

PSYCHOTHERAPY RESEARCH: THEORY AND FINDINGS\*

THEORETICAL INTRODUCTION

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RESEARCH FINDINGS

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## THEORETICAL INTRODUCTION

Joseph Weiss, M.D.

It is a privilege and a pleasure to participate in this mini-series and to offer the following remarks as background material for our discussions.

Our topic is a particular psychoanalytic concept of the mind, of therapy, and of technique. We shall present this concept, illustrate it, discuss it, and support it with observations obtained in formal research.

I shall offer a broad view of our approach. It is psychoanalytic. It is based entirely on concepts developed by Freud and other analysts or on logical extensions of their ideas. It is distinctive, however, in that it makes considerable use of certain ideas which Freud developed in his late theorizing. These ideas are not contained in Freud's early theory, or are contained in it merely by implication or in certain clinical discussions.

As I have just implied, certain of Freud's late ideas are, in their basic premises, quite different from the ideas of his early theory. Both sets of ideas are still used in psychoanalytic thinking. However, the two sets of ideas, being based on different premises, are, as Holt and other analysts have pointed out, not well integrated with each other. Indeed, certain of the early and the late ideas co-exist in current psychoanalytic theory without profoundly affecting each other.

Let me briefly contrast Freud's early and late views of unconscious mental functioning.

According to Freud's early theory, the unconscious mind is relatively simple in three things: in its contents, in the criteria by which it is regulated, and in its mode of regulation.

The contents, according to the early theory, are impulses and defenses. The impulses seek their infantile gratifications, and the defenses--or, more precisely, the forces of repression--keep the impulses unconscious. Moreover, the impulses are additive. They are all, therefore, on the same level of the mental hierarchy. They interact dynamically with each other, and with the defenses, and by their dynamic interactions they determine behavior.

Repression, according to the early theory, is maintained primarily to protect the infantile gratifications which the impulses unconsciously are obtaining. If a person were to become aware of such gratifications, he would have to relinquish them.

How, according to the early theory, is the unconscious mind regulated? It is regulated according to particular criteria--namely, indications of pleasure and pain. That is, it is regulated by the pleasure principle. And what is its mode of regulation? It is regulated automatically, beyond the ego's control and without regard for thought, anticipation, belief, or reality.

Now let's consider the late theory. The unconscious mind, as conceptualized by Freud in his late theory, is much more complex. It includes the contents and regulations of the mind as conceptualized in the early theory. However, it contains additional unconscious contents, and, in some of its parts, it is subject to more complex unconscious regulations.

The mind of the late theory, besides containing repressing forces and impulses seeking gratification, contains motives which stem from the unconscious parts of the ego. It contains motives stemming from certain crucial identifications with parents or other important persons. It contains motives stemming from the wish to comply with parents. It contains, as Erikson has described, motives seeking, not immediate gratification, but certain long-term goals--such as the goals of attaining autonomy or initiative. It contains an unconscious wish for mastery.

It contains motives stemming from the superego, such as the wish to suffer or to remain ill. It contains self-punitive motives, motives to atone for a crime against an object, to sacrifice an object, or to restore an object.

It also contains grim unconscious beliefs which arise in the traumas of childhood, such as the unconscious belief in castration as a punishment. It contains motives stemming from such beliefs, and from the fears, anxieties, and feelings of guilt which arise in them.

According to the late theory, repression is directed not only against infantile gratifications. It is also directed against the various motives described above. It is directed, too, against unconscious beliefs and against infantile traumatic experiences.

The unconscious mind of Freud's late theory is regulated not merely by indications of pleasure and pain. Parts of it (in particular, parts of the unconscious ego, including the repressions) may be regulated by assessments (or, indeed gratifications) of danger and safety. This latter regulation, unlike regulation by the pleasure principle, is not automatic. It may be carried out only by use of higher mental functions--that is, by thoughts, anticipations, and judgments.

A person who would like to carry out a particular act cannot know, automatically, whether he could carry it out safely, or whether he would, in carrying it out, put himself in a situation of danger. He can know such things only if he anticipates the possible consequences of the act, and in addition evaluates his capacity to deal with such consequences. Thus, in unconsciously regulating certain behavior, he must take account unconsciously of his beliefs, his conscience, and his assessments of his current reality.

I should especially like to emphasize that according to Freud's late theory, certain grim unconscious beliefs, such as the belief in castration as a punishment for sexuality, play a central part in unconscious mental life. A grim unconscious belief is neither a defense nor an impulse and thus is not readily assimilated to the early theory.

Indeed, the unconscious mind of Freud's early theory cannot accommodate grim unconscious beliefs. The unconscious mind of the early theory does contain ideas, but these ideas are simply wishful fantasies, determined automatically by the pleasure principle.

In the early theory, all unconscious mental processes, including unconscious beliefs, are determined by impulse and defense. Indeed, in the early theory, unconscious beliefs, being wishful fantasies, while determined by impulses and defenses, do not themselves determine behavior. According to the late theory, however, certain grim unconscious beliefs, such as the belief in castration as a punishment, do determine behavior. A person who unconsciously believes he will be castrated if he pursues certain sexual objects may, in obedience to this belief, relinquish the sexual objects. He may give up masturbation. He may avoid sexual relations, or he may permit sexual relations only under unusual circumstances.

The grim unconscious beliefs of Freud's late theory, such as the belief in castration as a punishment for sexuality, give rise to powerful feelings of fear, anxiety, or guilt. The young child, according to Freud in Inhibitions, Symptoms and Anxiety, acquires the horrifying belief in, say, castration, by normal processes of thought, albeit thought which may be highly subjective and which necessarily reflects the child's limited perspective.

The experiences from which the child acquires grim unconscious beliefs are traumatic. Such experiences may be objectively unimpressive, or they may be truly horrifying, as in the case of Little Hans, a child discussed by Freud, whose mother threatened him with castration as a punishment for masturbation.

In Freud's late theory, psychopathology arises from grim unconscious beliefs which arise in traumatic experiences. It is in obedience to such beliefs that the child may repress his sexual impulses and thus cause them to be fixated.

