

The Analyst's Task: *To Help the Patient Carry Out His Plan*

Clinical thinking over the last thirty or more years has reflected an increasing emphasis on the patient's relationship to the analyst, and, in particular, on the patient's efforts to work unconsciously with the analyst at the task of solving his problems. The concepts about the patient's unconscious efforts to solve his problems stem ultimately from certain of Freud's late works. In these he wrote directly about the patient's unconscious motivation to master his traumas (1920, pp. 32, 35) and to work with the analyst to gain control of the instincts (1937, p. 235). In addition Freud endowed the patient with a capacity to do this work. He wrote that the patient unconsciously controls his repressions by the criteria of danger and safety (1940, p. 199) and he introduced the idea that a person may unconsciously make use of trial actions to test his environment in preparation for carrying out an unconscious plan of action (1940, p. 199).

Freud's contributions have been subsequently elaborated by many authors. Freud's concept, that the patient unconsciously controls his repressions by the criteria of danger and safety has been applied clinically by Bemfeld (1941) who wrote that part of the analyst's task is to help the patient to feel safe. Freud's con-

cepts about unconscious testing have been developed by Rangell (1969a, 1969b, 1981a, 1981b) and by Dewald (1976, 1978). Rangell wrote that the patient unconsciously tests the analyst and the analyst may help the patient by passing the patient's tests. Freud's idea that the patient may unconsciously regulate the coming forth of previously repressed mental contents has been discussed repeatedly by Kris (1950, 1951, 1956a, 1956b). This idea has also been elaborated by Sandler and Joffe (1969) who wrote that the patient controls his repressions not only by anticipations of danger but also by anticipations of safety.

My purpose in this paper is to present a concise discussion of the patient's working with the analyst. I attempt to show that the patient works unconsciously by planful testing of the analyst and that the analyst may help the patient by passing his tests. I illustrate these concepts with clinical examples which I hope will enable the reader to judge the usefulness of the concepts. I also summarize evidence for the concepts from formal research.

My approach assumes that the analytic patient is highly motivated to seek certain important, adaptive, and in varying degrees unconscious goals. However, he holds himself back because he unconsciously believes that if he moves toward these goals he will be endangered. Throughout analysis he works with the analyst to convince himself that the dangers predicted by his beliefs are not real and thus that he may move forward. A large part of the analyst's task is to help the patient with this work.

Pathogenic Beliefs

A person suffers from maladaptive beliefs, here called "pathogenic", that he develops in childhood by inference from traumatic experiences with parents and siblings, or that he learns directly from parental teachings. Pathogenic beliefs impede the patient's functioning, adversely affect his self esteem and prevent him from pursuing highly desirable goals. They warn him that if he pursues such goals he may develop guilt, shame, fear, or self torment, or he may produce a serious disruption in his relations with others.

Pathogenic beliefs may be extremely powerful. They are acquired from parents at a time when the child endows his parents with great authority. Therefore when in conflict with parents the child assumes that his parents are right and he is wrong. This may be illustrated by David Beres's (1958) study of children placed in

foster homes. He found in each case that the child believed that he had been sent away as a punishment and that the punishment was deserved.

Pathogenic beliefs are concerned with reality and morality (which for the infant and young child is part of his reality). Thus the child may learn from the way his parents treat him how he may expect to be treated (reality) and how he should be treated (morality). For example, a child who is rejected by his parents may learn that he may expect rejection and that he should be rejected.

A person may suffer from any of a number of pathogenic beliefs. He may come to believe that almost any impulse, attitude or goal is dangerous, in that by expressing the impulse or attitude or by pursuing the goal he would either cause a disruption in his ties to his parents, or suffer a painful affect such as anxiety, fear, shame, guilt or remorse. For example, he may develop the pathogenic belief that he is worthless, or that if he is dependent on his parents he will drain them, or that if he is independent of them he will hurt them.

The Patient's Work

The patient exerts some control over his unconscious mental life and uses it to work unconsciously (as well as consciously) with the analyst to disprove his pathogenic beliefs. He unconsciously makes decisions and carries out plans. Also he unconsciously regulates his repressions. He maintains them as long as he assumes he would be endangered by the mental contents warded off by them and he may lift them when he unconsciously decides that he can safely experience these contents.

