

ADVICE TO THERAPISTS

By Joseph Weiss

The following consists of excerpts from Joe's book *How Psychotherapy Works*. Its purpose is to give readers a concentrated dose of Joe's therapeutic insights as an introduction to or refresher course on control-mastery theory. Some text from the book has been moved around so that related insights that were scattered throughout the book could be presented in one place. –Vic Comello

A REVIEW OF BASIC THEORY

Motivated to Adapt. A person's most powerful motivation is to adapt to reality, especially the reality of his interpersonal world. He begins in infancy and early childhood to work at adapting to his interpersonal world, and he continues to do this throughout life. As part of this effort, he seeks reliable beliefs (knowledge) about himself and his world. He works throughout life to learn how he affects others and how others are likely to react to him. He also works to learn the moral and ethical assumptions that others will expect him to abide by in his relations with them, and that they will abide by in their relations with him. He begins in infancy to learn about these things both by inference from experience with his parents and siblings, and by their teachings.

Pathogenic Beliefs. A person's beliefs about reality and morality are central to his conscious and unconscious mental life. These beliefs are endowed with awesome authority. They guide the all-important tasks of adaptation and self-preservation. They organize perception; a person perceives himself and others largely as he believes himself and others to be. In addition, such beliefs organize personality. It is in accordance with his beliefs about reality and morality that a person shapes his strivings, affects, and moods, and by doing so evolves his personality. Moreover, it is in obedience to certain maladaptive beliefs, here called "pathogenic," that a person develops and maintains his psychopathology.

Unconscious Functioning. A person may carry out unconsciously many of the same kinds of functions that he carries out consciously. He may think, make inferences, test reality, and make and carry out decisions and plans. Moreover, he may exert some control over his unconscious mental life in accordance with these decisions and plans. In regulating his unconscious mental life, he is especially concerned with seeking safety and avoiding danger. He regulates his repressions and his inhibitions in accordance with this concern. He maintains the repression of a mental content as long as he unconsciously assumes that experiencing it would endanger him. He lifts the repression of the content when he decides he may safely experience it.

Psychopathology. Psychopathology is rooted in pathogenic beliefs; these are compelling, grim, and maladaptive. They warn the person guided by them that if he attempts to pursue certain normal, desirable goals, such as a satisfying career or a happy marriage, he will endanger himself or others. He fears external dangers such as the disruption of an important relationship, or internal dangers such as a painful affect (e.g., fear, anxiety, guilt, shame, or remorse). It is in obedience to his pathogenic beliefs and the dangers they warn him against that a person maintains his repressions and inhibitions. He represses the goals he believes to be dangerous, and he inhibits himself from pursuing these goals.

A person develops pathogenic beliefs in childhood by inferring them from traumatic experiences with parents and siblings. These are experiences in which he finds that by attempting to attain a normal, desirable goal, he brings about a disruption in his ties to his parents. For example, he may infer that he burdens his parents by being dependent on them, or that he causes them to

feel hurt and rejected by being independent of them. The power of pathogenic beliefs derives from the fact that they are acquired in infancy and early childhood from parents and siblings, whom the child endows with absolute authority. His parents are critically important to him because he needs them in order to survive and flourish. His only good strategy for adaptation is to develop and maintain a reliable relationship with them. Because his parents are so important to him, he is highly motivated to perceive them as all-powerful and wise. Moreover, he has no prior knowledge of human relations by which to judge them. Therefore, when in conflict with his parents, he tends to perceive them as right and himself as wrong.

Just how a child who is placed away from home blames himself for parental rejection depends on several factors, including how in his opinion he upset his parents before they rejected him. For example, a child whose parents were persistently angered by his demands may infer that he was rejected for being too demanding. Or a child whose parents blamed him for his assertiveness may infer that he was rejected for being too assertive.

Since pathogenic beliefs develop in early childhood, they are concerned with the motivations of the young child in relation to his parents. These include the child's wishes to depend on his parents, to trust them, to be able to be independent of them, to compete with them, and to identify with them. The child may infer and so come to believe that almost any important impulse, attitude, or goal, if experienced or acted upon, will put him in a situation of danger.

The dangers that the child's beliefs warn him against may be internal or external. He may assume that if he pursues a forbidden goal he will suffer fear, shame, remorse, or self-torment, or that he will bring about a serious disruption in his relations with his parents. He may expect to hurt them or to be rejected or punished by them.

Pathogenic beliefs reflect the child's egocentricity, his lack of knowledge of causality, and his ignorance of human relations. The child tends to take responsibility for whatever he experiences. He may take responsibility for anything unfavorable that a parent does, or for anything unfortunate that happens to a parent. For example, he may take responsibility for the depression, illness, or death of a parent, or for the unfavorable ways his parents treat each other. A child may take much more responsibility for his parents than is justified by his real power to affect them.

- A child may acquire pathogenic beliefs simply by assuming that the ways his parents treat him are the ways he should be treated.
- A child may also develop pathogenic beliefs by instruction from his parents.
- Sometimes a child develops pathogenic beliefs from accidental events.
- A child may develop pathogenic beliefs from either "strain" traumas or "shock" traumas. A child incurs a strain trauma over a long period of time in a pathogenic relationship with a parent. A child incurs a shock trauma from a sudden overwhelming event, such as placement away from home or the unexpected illness or death of a parent. The child is prone to take responsibility for such an event, and thus to develop pathogenic beliefs from it by retrospective inference. He assumes after the event that he brought it about by attempting to seek certain goals, to maintain certain attitudes, or to exercise certain functions.

The Patient's Unconscious Work during Therapy. A person suffers from pathogenic beliefs and is highly motivated to disprove them. Throughout therapy he works with the therapist to do this. He unconsciously tests these beliefs with his therapist, and he uses the therapist's interpretations to become conscious of the beliefs and to realize that they are false and

maladaptive. The therapeutic process is the process by which the patient works with the therapist at the task of disconfirming his pathogenic beliefs.

The patient works to change his pathogenic beliefs in an orderly way: He makes simple plans (which are in varying degrees unconscious) about which problems to tackle during a particular phase of treatment and which ones to defer tackling until later. In addition, he takes into account the dangers predicted by the beliefs, and the painful affects to which the beliefs give rise. Also, he takes into account his abilities and his current reality, which includes his assessment of the therapist. He may in some instances decide not to tackle his more difficult problems at the beginning, but to work to acquire the strength to tackle them later. If at the beginning he believes himself especially threatened by a particular danger, he may begin therapy by working to assure himself that this danger is not real.

Testing. A patient tests his pathogenic beliefs by experimental actions. He carries out an action that, according to his pathogenic belief, will affect the therapist in a particular way. The patient hopes unconsciously that this action will not affect the therapist as the belief predicts. If the patient's pathogenic expectation is not borne out, the patient may feel relieved and take a small step toward disconfirming the belief.

The patient may test his pathogenic beliefs verbally. For example, a patient who unconsciously believes that he will or should be punished for feeling proud may test this belief by a trial expression of pride. He hopes that the therapist will not put him down. A patient may also test his pathogenic beliefs by a trial change in nonverbal behavior. For example, a patient who unconsciously believes that he does not deserve treatment may test this belief by missing sessions. He hopes that the therapist will help him realize that he deserves to come to his sessions.

In unconsciously planning his tests, the patient wishes to garner maximum evidence against his pathogenic beliefs at minimum risk. In some instances the patient, by careful unconscious planning, is able to test his pathogenic beliefs gradually in a series of graded tests, none of which puts him at much risk. In other instances the patient is unable to work at a safe rate. This was true of a patient who suffered such severe survivor guilt at the beginning of treatment that she could not commit herself to treatment until she had given, and the therapist had passed, a dangerous test: She provided the therapist with considerable (albeit false) evidence that she was so disturbed that she was untreatable. She was able to let herself become a patient only after the therapist had demonstrated that he was not deterred by her damaging self-accusations and that he did not take them at face value.

Two Types of Tests. The patient may test his pathogenic beliefs in two different ways: namely, by turning *passive into active*, and by *transferring*. In both kinds of tests the patient re-enacts the childhood traumatic experiences from which he inferred his pathogenic beliefs. In passive-into-active testing, the patient behaves to the therapist in the traumatic ways that a parent behaved toward him. The patient hopes to demonstrate that the therapist will not be upset by him as he was by his parents. He does not want the therapist to be constrained by pathogenic beliefs such as those from which he himself suffers. If the patient infers that the therapist is not upset, he may be relieved. He may observe the therapist dealing effectively with behavior that was for him traumatic, and so may learn from the therapist how to deal effectively with such behavior.

A patient may test his pathogenic beliefs more directly by transference tests than by passive-into-active tests. In transference tests, he behaves with the therapist as in childhood he behaved with his parents. He reproduces the behavior that, in his opinion, provoked the parental reactions from which he inferred his pathogenic beliefs. The patient unconsciously hopes that he

will not affect the therapist as he affected his parents. He may hope, for example, that he will not, by his sexuality, provoke the therapist to punish him, or by his contentment provoke the therapist to charge him with complacency, or by his independence cause the therapist to feel rejected. If the patient observes that he does not affect the therapist as he affected a parent, he may take a step toward disconfirming the belief that he provoked the traumatic parental reactions.

All patients test the therapist throughout therapy, both by turning passive into active and by transferring. Often the patient gives both kinds of tests simultaneously by the same behavior.

