NARCISSISM, MASOCHISM, AND THE SENSE OF GUILT
IN RELATION TO THE THERAPEUTIC PROCESS

Arnold Modell, M.D.
Joseph Weiss, M.D.
Harold Sampson, Ph.D.

THE PSYCHOTHERAPY RESEARCH GROUP
DEPARTMENT OF PSYCHIATRY
MOUNT ZION HOSPITAL AND MEDICAL CENTER

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Self Preservation and the Preservation of the Self:

An Overview of the More Recent Knowledge of the Narcissistic Personality

Arnold Modell, M.D.

As you know psychoanalysis has for the past decade or so been undergoing and continues to undergo a period of turmoil, confusion, and change. The calm assurance and optimism that has marked the period of ego psychology has given way to a time where psychoanalysis is constantly challenging itself from within its own ranks. The theoretical premises of metapsychology have been considered by some psychoanalysts to be in serious disarray; others consider metapsychology to be a useless relic of Freud's materialistic intellectual history. There is an active debate concerning what the philosophers call the "placement" of psychoanalysis; whether it is a science or a branch of history, hermeneutics, or linguistics. The impetus for this turmoil does not arise simply from philosophical or intellectual considerations, it has I believe a definite empirical—that is, clinical—base; I believe that our patients have been changing and some of our theoretical assumptions have been based upon a model of the neurosis that has in part become antiquated. It is these clinical issues that will be the focus of this presentation.

There are some who see this as a sign of a crisis within psychoanalysis; but crisis has a positive potential—for without change we are moribund, and crisis may lead to a new synthesis that is in closer accord with experience. All of this is not simply of parochial interest, for if it is true that the structure of the neuroses is changing this will have an impact not only on psychoanalysis but on the concepts and techniques used by all those psychotherapies that are all influenced by psychoanalysis.

My assertion that the forms of the neuroses are continually changing is not something that can be proven by a clinician. It would take a sociologist of the stature of Durkeim to demonstrate for neurosis what he did for suicide—that the frequency of suicide transcended considerations of individual psychopathology. But without being able to prove my assertion, I firmly believe that the neuroses are a barometer of historical change, that the current interest in narcissism follows from an actual increase in the so called narcissistic disorders, which in turn is the result not of chance but has been thrust upon us by social forces which we can only dimly perceive. The flamboyant, hysterical symptoms, those anesthesias and paralyses of Freud's day, are all but extinct. I can recall seeing a case of an hysterical paralyses of the legs when I was a resident, but I have not seen such a case since then. These symptomatic neuroses have been replaced by character neuroses—the so called classical psychoanalytic case. This type of patient is still with us but they are becoming rarer; they are now sought after by analysts in training, and as analytic students can attest, they are not easy to find.

The term narcissism has unfortunate connotations arising from its mythic origins. It is of course the myth of the youth who fell in love
with his own reflection and was tortured by the wish to possess what he
could not possess; so that he eventually stabbed himself to death. Psycho-
analysis originally considered the term to be descriptive of self love, a
series starting in auto-eroticism and ending in the love of one's own ego
ideal. This is misleading because what we call narcissistic is not primarily
erotic, but is a reaction to a disturbance between the self and the human
protective environment, what Winnicott called the holding environment. The
connotations of eroticism and self absorption inherent in the myth of
Narcissus have prevented us from recognizing that narcissism is the end
result of conflict between the self and the affirming or negating human
environment; in a larger sense it is a reflection of the sense of one's
safety in the world. The issue is further beclouded by certain theoretical
assumptions; that neurosis is an expression of intra-psychic conflict in
contrast to the psychoses in which the ego or the self is in conflict with
the external world. It is true that we have learned most about conflicts
concerning the separateness and autonomy of the self from our treatment of
the psychoses, and indeed the ever present wish for and fear of merging that
is characteristic of the narcissistic personality has been termed a psychotic
core. There is no technical justification to describe these phenomena as
psychotic; there is no concurrent loss of reality sense, and the people we
term narcissistic cover a broad spectrum from the frankly ill to those who
are socially very effective and successful.

In contemplating a change in the model of the neuroses we are forced
to consider the relation between this new arena of conflict, that between
the self and the environment and the more traditional source of conflict
in the neuroses—the Oedipus complex. The Oedipus complex may also be
active in the so called narcissistic personality, and I shall later return
to consider the relationship between these two sectors of the personality.

The relationship between the self and the human environment is in part
mediated through the sphere of affects; states of non-relatedness are one
type of manifestation in response to disturbances in the holding environment.
We are aware of whether someone is relating to us or not through the medium
of affects. States of non-relatedness may be characterized by the non-
communication of affects or the display of essentially false affects that
serve not so much as a communication but as a manipulation of the affective
response in the other. We are all aware of patients who induce in us a
feeling that there are not two people present in the consulting room, who
fill up the hours with talk, but whose words are essentially shorn of their
affective meaning. Or there may be sessions filled with strum and drang
but only later do we recognize that these affects are not genuine. This
is not to imply any conscious attempt to mislead but is understood as an
unconscious defense in which an affective response is elicited in the other
so that the other in turn will place this affective response back into the
patient who otherwise feels empty and dead. When someone is not relating
to me, I often feel sleepy and bored, and although we may all respond in
our own particular way, I believe it is axiomatic that when we are continually
in the presence of someone who is physically near us but not relating, we
will experience a profound affective reaction.

I have used the metaphor of the cocoon to describe the patient's
endopsychic perception of this state of non-relatedness. A cocoon is like
a fortress, yet it is self sufficient and requires no further nourishment,
it has the capacity for further growth but is in a state of suspended animation. To follow the analogy further, although it is walled off it needs to be attached to something. What I am describing is a state of omnipotent self-sufficiency; the belief that one does not need anything from others, which is an illusion that may paradoxically deny an extreme dependency. Such people may not be able to freely give or receive affection; they may be truly isolated within their fortress so that they neither hear nor receive anything from the outside. Some of my patients describe themselves as being encased in a plastic bubble, a mummy case, or, as Sylvia Plath perceived it, a bell jar. As one penetrates further into this phenomenology, one learns that the illusion of self sufficiency is reinforced by a magical belief that they occupy a protected sphere, removed from the dangers of the world, removed from the possibility of death, disease, and misfortune, that they are not "really in the world". In this sense they have achieved an illusion of invulnerability; they cannot be surprised, influenced, or controlled.

This kind of character formation has been understood as a response to trauma. This is explicit in Winnicott's work and more recently in Kohut's contribution. There is then a group within psychoanalysis that seeks to reinstate a model of the neurosis that Freud first proposed and then disclaimed. Ever since Freud learned that he had been misled by believing in his patient's phantasies of seduction by their caretakers, psychoanalysts have guarded themselves against any naive belief in the stories their patients tell them. We have become distrustful of our reconstructions. Of course there are no definitive guidelines that enable us to separate phantasy from historical fact. All we can say with certainty is that our reconstructions correspond to the patient's psychic reality, whether or not the patient's parents behaved as they have been reported to in the patient's treatment may be fact or phantasy. In spite of all these disclaimers, I tend to believe in certain reconstructions. For what we accept as the truth is not what the patient first presents to us, but is a picture that only gradually emerges after considerable resistance has been overcome. The initial portrait of a parent is usually idealized and a truer picture may take many months or in some cases several years to emerge. Although I do believe that significant failures of the parental holding environment have occurred, and what we term narcissism is in part a response to these traumas, as I shall shortly describe, we have also suggested that narcissistic disorders may reflect unspecified social forces, so that individual trauma alone cannot account for the adult neurosis. It is possible that certain issues may be selectively emphasized because of a restructuring of memory that occurs in adolescence and adult life. It has long been recognized that our memories behave very much as the Russians write their histories; that is, in accordance with current and immediate requirements.

Much of what we call narcissism is really a system for self preservation. We know that in human development, as is true of other species, the parents stand as a buffer between the young and a potentially dangerous environment. Information concerning this environment is usually transmitted through speech charged with a certain quota of affect. We have only to recall the observations of Anna Freud and Burlingham made during World War II that young children remained calm during bombing raids if their mothers were not anxious. So that, in a literal sense, the communication of affect between parent and child is vital for the survival of the child. What we can reconstruct from
our case histories is nothing as dramatic as the reaction to a bombing raid, but something that is more subtle and insidious. A common pattern in patients who are significantly narcissistic is that one parent is emotionally absent for significant periods of time and hence is simply not there to communicate. Such a parent may disguise this absence through the communication of affects that are essentially false and misleading such as "everything is wonderful dear". In some cases intelligent children will correctly observe that their parents are "off". In some instances a child may sense that a parent is in fact crazy although this fact may not be acknowledged either within or without the family. In other instances a parent may be correctly judged to be silly, or fatuous— that is, lacking good social judgment. These parents then become unreliable sources of information about the external world. George Orwell in his memoir of his life in an English boarding school described "a sense of desolate loneliness and helplessness, of being locked up not only in a hostile world but in a world of good and evil where the rules were such that it was actually not possible for me to keep them."

Added to the fact that such parents are an unreliable source of information concerning the world, they may ignore the child's right to his or her own autonomy, a lack of the parent's acknowledgement that the child is a separate being. This leads to a failure to grant a right to privacy, a right to control one's bodily functions and to retain an area of mind that is secret and cannot be found.

The response to these relative failures in the parental holding environment is a precocious maturation as if the child is saying to himself, "I cannot rely on my mother's judgment, therefore I have to be a better mother to myself." There is then a turning away from the caretakers and the establishment of an illusory system of self sufficiency—the cocoon. In the face of actual helplessness this system needs to be buttressed by grandiose and omnipotent illusions. It is in this sense I understand narcissism—that is, that the preservation of the self is a manifestation of self preservation. Affects are the markers of this process: non-relatedness signifies a giving up, a turning away; if affects are object seeking as I believe them to be, non-relatedness signifies that there is nothing to be had. This state of non-relatedness and playing the game of compliance or the introduction of false affects serves also to hide what is genuine and real. It serves to protect what Winnicott called the true self from being shattered by an unempathic response.