In the early theory, fixation also depends on experience, but in a different way. An impulse becomes fixated to a particular object and aim either because it is gratified too much or not gratified enough. It becomes fixated, not in obedience to a belief, but automatically. Then, after it is fixated, it is repressed. The repression of the impulse causes it to be fixated, and its fixation is instituted by the pleasure principle. Repression is intended to protect the gratifications which the impulse unconsciously is obtaining.

How about symptoms? Freud, in his late theorizing, added to his conception of symptoms. In the early theory, he assumed that symptoms are disguised expressions of unconscious impulses seeking their gratifications. In his late theory, he retained this idea, but added a new one--namely, that a person's symptoms may express his attempts to remove himself from a situation of danger, or they may express the anxiety he feels when he faces the danger. For example, in Inhibitions, Symptoms and Anxiety, Freud assumed that Little Han's anxiety, which he stated was the essence of Hans's symptoms, was simply untransformed castration anxiety, which, in the case of Little Hans, was justified by his mother's actual castration threats.

Freud's late theory also offers a new explanation for peremptory, maladaptive behavior. In the early theory, such behavior is determined automatically by unconscious maladaptive infantile impulses which seek immediate gratification without regard for reality. In Freud's late theory, too, peremptory maladaptive behavior may be caused by powerful unconscious impulses. It may also, however, be caused by certain grim unconscious pathogenic beliefs and the feelings of fear, anxiety, and guilt which stem from them. Indeed, unconscious fear, anxiety, and guilt may cause peremptory behavior just as efficiently as the unconscious search for gratification. For example, a person may, as described by Fenichel, masturbate compulsively, not primarily because he finds masturbation so gratifying (though he may find some gratification in it), but because he unconsciously believes that by masturbating he injures his penis. He may then after masturbating become worried about his penis, masturbate again in order to assure himself that he is still functioning properly, but instead of becoming reassured, become all the more anxious and so feel compelled to continue his masturbation.

Freud's late theory, with its more complex view of unconscious motivation, is able to discriminate between various motives, all of which in the early theory are conceptualized as impulses seeking gratification. Behavior which in the early theory is thought to express a primary impulse may, according to the late theory, serve the ego or superego, and it may serve it for a purpose other than the attainment of gratification.

For example, according to the early theory, a patient's homosexual attachment to the analyst is simply the expression of a primary impulse which unconsciously seeks gratification from the analyst, as it once sought it from a parent.

According to the late theory, however, a patient may develop a homosexual attachment to the analyst for a variety of reasons. For example, a person who believes he has hurt the analyst may develop a homosexual attachment to him in order to restore him. His purpose may be, not gratification, but relief of anxiety or guilt. Moreover, he may be guided, not automatically, but by a belief--namely, that love restores.

Or, as Freud stated in the Outline of Psychoanalysis, a patient may develop a homosexual attachment to the analyst to placate him, because he fears castration from him. Such a patient is not seeking gratification, but relief of anxiety; and his behavior is guided, not automatically, but by a belief that if he competes with the analyst, the analyst will castrate him. Moreover, according to Freud in the Outline, a patient's homosexual attachment to the analyst may be embedded in an identification. He may love the analyst as his mother loved his father.

Or a male patient who was traumatized by a seductive father may identify with the aggressor, and be seductive with the analyst (by expressing a sexual interest in him) as his father had with the patient. The patient, by identifying with the aggressor, is repressing, not gratification, but an infantile trauma.

Or a patient may develop a homosexual attachment to the analyst in compliance to the analyst, as in childhood he complied with his father. (Freud, in his late theory--as, for example, in his paper on The Economic Problem of Masochism--emphasized the part played by the child's compliance to his parents in the development of his motivations.)

I could, using Freud's late theory, offer still other explanations for a patient's homosexual attachment to the analyst in which the attachment is guided by a belief embedded in an identification and is intended, not to bring gratification, but relief of fear, anxiety, or guilt.

I shall end this brief comparison of Freud's early theory and his late theory by citing two passages from Freud's Outline of Psychoanalysis, which was one of the last of Freud's writings.

My purpose is to make clear how far Freud went in emphasizing the part played by guilt and self-destructiveness in unconscious mental life, and, in addition, how far he went in emphasizing unconscious regulation by higher mental functions through assessments of safety and danger.

In the first passage, which is on resistances, Freud does not even mention the resistance which in the early theory he considered primary--namely, the wish to maintain infantile gratification. Instead, he focuses on just two resistances--namely, the unconscious need to suffer and the unconscious need to be ill. He writes:

The further our work proceeds and the more deeply our insight penetrates into the mental life of neurotics, the more clearly two factors force themselves on our notice, which demand the closest attention as sources of resistance. Both of these are completely unknown to the patient...They may both be embraced under the single name of "need to be ill or to suffer".

The first of these two factors is the sense of guilt or the consciousness of guilt, as it is called, though the patient does not feel it and is not aware of it. It is evidently the portion of the resistance contributed by a super-ego that has become particularly severe and cruel. The patient must not become well but must remain ill, for he deserves no better...

It is less easy to demonstrate the existence of another resistance, our means of combating which are specially inadequate. There are some neurotics in whom, to judge by all their reactions, the instinct of self-preservation has actually been reversed. They aim at nothing other than self-injury and self-destruction... Patients of this kind are not able to tolerate recovery...

The next passage, also from the Outline, indicates how far Freud had moved toward developing the idea that the unconscious processes of the ego are regulated, not automatically by indications of pleasure and pain, but by the use of higher mental functions and their evaluations of safety and danger. Freud writes:

The ego's constructive function consists in interpolating between the demand made by an instinct and the action that satisfies it, the activity of thought which, after taking its bearings in the present and assessing earlier experiences, endeavors, by means of experimental actions to calculate the consequences of the course of action proposed. In this way the ego comes to a decision on whether the attempt to obtain satisfaction is to be carried out or postponed or whether it may not be necessary for the demand by the instinct to be suppressed altogether as being dangerous.

Just as the id is directed exclusively to obtaining pleasure, so the ego is governed by considerations of safety...The ego has set itself the task of self-preservation...It makes use of the sensations of anxiety as a signal to give a warning of danger that threatens its integrity.

