The Role of Interpretation

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MY THESIS HERE IS THAT INTERPRETATION is useful to the extent that it contributes to the patient's working to disprove the unconscious beliefs that underlie his psychopathology. These beliefs are grim and maladaptive. They warn the patient that if he pursues certain normal, desirable goals he will put himself in danger. Therefore they hinder him in the pursuit of these goals. For example, the male's unconscious belief in castration as a punishment may impede him in the pursuit of a good sexual relationship. Interpretation helps the patient to gain insight into the maladaptive beliefs and the forbidden goals, thereby facilitating his working to disprove the beliefs and pursue the goals.

The ideas summarized above are part of a psychoanalytic theory of the mind, psychopathology, and therapy that I developed and that the Mt. Zion Psychotherapy Research Group, which I codirect with Harold Sampson, has been investigating for the last 20 years (Weiss et al., 1986). The Mt. Zion Group carries out its studies by formal quantitative methods, using the transcripts of psychoanalyses and psychoanalytic psychotherapies. It has completed several investigations on how interpretation influences the patient, which will be discussed below (Castan, in Weiss et al 1986; Bush and Gassner, in Weiss et al 1986; Fretter, 1984; Broitman, 1985; Norville, 1990). The findings support our theory and throw light on the role of interpretation.

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The Basic Theory

The theory expands and elaborates certain formulations that Freud presented as part of his ego psychology (1926a, 1940). It assumes that the patient is able to exert some control over his unconscious mind, including his repressions (1940, p. 199). He regulates these in accordance with unconscious thoughts, beliefs, and assessments of his current reality, which includes his analyst's attitude toward him. By this regulation he attempts to avoid putting himself in situations of danger. He maintains his repressions for as long as he unconsciously assumes that he would be endangered by awareness of the mental contents that they are warding off. He lifts them when he unconsciously decides that he may safely experience these contents (Rangell, 1971). He regulates his unconscious inhibitions in the same way. He maintains them as long as he unconsciously assumes that it would be dangerous for him to pursue the goals inhibited by them, and he removes them when in his unconscious judgment he may safely pursue these goals.

The maladaptive beliefs underlying psychopathology may be called pathogenic. These beliefs warn the patient that if he attempts to pursue normal desirable goals he will risk either an external danger, such as a disruption in his relations with someone important to him, or an internal danger, such as the experience of a painful affect, e.g., fear, anxiety, guilt, shame, or remorse.

A person develops pathogenic beliefs in early childhood by inferring them from traumatic experiences with parents and siblings. These are experiences in which he attempts to attain a normal, desirable goal but finds that by doing so he risks a disruption in his ties to his parents. He may infer, for example, and so come to believe that if he is dependent on his parents he burdens them, or, if independent of them he worries them, or, if challenging to them, he risks punishment, or, if proud, he risks being humiliated.

A person's pathogenic beliefs derive their authority from the fact that they are developed during the only time in life—

childhood—when he endows others—his parents—with absolute authority. He does this because he must maintain a good relationship with his parents in order to survive and flourish; they are so important to him that he is highly motivated to perceive them as trustworthy, powerful, and wise; and he has no prior knowledge of human relations by which to judge them.

Because his parents are supreme authorities, the young child, when in conflict with them, perceives them as right and himself as wrong. Beres (1958), studying a number of children placed in foster homes, found in each case that the child assumed he had been sent away as a punishment and that the punishment was deserved.

A person's beliefs may be pathogenic if they depict a constricting and frightening reality or if they give rise to an overly critical and constricting conscience. A young child may develop both of these from the same traumatic experiences. This is because he assumes that the ways his parents treat him (and thus the ways he expects to be treated) are the ways he deserves to be treated. For example, if a child experiences his parents as rejecting, he may assume that he will be rejected by others and that he deserves rejection. Also, the child does not distinguish between parental judgments of reality and morality. For the child, the judgment that he is bad is no different in kind from the judgment that he is stupid.