What happens when someone with this type of defensive organization enters into psychotherapy or psychoanalysis? Problems of safety or the entrustment of the self to another become paramount. If the trauma has been severe these issues may occupy the treatment to the exclusion of anything else, and may do so for months and even years. If treatment proves to be successful, if there is still a willingness to try again, the therapeutic setting will function as a new holding environment. Therapeutic gains may still occur in states of non-relatedness; one can have an object tie sometimes of great intensity and still not relate. I have used the visual metaphor in describing this as a sphere within a sphere; the patient may still be contained within his own omnipotent self sufficiency and yet is held by the larger sphere of the therapeutic environment. The
idealization of the therapist which may or may not be openly acknowledged
is, I believe, derived from the wished for illusion that someone stands
now between the self and the dangerous world. I have described this as a
form of transitional relatedness emphasizing the illusion of protection.
Kohut has, I believe, described essentially the same thing as a self-object.

This clinical description was intended to illustrate some aspects of
the phenomenology of narcissism as a contrast to what has been considered
the classical model of the neurosis. I have already alluded to the role
of trauma in the narcissistic neuroses. There is also implicit in these
neuroses a blurring of the boundaries between self and object, a condition
we have first encountered through our treatment of psychoses. In describing
a new model of the neuroses we now have to consider the Oedipus complex and
the related subject of transference. The belief that the Oedipus complex
is at the center of the neuroses has been until recently an almost unquestioned
assumption. Freud stated: "The Oedipus complex is the nuclear complex of
the neuroses, and constitutes the essential part of their content. It
represents the peak of infantile sexuality, which through its after-effects,
exercises a decisive influence on the sexuality of adults. Every new
arrival on this planet is faced by the task of mastering the Oedipus complex;
anyone who fails to do so falls victim to neurosis" (Three Essays on Sexuality,
p. 226).

We know that the centrality of the Oedipus complex was questioned by
Kohut who proposed that it is the disturbance of the self rather than the
Oedipus that is at the center of the narcissistic personality. We know
also that this idea is not entirely new as it is consistent with the
observations of Winnicott and others, but we are indebted to Kohut for so
forceably confronting us with this issue. What I have described earlier
under the heading of narcissism is a mixture of wishes, fears, and defenses
related to the autonomy and separateness of the self, and Kohut has tended
to view this as part of a self/object transference. However, I have come
to think that the term transference may be misleading here, as what we
observe is conceptually of quite a different order as compared to the
transference neurosis in which the Oedipus complex is central. The
uniformity of these manifestations, the fact that they recur repeatedly
in such a broad range of people, suggests that we are witnessing the
working through of developmental conflict concerning self/object differen-
tiation, and the related issue of the protection afforded by the human
environment. This is in sharp contrast to the variegated, highly
personalized transference neurosis reflecting an externalization of
imagoes derived from the Oedipus complex.

It would be a simple matter if we could adopt a nosological solution
for the model of the neuroses. If we could claim that the transference
neurosis occurs in the classical case where the Oedipus is still at the
center, then we can call these narcissistic phenomena something else.
Unfortunately, this cannot be clinically confirmed; there are instances
in which elements of transference neuroses and derivatives of the Oedipus
never appear to any significant extent; this, however, is the exception,
most people present a mixed picture with narcissistic features as well as
derivatives of the oedipus complex contributing significantly to their
conflicts and character problems. I do not believe that the disorders of
the self have essentially displaced the Oedipus complex: What I am proposing is that we maintain a certain balance about this problem; that the Oedipus complex, on one hand, and the system of self preservation encompassing the self and the human environment, on the other, comprise two separate organizations within the personality, or, if you will, two separate lines of development.

Kohut also spoke of developmental lines but in a very different sense. He separated the line of narcissism from that of object love, and viewed the self and the Oedipus complex not simply as separate developmental lines but as encompassing separate psychologies. He has contrasted the conflict, drive, and structural psychology to which the Oedipus belongs with the psychology of the self. In his last paper Kohut has in a sense "cleaned up" the Oedipal myth suggesting that parricidal wishes are the consequence of abnormal inter-generational relationships; that normally there is a joyous inter-relationship. My own analytic experiences do not support these conclusions.

I do not think that it is possible to think of the self apart from its affirming or negating object; the self cannot be separated from objects. It may at first appear perfectly obvious that the assertion that the Oedipus complex and the self system form separate developmental lines. But this is not the traditional psychoanalytic position. In the traditional view the history of object relations and the history of the Oedipus complex are completely intertwined. If we separate out the development of the self from the Oedipus complex we will have to revise radically our notions of what we mean by pre-Oedipal. The conflicts that I have described earlier concerning the autonomy and separateness of the self are traditionally placed within the pre-Oedipal period—that is, on a developmental line culminating in the Oedipus. The term pre-Oedipal itself denotes that the Oedipus is the point of reference, much as we date our calendars from the birth of Christ. The centrality of the Oedipus complex and the earlier centrality of the erogenous zones have had a lasting imprint upon the way we think of psychic development. Erogenous zones have points of closure; they are not unlike archeological strata, in that elements of earlier periods may persist into later strata. The pre-Oedipal phase has been thought of as such a layer with its point of closure at self/object differentiation. Therefore, the persistence of problems of self/object differentiation and problems of the autonomy of the self bespeak something primitive, archaic, or at least regressed. Our experience with the analysis of the so called narcissistic personality indicates that such problems can persist well into adult life and do not necessarily have such a pathological implication. There is a different developmental time table here, one that extends into adult life. On this point I am in agreement with Kohut. I have described this as a continued need for transitional objects that provide a sense of safety in the world and Kohut has described our continued need for self/objects. Self object differentiation does not reach a point of closure in the pre-Oedipal period. Narcissism is not so neatly arranged in a developmental hierarchy.

In thinking about the pre-Oedipal period, you might ask: Is not the pre-Oedipal mother a protective object for both sexes and is not one's relation to her eroticized? If this is true, how can you argue for a separate developmental line? Because of observations of this type, these
two lines have been thought to be intertwined. Freud, it seems, may have proposed a solution to this problem. In his Three Essays on Sexuality, regarding his description of autoeroticism, sucking, and the erotogenic zone, Freud states: "To begin with, sexual activity attaches itself to functions serving the purpose of self preservation and does not become independent of them until later". We know that something may be lost to us in translating Freud; it has been suggested that a more accurate term would be the word "props" rather than attaches. This emphasizes the temporary nature of this inter-relationship. One could say self preservation leans upon or borrows something from the erotic. The erotic provides a point of crossover in what are otherwise two separate systems with separate developmental time tables and organizations.

There is then a decided shift in our view of the role of the Oedipus complex in the structure of the neurosis. What I am describing are, of course, my own views; there is no uniformity of opinion within psychiatrists. There are those who believe that nothing has changed; that the Oedipus is still at the center and that narcissistic character structure is but an epiphenomenon. The self psychologists would have us believe that a complete revolution has occurred and that the Oedipus complex has in effect been replaced by disorders of the self. From what I have said earlier you will understand that I do not believe that the Oedipus complex has been extinguished by problems of the self; but that the Oedipus complex shares the stage with other forces equal in power, and as is true for the Oedipus, these other forces also have their roots in our phylogenetic history. I would like to illustrate this dualistic and what I hope is a balanced view of Oedipal and self psychology by referring to a common if not ubiquitous symptom—unconscious guilt. Some years ago, I described a form of guilt that was not derived from the Oedipus complex. At that time I mistakenly labeled it as pre-Oedipal, not understanding that I was observing a different series. This is a form of guilt that has its origin not so much in the preservation of the individual but in the preservation of the nuclear family. I first described this in a paper "On Having a Right to a Life". I understood this form of guilt as something that is experienced in the process of individuation—having the right to a separate existence is fraught with guilt. In this sense one can speak of separation of guilt. Behind this may be the universal belief that in order to be born someone else must die. Of course I am referring to the guilt of the survivor. We have learned about this guilt in its most extreme forms from survivors of holocausts. But survival also takes on more subtle forms and in this sense we may all be survivors. There is, I believe, in mental life an unconscious bookkeeping system that takes into account the current fate of other family members. Frequently other members of the family do not survive; those who achieve upward mobility may do so at the expense of the guilt of leaving the other family members behind. The suffering that this form of guilt imposes is not insignificant. This form of guilt does, of course, co-exist with the more familiar Oedipal guilt of surpassing the achievements of the parent of the same sex. But here the sex linkage is not so apparent; a son may feel guilty because of separation from his mother, and, as I have said, the fate of the other siblings is significant.

In addition to individuation, one can observe a related belief: that there is a limited quantity of "good" available to the nuclear family. If
someone has more the others invariably have less. So that the mere
possession of something good can evoke guilt. This, of course, includes
the good that one obtains from psychotherapy and psychoanalysis, so that
this form of guilt may contribute to the negative therapeutic reaction.
It will not have escaped you that there is a clear analogy between the
belief in a quantity of "good" as a concrete substance and the idea of a
limited supply of food upon which the survival of all depends. In addition
to the fate of other family members, there is no doubt that this type of
guilt will be affected by the intensity of one's envy and greed. So that
the analogy of "good" to food is even more apparent.

What I have been describing are essentially parallel organizations or
developmental lines within the personality: the Oedipus and the preserva-
tion of the self. Both foci obviously serve adaptive purposes. Oedipal
guilt enforces, however imperfectly, the maintenance of the incest taboo.
In this sense it is a biological given whose evolutionary function was
suggested by the geneticist Darlington as follows: "The incest taboo has
been the decisive agent in holding together not only each human tribe but
also the whole human species." The guilt that ensues from having more may
be the remnant of a similar originally adaptive "primal phantasy". In
many primitive societies there are unavoidable times of hardship during
which the band is threatened by extinction through starvation. The
prevalence of infanticide as a means of population control in primitive
societies attests to the need to adapt to a limited food supply. Therefore,
the altruistic impulse to share food promotes the survival of the group.
There are good biological reasons to inhibit greediness; the alternative
would be the survival of a few stronger individuals, but as has been
observed there is greater survival value in the group. I must add that
these ideas were proposed some years before the movement currently known
as sociobiology. They have popularized the survival value of altruism,
but: I wish, however, to disassociate myself from their simplistic belief
in the genetic origins of complex characterological and cultural phenomena.

