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On Understanding and not Understanding: Some Technical Issues

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This paper is about understanding and being understood. It concerns ways and motives our patients have for making themselves understood or not understood, and the problem for the analyst in gaining understanding as well as tolerating not understanding.

We could describe the beginnings of psychoanalysis as the attempt to make the incomprehensible in mental life comprehensible, and the tools used as free association and listening. Freud started by listening to his patients, taking everything that they said extremely seriously, and from this building up the unconscious meaning of their communication, using, of course, not only words but also tone, gesture and the like. Following Freud's discoveries Melanie Klein explored the very early period of the child's life, of object relationships, anxieties and defences, and began to make more comprehensible areas which had previously been beyond our understanding. It is about some of the consequences of her findings on our technique that I want to talk today.

I think that we, as analysts, need to approach the question of understanding our patients, in a sense, differently, depending on whether they seem to be operating more within the paranoid-schizoid or in the depressive position. Broadly we can include under the latter, patients who are able to relate to themselves as whole people and to feel some responsibility for their own impulses and themselves, as well as relating to the analyst as a whole person. Those who are still caught up in the paranoid-schizoid position are necessarily splitting off and projecting a great deal of themselves and their impulses and are unable to relate at all fully to either themselves or the analyst.

All our patients come to us, we and they hope, to gain understanding, but how they hope to gain it must vary, I am suggesting, according to their position; that is, according to the basic nature of their object relations, anxieties and defences. The very nature of the defences used in the paranoid-schizoid position in itself militates against understanding, understanding is frequently, but not always, not what these patients want. In fact, many are against

understanding despite their protests to the contrary. Of course, there is another aspect of being against understanding, that is the aspect of attacking, destroying and undermining the patient's understanding of his analyst's understanding aggressively and enviously, but it is not this aspect that I so much want to discuss, although, with the patients I am going to speak about, there is often a mixture of destructive anti-understanding and the use of primitive splitting defences which are working against understanding. It is, to my mind, very important that we tease out with our patients, and clarify, the difference between these two elements, and also that we constantly attempt to tune in to our patients sufficiently accurately to gauge where they are: basically in the paranoid-schizoid or depressive position. Otherwise I think we shall find that we are, as it were, able to understand the material but not the patient. I shall try to exemplify these points.

First I want to clarify what I mean by understanding in the depressive position. I suspect that it is only those patients who are really well into the depressive position who can use understanding in the sense that we tend to think about the term ordinarily, I mean in the sense of discussing, standing aside from a problem, seeking, but even more, considering explanations. Such mental activities probably involve the capacity to take responsibility for one's impulses and, as I have said, to relate to the analyst as a whole person and to introject freely, etc. I want,

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therefore, to leave aside this slightly hypothetical, more mature group of patients, since they do not present us with our real technical problem, and to concentrate on aspects of gaining and giving understanding to patients who are more tied up in the paranoid-schizoid position.

If we consider briefly Melanie Klein's work on the types of object relationships, anxieties and defences mainly used in the paranoid-schizoid position (Klein, 1946), we are thinking of relationships not just with people, but with people or

parts of people used as part objects: we are thinking of the kind of anxieties of a very disturbing or persecuting kind that set going and support defences such as maintaining a highly omnipotent and narcissistic attitude, splitting off various parts of the self or internal objects, and the considerable use of projective identification. Taken at the simplest level it can be seen that constantly to split off and project out parts of the self must necessarily be inimical to understanding. But, as I want to go on to discuss, the problem is not so simple, because even such projective identification can be used as a method of unconscious communication between patient and analyst. Our understanding of this aspect of Melanie Klein's work has been considerably augmented by the work of W. R. Bion (1962), (1963), for example on container and contained, communication between infant and mother, in other words on aspects of the healthy use of projective identification as opposed to the more pathological. I think it is impossible to over-estimate the importance of Melanie Klein's concept of projective identification for the development of our sensitivity and our technique in this generation.

