

# FOCUS

by Hal Sampson, Ph.D.

## Treatment by Attitudes

*Author's Note: This is an excerpt from the introductory section of an article I am writing on "treatment by attitudes." I plan to take up subsequently: 1) how treatment by attitudes is related to prominent currents in contemporary psychoanalytic thought; and 2) how certain unusual therapies—successful treatments carried out for long periods of time without interpretation, and with little explicit discussion by the therapist of the patient's psychology—illustrate the limitations of most theories of technique, and support Weiss's view that the essential feature in successful therapy is the changing of pathogenic beliefs.*

A young woman saw a therapist for consultation about beginning psychotherapy. In the first two sessions she said she was considering psychotherapy because she was unable to get into close relationships, especially with men. She was skeptical, however, about psychotherapy. Also, she lived about an hour away from San Francisco so that if she were to begin with this therapist it would take three hours to have one session. If she decided to begin therapy, it would be better to see someone down the Peninsula, near home. In the third session—during which the therapist was expected to make his recommendation—the patient began by saying she had decided *not* to begin therapy at this time. She might start later on. If so, she would see someone down the Peninsula. The therapist said he was ready to make his recommendation. He said therapy would be helpful, recommended that she begin now, and added that he would be happy to work with her if she wanted to do so. She immediately accepted, and added that she could start right away. She said she was very pleased to have the opportunity to work with him. The friend who had recommended him said he might be too busy to see her. Her thoughts turned to her father. She was going to visit him on the East coast. She called him several nights ago to discuss the visit. He had only a few minutes to talk. He was working on a big project and thought he would be free only two nights during her visit. She had become aware, to her surprise, of a twinge of disappointment.

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*She might start later on....*

I ask the reader to put aside questions about alternative ways the therapist might have addressed the patient's concerns, and to examine instead

what did in fact happen between these two people. The opening sessions have an almost paradoxical quality. The patient arranged to meet with a therapist in San Francisco, and presented a good reason for seeking therapy. She soon suggested, however, that she

didn't want therapy now and if she changed her mind later she would not see this therapist. The therapist did not investigate her views, explore her feelings, or attempt to interpret possible meanings of her ambivalence or of her decision. Instead, he ignored what she had just said, and recommended therapy, therapy *now*, and therapy with him. She accepted enthusiastically, and then recalled a recent experience in which her father did not seem very involved with her, and she had become aware, unexpectedly, of a "twinge" of disappointment.

This miniature therapeutic process, in spite of its paradoxical quality, seems immediately understandable in everyday human terms. I propose the following story. The patient anticipated that the therapist would not see her. I assume that this was not only because

he was reputed to be busy, but because she believed, perhaps unconsciously, that a man would not be interested in making time for her. In order to avoid the painful disappointment of rejection by a man whom she uncon-

sciously wished would be interested in her, she was cautious about investing emotionally in the possibility of working with him. The therapist, by committing himself to work with her, conveyed an attitude toward her which contradicted her own beliefs about rejectability. This attitude enabled her to feel, at least momentarily, more positive and hopeful about herself and therapy, and safe enough to make a commitment to it. The therapist's attitude also made it safe for her to begin to face, in however tentative and limited a way, what turned out to be lifelong feelings of disappointment and personal inadequacy in relation to her father.

The story I have proposed found support and enrichment in subsequent work between this patient and therapist. As the patient gradually unfolded her own story, the experience of rejection by a busy, successful, self-involved father played an important part in it. The patient had constructed in childhood, by inference from experiences of rejection, the beliefs that her father ignored her because she was uninteresting and unimportant, and undeserving of his time and involvement. In response to these beliefs, she was cautious about becoming emotionally involved with men. In therapy, the opening drama of hesitance to commit herself until the therapist did so first was repeated over and over in the transference, and was gradually explored, discussed and understood.

This vignette introduces, but cannot in itself fully illustrate, the theses of this paper: First, the attitudes a therapist conveys about a patient, as these attitudes are discerned and construed by the patient, are powerful determinants of the patient's progress. Second, concepts akin to *treatment by attitudes* are much in the air in contemporary psychoanalytic thought. They are present, for example, in the writings of the many analysts of diverse theoretical backgrounds who now emphasize the curative effects of the therapeutic relationship. Third, as Joseph Weiss discusses in his recent book, attitudes may be curative only if they help to change a patient's pathogenic beliefs about himself and his interpersonal

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world. Fourth, treatment by attitudes produces internal change; specifically, a change in intrapsychic beliefs that organize a person's expectations, feelings, and behavior, and underlie his or her symptoms and inhibitions. This internal change usually takes place only gradually and incrementally over long periods of time, but it may become firmly established and independent of the transference relationship, hence reliable and long-lasting.

Every psychotherapy or psychoanalysis involves treatment by attitudes. This is true even of the most austere treatment in which the therapist strives to maintain analytic neutrality and to influence the patient almost exclusively through interpretations. The therapist inevitably conveys throughout treatment, attitudes about himself and about life, as well as about his patient. He conveys attitudes by interpretation, by silences, by non-interpretive interactions, by his manner, and by who he is. He does so implicitly as well as explicitly, unintentionally as well as deliberately, and unconsciously as well as consciously.