The parallel lines of the Oedipus complex and self/object differentia-
tion are also illustrated by the life stage of adolescence. Adolescence
is well known to be under the domination of the Oedipus complex, but Peter
Blos also described adolescence as a second individuation; there is no
doubt that for the adolescent problems of separateness and autonomy are
as compelling as the problems of sexuality and the Oedipus. We would then
anticipate that the adolescent suffers from the guilt of separation as well
as the guilt of parricide. The destructive and self destructive behavior
of the adolescent may be an expression of the guilt of separating from the
nuclear family. Rage may, of course, also reflect the negativism that
promotes individuation. We assume that at every developmental step conflicts
derived from the Oedipus are interpenetrated by the conflicts of individuation.

I have been describing the narcissistic neuroses to be in part a
response to a relative failure in the parental holding environment, and I
have also invoked two organizational foci--the Oedipus complex and the
preservation of the self, both of which can be traced phylogenetically.
This view may appear, on the surface at least, to be inconsistent with our
earlier statement that neuroses are a barometer of social change.
Although we do not know the pathways through which society impacts upon the personality, to acknowledge these social forces is not inconsistent with an equal acknowledgement of developmental trauma and genetically predisposing primal phantasies. For example, the grande hystérie of Victorian days was no doubt in part a response to a society that forbade the open expression of a woman's sexuality within the home yet hypocritically permitted the luxuriantation of prostitution. The hysterical symptom was both a defiant sexual expression and simultaneously carried within its structure an element of punishment for what was forbidden.

The relation between culture and character formation is a very large subject indeed, so that I will not attempt an examination of the current literature other than to state that psychoanalysts are very much divided on this issue. There are many who are totally opposed to the view that narcissistic cases, although not a new form of neurosis, are increasing in numbers.

If it is true that the increase of narcissism is in part secondary to cultural change, then how does culture influence development? There are two general hypotheses: One, that cultural change is transmitted through the personality of the parents. This could be described as indirect cultural transmission. Another hypothesis, and one to which I subscribe, is the belief that the individual experiences directly the impact of culture during adolescence, and this impact may accentuate already existent character traits. For it is generally recognized that there is a re-organization of the personality in adolescence, that adult neuroses are by no means a simple recapitulation of a childhood or infantile neuroses. This second hypothesis can be termed a theory of direct cultural transmission. These two hypotheses are not, of course, incompatible.

If parents are increasingly emotionally unavailable to their children or are unempathic and intrusive, what we are describing is essentially that the parents themselves are more narcissistic. Then we would have to account for the increase in parental narcissism. Let us suppose that a marked increase in the incidence of narcissistic personalities occurred in the last fifteen years. If we are correct in this assumption, we are describing young adults who were adolescents in the late fifties and sixties, and had their infancy and childhood in the years following World War II. Their parents would for the most part have been children in the middle twenties. So that we would have to explain why this group of parents would have become increasingly narcissistic. The end of the twenties, of course, marked the beginning of the great depression, but the previous years were ones of relative stability compared to our own era.

An alternative hypothesis is: We need not posit an increase in parental narcissism, but only that the effect of the parent's neurosis has become magnified because of the loss of the extended family. The loss of the extended family may mitigate the pathogenic effect of a parent's narcissism. This is a plausible hypothesis but I personally find it less than fully convincing, as I believe that there is a more direct and profound relation between the failure of the human protective environment and narcissistic neuroses.
The critic Lionel Trilling, in his celebrated essay, "Sincerity and Authenticity", has grappled with the same problem. As he was a critic and not a clinician, he examined literature and not patients. He believed that in the late sixteenth or early seventeenth century something like a mutation of human nature took place, with the formation of a new type of personality, a personality centered on the virtue of sincerity. Trilling defines sincerity as the degree of congruence between feeling and avowal. Sincerity is judged to be a virtue as it supports the workings of society. Social institutions require a measure of trust in order to function so that sincerity, the congruence between feeling and avowal, is in its turn a measure of truthfulness. Trilling further believed that this mutation of personality coincided with the emergence of the idea of society much as we now conceive it; that there was a time in which the concept of society did not exist. If Trilling defines sincerity as the congruence between feeling and avowal, the breakdown of sincerity corresponds to what I have described as states of non-relatedness and non-communication.

We believe that the shaping of character is bi-phasic. The first phase is the familiar one of early development. The second phase may consist of a certain selective reinforcement or reorganization of the personality which occurs during adolescence when the individual begins to interact with and perceive directly the social environment in which he/she will become a full member. Our contemporary world confronts the adolescent with failures in the protective environment analogous to those experienced earlier in relation to the parental environment. This second disillusionment with our social institutions, a disillusionment that is far reaching indeed, is in part supported by the fact that there is in public life a gradual and accelerating erosion of trust; there is no longer any congruence between what people believe and what people say. This second disillusionment of adolescence will reinvolve those same coping mechanisms the individual used earlier.

Sincerity was rightly considered to be a moral virtue as it supported the underpinnings of society itself. So that spurious or counterfeit communications by the leaders of our society will reinforce those same responses that the individual learned earlier in coping with parental falseness. There is a reflexive reinforcement of the privacy and secrecy of the self which remains hidden behind a facade of compliance—that is, the facade of playing the game. The authenticity of the self remains private. It is the tragedy of those who present themselves to us as patients that they are also cut off from their inner authentic self—they have played the game too well.

In 1950 David Riesman and his collaborators in a remarkably prescient book, The Lonely Crowd, described a change in American culture—a shift from "inner directed" to "other directed"—a character change in the direction of compliance, turning off, and playing the game. This suggests that a certain degree of counterfeiting affects is socially adaptive. Pathology ensues when the counterfeiting of affects extends from the outer public sphere to the inner private sphere; so that the preservation of the private authenticity of the self is perhaps the paradigm of the normal narcissistic personality of our time.
There are additional analogies to be observed between our contemporary institutions and the early parental environment. Defensive narcissism is in part as we have described earlier, a reaction to the perceived loss of the parental protecting environment. The child correctly perceives that the parent cannot in fact protect him/her from the dangers of the real world. This is, of course, our present condition. The individual has always experienced a certain helplessness regarding his own fate. Human beings have always been at the mercy of uncontrolled social eruptions which can and do inalterably change their lives. Pasternak's Dr. Zhivago is perhaps the clearest example of this. But even after revolutions there is hope for the future. We all know that with the spread of atomic weapons there is a real possibility that civilization will be entirely destroyed—there is a possibility that there will be absolutely no hope. The response has been a search for hopefulness not in relationship to the world, but in relationship to the self. One cannot master one's own fate, but at least one can master the self, or the body that stands as a proxy for the self. Of course, this too is an illusion. Today the options for self determination appear to be limitless—one even has the option of changing one's sex. This is, of course, an extreme example, but we are witnessing amongst women an almost national obsession with bodily weight; it provides the illusion that at least the self as portrayed through the body can be controlled. The adolescent's search for consciousness altering drugs and the adult's quest for some quick psychological fix, is, I believe, in part a reflexive turning back to the self because one recognizes that our institutions are hopeless as sources of protection.

We all have a need for privacy and secrecy. We need to keep a part of ourselves isolated, hidden, and unfound. It is ironic that the social revolution that has resulted from Freud's discoveries may have inadvertently contributed to an intrusion upon this privacy. This is true for the unfortunate child whose psychoanalytically oriented parents interpret the unconscious meaning of his/her behavior. With the spread of psychological sophistication throughout society, almost anyone now can be an amateur psychoanalyst. So that public inauthenticity has combined with a certain intrusiveness to result in the narcissistic defense of non-communication.

The preservation of the self is a form of self preservation; narcissism is not a moral issue. It is an issue of adaptation and survival.

Arnold H. Modell, M.D.
401 Woodward Street
Waban, Massachusetts 02168
Notes on Unconscious Guilt, Pathogenic

Beliefs, and the Treatment Process

Joseph Weiss, M.D.

Thank you, Dr. Steinberg and Dr. Sokol, for arranging this symposium, and thank you, Dr. Modell, for your fascinating introduction to it.

Dr. Modell, I agree with many of your ideas. However, I shall approach them from a different angle.

My talk this morning will be mainly on "pathogenic beliefs". Pathogenic beliefs, as their name implies, are beliefs which give rise to psychopathology and conflict in the person who adheres to them.

Pathogenic beliefs are unconscious. They are a source of unconscious fear, anxiety, guilt, shame, and remorse. They arise in childhood from internal and external factors; that is, from impulses, purposes, and goals, and from experience. They play an important part in the development of all psychopathology, including masochism and narcissism.

(Parenthetically, masochism is a broader category than narcissism. Narcissism implies self-love—yet, narcissism is a source of unhappiness, and it is maintained by unconscious fear, anxiety, and guilt.)

Pathogenic beliefs underlie masochistic symptoms and traits, as well as narcissistic symptoms and traits. Incidentally, narcissistic symptoms and traits are almost always masochistic. For, despite being called narcissistic, they are a source of unhappiness and are maintained by unconscious fear, anxiety, and guilt.

Indeed, as Freud pointed out in some of his late writings, all psychopathology is maintained, partly, by guilt, and all psychopathology is, to some degree, masochistic.

The concept of pathogenic beliefs was evolved by Freud. Freud put great stress on the boy's idea that if he is sexually aroused by his mother, he will be castrated by his father. Moreover, he often, in his late writings, referred to this idea explicitly as a belief or a conviction.

Freud, however, did not fully develop his theory about pathogenic beliefs and their importance in mental life.

