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The Role of "Real" Experience in Psychopathology and Treatment

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In contrast to classical psychoanalytic theory, Weiss (1986, 1990) has proposed that a person works, from infancy onward, to understand his reality and to adapt to it. In doing so, the person constructs, by inference from experience, a system of conscious and unconscious beliefs about his or her reality. These beliefs organize personality; some of them are pathogenic in that they lead to the development and maintenance of psychopathology. The patient works in therapy to change pathogenic beliefs and may use experiences with the therapist to disconfirm them and make progress.

MY TOPIC IS THE PLACE OF REALITY and a person's beliefs about his or her reality in psychopathology and treatment. The ideas I shall present are based on the distinctive psychoanalytic theory developed by Weiss (1986). I shall take up three interrelated topics. The first is the nature of a person's interest in reality. I will argue that that interest is innate, primary, and powerful. This fact is important not only for our theories, but also for our understanding and treatment of our patients. The second topic is psychopathology. I will develop the view that our beliefs about our reality play a central role in all aspects of our mental life, including the development and maintenance of psychopathology. My third topic is therapy. I shall discuss the importance of actual experiences between patient and therapist for the patient's

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progress. I will also touch on certain significant functions of a patient's criticism of parents during treatment.

Interest in Reality

I shall begin with an anecdote that is not directly about psychoanalysis; in fact, it is not even about people. It is a story about *rats*—about the differences between New Haven rats and Berkeley rats. When I was a graduate student at Berkeley, I took a course from Professor Edward Tolman, an eminent psychologist whose specialty was learning theory. One of his great theoretical antagonists was at that time at Yale. Tolman told us that there were remarkable personality differences between laboratory rats at these two institutions of higher learning. Berkeley rats liked to think. They were very interested in their environment. They developed hypotheses about it, and they tested these hypotheses. If you put a Berkeley rat in an unfamiliar maze after feeding him or her a nice, filling dinner, the rat wandered about the maze with evident interest and learned it. The rat developed a cognitive map of the maze. This was shown by the fact that if the experimenter put food in the maze at a later time, and the rat discovered its location, it could find the way back to the food expeditiously and with few wrong turns from a starting point elsewhere in the maze. This finding was not in accord with many prevailing learning theories. What in the world caused the rat to learn the maze in the absence of drive reduction? Was the rat doing science? Had he or she overheard one of those hallway conversations in which an eager young professor proclaimed that there was nothing so practical as a good theory—that a good theory about the external world is the best guide to getting where you want to go?

In contrast to their brethren at Berkeley, the New Haven rats *never* thought. Nor did they have any primary interest in their environment. They were driven by the imperious demands of the hunger drive. They did not learn the maze. What they learned was a sequence of movements, cued by visual and internal proprioceptive stimuli, which led to tension reduction.

I must confess that at the time I secretly preferred the Yale rats. I could understand their motivation, and I also appreciated their lack of theoretical pretensions. It made it easier, I thought, to find laws for their

behavior. But since then, as I have wandered through some of the mazes in our own field, I have developed a greater fondness for my fellow investigators, the theory-building rats of Berkeley.

And now back to psychoanalysis. Freud (1895, 1900b, 1911), in his early theory of the mind, imagined an infant who had no primary motivation to understand his reality. The infant was ruled exclusively by the pleasure principle. After a first feeding at the breast, the infant, when next hungry, sought to regain the original situation of satisfaction by hallucinating the breast. It was only the "bitter experience of life" (as Freud characterized it, 1900b, p. 566), the disappointment that came about when hallucinating the breast did not reduce hunger more than momentarily, that compelled the infant "to form a conception of the real circumstances in the external world and to endeavor to make a real alteration in them" (Freud, 1911, p. 219). Freud's infant turned toward reality only reluctantly, and this reluctance persisted throughout life. A great portion of our mind—the entire system unconscious—remained throughout life under the exclusive dominance of the pleasure principle; only the conscious-preconscious part of our mind was concerned with reality and was governed by the reality principle.