Incidentally, in the Outline Freud assumes that the libido in the id is almost unknowable. The ego is the great reservoir of the libido, and the various behaviors which, according to the early theory, are the expression of primary impulse are, according to the Outline, organized by the ego and therefore regulated, at least to some extent, by thought.

I have, by my brief account of Freud's late views, gone some way toward introducing those views which are the subject of this mini-series. Let me briefly review what I have pointed out. It is that Freud's early theory conceives of the unconscious mind as a relatively simple apparatus, composed of impulses and defenses and regulated automatically by the pleasure principle. Unconscious behavior, according to Freud's early view, is determined automatically by the dynamic interaction of impulse and defense.

Freud's late theory, while containing his early views, also assumes that the unconscious mind may contain much more complex motivations and that parts of it may be regulated, not automatically, but by the person's higher mental functions, and his assessments, by these functions, of danger and safety.

Freud's late theory assumes that unconscious behavior may be based on childhood identifications or that they may express the child's infantile wishes to comply with his parents. It assumes that unconscious behavior may be guided by unconscious beliefs acquired in the traumas of childhood, and that it may express feelings of fear, anxiety, and guilt, which stem from such beliefs. Indeed, Freud's late theory stresses the great part played in unconscious mental life by the need to suffer and the tendency to self-destruction.

The concepts which are the subject of this mini-series are based on Freud's late theory.

I shall not attempt here a comprehensive view of these concepts. Instead, I shall take up briefly two important topics: psychopathology and the behavior of the patient during analysis.

We assume, as does Freud in the New Introductory Lectures, that psychopathology invariably expresses, not simply infantile impulse unconsciously seeking its gratification, but in addition feelings of fear, anxiety, and guilt. It also assumes that such feelings are derived ultimately from beliefs or ideas which are acquired by inference in the traumas of childhood.

Let me illustrate, by an example, how an adult patient's psychopathology, which at first glance seems to express simply a powerful infantile impulse, may be maintained by anxiety and guilt which stems from a grim unconscious belief.



The patient, who in childhood had assumed that she was much more attractive than her petulant mother, had competed with her mother for her father's love and, as she experienced it, defeated her. However, she became guilty about her victory. Indeed, she believed that by having so much fun with her father, she was devastating her mother. She was plagued with worry about her mother until she found a way of restoring her--namely, by having temper tantrums. She assumed, whether or not correctly, that she was, by her temper tantrums, enabling her mother both to feel morally superior to her and to defeat her in her competition for her father. Her mother, who was usually somewhat depressed, would become lively and indignant when the patient had a temper tantrum and would, moreover, induce the patient's father to punish her. The mother, as the patient experienced it, would feel restored, as she demonstrated to the patient that her claims on the patient's father took precedence over those of the patient.

The patient may originally have had occasional temper outbursts which were not connected with her wish to restore her mother. Indeed, her temper tantrums may originally have served such infantile purposes as those assumed by the early theory. However, later the patient unconsciously found that she could use her tantrums to restore her mother. Then they became compulsive, and they remained so for many years.

The patient whom I have just described suffered, not from an uncontrolled impulse seeking discharge, but from an unconscious omnipotent belief, which she acquired during her Oedipal period. It was the belief that if she defeated her mother in her rivalry for her father, she would devastate her mother. Her temper tantrums were intended, not primarily to discharge infantile rage or to bring her infantile gratification, but to reassure her that she was not hurting her mother. The patient, as a consequence of this belief, was anxious and guilty. She was afraid to enjoy herself with her father. Her temper tantrums were intended, not to bring her gratification, but to remove her from a situation of danger--namely, the danger of hurting her mother and thus of losing her mother's love.

I shall now give another example, similar to the first, to illustrate the part played by unconscious guilt in the maintenance of psychopathology:

A woman, in her childhood, believed that she was more attractive than her mother, and that her father preferred her. Moreover, she developed the omnipotent belief that by her youth and attractiveness, she was humiliating her mother and making her mother painfully envious.

She, like the patient in the last example, became plagued with guilt to her mother, until she found a way of placating her conscience. It was to punish herself for the crime of making her mother envious by intensifying her envy of her younger brother for his possession of a penis. In torturing herself with envy of her brother she was administering to herself a punishment which nicely fit her crime. The patient attempted to overcome the guilt to her mother by experiencing her brother as doing to her the same thing which she believed she was doing to her mother.

This patient's envy of her brother may originally have been unconnected with her wish to placate her conscience. However, she came to use it for that purpose, and in so doing, both intensified it and made it a part of her personality.

This patient's behavior was not primarily the blind expression of a powerful unconscious impulse--envy. Rather, it was regulated by a belief--namely, the patient's belief that she had humiliated her mother. Moreover, it was intended primarily, not to bring infantile gratification, but to bring her relief from her worry about her mother, which she based on the belief that she was hurting her mother.

Both of the patients discussed above suffered from grim unconscious beliefs which they developed during their Oedipal periods. These beliefs, in each case, gave rise to anxiety and guilt and, in addition, fear of loss of love.

Both the women in the examples cited above believed in their omnipotence. The one believed that by her Oedipal victory over her mother she would omnipotently damage her, and that by her humiliating displays of temper she would omnipotently restore her. The other believed that she had omnipotently damaged her mother and thus that she deserved to be tortured by envy.

Since an unconscious belief in omnipotence is part of many grim unconscious beliefs, I would like now briefly to describe it and to discuss its development.

A grim belief, which includes a belief in omnipotence, is not like a wishful fantasy which a person would like to retain, but a constricting and horrible idea which a person would like to get rid of.

A man who believes that if he were successful in his work he would kill his father may be just as constricted by this belief as he would be by the idea that if he were successful his father would castrate him. He may be prevented by such a belief from becoming successful; or if

successful, forced by it to torture himself. He is as handicapped by it as he would be by a belief in castration as a punishment. Moreover, he is motivated, unconsciously, to change such a belief, just as he is motivated to change the belief in castration.

A grim omnipotent belief of this kind is, in my view, the product, not of primitive wishful thinking, but of primitive theorizing. A person develops it just as he develops a belief in castration: by reasoning from observation. He may draw a causal connection between his pursuit of some goal which is important to him and some unfortunate consequence.

