THE NATURE AND THERAPEUTIC ACTION OF PSYCHOANALYTIC INTERPRETATION

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THE MOST GENERAL STATEMENT THAT can be made about a psychoanalytic interpretation is that it is an act of illuminating personal meaning. Since meaning is something that exists only within a world of subjective experience, all psychoanalytic interpretations, as Kohut (1959) eloquently demonstrated, must be informed by the psychoanalyst's empathy, which provides access to the patient's world of experience. Thus, any discussion of the nature and therapeutic action of psychoanalytic interpretation must begin with a consideration of the thorny question of what constitutes the essence of analytic empathy.

In an important paper delivered at the Eleventh Annual Conference on the Psychology of the Self in Washington, D.C., Brandchaft (1988) voiced certain concerns and caveats about the conflation of two uses of the concept of empathy appearing in Kohut's later writings. In one usage, consistent with his original pathbreaking essay (1959) on the subject, Kohut (1982) describes empathy as a "mode of observation attuned to the inner life of man" (p. 396), an investigatory stance that constitutes the "quintessence of psychoanalysis" (p. 398). In a second usage he depicts empathy as a "powerful emotional bond between people" (p. 397) and claims that "empathy per se, the mere presence of empathy, has... a beneficial, in a broad sense, a therapeutic effect—both in the clinical
setting and in human life, in general" (p. 397). The same term, empathy, is being used to designate both a mode of psychological investigation and a mode of affective responsiveness and bonding.

In agreement with Brandchaft (1988), I have come to believe that such conflation of usages contains serious potential pitfalls, as do a number of otherwise valuable formulations, such as Bacal's (1985) concept of optimal responsiveness and my own previously proposed conception of optimal empathy (1983). Many people who become psychoanalysts have in their childhood histories a common element of having been required unduly to serve archaic selfobject functions for a parent (Miller 1979), a requirement that is readily revived in reaction to patients' archaic states and developmental longings. When empathy is equated with an ideal of optimal human responsiveness and at the same time rightfully claimed to lie at the heart of the psychoanalytic process, this can exacerbate the analyst's countertransference dilemma, which takes the form of a requirement to provide the patient with an unbroken selfobject experience uncontaminated by painful repetitions of past childhood traumas—a requirement now invoked in the name of Kohut, Bacal, or Stolorow. As Brandchaft (1988) observes, when an analyst comes under the grip of such a requirement, the quintessential psychoanalytic aim of investigating and illuminating the patient's inner experience can become significantly subverted.

Considerations such as these have led my collaborators and me (Stolorow, et al. 1987) to reaffirm Kohut's (1959) original conceptualization of analytic empathy as a unique investigatory stance. We have characterized this stance as an attitude of sustained empathic inquiry, an attitude that consistently seeks to comprehend the meaning of a patient's expressions from a perspective within, rather than outside, the patient's own subjective frame of reference. I suggest that we restrict the concept of analytic empathy to refer to this distinctive investigatory stance and use some other term, such as affective responsiveness, to capture the "powerful emotional bond between people" (p. 397) that Kohut (1982) believed can also produce therapeutic effects. By making this suggestion, I do not mean to imply that analysts should routinely inhibit their natural affective responsiveness, although under some circumstances it might be desirable to do so. However, an essential ingredient of the analyst's attitude of empathic inquiry is his commitment continually to investigate the meaning of his affective responsiveness, or its absence, for the patient. After all, what is affective responsiveness for the goose might be something quite different for the gander. What the analyst experiences as affective responsiveness the patient may experience as a covert seduction or a promise that revived archaic longings will literally be fulfilled in a concretized form. On the other hand, an analyst's emotional reserve can at times be experienced by a patient as a yearned-for haven of safety in which his own experience can be articulated free from the requirement to adapt to another's affectivity. Whether or not the analyst's affective responsiveness will itself have a beneficial or therapeutic effect will depend on its meaning for the patient.

I wish to stress that our emphasis on inquiry does not mean that the analyst is constantly asking questions. On the contrary, the analyst uses all the means at his disposal to facilitate the unfolding and illumination of the patient's subjective world, which may include prolonged periods of silent listening and reflection, in which the analyst searches his own world of experience for potential analogues of what the patient is presenting to him. Such analogues may be drawn from multiple sources, such as the analyst's own childhood history, his personal analysis, his recollections of other patients' analyses or of case reports by other analysts, his readings of great works of literature, his knowledge of developmental research, and his studies of psychoanalytic theories. It is my view that psychoanalytic theories vary greatly in their capacity to enhance empathic access to the patient's subjective world and that differing psychoanalytic theories often address fundamentally different realms of experience. When any theoretical system is elevated to the status of a metapsychology whose categories are presumed to be universally and centrally salient for all persons, then I believe such a theory actually has a constricting impact on analysts' efforts to comprehend the uniqueness of their patients' psychological worlds.

