Introduction

Francis Bacon noted several centuries ago that once people become wedded to a certain idea or concept, their minds are no longer open. They will continue to look for evidence, however flimsy it may be, to buttress preconceived notions, and will reject all evidence that contradicts them.

Bacon's idea is broadly valid. It has practically turned into one of the "covering laws" of a depth-psychology-informed social psychology. It holds true for all people, in all human endeavors, including psychoanalysis. At a first glance this should not be surprising, after all, psychoanalysis, as an avenue to self-knowledge and self-healing, evolved naturally out of immanent gifts and propensities inherent in our psychic structures as human beings. These everyday, ubiquitous gifts and propensities for empathy and introspection were, sooner or later, bound to be elaborated into a method: the scientific endeavor of psychoanalysis. On further reflection, however, the idea that Bacon's judgment includes psychoanalysts as well, is greatly surprising. Have psychoanalysts not developed a method whereby their very enslavement to an idea, concept, fantasy, or preconceived notion was to be lifted? Is not psychoanalysis in general—and the psychoanalyst's training analysis in particular—supposed to transform this human propensity for ideological enslavement into a modicum of cognitive-emotional freedom, the achievement of "analyzed man"?

The successes of psychoanalysts on this score have thus far been greatly disappointing even if psychoanalysts do, indeed, have a method for the diminution of ideological enslavement. This polarity between ideological enslavement and ideological freedom in psychoanalysts is also a function of the social-psychological matrix in which the psychoanalytic enterprise is embedded.

Analytically attained openness or ideological freedom was to fashion in us a listening perspective in which our theories would essentially serve
as “tools of observation” (Kohut, 1973). When theories are used as tools of observation, they have a properly limited half-life, which is determined by how long they maintain their heuristic and explanatory potential. Such an attitude, if attained and maintained, could perhaps exempt psychoanalysts from Bacon’s covering law and better insure psychoanalysis its coveted scientific status.

We will, however, not continue at this point to paint this larger picture of the scientific status of psychoanalysis in further detail, no matter how enticing the task and how useful a fuller picture might actually be. But the issue of openness to new configurations of inner experience is of special importance in the interpretive process, hence this brief preamble should serve as a broad frame for a closer examination of some aspects of the central operational elements of psychoanalysis, namely, the issues of understanding and explaining.

Understanding and Explaining: Two Steps in the Interpretive Process

For a variety of historical reasons, understanding, which should have been alongside explaining as the two distinct steps in the interpretive process, has either been taken for granted or seriously underplayed as a specific and necessary intervention in psychoanalysis—in both clinical and theoretical discussions and writings. Hartmann (1927) and Eissler (1968) explicitly excluded understanding as a significant step in its own right in the interpretive process—for what appear to be ideological reasons. They considered psychoanalysis an “explaining psychology,” to be sharply demarcated from “understanding psychology,” which they regarded as nonanalytic and viewed with suspicion. In order to buttress their claim, they needed to consider interpretation (which was equated with explanation) as the sole analytic tool and could not afford to grant understanding a separate clinical or theoretical position.

Loewenstein (1951) and Kris (1951) in their extensive, influential work on interpretation do not address this artificial and unwarranted dichotomy between understanding psychology and explaining psychology. They define interpretation and the interpretive process so broadly and encompassingly, however, that they implicitly accommodate—albeit under a different label—what we call here understanding. But by not placing understanding explicitly into the interpretive process as a separate and clearly defined step, they have overlooked some significant and obligatory functions of understanding as compared to and contrasted with explaining. Not until Kohut (1973) placed understanding and explaining (interpretation in the narrower sense) side by side and accorded understanding a systematic, clinical and theoretical position within the more broadly conceived interpretive process, was this anomaly significantly corrected.
As we have described elsewhere (Ornstein & Ornstein, 1980), Kohut (1973, 1977) demonstrated that psychoanalysis as a scientific psychology consisted of two interrelated layers: (1) understanding psychology—with introspection and empathy as its methods—encompassing meanings, motives, and relationships, and (2) explaining psychology—with inference, concept formation, and theory building as its methods—searching for causal connections. We had earlier joined Kohut in asserting that the two layers together, in a particular relationship to each other, constitute present-day psychoanalysis. Kohut linked the two layers by saying that “psychoanalysis explains what it has first understood.” There is here no sharp demarcation between these two layers of psychoanalysis, but their conceptual separation has both clinical and theoretical advantages.

Up until this correction, interpretation (i.e., explaining) alone was considered to be the key—even if not the exclusive—operation in psychoanalysis. Nothing portrays more vividly the ambiguous epistemological status of psychoanalytic interpretation than when analysts speak of “having interpreted to the patient,” or “having given an interpretation”—without further reference to the form and content of the interpretation. This conveys the idea that there is something magical about interpreting per se, that is then considered not magical at all, but is thought to be purely dependent on the form and content of the explicit verbal statement of the analyst. The content, however, is treated here as self-evident and correct, well known and standard. It is as if the activity of interpreting, or of giving an interpretation carried a force and power that other kinds of verbal communications—not regarded as interpretations—could not or did not possess.