The Therapeutic Process

The patient suffers from his pathogenic beliefs and is highly motivated unconsciously to disprove them. They constrict him; they prevent him from pursuing highly desirable goals; they give rise to painful affects; and they limit his control over his mental life. In psychoanalysis or in psychoanalytic psychotherapy, the patient seeks the analyst's help in his efforts to disconfirm his pathogenic beliefs. He works with the analyst throughout treat-

ment at the task of disconfirming the beliefs and pursuing the goals that they warn him against. The therapeutic process is in essence the process by which the patient does this.

The patient works in two ways: He tests his pathogenic beliefs with the analyst by carrying out trial actions in the hope that the analyst will not behave as the beliefs predict. For example, if the patient believes that he will be rejected by the analyst, he may test this belief by threatening to cut down on the frequency of his visits. He hopes that the analyst will help him not to cut down.

The patient also works by making use of the analyst's interpretations. He may learn from these that he suffers from certain beliefs, that he derived these from traumatic experiences with his parents, that the beliefs are now false and maladaptive, that they have impeded him in his efforts to pursue certain desirable goals, and that he may safely pursue these goals.

As the patient becomes less bound by his pathogenic beliefs, he begins to lift the repressions and remove the inhibitions that he had maintained in obedience to them. He becomes more aware of the beliefs and of the goals they warn him against, and he begins to pursue these goals more directly.

The patient works in therapy in accordance with simple unconscious plans that tell him which problems to tackle during a particular phase of therapy and which ones to defer until later. In developing his plans the patient is especially concerned with avoiding danger. He generally does not tackle a problem until in his unconscious judgment he may safely do so, as illustrated by the opening phase in the treatment of Miss J.

Miss J came to the analysis burdened by the unconscious pathogenic belief that unless she was completely compliant to the analyst she would hurt him. She was unconsciously endangered by this belief because she feared that she would be forced to accept damaging interpretations or follow bad advice. She therefore unconsciously decided that before tackling any other problems she would have to test this belief and, she hoped disprove it. During the first nine months of the analysis she tested this belief and

succeeded in disproving it. She tested it by questioning the analyst or disagreeing with him. At first she did this cautiously; after observing that she did not upset the analyst by her challenges, however, she was more direct.

Miss J was helped, too, by the analyst's interpretations. He told her that she was excessively cautious in disagreeing with him for fear that she would hurt him. After the analyst either passed the patient's tests or offered her helpful interpretations, she moved forward. (Interpretations are especially helpful when, in addition to conveying useful insights, they pass the patient's tests.) She demonstrated greater insight into her fear of hurting the analyst and more ability to challenge him.

It was only after Miss J had succeeded in assuring herself that she could safely disagree with the analyst that she stopped testing and permitted herself to take the analyst's ideas seriously. She began to tackle new problems, including those stemming from her belief that if she enjoyed a good relationship with the analyst she would hurt her women friends.

Throughout therapy the patient is vitally concerned with the analyst's reactions to his struggle to disconfirm his pathogenic beliefs. He unconsciously wonders whether the analyst is sympathetic or opposed to his struggle to disconfirm them, and, to determine this, carefully monitors the analyst's behavior. The patient's level of anxiety fluctuates in accordance with his unconscious judgments about the analyst's position. To the extent that the patient assumes that the analyst is sympathetic to his plans, he feels calm and secure. To the extent that he assumes the analyst opposes them, he becomes defensive and tense (Fretter, 1984; Broitman, 1985; Silberschatz et al., 1986).

The Analyst's Basic Task

The analyst's basic task follows logically from the theory just outlined. It is to offer the patient the help he seeks in his struggle to disconfirm his pathogenic beliefs and pursue the goals they warn

him against. Since his problems are rooted in these beliefs, his progress in therapy may be measured by the degree to which he succeeds in disconfirming them. Indeed, the analyst may judge a particular technique by the simple criterion: Does it help the patient, directly or indirectly, to disconfirm his pathogenic beliefs?