I also wish to emphasize that the attitude of sustained empathic inquiry is not to be equated with an exclusive preoccupation with conscious elements in a patient's experience, a common misconception voiced by self psychology's critics. Indeed, empathic inquiry may be defined as a method of investigating and illuminating the principles that unconsciously organize a patient's experiences. Such unconscious principles become manifest, for example, in the invariant meanings that the analyst's qualities and activities recurrently come to acquire for the patient. Such meanings may contain defensive purposes, and failing to investigate unconscious defensiveness when a patient has shown a developmental readiness for such analysis is not empathy (Trop and Stolorow 1991).

I prefer the concept of sustained empathic inquiry to the commonly used phrase prolonged empathic immersion (Kohut 1977) partly because the former, as I have indicated, underscores the analyst's investigative function. In addition, I believe that the idea of empathic immersion contains another potential countertransference pitfall, wherein the analyst feels required to immerse himself completely in the patient's experience, banishing his own psychological organization from the psychoanalytic dialogue so that he can gaze directly upon his patient's subjective world with pure and presuppositionless eyes—surely an impossible feat for even the most gifted of analysts. Such a requirement defies
the profoundly intersubjective nature of the analytic process, to which the analyst’s organizing principles, including those enshrined in the theory through which he attempts to order the analytic data, make an inevitable and unavoidable contribution.

My collaborators and I (Atwood and Stolorow 1984, Stolorow et al. 1987) have conceptualized the development of psychoanalytic understanding as an intersubjective process involving a dialogue between two personal universes. Hence, the process of arriving at a psychoanalytic interpretation entails making empathic inferences about the principles organizing the patient’s experience, inferences that alternate and interact with the analyst’s acts of reflection upon the involvement of his own subjective reality in the ongoing investigation. Thus, the attitude of sustained empathic inquiry, which informs the analyst’s interpretations, must of necessity encompass the entire intersubjective field created by the interplay between the differently organized subjective worlds of patient and analyst.

Having elucidated my view of the empathic stance that forms the basis for constructing psychoanalytic interpretations, I turn now to the primary focus of this chapter: conceptualizing the therapeutic action of psychoanalytic interpretation. My emphasis on the therapeutic effect of interpretation, as opposed to noninterpretive elements within the therapeutic interaction, parallels and complements my reaffirmation of the investigative function of analytic empathy. I hope, thereby, to provide an answer to those critics—Mitchell (1988), for example—who mistakenly portray self psychology as attributing therapeutic action primarily to the analyst’s “affective tone and its emotional impact” (p. 294) rather than to the analyst’s interpretations.

There has been a long-standing debate within psychoanalysis over the role of cognitive insight versus affective attachment in the process of therapeutic change (see Friedman 1978, for an excellent historical review of this controversy). In recent years the pendulum seems to have swung in the direction of affective attachment, with a number of authors, each from his own theoretical viewpoint, emphasizing the mutative power of new relational experiences with the analyst: Kohut (1971, 1977, 1984), who spoke in terms of the establishment, disruption, and repair of selfobject ties; Modell (1984), who emphasizes the holding functions of the analytic setting; Enne (1983) and P. Tolin (1988), who view the emotional availability and engagement of the analyst as correcting for early deficits; and Gill (1987), Weiss and Sampson (1986), and Fosshage (1992), who stress the new interpersonal experiences with the analyst as disconfirming transference expectations (for earlier versions of this position see also Strachey 1934, Alexander 1950, Stone 1957, Fairbairn 1958, Loewald 1960). It is my view that once the psychoanalytic situation is recognized as an intersubjective system, the dichotomy between insight through interpretation and affective bonding with the analyst is revealed to be a false one (Stolorow 1991, Stolorow et al. 1987). The therapeutic impact of the analyst’s accurate transference interpretations, for example, lies not only in the insights they convey but also in the extent to which they demonstrate the analyst’s attunement to the patient’s affective states and developmental longings. The analyst’s transference interpretations, in other words, are not disembodied transmissions of insight about the analytic relationship; they are an inherent, inseparable component of that very bond. As Atwood and I (1984) stated:

Every transference interpretation that successfully illuminates for the patient his unconscious past simultaneously crystallizes an elusive present—the novelty of the therapist as an understanding presence. Perceptions of self and other are perforce transformed . . . to allow for the new experience. [p. 60]

It is not so much, I would now add, that existing psychological structures are thereby changed as that alternative principles for organizing experience gradually come into being.