The term, interpretation, per se, does not carry the kind of precision and power that such a stance imputes to it. The power interpretations do carry, resides in the overall context of the analytic relationship and experience and can be captured more accurately through a broader definition of the interpretive process and the total setting in which this occurs.

There is also the difficulty that arises from treating verbal communications of the analyst—designated as interpretations—very differently from the verbal communications of the patient—designated as free associations. In this process the analyst is listening for the inevitably present latent meaning or the metamessage of the patient's communications. He expects, however, that the patient will hear his explicit, manifest, and intended message, as if he himself conveyed no metamessages in his communications at all. When the patient does not hear the explicit, intended message—or, more accurately, when he does not focus on it, but detects the metamessages and responds to those instead—certain communicational problems arise. The solutions to these communicational problems are of utmost importance for the proper conduct of an analysis. The analyst's response to the patient's way of treating his interpretations will determine what kind of analytic experience the patient will be allowed to have. Because of the striking difference in the manner in which the two participants' communications are
treated, we shall briefly focus on what specific impact these divergent ways have on the patient's analytic experience.

The patient may, for instance, treat the analyst's interpretations as expressions of love, praise, and admiration, or rejection, criticism, and demand; as food to be filled up with; as soothing or calming and to be savored; as painfully penetrating and therefore to be warded off; as holding, caressing, or sexually exciting, and so forth. The possibilities are legion and well known.

The analyst's responses to the patient's way of treating his interpretations may fall into two opposite clusters and a third form of response that attempts to combine the two.

1. From one listening perspective and theoretical position the analyst will essentially convey that the patient's treatment of his interpretations deviates from the “norm” and will obstruct the attainment of insight. The analyst will remind the patient that his words are not to be eaten (or to be taken as praise or as sexual penetration) and that such responses are defensive efforts at defeating the analyst's objectives and aim at perpetuating regressive drive gratifications. Responding in this manner, even if tactfully and kindly and with explanations that seem to maintain objectivity, the analyst rejects the patient's subjective experience of his interpretations. Whatever the immediate impact of this implicit rejection or disapproval, the analyst, nevertheless, feels justified in maintaining this interpretive stance, since in this manner he can pursue the necessary defense analysis. He does this in the service of his long-term analytic goals of conflict resolution through insight. He thereby dismisses the patient's subjective experience of disapproval, although drive-defense interpretations inevitably express disapproval.

Since the disapproval that the patient hears was not intended, the analyst takes it for granted that it was not expressed in his interventions. When the patient insists that he has heard it, this is further interpreted as a distortion. Of course, there is a “distortion” of what was consciously, explicitly, and deliberately intended by the analyst, but this is not the issue. The issue is that from the vantage point of the patient's self-experience in the transference there is no distortion: the patient perceives the unintended message, the kernel of truth around which his transference reactions crystalize. The analyst, by claiming neutrality, hopes to elucidate the genetic-dynamic origin and meaning of the patient's responses to his interpretations. By considering the patient's responses as “regressive,” however, the analyst's subsequent interpretations aim at pulling the patient out of that regression to a higher level of functioning, from which the patient's reaction, mode of perception, and communication are seen as a retreat.

To illustrate, a 36-year-old patient in his 5th year of analysis shared a fantasy of himself sitting on the analyst's lap, slowly unbuttoning her blouse and sucking on her breasts. He felt comforted by the fantasy and found
himself using it to fall asleep. He added that he could not imagine his mother ever holding him in such a way that he could relax with her; she always appeared to be in a state of agitation.

The fantasy was understood as a “regressive (pregenital) evasion” of the patient's oedipal sexual wishes. The analyst interpreted this by saying that the patient persisted in this resistance to the recognition that he wished to possess the analyst-mother sexually. This interpretation was to help the patient give up the preoedipal attachment to the mother and move on to the oedipal phase, where the analyst—as she stated in her report—would “represent reality that dictated the need for adaptive autonomy.” (The transference was obviously seen here as repetition of the infantile, in spite of the patient's statement that he had just expressed a longing for an experience he could not recall having had with his mother.)

This way of listening and responding is restricted by holding on to the view that all psychopathology of analyzable patients can be understood and treated on the basis of the drive-defense model, irrespective of the developmental level to which their origins can be traced. In this context it is also important to differentiate between “regression” versus “fixation” at the root of the psychopathology, since patients with (preoedipal) fixations are not considered to respond favorably to analytic efforts at drive-defense interpretations.

In a clinical situation such as the one just described, the psychopathology is considered to be mainly regressive in origin, and the analyst's communication aims at achieving a split in the patient's ego. Such communications represent a continued appeal to the observing ego, fostering the therapeutic alliance, the secondary process thinking, and so forth—all in order to undo the regression and continue the analytic work toward insight into the pathogenic conflicts. This emphasis seems to bypass (and thereby often discourage) the emergence of those aspects of the patient's archaic self-experience that cannot be understood as the avoidance of certain specific (oedipal) conflicts or as the retreat from more mature object relations. What is of significance here is that the recognition of the preoedipal components of the transference did not change the drive-defense model for their interpretation.