Freud's infant was, as he said, fictional (1900b, p. 598). This infant was not derived from observation, but constructed as a useful model in Freud's overall theory of the mind—a compelling and elegant theory that accounted parsimoniously for such phenomena as dreams, jokes, slips of the tongue, neurosis, psychosis, and therapy. This early theory, in spite of its power, was *also* incomplete, narrow, and in some regards misleading.

Freud's views about our interest in reality were modified over time by himself (1920, 1923, 1926), by ego psychologists such as Hartmann (1939) and White (1963), by the interpersonal theorists, and by some of the object relations theorists, as well as by many contemporary analysts and also by contemporary students of infant development. Freud's early theory, however, has been taught to generations of analysts, and our psychoanalytic intuitions about human nature are still influenced to some extent by Freud's early model of the infant's mind (Sampson, 1990).

We know now that Freud's early view that infants have no primary, innate interest in reality is incorrect and promotes misleading intuitions about human motivations. The findings of contemporary research on infant development (e.g., Stern, 1985) are incontrovertible on this issue. Infants are keenly interested in their environment, and especially their

social environment, from birth. They are deeply engaged with social stimuli. Their interest in reality has all the characteristics of a drive. They seek sensory stimulation, they seek novelty, and they will do work to make a novel stimulus appear in their visual field. They have astonishing capacities, from the beginnings of life, to make sensory discriminations and to categorize their environment. They are, from birth on, theory builders: they form and test hypotheses about what is occurring in their world. They soon begin to develop representations of generalized interpersonal patterns. They display accurate expectancies in interpersonal transactions with parents.

This research shows us that human infants need not defer to Tolman's rats in their innate interest in their environment and in their motivation and capacity to understand it. It tells us that *one* thing that people are about, from the earliest days of life, is figuring out what their reality, their world, is like. This motivation and activity are innate, primary, and powerful. They are no less a part of our nature than, for example, sexuality or aggression. Nor are they a *trivial* aspect of our nature: the Goddess of Evolution, in deciding what must be wired into the core of our beings, knew that there is nothing so practical as a good theory about one's world.

But what has this to do with our clinical observations and with psychopathology? We observe that people often manifest only limited interest in understanding their reality. They may actively avoid understanding it; they may deny it; they may actively distort it. They may behave unrealistically and irrationally; they may act peremptorily on powerful urges of which they are unaware; they may develop bizarre symptoms. They may destroy themselves.

Let us turn then to the topic of psychopathology.

Maladaptation and Psychopathology

My next thesis, based on Weiss's theory, is that a *person's beliefs about his reality* are a central, organizing factor in his mental life, and such beliefs underlie maladaptation and psychopathology. This theory differs strikingly from Freud's early theory, but has roots in his ego psychology and is compatible with certain conclusions of some interpersonal theorists

and some object relations theorists. I shall trace this historical context briefly and then discuss Weiss's concept of *pathogenic beliefs*.

Historical Context

In Freud's early theory, the demonic in human life—the irrational, the perverse, the maladaptive, and the psychopathological—expressed powerful, unconscious, instinctual wishes not subject to the educative influence of reality.

In *Inhibitions, Symptoms, and Anxiety* (1926), however, Freud introduced new hypotheses that made concern with reality a more important part of his theory of psychopathology. Specifically, he introduced the idea that a person's unconscious, infantile beliefs about reality may lead the person to institute defenses and to develop inhibitions and symptoms. In Freud's example, the male child who believes that he will be castrated if he expresses sexual interest in his mother institutes defenses against his sexuality in order to avoid this danger, which he believes to be real. In order to avoid this danger, he may also develop inhibitions and symptoms. In Freud's (1926) new formulation, "symptoms are created in order to remove the ego from a situation of danger" (p. 144).

Freud's new hypotheses supplemented, rather than replaced, his earlier explanations of psychopathology. Nonetheless, they marked a shift in emphasis from considering pathology a product of powerful impulses seeking gratification *without regard to reality*, toward seeing pathology as *an adaptation to a perceived reality*, to a danger believed to be real. The new hypotheses, by linking a motive to a danger situation, also provided a potential framework for integrating inner strivings and external reality within a unitary theory (as noted by Rapaport, 1958, p. 749; but see also qualifications by Greenberg and Mitchell, 1983, pp. 66–67).

