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Affects in Psychopathology and Psychotherapy

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INTRODUCTION

This chapter examines the role of affects in psychopathology and in psychotherapy from the perspective of "control-mastery theory,"[1] a cognitively oriented psychoanalytic theory developed by Weiss (1971, 1986) and empirically tested by the Mount Zion Psychotherapy Research Group (Weiss, Sampson, & the Mount Zion Psychotherapy Research Group, 1986; for an overview of this research, see Silberschatz, Curtis, Sampson, & Weiss, in press). We will briefly describe Weiss's theory, focusing on the adaptive nature of affects. We will then discuss why affects may be inaccessible, and how such affects may be recovered in psychotherapy. In this context, we shall note how a patient's unconscious guilt may play a significant role in making his affective life inaccessible to him/her, and how overcoming this guilt may make it possible to recover his/her affects. Finally, using transcripts of a brief psychodynamic psychotherapy, we will present a case of a patient who sought treatment because of difficulty experiencing any kind of emotion and illustrate how unconscious guilt (based on certain pathogenic beliefs developed during the patient's childhood) had prevented him from having access to his emotional life.

ADAPTATION AND AFFECT

The control-mastery theory assumes that, from infancy, human mental life is regulated by efforts to adapt to reality (Weiss, 1986, 1989; see also Sampson, 1989). As part of this adaptive effort, the infant actively seeks reliable knowledge about reality, which includes him/herself, his/her interpersonal world, and the moral and ethical assumptions of his/her world (Weiss, 1989). The infant urgently needs this knowledge as a guide to behavior, and acquires it through experiences. This acquired knowledge is represented intraspsychically by beliefs—unconscious as well as conscious—about oneself and the world.

Affects are an innate part of a person's appraisal system and hence represent a central aspect of one's adaptive capacities. Affective responses may be seen as internal cues (signals) that help a person understand him/herself, relationships, and reality. Indeed, they provide crucial guides to one's overall assessment and experience of the world (i.e., is it pleasurable or frustrating, frightening or interesting, exciting or depressing).

A person's beliefs about reality (unconscious as well as conscious beliefs) ordinarily determine to a large extent one's affects. For example, a person who believes that he/she is in a dangerous situation is likely to feel anxious; a person who believes that he/she has been rejected by someone who is important is likely to feel sad; a person who believes that he/she has been unfairly criticized may feel anger. In other words, affects are ordinarily reactions to a person's appraisals of (i.e., beliefs about) one's reality; they serve as guides to potential courses of action and as motivators for action.

Emotional reactions and cognitive appraisals are typically intertwined in a person's ongoing appraisal of his/her reality. For example, a jogger confronted by a big dog running toward him may immediately feel frightened. His instantaneous affective reaction is based on a belief that the situation is potentially dangerous. The affective reaction alerts the runner and prepares him to take action. Fright may decisively shape his subsequent appraisals of the danger situation; however, his appraisal may be substantially modified by later perceptions. The jogger may, for instance, notice that the dog's tail is wagging, the dog is a golden retriever (a usually friendly breed), and the dog appears to be very playful. Because of his altered appraisal of the situation, his fear will subside.

Our conception of affect is consistent with an evolving cognitive view of emotions evident in many recent psychoanalytic contributions to affect theory that emphasize the continuity between affect and cognition (e.g., Basch, 1976; Brenner, 1974; Dahl, 1979; Emde, 1980; Lewin, 1965; Schur, 1969). Emotion is not regarded as the antithesis of thought or reason; rather, "affective reactions are part and parcel of the cognitive process" (Basch, 1976, p. 771). For example, in Dahl's (1979) model (see Chap-

ter 6, this volume), anxiety, depression, contentment, joy (and other "me" emotions) represent an appraisal of the status of one's goals or enterprises: "Positive me" feelings convey a signal or message that important wishes are being satisfied, while "negative me" feelings indicate that wishes are not being satisfied.