To stress this once more, when the analyst persists with his drive-defense interpretations, in spite of the fact that the patient perceives and responds to the unintended dismissal of his archaic longings as defensive, he directly thwarts the patient's conscious and unconscious longings in the transference, instead of welcoming them as grist for the analytic mill of understanding and explaining. To be even more explicit, the patient's communication in the transference is, by definition, archaic—in the sense in which it expresses revived, unresolved, infantile and childhood issues, including the childhood solution to the problems. Appeals to the so-called therapeutic alliance, to be achieved by the observing part of the adult ego,
seem to us to reject the infantile or the child in the patient. Patients almost invariably experience them that way. Such appeals certainly demand of the adult ego a reevaluation and renunciation of infantile drives and defenses. In the face of such a demand how could the patient not draw the conclusion that the analyst disapproves of those archaic longings? Analysis of the transference, in our view, necessitates just the opposite: it is only the empathic acceptance, understanding, and explanation of infantile and childhood longings that will allow their slow transformation and their ultimate integration into the adult psyche.

2. From another listening and theoretical position the analyst fully accepts the patient's mode of response as an expression of his archaic level of experience and he tries to elucidate the meaning of what the patient's way of experiencing his interventions expresses (in the transference and genetically), rather than what it defends against or distorts.\(^1\) From this perspective, the patient's mode of communication reveals his efforts at establishing an emotional connection to the analyst in the service of attaining or maintaining the cohesiveness of his self and ultimately in the service of a belated maturation and growth, that is, structure building. These efforts reveal not only the particular structural deficits that spark the patient's efforts in the transference, but also his specific ways of trying to fill in or replace the missing psychic structures.

The clinical example cited earlier would indicate to this analyst that the patient, who puts himself to sleep with the fantasy of sucking on her breasts, has reactivated his “thwarted need to grow.” This fantasy is secured as a transference expression of the patient's longing to acquire his own capacity to soothe and to calm himself in the analyst's presence. In other words, rather than considering the fantasy as a “resistance to growing up,” to this analyst, the same fantasy indicates that the analysand has overcome his shame—which served as a resistance—and he is now able to express to himself and to the analyst his most deeply felt longings and desires. Rather than seeing it as a resistance, the presence of the fantasy and its expression indicate progress in the analysis.

This way of listening and responding means that the analyst fully accepts that patients with a psychopathology based on developmental deficits or derailments (so-called fixations) are analyzable, once the patients are able to mobilize the transferences that correspond to their specific form of psychopathology. The recognition of these transferences—the selfobject transferences (the mirror transference and the idealizing transference)—

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\(^1\) We acknowledge that from the external observer's point of view the patient's response to the analyst's interpretations might well be regarded as “defensive” and “distorted”. We are not questioning here the validity of these observations, but claim only that for our analytic purposes the observations made from the empathic vantage point are the only decisive ones. We focus our understanding and explaining exclusively on these (cf. Schwaber, 1983).
their archaic as well as their more mature forms, permits the analyst to respond with understanding and explaining, hence entirely within the interpretive process, on that level of psychic organization on which the patient functions in the transference. The idea here is not to undo the regression or fixation directly, or to pull the patient up to a higher level of psychic functioning, but to make contact with and accept whatever he brings to the analyst and in whatever form and on whatever level he does so, with the aim of structure building through understanding and explaining in a climate of optimum frustration. Structure building is here conceived of as a process of belated maturation and growth, as opposed to change through adaptation.

3. From a third, intermediate position (hard to justify both clinically and theoretically) the analyst believes that the two preceding antithetical approaches can be combined into one coherent treatment process. The idea is to do this by not confronting the patient for some time with what the analyst thinks is the regressive-defensive meaning of the patient's behavior and experience. Instead, at least temporarily and tactically, the analyst accepts the more archaic communication—only privately considering it as defensive regression (as if such a private opinion would not find its way into his communications). The analyst's hope is that this prolonged withholding of the otherwise correct interpretation will allow time for the strengthening of the patient's ego (via identifications?) and consequently the therapeutic alliance. This should then permit the analyst to proceed with the hitherto withheld, unaltered, drive-defense interpretation.

The above two-step sequence is a schematic outline. The fact of the matter is that in analysis the more archaic and the less archaic levels of communication oscillate or alternate in the flux and flow of the analytic experience. To follow this flux and flow in the manner just outlined, would seem to require of the analyst a frequent and rapid shift to contradictory attitudes, from drive-defense interpretations to noninterpretive interventions, that is, from nonacceptance to acceptance of archaic longings in their own right, thus contributing to the chaotic ups and downs observed in such an analytic process. It is therefore only with gross disregard for the patient's tendency to develop a sustained and cohesive transference, and undue attention to the content of the patient's communications instead, that the two antithetical attitudes can be combined. For how can “accepting the archaic experiences as valid in their own right” be held simultaneously with “viewing the archaic experiences as drive-related defensive regressions”? In such a combined approach the analyst actually views the patient's communication as evidence of regressive defense, not valid or analytically legitimate in its own right, since the latter would spell “fixation” and hence unanalyzability. The analyst withholds the “correct” interpretation to avoid confronting the patient when he judges that the patient's ego could not tolerate such a confrontation. It is obviously the patient's ego then, that needs to be
strengthened, rather than the analyst's interpretation to be made more accurate and more useful to the patient.

