

## **RECONCEPTUALIZING THE THERAPEUTIC PROCESS**

by Vic Comello

*Published on <http://hdbkpersonality.com> January 26, 2007*

I have heard more than one psychotherapist confess to taking a smorgasbord approach to psychoanalytic theory in his or her practice, consisting of perhaps a little control-mastery, perhaps a little self-psychology, perhaps a little behavioral theory, and perhaps a little something else. I think the reason for this is that no psychotherapeutic theory comprehensively describes how best to help patients, which is true of control-mastery largely because of the newness of the theory.

It is often said that control-mastery theory is about 50 years old. It is not. Joe Weiss and Hal Sampson began their program of empirical research about 50 years ago with the intent of investigating certain discrepancies between Freudian theory and what they found to be true in clinical practice. Control-mastery theory developed gradually, as Joe and Hal applied their empirical results in piecemeal fashion while expanding the focus of their theorizing and research. The version of the theory that we have today came into existence around 1980 and was first published in 1986 along with the empirical evidence to support it. Since then, Joe and Hal devoted themselves to advertising the existence of the new therapeutic viewpoint, at the expense of making refinements to the theory. The result is a theory that is as serviceable as other theories, as far as therapists are concerned, but one that also leaves many questions unanswered. And since Hal is retired and Joe no longer with us, it is up to the members of the San Francisco Psychotherapy Research Group to take the theory farther.

At first glance, the control-mastery concept of the therapeutic process is crystalline in its clarity. People who acquire pathogenic beliefs through childhood experiences seek therapy because their pathogenic beliefs make them miserable. Therapy consists of having those beliefs disconfirmed. A therapist disconfirms the beliefs largely by passing a patient's unconscious tests. These tests express the patient's unconscious plan for getting better. The therapist's job is to infer the patient's plan and react in ways that constitute pro-plan interventions. A pro-plan intervention is one that disconfirms one or more of the pathogenic beliefs that are the patient's current focus of attention. Nothing could be simpler or more straightforward. Yet a closer look reveals that various facets of the theory don't quite fit together as closely as one would like, not because they don't belong together, but because they have been left in an unfinished state. There are also several crucial considerations that are not touched upon in the theory.

### **GAPS IN CONTROL-MASTERY THEORY**

One of the latter is the question of what happens when a pathogenic belief is disconfirmed. Does the belief dissolve, never again to be a force in a person's life? Joe and Hal believed not, but neither conceptualized the fate of a disconfirmed belief. This is a matter of some importance in deciding the question of what therapy accomplishes and in addressing the concern about preventing recidivism after therapy has concluded.

Joe and Hal stressed the importance of disconfirming beliefs, but both also noted that a patient's efforts to model the therapist's behavior could be crucial. Some of these modeling activities can be classified as disconfirming, but others cannot. So what is

going on here? Joe and Hal maintained that various aspects of the relationship that the therapist has with the patient are therapeutic, but neither specified in detail how they contributed to therapeutic gains.

And then there is the whole business of patient coaching. The notion of disconfirmations providing therapeutic gains implies that the force of experienced reality represented by the therapist's actions, attitudes, and interpretations leads patients to adapt in ways that loosen the hold of pathogenic beliefs. Yet when patients coach, they manipulate the therapist to produce those reactions. Successful unconscious manipulation of the therapist would seem to be at odds with the notion of patients being helped by a therapist's realistic interventions.

There is also the question of how one or two hours of therapy a week could alone have the power to change a patient's life. This simply does not make sense, cognitively speaking. The only thing that does make sense is the notion that therapeutic interventions motivate patients to make changes in their daily lives, with helpful disconfirmations taking place both inside and outside the therapist's office during the course of therapy. Yet no attempt has been made to conceptualize the therapeutic process in a way that integrates the effects of in-office and daily-life disconfirmations.

Additionally, there is the empirical finding that a patient immediately becomes more relaxed and insightful when a therapist passes a test, but less so when the therapist fails. This is usually interpreted as resulting from the disconfirmation of a pathogenic belief, yet if that were the only factor, one would not expect such a reaction, given that the therapist must disconfirm a belief for months or years before causing significant psychological change in the patient. The immediate noticeable change would seem to be an overreaction, which would argue that factors not being discussed are contributing.