One common element in these recent psychoanalytic theories is that affects are an important source of adaptive information. Many emotion theorists working outside of a psychoanalytic framework have advocated a similar view (e.g., Arnold, 1970; Greenberg & Safran, 1987; Lazarus, 1984; Leventhal, 1984; Plutchik, 1980). In their recent review paper on the role of emotions in psychotherapy, Greenberg and Safran (1989) pointed out that the distinctions that have often been made between affect and cognition are breaking down and being replaced by information-processing models that integrate cognition and emotion. They noted that affective responses are often an important aid to problem solving and that it is therefore highly adaptive for a person to be able to access disavowed (i.e., repressed) emotions:

> Organisms that ignore their own affective feedback are not well situated to behave adaptively. Acknowledging affective responses that were previously disallowed makes certain reactions and moods more understandable and acknowledging disclaimed tendencies provides new impetus for action and need satisfaction. (p. 24)

AFFECTS IN PSYCHOPATHOLOGY

According to Weiss (1986), psychopathology stems ultimately from certain beliefs that impair functioning. Weiss refers to these as *pathogenic beliefs*. Pathogenic beliefs are beliefs about oneself and the world that are inferred from experience—typically, from traumatic experiences in childhood. Pathogenic beliefs warn the person who adheres to them about the dangerous consequences of pursuing certain important goals or experiencing certain ideas, wishes, or affects. For example, a child who noticed that his mother became depressed shortly after he began school and started to develop relationships outside of the home, developed the unconscious pathogenic belief that his independence caused his mother's depression. In obedience to this belief he renounced strivings toward independence and remained emotionally dependent upon his mother.

Pathogenic beliefs may impair emotional functioning. In some instances, a pathogenic belief may make a person unable to experience certain affects. For example, a patient whose father was chronically ill throughout the patient's childhood, warded off powerful feelings of anger, sadness, and depression because he was reluctant to burden his preoccu-

pied mother with his feelings. In other cases, pathogenic beliefs may compel a person to experience powerful affects that produce distortions of current reality and impede adaptation.

Pathogenic Beliefs and Inaccessible Affects

In general, a person may lack access to certain affects because he/she believes it would be dangerous for him/her to experience them. In certain instances, a person may believe that he/she is not entitled to virtually any affect. For example, a woman who grew up with a schizophrenic brother did not feel entitled to almost any strong feelings because she feared that such feelings would burden her beleaguered and overwhelmed parents.

It is maladaptive to be cut off from one's emotional responses because these responses provide crucial information of how one experiences and appraises important situations. Therefore, gaining access to previously inaccessible emotions can be an important step in correcting distorted (maladaptive) views of oneself and of important relationships. Weiss (1989) described a case of a patient who initially was not aware of mistreatment by his parents during his childhood. During his psychoanalysis, his first awareness of such mistreatment was becoming conscious of intense angry feelings toward both parents. This affect was followed by memories of humiliations by his mother and rejections by his father. The patient's becoming conscious of his previously repressed anger toward his parents was an important step in his recovery of key childhood memories and in his changing earlier beliefs about himself and his parents. Greenberg and Safran made a similar point in suggesting that the "evocation of emotional experience makes previously inaccessible beliefs available to consciousness" (1989, p. 24).

Pathogenic Beliefs and Dysfunctional Affects

Although emotional responses are part of a person's appraisal system, and hence crucial to adaptation, powerful affects (based on pathogenic beliefs) may in certain instances disrupt effective problem solving and impede successful adaptation. For example, a person who was ignored and disregarded by his parents in his childhood developed the belief that he was worthless, a "nothing." As an adult, he experienced the slightest instance of nonrecognition by his spouse or his boss as an unbearable insult confirming his worthlessness. He reacted by intense anger and urges toward violent attack against the person who had offended him. His anger was adaptive in the sense that it was a way of fighting back against the belief that he deserved to be disregarded; however, the rage distorted his percep-

tion of current situations, and was an inappropriate reaction to these situations. It also impaired his capacity to form a realistic judgment about useful courses of action. The solution to his problem did not lie in becoming more aware of his anger; rather it involved overcoming the underlying pathogenic belief so that he could react more appropriately and effectively to contemporary situations.