Freud's paradigmatic example of a pathogenic belief is, as I have stated, the idea of the young boy that if he desires his mother sexually, he will be castrated by his father. Such a belief, according to Freud, underlies much of the psychopathology of the neurotic male patient.
A narcissistic patient, such as Dr. Modell described, also suffers from an unconscious belief which warns him of danger. It warns him that were he to emerge from his cocoon he would risk the loss (not of his penis, as is the case with the male who suffers from castration anxiety), but of his sense of himself.

A patient who suffers from a pathogenic belief is not able, at least at the beginning of treatment, to state the belief in verbal propositional form. The belief is, at the beginning of therapy, generally unconscious. Moreover, it may never have been formulated in words. Indeed, it may function something like the inherent knowledge described by Michael Polanyi.

Yet an unconscious pathogenic belief, as Freud exemplified it by his discussion of the belief in castration, is a true belief. It is acquired, as Freud tells us (in Inhibitions, Symptoms, and Anxiety), by inference from experience through normal processes of thought. Moreover, the person who adheres to such a belief (according to Freud's model of mental functioning as he presented it in the Outline) is guided in his behavior by this belief, through use of his higher mental functions.

Freud's concept, of his late theory, that a person may guide his behavior unconsciously in accordance with an unconscious belief illustrates a crucial difference between Freud's early theory and his late theory.

In Freud's early theory (as in The Interpretation of Dreams) Freud assumed that unconscious behavior is always regulated automatically (that is, without thought) by memories of frustration and gratification which direct the flow of energy in the psychic apparatus.

In Freud's late theory (as presented in the Outline) the patient may think about a proposed course of action, and judge, on the basis of his unconscious beliefs, whether he may safely carry it out. He will, for example, not undertake a piece of behavior which he unconsciously assumes will put him in danger of being castrated.

I shall describe a number of pathogenic beliefs. But before I do so, I shall discuss the paradigmatic pathogenic belief, which is the belief in castration as a punishment for sexuality. I shall discuss this belief fully, not in order to emphasize its importance, but to prepare the reader to understand other pathogenic beliefs.

Freud's conviction about the importance of the belief in castration developed gradually. In The Interpretation of Dreams Freud referred to castration only once. He merely stated that it may be symbolized by baldness, decapitation, or loss of teeth. It was not until 1911 that Freud began to assume that it was the belief in castration which put an end to the Oedipus complex.

Freud did not assume the centrality of the belief in castration until, in his ego psychology, he stated that it is around the belief in castration that the superego is formed, and, in addition, that it is in obedience to the belief in castration that the child represses his sexuality.

(Parenthetically, Freud, in his ego psychology, described a common pathogenic belief other than the belief in castration. It is the girl child's belief that if she is sexually aroused by her father she will lose her mother's love.)
I shall continue now with more about Freud's development of his ideas about the castration complex.

Freud's conviction, which he developed over a number of years, that the unconscious belief in castration plays a central part in the life of the male was, in my opinion, an important factor in his developing his ego psychology.

The belief in castration, as Freud concluded, is deeply repressed, yet not part of the id. It is not a wishful fantasy. Indeed, it is a grim idea. Moreover, the id does not produce beliefs. It reacts to horrible realities, such as the possibility of castration, by automatically turning away from them.

The boy's belief in castration is contained in his ego, and it represents an attempt by his ego to understand the Boy's reality. In Freud's words it represents "a realistic fear, a fear of danger which is actually impending or judged to be a real one" (Inhibitions, Symptoms, and Anxiety).

Since the boy's fear of castration is, from the boy's perspective, a real fear, the boy's decision to repress his Oedipal strivings is adaptive. The boy represses these strivings in order to avoid danger. The boy's repression of his sexuality, in obedience to the belief in castration, may, of course, cause him serious symptoms. The boy, and the adult he becomes, may, because of such repression, become sexually inhibited, impotent, or unable to enjoy sex except under special circumstances. He may, in addition, develop a variety of symptoms, including obsessive hand-washing or agoraphobia. Both of these symptoms Freud traced ultimately to the castration complex.

As Freud pointed out in Inhibitions, Symptoms, and Anxiety, his new theory that repression is carried out in obedience to the belief in castration, transforms his concept of symptom formation. Earlier he had conceived of symptoms simply as compromise formations. Now he saw them as adaptive. For he conceived of symptoms as developed for the purpose of avoiding the danger of castration, which is perceived as a real danger.

Freud's conviction about the centrality of the belief in castration may have contributed not only to his concept of an unconscious ego but also to the revival of his belief in the importance of trauma in the development of psychopathology. For, according to Freud in Inhibitions, Symptoms, and Anxiety, the boy's coming to believe that he will be castrated for his sexuality is traumatic.

Trauma, then, plays a central part in the new theory of repression which Freud introduced in Inhibitions, Symptoms, and Anxiety. Freud's new theory raises an important question. It is: How does the boy acquire the belief in castration which he finds so traumatic?

In answering this question, Freud pointed to several factors:

A boy, Freud wrote, may acquire the belief in castration in relation to parents who are not especially threatening, for the boy may project his
own rivalry onto his father and thus perceive his father as threatening, even though objectively his father is not.

However, as Freud wrote in *Inhibitions, Symptoms, and Anxiety*, the boy's belief in castration may be abetted by real experiences with his parents. Indeed, Freud reminded the reader of *Inhibitions, Symptoms, and Anxiety* that Little Hans (a child whom Freud had studied years before) acquired his belief in castration directly as a consequence of his mother's threats to castrate him as a punishment for masturbation.

In the theory which Freud developed after *Inhibitions, Symptoms, and Anxiety*, he tended to emphasize the part played by the boy's real (and relatively undistorted) experiences with his parents in the development of the belief in castration. For example, in the Outline, Freud's last major theoretical work, he described the development of the boy's belief in castration in a typical case as follows: The young boy is sexually aroused by his mother as a consequence of her care for him. The boy then expresses his interest in his mother by showing her his male organ. As his interest in his mother continues, the boy comes to realize that his father is a rival for her and that his father stands in his way. Moreover, the boy's mother, realizing that the boy's masturbation is related to his sexual interest in her, forbids it. Since her prohibition has little effect, she threatens the boy with castration. She makes the threat credible by telling the boy that his father will cut his penis off. However, the threat may still have little effect unless the boy recalls (or perceives for the first time) the female genitalia. He then takes the threat seriously and in Freud's words, "experiences the severest trauma of his young life."

I have presented Freud's typical case from the Outline in some detail in order to show how, according to Freud, the boy's real and relatively undistorted experiences with his parents may play a considerable part in the boy's development of a belief in castration. I also have presented it in order to illustrate Freud's conception of how the boy develops the belief in castration by inference from experience through use of his higher mental functions. The boy puts two and two together. He infers from his mother's threats and from the sight of the female genitalia that castration is indeed used as a punishment for masturbation.

Freud's discussion of the boy's development of the belief in castration points to an object relations theory of development. The boy develops this pathogenic belief in relation to his parents, who are his first and most important objects. Freud's tendency, in his late theorizing, to assume an object relations theory of development is evident, too, in his discussions of the child's development of an ego and a superego.

Thus, Freud, in writing about the development of the superego in *Civilization and Its Discontents* and in the Outline, made the following points:

The motive for the child's developing a superego is his intense need for his parents. The child's wish to maintain his good relations with his parents is the most powerful motive of his life. The child desperately needs his parents to protect him from a variety of dangers. He thus dares
not risk the loss of their love. The child's wish to maintain his ties
to his parents is, of course, more powerful than his Oedipal strivings.
For it is to maintain his good relations to his parents and thus to avoid
punishment or rejection that the child decides to repress his Oedipal strivings.

The child must condemn in himself not only Oedipal strivings, but any
impulse, purpose, or goal which threatens his ties to his parents. What
his parents condemn in him he must assume is bad.

The child, by such condemnation, develops a conscience which at first
is external (that is, it is a fear of parental authority) but later becomes
internalized. The conscience, which the child develops in this way, continues
throughout the child's life, in Freud's words, "to observe his ego, give it
orders, judge it, and threaten it with punishments exactly like the parents
whose place it has taken" (Outline).

As Freud's discussion, summarized above, makes clear, the superego
as well as the ego contains beliefs. Some of these beliefs may be pathogenic.
Indeed, the superego (according to Freud in The Ego and the Id) is built
around a particular pathogenic belief—the belief in castration as a punish-
ment. The superego may contain primitive beliefs, such as the belief in
the law of the Talion. It may, as Freud wrote in the Outline, contain the
pathogenic belief, which is in back of most masochistic behavior, that the
person "must suffer and remain ill for he deserves no better." Or it may
contain mature moral principles by which it judges behavior.

The pathogenic beliefs of the superego may be sources of intense
irrational guilt. Such beliefs may play a great part in the development
and maintenance of psychopathology.

As Freud wrote in the Outline, a patient's need to suffer or to remain
ill (which I have pointed out Freud wrote may be based on the belief that
the person deserves no better) may be a source of the most stubborn resistances
to analysis.

Freud's views on the development of the superego (as I have already
indicated) suggest that the young child may develop a variety of pathogenic
beliefs and not just those which tell him that his Oedipal strivings are
dangerous. This is because the child must condemn in himself any strivings
which, as he perceives it, threaten his all important ties to his parents.

The three kinds of guilt which Dr. McDell touched upon this morning—
Oedipal guilt, separation guilt, and survivor guilt—are all based on
pathogenic beliefs, and all three kinds of guilt may give rise to serious
psychopathology.

I shall first consider separation guilt. Underlying this kind of
guilt (which Loewald considers universal) is a belief acquired in childhood.
It is the child's belief that if he becomes stronger or more independent
in relation to a parent, he may hurt that parent.

The child acquires this belief in the same way that he acquires the
belief in castration; that is, by inference from experience. Moreover,
as in the example of the belief in castration, his acquisition of this belief depends on various factors, some internal, others external. These factors include: the strength of the child's wish to become independent, his sense of omnipotence, his projections onto his mother of his feelings of dependence and, in addition, his real undistorted experiences with his mother.

The boy whose mother clings to him and becomes upset and weepy when he attempts to become more independent of her is more likely, all else being equal, to develop the belief underlying separation guilt than the boy whose mother is happy and accepting of his strivings for independence.