The relation between efforts to adapt to one's reality and psychopathology was developed in a more fundamental way by analysts who rejected, in whole or in part, Freud's drive-structure theory. For example, Sullivan proposed that schizophrenia may be a reaction to processes and events taking place between a person and his environment (Greenberg and Mitchell, 1983, p. 84). Fairbairn (1952) connected psychopathology to the repression of "bad objects" (pp. 55–81). Winnicott (1958) described

the "false self" as a compliance with environmental demands (p. 225), and he often described the adaptive purpose of pathological behavior. For example, he proposed that a destructive adolescent may be attempting to compel the family, or the community at large, to provide the stability and control that were lost at some earlier time in his life and that he still needs (p. 310).

These analysts also showed that denials of reality and distortions of reality may be based not on primary instintual wish-fulfillment or defenses against these wishes, but on motives serving adaptation, such as loyalty to parents, efforts to protect the parents, or efforts to continue to see the parents as good (Fairbairn, 1952; Sullivan, 1954, pp. 21–23).

The psychoanalytic theory developed by Weiss builds on Freud's 1926 hypotheses. It is compatible with the observations of Sullivan, Fairbairn, and Winnicott on the close links between psychopathology and reality. In addition, although Weiss's theory evolved in clinical work with adult patients, it is also compatible with findings from contemporary infant development research in emphasizing a person's intense motivation to understand his reality and in stressing the central role that such understanding plays in mental life.

Weiss's Concept of Pathogenic Beliefs

According to Weiss (1990), a person works, from infancy onward, to understand his reality and to adapt to it. The child's first reality is that of himself and his parents. He acquires his first knowledge of himself and others in relation to them. This knowledge becomes organized intrapsychically as a system of beliefs, unconscious and conscious, about his reality.

> These beliefs . . . are central to a person's conscious and unconscious mental life. . . . They are an indispensable guide to the all-important tasks of adaptation and self-preservation. . . . They are organizers of perception. A person perceives himself and others largely as he consciously and unconsciously believes himself and others to be. . . . They are organizers of personality and psychopathology. It is in accordance with his beliefs about reality that a person shapes his inborn strivings and by doing so evolves his personality [p. 660].

Moreover, affects are ordinarily based on beliefs about reality. A person who believes he is endangered will feel anxious; a person who believes she is rejected and unlovable may feel depressed; a person who believes she is being treated badly may feel anger (Silberschatz and Sampson, 1991). Fantasies, according to Weiss, are *secondary* to one's beliefs about reality. It is the person who believes he is poor and powerless who fantasies he is rich and powerful. Or, to take an example from Freud (1940), it is the man who unconsciously believes women have been castrated who holds onto fantasies that women have a penis (pp. 202–203). In an example from Griesinger cited by Freud (1900a), it was a woman who had lost her child who experienced delusionally the joys of motherhood (p. 91).

Certain beliefs may be called *pathogenic* because they impair functioning. As we shall see, a person, because of such beliefs, may develop crippling inhibitions, may torment himself, may persist in infantile behavior, may act self-destructively, may express powerful rage or bizarre sexuality, and may develop disabling symptoms. Therefore, although pathogenic beliefs are theories about reality, they are by no means dry, lifeless, and academic to the person who holds them.

A pathogenic belief often links an inner motive or goal—for example, a normal developmental striving—to a grim, intensely undesirable consequence. For example, it may warn a child that if he makes friends, he will cause his mother, whom he believes to be needy of him and possessive, to become miserably depressed, and it predicts that he himself will suffer remorse. Because of this belief and the dangers it foretells, the child may renounce the pursuit of friendships and maintain an infantile attachment to his mother.

A child acquires (i.e., constructs) beliefs about reality by inference from experience. Pathogenic beliefs are usually acquired in childhood and in relationship to parents and siblings, but they may be acquired at any time in life from powerful experiences. The child's inferences in constructing a belief are influenced by various factors. These include his limited experience of the world, overgeneralization from a sample of only one mother or one father, the child's native predispositions, his role in the family, his prior experiences, his preexisting beliefs, his immediate life situation, and his motives (wishes, fears, goals) at the time the belief is formed. Beliefs about reality are, of course, subjective, but they are influenced, in most instances quite powerfully, by actual experiences.

