

How the Patient's Sense of Danger and Safety Influence the Analytic Process

Harold Sampson, PhD

*Mount Zion Hospital and Medical Center
San Francisco Psychoanalytic Institute*

Weiss (this issue) has proposed that a person may exercise unconscious control over repressions on the basis of unconscious appraisals of danger and safety. This hypothesis derives from Freud's (1926) theory in which a person institutes repression because of an anticipation that certain inner feelings or intentions would bring about a danger situation. The person's anticipation of danger (based on a pathogenic belief) evokes anxiety and leads to defense. The person maintains repressions and symptoms in obedience to such beliefs and the dangers they foretell.

Although this hypothesis is not new, its implications have not been integrated fully within psychoanalytic theory. It implies that a person's anticipation of danger, and the pathogenic belief which underlies it, is the *linchpin* that holds pathological formations in place. The analytic patient will maintain repressions, inhibitions, and symptoms if he or she believes it would be dangerous to relinquish them. The patient will make analytic progress, lift repressions, and relinquish inhibitions and symptoms when pathogenic beliefs about danger are overcome, and thereby he or she comes to believe that such changes can be made safely.

Clinical observations illustrate that a patient's unconscious appraisals of danger and safety regulate analytic progress. These observations also change certain intuitions, based on Freud's earlier theory, about how powerful unconscious contents may become conscious during analysis.

INTRODUCTION

I focus on a single hypothesis, proposed by Weiss, and its implications for psychopathology and treatment (Weiss, Sampson, & the Mount Zion Psy-

Requests for reprints should be sent to Harold Sampson, PhD, San Francisco Psychoanalytic Institute, 2420 Sutter Street, San Francisco, CA 94115.

chotherapy Research Group, 1986): A person may exercise unconscious control over his or her repressions on the basis of unconscious appraisals of danger and safety. This means the person typically maintains his or her repression of a mental content when he or she anticipates that experiencing that content would create a situation of danger. The person may lift his or her repressions and make the content conscious when he judges that it may be experienced safely. This hypothesis implies that the patient's progress in the psychoanalytic situation is regulated by unconscious appraisals of danger and safety. The analytic patient will maintain his or her repressions, inhibitions, and symptoms if the patient believes it would be dangerous to relinquish them. The patient will make analytic progress and overcome inhibitions and symptoms when he or she believes that this can be done safely.

This hypothesis is not new; however, its implications have not been integrated fully within psychoanalytic theory and practice. It derives from Freud's *Inhibitions, Symptoms, and Anxiety* (1926). Even earlier, however, Freud had sometimes noted that repressed contents might become conscious if it became safe for the person to experience them. I mention two familiar examples.

In *The Interpretation of Dreams*, Freud (1900) noted that unconscious impulses may "prance upon the stage" (p. 568) harmlessly in dreams because the gateways to motility are closed during sleep. The dreamer may safely experience ordinarily repressed impulses because he or she is not in danger of acting on them.

In his paper on transference love, Freud noted that if the analyst maintains an analytic attitude in the face of his patient's demands for love, the patient may feel safe enough to lift her repressions and bring to light her infantile sexuality:

The more plainly the analyst lets it be seen that he is proof against every temptation, the more readily will he be able to extract from the situation its analytic content. The patient, whose sexual repression is of course not yet removed but merely pushed into the background, *will then feel safe enough* to allow her preconditions for loving, all the phantasies springing from her sexual desires, all the detailed characteristics of her state of being in love, to come to light; and from these she will herself open the way to the infantile roots of her love. (1915, p. 166, italics added)

Such observations were not, however, part of a systematic theory until 1926. In earlier theory, repression was brought about by the unconscious mental process turning away from the beginnings of unpleasure (Freud, 1900). For this reason, Freud characterized repression as "an automatic regulation by unpleasure" (1905, p. 266). The analytic patient could not lift his repressions without the analyst's interpretive help: "The process of bringing

... unconscious material to light is associated with unpleasure, and because of this the patient rejects it again and again. It is for you then to interpose in this conflict in the patient's mental life" (p. 266).

In Freud's earlier theory, anxiety did not cause repression; rather, repression caused anxiety. Anxiety was the product of an automatic transformation of repressed libido rather than a reaction by the ego to an anticipation of danger.

In his 1926 revision, Freud argued that the ego instituted repression on the basis of an anticipation of danger. This anticipation stemmed from a conviction that certain inner feelings or intentions would lead to danger. For example, the young boy may believe that his oedipal wishes will put him in a situation of danger; namely, the danger of castration. The ego's anticipation of danger evokes signal anxiety and leads to repression. Weiss noted (Weiss et al., 1986) that for many patients dangers other than castration are of central importance to their psychopathology, for example, the dangers associated with separation guilt and survivor guilt.

