

# Pathological Identification

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“Pathological identification” is a learned, psychological phenomenon in which patients unconsciously repeat pathological behaviors, attitudes, and affects their parents displayed in the past causing current problems in relationships with spouses, children, coworkers and friends. This phenomenon explains a wide range of pathologies that occur in everyday life that present frequently in psychotherapy and is often a hidden cause for patients failing to get better. The perspective on pathological identification developed in this article was first described by Joseph Weiss, who noted that patients unconsciously repeat their parents’ mistakes as a way to protect them and maintain an attachment. This article goes further to suggest that patients may reenact their parents’ problematic behaviors to avoid being aware of what their parents did to avoid their own scornful feelings in response, ultimately to protect parents from potential rejection or abandonment. This article traces the developing concept of pathological identification by writers including Sigmund Freud, Anna Freud, W.R.D. Fairbairn, and Joseph Weiss. It reviews the literature on how children protect their dysfunctional parents and the important role of altruism and loyalty in creating psychopathology. Based on this conceptualization, psychotherapy can help patients relinquish pathological identifications. How the therapist can recognize pathological identifications and the implications for treatment technique are illustrated with clinical examples.

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“Pathological identification” is defined in this article as “a learned, psychological phenomenon in which a person unconsciously repeats or reenacts problematic behaviors, feelings, attitudes, relationship patterns or dilemmas exhibited by significant others, usually parents, in the past.” These problematic behaviors represent more than just imitation or simple learning. This article will address the question of why people faithfully repeat the negative, hurtful, and destructive behaviors that their parents exhibited, even when they may have consciously vowed never to do so.

Pathological identifications appear most obviously in parenting situations in which people repeat their parents’ negative behavior while attempting to raise their own children (Foreman, 2009). It may be one of the central dynamics in child abuse and often plays an important role in substance abuse (Foreman, 2009). It is a common cause of marital discord as one or both members of a couple repeat unworkable aspects of their parents’ dysfunctional relationships (Foreman, 1996a; Zeitlin, 1991).

Pathological identification can affect all relationships negatively including family, work, and friendships. It is a prevalent and often underrecognized cause of pathological behaviors and feelings that often make patients unhappy enough to come to therapy. It is a

ubiquitous phenomenon that occurs in normal psychology as well as in psychopathology.

An example of pathological identification in “normal psychology” was the case of Jim, a 30 year-old man who described a fight with his wife. In the course of the fight, his wife started to cry and asked him to stop yelling at her. Jim had not even realized he was yelling and stopped as soon as she pointed it out. While discussing this fight with his therapist, Jim noted his father yelled at his mother and at him often when he was a child. Without any interpretation from the therapist, he realized he was repeating his father’s pattern of yelling. He had already talked about his efforts to improve on some other unattractive qualities of his father he noticed he was repeating such as taking an imperiousness tone with waiters in restaurants and using an intimidating sarcastic style while arguing with friends. None of these behavioral quirks caused severe damage to his relationships and he was able to change them when he became aware of their impact.

More problematic was another patient, Alan, who mercilessly yelled at his wife and called her abusive names during fights. He could not stop himself, even when his wife stopped having sex with him and threatened to leave him. Like Jim, Alan was also repeating patterns of behavior that were borrowed from his father. Alan’s behavior was more severe, more hurtful, and less amenable to change, an example of greater pathological behavior than Jim’s.

Why would anyone identify with or repeat pathological patterns from a parent’s life? If children were motivated primarily by profit and self-interest, it would make sense that they would identify with positive aspects of their parents, learn skills and virtues, and take on the successful parts of their parent’s identity to bolster their fledgling attempts to be successful or happy. Why would a person choose to adopt parents’ negative attributes such as alcoholism, abusive behavior, failure, defeatist attitudes, powerlessness, de-

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pression, or relentless misery? Whereas these pathologies are multidetermined by genetic, biological, cultural, socioeconomic factors, and other compromise formations (Waelder, 1936), this article argues that pathological identification is a discrete psychological phenomenon that often plays a significant additional role in causing these pathologies.

It is important for clinicians doing individual, couples, and family therapy to be aware of the possible role of pathological identification because it is a common cause for patients failing to get better and it is amenable to change with psychotherapy. This article will review several important contributors to the understanding of both healthy and pathological identification, outline a psychodynamic formulation that might explain it, and suggest a therapeutic strategy for its resolution.

### Sigmund Freud

Freud suggested several examples of nonpathological identification. He noted a small child had as his most “intense and momentous wish” in early childhood to be “like his parents . . . big like his father and mother” (Freud, 1909/1959d, p. 74). Identification with mother or father allowed children to enhance their power in relation to others (Freud, 1909/1959d, 1928/1959e) and was central to developing gender identity (Freud, 1925/1959b, 1923/1961b). Others have elaborated on the role of identification in the development of gender identity (Roiph & Galenson, 1981; Stoller, 1968).

In formulating the Oedipus complex, Freud (1928/1959c, 1923/1961b) argued that a boy’s identification with his father was part of natural ambivalent feelings, wishing to be like his father while at the same time wishing to be rid of him. Freud (1961) said identification played a central role in the resolution to the Oedipus complex and the formation of the superego. He wrote, “If the father was hard, violent and cruel, the superego takes over those attributes from him” (Freud, 1928/1959c, p. 231). Here, for the first time Freud suggested identification could be a source of pathology, leading to the formation and internalization of a punitive, harsh superego. Sandler (1960) elaborated on how children identify with both parents.

In “Mourning and Melancholia,” Freud (1917/1959f) suggested a second function of identification that could lead to pathology. He hypothesized that melancholic patients have ambivalent feelings toward their loved ones. They direct their angry, violent reproaches that they really feel toward their love objects to their own egos, resulting in the painful experience of melancholia. He called this process “identification of the ego with the abandoned object” (p. 159). Melanie Klein (1946/1984a, 1955/1984b) credited “Mourning and Melancholia” as the origin for her ideas on the interrelationship between projection and introjection in her work on projective identification.

Freud posited a third pathological form of identification in which people may identify with a parent out of guilt. He reported that Dostoevsky feared he would die from his seizure disorder because he identified with his father who had suffered a frightful death (Freud, 1928/1959c). Freud reasoned that Dostoevsky *wanted* his father dead and then feared for his own death “in identification with his father as a punishment” for his parricidal wishes (p. 233).

In “Beyond the Pleasure Principle,” Freud (1922/1961a) introduced the concept of “repetition compulsion” where patients in psychotherapy repeat childhood relationships in the transference, children repeat life experiences in play, and trauma victims experience repetitions in traumatic neuroses.

### William Niederland

Freud’s description of identification with the dead out of guilt presaged Niederland’s work on what he termed “survivor guilt.” Niederland (1981) described Holocaust survivors who identified with those who were murdered by the Nazis, taking on the appearance of the living dead, feeling as if they were dead because they felt guilty for surviving. Niederland believed survivors felt guilty just for surviving, unlike Freud who thought that Dostoevsky felt guilty because he *wished* his father dead.

### Anna Freud

In her article, “Identification With the Aggressor,” Anna Freud (1936/1966) added “mastery” as a new component in understanding the function of identification in traumatic or anxiety provoking circumstances. She began with a story of her colleague, August Aichhorn, who had consulted on a case where a young boy was making faces at his teacher while being scolded in school. The headmaster felt the boy was either making fun of the teacher or possibly suffered from an involuntary tic. Aichhorn suggested that the grimaces the boy made were a caricature of the angry expression of his teacher and that the boy “tried to master his anxiety by involuntarily imitating” his teacher. “Through his grimaces, he was assimilating himself or identifying himself with the dreaded external object” (p. 110).

Another example of children who identified with the aggressor to master anxiety was a young girl who was afraid of ghosts and ran through the hall in her house, acting like a ghost. She told her little brother, “There’s no need to be afraid in the hall, you just have to pretend that you’re the ghost who might meet you” (p. 111).

Anna Freud described a child who had endured a visit to the dentist, came home, and engaged in aggressive play. Though not specifically playing the role of the dentist, Freud said the little girl identified with the dentist’s aggression. She concluded, “(T)here are many children’s games in which through the metamorphosis of the subject into a dreaded object anxiety is converted into pleasurable security” (p. 111).

### Melanie Klein

Klein (1946/1984a) introduced the term “projective identification” in “Notes on Some Schizoid Mechanisms,” and developed the concept further in “On Identification” (Klein, 1955/1984b). She suggested that the infant could not differentiate the self from the object so that when the bad parts of the self were projected into the object, the infant felt the object was not separate but existed as the bad self. Klein (1946/1984a) asserted that the infant projects good parts onto and into the object as well as bad. Identification with the object after projecting loving parts of the self helped the individual develop good object-relations and helped to integrate the ego. She argued that projective-identification was necessary for

normal healthy development, but that abnormal object-relations developed when unbalanced projection and identification led to weakening and impoverishment of the ego, ultimately leading to schizoid and schizophrenic pathologies.