The main way the patient works to disprove his pathogenic beliefs is by testing them in relation to the analyst. He carries out trial actions (Freud, 1940, p. 199) in the hope that the analyst will not react to them as the beliefs predict. If, as the patient perceives him, the analyst does not react in these ways, the patient may feel relieved and take a small step toward disproving the beliefs. He may also feel less endangered by the mental contents warded off in obedience to the beliefs and therefore may permit himself both to experience these contents and to act upon them. That is, he may become more insightful and less inhibited.¹ For example, a patient who unconsciously believed that if he were proud the an-

¹ For evidence from formal research supporting this proposition see Weiss et al., 1986; Weiss, 1988, 1990, 1993a, 1993b.

analyst would put him down, repeatedly tested this belief by trial expressions of pride. When, as the patient experienced it, the analyst did not put him down, the patient became less convinced of the pathogenic belief, he permitted himself to express his pride more directly both in analysis and in everyday life and he remembered more about his father's put-downs. The patient may react in much the same way to interpretations that he can use in his efforts to disprove his pathogenic belief; he may become less anxious, more insightful, and less inhibited.

The patient plans his analytic work. His unconscious plans are simple and tentative; they merely point the patient in a particular direction. They tell him which problems to tackle at a particular time and which ones to defer. In making these plans the patient is especially concerned with avoiding danger.

Mrs. G.

Mrs. G. came to treatment because she could not get close to her husband. She suffered from the pathogenic belief that unless she complied with men, including her husband and the analyst, she would upset them. At the beginning of her analysis she felt endangered by her belief that she should comply with the analyst. She feared that she would be compelled by it to accept bad interpretations or follow bad advice. Therefore during the opening phase of her treatment she worked unconsciously to disprove this belief. She tested it in relation to the analyst by repeatedly disagreeing with him and by occasionally criticizing him.

In most instances Mrs. G. experienced the analyst as unhurt by her challenges and thus as passing her tests. When she experienced him as unhurt she became more relaxed and more confident. On several occasions she remembered more about her father's vulnerability. She reacted in much the same way to the analyst's occasional comments that she was reluctant to disagree with him for fear of hurting him.

Over a period of time the patient learned from the analyst's reactions to her tests and from his interpretations that she did not have to comply with him. As she learned this she became able to cooperate with him and even to like him. She could like him and take his comments seriously once she realized that she could reject his ideas. She also became more able both to disagree with her husband and to feel close to him.

The opening phase of Mrs. G.'s analysis indicates that a patient

may learn from the analyst passing his tests that his pathogenic beliefs are false. Indeed, Mrs. G. reacted to the analyst passing her tests much as to the interpretations that she could use in her effort to carry out her plan (here called a "pro-plan" interpretation). She learned from both that the analyst was not hurt by her disagreeing with him and that he did not consider such disagreement hostile. Thus, from the patient's point of view, passed tests are in some ways the equivalent of pro-plan interpretations.

A patient may develop important insights without being helped by interpretation. For example, a patient whose parents had been highly critical of him developed the pathogenic belief that he was defective and so deserved their criticisms. In his analysis he developed a strong relationship to a friendly analyst which raised his self esteem. He began to question his belief that he was defective and to realize that he did not deserve his parents' criticisms. As he came to realize this, he lifted his repressions on his own and remembered more about his parents' put downs and his compliance with them.

The Analyst's Task

The analyst's task is to help the patient to carry out his plan for disproving his pathogenic beliefs and pursuing the goals that the beliefs warn him against. The accomplishment of this task is so central that the analyst may judge a particular technique by the criterion "Does it help the patient to disprove his pathogenic belief and to pursue the forbidden goals?"

The analyst's approach is case-specific. He attempts to help each patient to disprove his particular pathogenic beliefs and to pursue his particular goals. He does this by passing the patient's tests, by offering him pro-plan interpretations and by his overall approach and attitude. For example, if the patient suffers primarily from the disturbing belief that he will be rejected, the analyst should be careful not to be rejecting and in many instances should be friendly and accepting.

