THE FALL WORKSHOPS

A DISCUSSION OF JOE WEISS'S THEORY OF THE PSYCHOANALYTIC PROCESS AS PRESENTED IN THE PSYCHOANALYTIC PROCESS: THEORY, CLINICAL OBSERVATIONS, AND EMPIRICAL RESEARCH, BY WEISS, J., SAMPSON, H. AND THE MT. ZION PSYCHOTHERAPY RESEARCH GROUP (GUILFORD PRESS, MAY 1986)

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PREFACE

Joseph Weiss, M.D.

The papers collected in this Bulletin were originally presented in a series of three debates about psychoanalytic theory conducted at the San Francisco Psychoanalytic Institute (Fall Workshop Series, 1985). The controversy concerned the validity of a particular psychoanalytic theory of the mind, therapy, and technique. It is the theory that I developed over the last 25 years and that the Mt. Zion Psychotherapy Research Group (co-directed by Hal Sampson and myself) has studied and tested by quantitative, scientific research methods since 1972. (It is known at the Institute as the "control-mastery" theory.)

The workshops were organized around the section of a forthcoming book on the theory and research in which I present the theory and illustrate it with clinical examples (The Psychoanalytic Process: Theory, Clinical Observations, and Empirical Research, Weiss, Sampson, and the Mt. Zion Psychotherapy Research Group, Guilford Press, May 1986). Each meeting took up several chapters of the section.

The controversy in our Society and Institute parallels similar controversies taking place in psychoanalytic institutes around the country. Such controversies, as Arnold Cooper pointed out in his presidential address to the American Psychoanalytic Association (JAPA, 1984) are a sign of health. They indicate that psychoanalytic institutes are now strong and confident enough to tolerate intense disagreement.

Our workshops illustrate how, in my opinion, an institute and society should deal with scientific differences. It should bring these into the open and discuss them. Such discussion inevitably provokes a great deal of thought. It induces the participants to reexamine the bases of their ideas. It also enables each side to the controversy to understand the other better.

Our workshops had these good effects. The disagreements were strong, yet formulated carefully and with dignity. The audience was large, enthusiastic, and attentive. Both sides to the controversy learned a lot, and both sides agreed that the workshops were a credit to the Institute.

The papers collected here will not be completely comprehensible to a reader unfamiliar with the part of the book with which they are concerned. In other words, the reader, in order to understand this Bulletin, must first read the book. However, for the reader for whom this book is not immediately available, I shall include here a summary of the first chapter of the book. This summary will offer the reader only a general and very incomplete view of the theory discussed.

The theory is Freudian. It is also new in that it relies on and elaborates certain ideas contained in the structural model that Freud developed in his late writings. It assumes, in contrast to Freud's earlier views, that a person is able unconsciously to make use of his higher mental functions. He unconsciously can assess reality, think, anticipate, decide, and plan, and he can regulate his behavior unconsciously in accordance with his decisions and

plans. The theory's basic tenets are concerned with a person's unconscious control of his repressions (and of other unconscious behaviors), with his unconscious pathogenic beliefs, and with the work he unconsciously performs in his efforts to overcome his problems.

The theory assumes that a patient exerts considerable control over his repressions. He may, as Freud stated in the Outline (1940, p. 199) repress a particular impulse or other kind of unconscious mental content if in his unconscious judgment he is endangered by it; he may maintain the repression of the impulse as long as he considers it dangerous; and he may lift the repression of the impulse and bring it forth when in his unconscious judgment he can safely do so.

A person, in unconsciously deciding whether he may safely carry out a course of action, is governed by certain unconscious beliefs. It is in obedience to such beliefs that he maintains his repressions and indeed his psychopathology. Since these beliefs play a crucial part in psychopathology, they are here called "pathogenic". A familiar example of a pathogenic belief is the male's belief that if he develops and maintains a sexual interest in his mother, he will be punished by castration by his father.

Pathogenic beliefs should be distinguished from fantasies, as Freud defined fantasy in Formulations on Two Principles of Mental Functioning (1911). There Freud wrote that fantasies are wishful, regulated by the pleasure principle, and not subject to reality testing. In the language of Freud's structural model, fantasies are derived from the id. Pathogenic beliefs, however, are not wishful. They are grim and constricting and they represent reality (see Freud, 1926, p. 108 re the belief in castration). Moreover, pathogenic beliefs, according to the structural model, are contained within the ego. The id, Freud tells us, is regulated by the pleasure principle and so cannot create beliefs about unpleasant reality. It effortlessly turns away from it.

A child may acquire a variety of pathogenic beliefs (and not just the belief in castration) by inferring them from certain traumatic experiences with his parents and siblings. He may by such inference come to believe that almost any impulse or goal is dangerous and that he might, by experiencing it, risk the disruption of his ties to a parent and so leave himself insufficiently protected and cared for. A child, for example, may come to believe that, by expressing a particular impulse or pursuing a particular goal, he might either provoke punishment from a parent, or worry, injure, or even kill the parent.

A patient suffers a great deal unconsciously from his problems and from the pathogenic beliefs in which they are rooted. He wishes unconsciously to disconfirm his beliefs so that he works unconsciously in relation to the analyst to disconfirm them. He works to disconfirm them by testing them in relation to the therapist and by assimilating insight into them that the therapist conveys to him by interpretation. He tests his pathogenic beliefs by trial actions, hoping by these actions to demonstrate to himself that he does not affect the analyst as the beliefs predict. For example, a patient whose pathogenic beliefs warn him that if he is rivalrous with the analyst he will provoke punishment from him may test this belief unconsciously by a trial expression of rivalry. He hopes unconsciously to demonstrate that he does not

provoke the analyst as the belief predicts and thus that the belief is false. As the patient succeeds in his unconscious efforts to weaken a particular pathogenic belief, he may dispense with the repressions and resistances that he had been maintaining in obedience to the belief. He may then begin to express and experience the impulses and other mental contents that he had been repressing in obedience to it.

The idea that a patient may exert control over his unconscious mental life, regulating it by the criteria of safety and danger, was suggested to me years ago by the phenomenon of crying at the happy ending (Weiss, 1952, 1971). This phenomenon may be exemplified by the experience of Dr. N. who was moved to tears when soon after his birth her second son was brought to her room. Dr. N. wept profusely and she retrieved previously deeply repressed memories of a son from another marriage who had died nine years earlier. Before the birth of her second son, Dr. N. had scarcely been able to remember her first son. Now she was able vividly to remember her fun with him and her sense of devastation at his death.

According to my explanation, Dr. N. had felt overwhelmed by her sadness at the death of her first son. She therefore had repressed not only the sadness but everything that might remind her of it. The birth of her second son made Dr. N. happy. It made up for the earlier loss and so made it safe for Dr. N. to remember the loss and to experience the sadness connected with it.

Freud's early theory, which attempts to explain all behavior in terms of the dynamic interplay of impulse and defense in accordance with the pleasure principle, cannot explain Dr. N.'s behavior. According to the early theory, Dr. N. could exert no control over her repressions and so could not lift them. Therefore, her unconscious sadness would come forth only if it became intensified relative to the repressions opposing it. Yet, the early theory can account neither for a weakening of Dr. N.'s repressions nor for an intensification of her sadness. Nor could it explain why either of these things would occur precisely when Dr. N. became happy.

Moreover, according to the early theory, the sadness would have no impetus to become conscious. This is because the only impetus to becoming conscious recognized by the early theory is the push towards gratification. Yet, sadness is not gratifying as gratification is defined in the early theory. The coming forth of Dr. N.'s sadness is an example of the kind of process that Freud described as contradicting the earlier assumption that unconscious mental life is regulated exclusively by the pleasure principle (1920, p. 32).

From a careful study of the process notes of a number of analyses, I found that the patient in treatment behaves as did Dr. N. He keeps certain impulses and other mental contents repressed until in his unconscious judgment he may safely experience them. He then brings them forth. However, in contrast to Dr. N., the patient in analysis need not wait passively until a change in his circumstances makes it safe for him to experience the mental contents that he has repressed. He works unconsciously by testing his pathogenic beliefs in relation to the analyst to create conditions that will enable him safely to experience them.

One patient I studied (Miss P.) had felt rejected in childhood by her

mother. She had blamed herself and so developed the pathogenic belief that she was rejected because she was draining her mother by making excessive demands on her. She repressed her sense of rejection, the sadness connected with it, the pathogenic beliefs, and the experiences from which she inferred these beliefs. (These experiences were, no doubt, to an undetermined extent, subjective.)

In her analysis, Miss P. developed a mother transference; she feared rejection by the therapist. She worked unconsciously to overcome the pathogenic belief that she deserved to be rejected by the analyst. She worked both by testing the belief and by making use of the analyst's interpretations about it.

After four years of treatment, Miss P. presented the therapist with a large scale test. She stated that she would stop treatment in a few months. She hoped unconsciously that the analyst would not accept her stopping. When after much discussion the analyst made it clear that he thought Miss P. should continue at least until her motives for stopping became clear, the patient appeared relieved. She also wept profusely and brought forth several new and poignant memories of maternal rejection.

Miss P., like Dr. N., brought forth repressed sadness when she unconsciously decided that she could safely experience it. Dr. N. could safely experience her sadness after her second son was born. Miss P. could safely experience her sadness after she felt more accepted by the analyst. She was able to feel more accepted by him after a successful piece of analytic work in which she began to resolve her mother transference. This had led her to become better able to distinguish between the therapist and the mother and thus to realize that the therapist was not rejecting her as her mother had. The partial analysis of the mother transference led to Miss P.'s remembering more about her childhood relationship to her mother.

Another patient, Mrs. G., whose analysis I studied from process notes, brought forth previously repressed sexual fantasies of being beaten by the analyst after by testing the analyst and by making use of his interpretations, she established a capacity to oppose, criticize, or disagree with him. Earlier, she had been afraid to bring these fantasies forth lest she act upon them and so fall into a masochistic relationship from which she would be unable to extricate herself. After acquiring the capacity to assert herself in opposition to the analyst, she could safely bring these fantasies forth. This is because she knew then that she could protect herself from domination by the analyst.

Mrs. G.'s fear of falling into a masochistic relationship with the analyst stemmed from a father transference. In childhood she had perceived her father as hurt by any display of independence and so had complied with his demands and agreed with his views. In the part of her analysis presented here Mrs. G. began to resolve her father transference. She began to realize that the analyst was not vulnerable as her father had been and thus that she could safely oppose him and thereby protect herself from the danger of falling into a masochistic relationship with him.

I shall not attempt to discuss the subsequent chapters here. Suffice to say they take up and develop all of the topics discussed in Chapter 1 and introduce a number of topics not discussed there.

The debates were concerned with many different issues. Perhaps the central concern was the questions: Is the theory Freudian? Is it psychoanalytic? The opponents of the theory approached it from a traditional point of view. They argued that it failed to give sufficient emphasis to certain familiar, traditional psychoanalytic ideas such as those concerned with impulse, defense, and resistance. In their opinions the theory was narrow, emphasizing just one part of psychoanalytic theory, and neglecting another part.

The supporters of the theory argued that the theory is broader than the traditional theory. They asserted that it includes traditional concepts such as those about impulses, defenses, and resistances, but, by emphasizing the importance of the unconscious ego and superego, puts them in a new context.

As Robert Wallerstein, the moderator, pointed out, each side of the debate presented a mirror image of the other in that each asserted that its own view was the broader.

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[INTROREF]

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We thank Drs. Robert Friend, Daniel Greenson, and Mel Schupack for organizing the fall workshops. They spent a great deal of time and effort. The success of the workshops is largely due to their careful and thoughtful planning.

We thank Dr. Robert Wallerstein for being the moderator. His intelligent, informed, and focusing comments were crucial in making the workshops into an outstanding educational experience.

Joseph Weiss

Harold Sampson

FALL WORKSHOP DISCUSSING WEISS'S

CONTROL-MASTERY THEORY

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October 29, 1985

My discussion this evening will, I hope, not be for or against the higher mental functioning hypothesis or for or against the automatic functioning hypothesis as Weiss has defined it. Rather, I hope that I can comment on my thinking about these hypotheses and ideas, trying to understand with the rest of you where they originate, their empirical application, and our individual bias for or against them based on our predilections for the way we prefer to conceptualize the psychoanalytic process. Wallerstein and Sampson in their 1971 paper on research in psychoanalysis raise questions on how data are related to concepts. Empirical hypothesis testing is complicated because of principles of multiple determination and over-determination.

To quote Anton Kris (1977) in an article on "Either Or" dilemmas, he pointed out such conflicts in the clinical situation can be converted to both - and - solutions. I feel it is possible to apply a "both - and" solution to the conflict about which should be the predominant model: the higher mental functioning hypothesis or the automatic functioning hypothesis. I feel I then ally myself with Abram's position (as reported by Weiss), going somewhat further than he did. That is, that the integration of various psychoanalytic perspectives is not at present possible and we have to be satisfied with a multiplicity of psychoanalytic models. Here, Rapaport's (1960) monograph on the "Structure of Psychoanalytic Theory" describes my sense of the complexity of the interacting paradigms that analysts are governed by in their theories. In talking about clinical material we usually are not aware of the complexity of the theoretical structure we are using to understand sequences. The points of view listed in Chapter 2 of this monograph can be viewed both as complementary to one another as well as conflicting with one another. The same might be stated about the automatic functioning hypothesis and the higher mental functioning hypothesis. There are elements in both of these theories that complement one another as well as discontinuities. Some of these can be subsumed under Rapaport's headings of points of view, particularly "The Ultimate Determiners of All Behavior Are the Drives (the dynamic point of view)". This point of view has much to do with the automatic mental functioning hypothesis, and the other point of view, "All Behavior Has Structural Determiners (the structural point of view)" has more to do with the higher mental functioning hypothesis. Among other theories that govern our thinking, we all agree that there are incompatibilities with these two points of view as outlined by Rapaport.

Another question should be asked about Weiss's theory as well as any new theory that is presented to us. That question could be raised so as to help us to understand the special perspective the theorist uses to study and formulate his ideas. It seems to me that Weiss's ideas center on his studies of the therapeutic process where he has carefully reviewed a few cases in great detail over long sequences. He has focused his attention on how analysands gradually change. I believe there is an axiom that he established prior to the beginning

of his study which is shared by many other analysts but certainly not by all. That axiom is "patients wish to get better and do so by experiencing their conflicting libidinal and aggressive feelings in relationship to the analyst in the transference in order to master them rather than re-experience them." Here I think Weiss chooses a modern version of the repetition compulsion which not everyone accepts. In this version the analysand repeats earlier traumatic experiences in a more dilute form during the course of the analysis with the unconscious purpose of mastering them (unconscious plan). Here, the concept of the drive to mastery replaces the original death instinct in the "Beyond the Pleasure Principle" paper.

Another axiom: patient's difficulties are primarily due to earlier traumatic experiences which have produced unconscious fantasies (Weiss calls these pathogenic beliefs) which are the primary cause of neurotic behavior. In this formulation there is a de-emphasis on drive-related factors and an emphasis on early traumatic experience. Analysis therefore focuses on uncovering the early experiences that have caused the pathogenic beliefs. The alternate axiom that would conflict with this one would de-emphasize the role of early traumatic experience and emphasize how the inborn drives would color a sequence of experiences in a particular way, distorting and complicating the relationships with primary objects in accord with drive derivative conflicts. Analysis in this model would uncover the vicissitudes of drive conflicts and defenses with corresponding revision of the distortions of early memory and relationships. But apart from these axioms, I believe that Weiss in his detailed study of the therapeutic process has attempted to find a pattern to the process. As he theorizes about the process and describes this pattern, we clinicians who are evaluating this will compare the sequences he describes with clinical sequences within our own clinical experience and determine by our educational biases, preferences, and/or research perspectives which patterns we choose.

Here I would like to take Spence's (1982) perspective on the meaning of what is uncovered in psychoanalysis. He uses the term "narrative truth". I don't think it's too far-fetched to imagine the psychoanalytic process and the description of change evolving in a variety of ways depending on the perspective of the analytic pair and their shared values and philosophy. In evaluating process and outcome, this audience may agree in their theoretical understanding of such concepts as (1) the resolution of the transference, (2) a corrective emotional experience, (3) transference cure, (4) the holding environment. However, in a critical evaluation of actual clinical data which may be studied in detail, much disagreement would be evoked.

In terms of where the concepts of higher mental functioning originate, I accept the author's idea that they stem from Freud's later works as well as the elaborations by ego psychologists on the functioning of the ego and superego. I think in general that concepts of the unconscious ego, its integrative functioning and its intrasystematic conflict, although compatible with earlier ideas of drive conflict not mediated by the ego, often pose discontinuities and differences in clinical conceptualization.

For the remainder of my discussion I would like to focus on more specific issues from Chapter 1. First, the concept of pathogenic belief. Pathogenic belief is contrasted with unconscious fantasy by Weiss by the suggestion that a pathogenic belief is not wishful but grim and constricting. I think the concept of pathogenic belief as Weiss uses it would throw the focus on those unconscious ideas that play a part in the development and maintenance of psychopathology.

The boy's belief in the possibility of castration if he maintains a sexual interest in his mother would be such a pathogenic belief. I can see where such a theory would develop if one narrowly defined the task of psychoanalysis as correcting the belief in the possibility of castration through the analysand's experience of safety within the psychoanalytic process, and subsequently helping him to bring forth earlier traumatic experiences at the hands of the father that caused this castration anxiety, and to work through in the transference such fears as vis a vis the analyst, and to remove that pathogenic belief as a result of the misunderstanding of the previously warded off memories in earlier anxiety provoking situations.

I prefer to conceptualize castration anxiety and its meaning in an analytic process in a somewhat different way. The feeling the little boy has that he will be punished by castration by his father because he loves his mother relates to the depth of his desire for his mother in the first place. Certainly, experiences of seduction by the mother and/or punishment by the father heighten his anxiety, but his fear of castration is most directly linked with his phallic oedipal drive for the mother. In analysis he experiences castration anxiety not only because of the safety of the analytic situation, but because of competitive strivings with the analyst. Certainly his bringing forth these competitive strivings would partially have to do with the appropriateness of the analytic setting (safety) as well as other factors. Despite the analyst's neutrality, the patient might frequently interpret various aspects of the analyst's behavior as punishing or castrating despite the fact the analyst does not mean them to be so. Indeed the patient may act in such a provocative way as to cause the analyst to punish him. The analyst may only become aware of his departure from neutrality through his continued self-analysis. The analyst's capacity to interpret the conditions within the transference or in relationship to significant objects in which castration anxiety occurs, is what permits the patient to gain control of the castration anxiety by recognizing and anticipating those situations in which it might occur.

Because I conceptualize castration anxiety and other punishing ideas as being so closely linked with pleasurable wishes, I don't find it useful to separate the concept of unconscious fantasy from pathogenic belief. There are many unconscious fantasies that appear to be punishing and yet are compromise solutions in which both gratification and punishment are combined. For example, a man in anticipation of closeness with an oedipal object might experience impotency. In terms of anticipated intimacy with the oedipal object, he might have a mixture of fear and intense excitement with regression from genital sexuality. For these reasons, I feel that the concept of pathogenic belief artificially separates fantasies into categories of wishful and punishing which do not do justice to the concept of compromise formation and impulse-defense configuration.

I have a similar criticism of the concept of "crying at the happy ending". I do accept Weiss's explanation of those instances of individuals crying at moments of great joy, the explanation being that they can then bring forth painful memories from the past that had previously been repressed and can now be expressed because it is safe. However, there are a number of other explanations for the same phenomena: occasionally a masochistic fantasy accompanies a happy ending which produces tears (for example, the fear that a member of one's immediate family might die during the experience of intense pleasure at one's wedding); a subjective sense of sadness, tears, and/or anxiety despite the external trappings of triumph (after obtaining a high honor an ensuing

subjective sense of unworthiness, hollowness, or triviality associated with the honor). We commonly think of the success neurosis as an example of this.

The term unconscious plan would be a useful term particularly if it could predict how the analysand would go about engaging the analyst in the analysis in terms of which themes would be prominent in the transference and in which order. If the analyst, after an extended evaluation with the patient or in the earliest phases of the analysis, could develop a concept of what this plan was, this certainly would be useful in conducting the analysis. The question is, can we predict this plan? I think there is a great difference of opinion about this. Obviously, all analysts have hypotheses about the dynamics of their patients. Just constructing hypotheses about the analytic situation certainly is connected with a prediction of the unfolding of the analysis. Yet, it is my belief prospectively that we don't know, nor is it proper to impose a long term judgment on how the process will unfold since it leads us to unnecessarily focus on those aspects of the patient's productions that fit our preconceptions. It is my fear that the term "unconscious plan" will lead us in that direction. I would be more satisfied if the term unconscious plan were to be matched with the term unconscious process with respect to the analyst's thought of how the process is unfolding. If that were the case, the term would be acceptable to me. Obviously, this does not apply to a retrospective view of material with the proviso that researcher/clinicians don't make the presumption that they can then take their knowledge of cases that they have studied retrospectively and apply this to predictions of patients that they are prospectively working with. It may be argued from another perspective that the bias of the unconscious plan concept is no more damaging than any other psychoanalytic perspective. But that would be just my point, that we must restrain ourselves from prejudging material as it develops or as we do this, we can use the patient's reactions to our interpretations as a clue to the correctness or incorrectness of our hypotheses.

The clinical material that is presented of several patients in the first chapter is coherent and convincing in and of itself. I will focus on the case of Mrs. G., the woman who brought forth what appeared to be a previously repressed sexual fantasy. The fantasy which was in association to a dream that the analyst "does something to her", concerns her being turned over his knee and spanked. She hadn't had such a fantasy since adolescence. Her associations lead Mrs. G. to remember how easy it was to provoke her father and how he over-reacted in a variety of situations. The analyst also gives in his study of the process notes preceding the emergence of this beating fantasy, a series of "tests" that the patient gave the analyst unconsciously to see whether she would hurt him. The theory makes sense in that it seems rational to presume that if the analyst didn't react to Mrs. G.'s provocations, then it would be safe to bring forth this repressed sexual material. As reasonable as this theory is, it contradicts my experience in similar situations. Here, the concept of reenactment that Sandler has written about would apply. That is, that the patient perceives that the analyst <u>is</u> provoked by her behavior in a variety of ways. The analyst, in his turn, not only experiences the patient as being provocative which he may react to by a signal affect, but which also might actually interfere with his neutral analytic behavior. Obviously, it is the capacity of the analyst and the patient to study this interaction, then, that represents the analyst's ultimate neutrality. In my experience, it is the vividness with which the analyst experiences his reactions to the patient both in feelings and occasionally in reaction that lends validity to the ultimate mutual understanding of the patient's conflicts.

