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The Nature of the Patient's Problems and How in Psychoanalysis the Individual Works to Solve Them

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The patient's psychopathology stems from pathogenic beliefs acquired in childhood from traumatic experiences with parents. The patient's pathogenic beliefs warn the patient that if he or she attempts to gratify certain impulses or to seek certain developmental goals the patient will risk the disruption of his or her all-important parental ties. It is as a consequence of these beliefs that the patient develops fear, anxiety, guilt, shame, or remorse; institutes repressions; and develops symptoms, inhibitions, and faulty object relations. The patient suffers unconsciously from pathogenic beliefs and so is powerfully motivated unconsciously to work with the analyst to disconfirm them. The patient works by testing the beliefs in relation to the analyst in the hope of disconfirming them, and by assimilating insight into the beliefs (and their falseness) conveyed by the analyst's interpretations. Indeed the therapeutic process is in essence the process by which the patient works consciously and unconsciously with the analyst to disconfirm pathogenic beliefs.

This article is about the nature of the patient's problems and how in treatment the individual works to solve them. My presentation is based more or less on the theory I developed and that Sampson, myself, and the Mount Zion Psychotherapy Research Group supported by quantitative, empirical research (Weiss, Sampson, & the Mount Zion Psychotherapy Research Group, 1986).

My main thesis is that the patient's problems stem most directly from certain unconscious beliefs about himself or herself, his or her interpersonal world, and himself or herself in relation to this world. These beliefs are generally acquired in early childhood. They impede or prevent normal functioning and so may be called pathogenic. In a successful analysis, the patient solves his or her problems by changing these beliefs. The psychoan-

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alytic process is in essence the process by which the patient works with the analyst to do this.

This thesis is embedded in the theory of the unconscious mind that Freud developed in some of his late writings as part of his ego psychology. In these writings Freud (1926, 1940) stated explicitly that a person may exert control over his or her unconscious mental life, including his or her repressions. In his last major work, *An Outline of Psychoanalysis* (1940), Freud wrote that in regulating his or her unconscious mental life, a person is especially concerned with safety and danger. In unconsciously deciding whether he or she may safely carry out a particular action, a person thinks, assesses reality, and takes account of beliefs based on past experience. In assessing reality he or she may make use of trial actions—that is, tests of the environment. The individual may then, on the basis of thoughts, beliefs, and assessments of reality, unconsciously decide whether he or she may safely carry out the action, or whether to delay carrying it out or to repress the wish to do so.

The idea that psychopathology arises from certain pathogenic beliefs is derived particularly from Freud's views, as developed in his late works, about the great part played by castration anxiety in the psychopathology of the man (1926, 1940). According to Freud, the male's castration anxiety is rooted in the belief that if he maintains a sexual interest in his mother, his father will punish him by castration.

Pathogenic beliefs should be distinguished from fantasies as Freud defined them. Freud (1911) wrote that fantasies are wishful, regulated by the pleasure principle, and exempt from reality testing. In fantasying, a person turns from reality. In contrast, pathogenic beliefs are not wishful, but grim and constricting. They are not opposed to reality; they represent reality. In the language of Freud's structural model, they are part of the unconscious ego (Freud, 1926, 1940). The id or primary process as described by Freud cannot create beliefs. The id simply turns effortlessly (automatically) away from painful realities.

Freud emphasized that the belief in castration is about reality. He used the phrase *belief in castration* and not *fantasy of castration*. For example, he wrote that after a boy who has been threatened with castration perceives the female genitals, "he cannot help *believing* in the *reality* of the danger of castration" (1940, p. 277, italics added).

The theory in which my views are embedded, although Freudian, is quite different from the theory that Freud presented in his early writing (1900). For example, in *The Interpretation of Dreams* (1900) Freud endowed a person with little or no capacity unconsciously either to think or to make use of higher mental functions. Freud assumed that the mind functions automatically—that is, without thought. It consists of psychic forces: namely, instinctual impulses (wishes) and defenses. The impulses seek immediate gratification; the defenses oppose their coming forth. The impulses and de-

fenses interact automatically, uncoordinated by thought, plan, belief or assessment of current reality. From the dynamic interactions of these forces may be derived all or almost all of the phenomena of mental life.

The theory presented in *The Interpretation of Dreams* may be referred to as the "hypothesis of automatic functioning." It contrasts with those parts of Freud's ego psychology from which the theory proposed here is derived, and which is based on what I refer to as the "hypothesis of higher mental functioning." Although this latter hypothesis does not rule out all unconscious automatic functioning, it assumes that a person may exert a considerable degree of control over his or her unconscious mental life, and that he or she may regulate it in accordance with *unconscious* thoughts, beliefs and assessments of current reality.