Because pathogenic beliefs are acquired by inference from experiences, they may, because of differing experiences, link virtually any motive,

goal, or psychic state to a grim and constricting consequence. For example, depending on the child's interpersonal reality, a child may come to believe that if she is sexual toward her father, he will be disgusted with her or that he may lose control or that he will perk up, become less depressed, or that she will make her mother envious and angry.

Several examples illustrate that the demonic in human life—the irrational, the maladaptive, the peremptory—may arise *from pathogenic beliefs about reality*. The first two examples illustrate that a person's sexual fantasies, symptoms, and behavior are all regulated by pathogenic beliefs and are *secondary* to these beliefs.

The first example is Mr. J, a 29-year-old physicist who was seductive with every woman he met and had brief affairs with many of them. With each new woman, he experienced intense excitement, and he glamorized each in turn. The breakup of each relation tormented him with intense feelings of loss, although in each case he was the one who was no longer interested in continuing it. He was most particularly drawn toward depressed and weepy women.

Mr. J's behavior and feelings were based on an unconscious belief formed in childhood in relation to his seductive but depressed mother. Mother confided to him that she was unhappy because of father's inattention to her. She had become animated and even cheerful when Mr. J, in childhood, conveyed sexual interest in her. Mr. J developed the unconscious belief that women needed his intense sexual interest in order to feel good about themselves and that it was cruel and selfish of him to turn away from them and to pursue his own interests. He felt unconsciously guilty toward his mother when not enmeshed with her and when he instead pursued his own goals.

Mr. J felt compelled to show sexual interest in every woman he met because he unconsciously believed she would be hurt if he did not want to sleep with her. He became excited and glamorized each woman in an unconscious attempt to make her feel good. He was particularly drawn to depressed women because he unconsciously believed that he was responsible for making them happy and that he *could* do so if he weren't selfishly concerned with his own interests. After leaving a woman, *he* experienced loss in order to ward off feelings of guilt; that is, he warded off guilt by the conscious idea that it was he, not the woman, who was sad and rejected.

In the second example, Mr. D, the only child of a divorced mother, unconsciously believed that he would harm women if he allowed himself to be strong and did not remain under a woman's thumb. This belief

guided his actual relations with women: he was passive and could be sexual only if the woman dominated him. He masturbated to fantasies of being bound by a woman who then used him sexually. His fantasies, as well as his behavior, were secondary to his belief that it would be dangerous not to remain under a woman's thumb: both his behaviors and his fantasies reassured him that he was controlled by a woman and that he was therefore not harming her.

A different type of case illustrates that the experience and expression of rage may *not* be based primarily on underlying anger, but may be *secondary* to an unconscious pathogenic belief.

Mrs. F, who had a husband and children she loved, had occasional violent outbursts of rage toward them. She feared these rages might ruin her marriage and alienate her from her children. Mrs. F's rage was not based on primary impulses of hostility, nor was it based on genuine feelings of resentment toward her husband and children. Mrs. F's mother had had chronic rages toward *her* husband and children, and these rages had in fact destroyed the mother's marriage and made her relationship to her children difficult. Mrs. F suffered from unconscious survivor guilt; she unconsciously believed that it would be a betrayal of her mother to have a happy marriage and a good relationship to her daughters when her mother had been deprived of this pleasure. In obedience to this belief, she unconsciously identified with her mother and behaved like her toward husband and children and thereby jeopardized her own happiness. She overcame this problem by becoming aware of the unconscious identification and by understanding and overcoming the pathogenic belief on which it was based. As this change was taking place, Mrs. F would feel intense rage, then pause, recognize its basis, and a moment later feel calm, friendly, and loving toward the object of the rage. The intense anger she had been experiencing had disappeared not because of repression, but because of understanding of its source.

Finally, a person may act self-destructively in compliance with a belief about a parent's wishes or needs.