By far, however, the most important gaps associated with control-mastery theory do not involve one aspect of the theory with another, but rather with aspects of the theory in relation to concepts being employed by other fields of science having a bearing on the theory. As wonderful as Joe and Hal's research was, there was an insular quality about it derived from its focus on developing and empirically validating concepts having exclusive application within the psychotherapeutic setting. The result of this therapy-based theoretical focus is a dearth of connections to cognitive theory and a failure to address instances in which control-mastery concepts seemingly conflict with empirically validated concepts in other fields of inquiry. Because of these disconnects and seeming discordances, researchers in other fields would tend to discount the importance and relevance of control-mastery research. I am not saying that control-mastery research shouldn't be therapeutically focused; I'm saying merely that an effort should be made to recognize and include relevant findings from other research in interpreting therapeutic data. Control-mastery theory should be formulated as something integral to modern psychological research, not as a thing apart.

The perceived standing of psychoanalytic research by members of the non-psychoanalytic research community is, I believe, an important consideration. The world today is awash in psychoanalytic theories, with there currently being no objective way of deciding whether any one of them is more correct than the others. Like it or not, the way that issue will get decided is through the agency of researchers in other fields accepting,

utilizing, and building upon the conceptual framework of one of these theories. I believe that control-mastery theory is the only psychoanalytic theory capable of such future, but this eventuality will never come to pass if the research done by the San Francisco Psychotherapy Research Group fails to at least tangentially address the concerns and findings of researchers in allied fields.

The concept of transference is a case in point. Psychoanalysts glibly toss the term around as if it were a universally established fact, yet I know of no research that has empirically validated the concept, except indirectly through Joe and Hal's research into unconscious testing. All sorts of questions remain to be answered, not the least being how it is possible for a person to manipulate his memories in order to behave in this way. It is simply not credible that transference phenomena are exhibited solely in a therapeutic setting. Yet where else should one look for transferences? And how do those incidences relate to what goes on during therapy?

Everywhere you look in control-mastery theory there are concepts that need further work, both theoretically and empirically—for instance, the concepts of “safety” and “danger.” These are terms laden with psychological significance, yet I have not seen any attempt to delve deeply into their meaning. As another example, control-mastery therapy is predicated on patients being normal to a considerable extent; otherwise it would make no sense to ask therapists to let patients direct the therapeutic process. Neither would it be legitimate to instruct therapists to assume that patients are motivated in their unconscious plans by normal life goals, which may be quite different than the goals the patients see themselves as consciously pursuing at the moment. Yet what does this presumption mean? Does it mean that the control-mastery approach is suitable only for those who are minimally impaired? If not, how does one show that the fundamental assumption of control-mastery theory remains valid even for those who are sorely afflicted?

It might be argued that the assumption is valid because all patients are made miserable by their pathogenic beliefs, and this misery makes them eager to get better. Yet a look at the general population shows innumerable examples of people whose lives are saddled by pathogenic beliefs who are dedicated more to burrowing into lifestyles defined by their pathogenic beliefs than reaching for new lives. Unhappiness alone does not provide a willingness to change. There must also be hope. How prospective patients find a basis for hope is an unexplored dimension of the control-mastery story.

I believe that the precepts of control-mastery theory are rooted in fundamental human truths, which is not to say that I believe these precepts are expressed in a way that makes their relationship to such truths transparently evident; this is why I make this call for a reformulation of control-mastery theory. I understand the reluctance to undertake this; I myself feel the tug of survival guilt. Yet for years, with Joe's encouragement, I have been attempting to reformulate control-mastery theory in terms of attachment theory. I must think that he valued that effort and hoped I would contribute in some way to, as he used to put it, “the never-ending quest for psychological truth.” I must believe also that he hoped the same from other members of the San Francisco Psychotherapy Research Group. As I indicated previously, Joe once told me that he feared the Group was dead. He was bitterly disappointed when he said this, which would indicate that he expected all of

us to attempt to build on his legacy. Below is a fledgling effort at reformulating control-mastery theory using attachment-related concepts.

