A re-consideration of interpretation. A relational approach

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ABSTRACT

This paper is a discussion paper and it seeks to re-consider the Freudian psychoanalytic concept of interpretation within the relational approach to psychoanalysis. As such, it aims to argue the Freudian approach to interpretation is rejected because it is not relational but involves only the analyst as interpreter of the patient's experience. Instead, within the relational approach, it is suggested that if interpretation, as a process of making meaning of experiences, is re-considered as the outcome of the intersubjective relationship in which the process of making-meaning is essentially a co-creational process of the patient's experience of the analyst in the here-and-now, interpretation can potentially be an agent of change. The clinical implication is that interpretation must be the construction of the patient's meaning of his experience but within the relational context. A clinical verbatim transcript is documented as it illustrates this relational process in interpretation.

Key words: Interpretation; relational; intersubjective; meaning; experience.

Therapist: *You are angry and disappointed in me right now for going away on holiday, but it is possible that your anger is about your father and how he was never there for you, and how you felt abandoned and disappointed in him.*

Patient: *Okay. If you say so.*

Therapist: *Your anger and disappointment directed towards me is really your anger about your father. You told me he was never there for you, and so when I was away on my holiday, my leaving you reminds you of that experience.*

Patient: *Okay. So, what I feel is actually not about you but about my father.*

Therapist: *Exactly. Maybe we need to explore your experience with your father. Tell me more about your father.*

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Freud's (1893, 1912, 1925) psychoanalytic theory describes the psycho-dynamic relationship between the past and the present, as embodied in his concept of transference. He first wrote of transference in *Studies on Hysteria* (Freud, 1893) and later, in the *Interpretation of Dreams*, in 1900, where he discussed how the unconscious wish is transformed in a masked way. Freud noted, '*It must not be supposed that transference is created by analysis and does not occur apart from it. Transference is merely uncovered and isolated by analysis. It is a universal phenomenon of the human mind, it decides the success of all medical influence, and dominates the whole of each person's relations to his human environment*' (1925, pp. 42).

In Freudian psychoanalytic theory, the focus is on the patient becoming aware of his unconscious mental processes in everyday life - making the unconscious conscious. This is achieved by way of recovery of the (memories of) past events and patterns of the relationship to the internal objects or people, particularly the oedipal couple, and how these patterns reoccur later in adulthood. There is the assumption that there may be some resistance to, and repression of, sexual wishes and impulses (Freud, 1925). This recovery process makes sense when one understands that Freud wished to make psychoanalysis an *archaeology of memory* (Eriksson, 2015). The assumption seems to hold some relevance considering Freud's article 'Freud's psycho-analytic procedure' (1904), where he described the chief objective of psychoanalytic treatment as to fill in the missing gaps of the memory by re-constructing events of the past (Eriksson, 2015). Comparing the work of a psychoanalyst to an archaeologist, Freud wished to dig into the patient's layers of experiences and to reach down below into the forgotten events of the past, embedded in the unconscious level. He tried to re-construct the past by working with the patient's memory. He did this using interpretation about what he thought was

happening or had happened to the patient. At one point in the development of technique and theory, however, Freud miss-interpreted (perhaps betrayed) the experiences of some of his patients when he changed his original reconstruction of memories of the past of parental seduction to fantasies, which later became the source for his notion of the Oedipal Complex (Eriksson, 2015). What does stand out here concerning Freud's view of interpretation was that he thought there were experiences that patient had *no knowledge of*, and the analyst's interpretation was a technique to uncover or dig up contents the unconscious, and to make known what was not yet known (a similar point made by Etchegoyen, 1991).

Accordingly, psychoanalysis assumes that the past impacts on the present moment, shapes and defines the sense of self, and thus is crucial in the development of the self. In fact, psychoanalysis is grounded on the re-construction of the past in service of understanding the present moment, or more specifically, the making the unconscious conscious. This re-construction of the past as technique is what differentiates and defines psychoanalysis from other therapies. Within Freudian psychoanalysis, it is crucial to re-emphasize that the interpretation of the past will always be important to understanding transference in the present (Blum, 1999). This analytic process of the past as influencing the present (transference) and its meaning (interpretation) is the basis for the well-known technique of 'interpretation of the transference' (Freud, 1912, 1937).