### W. R. D. Fairbairn

Fairbairn (1943/2002) was particularly interested in the child's repression of and identification with what he called "bad objects," parents who were drunk, quarrelsome, and abusive. He observed that delinquent children in dysfunctional families were very rarely willing to volunteer or even admit that their parents were bad, even though they had no reluctance admitting that they themselves were bad. "The child would rather be bad himself than have bad object," Fairbairn wrote:

(O)ne of his motives in becoming bad is to make his objects 'good'. . . . To say that the child takes upon himself the burden of badness which appears to reside in his objects is, of course, the same thing as to say that he internalizes bad objects. (p. 65)

Summarizing the dilemma these children experienced, Fairbairn said, "It is better to be a sinner in a world ruled by God than to live in a world ruled by the Devil" (pp. 66–67).

Fairbairn explained this repression of and identification with bad objects by suggesting that the child feels more secure being in a sane world, even if it means she has to view herself as bad. He concluded, "Outer security is thus purchased at the price of inner security" (p. 65). Fairbairn was one of the first of several (Foreman, 1986, 2009; Miller, 1985; Summit, 1983) to observe how abused children protect their abusers from external threats such as public ridicule and legal action as well as from their own internal feelings of anger, scorn, and criticism.

### Joseph Weiss

Weiss (1993) illustrated many cases of pathological identification in which patients repeated their parents' negative, problematic behaviors, and feelings in their relationships. He described a man who experienced a lot of shame because he identified with his parents who also experienced shame. Weiss thought the unconscious motivation of the patient feeling shame, as the parents did, was to maintain "his ties to parents" (p. 42). Weiss reasoned if the patient stopped feeling shame, he may have felt guilty that he had lost an important connection to his parents and that would make him sad. Weiss said that this feeling shame in identification with parents was "held in place by survivor guilt," (p. 43) the guilt over doing better than or leaving a loved one behind (Modell, 1965, 1971, 1983).

Weiss (1993) presented another patient who came from a family tradition where everyone sadistically teased everyone else and family members could not express love simply and directly. The patient identified with her parents' behavior and consequently had difficulty expressing love and affection to her boyfriend. She made progress on this problem in therapy and was finally able to tell her boyfriend, "I love you." Immediately after saying that, she felt sadness because she felt sorry for her parents who always teased her and her siblings. Now that she was able to express affection directly to her boyfriend, she felt more disconnected from her parents. She described herself as "cut off (from them), floating in outer space" (p. 43).

Weiss described another patient whose parents were inadequate in their ability to assert authority. As an adult, the patient, like the parents, was unable to make and carry out plans decisively. Weiss suggested that by identifying with the parents, the patient protected his parents' authority by not allowing himself to be more assertive and effective than they were.

In the examples of patients repeating parents' weaknesses, problematic behaviors, or shameful feelings, Weiss explained that pathological identifications resulted from the patients attempting to protect their parents and make them look better than they were. In addition to maintaining a connection and attachment to the parents, these patients would feel guilty if they allowed themselves to outdo their parents or leave them behind. He saw children as strongly motivated by loyalty to protect their parents as well to connect with and maintain an attachment to them.

In Weiss' perspective (Weiss, 1993; Weiss & Sampson, 1986), attachment and guilt are not mutually exclusive motivations but strongly complementary and reinforcing. Because of attachment, patients feel guilty leaving parents behind. Because of attachment, patients also experience the strong affect of fear that if they leave their parents behind, they might lose the connection to the parent who cares for them, which they would experience as catastrophic.

Whereas other attachment theorists (Obegi & Berant, 2008) downplayed the caretaking role of children toward their parents, Weiss emphasized the child's motivation to care for the parent as much as the parent is motivated to care for the child (Foreman, 2009). Weiss and Sampson (1986) noted if children fail to care for their parents by separating and leaving them behind, they might experience separation guilt or survivor guilt. In response to these feelings of guilt, patients might then expect "punishment" (being cut off) that would fit the "crime" (cutting off the parent). Patients who experience separation guilt might consciously experience anxiety that they would be cut off and lose their connection with their attachment figures as a punishment for the crime of separating from the parent. This dynamic might explain the experience of Weiss' patient who felt "cut off, floating in space" when she was finally able to express affection to her boyfriend and separate from her parents.

When Weiss described the role of "guilt" in pathological dynamics (Weiss, 1993; Weiss & Sampson, 1986), he did not assert that conscious feelings of guilt were the only or most powerful affects that influenced behavior. In fact, Weiss emphasized the importance of "unconscious guilt" to explain why patients hold themselves back from a more adaptive path. He observed that patients fear that if they take certain actions, in their estimation, those actions might hurt a loved one. That "guilt" could be thought of more as a "potential guilt" of how the patient *would* feel if the patient hurt the parent. This potential guilt is often not conscious to the patient as guilt because the patient has not done any harm yet. What is more often conscious to patients are feelings of worry and anxiety that their parents might get hurt.

Patients who identify with their parents negative behaviors do not often consciously feel guilty. Consciously, they may feel anxious, unworthy, numb, sad, or ashamed about their own behavior or circumstance, but they usually are not even aware of the guilt they would feel if they did not repeat their parents' pathological behavior.

In Weiss' examples above, patients identified with their parents because they *would* have felt guilty doing things differently than

their parents: (a) not feeling shame like the parent in the first example, (b) not sadistically teasing, or feeling free to express love in the second example, and (c) being decisive in the third example. The guilt Weiss alluded to was the *potential* guilt the patients would have felt if they allowed themselves to surpass their parents.

In addition to identifying, Weiss (1993) also observed that patients *comply* with messages and treatment received from parents, resulting in self-sabotage, inhibition, or self-destructive behaviors. In Weiss' view, compliances occur when patients believe and act according to negative beliefs about themselves that derive from negative parental statements and also what they infer from their parents' negative treatment of them.

Compliances and pathological identifications are both current repetitions of aspects of past pathological relationships with parents or siblings. Both are mediated by what Weiss and Sampson (1986, 1993) called "pathogenic beliefs." In the case of compliances, pathogenic beliefs say that the person deserved the negative experience he or she endured in relation to the parent or sibling. In the case of pathological identification, the pathogenic beliefs say that the parent, who exhibited pathological or hurtful behavior in the past, was really doing the right thing and that the patient would be wrong to act in any other way. In pathological identification, the pathogenic beliefs dictate that the patient would be wrong to do better than the parents, to make parents look bad by having a better relationship with a spouse or child than the parents had with the patient or with each other in the past. Both compliances and pathological identifications have the effect of "making the parents right" and protecting the parents' by undermining the child's sense of justification for feeling scorn and criticism for the parent (Foreman, 2009, p. 89).

The clinician can distinguish compliances from pathological identification by taking a careful history of how the parents treated the patient and each other. If the patient presently continues to play the same role she played as a child, whether helpless victim, or spoiled brat, the patient is complying with pathogenic beliefs about the self, derived from how she was treated in interaction with parents and siblings. If the patient, in his current life, plays the role that the parent played in the past in relation to him or other family members, whether depressed and helpless, abusive or neglectful, that repetition would be seen as a pathological identification, fueled by pathogenic beliefs that he should not or could not act in any other way (Foreman, 2009; Weiss, 1993).

### How Children Self-Sacrifice to Protect Parents

The family therapy literature asserts that children loyally protect their parents at their own expense. Virginia Satir (1967) described the "Identified Patient" (IP) as a child who plays a pathological role to loyally protect dysfunctional parents. The IP is a family member, usually a child, who both absorbs the pain of the parent(s) and serves as a red flag so that other family members can get help. Family members may assign the role of identified patient and scapegoat the child, but the IP also actively participates in playing the sick role in the family. A child, in the role of identified patient, becomes the object of the parents' anxiety and allows the parents' negative expectations to come true. The IP not only takes on the sick role but also the blame for whatever problem exists in the family (Satir, 1967).

Bateson (1972) said that children, in the role of IP, work hard to make their parents seem right. He said they "sacrifice themselves" to maintain the "sacred illusion" that their dysfunctional parents are making sense (p. 237). Searles (1965) and Laing (1972) described schizophrenic patients who sacrificed their own individuality and sense of self to protect their pathological parents and family.

