 DOI: 10.18231/2455-8559.2017.0015

Interpretations for new era psychoanalysis

Anurag Srivastav

Professor & HOD, Dept. of Psychiatry Mediciti Institute of Medical Sciences

***Corresponding Author:**
Email: asrivas2@gmail.com

Introduction

Interpretations have been widely considered to be an important tool in achieving a breakthrough in dynamic therapies. This dates back to Freud's work on neurosis, mainly based on the study of hysteria, according to which, the function of the neurotic symptom was to defend the patient's personality against an unconscious trend of thought that was unacceptable to it, while at the same time gratifying the trend up to a certain point. It seemed to follow, therefore, that if the analyst were to investigate and discover the unconscious trend and make the patient aware of it—if he were to make what was unconscious conscious—the whole raison d'être of the symptom would cease and it must automatically disappear.[1,2] This could be achieved by interpretations.

Freud and Strachey

With the evolution of analytic technique, several controversies have developed as well regarding the meaning and applications of interpretations. In a landmark paper, published in 1934, "THE NATURE OF THE THERAPEUTIC ACTION OF PSYCHO-ANALYSIS", James Strachey laid out the nature, types, efficacy and applications of interpretations.[3] This has been considered to be perhaps the most widely read of all psychoanalytic papers, barring the works of Sigmund Freud, and has had a deep impact on psychoanalytic technique and thought. Strachey points out the lack of clarity in various terms used to describe and classify interpretations. "…the vexed question of whether and when we should give a 'deep interpretation', while we have no clear idea of what we mean by a 'deep interpretation', while, indeed, we have no exactly formulated view of the concept of 'interpretation' itself, no precise knowledge of what 'interpretation' is and what effect it has upon our patients?" Apart from defining the various types of interpretations, Strachey firmly turned to interpretation of the transference as the primary tool to break down resistances. Pointing out that transference itself is a resistance, he focused on the need to interpret the transference as crucial to therapeutic success. "…the transference itself could be analysed. Its analysis, indeed, was soon found to be the most important part of the whole treatment. It was possible to make conscious its roots in the repressed unconscious just as it was possible to make conscious any other repressed material—that is, by inducing the ego to abandon its resistances—and there was nothing self-contradictory in the fact that the force used for resolving the transference was the transference itself. And once it had been made conscious, its unmanageable, infantile, permanent characteristics disappeared; what was left was like any other 'real' human relationship."[3]

Freud gave importance to the alterations produced by interpretations of the transference.

The change is made possible by alterations in the ego occurring as a consequence of the analyst's suggestions. At the expense of the unconscious the ego becomes wider by the work of interpretation which brings the unconscious material into consciousness; through education it becomes reconciled to the libido and is made willing to grant it a certain degree of satisfaction; and its horror of the claims of its libido is lessened by the new capacity it acquires to expend a certain amount of the libido in sublimation. The more nearly the course of the treatment corresponds with this ideal description the greater will be the success of the psychoanalytic therapy'.[4]

S. Radó went along similar lines: the hypnotic subject introjects the hypnotist in the form of what Radó calls a 'parasitic superego', which draws off the energy and takes over the functions of the subject's original superego.[5]

Melanie Klein

Melanie Klein emphasized the importance of breaking the neurotic vicious circle of introjection-projection-introjection of the archaic "bad" object. Thus, for instance, during the stage of a child's libidinal development in which it is dominated by feelings of oral aggression, its feelings towards its external object will be orally aggressive; it will then introject the object, and the introjected object will now act (in the manner of a superego) in an orally aggressive way towards the child's ego. The next event will be the projection of this orally aggressive introjected object back on to the external object, which will now in its turn appear to be orally aggressive. The fact of the external object being thus felt as dangerous and destructive once more causes the id-impulses to adopt an even more aggressive and destructive attitude towards the object in self-defence. A vicious circle is thus established.[6] During therapy, the therapist's non-aggressive behaviour lends to the introjection of a less aggressive object, thus diminishing the viciousness of its own projection, and breaking the vicious circle.