CERTAIN IMPLICATIONS OF FREUD'S (1926) HYPOTHESES

Freud's (1926) hypotheses have many implications for psychoanalytic understanding of psychopathology and treatment. Freud explicitly recognized some of them. Other implications were recognized and developed by later analysts, including Hartmann (1964), Rapaport (1967), Sullivan (1947, 1953), Horney (1939), Sandler (1960), Rangell (1968, 1969), Schafer (1983), Greenberg and Mitchell (1983), Wachtel (1982), Weiss (1971), and Weiss et al. (1986).

Certain implications of the 1926 hypotheses are important for Weiss's theory as well as for the specific hypothesis which is the focus of this article.

The 1926 theory gives the ego the power to control the drives. In his reminiscences about the Viennese Psychoanalytic Society, Sterba (1982) recalled that "The catch phrase: 'we are lived by our id' . . . lost considerably its impressiveness and validity when Freud emphasized the . . . anxiety signal, which gives the ego power over inadmissible drive impulses of the id" (p. 78).

Freud's (1926) theory implicitly introduced a second noninstinctual motive—*anxiety and its avoidance*—into a central place in the theory of psychopathology (White, 1963). (In 1923 Freud had introduced another powerful non-instinctual motive, the unconscious sense of guilt, as a major unconscious force in psychopathology and resistance to recovery.)

The 1926 theory remarkably changed psychoanalytic understanding of defense and psychopathology. It placed them within the context of adapta-

tion to reality. As Freud put it, defensive behavior was “transfigured in a rational light” (1926, p. 146). The person institutes defenses in order to avoid a “realistic fear, a fear of a danger which was actually impending or was judged to be a real one” (p. 108). Defense, then, is no longer an automatic avoidance of unpleasure.

Freud’s new hypotheses transformed *symptoms* in a more adaptive and rational light: “. . . symptoms are created in order to remove the ego from a situation of danger . . . the generating of anxiety sets symptom formation going and is, indeed, a necessary prerequisite of it” (1926, p. 144).

The “riddle of neurosis” was also transformed by Freud’s (1926) hypotheses. It became: Why do some people retain, rather than overcome, early childhood beliefs about danger situations?

The 1926 theory also provided important new ways of integrating the role of experience and of object relations into the psychoanalytic theory of psychopathology. In Freud’s early theory, experiences with others affected the child primarily through gratification or frustration of his instinctual wishes. The new concept that the ego was built out of identifications, as well as the concepts of the ego ideal and the super-ego, greatly broadened the theoretical role assigned to early objects in development and pathology (Freud, 1923). The 1926 hypothesis emphasized two other important aspects of object relations. The parents are primary sources of protection against external dangers throughout the long period of the child’s helplessness and dependence. This “biological factor” (Freud, 1926, pp. 154–155) intensifies the child’s ties to the parents.

This conception provides a bridge toward a broader view of how object relations influence normal development and psychopathology. For example, it prefigures Winnicott’s work on the importance for psychic development of a range of parental functions that are independent of drive gratification or frustration. It also provides a bridge to some of the recent research on infant development as summarized recently by Stern (1985) and Silverman (1986). This recent work asserts that virtually from birth the infant is wired in to perceive objects, adapt in a highly discriminating way to the human environment, and form strong bonds to others.

In addition, as Greenberg and Mitchell (1983) noted, Freud’s new hypothesis turns our attention to the environmental circumstances in which the ego senses that an impulse may be dangerous. Although Freud did not fully develop this implication, it suggests that differential early relationships will lead to different links between internal motives and danger situations (Greenberg & Mitchell, 1983, pp. 66–67). This implication is highly developed in Weiss’s concept of pathogenic beliefs.

The 1926 revisions also indicated that *higher mental functions*—for example, thoughts, judgments, anticipations, decision, and beliefs—play a central role in the unconscious regulation of repressions and in pathogenesis. Freud wrote that the ego interpolates

between the demand made by an instinct and the action that satisfies it, the activity of thought which, after taking its bearings in the present and assessing earlier experiences, endeavours by means of experimental actions to calculate the consequences of the course of action proposed. In this way the ego comes to a decision on whether the attempt to obtain satisfaction is to be carried out or postponed or whether it may not be necessary for the demand of the instinct to be suppressed altogether as being dangerous. (1940, p. 199)

In all the preceding ways, the 1926 theory is an essential context for Weiss's powerful concept of pathogenic beliefs. In terms of the 1926 theory, a pathogenic belief is the conviction that underlies the ego's anticipation of danger. For example, a person who suffers from castration anxiety unconsciously believes that sexual wishes may lead to the danger of castration. The person anticipates this danger when he experiences these wishes. The person may, in obedience to this belief and the dangers it foretells, attempt to repress his sexual wishes, and he may develop inhibitions and symptoms.