Freud never was able to stick rigidly to the automatic functioning hypothesis. Even in *The Interpretation of Dreams* he violated it in a number of places. Today, most analysts assume both kinds of regulation. However, even today the automatic functioning hypothesis exerts considerable (perhaps predominant) influence on clinical thinking.

PATHOGENIC BELIEFS

I now return to the topic of pathogenic beliefs. These may be beliefs about how things are (reality) or how they should be (morality). They impede normal functioning by giving rise to fear, guilt, shame, remorse, helplessness, and inadequacy. They may cause constriction, inhibition, or repression. A person acquires pathogenic beliefs, usually in early childhood, by inference from traumatic experiences with parents and siblings. These experience are, of course, limited by the child's level of intellectual development and by the child's outlook and needs. They may or may not be highly distorted. In the *Outline* (1940), Freud assumed that the boy infers the belief in castration from real and relatively undistorted experiences. A boy may first become aware of the danger of castration from parental castration threats. The boy may not be much impressed with these threats at first. However, after he perceives or remembers seeing the female genitalia, he may put two and two together and become convinced that the threats are real. Thus the belief in castration may represent a reasonable intellectual achievement given the limitations of the boy's perspective.

A child, as already noted, may acquire a variety of pathogenic beliefs. For example, a child may infer and so come to believe that if dependent on a parent he or she will drain that parent's strength, or that if independent of a parent he or she will devastate the parent. Or the child may develop both of these beliefs. Or the child may infer that if competitive with a parent he or she will risk punishment from the parent, or that he or she must be competitive in order to reassure a worried parent that he or she is able to

compete. Indeed, the child's pathogenic beliefs may link almost any impulse or goal with any danger.

Pathogenic beliefs usually reflect the child's early parental relations. They reflect the child's early motivations, and they may be concerned with normal developmental goals. Thus, they may be concerned with the child's wishes to depend on his or her parents, to trust them, to develop the capacity to be independent in relation to them, to compete with them, or to identify with them.

Pathogenic beliefs also reflect the child's tendency to endow his or her parents with supreme authority. The young child assumes without question that parental behavior, attitudes, and ideas represent not only the way things are but the way they should be. That is, the child assumes that the way his or her parents treat him or her is the way he or she should be treated. The child endows parents with such great authority for several reasons: First, they are the child's first authorities; the child has no prior experience by which to judge their behavior; second, the child needs his or her parents in order to survive. Because parents are such an important part of the child's life, the child wants to consider them trustworthy, powerful, and wise. The child wants to be proud of them, emulate them, comply with them, believe them, and be loyal to them. The child's wish to maintain ties to parents in these ways is a very powerful motivation.

Finally pathogenic beliefs reflect the child's tendency, based on egocentricity and lack of knowledge of causality, to take responsibility for whatever he or she experiences. The child may take responsibility for anything unfavorable that a parent does or for anything unfavorable that happens to a parent. For example, the child may unconsciously assume responsibility for the depression, illness, or death of a parent or for the destructive ways his or her parents behave toward each other. Because the child is so highly motivated to protect parental authority and because the child takes responsibility for whatever happens to his or her parents, the child tends, when in conflict with parents, to perceive them as right and himself or herself as wrong.

A young child whose mother is chronically depressed and complaining may assume that it is his or her responsibility to make her happy, and may try desperately to cheer her up. (This has been demonstrated by the research of Zahn-Waxler and Radke-Yarrow, 1982.)

A child may acquire certain pathogenic beliefs simply by assuming that the way he or she is treated by his or her parents is the way the child should be treated. A patient, who in childhood experienced her parents as having no time for her, developed the idea that she should be treated as unimportant. In adult life she became uncomfortable about making demands, taking herself seriously, or complaining when mistreated. She accepted the little given her by her husband and children as all she deserved from them.

A child may also develop certain pathogenic beliefs simply by parental

instruction. A patient whose mother taught him that he belonged to her and that he should sacrifice his happiness for her, consciously repudiated this idea but unconsciously accepted it. In adult life he worked hard for little money or pleasure and he married a woman who demanded much from him but gave him little. (See Asch, 1976.)

