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Lichtenberg's Theory of Therapy

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I ENJOYED READING *PSYCHOANALYSIS AND MOTIVATION*. It is thoughtful, interesting, and carefully reasoned. The therapist who reads Lichtenberg's account of the maturation and expression of the five motivational systems in infancy and early childhood will acquire a heightened sense of his or her patient's varied motivations. By his careful delineation of these systems, Lichtenberg has broadened the developmental concepts on which self psychologists and other therapists may draw in their attempts to understand the motives of their patients.

In my discussion of Lichtenberg's (1989) *Psychoanalysis and Motivation*, I focus on his theory of therapy. I attempt to illuminate his theory by comparing it with a theory of therapy that I developed and that the Mount Zion Research Group (now known as the San Francisco Psychotherapy Research Group), which I co-direct with Harold Sampson, has investigated by formal research studies (Weiss, Sampson, and the Mt. Zion Psychotherapy Research Group, 1986).

Having worked for the last 25 years on developing my own understanding of the therapeutic process, I have no choice but to perceive Lichtenberg's theory through the lens of my own concepts. Also, I inevitably must discuss Lichtenberg's theory from the vantage point of an outsider. As I know from my own experience, a person on the outside can never understand a theory of therapy in the same way as someone who uses it in the daily work with his or her patients.

Lichtenberg's theory and mine have much in common. They are closer to each other than either is, for example, to the theory of ther-

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apy that Freud presented in his Papers on Technique (1911–1915). Both theories assume that the infant and young child's motivations are shaped by "lived experiences" with his or her parents. Both assume that the experiences with his or her parents are crucial for normal development. Both assume that the infant and young child may be damaged by parental failures of empathy. Also, both assume that the patient in therapy may be helped by interactions with the therapist that he or she experiences as empathic and understanding of his or her perspective.

Lichtenberg offers an original and useful means of understanding the patient's productions, namely by relating them to "model scenes" in the patient's early life. In these scenes, which the therapist and patient construct or reconstruct in their work together, the patient is depicted in prototypical situations with his or her parents. For example, in one scene, a patient endangered herself while neither parent protected her. Model scenes help orient the therapist to what the patient will talk about, dream about, and re-enact in treatment.

Lichtenberg stated that the therapist, in all communications to his patient, should keep in mind what these communications might mean to the patient. I agree. For example, I assume that the therapist should not tell the patient something, just because it is true, if the patient may experience it as unempathic or out of sympathy with his or her goals.

In his concepts of self-righting and symbolic reorganization, Lichtenberg is pointing to something that I consider quite important, namely—the patient's powerful urge to master his or her problems. For example, according to Lichtenberg, a patient may right himself after obstructions to his goals have been overcome. He may move forward to the fulfillment of his goals. Also, as he is helped in therapy, a patient may reorganize symbolically his concepts about himself and others. For example, a patient reacted to Lichtenberg's interventions by changing his images both of himself and of Lichtenberg. He began to see himself as no longer alone and to see Lichtenberg as an ally.

I can point to evidence for both self-righting and symbolic reorganization in the research carried out by the Mount Zion Psychotherapy Research Group. In some of our studies, we demonstrated that after the patient receives interventions or interpretations that can be used in efforts to pursue his or her goals, the patient may become bolder and more insightful (Caston, Goldman, and McClure, 1986, chap. 19).

Also after such interventions the patient may move toward his or her goals (Bush and Gassner, 1986, chap. 20). In movement toward his or her goals, the patient is righting himself or herself; in developing greater insight, he or she is symbolically reorganizing concepts about himself or herself.

Our research also provides evidence that after the therapist behaves in such a way as to encourage the patient to pursue his or her goals, the patient may demonstrate what Lichtenberg refers to as "vitalizing" affects. George Silberschatz (1986, chap. 18) demonstrated this from a study of the transcripts of the first 100 sessions of Mrs. C's analysis. He showed that Mrs. C reacted to the analyst's favorable responses to her initiatives by becoming significantly bolder, more relaxed, and more loving.

Though Lichtenberg's theory and mine are in certain ways quite compatible, they rely on different concepts, they point to different observations, and in some circumstances they recommend different techniques.

For example, both theories assume that the infant and young child may be damaged by unempathic parents. However, the two theories differ as to how this damage may occur. Lichtenberg assumed a direct effect. I assume that the infant and young child react to parental failures of empathy by feeling traumatized and by inferring from the traumatic experiences a maladaptive belief that impedes him or her in the pursuit of certain desirable goals.