I have outlined in the second part of the paper some of my disagreements with the clinical aspects of the control-mastery theory. I wish to again remind you that I have put these disagreements in the context of competing and complementary hypotheses about the nature of the therapeutic process. In the first part of my discussion, I have discussed my position on the competing and complementary theories that are part of what we would agree to call psychoanalytic theory. By shifting our focus to the ego and superego, do we neglect the id? How much structure can be imposed on a process that has so many independent variables that even when we attempt to study it through the most sophisticated research methods, we can't agree on the basics of our methods of observations?

[SKOLNIK]

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[S-REF]

DISCUSSION OF DR. SKOLNIKOFF'S PAPER

Harold Sampson, Ph.D.

October 29, 1985

Alan's thoughtful and broad critique of the theory presented by Joe Weiss in Chapters 1 and 2 of our forthcoming book has set a high standard for this workshop. He has presented a carefully reasoned statement of the basis for his differing position on a number of issues. In my reply I shall develop further the basis for Joe Weiss's position on these issues. I hope thereby to contribute to your understanding of Joe's views, and to a clarification of areas of both agreement and disagreement.

I shall focus first on the the central concept of pathogenic beliefs. I will use an historical perspective to clarify the way Joe uses this concept, and also to develop the following thesis: The concept of pathogenic belief provides an integrated and a unifying view of the interaction of the drives with superego imperatives and with the ego's concern with reality and adaptation. This unified view may emphasize unconscious ego and superego factors more than some other analytic views do, but it does not overlook the id, nor does it focus on the role of traumatic childhood experiences to the exclusion of the drives.

I shall begin by contrasting Freud's early theory about the unconscious control of repressions with the theory he proposed in his ego psychology. In brief, in Freud's early theory repression was instituted automatically at the beginnings of the release of unpleasure. In his 1926 theory, the ego, on the basis of an anticipation of danger, produced an anxiety signal which led to the institution of repression.

Freud, in Chapter VII of the Interpretation of Dreams, said that "pleasure and unpleasure automatically regulate the course of cathectic processes" (SE V, p. 574). The prototype of repression, he stated (p. 600), is the "effortless and regular avoidance by the psychical process of the memory of anything that had once been distressing." I.e., the mind automatically turns away from the memory of a painful perception. This prototypical instance of repression accounted for the automatic avoidance of painful memories, but it required an additional step to account for the repression of an instinctual wish, for the gratification of such a wish is by definition intrinsically pleasurable. Freud explained in Chapter VII that through a "transformation of affect" the fulfillment of the wish has become unpleasurable, and therefore the wish becomes subject to repression. Similarly, in his paper titled "Repression" (1915), Freud wrote that the fulfillment of an instinctual wish would generate more unpleasure than pleasure. For this reason the wish causes the release of unpleasure, and this automatically leads to its repression.

In applying the early theory of repression to psychoanalytic treatment, Freud wrote: "The process of bringing this unconscious material to light is associated with unpleasure, and because of this the patient rejects it again and again" (SE VII, p. 266). In the same passage, he referred to this rejection of emerging unconscious material as "automatic regulation by unpleasure."

In Inhibitions, Symptoms, and Anxiety (1926), Freud modified his theory of how repressions are instituted. The ego, on the basis of an anticipation of danger (if an impulse were to be satisfied), produces a signal of anxiety. This anxiety signal in turn brings the pleasure principle into play, resulting in the repression of the dangerous impulse.

Thus, in Freud's 1926 theory, repression is not instituted automatically by releases of unpleasure, but is brought about by the ego on the basis of an anticipation of danger. This theory has a number of important implications pertinent to the concept of pathogenic beliefs:

1. It is in the context of the 1926 theory that we must understand what is meant by a pathogenic belief. The ego's anticipation of danger is based on a belief--e.g., in the 2 phobic patients that Freud described in Inhibitions, Symptoms, and Anxiety (Little Hans and the Wolf Man), the motive force of the repression was their belief in castration as a punishment for their wishes, and the intense anxiety which stemmed from that belief. A pathogenic belief is the belief underlying the ego's anticipation of danger. It is a belief about the dangerous consequences of experiencing or attempting to satisfy certain wishes. Because this kind of unconscious belief plays a crucial role in producing repression and in maintaining conflicts and symptoms, we consider it useful to distinguish it from other mental products such as simple wish-fulfilling fantasies, other kinds of unconscious belief, etc. For example, the belief that women have penises is not what we mean by a pathogenic belief. That belief, as Freud noted, denies the patient's pathogenic belief, i.e. his belief in castration. Thus, it is a reassuring belief or fantasy rather than the belief underlying the ego's anticipation of danger and leading to repression.

2. A pathogenic belief is a belief about a danger believed to be coming from the outside, and believed to be real. This is so even though the belief itself is colored or distorted by wishes, defenses, and primary process thinking, and may be a compromise formation. Freud went to great lengths to make clear that he considered the belief in castration to be a part of the child's judgment about the nature of reality--which is not the way Freud treated other unconscious fantasies. I will cite two quotations which make this point emphatically:

"The anxiety belonging to the animal phobias was an untransformed fear of castration. It was therefore a realistic fear, a fear of a danger which was actually impending or was judged to be a real one" (1926, SE XX, pp. 108-109).

The second quote, from the New Introductory Lectures, is even more pointed:

Speaking of the anxiety which leads to repression in the case of a phobic boy, he wrote: "But what sort of anxiety can it have been? Only anxiety in the face of a threatening external danger--that is to say, a realistic anxiety. It is true that the boy felt anxiety in the face of a demand by his libido--in this instance, anxiety at being in love with his mother; so the case was in fact one of neurotic anxiety. But this being in love only appeared to him to be an internal danger, which he must avoid by renouncing that object, because it conjured up an external situation of danger...The danger is the punishment of being castrated, of losing his genital organ. You will of course object that after all that is not a real danger...But the matter cannot be dismissed so simply. Above all, it is not a question of whether castration is really carried out; what is decisive is that the danger is one that threatens from outside and

that the child believes in it" (1933, SE 22, p. 86, italics mine).

As you can see, Freud argues that the objection that castration is not a real danger is too simple, and that the idea that it is a danger which is believed to threaten from the outside, and which the child believes is real, is the decisive factor leading to repression.

3. But the concept of pathogenic beliefs also does involve a motive, an instinctual danger, as is also evident from the preceding quotation. I agree with Alan that it is a pleasurable wish which activates the child's fear of castration in development, or activates the patient's fear of castration in analysis. Joe's view about pathogenic beliefs is based on Freud's observation (1926, p. 45) that the danger which leads to repression is perceived as coming from the outside "...but the loved one would not cease to love us, nor should we be threatened with castration if we did not entertain certain feelings and intentions within us. Thus, such instinctual impulses are determinants of external dangers and so become dangerous in themselves; and we can now proceed against the external danger by taking measures against the internal ones."

This is virtually identical to Joe Weiss's formulation that a pathogenic belief links a motive with a dangerous consequence, and the ego proceeds against the dangerous consequence by taking measures against the motive. Every pathogenic belief is about internal motives as well as about dangerous consequences.

Joe also makes clear that pathogenic beliefs are developed by inference from childhood experiences. The child's inferences are influenced by his motives, including his infantile wishes and his defenses. The childhood experiences which lead to pathogenic beliefs would not be traumatic if the child did not have powerful impulses seeking satisfaction.

4. The development and maintenance of pathogenic beliefs is also influenced by the superego, as is, I think, evident in Joe's formulations and clinical examples.

My overall point in this discussion is that the concept of pathogenic beliefs is part of a coherent, unified conception of how the drives, the defenses, superego factors, and the ego's concern with safety and adaptation interact in producing repression and in maintaining unconscious conflict and symptoms. Alan's point that a pathogenic belief such as the belief in castration will not be overcome simply because the analyst is not threatening and competitive is true. Change requires analysis of the belief and of all of the factors which led to its development and cause it to be maintained in the present.

Rapaport's overview of the advances contained in Freud's 1926 theory is very similar to that I have proposed here:

"In this conception Freud finally achieved what he had previously attempted (1911, p. 13f): namely, external reality is brought into the center of the theory (1926, pp. 62, 101, 116)...but the central role of instinctual drives (p. 87) is retained...this theory of the ego provides a unitary solution for the ego's relation to reality and to instinctual drives" (1958, p. 11).

I shall turn now to other issues. I do not believe that Weiss has

presented a strict either-or choice between higher mental functioning and automatic functioning. Weiss writes in Chapter 1 that the hypothesis of higher mental functioning "does not rule out unconscious automatic functioning. However, it assumes that a person may exert a certain degree of control over his unconscious mental life, and that he may regulate it in accordance with his unconscious thoughts and beliefs and his assessment of his current reality." Weiss adds that most analysts assume both automatic regulation and regulation by higher mental processes.

Nonetheless, Alan's point does capture the special emphases of the theory presented in Chapters 1 and 2. Weiss does take more seriously than perhaps many analysts do the control that the unconscious ego may exercise over behavior, (although, as you know, Rangell and Sandler, among others, have also done so). Moreover, Weiss applies higher mental functioning concepts more consistently and more explicitly than many theorists do to an understanding of the analytic process. I refer to such concepts as that the patient may lift his repressions and make an unconscious content conscious when he believes he can safely experience it, as well as such concepts as testing the analyst, and the patient's unconscious plan. Each of these concepts, however, has numerous precedents in the psychoanalytic literature. Weiss also emphasizes more than some psychoanalysts would the role of the superego and of unconscious guilt in psychopathology, although many other psychoanalytic writers (e.g., Modell and Asch, as well as Freud himself in his later writings) have also done so.

In our research we have tested a pure automatic functioning hypothesis against a pure higher mental functioning hypothesis. We have done so because these are the only broad psychoanalytic hypotheses which are explicit enough, and internally consistent enough, to permit rigorous research. Moreover, there is some value in examining the comparative explanatory power and accuracy of the sometimes competing and incompatible deductions which may be drawn from these hypotheses. Our findings do not rule out automatic functioning, nor could they do so. The findings do, however, suggest the importance, in accounting for certain aspects of a patient's behavior in analysis, of unconscious regulation by danger and safety, of pathogenic beliefs, of testing, and of the patient's unconscious plans. I think our findings are in this way instructive, but I agree with Alan and others that they do not confirm an either-or paradigm. They do not support the view that we can do without multiple perspectives and paradigms.

The crying at the happy ending phenomenon--to turn to another topic--illustrates the theoretical principle that the unconscious ego may exert control over its repressions on the basis of appraisals of danger and safety. I believe Alan agrees that this may happen. If it does happen on some occasions, it makes the theoretical point. I have no argument with Alan's observation that a person also may cry at the happy ending for other reasons.

I want to reiterate a point I made on an earlier occasion. Joe believes that the patient has an unconscious ego wish to master his unconscious conflicts, and that the well-known resistances are strongly opposed to this wish. In Joe's view, powerful resistances accompany every step of the analytic process. But this does not mean that there may not also be powerful wishes for mastery.

In our research on the unconscious plan concept, we have demonstrated that it is possible for clinicians familiar with this concept to study independently extended sequences of clinical material and to agree highly with each other in

their independent judgments about the patient's unconscious ego goals, pathogenic beliefs, and on certain ways he may work in analysis to attempt to change his pathogenic beliefs. Moreover, our current studies demonstrate that these clinical judgments do have considerable predictive power. This work obviates some of the questions raised by Alan, for the clinicians are predicting the patient's behavior from initial interviews, and without knowledge of the later sessions. Moreover, since the analyses and psychotherapies we have studied were carried out by clinicians who are not particularly predisposed to use our concepts, and the treatments were completed before we began our studies, there is no possibility that our self-fulfilling prophecies guided the treatment process.

Alan has made the important point that theoretical preconceptions inevitably influence what one observes and remembers as well as how one understands the observations. Since everyone has preconceptions, whether or not they are aware of them, it may be useful for the clinician (or, for that matter, the research investigator) to be aware of his hypotheses so that he can more readily modify them in the face of contradictory observations. This is of course one of the considerations which has led us into formal research. (But as Peyton Jacob demonstrated so ably last week at the Society meeting, it is also possible for the careful clinician, studying process notes, to formulate explicit hypotheses, and then to test and modify these hypotheses with further clinical material.)

Alan's warnings about the many difficulties and possibilities of error which can arise in attempting to impose rigorous order on the complex data of the psychoanalytic process are well founded. They are based on his considerable experience in psychoanalytic research as well as psychoanalytic practice. Nonetheless, Joe and I and other members of our research group believe not only that psychoanalysis is a science, and that it asserts lawful relations between variables (mental processes), but also that its major phenomena are recurrent and observable, and that formal research may prove useful in advancing knowledge in psychoanalysis as it has in other sciences.

[HS-OCT29]

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[OCT29REF]

DISCUSSION OF WEISS'S VIEW OF THE PSYCHOANALYTIC PROCESS

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Every analyst beginning with Freud has encountered several clinical enigmas not easily explained by existing theory. Among these puzzles are: the negative therapeutic reaction in patients thought to be analyzable, non-psychotic patients deemed to be poor prognoses for analysis often described as borderline or severely narcissistic; analytic stalemates characterized not so much by therapeutic failures or worse but by a mutual sense by both patient and analyst of a therapeutic impasse, an endless task (Calef) never to be completed. Other difficult-to-explain clinical issues include the intensity and tenacity of the transference neurosis, and the empirical observations of the close clinical linkage between repetition and trauma as in the war neuroses. Many analysts, Freud included, proposed new theory to explain these phenomenon. Freud proposed an unconscious sense of guilt, the repetition compulsion, the death instinct and primary masochism. Many analysts since, understandably, have not found some, if not all, of these theoretical additions convincing, apposite, or persuasive and have offered different theory and approaches.

Some analysts have suggested alternatives to interpretive techniques. Ferenczi (1919) suggested, first, selective instinctual frustrations, later deciding it would be better to enact transference gratifications. These recommendations for non-interpretative alternatives have been few but have reappeared from time to time as, for instance, in Alexander's corrective emotional experience and perhaps in Kohut's empathic stance.

Very often the search to explain the tenacity of the transference and the failure to resolve this resistance by interpretation has led some authors to reconceptualize the "essence" of transference. Stone (1973) has written about the "primordial transference" and "the object involved in the primordial serial experiences of separation" (1961), "Thus the originally unmastered or regressively reactivated struggle around separation revived by developmental conflict would in this schema represent the bedrock of ultimate resistance..."

Severe psychopathology, clinically manifested by primitive reactions and organizations and/or implacable resistances, have led some authors to distinguish "borderline" as a distinct diagnostic entity with a specific etiologic matrix. Mahler (1971) has carefully described a rapproachment, "fixation in borderline patients who fail to reconcile, integrate and synthesize the image of the erstwhile 'good' symbiotic mother whom we long for from the cradle to the grave with the image of the ambivalently loved--dangerous because potentially re-engulfing 'mother after separation'." Of course what Mahler has in common with Stone (and I would add, to some extent, with Kernberg) is a view that in severe psychopathology a specific etiologic factor can be implicated: a developmental failure to resolve the separation/individuation phase.

For Kohut, it is not the disturbances in the separation-individuation process, per se, which is at fault in the group of narcissistic disorders he

describes, but failures in maternal (and paternal) mirroring. The parents are not self-objects required for developing healthy self-esteem via transmuting internalizations.

Although Weiss focuses more on the theory of the analytic process and the theory of analytic technique, what he shares in common with the recent writers I have cited is his evident dissatisfaction with existing theory and practice and his attempt to offer significant revisions of it. Weiss claims his theory is both Freudian and new, stating, "The theory is in the mainstream of psychoanalytic advance. It continues a trend, perhaps the predominant trend, in Freud's theorizing and the theorizing of a number of analysts since Freud" (p. 551). Far from being in the mainstream of psychoanalytic advance, in my opinion, the Weiss theory is a major revisionist proposal which repudiates either explicitly or implicitly by shifts in emphasis several fundamental psychoanalytic propositions: (1) a theory of drives as primary motivators of human behavior and the engine which propels the analytic process; (2) the centrality of the Oedipus Complex in human development and in the analytic process; (3) a psychoanalytic view of psychopathology; (4) a psychoanalytic theory of technique as articulated by Freud in his major papers on this matter and never repudiated by him as far as I know; (5) further, it seems to me Weiss very seriously skews the conception of psychoanalysis as a dynamic and genetic psychology regulated by energic shifts; and (6) explicitly rejects the central role of fantasy in human development and in the analytic process.

--One--The Theory of Instinctual Drives. As Rapaport (1960) has noted, "Freud developed the theory of instinctual drives to make sense of his clinical observations. In his effort to do this he found his theory must and does meet the following requirements:

1. To explain certain pathological phenomena.

2. To account for irrational ideas and behavior which are not necessarily pathological.

3. To explain the origin of behavior and thoughts that man experiences as being beyond his control in contrast to those which he experiences as subject to his 'will'.

4. To account for the origin of behaviors and ideas which emerge 'spontaneously', that is which are not obvious responses to an external stimulation or somatic condition."

Weiss, using his illustration of "crying at the happy ending", argues that the ego's unconscious, yet purposeful, quest for safety better explains these phenomena. It is this search for safety which, at base, regulates psychopathological phenomena, irrational thoughts and ideas, parapraxes and spontaneously emerging behaviors and ideas. I believe it becomes apparent that in this theorizing there is a radical shift in the conception of the mind. Weiss proposes motivations which are no longer considered to have biological origins. Motivations are ego plans to regulate unpleasurable affects. Motivations also arise from the child's wish to maintain his ties to his parents. Freud has been unjustly accused, I believe, by Sulloway of being a cryptobiologist. As far as I know, Freud never abandoned his biological view of human motivation. What was abandoned after the "Project" was something of a different order. As Rapaport has written (1960), "There is no doubt that the

theory of instinctual drives was always the center of Freud's psychoanalytic theory and in spite of all the changes and additions which have accrued with the development of the theory, it is still indispensable."

--Two--The Centrality of the Oedipus Complex. Of the child's reaction to his parents, Weiss asserts, "If a child infers and so comes to believe that his attempts to gratify certain crucially important impulses or to reach certain crucially important goals, will threaten his all-important ties to his parents, he may decide to repress or inhibit these impulses or goals, thus he may seriously damage himself in order to maintain his ties to his parents. He may also develop symptoms which in the last analysis are intended to maintain these ties. The child's wish to maintain his ties to his parents is his most powerful motivation. Much of the adult's psychopathology expresses his wish to maintain such ties." Now this brief quote probably does not do justice to the Weiss view of the Oedipus, but there is enough there for me to sharply disagree with. The child's wish to maintain his ties to his parents is the outcome of the successful resolution of the Oedipus--a resolution achieved via repression. We all know what has been repressed: lust and murder; mother and father; sister and brother. The resolution has been achieved by a relative instinctual renunciation of aim and object. One consequence of such renunciations are momentous identifications with substantial shifts in object and narcissistic cathexes. There is a massive reorganization of mental content and function with the appearance of new mental organizations. For many writers, and I am of the same opinion, the Oedipus marks a period of developmental discontinuity--antecedent strands are now transformed into new structures--functions with slow rates of change. In this tripartite model, the id becomes organized under the aegis of phallic Oedipal dominance to include the pregenital and partial drives. There is further taming and fusions of aggression. The ego achieves substantially enhanced capacities (augmented undoubtedly by a spurt in cognitive development) for reality testing, synthesis, integration, and the ascendancy of the secondary process. The instinctual renunciation and identifications consolidate in the superego, the guardian and protector of the incest barrier, the guarantor and protector of individual and group morality. For Weiss to assert that what motivates the child is his wish to preserve his ties to his parents seems to me to miss the whole point of the Oedipus. To suggest an independent line of development for separation guilt and survivor guilt as distinct from Oedipal guilt seems to me to miss the point of Oedipal guilt as the guarantor and protector of morality and self esteem.

For Weiss what dominates the analytic process is the patient's search to disconfirm his pathogenic beliefs in a climate of safety according to an unconscious plan devised by his ego. Transference is employed to test and disconfirm pathogenic beliefs. In several places in his manuscript he refers to "and later the Oedipus was analyzed" (a free paraphrase).

My view of the analytic process is quite different. The initial phase of every analysis is frequently dominated by character defenses as Abrams (1985) has recently noted which function as resistances to the emergence of the transference neurosis. Analysis of the transference neurosis is the sine qua non of psychoanalysis and is at the center of psychoanalytic activity. It is the Oedipal neurosis which is revived in the transference neurosis. It is the Oedipal neurosis which is at the heart of the transference neurosis--it is not the child's wish to maintain his ties to parents which parenthetically undergoes substantial revisions across the span of development.

--Three--A Psychoanalytic View of Psychopathology. Weiss states, "...most, perhaps all, psychopathology is rooted in pathogenic belief" (p. 140), (about which I will comment further later), and "much of the adult's psychopathology expresses the wish of the child to maintain his ties to his parents" (p. 119). "The neurotic, then, in his symptoms attempts to avoid (breaking his ties to his parents) either by unconsciously complying with his parents, or by unconsciously identifying with them. He carries out certain maladaptive behaviors, such as he unconsciously believes his parents wanted him to carry out, or such as, in his unconscious judgment, they themselves carried out" (p. 141). This is quite a novel view of symptom formation and character. Central to a psychoanalytic view of symptom formation is compromise and a return of the repressed. Compromise is effected by the ego to resolve the conflicting demands of id and superego. And I would underscore that conflict is a central psychoanalytic conception of neurosis. Such compromise formations between defense and impulse are hierarchically ordered and derived from serial development. Further, symptoms and symptomatic behaviors are janus-faced, acting as defense against more advanced libidinal organizations, impulse vis-a-vis pregenital drives. For example, in compulsive hand washing, what is defended/cleansed may be a wish to sadistically debase and dirty a love object; what is gratified is a displaced auto erotic wish to touch and manipulate one's genitals.

Weiss extends his view to perversions once again viewed as adaptations in the service of pathogenic beliefs. Compulsive masturbation is not sexual; bondage fantasies do not stem primarily from hostility (the example of Mr. R). It is formulations such as these which suggest to me what much of Weiss's view of psychopathology has in common with other revisionist views: a de-instinctualization of our theory. Moreover, in his view of psychopathology distinctions between primary gain and secondary gain have been conflated and so confused in the assertion of the primacy of the child's wish to maintain his ties to his parents.

