

THE THEORY WHICH WE ARE TESTING AND THE EVIDENCE FOR IT

Presented by Joseph Weiss, M.D.
October 2, 1976 - Langley Porter
Research Conference

In my talk, which will be brief, I shall do two things:

I shall discuss the theory which we are testing in our research,
and I shall indicate, in a general way, the kinds of findings which
would be evidence for it.

Our theory is quite broad. It pertains to such questions
as: How does analysis work? What does a patient do in analysis?
How should the analyst try to help him? Our theory is relevant, not
only to analysis, but also to other kinds of therapy, and despite being
broad, it is, as Hal Sampson and Joe Caston will demonstrate, testable
by rigorous and replicable research methods.

Our theory is an extension of Freud's Ego Psychology. It

elaborates and develops Freud's Ego Psychology, and it contrasts with the traditional psychoanalytic theory of therapy and technique which Freud put forth before he developed Ego Psychology and which, despite Ego Psychology, is still the basis of the present-day theory of therapy and technique.

Let me state the major tenets of the theory which we are testing. It assumes that the patient exerts considerable control over his unconscious mental life and that his chief unconscious wish is to solve his problems by resolving the conflicts which underlie them. It assumes, too, that the patient works throughout his analysis to resolve his unconscious conflicts by attempting to make conscious the mental contents which he has warded off so that he can put them under conscious control.

A good way to make our theory clear is to contrast it with the traditional theory.

The traditional theory assumes that all the processes of therapy and, indeed, all mental processes, except for the reception of external stimuli, can be explained in terms of powerful psychic forces or drives, which interact, dynamically, beyond the patient's control. The ego itself, in its interactions with these forces or drives, behaves as such a force. It interacts dynamically with the drives and does not control them. Another way of saying this is that in the traditional theory, all mental processes are determined by psychic forces, each of which has a strength and a direction. These forces are additive like vectors. They interact with one another, cancelling out one another, reinforcing one another, etc. From their interactions, all behavior can be derived.

The theory which we are testing agrees with the traditional theory about the importance of powerful forces, or drives. However, in contrast to the traditional view, it assumes that the patient generally exerts at least a crude unconscious control over these forces, though he may at times lose his control over them.

In our view, then, behavior is not determined by the dynamic interactions of powerful forces, but is directed by the patient, who controls it in accordance with unconscious decisions and plans. He decides what he will do and then he does it. In deciding what he will do, he takes the forces, or drives, into account, but his decisions may be, as suggested by Hartmann, independent of the drives, and are not, as in the traditional theory, merely expressions of the drives and thus epiphenomena which have little or no effect upon behavior.

Let me put this contrast in the simplest possible terms:

The traditional theory is a drive theory; behind every unconscious process it sees a dynamic interaction. For example, the traditional theory explains the development of the transference neurosis dynamically by assuming either that the transferences were intensified, or that the defenses which were warding them off were weakened, or that both of these things took place.

Our theory, on the other hand, besides assuming the importance of drives, also assumes the importance of decisions which are about drives but which may be independent of the drives.

Where the traditional theory would explain the expression of a drive, by saying that the drive is mobilized, we might say that the patient decided to express the drive. In our theory, the transference neurosis may develop in two ways. It may develop as described in the

traditional theory--beyond the patient's control. This, however, in our view, happens rarely, and when it does happen, it is not therapeutic but disruptive. It causes the patient great anxiety, and does not lead to insight. We believe that, most of the time, the transference neurosis develops within the patient's control; it develops as a result of the patient's making his transferences prominent, as part of his working to make them conscious, and to master them.

This brings me to an additional contrast between the traditional theory and our views. The traditional theory sees the patient as motivated unconsciously to seek drive satisfaction and attributes no other kind of unconscious motivation to him. We, on the other hand, assume that the patient's most powerful unconscious wish is to solve his problems. We assume that he knows, unconsciously, that his problems stem from his poor control over the mental contents,

(that is, impulses, affects, ideas and attitudes) which he has warded off, and he knows, too, that to solve his problems, he must make these contents conscious and master them. Therefore, he works against his resistances to solve his problems by attempting to bring the unconscious contents to consciousness so that he may put them under conscious control.