In a second example, the patient suffered from the unconscious pathogenic belief that it would be a betrayal of her mother to have a better marriage and family life than her mother. The patient's mother had ruined her marriage and family life by her constant outbursts of rage that alienated her from her husband and children. The patient, in obedience to her pathogenic belief, constantly flared up toward her husband and children, thereby spoiling her relationship to them. The solution to this patient's problem was not an increased awareness of anger or insight into its ostensible contemporary sources. Rather, the solution required that she become aware of her unconscious identification with her mother and overcome the pathogenic belief (i.e., that she should not be happier or better off than her mother) that gave rise to this identification. As the patient overcame her pathogenic belief she no longer had to be an angry person who spoiled intimate relationships as her mother had done.

HOW PREVIOUSLY INACCESSIBLE AFFECTS BECOME CONSCIOUS IN PSYCHOTHERAPY

The patient's problems may arise from the all too ready emergence of dysfunctional affects, as just discussed, or from the inaccessibility of affects that are defended against. We shall take up here the broad issue of how a patient in psychotherapy becomes conscious of previously inaccessible affects. In doing so, we shall focus on underlying processes that determine whether an inaccessible affect may become available to the patient.

A central question for all uncovering therapies is: How do previously warded-off feelings or ideas become conscious? The control-mastery theory emphasizes that a person exerts considerable control over one's conscious and unconscious mental life, and that perceptions of danger and safety (derived from beliefs about reality) play a central role in explaining human motivation and behavior (Weiss, 1971, 1986). The theory postulates three broad principles concerning the emergence of previously repressed material: (1) a patient may *unconsciously decide* to bring previously warded-off feelings into awareness; (2) the patient's decision is based on whether he/she feels he can do so safely; (3) the patient

brings previously warded-off mental contents into consciousness as part of an effort to master problems and conflicts and not to gratify infantile wishes.

Weiss (1971) identified three processes in psychotherapy that may influence a person's perception of safety or danger: external circumstances, degree of control over defenses, and the therapeutic relationship. The phenomenon of "crying at the happy ending" (Weiss, 1952, 1986) is an example of how an external change may make it safe for a person to experience previously warded-off affects. A person watching a movie of a love story may experience little emotion while the lovers quarrel, but is moved to tears at the happy ending when they are reunited. According to Weiss's explanation (1986), the moviegoer identifies unconsciously with one of the lovers. When the lovers are separated, the viewer is in danger of feeling intensely sad and consequently intensifies his/her defenses against sadness. When the lovers reunite, the moviegoer no longer has reason to feel sad. He/she unconsciously decides that it is safe to experience sadness (since it is now less of a threat) and lifts his/her defenses against the previously warded-off sadness. Patients in psychotherapy similarly make unconscious decisions to experience previously warded-off feelings when they feel that it is safe to do so (Weiss, 1986; for empirical research supporting this view, see Gassner, Sampson, Brumer, & Weiss, 1986).

Another example of how an external event may make it safe for a person to bring forth previously repressed painful affects is Weiss's vignette of Dr. N (Weiss, 1986, p. 10). In her second marriage, Dr. N was intensely moved by the birth of her son. Shortly after her son's birth, she wept profusely and retrieved memories of a son from her first marriage who had died several years earlier. Prior to the birth, she had no memories of her dead son (in fact, she had not recognized his picture in a family album). However, after the birth of her second son, she was able to recall and experience both how happy she had been with him and how devastated she was by his death. Weiss's explanation of Dr. N's bringing forth previously warded-off memories and affects parallels his description of the moviegoer's crying at the happy ending: Dr. N had repressed her sadness (and any memory of the dead son) because she was in danger of feeling overwhelmed by feelings of grief and loss. The birth of her second son is analogous to the happy ending in the movie. She was overjoyed by the birth, experienced it as partly making up for her earlier devastating loss, and consequently felt that she could now tolerate and face her sadness without feeling devastated and overwhelmed.