--Four--A Psychoanalytic View of Technique. Freud, in his papers on psychoanalytic technique written between 1911-1915, consolidated his view that the principal task of the analyst is to analyze the resistances. Resistance indicates conflict and is a sign of the mental work of the patient. One resistance is aimed at preserving a sense of safety. The transference neurosis is conceived of as the principal resistance to remembering and working through. Freud classified resistance as emanating from the superego, the ego and the id. In an unpublished paper Calef specified resistances within each category: for the superego, the need for confession, the need for absolution and the need for punishment; for the ego, the narcissistic gains, the transference and the resistance of repression, introjection, projection, etc; for the id, the repetition compulsion. As Weinshel and his associates have noted in the Compendium project, "In 1951, Lowenstein stated that 'as a matter of fact there has been no fundamental change in analytic technique. The increase in tolerance of the patient's ego to his unconscious drives has always been sought. It is now, however, being achieved with greater security and greater ease.' Kanzer and Blum in 1967 concluded that, 'Nevertheless, Classical analysis, as the innermost core of analytic theorizing and therapy, has undergone relatively little change--one that is measured more in the analyst's outlook and use of his technique than in their formal aspects'." The technique which Weiss proposes conceives of but two resistances, the safety resistance--a resistance employed to disconfirm pathogenic beliefs--and the resistances arising from a variety of guilts over ego purposes and ego interest. This is certainly a major departure and revision according to my reading of Freud and contemporary writers.

--Five--A Shift in the Conception of Psychoanalysis as a Dynamic and Genetic Psychology Regulated by Energic Shifts. In the dynamic point of view in psychoanalysis are assumptions of psychological force which underlie propositions concerning drives, ego interests, conflicts, overdetermination, fusion, defusion, and integration of pregenital drives under genital primacy. Let me cite just one example of the implication of a dynamic/energic point of view. This point of view impels the analyst to examine the forces at work in psychic conflict and the energies which sustain these forces. When repressed content achieves consciousness, what shifts in dynamic and economic forces has permitted this hypercathexis? Has there been a dimunition in the countercathexis? Has there been an increase in the cathexis of the repressed? Perhaps some combination? These are the questions I ask of myself. In the Weiss model content achieves consciousness only when there is perception of a climate of safety. The reality principle is the exclusive regulatory principle of the mental apparatus. In the Weiss model the pleasure principle is not a regulatory principle. Now this is freely discussed in Weiss's work but of the many ramifications, I will note just one. In the standard model most conflicts are viewed as intersystemic--between the id and the other mental agencies. In the Weiss model, conflict is either intrasystemic (safety vs. the wish to disconfirm pathogenic beliefs) or between the ego and a variety of guilts (the ego's motives and goals and the wish to preserve the child's tie to his parents).

As for a genetic/development point, Weiss, relying on reconstructions from adult analyses, portrays as far as I can tell character formation and symptom formation as being shaped primarily (if not exclusively) by the child's wish to maintain his ties to his parents and to avoid the grim constricting reality contained within his pathogenic beliefs. This he achieves by identifications with or compliances to his parents. Development is a vast terrain which I cannot explore this evening. However, I cannot improve upon Anna Freud in her descriptions of developmental lines which are products of the complex interaction between nature and nurture across the span of development. Identification, compliances and the wish to preserve an object tie are but a few of the many variables. Moreover, development proceeds both continuously and discontinuously, and reconstructions in adult analysis need to account for this phenomenon also.

--Six--Role of Fantasy in Human Development and in the Analytic Process. Weiss rejects out of hand the role of fantasy in development and its central importance for the analytic process.

In his writing, Weiss carefully distinguishes between pathogenic beliefs and fantasies. He writes, "Pathogenic beliefs are not fantasies. Though they may appear similar to the adult, they are from the perspective of the child (and in the unconscious mind of the adult) different. A child unconsciously derives pleasure from fantasies but not from pathogenic beliefs. Indeed a child may be unconsciously terrified or weighed down by pathogenic beliefs. In producing a fantasy a child ignores the frightening, frustrating aspects of reality or he changes reality so as to perceive it as the fulfillment of various wishes. However, in producing a pathogenic belief a child faces reality. He infers a pathogenic belief from the frightening, grim, traumatic aspects of reality as he perceives it. In producing a pathogenic belief a child attempts, albeit inadequately, to grapple with the dangers and frustrations of reality."

The author cites Inhibitions, Symptoms and Anxiety to support his idea of distinctions between fantasy and pathogenic beliefs. It is true that Freud wrote in that paper, "Little Hans gave up the aggressiveness toward his father from fear of being castrated by him," and that the fear of castration is a principal motive force for repression of the Oedipus. But in that paper Freud was not principally exploring the grim realities of childhood which are at the heart of pathogenic beliefs, but the compromise formations which are inherent in all symptom formation and, more widely, in neurosis. It is true that a pathogenic belief may have something to do with repression, but it is also correct to state that what returns in symptom formation has something to do with the return of the repressed and the compromises that issue therefrom. Little Hans was afraid to go into the street because he was afraid that a horse was going to bite him. Hans had seen a horse fall down in the streets, and he had also seen a playmate with whom he was playing at horses fall down and hurt himself. "Analysis justified the inference that he had a wishful impulse, that his father should fall down and hurt himself as his playmate and the horse had done. Moreover, his attitude toward someone's departure on a certain occasion makes it probable that his wish that his father should be out of the way also found less hesitating expression, but a wish of this sort is tantamount to an intention of putting one's father out of the way oneself. It is tantamount, that is, to the murderous impulse of the Oedipus complex." There is no question that his symptom formation, the phobia, was a compromise between his hostile impulses against his father and fear of punishment.

Freud also went on to describe the case of the Wolfman in which the fear of being devoured by the wolves also had in it the unconscious passive homosexual longings toward the father. Again, the implied compromise between a wish and the punishment for such a wish. Why is the fear of castration any more a grim reality than the wish that your father be out of the way?

As Arlow has written, "The role of unconscious fantasy in mental life has been recognized as of primary importance in psychoanalytic theory and clinical practice from the beginning. Expressing the fulfillment of unconscious wishes such as fantasies were recognized by Freud as the common basis of dreams and the symptoms of hysteria." Fantasies may be conscious and unconscious and range along this axis to accessibility for analysis. Again Arlow has written, "Unconscious daydreaming is a common feature of mental life. It is an everpresent accompaniment of conscious experience. What is consciously apperceived and experienced is the result of the interaction between the data of experience and unconscious fantasy as mediated by various functions of the ego. Fantasies are grouped together around certain basic childhood wishes and experiences. In these systems of fantasies, one edition of the fantasy wish may represent a later version or defensive distortion of an earlier fantasy."

This has certainly been my experience in analyzing, for instance, the central masturbation fantasy of patients. The fantasy which achieves ascendancy in adolescence is the product of serial revisions across latency and early adolescence. Analysis will reveal its earlier editions and the compromises they contain. And as Sandler and Nagera have pointed out, "Once a conscious or pre-conscious fantasy has been repressed into the system unconscious it functions exactly like the memory of an instinctual satisfaction and can provide the ideational content of the instinctual drives." Far from using the analytic situation to disconfirm pathogenic beliefs, patients, in my experience, attempt to use the analytic situation to fulfill unconscious fantasy. Abend (1979) in "Unconscious Fantasy and Theories of Cure", describes the way patients

frequently entertain their own theories of how psychoanalysis works. From the analysis of his patients, Abend was able to show that the theories of cure represented derivatives of unconscious conflicts that had persisted in the patient's mind since childhood. And, in fact, the unconscious fantasies of cure were related to the very pathogenic conflicts that gave rise to the patient's illness.

I would now like to discuss some rather specific issues raised in Chapters 3 and 4. In Chapter 3, Weiss proposes new ways of understanding guilt and implicates new sources for guilt not sufficiently stressed in our literature. He writes, "...a child may develop guilt, not simply over Oedipal strivings, but over a wide variety of impulses, attitudes and goals." Again, "a child may develop not only Oedipal guilt, separation guilt and survivor guilt, but guilt about any motive or behavior" because "the ego wish of the child to retain his parents as protectors is much stronger than the child's libidinal attachments to them."

This view of guilt is, I believe, radically different from the view described by Freud in The Ego and the Id. Freud wrote there, "The broad general outcome of the sexual phase dominated by the Oedipus complex may, therefore, be taken to be the forming of a precipitate in the ego consisting of the two identifications in some way united with each other. This modification of the ego retains its special position; it confronts the other contents of the ego as an ego ideal or superego." And again, "This double aspect of the ego ideal (you ought 'to be' and 'you may not') derives from the fact that the ego ideal had the task of repressing the Oedipus complex; indeed it is to that revolutionary event that it owes its existence." For Freud, the superego owes its existence as a distinct mental structure to the renunciations of the Oedipus--specifically the sexual love for both parents. This renunciation is followed by identifications which enforce the prohibitions. One of its products is a quality of anxiety never before experienced--guilt--an anxiety related to forbidden incestuous and murderous wishes. Another product is the child's capacity for a non-sexualized relationship to his parents.

What I wish to emphasize is that a major developmental transformation has taken place with substantial revisions of the structures and contents of the mind. What is at base of all our moral perceptions is the Oedipal renunciation. Freud, indeed, assigned to the superego a broad content: personal morality, religion and social conscience. That a child or adult may become guilty over a variety of motives should not obscure the origins of a sense of guilt. And to suggest, as Weiss does, that the affect of guilt can have several different origins independent of Oedipal guilt is a substantial departure, a departure from a theory of conflict and compromise formation to a theory in which the pursuit of safety and the preservation of non-libidinal ties to parents are the prime movers and shakers.

I would like to discuss in more detail the notion of separation guilt and survivor guilt. Separation guilt is defined as "(That guilt which) may be developed by a child who wishes to become more independent of a parent and who infers that were he to do so he would hurt the parent." Weiss asserts that "the child's acquisition of separation guilt may be his response to his perceptions, both real and distorted, that his parents will be hurt as he tries to become more independent of them," and cites Loewald, who considered this form of guilt to be connected with both Oedipal conflict and conflict about separation and individuation. I assume Loewald takes the position he does because of his

conception of the primordial transference--an archiac maternal transference which he believes is the bedrock analytic transference. Weiss takes his position evidently from reconstructions which have suggested to him that a toddler during separation/individuation can experience the complex affect of guilt over his wish to separate and individuate from mother. The toddler's pathogenic conviction is that his wish for autonomy will injure his mother. I can only say that I have never seen this phenomenon in children--either in analyses or observations. What I have seen in toddlers, of course, is anger and rage over control and anxiety over loss of the object or object's love as punishment--never guilt as I identify that affect. Again there are, I believe, important distinctions to be made between antecedents and transformations. Weiss cites Stuart Asch, who has also written about separation guilt. In the cited paper Asch is grappling with the phenomenon of the negative therapeutic reaction, and he suggests that more common than guilt over Oedipal crimes is guilt over pre-Oedipal crimes which fortifies unconscious guilt and/or the need for punishment.

Indeed, the negative therapeutic reaction is a phenomenon which has puzzled many authors and I would be straying too far afield to cite some of that data. The issue for Asch and Weiss seems to be with the notion that the more pernicious or tenacious a reaction, the earlier must have been its origin. This, I believe, is a prime illustration of the genetic fallacy. Negative therapeutic reactions are complex and unexpected developments within an analysis. To speculate that it's because of failure in early separation individuation is to grossly overlook the complexities of subsequent character formation as character develops across the span of childhood and young adult development. Such careful clinical investigations I believe always reveal the many complex determinants of this untoward reaction in analysis, not as Asch suggests because we felt guilt about wrestling autonomy from our mothers in the second 18-month span of life.

Weiss describes a patient who suffered from separation guilt, "developed in childhood an intense fear of using any toilet outside the home and thus kept himself close to his mother." In the children I have seen who refuse to use the toilet outside their home, staying close to mother may become an important motive, but not as a consequence of the primary neurotic conflict but of the secondary gain. A fear of using the toilet outside the home is a phobia containing wishful fantasy, prohibitions, and return of the repressed. I have encountered in adolescents and in adults a belief that achieving an existence independent of their parents threatens the parents--but I view such beliefs as compromise formations--the reality of parental attitudes notwithstanding.

Weiss also elaborates on survivor guilt. Employing the extended meaning offered by Modell, Weiss writes, "Survivor guilt too is based on a belief. It is a person's belief that by acquiring more of the good things of life than his parents or siblings he has betrayed them...The person believes that his acquisitions have been obtained at the expense of his parents and siblings."

Claiming support by Niederland's studies of the Holocaust, Weiss suggests "that the kind of guilt which a child develops depends on the same kind of trauma which he suffers." The patients whom Niederland studied were victims of concentration camps who had been brutally persecuted, incarcerated and tortured. They clearly suffered from a survivor syndrome characterized by chronic or recurrent states of depression, anhedonia, anxiety, hypermnesia for the persecution events and alterations in the sense of reality and identity. There

is no question in these patients that their survival was consciously experienced as a betrayal of dead parents and siblings, and the guilt is enormous. But Niederland was describing a very special population of severely traumatized individuals. The question is, how much can we generalize for normal development from this very special population? There is no question that our theory concedes that an event in reality, a trauma, which confirms dangerous fantasy, creates abiding relations between a wish and the experience of the danger of such wishes. Ordinarily we view such abiding relations as points of fixation and the origins of profound resistances to analyzability. Indeed if traumas have been too prolonged, intense or severe, analyzability is clearly an issue--precisely because blinding reality conceals the wish.

There is, of course, another problem in citing the Holocaust victims, and that is the uneasy fit in our theory for the severe traumatic neuroses which Freud wrote about. In 1917, he wrote, "Traumatic neuroses are not in their essence the same things as spontaneous neuroses which we are in the habit of investigating and treating by analysis, nor have we yet succeeded in bringing them into harmony with our views." Yet two years later Freud attempted to reconcile the war neuroses with the psychoneuroses and the actual neuroses. In the war neuroses the ego is threatened by external danger. In the transference neuroses the danger is from within; an elementary traumatic neurosis. Wallerstein, in a recent panel at the American, viewed this as a forced and unconvincing formulation. Waelder, in reviewing Freud's conceptions of the war neuroses, concluded that by focusing on the repetition and struggle for mastery, under one heading, Freud was considering phenomena as different as the play of children and the war neuroses. The problem for analysts in considering the war neuroses as contiguous with the psychoneuroses is the difficulty in identifying and isolating the infantile/sexual contribution to the clinical picture in the war neuroses. For Weiss, this is somewhat reversed as he searches for the experiential, real and imagined, which induces survivor guilt.

In Chapter 4, Weiss's assertion that "pathogenic beliefs and the fear, anxiety, shame, and guilt to which they give rise provide the primary motives for the development and maintenance of repression, inhibitions and symptoms" is not only in my opinion an assertion which confuses causes and motives, but also is a clear statement of the significant departure in formulating theories of psychopathology. Psychopathology in this view is not the product of conflict, regression and compromise formation. Pathogenic beliefs are "a part of the child's effort at adaptation". They are attempts by the child to understand the dangers of the world and by understanding them to avoid them. The id, or the primary process as Freud described it, cannot produce a pathogenic belief. This is because it is regulated by the pleasure principle and thus effortlessly, automatically, avoids all painful experience. It certainly does not form beliefs to explain them."

Freud was never quite so puristic about what formed the content of the id and what formed the content of the ego. In <u>The Ego and the Id</u>, Freud wrote, "Moreover, one must not take the difference between ego and id in too hard-and-fast a sense, nor forget that the ego is a specifically differentiated part of the id." Whether one agrees with this view or with the view Hartmann proposed that id and ego differentiate from an undifferentiated matrix, permits one to perceive the constant state of mutual relations between these two structures--relations which enable us to understand clinical phenomena such as sexualization and aggressivation. Weiss's theory, in my opinion, leads toward a de-instinctualization of our theory.

Pathogenic beliefs are neither impulse nor defense, yet powerful sources of motivation. A person who compulsively masturbates, masturbates not to obtain gratification, but to reassure himself that he's intact. Weiss writes, "Most, if not all, psychopathology is rooted in pathogenic beliefs" and an example of this view is illustrated in Weiss's discussion of fetishism. Fetishism stems from the pathogenic belief in castration as a punishment for sexuality. Weiss describes a fetishist as "though he appears to be excited by the fetish. He does not love it per se but is simply made to feel safe enough by it to experience sexual feelings which ordinarily would arouse castration anxiety." There is no question that fetishism contains a safety resistance to allay massive castration anxiety. But that's just the beginning, not the end. The "safety" notion simplifies beyond clinical recognition the complexity of the psychopathology of fetishism. Fetishism, a complex compromise formation, has to be described both from a phenomenological/clinical view and from a dynamic/genetic point of view in order just to begin understanding it. A phenomenological description (after Greenacre) defines fetishism as "a distortion of sexual behavior in which there is the obligatory use of some nongenital object as a substitute (for) the sexual act without which gratification cannot be obtained." A dynamic/genetic explanation must account, among other issues, for the central masturbation fantasy which is the product of serial revisions throughout latency and adolescence. Considerations of fetishism must include the altered sense of reality (infarct in reality according to Greenacre) the role of trauma, the role of aggression, and the unique defense employed by the fetishist.

To the last point first, Freud described the split in the ego, which was for him the essence of the fetishistic pathology, the split which permits the dual view of the female anatomy. Calef and Weinshel recently clarified that it is not the split in the ego which is the defense, rather the split is "used in the service of defense by regression which is the defense. The split describing an archaic form of thinking which antedates the development of an integration between conscious and unconscious mental processes and reality and fantasy in the instinctual drives of the id form the prohibitions of reality." It is this split which accounts for the compromises in the reality. "Now I see it--now I don't."

The importance of trauma, especially pre-Oedipal trauma, has been widely debated in the literature. Greenacre, a leading proponent of the pregenital trauma theory, has written, "I was impressed by the fact that these patients have suffered characteristic trauma at the age of two and four and the injury which had such a specific and strong effect was one involving bleeding and mutilation." Robert Bak, on the other hand, contends that "while the possibility of an early traumatic origin of body image certainly cannot be excluded, it is a later regressive phenomenon that derives from the "uncertainty of the perception of the phallic/non-phallic mother and extends to the entire body surface."

Recent literature has emphasized the role of aggression and clinically I have been impressed in my experience of the intensity of the aggression regressively derived from late oral and anal development.

The intensity and severity of the castration anxiety generally agreed upon by most writers has again led to surmises about the force of pre-Oedipal facts. In the late 60's, Greenacre, particularly, wrote about disturbances in the early mother-infant relationship which she believed to be critical in the development

of perversions. Other writers (Bak and Paine) have implicated the early and adhesive attachment to mother or her substitute often as a result of prolonged and precocious intimacy. More recently, I believe there has been a shift away from describing the more general disturbances of the mother-child relationship more to dissecting the overdetermined meanings in the regressively distorted masturbation fantasy. Chassequet-Smirgel has emphasized the often anally-degraded meaning of the fetish as the fecal phallus and the fecal baby.

The last issue I wish to raise in considering this perversion is the role of action. Although our psychoanalytic theories of action are incomplete, most explanations of this perversion stress the role of action in magically patching over the flaws in the sense of reality. It is in this instance that action speaks louder than words. The action is more compelling to the audience whether the audience be real or imagined. The fetishist creates a new reality (a new sexuality according to MacDougal) which affirms a denial—there is no genital difference, no castration, no death.

I have perhaps belabored the dynamics and genetics of the psychopathology of fetishism--but if I have, it is because I believe complex clinical phenomena are not readily reducible. Fetishism, I do not believe, can simply be explained by the search for safety.

Finally, I would like to make a brief comment on Weiss's view of the nature of the psychoanalytic process. That view asserts that the psychoanalytic process consists of the patient's attempt to disconfirm his pathogenic beliefs. The patient has an unconscious plan to achieve this; a plan which is put into effect by testing the analyst. It is the analyst's task, both in word and deed, to pass these tests in order to disconfirm his patient's pathogenic beliefs. This is a marked departure. Freud described that analysis ultimately had to do with the analysis of resistances.

Two recent presentations, those by Weinshel and Abrams, reaffirmed this view. Resistance in its manifold presentations is not the critical core of the analytic task in Weiss's view--the ego's search to disconfirm pathogenic beliefs is.

I would like to close on an anecdote from my days as a candidate. My class was taught Development IA by Emmy Sylvester. Emmy began one class discussion of some Hartmann papers with the observation, "Last night I fell asleep before completing the assignment. When I woke up, I thought, 'all ego and no id makes Heinz a very dull boy!'"

[PELTZ]

DISCUSSION OF DR. PELTZ'S PAPER

Harold Sampson, Ph.D.

November 12, 1985

I

Thank you, Morrie, for a very lively paper. No one here will say about Morrie's paper what Emmy said in jest about Hartmann's article. Morrie's paper is not dull. Nor will I, for one, accuse Morrie of overemphasizing the role of the ego in mental life. (In reading Morrie's paper, I was surprised to discover that I only disagreed with about 85% of it. This probably reflects my increasing tolerance for differences as I grow older.)

In a more serious vein, I appreciate Morrie's frank, articulate, and forceful critique of Joe's work from the perspective of his own theoretical position. I welcome the opportunity to discuss the issues he has raised. These issues, as I shall argue, pertain crucially to (1) implications of Freud's ego psychology for psychoanalytic theory, and (2) varying ways of integrating Freud's later theorizing (as well as certain contributions of subsequent analysts) with Freud's early theory, which is both a powerful theory and a highly coherent one.

I believe that Morrie uses Freud's ego psychology in only a limited way, at least in his critique of Joe's work. For example, as I hope to make clear, he has not integrated very much of Freud's 1926 theory into his understanding of psychopathology and treatment. Weiss has built not only on Freud's ego psychology, but also on the advances of such brilliant thinkers as Hartmann, Kris, Loewenstein, Rapaport, and Anna Freud, as well as on the contemporary work of such people as Rangell, Erikson, Loewald, Settlage, Sandler, and others. He has tackled what he takes to be certain unresolved problems in the field: e.g., how the 1926 theory's account of the ego's regulation of the id by criteria of danger and safety casts light on psychopathology and treatment. Thus, he has examined how the 1926 theory applies to the emergence of warded off contents in analysis. These are the themes of Weiss's earlier work on crying at the happy ending, on the integration of defenses during analysis, and on the emergence of new contents in analysis. And these are the themes of our research over the past 15 or more years. In these areas I believe that Weiss has made some contributions to psychoanalytic knowledge.

As these introductory remarks imply, I do not consider it either accurate or useful to conceptualize the differences between Morrie's and Joe's positions as differences between an "existing" theory and a "revisionist" theory.

It is inaccurate for several reasons.

First, it does not recognize, or misunderstands, or ignores the relationship between the theory proposed by Weiss in these chapters and the lines of psychoanalytic thinking, beginning with Freud's ego psychology, which Joe traced in Chapter 2.

Second, it presumes that psychoanalytic theory is monolithic, and that

there is one correct way of integrating the complex psychoanalytic legacy into one vision, one "existing theory." As Wallerstein noted in his recent paper on change and intregration in psychoanalysis: "...there will inevitably be 'the range of differing views' within the faculties of all but the smallest institutes, and none has a corner on what psychoanalysis is, because it isn't just one monolith that we all try imperfectly to approximate" (1985, p. 173).