Ms. N had made a serious suicide attempt earlier in life because she unconsciously believed that her parents did not wish her to live. In a subsequent intensive psychotherapy, she made repeated requests to terminate. Her therapist finally told her that he believed she should

continue. He said she was expressing a wish to stop out of beliefs that she was a burden to him and that he did not want to continue with her. Shortly thereafter, Ms. N spontaneously became aware of painful memories that had led to the childhood conviction that her parents found her a burden and wished she would go away, die.

In another example, a patient told me a chilling incident from her eighth year. Her parents were once again fighting, with loud recriminations and threats. She and her sister, two years older, were awakened by the noise and watched the fight from the upstairs banister. Her sister said to her that if either sister became sick or died the parents wouldn't fight anymore; they'd get together and love each other again. Two days later her sister was found dead, hanging in the closet of her room.

The literature illustrates that certain kinds of external events tend to produce characteristic beliefs in those who experience them. This regularity shows the importance of actual experiences in the development of these beliefs. The examples also show that children tend to assume that they are responsible for whatever happens to them, such as abuse or mistreatment, as well as for family misfortune. Moreover, there is a moral component to this belief: what did happen, should happen. The child deserved what happened; the child deserves for it to happen again.

Beres (1958) found, in a study of young children placed in foster homes, that the children invariably inferred that their parents had rejected them and did so because the child was bad. The rejection was deserved. The pathogenic belief that they deserved to be rejected because they were bad regulated their subsequent relationships. They believed not only that they *would* be rejected, but that they *should* be rejected.

Fairbairn (1952) found in a large series of children who had been sexually abused or otherwise grossly mistreated by their parents that the children invariably believed that they were bad and were responsible for how they had been treated (pp. 59–81). Such a belief carries the implication that the child deserves, in the future, to be abused or mistreated again. Fairbairn's young patients almost never blamed the parent. His findings have been confirmed repeatedly in contemporary studies of child abuse: the child believes he or she deserved what happened (Suffridge, 1991). They almost never blame the parent. They are not helped by therapists who inquire what they did to provoke parental mistreatment. They are helped by coming to believe that they did not

deserve the abuse or mistreatment. Thereby, they are enabled to believe that they are entitled to better treatment and that their parents were wrong to abuse them.

Ferenczi (1933) observed in his clinical practice that if parents were miserably unhappy and complained to their children about their suffering, the children unconsciously believed they were responsible for the parents' suffering. They attempted to fix it and, in Ferenczi's words, became "nurses for life" who sacrificed their own interests to take care of sufferers (p. 229).

We have also observed a number of other regularities between certain experiences and the beliefs to which they give rise. An interesting example is this: if a parent repeatedly scolds a child for not doing something, the child does *not* usually infer that the parent wants him to do it; he is more likely to infer that the parent wants to scold him. I think that this is a plausible—although not necessarily correct—inference.

Reality in the Analytic Process

I shall take up two topics in my concluding section. The first is the role of real experiences between the patient and analyst in the analytic (or psychotherapeutic) process. The second concerns the functions of patients' criticisms of their parents in treatment.

Crucial Experiences Between Patient and Analyst

The patient in psychoanalysis, according to Weiss (1986), is unconsciously motivated to change his pathogenic beliefs because they are grim and constricting and have led to impairments in the pursuit of valued goals. The patient unconsciously works to change them.

He works in two ways. First, he tries to understand his beliefs and their relationship to his problems. He is greatly helped in this work by interpretations that convey insight into his beliefs and the problems to which they give rise and that enable him to disconfirm the beliefs.

Second, the patient also works to change his beliefs by unconsciously testing them in relation to the analyst. If the patient unconsciously perceives the analyst's behavior and attitudes as disconfirming the belief

he is testing, the patient will make progress. In this way, direct experiences with the analyst sometimes may lead to significant analytic progress even without interpretation.

The following clinical vignette[1] illustrates this process.

Mr. A was a 33-year-old, financially successful lawyer who was referred to me by a colleague who was also a close friend of Mr. A. My colleague told me that Mr. A had had no successful, long-term relations with women. He could be difficult interpersonally: rude, blunt, irritating, and often abrupt and rejecting. He was brash. He never heard what others said to him, and he interrupted conversations. Some people found him obnoxious. Nonetheless, my colleague said that she genuinely liked Mr. A and that Mr. A did need help.