In some therapies the patient is comfortable giving transference tests from the beginning. In other therapies the patient may feel safer giving passive-into-active tests in the beginning, because while turning passive into active the patient is putting himself in the strong position of the aggressor, and thereby providing himself with a defense against being traumatized by the therapist. In still other therapies the patient at the beginning unconsciously considers it dangerous to turn passive into active. He may fear that he will traumatize the therapist so severely that he will render the therapist unable to help him; or he may realize how much he was hurt by his parents' behavior, and so may fear that he would feel intense guilt if he were to behave with the therapist as his parents behaved with him.

The Relationship Between Shame and Guilt. A sense of shame plays a powerful part in the development and maintenance of psychopathology. Shame, like guilt, anxiety, and fear, stems from pathogenic beliefs that a person acquires in childhood from traumatic experiences with parents and siblings. A person may develop such beliefs by identifying with shameful parents or by complying with their putdowns.

A child may develop a sense of shame if he infers that his parents are suffering from shame. Since a child develops shame from compliance with his parents or from identification with them, he feels compelled to maintain his sense of shame in order to maintain his ties to his parents. Therefore, the patient who struggles successfully to overcome his sense of shame may feel guilty to his parents, or he may lose his sense of connection to them so that he becomes sad.

Ambivalence. A person's manifest behavior may express adaptive efforts to compensate for certain weaknesses that he maintains in compliance with his unconscious pathogenic beliefs. A person who is weakened and hence endangered by his pathogenic beliefs may attempt to protect himself by two different and incompatible strategies: He may demonstrate intense ambivalence, and he may engage in what is sometimes referred to as "splitting." However, neither the ambivalence nor the splitting is primary. Both are secondary to the pathogenic beliefs and the contradictory methods of dealing with the weaknesses that stem from them.

THERAPEUTIC TECHNIQUE

The theory of technique proposed here follows from the formulations presented above. It assumes that the therapist's basic task is to offer the patient the help he seeks in his struggle to change his pathogenic beliefs and to pursue the goals they warn him against. The therapist, by his overall approach, his attitude, his reactions to the patient's tests, and his interpretations, helps the patient to feel safe and secure with him. He thereby helps the patient to face the dangers predicted by his pathogenic beliefs, and to work at the task of disconfirming them.

The means the therapist may use to help a patient feel safe and secure depend on the nature of the patient's pathogenic beliefs. The therapist's approach is case-specific. His techniques are

geared to helping the patient feel reassured against the dangers predicted by his particular pathogenic beliefs, and to work at disproving these beliefs in accordance with his own plans for doing so.

The theory of therapy on which my views of technique are based ... assumes the following:

1. The patient's symptoms and character problems are maintained by pathogenic beliefs that are developed in early childhood by inference from experience. These beliefs warn the patient that if he relinquishes his psychopathology, he may put himself or his loved ones in danger.
2. The patient is powerfully motivated unconsciously to make progress but is afraid to do so, lest he put himself or someone he loves in danger. His anxiety about moving forward stems from his pathogenic beliefs and from the feelings of danger to which they give rise.
3. The various repetitions in the transference of the patient's childhood experiences are unconsciously purposeful. They are brought about by the patient for various purposes, one of which is to test his pathogenic beliefs.

...the therapist guided by the theory presented here asks himself, "What are the patient's pathogenic beliefs? How is he working to change them? What are his current goals and plans? How is he testing me? How may I make it safer for him to carry out his plans and thus to reach his goals? How may I best pass the patient's tests? What interpretations may help him to reach his goals?"

Powerful, Urgent Maladaptive Impulses Reflect Adaptation to a Maladaptive (Pathogenic) Picture of Reality. Thus, powerful maladaptive impulses may be maintained by pathogenic beliefs that are developed in infancy or early childhood in an attempt at adaptation. An infant or child may develop such beliefs in order to maintain his ties to his parents. For example, as already pointed out, a patient may become maladaptively "bad" if he infers that by being so he pleases a parent by giving the parent an opportunity to feel morally superior to him. Moreover, he may generalize this belief, and so may continue for years to behave provocatively with parent surrogates in an unconscious attempt to maintain his ties to them.

The Patient Is Almost Always Working to Get Better. Much of the patient's behavior—including behavior in which the patient appears bored, insulting, or grossly uncooperative—is part of the patient's working, both consciously and unconsciously, to get better. Even when the patient is unable unconsciously to control his behavior, as when he gives in to guilt and becomes self-destructive, he may secondarily observe the therapist to determine whether the therapist approves of or opposes his self-destructiveness.

A patient who is uncooperative may be testing the therapist by turning passive into active. That is, he may be behaving toward the therapist as in his experience a parent behaved toward him. The patient hopes that he will not discourage or crush the therapist as he himself was discouraged or crushed by the parental behavior. If a therapist passes the patient's tests by not reacting as the patient reacted to the traumatizing parental behavior, the patient may feel better. Then he may use the therapist as a model to fight the parental attitudes that he has internalized.

The Patient Sets the Agenda. The patient rather than the therapist sets the agenda. The patient conveys to the therapist, albeit at times indirectly, how he would like to work in therapy. He permits the therapist to infer the goals he would like to pursue and the pathogenic beliefs that prevent him from pursuing these goals. The therapist's task, then, is to help the patient, in

accordance with the patient's unconscious plans, to disprove his pathogenic beliefs and to pursue his goals. The therapist may learn whether or not he is passing the patient's tests or making helpful (pro-plan) interpretations by observing the patient's reactions to him. If the therapist is on the right track, the patient will become bolder and more insightful. Then in some instances, after a brief period of relief, the patient may develop the courage to test his pathogenic beliefs more vigorously. If the therapist is on the wrong track, the patient will become more timid, more depressed, and less insightful, and he may test his pathogenic beliefs less vigorously.

No Non-Case-Specific Set of Technical Rules Is Sufficient to Offer Optimal Help to the Patient.

The patient uses his considerable unconscious capacity for inference to infer as accurately as he can just what the therapist intends by his attitudes, interventions, and interpretations. The patient is especially concerned with discerning the therapist's attitudes toward his pathogenic beliefs and plans. The therapist may offer optimal help to the patient only if he infers the patient's plans and helps him to carry them out by passing the patient's tests and by giving him pro-plan interpretations.

If the therapist is guided in his behavior by a set of non-case-specific technical rules, no matter how subtle these may be, he is unlikely to pass all of the patient's tests unless he is in fact sympathetic to the patient's plans. This is because the patient unconsciously will see around the rules and infer the therapist's attitude to his plans. Nonetheless, certain patients, because of their considerable ability unconsciously to infer the therapist's intentions, may be helped (if not optimally) by a therapist who is guided by a certain set of technical rules. Such a patient, by inferring the therapist's rules, may know just how the therapist is likely to react to him, and he will use this knowledge to devise tests that the therapist is likely to pass.

The Therapist Should Attempt to Help the Patient Reconstruct the Traumatic Experiences from Which the Patient Inferred His Pathogenic Beliefs. The present theory disagrees with those theoreticians who recommend that the therapist focus primarily on the impulses and affects that the patient expresses to the therapist in the here and now, and that he be concerned only secondarily (if at all) with the reconstruction of the patient's childhood traumatic experiences.

The reconstruction of the childhood traumas is of great importance. Unless the therapist knows how the patient acquired his problems, the therapist cannot know the patient's pathogenic beliefs, or his goals, or how to pass his tests. A patient may express a particular impulse to the therapist for a variety of reasons, and unless the therapist knows why the patient is expressing it, he will not know how to deal with it. For example, a patient may have developed a tendency in childhood to express maladaptive anger and hostility because he inferred that by being unreasonably angry, he permitted his mother to feel morally superior to him. Another patient may have developed a tendency to hostility and negativism as part of a struggle to fight off compliance to a parent who abused him. The two patients, by expressing hostility to the therapist, are giving him different kinds of tests. The patient who became enraged to please his mother attempts by his display of anger to assure himself that the therapist is not motivated to feel morally superior to him. This patient wishes to convince himself that the therapist wants him to be reasonable and controlled. The patient who is angry in order to fight off compliance attempts by his display of hostility and negativism to assure himself that the therapist does not object to his hostility. He wants to convince himself that the therapist will not deprive him of a tool he needs to protect himself from being abused. Such a patient may be unwilling to relinquish his anger until he knows the therapist can comfortably tolerate it.

Corrective Emotional Experience. The present theory assumes that the patient seeks corrective

emotional experiences through his testing, and that the therapist should provide the patient with the experiences he seeks. The therapist who attempts to pass the patient's tests by offering the patient the experiences he seeks need not fear that he will go far astray, for he may check the pertinence of his behavior to the patient by the patient's reactions to him.

This conceptualization indicates that in order to understand the patient, the therapist should infer the patient's conscious and unconscious beliefs about himself and his interpersonal world. The therapist may then perceive the patient's situation, with its dangers and its opportunities, much as the patient himself perceives it. The therapist may thus come to understand how to help the patient to deal with the dangers and to take advantage of the opportunities.

The therapist who uses his theory and his empathy to understand the patient's unconscious motivations is not role-playing when he responds appropriately to the patient's tests. Consider, for example, the therapist who realizes that though his patient is threatening to quit, he is hoping unconsciously that the therapist will not let him do so. This therapist is not role-playing when he urges the patient to continue; rather, he is being appropriate and empathic. Indeed, to pass the patient's tests in accordance with the present theory requires no more role playing than to maintain the detached, impersonal attitude prescribed by the 1911-1915 theory in the face of a patient's dramatic and upsetting disclosures.