I want to start with an example, to indicate both the difficulties and the importance of locating the main position in which the individual is operating. I shall use a fragment of material from the work of Dr Mauro Morra, who was discussing this case with me. This comes from the analysis of a 4-year-old boy who had been in treatment for a few months and as the holidays were approaching the child had been showing behaviour in which he wanted to be near to the analyst, as if inside him, or, as he demonstrated with sticking plaster, stuck to him. Then on the following day he came in, called the analyst a stupid idiot, threw a small container in the analyst's face, tied up his ankles with string, stuck him round with sellotape, got glue on to his trousers and a bit of chewed chewing gum on to him. He talked about the analyst being tied up and unable to move, and indeed the analyst felt quite immobilized. Here we can see that there is manifestly an attempt to tie the analyst up, control and hold on to him before the holidays, but I think there is also another communication going on: that the child is projecting into the analyst his own infantile self, with its experience of being desperate and a stupid idiot of an infant, unable to move, immobilized, stuck in his gluey, gummy faecal nappies, wet and dirty, while his parents came and went and left him alone in his distress, and this is called 'holidays'! (Indeed, there is a story of his having cried ceaselessly for eighteen hours when he was aged only a few months, on being left by his parents.) This is the only way that he can as yet convey something of his experiences, which are outside his verbal range. When the child sticks, attaches and attacks, his behaviour seems direct, a direct, non-verbal communication. But where Melanie Klein's understanding has given us a new technical tool is in the

understanding of projective identification—its concreteness in the transference and in the countertransference. The analyst feels immobilized, responding to a projective identification of the child, as I have tried to describe. The awareness of the use of projective identification in this way gives us an additional dimension, it enables the analyst to use his counter-transference as a positive tool in his understanding. But the child, by projecting this experiencing part of the self into the analyst, both communicates his distress and temporarily rids himself of it and therefore of his understanding.

If our patients are operating largely with early defence mechanisms, and to some extent every patient is, then we may expect that our technique has to deal with two factors: one, that the patient who believes he comes in order to be understood, actually comes to use the analyst and analytic situation to maintain his current balance in a myriad of complex and unique ways; two, that verbal communication, therefore, has to be listened to, not only or even primarily as to its content, but in terms of what is being acted in the transference. Defences like projective identification,

splitting, omnipotent denial are not just thought, they are in phantasy lived in the transference. These two points I want to develop as I go on.

Understanding, as such, belongs, I am suggesting, to the depressive position. The patients I am concerned to discuss have hardly reached, and certainly not worked through, the depressive position and, as I said, though they believe they come for understanding, immediately other forces in their personality take over, and unconsciously they attempt to engage the analyst in all kinds of activities, drawing the analyst into their defensive structures and so on. These are the things then that need to be understood. All of us, I assume, have had the experience at times of listening to our patients, believing we understood the material and its unconscious meaning, its symbolic content, only to find that our subsequent interpretations seem to fall flat, or that we are getting bored in the middle of an interpretation. If I am bored I stop, assuming I am talking about material but not to the patient. This highlights a point, which in a sense is only too obvious, that analysis to be useful must be an experience, in contrast, for example, to the giving of understanding or explaining.

It also helps to clarify an issue often raised in discussion on technique—does one interpret only in the transference, or also about other areas of the patient's life? I don't think it is only/or, but rather whether one can focus one's understanding and therefore interpretations on what is being lived and

experienced and then fan out or down or back from there. Out, I mean, into the outer or inner world, down or back into history or more unconscious phantasy.

I am going to give a brief example of a patient apparently intellectually trying to understand, though actually negating my attempts at understanding, and yet communicating a very significant part of her early relationships. This is the kind of mixture that I feel we need to tease out. A rather new patient, whom I shall call A, a young professional woman, arrived a few minutes late, explaining that she was very tired and had overslept. Her boss was expecting her to do a great deal of the work which should be shared out to other people as well, she was very angry, she was going to discuss it with him. No, no, no, she was not going to do that work. The reason for anger, if genuine, seemed real enough, but the way that she talked was rather like a self-consciously naughty little girl. I made a rather general interpretation linking what she was saying with what we had been seeing in previous sessions about her actual annoyance being that I don't let her do my work, so she digs in her heels and rejects what I have to say. She replied, 'Yes, I always dig in my heels, I can't let people be over me, just as when I was at the university and people tried to bully me. I ...'