Third, this characterization of the differences is not accurate because the disagreements which concern us are pervasive and are longstanding. They do not begin with Joe's work, nor are they confined to it. They are intrinsic to this field and to the multiple paradigms and perspectives it contains. Arnold Cooper wrote in his 1982 Presidential Address: "As each group struggles to dominate our scientific life, we are reliving many of the enduring controversies in psychoanalysis...Some of these disputes are more philosophical than scientific and will always be with us. Others are disputes that, one day, will be settled by scientific data. Embedded in the debates between schools or points of view are such fundamental controversies as..." and then he lists such controversies as that over the relative importance of nature and nurture, over whether the nucleus of neurosis is oedipal or preoedipal, over the origins of motivation, and over the nature and source of therapeutic effectiveness. He goes on: "These kinds of questions have always been at the core of our field. What is different at the present time is that our questioning goes on with a new openness and with no possibility that the questions can be answered, or thrown out of court, by appeal to authority" (1982, p. 257).

Nor is it useful to characterize the differences in this way, for it tends to obscure the fact that what is at issue are scientific problems which have not been solved once and for all, and which will not go away. We will differ in our various definitions and understanding of these problems, and in our preferred ways of thinking about how they may be resolved. Let us agree, however, that they are intellectual and empirical problems of the first magnitude, and warrant our best efforts to clarify conceptually and to investigate empirically.

We may not complete this task tonight!

II

I have suggested that many of the issues which concern us in this dialogue are linked to a general theme in psychoanalysis; namely, the implications of Freud's ego psychology for theory and practice, and the integration of it with his earlier theory. I will remind you of the difficulty of integrating some of Freud's later concepts with his earlier theory--and also of the reality and the vividness of the issues involved--by use of a few pertinent quotes:

Glover observed (1968) that many of Freud's followers found it difficult to reconcile the views set forth in The Ego and the Id with Freud's earlier formulations, "and to this day confusions exist...It is therefore no exaggeration to say that from 1924 onwards there gradually developed a number of schisms."

Zilboorg's comments were even more trenchant: "...ever since the attention of psychoanalysis was drawn to ego psychology as the center of our research and therapeutic interests, the fragmentation of psychoanalysis began...This breaking up of the scientific unity of psychoanalysis was not accidental...and the coincidence of this breakdown with the development of ego psychology was not at

all accidental" (1952, p. 21).

Hartmann, Kris, and Loewenstein, who devoted their professional lives to the integration of Freud's ego psychology with the earlier theory noted the difficulties of doing so and that the task has yet to be completed. E.g., they wrote: "Since a structural viewpoint was introduced into psychoanalytic thinking, hypotheses previously established must be reintegrated. The task of synchronization is larger than it might seem at first" (1946, p. 12).

Kris gave particular emphasis--as I will later--to the far reaching implications of the 1926 theory: "In 1926, in Inhibitions, Symptoms, and Anxiety, Freud reformulated a considerable set of his previous hypotheses. I am convinced that this reformulation reaches further than was realized at the time of publication, possibly by Freud himself" (1947, pp. 25-26, italics mine).

I will show next that this is not simply ancient history, and that this issue reverberates throughout Morrie's critique of Joe's work. Before I do so, let me quote one more author--Richard Sterba in his Reminiscences of a Viennese Psychoanalyst. His comments anticipate some of what I shall have to say:

"The need to accept the new structural theory...met with great resistance. Some of the members refused to accept it altogether.

"...I found the new concept especially helpful for the understanding of resistances. The acknowledgment of an unconscious part of the ego makes it much easier to explain the effect of infantile, real or imaginary dangers in the form of resistances of which the patient is not consciously aware.

"...Three years after the publication of The Ego and the Id, Freud published another work that made a radical change in a fundamental part of our analytic thinking necessary: Inhibition, Symptoms, and Anxiety...anxiety became the motivational cause of the repression of the drive...Neurotic anxiety is therefore a function of the ego generated as a warning of dangers that a certain drive gratification would bring about, a danger signal that motivates the ego to repress the dreaded drive.

"The catch phrase: 'we are lived by our id,' which George Groddeck had coined...had lost considerably its impressiveness and validity when Freud emphasized the mighty tool of the anxiety signal, which gives the ego power over inadmissible drive impulses of the id. The signal anxiety produced by the ego against dangerous id strivings was then the motor force for repression...[This change] was bewildering to some members of the group, since it necessitated the adaptation to a new way of theoretical understanding of clinical material" (1982, pp. 76-78).

III

I will now develop this topic in a way which is directly pertinent to a number of specific points made by Morrie.

As I noted 2 weeks ago, Freud's 1926 theory provides the context for understanding what is meant by a pathogenic belief. A pathogenic belief is the belief underlying the ego's anticipation of danger. This kind of belief has a special function in mental life; namely, the function of warning the ego of the

danger of attempting to satisfy certain wishes. It is because of this crucial, special function that Weiss considers it useful to distinguish pathogenic beliefs from other kinds of mental products, such as primarily wish-fulfilling fantasies, or other unconscious beliefs which serve a reassuring function against a danger. [For example, the unconscious belief that women have penises denies the danger of castration, and provides a reassurance against this danger.]

In Freud's 1926 theory, the immediate motive for repression is anxiety brought about by an anticipation of a danger that is believed to be threatening from the outside. This conception made clear how the ego's concern for safety, self-preservation, and adaptation actually operate in the regulation of the drives. Rapaport commented: "In this conception Freud finally achieved what he had previously attempted (1911, p. 13f): namely, external reality is brought into the center of the theory (1926, pp 62, 101, 116)...but the central role of instinctual drives (p.87) is retained...this theory of the ego provides a unitary solution for the ego's relation to reality and to instinctual drives" (1958, p. 10). This is also what Weiss is attempting in developing new clinical implications of the 1926 theory.

Indeed, the concept of pathogenic beliefs does explicitly involve a motive, an instinctual wish, as well as a belief about a danger threatening from outside. E.g., it is a pleasurable, a libidinal wish which activates the child's fear of castration. Freud wrote that the danger which leads to anxiety and repression is perceived as coming from the outside "...but the loved one would not cease to love us, nor should we be threatened with castration if we did not entertain certain feelings and intentions within us" (1926, p. 45). This is precisely the position Joe has taken in regard to pathogenic beliefs. A pathogenic belief links a motive with a dangerous consequence. The ego proceeds against the dangerous consequence by taking measures against the motive. Every pathogenic belief is about internal motives as well as about dangerous consequences believed to be real. Moreover, the childhood experiences which lead, via subjective inference, to pathogenic beliefs would not be traumatic if the child did not have powerful impulses seeking satisfaction. (In our discussion last time I noted that the child's belief in castration would be of only academic interest to him if he did not have oedipal wishes.)

The concept of pathogenic beliefs is part of a unified conception of how the drives, the defenses, superego factors, and the ego's concern with safety and adaptation interact in producing repression and in maintaining unconscious conflict and symptoms.

This concept strengthens our understanding of the biological origins of human motivations.

First of all, it retains the importance of the instinctual drives of sex and aggression (while recognizing that the ego has some power to regulate these drives through the anticipation of danger and the anxiety signal). We can no longer simply speak of being lived by our Id.

Second, in recognizing the importance of the ego's use of higher mental processes in regulating the drives in accord with adaptive considerations, it recognizes the biological significance (for adaptation) of thinking, anticipating, and judging. Thinking and anticipating are as biological as lusting and murdering, as Hartmann observed. Moreover, the avoidance of anxiety

is a powerful, biologically based motive.

Third, Weiss emphasizes strongly a biological factor which Freud believed played an important part in the causation of neuroses. "The biological factor (in the causation of neuroses) is the long period of time during which the young of the human species is in a condition of helplessness and dependence...As a result, the influence of the real external world upon it is intensified and an early differentiation between the ego and the id is promoted. Moreover, the dangers of the external world have a greater importance for it, so that the value of the object which can alone protect it against them and take the place of its former intra-uterine life is enhanced. The biological factor, then, establishes the earliest situations of danger and creates the need to be loved which will accompany the child throughout the rest of its life" (1926, pp. 154-155). [This quotation, by the way, also illustrates what we mean in stressing the importance of the child's ties to his parents.]

Weiss emphasizes--possibly more than some others would--the importance of danger situations in the development of psychopathology. In bringing the 1926 theory into full play in explaining psychopathology, Weiss brings together the importance of the daemonic instincts along with the importance of the ego's attempts to regulate the instincts in accord with considerations of danger and safety. This does not de-instinctualize the theory.

A closely related topic is that of symptom formation and the function of symptoms. Freud used a number of cogent formulas throughout his theorizing to capture various aspects of the meaning of symptoms. In his pre-analytic work, one key formula was that a symptom is a disguised repetition of a traumatic experience. Freud had to modify this formula when he developed the libido theory: a symptom became a disguised expression of an infantile sexual wish--e.g., Dora's symptoms were portrayed as disguised expressions, disguised gratifications, of her infantile sexual life. In this formulation, the symptom is a compromise formation between the Uncsc. libidinal wish and the defensive activities of the system Pcs/Cs.. In 1926, Freud added a new formula which was necessitated by his new theory: "...symptoms are created in order to remove the ego from a situation of danger...the generating of anxiety sets symptom formation going and is, indeed, a necessary prerequisite of it" (1926, p. 144). This new formulation adds the avoidance of anxiety, by removal of the ego from a situation of danger, as a crucial function of symptom formation. It clarifies our understanding of the stringencies the ego must meet in effecting a compromise between id, superego, and the ego's concern for adaptation.

The examples presented by Weiss add to our understanding of familiar symptoms by showing how they remove the ego from a situation of danger, a situation of danger warned of by the patient's pathogenic beliefs.

Moreover, in an important sense, the ego's anticipation of danger is the linchpin which holds the pathological formation in place. If the patient's pathogenic belief was changed, and the patient's anticipation of danger was thereby reduced, a progressive course could begin to unfold. Fenichel observed that "In the neurotic, the pathogenic defenses remain effective because anxieties and guilt feelings, developed once in childhood, still are at work...Freud once designated as the essence of neurosis the retention of anxieties beyond the period when they were appropriate" (1945, p. 569). Fenichel goes on to describe how interpretations help educate the defending ego to a tolerance of more and more undistorted derivatives, and: "The 'analytic

atmosphere' that convinces the patient he has nothing to fear in tolerating impulses formerly warded off seems not only to be a prerequisite for any transference interpretation; it is also the decisive means of persuading the ego to accept on trial something formerly repulsed" (ibid, p. 570, italics mine).

If I may anticipate next time's discussion of Joe's chapters on the analytic process and on technique, I would describe these chapters as a detailed exposition of how the analyst actually helps the patient to recognize that old situations of danger no longer exist, and thereby enables the instinctual impulse and the entire conflict in which it is embedded to become manifest and to be analyzed.

IV

I would now like to take a step back and examine an aspect of Morrie's argumentation, which, in my opinion, involves a particular kind of misunderstanding of what we are up to. Each time that Weiss adds an ego psychological factor to discussion of a clinical phenomenon, Morrie concludes that he is neglecting all other factors. For example, when Weiss speaks of how a symptom enables the ego to avoid a situation of danger, Morrie states that he is leaving out the instinctual drives or compromise formation or regression or the resistances.

This is an important enough misunderstanding--and a familiar enough one in the response of some other readers--that I want to take it quite seriously and try to clarify further what Weiss is doing. I will approach this problem from several angles.

I shall refer first to the case of Miss P. which was described in Chapter 1 and was discussed here last time. If Joe had been writing a case study of Miss P. and her treatment, it would be appropriate to ask: What about her infantile sexual and aggressive wishes? What about the role of regression and compromise formation in her symptoms? Why haven't you detailed all major resistances and transferences? Why is there only passing reference to "later, the Oedipal" as Morrie put it?

In fact, Joe has not written a case study of Miss P. He has written instead a chapter on the topic of the ego's unconscious control of its repressions, and the conditions which may enable patients to lift their repressions. He has focussed explicitly, deliberately, and clearly on a phenomenon occurring in each of several cases: the emergence into awareness of a previously repressed content when it became safe for the patient to experience that content. He has used these cases to make an important theoretical point. Miss P., no matter what else was going on, did bring forth her warded-off sadness when she considered it safe to do so. This was Joe's point, and he gave a lot of evidence for this conclusion.

Let me describe this situation by a fanciful analogy to another difficult science, that of nutrition. Suppose that an investigator noted the discovery some 60 years ago by a great nutritionist that a particular food ingredient was important to human growth and the maintenance of health. The investigator then did a lot of work, and carried out a lot of studies, to develop the implications of the earlier discovery. Now suppose that his critics pointed out that he was not showing how meat and other proteins were essential to growth, and how

carbohydrates were involved in growth and health. These critics would not only be incorrect in suggesting that the investigator was repudiating the fundamental propositions of nutritional science. Even more importantly for their own understanding of their field, they would be ignoring the investigator's contribution to understanding nutrition. I think that something like this may be happening in Morrie's critique of Joe's work.

This misunderstanding is not tendentious. I think it is based on two problems. First, the theoretical preconceptions of some readers make it difficult for them to follow sympathetically even the most careful and empirically based examination of implications of Freud's 1926 theory for the psychoanalytic process. Second, psychoanalytic writing tends to err somewhat on the side of overinclusiveness--perhaps because the writer wishes to avoid criticism. (Incidentally, I believe that's the real reason why Hartmann's papers are difficult to read and, yes, perhaps even a bit dull. He writes as though beleaguered by an anticipation of danger--i.e. the danger that he may be criticized by colleagues if he leaves out any qualification, or fails to discuss every possible aspect of an issue. I leave it to you to decide whether that is a realistic danger or a fantasy.) In an early draft of Joe's paper on on crying at the happy ending, Joe said in paragraph 1 that the person cries at the happy ending because it is then safe for him to face his sadness. In paragraph 2 he added that the crying could be a disguised expression of various sexual and aggressive impulses, which he then specified, as well as having various defensive functions, which he also specified. The second paragraph was true, familiar to everyone, comfortable to read, and totally irrelevant to the real point Joe was trying to make. Thirty years later, Joe is omitting the second paragraph.

Now let me take up [briefly] a few ways in which this kind of misunderstanding is pertinent to certain points in Morrie's paper. I have already noted that Joe's thesis does not do away with the biological origins of motivations. It does not do away with instinctual drives. It does not do away with compromise formations. It does not do away with conflict. It does not do away with regression. It does not replace (although it does supplement) the theory of symptom formation presented by Morrie. However, in each instance, by adding something, it does change our understanding of clinical phenomena, as I think Morrie correctly recognizes.

The theory presented in these chapters does not do away with unconscious wishful fantasies or with unconscious reassuring beliefs and fantasies (such as the fetishist's belief that women have penises, a belief which serves to reassure the fetishist that he need not fear castration), nor does it do away with the view that such fantasies may be very complex and subtle compromise formations influenced by regressions, altered ego states, and the like. It does, however, add that a certain kind of unconscious belief or fantasy may serve as a warning to the ego of a danger which will occur if an infantile wish is satisfied.

Weiss does not ignore the familiar resistances. He does add that the patient can only overcome a resistance and make further progress as he becomes convinced that he can safely relinquish that resistance. He has also added, or at least emphasized, the ego's wish to overcome resistances by disconfirming the pathogenic beliefs which support them. He has added a valuable idea without subtracting the familiar idea that the instinctual wishes, and the fantasies arising in relation to them, press insistently for gratification throughout

treatment.

Similarly, in emphasizing that compulsive masturbation (or other sexual activities) may serve as a reassurance against anxiety, or in illustrating how compulsive masturbation may serve as a punishment designed to alleviate guilt, he is not contradicting the idea that it is also serving as a gratification of a sexual wish. The same point holds for Joe's discussion, in these chapters, of perversions and fetishism.

V

I know you've all been waiting for me to really disagree with Morrie. Be patient. I'm coming to that now.

First, The importance of the child's tie to his parents

Weiss believes that the child's tie to his parents is fundamental to the development of psychopathology. The importance of this tie was described by Freud in the quotation I referred to earlier about the biological factor which plays an important part in the causation of neurosis. This factor, according to Freud, is "the long period of time during which the young of the human species is in a condition of helplessness and dependence." Freud noted that as a result of this the influence of the real external world is intensified for the child. The dangers of the external world have a greater importance for him, "so that the value of the object which can alone protect it against them and take the place of its former intra-uterine life is enhanced. The biological factor, then, establishes the earliest situations of danger and creates the need to be loved which will accompany the child throughout the rest of its life" (1926, pp. 154-155).

This need for the parents is closely connected to the need for self-preservation. It is crucial, as Freud indicates, from early in life, and it is not a product of the resolution of the Oedipus complex. This fundamental tie to the parents is threatened repeatedly, from early in life, by powerful instinctual wishes which are perceived by the child as threatening this tie. For example, as described by Anna Freud (1936), the child's rivalry and destructive wishes toward a sibling threatens him, he believes, (often correctly) with loss of his mother's love, and, because of this danger, he attempts to repress his rivalrous wishes. The powerful sexual and murderous wishes of the Oedipal period also endanger the child's tie to his parents. We may infer that this tie is even more powerful than the instinctual wishes that threaten to disrupt it, for the child makes every effort to repress these wishes and preserve the tie to the parents.

Other Sources of Guilt than Oedipal Guilt

Oedipal guilt is of great importance in psychopathology. Weiss thinks there is evidence that other sources of guilt are also important; for example, separation guilt, survivor guilt, and, as Rangell also discusses, guilt about ego interests and goals.

These other kinds of guilt are not necessarily preoedipal. They can arise at any age.

Pathogenic beliefs underlie all varieties of guilt; e.g., in separation guilt, the belief is that one's separate existence or autonomous functioning will damage a parent. Instinctual impulses enter into the development of such beliefs, but experience also enters into the formation of such beliefs as an independent factor.

I am going to discuss some of the evidence for these views. Morrie, in reviewing the evidence which Joe presented in Chapter 3, offered a number of ad hoc hypotheses to account for this evidence in ways compatible with his preconceptions, or else he dismissed the evidence as not pertinent. For example, Niederland's observations, he concluded, pertain to a special population of severely traumatized individuals and Niederland's findings therefore may not be generalizable; Asch's observations pertain to the negative therapeutic reaction which is a therapeutic stalemate explicable in other ways; Loewald's observations are probably determined by his theoretical preconceptions about a primordial maternal transference; Weiss's observations are reconstructions from adult analyses, and confuse antecedents with subsequent transformations.

Morrie also offered an observation in support of his position: He has not seen in toddlers or young children a single instance of the pathogenic conviction that the child's wish for autonomy will injure the mother.

I will now take up a few observations bearing on our views. First, observations of children:

Marjorie Sprince (1972), in describing the analysis of a 12 year old boy at the Hampstead Clinic (which was carried out with the help of Anna Freud), observed what she considered to be preoedipal guilt about separation from mother. She also emphasized the role of experience in the development of the convictions associated with this guilt.

Sprince's patient, Paul, was a 12 year old boy "in whom the wish to be cured appeared to be entirely missing." He was "locked in an ongoing preoedipal partnership with his mother". Paul's "deep seated loyalty conflict, which was aroused by any attempt to separate Paul emotionally from his mother, pervaded all areas of his life and threatened to make treatment impossible...Paul had been preoccupied with his mother's health ever since his mother had been hospitalized for 2 weeks with a nervous breakdown when he was 6 years old."

Sprince thus observes: "Paul's pathology hinged upon his unconscious conviction that his mother's health and sanity depended upon his remaining a sick and helpless failure."

Paul sobbingly clung to his mother in early sessions. When, after several weeks, he allowed his mother to remain in the comfortable waiting room with a fire in the fireplace and a book, his mother commented: "Now I have to go to a little cubby hole and leave you to the nice big room--it isn't fair." For a whole year Paul insisted that his mother had not been complaining about the room, but had used the word "not fair" to refer to the inclement weather. (This was after all in England.) "It was equally characteristic of Mrs. R. to greet any sign of independence with a demonstration of illness or martyrdom." And later: "In Paul's case we are dealing not only with his aggressive drives but also with the reality of his mother's aggressive envy and unconscious impulsion to denigrate the male members of her family."

This is of course not the entire case. When what Sprince considered Paul's preoedipal guilt and instinctual conflicts were analyzed, he did begin to work on his sexual interest in his mother, and his rivalry with and his love for his father.

The literature has many cases like this. E.g., in another child analytic case seen at the Hampstead Clinic and reported by Novick and Kelly, similar observations were made and similar conclusions drawn. The young patient, in the initial phase of treatment, first analyzed his primitive fear of abandonment if he did not continue to comply with his mother's view of him as damaged, messy, and stupid. After overcoming this fear, he became aware, according to the authors, of his mother's sadness, and of his own intense feelings of guilt over depriving his mother of a needed vehicle for externalization. The authors' comment: "To a certain extent this material related to Tommy's own feelings, fears, and fantasies, but to a marked degree it also reflected the reality" (1970, pp. 89-90).

Berliner (1940, 1947, 1958) and also Shengold (1979, 1985) have observed that children tend to blame themselves for any mistreatment they experience at the hands of their parents, to feel bad about themselves, and to experience guilt toward the parents for their supposed badness. They have described the extreme lengths to which children may go in their attempt to deny and repress their experience of being unjustly maligned, hated, abused, rejected, or neglected by their parents. These children take the guilt for their parents' abusive behavior on themselves, according to the authors.

Green (1978) studied a sample of 59 physically abused children and compared them to samples of 30 neglected and 30 normal children. He concluded: "Our observations of abusing parent-abused child interaction have revealed a tendency of the child...to regard himself with the same hostility and criticism that his parents accorded him, forming the nucleus of a 'bad' self-image. The introjection of parental hostility might represent an early stage in the formation of a punitive superego" (p. 581).

Beres' observations of children separated from their parents also illustrates the role of experience in leading to the development of guilt in children:

"Our observations indicate the extraordinary readiness of the child to interpret the experience of separation as an expression of hostility on the part of the parent, and to assume that this action was justified by the child's wrongdoing. The child identifies with the hostile rejecting parent, an example of identification with the aggressor, accepts the fantasy of a crime that deserves punishment, and assumes the guilt which such an act requires" (1958, p. 348, italics mine).

Now let me turn to observations in adult life, including in adult analyses.

Niederland (1961, 1981) observed the importance of survivor guilt in survivors of the holocaust, whatever their age at the time of the trauma. The experience played an important part in producing this guilt, however strong or weak their murderous wishes toward their parents. This is theoretically important. The extreme circumstances highlight things we might not be able to see so clearly in more usual situations, especially because of our theoretical

preconceptions.