For example, according to my view, a child may infer from parents who fail to respond empathically to his wish to be close to them that he is unattractive and can expect rejection both from the parents and from others. Moreover, the child may develop a maladaptive belief from any unfavorable interactions with parents from which he infers that if he attempts to exercise certain normal functions or to pursue certain normal desirable goals, he endangers himself or others. Also, as a consequence of this belief, he may renounce the desirable goals or become impeded in the normal functions. For example, he may infer from possessive parents that if he attempts to be independent, he will hurt them and so should not wish for independence. Or he may infer from depressed, fragile parents that he must take responsibility for their happiness and so sacrifice certain of his own interests for theirs. Or he may infer from the fact that a parent or sibling is severely

handicapped that he has received more of the good things in life than his share and so must limit what he achieves or acquires (Modell, 1971). Or he may infer from a catastrophic experience, such as being placed in a foster home, that he is being punished for wrongdoing and that he deserves the punishment (Beres, 1958).

The beliefs that a child infers from traumatic experiences with parents may be referred to as *pathogenic*. They may be encoded in words or they may be encoded by other means, as they must be in the infant. The infant, according to Stern (1985, p. 98), encodes his beliefs about himself and his world in RIGS, that is, Representations of Interactions that have been Generalized.

The list of the kinds of traumas from which the child may develop pathogenic beliefs may be greatly extended. I assume that many of these traumas may be thought of as resulting from painful parental failures of empathy. However, in my opinion, it is useful for the therapist to keep in mind the particular kind of trauma from which the infant or young child suffered, the pathogenic belief he inferred from the trauma, and the goals that these beliefs prevent him from pursuing. The therapist's understanding of the patient's pathogenic beliefs and of the goals these beliefs prevent him from pursuing should help the therapist to perceive the world from the patient's perspective and thus help the therapist to empathize with the patient.

Just as I agree with Lichtenberg that parental failures of empathy may be damaging, I agree that the therapist's empathy may contribute to cure. The patient who feels empathically understood may feel less anxious and more coherent. However, in my view, the effect of the therapist's empathy may be explained by the idea that the patient takes the therapist's empathy as evidence against his or her pathogenic beliefs. For example, a patient, who in everyday life inferred from interactions with unempathic parents that he should be rejected, took the therapist's empathic responses as evidence against this belief. He then began to disprove the belief. As the patient was helped by the therapist's empathy to disprove this belief, he became better integrated. He overcame an internal conflict between his wish to be friendly and his fear, stemming from the pathogenic belief that if he did this he would be rejected.

I have already remarked on Lichtenberg's idea that the therapist may make use of model scenes to orient him or her to what the patient

may re-enact in therapy. In my view, this use of model scenes is especially pertinent when the scenes depict the patient's traumatic experiences with his or her parents from which he or she inferred a pathogenic belief. In this circumstance, the patient will invariably re-enact the model scene in therapy. The purpose is to recreate with the therapist the childhood situation in which his or her parents failed to act in his or her interests. The patient does this to test the pathogenic belief with the therapist in the hope that the therapist will not behave in the adverse ways that his or her parents behaved. If the therapist does not repeat the parental mistakes, the patient may feel helped in his or her efforts to disprove the pathogenic belief.

My formulation fits an example of a model scene presented by Lichtenberg, in which a female patient suffered a severe trauma in early childhood. When she was 2 years old, she put her hand in a bucket of lye and developed serious burns. At the time, she was surrounded by adults, including her parents, but no one took responsibility for her. Each adult assumed that someone else was monitoring her activities. Throughout her childhood her parents neglected her. They denied and ignored her suffering. From this incident, Lichtenberg developed a model scene in which the patient was neglected and unprotected by her parents. In therapy, the patient talked occasionally about her use of drugs and at times gave evidence of being intoxicated. However, Lichtenberg assumed that a physician who specialized in the use of medication was taking responsibility for the patient's use of drugs and monitoring it. Therefore, he did not question her aggressively about her drug use. Then, on one occasion, the patient forced Lichtenberg to become aware that she was endangering herself. She came to the office in so toxic a state that Lichtenberg instructed her to leave her car and take a taxi home. He also told her not to return to work. In addition, he immediately contacted her family and her physician, and a program of detoxification was arranged.

In my theory, the patient reacted to her parents' failures to protect her by inferring, and so coming to believe, that she did not deserve protection. She tested this belief with Lichtenberg in the hope that he would protect her and so help her to disprove this belief. When at first Lichtenberg failed to protect her, she tested him with increasing vigor, ultimately forcing him to provide the protection stance that she sought. According to my approach, all patients test several major

pathogenic beliefs repeatedly throughout therapy as part of their efforts to disprove them.[1]

My theory assumes that self-righting occurs as the patient succeeds in disproving a pathogenic belief and pursues the goals previously forbidden by it. Symbolic reorganization occurs as the patient changes his or her pathogenic beliefs about himself or herself and others and by doing so acquires more adaptive beliefs about them.

