# Freeing Oneself From Pathogenic Adaptations: A Contribution to Control-Mastery Theory

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*Control-Mastery theory, proposed by Joseph Weiss, is receiving increasing acceptance among psychotherapists. Two main tenets of the theory are that psychopathology is caused by* pathogenic beliefs, *ideas about oneself and the world which interfere with healthy functioning, and that people attempt to* disconfirm *these beliefs by testing their validity in their interactions with the therapist. I suggest that pathogenic beliefs are more accurately and profitably seen as pathogenic* adaptations, *modes of acting, thinking and feeling which seem required of them by others. I also offer a modification to the testing paradigm called* passive-into-active *testing. Both of these changes make the theory more powerful, improve its internal consistency, and make it easier to apply.*

**Introduction**

Control-Mastery theory is a relatively new, powerful approach to psychodynamic psychotherapy proposed by Joseph Weiss and further developed and researched by Weiss, Sampson, and the San Francisco Psychotherapy Research Group (1986). The theory offers a comprehensive view, based on a few central ideas, of how psychotherapy works. These include the ideas that psychopathology is a result of early experience, that people are healthy by nature (there are no inherent unconscious conflicts), that people are motivated to overcome their problems (resistance in therapy is only apparent, never real), that people will relinquish their pathological behavior as soon as they find it safe to do so, that patients *test* their therapist in the hopes of finding this safety, and that the task of the therapist is to provide the safety for healthy behavior which the patient seeks to acquire. A growing body of research is providing support for these ideas (e.g., Weiss et. al., 1986; Fretter, 1984; Broitman, 1985; Norville, 1989; Davilla, 1992; Silberschatz and Curtis, 1993).

One of the central concepts of Control-Mastery theory is that of *pathogenic beliefs*. These are held to be maladaptive beliefs acquired in early life which are responsible for psychopathology. Patients are seen as coming to therapy in the hopes of *disconfirming* these beliefs. Control-Mastery theory also has elaborated the idea of *testing* in therapy. Two major testing paradigms have been identified: *transference* testing, in which the patient adopts the role of the child and puts the therapist in the role of the parent, and *passive-into-active* testing, in which the patient adopts the role of the parent and puts the therapist in the role of the child. In this article I suggest changing the concept of pathogenic beliefs to that of *pathogenic adaptations*, replacing the idea of "disconfirming a pathogenic belief" with the formulation that a person is seeking the safety to discard a pathogenic adaptation, and extending the idea of passive-into-active testing to show its similarity to transference testing in its nature and purpose.

**The Nature of Pathogenic Beliefs**

Control-Mastery theory holds that the causes of psychopathology are pathogenic beliefs, invalid and dysfunctional concepts of oneself and others acquired during our formative years which interfere with healthy interpersonal functioning (Weiss, 1993).(For example, a person who is neglected by parents during childhood may come to believe he or she caused and deserved the neglect, and may find it hard to attract and enjoy others' attention in adulthood. The idea that the person caused and/or deserved the neglect would be seen as a pathogenic belief. As another example, someone who was attended to by a parent only when he or she was serving the parent's needs may come to believe that it is important to be attuned to others' problems, and may not be able to act easily in his or her own healthy self interest. In this case, the notion that one must attend to the needs of others to one's own detriment would be a pathogenic belief.) A central principle of the theory is

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that people are motivated to overcome their problems, and that they come to therapy in the hope, often unconscious, of disconfirming these beliefs in order to be freed from their constraining effects. It is proposed that patients have a plan, which is a flexible, general strategy, largely unconscious, for their therapy, by which they hope to accomplish this end.

The concept of disconfirming pathogenic beliefs is powerful, but it is inherently contradictory, for if someone holds a belief, what would make them seek to prove it wrong? One must at least suspect that a belief is not true in order to try to disconfirm it. If a belief is suspected to be untrue, what then does it mean to call it a belief? Thus, the use of the term belief in this context is not fully accurate. Further, if the person does not actually believe the concept, what are they trying to accomplish in attempting to disconfirm it?

As an attempt to address this issue, it has been proposed that the person holds two contradictory beliefs at the same time, one healthy and one unhealthy, and is motivated to eliminate this contradiction for one of two possible reasons: either the person tries to adopt the healthy idea and abandon the unhealthy one out of an inherent motivation to move toward psychological health, or they wish to eliminate the cognitive dissonance resulting from simultaneously holding two contradictory ideas (S. Foreman, personal communication, Nov. 11, 1994). I find it logically impossible to conceive of someone simultaneously believing in two mutually contradictory ideas. It negates the very meaning of the term *belief* ("something accepted as true"). When someone does momentarily try to accept two contradictory ideas as true, the result is mental paralysis or confusion. Further, this formulation does not do justice to the plan concept, which is fundamental to Control-Mastery theory. The plan concept holds that the person has healthy goals which they are trying to achieve, implying that the healthy beliefs are fundamental.