From within a Freudian understanding of interpretation, interpretation of unconscious conflict and fantasy was fundamental to the psychoanalytic enterprise (Blum, 2016). Interpretation, particularly of the analytic transference, supplemented by genetic interpretation of unconscious fantasy and trauma rooted in childhood, would lead to insight into unconscious conflict. Insight was regarded as the major agent of therapeutic action and progressive analytic change in symptoms, character pathology, and the overall personality (Blum, 2016). In other words, Freud regarded interpretation as a technique for lifting the repression, which was a key curative factor in psychoanalysis during which the patient is being brought to recall certain experiences and memories and affective impulses which he has for the time being forgotten (Eriksson, 2015). This type of interpretation is of the 'then and there', as opposed to the more recent shift towards the 'here-and-now'.

The clinical implication is that since Freud's time, interpretation of the past through the analysis of the transference has been viewed of as curative. Giving an interpretation to a patient has been assumed the 'golden standard' of psychoanalytic practice and the understanding of how change is presumed to occur (Kauff, 2016). Put in another way, to interpret and elucidate the meaning of the patient's life, in the context of the real or imagined past, was assumed the agent of change.

However, it has been argued that the Freudian conceptualization of interpretation is not curative but *explanatory* (Kauff, 2016). The example above of the dialogue between therapist and patient is a case in point. This interpretation of the transference is not wrong because it explains what is happening between patient and analyst as a repetition of the past. It can be argued that this 'repetition compulsion' was one of the central contributions and genius of Freud (1925). Flowing from his understanding of interpretation of the transference is his allegiance to the notion that the analyst knows best and more about what is going on in the therapy process than does the patient. It makes sense then that he would view the analyst as the interpreter of the patients' experience, and interpretation as principle technique for change. To this end, a critique of this approach is that the interpretation is the analyst's explanation of this patient's experience, and thus it is something that the analyst does in response to the patient's experience. The analyst is therefore the 'explainer' (Kauff, 2016). In this regard, interpretation is an expression of the analyst's subjectivity (Aron, 1992).

If Freudian psychoanalysis assumes cure by the reconstruction of the past and thus interpretation, the present therapeutic engagement between analyst and patient is essentially a return to the past - a process of the archaeology of memory. The clinical implication is that the present moment is a repetition of the past and not much new can happen.

While there has been a recent re-consideration of interpretation (Blum, 2016; Haynal & Haynal, 2016; Geist, 2020; Kauff, 2016; Lichtenberg, 2016), Geist (2020) remarked that interpretations are the carriers of selfobject functions, the internalization of which are needed to concurrently strengthen one's sense of self and to modify defensive structures. He asserted that when an interpretation or genetic reconstruction that carries selfobject functions is experienced as accurate, it can be almost immediately structured building for a patient as long as the patient and therapist share a sense of connectedness.

Kauff (2016) proposed a shift on an emphasis on explanation to an attention on exploration as a way of resolving some problems related to interpretation in analytic treatment. She argued that psychoanalysis could meaningfully proceed by connecting the internal psychological world to current functioning without depending upon connections to the past. This idea has brought in an understanding that interpretation does not always have to be on the re-construction of the past. In her understanding of interpretation, she wrote that the focus is on, but not limited to, the validity and use of reconstructive or genetic interpretations, for example those which purport to connect the past to present behavior, pathological and otherwise. She explored the respective roles of the analyst and patient in the interpretation process, but it was not within a relational approach to psychoanalysis and interpretation.

Blum (2016) is closer to the relational approach but does not view interpretation as an outcome of the rela-

tional analytical couple. He presented a clinical vignette to illustrate the continued importance of the past in the present without neglect of current determinants and perspectives. While integrating newer considerations of the two-person analytic field, Blum wrote that interpretation and insight into the dynamic unconscious are regarded as the *sine qua non* of psychoanalysis.