In the simplest case, a young child who suffers from a certain catastrophic event (such as rejection by a parent or the illness or death of a parent) may assume that he caused the event, and that he did so by pursuing a particular goal. He may then develop the belief that if he continues to pursue such a goal, he will bring on a similar catastrophic event.

For example, a patient was traumatized during his fifth year when his father became crippled in an automobile accident. Since he was, at that time, succeeding in his struggle to become more independent and happy, he assumed that by becoming these things, he had caused the accident. He developed the unconscious pathogenic belief that were he again to become independent and happy, he would bring about another catastrophe, and that by suffering and by being dependent, he would stave off disaster.

As a young man, the patient had a great deal of trouble leaving home. He went to a college about 50 miles away, and though he was a friendly, outgoing person, he did not let himself enjoy the college social life. Indeed, he came home almost every weekend to be with his family.

In his analysis, his unconscious belief that if he were independent and happy he would bring on a trauma was a major theme. He became anxious when things were going well and would often, after a good day, become worried that something terrible would happen.

This patient's seeming dependency on his parents was not the expression of a primary wish to be dependent, stemming from a primary impulse seeking gratification, automatically, beyond the patient's control.

It was, instead, based on the patient's belief, which he had acquired in experience, that by being strong he would damage his parents. The patient was guided by this belief, not automatically, but by use, unconsciously, of his higher mental functions.

A child may develop a grim unconscious belief in his omnipotence from an early pathogenic relationship with a parent, especially if, as is not unusual, the parent, by his behavior, encourages the development of such a belief.

For example, a patient, in early childhood, had observed that when he offered his mother a chance to take care of him, she would become cheerful, and that when he was strong and challenging, she would become upset and on occasion would complain that he was "killing her". The patient's memory that his mother told him he was killing her was probably accurate, for during his analysis he observed that when his son challenged his mother, she would complain to his son in such terms.

The patient, as a result of his early experience with his mother, acquired the pathogenic belief that he was responsible for her happiness. He believed that if he were to become independent of her, he would hurt her, and that if he were to remain dependent on her, he would keep her happy. As a consequence of this belief, the patient became intensely worried about his mother, especially when she complained that he was neglecting her. Indeed, he became so worried about her that he repressed his wish to become independent. Moreover, he even repressed his image of his mother as weak and helpless. Indeed, at the beginning of his analysis he reported that during his childhood his mother had been strong and resourceful, and that he had enjoyed letting her take care of him.

The patient in the example presented above had been correct in inferring a connection between his struggle to become independent of his mother and her becoming upset. Moreover, his inference was probably based on certain accurate observations. Nonetheless, the belief he acquired was inaccurate.

The patient had greatly exaggerated his effect on his mother. The patient, of course, in his reasoning about his relationship to his mother, was severely handicapped by his limited perspective. He had no prior relationships by which he could evaluate his relationship to his mother, nor did he, like the older child or adult, have access to knowledge about how one person is likely to affect another.

A patient's symptoms and inhibitions often stem from the pathogenic belief that he will damage a parent, by disobeying what he believes to be the parents' wish that he fail or suffer, or from the pathogenic belief that he will damage a parent by not suffering and failing like the parent is suffering and failing. A patient who suffers from the first kind of

belief may attempt to remove himself from danger by torturing himself, as he believes unconsciously a parent wanted him to torture himself.

A person who unconsciously believes that he would damage a parent by not suffering as, in his opinion, the parent had suffered, may handicap himself, or torture himself, as he unconsciously believes a parent handicapped himself, or tortured himself.

The patient in the example presented above remained dependent on his mother in obedience to what he believed were her wishes. Another patient, whom I shall not present, fought with his wife in order to ruin his marriage, as his father, in his opinion, fought with his mother and thereby ruined his marriage.

It is time now to offer a few ideas about the motives and behaviors of the patient during treatment, and to contrast these briefly with the concepts of Freud's early theory.

In Freud's early theory, the patient has no unconscious wish to overcome his symptoms. They are sources of unconscious gratification, so that the patient is strongly motivated to maintain them.

Freud, however, in Beyond the Pleasure Principle, suggested that a patient may wish unconsciously to overcome his problems, and indeed that he may repeat traumatic experiences in order to master them. Freud, in certain later works, implied an unconscious wish for mastery by his concept that the ego may develop an alliance with the analyst in order to subdue (master) certain uncontrolled parts of the id.

The idea that the patient may have an unconscious wish to master his problems has been developed by a number of analysts, including Loewenstein, Kris, Loewald, Greenson, and Rangell.

We also believe that the patient has an unconscious wish to overcome his problems. Indeed, the idea that a patient would like to master them follows from the assumption that his problems may arise from grim unconscious beliefs acquired in trauma. If (as the early theory assumes) a person's symptoms unconsciously are highly gratifying, he would presumably want, unconsciously, to keep them. If, however, as in the late theory and as we believe, they are unconsciously distressing and if they stem from horrifying and constricting unconscious ideas, a patient would presumably wish, unconsciously, to overcome them.

According to our observations, the patient does wish to overcome his problems. Moreover, he may work to overcome them, by attempting, unconsciously, to change the pathogenic beliefs which underlie them. He may work to change these beliefs by testing them, as has been described by Rangell and Dewald.

A patient may use his transferring to test the analyst. Suppose, for example, that a patient unconsciously believes that he had, in his childhood, hurt his father by competing with him and that if he were to compete, even now, with authorities, he would damage them. Such a patient may compete with the analyst, not to hurt him as he believed he hurt his father, but to assure himself that he does not, by competing with him, hurt him. A patient, by such testing, hopes to overcome the constricting idea that, by competing with authorities, he necessarily damages them.

In the following example, a patient tested the analyst in order to assure herself that the analyst would not reject her as her mother had. She believed, in childhood, that by being dependent on her mother she had provoked her mother to reject her. By testing the analyst, she attempted to disconfirm the belief that by wanting help from him, she would necessarily provoke rejection from him.

The patient was an unmarried lawyer in her early thirties who had low self-esteem. She was inhibited, plodding, and unimaginative. Though she attempted, by a dogged kind of cheerfulness, to make herself interesting, she assumed she was boring and inherently rejectable.