Strachey's stages of mutative interpretation

The importance of the use of transference, and an interpretation of it, has been a cornerstone of efficacy of analytic therapy. The ability of an interpretation to bring about change, which characterizes a mutative interpretation, is thus considered to be heavily dependent on its transferential connection. Strachey delineated two stages of a mutative interpretation:" The first phase of a mutative interpretation—that in which a portion of the patient's id-relation to the analyst is made conscious in virtue of the latter's position as auxiliary superego—is in itself complex. In the classical model of an interpretation, the patient will first be made aware of a state of tension in his ego, will next be made aware that there is a repressive factor at work (that his superego is threatening him with punishment), and will only then be made aware of the id-impulse which has stirred up the protests of his superego and so given rise to the anxiety in his ego. This is the classical scheme. In actual practice, the analyst finds himself working from all three sides at once, or in irregular succession. At one moment a small portion of the patient's superego may be revealed to him in all its savagery, at another the shrinking defencelessness of his ego, at yet another his attention may be directed to the attempts which he is making at restitution—at compensating for his hostility; on some occasions a fraction of id-energy may even be directly encouraged to break its way through the last remains of an already weakened resistance. There is, however, one characteristic which all of these various operations have in common; they are essentially upon a small scale.[3]

In the second phase of a complete interpretation, therefore, a crucial part is played by the patient's sense of reality: for the successful outcome of that phase depends upon his ability, at the critical moment of the emergence into consciousness of the released quantity of id-energy, to distinguish between his phantasy object and the real analyst.

A mutative interpretation can only be applied to an id-impulse which is actually in a state of cathexis.

At any given moment some particular id-impulse will be in activity; this is the impulse that is susceptible of mutative interpretation at that time, and no other one."[3]

Strachey's deeply influential paper equates mutative interpretations with transferential ones, and also gives several reasons why extra-transferential interpretations can never be as effective as interpretations of the transference: "In the first place, extra-transference interpretations are far less likely to be given at the point of urgency. This must necessarily be so, since in the case of an extra-transference interpretation the object of the id-impulse which is brought into consciousness is not the analyst and is not immediately present, whereas, apart from the earliest stages of an analysis and other exceptional circumstances, the point of urgency is nearly always to be found in the transference. It follows that extra-transference interpretations tend to be concerned with impulses which are distant both in time and space and are thus likely to be devoid of immediate energy.

But in the second place, once more owing to the fact that the object of the id-impulse is not actually present, it is less easy for the patient, in the case of an extra-transference interpretation, to become directly aware of the distinction between the real object and the phantasy object. Thus it would appear that, with extra-transference interpretations, on the one hand what I have described as the first phase of a mutative interpretation is less likely to occur, and on the other hand, if the first phase does occur, the second phase is less likely to follow. In other words, an extra-transference interpretation is liable to be both less effective and more risky than a transference one. Each of these points deserves a few words of separate examination.

But the most serious risks that arise from the making of extra-transference interpretations are due to the inherent difficulty in completing their second phase or in knowing whether their second phase has been completed or not. They are from their nature unpredictable in their effects. There seems, indeed, to be a special risk of the patient not carrying through the second phase of the interpretation but of projecting the id-impulse that has been made conscious on to the analyst. This risk, no doubt, applies to some extent also to transference interpretations. But the situation is less likely to arise when the object of the id-impulse is actually present and is moreover the same person as the maker of the interpretation."[3]

This current paper seeks to re-evaluate the efficacy of extra-transferential interpretations in contemporary psychoanalytically oriented psychotherapy. Some preliminary observations must be made, however. This re-evaluation does not seek to diminish the importance or transferential interpretations; if applied accurately, they can bring about significant change. Rather, it is to raise a question as to whether extra-transferential interpretations can be mutative or not.

Development of transference

Psychoanalytic technique creates an infantile setting, of which the 'neutrality' of the analyst is but one feature among others. To this infantile setting the analysand—if he is analyzable—has to adapt, albeit by regression.

The factors which constitute this infantile setting are manifold.[7] They have been described singly by various authors at various times.[8,9,10] It is not pretended that this thesis has anything new to add to them except in so far as the aggregate has never been described as amounting to a decisive outside influence on the patient. These factors are given here in outline, this description attempting only to establish the features of the standard psychoanalytic technique

1. Curtailment of object world. External stimuli are reduced to a minimum (Freud at first asked his patients even to keep their eyes shut). Relaxation on

the couch has also to be valued as a reduction of inner stimuli, and as an elimination of any gratification from looking or being looked at. The position on the couch approximates the infantile posture.