A pathogenic belief serves an adaptive function. It warns the person of the dangerous consequences of attempting to fulfill a wish, attain a goal, feel a certain way (e.g., self-confident or happy), or change a view of himself or herself (e.g., the view that he or she is not sociable). As Weiss's article (this issue) notes, reasonable ego goals such as to become independent, or happy, or sociable, or to be a good parent, may become linked to a dangerous consequence. The link is formed by inference from the person's experiences. The inference is influenced both by subjective factors and by real experience with others.

Moreover, the 1926 theory implies that the person's anticipation of danger—and the pathogenic belief which underlies that anticipation—is the linchpin which holds the pathological formation in place. The patient maintains repressions and symptoms in obedience to pathogenic beliefs, the dangers they foretell, and the anxiety, guilt, remorse, or shame which stem from them. If the patient can change his or her pathogenic beliefs in analysis, he or she will become less anxious, and will feel safe enough to make unconscious conflicts conscious, to develop insights, and to relinquish symptoms.

The 1926 theory also provides an essential context for Weiss's concept of unconscious testing of the analyst. The patient, in testing a pathogenic belief in relation to the analyst, is testing reality. He or she is unconsciously trying to determine whether a danger anticipated on the basis of inferences about past experiences remains real in the current analytic relationship.

CLINICAL OBSERVATIONS

I now return to the hypothesis that the patient unconsciously controls his defenses, and does so primarily on the basis of appraisals of danger and

safety. These appraisals also regulate the patient's progress in analysis. I turn to clinical observations in order to illustrate this hypothesis. I also wish to use these observations to convey some of the ways that this hypothesis may provide the clinician with distinctive intuitions.

I begin with an observation of a prototypical phenomenon which Weiss (1971) referred to as "crying at the happy ending" (p. 462). The phenomenon is illustrated by the following example.

The patient, Dr. H., had just returned for his first session following his analyst's 2-month vacation. Dr. H. reported that he had not missed the analyst during this long break. However, midway through the session, and without the analyst's assistance, the patient became aware of strong feelings of sadness regarding the separation. He wept briefly, and then began to link his previously repressed feelings of sadness to childhood memories concerning separations from his mother.

Weiss (1971) posed a question about this observation: Why did the patient experience his sadness at just the moment when he had been reunited with the analyst? Certain familiar psychoanalytic explanations, based on Freud's pre-ego-psychology theorizing, do not provide a convincing answer to this question.

According to Freud's earlier theory, the patient could not lift his repressions without the analyst's help. The patient could not make unconscious material conscious, for this material was subject to automatic regulation by unpleasure. However, unconscious material may become conscious in spite of repression. It may become intensified, and thrust its way toward consciousness, thereby mobilizing defensive efforts. The outcome of this struggle would depend on the relative strength of the repressing and the repressed forces. The repression may be maintained, or the unconscious material may force its way into awareness in a relatively undisguised form, or the unconscious material may find conscious expression in a compromise formation.

Dr. H.'s sadness had not just intensified and thereby thrust its way into consciousness. His sadness had been most intense during the summer separation from the analyst. Indeed, the reunion with the analyst eliminated the cause of the sadness. Yet the patient did not experience his sadness during the summer separation, when it was most intense, but only after the reunion.

Moreover, if the patient became aware of his sadness because of its strength, and in spite of his efforts to defend against experiencing it, the patient would have remained in conflict with his (now conscious) sadness. He should have struggled to re-repress it, and to repress the contents which had made him aware of sadness. Yet the patient was not anxious as his sadness became conscious, and he retained it in consciousness without conflict, continued to explore it, and linked it to childhood memories.

It is also evident that the repressed content did not become conscious as a

gratification, for sadness is not intrinsically gratifying. Dr. H.'s becoming aware of sadness is instead an example of the kind of process which Freud stated in *Beyond the Pleasure Principle* (1920) contradicts his earlier assumption that unconscious processes are regulated exclusively by the search for pleasure. Freud noted in this work that people repeat, both in everyday life and in analysis, experiences which cannot at any time have been pleasurable.