Nor does the therapist's approaching the patient in a way designed to pass one kind of test cast the patient-therapist relationship in a certain mold, so that the patient is less able to offer a new kind of test that requires a different approach. The patient can always find a way of changing his relationship to the therapist when his unconscious plan requires him to do so.

THE THERAPIST'S TASK

According to the present theory, the therapist's basic task is to help the patient in his working to disprove his pathogenic beliefs and to pursue the goals forbidden by these beliefs. Thus, the present theory assumes that the patient and therapist have the same purpose—namely, the disconfirmation by the patient of his pathogenic beliefs. Indeed, the disconfirmation of these beliefs is so important that the therapist may judge a particular technique by this simple criterion: Does it contribute directly or indirectly to the patient's disproving his pathogenic beliefs?

When the patient perceives the therapist as sympathetic to his plans, the patient almost invariably reacts immediately by feeling less anxious, more secure, and more confident in the therapist. The fact that the patient reacts this way immediately after a passed test or a pro-plan interpretation has been demonstrated by formal quantitative research. The patient may reveal his greater sense of security with the therapist directly, by being bolder, more insightful, and more confident with the therapist. Or, after a brief pause, he may reveal it by testing the therapist more vigorously. In cases where the patient perceives the therapist as opposed to his plans, he becomes less secure and more anxious and defensive, and is impeded in his efforts to test his pathogenic beliefs.

The therapist's approach is case-specific; that is, the therapist should help the patient to feel secure enough to face whatever dangers are foretold by his particular pathogenic beliefs, and to pursue whatever goals his particular beliefs have prevented him from pursuing effectively.

The Use of Reassurance or Authority. In contrast, the theory proposed here assumes that the therapist should employ a variety of means besides interpretation, including in some instances reassurance or the use of authority.

Though the use of authority or reassurance is pro-plan in some instances, it is anti-plan in others. For example, some patients experience reassurance as patronizing, and some patients consider the use of authority as infantilizing or humiliating. Just how the therapist may help the patient feel safe depends on how the patient felt endangered in his childhood.

A patient who in childhood infers from parental neglect that he does not deserve protection may feel unsafe in therapy until the therapist uses his authority to demonstrate that he will protect the patient.

Patients who require reassurance or the use of authority are not necessarily more disturbed than patients who do not. The fact that the patient is not suitable for treatment by the traditional technique may reflect the limitations of that technique rather than the patient's degree of disturbance.

In some instances the patient benefits primarily from the good relationship he establishes with the therapist and the new experiences he acquires in this relationship. He may then develop insights secondarily by reevaluating his present and past situations in the light of his new experiences.

A better guide to the patient's goals than his conscious statements is his reactions to the therapist's interventions.

The Importance of Helping the Patient to Realize that He Developed His Psychopathology in His Relations with His Parents. According to the present theory, the patient who explores the traumas of his childhood does so not to escape responsibility for his problems, but as part of his working to understand these problems and to solve them. He takes a step forward when he begins to realize that he suffered from parental mistreatment, complied with it, and as a consequence developed the pathogenic belief that he deserves mistreatment. His realization that he suffers from pathogenic beliefs inferred from traumatic experiences with his parents helps him to take responsibility for solving his problems. He also learns how he may solve them—that is, by changing these beliefs. However, if the therapist discourages the patient from recognizing the part his parents played in the development of his psychopathology, the patient may be impeded in his effort to solve his problems. He may continue to believe, as he did in early childhood, that he deserved the parental treatment he received.

Resistance Analysis. From the perspective of the theory proposed here, resistance interpretations may be counterproductive, especially in the treatment of patients who experience resistance interpretations as criticisms. Such interpretations may prevent the patient from feeling safe enough with the therapist to discuss his feelings of being inadequate, guilty, or unappreciated.

According to the present theory, the therapist's basic task is to help the patient in his struggle to disprove his pathogenic beliefs and to pursue the goals forbidden by these beliefs. In carrying out this task, the therapist does a number of things: He helps the patient feel safe with him by demonstrating that he disagrees with the patient's pathogenic beliefs and sympathizes with his goals. He does these things not only by interpretation, but by his overall approach and attitude to the patient, and by passing the patient's tests. Also, he varies his approach from patient to patient: He adapts it to each patient's particular pathogenic beliefs, goals, and plans.

In general the therapist should not be neutral, but should be the patient's ally in his efforts to disprove his pathogenic beliefs and to pursue his goals. Nor should the therapist avoid the use of reassurance or authority in situations where reassurance or authority may be helpful. Thus, interpretation is not the sine qua non of therapy. In some instances the patient may be helped to disconfirm his pathogenic beliefs and to pursue his goals primarily by his experiences with his therapist. After this is accomplished, he may feel safe enough with the therapist to develop insights on his own, without benefit of interpretation.

INFERRING THE PATIENT'S PLAN FROM THE FIRST FEW SESSIONS OF THERAPY

The therapist should begin during his first contact with the patient to try to understand him. The therapist should attempt to formulate the patient's pathogenic beliefs, his goals, and his plans for working to disconfirm the beliefs and to pursue the goals. If the therapist develops explicit (albeit highly provisional) hypotheses about these, he has something to work with. He may check the hypotheses against new observations and thereby confirm them, alter them, or dismiss them. Moreover, the therapist who has in mind the best hypotheses that his current knowledge supports is prepared for the patient's tests, including tests that the patient may give him quite unexpectedly.

During the first few sessions the therapist should try to develop a provisional formulation (theory) specific to the patient. In developing it the therapist relies on information from various sources, including (1) the patient's own formulation of his current problems and goals, (2) the patient's childhood traumas, (3) the therapist's affective responses to the patient, and (4) the patient's reactions to the therapist's approach and interventions.

The therapist may begin to develop his ideas about the patient from one source of information, then check or refine these ideas with information from other sources. The therapist should not be satisfied with a formulation unless it helps him to understand all or at least most of what he knows about the patient.

In attempting to determine where the patient wants to go, the therapist is thinking about him in familiar, everyday terms. Unlike the therapist who attempts to infer the patient's impulses and defenses, the therapist who attempts to infer the patient's goals is calling upon well-developed intuitions based on everyday experience. The therapist who is not accustomed to listening for the patient's goals may be surprised to discover how often they are easily perceived.

Evaluating the Patient's Stated Goals. In attempting to infer the patient's true unconscious goals from his stated goals, the therapist should assume that the patient's true goals are normal and reasonable. If the patient states implausible goals, he is probably doing so in obedience to powerful unconscious pathogenic beliefs. For example, the therapist should not take at face value a patient's statement at the beginning of treatment that he is interested in a woman who (he implies) is ungiving, demanding, and insulting. The patient's true goal may be to leave her; however, he may be maintaining an attachment to her for various maladaptive reasons. For instance, the patient may believe that he is obliged to suffer in his relations with women as his father suffered in his relations with the patient's mother.

In some cases, a patient at the beginning of therapy may be unable to state his goals directly. Throughout therapy, but especially at the beginning, he is in unconscious conflict about his wish to reveal his true goals and his fear of doing so. He would like to reveal his goals so that the

therapist may help him to pursue them. However, he unconsciously believes that by revealing them he risks being traumatized by the therapist, because he fears that the therapist (whom he has not yet tested) will agree with the pathogenic beliefs that warn him against pursuing his goals.

The degree to which the patient is able at the beginning of therapy to state his true goals varies from patient to patient; it depends, among other things, on the degree to which the patient is bound by his pathogenic beliefs. A patient beginning therapy may be surprisingly insightful about his goals, but may seem to lose his insight soon afterward. At first he may be so powerfully motivated to orient the therapist to his problems that he does so despite his pathogenic beliefs. However, having oriented the therapist, he may soon begin to test him by stating false goals in the hope that the therapist will not take such statements at face value.

In other instances, the patient in his opening remarks may compromise between the wish to reveal his goals and the fear of doing so. For example, a patient who wished to overcome the belief that he should not be proud of his intelligence began the first session by describing himself as a slow learner. However, during the rest of the session he supplied evidence for his intelligence by his cogency and clarity in describing his development and his current difficulties.

Another patient who wished to face his drinking problem and ultimately to stop drinking began his first hour by stating that he had been nervous about starting therapy, and so drank a glass of wine the night before. Similarly, a patient who wanted to convey that he had been unprotected by his parents, and who hoped in therapy to learn to protect himself, told the therapist in the first hour that he had gone with an extremely wild crowd in high school.

In still other instances, the patient may be so afraid to state his goals that he does not state them at all, or he states goals opposite to his true goals. However, even in such cases the patient generally provides some clue as to his true goals. For example, a man who was fond of his girlfriend unconsciously believed that his having a successful relationship with her would show up his mother, who during his childhood frequently told him that no one could get along with him. During his first few sessions he disparaged his girlfriend as too sweet and agreeable, and implied that he was considering leaving her. However, by offering obviously weak arguments for leaving her, he provided the therapist with indirect evidence for his true goal, which was to develop a close relationship with her.

A patient whose unconscious goals included overcoming the belief that he should be rejected revealed this goal indirectly by coolly telling the therapist that he was considering therapy but was very particular about finding a therapist whom he considered suitable. He revealed his fear of rejection indirectly by assuming a rejecting attitude toward the therapist, which was intended to protect him from the danger of rejection by the therapist.