Lichtenberg, (2016) takes up the interplay and relative contribution to change of explicit communication via interpretation and implicit communication from other sources. For him, interpretation is considered from the standpoint of source, process, context, technique, and effect.

However, these recent works have not been located entirely within a relational perspective, nor has there been a clinical verbatim transcript provided to illustrate a relational approach to interpretation.

What this paper is about

This paper is a discussion paper, and it seeks to re-consider the Freudian psychoanalytic concept of interpretation within the relational approach to psychoanalysis. As such, it seeks to emphasize the relational in the change process. In this regard, the Freudian approach to interpretation is rejected as it stands because it involves only the analyst as involved in the process of making meaning, and thus as the expert in the patient's experience. Instead, it is suggested that if interpretation, as a process of making meaning of experiences, is re-considered as the outcome of the intersubjective relationship in which the process of making-meaning is essentially a co-creational process of the patient's experience of the analyst in the here-and-now, interpretation can go some way to contribute the change process. The clinical implication is that interpretation must be the patient's meaning of his experience within the relational, intersubjective context. A clinical verbatim transcript is presented as an example of this process.

A re-consideration of interpretation: A relational approach

The changing view of interpretation within psychoanalysis and psychoanalytic psychotherapy is linked to the post-modern shift towards the intersubjective position, and the emergence of the relational approach. The intersubjective position, as described by Stern *et al*. (1998), Stolorow (1988), and Atwood and Stolorow (1984), is defined as a new thinking in contemporary psychoanalysis that implies the analyst and the patient as separate subjects who take one another as objects. This has clinical implications for the contemporary analytical understanding of interpretation. Ogden (1994) suggests that interpretations should be made at the interface between analyst and patient at an *intrapsychic level* rather than intrapsychic dynamics (Eriksson, 2015). This point of view is shared by Stolorow (1988) and Goldberg (1985), who think about the intersubjective process as a dialogue between two universes, generated by an interaction of transference and countertransference in an environment or analytic space in which meaning and interpretations are mutually created (Eriksson, 2015). The intersubjective position is that unconscious material 'is lifted' through an intersubjective dialogue to which the psychoanalyst contributes with his empathic understanding (Eriksson, 2015). These authors, notes Eriksson, assume that 'intersubjective dialogue unfolds unconscious organizing activity through the analyst's empathic understanding … subjective experience is not discovered or created by the analyst but instead 'articulated' (Eriksson, 2015, pp. 97). This is a shift away from Freud's (1913) metaphor of the analyst as an archeologist, and thus the analyst as digging up and uncovering/recovering the patient's unconscious. To this end, Stern *et al*. (1998), Stolorow (1988), and Atwood and Stolorow (1984), stress the use of countertransference as a means of accessing the unconscious. The outcome of this approach means that understanding past patterns of relating in light of the present relationship, while not ignored, has now an added contribution to thinking about thinking about interpretation - it arises out of an 'immediate', in the here-and-now experience between analyst and patient - two subjects engaging in a new constellation (Eriksson, 2015). The additional implication of the intersubjective position is that the analytic couple is conceptualized as two interrelating subjectivities in the consulting room, both with independent intrapsychic material, both engaging with each other so that both co-influence what is happening in the room. Therefore, countertransference becomes important because it is a way to make sense of the patient's unconscious. Transference interpretations and immediate or 'here and now' interventions within the intersubjective position are core processes.