A second factor that may increase a person's sense of safety and facilitate the emergence of warded-off affects is a change in defensive structures, or what Weiss (1967) termed the integration of defenses. A person who has little control over a defense is likely to feel endangered by

the affects, ideas, or memories that the defense is warding off. If a person is able to develop control over one's defenses (e.g., through successful therapeutic work) then he/she can use the defense to regulate the emergence of unconscious contents: "The patient's capacity to regulate the warded-off mental content makes it safe for him to experience it, because he can control the experience, turning away from it at will if it becomes too painful or threatening. In this way, the patient can dose the new experience (the warded-off content), and can reassess the danger associated with it" (Sampson, Weiss, Mlodnosky, & Hause, 1972, p. 525).

Sampson, Weiss, et al. carried out an empirical study of a psychoanalytic case that investigated the relationship between a patient's developing greater control over his defenses (in this particular case, the defense of undoing) and the emergence of previously warded-off affects. A strong, statistically significant relationship was found between the patient's developing control over undoing and his capacity to tolerate previously repressed affects. These results support the hypothesis that the patient's increased capacity to control his defenses made it possible to regulate previously warded-off emotion and, hence, made it safe to experience the affect. In a study of a different psychoanalysis (the case of Mrs. C; see Weiss, Gassner, & Bush, 1986, for a description), Horowitz, Sampson, Siegelman, Weiss, and Goodfriend (1978) investigated the relationship between the patient's ability to distance herself from others (referred to as Type D behaviors and feelings) and her ability to express positive, loving feelings and to be close to others (Type C feelings). Mrs. C sought psychoanalysis because of a chronic inability to feel close to her husband and to enjoy sexual relations with him. Horowitz et al. suggested that Mrs. C's difficulty feeling close to others was related to her inability to distance herself from others. They reasoned that if Mrs. C lacked the capacity to distance herself, then intimacy could be experienced as dangerous because she would not be able to disengage from closeness when she wanted to and would thus run the risk of feeling stuck or entrapped. They hypothesized that once Mrs. C gained the capacity to distance herself, she would have more confidence in her ability to regulate intimacy and consequently feelings of closeness would not be as threatening. Indeed, they found that progress in Type C feelings followed progress in expressing Type D feelings. As Mrs. C became more comfortable disagreeing with others and expressing critical feelings, she progressively felt less vulnerable. As a result, she could allow herself to experience feelings of closeness, affection, and intimacy.

The third factor influencing a patient's feeling of safety is the therapeutic relationship. Just as a change in external circumstances or in the degree of control over defenses can make it safe for a person to experience previously warded-off affects, so too may a change in a patient's relationship with the therapist. An important part of a patient's effort to solve

problems and conflicts in therapy is bringing warded-off mental contents (wishes, affects, memories, experiences) into consciousness.

> The patient must do a great deal of work to overcome the internal danger he would face were he to experience a mental content he had warded off by defense. He does this work by attempting to create with the analyst a relationship that would protect him from this danger. An important part of this work is the patient's testing the analyst to assure himself that were he to bring the warded-off mental content to prominence or to consciousness, the analyst could be relied upon to respond in a way that would afford protection against the danger. (Sampson, 1976, p. 257)

