient’s new productions to this picture, thereby changing the picture, adding to it, or filling in its details.
The more the therapist succeeds in putting the patient’s productions into a broad perspective, the more he is likely to help him. Sometimes the patient is helped by simple comments, such as “You like to look,” “You are hostile,” “You are angry or dependent,” or “You are withdrawn.” More often, he is not. He may experience such comments as criticisms, because hostility, dependency, or withdrawal is generally not highly regarded. Nor do such comments help the patient to understand why he developed such motives or defenses; therefore, they may fail to help him to perceive himself sympathetically. A patient may want to know, “How did I become so interested in looking?” Other patients may want to know, “Why am I so dependent?” “Am I different from other people, and, if so, how did I get that way?” “Should I not be interested in looking?” “Should I stop being dependent, and, if so, how do I go about doing so?”

Any perspective that the therapist adds to a simple statement of the patient’s impulses or defenses may be helpful. Thus it may be helpful if the therapist shows the patient that his behavior was developed to serve some reasonable unconscious moral or adaptive purpose (e.g., to express loyalty to parents, to make amends for being better off than siblings, or to adapt to an interpersonal world he perceived as hostile or unrewarding). Such explanations make intuitive sense. They help the patient to see himself sympathetically, and to feel normal and good as opposed to abnormal and bad. They help the patient forgive himself for behavior he considers shameful or reprehensible.

The treatment of the seemingly intractable patient described in Chapter 5, who tests the therapist by turning passive into active, illustrates the value of showing the patient through interpretation that his behavior has an adaptive function or serves an unconscious moral purpose. Such interpretation may help the seemingly impossible patient to understand his behavior; to feel less guilty about it; and to relate it to his childhood experiences, his pathogenic beliefs, and his goals. Thus a seemingly impossible patient may be helped if told that he is being difficult out of loyalty to parents whom he experienced as impossible (and thus that his behavior serves a moral purpose); or that he is being difficult to show the therapist how he felt in childhood with an impossible parent (and thus that his be-
behavior serves the purpose of advancing the therapy); or that he is being difficult to test the therapist (and thus that he is working to change a pathogenic belief).

**The Patient May Benefit from Interpretations That Help Him to Develop the Strength to Protect Himself**

A patient may be unable to develop close relations with others because he lacks the capacity to protect himself from the danger that he assumes is inherent in close relationships. If so, his plan may require him to work in therapy, sometimes for long periods of time, to develop the capacity to protect himself from the perceived danger. The therapist may use interpretation to help the patient to develop this capacity. Then, after the patient has accomplished this, he may permit himself the close relationships that he feared earlier.

Consider, for example, a male patient who was unable to say “no” to his girlfriend. He was afraid to fall in love with her for fear that he would have to comply with all her wishes. He worked to develop the capacity to say “no” to her, and was helped to acquire this capacity when the therapist pointed out his fear of refusing her, lest he hurt her. After the patient was able to say “no” to her, he permitted himself to feel close to her.

Another example concerns a patient who, when shamed by another person, felt compelled to comply by feeling ashamed. This patient was so afraid of being shamed that he was unable to feel comfortable with others. He was helped when the therapist made him aware of his belief that he would hurt a person if he did not comply with that person’s wish to shame him. As he became able to resist being shamed, he became more comfortable in social relations.

If a patient appears to make difficulties for himself by being stubborn, the therapist may err if he attempts to make the patient aware of his stubbornness with the implied purpose of inducing him to stop being stubborn. In some instances, depending on the patient’s plan, the therapist should do the opposite. The patient may be testing him by a show of stubbornness as part of his working to acquire the right to be stubborn. If so,
the patient’s stubbornness is counterphobic. Although he may seem comfortable being stubborn, he is unconsciously anxious or guilty about being that way. The therapist may then be most helpful by interpreting the patient’s unconscious guilt about his stubbornness, thereby helping him acquire the ability to avoid self-destructive compliance. As he develops the capacity not to comply with others, he may permit himself to feel close to them. Paradoxically, then, the therapist, by helping the patient to acquire the capacity to resist the demands of others, may enable him to get along better with them.

It is often futile to tell a patient who is bragging that he is feeling proud in order to ward off his sense of humiliation. The patient may experience the therapist who does this as wanting to put him down, and so as repeating a parental mistake. On the other hand, if the therapist points out the patient’s unconscious fear or guilt about feeling proud, the patient may develop the self-esteem necessary to acknowledge his shortcomings. In addition, he may feel less compelled to brag.

The same applies to the patient whose tendency to blame others appears to be an obstacle to his feeling close to them. Here too, depending on the patient’s unconscious plan, the therapist may err if he attempts to induce the patient to stop blaming others by interpreting his tendency to blame them. The patient who blames others may unconsciously be vulnerable to being blamed, and so may believe that any criticisms he receives are deserved. He may blame others to protect himself from feeling blamed. In this case, the patient, if told by the therapist that he is blaming others to protect himself from guilt, may simply feel blamed. He may assume that the therapist wants him to feel guilt. He may then feel endangered by the therapist and fight back by blaming him.