In the following example, the analyst's reaction to a major test was crucial to his passing it and indeed to the success of the analysis.

Miss P.

Miss P., a professional woman in her mid-thirties, came to analysis because she was unable to make friends or form intimate rela-

tionships. She was inhibited by a powerful fear of rejection. In childhood she assumed that the little interest her parents showed her expressed not affection but duty.

The analyst, who considered Miss P.'s fear of rejection to be her paramount concern, tried to show her that he cared about her. He accommodated her frequent requests for schedule changes, took pains to answer her questions, and showed a lively interest in the various topics she introduced. The analyst also interpreted Miss P.'s fear of rejection. Miss P. agreed with this interpretation, seemed to feel calmed by it and confirmed it by examples from childhood and everyday life. However, she did so without experiencing the loneliness, sadness, and humiliation that are usually part of the experience of being rejected.

During the first three years of her analysis Miss P. made slow progress. She achieved a better position at work, made a few friends, and began to date. Then one day in the fourth year of analysis Miss P. announced that she planned to stop treatment in three months. She stated that she had achieved what she had come for.

The analyst reacted by implicitly opposing Miss P.'s stopping. He interpreted it as motivated by her fear of rejection. He told her that she was afraid he would reject her and so was planning to reject him first, that she was afraid she was a burden on him, and that she assumed she did not deserve more help from him. Miss P. again seemed pleased. She told the analyst that his interpretations made sense. However, she was undeterred by them: she persisted in her plan to stop. Then, as she came close to her deadline, she responded to the analyst's questions by acknowledging that she was not sure why she was so determined to stop. The analyst urged her to continue until she understood more about this. She grudgingly agreed to continue until she understood more about her plan to stop treatment.

A few days later Miss P. brought forth poignant memories of maternal rejection. She became intensely sad while reporting these and wept during most of the analytic hour. Though these memories were painful the patient did not re-repress them. Rather, she kept them conscious and used them to understand herself. Nor did Miss P. threaten to stop treatment again. She continued in analysis for four more years and was helped considerably by it.

As is evident from this report, a crucial part of Miss P.'s analysis was the analyst's reaction to her rejection test. Before the analyst passed this test, Miss P. thought of him as dutiful but unconcerned about her. She did not consider it safe to expose her sadness to him. She would have felt all the more hopeless and ashamed if her expressions of sadness had been met by indifference.

In her test of the analyst Miss P. made it easy for him to reject her and difficult for him not to do this. She assumed that if the analyst did not care about her he would take the line of least resistance and permit her to stop. Miss P. was moved by the analyst's urging her to continue. She began to feel cared for, and this made it safe for her to bring forth her memories of rejection.

As the example of Miss P. indicates, the patient's experiences with the analyst are crucial to the success of the treatment. The analyst was unable to help Miss P. by interpretation alone to realize affectively how rejected she had felt. She realized this only after she was helped to have the corrective experience which she sought by her testing.

If the analyst out of concern for Miss P.'s autonomy had remained neutral while she was trying to decide whether or not to quit treatment he would have failed her test. She would have left treatment not much helped and with her pathogenic belief that she deserved to be rejected confirmed by the analyst's permitting her to stop. Nor would the analyst have protected her autonomy, for although Miss P. could not acknowledge it and indeed was not conscious of it, her wish to continue treatment was more powerful, more adaptive, and more central to her personality than her wish to stop.

Finally, the example of Miss P. illustrates how the analyst's approach may be validated, namely, by the patient's reaction to it. The analyst's assumption that he would pass Miss P.'s test by urging her to continue treatment was confirmed by Miss P.'s subsequent behavior: She decided to stay in treatment, became calmer, and on her own brought forth and kept in consciousness crucial memories of rejection that threw light on her psychopathology.