Now that sounds as if my patient is agreeing with my too general remark that she can't let people be over her (but said very, very easily) but if they, I, am over her then apparently I am like her bullying boss—so one would think she would be right to dig in her heels. So she agrees and placates me—because I am said to be right, but in so far as I am bullying one would assume that I must be in the wrong, but she indicates that her behaviour is wrong. So I am quietly placated by her statement of guilt. But this ambiguity and twist takes all the meaning out of our communication and leaves it useless. I show her this. She quickly adds that this must be 'because ...', so that long before anything has been established between us, any understanding, it is explained away —'because ...' So here I think she shows that there is no belief or trust in the reality of what we are doing together in the analysis. It seems as if there is nothing genuine and sincere going on. I tried to show this point, which is linked, I think, with her ambiguity. Immediately she responded that the word that really affected her in what I was saying was about there being 'no trust'— and she started again to explain about the notion of no trust in the abstract 'because ...' But again the meaning has gone, there seems to be no feeling about what I was trying to show her but a quick explaining it away 'because ...'

I have brought this fragment because it raises the particular kind of issue that I am trying to discuss. One could interpret the content of parts of her material— e.g. how I (and the analysis) am experienced in a persecuting way as her bullying boss, or one could explain something about the fragments of her

childhood that are brought up after the 'becauses'. But I believe that that would not help us. I think the experience that is going on, the thing being acted out in the session, is an extraordinary ambiguity constantly followed by a

kind of placating and agreeing with me: and my patient always having to know what she means or what I am saying. Actually in this way the meaning of what I am saying disappears. I think this quality in the work needs to be linked with another feeling that I have, almost constantly, with this patient and which seems unique to her. I find I listen to but almost do not believe what she is telling me, as if she were confabulating history, inventing boyfriends, or details about boyfriends, or stories that she tells me that people have told her. Yet I do not think that I think that she is consciously lying, but my countertransference is very uncomfortable. My suspicion is—and only time will or may show whether I am right—that this patient as an infant or young child had no real belief in her world, in her emotional surroundings, as if deep sincerity was lacking between her parents and herself and that there was a lack of belief in, and a phoney idealization of, her parents—whom I suspect at depth she felt she saw through. And this mixture of disbelief and pretence in real relationships is what she is living out with me in the transference. I have already alluded to that in the fragment of material I gave, but these interpretations, too, get absorbed into the defensive system and cannot, or dare not, be taken seriously by her.

It is interesting that the picture of her family that I get is of a very unreal mother, who, although quite unconnected with psychology, so far as I yet know, seemed to talk to her daughter and husband in a quasi-interpretive way, a role that I am clearly being invited to play, as if interpretations took the place of emotions and real living. What is also manifested in the session is the way in which defences are mobilized at the moment of her nearly having to face her psychic reality. Thus, when I interpret her conviction of the emotional falseness and lack of sincerity in her objects, the very words, or some, that I use, like 'trust', will be used defensively to make it meaningless. And she will get power over the meaning of what I say by dislocating the word from its context and then explaining away its non-meaning with the 'because'. Thus her anxiety is evaded and her psychic history distorted.

This whole complex system of object relationships, phantasy, anxiety and defences against anxiety is brought into the transference and countertransference, as I feel useless and impotent in the face of the pseudo-lies. The patient is clearly against understanding—though believes she is for it. Understanding, so far as I know at the present, would mean facing the

unsatisfactory nature of her early objects and her complaints and doubts, as well as their value and maybe the value of her current object—myself. We can also see this patient's omnipotence and omniscience; she believes that she wants to be understood but she cannot tolerate not knowing. Her aggression is mobilized when this omniscient balance is disturbed by my interpretations; then placating is mobilized to deal with this, as she unconsciously tries to draw me into her defensive organization and keep us in perpetual agreement. It is also only through my attempts to tolerate long periods of not understanding at all what is going on, that I can perhaps begin to clarify a little what it is about.