We shall not pursue here further the comparison and contrast of the three approaches to the analytic process just described. Instead, in what follows, we aim at bringing our ideas regarding the interpretive process up to date, that is, in line with the method of the analyst's prolonged empathic-introspective immersion in the patient's self-experience and the findings and theories derived from it.

The Interpretive Process in the Self-Selfobject Matrix

With our focus on the analyst's activities as these affect the patient's subjective experience, it is important to reemphasize that what is ultimately of significance for the analytic process is not what the analyst says, or thinks he says, but what the patient experiences in connection with what the analyst says.

In other words, the analyst cannot afford to lose sight of his own impact on the patient's experiences and with that on the process of analysis. In this connection it should also be noted that the effectiveness of the working together of the analytic dyad—the work that a particular patient and analyst pair can do together—is more important for the course and outcome of an analysis, than is the level of the psychic organization of the patient alone.

It follows then, that the psychoanalytic process is set into motion, or is actually created, by what the patient brings to the analyst and by the analyst's responses to it. We now recognize that an analysis does not automatically mobilize all of the patient's psychopathology; what does eventually become activated also depends on the analyst's responses.

To focus our discussion on the analytic process we should recognize some significant elements in the process: (1) the moment-to-moment interchanges between patient and analyst that lead both participants to grasp the nature of the patient's inner life; (2) the progressively increased centering of the patient's inner life on the analyst as a selfobject; (3) the deepening understanding that patient and analyst achieve in the course of the analysis regarding the meaning of the patient's behavior and experiences; (4) the way in which this deepened understanding affects the moment-to-moment interchanges between patient and analyst and thereby the patient's experiencing of the analyst-selfobject.

It is the most important characteristic of this entire process—which has a spiral rather than a linear momentum—that all of what transpires in it occurs in the self-selfobject matrix and can only be understood in reference to this matrix or more accurately, with the empathic vantage point from within that matrix.
Understanding and Feeling Understood

When we speak of the analyst's activity in terms of a particular level of understanding, we recognize that only the patient who is the object of the effort to be understood can indicate to us whether or not he was actually understood. The patient's reaction of feeling understood, then, attains a special significance in the interpretive process. The analyst's efforts to identify the patient's subjective experiences accurately and the patient's reaction to feeling understood, are both central for the subsequently emerging explanations to become experience-near and emotionally meaningful as well.

A small segment of an interaction of the effort to understand and the feeling of being understood (or not being understood) should serve as an illustration. Mr. K, in analysis for some time, presented the following dream shortly after a prolonged vacation. With two of his brothers present and aiding him, he was running toward an airplane to board it. It was like those last-minute evacuation scenes around Saigon, in Vietnam. He had two obstacles to overcome to make it to the plane in time. In the end he made it. TR, a friend, was at the plane organizing it all.

In his associations the patient emphasized the horrors of his “internal Saigon” from which he was running, without putting much stress on the fact that (manifestly at least) he actually made it. In his effort to summarize what had been said by both of them thus far, the analyst included the question: “In the end you were then rescued, weren't you?” The patient felt deeply hurt and misunderstood. As it turned out, he presented the dream to show—and wanted the analyst to recognize—that in spite of his inner turmoil during the vacation, he felt a “unity” within himself (his two brothers were acting helpfully and in unison with him, indicating that the split-off parts of him were now in greater harmony and connected with his core-self, as he put it); and that he had overcome obstacles, reached the plane and escaped. The analyst's use of the word “rescued” made the patient feel that he was perceived by the analyst as passive and dependent, in need of a rescuer. It even felt to him that the analyst might have considered himself to be in the role of a rescuer, when in fact he felt that he escaped as a result of his own activity and strength in the analyst's absence.

Here, finding the word “escaped” (with its connotation of self-generated activity) was crucial, since it was the one that best described the patient's self state. Understanding, then, on this level means to establish communication, in which finding the expressions that best describe the patient's subjective experiences in the objective. Understanding in this sense is an achievement within the analytic dialogue and comes about through a sustained focus on the patient's self-experiences. The moment-to-moment interchanges between patient and analyst consist of such efforts at understanding.
Explaining and Feeling More Deeply Understood

But when and how does the analytic dialogue include more than the moment-to-moment experiences? Is it in keeping with the empathic mode of listening and interpreting, to offer explanations that the analysand cannot resonate with, although he might, nevertheless, ultimately accept them? In other words, how does the empathic vantage point and mode of interpretation expand the patient's self-awareness? How and when does the analyst include in his interpretations the unconscious, split off, and repressed aspects of the self? There is also the question of how the analyst can, while maintaining an empathic position, include a statement about the patient's defensive operations in his interpretations?