She made slow progress in her analysis. She gradually, over a period of years, became aware of her fear of rejection, and she remembered more about her belief that neither of her parents cared much for her. She also began to make some progress in her career and to go out with men.

Then, during the fourth year of her analysis, she informed the analyst that she had decided to terminate in six months. She pointed to the progress she had made and stated that she was now ready to work on her own.

The analyst attempted to investigate the patient's wish to terminate (and to offer some interpretations about her wish to terminate) but without much success. The analyst then told the patient that she was not, in his opinion, ready to stop and indeed that she had scarcely begun to realize her goals.

The patient protested bitterly for a few sessions, then decided to follow the analyst's advice. She was obviously quite relieved that the analyst thought she should continue. Then, a week after she decided to stay, she brought forth a new memory which made her so sad that she wept while telling it. She remembered that one day when she was seven, the workers in a factory near her home began to riot. The rioting was so violent that almost everyone in the neighborhood went into their houses and locked their doors. All of the mothers

in the neighborhood made their children stay inside. However, the patient's mother reacted differently. Instead of making the patient stay home, her mother sent her into the middle of the riot area to buy groceries. The patient developed the belief that her mother was drained by her dependency on her and wanted her to be killed.

The patient's recovery of this memory ushered in a new and productive phase of her analysis. The patient became less afraid of rejection by the analyst. She began to face more directly how much she had felt rejected by her mother and father, and how much she had feared it from the analyst and from her boyfriends.

In this case, the patient threatened to leave treatment, not primarily to express hostility to the analyst, nor to satisfy a wish for, say, independence. She threatened to terminate and she protested the analyst's refusal to let her terminate primarily in order to test the analyst. Her purpose was to assure herself that the analyst would not reject her as, in her opinion, her mother had rejected her. She wanted thereby to prove that she was not inherently rejectable.

When the analyst did not reject her, the patient felt reassured. She began to disconfirm the belief that if she wanted help she would be rejected. She, therefore, developed more trust in the analyst. Moreover, her greater trust in him made it safe for her to remember a painful occasion when her mother was particularly untrustworthy.

I shall now offer a few ideas about how the concepts presented above pertain to technique. I shall be very brief. My purpose will be simply to stimulate your thinking about the relationship of theory to technique and thus to help you to focus on certain technical issues which you may discuss more fully later.

According to our theory, the patient suffers unconsciously from his problems and wants to get over them. Moreover, he is able to work unconsciously, by testing the analyst, toward solving his problems. He may, by testing the analyst, work to change the pathogenic beliefs which underlie his difficulties.

The therapist, therefore, may help the patient primarily, not as the early theory assumes, by inducing him to do what he does not want to do--that is, to relinquish his infantile gratifications. Instead, the therapist may help the patient by enabling him to do what he unconsciously wants to do--that is, to change his pathogenic beliefs and overcome the feelings of fear, anxiety, and guilt which stem from them.

The therapist may do these things by inferring how the patient is working to change his pathogenic beliefs and then, through interpretation, helping him in his efforts to change them.

The idea that the therapist may help the patient to do what he unconsciously wants to do, does not mean that the therapist must agree with the patient's conscious purposes. The therapist may have to oppose the patient's conscious purposes, as was the case in the example presented above, when the therapist opposed the patient who wanted consciously to terminate her treatment prematurely. The therapist opposed the patient by telling her that she was not yet ready to stop.

The therapist who is attempting to understand the patient's problems may find the following rule of thumb useful:

A patient who has suffered a severe trauma in early childhood, such as the death or illness of a parent, rejection by a parent, or a prolonged relationship with a possessive parent, generally comes to believe unconsciously that he was responsible for the trauma. Moreover, his symptoms generally express his efforts to prevent the recurrence of a similar trauma.

The therapist generally is on solid ground if he assumes that a patient often (if not always) maintains his symptoms because he unconsciously believes that were he to relinquish them, he would risk hurting a parent or being hurt by him.

A patient may believe that by relinquishing his symptoms, he would hurt a parent, either by disobeying him or by being disloyal to him, or by becoming superior to him.

As I have already pointed out, a patient whose behavior (from the perspective of the early theory) is simply the expression of a primary impulse, may, according to the late theory (and according to our views), be the expression of one of a number of different possible motives.

Moreover, the patient's compulsive motivations, though appearing to express primary impulses, in the early theory, are almost always guided by beliefs and based either on compliances with a parent or identifications with a parent. In addition, the patient, in expressing such motives in treatment, is often doing so in order to test the therapist.

The therapist, then, who recognizes the complexity of unconscious motivation is in a better position to provide the patient with useful information about his motives than the therapist who sees all behavior as the expression of primary impulse and defense.

The therapist should try to help the patient to understand, not only the nature of a particular motive, but how it arises in relation



to a parent, what beliefs it is guided by, and how the patient, by expressing it, may be testing the therapist.

For example, though it may help a patient to learn that he has developed a homosexual attachment to the analyst, it may help him even more if he learns that he developed it out of identification with his mother. It may help him still more to learn that he is expressing it in accordance with his belief that he has hurt the analyst and must love him in order to restore him.

And, in addition to all of the above, it may help the patient to learn that, by his attachment to the analyst, he is testing him to determine whether the analyst does, in fact, need the patient to love him.

## RESEARCH FINDINGS

Harold Sampson, Ph.D.

### I.

I am pleased to have an opportunity to discuss some of our work with you. Our work on the therapeutic process is concerned with hypotheses which were developed by Joe Weiss over a period of years. These hypotheses grew out of clinical practice. They are applications of ideas which are contained in Freud's later theorizing, but which have not been applied in an entirely systematic and central way to therapy.

I shall focus this presentation on a single hypothesis which was described briefly by Joe. I shall elaborate further on this hypothesis, discuss some of its clinical implications, and present evidence, both informal and formal, which bears upon it.