In another example, the patient was so endangered by powerful pathogenic beliefs that she was unable to state any goal. She suffered a great deal from survivor guilt toward her emotionally handicapped parents and siblings, and was afraid that the therapist would agree with her belief that she did not deserve treatment. In her first few hours she depicted herself as psychotic and thus as too disturbed for outpatient therapy. However, she also provided the therapist indirectly with evidence of adequate functioning by the intelligent, organized way that she told her story. She was relieved when the therapist accepted her for treatment. Over a period of time, she revealed both her considerable talents and accomplishments and her concern for her handicapped family. In a sense this patient first conveyed her goal (which was to overcome her

survivor guilt) not directly through words, but indirectly through the way she tested the therapist.

Evaluating the Patient's Childhood Experiences with His Parents. In attempting to understand the patient's problems from a description of his childhood, the therapist is especially interested in determining what traumas the patient suffered in childhood and what pathogenic beliefs he inferred from these traumas. As the therapist comes to understand the patient's pathogenic beliefs, he also comes to understand his goals, which always include disproving these beliefs. The therapist, in inferring the patient's pathogenic beliefs, should keep in mind that a child tends to take responsibility for the unfortunate things that happen to him and to his family. These include catastrophic events, which give rise to "shock" traumas, and protracted strains resulting from pathogenic relations with parents, which give rise to "strain" traumas.

The patient who suffers a sudden catastrophe in childhood tends to experience it as a punishment for something bad he has done. Since he considers it a punishment, he may become unduly guilty, and since he believes himself responsible for it, he may develop a belief in his omnipotence. The more severe the catastrophe, the more guilty and omnipotent he may believe himself to be. In addition, he may infer from the sudden unfortunate turn in his fortunes that catastrophe may strike at any time. He must therefore keep himself vigilant and thus prepared for another blow by fate.

A child who is exposed to continuing overwhelming trauma may develop the belief that there is no help for him. He may attempt to ease the pain by withdrawing and anesthetizing himself.

The Child's Compliance with Inadequate Parents. In making inferences about the patient from a description of his childhood, the therapist should keep in mind that the child considers his parents supreme authorities with whom he must get along at almost any cost. He works to develop and maintain his ties to them. He tries to fulfill their expectations and assumes that the ways they treat him are the ways he should be treated. For example, if his parents are rejecting, a child may infer that he deserves to be rejected; his self-esteem may be damaged, and he may believe himself incapable of being loved, not only by his parents but by others.

- If the child perceives his parents as depressed, needy, or fragile, he may take responsibility for their happiness and go to great lengths in his efforts to make them happy.
- If a child's parents are unconcerned about him yet demand that he show solicitude and respect to them, he may become depressed, for he may infer that it is his lot to give but not to receive.
- If a child's parents persistently criticize him for various faults, such as selfishness, arrogance, or stupidity, he may consciously repudiate the criticisms, but unconsciously believe them. As a result, he may come to believe unconsciously that he is not a good person.
- If one of the parents is a severe alcoholic, the child is likely to feel both rejected by the parent and worried about him. He may, as a consequence of such trauma, experience a sense of shame. If the family denies the alcoholism, he may experience even more shame. He may also develop the idea that he is not supposed to perceive things as they really are.
- If a child perceives his parents as volatile and capricious—if, for example, they surprise him by unpredictable fits of anger—he may develop the belief that he is always in danger, and so may become hyper-vigilant.

- If the child's parents fail to protect him and so expose him to dangers beyond his capacity for coping, he may come to believe that the world is dangerous and that he does not deserve protection. He may become withdrawn or anxious, or subject to attacks of panic.
- If the child is sexually abused by a parent, he will blame himself for the abuse and develop a sense of shame. If the parent denies the abuse, the child will infer that he must not remember it. His sense of reality may be impaired. If the abuse occurred at an early age, the child is confronted with the following problem: In order to adapt to his world, he must both forget the abuse and remember it. He must forget the abuse in order to adapt to the members of his family, who insist on denying it, for he cannot be friendly and close to a parent who he knows is abusing him. However, he must remember the abuse in order to prepare for further abuse. If abused while quite young, he may deal with this problem by dissociating, or in certain instances by developing several personalities—one or more of which has no memory of the abuse, and one or more of which remembers it.

The Child's Identifications with Inadequate Parents. In attempting to infer how the patient was affected by his parents, the therapist should keep in mind that for the child his parents are role models. It is from his parents that the child learns how to relate to others. Thus it is extremely difficult for a child to develop abilities that his parents have not developed. If a child perceives his parents as ashamed, he too is likely to develop shame.

Survivor Guilt. In inferring the patient's pathogenic beliefs from his account of his childhood, the therapist should keep in mind the prevalence of survivor guilt. Most persons suffer from survivor guilt. They assume that in some ways they have been treated better by fate than their parents and siblings, and that their favorable treatment was at the parents' and siblings' expense. A person who suffers from survivor guilt may fail to take advantage of his opportunities, or, if he does take advantage of them, may find some way of punishing himself for doing so.

Survivor guilt may underlie a variety of symptoms. A person who suffers from survivor guilt may torment himself with envy of others who have more than he. By feeling envious, he identifies with his parents and siblings, who (he assumes) are envious of him. Or he may torment himself with shameful ideas, such as that he is absurd, perverted, or unpleasant. He may spoil his relationship with his wife so as not to enjoy a better relationship with her than his parents enjoyed with each other. If his parents were not able to enjoy their children, he may not let himself enjoy his children. If a parent died at an early age, he may become anxious about dying when he reaches that age. If a sibling failed in his career, he himself may become depressed or anxious when he is becoming successful.

Survivor guilt may be both extremely powerful and extremely elusive. A child who grows up in an unhappy family may take unhappiness for granted. He may not realize that even after leaving home he maintains his unhappiness out of loyalty to his family. One patient who became aware of survivor guilt only after considerable work in therapy said, "It was so hard to see because it was like the air I breathe."

A patient may first become aware that he suffers from survivor guilt by inference from experience. He may observe that he develops symptoms either after he is successful or after a close friend or relative suffers a setback. He may only later realize that he feels sorry for certain members of his family and that he considers his advantages unfair.

Separation Guilt. Separation guilt is also extremely common, if not universal. The patient who suffers from separation guilt believes that if he becomes independent of his parents or siblings, he may upset them. In extreme instances the patient may feel that he has no right to a life of his

own. He may, as a consequence of an unconscious belief that he does not deserve to be a separate independent person, convince himself that he enjoys being dependent.

The Therapist's Affective Reactions. The therapist, in making inferences about the patient from the ways the patient begins to relate to him, uses his affective reactions as a signal. He senses from his affects how the patient is acting on him, what dangers the patient is warding off, or how the patient is testing him.

In general, if the therapist while listening to the patient feels an unpleasant affect such as confusion, rejection, guilt, or humiliation, he may assume that the patient is turning passive into active.

Sometimes the therapist during the first few sessions may find the patient completely opaque. The therapist may be unable to begin to formulate the patient's problems. In these instances the patient may be concealing a shameful secret. He may be so afraid that the therapist will shame him that he adopts a highly defensive posture. He assumes that if he offers the therapist any clues as to the nature of his problem, the therapist will infer his secret and shame him for it.

The Patient's Reactions to the Therapist. The therapist may check the validity of his ideas about the patient's goals and plans by observing how the patient reacts to him. If the therapist is passing the patient's tests or offering the patient pro-plan interpretations, the patient over a period of time should react favorably. He should demonstrate greater confidence in the therapist, a sense of relief, greater insight, and more boldness. If the patient consistently reacts in these ways, the therapist may assume that he is on the right track and that the formulations on which he bases his behavior with the patient are correct. If the patient consistently fails to respond favorably to the therapist or becomes more depressed and anxious, the therapist may assume that he is on the wrong track. Sometimes the therapist may gain confidence in his approach when the patient reacts to just a single passed test or a single pro-plan interpretation.

TESTING

Testing is a fundamental human activity prominent in everyday life and in therapy. It is a manifestation of the human being's effort to adapt to his interpersonal world. Through his testing he explores the world to determine its dangers and its opportunities, so that he may protect himself from the dangers and take advantage of the opportunities.

In therapy, the patient tests the therapist from the beginning to the end of treatment. He is vitally interested in finding out how the therapist will react to his plans. Will the therapist oppose his goals, or will he be sympathetic to them and encourage him to pursue them? The therapist's ability to recognize the patient's tests and pass them is central to the therapy. The success or failure of a therapy may depend upon this.

In this chapter on testing, I take up such topics as how the therapist recognizes the patient's tests, how he infers what the patient is trying to find out, how he may know whether he has passed or failed a series of tests, what he should do if he fails the patient's tests, and so forth.

Inferring How the Patient May Test. In inferring how the patient may test him, the therapist uses everything he knows about the patient. From this information, he develops a case-specific theory about the patient, which includes the patient's pathogenic beliefs and the goals that the patient has inhibited in obedience to these beliefs. The therapist who has developed a good theory (plan formulation) may check it by assessing its power to explain the patient's ongoing

behavior. The therapist may determine whether he is passing the patient's tests by observing the patient's reactions. If he is passing the tests, the patient should react by demonstrating more confidence in the therapist and more movement toward his goals. Also, the patient may bring forth new pertinent information about himself.