Weiss (1971) explained why the patient became conscious of his sadness only after the analyst's return in this way: The patient had repressed his sadness about the separation while the analyst was away because it would have endangered him to experience it then. The patient lifted his repression and began to face his sadness only after reestablishing his sense of having a relationship with the analyst. This made it safe for him to face his sadness. The reunion with the analyst also made it safe for him to face his sadness about his mother's absences during his childhood.

An explanation in terms of appraisals of danger and safety may account for the uninterpreted emergence of any type of repressed content, not just sadness. For example, a patient, Miss Z., became conscious of sexual feelings toward the analyst along with conscious fears that the analyst might reciprocate and then take advantage of her sexual feelings. These feelings and ideas became conscious without interpretation. The patient was calm as she discussed these contents. She kept them in consciousness over many hours, as she explored their origins and meanings. This productive process followed an extended period of unconscious testing of whether the analyst was seducible. It was only after she had unconsciously decided that he was not seducible that she felt safe enough to become conscious of her sexual feelings and concomitant fears. These feelings and fears did not become conscious because they had become intensified. (This case example is similar to the one quoted from Freud in his paper on transference love.)

Another patient, Mrs. L., suffered from severe masochistic difficulties. She was very meek, submissive, and compliant during the first 2 years of treatment. She then tentatively disagreed with her analyst about his charging for a missed appointment. When he commented that she seemed hesitant to express her thoughts and feelings, the patient began to complain more directly about the analyst's policy. She acknowledged feeling resentful about it. Over the next few sessions she reported various fantasies of defiance toward and revenge upon the analyst. Her overall manner seemed relaxed and somewhat freer. Several sessions later she described—for the first time in her treatment—recent incidents which had made her angry. For example, she had felt furious when another driver cut in front of her. Also, she had had a fight with her husband—which was an event which had rarely happened before—and she had felt very angry at him. In fact, she added with amusement, she had thrown a dish at him. She related these incidents calmly. The analyst asked her how she understood these events. She thought for a couple of moments, and then replied that since she had had that "fight" with the analyst

(over being charged for the hour) she was aware that she was no longer so afraid of angry feelings. She had noticed that her disagreement with him, and feelings of resentment, had not appeared to harm him. Nor had there been any apparent harm to their relationship. She spontaneously associated to her childhood, when her mother would collapse into tears if the patient raised any questions, or acted even slightly irritated with mother. She remembered that she used to think that her father drank heavily because of her childhood misbehavior. He would sometimes pound the wall in frustration if the children did not immediately follow his orders, or if they differed with his views. Once again, a warded-off content became conscious during treatment not because it had become intensified, but because it had become safer for the patient to experience it or to express it in behavior.

Another patient, Mr. A., challenged my recall of our work on a number of occasions during the 1st year or more of treatment. For example, following an hour in which he had for the first time manifestly experienced the work as helpful, he started the next hour by complaining that we had been stuck for the past 6 weeks. Our early progress, he said, had come to a complete halt. In another instance, after I had interpreted to him that he might be inviting me to scold him as his mother had done, he shouted at me indignantly: "My mother never scolded me—what in the world are you thinking about?" I cited a few examples. He replied, "Yes, I guess she did scold me," and began to wonder why he had forgotten this.

In another session, I referred to a dream he had reported a couple of days earlier. Mr. A. told me forcefully that I must have him confused with another patient, for he had never had such a dream! If he had had such a strange dream, he certainly would have remembered it! I brought out additional details of the dream, and discussed its relevance to some material of this hour.

After a series of such incidents—in which the patient forcefully challenged my memory of what had happened recently in our work and I retained my memory, the patient recalled a childhood incident with his mother. She had become enraged at some behavior of his which he had experienced as innocent. She had hit him violently, and sent him upstairs to his room. By the next day, he had gotten up the courage to ask her why she had been so enraged at him. She told him that she had never been angry at him, and that she would never hit him. In this instance, as in many others which came to light over a long period of time, the patient had complied with his mother's interpretation of what had or had not happened between them. He had become confused and uncertain about what she had said and done, and then would repress the memory she had forbidden him to have.

The patient, in challenging my memory of what happened between us, had been carrying out unconscious passive-into-active tests with me; that is, he treated me as his mother had treated him. He did so in order to test whether I had to comply with his prohibition on my remembering what had

occurred, as he had had to comply with his mother's prohibitions. These tests gradually began to disconfirm his belief that it was disloyal and harmful to retain memories that mother did not wish him to have about her. This made it safer for him to begin to remember terrible things that she had done to him, and then had forbidden him to recall.