In considering these issues I have had to reformulate my definition of a pathogenic belief, and I have concluded that in essence it is not a belief but a *pathogenic adaptation* to an unhealthy interpersonal environment. Pathogenic adaptations are patterns of functioning a person has adopted to cope with his or her interpersonal environment which prevent the person from being fully themselves. Although these adaptations limit the person's functioning, they are assumed to have had some survival value which caused them to be adopted. Control-Mastery theory has considered their advantage to be the preservation of one's ties to one's caregivers, upon whom survival ultimately depended. However, to the extent that we believe our caregivers require pathological behavior of us, *our* ties to *them* are weakened. We feel less trusting, safe, and connected to those who harm us. (The damage to the ties we have to them can be repaired when, through a change of circumstances or psychological growth, they are no longer a danger to us.) The survival advantage of pathogenic adaptations is that they tend to preserve the *caregivers'* ties to the *child*. Since the child's survival depends on how willing caregivers are to take care of them, anything that makes the caregivers less likely to care for them is threatening. Therefore, to the extent the child believes that certain behaviors make the caregivers feel less connected to them and less well intentioned towards them, they tend to relinquish those behaviors. This tendency to relinquish healthy behaviors and adopt unhealthy ones is balanced by the child's attempt to hold on to as much healthy functioning as possible. As a result there is a constant weighing of the advantages and disadvantages of each adaptation, each giving-in or fighting back, with the person trying to do the best they can for themselves.

For example, suppose a child's parent is threatened by the child's assertive behavior. To the extent that the parent's good will toward the child was weakened by the child's assertiveness, the child would be motivated to become less assertive with that parent. This would not be a pathogenic adaptation at this point, for it has survival value for the child in relation to the parent. But if the child makes it a general hypothesis for interpersonal interactions, i.e., "I should not be assertive with others because it threatens them and they will punish me or withdraw their support for me if I do," it then becomes a pathogenic adaptation, since this person is likely to feel anxious and act unassertively whenever they are faced with a situation which requires an assertive response. This generalized hypothesis for predicting interpersonal events is what has been called a pathogenic belief. I am suggesting that it is not actually a belief but an hypothesis about how the interpersonal world works in which the person does not fully believe, since the person hopes to find a way not to be governed by it and is actively looking for evidence that they do not have to conform their behavior to it. Rather than a belief, it is more like a law which they fear to disobey but whose validity and morality they do not accept.

Rather than adopting the pathogenic adaptations formulation, the pathogenic beliefs concept might be defended by proposing that a person may hold competing beliefs if they are held with varying degrees of conviction, or at different psychological levels. In this case, the idea would be that the pathogenic belief is superficial, an adaptation to the unhealthy needs of important caregivers, while the healthy belief is fundamental, an inherent, necessary belief of a healthy organism. This would account for a person's healthy

motivations despite the presence of pathogenic beliefs. Such a formulation might be workable, but it is convoluted. It proposes a somewhat superficial belief in which the person does not "really" believe, and a more fundamental belief which is "fully believed". This becomes rather strained, especially if we take the word "belief" to mean "something accepted as true." In addition, this model does not clearly differentiate between what a person truly believes and what they have been required to accept as if they believed it. Someone who has been through brainwashing, or has been indoctrinated into a cult, may profess to believe many things which are at odds with the person's entire earlier life. Does this person really *believe* these things? I suggest the word *belief* is not appropriately used to characterize such statements, nor does it apply to the self-defeating notions people found they were required to accept as children in order to survive perilous situations.

Pathogenic adaptations may be thoughts, feelings, and/or behaviors. As thoughts, they may be injunctions (e.g., "I must...," "I must not..."), self-concepts (e.g., "I am a depressed person," "I am a loser," "I am always honest," "I am mean"), moral judgments (e.g., "I am a bad person if I...," "I deserve to be punished if I..."), and beliefs (as expectations), (e.g., "Things never work out," "People won't like me if I am assertive," "Other's feelings are easily hurt and they will condemn me if I don't put their needs before my own."). As feelings, they may be traits of sadness, anger, or any inflexible emotional posture, e.g., a child learning to be predominantly sad because their mother only seems to feel close to them when they are sad. As behaviors, they may be any of a myriad of behaviors which are not freely chosen by the person nor responses to current environmental stimuli, but have served to help a parent feel close to or value a child. Unconsciously, if not consciously, the person is always seeking a way to relinquish them since they are painful, take psychic energy, are maladaptive, and make it impossible to live fully.