In some instances the patient reveals his greater confidence in the therapist by giving him bolder tests. Consider, for example, a patient who believes that his pride will provoke others to put him down, and who tests the therapist by putting himself down in the hope that the therapist will not agree with his self-putdowns. If the therapist consistently refrains from putting him down, the patient not only may become more relaxed and confident in the therapist; he may also test the therapist more vigorously by putting himself down more convincingly than before. He hopes by such testing to garner even greater evidence against his pathogenic beliefs.

The therapist may assume the correctness of his plan formulation, and thus of his understanding of the patient's tests, if his formulation enables him to see the continuity and the coherence of the patient's behavior. The therapist who understands the patient's pathogenic beliefs, tests, and goals perceives in the patient's behavior a coherence and a continuity that the therapist unfamiliar with these concepts cannot perceive.

The Characteristics of Tests

Just what patient behaviors should be considered tests is somewhat arbitrary, because tests may differ from other behaviors mainly in degree. Since the patient is interested in the therapist's reactions to everything he says or does, the patient in a sense is always testing the therapist. Moreover, the patient seldom is simply testing him; the patient's behavior while testing the therapist invariably serves a variety of other adaptive functions. In testing the therapist, the patient makes use of the events in his everyday life. Suppose, for example, that a patient who fears rejection wants to test the therapist by threatening to stop treatment and hopes that the therapist will urge him to continue. Such a patient may not make this threat until he has a good reason to do so—as when, for instance, he is offered a job in another city. Or a patient who wishes to assure himself that he cannot worry the therapist may not test his potential for worrying him until he suffers a setback in his everyday life that will justify the therapist's worrying. Then he may test the therapist by appearing deeply upset, in the hope that the therapist will not worry unduly.

As implied above, the patient's behavior while testing the therapist may be indistinguishable from his usual behavior. The therapist may assume that the patient is testing him in the following circumstances, which are overlapping:

1. The patient behaves in such a way as to arouse powerful feelings in the therapist—for example, by being provocatively boring, contemptuous, seductive, or impossible.
2. The patient exerts a strong pull for the therapist to intervene. He may do this by being silent for long periods of time, by making false or absurd statements, by not paying for some sessions, by feeling highly insulted when the therapist says something clearly intended to be benign, by suddenly threatening in great anger to stop treatment, by insisting the therapist step out of his role as therapist, and so forth.
3. The patient makes use of provocatively wild exaggeration.
4. The patient displays behavior that is out of keeping with his usual behavior, in that it is more foolish or more self-destructive.

The Patient May Use Different Behaviors to Test the Same Pathogenic Beliefs. The therapist may be helped to understand certain testing sequences by realizing that the patient may use a variety of behaviors to test the same pathogenic beliefs. In one instance, a patient attempted to disprove a particular pathogenic belief by testing it in two seemingly opposite ways. The patient, a young man who wanted to determine whether the therapist was competitive with him, first tested for this by putting himself down. He told the therapist about a blind date in which he had behaved awkwardly and alienated the woman. He hoped unconsciously that the therapist would give no evidence of enjoying his failure. When the therapist did not, the patient felt encouraged; he assumed that if the therapist did not enjoy his failing, he might not object to his succeeding. The patient then tested the therapist by telling him about a success. He described an encounter with a woman who was charmed by him and eager to continue seeing him. The patient hoped that the therapist would give no evidence of being jealous or challenged. When the therapist did not, the patient felt relieved and told the therapist more about his comfort with women.

The Therapist May Sometimes Understand the Meaning of a Test Only after He Has Passed It and the Patient Has Brought Forth New Material. In most therapies, there are times when the therapist knows he is being tested but does not know just what pathogenic beliefs the patient is attempting to disprove. In such circumstances, the therapist may not know whether he has passed the patient's tests until the patient responds. If the patient reacts to the therapist's interventions by retreating, the therapist may assume that he has failed the tests. If the patient moves forward, he may that assume that he has passed the tests. If the therapist passes the tests and the patient responds favorably, the therapist may infer from the nature of the patient's responses just what pathogenic beliefs the patient was working to disprove.

Testing with Attitudes. In some therapies the patient gives the therapist sharply defined, powerful tests. In contrast, there are therapies in which the patient, instead of attempting to disprove his pathogenic beliefs by discrete tests, attempts to disprove them by displaying a persistent attitude that serves the same testing function. For example, a patient may work to disprove the belief that if he is friendly he will be rejected. He may test it with occasional discrete displays of affection, or he may attempt to accomplish the same thing by displaying a persistently friendly attitude. The therapist, in treating such a patient, should develop an attitude toward him that is designed to help the patient disprove his pathogenic beliefs. For example, in treating a patient who displays a persistently friendly attitude in order to test the belief that he should be rejected, the therapist should return the patient's friendliness.

Discriminating Between Transference Tests and Passive-into-Active Tests. The therapist may sometimes distinguish predominantly transference tests from predominantly passive-into-active tests by the way he experiences the patient's testing behavior. When the patient transfers, he endows the therapist with the authority of a parent, so the therapist tends to feel relatively safe. However, when he turns passive into active, the patient assumes the role of the traumatizing parent, and the therapist may feel considerable strain. Thus, if the therapist experiences the patient's behavior as confusing, worrisome, outrageous, frightening, or impossible, or if the therapist finds himself feeling guilty, the patient is usually giving a passive-into-active test. (He may also be transferring.)

The fact that the tests most disturbing to the therapist are almost always passive-into-active tests may be understood in terms of the difference between the relationship of the child to his parent and that of the parent to his child. As I have noted throughout this book, the child is powerfully motivated to maintain his ties to his parents; for the child to do this is a matter of life and death. The child is so highly motivated to get along with his parents that he will not behave

outrageously unless he does so in compliance with his parents, or through identification with his parents' outrageous behavior.

However, some parents are not highly motivated to maintain their ties to their child or to get along with the child. Sometimes a parent may abandon, beat, worry, or seduce a child. Thus if a therapist feels quite belittled by a patient, guilty to him, confused or humiliated by him, or helpless to treat him, the patient is almost always behaving like a parent—and thus turning passive into active.

A patient who could not learn from his parents how to deal with a particular kind of trauma may turn passive into active in order to learn from the therapist how to deal with it. Consider, for example, a patient who could not tolerate being criticized. He was so compliant to criticisms that at times he felt completely unable to counter them. He had developed this problem in childhood in relation to parents who, though quite critical of him, were themselves unable to tolerate criticism from him. The patient believed he had to accept his parents' criticisms lest he hurt them. In his therapy he tested the therapist by criticizing him, often vehemently, hoping that he would not upset the therapist or that the therapist would fight back, so that he could learn from the therapist how to tolerate criticism and how to fight back.

A patient is likely to turn passive into active if in childhood he complied with parental mistreatment, but did not realize either in childhood or in later life that his parents' treatment of him was unreasonable. A patient may not realize how badly his parents treated him if he was socially isolated and so had no opportunity to observe normal parent-child relations. A patient such as this may be afraid of transferring; he may fear that the therapist will mistreat him in the same ways his parents mistreated him. However, he may feel no compunction about turning passive into active. Since he believes that his parents' traumatizing behavior was justified, he is likely to feel somewhat justified in repeating such behavior with the therapist.

There are exceptions to the rule that the patient whose requests are burdensome or extremely difficult to satisfy is turning passive into active. A patient who has been severely deprived, or who has been criticized by his parents for making reasonable requests, may make burdensome demands in order to give transference tests. He may stridently request extra hours or the right not to pay for several missed sessions, in the hope that the therapist will not be burdened by him or critical of him, as his parents were. The therapist may help the patient who tests in this way by attempting to grant his requests, or, if he cannot grant them, by telling the patient that he deserves to have them granted but that he (the therapist) is not in a position to do this.

Testing by Turning Passive into Active. Most patients, but not all, test by turning passive into active at some time during their therapies. Some patients do so only occasionally, in response to particular traumatic events or in preparation for difficult challenges. Others do so frequently throughout their treatments.

A patient who is struggling with powerful affects that he cannot master may work to master them by turning passive into active. For example, a female patient whose mother and sister were both dying tragic deaths was overwhelmed with sadness that she could scarcely face. In her therapy, she tested the therapist by describing her mother's and sister's situations in such poignant terms that the therapist felt like weeping. The patient was helped to tolerate her sadness by identifying with the therapist's capacity to tolerate sadness.

A patient in therapy who experiences intense guilt about his wish to oppose a parent may give the therapist a passive-into-active test, which the therapist may pass by displaying an ability to oppose the patient. Consider, for example, a female patient whose father abused her and at the

same time denied he was doing so. The patient unconsciously wished to expose her father, but was prevented from doing this because she considered exposing him disloyal. In therapy the patient told the therapist about the abuse, then tested him by telling him that it really did not happen. The therapist passed this test by telling the patient that he believed she had been abused but was uncomfortable about acknowledging it. The therapist's ability to challenge the patient's denials helped the patient to challenge her father's denials.

A patient who is planning to take a certain initiative but is unsure about how to carry it out may prepare for it by giving the therapist passive-into-active tests. Through such tests, the patient attempts to present the therapist with the same kind of problem that he expects to face; he hopes to learn from the therapist how to handle this kind of problem.