Kohut (1984) divided the interpretive process into two phases, a first in which the analyst conveys an empathic understanding of the patient’s emotional experience and a second in which the analyst offers an interpretive explanation of that experience. I have not found this formulation especially congenial because it seems to me to separate the affective and cognitive components of the analyst’s investigative activity, components that I believe are indissociable. Instead of the two discrete phases proposed by Kohut, I envision a continuum of interpretations of increasing cognitive complexity, with both the analyst’s affect attunements and cognitive inferences playing a part at every point along the continuum. Despite my reservation, however, I find Kohut’s formulation of the interpretive process to be extremely valuable in that it makes explicit what is implicit in all of his writings, namely, that if an interpretation is to produce a therapeutic effect, it must provide the patient with a new experience of being deeply understood. This emphasis on the therapeutic benefit of new selfobject experiences provided by the analyst’s communications of empathic understanding has been usefully amplified by a number of contributors to the self psychology literature (Bacal 1990, Lindon 1991, J. Miller 1990, Ornstein and Ornstein 1980, M. Tolpin 1987, Wolf 1990).

But now, in an apparent reversal of my earlier position, I wish to point out a potential pitfall of this emphasis on the newness of the selfobject experiences provided by the analyst’s empathic communications: the danger of neglecting the contribution of the patient’s psychological organization, what Bacal (1990) describes as the patient’s “creative phantasy” (p. 369), to the therapeutic impact.
of the analyst's interpretations (see also Brandchaft 1991). To the current emphasis on new relational experiences, I wish to add the essential therapeutic contribution of something old, something derived from the patient's psychological depths, namely, the specific transference meaning for a particular patient at a particular point in the analysis of the experience of being understood, a meaning that itself will eventually need to be investigated and interpreted (Gill 1982). It is my central thesis here that such specific transference meanings constitute a crucial ingredient of the therapeutic action of psychoanalytic interpretations and that this applies both to transference interpretations and interpretations of extratransference material (see A. Ornstein 1990).

Winnicott (1954) claimed that "whenever we understand a patient in a deep way and show that we do so by a correct and well-timed intervention we are in fact holding the patient" (p. 261). Winnicott here seems to assume that the experience of being understood has a single transference meaning, the feeling of being held, that applies universally to all patients across the board. In contrast, I envision a vast multiplicity of possible transference meanings, with the specific meaning of the analyst's attuned interpretations being determined by the particular developmental needs and longings mobilized in the transference at any given juncture. Let me illustrate with a brief vignette.1

Stuart sought analysis at the age of 26 to find relief from tormenting states of obsessional rumination that regularly followed injurious experiences that made him feel intensely vulnerable, anxious, overwhelmed, and confused. The oldest of two children, he described his father as a passive presence in the home, seemingly controlled by his wife and appearing weak and helpless in the face of her frequent outbursts of rage. In relation to himself, Stuart experienced his father as distant, uninterested, and emotionally unavailable. The patient described his mother as anxious, unhappy, and frequently overwhelmed, and also as intrusive and "controlling [his] identity." He felt he had to function as a "substitute husband" for her and to be a "father" to his younger sister, to "see an example for her" by suppressing his own emotional reactions to events within the family. He was always aware of his mother's emotions, he said, and felt responsible for comforting her when she was upset. Being organized around her neediness made him feel "special" to her, but his specialness had come at the price of a constant requirement to be "big" and "strong" in order to take care of her and maintain her emotional equilibrium. When he brought his own difficulties to her in the hope of a comforting response, she would become frustrated and overwhelmed and invariably tell him to leave her alone.

The most profound emotional truth of Stuart's childhood was his sense of being totally alone with painful experiences, both within and outside the family. He felt a complete absence of a strong, idealizable figure who could protect him and help guide him through painful situations; hence, he turned to his own excellent mind to find a sense of control and safety. Omnipotent thought became his substitute for the missing idealizable parent, setting the foundation for his later obsessional symptomatology.

As might be expected in light of this history of profound emotional neglect and abandonment, the early months of Stuart's analysis centered around his fears of exposing his needs to his female analyst. He felt that he had to be big and strong and brave in order to please the analyst, and he expected her to desert or punish him for expressing any wish to be taken care of. He feared that the analyst, like his mother, would be overwhelmed by his needs and painful feelings and that she would become injured and even "destroyed" if he were to voice any angry reactions to her disappointing him. Gradually and conflictually, Stuart began to acknowledge his growing attachment to the analyst, along with the disruptive impact of separations from her, which evoked severe anxiety and an intensification of his obsessional brooding. After about 18 months of analysis, he was able to articulate a deep yearning for the analyst to provide complete protection from painful affect.