Another manifestation of children taking excessive responsibility and protecting the parents and family is the phenomenon of the "parentified child" (Foreman, 2009; Satir, 1972). In dysfunctional families, parents may switch roles with the child, playing the dependent role while the child plays the adult role, often taking care of the parent and even the other children. The child often ends up feeling like a failure because the parents continue to be dysfunctional and the other siblings do poorly as well, despite the best efforts of the parentified child to save them (Foreman, 2009). Feiner and Levenson (1968) reviewed a vast literature on how children sacrifice themselves and their well-being to protect their families.

### The Role of Empathy, Altruism, and Loyalty

What motivates children to self-sacrifice to protect their parents and families? This article supports the argument made elsewhere (Foreman, 2009; O'Connor, 2002) that children have fundamental abilities, motivation, and even what can be called "drives" to be empathic, caring and protective of their parents and families on a genetic basis determined by natural selection.

Whereas some in the psychoanalytic tradition restrict their definition of "instincts" or "drives" to those of sex and aggression, others, such as Bowlby (1982) included affiliative or attachment instincts as holding equal primacy in human motivation. The developmental psychiatrist, Daniel Stern (1985), argued that "classical libido theory, in assuming one or two basic drives that shift developmentally from one erotogenic zone to another (was not) helpful in viewing an actual infant." He added the "concept of motivation (will) clearly have to be reconceptualized in terms of many discrete, but interrelated, motivational systems such as attachment, competence-mastery, curiosity and others" (p. 238).

Although the genetics of altruism has been debated (Dawkins, 2009; Williams, 2004), there is a large body of work supporting the argument that prosocial, caring, and altruistic behavior is genetically transmitted in humans (Hamilton, 1964; Hoffman, 1981; Slavin & Kriegman, 1992; Trivers, 1971, 1985; Wynne-Edwards, 1962) as well as in animals (Trivers, 1971, 1985).

Trivers' (1971) concepts of "kin altruism" and "reciprocal altruism" helps explain how "altruism" genes may be selected for by evolution even if self-sacrificing behavior puts the individual who carries that gene at risk, because it increases the survival of the gene in the genetically related group or tribe. Hamilton's concept of "inclusive fitness" (1964) describes how copies of an organism's genes can survive "in other individuals and in the resultant future gene pool for the species" (Slavin & Kriegman, 1992, p. 86).

Freud (1915/1957) did not believe that altruism was an essential part of human nature, but thought it was instead a reaction formation against sadism. Darwin (1859/1967, 1871/1981), on the other hand, argued that humans have an evolutionarily derived, genetic basis for altruism and prosocial behavior. Bowlby (1982) wrote that altruistic behavior springs from roots just as deep as egoistic.

Some may argue that prosocial behaviors and altruism result from superego development (Brenner, 1982; Freud, 1923/1961b) or adolescent identification with idealized objects (Blos, 1962). However, developmental psychologists have observed that prosocial behaviors are demonstrated early in life before the development of the superego or the ego ideal. Infants show empathic responses to family members' distress from the age of 10 months and perform caregiving functions by 18 to 24 months (Gopnik et al., 2001; Zahn-Waxler & Radke-Yarrow, 1982). This article argues that loyalty in families is not just based on higher-level learned values and superego development but is based on instincts as fundamental as sex, aggression, and eating.

These caring, protective feelings of children toward their parents are automatic, powerful, often unconscious, and include a wide range of feelings such as love, worry, anxiety, and guilt. They are not primarily a reaction to guilt or necessarily motivated by an attempt to ward off guilt. Ten month-old babies who are distressed by their mothers' distress and 18 month-olds who desperately try to cheer up their mothers are not responding to guilt or trying to ward it off. Their care taking efforts are deep-seated, automatic, and continue to be throughout the life cycle.

Though children are wired to worry and care for their parents, they can also be angry and hurtful. Aggressive behavior in children does not contradict the existence of prosocial, caring instincts any more than celibacy contradicts the existence of sexual instincts. Foreman (2009) described children who were locked in conflict with parents, ending up in the role of "the bad child" in the family. He observed that children can "act angry and blaming, which leads their loved ones to lose sight of their underlying worry and concern" (p. 71). These children who are caught in persistent painful conflict with parents often feel guilty, desperate, and even suicidal.

### Parental Instincts

Consistent with Freud's skepticism about the centrality of altruism in humans, he also disputed the idea that parents had a fundamental instinct to care for their children (Freud, 1914/1948). "Parental love," he wrote, "which is so moving and at bottom so childish, is nothing but the parents' narcissism born again" (p. 91).

In contrast, Kohut (1982) argued that there is a "primacy" in the parent's support of the next generation,

. . . which is normal and human, and not intergenerational strife and mutual wishes to kill and to destroy—however frequently and perhaps even ubiquitously, we may be able to find traces of those pathological disintegration products . . . which traditional analysis has made us think (of) as a normal developmental phase. . . . (pp. 403–404)

Slavin and Kriegman (1992) stated that kin altruism is not a higher-level cortical achievement but is "in all senses, a primitive biologically based wellspring" (p. 97).

Foreman (2009) said "children worry about parents (and to a large degree, siblings) as much as parents worry about children, using the same instincts." (p. 59) Parental instincts that motivate mothers and fathers to sacrifice life, limb, and livelihood to protect and promote their children may be "present from birth and are expressed throughout the life cycle." (p. 59).

### Neurobiology

Empathy, loyalty, bonding, and attachment behaviors have biological, structural, and neurochemical underpinnings. The role of mirror neurons reveals how empathy is not just a learned experience in humans but is partly hard wired in the brain (Iacoboni, 2008). Neurotransmitters and hormones such as oxytocin, endogenous opioids, and norepinephrine mediate attachment and bonding behaviors between parents and children as well as between adults in romantic relationships (Nelson & Panksepp, 1998; Newton, 1978; Swanson, 1996).

Oxytocin is a hormone that is particularly interesting because it plays a central role in aggressive, sexual, and bonding instincts that may seem very different or even contradictory (Foreman, 2011). Oxytocin, a neuropeptide, related to vasopressin, produced in the hypothalamus and released to the posterior lobe of the pituitary, is often called the "attachment" hormone because it is released during sexual arousal and orgasm in both sexes (Neumann, 2008). It is the milk "let-down" factor that is released in the mother in response to the infant suckling or the sound of the infant's cry (McNeilly et al., 1983). It promotes monogamous pair-bonding in mammals (Insel et al., 1998). It also promotes anxiety relief and protects from stress because it dampens the amygdala's response to fear (Kirsch et al., 2005). It increases trust in human relationships (Cardoso et al., 2013; Lane et al., 2013; Theodoridou et al., 2009). It even facilitates bonding between women and their abusive fathers and husbands (Taylor et al., 2000).

In addition to its affiliative sexual and bonding effects, oxytocin also results in aggressive behavior in men and lactating women (Lawson, 2010). Oxytocin has been shown to lead to discriminatory and aggressive behaviors against members of a different clan or tribe (De Dreu, et al., 2010, 2011).

The complex functions of oxytocin help clarify an apparent contradiction of how humans can be biologically programmed to bond and at the same time to be aggressive. Those who question the genetic basis of prosocial behaviors ask, "How can parental and other pro-social instincts be inborn when people can be cruel and commit heinous crimes against neighbors and even against loved ones?" These data suggest that people can be genetically programmed to be loving, protective, and bonded with members of the "in group," usually one's own family or clan, while capable of sadism, murder, and aggression against those discriminated against as the "other." Even within families and clans, members make distinctions between the in group and the "out group." Family members discriminate by favoring "good" kids and targeting "bad" kids as scapegoats. Whereas the capacities to bond and also to be aggressive are both inborn, each person's determination of who constitutes the in group or the other is determined by individual learning and culture (Foreman, 2011; Slavin & Kriegman, 1992).

This article argues that loyalty to partner, kin and tribe is instinctual and evolutionarily determined, and that loyalty to parents is central to pathological identification. Patients are highly motivated to protect their parents, even at their own expense (Foreman, 2009). As Friedman (1985) wrote, "To a degree not generally recognized, psychopathologies are pathologies of loyalty" (p. 530).

## The Role of Repression

Repression, defined here as “the unconscious process of keeping certain thoughts, feelings, and memories out of consciousness,” is postulated to be an important component of children repeating their parents’ maladaptive behavior in pathological identification.