I was returning to my office a few minutes before my first appointment with Mr. A, and as I was about to close my door, a large, well-dressed, energetic man rushed up to me. "Hal," he said, "don't shut the door on me. I'm Fred A. I have an appointment with you."

He told me he wanted help with his inability to make a commitment to a woman. And his mother was driving him crazy. He then characterized himself in almost identical terms to those used by my colleague, but added that he was completely insensitive to the feelings of others. Moreover, he said that he had no access to his own feelings and no understanding of his own psychology or that of others.

Over the first months, Mr. A characterized my comments and interpretations as ridiculous and useless. For example, he would invite comment about his behavior, and if I said anything, he would reply: "That is the stupidest idea I've ever heard." In addition, he could not remember what either of us said from one session to the next, and he attributed this to his complete lack of interest in feelings or in understanding relationships. In spite of his provocativeness, my general approach was to be serious about our work and to take him seriously.

The specific sequence of sessions I shall describe began after several months into the therapy and began as a self-observation. I recognized that in the past several sessions I had been feeling confused, that I could not recall what we had been talking about, and that I felt disconnected from the patient and uncharacteristically discouraged. Over the next sessions I began to observe how my feelings of confusion began. I noticed

[1]This vignette and considerable portions of my discussion of it are taken from Sampson (1991) with permission of the copyright holder.

a typical sequence that went something like this: The patient talked about topic A for several minutes. I expressed interest, maybe asked a question. He responded in a sentence or two, then changed the subject to topic B, which lent itself to interpretation of a problem we had begun to identify. I interpreted. The patient, often without any acknowledgment of my interpretation, switched to topic C. He said something serious, reflective, and insightful about it. I picked up that topic. He switched immediately to topic D, which did not seem connected to A, B, or C. We proceeded in this fashion with topics E, F, G, and so forth. Eventually I became forgetful, confused, lost, and discouraged. I also felt unimportant and rejected. I began to think that perhaps my comments *were* a bit stupid.

During one such hour, I listened carefully and kept in mind the first 30 minutes of the session. Then I said, "Let me summarize the session." I did do so in detail and then asked if he had any ideas about this hour. Somewhat to my surprise, he said he did. He said that what was happening was that he was flitting from topic to topic and that we never talked together about the same thing for even one minute. Had I noticed? "Yes," I said.

He continued spontaneously, adding that his purpose in flitting from topic to topic was to prevent any closeness: "I am treating you just the way my mother treated me." He then described his mother's intolerance of any intimacy with him, her inability to listen to him, and her inability to remember what he said. He began the next hour by describing in vivid detail childhood conversations with her. Her quick changes of subject confused him. His head would spin. He felt as though a real conversation with her was impossible. He couldn't feel close to her. He felt alone and discouraged after each interaction. She repeatedly rejected him. He felt inadequate with her.

He related this new material in a more serious and dignified manner than he had shown previously. This was our longest period of collaboration—of mutuality, of intimacy—to that point.

During this period, I became able, over time, to tolerate, and to begin to master, the trauma inflicted on me—the trauma that he experienced as having been inflicted on him in childhood by his mother. In carrying out this enactment with me, Mr. A was unconsciously testing with me a pathogenic belief he had acquired in childhood in relation to his mother. He believed unconsciously that he was rejected by his mother because he was stupid and inadequate and a bad person. Moreover, he believed that

he deserved to be treated in this way. Because he believed that her contempt and rejection were deserved, it was too painful for him to face clearly what had been done to him, to remember it in detail, to think about it, and to master it.

In inflicting this trauma on me, he unconsciously hoped that I would not be quite as traumatized as he had been. He unconsciously hoped that I would not believe that it was my fault—that is, that I would not believe that he treated me this way because of my inadequacies and my badness. My ability over time to face my own feelings, to think and talk clearly about what was happening between us, meant to him that I did not feel responsible for his contempt and rejection. This helped him to disconfirm his pathogenic belief and made it safe for him to recall the childhood circumstances in which it arose and his own childhood feelings.