Another illustration of the value of a case-specific approach occurred in the analysis of a patient whose psychopathology and analysis are analogous to those of Miss P. Miss P. experienced her parents as rejecting; she developed the belief that she did not de-

serve to be accepted; she gave the analyst a powerful rejection test; and she brought forth new and significant memories after the analyst passed this test. The patient presented below experienced his parents as failing to protect him; he developed the belief that he did not deserve protection; he gave the analyst a powerful protection test; and he brought forth new memories of being unprotected after the analyst passed this test.

Dr. G. B.

The patient, Dr. G. B., was the only child of immigrant parents. He came to analysis after a previous analysis had failed because, as the patient explained, during treatment he had become irresponsibly promiscuous. However, he added, he had learned his lesson and would not let this happen again.

Dr. G. B. complained of difficulties in his career and marriage for which he took responsibility. He thought of himself as battling a tendency to be self destructive. Dr. G. B. remembered little about his childhood. However, he contrasted himself with his parents, stating that whereas he was highly educated his mother could scarcely read and his father had not finished high school. He felt guilty that he used his parents' scant resources to achieve a much higher station than they.

Not surprisingly, Dr. G. B. became promiscuous a short time after starting analysis, and he was so indiscreet that he was threatening his marriage and his career. The analyst assumed that the patient was behaving self destructively in order to determine whether he (the analyst) would try to protect him from his self destructiveness. The analyst did try. He repeatedly told the patient that his promiscuity was self destructive and that his continuing it was dangerous. The patient would listen carefully to the analyst's comments, then assert that in his opinion his promiscuity was not a problem. Finally realizing that Dr. G. B. would not respond to his interpretations, the analyst told him that unless he stopped being promiscuous he (the analyst) would discontinue the treatment.

Dr. G. B. became angry, wept, and berated the analyst for not maintaining an "analytic" attitude. However, he then became calmer and stopped being promiscuous. A few days later he brought forth a memory of his parents failing to protect him: On a number of occasions while in the fourth grade the patient ex-

posed himself in the school corridors. His teachers tried to enlist his parents' help in getting him to stop, but his parents did not respond.

During the next year of treatment it became evident that Dr. G. B.'s most fundamental pathogenic belief was that he had achieved his success at his parents' expense. He had become self destructively promiscuous in order to destroy his success and thus to put himself on a par with his parents. He unconsciously assumed that his parents wanted him to fail, and he took their not stopping him from exposing himself as evidence for this. He had feared that the analyst out of envy would permit him to ruin his marriage and career and was relieved when the analyst made it clear that he would not.

In the case of Dr. G. B. (as in the case of Miss P.) the analyst could pass the patient's test only by use of authority. If the analyst in an attempt to be neutral or in order to protect the patient's autonomy had not used his authority, he would have failed Dr. G. B.'s test and the patient, as he later acknowledged, would have felt betrayed.

The fact that in order to treat Dr. G. B. successfully the analyst had to depart from the neutral approach recommended by the *Papers on Technique* (1911-1915) does not mean that Dr. G. B.'s psychopathology was more severe than that of patients who can be treated successfully by the 1911-1915 theory of technique. A patient's not being suitable for treatment by the 1911-1915 theory reflects the limitations of that technique rather than the patient's degree of disturbance.

Dr. G. B.'s analysis, like Miss P.'s, also illustrates another important point, namely, that helping the patient to carry out his plan does not necessarily mean going along with his conscious wishes. Dr. G. B. unconsciously carried his protection test to the point that the analyst in order to pass it had to be confrontational and, in effect, issue an ultimatum. Dr. G. B. consciously became quite upset as though the analyst was forcing him to relinquish an important source of pleasure. However, his subsequent calmness and his retrieval of the memory of being unprotected by his parents made it clear to both analyst and patient that Dr. G. B. had a powerful unconscious wish for the analyst to use his authority to protect him from his self destructiveness.

As illustrated by the case of Dr. G. B. a patient may consciously object to an interpretation or intervention but by becoming less

anxious and by producing new material reveal that the intervention was helpful.