It is in relation to this last question that the maintenance of the empathic vantage point for interpretation is of particular importance. Certain defenses that are themselves unconscious (disavowed or repressed) and defensive personality traits cause suffering that patients and/or the environment have to endure. These have to be understood in terms of their genetic origins in order to be interpreted from within the vantage point of the patient's own experiences. This may be conveyed in statements such as this: “As I listen to you, I am having trouble discerning what it is you are trying to tell me, as if you could make your wishes known only in the vaguest manner, barely hinting at them.” Once the analyst understood the patient in greater depth, he can add a genetic “explanation”: “I think I can now understand better where the vagueness in your manner of speech may come from. Based on some of your experiences (and these should be specifically stated) you developed a cautious way of communicating, as if you could never be sure how others would respond to what you say—especially, when this concerns something you want for yourself.”

However, the introduction of genetic explanations also introduces more explicitly the analyst's theoretical biases. Reconstructions are not predominantly discoveries of preexistent truths, but the creation of the particular, unique, analytic experience. For such a reconstructive interpretation to further the analytic process and the attainment of insight, it has to resonate with the patient's own experiences; it has to evoke in the patient the feeling, that the analyst has captured something of his past that illuminates his present—that it all fits in with the patient's own changing and expanding image of himself, in cross-section and longitudinally. These reconstructions concern themselves with infantile and childhood self states and not simply with events of the past. If these reconstructions are arrived at jointly, if the patient feels that he has participated in their formulation, his own responses to these reconstructions will demonstrate how powerfully they promote the analytic process.

Some of the responses that promote the process are identified as feeling understood in depth this time, rather than only in terms of the feeling states
that arise in the moment-to-moment interchanges. It is these reconstructive interpretations that add the new dimension to the analyst's understanding and to the patient's feeling of being more deeply understood. Patients frequently respond to meaningful reconstructions in one of the following ways: (1) “Now I am beginning to have a sense for where I came from, who I was, and what explains my feelings and experiences.” (2) They show a sense of mastery and an attainment of a unification of disparate, contradictory, or conflicting feelings and strivings: “I can now see how all these feelings belong to me—I am the same person, no matter how I feel.” The feeling of being understood, hence of understanding oneself better, can also be enhanced by the patient's active participation in arriving at explanations. This can be fruitfully contrasted with the patient feeling somewhat jarred and surprised when the analyst offers explanations that had not been built up from the detailed exchanges of the analytic dialogue.²

Thus, evidence for the progression and deepening of the analytic process is provided by the lessening of the patient's need for the defensive use of repression and disavowal. With this lessening, the split-off parts of the self will be increasingly experienced as part of the total, expanding, and now more unified self, leading to the enhancement and firming up of the cohesion of the self. It is then secondary to this increased self-cohesion that what had previously been repressed and/or disavowed (horizontally or vertically split), is now brought into the orbit of awareness. It should be clear that it is not the bringing into awareness by the analyst that is of primary significance here, but rather the bringing into awareness by the patient himself, since that is the consequence of the strengthened self-cohesion.

The analyst's empathic acceptance of the patient as he or she is (with symptoms, self-recriminations, rages, and the rest) serves as a selfobject function (analogous developmentally to the gleam in the mother's eyes) that becomes transmutedly internalized. In other words, when the analyst

² We realize that no one advocates importing such jarring, abstract, experience-distant reconstructive interpretations into the psychoanalytic process—interpretations that spring forth from the analyst's own theoretical system as his private association and explanation, without properly considering the patient's associations. Yet, the joint effort and the patient's immediate and long-term responses will be of decisive importance. A beautiful example is offered in Kohut's description of “The Two Analyses of Mr. Z” (1979). An aspect in a termination dream is interpreted in the first analysis as the patient's defensive refusal to allow the entrance of the gift-bearing father through a slightly open door, in order to safeguard the regressively colored, but basically oedipal relationship to the mother. The same detail in the dream is seen in the second analysis as an effort on the patient's part, to slow down the reception of the desperately longed-for paternal gifts (the missing masculine substance). Both reconstructive interpretations aimed at capturing the patient's experiences from within the vantage point of his own inner state. Both fitted into the overall context of the larger picture of the whole analysis. Yet, the first interpretation seems to have been reacted to more as a foreign body, whereas the second one seemed to resonate more profoundly with the patient's own grasp of the meaning of his experiences.
accepts the patient's infantile and childhood self, the patient, too, can ultimately accept his own infantile and childhood longings. The central aim of analytic understanding and explaining is just that.

Being a patient, however, involves a variety of self-recriminations and self-punishments regarding infantile needs. When the analyst, through interpretation, also rejects the infantile in the patient, that increases, rather than decreases, self-recrimination and self-punishment. Freud considered this to emanate from the repetition compulsion and from unconscious guilt (the negative therapeutic reaction), which constitute the core of resistance.

When Freud's view of resistance as an expression of the repetition compulsion and of unconscious (superego) guilt is translated into interpretation, it is as if the analyst were saying: “You are resisting in order to hold on to your guilt (and to your self-recrimination and self-punishment), so as to camouflage your wish to hold on to your infantile longings and gratifications (expressed in your sadomasochistic activities).” It is our view, that whenever such a statement is heard by the patient in a drive-defense interpretation, this triggers an intensification of the patient's resistances and most likely unnecessarily prolongs the analysis. At best, it leads to a surface adaptation to the analyst's implicit demands, rather than to emotional growth via structure building.