My discussion of the testing of pathogenic beliefs during therapy permits me to take up several situations where, in my opinion, the therapist's demonstration of empathy with the patient, in the narrow sense of this word, is not the optimal response. This applies to a patient who in childhood experienced her parents as fragile and as insisting on complete compliance. If she were not totally submissive, they would behave as though they were deeply disappointed and would complain until the patient submitted completely to their wishes. The patient inferred that she was responsible for her parents' happiness and that to keep them happy she had to be servile. In therapy she tested this belief by taking her parents' role and assigning her role to the therapist. Because she behaved toward the therapist as her parents had behaved toward her, she was, in my terms, turning passive into active. She repeatedly accused the therapist of being disrespectful, told him bitterly that she was deeply hurt by him, and threatened to leave therapy unless he apologized. In testing the therapist in this way, the patient was looking to the therapist as a model of someone who was not compelled to feel an exaggerated sense of responsibility for her and who did not feel obliged to submit to her unreasonable demands. She wanted to learn from her therapist that blame does not necessarily compel obedience. When the therapist was empathic to her misery, in the narrow sense of empathy, she failed to benefit. When he matter-of-factly refused to accept responsibility for causing her unhappiness, she felt better. Eventually she learned from the therapist's not accepting her blame to stand up to her internalized parents and to others in her interpersonal world.

The patient just depicted is aptly described by Lichtenberg as dominated by the aversive motivational system. This patient, and others like her, are always ready to react with complaints and accusations. In my reading of the case of Lichtenberg's Mr. R, who Lichtenberg described as dominated by the aversive system, I wondered if Mr. R too hadn't developed aversiveness by identification with a parent and whether he too tested the therapist by turning passive into active. In infancy, he had a depressed mother whom he could not make happy. In therapy, he had great trouble letting Lichtenberg help him. If I am correct in my inference, then Lichtenberg did help his patient after a long struggle, partly because he refused to feel discouraged and continued to be hopeful in the face of Mr. R's discouraging attitude. He thereby demonstrated to the patient that a person does not have to feel defeated if he is unable readily to bring cheer to someone to whom he is close.

[1] For supporting empirical research, see Curtis and Silberschatz, 1986; and Silberschatz and Curtis, 1986, 1993

From my perspective, Lichtenberg's demonstration each hour of his empathy for the patient, while often helpful, may be limiting. The therapist who makes the demonstration of empathy his or her primary concern tends to think about each hour separately; he or she asks, "What is the patient working on this hour? What goals is he seeking? How may I affirm these goals?" In contrast, the therapist who is guided in his or her work by his or her understanding of the patient's pathogenic beliefs, goals, and tests may perceive a remarkable unity in the patient's behavior over a long stretch of sessions. He or she may perceive the patient working for many months or years in various different ways to disprove just a few pathogenic beliefs and to seek affirmation of just a few goals prohibited by these beliefs.

Regarding the motivational systems delineated by Lichtenberg, it seems to me that, although they are all important, the attachment system has a special place. This is because the infant's and the young child's wish to maintain ties to his or her parents is paramount. If he or she develops problems in another system, it is because pursuing the goals of that system brings him or her into conflict with his or her parents, thereby threatening the ties to them. He or she may then develop a pathogenic belief that impedes him or her in the pursuit of these goals.

To what extent do the five systems remain separated? It seems to me that though they may be separate in early infancy, they soon come together. Also, although a person may certainly have more difficulty in pursuing the goals of some systems than others, in my opinion, a patient's pathogenic beliefs often cut across a number of systems, if

not all of them. For example, a person who sees his or her parents as fragile, and so weakens himself or herself to protect their authority, may not permit himself or herself to be comfortable either in sexual or in exploratory activities. This person may keep himself or herself weak by not establishing control over physiological functions. In addition, he or she may attempt to protect others by not letting himself or herself be appropriately aversive.

Our research provides some evidence for Lichtenberg's concept about the changing dominance of the motivational systems. After the therapist fails a test or offers an interpretation contrary to the patient's goals, the patient becomes more aversive. Indeed, his or her level of experiencing declines. After the therapist passes a test or offers a helpful interpretation, the patient becomes less aversive and his or her level of experiencing increases (Fretter, 1984; Silberschatz, Fretter, and Curtis, 1986). Also we demonstrated in the analysis of one patient that after the therapist passed her tests, the patient became more loving (Silberschatz, 1986, chap, 16).

I hope that the delineation by Lichtenberg of the five motivational systems may stimulate investigators to develop and test hypotheses about the relation of each system to the others and about their changing dominance during the process of therapy.

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