Just how the therapist should respond to a request varies from patient to patient, depending on his understanding of the patient's unconscious plan. Sometimes when the therapist persistently grants the patient's requests, he fails the patient's tests, and the patient becomes progressively worse. A patient who unconsciously has a powerful need to learn from the therapist how to say "no" may make progressively more outlandish requests, in the hope that he can force the therapist to refuse him.

However, as noted above, there are numerous instances in which the therapist in order to pass the patient's tests, should go along with him. In such instances the therapist by refusing the patient's requests so as to follow the rule of abstinence may be quite harmful.

Testing That Disturbs the Therapist. This section is concerned with patients whose testing disturbs the therapist. Among these are patients who are extremely insulting; patients who frequently take offense and blow up angrily at remarks obviously intended to be benign; patients who, while seeming to benefit from therapy, complain that the therapist has ruined their lives; patients who complain bitterly about the therapist's ineffectiveness while telling the therapist nothing about themselves; patients who repeatedly imply that unless the therapist is more helpful they will kill themselves, patients who persistently refuse to pay for certain hours in which they claim to have received no help; patients who with no cause threaten to sue the therapist for malpractice, patients who unjustifiably give the therapist the feeling that he is making serious mistakes; and so forth.

In general, therapists should not try to treat more than one or two such patients at a time, for they require much time and effort. Moreover, a therapist who is especially uncomfortable with such patients should not try to treat them. However, in sending such a patient away the therapist should not imply that he is untreatable, for the patient may be helped by a therapist who is comfortable with him and who knows how to treat him.

The patient who disturbs the therapist is almost always turning passive into active; that is, he is testing the therapist by behaving as a parent or older sibling behaved toward him. He hopes that the therapist will not be crushed by his behavior as he was crushed by a parent's or sibling's behavior. In most instances the patient is also transferring. For example, the patient who threatens the therapist, or who disturbs everyone in the building by screaming and slamming doors, is both turning passive into active and transferring. He is implicitly asking the therapist to set some kind of limit; he also hopes that despite his disturbing behavior, the therapist will not reject him by giving up on him.

The therapist who realizes that the patient who disturbs him is working by testing him may be in a better position to help the patient than is the therapist who assumes that the patient is being obnoxious, vile, or destructive simply to gratify himself. It is easier for a therapist both to respect

a patient and to empathize with him when he realizes that the patient, through his disturbing behavior, is working to overcome his problems. Moreover, the idea that the patient is testing alerts the therapist to a way of helping the patient—that is, by passing his tests—and so may protect the therapist from discouragement.

In treating such a patient, the therapist tries to figure out how he is being tested. He attempts to infer this from everything he knows about the patient, including the patient's account of how he behaved toward his parents and how his parents behaved toward him. The therapist also relies heavily on his affective responses to the patient. Often he may infer from the way he feels when he is with the patient how the patient felt when he was with his parents. The therapist may tentatively assume that if he feels helpless, defeated, extremely anxious, overly responsible, or intensely guilty, the patient felt that way toward a parent.

The therapist who feels that unless he is extremely careful with his patient he will make a serious mistake may be reacting to passive-into-active omnipotence tests, which the patient hopes will not induce the therapist to worry inappropriately. Thus the therapist who feels he must be extremely careful with his patient may tentatively infer that the patient felt an omnipotent sense of responsibility for a parent about whom he worried a great deal.

As another example, consider the patient who professes envy of the therapist and who induces the therapist to feel guilt about being better off than the patient. The patient is probably giving the therapist a passive-into-active survivor guilt test, and the patient hopes that the therapist will not be upset by the patient's envy. The patient may then, by identifying with the therapist, become less concerned about a parent's envy of him. To give still another example, the therapist who feels quite worried about leaving a patient when he takes a vacation may be reacting to passive-into-active tests by which the patient hopes to disprove a belief that he (the patient) should feel guilty when leaving a parent.

In order to pass the patient's passive-into-active tests, the therapist tries to demonstrate a better way of dealing with the patient's disturbing behavior than the patient used in childhood to deal with his parents' disturbing behavior. The therapist's approach and attitude are as important as his interpretations, if not more so. In general, the therapist should not interpret the patient's disturbing behavior as soon as he displays it. Before he interprets it, he should attempt to demonstrate that he is able to deal effectively with it. Suppose that a patient identified in childhood with an unhappy, blaming mother, and complains in therapy about how depressed he feels and how little the therapist is helping him. In general, the therapist should not attempt to explain the patient's blaming him by pointing to his identification with his blaming mother until he has demonstrated that he can tolerate the patient's misery and blame. If the therapist interprets this identification before demonstrating that he can tolerate the blame, the patient may assume that the therapist is blaming him in order to protect himself. The therapist may appear defensive to the patient, and thus may fail to provide the patient with a good model of how to deal with his mother's disturbing behavior.

The therapist may sometimes be thrown off course by disturbing accusations. If the therapist recovers and deals effectively with these, the therapist's temporary upset does no harm. Indeed, the patient may be reassured by it: He may realize that the therapist is not glib or overly defended, and that even if upset by the patient's accusations he may recover and behave appropriately. The patient then, by using the therapist as a model, may learn that he too may become upset and then recover.

When the therapist does begin to make interpretations to the disturbing patient, he should be concerned not only with the content of his interpretations, but also with his attitude while delivering them. For example, if the patient is giving the therapist passive-into-active worry tests, the therapist may detract from a good interpretation by delivering it in a tense, worried manner.

A patient may find the interpretation of his disturbing behavior quite helpful. He may not understand why he is disagreeable, and he may feel quite guilty about being that way. He may be greatly relieved when the therapist demonstrates an understanding of his behavior by telling him, for example, that out of loyalty to a parent he is imitating the parent, or that he is reenacting childhood traumatic experiences with a parent and taking the parental role, or that he is attempting to show the therapist how he felt as a child. The patient may be relieved to realize that his behavior does not derive from inherently bad impulses, and that he is not being frivolous, self-destructive, or wanton simply to gratify himself. Rather, his behavior derives from childhood identifications with a traumatizing parent, and he is working in therapy to understand his childhood traumatic experiences and to disprove the pathogenic beliefs inferred from them.

In treating the patient who is insulting and blaming, it may be important for the therapist to demonstrate a variety of reactions. For example, the therapist should at times fight back against obviously unfair or extravagant or foolish accusations, in order to demonstrate that it is possible and reasonable for a person to stand up for himself. However, if he fights back too readily against unimportant accusations, he will leave the impression that he is weak or defensive, and thus that he has been hurt by the patient's criticisms. Also, if a therapist responds to the patient's tests in a stereotyped way, the patient may infer that the therapist is putting little effort into his work. The patient may then assume that the therapist is behaving in accordance with some preconceived technical prescriptions or rules.

Failing the Patient's Tests

Inevitably, the therapist fails some of the patient's tests or series of tests. When the failure is minor, the mistake may be corrected easily, and the therapist may learn from it. When the failure is major, it may be difficult to correct, and sometimes it cannot be corrected.

Often the therapist may infer from the patient's response that he has failed a test. The patient usually reacts differently when the therapist fails a test than when he passes it. If the therapist fails a test by giving a poor intervention, the patient may respond less enthusiastically than usual, or he may become slightly depressed or silent. Also, he may fail to bring forth new material, or he may ignore the interpretation or change the topic. If the patient responds in one of these ways, the therapist may ask him, "How do you feel about what I just said?" or "Have I missed the point of what you were saying?"

Once the therapist begins to understand how he has failed a particular test, he may explain his failure to the patient. For example, he may tell a patient, "When you were complaining, you wanted me to help you realize you had a right to complain. Therefore, you were disappointed when I tried to encourage you. You took this to mean that I didn't want to hear your complaints."

After Failing a Minor Test. Sometimes after he fails a minor test, the therapist may simply wait for the patient to offer him a new chance by giving him another test similar to the one he failed. For example, a patient was burdened by the belief that he could force authorities to give him whatever he wanted. He provocatively demanded an extra hour and became upset when the therapist granted his request. The therapist realized he had made a mistake, but rather than pointing this out, he waited for the patient to test him again. A few sessions later, the patient

asked to be permitted to miss several sessions without being charged, and he was relieved when the therapist refused him.

Sometimes after the therapist fails a test, the patient will coach him on how to pass it. The therapist in most instances should heed the patient's coaching. This may be illustrated by the example of a patient who suffered from the belief that if he criticized the therapist he would upset him. He tested this belief by criticizing the therapist, telling him, "I appreciate your readiness to be helpful. However, I'm hurt that you don't think I can solve problems myself. You don't seem to value my opinions and judgment." The therapist tried to reassure the patient by telling him that he did respect and appreciate his abilities and judgment. However, the patient felt not reassured but disappointed. He assumed that the therapist was being defensive and thus that he had hurt him. Therefore, before giving him a new test, he told the therapist how much his girlfriend was benefiting from the way her therapist dealt with her complaints. His girlfriend's therapist would simply point out how uncomfortable she (the girlfriend) felt when complaining about the therapist. The next time the patient complained, the therapist pointed out his discomfort with complaining. The patient appreciated the therapist's change of approach and elaborated on his fear of hurting the therapist.

Sometimes the patient signals the therapist that he is failing a test or a series of tests by ignoring the therapist's incorrect responses to his testing.

Sometimes the therapist may infer that he has failed an important test if the therapy becomes stalemated, as when, for example, a patient who is usually talkative becomes relatively silent for several weeks. If this happens, the therapist should try to remember when the stalemate began. He should also discuss it with the patient and should ask him how he thinks it started.