The Analytic Dialogue and the Deepening of the Treatment Process

The metaphor of climbing a mountain together may be helpful in picturing the analytic dialogue and the role of the genetic reconstructive interpretations within it. Patient and analyst walk the mountains together. At times one is ahead and the other trails behind (the analyst, it is hoped). They are, in their manner of walking, their speed, and so forth, getting to know each other's temperament, ways of proceeding and orienting themselves: their respective modes of expression and communication; the idiosyncratic elements of their style of relating. They are thus constantly in search of each other on this climb: this is the dialogue on the level of understanding. It is the maintenance of contact, the noticing of where the patient is, noting what route he is taking, what obstacles he has to master, and how he feels as he struggles to move ahead. Through many difficulties (repeated stumbling and falling down; losing their way on a side trail) from time to time they reach a plateau where they take a rest and look back at how far they have come. They have arrived at this view through a jointly coordinated effort. They can point to landmarks they have passed together. In the course of the climb itself they do not have this perspective; they are busy getting on with the journey. On a plateau they reach a point where they understand enough to put their understanding into a larger frame.

Putting one's past (and one's current experiences) into such a perspective by connecting past and present meaningfully, is a life-long task in which
people engage (consciously or unconsciously) in and out of psychoanalysis. Psychoanalysts have to recognize this tendency more than they have thus far and build on it (rather than center their attention on the resistances against it) in order to elicit optimal participation by the patient in the analytic work.

The analyst's effort to understand and the patient's feeling of being understood, as negotiated through the analytic dialogue, lead to the deepening of the treatment process. This deepening is evidenced by the expansion of the patient's needs, demands, wishes, fears, expectations, and fantasies, which will then move more freely into awareness and become expressed in the transference. When this occurs, it is a dramatic demonstration of the advantages of not pursuing the resistances by direct confrontative interpretations. This “deepening” of the transference inevitably and regularly increases the patient's feelings of vulnerability in the analytic situation—relatively independently of the nature of the preanalytic psychic organization. Although both qualitative and quantitative aspects of this vulnerability will have their specific genetic antecedents, it is this increasing vulnerability vis-à-vis the analyst-selfobject that leads to the frequent and painful disruptions of the transference, which become the pivotal points of the analyst's reconstructive interpretations.

**Self-Cohesion and the Process of Understanding and Explaining**

As we indicated at the outset of this chapter, a survey of the pertinent psychoanalytic literature quickly reveals how broad, encompassing, and at the same time imprecise the term, interpretation, is. Yet, many a debate about what qualifies as a psychoanalytic treatment revolves around the meaning attached to the concept and to the assumption that interpretation has a clear-cut and precise meaning.

In our earlier contributions we tentatively resolved this dilemma by speaking of the interpretive process, in which we saw various forms of the analyst's verbal communications as components of interpretation and cumulatively contributing to the attainment of insight. It seemed to us that to focus on a particular form of the analyst's verbal communication was less important than what the patient made of it: understanding was only achieved if the patient felt understood and if something about him was truly explained and he actually felt more deeply understood as a result. Thus, whatever the form and content of the analyst's intervention, it always hinges upon understanding and being understood.

But the conceptual separation between understanding and explaining is still necessary and makes good theoretical sense—even though in practice these are almost always intermixed, they blend together and are often indistinguishable.
from each other, except in their extreme or “pure” form. When communication flows naturally between patient and analyst, focused on the moment-to-moment experiences of the patient, as they walk up to the mountain toward a plateau, bits of understanding and bits of explaining cannot be distinguished from each other by scrutinizing the form and content of the analyst's contributions alone. Furthermore, both understanding and explanation are arrived at cumulatively. What appears as understanding at one point can be part of the process of explaining at another. Similarly, what seems like an explanation at one point might well be a step in the deeper understanding at another.

What Constitutes Understanding in Psychoanalysis?

No effort at grasping one's own or another's inner experience is theory free. But in contrast to explanations that are offered on the basis of explicitly formulated formal theories we hold regarding the nature of health and illness, understanding is relatively theory free. The theories that inform our empathic introspective understanding of the nature and meaning of another's experience are self-knowledge and accumulated commonsense about human nature, both of which are at the basis of every form of communication.

Analytic empathy and introspection undoubtedly go beyond being guided by commonsense and self-knowledge attained through life experience (and not through a psychoanalytic treatment process). When prior psychoanalytic experience and training guide the analyst's empathic-introspective observations, it is perhaps more difficult for the analyst to separate his empathic understanding from his theory-based explanations. Only if the analyst himself felt understood in his own analysis, or if he has successfully overcome the trauma of having only been explained, but not really understood, can he direct his theoretically informed listening to be empathically centered on the patient's experience, to view this experience from the patient's own vantage point, without the need to explain before he has understood. Patients often experience the analyst's need to explain as intrusive, especially when prematurely offered or without the preceding step of understanding.

In the sense, then, in which we use the term, understanding means essentially staying with the patient's own experience without the effort, at first, of making sense of it; establishing and maintaining contact; reflecting back what the analyst has heard, to indicate that he indeed heard it; making his presence known at moments when the patient needs to know that the analyst is close behind and has not lost sight of him on this journey. Some patients can feel their own genuine presence and meaningful participation in the analytic process only after such steps of repeated affirmation or validation through the process of understanding.
What Constitutes Explaining in Psychoanalysis?