Some analytic patients especially during the opening phase of treatment feel endangered by any interpretation. They assimilate the analyst making interpretations to a parent lecturing them, pulling rank, limiting their freedom, or giving them unsolicited advice. With such patients (and indeed with all patients) the analyst's first priority is to help the patient to feel safe. Therefore the analyst should refrain from interpretation or use it sparingly until the analyst receives some indication that the patient no longer is endangered by it. Until then the analyst may communicate by passing the patient's tests and by his overall approach. If the analyst helps the patient by non-interpretive means to feel less endangered so that the patient becomes less defensive and develops insights on his own, the analyst may add to the patient's developing self knowledge by providing the patient with explanations that help him to organize this knowledge. For example, if the patient brings forth a childhood traumatic experience, the analyst may point to the pathogenic beliefs he inferred from this experience and show him that he is still struggling to change these beliefs.

Mr. T. C.

Before his first interview with Mr. T. C. the analyst had heard from the referring family physician that Mr. T. C. was depressed and having difficulty working. Mr. T. C.'s parents, siblings, and wife all worked hard themselves and all were worried about his not working. However, during his first session Mr. T. C., a computer programmer, who knew that the analyst had been informed by the referring physician of his difficulty working, did not talk about this problem. Instead he chatted informally about the computer he saw in the secretary's office. He talked about its capabilities and discussed various programs that the secretary might find useful. He also talked about several friends and acquaintances whom the analyst knew.

The analyst became aware that Mr. T. C. was doing the same thing in analysis as in everyday life, that is, making a point of not working. The analyst was tempted to point this out. However, he suspected the patient's wife and parents had been nagging him to work, that he resented this, and that he was testing the analyst to determine whether the analyst would also try to induce him to work. Therefore the analyst decided not to question him and in-

deed not to offer any interpretations until the patient gave some indication that he wanted to be helped interpretively. The analyst simply showed interest in whatever topic the patient introduced.

About two weeks after Mr. T. C.'s first session the analyst received a call from the referring physician stating that Mr. T. C. was feeling better and beginning to work more enthusiastically. (Mr. T. C. made no mention of his working.) The analyst inferred from this that he was on the right track and continued his non-interpretive approach.

Over a period of time the patient began to talk more freely about himself. After several months he talked about the high value he placed on a sense of freedom. He stated that he felt constrained by a schedule and he linked his need for freedom to the constraints his parents had placed on him. They worked all the time and were uncomfortable when he did not. If he watched T.V. they would remind him of tasks that he had not completed.

At this point the analyst told Mr. T. C. that he had apparently accepted his parents' opinion that he should work all the time and was now struggling against believing this. Mr. T. C. seemed pleased and agreed. As a consequence of these and other comments the patient became less averse to interpretation. Though the analyst continued to treat the patient mainly by his attitude, he made a number of comments designed to help Mr. T. C. fit his memories and his current problems into a broad explanatory framework, thereby enabling him to understand himself better and to see himself more sympathetically.

Mr. T. C.'s difficulty working was rooted in the pathogenic belief that he should work very hard and should not enjoy leisure or freedom. In childhood he had felt so burdened by his parents' insistence that he always be working that he had become averse to doing any work. In his analysis he feared that the analyst would insist that he work continuously on his problems and so confirm his pathogenic belief that he should not feel free in treatment to talk about whatever he wanted. When the analyst did not insist on his working Mr. T. C. permitted himself to become more relaxed both in his everyday life and in his treatment. As he felt more free and began to enjoy his leisure he found work less burdensome.

Inferring the Patient's Unconscious Plan

The technical approach proposed here assumes that it is possible for the analyst to know in a general way what the patient un-

consciously would like to accomplish, that is, the patient's plan. An analyst who has not tried to determine the patient's plan may believe that he cannot do so. However in practice it often is not difficult. The analyst in inferring where the patient wants to go (his plan) makes use of everything he knows about the patient, including the patient's stated goals, his childhood traumas, his affective responses to the patient, and the patient's affective responses to the analyst. (For a detailed description of the process of inferring the patient's plan, see Weiss, Chapter 5, 1993a.) Moreover, the analyst in making this inference thinks about his patient in familiar terms, much as in everyday life one person thinks about another. Thus in inferring the patient's plan the analyst calls upon well-developed intuitions based on common sense.