In treating a patient with this kind of problem, the therapist may help the patient by showing him that he is too ready to accept blame from others, and that unconsciously he has difficulty knowing when others are in fact blaming him unfairly. If the patient is helped to stop complying with unfair blame, and to know when others are treating him unfairly, he may become less vulnerable to them and have less need to protect himself from guilt by blaming them.
This point is illustrated by the patient mentioned in Chapter 2 who repeatedly blamed his mother for her mistreatment of him. This patient continued to blame her until the therapist agreed that she had mistreated him, and that the patient had blamed himself unfairly for her abusive behavior. The patient became relieved. In addition, he acknowledged that on a few occasions he had provoked his mother.

There are always exceptions to the principles presented above. Though often a patient is set back when told that he is stubborn, vainglorious, or blaming, he may in some instances benefit. For example, the patient may be maintaining his unfavorable behavior in order to punish himself, perhaps out of compliance to a parent to whom he feels guilty. The patient may unconsciously be highly motivated to give up the unfavorable behavior, but may believe that he should not. In such instances the therapist's direct attempts to make the patient aware of his unfavorable behavior, with the implication that he should give it up, may be helpful. This reminds us again that the only technical rule broad enough to include most instances is that the therapist should help the patient to carry out his unconscious plan.

Interpretations May Be Helpful if They Imply a Promise Not to Mistreat the Patient

Sometimes the therapist may help the patient by pointing out the patient's irrational transference expectations. The therapist may do this by telling the patient, for example, “You’re afraid that if you continue to attack me I will reject you,” or “You’re afraid that if you’re proud I will put you down,” or “You’re afraid that if you’re seductive I’ll try to have sex with you,” and so forth. Such interpretations may provide the patient with a sense of safety, for they imply a promise not to behave as the patient fears. It would be almost unthinkable for a therapist to imply by interpretation that he will not react as the patient fears, but then, having lulled the patient to feel secure, to go back on his implied promise.

This may be illustrated by the therapy of a young attorney who in childhood inferred from certain experiences with his father that if he were arrogant with an authority he would
provoking ridicule. During the first few months of his therapy, the patient became anxious about expressing pride in his achievements and found relief when the therapist told him, "You are anxious because you are proud and are afraid that I'll ridicule you for your pride, as your father did." The patient was relieved by the interpretation, because he unconsciously inferred from it that the analyst would not ridicule him for his pride. He assumed that the analyst, after inducing him to display his pride, would not betray him by punishing him for it. As evidence that he felt relieved, he retrieved a new memory: When he was a young child, he would provoke his father by saying "I know" to everything his father told him.

Another patient, a young man, had indulged surreptitiously in sex play with his mother from early childhood until he was 13. He and his mother occasionally slept in the same bed, and while pretending to be asleep they would rub against each other. Neither the patient nor his mother ever alluded to this; the patient was not even sure that his mother had been aware of it. At one point in his therapy, the patient, despite his female therapist’s correct, nonseductive demeanor, became unconsciously afraid that he would seduce her. However, he was relieved when the therapist told him, "You are afraid that you will seduce me as you believe you seduced your mother." The patient was helped by this interpretation to become aware of his fear of seducing the therapist, and to remember more about his sex play with his mother.

The patient gained relief from this interpretation because he inferred a promise from it. He took the analyst’s discussing his fear that he would seduce her as a promise that she would not be seduced. He was reassured by the very fact that the analyst spoke openly about this fear. In his childhood he and his mother could continue their sex play, because by not talking about it they were not facing it.

**ANTI-PLAN INTERPRETATIONS**

If the therapist consistently makes anti-plan interpretations, the patient may fail to improve or, in some cases, he may stop treatment. This point may be illustrated by the case of Esther A.
Esther A.

In her childhood, Esther A. had felt cheated by her mother, whom she described as self-important and "queenly." According to Esther, her mother sometimes failed to keep her promises. She readily became impatient and screamed at the patient upon slight provocation, and she refused to listen to Esther's attempts to make herself understood.

Esther's conflict with her female therapist was confined to a particular situation. The therapist would be 1 or 2 minutes late for her appointment, but would not extend the session to make up for the lost time. Esther would complain provocatively that the therapist was irresponsible, cheated her, cut corners, failed to take her seriously, and so forth. The therapist would tell the patient that she was suffering from a mother transference, and so she felt cheated even though the therapist had no intention of cheating her. The therapist would explain that the occasional loss of a minute was inevitable and of no great importance, and that Esther was losing much more than a minute of her time by making such a fuss about it. If the patient had not felt cheated by her mother, she would scarcely have noticed the loss of a minute.

Esther was provoked rather than placated by such explanations. She insisted that the therapist was rationalizing her own irresponsible behavior. She acknowledged that she had felt cheated by her mother, but emphasized that this made the therapist's cheating her even less acceptable. The argument between therapist and patient went on throughout Esther's first therapy, which lasted for about a year. Sometimes the therapist would say, "Look, I'm not your mother," or "Can't you see that you were mad at your mother and now you're taking it out on me?" As a consequence of the therapist's adherence to her position, Esther decided to stop treatment, despite the fact that the therapist had been helpful.