After Failing a Major Test. The failure of a test or a series of tests is damaging if the patient reacts by giving up an important unconscious goal. It is especially damaging if the patient gives the therapist no indication that he is giving up the goal. It may be devastating if the patient, in obedience to his pathogenic beliefs, feels obliged to make a self-destructive decision that he cannot easily correct.

How to Avoid Failing Important Tests. In order to minimize the chances of making serious errors, the therapist should keep in mind the best hypothesis he can make about the patient's pathogenic beliefs, goals, and plans.

If the therapist who is being tested by the patient's indecisiveness is not sure what the patient really wants to do, he may discuss this with the patient. He may say, "I think you should delay this decision until you're sure of it." Or he may ask a patient who is considering taking an important initiative, "How would you feel if I encouraged you, or if I did not encourage you?" If the therapist is concerned that a patient in making a decision is motivated by a wish to placate him, the therapist may tell the patient, "Whatever you decide here is fine with me. But you should take your time, so as to be sure the decision is the one you really want to make."

If the therapist is unsure about the motives underlying the patient's wish to stop treatment, he should generally urge the patient to take his time about deciding. The therapist's urging the patient to postpone the decision will generally do little harm. However, the therapist, in not urging delay, may fail a rejection test. This may result in serious harm that cannot easily be repaired.

The therapist should always be aware that the patient in making a decision may be motivated by an unconscious wish to comply with him. Unconscious compliance to authority is universal.

During the first few years of life every child regards his parents as absolute authorities. Some patients, especially at the beginning of treatment, may be so compliant that the therapist is impeded in his treatment of them. With such a patient the therapist is deprived of feedback, and therefore he may have difficulty in inferring the patient's plans; he may not know whether he is passing or failing the patient's tests. The therapist treating such a patient should be especially careful not to impose his own ideas on the patient inadvertently, and not to take the patient's agreeing with him as evidence that he is on the right track.

In most instances the highly compliant patient has the goal of overcoming his compliance, but cannot make this goal evident for fear of hurting the therapist. However, the highly compliant patient may be responsive to the therapist's attempts to help him overcome his compliance. In some instances the therapist should discuss the problem with the patient, being careful in doing so to avoid giving the impression that he is criticizing the patient or expecting a quick resolution of the problem. The therapist should attempt to find out the nature of the pathogenic beliefs underlying the patient's compliance. Many extremely compliant patients are burdened unconsciously with an intense sense of omnipotent responsibility for others. Such a patient may be afraid to express his opinions for fear of hurting the therapist and risking punishment and rejection from him. Perhaps he experienced his parents as fragile and kept himself highly compliant to protect their sense of authority, or perhaps they were extremely intolerant of any disagreement.

It is hard to overestimate the importance of unconscious compliance in the mental life of most patients. The therapist should not expect a patient to give up such compliance easily; the patient may be unable to do this. However, the therapist should try to prevent the patient from letting his wish to please the therapist interfere with important decisions.

Summary

Throughout therapy, the patient tests his pathogenic beliefs with the therapist in the hope of disproving them. In a sense the patient is always testing the therapist, since he is always attempting to infer whether the therapist will help him to disprove his pathogenic beliefs and to pursue his goals. However, most patients test their pathogenic beliefs especially vigorously at times, and they do this throughout therapy. During these times, they behave in a way especially calculated to give them more explicit knowledge of the therapist's attitude toward their pathogenic beliefs and goals. For example, a patient who fears rejection may offer the therapist a powerful rejection test by threatening to quit treatment, hoping that the therapist will urge him to continue.

Some testing behavior is indistinguishable from ordinary behavior; however, some tests have special characteristics. The therapist may assume that the patient is testing him if the patient arouses powerful affects in him, forces him to intervene, or behaves much more foolishly or self-destructively than usual.

A patient may test by transferring or by turning passive into active. When a patient tests by transferring, he repeats with the therapist behavior similar to the behavior that in childhood he experienced as provoking his parents to traumatize him. He hopes that the therapist will not react to him as his parents reacted. When the patient tests by turning passive into active, he repeats the parental behavior that traumatized him. He hopes that the therapist will not be traumatized as he was, and thus that the therapist will provide him with a model of how to deal with the behavior that he experienced as traumatizing.

The patient may test by turning passive into active before taking an initiative that he considers dangerous. Through such testing he confronts the therapist with the dangers that he anticipates, hoping that the therapist will provide him with a model for dealing successfully with such dangers.

If the therapist feels extremely upset, worried, humiliated, or uncomfortable with the patient, the patient is almost always turning passive into active. He is repeating parental behavior that he experienced as extremely distressing. The reason why transference tests are generally much easier for the therapist to tolerate than passive-into-active tests is evident from the lopsided relationship of children to parents. A child is highly motivated to get along with his parents and will rarely do anything to greatly disturb a parent. However, a parent may not be highly motivated to get along with a child; a parent may worry a child, reject him, beat him, or abandon him.

A patient may test the therapist by proposing a course of action that he assumes the therapist wants him to take, but that from the therapist's point of view is self-destructive. Therefore, the therapist should be especially careful to give the patient an opportunity to reverse a decision that may be against the patient's interests. The therapist should make clear to the patient that he may take as much time as he needs to make the decision, and that the therapist will support any reasonable decision that the patient makes.

INTERPRETATION

The therapist may use interpretations for a variety of purposes. He may use them to pass the patient's tests, to help the patient feel more secure in therapy, and to help the patient see himself more sympathetically. Also, the therapist may use interpretations to help the patient become conscious of his pathogenic beliefs and goals, and thus to work more effectively at disproving these beliefs and pursuing these goals.

Interpretations may provide the patient with explanations that help him to understand his development and his psychopathology. For example, he may learn that he developed maladaptive beliefs in his attempts to maintain his ties to his parents, and that these beliefs require him, for example, to maintain his psychopathology out of loyalty to his parents. Such explanations may be demystifying and normalizing. They may help the patient to realize that he is not inherently bad, perverse, crazy, or borderline, and that the symptoms that make him ashamed and guilty are readily understood in terms of his childhood experiences and his attempts to cope with them.

The value of the therapist's interpretations depends not simply on the knowledge they convey, but on the authority of the therapist who conveys this knowledge. A patient may have considerable understanding of his psychopathology, yet be unable to use this self-knowledge constructively. However, the same knowledge conveyed by the therapist may be quite helpful. For example, a patient may know that he is not protecting himself from certain dangers, but be unable to give himself the protection he needs. However, he may be helped if told by his therapist that he deserves to be protected, especially if he becomes convinced that the therapist wants him to avoid taking unnecessary risks. In this case, as in all instances of the successful use of interpretation, the patient relies on the therapist's authority to help him do what he unconsciously wants to do. It is one thing for a patient to know that he wants to go in a certain direction; it is another thing for him to realize that a person whom he endows with considerable authority wants him to go in that direction and will help him to do so.

The Therapist's First Priority: Helping the Patient Feel Safe. The therapist's concern for helping the patient to feel safe takes precedence over his attempts to give the patient insight by interpretation. In those instances in which the patient is threatened by any interpretation, the therapist should refrain from interpreting until the patient can safely tolerate his doing so. This applies to the patient who likens the therapist's interpretations to his parents' lecturing him, pulling rank, or giving unsolicited advice.

If the therapist succeeds by noninterpretative means in providing the patient with a sense of safety, the patient may begin to develop insights on his own. He may remember more about his childhood traumas and become more aware of his pathogenic beliefs and goals. At this point, the therapist may add to the patient's developing self-knowledge by providing explanations that the patient can use to organize this knowledge and to fit it into a comprehensive picture of his personality and development.

Characteristics of Good Interpretations

Good Interpretations Are Not Neutral. The patient is always in psychic conflict. He wants to work at disproving his pathogenic beliefs and pursuing his goals, but in order to do this, he must defy his pathogenic beliefs and thus experience anxiety. In this conflict the therapist is never neutral. He is always on the side of the patient's attempts to solve his problems. Moreover, even if the therapist tries to be neutral, the patient does not experience him this way. The patient relates everything the therapist says to his efforts to disprove his pathogenic beliefs; therefore, he experiences the therapist's comments either as sympathetic to his goals, as opposed to them, or as irrelevant to them.

A patient is especially helped by an interpretation that he can put to immediate use in his working to carry out his unconscious plans—that is, by a “pro-plan” interpretation. The patient is set back by interpretations that hinder him in his efforts to carry out his plans—that is, by anti-plan interpretations.

Sometimes an interpretation may be true but anti-plan because it sends the wrong message to the patient. In such instances, the addition of a new element may make the interpretation compatible with the patient's plan. This may be illustrated by comparing the interpretation “You are critical of me” with the interpretation “You are uncomfortable about being critical of me.” If the second interpretation is true, so is the first. Yet the two interpretations may carry quite different messages. The first interpretation implies that the patient should become aware that he is being critical and should stop being that way; the second implies that he should become aware that he is uncomfortable about being critical and should permit himself to be critical.

Whether one of these interpretations helps or hinders a particular patient or seems irrelevant to him depends on the nature of the patient's plan. If the patient is attempting to overcome his fear of criticizing others lest he hurt them, he may experience the interpretation “You are being critical” as a complaint, and so may assume that he has hurt the therapist. If so, he may experience the interpretation as confirming his pathogenic belief. On the other hand, he may experience the comment “You are uncomfortable about being critical” as helping him to disprove the pathogenic belief, for he may assume from it that he has not hurt the therapist by criticizing him.