I should like to emphasize the intuition associated with these examples, and with the hypothesis (implied in Freud's 1926 theory) that the patient unconsciously regulates his or her defenses, and does so by the criteria of danger and safety: When a patient begins to experience a powerful mental content, or to express that content prominently in his or her behavior, it is ordinarily because the patient has partially overcome his or her unconscious belief concerning the danger of experiencing or expressing it. This intuition contrasts with that associated with Freud's early theory. According to the early theory, when a patient begins to experience a powerful mental content, or to express that content prominently in his behavior, it is because that content has become intensified, or because the defenses against it have been weakened.

I would like to conclude by linking the hypothesis I have been discussing to Weiss's overall theory of therapy. According to Weiss, analysis is a process in which the patient works, unconsciously as well as consciously, to disconfirm and change pathogenic beliefs. These beliefs warn the patient that he or she will be endangered if problems are resolved and inhibitions and symptoms relinquished. As the patient does change his or her pathogenic beliefs in analysis, it becomes safer to become conscious of and to understand aspects of mental life which previously were believed to be dangerous. It becomes safer to make analytic progress, and to overcome problems.

ACKNOWLEDGMENTS

An earlier version of this article was presented to the American Psychological Association Division of Psychoanalysis meetings in San Francisco on February 27, 1988.

This work was supported in part by the Research Support Program of Mount Zion Hospital and Medical Center.

REFERENCES

- Freud, S. (1900). The interpretation of dreams. *S.E.*, 4, 1-338; 5, 339-627.
 Freud, S. (1905). On psychotherapy. *S.E.*, 7, 255-568.
 Freud, S. (1915). Observations on transference-love. *S.E.*, 12, 157-171.
 Freud, S. (1920). Beyond the pleasure principle. *S.E.*, 18, 3-64.
 Freud, S. (1923). The ego and the id. *S.E.*, 19, 3-66.
 Freud, S. (1926). Inhibitions, symptoms and anxiety. *S.E.*, 20, 77-175.

- Freud, S. (1940). An outline of psychoanalysis. *S.E.*, 23, 141–207.
- Greenberg, J. R., & Mitchell, S. A. (1983). *Object relations in psychoanalytic theory*. Cambridge, MA: Harvard University Press.
- Hartmann, H. (1964). The development of the ego concept in Freud's work. In *Essays on ego psychology* (pp. 268–296). New York: International Universities Press. (Original work published 1956)
- Horney, K. (1939). *New ways in psychoanalysis*. New York: Norton.
- Rangell, L. (1968). The psychoanalytic process. *International Journal of Psycho-Analysis*, 49, 19–26.
- Rangell, L. (1969). The intrapsychic process and its analysis: A recent line of thought and its current implications. *International Journal of Psycho-Analysis*, 50, 65–77.
- Rapaport, D. (1967). Present-day ego psychology. In M. M. Gill (Ed.), *The collected papers of David Rapaport* (pp. 594–623). New York: Basic Books.
- Sandler, J. (1960). The background of safety. *International Journal of Psycho-Analysis*, 41, 352–356.
- Schafer, R. (1983). *The analytic attitude*. New York: Basic Books.
- Silverman, D. (1986). Some proposed modifications of psychoanalytic theories of early childhood development. In J. Masling (Ed.), *Empirical studies of psychoanalytic theories* (Vol. 2, pp. 449–472). Hillsdale, NJ: The Analytic Press.
- Sterba, R. F. (1982). *Reminiscences of a Viennese psychoanalyst*. Detroit: Wayne State University Press.
- Stern, D. N. (1985). *The interpersonal world of the infant*. New York: Basic Books.
- Sullivan, H. S. (1947). *Conceptions of modern psychiatry*. Washington, DC: The Williams Alanson White Foundation.
- Sullivan, H. S. (1953). *The interpersonal theory of psychiatry*. New York: Norton.
- Wachtel, P. L. (1982). Vicious circles. *Contemporary Psychoanalysis*, 18, 259–273.
- Weiss, J. (1971). The emergence of new themes: A contribution to the psychoanalytic theory of therapy. *International Journal of Psycho-Analysis*, 52, 459–467.
- Weiss, J., Sampson, H., & the Mount Zion Psychotherapy Research Group. (1986). *The psychoanalytic process: Theory, clinical observation and empirical research*. New York: Guilford.
- White, R. W. (1963). Ego and reality in psychoanalytic theory [monograph]. *Psychological Issues*, 3(3). New York: International Universities Press.