2. The constancy of environment, which stimulates fantasy.
3. The fixed routine of the analytic 'ceremonial'; the 'discipline' to which the analysand has to conform and which is reminiscent of a strict infantile routine.
4. The single factor of not receiving a reply from the analyst is likely to be felt by the analysand as a repetition of infantile situations. The analysand—uninitiated in the technique—will not only expect answers to his questions but he will expect conversation, help, encouragement, and criticism.
5. The timelessness of the unconscious.
6. Interpretations on an infantile level stimulate infantile behaviour.
7. Ego function is reduced to a state intermediate between sleeping and waking.
8. Diminished personal responsibility in analytic sessions.
9. The analysand will approach the analyst in the first place much in the same way as the patient with an organic disease consults his physician; this relationship in itself contains a strong element of magic, a strong infantile element.
10. Free association, liberating unconscious fantasy from conscious control.
11. Authority of the analyst (parent): this projection is a loss, or severe restriction of object relations to the analyst, and the analysand is thus forced to fall back on fantasy.
12. In this setting, and having the full sympathetic attention of another being, the analysand will be led to expect, which according to the reality principle he is entitled to do, that he is dependent on and loved by the analyst. Disillusionment is quickly followed by regression.
13. The analysand at first gains an illusion of complete freedom; that he will be unable to select or guide his thoughts at will is one facet of infantile frustration.
14. Frustration of every gratification repeatedly mobilizes libido[11]

Though transference phenomenon can be seen in virtually all therapeutic interactions, the development of a transference neurosis is far more complicated and difficult to establish. Sharing a place with the transference neurosis are at least two other kinds of relationships: one based on ordinary transference feelings and the other on reality considerations—those of a patient to his doctor. These three share the time, as it were. All are important, all overlap, but each is specific. Each comes and goes, appearing and disappearing in response to a seemingly endless number of influences. The easiest relationship to maintain and to work with, and the one most generally used in analysis, is characterized by the patient's almost constant attribution of transference feelings to the person of the analyst. The most difficult relationship to establish and to work with, the one most easily lost hold of, the one that is essential if definitive analytic work is to be done, is the transference neurosis.[12,13,14]

The technical difficulties in establishing a transference neurosis severely limit the applicability of psychoanalytic therapy. The frequent sessions which help in deepening the transference were much more likely a century ago than in the rush of modern life. Practical experience in India shows the difficulty even motivated clients have in showing up for therapy 3-5 times a week during working hours. Once a week or twice a week sessions have far more takers. This not only increases the difficulties of establishing transference but also substantially slows down pace and threatens to make therapy interminable. The pressure of getting better faster, the prohibitive (for most people) cost of classic psychoanalysis, and the logistic reality mentioned above basically limits 3-5 times-a-week psychoanalysis to a miniscule portion of population.

The question being raised here is that is it truly necessary to limit the benefits of psychoanalytic therapy to a limited few? In fact, cannot the use of extra-transference interpretation, by not being entirely dependent on the development of a transference neurosis, expand the use of psychoanalytic therapy to a much wider population of patients?

The importance of extra-transference interpretations has been recognised for since a long time: "Transference analysis is essential, but extra-transference interpretation, including genetic interpretation and reconstruction, is also necessary, complementary, and synergistic. Transference is a repetition that requires analysis of its genetic sources in childhood conflict and fixation. Transference and reality, past and present, are newly defined, understood, and integrated in the analytic process."[15]

It is not just the practical and logistic difficulties which are such an obstacle to the wider adoption of psychoanalytic therapy as a modern day therapeutic option. The complicated and difficult-to-understand theoretical underpinnings and the apparently speculative generalizations of concepts and interpretations have further alienated budding therapists. The simple and implementable concepts of psychoanalysis have been buried under a mountain of jargon and seemingly impossible practical demands of therapy.