The hypothesis concerns how unconscious mental life is regulated, and the criteria for that regulation. In Freud's early theory, repressed mental contents are regulated by pleasure and pain, and this regulation is automatic. In his later theorizing, however, Freud proposed that repressed mental contents may be regulated by assessments of danger and safety, and that this regulation takes place on the basis of thoughts, anticipations, judgments, and decisions. The later theory was set forth clearly in Freud's final statement on the subject in An Outline of Psychoanalysis, and here I shall repeat a quote from that work already presented by Joe:

The ego interpolates "between the demand made by an instinct and the action that satisfies, the activity of thought, which, after taking its bearings in the present and assessing earlier experiences, endeavors by means of experimental actions to calculate the consequences of the course of action proposed. In this way the ego comes to a decision on whether the attempt to obtain satisfaction is to be carried out or postponed or whether it may not be necessary for the demand of instinct to be suppressed altogether as being dangerous" (p. 199). (Note Freud's explicit reference here to a decision, based on an assessment of danger, about whether or not to repress a warded off mental content. Freud added in the next sentence that the ego is governed by considerations of safety.)

I should like now to turn from theory to observation in order to illustrate certain clinical implications of Freud's later hypothesis, as well as to introduce the nature of the evidence which supports it.

My prototypical observation is one which was described and explained by Joe many years ago. The observation concerns an experience from everyday life, that of "crying at the happy ending". The example Joe gave was this:

A person who was watching a movie about a love story experienced little or no emotion when the lovers quarreled and left each other. He was moved, however, when, at the happy ending, they resolved their difficulties. He became happy, then experienced a brief but not unpleasant sense of sadness, and wept.

Joe posed a question about this experience: Why does the person experience his sadness at just the moment when he has become happy? The question indicates the paradoxical--and as I will suggest, somewhat contra-intuitive character--of the observation.

A successful answer to Joe's question is not readily provided by Freud's early theory:

It is evident that the viewer did not experience his sadness because it had become intensified and thus thrust its way into consciousness (or welled up into consciousness)--for the sadness was most intense when the lovers separated, and the occasion for sadness was eliminated by the happy ending. Yet the viewer did not experience sadness at the separation, but only after the happy ending.

Moreover, if the sadness had come forth in spite of defenses against it because of its power, its emergence would have resulted in conflict. The moviegoer in that case should have felt tense or anxious before and during the coming forth of his sadness, and he should, after it came forth, remain in conflict with it. Yet the moviegoer was not anxious as his sadness became conscious, nor was he in conflict with it.

It is evident that the repressed content did not become conscious as a gratification, for sadness is not intrinsically gratifying. Indeed, the coming to consciousness of sadness in the "crying at the happy ending" phenomenon is an example of the kind of process which Freud stated in Beyond the Pleasure Principle contradicts his earlier assumption that unconscious processes are regulated exclusively by the search for pleasure. As you will recall, Freud stated in that work that people repeat, both in life and in analysis, experiences which cannot at any time have been pleasurable. These experiences are of trauma rather than of gratification.

Joe offered the following explanation of why the viewer experienced his sadness at just the moment when he became happy: The viewer was saddened by the lovers quarreling and separating from each other. However, he had felt endangered by his sadness then, and so repressed it. Later, at the happy ending, he stopped being endangered by his

sadness, and so could experience it safely. Since he no longer needed to repress it, he lifted his repression, made the sadness conscious, and gained relief from the effort he had been making to keep it repressed.

In summary, the crying at the happy ending phenomenon is most readily explained by concepts which assume:

First, that a person has a capacity to lift his defenses and to experience a warded off mental content, such as defended against sadness.

Second, that he is likely to do so when he decides unconsciously that it is safe for him to experience the warded off content.

Third, that he may experience the content not in order to gratify it, but rather to resolve his conflict with it.

## II.

In subsequent studies carried out on the process notes of analyses, Weiss sought to investigate how, and under what circumstances, the analytic patient becomes conscious of repressed mental contents, especially if such contents are not interpreted. He found that the analytic patient behaves much as the moviegoer in the preceding example. The patient generally maintains the repression of a particular warded off mental content until he unconsciously decides that he may experience it safely, then he lifts his defenses and makes it conscious. Thus, processes such as described in the crying at the happy ending phenomenon take place regularly in psychoanalyses and in psychotherapies.

Let me give a few brief examples to illustrate this phenomenon, to suggest its pervasiveness in therapies and analyses, and to give a sense of the distinctive clinical intuitions it affords.

In his presentation, Joe described a woman patient who had decided to terminate her analysis, which was then in its fourth year. She cited the progress she had made and stated that she was ready to work on her own. The analyst, after an initial investigation of her plan, told her that he did not believe she was ready to stop, and that she had scarcely begun to realize her goals. After a few sessions of protest, the patient decided to continue, and she then brought forth a new memory in which she felt rejected by her mother. The memory made her sad, and she wept while telling it.

This is a direct example, from an analysis, of crying at the happy ending. It shows that a deeply repressed sadness, a sadness repressed

for many years, may become conscious in the same way as the moviegoer's sadness. The patient threatened to terminate in order to test whether the analyst would reject her as she had perceived her mother as doing. When the analyst did not do so, she was unconsciously pleased and reassured, and she then brought forth a powerful unconscious content--the new memory--and the sadness associated with it.

Thus, the patient brought forth her repressed sadness at the happy ending caused by the analyst not rejecting her. She brought it forth when she unconsciously perceived that it was safe to experience it. Paradoxically, the intense sadness and feelings of rejection which she now experienced reflected a reduced fear of rejection and reduced feelings of sadness, for she now felt non-rejected and happy in her analysis.

Similarly, in another case, a male patient experienced powerful feelings of being lost, confused, and adrift just at the moment when he unconsciously committed himself to the analyst and felt "found", as it were, by the analyst. The patient had been withdrawn and at loose ends for several years prior to beginning analysis, but he had not experienced then feelings of being lost and confused. When he did experience these feelings and expressed them powerfully, it was because he was no longer so lost and confused and therefore was not so endangered by these feelings.

In another case, a woman patient began to experience for the first time sexual fantasies toward the analyst, sexual feelings toward him, and conscious fears that he might be interested in her sexually. This took place after a number of sessions in which she had unconsciously tested whether he was seducible. It was her unconscious appraisal of his non-seducibility which made it safe for her to become conscious of sexual feelings, fantasies, and fears. Paradoxically, then, she was experiencing powerful sexual feelings, as well as fears about how the analyst might respond, just when she was feeling safe with the analyst, and unconsciously reassured that he would not respond sexually to her. It was not an intensification of her sexual feelings or of her sexual fears which led to their becoming conscious.