Another way of explaining our theory is to describe a familiar phenomena which seems paradoxical, but which our concepts make comprehensible. It is the phenomena of crying at the happy ending. Years ago I found this phenomena illuminating. Let me describe a typical instance of it:

A person who is watching a movie about a love story, experiences little, or no emotion as he observes the lovers quarrel and separate. He is deeply moved, however, when they are happily reunited. He shares their happiness, and at the same time begins to weep.

The moviegoer's reaction is paradoxical; one would expect him to become sad when the lovers separate, but not when they are reunited.

In the article which I wrote in 1952 about crying at the happy ending, I explained this paradox as follows: The moviegoer is saddened by the separation of the lovers. However, he is threatened by his sadness so that he wards it off, and thus does not express it. Then, when the lovers are re-united, he no longer has a need to ward off his sadness about their separation, so that he lifts his defenses and brings the sadness forth. He brings it forth in order to master it and thus to resolve his conflict with it.

This explanation assumes that the sadness comes forth because the moviegoer brings it forth and not because, as the traditional theory assumes, the sadness breaks through the patient's defenses to consciousness.

It assumes, too, that the moviegoer controls the coming forth of the sadness, bringing it forth when he unconsciously realizes that he could safely experience it.

The traditional theory is hard put to explain the phenomena of crying at the happy ending. It assumes, of course, that the sadness breaks through the patient's defenses to consciousness. Since it does not acknowledge that the patient could lift his defenses, it has no other way of explaining the sudden emergence of an unconscious mental content which has not been interpreted.

The traditional theory does not give a good explanation about why the sadness breaks through just when the moviegoer becomes relieved and happy. In order to explain this, in its own terms, the traditional theory should show that the sadness was intensified, or that the defenses

opposing it gave way, and it should link these events to the moviegoer's sudden happiness. This it does not do, for the moviegoer's sudden happiness would neither intensify his sadness, nor weaken the defenses opposed to it.

The traditional theory also fails to account for the moviegoer's not feeling anxious and upset as he experiences the sadness. For, if the sadness had become conscious because it had become so strong in relation to the defenses, that it had broken through them to consciousness, the moviegoer would have become anxious about the sadness and would develop a conflict with it.

This brings us to the second topic of my paper; that is, the evidence for our theory, in particular, for two of its central tenets. These are that the patient generally exerts control over his unconscious

mental life and that he is powerfully motivated to gain mastery over the mental contents which he has warded off by defenses.

To find such evidence, we must do two things: We must find in patients certain behavior patterns which our theory could explain, but which the traditional theory could not. We must then study patients carefully, by clinical methods, by research methods, or by both of these, to determine whether or not they demonstrate these behavior patterns.

We have not discovered any behavior patterns which the traditional theory could explain, but which our theory could not explain. However, we have found a number of patterns which our theory could explain, but which the traditional theory could not. I will take up just two such patterns. Then Hal Sampson will describe the research methods we have

used and are using to determine whether or not patients demonstrate these patterns.

The first pattern emphasizes the patient's ability to bring forth a powerful mental content, on his own, unaided by the analyst.

It is the patient's becoming conscious of a previously warded off mental content on his own, unaided by the analyst, his not feeling much anxiety about this content, his keeping this content in mind without a great deal of conflict about it, and his proceeding to master it.

An example of this pattern is a patient becoming aware, say, of a powerful homosexual impulse which had not been interpreted, his not feeling anxious about this impulse, his keeping it in consciousness without feeling much anxiety about it, and his using his knowledge of it

appropriately, to understand more about his relationship to the analyst and to the objects of his past and present life.