### **RECONCEPTUALIZING CONTROL-MASTERY THEORY**

I began this reformulation of control-mastery theory with the insight that the control-mastery concept of the therapeutic process is largely a set of rules aimed at helping the therapist establish, deepen, and maintain a secure attachment relationship with a patient. So I set about trying to describe control-mastery theory in a way that makes its implicit use of attachment theory explicit. The more I tried to do that, however, the more problems I encountered. Gradually it became clear that the trouble lay with John Bowlby's early writing on attachment theory, which supposed that attachments served the need for physical and emotional security.

Bowlby was not the only one to make the mistake of saying that attachments are formed because of some kind of ulterior motive. Freud did also. So did Joe when he argued that a child's "parents are critically important to him because he needs them in order to survive and flourish," and that therefore "his only good strategy for adaptation is to develop and maintain a reliable relationship with them." I also made the same kind of mistake in early versions of what I present now when I claimed that attachments are formed for the purpose of psychological development.

Attachments do participate in the learning and other processes that are responsible for psychological development throughout a person's life. Attachments play a role in an infant's proximity-seeking behavior, too, and in the vestiges of it that are evident throughout a person's life. They are also integral to romantic and social relationships and form the glue that holds societies together. They also help bind humans to their God. Human attachments operate ubiquitously. There is no aspect of human life that does not have an attachment component. That is why it is wrong to single out one aspect of life and claim that this alone is what attachments are all about. Attachments are fundamental to everything humans do. How a person manages the compliances associated with his attachment relationships over the course of his lifetime determines the arc of the person's life.

This means that psychoanalytic interpretations are most likely on the right track when they take a person's continuing desire to maintain attachment relationships into account. This is precisely the stance that Joe and Hal invariably took in their writing. Time and again, you will see Joe or Hal saying that a patient maintained his pathogenic beliefs largely out of "loyalty" to a parent. I have long had trouble with that explanation and have long considered it not as being a fundamental truth but as an element of a congenial story to be told to patients by way of helping them rationalize their lives. I have come to see, however, that Joe and Hal's explanation was exactly on the mark. People have no choice but to maintain their attachment relationships with parents who have hurt them. The hurt creates great anger, and the patient's lack of psychological understanding creates the impression that the only way of dealing with that anger is to make a clean break, which the patient cannot do. Part of the therapeutic process involves showing patients how they can modify their attachment relationships in ways that address their justified anger while letting the attachment relationships persist.

Bowlby saw an infant as developing conceptual models of interpersonal relationships as a result of its attachment relationships with its caregivers, and as using the models in guiding its behavior from that point forward, irrespective of security-related considerations. These conceptual models may be thought to be related to the beliefs that Joe talks about. Bowlby's position was, however, that a person's adaptive state is always a product of cumulative history and current circumstances, which would argue that the cognitive models should change with experience. Cognitive theory would also have one suppose that our life experiences bring us new information each day and that the way we process that information determines how we subsequently behave, implying that any beliefs a person developed should change over time as the result of new data. Yet implicit in the control-mastery description is the view that, once formed, pathogenic beliefs remain essentially impervious to change until a person enters therapy.

It may be argued of course that it is not important to control-mastery theory whether or not pathogenic beliefs change over time, only that they have not changed enough to make much of a difference in a person's life. That's not exactly true, because pathogenic beliefs in fact don't change much over time even though they should, which means control-mastery theory should explain why. As I will show, that explanation will lead to a somewhat altered view of the therapeutic process.

The explanation begins with the fact that we are highly adaptable beings, which means that our life experiences have psychological impacts on us, for good or for ill. This implies that we need to be careful about what we allow ourselves experience. Because of this protective need, we attempt to anticipate whether potential experiences will have a positive or negative effect on our development. Those situations judged to be beneficial or neutral are considered as being "safe" to experience, while those judged as being possibly detrimental to our self-esteem, and thereby our psychological development, are shunned as being "dangerous."

A person saddled with pathogenic beliefs will see many more types of situations as being dangerous than someone not having such beliefs. That is because a person with pathogenic beliefs harbors a shameful secret self. Danger comes from the possibility of exposure of that self either through an inability to perform as competently as other people or through a lack of acceptance by other people. Because of these defensive anticipations, people with pathogenic beliefs stemming from bad parental treatment are much less likely than other people to permit themselves the experiences that they need to change their belief systems.