In cases such as the one I have just quoted, where primitive defence mechanisms and omnipotence are so striking, we can see that aggression apparently arises when interpretations disturb the patient's balance, since the balance aims in one part to obviate envious aggression. Many patients, as we are only too aware, will try to destroy their understanding, will develop a negative therapeutic reaction and annihilate their knowledge, will enviously beat down and devalue what the analyst has just shown them. But as I indicated at the beginning of the paper, it is not these patients who show such manifest and active, or silent but significant, attacks that I am so concerned about here. I am concerned with those who are more split and stuck and unavailable. The particular ones that I am going on to describe are those in whom part of the apparatus that is needed for understanding, part of the ego, seems to be unavailable owing to early splitting and projective mechanisms. If we do not find the missing parts of the apparatus we talk, we interpret, in vain.

To take an example from B, who came into analysis worried about his relationship with his wife—or, to be more accurate, worried that she was worried that their relationship seemed poor and unsatisfactory to her; he did not see anything particularly wrong with it. He seemed a very decent man, basically honest, immature and terribly lacking in awareness of himself and his

feelings. It soon seemed that he unconsciously wanted an analysis in which things would be explained in relation to the outside world, not experienced in the transference, and usually when I interpreted he would go quiet, blank, unable to remember what I said, and shift off untouched on to another topic. Or he would repeat what he had just said. The impression I got was that he became anxious, broke up his mind, stopped being able to listen or hold together what we were discussing. This began to improve. Slowly I gained the feeling that I was supposed to follow him, almost pursue him with interpretations, but he did not seem interested in trying to understand or

actively to use the analysis—it was as if it was I who wanted him to use individual interpretations or the analysis in general, just as it was his wife who apparently wanted him to have the analysis and who was worried about the marriage. So we could see that the active, alert, wanting part of the self was split off and apparently projected into me and he remained passive and inert.

Unless one becomes aware of this and begins to focus on this aspect of the work, one can interpret endlessly and uselessly about what the patient is talking about, and it will not reach him, or he will become harassed, persecuted or even excited. In such patients I think progress will be indicated not only by a broadening and deepening of emotions but by signs of parts of the ego engaging in a new way in the analytic work. For example, B was anxious but also rather relieved as he began to feel himself coming more alive sometimes during the sessions. I have not the space here to give details of such a session with a dream, just before a holiday, when B became very clear about simple feelings of jealousy and anger linked clearly with his early and current family experiences. He was unusually moved by this dream and our work on it and as the session was coming to an end, said in a happier voice: 'I must tell you about my grandiose idea. I think that car manufactures should build a front passenger seat so that it can turn round and the passenger join in with and face the children sitting at the back, or a child could sit in the front and turn to the others. I shall write to the head of B.L.'

So I showed him, by his tone and the way that he spoke to me, as well as by what he said, the pleasure in the session of getting into touch with his childhood, the experience of being really able to love and feel jealous, that what he had been talking about had brought him into contact with the child in himself, which he was beginning to turn to and face, instead of his usual way of withdrawing, losing contact and projecting the needing-to-know part of himself into me. Here some part of him wants to have a look at what is going on. Until he can integrate this part more fully and consciously into his personality he will remain passive, which he complains about, and not able to use his mind properly.

Here we are talking about patients who seem to be beyond understanding, because the part that could aim at understanding and making progress is split off and projected into the analyst—in the transference. We see similar interference when sanity and intelligence is projected, and the patient acts and talks as if stupid—unable to hold things together or draw conclusions about what he or she is saying. I am thinking about a particular man whom I shall call S, who described happenings in such a way that the analyst was bound, and must, I think, be known by the patient to be bound, to draw conclusions. For

example, he would give a long description of the behaviour of his girlfriend, whether accurate or not is not the issue at the moment, but which seemed to convey that any sane person in the room would assume that she, the girlfriend, was very sadistic, to the point of being seriously emotionally disturbed.

This raises an interesting technical problem, since the patient would go on talking as if not drawing any conclusion from his own remarks, thus as if the capacity to understand was split off and projected into the analyst. If the analyst does not deal with this aspect of the transference, but instead acts sane and demonstrates that the patient must realize that he is talking about a girlfriend who is deeply disturbed, the patient is likely to react as if the analyst were attacking his girlfriend and then be upset, hurt or offended, and the analyst may find himself or herself urging, almost bullying the patient to see her 'point of view'—so a vaguely forcing or near sadomasochistic situation arises, as if the problem has shifted from the home to the consulting room. I think that in this kind of situation one can see both the projection of apparent sanity into the analyst and the appearance in the patient of

naivety bordering on stupidity—which is apparently innocent but, in fact, is splendidly provocative. Real understanding is not the patient's aim at this moment, but nor is the behaviour consciously provocative, though I think it is secondarily often used in this way.