Modell (1971), on the basis of many case studies, concluded that separation guilt and survivor guilt--guilts which he considered to be based on preoedipal drives and preoedipal experiences--are universal phenomena, an aspect of universal or near universal developmental conflicts.

Asch (1976), in his case histories, observed several patients' compliances with their depressed, suicidal mothers' wishes that they do not separate from them, that they accept responsibility for their mothers' happiness, and that they themselves continue to suffer and remain unhappy like their mothers. Asch considered these patients' feelings of guilt and need for suffering to be based on preoedipal conflicts.

Loewald, in his paper on the waning of the oedipus complex, observed that the oedipal child is guilty not only about his incestuous and murderous wishes toward his parents, but also about relinquishing these wishes. The child, that is, is also guilty, according to Loewald, about rejecting his mother as a sexual object, and rejecting his libidinal and aggressive involvement with his father: "In an important sense, by evolving our own autonomy, our own superego, and by engaging in nonincestuous object relations, we are killing our parents. We are usurping their power, their competence, their responsibility for us, and we are abnegating, rejecting them as libidinal objects...Parents resist as well as promote such destruction no less ambivalently than children carry it out" (1979, p. 758).

Let me cite just two more observations: Anton Kris has described patients who experience unconscious guilt in relation to conflicts over separation and bodily autonomy, and who do not believe that they have a right to know their own feelings (1982, p. 50). Harold Blum, in discussing a case of an unusual perversion reported by Abraham Freedman, commented: "What is extremely important and not mentioned in the report is the role of survivor guilt and triumph, and the patient's identification with the pathetic victims of tyrannical cruelty as well as identification with the aggressors and transgressors of later life; i.e., not only of childhood but also of his adolescence and young manhood" (1978, p. 786).

I believe that this introductory sampling of observations does support the hypothesis that there are other kinds of guilt than Oedipal guilt which play a role in psychopathology. It also supports the hypothesis that experience as well as instinctual wishes play a role in the development of guilt.

I believe the moral of this account is that by too narrow a theoretical framework, we may endanger the development of the field by limiting our capacity to make clinically relevant observations, for it is hard for most of us to see what our preconceptions tell us cannot exist.

VI

In conclusion, I think we have taken a useful step tonight in making some of our differing perspectives about psychoanalytic theory explicit. Let us continue our dialogue in the spirit suggested by Arnold Cooper: "We will most benefit from our scientific debate if we pursue boldly the implications of our differences. It would be astonishing, and disturbing, if the psychoanalytic

situation and the psychoanalytic technique...devised more than half a century ago were never to develop further" (1984, p. 258). He added, I think wisely, "Our exciting debates will become arid if they are not sprinkled with new data", for "...in contrast to philosophical debates, which can be endlessly enriching, scientific debates can often be settled with startling suddenness by new data" (ibid, pp. 258-9).

[HS-NOV12]

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DISCUSSION OF THERAPEUTIC PROCESS AND TECHNIQUE

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My task is to discuss Weiss's work as it pertains to therapeutic process and technique. I shall do this by describing the major ways that the concepts, principles, and observations set forth in this work are different from, contrary to, and exclusive of particular basic and essential concepts and facts of the psychoanalytic process as I understand it and of psychoanalytic technique as I strive to practice it. In particular, I shall focus on the undesirable consequences of Weiss's conceptualization of process and undesirable consequences of implementing his technical recommendations.

I use the term "psychoanalytic process" in place of Weiss's term, "therapeutic process", because, although I assume the two are taken to be synonymous in this work and, while in many ways, the two terms do coincide, the differences in the emphasis they connote indicate important differences in approaching the difficult work of thinking about and practicing psychoanalysis. I believe the term, therapeutic process, as used in the Weiss work, indicates an emphasis that is problematic, at least when viewed from the psychoanalytic perspective I employ. More about that later. I am convinced that psychoanalysis is therapeutic and that the psychoanalytic process leads to therapeutic outcomes.

To facilitate understanding of my evaluation of Weiss's work, I should state I am of the school that believes psychoanalytic process has to do primarily with the analysis of resistances, including transferences, through interpretation. In a recent paper, Ed Weinshel articulates this orientation by writing: "The pattern of resistance and confession, then, constitutes...the basic unit of the psychoanalytic process..." (1984, p. 80). I would make one minor change in this statement by substituting "disclosure" for "confession", since the connotations of "confession" bias one toward moral, super-ego considerations. So what we have is a pattern or patterns of resistance and disclosure. This all too brief formulation means I am also of the school that believes people live primarily according to desires, both sexual and aggressive, and according to their particular solutions to conflicts involving these desires.

The Weiss conceptualization of psychoanalytic process goes as follows: "According to my thesis, therapeutic processes are in essence processes by which the patient works with the analyst to disconfirm his pathogenic beliefs" (p. 148). And, "The views presented here also extend those proposed by Freud by assuming that the patient's changing his pathogenic beliefs is the essential process of therapy" (p. 554). The patient works to disconfirm his pathogenic beliefs primarily by testing them unconsciously in relation to the analyst but also by assimilating insights into them, these insights being conveyed by the analyst's interpretations. He (the patient) disconfirms pathogenic beliefs in in an orderly way "in accordance with unconscious plans which tell him, for example, what problems he will work to solve at a particular time and what problems he would defer working to solve until later" (pp. 148-49). Unconscious plans are regulated by considerations of safety. To my reading, then, the

psychoanalytic process here consists of the following: testing (a solely rational, adaptive behavior), which is guided by an unconscious plan (another solely rational and adaptive operation), so as to disconfirm (yet another solely rational and adaptive activity) a pathogenic belief (a solely pathogenic structure). Each of these concepts--testing, unconscious planning, disconfirmation, and pathogenic belief--is a "bedrock concept", that is, each is considered to be irreducible, at least in the process of clinical analysis, and each has just one function, namely, to determine one kind of behavior* or set of behaviors. Such a reductionist view is untenable because of our knowledge of overdetermination, multiple function, and change of function. Thus, any mental content or behavior has a number of determinants and can serve a number of different functions. Moreover, while serving a particular, dominant function at one time, it will serve a very different dominant function at another time. The authors seem to disregard these facts, thereby promoting a view that process consists of two, mutually exclusive kinds of interchanges between patient and analyst: one kind that is irrational and pathological, the other kind, rational and adaptive. In this way, we are led to remain unaware of crucially significant constituents of the process, to wit, motives, operations, and connections, within and between the domains of conscious and unconscious mind. More concretely, this view has, among others, two related, undesirable consequences: (1) The mind, including experiences and behaviors, is conceived of as inherently discontinuous, and (2) a given behavior is defined from just one point of view. To regard one's mind as discontinuous is one defining feature of neurosis: Symptoms, troublesome character traits, dreams, etc. are regarded as alienated and alienating foreign bodies, having no relationships to other behaviors. Indeed, the split between conscious and unconscious, which we all maintain, is another reflection of the inclination toward discontinuity. We and our patients are forever slicing, severing, and dividing our experiences and behaviors in a variety of ways; a common one, fostered by health values and evident in the work under consideration, is to designate some as pathogenic or pathological, therefore to be gotten rid of, and others as adaptive or healthy, to be nurtured and strengthened. I take it to be axiomatic from a psychoanalytic point of view that the human mind is continuous, that any significant behavior, no matter how designated, is intimately linked to other behaviors, intimately interwoven with them. And just as it is a task of psychoanalysis to reveal these linkages and interpenetrations, to make clear that the mind is continuous, so too acknowledgement of this fact is essential to any conceptualization of psychoanalytic process.

The problem of understanding a given behavior or set of behaviors from just one viewpoint is obvious in the assertion that it is pathological or pathogenic, on the one hand, or desirable and healthy, on the other. Another, less obvious, one-sidedness is a consequence of the notion that certain activities are determined by a pathogenic belief, "in obedience to the pathogenic belief". Most of the articulations or descriptions of a pathogenic belief, always described as grim and undesirable, take the form of "If you do thus and so, then an unhappy thus and so will result", or "You must do thus and so, or thus and so will result". Such formulations of motivation of manifest behavior means that behavior is simply reactive, either in accordance with the formulation or against it. Consequently, most interpretations of behavior are of solely

*Throughout this discussion, I use the term "behavior" in its broad sense that includes all mental activities--thinking, perceiving, feeling, wishing, fearing, etc.

reactive activities. Other kinds of motivation are omitted or neglected, most notably those which are desire-fulfilling (or wish fulfilling). Any one-sided orientation with regard to understanding behavior unnecessarily biases and restricts understanding the full range of motives that go into the psychoanalytic process. Before leaving discussion of the consequences of Weiss's presentation of bedrock concepts, I wish to comment on a curious thing: Although a pathogenic belief is in the clinical situation an irreducible motivator, it is described, apparently only at a theoretical level, as containing at least four components (p. 555). What is curious about this is that this description is a very nice description of the construction of a compromise formation: There is a desire or wish component (1), an anxiety or guilt component (2), and a defense component (3). If this is the conceptualization of a pathogenic belief on a theoretical level, why would not this conceptualization be used on a clinical level? That is, why would one not analyze it as any other prominent, troubling compromise formation? Why would one not use this knowledge about the construction of a belief to include it in one's understanding of psychoanalytic process, to see it, for example, as a manifestation of resistance?

If one uses the notion of pathogenic belief as set forth in this work, one's understanding of psychoanalytic process is limited in depth and breadth, for essential features of that process, as I understand it, consist of the presentations of compromise formations as resistances, the revelation of these structures as resistances, and, through further disclosure, the dissection of these formations into their component parts, as they reveal themselves in other compromise formations, such as transferences, fantasies, dreams, etc., which themselves also serve resistance functions. In this way, patient and analyst identify and elucidate compromise formations and their component parts, their origins, their functions, and their vicissitudes, current and developmental, including the roles they play in troublesome behaviors (symptoms, character traits, etc.). In this way, for example, the patient learns about the component of unconscious defense--what it is and how he uses it, and about the component of unconscious desire--what it is and how it can be realized (fulfilled or transformed).

In certain important respects, the role of unconscious pathogenic belief replaces the traditional role of unconscious fantasy. This is done, in part, due to a misunderstanding on the author's part of unconscious fantasy, that is, it is incorrectly asserted that fantasy only provides pleasure and is used only to ignore the frightening, frustrating aspects of reality. There is abundant evidence, clinically and anecdotally, that fantasies, like dreams, can be and often are the most terrifying, burdening, frustrating experiences we know. By using the idea of pathogenic belief in place of fantasy, one's knowledge of the patient's inner life, his troubles, and his behavior in analysis is severely compromised, for unconscious fantasy is an essential determinant, perhaps the most essential, of all these things. The dismissal, or at least demotion, of the role of fantasy bears on a crucial shortcoming of the Weiss work: the neglect of psychic reality, by which I mean unconscious desires and associated fantasies that have a consistency, resistance and force comparable to material reality. This neglect of psychic reality is evident in the presumed formation of a pathogenic belief: it is conceived of as an inference based on internalizations of interchanges that have occurred in material reality. Acknowledgement of the role of psychic reality is, I gather, to be found in Weiss's use of qualifying phrases such as, "in the patient's experience", or "...the patient repeats the infantile situation with his parents which, <u>as the</u>

patient experienced it, had led to his being traumatized..." (p. 188, italics mine). While I understand that these phrases are to be read as acknowledgements of the role of psychic reality, there is no concrete evidence in the case presentations or in the theory as a whole that such is the case. In addition, I believe that psychic reality is at the center of the psychoanalytic enterprise and cannot be assigned a peripheral role, as it is when put in terms of qualifying phrases. If one needs to assign pathogenicity to any one kind of mental content, it is unconscious fantasy (and many analysts do this) but doing so entails all the problems of reductionism I referred to earlier, as well as other problems. Themselves compromise formations, fantasies are the primary vehicles for the expression of desires, and, by virtue of this fact, are the most powerful of motivating elements and the most deeply repressed. The "deep-sixing" of psychic reality, of unconscious fantasy, by Weiss has a number of extremely important consequences. I shall describe just a few. One consequence is the remarkable absence in the case presentations and formulations of material indicating the central role of infantile sexual and aggressive desires and conflicts. Such desires and conflicts are not accurately or adequately expressed by patient or analyst in terms such as "sexual attachment" or "anger" or "defiance". They are more accurately and adequately expressed in terms referring to perceptions and activities of the body: touching, looking, smelling, holding, feeding, sucking, biting, shitting, penetrating, stabbing, slicing, mutilating, killing, fucking, etc., etc. It is this order of speech, denoting infantile sexual and aggressive categories of action and experience, that are the common ingredients of interchanges between analyst and patient.

A second consequence of the stress on material to the neglect of psychic reality is that the patient does not get a comprehensive picture of himself, of others, and of his life history. Thus, he does not come to realize that he has a number of versions of himself and others, versions based on infantile categories of sexual and aggressive experiences derived from psychic reality. He does not come to appreciate an expanded life history that includes changing and cumulative experiences determined in large measure by his psychic reality. The neglect of psychic reality has another consequence: The patient is viewed by us and by himself as the innocent victim of actual parental abuse, neglect, or ignorance. Of course, what really happened in material reality is important, but its psychological importance derives primarily from what meanings the child assigns such external events. And the most significant, troublesome, and persistent of these meanings derive from psychic reality. Portraying the patient as innocent victim, simply carrying and enacting versions of pathological beliefs or reactions to pathological beliefs, is to deny the central place of personal agency. It is commonplace that a typical patient does see himself as the passive victim of symptoms and is more ready to attribute his troubles to others, especially his parents. If one follows the theory under consideration tonight, the patient is not viewed as, and therefore does not come to view himself as, actively and for his own purposes constructing and maintaining his versions of himself and others in his psychological troubles, as having a real stake in these things, not only as a consequence of interactions with parents, but also in order to attempt to gratify his very own desires and to disguise and conceal such gratifications by means of defense and self punishment. The psychoanalytic process, as I understand it, counts on the personal agency of the patient--he is the one who resists or discloses--he does not do these things, or anything else for that matter, only as a reaction to some mental structure derived from past experiences of external interactions. One important outcome of psychoanalysis is to reveal to the patient or, more accurately, for the patient to reveal himself as the active agent in the genesis

of his troubles and as the active agent in the maintenance of them.

The "control-mastery" theory asserts that the primary motivation for the patient's engaging in the psychoanalytic process is the anxiety or guilt connected with the pathogenic belief, much as a patient engages in treatment because of the distress of a symptom. But we commonly observe that the motivation provided by such distress is inconstant, since the anxiety and guilt are easily displaced and/or repressed and/or transferred. It is desire, from the realm of psychic reality, expressed in and through positive transferences that is reliable and sustains the process. Further consequences of the neglect of psychic reality should be evident in other parts of my discussion.

As I noted earlier, Weiss asserts that "the process is in essence processes by which the patient works with the analyst to disconfirm his pathogenic beliefs". I assert the opposite for these reasons: The dictionary definition of disconfirm is, "to establish as untrue or invalid". I believe it is the business of psychoanalysis to disclose and confirm, that is, to establish as true and valid any symptomatic structure that comes into view. It is by means of the psychoanalytic process the patient comes to realize that his irrational, troublesome, alienating and alienated beliefs, symptoms, traits, and other behaviors have a sense, embody meanings that are faithful to his experience, and conform to his reality. It is in this confirmatory process he learns that these so-called pathological structures were the necessary, often essential, and therefore true and valid expressions and outcomes of his experience, experience determined by complex interactions between elements of his psychic and material realities. Only by means of this confirmation can the patient assign symptomatic structures and behaviors their correct place and thereby realize options for change, as their constituent elements are transformed, substituted, raised to higher levels of organization, sublimated, or reconstituted to form more adaptive compromise formations.

But this psychoanalytic process of disclosure and confirmation involves powerful obstacles, traditionally named resistances. Again, here is a well-established concept that I believe now has the status of easily-verified fact, which is virtually absent in the Weiss scheme. In fact, I believe there is abundant evidence in his case material and formulations that in the process of "disconfirming pathological beliefs" significant resistances are by-passed and reinforced. I cannot stress emphatically enough the importance of resistance, for I believe, with many others, that the essence of the psychoanalytic process is the analysis of resistances. It is by means of the analysis of resistances that the patient not only becomes aware of unconscious defenses and gains access to unconscious material, he also develops the ability to carry on self-analysis, an activity that is just as important as transformations of symptomatic constructions into more adaptive ones. Manifestations of resistance are in the form of compromise formations (and in this light, I would note that what Weiss describes as pathogenic beliefs are not uncommonly encountered as resistances). Although in some ways the author seems to acknowledge the role of resistance in transference, this particular function of transference is often not taken into account in interpretations, for example, the patient does not get to know his reasons for transferring, more specifically, his motives for resisting in this particular way.

This brings me to another significant problem in the framework we are considering, namely, the simplification of the concept of transference. In this scheme, transference represents attempts on the part of the patient to repeat

with the analyst earlier problematic relationships with objects in material reality. Such a definition is evident, for example, in the idea that transference should be distinguished from the patient's changing passive into active. It is true that changing passive into active can be a defensive maneuver enforcing resistance to awareness of the transference, but it is only one of many kinds of defensive maneuvers serving this function. But it is also true that changing passive into active can be an important ingredient of the transference itself, can be a repetition of the defense used by the child and internalized as part of a version of earlier interchanges with parents. It is more fruitful and accurate to define transference as a complex compromise formation, having many determinants, including memories of actual interchanges with parents and, even more important, elaborations, distortions, and interpretations of those memories through the operation of unconscious defensive operations, desires, and fantasies. Related to Weiss's inadequate account of transference is another misunderstanding which I would label as "the privileged position of recovered memories". Recovered memories are regarded as bonafide representations of what really happened, therefore presumably comprise evidence for origins of pathogenic beliefs and transferences. In fact, recovered memories are themselves compromise formations and serve different functions, including defensive ones. Thus, a recovered memory may function as defense against awareness of the negative transference by serving as the object of displaced negative transference. I believe this is the case in some of the case reports. Another related consequence of the privileged position of remembering is that to the extent one is looking at recovered memories as "the right stuff", one is distracted from the more important activities of resisting and transferring.

That transference is always ambivalent is not sufficiently acknowledged by the author. In the case reports and formulations, transference seems to be regarded at any given time as either negative or positive-negative only when the patient is transferring earlier pathogenic interchanges and positive other times. Positive transference is regarded as based on "accurate, current impressions" of "the analyst's current behavior" (p. 179), not, as I understand it, based on versions of early, positive childhood experiences with caretakers. This understanding, I would say misunderstanding, of positive transference and the central importance given to the analyst passing the patient's tests requires that the analyst view himself as basically a consistently, all-good object. It also, therefore, requires the patient to regard the analyst in this same light. This arrangement fosters a very common defensive splitting off of subtle negative transferences and, for example, displacing them onto negative representations, including memories, of parents. There are examples of this in the case reports. Again, this limited and limiting conceptualization of transference has a number of consequences, chief among them the patient does not get to learn that he always simultaneously loves and hates his analyst, just as he did and does his parents and others. Moreover, he does not get to learn that significant sources of his troubles are due to his ambivalence and, more particularly, are consequences of the ways he tries to ignore his ambivalences.

Testing the analyst is one way of conceptualizing the patient's on-going activity in the analytic situation, but it is too narrow a conceptualization, too narrow in the sense it is viewed as only pertaining to one kind of mental content, the pathogenic belief, and as the primary activity involving transferences. Provoking and inviting the analyst to engage in repetitions of earlier relationships derives from the full gamut of mental contents and activities; and patients do so for a variety of reasons, not just one, that is,

testing. Another, more important reason, he repeats is to attempt to satisfy, to gratify, old, but currently active, infantile desires. Weiss's exclusive emphasis on repetitions as only constituting testing, as well as his notion of grim, pathogenic beliefs as the only source of patients' difficulties, helps me understand why his patient's troublesome behaviors are interpreted from predominantly one angle, namely a defensive one. One example: "He (the patient) hopes...that he will not hurt the analyst by his defiance, as, in his opinion, he had hurt a parent, or that he will not humiliate the analyst by his contempt, or seduce the analyst by his admiration" (p. 192). I have no doubt that the patient, in repeating, hopes and wishes just as fervently, and tries his best to hurt, humiliate, and seduce the analyst, that is, to satisfy his infantile sexual and aggressive desires. It is essential for a viable psychoanalytical process and an effective analysis that such desires and their associated conflicts be disclosed. And so we come to what I believe is another reason for the patient's attempt to engage the analyst in repetitions, that is, to reveal and confirm the meanings of symptomatic constructions, thereby enabling him to arrive at knowledge about himself, knowledge that provides opportunities for change. To the extent that testing the analyst and the analyst passing the tests is aimed at disconfirming, it is an activity aimed at reinforcing and promoting defense and resistance. Thus, the patient is unwittingly encouraged to say to himself something like, "Oh!, I see now that I was mistaken in my perception of my analyst as a bad parent, therefore, I should dismiss this perception". And I think he dismisses it mostly by denying it, repressing it, displacing it, projecting it, to list some of the more common defensive moves.

Weiss indicates that testing should be allowed to proceed silently, unconsciously. Contrarily, I assert that often it is part of the analytic work to make explicit that testing is going on and to make explicit how and why the patient is doing it. A person can learn a great deal about himself by becoming aware of his particular concerns about the reactions of others, his particular modes of conducting trial actions, and his particular motives for testing another. Another unconscious activity carried on by the patient in the process of testing and disconfirming pathogenic beliefs, and one that is considered desirable, therefore, not interpreted, is that of transient identifications with the analyst, specifically, identifications with his presumed imperturbability (pp. 190 and 192). Such identifications are defensive, that is, they are one of the many ways the patient obtains defensive relief from, for example, guilt or anxiety, and they should be interpreted.

The primary task of the analyst, according to the work under consideration, is to pass successfully the tests put to him by the patient, that is, to not yield to the patient's invitation to enact past exchanges. One consequence of this position is to relegate the analyst's activity of interpretation, which I believe is the analyst's primary task, to a secondary position. It thus also inclines the analyst to activities other than interpretation when interpretation is indicated, for example, in one reported case to advise the patient not to stop treatment or, in another case, to tell the patient her boyfriend is not good for her. Other examples of non-interpretive activity resulting from the analyst's devotion to passing tests are obvious in his affirmative articulation of the unconscious plan and his supporting the patient's pursuit of certain goals, for example, to become independent, to have good relationships with women, etc. Such non-interpretive activities violate the principles of abstinence and have a number of undesirable consequences, not the least of which is reinforcing defenses and resistances. Pertinent here is the author's

discussion of the roles of experience and insight in the psychoanalytic process. After declaring that it is not a matter of either/or but both, and claiming his theory shows this, he goes on to state that the patient works in two ways, namely, by (1) testing, and (2) assimilating insight. That is, he proceeds to maintain the split between experience and insight. I believe this split is untenable: significant insight is gained primarily through experience, often painful and threatening experience, in the analytic situation, and it is gained in this context primarily because of the analyst's interpretive activity, made possible by his abstaining from non-interpretive activity. Passing tests, or as I would prefer to put it, maintaining a state of abstinence, is not the ultimate activity of the analyst; it is simply a pre-condition for the primary task of interpretation. In this respect, resisting the patient's invitations to enact is not done to demonstrate to him the error of ways or perceptions, it is done so that he can become more conscious of the fantasies he is trying to enact, fantasies that he ordinarily renders unconscious in a variety of ways, not the least of which is enacting them (or acting them out).