The situation is somewhat similar to that of those afflicted with pathogenic guilt. The hallmark of attachment relationships is compliance with those with whom we have such relationships. These instinctive compliances have the purpose of sustaining the relationships. Enforcing this compliant tendency is guilt; whenever we don't do whatever is necessary to sustain an attachment relationship at its current level, we feel guilty. This is a normal instinctive reaction that is part and parcel of the attachment instinct. And under normal circumstances, this instinctive reaction enforced by guilt does not seriously impede a person's development. This instinctive reaction can, however, become pathogenic in the event that something bad happens to the person or persons with whom we are attached. If the attached other should die, for example, the instinctive reaction

would create the impression that the surviving person does not deserve a life, either, and unconscious guilt would prevent the person from seeking self-betterment. This is not a pathogenic belief. It is not rational in any sense. It is a pathogenic instinctive reaction, pure and simple.

The natural and normal guilt that a child feels upon separating from or surpassing a parent can of course become pathogenic through the agency of belief, but for this to happen, the parent must indicate in some way that he or she is harmed by the separation or the child's progress. Of course it is a matter of only academic importance whether guilt becomes pathogenic because of an instinctive overreaction or because of a pathogenic belief. The net result is the same in either case—the person's life remains frozen in place. This becomes a self-esteem issue because the afflicted person has no clue about why he is so inhibited. As with the case of a person saddled with pathogenic beliefs, the person saddled with pathogenic instinctive guilt would view as psychologically dangerous situations that would expose his disabilities to other people and that would tend to induce him to seek change. So once again a pathogenic complex would be maintained in place by an inability to seek the experiences needed to kickstart the developmental process.

As Joe indicated, a child growing up with abusive or unappreciative or neglectful or needful parents will tend to blame himself in rationalizing his situation and, through an identification with his parents, will come to feel that his treatment is justified. The pathogenic beliefs that result from these rationalizations would seem initially to predict the impossibility of change. So if nothing more happened to the person, one would not expect such a person to seek therapy, even though he was miserable, because there would be no basis for hope.

To explain the hope that eventually leads a person to therapy, one needs to assume that the child upon growing up notices discrepancies between the way he is treated by his parents and the way other adults treat him and treat each other. Accomplishments along the way also have a disconfirming effect. So do observations that the person is just like other people and that what seems to be true of them should also be true for him. Although a person's pathogenic beliefs remain largely intact because of an inhibited openness to new experiences, the person does acquire enough disconfirming evidence to make a hoped-for self a reality in the person's life. This creates a state of ambivalence between the person's real self—the self that has seemingly been confirmed through experience—and a hoped-for self, whose validity has been confirmed by experience only to a marginal extent.

Under normal circumstances, it is virtually impossible for a person to become committed to pursuing a life based on his hoped-for self, because the person's pathogenic adaptations will keep pulling the person back to "reality." What such a person needs is a friend who will confirm the validity of the person's hoped-for self through acceptance, encouragement, and example. An attachment relationship with such a friend will help the person because he will be led instinctively to comply with the friend's vision of who he fundamentally is. The person's relationship with such a friend will not only disconfirm some pathogenic beliefs, it will also confirm the person's belief in his hoped-for self, thereby making this self concept a greater force in a person's life while the pathogenic one becomes weaker.

While such friendships can truly make a difference in a person's life, they are generally only of limited value. This is because in order to seriously weaken the pathogenic self, a person must continually seek ways of disconfirming the validity of various aspects of that self through experience. To do this, the person must manipulate his memory system so as to create a basis for unconscious dramas, tests that will be hopefully passed by the friend. Generally speaking, even best friends won't tolerate too much of this kind of testing, not only because they won't understand what is going on, but also because they are probably intent on having their own tests passed. Nevertheless, such friendships can be extremely valuable because of the encouragement that a friend will give a person in seeking a wider range of subjectively judged dangerous experiences that will not only turn out to be safe but beneficial as well.