I have been describing patients in whom understanding seems to become unavailable because the part of the ego that might want it is projected into the analyst, and the analyst becomes identified with that part of the self and is then warded off, as with B. I have also indicated with the man patient, S, how the resulting naivety or stupidity can often be felt in the transference as having something vaguely provocative about it. In such cases the patient seems unconsciously to be trying to involve the analyst in acting out with him. If the analyst does not watch what is going on in the transference most carefully he may be tempted to prod, as if to suggest that the patient ought to work harder, or be tempted to push superego-ishly to get the patient moving. If the analyst does act out the role of the active ego or superego with the patient it will simply encourage the patient's passivity or his masochism and perpetuate the problem. In fact, the analyst is fortunate in being given the opportunity to experience his impotence, his desire for change, his desire for the patient to make progress. If he can really contain this and try to understand why the patient needs to split off and project so much that is potentially valuable in his ego into the analyst, then analysis will go on, as opposed to subtle acting out

and moralizing by both patient and analyst: such acting out must lead to a stalemate and most likely to a repetition of what has gone on in the patient's past.

This type of splitting and projective identification of valuable parts of the ego into the analyst is also seen in another group of patients, who are basically very masochistic and more or less perverse in character or behaviour, a group whom I cannot discuss in detail here. In them one gets the impression that there is a profound split in which the patient remains almost dominated and imprisoned by death instincts, emerging as self-destruction and constant despair, while life instincts, hope, sanity or the desire for progress, are constantly projected into the analyst. In such cases there is little in the patient to balance the pull of the self-destruction, and the patient becomes enthralled and captivated by the exciting self-destructive part of the personality. The patient will unconsciously attempt constantly and actively to undermine the analyst's hope and drag him down into despair. It is very hard for mere understanding to be anything like as important for these patients as their awful and active masochistic pleasures.

When discussing one group of patients, who use projective identification a great deal to be understood and not understood, I spoke about our being fortunate in being given the opportunity to experience what is going on. And yet we know that the experience is by no means an unmixed blessing, and can be very disturbing or pressurizing or invasive. I shall return to this latter point in a moment. But, in any case, there is always a problem as to how to keep the transference uncontaminated—not, or minimally, contaminated by the analyst's acting out verbally, in tone or attitude, etc. It is clear that we are demanding that the analyst should be able to feel and explore most carefully the whole range of disturbance and yet not act out and not masochistically suffer without verbalizing. To go back to our first example, the case of the child—the analyst knew he felt immobilized and disgusting; it was important not just to interpret as if the child were only trying to tie him up, but also to suffer, and verbalize to the child the child's own unverbalized and, then, unverbalizable suffering.

It is important to explore in detail the nature of the patient's phantasies, ideas, convictions, ourselves, rather than hurriedly to try to interpret them back into the patient as projections or mere history. With one patient it was possible to open up her feelings that I was antagonistic and controlling, that I did not want her to get on in life or in her career. As we looked at her feelings about my motivation it became clear that in her mind I felt threatened by her, and deeply envious of her as a young intelligent person with her life ahead of her. I would then wish to explore most carefully her picture of me, this old, supposedly lonely, rather embittered person, and her quiet conviction of what I was like,

and only very slowly and over a long period, hope to explore how much of these ideas might be linked with actual observations of myself or the way I function, how much projected parts of herself,

and so on. This is, after all, in a large part what we mean when we talk about 'containing'. To assume that all these ideas were projections from the beginning would almost certainly be inaccurate, would numb one's sensitivity as to what was going on and prevent one from seeing what else was being talked about or why it came up at that moment.

To return, then, to the issue of invasiveness: the types of projective identification that help us to experience and to understand our patients better are often, as I have tried to indicate, quite subtle and fine. But sometimes they are so powerful that the analyst has difficulty in not being drawn into acting out in one way or another. With a certain group of such patients, who are not interested in real understanding but demand understanding on their own terms, one's personality, one's body and mind is being assaulted. These patients are observant in certain directions, but quite blind in others. They are convinced that they know what is going on, and that their theories are correct —as the woman I have just quoted, who was certain of my subtly envious attitude to her and some of the reasons for my attitude.