The child or adult who suffers from separation guilt may attempt to avoid the danger of experiencing his guilt by remaining weak, dependent, or helpless. Or he may even attempt to placate his conscience by becoming ill so that a parent or parent figure will have the opportunity of taking care of him.

I shall now consider survivor guilt. A person who suffers from survivor guilt (as Dr. Modell has written) assumes that the good things in life come in limited quantities. Therefore, the good things which a person acquires, such as friendships, health, love, money, fame, etc., he assumes he has acquired at the expense of others—especially the other members of his family: his parents and his siblings.

The child's development of the belief that he has acquired more than his share of the good things of life depends on a number of factors. These include the child's sense of omnipotence, his projections onto his parents and siblings of his oral cravings, the actual intensity of his oral greed, and, in addition, the way fate has, in reality, dealt with the other members of his family.

If all else is equal, the child whose parents and siblings have fared poorly is more likely to develop survivor guilt than the child whose parents and siblings are healthy and happy.

Survivor guilt may give rise to a variety of masochistic and narcissistic symptoms and traits.

A patient who is burdened by the belief underlying survivor guilt (namely, that he has received more than what he deserves and that he has acquired it at the expense of his parents and siblings) may avoid experiencing the guilt by giving up those desirable things which he has acquired but which his parents and siblings have not. He may torture himself as a parent tortured himself. For example, if a parent suffered from poverty, the patient may give away—or unconsciously arrange to lose—his money.

A patient whose father had ruined his own marriage by his uncontrollable temper dealt with survivor guilt (which in this case was inextricably mixed with Oedipal guilt) by ruining his marriage through producing uncontrollable temper. This patient's behavior, incidentally, is explained in Freud's early theory, not as stemming in part from survivor guilt, but as the expression of a primary affect—namely, rage.
A patient out of survivor guilt may suffer from any kind of maladaptive behavior, such as a parent had suffered from.

Dr. Modell has written of a woman who out of survivor guilt appeared cruel and heartless and thus narcissistic.

Erikson and Kris have both written case reports of men who because of survivor guilt lived impoverished lives such as their fathers had lived, even though they had the means and capacities to lead full rich lives.

Incidentally, Niederland's study of Holocaust survivors makes clear that a person may develop survivor guilt at almost any age if faced with a severe enough trauma. For in Niederland's study, persons of various ages who survived while their parents and siblings did not were subject to intense survivor guilt. Niederland's findings make clear, then, that there is not a specific age for the development of survivor guilt. The acquisition of survivor guilt depends on the kind of trauma which the child suffers rather than simply on when in the child's development he experiences the trauma.

The survivors whom Niederland studied expressed their guilt (or loyalty) to their dead parents by behaving as if dead. They looked like corpses, became pallid, silent, and moved quietly. They gave up all zest for life. Some of these survivors, with their lack of relationships with others, may be considered narcissistic.

There are a variety of pathogenic beliefs other than those which I have already discussed. A child may come to infer that almost any of his impulses, purposes, or goals may threaten his ties to his parents. He may, moreover, infer that his parents will react to various of his impulses, purposes, and goals in a variety of threatening ways. Thus a child may, in developing a pathogenic belief, make a causal link between any of a variety of purposes and goals and any of a variety of dangers and punishments.

One child may infer that if he is happy and independent he will worry his parents. Another child may infer that if he is dependent and clingy he will drain them. Or, the same child may infer both of these.

A child may infer that he must be a bad boy in order to protect an older sibling whom his parents are worried about and whom they wish to perceive as the good child.

One child may infer that by competing with a parent, he will provoke the parent to compete with him. Another child may infer that by competing with a parent he will provoke the parent to reject him. Still another child may infer that he must be competitive with a parent, in order to assure the parent that the parent hasn't crushed him.

I have so far described just one sequence of events by which a child may develop a pathogenic belief. According to this sequence a child first attempts to gratify a particular impulse or to reach a particular goal in relation to his parents, only to discover (as he experiences it) that by doing so he threatens his all important ties to his parents. The child
then develops and retains a belief which causally connects his attempts to gratify the impulse or to reach the goal with the threat to his parental ties.

I shall now discuss a second sequence of events by which a child may develop a pathogenic belief. It begins with an inherently traumatic event, such as the illness or death of a parent. The child then retrospectively blames himself for the event. He concludes retrospectively that he brought it about by attempting to gratify a particular impulse or to reach a particular goal. The child then develops and retains a pathogenic belief making a causal link between his attempts to gratify the impulse or to reach the goal and the catastrophic event.

A child, for example, who is separated from a parent may retrospectively conclude that he provoked the parent to leave him. He may assume that he was too strong for the parent, too hostile, too demanding, too competitive, too active, too dependent, etc.

Just how and for what crime the child blames himself retrospectively for a traumatic experience, such as separation from a parent, depends on a number of factors. One such factor is the child's motivations at the time of the trauma. The child is likely to assume that he provoked the trauma, not by some trivial motivation, but by his attempts to realize some crucially important purpose or to reach some crucially important goal.

Another factor is the way the child had perceived his parents as reacting to him before the trauma. A child is likely to blame himself retrospectively for those of his impulses, purposes, and goals which, before the trauma, he had experienced as upsetting to his parents. That is, he is likely to blame himself for impulses, purposes, or goals which seemed to him to provoke worry, anger, or punishment from his parents.

The great part played by retrospective inference in the lives of many children points to the child's tendency to take responsibility for whatever happens to him. The child assumes that what his parents or fate mete out to him is what he deserves. (As Freud pointed out, those whom fate treats well tend to feel they are good. Those whom fate treats poorly tend to feel they are bad.)

It is the child's tendency to assume that what he gets from his parents or from fate is what he deserves that makes possible his developing a superego. If the child did not feel that he deserved the treatment preferred him by his parents, he would not develop a superego which, as Freud wrote, "threatens him with punishments exactly like the parents whose place it has taken."

The idea that the child takes responsibility retrospectively for what happens to him is strongly supported by an empirical study conducted by David Beres about the effect on certain children of separation from their parents. Beres (whose findings are reported in the Psychoanalytic Study of the Child, 1958) studied a number of children who were separated for various reasons from their parents. He found that the child who was separated from a parent invariably assumed that he had provoked the separation from the parent by being bad in one way or another.
The readiness of the child to blame himself for separation from a parent (as reported by Beren) may be explained by the child's intense need for the parent. Most children, of course, blame their parents for a variety of lesser crimes. However, generally a child would be terrified if he were to permit himself to be conscious of his belief that a parent has no love for him, or that a parent might wish to get rid of him, or to kill him. Such an idea is terrifying because the child must depend on his parent for his very existence. A child can scarcely tolerate perceiving his parent as malevolent, fatuous, or intensely hostile. He would rather see the fault in himself.

I shall end my discussion of the development of pathogenic beliefs from retrospective inference with a brief example.

A patient, at 2½, was, without warning, sent away for three months to stay with his uncle and aunt. He was sent away because his younger brother had developed rheumatic fever and the family did not have the energy to care for the patient.

The patient was not told why he was sent away. His father drove him to his uncle's and aunt's home and left him there with no explanation. The patient, as we were able to discover in analysis, had become active, rowdy, mischievous, and defiant before he was sent away. Moreover, he had, by his rowdy, defiant behavior, been provoking his parents. The patient had assumed, obviously incorrectly, that he had been sent away as a punishment for this behavior. At his uncle's and aunt's, he became extremely docile. He stopped being rowdy and became a model boy. Moreover, on returning home, he was less playful and outgoing than before, and he remained so from that time on.

The patient, who was unmarried, entered analysis in his early thirties. In his treatment he reenacted some of the elements in his childhood situation. Though he was a model patient at first, he eventually became rowdy and mischievous. He began to have numerous affairs, to drink excessively at times, and to cut up at parties. He became aware then that he feared that the analyst would disapprove of him and indeed that he would consider him a very difficult patient, or even would reject him.

It was only after the patient's fear of provoking the analyst was analyzed that he was able to tell the analyst, with some clarity, about the childhood situation which I have described above. Moreover, the patient, after remembering more about the story which I have reported, confirmed his recollections by asking his parents about his behavior before, during, and after the separation.

Many factors other than those I have discussed played a part in this patient's childhood trauma. Among them was
his jealousy of his brother, who was allowed to stay home, and
his anger at his parents for sending him away. Nevertheless,
a crucial part in this patient's neurosis stemmed from his
unconscious belief, which he inferred after being sent away,
that unless he were compliant and unless he curbed his
exuberance, he would be punished by rejection. He curbed
his exuberance out of compliance to what his parents had, as
he experienced it, meted out to him.

I have, until now, been developing the thesis that pathogenic beliefs
and the fear, anxiety, guilt, shame, and remorse which stem from them play
an important part in the development and maintenance of psychopathology.
It is, I have argued, in obedience to pathogenic beliefs that the child
wards off the impulses, purposes, and goals which he perceives as dangerous.
Moreover, it is to avoid the dangers which his pathogenic beliefs foretell
that he may develop symptoms.

This, of course, does not mean that pathogenic beliefs are the only
factors in the maintenance of psychopathology. The impulses and goals which
the patient wards off in obedience to the pathogenic beliefs also may play
an important part. The gratifications which the warded off impulses and
goals find in the patient's symptoms or character distortions may provide
the patient with another motive for maintaining his repressions and indeed
his psychopathology.

Consider, for example, a child who would like to be independent of
his parents, but because of separation guilt feels obliged to remain dependent
on them. Though such a child would rather be independent than dependent, he
may derive considerable gratification from his dependency on his parents.
He may then maintain his dependency not only because he is afraid to become
independent, but also in order to maintain the gratification which he attains
by being dependent on his parents.

I would like now to compare the view of psychopathology which I have
been presenting with the alternative view, that certain psychopathology
arises from a personality deficit, which a patient may incur as the result
of poor parental care.