Around this time, the analyst's accurate interpretations of the meanings of the patient's painful emotional experiences, both within and outside the transference, began to produce remarkable effects. Here is a sampling of his reactions to interpretations that provided him with the experience of being understood:

I feel so good. You're an expert, taking care of me. I feel happy, protected, in the right place.

I feel protected by you. I have a resource, so I'm able to feel sad and uncertain.

Ooh! I'm feeling really happy. You're helping me, giving me direction. You're calm and strong, not frivolous like my mother. This is big-time help!

I feel so good here, hearing your sweet voice behind me. You know things; you're clear and logical. You're in charge of the situation, and I feel protected, less vulnerable.

Following therapeutic moments such as these the patient would experience states of calm of increasing duration, and his obsessional preoccupations would diminish and even disappear. His anxiety and obsessional thinking would return, of course, in reaction to misattunements and separations, although less
so as the treatment progressed, and his disruptive reactions, wherein the analyst became the emotionally abandoning mother of his childhood, still needed to be analyzed. But what I wish to stress here is that at this point the powerfully ameliorative impact of the analyst's attuned interpretations and of the patient’s consequent feeling of being understood derived from the profound transference meaning that both had come to acquire for him. They materialized the analyst as the deeply longed-for, calm, strong, knowing, and protective mother so sorely absent during his childhood. To the extent that the patient now felt protected by an idealizable parent, the illusory protection afforded by the activity of his own mind became unnecessary and dispensable.

Similar observations can be made about the therapeutic effect of the transference meaning of interpretations when other selfobject needs are in the foreground. For a patient immersed in a primary mirror transference, the experience of being understood can evoke a sense of being deeply treasured by the analyst, of having attained a position at the very center of the analyst's world. In the context of a twinship transference, the analyst's understanding can be organized as evidence of the patient having found the yearned-for soul mate whose experiential sameness promises to alleviate lifelong feelings of painful singularity. Interpretations of defensiveness, in some instances, can establish the analyst in the transference as an idealizable, benign adversary (Lachmann 1986, Wolf 1988), facilitating the patient's demarcation of self-boundaries. All such transference experiences, as Kohut (1971, 1977, 1984) repeatedly emphasized, reanimate stalled development and thereby fuel the process of therapeutic transformation.

Anyone who has conducted an analysis from a self psychology perspective has witnessed the enormous therapeutic benefits of analyzing ruptures in selfobject transference ties. Throughout his writings, Kohut (1971, 1977, 1984) explained these therapeutic effects by invoking his theory of optimal frustration leading to transmuting internalization, an explanation that has been questioned by a number of self-psychologically minded authors (Bacal 1985, Socarides and Stolorow 1984/1985, Stolorow et al. 1987, Terman 1988). How might the therapeutic action of analyzing disruptions be explained according to the thesis I have been developing here?

Most patients who come to us for analysis have, as children, suffered repeated, complex experiences of selfobject failure, which I conceptualize schematically as occurring in two phases. In the first phase a primary selfobject need is met with rebuff or disappointment by a caregiver, producing a painful emotional reaction. In the second phase the child experiences a secondary selfobject longing for an attuned response that would modulate, contain, and ameliorate his painful reactive affect state. But parents who repeatedly rebuff primary selfobject needs are usually not able to provide attuned responsiveness to the child’s painful emotional reactions. The child perceives that his painful reactive feelings are unwelcome or damaging to the caregiver and must be defensively sequestered in order to preserve the needed bond. Under such circumstances, as my collaborators and I (Socarides and Stolorow 1984/1985, Stolorow et al. 1987) have stressed, these walled-off painful feelings become a source of lifelong inner conflict and vulnerability to traumatic states, and in analysis their reexposure to the analyst tends to be strenuously resisted.