Weiss’ view of repression differed from that of Sigmund Freud (1915/1959a, 1966) who thought that repression was driven by an attempt to hide unacceptable libidinal impulses or wishes. In contrast, Weiss (1993) thought repression was driven by guilt over potentially hurting loved ones and a desire to protect them. Weiss believed that people repress memories, thoughts, feelings, and motivations often to protect loved ones out of a fundamental sense of loyalty to them. He said that a person may hold back from pursuing “certain normal, desirable goals, such as a satisfying career or a happy marriage” because of a concern

... he will endanger himself or others. He fears external dangers such as the disruption of an important relationship, or internal dangers such as a painful affect (e.g., fear, anxiety, guilt, shame, or remorse). . . . He represses the goals he believes to be dangerous, and he inhibits himself from pursuing these goals. (pp. 5–6)

Similar to Weiss, Fairbairn (1943/2002) contradicted Freud’s view of repression. When children repeat their parents’ pathological behavior, “what are primarily repressed,” Fairbairn said, “are neither intolerably guilty impulses nor intolerably unpleasant memories, but intolerably bad internalized objects” (p. 62, italics in the original). According to Fairbairn, children do not want to remember or be aware of the behaviors of their “bad objects” (their abusive or neglectful parents). Instead they repress memories of their dysfunctional parents by “internalizing” or “identifying” with them. This observation is central to the conceptualization of pathological identification presented here.

## Acting Out

Freud (1914/1958) thought that to maintain their repressions, people “acted out” or “repeated” instead of remembered. Fairbairn thought children internalized or introjected their parents’ pathological behaviors rather than remember what their parents did. Fairbairn’s concept of children introjecting parents’ behavior to not remember is analogous to Freud’s concept of acting out to not remember. The difference was that Fairbairn shifted away from Freud’s focus on repressing unacceptable *impulses* to his view that children repress *awareness* of their parents’ dysfunctionality.

Weiss (1993) said that children tend to give their parents absolute authority. They tend to believe what their parents say is true and assume that parents are correct in how they behave. Children idealize parents and “normalize” parental behavior that is pathologic. When children idealize dysfunctional parents, it is a distortion of reality that gives undo credit or credibility to the parent and is also a form of repressing what a child knows or senses to be true. Sounding very much like Fairbairn (1943/2002), Weiss (1993) observed “when in conflict with his parents, (a child) tends to perceive them as right and himself as wrong” (p. 6).

Pathological identification is a way for people *not* to remember their parents’ pathological behaviors (Foreman, 2009). The child repeating behaviors to repress memories and feelings serves to protect parents from the child’s own feelings of anger, scorn, disgust, and rejection that are natural reactions to the parents’

hurtful behaviors. Children avoid their negative feelings that they unconsciously worry could lead them to reject or fail to protect their parents.

This is the thesis of this article in summary: The psychological function of pathological identification with hurtful parents is that it is a form of “acting out,” the unconscious goal of which is to repress the patient’s negative thoughts, feelings, and memories about their parents to protect their parents from the potential hurtful consequences of those feelings and judgments.

## Albert Bandura

Even though this article argues that pathological identifications are “learned” behaviors, it does not suggest that Social Learning Theory (Bandura, 1971) is an adequate explanation for why these behaviors develop or are maintained. The word “learned” is used here in the sense that the child initially witnessed specific parental behaviors and then mimicked them first in childhood and later in adult life. The underlying motivation for the pathological behavior described here is much different than Bandura suggested and more complex than based on simple modeling or learning by observation. Unlike simple modeling, pathological identification is motivated instead by loyalty to family and involves idealization of family members and repression of memories and affects. It also involves self-sacrifice and self-blame.

Most of the learned behaviors Bandura (1971) described were adaptive and not pathological. He did describe some pathological behaviors that might overlap with what this article refers to as “pathological identifications.” For example, he noted that aggressive behaviors were more likely to be learned by those growing up in delinquent gangs rather than in Quaker groups.

Bandura (1971) argued that four subprocesses are required for observational learning of modeled behavior—attention, retention, motoric reproduction of the behavior, and positive reinforcement for the behavior. In other words, for learning modeled behavior to take place, people need to be aware of the modeled behavior, be able to remember it, be able to reproduce it, and then be positively reinforced for the behavior.

This form of learning is not automatic or rote. In Bandura’s view, there is a rational and adaptive basis of observational learning. He noted, “(People) can solve problems symbolically without having to enact the various alternatives; and they can foresee the probable consequences of different actions and alter their behavior accordingly.” This kind of learning reflects “higher mental processes (that) permit both insightful and foresightful behavior” (p. 3).

Social Learning Theory might help explain why children repeat what they see their parents do initially, but it does not explain why children continue to repeat painful, unsuccessful behaviors over time, especially when they become adults and consciously realize how unsuccessful these behaviors are. Social Learning Theory is a rational, reinforcement model. Bandura asserted that behavior is learned before it is performed and it is motivated by expected positive reinforcement before it is enacted. In this regard, Social Learning Theory seems to apply more to nonpathological identifications. Bandura observed, “Because people usually display modes of behavior that are appropriate and effective, following good examples is much more reinforcing than tedious trial and error” (p. 18).

With regard to pathological behaviors, Bandura emphasized that people inhibit behaviors when they see the model's actions punished. Conversely, they repeat the model's negative behavior when the model does not appear to experience any adverse consequences. This adaptive, rational view of modeling does not explain why alcoholics drink themselves to death after watching their own parents drink themselves to death. Nor does it explain why parents beat their children, lose custody, and destroy their marriages when their abusive parents endured the same negative outcome a generation earlier. According to Bandura, modeled behavior that has obvious negative consequences should be avoided in the learning process.

As a rational, reinforcement model, Social Learning Theory also does not account for why children idealize their dysfunctional parents. The delinquent children described by Fairbairn called themselves "bad" while describing their parents as "good" or "normal." Nor does it address the role of guilt and how people punish themselves with self-destructive behavior. It does not speak to the strong pull children have to protect their dysfunctional parents that can lead the child to reverse roles with the parent, self-sacrifice, and self-blame.

Social Learning Theory does not explain why adults abused as children often forget the negative experiences they experienced as children, while idealizing the memory of their parents. Forgetting hurtful parental behavior contradicts Bandura's presumption that observational learning requires not only awareness of the parents' behavior, but *remembering* it as well. In clinical practice, people often repeat pathological behaviors without remembering what their parents did. Not remembering and failing to get positive reinforcement not only occur but are often essential correlates to pathological identification. Not remembering parental behavior is inconsistent with Bandura's Social Learning Theory but it is explained by the role of repression that is postulated to occur in pathological identification.

### Disidentification

It is important to note that many people are able to avoid the pull to identify with a parent's pathological behavior (Foreman, 2009; Johnson & Szurek, 1952) and behave in ways completely different from what their parents did. Some patients "disidentify" and can successfully commit to be different from their parents, which may be adaptive or maladaptive.

In one case, a young, single mother complained that her 2-year-old son insisted on letting go of her hand while crossing the street. She worried for his safety and struggled anxiously but unsuccessfully to hold onto his hand in the crosswalk.

She had been raised by a domineering mother who abused her and her siblings. As a parent, she worked hard to disidentify from her mother. She tried to honor her son's wish for autonomy and let him do things his way whenever possible, so as not to be overcontrolling like her mother. The toddler sensed her dilemma and continued to walk ahead of her, resisting her attempts to hold his hand.

Her therapist helped her to see that the child was testing her ability to set limits and keep him safe. The therapist advised her that she could be more directive with her 2-year-old and firmly hold his hand without worry that she would be abusive and overcontrolling like her mother. Through her efforts to disidentify

with her mother, she created a new problem by being unable to set appropriate limits with her toddler.

### Clinical Examples

The clinical examples that follow will illustrate how patients act out and repeat their parents' pathological behaviors so as not to remember what their parents did to them and avoid negative feelings about their parents. In the course of their therapeutic work, the patients were able to change their behaviors and stop repeating their parents' pathological actions. Sometimes just becoming aware that they were reenacting their parents' behavior was enough to allow them to stop. In other cases, their behavior changed when the therapy allowed them to safely remember what their parents did and they became more aware of their own negative feelings without their parents experiencing harm. All clinical case material has been disguised, with the age, gender, occupation, and family constellation changed to protect the identities of the patients described.

#### The Man With Nazi Genes

William was a 50-year-old dentist who had been married to a woman with a teenage son from a previous marriage. He described coming home from work at the end of the day. As he drove up the driveway, he could feel himself turn from Dr. Jekyll to Mr. Hyde. For no apparent reason, he became hostile and surly, sarcastic and verbally abusive to his stepson when he walked in the door. At the time of our therapy, he was no longer married and no longer saw his stepson. However, he complained that he treated his secretary abusively, in much the same way as he had treated his stepson, and he felt very bad about it.

Before our therapy, William had been in psychoanalysis for 8 years with a well-respected senior analyst whom he had liked and respected. We met twice weekly and for about 4 years.