Having arrived at a tentative plan formulation the analyst may check its validity by observing how the patient responds both to his interpretations and to his (the analyst's) reactions to the patient's tests. When the analyst's reactions to the patient are pro-plan the patient becomes calmer, more insightful, and bolder. He may bring forth new material on his own (without being helped by interpretation) or he may undertake a pro-plan activity. Alternatively, he may use the security he obtains from the analyst's helping him to test the analyst more vigorously. While testing the analyst, the patient may not agree with the analyst's comments even when these are helpful; however, he usually will reveal, by demonstrating a greater sense of security or by some parenthetical indications of progress, that the analyst is on the right track. If after a period of several weeks the patient gives no indication of progress, the analyst is probably working in accordance with a faulty plan formulation and should attempt a new one.

In many instances the patient states his goals and pathogenic beliefs directly during the first few sessions of therapy or he strongly implies them. His purpose is to orient the analyst so that when he (the patient) begins to test him (which he may do soon after the initial session) the analyst will know how to pass his tests. He may then test the analyst in a variety of ways. For example, he may deny his true goals or he may make other kinds of false statements about himself in the hope that the analyst will refute them.

Mr. D. F.

Mr. D. F. tested the analyst soon after the opening phase of his treatment. He came to analysis when his wife, who was chronically

ill, became so weak that he could no longer take care of her himself. His having to hire nurses to care for her induced him to re-think his situation, and though he was anxious about working, he decided to go to work.

Mr. D. F. was independently wealthy. He had worked for a few years after graduate school, then quit to write a novel and continued to stay home to be with his sick wife. In the first few sessions of analysis Mr. D. F. stated that he wanted to go to work. He added that one barrier to his working was his fear that since he had not worked for a long time he had lost his skills. Another was his concern that his wife would object strenuously to his leaving home.

In the second week of analysis Mr. D. F. tested the analyst by expressing serious doubts about his plan to get a job, stating that he no longer had the necessary skills. In his first session with the analyst he had considered his doubts neurotic. Now he spoke of them as warranted by reality. He reported that a former colleague had told him that their field had developed so rapidly since he last worked that he had fallen hopelessly behind. He now thought that he would be happier working at home on his novel. When the analyst challenged the patient's objections to working Mr. D. F. seemed relieved. However, the next hour he raised similar objections in a new and vigorous form and was relieved again when the analyst disagreed.

The patient's relief when the analyst disagreed with his objections to seeking work is evidence that Mr. D. F. presented these objections in order to test the analyst. If the patient had stated them in order to convince the analyst that he shouldn't try to get a job, he would have been frustrated rather than relieved. There was other evidence that Mr. D. F. expressed doubts about working in order to test the analyst. Often while raising these doubts he would, without realizing it, offer evidence against them. For example, after insisting that his knowledge of his field was hopelessly dated, he gave evidence of mastering a difficult topic in a related field rapidly and well.

As Mr. D. F. became assured that the analyst did not consider him incapable of work he remembered his father's implying that he was lazy and would never amount to anything. Apparently by his self criticism he was complying with his father's opinions. He also remembered that his father had assigned him the job of

keeping his depressed mother happy, while he (the father) pursued his own interests. After 14 months of analysis in which the patient's current concerns were linked to his childhood compliance with his father and his childhood worry about his mother, Mr. D. F. obtained an interesting job and began to work away from home.

Sometimes the patient does not spell out his plans at the beginning of treatment for fear the analyst will oppose the plans. However, in these instances the patient generally gives the analyst considerable evidence for them. For example, a patient, whose unconscious plan was to leave his wife, but who at the beginning of treatment unconsciously felt too guilty to say so, stated instead that he had come to analysis in order to work at improving his relationship with her. However, he described her in such unflattering terms that he conveyed the possibility that he wished to leave her.