The notion of unconscious plan, as set forth in this work, is problematic because it asserts there are powerful, motivating ideas that are totally rational, completely separate from and free of conflict. I do not believe that the concept of conflict-free spheres applies to the idea of unconscious plan because it is so complex, so intimately associated with versions of self and others, so filled with desires that it cannot be free of conflict. Weiss does not describe the origins and composition of the unconscious plan or motives for it; if pushed to do so, I believe he would arrive at conclusions similar to mine. To encounter such a construction in the analytic situation is to encounter a manifestation of resistance, since it is regarded as isolated from other parts or contents of the mind and by definition then is considered to be free of desires, fantasies, and conflicts. In my experience, the patient's unconscious plan consists of his attempts to carry out repetitions of unconscious fantasies, compromise formations composed of elements from material and psychic reality. In the analytic situation, these repetitions constitute resistances. However, it is true they also represent attempts to master and change the powerful, resistant, underlying fantasies. To give a simplistically schematic example: In unconscious fantasies, along with troublesome versions of self and others engaging in gruesome or ecstatic interchanges are other versions of self and others that, although feeble and nascent, offer the potential for different, in some ways less troublesome and more adaptive, versions of self and others. It is by making these fantasies conscious, disclosing and confirming them, that this potential can be realized. But this promising process cannot be thought of as a purely rational process separate from nonrational, conflicted aspects of inner life.

Another problem associated with unconscious plan as articulated by Weiss is that it dictates the analyst should follow the patient's lead by following his conscious preoccupations and productions, these presumably being determined for the most part by the unconscious plan regulated by considerations of safety. This process is described as "working at the surface". But this sense of the term is contrary to what I consider "working at the surface", namely, identifying and analyzing manifestations of resistances. If the analyst follows "where the patient wants to go" or "helps him where he wants to go", he is acquiescing to, indeed often reinforcing, resistances, for "where the patient wants to go" is to positions in which he can most effectively conceal (from both the analysis and himself) and at the same time unconsciously actualize his unconscious defenses, wishes, fears, and fantasies. Indeed, as Weiss states:

"...the surface is defined as that which the patient may safely experience" (p. 567).

It is asserted in the theory under discussion that a requirement for the patient gaining insight is that he feel safe. This assertion is based on alleged, repeated observations that "if the analyst retains his neutrality in the face of the patient's transferring, the patient may become less anxious and more relaxed than he had been. He may, moreover, while relaxed, become more insightful" (p. 185). This statement is supplemented by case reports in which it is more emphatically stated that the patient does become, for example, "less tense and anxious" or "more relaxed", when the analyst maintains neutrality and/or after he gives an accurate interpretation. My observations of patients' responses are different. I observe, and I believe other analysts do too, a wide variety of emotional states, encompassing the whole range of human emotions. There are a number of determinants of these varied emotional responses, chief among them, of course, is the nature of the prominent transference. And so, for example, I observe states of relaxation, not only when the patient's defensive activities are successful, but also when he experiences my neutral silence as me tenderly holding him and nursing him or when he experiences my neutral interpretations as good feedings or as constipation-relieving enemas. Other times he is deeply hurt, bitterly frustrated and unspeakably enraged when I, from my neutral stance, do not satisfy his desires and when, by virtue of my resistance interpretations, he becomes aware of previously repressed emotional states, including his frustrated desires, his guilt, or his anxiety. Not uncommonly, patients become more anxious, tense, hurt, guilty, angry or depressed as I refrain from acting out with them their desires for gratification, punishment, etc. It is, perhaps needless to say, a most stressful state of affairs for both of us. But usually it is the only way I know of whereby a patient becomes conscious of versions of his unconscious fantasies, fantasies that heretofore he has kept unconscious by successfully acting them out. I observe that it is in the midst of these states of great emotional turmoil, and sometimes in reflecting on them while partially reliving them, the patient gains his most important insights. Indeed, I believe with others that a patient cannot be spared such experiences if he successfully engages in the psychoanalytic process. I am highly skeptical of insights occurring in a relaxed state--too often they are subtle and effective intellectualizations. These differences in observation by the author and myself have many important implications, some of which I referred to earlier, all of which I do not have time to spell out. How do I account for these differences? One general explanation is that I see the human mind, psychological problems, the aims of analysis, the tasks of patient and analyst, and the nature of psychoanalytic process very differently from the author.

Describing implications for technique, Weiss advocates that the analyst align himself with the patient's ego. He refers to Anna Freud's helpful idea that the analyst has no access to the patient except through his ego, but then he ignores another, more important of her contributions, namely, that the analyst's position should be equidistant from ego, super-ego, and id. For when the analyst is exhorted, as Weiss does, to help the patient become successful or independent, to become less worried about his wife, to become less afraid of being competitive, then indeed the analyst is being asked to align himself with the patient's ego, his defensive ego. There are many problems associated with the analyst's promoting such goals. One set of problems derives from the a priori assumption that such goals are good and desirable. I do not believe that an analyst can or should make such judgments. Another set of problems derives

from the fact that patients always have plans to get better by having us help them solve this particular problem or that. These plans invariably are versions of repetitions of unconscious fantasy in which, for example, the analyst is the good mother, the good feeder, the efficient enema giver, the potent lover, the unfailing rescuer, etc. To the extent he participates in the pursuit of these kinds of goals, the analyst is playing an active role in the patient's enactment of his fantasy and thereby colludes with the resistance of acting out. Another angle on this problem: By explicitly supporting the patient in his pursuit of specific, conscious goals, the analyst sets himself up as the patient's beneficent super-ego. This has at least two undesirable consequences--(1) troublesome, for example, punitive features, of the patient's own super-ego get hidden from view, and (2) since the analyst's role as this kind of super-ego is not analyzed, a significant part of this form of transference is not analyzed. The main set of problems resulting from the analyst's ego-alignment, actually ego-super-ego alignment, is due to the fact that as analysts, the only thing we can legitimately do is to analyze; the only goal we can pursue with the patient is greater self-understanding. As Freud noted, patients "over-estimate the selective power of analysis. The analyst is certainly able to do a great deal, but he cannot determine beforehand exactly what results he will effect. He sets in motion a process, that of the resolving of existing repressions" (p. 130, "On Beginning the Treatment", 1913). I hope I have been clear that, from my point of view, for the analyst to do anything other than analyze, that is, to abstain and interpret, means he is not engaging in the analytic process, often he is, in fact, thwarting it. God knows we all fail frequently enough to live up to this ideal behavior.

Turning to the question of therapeutic effects, I do believe implementing this theory and its technical recommendations has therapeutic effects. It does so because it satisfies the main requirements for effective suggestion. Before pursuing this assertion, I would say that, just as in everyday practice every analyst must constantly be concerned about the role of suggestion in his activities and must be ready and able to refute the "charge of suggestion", so too must any new theory of psychoanalysis, particularly a theory that includes recommendations for changes in technique. In his classical paper on suggestion, "The Therapeutic Effect of Inexact Interpretation", Glover describes the methods whereby effective suggestion, that is, suggestion having therapeutic effects, is accomplished. They are classified, as he puts it, "...in accordance with the amount of deflection from psychological truth, or the means adopted to deflect attention" (p. 360 in The Technique of Psychoanalysis, 1955). He outlines three types of suggestive procedures: One is "the method of 'neglect' combined with 'counter-stimulation' or 'counter-charge'" (p. 360). 'Neglect' means that psychological truth is ignored, repression is thereby reinforced. In Glover's words, "The physician unwittingly tries to reinforce the mechanism of repression (neglect) and quite definitely invokes a system of counter-charge, or anticathexis" (p. 360). Counter-stimulation or counter-charge promotes an obsessional kind of defense, for example, "The patient must do or think something new, or take up some counter-action" (p. 360). In terms of the theory under discussion, neglect is, for example, evident with respect to desire and fantasy, repression is further reinforced in the ways I have indicated, counter-stimulation is provided by focusing on the unconscious plan and immediate conscious goals. Further counter-stimulation is provided by the analyst passing tests, demonstrating that he is totally different from the offending parent; thus, the patient is encouraged to think of the analyst as "something new" and to react to the analyst differently, that is, he "must do something new". In the second type of suggestive method outlined by Glover, the therapist "admits

that he knows something of his patient's condition but either commands or begs the patient to neglect it (auxiliary to repression)" (p. 360). The commanding or begging takes the form of statements conveying the idea that "The patient can and will get better, is in fact better and so on" (p. 360). Also, "Interest has to be transferred to 'something else' more or less antithetical in nature to the pathogenic interest..." (p. 361). In the theory we are discussing, the analyst certainly does acknowledge something of the patient's condition. By articulating the unconscious plan and by certain statements, the analyst essentially says to the patient that he "can and will get better". An example of such a statement made to a patient is "he would rather overcome his anxiety and relinquish his homosexual attachment to the analyst...than maintain this attachment to him" (p. 569). By stating the unconscious plan, by "passing the patient's tests", and by emphasizing a strong positive transference, the analyst succeeds in transferring the patient's interest to something else, namely, himself as good object. The third method, according to Glover, "is distinguished by the fact that a certain amount of use is made of psychological truth or analytic understanding. Explanations varying in detail and accuracy are put before the patient or expounded to him. This is followed by direct or indirect suggestion" (p. 360). I believe the Weiss framework satisfies the requirements of this method by the operations I described in methods 1 and 2. Glover goes on to say, "There is one feature in common to all these methods; they are all backed by strong transference authority, which means that by sharing the guilt with the suggestionist and by borrowing strength from the suggestionist's super-ego, a new substitution product is accepted by the patient's ego" (p. 361). The theory we are discussing tonight does promote strong transference authority by means of the analyst "passing tests", maintaining strong, positive transferences, and by aligning himself with the defensive ego-super-ego system.

I hope I have communicated clearly my evaluation of Weiss's work as it pertains to psychoanalytic process and technique. In brief summary, I believe the work does not adequately encompass in range or in depth the complex behaviors that constitute the analytic process. This, in good measure, is due to the fact that to a great extent it ignores or contradicts concepts and facts I take to be well-established in our field. It recommends a technique that promotes effective suggestion, not psychoanalysis as I currently understand it.

[MARCUS]

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[M-REF]

RESPONSE TO MAURY MARCUS

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General Considerations

My discussion will further develop some ideas Hal Sampson introduced in our last meeting. As Sandler, Dare, and Holder (1973) pointed out, there were three phases in Freud's development of psychoanalytic theory. He began with a traumatic-origin model of neurosis, he shifted to a drive-gratification model which seriously neglected the role of reality, and he subsequently integrated his earlier two models into a much more powerful and comprehensive theory. The main point I will make is that Weiss's views are consistent with Freud's final theory. I will further show that Maury does not understand the crucial significance of Freud's later discoveries. He bases his criticisms of Weiss's views on a stage of psychoanalysis that Freud himself went well beyond.

The tension between Freud's earlier and later theories of neurosis and their implications for treatment

The division between the first two phases of Freud's theorizing can be made at the point where Freud (1897) abandoned the traumatic-origin, seduction theory of hysteria and began to formulate the topographical model of the mind (Freud, 1900). The transition between the second and third phases occurred more gradually. It began with Freud's renewed attention to the effects of trauma on mental functioning in Beyond the Pleasure Principle (1920); it was greatly accelerated by his introduction of the structural model in The Ego and the Id (1923); and it culminated in his revised theory of neurosis in Inhibitions, Symptoms and Anxiety (1926). The tensions between the latter two phases of Freud's theorizing have their roots in the evolution of his earliest ideas about the origins of neurosis.

1. Phase One

It was during his first phase of theory development that Freud made his great discoveries about the phenomena of resistance, of transference as a special form of resistance, and of the overdetermination of hysterical symptoms by associatively interrelated traumatic memories and pathogenic ideas. Starting from an initial premise that hysterical attacks are produced by split-off traumatic memories whose affect has not been adequately abreated, Freud (1985) evolved an elaborate model of the unconscious mind as a mnemic reservoir. According to that model, the unconscious contains the memories of all traumatic events and distressing ideas (along with their associated affects) that an individual has ever experienced. Freud discovered that these memories and pathogenic ideas are organized in a variety of ways according to the principles of chronological sequence, degree of resistance to recall (or proximity to a traumatic nucleus), and logical order.

Freud developed his "pressure technique" to overcome the patient's resistances to remembering and associating. By 1895 he had already formulated the goal of psychoanalytic therapy--to cure a patient by making repressed

contents conscious through the removal of resistances. He devised converging criteria for evaluating the truth or falsity, as well as the pathogenic significance, of a given memory or idea. When he published his seduction theory of hysteria in 1896, he presented a number of forceful and compelling clinical arguments for why these infantile scenes are neither the patient's inventions nor the products of suggestion by the analyst. Freud believed that he had achieved a unified theory of hysteria which combined his leanings towards a sexual etiology of neurosis with a causal explanation of the role traumatic experiences play in producing symptoms.

The following quotations from The Aetiology of Hysteria (1896) illustrate Freud's early approach to understanding the role of traumatic memories in the hysteric's exaggerated emotional reactions to external events:

> The reaction of hysterics is only apparently exaggerated; it is bound to appear exaggerated to us because we only know a small part of the motives from which it arises (p. 217).

> It is not the latest slight--which, in itself, is minimal--that produces the fit of crying, the outburst of despair or the attempt at suicide, in disregard of the axiom that an effect must be proportionate to its cause; the small slight of the present moment has aroused and set working the memories of very many, more intense, earlier slights, behind all of which there lies in addition the memory of a serious slight in childhood which has never been overcome (p. 217).

I am calling attention to this early phase of Freud's theory construction because the following phase represents a strong reaction against it. As Sandler and his colleagues (Sandler et al., 1973) noted, "There was a radical swing from the consideration of the person's relation to external reality to the study of his relation to his unconscious wishes and impulses" (p. 15). In the year following publication of his seduction theory, Freud wrote a letter to Fleiss (September 21, 1897) in which he confided his disbelief in his "neurotica". He gave the following reasons for his change of mind: (1) his disappointment in the therapeutic results of his analyses; (2) his surprise that in every case, including his own, the father had to be blamed as a pervert; (3) his discovery that there are no indications of reality in the unconscious, so that one cannot distinguish between the truth and fiction that is cathected with affect; and (4) his observation that in psychosis the unconscious memories do not break through, so that the secret of childhood experience is not betrayed even in the most confused delirium.

2. Phase Two

In his second phase of theory construction, Freud (1900) put forward a strikingly different model of the unconscious mind. According to the topographical theory, the system termed the Unconscious contains only libidinal impulses and wish-fulfilling fantasies derived from memories of gratification. Freud's prior model of the unconscious mind as an intricate secondary process organization of traumatic memories and pathogenic ideas was replaced by a primary process system regulated by the pleasure principle.

Neurosis resulted from the excessive repression of an individual's libido. Freud (1906) considered a neurosis to be the "negative" of a perversion in that

neurotic symptoms emanated from the repression of the same components of infantile sexuality that were acted out in perversions. Trauma was dropped as a significant etiological factor (Freud, 1906), and external influences were replaced by constitutional variables (Freud, 1906, 1917a). In his lecture on analytic therapy, Freud (1917a) stated that "neuroses are in principle curable in spite of their being based on constitutional disposition" (p. 457). The role of reality in the production of neurosis was described in terms of external conditions which contributed to drive frustration (Freud, 1917b).

> You can declare, as a schematic abbreviation, that libidinal fixation represents the predisposing, internal factor in the aetiology of the neurosis, while frustration represents the accidental, external one (Freud, 1917b, p. 346).

Neurotic symptoms were reconceptualized as products of a conflict between the forces of repression and the sexual instincts (Freud, 1906). Symptoms, like dreams, were considered to be compromise formations unconsciously produced by primary process modes of functioning. They were seen as substitute gratifications for repressed sexual impulses. Repressed impulses that could not be completely suppressed or adequately discharged through the patient's symptoms were somatically discharged in the form of anxiety or some other affect (Freud, 1915).

Hysterical symptoms now represented a return of repressed sexual impulses rather than a return of repressed traumatic memories. They were seen as attempts to enact unconscious wish-fulfilling fantasies (Freud, 1906). Seduction memories were typically considered to be unconscious wish-fulfillments and/or defensive disguises for the patient's own masturbatory activity (Freud, 1906, 1917c). Freud now emphasized that patients have a vested interest in treating their wish-fulfilling fantasies as historical realities.

> I have warned you that we still have something new to learn; it is indeed something surprising and perplexing. By means of analysis, as you know, starting from the symptoms, we arrive at a knowledge of the infantile experiences to which the libido is fixated and out of which the symptoms are made...Well, the surprise lies in the fact that these scenes from infancy are not always true. Indeed, they are not true in the majority of cases, and in a few of them they are the direct opposite of the historical truth...(Freud, 1917, p. 367).

> After a little reflection we shall easily understand what it is about this state of things that perplexes us so much. It is the low valuation of reality, the neglect of the distinction between it and phantasy...When he brings up the material which leads from behind his symptoms to the wishful situations modelled on his infantile experiences, we are in doubt to begin with whether we are dealing with reality or phantasies. Later, we are enabled by certain indications to come to a decision and we are faced by the task of conveying it to the patient. This, however, invariably gives rise to difficulties. If we begin by telling him straight away that he is now engaged in bringing to light the phantasies with which he has disguised the history of his childhood (just as every nation disguises its forgotten prehistory by constructing legends), we observe that his interest in pursuing the subject further suddenly diminishes in an undesirable fashion. He too wants to experience realities and despises everything

that is merely 'imaginary'...It will be a long time before he can take in our proposal that we should equate phantasy and reality and not bother to begin with whether the childhood experiences under examination are the one or the other. Yet this is clearly the only correct attitude to adopt towards these mental productions. They too possess a reality of a sort. It remains a fact that the patient has created these phantasies for himself, and this fact is of scarcely less importance for his neurosis than if he had really experienced what the phantasies contain. The phantasies possess psychical as contrasted with material reality, and we gradually learn to understand that in the world of the neuroses it is psychical reality which is the decisive kind (Freud, 1917c, pp. 367-368).

During this period Freud (1913, 1917c) repeatedly emphasized the pathogenic significance of the neurotic individual's disregard for material reality and overvaluation of psychical reality. He postulated that neurotics suffer from a cognitive disturbance characterized by magical thinking and a tendency to treat wishes as equivalent to deeds, a phenomenon he termed "omnipotence of thoughts". The neurotic's tendency to overvalue psychical as compared to material reality was explained in terms of "intellectual narcissism" and a sexualization of the process of thinking. The sexualization of thinking was attributed to constitutional factors and to the effects of sexual repression.

Thus the omnipotence of thoughts, the overvaluation of mental processes as compared with reality, is seen to have unrestricted play in the emotional life of neurotic patients and in everything that derives from it. If one of them undergoes psycho-analytic treatment, which makes what is unconscious in him conscious, he will be unable to believe that thoughts are free and will constantly be afraid of expressing evil wishes, as though their expression would lead inevitably to their fulfillment. This behaviour, as well as the superstitions which he practises in ordinary life, reveals his resemblance to the savages who believe they can alter the external world by mere thinking (Freud, 1913, p. 87).

Primitive men and neurotics, as we have seen, attach a high valuation--in our eyes an over-valuation--to psychical acts. This attitude may plausibly be brought into relation with narcissism and regarded as an essential component of it. It may be said that in primitive men the process of thinking is still to a great extent sexualized. This is the origin of their belief in the omnipotence of thoughts, their unshakable confidence in the possibility of controlling the world and their inaccessibility to the experiences, so easily obtainable, which could teach them man's true position in the universe. As regards neurotics, we find that on the one hand a considerable part of this primitive attitude has survived in their constitution, and on the other hand that the sexual repression that has occurred in them has brought about a further sexualization of their thinking processes. The psychological results must be the same in both cases, whether the libidinal hypercathexis of thinking is an original one or has been produced by regression: intellectual narcissism and the omnipotence of thoughts (Freud, 1913, pp. 89-90).

Freud's (1917) disregard of the importance of reality factors during this period was reflected in his view that it makes no difference whether the

childhood experiences which contribute to the formation of a neurosis are real or only imagined. In his discussion of childhood seduction fantasies and memories he made the following comment:

> The impression we gain is that these events of childhood are somehow demanded as a necessity, that they are among the essential elements of a neurosis. If they have occurred in reality, so much to the good; but if they have been withheld by reality, they are put together from hints and supplemented by phantasy. The outcome is the same, and up to the present we have not succeeded in pointing to any difference in the consequences, whether phantasy or reality has had the greater share in these events of childhood (Freud, 1917c, p. 370).

In his second phase of theory development, Freud decidedly focused on the idea that neurosis is divorced from reality and bears only the most tenuous relationship to external events. He considered the primary etiological factors to be constitutional qualities of the neurotic individual's drives and ego, that is, neurotics are individuals who make excessive use of repression and remain infantile in regard to their sexuality and their thought processes. Freud (1917a), nonetheless, continued to express the goal of analysis in terms of filling in the gaps in memory through overcoming the resistance due to repression. In "Remembering, Repeating and Working-through" Freud (1914) summarized the evolution of psychoanalytic technique in the following way:

> Finally, there was evolved the consistent technique used today, in which the analyst gives up the attempt to bring a particular moment or problem into focus. He contents himself with studying whatever is present for the time being on the surface of the patient's mind, and he employs the art of interpretation mainly for the purpose of recognizing the resistances which appear there, and making them conscious to the patient. From this there results a new sort of division of labour: the doctor uncovers the resistances which are unknown to the patient; when these have been got the better of, the patient often relates the forgotten situations and connections without any difficulty. The aim of these different techniques has, of course, remained the same. Descriptively speaking, it is to overcome resistances due to repression (pp. 147-148).

Filling in the gaps in memory now meant something different than it had in Freud's (1896) original theory of hysteria; it referred not to the recovery of historically accurate traumatic memories, but to the uncovering of the psychic reality to which the libido was attached. To the extent that one sought to recover childhood memories, they were the memories of infantile drive gratification that gave rise to unconscious fantasies and which were re-enacted in the patient's symptoms and transferences. One might say that the formula that hysterics suffer from reminiscences still held, but the reminiscences from which they suffer had changed from memories of traumatic experiences to memories of real or imagined drive gratification.