At the same time as the development of an intersubjective position, and influenced by this position, pioneers Lewis Aron and Steven Mitchell paved the way towards a new vision of psychoanalysis. Their work contributed to a paradigm shift within Freudian psychoanalysis that resulted in the relational approach to psychoanalysis, or what is now termed 'relational psychoanalysis' (Aron, 1996; Mitchell, 1988, 2000). Important to this paper, the relational approach re-defined the analytical couple. The couple was now assumed to function within a context of two minds - 'two-person psychology' (Aron, 1996) or 'two-body psychology' (Balint, 1952; Rickman, 1950) - meaning that both participants contribute to what emerges as the analytic material (Aron, 1996). Since then, traditional concepts within Freudian psychoanalysis have been transformed relationally, such as transference, countertransference, resistance, self-disclosure, and the analytical couple.

Within the relational approach, interpretation is viewed as co-created, and thus towards the notion that the so-called 'expertise' of the analyst as interpreter and explainer of the patient's experience is dis-lodged to allow

for the focus on the here-and-now experiences (Aron, 1996; Atlas & Aron, 2018; Benjamin, 2018; Mitchell, 1988, 2000). The clinical implication of the relational approach is that the relationship is the therapy. If this is the case, therapy is about the experiences of the patient, which can include experiences of the patient of the analyst. The relational approach, both theoretically and in practice, translates into the fundamental assumption that Freud's interpretation and insight is no longer viewed as the principle agent of change, nor in how the unconscious is made conscious. In other words, to some degree, this emphasis on the analysis of the intersubjective here-and-now diminishes the importance of traditional interpretation. In fact, this traditional understanding of interpretation has no place in relational psychoanalysis because it is assumed that explanation and insight do not bring about change. As Blum (2016, pp. 40) wrote, 'Analysts recognized that there could be insight without change and change without insight'.

Interpretation as a relational process of making meaning

From within the relational psychoanalytic perspective, this shift away from insight and interpretation as curative means psychoanalysis has a new goal and definition. This new goal and definition incorporates the emphasis on the exploration of the here-and-now of the analytical relationship - what goes on *between* patient and analyst and the patient's experience of the analyst (Aron, 1996). This relational exploration of the here-and-now is thought to be curative, as indicated earlier, and not re-constructions of the past. As indicated, contemporary relational psychoanalysis is the intersubjective exploration and analysis of the here-and-now of the patient's inner experience, which includes the experience of the analyst.

While the past will always be important and shadow the framing of this current experience, the focus of psychoanalysis is assumed to be on the here-and-now in service of the patient. This thinking of the intersubjective as agent of change has altered the traditional concept of transference. Transference and 'interpretation of transference' no longer have the same meaning to all analysts, and to some it refers to the immediate interpersonal exchange and interaction between analyst and patient, and thus transference in this approach is not seen as an ego-modified, edited revival and recapitulation of the past in the present (Blum, 2016). Instead, the role of the analyst has moved and developed from that of a neutral, detached observer and interpreter. Besides being a transference object, the analyst is now thought of to be a real object, a new object, and a fully participating person and observer in the process (Blum, 2016; Loewald, 1960). The analyst's personal influence on the analytic relationship and process has supplanted the now antiquated model of the analyst as neutral interpreter while remaining a blank screen (Blum, 2016; Renik, 1998).

Genetic interpretation and reconstruction of experience have tended to slip or fall by the wayside as both irrelevant to analytic processes and virtually impossible (Blum, 2016). Blum notes that although the past can never be exactly known and may be affectively remote, compared to what is directly experienced in the immediate psychoanalytic situation, the past, however, is essential in understanding the present.

If the Freudian understanding of interpretation is the analyst's construction of the patient's experience, and meaning is rooted in the re-visiting the patient's past, can interpretation be re-considered relationally in such a way as to make it valuable to the process of change? In other words, can interpretation be re-considered as a relational process of making meaning?

It is possible to do so if we de-emphasize the interpretation of unconscious conflict and fantasy and we move towards the process of making-meaning as essentially a co-creational process of the patient's experience of the analyst in the here-and-now. The clinical implication is that the analyst abdicates the position of interpreter or explainer of the patient's process. The follow-up clinical implication is that interpretation is the patient's meaning of his experience.