In these cases there is a very deeply encroaching type of relating, when the patient unconsciously in phantasy projects his mind and his eyes into the analyst and knows everything that is going on, and since he is living so omnipotently he has no awareness of wanting to know, he has no curiosity, all this is avoided and real relating is obviated. 'Knowing' and 'psychoanalytic knowledge' is put in its place. Such patients are often convinced that they should be psychotherapists or analysts and from an external point of view may, or may not, convince people around them that they are very insightful. But in analysis one can see that the insight is based on a subtle getting in and taking over which will sometimes emerge grossly in dreams, then more subtly in their ways of dealing with sessions and actual interpretations.

In many ways this omnipotent balance is similar to what I described in A, the patient who conveyed a sense of tragic falseness. But the very invasive patients bring an additional, potentially disturbing quality into the analysis which one can experience vividly in the countertransference. With one such patient, as I interpreted, either she did not hear—though this was not obvious because she continued to talk apparently relevantly—or she slightly distorted and altered my interpretations and repeated them in a slightly different form already

known to her; or the whole thing became text-book or tied up in some old interpretations, so that the newness, freshness or unexpected part was lost. But what she said sounded nearly, nearly all right and wasn't. This was a young woman who had anorexic difficulties when young and to some extent even as an adult.

I have raised this difficulty because in a sense the omnipotence and the extreme invasiveness and the sense of conviction and knowledge that these patients have make the problem look obvious—but they are difficult to help and to give real understanding because they depend so deeply on their rigidly held omnipotent and omniscient balance. And there is another technical problem; these patients often appear so narcissistic, so arrogant and disturbing that they ask to be badly treated or humiliated, and if they can get it, by a clumsy or unkind interpretation, they can slip into a, to them, very welcome sado-masochistic transference and insight will be further lost. After all, omnipotence is the hallmark of early defences, and one which we can easily underestimate. Our patients who in phantasy get into our bodies, our houses and our minds know and are not curious; in phantasy they live in our minds and therefore can talk about missing and gaps and weekends without having the trouble of experiencing them. We as their analysts have to recognize the omnipotence of omnipotence, and not, I believe, try to interpret their material as if these patients wanted it understood.

I have tried, in this paper, to raise some technical problems presented by patients locked in the paranoid-schizoid position where understanding is difficult to achieve if our attention remains focused on what they are actually saying. I have tried to show how the analyst, in order to understand, has to tune in to the patient's wavelength, which is a wavelength of action rather than words, though words may be used. All these patients are, to a great extent, using projective identification, either as a method of communication to achieve understanding on a deep non-verbal level, or to maintain their balance, in which case they are not interested in, or are inimical to, understanding as we understand it. If we approach such patients with the

notion that they want us to give them real insight, we lose touch with the patient as such, and in any case much that these patients are conveying and projecting will still be beyond our understanding. I have attempted, in this paper, to show something of the value, the richness and the depth of Melanie Klein's work on these early processes, and how the implications of her work have increased our sensitivity to what is going on both in our patients and

ourselves, and thus have helped to make more comprehensible that which was previously relatively incomprehensible.

SUMMARY

This paper discusses some technical problems arising from the diverse ways our patients have of making themselves understood or not understood. It aims to show how patients who have reached the depressive position are able to use understanding in a way that is very different from those in the paranoid-schizoid position. It describes particular methods that the latter patients have of avoiding understanding by splitting and projection and attempting unconsciously to draw the analyst into a type of acting out in the transference. It stresses the importance for the analyst, of listening to the patient in terms of the position from which he is operating, so that contact can be achieved and with it real understanding, as opposed to subtle acting out and pseudo-understanding.

REFERENCES

BION, W. R. 1962 Learning From Experience London: Heinemann.

BION, W. R. 1963 Elements of Psycho-Analysis London: Heinemann.

KLEIN, M. 1946 Notes on some schizoid mechanisms In The Writings of Melanie Klein London: Hogarth Press, 1975III*1-24*

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