Where understanding (when the analyst is “in sync” with the patient's feeling state and experiences and grasps their meaning) shades into explaining is traditionally that point at which causal connections are introduced by the analyst (or by the patient) into the analytic dialogue. The epistemological status of explaining in psychoanalysis has long been questioned (recently more vigorously) by those who view psychoanalysis as primarily a study of meaning, a hermeneutic discipline, in which causal explanations do not apply.

We maintain that “explaining” is a proper term for describing the second step in the interpretive process, if we specify its operational use. What we mean by explaining is the placing of the understanding arrived at by patient and analyst into a developmental-genetic context and the making sense of these experiences explicitly on the basis of the analyst's specific observational tools: his (always provisional) theories. Explaining in this sense aims at grasping the meaning of the patient's experiences in terms of motivation and purpose, all in the context of the self-self object unit.

Explanation here is “causal” only in terms of elucidating antecedent states whose discovery gives meaning to present experience.

*Webster's New International Dictionary* (Third Edition) does not differentiate sharply between understanding and explaining, and defines their meanings as overlapping in many ways. Our use of these two terms in psychoanalysis is thus in tune with traditional linguistic consensus. Our insistence, nevertheless, on their conceptual differentiation (cf. *Kohut, 1977*), as already indicated, has both clinical and theoretical justification, which we will introduce after a clinical example of the combined use of understanding and explaining.

Understanding and Explaining the “Thwarted Need to Grow”

The following clinical vignette demonstrates the combined use of understanding and explaining in the form of a comprehensive genetic reconstruction and the impact this had on the process of analysis.

The patient, in the 3rd year of her analysis (with A.O.) began to describe a sexual fantasy in considerable detail. As she spoke, she suddenly interrupted her narrative and said, “At this very moment, I have the distinct feeling that you really don't care about me right now. I wish I would die.” Then she added, “I want to escape you and I want to outrage you, shock you or excite you. Leaving here in the middle of the hour could be such a dramatic, outrageous thing. It is humiliating to have to beg you for your response. I am okay when I am not around you. But what is happening to me here with you? I don't understand....”
The analyst thought that the interruption of the patient's narrative was due to a sudden emergence of shame in relation to the sexual fantasy she was detailing. It was as if she had, to her own surprise, revealed more than what was comfortable for her. The image of feeling suddenly exposed, brought to the analyst's mind a story the patient told her some time ago. As a little girl, 3 or 4 years old, her T-shirt got torn off at a family gathering and she experienced an acute sense of shame, feeling that her family, especially her mother, disapproved of her naked body. The analyst used this memory to convey her understanding of what the patient was now experiencing on the couch: relating her sexual fantasies exposed her, making her feel as if she were standing naked in front of the analyst. The fear of the analyst's response was overwhelming and she wished she would die.

But the episode signified more than the reexperiencing of shame. The childhood memory of shame at her exposed body was a screen memory, related to her feeling throughout her childhood that her body evoked scorn and disapproval, rather than delight, in her mother. In view of the importance that this screen memory had for the patient's current self-perception (that she was not a good looking woman), the analyst commented on the urgency with which the patient “exposed” herself by giving the details of her sexual fantasy. The urgency indicated to her, she said, that there was a wish to create a situation in which she could stand naked in front of the analyst. But this was a risky position to be in: would her naked body (represented by the sexual fantasy) be found beautiful now?

After the analyst said this, the patient replied, “I very much want you to look at me—but then I want to look at you and see what your eyes are saying: do they say I am beautiful?” The analyst continued: “It was the fear that my eyes (my voice) wouldn't say that and you would rather die than have that happen to you again. Then there was the wish to shock me and outrage me by leaving the office. This sounds like your response to the expected disappointment that I would not find your naked body beautiful. Leaving the office is to express your rage for failing you this way. Now I will feel the painful humiliation too. But the dramatic way in which you would do this, would insure some kind of response from me. Not being sure that you can elicit a positive response from me, your “outrageous” behavior would secure at least an intensely negative one. It sounds as if the most important thing about all of this is that I notice you and respond to you intensely.”

This latter statement was an interpretation of the patient's life-long mode of protecting herself against feeling humiliated whenever she struggled with strong exhibitionistic wishes. The expression of these wishes, even in the most disguised form would be quickly followed by intense shame, so that she had to re-repress the wish: by doing something outrageous she would give expression to the exhibitionism and successfully re-repress the wish to be admired. The patient's response indicated that she felt further
understood as a result of the interpretation; instead of resorting to her lifelong defense of being provocative or “outrageous,” she spoke freely of her wish that the analyst look at her approvingly and with admiration.

The clinical vignette demonstrates an instance in which “the thwarted need to grow” was reactivated in the analysis. Crucial in her comments was the analyst's recognition of the meaning of the urgency with which the patient “exposed herself” by telling of the sexual fantasy in detail; an urgency that did not represent an irresistible drive that ought to be tamed or renounced, but recognized as a legitimate childhood wish that had now come to the fore.