In his first session, I asked him why he thought he was so mean to his stepson and secretary. He said he believed he had genetic tendencies toward sadism because his mother was of German descent. Basically, he believed he carried "Nazi genes." Because it was in his genetic nature, he felt he had no control and no choice. It was in his bones.

When he gave an initial history, he had only vague recollections about both parents. Gradually, he recalled memories of his father as quite critical and sadistic toward him, his siblings, and mother. It turned out his father's style, transforming from benign character to mean ogre, was exactly the same as he had demonstrated toward his stepson and now his secretary.

Despite his dawning image of his father as scary and hostile, he reported only protective feelings toward his father who was elderly and ill. His mother had passed away and no other siblings were willing to care for his father. As the therapy progressed, he remembered more clearly how badly his father had treated him. As he reported a growing awareness of angry feelings, he reported growing anxiety that he might stop being available to care for his father, which could lead to his father's death because no one else was willing to care for him.

For much of the therapy, William explored new memories and feelings about his father. He also talked about relationships with colleagues and bosses about whom he maintained "polite and

superficial” contact. He never did abandon his father despite his increased clarity and intensity of negative feelings. At the same time, without ever talking directly about his relationship with his secretary, he became more kind and solicitous toward her, which surprised him. Over 4 years of therapy, he developed very warm and caring feelings toward his secretary, and he eventually dispensed with his theory that he carried Nazi genes. His positive feelings and behavior toward his secretary gradually increased at the same time he remembered more clearly how badly his father actually treated him. As he remembered his father more clearly, he experienced and accepted his negative feelings toward his dad, while his fear of abandoning his father decreased.

This case illustrates the importance of recognizing the role of pathological identification. In his first analysis, William dealt with many psychological issues that resulted from his unavailable and rejecting mother, during which time he married and then divorced his ex-wife. However, in that analysis, his “sadistic” behavior with his step-son and then secretary was never considered in light of the possibility that he was identifying with his father out of loyalty. He liked his first analyst very much but he said this issue never arose in that therapy. As a result, he labored under the illusion that he was genetically sadistic and he believed he could never change that part of his life until his pathological identification with his father was recognized and then worked through in his second therapy.

### **The Father Who Did Not Remember Being Abused**

Richard was a very successful attorney in his early 40s, married for 20 years, with two children in private high school. I treated Marc, the older of his two boys for complaints of anxiety and underachievement at school.

An avid sportsman, Richard was handsome and likable. In his history, he remembered his relationship with his parents as ideal and his childhood was only remarkable for how successful he was as a student and athlete.

In his current life, Richard intermittently became enraged at Marc and often humiliated him for his academic failures, viciously calling him a “loser.” Early in the treatment, during an argument with Marc, Richard lost control, leapt across the family room, and punched Marc in his back and shoulders. Marc’s mother jumped in to pull Richard away and broke up the fight. She told her therapist the next day, who reported the incident to Child Protective Services.

Soon after, I met with both parents and Richard was mortified. I asked him if anything like this had ever happened before and particularly, if his parents had ever treated him this way. He said he could not remember any such incidents, and only remembered his parents as friendly and supportive.

Privately, I found that difficult to believe but took him at his word for the moment. I talked about strategies to deal with his angry feelings without violence, when provoked by Marc. A month later, Richard spontaneously told me he spoke with his adult sister about this event. She was working in her own psychotherapy at the time and said she clearly remembered their parents abusing both of them physically and verbally as children. He said he believed her but had no personal recollection of any abuse. Even though he did not remember his abuse, with the support of the therapy and Child Protective Services, he was able to avoid assaulting his son again.

I have treated scores of cases of child abuse and in almost every case the abusive parent was abused in childhood. Richard was unusual in not remembering the abuse at all. In addition to repeating their parents’ abusive behavior, abusive parents usually justify it as correct and appropriate. One abusive parent, when asked how he was disciplined as a child said, “My parents whipped me and they were right to do it.” *Alice Miller (1985)* wrote, “By the time of my therapy, I had grasped the fact that I had been abused as a child because my parents had undergone similar experiences in their childhoods and had learned to regard that abuse as having been for their own good” (p. 8).

### **The Man Who Owed the IRS**

Not all identifications are repetitions of abusive behavior. Charlie was a 38 year-old accountant who recently married and planned to have his first child. He had developed a successful business but had failed to pay taxes for the last 2 years. In the process of giving a history, he told me that his father was a tax attorney who had regularly cheated on his taxes and was caught by the Internal Revenue Service when Charlie was very young, sending the family into financial ruin. His mother divorced his father who left the family in shame, and spent years trying to get out from under terrible debt to the government. Now as Charlie was planning to launch his new family, he was flirting with the same financial disaster that crushed his father by cheating on his taxes.

When I pointed out that he was repeating the same risky, destructive financial pattern that ruined his father, he was completely surprised and amazed at the parallel. As soon as he realized that he was repeating his father’s behavior that created the same dilemma his father had and did not benefit him at all, he was able to change and pay his taxes. Understanding that he was engaging in self-destructive behavior to indirectly protect his father from his own feelings of disappointment in him was orienting and helped him step out of this pathological repetition.

Charlie was an example of pathological identification that was potentially very hurtful to his life but relatively easy to address and correct in therapy. Sometimes, patients can easily step out of potentially pathological repetitions, as Jim was able to stop yelling at his wife, even without interpretation from his therapist. Sometimes pathological identifications are much more difficult to address and are slower to change in therapies with more difficult patients, as in the case of the “narcissistic patient” below.

Charlie’s case was another example of how important it was for the therapist to be aware of the possibility that the patient may be repeating a pathological behavior out of loyalty to a parent. Another therapist might have failed to ask about a history of a similar pattern in his parents’ behavior in the past. Possibly the story of Charlie’s tax evasion might have been viewed by the therapist as a case of “super-ego lacuna” (*Johnson & Szurek, 1952*) or moral failure, rather than as an act of misguided loyalty motivated by an unconscious pull to protect a dysfunctional and suffering parent.

### **The Pothead Who Lied to his Girlfriend**

James was a 27 year-old man who lived with his girlfriend, Ginnie. She was a successful hardworking accountant at a small firm. He was trying to get a business off the ground as a graphic designer. He had a long history of anxiety and a marijuana depen-

dency that he was just becoming aware was holding him back. He was proud of his new efforts to cut back on pot, saying that without pot, he now felt much less anxious, much better about himself, and more confident.

James reported in the last week, he had had a pot brownie and lied about it to Ginnie, who then discovered the lie. She said she did not mind that he had the brownie, but was very disappointed that he lied about it. He saw this as an old pattern that was resurfacing. "I make promises other people don't ask me to make. Then I don't do it. I let others down. Then I get angry for her not believing me."

Spontaneously he went on to say, "Dad is like me. He has a lot of ideas, then doesn't do what he says he will. It lets me down when he does it. He also lies, then gets caught, about things that don't matter." James said his Mom lies too, "But when she lies, she doesn't own up. I'm more like Dad. He always owns up. So do I."

I asked about how he felt about his Dad. He said, "I'm disappointed in him. I feel, 'I don't know why he does this.'"

Therapist: "What's it like to be disappointed?"

James: "It's heartbreaking. He's trying to prove that he's doing something. It makes me sad. I wish I could help him. I see I do the same thing. I have low self-esteem. My Dad has good ideas that do not go anywhere. It's hard to believe he's going to do anything. I feel fed up (with him)."

Therapist: You sound angry at him.

James: I'm more than angry. I'm at the end of my rope. I'll pull away from him. Recently my dad made a promise to help me get clients. Then he let me down. I pulled away from him. I didn't talk to him for three months. I had a nervous breakdown. I was sleeping a lot and I panicked a lot."

James described his dad, like himself, as perpetually underemployed with a longstanding pot habit. He said his father "would rather be a CEO of his own company rather than work for someone else, even if it meant living in his car." James felt he followed his father's lead as an unsuccessful self-employed entrepreneur. He felt he could do better if he could just get a job working for an established company.

I pointed out that he was being like his dad by feeling stuck in his career and dependent on marijuana. Perhaps he was putting himself in the same boat as his dad because he did not want to feel so heartbroken and angry with his dad. At the end of the session, he said, "Thank you, that was a good session." In the next session, he started by saying "I feel more confident. I feel good. What we talked about last week, it is the biggest issue of my life. I've never fully addressed it." In the following week, he reported that he had stopped smoking pot completely for the first time and he had two job interviews scheduled. He said he had more confidence in his writing skills and felt more hopeful about the future than he had ever felt before.