The patient, in turn, is highly motivated to detect attitudes of the therapist that are pertinent to his beliefs about himself and his world. He construes these attitudes in terms of his own psychology and immediate concerns. Moreover, he actively tries to elicit from the therapist those attitudes that may prove helpful in his struggle against his pathogenic beliefs. He does so by testing these beliefs in relation to the therapist (Weiss, 1993). For example, the patient in our vignette may not only have been attempting to avoid disappointment if the therapist did not take her, but may also have been trying to find out how the therapist would react to *her* lack of commitment and rejecting attitude toward him and the therapy. In making a recommendation that

she start therapy now and with him, in spite of her professed decision not to do so, he consciously or unconsciously modeled an attitude she would want to acquire: an attitude of willingness to pursue a relationship even at the risk of disappointment and rejection.

Finally, I wish to suggest that treatment by attitudes involves a specific, understandable, orderly, and lawful treatment process. A specific therapist attitude helps to change a specific belief (or family of beliefs), and this in turn leads to progress specifically linked to the change in the belief. For example, the patient in the vignette, because her beliefs about her rejectability were slightly modified by the therapist's commitment to her, became able to feel friendly to the therapist, to commit herself to therapy, and at the same time began to become conscious of disappointment at her father's rejecting attitude. This patient would not have been helped to change these beliefs by other therapist attitudes, such as an attitude of neutrality, or an attitude of friendly support for her autonomy in deciding to defer treatment and then seek it elsewhere.

Treatment by attitudes is a ubiquitous process. It is usually readily understandable, although we may at times arrive at that understanding only later, when we have come by additional knowledge about what happened and what it meant to the participants. Treatment by attitudes is also a lawful process in that once we recognize how a patient is being helped by a specific attitude, we have discovered a recurring, predictable therapeutic sequence within that therapist-patient relationship. These views about order and lawfulness may seem to contradict the contemporary emphasis in much present-day psychoanalytic writing on the irreducible subjectivity of the analyst, and the intrinsic limitations about what he can

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## Shame and Guilt Studies...

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measured by the TOSCA. Contrasting with our past findings, the groups did not differ significantly in proneness to shame. As in our prior studies, we found women to be significantly higher in shame and adaptive guilt. There were, however, no differences between men and women in regards to the subscales on the Interpersonal Guilt Questionnaire.

This series of pilot studies suggests that broad theories of psychopathology may be studied by the kinds of instruments we have used. For example these studies suggest that the kinds of interpersonal guilt stressed in Weiss's theory are empirically related to childhood trauma and psychopathology. The particularly strong association between survivor guilt and trait and state guilt, automatic thoughts, pessimism, and depression suggests that this type of guilt may play a significant role in psychological distress. Survivor guilt may be an important contributor to a pervasive and general proneness to maladaptive guilt. Furthermore, the highly significant correlation between survivor guilt, omnipotent responsibility guilt, separation guilt and shame suggests that a person's excessive concern about harming others may be associated with shame about the self. These types of guilt and shame may be empirically connected although this association may not always be obvious or conscious.

The results of these pilot studies are suggestive, and need to be further investigated. We welcome other clinicians and investigators to work with us as we develop an empirically-based understanding of guilt and shame, psychopathology, and the possible effects of treatment.

### References

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## The Therapist's Task...

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The therapist by his reactions to the client's tests influences the client's behavior.

### The Corrective Emotional Experience

The theory proposed here assumes that the client in therapy may benefit from certain corrective emotional experiences, namely, the experiences that he himself unconsciously seeks by his testing of his pathogenic beliefs with the therapist. The therapist's reactions to the client's tests are in some ways similar to interpretations, for the client learns from both whether or not the therapist will help him to disprove his pathogenic beliefs and to pursue his goals. The idea of offering the client corrective experiences has been criticized as role-playing. In my view this criticism is unwarranted. All behavior is regulated by plans which may be conscious or unconscious. In everyday life the person adapts his attitude or approach to another person in accordance with his perceptions of that person's needs, capacities, and situation. For example, if a parent senses that his child feels overly constrained by his rules, he may relax them. Or if he senses that the child feels insecure from lack of structure he may attempt to provide structure. Similarly if the therapist senses that the client is threatening to stop in order to test the pathogenic belief that he deserves to be rejected, the therapist may urge him to continue. His doing this, in my opinion, is appropriate, empathic and therapeutic. By urging him to continue the therapist is helping him to disprove the belief that he should be rejected.

*Editor's Note: The version of this article appearing in Contemporary Psychoanalysis (30(2): 236-54, 1994) contains further case illustrations and an overview of the empirical research supporting the hypotheses presented in this article. That article was prepared for an analytic audience and thus the terms "analyst" and "patient" were used. This version, geared towards a wider audience, uses the terms "therapist" and "client."*



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know and when he can know it. They may also seem incompatible with writings about the intrinsic uncertainties of the analytic process. I shall take up later how my views are related to, and perhaps may be reconciled with, these contemporary emphases.

### Works Cited

- Weiss, Joseph. *How Psychotherapy Works*. New York: Guilford Publications, 1993.



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