A patient may test the therapist in order to assess the safety of bringing repressed affects or ideas into the therapeutic work (Weiss, 1971, 1986). For example, in the case of Mrs. C (referred to above) the patient tested the therapist by tentatively disagreeing with him and expressing critical feelings toward him (the patient's father had been unable to tolerate any criticism and would react to such feelings by either becoming enraged or by withdrawing and sulking). When the therapist responded to these tests by encouraging the patient to say more about her critical feelings or by pointing out her discomfort in criticizing him, the patient felt reassured (increased sense of safety) and frequently brought up previously warded-off memories and affects. Research studies have shown that when a therapist's behaviors and interpretations increase the patient's sense of safety ("pass the patient's tests"), the patient shows immediate improvement. For instance, in an empirical study of a psychoanalysis, Silberschatz (1986) found a significant correlation between the degree to which the therapist passed the patient's tests and changes in the patient's level of experiencing and expression of affects. Similar results have been found in other studies (e.g., Bush & Gassner, 1986; Fretter, 1984; Silberschatz, Fretter, & Curtis, 1986; for a review of this research, see Silberschatz, Curtis, & Nathans, 1989; Silberschatz et al., in press).

The concept of pathogenic beliefs helps explain why these three factors (external changes, defensive control, and the therapeutic relationship) all may lead to increased safety and accessibility of warded-off mental contents. A person's assessment of safety and danger is strongly influenced by his/her unconscious pathogenic beliefs. Thus, any experience or interaction that disconfirms a pathogenic belief will increase a person's sense of safety and thereby allow him/her to lift repression against warded-off affects, ideas, and memories.

In the phenomenon of crying at the happy ending, a change in external events may help a person to disconfirm pathogenic beliefs. For instance, Weiss (1986) suggested that Dr. N (who, following the birth of her second son, recalled previously repressed memories of her first son's

death) unconsciously experienced the death of her first son as a punishment and developed the pathogenic belief that she did not deserve to have a son. The birth of her second son helped her to disconfirm the belief that she was undeserving and thereby allowed her to feel less endangered by the previously warded-off memories of her first son's death. Once this belief was disconfirmed, she could recall the death of her son and experience it not as a punishment but as a tragic and undeserved loss.

Similarly, a patient in psychotherapy works to disconfirm pathogenic beliefs by testing them in relation to the therapist and by using the therapist's interpretations to understand and ultimately disconfirm these beliefs. As the patient disconfirms pathogenic beliefs, he/she becomes less frightened of the dangers they foretell. Consequently, the patient may decide (unconsciously) that he/she can safely experience certain previously warded-off contents and that it is safe to bring them into consciousness.

PATHOGENIC BELIEFS, FEELINGS OF GUILT, AND THE ACCESSIBILITY OF AFFECT

Traumatic childhood experiences lead to pathogenic beliefs that may block access to one's emotional life. Beliefs of being punished for expressing affect (e.g., anger, rivalry) or fears of being overwhelmed by the intensity of emotion (e.g., sadness) are widely understood obstacles to affective expression. We will briefly discuss a less recognized though significant factor for warding off emotions: pathogenic beliefs associated with unconscious guilt (for a thorough discussion of the role of unconscious guilt in psychopathology, see Bush, 1989; Friedman, 1985; Weiss, 1986, pp. 43–67).

The control–mastery theory emphasizes a person's fear of hurting others as the source of both rational and irrational guilt feelings. Bush (1989) defined irrational guilt as an acutely distressing feeling stemming from

> distorted unconscious beliefs about having done something bad in the fundamental sense of doing something hurtful or being disloyal to another person towards whom one feels a special sense of attachment or responsibility, such as a parent, sibling, or child. (p. 98)

Two major types of unconscious guilt feelings leading to psychopathology are stressed in control–mastery theory (Weiss et al., 1986): separation guilt and survivor guilt. Separation guilt stems from a pathogenic belief that becoming independent of a parent will hurt the parent (Modell, 1965;

Weiss, 1986). Modell has noted that for people who suffer from this type of guilt, separation from mother is unconsciously perceived as killing her. Similarly, Loewald (1979) has suggested that many patients unconsciously experience becoming autonomous from their parents as tantamount to parricide.