The pathogenic adaptations concept has more descriptive and explanatory power than does the pathogenic beliefs concept. It makes explicit that pathology is an ever-changing response to environmental demands ("conscious and unconscious assessments of safety and danger"), and is not inherent to the person. This makes for more compatibility with the idea of the plan, which is seen as an attempt of the person to return to their original state (before the pathogenic adaptations were acquired). In addition, the paradox of a person seeking to disprove (disconfirm) something in which they believe is eliminated.

**Testing of Pathogenic Adaptations**

One of the central contributions of Control-Mastery theory is the concept of testing. (Weiss, 1990). Testing refers to deliberate actions, often unconsciously mediated, which have the purpose of determining whether people in the person's current environment seem to require the same pathogenic adaptation as did the people in regard to whom the adaptation was originally adopted. If they do seem to have a similar need, the adaptation is maintained; but to the extent they seem not to, it is immediately relinquished in favor of more open, less fear-based behavior. Testing is considered to be the primary process by which change takes place in psychotherapy. (For example, a person who was often criticized by a parent may have concluded that authority figures need to criticize those in positions of lesser power. In therapy, such a person may offer the therapist something the parent would be critical of, as a way of finding out whether the therapist has the same need to criticize as did the parent. Such a patient may come late to sessions, dress sloppily, report failures on the job or at school, or not follow through on financial arrangements made with the therapist.)

Transference testing, illustrated in the preceding example, is a straightforward way of testing pathogenic adaptations in which the patient adopts the role of the child and places the therapist in the role of the parent. The patient acts in ways the parent required to see if the therapist also is gratified by this behavior, or acts contrary to the parent's wishes to see if the therapist is also threatened. This paradigm is familiar to most therapists, and is relatively easy to understand and to respond to in helpful ways.

Control-Mastery theory has identified a second form of testing, called passive-into-active testing, in which the patient takes the role of the parent and places the therapist in the role of the child. (The reader may be familiar with this paradigm under the names of *identification with the aggressor* or *projective identification*). Passive-into-active testing is traumatic for the therapist, since the patient is acting as did the traumatizing parent and may be demeaning, guilt-inducing, critical, rejecting, distant, etc. The therapist may feel disempowered, self-doubting, inadequate, and/or one of many other unpleasant emotions in the face of such behavior. (For example, someone who was abused in childhood may be verbally abusive to the therapist, criticizing the therapist's manner, interventions, fees, etc. A person whose parent was unreliable and uninvolved with them may come late to sessions or miss them altogether, and may seem to take offense when the therapist questions or interprets this behavior.)

Control-Mastery therapists usually see as the motivation for passive-into-active testing the patient's hope that the therapist can resist being traumatized by the testing behavior so that the patient can use the therapist's healthy responses as a model. That is, the patient wishes to identify with the therapist and adopt the therapist's responses as a way to resist being traumatized in similar situations. Not being traumatized means not complying with the traumatization (e.g., not losing self-esteem and not accepting the definitions and characterizations of oneself which the traumatizing behavior implies) nor rejecting the patient (which would be seen by the patient as defensive and thereby indicative of traumatization). A more fundamental explanation is that the patient is trying to determine how the therapist is able to resist traumatization. This was the challenge the patient originally faced, which he or she was unable to succeed at: how to resist traumatization by the parent while maintaining the parent's goodwill. In order to maintain the parent's goodwill, the patient as a child concluded that it was necessary to comply with the traumatization, thereby instituting a pathogenic adaptation. Currently, however, he or she suspects that this adaptation can be relinquished, and is looking for evidence to support this view.

Although passive-into-active testing is often considered to be safer for the patient than transference testing because it leaves the patient less emotionally vulnerable, passive-into-active testing also entails great risks for the patient since it may jeopardize the therapist's good will towards them. Thus, there would have to be a compelling reason for a person to adopt such a strategy. I propose the reason is that the necessity for the adaptation in question cannot be adequately tested by transference testing.

For example, suppose a patient wanted to test the common pathogenic hypothesis, "If I resist criticism, the other person will withdraw from me and will require me to accept the blame for their withdrawal." (The patient's alternative hypothesis, for which evidence is sought, might be, "It is perfectly natural for me to resist criticism I don't like or think is invalid; someone who won't relate to me when I resist such criticism is being irrational, and I am not to blame for their withdrawal.") If the patient were to employ transference testing to investigate the pathogenic hypothesis, he or she might wait for the therapist to be critical, resist the criticism, and see whether or not the therapist withdraws. The patient might even invite criticism to precipitate the testing situation. Such a strategy could help the patient gather evidence regarding these hypotheses. It might also be an effective approach to use with a somewhat critical therapist whose criticisms happen to be of the appropriate intensity to make for a good learning experience for the patient, and it suggests why even poor psychotherapy may have beneficial effects for the patient. This strategy would not work, however, if the therapist were too critical, not critical enough, or not critical in the ways of particular interest to the patient, and it also might not provide a powerful enough test. Additionally, of course, such behavior on the part of the therapist would pose other dangers for the patient, and is not typically engaged in by competent therapists.