Several points can be made about this vignette. First, it illustrates the important role of reality—of actual experiences between patient and analyst—in the therapeutic process. An experience with the analyst disconfirmed a pathogenic belief and thereby enabled the patient to begin to become aware of aspects of his unconscious mental life.

Second, the vignette thus supports the notion that the relationship itself is a crucial factor in treatment, including analytic treatment. Weiss's theory, however, adds a great deal of specificity to this notion. The attitude of the analyst is important to therapeutic progress *to the extent that it disconfirms a pathogenic belief* of the patient. For example, Mr. A was not helped by some generalized "relationship" or "closeness" or "warmth" or "empathy"—but by a specific attitude in a relationship that disconfirmed his particular pathogenic belief. Our clinical work and our formal research support this view. There is a lawful relationship in treatment between *specific experiences* that tend to disconfirm a pathogenic belief and *specific changes* in the patient that follow from the disconfirmation of the belief.

Third, the vignette illustrates the therapeutic importance of patients' unconscious appraisals of danger and safety to their analytic progress. For example, as Mr. A began to disconfirm his painful unconscious belief that his mother rejected him because he was stupid, inadequate, and bad, he felt safe enough to remember her rejections and how he had experienced them as a child. He also felt safe enough—because he was less in the grip of the belief that he was stupid, inadequate, or bad—to begin to risk openly feeling close to me. He could tolerate collaboration, because if I

were to reject him after he had disconfirmed this belief, he could recognize that this was not due to his badness or inadequacy, but due to some undesirable trait of mine. Rejection would then be less devastating to him, so he could risk greater intimacy.

We have demonstrated in a series of rigorous research studies of analyses and psychotherapies that patients continuously monitor, unconsciously, the analyst's behavior and attitudes. They show small but discernible indications of immediate progress when interpretations, or experiences with the analyst, disconfirm pathogenic beliefs and thereby reduce their unconscious sense of danger (Fretter, 1984; Sampson and Weiss, 1986; Silberschatz, Fretter, and Curtis, 1986; Weiss and Sampson, 1986; Weiss, Sampson, and the Mt. Zion Psychotherapy Research Group, 1986; Silberschatz, Curtis, Fretter, and Kelly, 1988; Weiss, 1988).

Thus, both our clinical observations and our research show that patients are sharply, unconsciously observant of the interpersonal reality of the therapeutic situation. They attempt to infer from the analyst's behavior and attitudes whether it is safe to make their conflicts conscious and to pursue their own strivings more openly.

Finally, this vignette and our group's observations also show that patients may make considerable analytic progress on their own, that is, without interpretive help. For example, they may acquire insight into previously unconscious transferences as well as into other aspects of their mental life; they may recover long-forgotten and presumably repressed memories; they may gain access to previously inaccessible feelings. This suggests that patients are unconsciously motivated to do so and that they are able to carry out unconscious work to resolve unconscious conflicts. In particular, they may test unconscious pathogenic beliefs in relation to the analyst.

Patients, in testing a pathogenic belief in their relationship to the analyst, carry out a trial action in the hope that the therapist will not react as their beliefs predict. Such testing, which also takes place outside analysis, is a part of a patient's reality testing. A person, in testing, attempts to find out whether what he anticipates in a current relationship is based only on a belief derived from his past or is true in the present relationship.

Mr. A was carrying out a particular type of test that we refer to as passive-into-active testing. He carried out a trial action of inflicting a trauma upon me such as a parent had inflicted on him in childhood. In reversing the childhood roles, a patient does actively to the analyst what

he or she had experienced passively in childhood. In such instances, the analyst experiences the trauma to some degree, works it over in his or her own mind, and gains some mastery of it. This helps the patient to begin to do so.

Testing is not an automatic repetition of the past or simply an unconscious resistance or an unconscious effort to perpetuate the past in the present in order to avoid change. Rather, it is an unconscious attempt to learn something about the analyst that may enable patients to disconfirm a pathogenic belief that is causing them much misery and interfering with their progress toward valued goals.