I have emphasized the paradoxical character of these examples in order to call attention to the relationship between theory and clinical intuition. The clinical intuitions associated with Freud's early theory are deeply ingrained in much clinical thinking, outside of psychoanalysis as well as within it. Freud once remarked that in a conflict situation victory goes to the side with the biggest battalions. The associated intuition is that if a person begins to experience a powerful mental content, or begins to express that content prominently in his behavior, it is because that content has become so powerful--that the content has the biggest battalions on its side. If a person, thus, experiences intense, formerly repressed sadness--and especially if he does so without interpretation--it is because of the power of the sadness, or at least its power relative to the power of the defenses opposing its expression.

The hypothesis we are considering, which is based on Freud's later theory, modifies our understanding of such phenomena, and thereby modifies our clinical intuitions. It proposes that a person may experience repressed sadness (or other unconscious contents) with considerable intensity not because the sadness or other content has become so powerful in relation to the person's defenses, but instead because the person feels less endangered by the sadness, decides unconsciously that he may experience it safely, and lifts his defenses and allows himself to do so.

Another clinical implication of this hypothesis is that the emergence of a previously repressed content often provides the clinician with additional knowledge about the therapeutic process which has enabled the patient to become conscious of the content. In Joe's example, the patient's request for termination--as we can now infer from the memories which followed upon the analyst not acceding to her request--was a test of whether the analyst, like her mother, would reject her.

### III.

We have said that the patient in therapy or analysis behaves like the moviegoer. He generally maintains the repression of a particular ward off mental content until he unconsciously decides that he may experience it safely, then lifts his defenses and makes it conscious. If this thesis, derived from Freud's later theory, is correct, we should expect to find that patients in analysis as well as in certain psychotherapies:

- (1) Regularly become aware of mental contents which they had previously ward off by defenses, even when these contents have not been interpreted.
- (2) That they often become aware of such previously ward off contents without much anxiety, for they will not ordinarily decide to lift their defenses and make the contents conscious until they have overcome to a considerable extent their fear of being endangered by the content.
- (3) That they may not come into powerful conflict with these contents when these contents become conscious--for the patient often will not make them conscious until he judges that it is safe to experience them.
- (4) Moreover, that the patient need not isolate these contents in consciousness or otherwise defend against awareness of their personal import for him. This is because the patient is likely to be making them conscious in order to increase his control over them, and is thus likely to work to understand these contents rather than to disguise their personal import.

In Freud's early theory, in contrast, a repressed mental content which is not interpreted ordinarily remains unconscious unless the content is intensified. A repressed content which is intensified pushes more powerfully toward consciousness, and evokes intensified defensive efforts. If the repressed content is powerful enough, it may emerge to consciousness in a relatively undisguised form, in which case the patient will continue to be in conflict with it, will feel anxious about it, and will attempt to rerepress it. If, however, the repressed content becomes conscious in a sufficiently disguised compromise formation, the patient may not experience further conflict with it, but, since its import is disguised, the patient will not understand the significance of the newly emerging content, and will not use the content progressively in his therapy until its significance has been interpreted.

Weiss, and later others of us, have confirmed in both clinical work and in informal studies of process notes of analyses and therapies, that patients do in fact behave in accordance with this hypothesis. That is, they bring forth regularly important, previously unconscious contents; they do so calmly and without coming into conflict with the newly conscious content; and they understand the new content and use it to further their understanding of themselves and to advance the therapeutic work.

In spite of clinical confirmation of the hypothesis, we have been committed for more than a decade to devising formal research methods to investigate this as well as all of our other hypotheses. Why is that? Why do we seek to go beyond our own sense of conviction, and to go beyond the usual psychoanalytic--and I should say more broadly, the usual psychotherapeutic--methods of investigation and proof?

I should like to take up briefly our reasons for going beyond exclusively clinical methods of testing hypotheses.

We were guided, first of all, by certain broad assumptions about the field. We assumed that psychoanalysis is a science; that its theories do not rest ultimately on authority, or personal conviction, or tradition alone; and that its theories are to be judged by the same kinds of broad criteria as scientific theories in other fields. We assumed, moreover, that the major phenomena within the domain of psychoanalysis are recurring and observable (and that these observations may potentially be made reliably); that its theories assert some lawful relationships between observable events; and that it is possible to deduce certain empirical consequences of psychoanalytic theories in a relatively unequivocal way.

We were guided also by the recognition of how much formal research has contributed to the development of other sciences. It fosters a tradition, which is relatively weak in psychoanalysis, of resolving theoretical differences by carefully designed and potentially replicable studies which may cast light on the relative power and accuracy of alternative conceptions about nature. It may lead, as it has in other

fields, to findings which pose a challenge to existing ideas and which require new understandings of nature. We think that some of our own findings, if replicated in further work, may perhaps have such an effect on the theory of therapy.

We assumed, in addition, that undertaking formal research would not only prove salutary to psychoanalysis, but would prove salutary to the further development, refinement, and modification of our hypotheses about the therapeutic process. Formal research requires an unusual degree of explicitness about one's hypotheses, the precise relation of these hypotheses to competing explanations of the same phenomenon, the empirical consequences deducible from such hypotheses, the specific observations which you anticipate, and the ways in which such observations can be made, made reliably, and checked against theoretical expectations. In short, formal research can clear the head. It could help us to become more explicit and more rigorous in our thinking about the therapeutic process.