The analyst works by inferring the patient's unconscious plans and by helping him to carry them out. He tries to pass the patient's tests, and he offers him interpretations that the patient can use to carry out his plans for disconfirming his pathogenic beliefs (here referred to as pro-plan interpretations). The analyst tries to help the patient feel secure enough to face the dangers foretold by the beliefs; he should not fear that by doing this he will deprive the patient of the motivation to do analytic work. The patient does not need to feel prodded at work, either by the analyst or by his own unconscious frustrations or anxieties. He is unconsciously highly motivated to disconfirm his pathogenic beliefs, and the more secure he feels with the analyst, the more rapidly will he be able to carry out his plans for disconfirming them.

Interpretation

Interpretation is not always necessary for the patient to make progress at disproving his pathogenic beliefs. If the analyst passes his tests by noninterpretive means, the patient may be helped to disprove these beliefs. Moreover, as our research has demonstrated (Gassner et al., 1982), a patient may develop insights on his own, unassisted by interpretation. This is because if the analyst passes his tests by noninterpretive means, the patient may feel safe enough to bring certain previously repressed mental contents to consciousness.

Nonetheless, interpretation is an essential technique. The insight a patient acquires from the analyst's passing his tests by noninterpretive means is likely to be partial, incomplete, and less than explicit. Interpretation, by enabling the patient to retain his insights in explicit, verbal form, helps him to focus his attention

on them and increases his ability to use them. For example, a patient who is helped by interpretation to know explicitly what pathogenic beliefs he suffers from and what goals he would like to pursue becomes considerably more able to work at disconfirming the beliefs and pursuing the goals.

In general, interpretation is effective only if it is pro-plan; that is, if the patient can use it in his struggle to carry out his plans. Indeed, if an interpretation is anti-plan, that is, if it tends to confirm the patient's pathogenic beliefs, the patient may be set back by it. The effect of a pro-plan interpretation was illustrated by the analyst's telling Miss J that she avoids challenging him for fear of hurting him. Miss J benefited from this interpretation—she became bolder and more insightful—because it implied that her pathogenic belief was false. She was helped, too, by the analyst's making the interpretation, for she inferred from it that the analyst was sympathetic to her wish to be able to disagree with him. She could safely assume that the analyst would not encourage her to challenge him unless he was prepared to tolerate her doing so.

On the other hand, Miss J might have been upset (experienced as anti-plan) the interpretation, "You are afraid to trust me" or "You are afraid to depend on me." She might have experienced such interpretations as confirming the pathogenic belief that the analyst wished her to comply with him and would be upset if she did not.

The idea that an interpretation is especially beneficial if it makes the patient feel more secure with the analyst may be illustrated by the following episode which occurred in the analyst's first contact with a woman patient.

On entering the room, the patient, in her early thirties, looked around and chose to sit in a chair about 15 feet from the analyst's chair. She spoke so softly that the analyst had trouble hearing her and asked her to move closer. The patient moved her chair so close that it was touching the analyst's chair. The analyst then said, "Not that close," and the patient moved her chair back to a normal distance. The patient looked frightened and talked of vague fears of starting therapy again. The analyst (who from what had just occurred and certain other cues had inferred the nature of the

patient's fear) said, "Perhaps you're afraid I'll want to have sex with you." The patient became visibly relieved and said that her father had been sexually interested in her and that she had had an affair with her previous analyst.

The analyst's interpretation (which passed the patient's test) relieved the patient because it implied a promise that he would not respond to her sexually. This made it safe for her to reveal an inability to protect herself from sexual advances. Apparently the patient had been so frightened of repeating the earlier trauma that she found it necessary to test her new analyst at her first meeting with him.