In all of the examples described above, patients suffered because they reenacted exact complex behaviors and attitudes that their parents had displayed. Their identifying behaviors, in each case, served to mask and disguise the scorn and shame they felt toward their parents. Instead, these patients were primarily aware of

feeling shameful, angry, and pathetic about their *own* behavior and invited others to feel that way about them too. Most were aware of feeling a mix of scorn, sorrow, and worry for their parents that they tried to suppress because the negative feelings made them feel bad. For example, James said he was "more than angry" at his dad, avoided him, then had a "nervous breakdown," panicked, and finally slept excessively, clearly uncomfortable with the emerging negative feelings toward his father.

All of the patients in these examples were initially unaware they were repeating their parents' behaviors but found it intriguing and helpful to learn that they were. They were all able to change their behavior eventually. One just needed to be told that he was repeating a problem his parent had. Some needed to face their negative feelings toward their parents and see that their parents would not be damaged by those feelings.

In each of these cases, the therapist was alert to the possibility that patients might be repeating their parents' pathological behavior and brought it to their attention by interpreting and exploring. This article does not assert that therapeutic technique relies solely or even predominantly on interpretation, but that recognizing that the patient may be repeating a parent's pathological behavior is an important first step.

The therapist in the above cases was highly influenced by relational theorists (Erikson, 1968; Fromm, 1941; Guntrip, 1971; Kohut, 1971, 1972; Sullivan, 1953; Weiss, 1993; Winnicott, 1965), who believed that the most powerful helpful element of psychotherapy was the relationship. The research of the San Francisco Therapy Research Group found that the therapist's ability to form a relationship, become an ally, and promote the patient's healthy agenda or "plan" was the most powerful predictor of immediate gains in multiple measures of patient improvement and in long term outcome (Weiss, 1993; Weiss & Sampson, 1986).

In the case examples above, the therapist created a therapeutic alliance by being caring and respectful, responding supportively to specific patient tests, and trying to further each patient's case-specific therapeutic goals. The purpose of this article is to illustrate the importance of the therapist recognizing, interpreting, and then exploring pathological identifications, which led to patients overcoming long-standing pathological patterns of behavior in each of the cases presented above. The next case illustrates a therapy with a difficult patient, in which the therapeutic relationship was the predominant therapeutic tool and interpretations by themselves were much less effective.

### The Narcissistic Patient

Robert was a 45-year-old man who also demonstrated the pattern of identifying with a pathological parent out of loyalty. His therapy was characterized by his extreme emotional vulnerability and his tendency to be harsh and reject his family members as well as the therapist. This therapy took place over a 15-year period at a frequency of 4 or 5 hr per week for the first 10 years.

Robert was a wealthy, divorced father of three who grew up with a mother who treated him as an outcast. He always felt she hated and rejected him. At family dinners, she seated him far away from her. She was always late picking him up from school activities and then berated him if he complained. If he ever made her wait for him, she yelled at him mercilessly.

His most painful memory was when he was 14 his mother planned an exotic family trip to Africa. The day before the family left, she told him he had to stay home with the nanny to take care of a younger sibling while she and the father took the older children.

If Robert ever complained about mistreatment, his mother viciously attacked him for being the problem. Even his father complained that Robert was not trying hard enough to get along with his mother. The other siblings all agreed that Robert was the difficult kid. Even as an adult, if Robert ever complained about his mother being unfair, the siblings would wink at each other and say how difficult he was. "What do you expect from Mother?" they would ask, as if there was something wrong with him for expecting too much from her.

Even though Robert complained his mother put certain social conventions such as manners and styles above her connectedness with him, he repeated the same pattern as an adult. Her house was perfect. As an adult, his house was perfect. Manners at the dining table were hugely important to his mother growing up and he made that a priority with his children. His mother would never take the kids to McDonalds or Burger King. As an adult, Robert similarly condemned fast food as "below his tastes."

Each of these details about tastes and manners does not necessarily represent pathology or even an identification with his mother as each may represent an appropriate judgment (e.g., about fast-food restaurants or table manners). However, taken together with Robert's larger pattern of critical judgmentalism, the details of his rules and tastes that he imposed on his children with the same haughtiness he disliked in his mother, who favored appearances over her children's feelings and desires, suggests a pathological identification.

In addition to the many specifics of his mother's narcissistic style that Robert reenacted, the most striking parallel with his mother was how he targeted his middle son, Todd, as "the difficult kid." That was the same role Robert had been assigned as a child and even as an adult.

As a parent, Robert tried hard to be a good parent, generous, supportive, and understanding. He tried to accommodate Todd, but ended up screaming at him all the time. No matter how hard Robert tried, Todd seemed difficult and Robert felt defeated. Todd became singled out at the problem child. Some of Robert's feelings were a natural reaction to Todd's personality and temperament that any parent might have experienced as difficult. This article argues that a major part of the pattern was determined by Robert's unconscious pull to "see" Todd the way his mother saw him as a child and to repeat the pathological relationship with Todd that his mother had with him.

The therapy with Robert was complicated and intense. Sometimes he talked about his relationships with his children, his parents, his ex-wife, his friends, and work. Sometimes, he threatened to end the therapy because I was not good enough for him. On a few occasions, he invited me to end the therapy by calling me repetitively at home in the middle of the night, or refusing to leave the office at the end of the session. He criticized, rejected, blamed, and once yelled obscenities at me so loud that therapists at the other end of my building called to complain. He set up consultation therapy sessions with my colleagues to complain about me.

This was not a therapy where a few well-placed interpretations carried the day. Most of the therapeutic work was in our relation-

ship. I had to set limits by threatening to end the relationship if he did not stop harassing me at home. I had to threaten to call the police when he refused to leave my office at the end of a session. I continued offering to work with him as long as he respected my boundaries, even though he continued to tell me how bad I was and that I had not helped him "lately."

Weiss (1993) said that patients actively engage the therapist by repeating traumatic relationships from their past in the therapy. Weiss saw these repetitions as adaptive in that they offered the patient opportunities to get better by helping to undermine what he called "pathogenic beliefs," a concept similar to Beck's "schemas" (Beck, 1976) or Bowlby's "working model" (Bowlby, 1988).

Weiss said these repetitions occurred in two ways: transference and passive into active repetitions. He saw these repetitions as "tests" of the therapist. In a transference test, the patient repeats a pathological relationship or dilemma from childhood with the therapist putting the therapist in the role of the traumatizing parent. By repeating the painful relationship in the transference, the patient unconsciously tests what the therapist will do. If the therapist does not repeat the traumatic behavior that the parent exhibited, the patient can start to feel more deserving of better treatment and start to undermine pathogenic beliefs about how bad the patient must have been as a child and still believes to be as an adult. In Robert's case, he invited me to reject him and revile him the way the mother did. My not rejecting or abusing him helped undermine his belief that he was such an evil, difficult, and defective human being.

The second type of testing Weiss (1993) described in psychotherapy was when patients treat therapists the way their parents treated them, called turning "Passive into Active" (Foreman, 1996b). This type of patient behavior in therapy is also seen as adaptive in the service of the patient unconsciously trying to get better. In Robert's case, he yelled at me, found fault with me, made me feel responsible for his suffering and his bad behavior in the same way that his mother treated him. By the therapist not being traumatized as badly as Robert was, by not developing the same pathology that Robert did, Robert was able to gradually identify with the therapist's relative strength and resilience. The technique for dealing with passive into active testing was described in more detail elsewhere (Foreman, 1996b).

In Robert's therapy, dealing with these painful repetitions of early pathological relationships was a central dimension of his getting better. Sometimes interpretations were clarifying but much of the therapy with this difficult patient was conducted without interpretation. Once, as Robert was leaving the office, he said, "How can you stand me? Aren't I the most difficult patient you have ever treated?" Another time he asked, "Why am I doing these horrible things?" I suggested that he was repeating the terrible things that were done to him, sometimes playing the role he played as a child, assuming I was mean and hated him like his mother (in the transference) and sometimes doing to me what his mother had done to him (turning passive-into-active). I suggested he was doing it not because he was a terrible person but because he was trying to understand what happened to him and to find a way to feel better about himself.

In relation to his son, Robert's was very distressed that he acted so badly toward Todd. He also felt bad when he acted haughty or demanding with others in his life such as friends, relatives, or coworkers. He was both relieved and threatened by the idea that he was repeating what his mother did with him.

Initially, when I suggested he was repeating his mother's behavior as an identification, he reacted negatively because he worried that I was saying he *was* his mother and that he *had* to act like her. This misunderstanding reflected his conviction that he did not have a choice. Often, when people identify with their parents, they feel that they could not be any other way. Over time, he found it a useful concept that he was repeating much of his mother's narcissistic, self-centered behavior as an homage to her. This insight helped clarify his longstanding distorted belief that everything in the relationship with his mother that went wrong was really his fault because he was the "difficult" child and she was the "perfect" mother.