To elaborate further, patients need to be involved in making sense of their own experiences of the analyst in the context of the here-and-now analytical relationship. Sometimes this can mean a revisit to the past (genetic interpretation) or to another figure in the patient's current life. Transferences illustrate the internal world of the patient, will be inevitable in the patient's experience of the analyst, and will always shape the present moment. When this happens, it must be principally from what the patient understands about what is happening. What is important is not the verification of the truth of the experience but the acceptance of the 'narrative truth' (Sandler *et al*., 1992) of the patient's experience. Thus, what the transference can reasonably be said to reveal are the processes that exist and are active currently in the internal psychological terrain, regardless of their origin (Kauff, 2016). It is these processes, not their content, which Freud (1925) thought, could be altered. The purpose of transference analysis in treatment, therefore, should be both to illustrate to the patient the importance of his own input into experience, and by extension, to identify what can, therefore, be changed (Kauff, 2016).

The role of the analyst is as an 'empathic' (Kohut, 1984) partner in the deep exploration of the patient's experience, to gently and caringly create the 'therapeutic space' (Winnicott, 1971) that can potentially facilitate the patient's process of openly speaking his story without being judged or hindered. In what is now viewed as a 'participatory dual process', analyst and patient listen to each other (Blum, 2016). This listening may sound overly simple but it is now thought that the analyst understands,

however, to a far greater degree than is possible for a patient, particularly in the early phase of analysis or therapy, by listening between the lines and considering what is absent or denied or avoided in the patient's communications. The analyst's intense listening, looking, and attention in all aspects of the patient's verbal and nonverbal communications is a chief influence in the developing analytic process (Blum, 2016). Some patients have never had the experience of being listened to and of being understood (Blum, 2016). With an analyst who is not in charge of providing meaning, the analyst is now more open to the patient's observations of the analyst. This implies that the contemporary analyst is in general, more open to the patient's realistic observations, assessments, and critique of the analyst, and thus the analyst today is more open to different points of view not only from the patient, but within the analytic field, considering the multiplicity of analytic theories and practices (Blum, 2016).

The unconscious, while core to psychoanalysis and understanding experience and behaviour, is not ignored. It is assumed to emerge in this relational present, in the here-and-now intersubjective milieu. It is worked with in a way that supports the patient's understanding of his experience. As there are two people in the relationship, it is possible for the unconscious processes of both participants to mingle and merge into the development of the 'analytic third' (Benjamin, 2004; Ogden, 1997).

Countertransference in the relational process of interpretation cannot be avoided. Like other processes, the analyst's response to the patient is inevitably partly her own echo of her past. In relational psychoanalysis, countertransference is not viewed of as a contaminant of the process, as Freud thought. Instead, it can support and aid the analyst to experientially and viscerally know what is happening with the patient. In other words, the analyst's response to the patient is a meaningful clue as to what may be going on inside the patient and what maybe some of the patient's relational templates and expectations of self and other (Blum, 2016; Benjamin, 2018; Heimann, 1950; Jacobs, 1991; Racker, 1968). While countertransference is inevitable, the focus remains clearly on the patient's inner psychological world.

Below is the same example used earlier but with a new twist to reflect this new approach to interpretation as the patient's meaning, and the notion that the analysis of the past need not always be necessary, unless the patient raises it.

Take note of how the process unfolds and develops and how the patient experiences the analyst.

Patient[1]: *You went away on holiday and left me. I am angry and disappointed in you.*

Analyst: *I am sorry for being away on holiday and leaving you. I can understand that you are angry and disappointed in me for going away. It makes sense to me that you would feel this way towards me. I would like to know more about your experience of me when this happens. Can you maybe tell me a bit more about what happens inside of you when you experience me this way?*

Patient: *I want to punish you by leaving you. I want to make you feel hurt and let down. I want you to feel how it is to be left alone. It is hurtful and horrible. I feel you could have gone away on holiday at another time and not now when I feel so vulnerable. It feels like you do not really care about me.*