A patient is unlikely to benefit from an interpretation that he unconsciously assumes, whether accurately or not, is intended to humiliate, cheat, or blame him as he had perceived a parent had humiliated, cheated, or blamed him. Such an interpretation tends to confirm the patient's pathogenic beliefs and makes him less secure with the analyst.

Mrs. A's first analysis came to grief as a consequence of her female analyst's persistence in an anti-plan interpretation. In childhood Mrs. A had felt cheated by her imperious mother, who occasionally did not keep her promises or became angry at her for no apparent reason. Mrs. A's conflict with her analyst was pretty much confined to a particular situation. The analyst was habitually one or two minutes late for their appointment, and Mrs. A complained provocatively that the analyst was cheating her by cutting corners, being less than meticulous, and so forth. The analyst reacted by telling Mrs. A that she was suffering from a mother transference and so felt cheated when in fact the analyst was reasonably careful to come on time. Mrs. A refused to be mollified by this explanation. She countered in various ways, by insisting, for example, that the analyst was rationalizing her behavior, that regardless of her good intentions she was late, that she should be more considerate, and so forth. The argument about time persisted for over a year. Sometimes the analyst said, "Look, I'm not your mother" or "You're transferring hostility from your mother to me." Finally Mrs. A decided that her relationship with

the analyst (who had been quite helpful in certain ways) was untenable, and she terminated treatment.

In her second analysis, which was also with a woman, Mrs. A behaved as before. She complained angrily when the analyst was a minute late. However, the second analyst reacted by agreeing with the patient. She acknowledged that she had been late, and then focused on Mrs. A's feeling guilty for complaining about it. (The patient had not been conscious of this guilt.) The analyst also told Mrs. A that even though she was just a little late, Mrs. A's complaints were justified, because her lateness had a powerful symbolic meaning. In addition, the analyst offered to make up the time. After this sequence was repeated a number of times, Mrs. A stopped being preoccupied with the time.

Mrs. A's behavior with the two analysts was part of her working to overcome the belief that she deserved to be cheated. This painful belief left Mrs. A feeling like a second-class citizen. Mrs. A's mother had implied as much, for she refused to acknowledge her responsibility for her unreliability or her anger, but instead blamed Mrs. A, whom she accused of provoking her. Mrs. A had suffered unconsciously from her pathogenic belief and so set out to test it (and if possible to disconfirm it) by her provocative complaining. Mrs. A's first analyst did not pass her tests. Mrs. A experienced the interpretations offered by her second analyst as passing her tests. She then began to realize that she had complied with her mother's cheating her and so had acquired the pathogenic belief that she deserved to be cheated.

As a consequence of the second analyst's interpretations, Mrs. A felt increased self-esteem. Also as she became convinced that the analyst, unlike her mother, would not accuse her of being provocative, Mrs. A could safely acknowledge that sometimes she had provoked her mother.

Present Approach Compared With that of Traditional Theory

In order to indicate what is distinctive in the approach recommended here, I shall compare it briefly with that of the traditional

theory presented by Freud in his papers on technique (1911–1915). I shall show that just as my approach follows logically from the theory of psychopathology and mental functioning on which it is based, the traditional approach follows logically from the concepts of the mind and psychopathology on which it is based.

The theory of technique Freud presented is the ancestor of all modern psychoanalytic theories and remains a powerful influence on psychoanalytic thinking. Indeed, subsequent psychoanalytic theory of technique has been cast more or less in its mold, enriched and modified by ego psychology. However, the technical ideas derived from ego psychology (e.g., that the analyst should help the patient to develop a therapeutic alliance or that he should analyze the patient's unconscious feelings of guilt) have simply been added to an existing theory without greatly changing its basic structure (Coltrera & Ross, 1967; Lipton, 1967).

The theory proposed here differs from most modern theories of technique in that it is built from the ground up on certain concepts that Freud developed as part of his ego psychology (e.g., the unconscious control of mental life by the criteria of danger and safety, pathogenic belief, the unconscious wish for mastery).