Heartened by the effects of attachment relationships with one or more friends, and perhaps knowledge of someone who has benefited from therapy, a person may come to conclude that an attachment relationship with a therapist may prove helpful. What the patient is looking for is a perfect friend, someone who will not only pass all of his tests, thereby disconfirming aspects of his pathogenic beliefs, but who will confirm the validity of his wished-for self and also serve as a model for how elements of this wished for self should take shape, someone who would thereby help him overcome his pathogenic defenses and will also act as a secure base, helping him to interpret his reactions to new experiences outside of the relationship.

The basic elements of my view of control-mastery theory are this:

- A person in therapy is seeking to reprogram himself. He became impaired through compliances arising from attachment relationships and now seeks to change through a new attachment relationship with the therapist. He has been led to think of this strategy because of the beneficial effects of previous attachment relationships in his life with teachers and mentors and spouses and friends. These people not only acted toward the person in ways that brought into question the validity of his pathogenic beliefs, they inspired him to comply with their attitudes and to use them as models of the kind of changes he should make.
- These experiences have left the person with a greater readiness for change in certain areas of his life than in others and have led the person to prioritize what he wants to accomplish. All of these decisions have been made at the unconscious level, and so cannot be adequately expressed consciously. Because there is no way for a therapist to accurately know where the patient is in his life and where he wants to go, the only reasonable course of action is to allow the patient to direct the course of therapy.
- The first issue that the patient must settle is whether it is safe to establish an attachment relationship with the therapist. Safety is a consideration because the patient instinctively realizes that an attachment relationship will induce him to comply with the therapist. So the patient needs the assurance that these compliances will serve his goals. The patient seeks this assurance by orientating the therapist verbally and then testing the therapist's understanding of his pathogenic beliefs and life goals. Passing the tests does involve disconfirmations, but the focus of the patient's attention is on the question of whether a therapeutic

relationship is possible. Toward that end, the patient wants to know whether the therapist will be traumatized by the patient's actions the way his parents seemingly were and whether the therapist will be traumatized the way the patient was by his parents' actions. This he accomplishes through transference tests and passive-into-active tests. When the therapist passes these tests, he feeds the hope that an attachment relationship can be safely established.

- The passing of a test creates a level of intimacy, which is the patient's proximate goal. Attainment of the goal causes the patient to relax and to become more insightful by way of confirming the existence of this more intimate level. This supposition implies that what a patient becomes insightful about should be related to the test that was just passed. I don't know of any research that has been done to confirm or disconfirm this supposition. The rule of thumb here is that the patient tests before he exposes, with the test indicating to the patient that the therapist will likely respond favorably to the self-disclosure.
- When the therapist fails to pass a test, the patient will become anxious because the prospect of a helpful attachment relationship has been put in jeopardy. The patient will also become less insightful for the same reason. The continuing desire for an attachment relationship, however, may induce the patient to coach the therapist either verbally or through a test that should be easier for the therapist pass. Again, disconfirmations are involved, but the focus of the patient is on the status of the attachment relationship the patient is attempting to establish with the therapist.
- After the patient has become assured of the safety of working with the therapist at a certain level of intimacy, the patient will begin working at that level for a time again through unconscious tests. I'm indicating that tests are used in two ways: (1) to establish a level of safety in working with the therapist and (2) then to work with the therapist within that zone of safety. It is difficult to say without further research how it would be possible to distinguish these two different activities. While working at a particular level, I would expect that the patient would utilize the therapist's interpretations and actively seek to internalize the model the therapist provides through his attitudes and reactions. I would also expect that the patient would use the therapist as the secure base in supporting growth initiatives outside of the therapist's office. After working at a certain level for a time, the patient will move to either a deeper level of intimacy or to a different area of his life. In either case, the patient would begin testing the safety of working at this new level or in this new area before proceeding to work there.
- In all of what I have said, I hope I have conveyed the impression that talk of disconfirmation is not wrong; it is often just beside the point. The patient's focus is on the relationship, and disconfirming pathogenic beliefs is only part of what the patient hopes to accomplish. The patient needs to establish his hoped-for self through experience, and to do this he needs to do more than establish that his pathogenic self is wrong. He needs also to make his hoped-for self concrete, which he accomplishes by seeing this self reflected in the therapist's eyes and in his attitudes toward the patient and by actively modeling the therapist behavior.