Over the course of a long and difficult therapy, he was able to dramatically change how he related to his son. He became much less self-punitive and much less punitive toward Todd over time. I had Robert's permission to speak with Todd's therapists during the course of our therapy and that confirmed significant improvement in Todd's personal growth as Robert's behavior improved.

Over the course of therapy, his own level of personal pain diminished almost completely and he felt great improvement in his relationships with siblings and at work. As a consequence of talking, but also re-experiencing these feelings and behaviors in the therapeutic relationship, Robert was able to eventually understand that he did not deserve to be treated the way he was treated by his mother, and he was not obligated to repeat the abusive relationship with his son.

The therapist's ability to stay in the relationship, to like the patient, to stay connected, and to not believe the patient's worst beliefs about himself helped the patient disconfirm his own worst fears. Over time Robert was able to identify with the therapist's capacity and strength to not be damaged by his abusive behavior in the way Robert had been damaged by his mother's abusive behavior. He was able to internalize the therapist's ability to view him as a human being with feelings and a psychology, rather than as the monster Robert thought he was.

### Implications for Therapy Technique

The formulation that pathological identification serves to repress certain thoughts, feelings, and memories to protect the patient's dysfunctional parent(s) suggests a certain therapeutic strategy that can help patients relinquish those unnecessary and unsuccessful behaviors.

#### Step 1: The Therapist Needs to Recognize the Behavior as a Repetition When It Is

Not all pathological behaviors are repetitions of pathological parental behaviors. Patients exhibit pathological behaviors for many reasons and as a result of a wide array of biological and psychological vulnerabilities. However, when patients do repeat problematic parental behaviors as pathological identifications, therapists need to be alert to that possibility, consider it, and explore it.

William, the man who thought he had Nazi genes, had been in psychoanalysis for 8 years before our therapy with a very experienced analyst whom he felt helped him. The analysis focused on his marriage and his troubled relationship with his mother. Even though William raised the issue of his "sadism" toward his son and

secretary many times with his analyst, the analyst never considered the possibility that this behavior represented a pathological identification with his father. The analyst never expressed and probably did not share the idea that William acted like his father as a way to repress his awareness of his father's abusive behavior to protect his father from his own judgment.

Often it is not easy for the therapist to recognize when the patient's complex pattern of pathologic behavior is a repetition of a parent's problematic behaviors, feelings, and attitudes. As evidenced in the clinical examples, patients are not aware they are repeating their parents' behavior. They do not consciously tip the therapist off. Because the unconscious purpose of patients reenacting their parents' mistakes is to take the heat off their parents and put it on themselves, patients are psychologically motivated *not* to see the connection with their parents' behavior.

Patients often present to therapy with very negative theories about themselves, that they are selfish, evil, and hateful, examples of what Weiss (1993) called "pathogenic beliefs." Consciously, they often believe *they* are the problem and their parents are ideal and perfectly acceptable, as did the delinquent youths that Fairbairn treated (Fairbairn, 1943/2002). Patients can be so convincing about how bad they are that their therapists may buy into their negative views immediately and fail to look under the surface for the psychological reasons why these patients present themselves as such bad apples.

To recognize that a family pattern might be repeating, the therapist should take a careful history and ask generally about the patient's relationships with each parent growing up. Whenever there is a problematic behavior, the therapist should explore where it might be coming from. Is the behavior familiar to the patient? When did it start? Did anyone in the family such as a parent or a sibling do this with anyone else? Did father or mother treat all the kids this way or just the patient? How did the parents treat each other? The therapist should explore whether the patient's pathology may represent an unconscious repetition of a pathological relationship from the patient's family of origin.

Although pathological identification as formulated in this article is not present in every case, it is common and often missed as in the case of William's first analysis. It is the intent of this article to invite clinicians to explore the possible role of pathological identification in the differential diagnosis of what is causing a patient's pathological behaviors in every case, particularly when the patient's problematic behaviors persist despite the therapist's best efforts in other therapeutic interventions. The important role of repetitions of pathological relationships in the form of compliances and identifications is one of the major contributions of Weiss' theory (Foreman, 2009; Weiss, 1993).

#### Step 2: The Therapist Comments That the Behavior May Be a Repetition

People are pretty good at pattern recognition so when the therapist observes that the patient is repeating a familiar pattern, it is often easy for the patient to grasp and even find it a little intriguing. The exactness of the repetition makes it clearly not coincidental. William was nasty and surly in exactly the same way his father was. James had a problem with marijuana, was floundering in his career, and got caught lying about things that did not matter in exactly the same way his father did.

Though recognizing the pattern of repetition is easy, patients often struggle with the question of “Why? Why would I repeat such a problem that my parent had? Why would I do something so stupid?” As in the case of Robert, hearing that he might be repeating his mother’s behavior was very threatening because he already incorrectly assumed that he was, had to be, and was destined to be like his mother. Especially with more disturbed, borderline patients, merely pointing out that the patient is repeating a parent’s behavior may leave the patient feeling accused of being just like the hated parent, often the patient’s worst fear.

By interpreting a patient’s pathological identification, quite the opposite, the therapist is trying to point out that the patient is *not* the parent but is *acting* like the parent. Furthermore, the therapist’s message is that patients actually have the ability and the right to not behave like their parents. Patients are so absorbed in their belief that they are terrible, and so motivated to *not* see their parents’ role that it is often initially incomprehensible that they do not *have* to act this way. Because, the whole discussion can be scary and easily misunderstood, the therapist should go slowly and interpretations should stay close to what is obvious to the patient.

### Step 3: The Therapist Explores the Patient’s Feelings About the Parent’s Original Problematic Behavior

Because the unconscious purpose of repeating the parent’s maladaptive behavior is to repress feelings and to protect the parent from the patient’s anger and potential rejection, it is important for the therapist to help patients face their own negative feelings about their parent when they are ready, and see that their parents will survive anyway. When William was able to face his angry feelings toward his father who had been cruel to him without abandoning or killing his father, he was able to stop being abusive to his secretary.

Initially, it was too threatening to encourage William to focus on his negative feelings toward his father or even look at his father’s abusive behaviors directly. After all, those were the very feelings and memories that William was trying to forget. William, however, was able to hear the therapist reflect what William had already told him, that William was worried about and protective of his father. That idea was not threatening to him. It was true and it was already obvious to him.

The view of William as protective and caring of his father helped contradict his negative self-image that he was inherently mean with Nazi genes. It helped William feel safe that he was not going to be judged by the therapist. He was also reassured that the therapist was not going to attack his vulnerable father or insist that William attack or abandon his father.

Patients show a range of abilities to face negative feelings toward their parents. Some are in complete denial and have no awareness of negative feelings. Others appear quite comfortable denigrating their parents. In the author’s experience, even those who seem more comfortable criticizing or thinking ill of their hurtful parents still struggle with those feelings. In healthier families, children are freer to criticize their parents because their parents are strong enough to tolerate it. In more pathological families, as in Robert’s case, children find out that their narcissistic or vulnerable parents cannot stand being challenged or criticized. For that reason, children in sicker families are more vulnerable to identifying with their dysfunctional parents.

### Step 4: The Therapist Points Out How Identifying Protects the Parent

Because William was already aware that he was worried about his father, it was not too much of a leap for the therapist to suggest that William’s worry and concern may make it difficult for him to be critical of his father. William spontaneously produced new confirmatory material saying that he worried he might abandon his father if he became too angry about how his father had treated him. He elaborated that this was particularly problematic since his other siblings had dropped out of the picture and he was the only one left to care for his father in his decline.

Once the pattern was clear that William repeated his father’s odious behavior and that he was highly motivated to protect his father, the last connection could be made that William was repeating his father’s behavior to protect him. Repeating his father’s behavior could be described as “putting himself in the same boat” as his father. As a result, he would no longer feel superior to his father. He would no longer have any right to be critical of his father since after all, he was just as bad as his father. Now, the therapist pointed out, William’s focus turned to how bad *he* was rather than on how bad his father had been. The last step was to help William accept and further explore his own negative feelings toward his father gradually and safely so that he could retain his compassion for his father while letting himself face angry, rejective, and noncompassionate feelings at the same time.

The therapist’s technique should be to start with the patient’s memories and associations and explore feelings about those memories. The therapist should go only as quickly as the patient allows and should never impose theories and hypothetical experiences on the patient that the patient does not confirm with real memories and feelings. Interpretations should be offered and not imposed. As the patient feels safe to remember more and allow feelings about those memories (without damaging the parent, the therapist, or the self), the patient will move forward and allow greater access to more memories (Weiss, 1993).