The method Freud recommended reflects his wish to base his technique both on a scientific theory of the mind and on a rational approach to the patient. In developing his theory of the mind Freud was influenced by the physics of his day, which assumed that all the phenomena of the physical world could be derived from a few simple elements governed by a few simple laws. Freud assumed that all or almost all mental functioning may be derived from a few simple mental elements, namely, impulses and defenses governed by a simple mental law, the pleasure principle (1926b, p. 265). Freud also assumed that impulses and defenses interact dynamically, much as do certain forces in the physical world.

In the traditional theory, psychopathology may arise from powerful unconscious impulses, either because these impulses seek highly maladaptive gratifications or because they seek conflicting gratifications. In either case, the patient is strongly motivated unconsciously to maintain the search for gratifications and thus to resist the analyst's efforts to help him. The analyst's task is to

make the unconscious conscious. In the case of maladaptive impulses, this may enable the patient to relinquish the gratifications and gain control of the impulses. In the case of conflicting impulses, this may help the patient become conscious of the conflict and thus to resolve it. The analyst, in discussing the conflict, is careful to remain neutral; he does not side with one impulse or the other. His goal is to offer the patient the self knowledge he needs to resolve the conflict in his own way.

In order to accomplish this task the analyst must rely on interpretation. The patient has little or no control over his repressions and so cannot become aware of repressed impulses unless they are interpreted.

Freud's recommendation that the analyst remain neutral reflects his ideal that the analyst respect the patient's autonomy. Freud was critical of certain psychotherapists of his day who tried to influence their patients by the use of authority, reassurance, suggestion, or mystifying ritual, or who imposed their own ideas upon them. He considered such techniques manipulative and assumed that, rather than freeing the patient from authority, they tended to keep him dependent. Such techniques may help the patient feel better temporarily but cannot help him render the unconscious conscious, and so cannot help him make fundamental changes in his mental life. Freud assumed that the analyst could best avoid the errors of which he was critical by relying as much as possible on interpretation, remaining more or less neutral, and avoiding the use of authority or reassurance. My approach differs from that of the traditional theory in the following ways: Whereas the traditional theory recommends that the analyst be neutral or impartial when confronting an unconscious conflict, my approach recommends that in general he take sides. Traditional theory typically conceptualizes unconscious conflict as between powerful conscious impulses that are unorganized by purpose or plan. Thus, in the traditional theory, no one impulse is necessarily more pertinent to the patient's progress than another, and the analyst has no reason to favor one impulse over the other. Moreover, the analyst has good reason not to do this: he is strongly opposed to imposing his views on the patient.

According to the theory proposed here, however, unconscious conflict is typically between certain of the patient's normal desirable goals and the expectation arising from his pathogenic beliefs that by pursuing these goals he will put himself in danger. Since the analyst's main task is to help the patient disconfirm his pathogenic beliefs and pursue the goals they warn him against, the analyst should, in general, take sides. He should help the patient realize that the dangers foretold by the beliefs are not real and that he may safely pursue the goals.

In contrast to the traditional theory, which assumes that the analyst should rely as much as possible on interpretation, the theory proposed here assumes that in some instances the analyst's passing the patient's tests by noninterpretive means contributes considerably to the patient's progress. By so doing the analyst may help the patient feel secure enough with him to face the dangers foretold by his pathogenic beliefs. Consider, for example, the analyst's task when confronted by a patient who suffers from the unconscious belief that he will be and should be rejected. Such a patient may test the analyst by being withdrawn or provocative or by threatening to leave treatment, while hoping unconsciously that the analyst will respond by trying to prevent him. The analyst may be able to pass the patient's tests by interpretation alone. He may help him by telling him, for example, that he is withdrawing or threatening to stop because he believes he does not deserve more help. However, the analyst may be more effective if, along with his interpretations, he demonstrates by his behavior that he will not reject the patient. Moreover, in some instances, a patient may believe himself so unworthy of treatment that he will stop unless urged by the analyst to continue. In this case the analyst should urge him to continue.