Disconfirmations create a void that needs to be filled by confirmations a positive nature.

- As Joe and Hal indicated, pathogenic beliefs do not dissolve upon being disconfirmed. They merely become temporarily deactivated as the person's hoped-for self takes control. As Bowlby believed, and as subsequent research has shown, however, a person's present state of adaptation is a product of both cumulative experience and the quality of the person's current attachment relationships. This means that although a person will never go back to being exactly what he was before therapy began, he may regress after therapy has ended, depending on the quality of the person's attachment relationships in his everyday life. If during therapy the person has not established any secure and intimate attachment relationships with anyone else other than the therapist, the likelihood is that the patient will regress without attachment support. Again, I know of no research that bears directly on this supposition that the degree of regression depends on the attachment relationships in the patient's life. Nevertheless, I believe that such a correlation should exist. Patients having secure attachment relationships after therapy ends should regress less than those lacking in such relationships.

#### **UNDERSTANDING CONSCIOUS–UNCONSCIOUS INTERACTIONS WITHOUT THE EGO OR ID**

As Joe Weiss pointed out, from about 1926 on, Freud began supplanting his drive theory—what Joe called his “automatic functioning hypothesis”—with elements of what Joe called a “higher mental functioning hypothesis,” a theoretical change that has been described as Freud's fledgling efforts at developing an ego psychology. Many theoreticians have taken up where Freud left off in developing their own ego psychologies, most of which are similar to Freud's in that they attempt to blend Freud's early automatic functioning hypothesis with his later higher mental functioning hypothesis. In stark contrast, Joe essentially abandoned Freud's automatic functioning hypothesis in his theory of the mind by declaring that the maladaptive infantile impulses Freud imagined “are never fundamental, for such impulses are invariably held in place by pathogenic beliefs.”

That declaration in effect did away with the id, as far as control-mastery was concerned, and since the ego was theorized as mediating between the demands of the id and those of the external world, it invalidates the concept of the ego as well. Yet neither Joe nor Hal offered replacement concepts to help in understanding the interactions between a person's conscious and unconscious selves.

In their later writings, Joe and Hal rarely used the term ego, preferring instead to speak of the person, by which they usually meant the unconscious person. The conscious person was recognized as being something somewhat distinct in Joe and Hal's formulation, but they never discussed what this somewhat distinct entity was and how it related to the unconscious self. I will take a stab at doing that now. And I will use the following quote from Joe as my source of inspiration:

A person may carry out unconsciously many of the same kinds of functions that he carries out consciously. He may think, make inferences, test reality, and make

and carry out decisions and plans. Moreover, he may exert some control over his unconscious mental life in accordance with these decisions and plans. In regulating his unconscious mental life, he is especially concerned with seeking safety and avoiding danger. He regulates his repressions and his inhibitions in accordance with this concern. He maintains the repression of a mental content as long as he unconsciously assumes that experiencing it would endanger him. He lifts the repression of the content when he decides he may *safely experience it* [my emphasis].

A repression may reach consciousness as a memory, which is to say as a visualization of a scene from a person's past, containing perhaps visual and auditory elements. A repression may also first surface as a mood or feeling or emotion. Joe's statement would seem to say that all of these manifestations should be considered as inner experiences in a literal sense. All of these types of manifestations are also part and parcel of a person's conscious self on an everyday basis, in that we visualize entities and utilize an auditory inner voice when we think, and we respond inwardly to life events in terms of moods, feelings, and emotions. This would argue that a person's conscious self is literally an experienced self, that it is a kind of self-created persona, and that the person's neurotic symptoms should be considered as inner experiences, too.

The control-mastery concept of unconscious testing would argue further that this experienced self is a creation of the unconscious self because the unconscious self's tests are put into play by this conscious persona, which turns out to be a mercurial entity whose characteristics are initially appropriate to executing the test and subsequently change depending on whether or not a test is passed. This implies that the general orientation of psychoanalysis is wrongheaded. The unconscious self doesn't merely repress; it is an active agent in creating a person's conscious persona. In understanding the unconscious, one should not merely be concerned about what is absent at the conscious level, but also what is present there, because whatever is there is put there by the unconscious self for a reason even when a test is not involved.