It seems that there may be merit in considering variations of psychoanalytic models which can serve a far greater number of people seeking help. If there is an accommodation of once or twice a week sessions, a lot many people will find therapy possible. The technique retains the basic principles of therapy: the importance of free association, the unconditional acceptance of material, the non-judgemental and non-directive nature of interactions, the attention to detail, the freely-floating

attention of the therapist. The patient is given freedom to narrate his or her story at his or her own pace. The initial intervention, as always, are about facilitation the narrative, building trust, strengthening the alliance, offering what support may be needed, and seeking clarification. The emphasis is on getting data and attaining deeper understanding of the patient's background and circumstances. Getting as detailed a picture as is possible is the key. The time this process consumes will vary from patient to patient, but will be always a matter of several sessions rather than of a few. The patient is encouraged to lose himself or herself in the narrative. The usual factors play a role in this. The constant, familiar surroundings of the therapy room, the safety built around the sessions, minimal interventions from the therapist, silence that allows deeper introspection and fading of the intrusiveness of the immediate situation all help in going back to the period of the narrative. The therapist encourages the patient to feel, to relive the situation, and is on the guard against a mere intellectual emotionless recall of the past. It is the associated emotions that are thrown up which will prove to be crucial in establishing recurrent patterns of behaviour.

In this setting, which may take several weeks or even months to develop and maintain, links between the patients past and present situations begin to show themselves. It is these links that the therapist attempts to bring to the patients attention by means of interpretations. This recall is not happening in the arena of the transference, but the therapist can see the situation unfolding before him or her. The patient immerses himself into the experience so that it is not an emotionless remembrance but a virtual reliving of the experience. As with any interpretation, the timing of extra-transference interpretations is crucial. It is of great importance that the link between the past and present be shown when the emotional recall of the event is active. This happens often during course of therapy; it is the immediacy of the emotional recall which gives the extra-transferential interpretation its power. This, along with the ability of the therapist to show the continuation of the pattern into current situations, is what brings about mutative changes.

Thus the focus of therapeutic action is on making the patient aware of the patterns that seem to be repeating in his or her life, repetitions that are no longer expedient.

In 1914 for the first time Freud mentioned, specifically, a compulsion to repeat as an independent force to reckon with in psycho-analytic technique.[16] Freud here identified the 'compulsion to repeat' with the tendency repeatedly to act out unresolved neurotic problems (childhood and infantile attitudes), instead of remembering them: indeed the compulsion to repeat becomes for the duration of the treatment itself 'a way of remembering'. He emphasized further that it is accentuated by all the forces of resistance, which in turn are attacked through the transference which is itself a manifestation of the repetition compulsion; and that a transference which becomes unduly intense or hostile forces repression, whereupon remembering is blocked and supplanted by further acting out of repetitive patterns. Freud characterized the manifestation of the 'repetition compulsion' as a tendency dramatically to relive earlier emotional experiences which left a deep and perhaps traumatic impression—reliving them either in life situations, in play, in symptoms, or in dreams. He pointed to the dreams of sufferers from traumatic neuroses and war neuroses, and to the simple repetitive play of children as examples of this phenomenon; and emphasized the fact that the traumatic experiences could have contained no pleasure value and no gratification to the individual, and that, therefore, their recurrent manifestations in the patient's later life cannot be explained by the dynamics of the pleasure principle (that is, that they do not recur in the course of an effort to reduce psychic tension) and can best be explained on the basis of the hypothesis of a 'repetition compulsion. [17]

Case Vignette 1

A 35 year old married HR executive working in a multi-national company came into therapy for his chronic depression. During course of therapy, it came to light that he was stuck at the post of Assistant Vice-President for the past 6 year, a post that was usual a stepping-stone to Vice-President within a year or two. He also was in many conflicts with his immediate bosses, which he felt was one of the reasons for not moving up the ladder. In course of therapy, he described a very ambivalent relationship with his dad. He was sporadically caring and affectionate, but mostly pre-occupied with his own life and the very difficult financial situation that they were in (The father worked as a driver of a van for a local soft-drink company). He forced the patient, a very bright young man, to give up on his studies and forced him to work as a clerk in a bank in Saudi Arabia from the age of 19. The patient hated the job, and his father for making him do it. But at the same time, he also used to recall several acts of care and affection that his father had done, including undergoing a vasectomy in order to buy a good dinner for the family from the incentive that was on offer for the surgery. These ambivalent feelings remained unresolved and suppressed as his father dies of a myocardial infarction while the patient was still in Saudi Arabia.