The Patient's Relationship to the Analyst

The theory proposed here is an object relations theory. It assumes that the patient develops his psychopathology in relation to his parents and that he may resolve it in relation to the analyst. More specifically, he develops pathogenic beliefs in relation to his parents and he may disprove these beliefs in relation to the analyst. In the process of analysis the patient influences the analyst and the analyst the patient. The two-way street between analyst and patient is built into the approach proposed here by the concept of testing. The patient by his testing influences the analyst's behavior. The analyst by his reactions to the patient's tests influences the patient's behavior.

The Corrective Emotional Experience

The theory proposed here assumes that the patient in analysis may benefit from certain corrective emotional experiences, namely, the experiences that he himself unconsciously seeks by his testing of his pathogenic beliefs with the analyst. The analyst's reactions to the patient's tests are in some ways similar to interpretations, for the patient learns from both whether or not the analyst will help him to disprove his pathogenic beliefs and to pursue his goals.

The idea of offering the patient 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 (Bader, 1993). 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 analyst senses that the patient is threatening to stop in order to test the pathogenic belief that he deserves to be rejected, the analyst may urge him to continue. His doing this, in my opinion, is appropriate, empathic and therapeutic. By urging him to continue the analyst is helping him to disprove the belief that he should be rejected.

Evidence from Empirical Research for the Concepts Presented Here

The concepts presented here have been tested by formal, quantitative empirical research carried out by the San Francisco Psychotherapy Research Group which is co-directed by Harold Sampson and the author.² The research, which has been presented extensively elsewhere (Weiss, et al., 1986; Weiss, 1988, 1990, 1993a, 1993b), will be summarized below. A number of our projects were carried out on the transcripts of the first 100 sessions of an analytic patient, Mrs. C. Our findings strongly supported the following hypotheses:

- Mrs. C. brought forth previously repressed mental contents on her own (that is, without their being interpreted) when she unconsciously decided that she could tolerate them. She was not anxious as they came forth and she fully experienced them (Gassner, et al., 1982; Gassner, et al., 1986).
- Mrs. C. made demands on the analyst not primarily to gratify unconscious impulses but to test her pathogenic belief that

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she could make the analyst do whatever she wanted. She was relieved when the analyst did not yield to her demands (Silberschatz, 1986; Silberschatz, Sampson, and Weiss, 1986).

- Mrs. C. made significant changes in her behavior with little help from interpretation. She became more able both to fight with the analyst and to feel close to him (Curtis et al., 1986).
- Mrs. C. worked in analysis in accordance with an unconscious plan for solving her problems. Independent judges familiar with the intake and first 10 sessions of her analysis agreed reliably on her plan (Caston, 1986).
- Mrs. C. demonstrated an immediate favorable response to interventions that judges familiar with her plan rated as likely to help her carry it out (Caston, et al., 1986; Bush and Gassner, 1986).

In situations of brief, time-limited (16-session) psychotherapy we demonstrated the following:

- Three patients showed an immediate favorable response to pro-plan interpretations.³ They experienced things more fully (Fretter, 1984), showed more insight (Broitman, 1985), and moved toward their goals (Davilla, 1992).
- Three patients demonstrated an immediate favorable response to passed tests (Silberschatz and Curtis, 1993). Two out of three patients reacted to a passed test by demonstrating an immediate decrease in tension as measured by the Voice Stress Measure (Kelly, 1989). One patient reacted to passed tests by immediately demonstrating more pro-plan insight (Linsner, 1987) and one patient reacted to passed tests by immediately demonstrating a greater capacity to exert control over regressive behavior (Bugas, 1986).

Our research also supports the hypothesis that the patient in brief psychotherapy demonstrates a long-term benefit from pro-plan interpretations as determined six months after termination. In a study of three patients, Fretter (Silberschatz, Fretter, and Curtis, 1986) demonstrated that the patient who received the

³ These studies were carried out under the supervision of Curtis and Silberschatz.

highest proportion of pro-plan interpretations did the best, the patient who received the second highest proportion did second best and the patient who received the lowest proportion did the worst. In a study of seven patients Norville (1989) showed that in six of these there was a close relationship between the degree to which the therapist gave the patient pro-plan interpretations and the outcome of the therapy as determined six months after termination.

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JOSEPH WEISS, M.D.

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