In light of this developmental formulation, how might we conceptualize the therapeutic impact of analyzing disruptions of selfobject transference ties, that is, transference repetitions of experiences of primary selfobject failure? In conducting such an analysis, the analyst investigates and interprets the various elements of the rupture from the perspective of the patient's subjective frame of reference—the qualities or activities of the analyst that produced the disruption, its specific meanings, its impact on the analytic bond and on the patient's self-experience, the early developmental trauma it replicates, and, especially important, the patient's expectations and fears of how the analyst will respond to the articulation of the painful feelings that follow in its wake (Stolorow et al. 1987). I believe that it is the transference meaning of this investigative and interpretive activity that is its principal source of therapeutic action in that it establishes the analyst in the transference as the secondarily longed-for, receptive, and understanding parent who, through his attuned responsiveness, will "hold" (Winnicott 1954) and thereby eventually alleviate the patient's painful emotional reaction to an experience of primary selfobject failure. The selfobject tie becomes thereby mended and expanded, and primary selfobject yearnings are permitted to emerge more freely as the patient feels increasing confidence that his emotional reactions to experiences of rebuff and disappointment will be received and contained by the analyst. Concomitantly, a developmental process is set in motion wherein the formerly sequestered painful reactive affect states, the heritage of the patient's history of traumatic developmental failure, gradually become integrated and transformed and the patient's capacity for affect tolerance becomes increasingly strengthened.

There is an additional transference meaning of the analyst's attuned interpretive activity that I believe may contribute a therapeutic element in all analyses but is especially important in the treatment of patients who have suffered severe developmental derailments in the articulation of perceptual and affective experience. These are patients often prone to fragmented, disorganized, or psychosomatic states, for whom broad areas of early experience failed to evoke validating attunement from caregivers and, consequently, whose perceptions remain ill-defined and precariously held, easily usurped by the judgments of others, and whose affects tend to be felt as diffuse bodily states rather than symbolically elaborated feelings. In such cases the analyst's investigation and
illumination of the patient's inner experiences, always from the patient's perspective, serve to articulate and consolidate the patient's subjective reality, crystallizing the patient's experience, lifting it to higher levels of organization, and strengthening the patient's confidence in its validity. The analyst thereby becomes established in the transference as the missing and longed-for validator of the patient's psychic reality, a selfobject function so fundamental and basic that my collaborators and I (Stolorow et al. 1992, Trop and Stolorow 1991) believe that its appearance in analysis deserves to be designated by a specific term: the "self-delineating selfobject transference."

I would like now to place my discussion of the therapeutic action of psychoanalytic interpretation within the broader framework of the conceptualization of transference that my collaborators and I (Stolorow et al. 1987) have previously proposed. In this formulation the transference, viewed as the product of unconscious organizing activity (Stolorow and Lachmann 1984/1985), is seen to consist of two basic dimensions: In one dimension are the patient's yearnings and hopes for selfobject experiences that were missing or insufficient during the formative years. In the other dimension, which is a source of conflict and resistance, are his expectations and fears of a transference repetition of the original experiences of selfobject failure (A. Ornstein 1974). All well-conducted analyses, we have suggested, are characterized by inevitable, continual shifts in the figure–ground relationships between these two dimensions of the transference as they oscillate between the foreground and background of the patient's experience of the analytic bond, shifts and oscillations that are profoundly influenced by whether or not the analyst's interpretive activity is experienced by the patient as being attuned to his affective states and needs. When the analyst's interpretations are experienced as unattuned or misattuned, foreshadowing a traumatic repetition of early developmental failure, the conflictual and resistive dimension of the transference is frequently brought into the foreground, while the patient's selfobject longings are driven into hiding. Attuned interpretations, by contrast, evoke, strengthen, and expand the selfobject dimension of the transference, and herein, I have argued, lies a principal source of their therapeutic effects.2

In closing, I wish to emphasize that by bringing to focus the therapeutic impact of the transference meanings of psychoanalytic interpretations, I do not discount the existence of other sources of therapeutic action, including those that may derive from enhancements of the patient's self-reflective capacity (Brandchaft and Stolorow 1990) or from the meanings of noninterpretive elements within the therapeutic process. I do hope to have demonstrated that the therapeutic action of psychoanalytic interpretation is something that takes form within a specific intersubjective interaction to which the psychological organizations of both analyst and patient make distinctive contributions. The analyst, through sustained empathic inquiry, constructs an interpretation that enables the patient to feel deeply understood. The patient, from within the depths of his own subjective world, weaves that experience of being understood into the tapestry of his unique, mobilized selfobject yearnings, enabling a thwarted developmental process to become reinstated. Psychoanalytic interpretations, I am contending, derive their mutative power from the intersubjective matrix in which they crystallize.

REFERENCES


2. Sometimes disruptions can occur that are quite confusing to the analyst because of unrecognized shifts in the patient's psychological organization, interpretations that were once experienced within the selfobject dimension of the transference suddenly become assimilated into the repetitive/conflictual/resistive dimension, producing unexpected exacerbations of the patient's suffering and manifest symptomatology (Trop and Stolorow 1991).
The Intersubjective Perspective