Pathogenic beliefs underlie various kinds of guilt. These include separation guilt and survivor guilt, both of which are widespread. In both kinds of guilt, the person assumes an irrational responsibility for others. Underlying separation guilt, which Loewald (1979) considered universal, is the child's belief that if he or she becomes strong or independent in relation to a parent he or she will hurt that parent. The child acquires this belief by inference from experience. The child's acquisition of it depends on various factors, some internal, others external. These include: the strength of the child's wish to become independent, the child's sense of omnipotence, the child's projections onto a parent of dependence and, in addition, his or her real experiences with that parent. If all else is equal the child whose parents are happy and who encourage independence develops less separation guilt than the child whose parents are unhappy and who discourage independence. A person who suffers from separation guilt may have trouble leaving his or her parents and may construct ways to keep them important in his or her life.

A person who suffers from survivor guilt unconsciously believes that to attain more of the good things of life than other family members is to betray them. The person assumes that the good things of life come in limited quantities, and therefore that the acquisition of good things is at the expense of other family members. The strength of the belief underlying survivor guilt depends on internal and external factors. These include the intensity of the child's greed, and also how fate, in reality, has dealt with other family members. If all else is equal, the child whose parents and siblings fare poorly is more likely to suffer from survivor guilt than the child whose parents and siblings do well.

A person burdened by survivor guilt may placate his or her conscience by giving up those desirable things that he or she has acquired but that his or her parents and siblings have not. Or the person may suffer from any kind of maladaptive behavior, similar to that from which a parent or sibling had suffered. For example, a patient whose father ruined his marriage by temper tantrums ruined his own marriage in the same way.

Niederland (1981) studied survivor guilt by interviewing over 2,000 Holocaust survivors. His findings make clear that survivor guilt may develop at any time during childhood and adolescence. Its acquisition depends on the kinds of trauma which the child suffers, not on when in his or her development the child experiences it. According to Niederland, the guilt which the Holocaust survivor developed did not depend on hostility toward parents or siblings. It depended more on love for them. The survivor suffered from the

pathogenic belief that, by remaining alive, he or she had betrayed his or her parents. In his or her symptoms the survivor expressed loyalty to his or her parents by behaving as dead, looking like a corpse, becoming pallid and silent, and moving quietly.

A child may develop pathogenic beliefs by two different sequences of events. According to the first, the child attempts to gratify a particular impulse or to reach a particular goal, and then discovers (as he or she experiences it) that by doing so he or she threatens his or her all-important parental ties. The child then develops and retains a belief that causally connects his or her attempts to gratify the impulse or to reach the goal with the threat to parental ties.

The second sequence begins with an inherently traumatic event, such as the illness or death of a parent. The child then retrospectively infers that he or she is to blame for the event. The child concludes that he or she brought it about by attempting to gratify a particular impulse or to reach a particular goal. The idea that the child may develop pathogenic beliefs by retrospective inference is supported by an empirical study, conducted by Beres (1958), about the effects on children of separation from their parents. A child who is separated from parents comes to believe that he or she committed a crime, and the child assumes the guilt that goes with this crime. The child assumes that being placed away from home is the deserved punishment for having committed the crime.

> For example, a boy of 2 1/2 was sent away temporarily to live with an uncle and aunt, after his younger brother had caught an infectious disease. His parents were overwhelmed by the task of taking care of the brother, and they wanted to prevent the boy from catching the disease. However, the boy (as we discovered in his analysis when he was an adult) had inferred and so acquired the pathogenic belief that he was sent away because his restless activity had burdened his mother. At his uncle's and aunt's, he became especially docile and passive, and he remained this way long after he returned to his parents.

This boy acquired a number of interrelated pathogenic beliefs besides the one just described: He inferred that his mother was untrustworthy, ruthless and powerful and that if he defied her she would mete out swift and hostile punishment. He also acquired the pathogenic belief that if he were complacent, relaxed, and happy, some catastrophe would befall him.

How is the theory of psychopathology presented here connected with the traditional theory with its emphasis on such factors as sex, aggression, conflict, and defense? In my view, a person's sex and aggression may create problems for a person only if his or her control of them is impaired by pathogenic beliefs. A person may be induced by pathogenic beliefs either to inhibit or repress sex or aggression when it would be appropriate to express them or to be aggressive or sexual when it is not appropriate. For example,

a patient, who in childhood believed himself responsible for his depressed grandmother, developed a sexual interest in her in order to stimulate her and thus help her to overcome her depression.

By developing a pathogenic belief, the child internalizes and maintains a conflict that originally was external. This conflict is generally between the child's wish to satisfy a particular impulse or to reach a particular goal, and the child's perception that by doing so he or she risks a disruption of his or her parental ties. The child internalizes the conflict by developing a pathogenic belief that links the impulse or goal with the feared disruption.