The concept of survivor guilt is based on Niederland's (1981) psychotherapeutic work with survivors of the Holocaust. He conceptualized it as a powerful, often unconscious feeling of guilt, together with unconscious fears of punishment, for having survived a calamity in which others suffered or perished. The concept of survivor guilt has been further elaborated (e.g., Bush, 1989; Friedman, 1985; Modell, 1965, 1971; Weiss, 1986) to include experiences of guilt by people who believe that they have better lives than their family members or loved ones. For instance, Modell (1971) noted that survivor guilt is "not confined to particular diagnostic groups, but represents a fundamental human conflict" (p. 340) and thus has universal significance. Unlike Freud's model of unconscious guilt, which emphasizes sexual or aggressive wishes as its fundamental source, survivor guilt originates from a person's love for his/her family and from the false conviction that one has inadvertently harmed a love object—for instance, by getting more of the good things in life than a loved one has received.

This conceptualization of pathological guilt clearly highlights the interconnection between pathogenic beliefs and the affective experience of guilt. In his review of theories of guilt, Friedman (1985), building on Hoffman's work on altruism and empathy (1982, 1984), identified three components of guilt: affective, cognitive, and motivational.

> The affective component of guilt is a combination of empathic distress, the content of which will vary across situations, plus a common feeling, difficult to capture in words, but perhaps best described by Melanie Klein's term, depressive anxiety. The cognitive content of guilt is the belief that one's plans, thoughts, or actions are damaging to a person for whom one feels responsible. The motivational component consists of a plan either to avoid an intended action, to make reparation, or to defend against the guilt. (Friedman, 1985, p. 529)

CLINICAL ILLUSTRATION

We turn now to a psychotherapy case to illustrate how the disconfirmation of pathogenic beliefs that give rise to guilt feelings may contribute to the emergence of warded-off affects and memories (parts of the case description are taken from Silberschatz & Curtis, 1986). The patient, Mr. M, was a 25-year-old, single college graduate who sought therapy because he was

unable to experience emotions strongly, "be they happiness, affection, or whatever." He had few interpersonal relationships, had a lifelong problem with sexual impotence, and was distressed about recurring sexual fantasies of being tied down or of tying a woman down. Although he had completed a year of graduate school, he felt very dissatisfied with and hopelessly stuck in a low-level job. Overall, he felt depressed, uninterested in anything, lonely, directionless, and in doubt whether it was worthwhile to go on living. He was very doubtful that therapy could actually help him.

Mr. M was the third of four children born in a small Midwestern city to very strict Roman Catholic parents. His father had remained in a low-level job throughout his career. Moreover, the father had had serious health problems since the patient's childhood but had never sought medical help. The father suffered from chronic emphysema, yet he refused to stop or cut down on his smoking. Similarly, the father refused for years to consult a dentist, and when he finally did so, his condition was so poor that all of his teeth had to be removed. The patient characterized his father as extremely passive, joyless, unable to "stick up for his rights," and as someone who was "hopelessly stuck."

The patient said little about his mother at intake, except to note that she was a kind, though "excitable" woman who sometimes took tranquilizers. He viewed her as a very weak woman who complied with her husband's drab life-style. Mr. M made clear that he disliked the dull, joyless, extremely sedentary life that both of his parents led: "When they were in their 40s, they lived their lives as if they were in their 70s." They did very little as individuals or as a family. The father came home from his low-level job and sat around passively or slept. The patient referred to his father as "dead at night."

Mr. M's primary pathogenic belief was that he was responsible for the unhappiness of both parents and, most manifestly, for the unhappiness of his father. Because he felt irrationally responsible for his father, the patient felt deeply frustrated by his inability to do anything useful for him. Throughout his life, the patient's own initiative had been squelched in various ways: by identification out of guilt with his passive parents, by the discouraging failure of any action he took actually to change his parents' situation, and by his belief that both parents were hurt by any initiative, independence, or happiness that the patient displayed.