One consequence of this altered perspective is the realization that when a person consciously thinks, it is the unconscious self doing the thinking. That insight makes it trivially obvious that "a person may carry out unconsciously many of the same kinds of functions that he carries out consciously. He may think, make inferences, test reality, and make and carry out decisions and plans. Moreover, he may exert some control over his unconscious mental life in accordance with these decisions and plans." The altered perspective also creates the question of why the unconscious self needs to create the context of an innerly experienced persona. Why doesn't it interact directly with the world outside?

Control-mastery theory stresses the human need to adapt to an interpersonal environment. Another way of saying the same thing is to say that humans are highly social beings and that as a consequence they are attached to one another, with the net effect of these attachments being to give each person the power to psychologically impact others through interpersonal interactions. These impacts take the form of tendencies to instinctively comply with what others want, both within one's immediate circle of relatives, friends, and acquaintances, and the person's wider social group as well. These

compliant tendencies represent the orientation of our cognitive processes, defining what it is unquestionably correct for a human to do. They are usually discussed in terms of “empathy” or “compassion,” or “altruism,” or “a concern for others.” My notion of these compliances goes beyond these special-situation concepts to include behavioral alignment across many levels. Stern noted that infants instinctively use caretaker personalities as scaffolds in organizing their own personalities. Elements of that tendency persist throughout a person’s life with respect to all of the abovementioned people. This means that in any action, a person attempts to simultaneously satisfy the requirements of very many people, which impacts on the person’s self-assertiveness.

This is just another way of saying what Joe has already said, namely, that “a person’s most powerful motivation is to adapt to reality, especially the reality of his interpersonal world.” If that were the whole story, however, no one would seek therapy, because each perspective patient is already adapted to his present and past interpersonal worlds. That a patient has goals indicates that the patient senses a disparity between his present self as defined by his current adaptations and a vague yet tangible future self defined by the person’s burgeoning sense of desired destiny. I’m saying that patients come to therapy not merely to stop feeling miserable, but also to begin pointing their lives toward lifelong goals and aspirations that may at this point have only skeletal definition.

Realizing this does impact the way a therapist responds to a patient. I’m thinking now specifically of the case of Millie, which is perennially taught to those new to control-mastery at the March workshop. The therapist involved with the case focused on Millie’s misery and did a decent job of helping her. But toward the end of her therapy, Millie started to coach the therapist toward helping him understand that she was not just the frumpy little Jewish hausfrau she seemed, that she was in fact someone truly extraordinary. Occasionally she would let slip that she had done this and that remarkable thing recently that she failed to talk about during her therapy, indicating that there was much more to her than met the eye. Focusing on her “problem,” the therapist didn’t catch on, which of course Millie sensed would be the case, and which was why she was reluctant to talk about these aspects of her life. While I’ve never read the entire case history, my guess is that the therapist remained ignorant of who he was dealing with to the last.

People come to therapists in an impaired condition and during the course of their therapies become better able to begin taking steps in the directions of their desired destinies. Therapists’ preoccupations with patients’ impairments can lead to an inability to recognize that elements of a new person are emerging as therapy proceeds. I’m saying that during the course of a long therapy, the therapist should be ready to shift from a preoccupation with the patient’s past to helping the patient define the shape of his future. The patient needs to not only come to see how the past is influencing his present but also how it may be limiting his vision of a future. Needless to say, none of this should be done while violating the injunction to allow the patient to take a leading role in determining the course of therapy. Millie was in fact attempting to lead the therapist; the therapist’s limited vision prohibited him from following her.

I believe that the notion of a wished for self driven by a sense of desired destiny has validity as a psychological force whether or not pathogenic beliefs have stunted

development. After all, a person with no impairments is not a person with no goals, but rather someone whose sense of desired destiny is more well defined and an even stronger force in the person's life precisely because pathogenic beliefs have not stunted the developmental process.