The two concepts are related but not identical. Both concepts assume
that poor parental care (or what is perceived as such) may result in psychopa-
thology. However, the concepts differ in their views about how this
happens. The one concept assumes that the child who does not receive
adequate care and love develops a personality deficit. The other concept
assumes that the child who does not receive adequate care and love develops
a pathogenic belief. He comes to believe that he does not deserve to be
loved and cared for. He assumes that the quality of the care he received
is the quality of the care he deserved.

Such a person does not need to overcome a deficit. Rather, he needs
ultimately to become conscious of and to change the pathogenic belief that
he does not deserve to be cared for. It is this belief which underlies
his symptoms. He may manifest this belief in many ways. He may refuse
to ask for love, or he may demand love provocatively. He may be self-centered,
or he may display his neediness and sadness.
Such a patient may test the analyst by attempting to provoke the analyst into rejecting him, or he may test him in some other ways. He may begin to be helped by the analyst if the analyst, in the face of his tests, maintains a reliable, steady course and thus does not reject him, but offers him a sense of safety and security.

If the patient does benefit from the analyst's steadiness, it is not because he is overcoming a deficit, but because he is beginning, by testing the analyst, to disconfirm the pathogenic belief that he deserves to be rejected. As I have pointed out, a patient, who, for example, displays a self-centered, arrogant behavior, is, by pulling for the analyst to reject him, testing the analyst. He is making use, as Freud described in the Outline, of a "trial action". More specifically, he is attempting, by testing the analyst, to find out whether he may rely on him.

The patient, by such testing of the analyst, may, if the analyst proves reliable, begin to develop more trust in him. If the patient develops such trust, he may be taking a first step in a process which, if successfully carried out, may lead him to certain insights. These are insights into the pathogenic belief that he does not deserve to be taken care of, and insights, too, into the origins of this belief in the motives and in the traumatic experiences of his childhood.

The patient, by such testing as I have described, is attempting to advance his therapy. He is, to use Anna Freud's words, attempting to "extract in the transference those experiences which he needs in order to do analytic work."

If the patient is able to convince himself that the analyst will not neglect him as, in his opinion, his parents had neglected him, he may develop a more secure relationship with the analyst. Such a relationship may make it safe for him to remember the pathogenic belief that he deserved to be rejected, and to remember, too, the motives and the traumatic experiences of his childhood from which he inferred this belief.

I have, in the schematic example presented above, pointed to several implications of my view that pathogenic beliefs play a large part in the development and maintenance of psychopathology. One implication is that the patient in a successful analysis must become conscious of and change his pathogenic beliefs.

The patient himself, in my view, is strongly motivated to do so. Indeed, though a patient may be strongly motivated to maintain the repression of certain infantile impulses because they are a source of gratification for him, he has no such motive for maintaining the repression of his pathogenic beliefs. Pathogenic beliefs are not a source of gratification, but of unconscious anxiety, guilt, shame, and remorse. The patient feels constricted, frightened, or weighed down by them, and so is powerfully motivated to make them conscious and to change them.

A patient keeps his pathogenic beliefs unconscious, not to obtain gratification, but to avoid fear, shame, anxiety, and guilt, and in addition
to avoid endangering himself by threatening his ties to his parents, his parent surrogates, or his conscience.

The patient, as I have suggested, works to disconfirm his pathogenic beliefs by testing them in his relationship to the analyst.

Another of the implications of the views I have presented is for technique. It is that the analyst must remain steady and reliable not simply to frustrate the patient's repressed impulses, but also to make it safe for the patient to work, by testing the analyst, to disconfirm his pathogenic beliefs, make them conscious, and ultimately to remember the childhood experiences from which they were inferred.

I shall end my paper now with a brief clinical example which illustrates the ideas about pathogenic beliefs, testing, and safety, which I have presented above, and which, in addition, throw light on the development of narcissism.

This patient, to use Dr. Modell's phrase, lived in a kind of cocoon. She had felt rejected in childhood and she still suffered from the belief that she deserved to be rejected.

The patient was an unmarried lawyer in her early thirties. She had low self-esteem, was depressed, plodding, and inhibited. She made no friends. She perceived herself as boring and deserving to be rejected, but attempted, by a dogged kind of cheerfulness to make herself interesting.

The patient pictured her home life in childhood as bleak. Her mother, as she remembered it, was depressed and almost incapacitated: She would make no effort to cook dinner, but would merely open some cans of food and put them on the table. Then everyone would sit around in silence. The patient did not receive much from her parents, nor did she give much to them. She was afraid that if she offered her parents something that they would reject it.

She made slow progress in her analysis. Gradually, over a period of several years, she became more able to tolerate her anger at her parents and her feelings of rejection by them. She also became aware of similar feelings to the analyst. As she faced these feelings, she improved a little. She developed a few friendships and did better in her work. Then, during the fourth year of her analysis, she announced one day that she would like to terminate analysis in about three months. She stated that she had made considerable progress, had learned a lot about herself, had several casual boyfriends, and would be able now to do alright on her own.

The analyst, over the next several months, attempted to investigate the patient's motives for terminating. The patient's associations to a dream suggested the interpretation that she wanted to terminate in order to protect the analyst from her
anger and disappointment with him. The patient considered this interpretation, thought it plausible, but did not change her mind about stopping.

On another occasion, the analyst, in response to the patient's productions, told the patient that perhaps she wanted to reject him before he rejected her. On still another occasion, he suggested that the patient was planning to stop because she believed she did not deserve more help. She had assumed that her parents considered her unimportant, and she wished to comply with what she assumed was their image of her. Though the patient was moved by this last comment and produced some corroborating material, she did not change her mind. However, she did acknowledge that she was uncertain about why she was so determined to stop.

Finally, as the patient's deadline approached, the analyst told her that though he had not been able to demonstrate to her in a convincing way that her wish to stop stemmed from her resistances, he nonetheless believed that it did. He also suggested that she continue treatment until the motives for her stopping, which she acknowledged were not clear to her, did become more clear.

The patient protested that there was no need to continue. However, she looked slightly less tense than usual. Then, at the end of the hour, she said grudgingly that though she was going against her better judgment, she would continue for a while longer. Then, in the next few sessions, the patient seemed less depressed and friendlier to the analyst. About a week after she agreed to continue, the patient, in associating to a dream, brought forth a new memory. She remembered that one day, when she was seven, gang warfare with shooting erupted in her neighborhood. Everyone was frightened, and the mothers in her neighborhood made their children stay inside. However, the patient's mother reacted differently. Instead of making the patient stay home, her mother gave her some money and sent her out to buy groceries. The patient assumed that her mother wanted her to be killed because she (the patient) was too much trouble for her mother.

The patient was so overcome with sadness at this memory, which she said she had not thought of for years, that she wept for half the analytic hour.

The patient subsequently recovered more memories about feeling deeply rejected by both parents. She recognized that she had, since childhood, always believed that she was a pest, a bother for people, and someone whom no one wanted to be with.

The patient decided to continue treatment, which now became more productive than before. During the next phase of her treatment, she faced more directly her fear of being rejected by the analyst, and by her boyfriends.
In this case, the patient, at the beginning of treatment, was aware of her fear of rejection, but she did not feel it affectively. In her analysis, she dealt with the danger of being rejected by threatening to quit. By threatening to quit she was identifying with her mother—that is, she was reversing roles and rejecting the analyst as her mother had rejected her. Moreover, she was by her behavior defending herself against the development of the transference.

However, in addition to the above, the patient, by threatening to terminate, was also testing the analyst to determine whether he would reject her. When he did not but instead stuck to his job of analyzing, the patient felt reassured. She experienced the analyst's tenacity and his suggestion that she continue for a while as evidence that he would not treat her as she assumed her mother had treated her.

The patient's increased trust in the analyst, and her conviction that he would not reject her, enabled her to face the sadness that she had been warding off for years. She had, by developing a more trusting relationship with the analyst, experienced a sense of safety with him such as she had not experienced with anyone for a long time. She was able, as a consequence of this sense of safety, to lift her repressions and to experience her sadness and loneliness.

The patient presented above also illustrates the point I made earlier that a patient may, because of survivor guilt, behave maladaptively, as a parent had behaved.

As the patient, much later in her analysis, became relatively happy and outgoing, she began to feel intensely sorry for her mother, whom she began to realize had lived a bleak and barren life.

As long as the patient had been withdrawn and constricted like her mother, she did not have to realize (affectively) how barren her mother's life had been. However, as she became happy and different from her mother, she could clearly see her mother's misery. Thus, one motive for the patient's maintaining her own misery was to avoid feeling sorry for her mother, and guilty to her.

Finally, this patient's analysis illustrates another point which I made earlier. It is that a person tends to believe that what he gets is what he deserves. His symptoms and traits, then, may express his compliance with his parents and with fate. The patient presented above had experienced her mother as rejecting and even as wanting to kill her. She had complied with what she perceived as her mother's wishes and so had felt unimportant, or perhaps even unworthy of life.
Pathogenic Beliefs and Unconscious Guilt in the Therapeutic Process: Clinical Observation and Research Evidence

Harold Sampson, Ph.D.

Thank you, Dr. Sokol. On behalf of the participants in this conference, I would like to express our appreciation to you for the gracious hospitality you have shown us.

I am pleased to participate in this symposium. The problems of masochism, narcissism, and unconscious guilt confront the clinician in his daily practice. These problems also engage the interest of any serious student of human behavior. Dr. Modell and Dr. Weiss have addressed these human problems with originality, with breadth, and with clinical sophistication.

Weiss, in his presentation, illustrated the role of pathogenic beliefs, and of the unconscious guilt to which they give rise, in both masochistic and narcissistic pathology. In my talk, I shall first review certain of the ideas which Weiss proposed about pathogenic beliefs, and their relationship to the unconscious sense of guilt. I shall then develop how these ideas apply to the therapeutic process. Finally, I shall present some preliminary evidence—both from clinical observation and from formal research—which cast light on the power of these ideas to explain certain therapeutic processes.