Pathogenic beliefs are in back of the unconscious signal anxiety that gives warning of danger and may induce repression (Freud, 1926). For example, a man who is guided unconsciously by the belief in castration, may, after becoming sexually aroused, develop signal anxiety. Moreover, he may, as a consequence of this anxiety, unconsciously decide to re-repress the sexual impulse.

THE PATIENT'S WORKING TO CHANGE HIS PATHOGENIC BELIEFS

The patient unconsciously (and to some degree consciously) suffers from his or her pathogenic beliefs and from the painful emotions, constrictions, inhibitions, and repressions to which they give rise. The patient is therefore highly motivated unconsciously to change them. The patient works to change them in two ways: (a) by testing them unconsciously in relation to the therapist, hoping, thereby, to disconfirm them, and (b) by making use of insight into them that the therapist conveys by interpretation.

In testing pathogenic beliefs the patient unconsciously makes use of what Freud described as "experimental actions" (1940, p. 199). The patient usually tests the therapist in a careful, controlled way and perhaps with fall back positions unconsciously prepared in advance. In testing the therapist the patient unconsciously does certain things in relation to the therapist (expresses certain impulses or seeks certain goals) that, according to the belief, should threaten his or her ties to the therapist and so put him or her in a situation of danger. If the patient infers from such experimental actions that he or she does not affect the therapist as the belief predicts, the patient may become less anxious and take a step toward disconfirming the belief. Also the patient may bring the belief closer to consciousness and begin to overcome certain inhibitions or to lift certain repressions previously maintained in obedience to the belief. If, on the other hand, the patient infers that he or she does affect the therapist as the belief predicts, the patient may temporarily become more anxious, defensive, or inhibited, and intensify the repression of the belief.

The various tests that the patient offers the analyst fall into two broad

categories: namely, turning passive into active and transferring. (The patient may do both of these things in the same test.) Both turning passive into active and transferring may be defined in terms of the patient's childhood traumas and the pathogenic beliefs that the patient inferred from them. The patient who turns passive into active subjects the analyst to the kind of parental behavior that (in the patient's opinion) had been traumatic. The patient who transfers reproduces the kind of childhood behavior that (in the patient's opinion) had provoked the parental traumatic behavior.

A patient who tests the analyst by turning passive into active seeks the disconfirmation of his or her pathogenic beliefs by demonstrating that he or she will not upset the analyst as, in his or her opinion, a parent had upset (traumatized) the patient. For example, a male patient who had felt rejected by his parents and inferred that he deserved this rejection tested the analyst by rejecting him. The patient hoped that the analyst would pass his tests by demonstrating that he (the analyst) did not believe he deserved the patient's rejections. The patient perceived the analyst as unhurt. The patient then, by identifying with the analyst, became less endangered by the rejections of his internalized parents and less bound by the beliefs he had inferred from these rejections.

A patient, by transferring, tests his or her pathogenic beliefs more directly than by turning passive into active. The patient reproduces the kind of behavior that, in the patient's opinion, had provoked parental trauma. The patient hopes that the analyst will not react to this behavior as his or her parent had reacted to it. The patient hopes, for example, that he or she will not hurt the analyst by defiance, as, in the patient's opinion, he or she had hurt a parent, or will not humiliate the analyst by contempt, or seduce the analyst by admiration. If, over a period of time, the patient infers, from observing the analyst, that he or she does not affect the analyst as the patient's pathogenic beliefs predict, the patient may take a step toward loosening the hold on him or her of these beliefs. The patient may become less convinced of his or her responsibility for the traumatic parental reactions. The patient may, therefore, come to feel less guilty, ashamed, or anxious about these traumatic reactions.

SUMMARY

The patient's psychopathology stems from pathogenic beliefs acquired in childhood from traumatic experiences with parents. The patient's pathogenic beliefs warn the patient that if he or she attempts to gratify certain impulses or to seek certain developmental goals the patient will risk the disruption of his or her all-important parental ties. It is as a consequence of these beliefs that the patient develops fear, anxiety, guilt, shame, or re-

morse; institutes repressions; and develops symptoms, inhibitions, and faulty object relations. The patient suffers unconsciously from pathogenic beliefs and so is powerfully motivated unconsciously to work with the analyst to disconfirm them. The patient works by testing the beliefs in relation to the analyst in the hope of disconfirming them, and by assimilating insight into the beliefs (and their falseness) conveyed by the analyst's interpretations. Indeed the therapeutic process is in essence the process by which the patient works consciously and unconsciously with the analyst to disconfirm pathogenic beliefs.

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