In such a situation, the patient is likely to use the passive-into-active approach as an alternative, or even as a supplement, to transference testing, whereby the patient would criticize the therapist to find out if the therapist subscribed to this pathogenic hypothesis (had made the same pathogenic adaptation as had the patient). If the therapist were able to resist (i.e., not be traumatized by) the criticism, the patient could use the therapist's response as evidence that the therapist agrees with the patient that the patient's old hypothesis is invalid, and that the pathogenic adaptation is unnecessary. This process is what we mean when we say that the therapist models healthy behavior that the patient can incorporate.

The patient uses passive-into-active testing to present the therapist with a good recreation of the original traumatizing situation because these situations are extremely unlikely to arise in the transference in a way that makes for a good learning situation for the patient, since the patient realizes the therapist is unable to enact the behaviors of interest with just the right features, nuances, and intensity. The patient, however, is in an excellent position to do so in regard to the therapist.

To continue with our example, let's suppose that as an additional feature of the pathogenic hypothesis, "If I resist criticism the other person will withdraw from me," the patient is also interested in investigating the notion, "If I do not allow myself to be hurt by a person's criticism of me and the person does withdraw from me as a result, it is a sign that he feels narcissistically injured by me and blames me for it. If I do not accept this blame the person becomes more distant from me and less well-intentioned towards me." (Another way of stating this belief might be, "Everyone seems to think that people are responsible for each other's feelings, and I must act as if I accept such responsibility if I want others to relate to me.") In order to test this hypothesis the patient may act injured if the therapist resists his criticism, and even threaten to end the relationship if the therapist does not seem to accept blame for the patient's supposedly injured feelings, as a way of seeing whether the therapist accepts responsibility for injuring the patient. If the therapist does not accept this responsibility and yet maintains the relationship, the patient's belief in the old hypothesis will be weakened,

and he or she will move towards relinquishing the pathogenic adaptation. The patient will have gathered evidence for the alternative hypothesis, which might be something like, “We are not responsible for each other's feelings, relationships handled in this new way are healthy and satisfying, and I can be close to others without acting as if I'm responsible for how they feel. Moreover, I am free to not accept responsibility for another's feelings, and yet to pursue the relationship if I wish to.” The patient will find support for this way of thinking in the therapist's passing of the passive-into-active test.

## Conclusion

I have advanced the idea that pathogenic beliefs are more accurately and productively seen as pathogenic adaptations, that such a view would be more consistent with the fundamental tenets of Control-Mastery theory, that "disconfirming" pathogenic beliefs means gathering evidence that the adaptations which were required of us in early life can be safely relinquished, and that passive-into-active testing is engaged in, as is transference testing, for the purpose of gathering this evidence.

## References


Broitman, J. (1985). Insight, the mind’s eye. An exploration of three patients’ processes of becoming insightful. *Dissertation Abstracts International,* **46(8),** 2269-A. (University Microfilms No. 85-20, 425)

Davilla, L. (Shields). (1992). *The immediate effects of therapist’s interpretations of patient’s plan progressiveness.* Unpublished doctoral dissertation, California School of Professional Psychology, Alameda.

Fretter, P. (1984). The immediate effects of transference interpretations on patients’ progress in brief, psychodynamic psychotherapy. *Dissertation Abstracts International,* **46(6)**, 1415-A. (University Microfilms No.85-12, 112)

Norville, R. (in press). Accurate Interpretations and Brief Psychotherapy Outcome. *Journal of Consulting and Clinical Psychology.*

Silberschatz, G., & Curtis, J. Measuring the therapist’s impact on the patient’s therapeutic progress. (1993). *Journal of Consulting and Clinical Psychology,* **61(3),** 403-411.

Weiss, J., Sampson, H., & the Mount Zion Psychotherapy Research Group. (1986). *The Psychoanalytic Process: Theory, Clinical Observation, and Empirical Research.* New York: Guilford.

Weiss, J. (1993). *How Psychotherapy Works: Process and Technique.* New York.: Guilford.

Weiss, J. (1990, March). Unconscious mental functioning. *Scientific American,* **262,** 103-109.