Analyst: *If I hear you correctly, I have really hurt you. I went away when you needed me the most. You want to punish me by leaving me so that I can know how hurt you were, and what it feels like for you. Do I have this right or do you feel I have missed something of your experience of me?*

Patient: *You have it right. It hurts. You have hurt me. It is your job to not hurt me. I think that being hurt by someone like you - a therapist - should never happen. It makes me think about my wife and how she hurt me recently when she had an affair. She should never have hurt me in that way. You are like her now, hurting me, letting me down … (Patient begins to cry).*

Analyst: *I can see you are upset. I am so sorry for how much pain you are feeling. It makes me aware that my going away is experienced by you as me being hurtful and not caring for you. I understand that I have hurt you deeply.*

Patient: *I think that at least you understand me, how I feel, my pain and hurt. It is the first time I feel someone has understood me.*

Analyst: *What does that feel like for you … to be understood?*

Patient: *It feels weird. I have never had this experience before. It feels weird but I am suspicious of you too. As if you are trying to get off the hook for causing me hurt.*

Analyst: *If I understand you correctly, it is the first time for you to feel understood, but also you are suspicious of me as if I am trying to dodge some responsibility for the hurt I have caused.*

Patient: *Yes, if I think about it I am suspicious of you. I like it that I feel understood by you but I am suspicious of your intentions. Kind of like with my wife. I was suspicious of her but she denied having an affair.*

Analyst: *I can understand how you may feel suspicious of me then because your thoughts about me are that maybe there is something going on here between us as well and that I am being deceitful. Do I have this right or is there something I have missed?*

Patient: *Yes, exactly. I think that maybe you also want to show you care and understand me but I think that maybe you are also maybe duping me.*

Analyst: *So I am fooling you. Can you tell me more*

[1] The verbatim transcript of this patient's exchange with me was used for this paper with permission of the patient, and once the patient had completed his treatment so that the research did not influence his process.

about this experience of me? What happens inside you when you feel that I am duping you?

Patient: *Okay so I have a sense that any kindness shown to me by anyone has a hidden meaning; like they want something from me or they are duping or tricking me. I do not know where this comes from but I feel it here with you. That you are also duping me.*

Analyst: *What if I am duping you? What then? What would happen between us?*

Patient: *I would feel angry… but also justified because my belief would be correct - that people want something when they are kind. What do you want from me?*

Analyst: *What if I were to say that my experience of you is that whatever kindness I show you, you will always be suspicious. No matter how much I deny fooling or duping you, you will be suspicious of me. What is your experience of me when you hear me describe my experience of you in this way?*

Patient: *I think I am beginning to feel that there is something about me and my suspicious nature that may cause me to push you away. If I am suspicious of you and I can protect myself from feeling vulnerable and maybe getting hurt.*

Analyst: *Okay, hearing you say this … I think we are getting onto something very important here about your feelings and what is happening to you.*

This clinical transcript of a verbatim interaction has many levels of analysis. It is not the scope of this paper to do a full analysis of the engagement but to focus on the development of the patient's meaning or the patient's interpretation without necessarily referring to the genetic interpretation. To this end, four main points are raised.

Firstly, when we focus on interpretation as the *patient's process* of making meaning of the current here-and-now dynamics with me, it is noted that I am not giving an interpretation to the patient, but I am a partner in his process of exploring his inner world. What I say is meant to open up and deepen his exploration, wherever it may lead. My goal is to explore with him, not to link his experience of me to the past. The transference is in the here-and-now, and the patient is making sense of his experience of both his wife and others as well as me. The transference is on multiple levels but one that stands out is that my 'kindness' is viewed suspiciously. I have a sense that this is rooted in childhood experiences, but I am not 'taking the patient' back into the past as the patient is not going there. It is not my role to lead the patient back into childhood experiences but to remain with the patient and his experiences of me in the here-and-now. Interpretation, as a meaning making process comes from the patient in the here-and-now.