Sharing with patients that they are really trying to protect their parent at their own psychological expense may be relieving in general but paradoxically may also be anxiety provoking to some patients because it contradicts their fundamental theories of themselves as selfish and evil. Guiltier patients and patients who have been highly traumatized may have a very difficult time giving up pathological identifications and feeling better. They may feel guilty seeing themselves in too much of a positive light. If they are not so bad, it means their parents are not so good. Patients may become anxious starting to see their parents in a more negative light because it could lead to greater awareness of their own negative feelings and provoke concern they may reject their parents.

The same four steps were useful with each of the patients described above. The therapist (a) noticed the patient was repeating a parent’s problematic behavior, (b) pointed out the repetition pattern to the patient, (c) explored the patient’s feelings about the parent’s original behavior, and (d) explained that the patient was protecting the parent by repeating the parent’s behavior rather than feel negative feelings about the parent. In all of the cases, patients were able to stop repeating their parents’ dysfunctional behavior.

In the case of Charlie, the man who cheated the IRS, just hearing that he was repeating his father’s behavior was enough to get him

to stop. He did not fully understand why he was doing it but it was clear he was repeating his father's behavior and consequent dilemma. He rectified his tax problem immediately as soon as he realized it.

Richard, who was abused and who abused his son, never remembered what his own father had done or how he felt about it but he believed his sister that it happened. He was able to stop abusing his son with the support of his therapist, Child Protective Services, and the understanding he was repeating his father's abusive behavior that served no positive purpose.

James improved immediately upon hearing that he was repeating his father's negative patterns of pot smoking, lying, and professional underachievement. That session was a turning point that freed him up to stop smoking pot completely for the first time in 15 years. He also made dramatic progress toward getting a good paying job after floundering for his entire adult life.

William's therapy took 4 years at a frequency of twice a week. He needed to experience his warded off negative feelings toward his father and realize that his father would not be damaged. He was able to relinquish his abusive behavior toward his secretary without even focusing on his relationship with her. His therapeutic work was achieved by lifting his repressions about his feelings and memories about his father.

In Robert's case, talking about the dynamic understanding of his identification with his mother was somewhat orienting but much less useful to him than it was in the other cases. Even though interpretation was not a central feature of the case, the therapist's understanding what motivated Robert was extremely important to Robert's improvement. Robert invited the therapist to see him as a bad person, "trouble," even "a monster." He certainly acted that way. But the therapist held a different view of Robert that he was complying with the "bad kid" role and identifying with the specific abusive and rejecting behaviors that his mother exhibited toward him. This formulation guided the therapy and eventually led to Robert giving up his view of himself as a monster and relinquishing his abusive, rejecting behaviors to his family members, particularly Todd.

### What Is New About This Formulation and Technique

This formulation moves away from standard conflict theory (Brenner, 2006) in that the repression that is central to pathological identification does not primarily represent a defense against an *impulse*. Instead, as Fairbairn reasoned, children repress not an impulse to hurt the parent but an awareness of the "badness" (Fairbairn's term) that was in their parents. Children repress awareness of hurtful things the parents actually did (in reality) to promote and protect their parents from multiple real threats, including the consequences of their own feelings of hurt, anger, and disdain. This formulation appreciates the primacy of reality over fantasy in the origins of symptoms (Sampson, 1992; Stern, 1985) and the primacy of attachment drives of children caring for their parents over the child's aggressive or sexual drives toward the parents (Bowlby, 1982; Slavin & Kriegman, 1992; Stern, 1985).

This article argues that compromise formations (Waelder, 1936) resulting in pathological identifications could be reconceptualized. Instead of viewing the fundamental conflict, as Freud did, between id impulses and superego prohibitions (Freud, 1923/1961b), these compromise formation could be viewed as an attempt to resolve

the conflict between two different fundamental drives: one drive "to *promote one's own needs and wishes* and another equally powerful conflicting drive to *promote the needs and wishes of other people in the family.*" (Foreman, 2009, p. 60)

There are other views of pathological identification in the literature that reflect different assumptions about motivation and defenses than are represented in this article. Williams (2004) argued that pathological identifications result from the incorporation of primitive characteristics of the object and a failure to contain projections. Sohn (1985) suggested that pathological identification could arise via projective identification with the defensive purpose to avoid awareness of envy as well as awareness of dependence. The purpose of this article is not to critique or debunk these other views of pathological identification but to introduce an alternative explanation that deemphasizes the drive/defense model of psychopathology and points more to a relational/attachment model of motivation. Instead of defending against envy or perceived dependence, this article argues that when patients pathologically identify with their parents, they are defending against their own potential behaviors or feelings they unconsciously perceive might ultimately threaten their parents or families.

The implications for therapeutic technique are quite different based on this formulation. Instead of assuming and interpreting the patient is repressing aggressive impulses toward the parent, the therapist can help the patient appreciate how protective and caring the patient is toward the parent. This allows the patient to feel safe enough to face scary, negative feelings about how the parent actually acted in reality.

William, who thought he had Nazi genes, already was convinced he had sadistic impulses toward his step-son and secretary. If the therapist presumed and interpreted that William was identifying with his father to defend against sadistic impulses toward his father, it would only confirm William's worst fears that he was inherently sadistic. That would only reinforce his identification with his father and strengthen his abusive behavior. This may have been the problem with his initial psychoanalysis where his analyst may have inadvertently strengthened William's pathogenic belief that he was sadistic rather than helped him relinquish it.

The interpretive line that helped William let go of his pathological identification with his father allowed him to see how protective and caring he was toward his abusive father. Only after he felt safe that he was not going to hurt his father, could he start to face how angry and disappointed he was in his father and remember how his father had treated him. When he could remember and see his father's abusive behavior more accurately without his father being hurt, he was able to let go of his own abusive behavior toward his secretary and others.

### Summary

Pathological identifications are a common source of patient suffering that interfere with healthy relationships in every setting. Sometimes patients who are most recalcitrant to change are locked in intense repetitions of their parents' problems and are not aware of it. Pathological identifications are maladaptive to the couple, to the child, and to the patient. Their origins can often be clearly seen in earlier relationships between the patient and parent(s), or between the patient's parents, but only if the therapist thinks to inquire about them.

There is an incorrect maxim often quoted by therapists that patients must be getting some gratification out of their behavior or else they would not be doing it. This idea that there is always primary or secondary gain to pathological behavior was challenged by Weiss (1993) who noted that patients often hold themselves back or punish themselves out of guilt toward loved ones who have suffered. In these examples of pathological behavior, the only “gain” is the avoidance or relief of guilt, which is not the same as gratification. The idea that patients slavishly repeat miserable patterns of behavior out of guilt and misguided loyalty is a different explanation of behavior and is a significant contribution of Weiss’ model of psychology.

Talking about change and relinquishing pathological identifications indirectly gives patients permission to step out of negative behavior patterns that they often feel obligated to repeat. They expect punishment and judgment and they often see themselves hopelessly trapped and doomed by fate or bad genes. When the therapist talks about the patient’s misguided loyalties and protecting parents by repeating their mistakes, it gives patients a sense of power and agency they did not believe they had.

Sometimes change is slow and the patient’s negative behavior may continue. Patients may be afraid to face memories and feelings they have long repressed. They may feel guilty getting better too quickly even though they are motivated to do so. They may feel guilty solving their problematic behavior and looking good while their parents never changed. Because of the patient’s fear or guilt, the therapy may need to progress in a gradual, step-by-step fashion.

Therapists may need to be patient in the face of the patient’s intransigence. Patients may turn passive-into-active and do to the therapist what their parents did to them (Foreman, 1996b; Weiss, 1993). Patients may fail to change in the face of their therapists’ best efforts in the same way their parents failed to change in the face of their own best efforts as children to help them. In many dysfunctional families, children poured alcohol down the drain while their parents went out to buy more. Kids begged their mothers to leave abusive husbands and the mother could not leave. These children may grow up to be our patients, drinking hopelessly in front of us or suffering in abusive relationships they will not leave. It is useful to remember Marsha Linehan’s concept of the dialectic, that therapists must *want* the patient to get better without *needing* the patient to get better (Linehan et al., 2001). Otherwise therapists will be tortured and defeated by the same guilt and frustration that tortured our patients when they were children.

Despite the patient’s guilt about progressing, Weiss (1993) argued that patient’s are highly motivated to get better. If the therapist stays attuned to the patient and supportive of the patient’s drive toward health, even very disturbed narcissistic and borderline patients like Robert can show dramatic improvement over time. Understanding the role of pathological identifications can help therapists read their patients better and allow a compassionate treatment approach that will facilitate disturbed patients to step out of pathological repetitions.

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