A few months after stopping treatment with this therapist, Esther entered an analysis with another female therapist. She soon began to behave with the new analyst as she had with her first therapist. She would complain provocatively when the analyst came a minute late. However, the analyst reacted by agreeing with the patient. She would apologize for being late and agree to make up the time; she would then focus on Esther's discomfort with complaining about her behavior. She thereby helped the patient to realize that unconsciously she had felt guilty about her complaining.
The analyst emphasized that Esther had every right to complain. She pointed out that even though she was only a minute late, her being late carried a powerful symbolic meaning to the patient, for it confirmed her belief that she had no right to be treated fairly. Esther found the analyst’s approach helpful. She came to understand that she had been concerned about being cheated because she had complied with her mother’s cheating her, and so assumed that she deserved to be cheated. In her analysis, she was struggling to convince herself that she did not deserve this.

In the following example, the therapist persisted for some time in maintaining a certain plan formulation. He then found his mistake and, to the patient’s benefit, corrected it.

Katherine A.

Katherine A., an intelligent woman of 30, had trouble keeping up with her monthly analytic fees. She complained to her analyst, at first mildly and then progressively more vituperatively, about his refusal to stretch out her payments. She screamed and sobbed at the analyst while criticizing him for his rigidity. She compared him to her stepfather, the only other person with whom the patient had ever lost her temper.

Katherine in early childhood had loved her father a great deal. She had been closer to him than to her mother, whom she considered both fragile and unattractive. Her parents, who were unhappily married, obtained a divorce when the patient was 8. She did not appear deeply upset about this, but was quite upset when during her 12th year her mother remarried. She took an immediate dislike to her stepfather, whom she considered an autocrat. She fought with him constantly.

The analyst assumed that the patient had been fighting with him about her payments because she had developed a stepfather transference. He attempted to deal with this transference both by interpreting it and by demonstrating in his behavior that he was not autocratic. Therefore he told the patient that he would allow her to delay her current payments by 1 month.

Katherine at first seemed overjoyed at the analyst’s flexibility. However, she soon became even more discouraged and angry. The analyst, who now began to realize he was on the wrong track, consulted a colleague, who tentatively offered the following explanation for the patient’s behavior:
Katherine had blamed herself in childhood for her parents' divorce. She assumed that her father found her so much more attractive than her mother that he stopped caring for her mother. After her mother remarried, the patient was determined to avoid repeating what she perceived as her Oedipal crime. She fought violently with her stepfather in order to make sure she was unattractive to him. In her current life, Katherine feared that she would seduce the analyst as she believed she had seduced her father; she fought with him, as she had fought with her stepfather, in order to make herself unattractive to him. The analyst’s telling her that she would be allowed to defer her current payment was frightening, for the patient inferred from it that she was indeed seducing the analyst.

Several months after his meeting with the consultant, the analyst had a good opportunity to check this formulation. The patient reported that she had begun to worry about her relations with her boyfriend. She was not sure she loved him; in fact, she had a strong suspicion that she was involved with him for some neurotic reason. The analyst assumed that Katherine was describing doubt about her love for her boyfriend in order to determine whether the analyst, out of envy, would agree with her doubts. He told her “It seems to me from what you’ve said about your boyfriend that you do love him, and that you are reluctant to say so for fear I will feel left out.” This time Katherine reacted favorably to the analyst’s comments. After this, she became encouraged and by her associations confirmed his point. She became more friendly to the analyst and less concerned about his rigidity.

TRANSFERENCE INTERPRETATIONS VERSUS NONTRANSFERENCE INTERPRETATIONS

The importance of transference interpretations is exaggerated by certain contemporary authors.1 A research study2 carried out by Polly Fretter (Silberschatz, Fretter, & Curtis, 1986) showed that transference interpretations are no more and no less beneficial than nontransference interpretations. The important distinction is not between transference and nontrans-

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1For a similar assessment, see Rangell (1981a) and Lomas (1982).
2This study was carried out under the supervision of Curtis and Silberschatz.
ference interpretations, but between pro-plan and anti-plan interpretations.

Also, the therapist may pass a patient’s transference tests without referring explicitly to the patient’s relationship with him. Consider, for example, a patient who is afraid to report an achievement for fear the therapist will belittle him. The patient may benefit from the therapist’s making a transference interpretation, such as “You’re afraid to tell me about your success for fear I will belittle it.” However, the patient may benefit just as much if the therapist responds to the patient’s reporting his success by saying, “That’s good news.” In both instances the patient will realize that the therapist is not motivated to belittle him. Just which approach is better for a particular patient depends on many factors. The patient who wants the therapist to be careful, deliberate, and analytic may prefer the former approach. The patient who feels put down by interpretation may prefer the latter.