Secondly, I am not avoiding his experience of me as hurting him. This is important in the process because it validates his experience of me. There is a 'real relationship' (Greenson & Wexler, 1969; Gelso, 2009, 2011; Watkins, 2012) happening and not a distortion of the past transferred onto our current engagement. I did hurt him when I went on holiday. In apologizing, I accept my responsibility for causing his hurt. I am not dodging what I did and how he feels. In accepting responsibility for this, I acknowledge the 'realness' of his feelings, and I 'recognize his subjectivity'. Such recognition of the subjectivity of the other is immensely therapeutic (Benjamin, 2018; Geist, 2010) as well providing an important 'holding experience' for the patient that supports the patient's inner change process (Slochower, 2011, 2014).

Thirdly, the importance of the patient's participation in the interpretive process is clear. This means that I am concerned about the type of engagement that occurs between us because it is this kind of relationship that gives a concentrated focus on the patient. The patient's own contribution is paramount. In the transcript, the patient makes connections himself, and the meaning of what was done to him by his wife and how this is echoed with us. His experience of me as understanding him but also his sense that I am duping him is linked by him and not me to his past experiences of being tricked and fooled. While we do not focus on the past, his understanding of his experience of me is the focus. This leads to his understanding of what may be happening between us. '*On the contrary, when the analyst does the interpreting, passivity is reinforced*' (Kauff, 2016, pp. 39). This re-asserts the shift to the patient as creating meaning within the relationship, and not the analyst as interpreter of the patient's experience.

Finally, as with perhaps all analytical therapy, the analyst and the patient bring to the process their own past and thus their unconscious processes of the experience of the here-and-now. This is inevitable. In this relational context of two subjectivities in service of exploring the one subjectivity of the patient (Aron, 1996) I am aware of my own response to the patient and how they contribute to what emerges in the therapy. For example, I reflected on my own history where I may have experienced something similar to my patient. While at the time of therapy I did not have such experiences, it is possible that some of my own unconscious bias will have slipped in and influenced the process. For example, there was a turn in the session when I asked the patient *What if I am duping you? What then? What would happen between us?* This did seem to shift the process and it is possible that this was not positive for the patient. He appeared, however, to be open and replied in a way that moved things forward. It is from this kind of interaction that he came to some meaning of his own experience. This was when he said, *I think I am beginning to feel that there is something about me and my suspicious nature that may cause me to push you away. If I am suspicious of you and I can protect myself from feeling vulnerable and maybe getting hurt.* This statement of his experience is a move towards making a link with his need to protect himself from vulnerability by erecting a wall of suspicion against experiences of kindness.

Conclusions

The value of the past is in understanding the present, but insight is not curative. While a negating and painful past will always be relevant to the *explanation* of the current sense of self, it is possible to change that sense of self. This is the underlying assumption of all therapies, how they get there to this change process differs according to the theory. In terms of interpretation, if there is a shift towards the understanding that the process of making meaning is relational, co-creational, and co-participatory, it adds value to the experience of the here-and-now of the patient. Interpretation is thus the patient's meaning of his experience that emerges within the relationship. In this way, interpretation contributes to the change process as it is about making sense of the current experiences in the here-and-now, and how these current experiences manifest. In so doing, the potential for changing these current relational templates is in and through the experience of the other (the analyst). Put in another way, the importance of the patient's participation in the interpretive process is clear. Of course, this co-participation brings into the analytic process the issue of countertransference. Nevertheless, within relational psychoanalysis, countertransference is not a contaminant but adds value to the process in that can allow the patient to gain a sense of their impact on the analyst in the here-and-now. The process is not about avoiding countertransference because the other is inevitably involved (the notion of intersubjectivity). It is about giving (and perhaps returning) focus to the patient's experience. In a sense, letting the patient make his meaning (interpretation) of current experiences with others, including the analyst, without such meaning constructed by the analyst.

The purpose of a shift towards the patient's meaning-making process or interpretation of the transference in the analytic process should be to both illustrate to the patient the importance of his own input and contribution into experience, and by extension, to identify what can, therefore, be changed (Kauff, 2016).

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