The analyst who subscribes to the traditional theory seeks to explain the patient's psychopathology in terms of the patient's unconscious impulses and defenses. He distrusts the patient's memories of the traumas he experienced with his parents, for he assumes that the patient, as a consequence of his projections, may be distorting them. Therefore, if he accepts the patient's description he risks leaving the patient's projections unanalyzed. Further-

more, he is concerned that if the patient is permitted to blame his parents for his problems—that is, to externalize them—he may escape responsibility both for the problems and for his efforts to solve them; that is, he may use externalization as a resistance.

In contrast to the traditional theory, I assume that the patient focuses on childhood traumatic interactions with parents not as a resistance but as part of his efforts to solve his problems. He is reluctant to focus on these traumatic interactions, for he would like to perceive his parents as strong and wise. Yet he must focus on them if he is to understand and ultimately disconfirm the pathogenic beliefs inferred from them. His realization that his problems stem from beliefs inferred from experiences with his parents does not relieve him of the responsibility of working to solve the problems. The knowledge that his problems stem from certain beliefs helps him to understand how to solve them—namely, by changing the beliefs.

Moreover, if the patient is discouraged by the analyst from his attempts to determine how in his experience, his parents contributed to the development of his psychopathology, he may be hindered in his attempts to solve his problems. Consider, for example, a patient who, as he experienced it, was traumatized by the extreme solicitude shown him by his nervous parents. By complying with their exaggerated worry, he developed the pathogenic belief that their worry was justified by his defects. If the analyst were to tell this patient that he provoked the parental worry, the analyst would be agreeing with the patient's pathogenic belief, thereby impeding the patient in his efforts to disconfirm the belief and to perceive himself as reasonably strong and self-reliant.

While the traditional theory minimizes the value of new experiences that the patient obtains with the analyst, the theory proposed here considers such experiences an essential part of the treatment.

As already mentioned, the traditional theory assumes that the patient has little or no control over his defenses, and thus may be helped effectively only if his defenses and resistances are successfully analyzed mainly by interpretation. The patient may be helped

to feel better temporarily if provided new experiences, but he cannot benefit fundamentally from them. Indeed, providing such experiences is manipulative and likely to impede the patient's progress, either by gratifying the patient's unconscious impulses and thus depriving him of motivation to work in treatment or by strengthening his defenses and thereby increasing his resistances.

However, according to the present theory, the patient may benefit in a fundamental way from certain new experiences: namely, those that the patient himself unconsciously seeks in his testing of the analyst as part of his effort to disconfirm his pathogenic beliefs. The idea that the analyst offers the patient the experiences that the patient himself unconsciously seeks distinguishes the present formulation from Alexander's formulation of the corrective emotional experience (Alexander & French, 1946, pp. 20–24). In Alexander's formulations the analyst is not guided in his behavior by the patient's unconscious testing, nor may the analyst check the pertinence of his behavior by observing the patient's immediate reactions to it.

Research

The theory of interpretation described above gives rise to predictions that may be tested by formal quantitative research methods. It predicts that the patient will react to an interpretation that he can use in his efforts to carry out his unconscious plan (a pro-plan interpretation) by becoming more insightful, less defensive, and so able to experience his feelings more vividly. He will react to an interpretation that hinders him in his efforts to carry out his unconscious plan (an anti-plan interpretation) by becoming less insightful, more defensive, and therefore less able to experience his feelings vividly.