During course of therapy, while it was being explored as to why he was stuck at the AVP post for such a long time, associations led to several conversations that he recalled having with his father. When the therapist attempted to link several emotions and reactions from that period to the current situation in the office and with his boss, the patient suddenly recalled a memory he "thought he had forgotten". He remembered his father saying (rather ominously, as the patient recalled, almost as a warning) that one should not attempt to rise above what one deserved, otherwise a catastrophic fall was sure

to follow. On further exploration his old associations came back. He always felt that despite not having enough qualifications, he had risen to a high position in the company. He had talked in the past of "feeling like an imposter" and his fear of being "found out and being fired". Before this he had dismissed these as not realistic, and never paid much attention to them. But after recalling his father's grim warning, all these fell together. He agreed to the interpretation that his fear of this prophesy coming true, and his guilt of going past the limits set by his father (guilt also linked to his ambivalence towards his father) had prevented him from going up the ladder.

Six months later, he was promoted to Vice-President, and took on an overseas appointment which he had so far resisted in his career, and was able to stay in Europe for 2 years without being driven back by panic and home-sickness like in the past.

This is but one example of the several extra-transferential interpretations that were given during course of therapy. The coming months showed that a mutative change had happened, and that the changes were sustained. The therapy was also marked by a remarkably consistent positive transference with little of the anger or hatred towards the father being transferred to the therapist. One factor which may have contributed to this was the ability of the patient to feel and tolerate these feelings as they emerged during therapy, thus reducing the acting-out.

Conclusion

This paper explores the possibility of extra-transferential interpretations being capable of bringing about mutative change in psychoanalytic psychotherapy. While the importance of interpretations of transference remains, it need not exclude other means of bringing insight and modifying defences. Thus a broadening of the scope of therapy may be made possible as it allows for interpretative change to be effected without the often restrictive use only of transferential interpretations, and the necessity of a transference neurosis in every instance. Both transferential and extra-transferential interpretations may be synergistic and will allow many more people to be helped by dynamic therapy and its applications.

Acknowledgements – Nil
Conflict of Interest – Nil
Source of Funding – Nil

References

1. Freud S. Papers on technique. Collected Papers, 1912–15:2 S.E. 12–13.
2. Eissler KR. The effect of the structure of the ego on psychoanalytic technique. J Am Psychoanal Assoc. 1953 Jan;1(1):104-43.
3. Strachey J. The nature of the therapeutic action of psycho-analysis. 1934. J Psychother Pract Res. 1999 Winter;8(1):66-82; discussion 64-5.
4. Freud S. Introductory Lectures on Psycho-Analysis 1916–17; London: Allen & Unwin.S.E. 15–16.
5. Radó S. The economic principle in psychoanalytic technique 1925. Int J Psycho-Anal;6:35–44.
6. Klien M. The Psycho-Analysis of Children 1932 London: Hogarth Press.
7. Loewald HW. On the therapeutic action of psycho-analysis. Int J Psychoanal. 1960 Jan-Feb;41:16-33.
8. Winnicott DW. The capacity to be alone. Int J Psychoanal. 1958 Sep-Oct;39(5):416-20.
9. Winnicott DW. The maturational processes and the facilitating environment; studies in the theory of emotional development. New York: International Universities Press; 1965.
10. Winnicott,D.W. 1971 Playing and Reality New York: Int. Univ. Press.
11. Maclpine I. The development of the transference. Psychoanal Q 1950; 19:501.
12. Bird B. Notes on transference: universal phenomenon and hardest part of analysis. J Am Psychoanal Assoc. 1972 Apr;20:267-301.
13. Freud S. An outline of psychoanalysis 1940. Complete Works Standard Edition; 23.
14. Loewenstein RM. Some thoughts on interpretation in the theory and practice of psychoanalysis. The Psychoanalytic Study of the Child. 1957;12:127-50.
15. Blum HP. The position and value of extratransference interpretation. J Am Psychoanal Assoc. 1983;31(3):587-617.
16. Freud S. Further Recommendations in the Technique of Psycho-Analysis', Collected Papers, Vol. II.
17. Freud S. "Beyond the pleasure principle" Collected Papers.