Background

Freud recognized only relatively late in his theorizing how powerful a role unconscious guilt plays in the therapeutic process. He himself noted (Inhibitions, Symptoms, and Anxiety, 1926, p. 160) that resistances to analysis stemming from the superego were "the last to be discovered". Moreover, he describes resistance based on the unconscious sense of guilt as the most powerful one of all, "and the one most dreaded by us" (The Question of Lay Analysis, 1926, p. 224).

Freud had introduced the new concept of an unconscious sense of guilt and of the resistances to analysis which stem from it (in The Ego and the Id, 1923, pp. 49-50), just a few years before the comments quoted above. He began his account of unconscious guilt with a clinical observation; namely, that:
"There are certain people who behave in a quite peculiar fashion during the work of analysis. When one speaks hopefully to them or expresses satisfaction with the progress of the treatment, they show signs of discontent and their condition invariably becomes worse...One becomes convinced not only that such people cannot endure any praise or appreciation, but that they react inversely to the progress of the treatment. Every partial solution that ought to result, and in other people does result, in an improvement or temporary suspension of symptoms produces in them for the time being an exacerbation of their illness; they get worse during the treatment instead of getting better. They exhibit what is known as a 'negative therapeutic reaction'."

Freud noted that for these people recovery is dreaded as a danger. Their resistance to recovery, he said, is based on a "moral" factor, a sense of guilt. He emphasized that the sense of guilt is unconscious: "...as far as the patient is concerned this sense of guilt is dumb; it does not tell him he feels guilty; he does not feel guilty, he feels ill."

Freud noted that the therapeutic obstacle posed by the unconscious sense of guilt is difficult to overcome: "Nothing can be done against it directly, and nothing indirectly but the slow procedure of unmasking its unconscious repressed roots, and of thus gradually changing it into a conscious sense of guilt."

Freud's insights into the powerful role the unconscious sense of guilt plays in psychopathology and in therapy were enriched over the years both in his own later work, and in the work of many others. I shall mention a few of the subsequent contributions which are particularly pertinent to my theme:

(1) Freud and others recognized that the unconscious sense of guilt is universal, and that resistances to recovery which stem from it are also universal. Modell, for example, in discussing patients who have a belief that they have no right to a better life, said, "I am attempting...to understand a human problem which influences to varying degrees the course of most people's lives."

(2) Freud and others recognized that in addition to Oedipal guilt, a sense of guilt may arise in a variety of other contexts. The sense of guilt may be related not only to murderous or incestuous impulses, but may also be related to reasonable ego goals, such as to have a life of one's own. For example, various people, including Modell, have written of "separation guilt" and of "survivor guilt."

Several writers have also suggested that a sense of guilt may arise from any traumatic experience. The child (or even the adult) is likely to feel responsible for the trauma. He is likely to experience it as a punishment, and to develop pathogenic beliefs about how he caused it and deserved it. Moreover, he is likely to develop guilt stemming from these beliefs.
As Weiss has emphasized, the child may link virtually any kind of impulse or goal to the trauma. For example, a child may believe he caused his mother to be burdened and unhappy because he is too dependent on her or too independent; because he is too strong or too submissive; and so forth. For example, Weiss presented a case yesterday in which a boy of 2½, who had been sent to his uncle and aunt's when his brother became ill, concluded that he had been sent away because he had been too active, too rowdy. (He thereafter became a very docile, model boy—in obedience to this belief and to the dangers it foretold.)

(3) Many analysts and other clinicians have also contributed to an increasingly rich clinical understanding of the diverse ways in which unconscious guilt may give rise to symptoms and may be a powerful factor in therapy. For example, behavior expressing rage or fury or lust may be based primarily on guilt, even though it may seem simply like an attempt to gratify an imperious primitive infantile wish. Or, behavior which is narcissistic, self-absorbed, and lacking in empathy for others may be based in part on identifications resulting from survivor guilt, as in one of the cases Weiss mentioned yesterday.

I should like to illustrate what I have just said with a brief vignette from a case described by Modell in his 1965 paper on having a life of one's own. I'm going to quote from this vignette because it illustrates so vividly how narcissistic behavior, and bizarre infantile behavior, may be motivated by an unconscious sense of guilt.

Modell's patient was a woman who had married well, and "had an interesting job at which she displayed considerable talent. But she was compelled to negate whatever she possessed. She dispelled the pleasure in her marriage by increasing provocations. And what she had in fact achieved in life—for she had risen above the economic and social status of her parents—she dispelled by means of the conviction that it was all unreal. She was only acting. She was simply playing the part of a young matron culled from the pages of a women's magazine." (That is, Modell's patient presented her real achievements and her more mature functioning as phony, as only acting.)

"Psychoanalysis was something that she was much too guilty to accept. She could enter analysis if she used the rationalization that she was doing it for her husband's sake. She could not bear having a better life for herself. She had too much already. Her deepest conviction was that she had no right to a life better than that of her mother, which was perceived by her as a life of hardship and degradation."

Let me pause to note that the patient did not present herself as guilty and undeserving and as having the conviction just noted—rather, this picture of the patient was gradually inferred by the analyst, and only later did it become conscious to the patient. Let us now see how she did present herself initially:
"At the beginning of the analysis her unconscious mind did all it could to sabotage the work of the analysis. There was a massive effort, completely unconscious, to present herself in such a manner that I would be convinced she was not unsuitable for analysis. In addition, I suspect that she was able to sense that analysts find it most difficult to accept those who have no feeling for others, and she correspondingly presented herself as someone entirely devoid of human feeling. For example, she related the death of a friend's child without revealing the slightest trace of an emotional response. She presented herself as bizarre, with the unconscious wish that I would think her psychotic; she recounted how she threw her cat against the wall of her apartment in a fit of rage, how she masturbated with a fireplace poker, etc.... It was only when I realized that the underlying issue was her conviction that she had no right to the analysis, that she had no right to a better life, that we were able to establish the beginning of a therapeutic alliance."

Finally, I should like to emphasize a contribution to the understanding of unconscious guilt which is implicit in the work of many writers, and has been explicitly developed by Weiss: Unconscious guilt stems from pathogenic beliefs. For example, in the clinical vignette by Modell which I have just quoted, the patient's guilt was linked to the pathogenic belief, initially unconscious, that she had no right to a better life than that of her mother. This belief was related to another unconscious belief, as Modell discovered; namely, the belief that if she possessed anything that was good, it meant that she had deprived someone else, in this case her mother. A good life was something she could have only at someone else's expense. Her sense of guilt about anything good in her life stemmed from this belief.

Pathogenic Beliefs and the Therapeutic Process

Now I should like to review and expand Weiss's ideas on pathogenic beliefs. These ideas give us insight into how the patient and therapist may overcome what Freud described as the most powerful resistance of all, resistance stemming from the unconscious sense of guilt.

As we've noted, pathogenic beliefs play a prominent role in the development and maintenance of psychopathology.

Pathogenic beliefs are acquired in trauma. In acquiring them, the patient's actual experiences are an independent factor in their development. They cannot be derived from impulses and defenses alone. For example, the child who wishes to become more independent of his parents is likely to develop more guilt about doing so if his parents appear to be hurt by his independence. And Niederland's holocaust survivors did not develop the belief that being alive was a betrayal of their murdered parents and siblings because of unique instinctual wishes and unique defenses against them but because of the unique and horrifying life experiences which befell them and their relatives.
(3) These beliefs are not like unconscious wish-fulfilling fantasies:

(a) They are not fantasies, but theories about reality. They are created by the ego, and not by the id. They warn the adherent of the belief about the dangers of certain impulses or goals. Hence, the purpose of these beliefs is adaptive rather than wish-fulfilling.

(b) They are grim, unpleasant, and constricting.

(4) Therapy must make these beliefs conscious and overcome them, for the patient's conflicts are maintained by the beliefs.

(5) The patient himself is powerfully motivated unconsciously to overcome these beliefs, with the help of the analyst. The patient is motivated to overcome these beliefs because they are grim, unpleasant, and crippling, rather than unconsciously gratifying.

(6) Indeed, the patient works actively to overcome these beliefs. This work is carried out unconsciously, for the most part. The patient, in working to overcome these beliefs, may:

(a) Develop and carry out unconscious plans to test these beliefs in relation to the analyst.

(b) He may also hear the analyst's comments and interpretations primarily in terms of whether or not they disconfirm the beliefs he is working to overcome.

Evidence Pertaining to These Ideas

I should now like to take up evidence pertaining to the explanatory power of these ideas. I shall do so through the use of both clinical observation and formal research. I shall begin by reviewing in capsule form a case presented yesterday by Weiss. I will show how this case illustrates an important sequence of events which is predicted by these ideas. I shall then present additional clinical observations which are in accord with the predictions. Finally, I shall describe some formal research which yielded findings consistent with the predictions.

My exemplary case is that of the woman lawyer who believed she deserved to be treated as unimportant, and to be rejected. Weiss described how this patient tested the analyst unconsciously by announcing her plan to terminate analysis. She was trying to determine whether the analyst, by agreeing with her termination plan, implicitly would agree that she did not deserve further analytic help, and thereby would reject her. When the analyst did not do so, but instead recommended that she continue, and should attempt to understand her intention of terminating, the patient felt less tense. She became more friendly. She brought forth, over an extended period of hours, new memories of childhood rejection by both parents. She developed considerably more insight into her beliefs about rejectability.
And she made direct progress toward her life goals; for example, she became more outgoing, more able to date, and more able to enjoy herself.

This brief vignette illustrates a therapeutic sequence predicted on the basis of the ideas which I described earlier. Let me describe the predicted sequence as an hypothesis which can be investigated:

If a patient tests a pathogenic belief in relation to the analyst, and the response of the analyst tends to disconfirm that belief, the patient may:

1. Become less anxious, for the danger he feared is disconfirmed.

2. Produce new memories about the traumatic situations in which the belief arose, for these memories are no longer quite so dangerous.

3. Become conscious of the belief, and/or develop new insights about it.

4. Make progress toward goals which the patient could not pursue earlier because the pathogenic belief which he has now begun to disconfirm had warned him of the danger of pursuing those goals.