According to Freud's revised theory, the therapeutic effect of psychoanalysis is produced by liberating repressed drive energies, rather than repressed affects, through the technique of resistance analysis. The patient's repressions were considered to be automatically regulated by the pleasure principle. During this stage of his theorizing, Freud believed that repressions are motivated by a quality of the drives themselves, something he termed a

"transformation of affect" (Freud, 1900) but which he could never adequately explain. Because of this transformation of affect the derivatives of repressed drives (when they attained a certain threshold intensity in the system Preconscious) give rise to unpleasure, which triggers repression. The technique of resistance analysis was predicated on the assumption that a resistance can be weakened by making the patient aware of it and gradually overcome by having the patient work it through by "continuing, in defiance of it, the analytic work according to the fundamental rule of analysis" (Freud, 1914, p. 155).

Because resistances were assumed to be directly produced by derivatives of the patient's repressed drives, the task of analyzing a resistance was conceptualized in terms of making conscious, through frustration and interpretation, the drive derivatives responsible for the resistance. Freud believed that the patient strenuously resists the analysis of his resistances because their removal exposes him to the anxiety directly produced by formerly repressed impulses. Freud (1917d) noted that a "violent struggle" takes place in the patient's mind around the overcoming of each resistance and that the patient's primary motive for engaging in this struggle is the power of the positive transference. In "Remembering, Repeating and Working-through" (Freud, 1914) he stated that "Only when the resistance is at its height can the analyst, working in common with the patient, discover the repressed instinctual impulses which are feeding the resistance; and it is this kind of experience which convinces the patient of the existence and power of such impulses" (p. 155).

I have reviewed certain aspects of the second phase in Freud's development of psychoanalytic theory in order to place Maury's views and his criticisms of Weiss's theory in their historical context. During this phase, external reality was primarily treated as a resistance behind which the patient attempts to conceal his internal psychic reality stemming from his repressed drives and wish-fulfilling fantasies. In terms of therapeutic technique, a premium was placed on the importance of exposing the patient's defensive attempts to use reality for the purposes of disguising his drive gratifications, externalizing the responsibility for his impulses, and strengthening his resistances.

I believe that this view of psychopathology and clinical technique was very one-sided in that it seriously neglected the effects of trauma on mental functioning and the role of experience in the etiology of neurosis. During his third phase of theory building, Freud corrected for this omission by integrating his original traumatic-origin theory of hysteria with his drive-gratification model of neurosis. I am going to selectively highlight those features of Freud's later theorizing which directly bear on Maury's criticisms of Weiss's theory.

3. Phase Three

In Beyond the Pleasure Principle, Freud (1920) began to modify his theory of neurosis in ways that subsequent analysts found difficult to integrate with his drive-gratification model of neurotic symptoms. He asserted that the task of mastering psychic trauma is the primary function of the mental apparatus and that this task has to be completed before the pleasure principle can begin to operate. He stated that the repetition compulsion repeats not just earlier gratifications of repressed sexual wishes, but all unmastered traumatic experiences that occur in conjunction with the child's attempts to gratify his impulses. Both types of repetitions have as their goal the binding, discharge, and mastery of unbound excitations in the repressed unconscious. In other

words, both freely mobile drive energies and unmastered traumatic memories derive their motivational force from the fact that they exist in an unbound state.

> If we take into account observations such as these, based upon behaviour in the transference and upon the life-histories of men and women, we shall find courage to assume that there really does exist in the mind a compulsion to repeat which overrides the pleasure principle. Now too we shall be inclined to relate to this compulsion the dreams which occur in traumatic neuroses and the impulse which leads children to play (Freud, 1920, pp. 22-23).

The repressed unconscious was now conceptualized as containing not only the drives and the wish-fulfilling fantasies to which they give rise, but also the memories of unmastered traumatic experiences. Freud (1920) emphasized that these traumatic memories pertain to "past experiences which include no possibility of pleasure, and which can never, even long ago, have brought satisfaction even to instinctual impulses which have since been repressed" (p. 20). He called attention to the fact that unmastered traumatic experiences are reproduced in dreams and in children's play for the purpose of belated mastery. He suggested that the mastery function of the dream is its original one and only later does the wish-fulfilling function come into operation. Freud also implied that unbound traumatic memories, like unbound instinctual impulses, give rise to unconscious fantasies as well as to dreams.

The main point I want to make is that according to these later ideas, the patient's psychic reality and unconscious repetitions in the transference are not solely the product of drive-based fantasies; they are the joint product of his unconscious wishes and his traumatic childhood experiences. Regarding the patient's repetition of traumatic memories in analysis, Freud (1920) observed that, "Patients repeat all of these unwanted situations and painful emotions in the transference, and revive them with the greatest ingenuity" (p. 21).

In discussing the implications of the repetition compulsion for the theory of therapy, Freud noted that the goal of making the unconscious conscious is not completely attainable by the technique of resistance analysis. "The patient cannot remember the whole of what is repressed within him and what he cannot remember may be precisely the essential part of it" (Freud, 1920, p. 18). Freud postulated that the crucial forgotten childhood experiences are re-enacted in the transference with "unwished-for exactitude" under the pressure of the repetition compulsion. Therapeutic success hinges upon the degree to which the analyst can bring the patient to "recognize that what appears to be reality is in fact only a reflection of a forgotten past" (p. 19). The analyst must expect that the patient will attempt to re-enact not only repetitions of infantile drive gratifications, but repetitions of childhood trauma as well.

In <u>Beyond the Pleasure Principle</u> Freud also began a new line of thinking about anxiety and its relation to trauma and psychic danger. In his earlier theory Freud conceptualized anxiety in two ways: (1) as an affect that is directly produced by preconscious drive derivatives and which automatically elicits repressions, and (2) as an affect produced when repressed drives are somatically discharged. Now Freud described anxiety as an ego state in which one expects and prepares for danger. He suggested that anxiety has a protective function in the face of traumatic experiences and that traumatic neuroses arise when a danger situation takes the ego by surprise. He also considered anxiety

to be an automatic reaction to trauma. These ideas anticipated the revised theory of neurosis Freud (1926) put forward in Inhibitions, Symptoms and Anxiety.

In The Ego and the Id (1923) Freud significantly revised psychoanalytic theory. Of particular relevance for tonight's discussion are his focus on the importance of unconscious guilt in psychopathology, his discussion of the warning and motivating functions of anxiety, his conceptualization of the ego's mediating role in psychic conflict, and his attempt to delineate the functional entities that come into conflict in the formation of a neurosis.

Freud (1923) stressed the fact that neurotic symptoms, in addition to serving the function of drive gratification, also serve the function of self-punishment. To illustrate the motivating power of unconscious guilt, he called attention to individuals who become criminals out of their sense of guilt. Freud's explanation of superego formation demonstrates both the motivating power of anxiety and the fact that the ego's self-preservative instincts take precedence over its efforts to secure drive gratification. It is the male child's fear of castration by his father that motivates him to repress his oedipal wishes and to erect within himself an internal agency whose retribution he will thereafter fear in the same way that he had originally feared his father. In his theory of superego formation, Freud showed how fears of external danger become transformed into internal anxieties. He made the ego the "seat of anxiety" and continued to develop the idea that anxiety is a reaction to danger. Fear of superego retribution became the greatest internal danger for the ego. The superego assumed a pivotal role in Freud's theory of neurosis because it is at the superego's behest that repressions are instituted.

Freud (1923) also offered a new explanation of neurotic guilt. Whereas he had earlier (Freud, 1913) explained it in terms of the primitive nature of neurotic individuals' conscious thought processes (the omnipotence of thought which causes them to feel intense guilt about their instinctual wishes), he now explained it in terms of the superego's harshness and its tendency to punish the ego for repressed impulses in the id.

Freud (1923) divided the ego into a portion which is normally conscious and has a coherent organization and a portion which is dynamically unconscious and produces the resistances which the analyst tries to overcome. Freud assigned to the ego the task of mediating between the demands of the id, the superego, and reality in accordance with considerations of safety and danger (the reality principle). To the maximum extent possible the ego attempts to meet simultaneously the demands of its three masters without jeopardizing its own existence.

In carrying out its mediating role the ego follows the "principle of multiple function", a term introduced by Waelder (1930). This principle accounts for the fact that while behavior is overdetermined by the demands of reality, the superego, the id, and the repetition compulsion, the compromises reached by the ego are normally arrived at through adherence to the reality principle and secondary process modes of thinking. In other words, the compromises reached through the principle of multiple functioning reflect the adaptive problem-solving and decision-making aspects of ego functioning and, hence, are very different from such compromise formations as neurotic symptoms that are automatically produced by primary process mechanisms. The former are ego-syntonic solutions to conflicting motives while the latter represent ego-

dystonic breakdowns of regulatory control in the face of a drive demand.

It was not until Inhibitions, Symptoms and Anxiety that Freud (1926) was able to achieve a unified theory which incorporates the role of trauma into a causal explanation of how external events interact with the drives to produce a neurosis. I will briefly summarize the key features of Freud's 1926 theory because it forms the conceptual foundation for Weiss's theory.

In Freud's (1926) new theory of anxiety, repression is no longer automatically regulated by the pleasure principle; instead, it is initiated by an unconscious portion of the ego which follows the reality principle. In other words, rather than repression being automatically evoked by some unpleasurable quality attached to the drives themselves, it is intentionally triggered by the unconscious ego in response to some anticipated danger that might result from attempting to gratify a drive demand. The unconscious ego now either contains or has access to repressed memories of childhood traumas, and it is guided by those memories in its task of self-preservation. On the basis of those memories, the ego forms its unconscious beliefs about situations of danger, anticipates the probable course of future events, and unconsciously calculates the potential consequences of gratifying a particular wish.

According to Freud' 1926 theory, anxiety exists in two forms, an automatic form which is the ego's original response to traumatic situations, and a signal form which is produced by the ego in order to institute repression and thereby avert the repetition of a previously experienced trauma. Primal repression was now assumed to result from the automatic anxiety produced by the earliest infantile traumas, while repression proper was assumed to result from the ego's intentional utilization of signal anxiety in the face of a danger situation. Freud (1920) had previously indicated that traumas can be produced from within the organism as well as from without, so that in assessing how to deal with an instinctual demand the ego considered both types of danger.

In Weiss's theory, "pathogenic beliefs" are generalizations about conditions of safety and danger that are drawn from repressed memories of actual traumatic experiences. They take into account the various dangers stemming from the threat of superego retaliation, the threat of being overwhelmed by the strength of one's instincts, and the threat of harmful reality consequences. Pathogenic beliefs are not compromise formations in the way Freud described dreams and symptoms as being compromise formations because they are not automatically formed by primary process mechanisms and are not the products of conflict between the ego and the id. They reflect the unconscious ego's adherence to the reality principle rather than to the pleasure principle. In referring to the ego's unconscious perceptions of danger, Loewenstein (1972) noted that "Here, for the first time, Freud described an aspect of ego development which, although it is involved in conflict, is not the result of conflict" (p. 212).

Waelder (1928) observed that Freud's explanation of signal anxiety shows that the ego can make use of the repetition compulsion for its own purposes and not just be dominated by it. He was referring to Freud's (1926) statement that the ego, which originally experiences traumas passively, can later repeat them actively in a weakened form for a variety of adaptive purposes: (1) as a warning of impending danger; (2) as a means of invoking the pleasure principle in order to institute repressions; and (3) as a means of mastery. Waelder (1930) elaborated upon the ego's purposive use of the repetition compulsion in

his article "The Principle of Multiple Function".

> The ego evidently takes an active stand toward its instinctive life; it has a tendency to master, or rather to assimilate it into its organization. When Freud (1920) introduced the concept of the repetition compulsion, he stressed the fact that the ego maintains a similar stand toward the repetition compulsion and uses the repetitions that are thrust upon it by this deepest psychic trend to master threatening experiences. In the actual occurrence of repetitions, it is not at all easy to determine to what extent the ego must submit to a force from "behind", and to what extent it uses this force as a means of control (p. 71).

Freud (1926) drew a number of important conclusions from his new theory of anxiety: (1) "This study of the determinants of anxiety has, as it were, shown the defensive behaviour of the ego transfigured in a rational light. Each situation of danger corresponds to a particular phase of the mental apparatus and appears to be justifiable for it" (p. 146); (2) "Since we have traced back the generating of anxiety to a situation of danger, we shall prefer to say that symptoms are created in order to remove the ego from a situation of danger" (p. 144); (3) "We have also come to the conclusion that an instinctual demand often only becomes an (internal) danger because its satisfaction would bring on an external danger--that is, because the internal danger represents an external one" (pp. 167-168); and (4) "A great many people remain infantile in their behaviour in regard to danger and do not overcome determinants of anxiety which have grown out of date. To deny this would be to deny the existence of neurosis, for it is precisely such people whom we call neurotics" (p. 148).

According to Freud's final theory, the most important distinguishing characteristic of the neurotic is his unconscious belief in childhood danger situations. These beliefs are derived from actual traumatic experiences and are considered to be the ultimate determinant of neurotic anxiety, repression, and symptom formation. One direct clinical implication of this theory is that the resistance of repression is produced by the patient's unconscious beliefs in situations of danger as he experiences them in the analytic situation. A true resolution of the repression resistance therefore requires that the patient's unconscious expectations of danger be analyzed in the transference relationship and traced back to their historical origins.

The etiological significance of traumatic experiences in the origins of neurosis assumed increasing importance in Freud's later writings. In Moses and Monotheism Freud (1939) stated that "Our researches have shown that what we call the phenomena (symptoms) of a neurosis are the result of certain experiences and impressions which for that very reason we regard as aetiological traumas" (p. 74). He discussed the psychological consequences of trauma in terms of its "positive" and its "negative" effects. The positive effects produce the repetition compulsion; the negative effects are characterized by the wish to forget and to avoid repeating the trauma. He also described neurotic symptoms as compromises between the positive and negative effects of childhood trauma, that is, as compromises between the need for mastery and the need for defense. In this same work he characterized a neurosis as a "belated effect" of trauma and he considered the splitting of the ego which occurs in neurosis to be a pathological consequence of childhood trauma.

The phenomenon of a latency of the neurosis between the first

> reactions to the trauma and the later outbreak of the illness must be regarded as typical. This latter illness may also be looked upon as an attempt at cure--as an effort once more to reconcile with the rest those portions of the ego that have been split off by the influence of the trauma and to unite them into a powerful whole vis-a-vis the external world. An attempt of this kind seldom succeeds, however, unless the work of analysis comes to its help, and even then not always; it ends often enough in a complete devastation or fragmentation of the ego or in its being overwhelmed by the portion which was early split off and which is dominated by the trauma (Freud, 1939, pp. 77-78).

The split-off part of that ego that is dominated by the trauma is the part which is governed by unconscious expectations of danger derived from the original traumatic situation. Freud (1940) made this clear in his article the "Splitting of the Ego in the Process of Defense". He described a case in which a little boy was traumatized by an explicit castration threat from his nurse. She found the boy masturbating and told him that he would be castrated by his father if continued the practice. A part of the boy's ego became split off as a result of this trauma and was subsequently dominated by an unconsious belief in castration. Although the boy appeared to have consciously rejected the threatened castration as a possible punishment for his masturbation, unconsciously he believed in it. He developed an intense fear of being punished by his father, as well as a fetish. Such an unconscious belief in castration is a good example of what Weiss means by a pathogenic belief.

In his article "Construction in Analysis", Freud (1937) cited an example of how unconscious memories of childhood trauma exert their influence on patient behavior. The reader will note the similarity to the quotation I cited earlier from "The Aetiology of Hysteria" (Freud, 1896).

> Often enough, when a neurotic is led by an anxiety-state to expect the occurrence of some terrible event, he is in fact merely under the influence of a repressed memory (which is seeking to enter consciousness but cannot become conscious) that something which was at that time terrifying did really happen (Freud, 1937, p. 268).

Along with the reemergence of trauma as the primary etiological factor in Freud's final theory of neurosis, the goal of removing the amnesias also assumes renewed therapeutic importance. Freud made it clear that analysis attempts to uncover not just the hidden psychic reality stemming from the patient's repressed instinctual wishes and fantasies; it more broadly attempts to reconstruct the patient's actual childhood interpretation of real historical events. As Freud (1937) said, "What we are in search of is a picture of the patient's forgotten years that shall be alike trustworthy and in all essential respects complete" (p. 258).

> The analyst finishes a piece of construction and communicates it to the subject of the analysis so that it may work upon him; he then constructs a further piece out of the fresh material pouring in upon him, deals with it in the same way and proceeds in this alternating fashion until the end. If, in accounts of analytic technique, so little is said about 'constructions', that is because 'interpretations' and their effects are spoken of instead. But I think that 'construction' is by far the more appropriate description.

'Interpretation' applies to something that one does to some single element of the material, such as an association or a parapraxis. But it is a 'construction' when one lays before the subject of the analysis a piece of his early history that he has forgotten, in some such way as this: 'Up to your nth year you regarded yourself as the sole and unlimited possessor of your mother; then came another baby and brought you grave disillusionment. Your mother left you for some time, and even after her reappearance she was never again devoted to you exclusively. Your feelings towards your mother became ambivalent, your father gained a new importance for you,' ...and so on (Freud, 1937, pp. 260-261).

The general point I want to make is that the last phase of Freud's theory development represents his attempt to explain, on the basis of ego psychology, how traumatic experiences enter into the formation of a neurosis. He showed how they produce unconscious beliefs about danger which lead the ego to institute pathogenic repressions through its purposive use of signal anxiety. He showed how they give rise to a need for repetition which reflects the ego's unconscious attempt at mastery. He also showed how a feared trauma (castration) becomes the primary motive for superego formation during the oedipal period and how traumatic experiences may intensify unconscious guilt at any time in the life cycle because they tend to be experienced as deserved punishments. This latter point Freud (1930) made in Civilization and Its Discontents: "As long as things go well with a man, his conscience is lenient and lets the ego do all sorts of things; but when misfortune befalls him, he searches his soul, acknowledges his sinfulness, heightens the demands of his conscience, imposes abstinences on himself and punishes himself with penances" (p. 126).

Weiss's theoretical contributions represent an effort to elaborate and to integrate Freud's later ideas about the causal connections that link together childhood trauma, unconscious wishes, unconscious beliefs about danger, anxiety and guilt, and defenses and resistances. His theory provides a scientifically testable explanation of how patients use the psychoanalytic process to master the various pathogenic effects of childhood trauma.

I have laid out a broad conceptual framework for understanding the historical origins of many of Maury's criticisms of Weiss's theory because I believe that most of them stem from "phase two" of Freud's theory development and do not take into account the crucial importance of Freud's later work. I will now take up the specific criticisms he raised in his precirculated discussion, although I will not have time to address all of them.

Responses to Specific Criticisms of Weiss's Theory

I was glad Maury called attention to Ed Weinshel's (1984) recent article on the psychoanalytic process because I find it useful to conceptualize the core of that process in terms of the work that needs to be carried out in order to resolve the patient's resistances. In my empirical research I have explicitly studied the basic clinical units of the psychoanalytic process as conceptualized by Weinshel: the resistance, its successful (or unsuccessful) negotiation by the analyst (most often by interpretation), and the patient's subsequent response. Weinshel justly emphasized the overlooked importance of an early article by Bernfeld (1941/1985) entitled "The Facts of Observation in Psychoanalysis". I will use Bernfeld's article as a point of departure in my response to Maury.

1. Is Weiss's theory a theory about the psychoanalytic process?

Weiss's theory is precisely a theory about how resistances are overcome in psychoanalysis. It is a theory about how the analyst's interventions enable the patient's ego to relinquish its resistances and to lift its repressions. It provides a causal explanation of how resistance analysis works. It is a response to Bernfeld's admonition that "if we we wish to improve the technique, we have to increase our knowledge as to how one recognizes obstacles and how one removes them effectively. Finding the laws of this removal is equivalent to establishing the optics of our instrument..." (Bernfeld, 1941/1985, p. 350).

As Calef and Weinshel noted in their preface (Bernfeld, 1941/1985), Bernfeld's conceptual model is valuable because it gives form and definition to the psychoanalytic process by identifying important functional units whose interrelationships can be objectively studied. According to Bernfeld's model, the analytic process can be followed by focusing on the following sequence of events: (a) the patient's usual behavior; (b) the state of hiding a secret, i.e., the state of resistance; (c) the analyst's intervention; and (d) the confession of the secret. Bernfeld (1941) explained how "c" leads to "d":

> The analyst uses the banal technique of removing communication obstacles. By saying the right things at the right time he creates the conditions under which the patient is likely to confess secrets. These communications are the facts to be observed, and the analyst gets them without illegitimately 'influencing' them (p. 346).

Bernfeld linked the principles by which the analyst removes obstacles to confession to the means by which people overcome obstacles to communication in everyday life. He gave the example of a friend coming over to ask for a loan but being unable to do so. The host notices that the door to the room is open and shuts it, whereupon the friend makes his request. Bernfeld explained that "What happened to your friend is simply that only when by closing the door you created an encouraging atmosphere did he feel sure of the complete confidentiality which he desired" (p. 344). After the obstacle is removed the secret can be confessed. Bernfeld then extended this principle to the analytic situation.

> Generally the obstacles to communication are not external--like an open door. They are internal, as when distrust or shame obstructs the confession. Then the removal of the obstacle will not consist in changes of the environment, but in attempts to induce confidence or to dissipate shame (p. 345).

Bernfeld gave a concrete clinical illustration of a resistance to communication that he overcame by addressing the patient's unconscious perception of danger, which was a fear of the analyst's reaction to his being a gossip. Bernfeld's intervention was effective because it conveyed insight into the cause of the resistance while providing reassurance against the unconsciously feared danger.

> Telling the story of last evening's party, the patient mentioned a certain Mr. X. whom he knows to be a friend of the analyst. The report on the remarks of some of the people present was obviously incomplete and the patient resisted completing it. 'As you know',

said the analyst, 'in psychoanalysis it is one's duty to say things which in ordinary life would be stamped as gossip'. Thereupon the patient admitted that he had heard some unfriendly remarks about Mr. X. and that he felt uneasy in his role as gossip. He then repeated the insults against Mr. X., some of which were new to the analyst. This episode is very similar to the removal of obstacles in everyday conversation discussed above. Under the pressure of the fear of appearing a gossip, or of making the analyst cross, a part of the material had become 'secret'. In reassuring the patient, the analyst removed this obstacle and the confession was forthcoming (p. 345).