To summarize this experience, we would say that the patient, as an adult, had an experience in the analysis that was analogous to her childhood experience, but that would now have to have a different outcome. It is as if the patient were saying: “As an adult, it is impossible for me to have an experience here in which I can feel my body admired by you. But that is what I need to get well. Telling you a story and experiencing it as if you were now looking at my naked body, is the closest that I can come to that experience. You can see why I would be anxious about your response—so much depends on that. At first, there was a fear of repetition—you too would find my nakedness unattractive. But then you indicated that you understood what I wanted from you when I told you the story. Your understanding of that helped me realize my wish that you would find me beautiful.”

At this moment patient and analyst had reached a new, comfortable plateau on their mountain walk together. The patient felt increasingly confident about the analysis and said, “I feel I am integrating something here with you. It was strange, your interpretation brought a lot of associations… primarily to being a little girl. … It felt sad. … I was amazed by what you said in a lot of ways but that you knew the intensity of it all was the most important; that you knew that I had to have some intense response from you. Your words could have destroyed it all, but they didn't. I feel very connected to you now. It feels as if you like me okay—you don't need to like me above everyone else!”

Similar episodes followed; the telling of fantasies and dreams had to have a shock value; they had to excite and involve the analyst. Many of these instances proved disruptive to the patient and each of them was followed by a new level of integration.

The Analytic Impact of Understanding and Explaining

The preceding clinical vignette illustrates how the analyst's understanding (aided by a recall of a screen memory reported to her earlier) conveyed her acceptance of the patient's experience on the couch. Tipped off by the urgency with which the patient communicated her sexual fantasy, and then by the content of the screen memory, the analyst explained—that is, she
understood more deeply and thoroughly, by placing into its genetic context—the meaning and motive for the patient's immediate experience. Understanding that the patient wished to evoke in the analyst an intense response of admiration for her physical beauty, and the extension of this by explaining what made it so risky for her to “expose” her wish and ask for this admiration freely, permitted the patient a more direct and less inhibited expression of the wish to be looked at and found beautiful.

The analyst was then able to combine her understanding and explaining into a comprehensive reconstructive interpretation, that connected the patient's immediate experience on the couch (the wish to be admired, the intense shame and humiliation it triggered, and the turning of this wish into a fantasy of “outrageous behavior” as a compromise) with her life-long, habitual ways of defending against her intense wish to be admired, which now had become associated with a sense of shame and humiliation.

This further understanding made it unnecessary for the patient to remain bound to her compromise solution and she now spoke more freely and without shame of her wish that the analyst look at her approvingly and with admiration—thus activating or liberating the patient's hitherto “thwarted need to grow.” When this inherent tendency to complete previously interrupted, derailed, or arrested development—whatever archaic form it may take initially—is recognized as a legitimate childhood wish and is accepted, understood, and explained, the process of belated maturation and growth is analytically enhanced. When it is countered by being viewed as an irresistible drive that needs to be controlled, tamed, or renounced, this non-acceptance may further thwart and often actually preclude structure building and the felicitous outcome of an analysis.

What we have thus far discussed and illustrated about the separate and combined functions of understanding and explaining, should now be summarized and elaborated on in order to bring these clinical activities in harmony with psychoanalytic self psychology.

1. The process of understanding forges an analytic contact with the patient on his or her own terms, in relation to feelings, thoughts, wishes, needs, fantasies, and demands, and the various ways all of these had to be dealt with at the moment (that is, in the transference) and habitually (that is, in keeping with the patient's character). This is a validation rather than a challenge to the patient as he or she is—a validation that includes the unconscious motives and the particular mode by which these motives are protectively defended. The acceptance and understanding of the infantile wishes (repressed or disavowed) and their defenses lead to the patient's subjective feeling of being understood in depth.

The feeling of being understood aids the patient in establishing a self-selfobject matrix (the various forms of selfobject transference) in which understanding continually reinforces the stability and cohesiveness of the self. Self-cohesion increases as the split-off parts of the self are progressively
included with the firmed-up core of the self. Increased and sustained self-cohesion leads secondarily to improved functioning in diverse ways and in many areas. Among them are self-awareness and insight, essentially as consequences of progressive structure building. Even at best, the analyst's empathic understanding still creates optimum frustration—since it always remains only verbal communication, no matter how gratifying the feeling of being understood is—and thereby contributes to the process of structure building.

2. The process of explaining deepens the analytic dialogue by connecting the past with the present and thereby offering a longitudinal perspective. By bringing together experiences from various developmental and later epochs of the patient's life, it enhances self-cohesion. It further anchors what has up to then been understood. There is added opportunity here for further empathic acceptance and understanding of infantile and childhood yearnings and their transmuting internalization. Understanding and explanation allow the infantile and childhood wishes to be finally more freely expressed in the atmosphere of unconditional acceptance, which is a precondition for their subsequent transmutation and internalization. This is in sharp contrast with the experience in which the symptomatic patient rejects the sick part of his or her own personality. This very rejection creates self-recrimination and contributes to symptom formation. Thus, every implied or subtle expression of rejection by the analyst places upon the patient a demand for rejection of his infantile longings and thereby creates further splits in the psyche.

References
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