I think that the vignette from Dr. Modell's case which I reported may also illustrate the predicted sequence of events—i.e., testing, disconfirmation of pathogenic beliefs, and progress in therapy. The patient, by her bizarre and unappealing behavior, invited Dr. Modell to find her undeserving of analysis. Instead, he understood and interpreted her unconscious belief that she did not deserve analysis. Then, as Dr. Modell noted, a therapeutic alliance was formed, pathogenic beliefs and fantasies became conscious, and insights were acquired.

It should be noted, in contrast to these progressive sequences, that if the analyst's response to the patient's tests tends to confirm rather than to disconfirm the pathogenic belief, the patient is likely to get worse. She is likely to remain tense. She is likely to recover few new memories, to acquire few new insights, and indeed the patient may even temporarily retreat from his or her goals.

Let me illustrate this with another clinical vignette (taken from a case studied by Weiss). I have selected this particular vignette because it is, in fact, a kind of "experiment in nature". The analyst's behavior and interpretations during the first 18 months of the analysis tended to confirm rather than disconfirm the pathogenic belief that the patient was attempting to overcome. At that point, the analyst changed his tack, and thereby began to disconfirm the pathogenic belief.

A woman of 28 sought analysis because of bouts of depression and a sense of purposelessness. She derived little pleasure in her career, and was unhappy in her personal life. She wished to marry and have children, but had not been able to find a husband.
She described herself as, in childhood, having been dependent on her mother, and as having had little to do with her father. Her mother, she remembered, had often been exasperated with her for being clingy. Indeed, she recalled, her mother had tried to force her to become independent by sending her off to camp. However, the patient, as she remembered it, had clung to her mother despite her mother’s disapproval.

The patient, in her analysis, developed a mother transference. She became dependent and clingy to the analyst as she had been to her mother. The analyst interpreted to her that she was repeating with him her childhood dependence on her mother.

The patient, however, over an extended period of time, failed to improve. She became more clingy, and more depressed. She introduced few new memories, and acquired little more insight.

The analyst, who felt frustrated by her lack of progress, discussed the case with a colleague. The colleague noticed that the patient, in addition to acting clingy and dependent, covertly did a number of things on her own. However, the patient concealed these subtle indications of independence, and made prominent her demonstrations of dependency. The colleague suggested to the treating analyst that perhaps the patient was guilty, unconsciously, about separation and independence from her mother, and, in the maternal transference, from the analyst.

We have, as I said, an experiment in nature here, for the analyst, after this discussion with his colleague, began to interpret to the patient that perhaps she maintained her dependent attachment to her mother and to the analyst for fear that if she were to run her own life, she would hurt them. The analyst also began to comment on ways in which she was functioning quite independently, but disguising that she was doing so.

The patient now began to do more things on her own and to feel less draggy. Moreover, she began to recall a number of new memories about her mother. She recalled that although her mother had complained about her clinginess, her mother never praised her for doing things on her own. Indeed, the mother had not even noticed how capable the patient was of taking care of herself. Moreover, when the mother sent her off to camp to teach her independence, the mother wept at the railroad station, and embarrassed the patient by calling her every other day on the camp’s only telephone.

The patient then became conscious of her childhood belief that her mother was secretly pleased by her dependency, and had urged the patient to be independent in order to assure herself that despite her urgings, the patient was unable to separate herself from her.
The patient began to recall, also, that she had worried about her mother, who often seemed draggy and listless. When the patient would come home from school, she would check to see if her mother was depressed. If so, the patient would try to cheer her up.

The patient had experienced the analyst unconsciously in the same way as she had experienced her mother. She had assumed that the analyst told her she was dependent on him, and that he did not notice or comment on her independent functioning, because he wished her to be dependent on him.

As the patient became aware of these ideas, she began to free herself from their hold on her. She did more things with her friends and went out more with men.

Thus, when the analyst did not disconfirm the belief from which her separation guilt stemmed, the analysis stagnated. When the analyst's interpretations began to disconfirm her belief, the patient felt better, recalled new memories linked to the origin of her belief, acquired new insights into the relationship between these beliefs and her life, and made progress toward her goals.

Weiss and I--along with others of our research group--have made similar clinical observations in a large number of cases. These observations are the basis for our formal research.

The purpose of our formal research is to go beyond clinical observation and beyond our own strong personal sense of conviction, and to test our hypotheses about the therapeutic process, by as rigorous methods as we can devise. In doing so, we test how well predictions based on these hypotheses fit observation. (The clinical observations I've presented are a paradigm for the formal research.)

I shall present an overview of two research studies. Both are concerned with hypotheses about testing pathogenic beliefs in relation to the therapist or analyst. Both studies test the hypothesis that when the therapist disconfirms the pathogenic belief which the patient is testing, the patient becomes more relaxed, more confident in the therapist and the therapy, and makes progress in his therapeutic work.

The first study was carried out by George Silberschatz. He used the verbatim transcripts of a recorded psychoanalysis—an analysis conducted, I might add, somewhere far away by an analyst entirely unfamiliar with our ideas.

Silberschatz demonstrated, first of all, that the study could be done! He demonstrated that the patient's key tests of the analyst could be identified reliably—that is, that analytic judges, independently studying segments of the patient's material, could agree that certain patient actions constituted key tests. (A key test is a test judged to be central to the patient's pathogenic beliefs.)
Moreover, these independent analytic judges could agree highly on whether the analyst's response to the patient's test would tend to disconfirm the pathogenic belief which the patient was testing. (We refer to such a response as "passing the test". For example, Dr. Modell, in the vignette I presented earlier, passed a prolonged series of key tests by not acceding to his patient's many invitations to see her as untreatable or unworthy of analysis.)

To return, then, to the Silberschatz study: His judges reliably identified key tests by the patient, and reliably judged how well the analyst, by his response, "passed the test".

New groups of judges were presented brief segments of the patient's speech. These segments were from the patient's speech just before or just after the test; however, the segments were presented to the judges in random order, and the judges did not know anything of when the segment occurred. The judges also did not know the analyst's intervention. The task of the new judges was to rate the patient's speech, in each segment, on a particular psychological dimension. One group of judges rated each segment for anxiety, another group of judges for relaxation, another group for Experiencing, (a widely used measure, in psychotherapy research, of the patient's degree of involvement with the material he is presenting), and another group for "Boldness" (a measure devised by Joseph Caston of our research group to assess the degree to which a patient is tackling meaningful problems boldly). All of these ratings were highly reliable.

Silberschatz could then examine how the patient tended to behave following a passed test. His results were definitive, and without exception they were in the predicted direction. The patient, immediately following a passed test, tended to become less anxious, more relaxed, more involved in therapeutic work, and bolder in tackling problems.

It is interesting to see that there may be such immediate effects of a passed test. We know (or think we know) from such clinical observations as those I have reported, that there are a number of more long term effects, such as the recovery of memories, and that these effects are based on a prolonged series of tests of the analyst rather than inevitably following a discrete test. Silberschatz's study demonstrates that there also may be lawful immediate effects. Joseph Caston, in a separate study of discrete interpretations, also found lawful immediate effects.

I should like now to turn to some work which is underway at this time. This work is being carried out by Saul Rosenberg, George Silberschatz, and John Curtis. Their work, in contrast to the original Silberschatz study, is based on brief psychotherapies instead of a psychoanalysis. In these therapies, they are studying the relationship between the patient's testing of the therapist, the therapist's response to these tests, and both the immediate effects of responses to discrete tests, and the longer term effects of the therapist's overall tendency (across the course of the whole therapy) to disconfirm the pathogenic beliefs the patient is testing.

For each case, we identify from the intake interview, and from the first two therapy sessions, three things: (1) the pathogenic beliefs the
patient is working to overcome, (2) the ways the patient is likely to
test these beliefs with the therapist, and (3) what kinds of therapist
responses are likely to disconfirm the patient's pathogenic beliefs.

We identify these aspects of the case by clinical inference. Then,
using a method developed by Joseph Gaston, we establish the reliability
of our inferences in each of these categories. I will not describe this
method, but will note that we have obtained very satisfactory levels of
agreement between independent judges for each of the categories.

Finally, we examine the patient's subsequent testing of the therapist
and the therapist's responses. We also study the outcome of therapy not
only at termination but at 6 and 12 months following termination.

We have some fascinating preliminary results. I shall mention a
comparison of results in two cases—the two cases taken together are a
kind of experiment in nature similar to the clinical example I gave earlier.

Both patients were women of about 30 who were somewhat depressed and
immobilized. Both suffered from intense separation guilt. We inferred
somewhat similar pathogenic beliefs in each case. We considered both
women to have a moderately positive prognosis for brief psychotherapy.

Both cases also presented similar tests. They invited the therapists
to see them as weak, needy, inadequate persons suffering from intense
dependency needs, rejection, and loss; they also—and usually in almost
the same breath—made evident that they could function effectively. For
example, one of these patients characteristically would make her problem
clear, and then would become confused and anxious and implicitly invite
the therapist to guide her.

As it happened, in one of these cases, the therapist focussed steadily
on the patient's discomfort with clarity, and with independent functioning.
She interpreted her need to placate others by her helplessness and dependency.
The patient made considerable progress during therapy. She brought forth
many pertinent memories and acquired some important insights. She was
still better a year after the therapy concluded. She had applied her
insights effectively to new situations, and had in some regards deepened
and elaborated her self-knowledge.

In the other case, the therapist focussed on the patient's dependent
needs inside and outside of the therapy. This patient—who, as you will
recall, was described by our independent judges as suffering from separation
guilt—brought forth few new memories and acquired little insight. However,
she felt quite good at termination, and she was for the most part laudatory
about her therapy. In the follow-up interviews, she was once again
depressed, clingy, and immobilized. Her primary insight about herself
was that she was ineffective, needy, and didn't handle things well.

In summary then, we have been accumulating evidence, both clinically
and in our formal research, which suggests that the hypotheses we have presented
about pathogenic beliefs, and the testing of them in therapy and analysis, has
considerable explanatory power. These concepts may help the analyst and the
psychotherapist in working with the formidable resistances stemming from an
unconscious sense of guilt.