The patient worked to disconfirm his pathogenic beliefs by testing them in relation to the therapist. For instance, he gave the therapist responsibility for his suffering and unhappiness as he had felt responsible for his parents' suffering and unhappiness. If the therapist did not feel irrationally responsible for him, this would reduce to some extent the patient's own belief that he was responsible for his parents. The patient also tested whether the therapist would feel helpless and discouraged by the patient's doubts, criticisms, and alck of responsiveness as he himself

had been discouraged by his parents' behavior. These tests, which took place repeatedly over many sessions, were an integral part of the therapeutic process. As Mr. M began to disconfirm certain pathogenic beliefs (particularly beliefs connected to his omnipotence and irrational guilt) he felt less need to identify with his parents' beleaguerment and grimness. He then started to become aware of powerful, previously inaccessible affects—initially, feelings of sadness and anger toward his parents and subsequently, feelings of enthusiasm, affection, and pleasure.

In the following (disguised) excerpt, taken from the beginning of the 16th session, the patient describes newly emerging affects about himself and his family. This excerpt follows an interchange with the therapist regarding the patient's being behind in paying his bill. The therapist commented that the patient may feel guilty about doing something (keeping current with his bill) that his father was unable to do (father was frequently behind on bills, especially health care bills).

PATIENT: It just appears that some things were too big for him. I mean, not too big but too uh, too frightening and took too much, I don't know what you say, effort or maybe courage for him and my mother to face directly. So I get the feeling that I didn't face them at all. The obvious one that I've just kept saying over and over again is just that as his health continued to decline back in the days when something could have been done about it, nothing was done about it, and gradually what happened was unhealthy and uncomfortable situations that would be obvious to someone else, to an outsider, that would be obviously in need of correction, in need of some kind of attention, (*sigh*) were just tolerated. (*silence*) And I get the feeling that at least as far as I can tell, I am the one that is most annoyed at our family. My mother is, she must have lived with some kind of anxiety for a long time. She was always kind of nervous, but say ten years ago when, uh, when my father began to grow more uncomfortable, and as he continued to go to the doctor without any, without much sign of benefit, I, she must have felt some kind of anger and some kind of rage that he wasn't saying more to the doctor and that more wasn't being done. What she feels now is just, uh, resignation and, uh, she has told me on more than one occasion she just takes each day as it comes. As far as my brothers and sisters, I don't think any of them feel the way that I do. I think they're just, uh, I don't think any of them are hostile, I think they're just tired of the way things have been for so long. And I think, and I know everybody is sorry to see my father as uncomfortable as he is, but I think I'm the only one that's angry.

THERAPIST: You've implied that at various times, and seem to feel now that you shouldn't be.

P: Yeah. That's, that's, I think it depends on how I feel that day. If I'm feeling uh, if I'm feeling well, fairly comfortable and hopeful and optimistic

and uh, I don't feel at odds with any particular thing in my life. (*sigh*) I don't, well I think I feel the anger but, uh, I'm not totally aware of it, and if I think, as I tend to think a lot, when I think about how, how the family ended up, how my folks ended up, I think, well that's too bad, it's too bad that it ended up that way. It's too bad that anybody has to live that way for so long, under such strained conditions, which you can't do anything about now. And I know it's days where I'm just sick of going to work or, uh, or another bill has come that I have to pay (*sigh*) that I'll get angry that I'm stuck or that I've been stuck, that I haven't made my life any different than it was, at least more comfortable, and almost always on days when I'm that, uh, when I'm that keyed up, I almost inevitably end up thinking about my father and myself and about the times that he did things that made me want to scream, even annoyed at myself. (*sigh*) I don't feel like I was pushed around but I just feel like I was so weak all the time, so weak and so afraid, afraid to say anything to him, afraid to, just to stand up against him.

T: Seems like you thought that you should've done more, that you felt some sort of responsibility.