Last, but by no means least, formal research can overcome various sources of bias and error which cannot be overcome as well in ordinary clinical observation. I shall give a single example here; namely, that of overcoming circularity between theory and observation. This example is of particular relevance to studies of the hypothesis I have been discussing. We had observed that some clinicians, on the basis of their theories, assume that if a patient becomes aware of a new fantasy--say, of a beating fantasy--without interpretation, and calmly, that the fantasy had not previously been repressed, or else if it had been repressed, it became conscious calmly and without conflict because of a subtle shift in the patient's defensive constellation which enabled him to become aware of the fantasy without recognizing its personal import. Such clinicians could not be expected to see in their own work the observations which we claimed take place regularly in analyses and therapies. We needed to devise a research method free of theoretical preconceptions, a method which would enable previously repressed contents to be identified whether or not their emergence was accompanied by anxiety and conflict; and a similarly theoretically neutral method which would enable us to determine whether or not a patient recognized the import of such emerging contents and worked with them to advance his or her therapy.

I would now like to describe a study which used such a method. The method was originally devised by Professor Leonard Horowitz of Stanford University in conjunction with several other members of our research group. In the study I shall report, this method was improved, and was applied to a new case, by Dr. Suzanne Gassner.

I shall summarize Dr. Gassner's study and its findings in bold outline. This study is one of a large series of studies which have been carried out by our research group to test how well different psychoanalytic hypotheses are in agreement with observation in the psychoanalytic or psychotherapeutic situation.



The purpose of Dr. Gassner's study was to determine whether, as our hypothesis would lead us to anticipate, a patient may become conscious during analysis of previously unconscious contents which have not been interpreted, do so without anxiety or coming into conflict with the new content, and use the content to advance his or her therapeutic work. The study was carried out on the first 100 sessions of an audio recorded psychoanalysis which was conducted in the 1960's by an analyst in another city who was unfamiliar, at the time he treated the patient, with our hypotheses. The patient was Mrs. C., a married woman in her late twenties who was suffering from sexual, social, and work inhibitions, a sense of drivenness, and a general lack of enjoyment. She had been diagnosed as having obsessive-compulsive character problems.

The first step in this study was to identify a series of new contents or themes in the later hours within the 100 sessions; that is, contents which had not been described by the patient earlier. In carrying out this step, Dr. Gassner identified new themes appearing in hours 41 to 100. The second step required psychoanalytic clinicians to judge, on the basis of their own individual case formulations derived from reading the process notes of the first 10 sessions, which of this pool of new themes had been unacceptable to the patient at the beginning of the analysis, and had been warded off then by defenses. We used 19 psychoanalytic clinicians for this judgment, and we accepted as previously warded off contents only those new themes which psychoanalytic clinicians agreed highly had been warded off earlier by defenses.

In order to avoid one of the problems of circularity which I mentioned above, the statements of new themes which were presented to the judges (for judgment as to whether these themes had been warded off earlier) omitted any cues as to whether or not the patient was anxious or conflicted when these themes first emerged. The judges rated each new theme on a 5 point scale. A rating of "5" reflected the judges strong belief that the new theme had previously been unconscious.

Nineteen judges made these ratings on 100 new themes. They did so, as I noted, on the basis of their own case formulation derived from reading the process notes of the first 10 sessions. Thirteen of the 100 statements received a mean scale score of "4" or greater--these statements, on which there is substantial agreement between judges that they had been previously unconscious--were designated as "judged previously warded off" themes.

Did our method actually yield clinically meaningful warded off contents? We believe so. The patient herself, the treating analyst, and finally, a research group working independently from the judges, all provided evidence that the statements judges as warded off had been previously warded off, and were of central significance to the patient.

Our evidence in regard to the patient's judgment is this: There were seven new themes which the patient had prefaced with phrases acknowledging the patient's own awareness of facing a previously warded

off theme. Examples of such phrases are: "I've never let myself before think or feel such and such" or "I can't believe I'm saying that..." We did not provide the judges with these cues, but had deleted these prefatory comments. Nonetheless, the judges gave these seven statements--which the patient herself identified as previously warded off--a mean rating of approximately "4".

The treating analyst also thought that the statements which our 19 judges identified as previously warded off indeed had been warded off earlier. The treating analyst independently completed the same judgment task as our 19 judges. He rated as highly warded off 11 of the 13 statements which they had identified as warded off. Moreover, he considered the statements to which our judges had given the highest ratings, as so revealing that he asked us to disguise their contents for purposes of publication.

Finally, our research group, working independently of the judges, made their own case formulation, and then evaluated the statements identified by the 19 judges as previously unconscious. The research group agreed that these new themes expressed significant, previously unconscious impulses or previous unconscious painful childhood memories and ideas.

Thus, three converging lines of evidence gave us confidence that our method--which is, after all, a variant of the usual clinical method of identifying unconscious contents--did identify clinically meaningful and significant previously unconscious contents.

Our next finding was that the analyst had not made any prior interpretations which related to the ideas expressed in 12 of the 13 themes judged as highly warded off.

Thus, a number of clinically meaningful unconscious contents became conscious in the latter part of the first 100 hours of Mrs. C.'s analysis, and they did so without prior interpretation.

Did the patient experience much anxiety or conflict as these contents emerged? We used three different measurements of anxiety or conflict: Mahl's speech disturbance ratio; the Gottschalk-Gleser anxiety scale; and clinical ratings of anxiety by experienced clinicians. We compared the anxiety level on each of these measures when highly warded off contents emerged, with the anxiety level accompanying the appearance of randomly selected patient statements. The patient was significantly less anxious on the Mahl scale when warded off contents emerged than when random statements emerged; the other two measures showed no differences in anxiety level in the two circumstances.

We concluded that the patient became conscious of clinically meaningful unconscious contents regularly, without interpretation, and without evidence of intensified anxiety or conflict.

Finally, we used the Experiencing Scale to determine whether or not the patient worked progressively with the material as she became conscious of warded off contents. This scale measures the patient's involvement with progressive therapeutic work. The patient's material when previously warded off contents emerged was rated significantly higher on the Experiencing Scale than her material when randomly selected statements were made. This means that the patient was actually more involved with reflecting on the feelings she had associated with the warded off contents and more involved in therapeutic work when these contents emerged, than she was at randomly selected times.

We believe that this combination of results lends support to our hypothesis (based on Freud's later theory) about how unconscious mental life is regulated, and how unconscious contents may become conscious, even without interpretation, in analysis and psychotherapy. If this finding is confirmed in further work by investigators both inside and outside of our research group, we believe it will lend support, beyond our own clinical observations and personal convictions, to the hypothesis we have described.