Weiss's theory provides an explicit, scientifically testable, causal explanation of how the four steps in Bernfeld's paradigm of the analytic process are linked together. Weiss's explanation follows directly from the signal theory of anxiety and may be schematically stated in the following way. A state of resistance develops when the patient's unconscious ego forms an anticipation of danger that links an emerging content to a feared consequence in the transference relationship. The analyst's interpretation enables the patient's ego to overcome the immediate resistance to communication because it provides both insight into the cause of the resistance and some form of implicit reassurance that the feared danger will not materialize in the therapeutic relationship, that is, the patient feels reassured that he will not be made to feel guilty, ashamed, or afraid. Armed with this insight and the reassurance implicitly conveyed by the analyst's neutral stance, the patient's ego is able to reality-test the feared danger and temporarily surmount the resistance to communication. The patient overcomes his immediate resistance because of a reduction in anxiety brought about by the analyst's intervention. Put in other terms, a therapeutically effective analysis of a momentary resistance leads to new disclosures because it obviates the need for the resistance. I believe that Fenichel (1945) implies a similar explanation of the therapeutic effect of resistance interpretations.

Although in analysis all methods available are used to induce the patient to lessen his production of defenses, the desired effect is the more lastingly and efficaciously obtained, the more the analyst succeeds in using no other means of eliminating resistances than the confronting of the patient's reasonable ego with the fact of his resistance and the history of his origin. This confronting, bringing to the patient the recognition of the unconscious part of his resistance, also renders the resistance itself superfluous (p. 571).

Weiss's explanation of how resistances are overcome applies to all kinds of resistances as well as to the gradual lifting of repression that occurs during analysis. The central assumption he makes is that resistances are relinquished and repressions are lifted when the ego unconsciously perceives that there is less need for them. In other words, structural changes and dynamic shifts occur as the interpretive work and the neutral stance of the analyst lead the patient's unconscious ego to revise its anticipations of danger in relation to unconscious wishes and formerly warded-off strivings.

I want to briefly comment on Maury's conceptual model of the psychoanalytic process as "the presentations of compromise formations as resistances, the relevation of these structures as resistances, and through further disclosure, the dissection of these formations into their component parts, as they reveal themselves in other compromise formations, such as transferences, fantasies,

dreams, etc., which themselves also serve resistance functions" (p. 47). Rather than giving form and definition to the analytic process, I find that his approach confuses normal ego functioning with symptom formation and leads to a dissolution of the conceptual order which Freud, Bernfeld, and many others worked to achieve. If one conceptualizes and analyzes almost every aspect of psychic functioning and patient behavior as a compromise formation, it is easy to lose the distinctions Freud introduced between structure, function, and process, as well as the distinction between compromise solutions that are accomplishments of the multiple function of the ego and primary process compromise formations that represent defensive failures and a loss of ego control in the face of internal conflict.

For an analyst not to get lost in the forest of the patient's clinical material and to know how best to intervene, it is very important for him to have a conceptual model which distinguishes between and links causes and effects, as does Bernfeld's. If the analyst does not have a predictive model of the analytic process, it will be very difficult for him to gauge his influence on the patient's behavior and to recognize and correct his own mistakes.

2. Is Weiss's theory overly reductionistic?

Weiss's theory should certainly not be rejected because it makes broad and powerful generalizations. That is one hallmark of a good theory. As Loewenstein (1972) noted, " 'good' theory has the advantage of brevity as well as of applicability to a larger variety of clinical situations" (p. 227). Bernfeld's model is valuable precisely because it distills the essential units of the analytic process and provides a causal explanation of how those units are functionally interrelated. Weiss's theory does the same thing. Maury fails to recognize that the power of Weiss's theory lies in its capacity to explain how the analyst's interventions lead to the overcoming of resistances, the lifting of repressions, and an expansion of the autonomous ego's control over unconscious mental processes.

Weiss sees the patient's behavior as being highly overdetermined according to the principle of multiple function in that the ego must take into account the demands of the drives, the superego, and reality, in addition to its own interests and goals. Maury's compromise formation theory of the analytic process leads him to confuse the motive for resistance with the resistance itself, and he thereby loses sight of the crucial causal relationships between unconscious perceptions of danger, signal anxiety, and defense that Freud (1926) introduced in the signal theory of anxiety. For example, he considers an unconscious pathogenic belief in danger to be a manifestation, rather than a cause, of resistance, and he recommends that it be analyzed like any other compromise formation in terms of its defense and gratification components. His view of pathogenic beliefs shows a lack of understanding of Freud's later ideas about the role of trauma in the etiology of neurosis and the role of anxiety in the production of resistances.

I previously explained why a pathogenic belief is not a compromise formation. An unconscious belief in danger is a psychic structure that is overdetermined in its origins according to the multiple functions of the ego, but it is not a source of unconscious drive gratification, it is not a defense against unconscious wishes, it does not undergo a change of function over time, and it serves only one basic function—to mobilize defensive activity in the face of an impending danger situation. Freud (1926) made it abundantly clear

that an unconscious belief in danger is a manifestation of a fixation to trauma within the unconscious ego. I will remind the reader of what Freud (1926) said about the stability of the neurotic individual's unconscious beliefs about danger:

> Yet that is how the neurotic behaves. Although all the agencies for mastering stimuli have long ago been developed within wide limits in his mental apparatus, and although he is sufficiently grown up to satisfy most of his needs for himself and has long ago learnt that castration is no longer practised as a punishment, he nevertheless behaves as though the old danger-situations still existed, and keeps hold of all the earlier determinants of anxiety (p. 147).

3. Does Weiss's theory promote the view that the mind is inherently discontinuous and that the analytic process consists of two, mutually exclusive kinds of interchanges between patient and analyst: one that is irrational and pathological; the other, rational and adaptive?

As I mentioned earlier, from 1920 on Freud increasingly took the position that trauma produces major disruptions in psychic functioning and profound discontinuities in psychic development and organization. A portion of the ego is split off by the effects of traumatic experiences (Freud, 1939, 1940) and remains dominated by unconscious memories of the trauma. According to Freud's later theory, the irrationality of the unconscious ego stems not from its mode of functioning but from the assumptions it makes about situations of danger based on prior traumatic experiences. This conclusion follows from Freud's (1926) assertion that his new theory of anxiety shows "the defensive behavior of the ego transfigured in a rational light" (p. 146). I previously quoted a passage from "Moses and Monotheism" in which Freud (1939) described the work of analysis in terms of coming to the ego's assistance in its attempt "once more to reconcile with the rest those portions of the ego that have been split off by the influence of the trauma and to unite them into a powerful whole vis-a-vis the external world" (pp. 77-78). Weiss offers a theory that explains how this discontinuity in the ego is overcome through analysis: the patient is made aware of his unconscious pathogenic beliefs and their historical origins and is provided with an opportunity to reality test his unconscious expectations of danger within the safety and the confines of the analytic situation.

Maury does not recognize the distinction between a neurotic process in analysis that strengthens a patient's resistances and a therapeutic process that lessens them. Weiss does indeed make such a distinction, as have others (G. Bibring, 1936; Dewald, 1982; Greenacre, 1959; Greenson, 1967; Loewenstein, 1957). Moreover, Weiss's ideas contribute significantly to an understanding of the differences between these two kinds of processes. Weiss stresses the necessity of distinguishing between positive and negative therapeutic sequences because that is the only way the analyst can judge whether he is helping the patient to overcome his resistances or unwittingly reinforcing them. The successful analysis of a resistance should have an observable, even if minute, therapeutic effect. Weinshel (1984) described that effect in the following way: "It is evidenced by shifts in the patient's material, his affects, his overall behavior, and by an increased interest in and focus on the analytic work--albeit most often in minuscule degrees" (p. 74). All of the empirical studies that I and other members of the research group have carried out confirm the assumption that therapeutically effective interventions tend to be followed by observable indications of some lessening of the patient's resistances. Weinshel (1984)

also emphasized the importance of developing methods for determining whether the analyst is effectively helping the patient overcome his resistances and whether the patient is participating in an analytic process.

4. Does Weiss's theory neglect psychic reality?

Maury asserts that Weiss misunderstands the nature of unconscious fantasy, replaces the traditional role of fantasy with his notion of pathogenic beliefs, and thereby "deep sixes" psychic reality--the center of the psychoanalytic enterprise. I will quote from Maury's paper:

> By using the idea of pathogenic belief in place of fantasy, one's knowledge of the patient's inner life, his troubles, and his behavior in analysis is severely compromised, for unconscious fantasy is an essential determinant, perhaps the most essential, of all these things. The dismissal, or at least demotion, of the role of fantasy bears on a crucial shortcoming of the Weiss work: the neglect of psychic reality, by which I mean unconscious desires and associated fantasies that have a consistency, resistance and force comparable to material reality" (p. 47).

I will respond to this criticism in several ways. First, I will remind Maury that Weiss presented Freud's definition of unconscious fantasy, not his own. I believe that Weiss's theory leads one to analyze a patient's fantasies in a very comprehensive rather than in a very limited manner. Weiss considers pathogenic beliefs, and the traumatic experiences from which they are derived, to be important determinants of unconscious fantasies, but not a replacement for the patient's fantasies.

Second, I want to point out that Maury's definition of psychic reality stems from the second phase of Freud's theorizing and neglects the profound effects of traumatic experiences on a person's psychic reality. The psychic reality Maury is referring to is that based on unconscious memories of drive gratification and on the fantasies which arise from these memories and from the drives themselves. It is the unconscious psychic reality of the id. According to Freud's later views, trauma leaves the deepest impressions in the patient's repressed unconscious and colors all of a person's fantasies and emotional reactions to later events. The important clinical implication of Weiss's theory in regard to analyzing the patient's psychic reality is not that it should be ignored, but that the analyst should focus on the unconscious causal connections that the patient has drawn between his infantile wishes and his infantile traumas. Greenson (1967) made a related point when he said that "If one probes what lies behind the painful affect, one will discover some dangerous instinctual impulse and eventually some link to a relatively traumatic event in the patient's history" (p. 81).

Third, I believe Freud moved away from the view that psychic reality, as defined by the patient's unconscious wishes, has all the force of material reality in the etiology of neurosis. In his later writings he gave increasing emphasis to the therapeutic importance of reconstructing the actual traumatic events that gave rise to the patient's repressions and produced a split in his ego. A number of writers, including Loewenstein (1957), Shengold (1979), Greenacre (1981), and Sandler (Sandler and A. Freud, 1985), have warned of the danger of treating fantasy as equivalent to reality or giving it priority over reality.

5. Does the concept of pathogenic belief lead the patient to deny responsibility for his own participation in the creation of his psychopathology?

This criticism stems from Maury's inclination to view psychopathology as Freud did during the second phase of his theory development. At that time Freud believed that the primary purpose of symptoms was to gratify unconscious wishes while concealing those gratifications from oneself and externalizing the responsibility for them onto the parents. Reality was treated as a defense against unconscious fantasy. Maury's position is based on the assumption that the primary purpose of defense is to protect unconscious drive gratification. Weiss bases his theory on Freud's (1926) later view that the primary purpose of defense is to remove the person from a danger situation. His position is similar to Bernfeld's in that he believes that the analyst should attempt to overcome obstacles to communication by addressing the primary motivation for the resistance, which is the patient's immediate expectations of danger connected to the confession of some emerging mental content. Weiss assumes, as did Bernfeld, that if the analyst consistently approaches the patient's resistances in this fashion, the patient will eventually be able to confess all of his secrets, i.e., his unconscious wishes and fantasies.

Maury sees the patient as "more than ready" to blame his parents for his troubles because he does not consider the effects traumatic experiences have in producing psychopathology and he ignores the importance of denial in the child's efforts to preserve an idealized image of his parents (Moore & Rubinfine, 1969). Shengold (1979, 1985), who has extensively studied the pathogenic effects of child abuse, confirmed Freud's hypothesis about the ego-splitting effect of significant traumatic experiences. He reported that children who have suffered actual abuse are compelled to deny such experiences and to idealize their parents. Their need to protect the illusion of a good parent becomes the source of greatest resistance in analysis. Rather than rushing to blame their parents, these patients cannot tolerate seeing their parents objectively. Other analysts, such as the members of the Ernst Kris Study Group who intensively studied the defense of denial (Moore & Rubinfine, 1969), have also commented on the profound resistances (in both child and adult analysis) which arise from the patient's need to deny his parents' inadequacies and mistreatment of him. I believe that Maury has a superficial and one-sided view of the patient's eagerness to blame his parents for his troubles. In my own clinical experience one just as often encounters the kind of resistance Shengold and others describe.

6. What is the patient's primary motivation for engaging in the analytic process?

Maury does not recognize unconscious ego motives for engaging in the analytic process. He states that "It is desire, from the realm of psychic reality, expressed in and through positive transferences that is reliable and sustains the process" (p. 49). He does not recognize the ego's wish to master the pathogenic effects of childhood trauma so that it can secure more real world gratification. As Blos (1962) noted in his book <u>On Adolescence</u>, "the mastery of trauma is an unending task of life, as unending as the prevention of its recurrence" (p. 132). I do not agree with Maury's view that unconscious desire, as expressed in the positive transference, is the sustaining and reliable motive for the patient's work in analysis. As Maury himself notes, the transference is always ambivalent and can readily shift from positive to negative. Nonetheless,

the patient may continue to effectively engage in the analytic process even during a negative transference. Kris (1956) made this clear in his classic article on insight: "It is not so that positive transference determines the successful integrative work of the ego. It can proceed, whatever the transference reaction may be (provided naturally that transference there was, and that it had operated at a certain intensity)" (p. 257).

7. The confirmation-disconfirmation issue

Maury's claim that analysis should be a process of confirmation rather than a process of disconfirmation creates a false and misleading issue by using these terms in a different sense than Weiss does. He says that analysis should confirm, that is, "establish as true and valid", the patient's symptomatic structures. By this he seems to mean that the analyst should convey emotional acceptance of the patient's psychopathology and help him understand its multiple meanings in terms of the patient's psychic reality and life experiences. I have no objection to viewing the analytic process as confirmatory in this sense of the word, although Maury's use of the term confirm has too many vague ethical connotations to be useful in a scientific discussion. In contrast to Maury, Weiss uses the concept of confirmation and disconfirmation in a precise way to refer to the patient's efforts to reality test his unconscious anticipations of danger. Weiss looks at the analyst's interventions in terms of whether they lead to an intensification or a lessening of the patient's resistances, and he does so in the context of an explicit causal theory about how the ego masters its unconscious anxieties.

8. Weiss's treatment of the concept of transference

Maury's criticisms of Weiss's conceptualization of transference is based on a distortion of Weiss's ideas. Weiss's theory builds upon Freud's (1926) discovery of the two forms in which patient's repeat their traumatic experiences in an attempt to master them. His theory also develops Freud's (1926), Waelder's (1930), Nunberg's (1948), Greenson's (1967), and Loewenstein's (1967) ideas about how the ego may use the repetition compulsion in the service of mastery and not just be dominated by it. Weiss offers some clarifying generalizations that may be useful for organizing one's thinking about the state of the transference. His views encompass the ambivalent nature and the complexity of transference. Maury distorts Weiss's theory when he claims that it leads to the analyst's pulling for the patient to idealize him and to the patient's engaging in new behaviors out of compliance to the analyst. Weiss's theory does not in any way imply that the negative transference or the patient's use of transference as resistance should not be analyzed. Weiss, in fact, gives great emphasis to the importance of analyzing the patient's compliances and idealizations of the analyst.

9. The testing concept

Maury's criticisms of Weiss's use of the testing concept suggest that he has lost sight of the fact that Weiss is offering a theory about how the ego uses the analytic relationship in its attempts to overcome unconscious expectations of danger. Maury does not seem to recognize that repetitions may be undertaken for the purpose of mastery as well as for the purpose of drive gratification. Rather, he sees the patient's unconscious behavior only in terms of attempts to gratify instinctual wishes while defending against awareness of such gratification. He also does not seem to distinguish between the autonomous

ego's unconscious efforts to overcome resistances and the defensive ego's efforts to sustain them. Weiss focuses on the conflict within the ego between its wish to overcome and its wish to avoid infantile sources of danger. His recommendations about technique are all based on the assumption that the analyst should align himself with the ego's unconscious efforts to overcome its own resistances. Weiss's position represents an elaboration of Loewenstein's (1972) description of the conflict within the ego with which the analyst must deal.

> Anna Freud (1936) made the important statement that the patient's ego is the medium through which analysis takes place and which permits us to observe with equal attention manifestations of his ego, id, and superego. Actually, the specific medium through which we observe these three substructures of the mental apparatus is the autonomous ego of the patient. The interactions and conflicts in which we are interested take place not only between ego, id, and superego, but also within the ego itself. The requirement of the basic rule accentuates the conflict between autonomous functions and defensive functions of the ego (p. 213).

Loewenstein went on to make three important points: (1) The success of the treatment depends on the alliance between the therapist and the patient's autonomous ego; (2) The analytic process takes place mainly within the autonomous ego; and (3) The patient's autonomous ego does the work of overcoming resistances. Weiss's testing concept helps explain how the patient's autonomous ego carries out this formidable task.

Maury concludes that "to the extent that testing the analyst and the analyst passing the tests is aimed at disconfirming, it is an activity aimed at reinforcing and promoting defense and resistance" (p. 51). I believe that just the opposite is true. To the extent that testing the analyst represents the autonomous ego's effort to reality test a feared danger situation, and to the extent that the analyst's interventions enable the patient to recognize that his unconscious fear is irrational, there should then follow some genuine lessening of the patient's resistances.

Maury also concludes that Weiss advises against analyzing the patient's testing behavior and therefore Weiss relegates interpretation to a secondary role and encourages the therapist to engage in nonanalytic activities with the patient. Weiss's position is quite the opposite. He does not recommend that the analyst not interpret the patient's testing behavior; he recommends that the analyst interpret the patient's testing behavior in a way that passes the test. The testing concept does not minimize the role or the importance of interpretation; it gives the analyst an additional perspective on how to frame his interventions, and it may help explain unexpected negative therapeutic reactions.

Maury criticizes Weiss for failing to analyze the patient's transient identifications with the analyst's test-passing behavior. He considers such identifications to be defenses against guilt or anxiety. I believe that Maury fails to differentiate between defensive imitative identifications with the analyst as a person, which need to be analyzed, and nondefensive identifications with the analyst's function which lead to nonconflictual insight (Loewenstein, 1972). The kind of identifications Weiss is referring to are the patient's identifications with the analyst's analyzing function.

10. Insight

Maury criticizes Weiss for maintaining a split between insight and experience. Again his theoretical bias, which ignores ego psychology, prevents him from understanding Weiss's views. A particular virtue of Weiss's view is that it presents an integrated conception of the role of insight and the role of experience in the analytic process. The patient's testing behavior leads to new experiences that facilitate the acquisition of insight into his resistances and into the unconscious perceptions of danger from which they stem. The analyst's interpretations provide insights which help the patient better understand his resistances and reality-test his unconscious perceptions of danger. The two processes are complementary. Weiss's position may again be seen as an elaboration of Loewenstein's (1956) views on this subject: "Insight which a patient may gain during analysis widens his capacity for reality-testing in the area of his mental processes and permits a far more differentiated use of it" (p. 466).

Weiss's application of the testing concept to the acquisition of insight provides a useful explanation for the crucially important question of how patients develop genuine conviction about the correctness of the analyst's interpretations and about the irrationality of their unconscious perceptions of danger.

Maury's criticism of Weiss's view that insight arises under conditions of safety shows his lack of attention to the relation between insight and resistance. Weiss's position is consistent with the views expressed by Freud (1914), Fenichel (1935, 1941), Nunberg (1955), Kris (1956), Bernfeld (1941/1985), and many others, about the emergence of insight following the overcoming of important resistances. Kris (1956), for example, explained "the good analytic hour", by which he meant sessions in which the patient achieves a high degree of autonomous insight, in terms of the unconscious ego's integrative activities following the dissolution of an important resistance structure. Maury's criticism also reflects a failure to distinguish between a genuinely relaxed ego state which results from the overcoming of a significant resistance and a seemingly relaxed ego state which is a manifestation of resistance. He overlooks the fact that genuinely relaxed ego states are typically affectively and associatively very rich, rather than emotionally and intellectually sterile.

The importance of safety in the overcoming of resistances and the acquisition of insight was clearly described by Nunberg (1955):

> The ego, once it is protected by the analyst, relaxes its defenses or resistances, thus enabling the patient to face the hitherto warded-off material without fear or with only slight fear. Then he can recollect what was forgotten and reproduce and relive old infantile experiences which in the past caused anxiety. Thus he gains courage to look into himself and see connections between fantasies, memories, and experiences of the past which had been interrupted by the process of defense or which never existed on a conscious level. He is freed not only of the fear of remembering, but also of the fear of seeing connections between separate elements of his complex psychic life. Freed of this anxiety, he is now able to recognize his conflicts and, consequently, the unconscious meaning of his neurosis (p. 341).

Maury's paradigm for the emergence of significant insight is based on the

breakthrough of unconscious fantasies following their frustration by the analyst. He states that it is in the midst of great emotional turmoil resulting from the frustration of unconscious fantasies that the patient gains his most important insights. His explanation of how significant insight is acquired not only ignores the role of the integrative functions of the ego, it also ignores the crucial determinants of the patient's resistances—the unconscious perceptions of danger which necessitate the repression of the patient's drives, fantasies, and desires.

11. Maury's criticisms of the plan concept

Maury rejects Weiss's concept of an unconscious plan because "it asserts that there are powerful, motivating ideas that are totally rational, completely separate from and free of conflict" (p. 52). Maury is creating here an artificial dichotomy between totally rational and conflict-free and totally irrational and conflict-laden mental processes, and he thereby distorts Weiss's ideas about unconscious plans. The patient's plans are not totally rational and conflict-free. In making unconscious plans for mastery, the autonomous ego attempts to follow the reality principle, just as the defensive part of the ego also attempts to follow the reality principle in developing its resistances. The conflict in the ego that Weiss focuses on is over whether to avoid or to try to overcome infantile sources of anxiety. That conflict is present in every stage of the patient's efforts to carry out an unconscious plan for mastery.

Maury believes the patient's unconscious plan consists of his attempts to carry out repetitions of unconscious fantasies. As I already noted, he sees the ego's unconscious activity in analysis as exclusively directed towards trying to gratify instinctual wishes in secrecy. Just as the idea of trauma is missing from Maury's formulations about the patient's psychopathology, so too is the idea of an unconscious ego attempting to master the id. Mastery is absent in Maury's conception of where the patient "wants to go". Maury states that "'where the patient wants to go' is to positions in which he can most effectively conceal (from both the analysis and himself) and at the same time unconsciously actualize his unconscious defenses, wishes, fears, and fantasies" (p. 52). The reason he sees Weiss as advocating that the analyst align himself with the patient's defensive ego is because he does not recognize at all the role of the autonomous ego in the analytic process and does not see the ego as having a significant motivation for mastery.

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