This sense of desired destiny can be thought of as having genetic roots. It is known that elements of a person's genetic makeup are expressed in a person's behavior on a piecemeal basis as the result of experience. This means that as a person continues to develop, more and more of his genome becomes expressed while leaving a considerable amount unexpressed. This sense of desired destiny can be thought of as the voice of this unexpressed portion of a person's genetic makeup. Because this portion hasn't been brought into a person's life through experience, it has an ephemeral quality. Contributing also to this sense of desired destiny are aspects of the person's genome that have been expressed through experience in an undesirable way through the development of pathogenic beliefs. In this instance, the person must deal with unpleasant realities due to a developmental process that has gone awry. Because pathogenic beliefs involve realities seemingly confirmed by experience and unexpressed potentialities are ephemeral due to their being unsupported by experience, there is a tendency for patients to focus initially on the former, both because of the pain these cause and because they seem to discredit the promise of the person's unexpressed potentialities.

The point of this argument is to indicate that there is a developmental need for a person to have a basis for self-assertion whether or not that person is afflicted with pathogenic beliefs. Few if any of the people the person is attached to can accurately sense what the person can become. There is therefore a need for something to act as a buffer against a person's tendency to comply with other people's visions of what the person should be doing with his life. The person's persona provides that buffer. Precisely because his persona is experienced, the unconscious person reacts adaptively to it much as if it were another person. The persona adds to a person's mix of attached others someone who will support and protect the person's individualistic needs that would otherwise be swamped by instinctive compliances to attached others.

A person's persona should be seen as a motivational device consisting inner experiences, such as thoughts (inner voice), visualizations (inner visual images), feelings, emotions, and possibly neurotic symptoms, that support and defend a person's motivational core to the extent possible, given the pathogenic beliefs the person may have developed in the past. When such beliefs are absent, the persona provides a balance between the individual's needs and those of attachment figures. When such beliefs are present, the persona acts in more of a defensive mode in the sense of producing thoughts, feelings, emotions, and symptoms that prevent the person from exposing himself to experiences judged dangerous—that is, to experiences that would damage the person's motivational core by leading to failures or mortifications. In extreme cases, such inner experiences may bring the developmental process to a halt and may even be used to shut out external experiences for the most part. More generally, the persona of a person with pathogenic beliefs supports an ambivalent stance, which is largely defensive but open to safe developmental initiatives.

The way one learns what is safe or dangerous is through unconscious testing, which should be seen as determining whether movement in a particular life direction is likely to produce enough success to support a conscious commitment in that direction. Control-mastery theory describes this activity in terms of transference tests and passive-into-active tests, which is extremely helpful to therapists, but it should be recognized that other sorts of tests exist as well.

This discovery was made by me over 30 years ago as I was attempting to analyze Freud's Irma dream. Analyzing that dream meant analyzing many aspects of Freud's relationship with Wilhelm Fliess. Puzzling over that relationship led me to conclude that Freud was unconsciously testing Fliess in various ways. The notion struck me as so bizarre that I started looking around to see if anyone else had postulated that people do this sort of thing. That search led me to Joe Weiss.

The Freud–Fliess relationship can be analyzed in terms of transference tests and passive-into-active tests, and this analysis would reveal an important dimension of the testing, but it would also leave other important facets hidden. As Freud's biographer Ernest Jones has stated, Freud's and Fliess's conceptions of neurotic phenomena were initially diametrically opposed to one another even though both stress sexuality, yet neither seemingly was aware of this. It is possible to suppose that Freud was unconsciously aware of this and that the relationship with Fliess was partly a way of testing the validity of Fliess's views. Freud did this largely by developing neurotic symptoms, such as nasal infections and heart attacks and becoming Fliess's patient with regard to them. Freud also tested Fliess by referring his own patients to Fliess, which led to tragic consequences for at least one patient, Emma Eckstein. When one looks at the details of this relationship, one sees that Freud developed symptoms that could not possibly be explained by Fliess's theories, yet Fliess continued to concoct explanations for the symptoms in terms of his theories, nevertheless. One lesson Freud took from all this is that one need not be right in an absolute sense to be professionally successful, as Fliess was, which helped free Freud from a preoccupation with self-doubt. When Freud struck out on his own, he also incorporated many elements of Fliess's personality by way of rooting out this doubt. He even started quoting Fliess's dodge of having derived questionable facts from privileged information that came to him through his clinical practice.