Our theory could readily explain this pattern because it assumes that the patient could control the coming forth of the homosexual impulse. He could keep it unconscious until he had overcome most of his anxiety about it, and then bring it forth in order to master it.

If he were to keep the homosexual impulse unconscious until he had overcome his anxiety about it, he would not, after bringing it forth, necessarily experience much anxiety about it, and he would be able to master it, on his own, unaided by the analyst.

The traditional theory, however, could not explain this pattern. Since it assumes that the patient could not lift his defenses, it

could explain the sudden emergence of the homosexual impulse in only one way--by the idea that the impulse broke through the patient's defenses to consciousness. Were this to happen, however, the patient would be very upset about the homosexual impulse, and he would develop an intense conflict with it. He would struggle to repress it and would not proceed calmly and without anxiety to master it.

Let me now turn to the second pattern. It is more elaborate than the first, and it includes an instance of the first.

Its main point is that the patient is unconsciously pleased, not frustrated, when the analyst does not attempt to satisfy an unconscious transference which the patient is pulling for him to satisfy.

Here is the pattern: The patient pulls unconsciously for the

analyst to gratify the transference. The analyst does not gratify it.

The patient then is unconsciously pleased with the analyst, though he would not be likely to acknowledge this. He becomes more optimistic than before and more confident that the analysis will help him. He tackles problems which before he had been afraid to tackle. He then becomes conscious of the transference which he had pulled for the analyst to gratify. He is not particularly anxious about it, he keeps it in consciousness, and he proceeds to master it.

Let me present an example of this pattern:

A patient is unconsciously sexually seductive toward the analyst. He pulls unconsciously for the analyst to admire him, to give him extra appointments, and to show special interest in his sexual fantasies. Each time the analyst does not accede to such a pull, the patient

becomes less anxious and more confident. Then, on one occasion, after the analyst does not attempt to gratify the patient's homosexual impulses, the patient becomes conscious of his homosexual interest in the analyst. He is not, however, anxious about his homosexual feelings. He keeps them in consciousness without coming into conflict with them, and proceeds to master them.

Our theory could readily explain this sequence of events as follows:

The patient would like to bring forth his warded off homosexual interest in the analyst in order to master it. However, he hesitates to bring it forth, fearing that the analyst would attempt to satisfy it and thereby endanger him. For the patient knows that his unconscious control of his homosexuality is weak, so that he would be in danger of losing his

control over it if the analyst were to behave sexually toward him.

Since the patient realizes that he could safely become aware of his homosexual interest in the analyst, only if he knows that the analyst would not be seduced by it, he decides to test the analyst in order to find out how the analyst would behave if he were to express this interest. He tests the analyst by pulling for him to satisfy the homosexual transference, thereby tempting the analyst to do the very thing which the patient would find threatening.

The patient infers from the analyst's not acceding to his pulls, that the analyst would not behave sexually to him. The patient, therefore, gains confidence in the analyst and becomes more hopeful that the analysis will help him. He becomes less afraid of the homosexual

transference, and he brings it forth. Since he has overcome much of his anxiety about expressing it before bringing it forth, he is not especially anxious about it after making it conscious. He keeps it in consciousness without coming into serious conflict with it, and puts it under conscious control, unaided by interpretation.

The traditional theory could not explain this pattern. It could explain the patient's becoming conscious of the transference by the idea that the transference is frustrated by the analyst so that it becomes intensified and breaks through the patient's defenses. However, if this were to happen, the patient would be in considerable conflict before the homosexuality came forth, rather than optimistic and confident. And he would be anxious while the homosexual feelings were becoming conscious and after they had become conscious. He would struggle to ward them off and would not proceed calmly to master them.

I have outlined, then, two patterns which, if verified in the behavior of patients, would support our theory over the traditional theory. Hal Sampson will now tell what we have done, are doing, and will do, to verify these and similar patterns.