P: Well, in some ways I feel, (*sigh*) I feel like all of us could have bugged him more to seek a better doctor than we had. But we didn't because nobody ever said to my father—my father never did anything he didn't want to do, and the family uh, struc—, the environment was not the kind that you might see on a TV show or the kind that Dr. Joyce Brothers might recommend where everybody gets together around the table and discusses problems bothering the family and makes suggestions. It wasn't like that. Things weren't going, on more than one occasion my father got up from the dinner table and just walked away because he didn't like what was being asked of him. (*sigh*) But more, (*pause*) the regret I feel and the feeling that I could have done more or taken more responsibility is not for him but for my own life. (*sigh*) And I did, I did do a lot of things that I didn't like doing or wasn't comfortable doing, uh, but I was, but I was always scared to take some other kind of step, to go in some other direction that nobody else was going in, such as staying out of school or, (*sigh*) or going to different schools when I didn't know what I was going to (*sigh*) or perhaps trying to mix with some other people than the people I used to hang out with that weren't always so much fun to be with. (*sigh*) And yet when I do something that I think is, is, uh, breaking away or going in another direction, I don't usually feel good about it.

This vignette illustrates the initial emergence of feelings of sadness and anger in a patient who came to treatment complaining of an inability to experience any emotions. In earlier sessions, as noted above, the patient had begun to disconfirm his pathogenic belief that he was responsible for his father's suffering by testing this belief in relation to the therapist. As the patient began to feel less irrational sense of responsibility, he could

allow himself to become more separate from his father and his father's suffering, and thereby he could feel both greater sadness for him and for the family's suffering and anger at his father's inability to change. The therapist's interpretations just prior to the transcribed excerpt focused on the patient's identification with his father—expressed by keeping himself small and ineffective—because of guilt about doing better than father. The patient's subsequent anger at his father was an important step in allowing him to be different from his father; for example, to be more active, less resigned to fate, more able to use help, more alive. Indeed, in subsequent hours, the patient began to take more initiative, to show more enthusiasm, and even to begin to feel some pleasure and emotional involvement. The patient continued these changes after therapy. At the follow-up interview 1 year after termination of this brief (20-session) treatment, further progress was evident. The patient had started a relationship with a woman toward whom he felt affectionate, and he was able to enjoy sexual intercourse with her. The independent clinical evaluator who interviewed Mr. M at the 1-year follow-up was impressed with his strong, positive feelings toward this woman, his hopefulness and aliveness. This contrasted sharply to the initial, pretherapy interview in which the patient complained of an inability to feel emotions or to be interested in anything.

CONCLUSION

A person's affects are typically determined by his/her conscious and unconscious beliefs about reality; for instance, one is likely to feel anxious if he/she believes him/herself endangered, angry or frightened if he/she believes him/herself attacked, elated if he/she believes him/herself triumphant. The affective response is itself a vital source of information in appraising reality as well as a motivator of corrective action. Affects thus play a crucial role in adaptation. Certain pathogenic beliefs (Weiss, 1986) may interfere with the adaptive function of affects. Such pathogenic beliefs may either cause a person to experience affects that are inappropriate to the present situation or prevent a person from experiencing certain emotions, thereby depriving him/her of essential information about his/her reality. Successful psychotherapy helps the patient to disconfirm the pathogenic beliefs leading to these problems.

We have examined how a patient in psychotherapy may disconfirm pathogenic beliefs and gain access to previously inaccessible affects. An instructive paradigm of how this happens is the phenomenon of "crying at the happy ending," in which a change in external circumstances (a happy ending) disconfirms a pathogenic belief and thereby makes it safe to experience previously inaccessible affect (sadness). In psychotherapy, patients change their pathogenic beliefs by testing them in relation to the

therapist and by using therapist interpretations to disconfirm these beliefs. As pathogenic beliefs are disconfirmed, the patient feels an increased sense of safety and may begin to experience previously inaccessible affects.

NOTE

1. The theory is referred to as the control–mastery theory because Weiss postulates that patients have *control* over their unconscious mental functioning and come to therapy to *master* their problems.

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