Passive-into-active testing is of particular interest in relation to our topic. It is very common in analyses and therapies. The patient, during such a test, *seems* resistant and anti-analytic, as in Mr. A's continuous devaluing of me and our work, ignoring or forgetting interpretations, avoiding collaboration, confusing me, and rejecting me. This behavior by Mr. A *seems* irrational, maladaptive, and scarcely guided by realistic considerations. But, in fact, Mr. A, in exhibiting these behaviors, was working unconsciously in a highly directed, planful, and effective way to overcome a crucial pathogenic belief that had prevented him from resolving his problems with intimacy and commitment.

Criticism of Parents

Finally, I want to make a few comments about the functions in treatment of a patient's criticism of his parents.

Freud (1905) taught us that when patients criticize their parents, even correctly, this may be a resistance to analysis, a way of "cloaking other thoughts which are anxious to escape from criticism" (pp. 34–35). The patient, if not shown that blaming his parents for his problems is a resistance, will continue to externalize responsibility and will not achieve the analytic goal of assuming responsibility for his own mental life.

This widely held view is misleading in many instances. Criticism of parents is often a progressive step toward a patient's understanding "that he suffered parental mistreatment, complied with it, and as a consequence developed the pathogenic belief that he deserved it" (Weiss, in press). In the same vein, Fraiberg and her associates (1975) showed that neglectful or abusive mothers stopped treating their children abusively

precisely at the moment that they remembered, with compassion and sadness for themselves, the neglect and abuse they themselves had experienced as children.

More broadly, if we interpret as resistance patients' criticisms of their parents, we may interfere with their reality testing, that is, with their right, and hence their capacity, to see their parents through their own eyes rather than as they believe their parents (and parental surrogates such as the analyst) would prefer to be seen. We may thereby reinforce the patient's tendency, developed in childhood, to sacrifice his own perceptions and judgments in compliance with the presumed or real needs of the other person. Children, as many analysts have noted, commonly repress perceptions of their parents' negative traits and instead "take the rap" themselves.

My view may seem contradicted by patients who blame parents repetitively, without making any progress toward resolving their problems. It also seems contradicted by patients whose criticism of parents, analysts, and others seems wildly exaggerated or an overreaction. But these behaviors may be quite consistent with my thesis.

Patients may criticize parents repetitively as an attempt to fight back against the unconscious belief that they themselves are at fault. The reason they do not make progress is that they *continue* to believe, in spite of blaming the parents, that they themselves are at fault. It is *this* problem they need help with, as illustrated in a case described by Weiss (1990a):

> In the following example a patient whose childhood had been marred by an extremely abusive mother demonstrated his sense of responsibility for her behavior by his persistent and vigorous attempts to disavow this responsibility. The patient complained hour after hour in a monotonous way about the harmful things his mother had done to him until the therapist (who had good reason to believe the patient) assured him that he (the therapist) believed the patient's account of his mother's behavior and that he believed, too, that the patient had not provoked it. The therapist also told the patient that he seemed to be struggling against a tendency unfairly to blame himself for how his mother had treated him. After this the patient gradually stopped his complaining about his mother and began to become aware that he had indeed previously believed in his responsibility for his mother's bad behavior [pp. 665–666].

If the analyst had understood this man's blaming his mother as a resistance and interpreted his doing so as an effort to avoid taking responsibility for his own impulses, it would have been neither correct nor helpful; it would have been incorrect, because it would have obscured the real function of his criticism, and it would not have been helpful, because it would have confirmed the patient's unconscious, pathogenic belief that he deserved the treatment he had received.

Patients who criticize us or their parents in exaggerated and implausible ways may be unconsciously testing us. They may be inviting us to show them the untenability of their criticisms or to tell them that they are "overreacting." They have probably heard that they are overreacting before ever meeting *us*. It means to them that they are being petty or oversensitive to react so strongly and that they have little, if any, genuine grievance. The patient often already believes *that* (unconsciously). Therefore, it is better to resist the patient's invitation and, in doing so, to resist interfering with the patient's attempts not to have to comply with parental blaming, put downs, rejections, and abuse. If we fail this test, we may make it harder for the patient to become aware of, and to take responsibility for, his own *real* feelings and wishes.

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