Two studies of interpretation during an analysis, one by Caston (in Weiss et al., 1986), the other by Bush and Gassner (in Weiss et al., 1986), tested and found support for these hypotheses. Since their work is readily available to analysts, I focus here on similar

research carried out in brief psychotherapy by Broitman (1985) and Fretter (1984) under the supervision of Curtis and Silberschatz. (For a discussion of the theoretical significance of Fretter's study, see Silberschatz et al., 1986).[1]

The investigators, using a method first developed by Caston (in Weiss et al., 1986) and improved by Curtis and Silberschatz (Curtis & Silberschatz 1986; Curtis et al., 1988; Silberschatz & Curtis, 1986), studied three psychotherapies, each consisting of 16 weekly sessions, which, with the patient's permission, were audiorecorded and transcribed. The method was to study the interpretations received by each patient to determine the degree to which each interpretation was planful (that is, pro-plan) and correlate its planfulness with the changes it produced in the patient's levels of experiencing and insight.

The investigators, determined the planfulness of each interpretation as follows: They first asked clinician judges to study the transcripts of the intake and first two therapy sessions to determine the patient's pathogenic beliefs and the goals that these beliefs warned the patient not to pursue. The judges then, on the basis of their understanding of the patient's beliefs and goals, generated a list of insights which in their opinion the patient could use in his efforts to carry out his plan for disconfirming the beliefs and pursuing the goals.

The investigators gave the list of pathogenic beliefs, goals, and proposed helpful insights to a second set of judges who were also given a list of the interpretations offered each patient. The second set of judges, who were blind to the patient's responses to the interpretations, were asked to rate each interpretation for its planfulness on a scale ranging from strongly anti-plan to strongly pro-plan.

The investigators' next step was to determine the changes produced by each interpretation in the patient's levels of insight and experiencing. In order to do this, they isolated segments of the

[1]The research was supported by Mt. Zion Hospital and Medical Center and National Institute of Mental Health Grants MH-35230, MH-34052 and MH-13915.

patient's speech from just before an interpretation and from just after it. These segments were given to two sets of judges who were blind both to the interpretations and to whether a segment preceded an interpretation or followed it. One set of judges used a standard scale to rate each segment for the patient's level of insight; another set of judges used a standard scale to rate each segment for the patient's level of experiencing. The investigators then determined the effect of each interpretation by calculating the residualized gain scores.

The investigators now correlated the planfulness of each interpretation with the degree of change it produced in the patient's levels of experiencing and insight. The findings strongly support our hypotheses: In each case there was a highly significant correlation (statistically) between the degree to which an interpretation was planful and immediate improvements in the patient's levels of insight and experiencing.

In a study to determine whether pro-plan interpretations had a lasting (as opposed to immediate) effect, Fretter calculated the percentages of pro-plan and anti-plan interpretations received by each patient and correlated them with how well the patient was doing six months after the termination of therapy as determined by clinical interviews and by a battery of non-theory-based outcome measures (Silberschatz et al., 1986). The percentages of pro-plan and anti-plan interpretations that a patient received correlated with outcome. The patient who received the highest percentage of pro-plan interpretations did well. The patient who received the next highest did moderately well, and the patient who received the lowest did poorly.

In a study of seven brief therapies (which included the three studied by Broitman and Fretter) Norville (1990), using another method, tested the hypothesis that the planfulness of the interpretations received by a patient during brief therapy correlated with the patient's outcome as determined by clinical interviews and outcome measures. Norville determined the planfulness of the interpretations received by a patient by providing judges with a plan formulation for that patient and having them use it to rate the

planfulness of all of the interpretations in a sample of five sessions of the patient's therapy. She then correlated the overall planfulness of the interpretations received by a patient with the outcome of the treatment. The findings confirmed the predictions of our hypothesis. For six of the seven cases there was a high correlation between the overall planfulness of the interpretations received by the patient and the patient's outcome as measured six months after termination.

These studies of interpretation support my clinical impression that an interpretation is helpful primarily to the degree to which it is pro-plan. It is more important, in my opinion, for an interpretation to be pro-plan than to be tactful or complete or to refer to the transference or to be at the right level of psychic depth.

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