However, if the patient is struggling to face the fact of his aggression, he may find the interpretation “You are being critical” to be pro-plan. This was the case in the therapy of a patient whose Pollyanna parents failed to confront the patient's aggression. They never spoke about it and appeared not to notice it. The patient had inferred from this that his aggressive

behavior was so unacceptable that it could not be talked about. The patient was therefore relieved at the therapist's blunt reference to his being critical.

The point that two interpretations, although both true, may carry different messages may also be illustrated by comparing the following interpretations: "You feel guilty about wanting to be independent of your parents" and "You are uncomfortable about being dependent on your parents." If the first interpretation is true, so is the second. Yet a patient may react quite differently to them. A patient who unconsciously is working to overcome separation guilt may be helped if told that he feels guilty about wanting to be more independent of his parents. However, he may be set back if told he is uncomfortable about depending on them, for he may experience this interpretation as telling him he should not try to be more independent.

In contrast, a patient who suffers from his fear of burdening others by needing them may benefit from an interpretation about his fear of dependency. This was the case in the therapy of a patient who wanted to rely on the therapist, but was afraid that the therapist would be burdened by his dependency. The patient was relieved when the therapist told him, "You are afraid of relying on me." The patient took the therapist's comment as evidence that the therapist would not feel drained by the patient's depending on him.

Good Interpretations Give the Patient Something He Wants to Receive. An interpretation is rarely helpful (pro-plan) unless it gives the patient something he unconsciously wants to receive. A good interpretation usually reduces the patient's level of anxiety, guilt, or shame. It may answer a question the patient is unconsciously asking. It may provide the patient with greater perspective on the course of his life or on the nature of his difficulties. It may help him to understand and forgive himself for behavior about which he feels ashamed or guilty. It may help him in his struggle to disprove a pathogenic belief. Unless the patient unconsciously wants to accept an interpretation, the interpretation will not be useful. If the interpretation is anti-plan, the patient will either ignore it, in which case it is ineffective, or comply with it, in which case it may be harmful.

The therapist cannot always assess the value (planfulness) of an interpretation by noting the patient's conscious reactions to it. A patient may consciously resist an interpretation that he unconsciously wants to accept; in doing this, he may hope to demonstrate to himself that the therapist has the courage of his convictions and so will stick with it.

The Therapist Should Help the Patient Develop a Broad Perspective. The patient has a strong wish to develop a broad, coherent picture of his psychopathology and development, for such a picture helps him to see himself sympathetically and to increase his mastery over his problems and his personality. The therapist should help the patient to acquire such a picture. The therapist should help the patient to understand where he came from, where he wants to go, and how he plans to get there. Once the therapist has helped the patient develop a broad picture of himself, the therapist should try to relate the patient's new productions to this picture, thereby changing the picture, adding to it, or filling in its details.

The more the therapist succeeds in putting the patient's productions into a broad perspective, the more he is likely to help him. Sometimes the patient is helped by simple comments, such as "You like to look," "You are hostile," "You are angry or dependent," or "You are withdrawn." More often, he is not. He may experience such comments as criticisms, because hostility, dependency, or withdrawal is generally not highly regarded. Nor do such comments help the patient to understand why he developed such motives or defenses; therefore, they may fail to help him to perceive himself sympathetically. A patient may want to know, "How did I become so

interested in looking?" Other patients may want to know, "Why am I so dependent?" "Am I different from other people, and, if so, how did I get that way?" "Should I not be interested in looking?" "Should I stop being dependent, and, if so, how do I go about doing so?"

Any perspective that the therapist adds to a simple statement of the patient's impulses or defenses may be helpful. Thus it may be helpful if the therapist shows the patient that his behavior was developed to serve some reasonable unconscious moral or adaptive purpose (e.g., to express loyalty to parents, to make amends for being better off than siblings, or to adapt to an interpersonal world he perceived as hostile or unrewarding). Such explanations make intuitive sense. They help the patient to see himself sympathetically, and to feel normal and good as opposed to abnormal and bad. They help the patient forgive himself for behavior he considers shameful or reprehensible.

The Patient May Benefit from Interpretations That Help Him to Develop the Strength to Protect Himself. A patient may be unable to develop close relations with others because he lacks the capacity to protect himself from the danger that he assumes is inherent in close relationships. If so, his plan may require him to work in therapy, sometimes for long periods of time, to develop the capacity to protect himself from the perceived danger. The therapist may use interpretation to help the patient to develop this capacity. Then, after the patient has accomplished this, he may permit himself the close relationships that he feared earlier.

Consider, for example, a male patient who was unable to say "no" to his girlfriend. He was afraid to fall in love with her for fear that he would have to comply with all her wishes. He worked to develop the capacity to say "no" to her, and was helped to acquire this capacity when the therapist pointed out his fear of refusing her, lest he hurt her. After the patient was able to say "no" to her, he permitted himself to feel close to her.

Another example concerns a patient who, when shamed by another person, felt compelled to comply by feeling ashamed. This patient was so afraid of being shamed that he was unable to feel comfortable with others. He was helped when the therapist made him aware of his belief that he would hurt a person if he did not comply with that person's wish to shame him. As he became able to resist being shamed, he became more comfortable in social relations.

If a patient appears to make difficulties for himself by being stubborn, the therapist may err if he attempts to make the patient aware of his stubbornness with the implied purpose of inducing him to stop being stubborn. In some instances, depending on the patient's plan, the therapist should do the opposite. The patient may be testing him by a show of stubbornness as part of his working to acquire the right to be stubborn. If so, the patient's stubbornness is counterphobic. Although he may seem comfortable being stubborn, he is unconsciously anxious or guilty about being that way. The therapist may then be most helpful by interpreting the patient's unconscious guilt about his stubbornness, thereby helping him acquire the ability to avoid self-destructive compliance. As he develops the capacity not to comply with others, he may permit himself to feel close to them. Paradoxically, then, the therapist, by helping the patient to acquire the capacity to resist the demands of others, may enable him to get along better with them.

It is often futile to tell a patient who is bragging that he is feeling proud in order to ward off his sense of humiliation. The patient may experience the therapist who does this as wanting to put him down, and so as repeating a parental mistake. On the other hand, if the therapist points out the patient's unconscious fear or guilt about feeling proud, the patient may develop the self-esteem necessary to acknowledge his shortcomings. In addition, he may feel less compelled to brag.

The same applies to the patient whose tendency to blame others appears to be an obstacle to his feeling close to them. Here too, depending on the patient's unconscious plan, the therapist may err if he attempts to induce the patient to stop blaming others by interpreting his tendency to blame them. The patient who blames others may unconsciously be vulnerable to being blamed, and so may believe that any criticisms he receives are deserved. He may blame others to protect himself from feeling blamed. In this case, the patient, if told by the therapist that he is blaming others to protect himself from guilt, may simply feel blamed. He may assume that the therapist wants him to feel guilt. He may then feel endangered by the therapist and fight back by blaming him.

In treating a patient with this kind of problem, the therapist may help the patient by showing him that he is too ready to accept blame from others, and that unconsciously he has difficulty knowing when others are in fact blaming him unfairly. If the patient is helped to stop complying with unfair blame, and to know when others are treating him unfairly, he may become less vulnerable to them and have less need to protect himself from guilt by blaming them.

There are always exceptions to the principles presented above. Though often a patient is set back when told that he is stubborn, vainglorious, or blaming, he may in some instances benefit. For example, the patient may be maintaining his unfavorable behavior in order to punish himself, perhaps out of compliance to a parent to whom he feels guilty. The patient may unconsciously be highly motivated to give up the unfavorable behavior, but may believe that he should not. In such instances the therapist's direct attempts to make the patient aware of his unfavorable behavior, with the implication that he should give it up, may be helpful. This reminds us again that the only technical rule broad enough to include most instances is that the therapist should help the patient to carry out his unconscious plan.

Interpretations May Be Helpful if They Imply a Promise Not to Mistreat the Patient. Sometimes the therapist may help the patient by pointing out the patient's irrational transference expectations. The therapist may do this by telling the patient, for example, "You're afraid that if you continue to attack me I will reject you," or "You're afraid that if you're proud I will put you down," or "You're afraid that if you're seductive I'll try to have sex with you," and so forth. Such interpretations may provide the patient with a sense of safety, for they imply a promise not to behave as the patient fears. It would be almost unthinkable for a therapist to imply by interpretation that he will not react as the patient fears, but then, having lulled the patient to feel secure, to go back on his implied promise.

Anti-Plan Interpretations

If the therapist consistently makes anti-plan interpretations, the patient may fail to improve or, in some cases, he may stop treatment.

Transference Interpretations Versus Nontransference Interpretations

The importance of transference interpretations is exaggerated by certain contemporary authors. A research study carried out by Polly Fretter (Silberschatz, Fretter, & Curtis, 1986: http://controlmastery.org/docs/Silberschatz_Fretter_Curtis1986.pdf) showed that transference interpretations are no more and no less beneficial than nontransference interpretations. The important distinction is not between transference and nontransference interpretations, but between pro-plan and anti-plan interpretations.

Also, the therapist may pass a patient's transference tests without referring explicitly to the patient's relationship with him. Consider, for example, a patient who is afraid to report an

achievement for fear the therapist will belittle him. The patient may benefit from the therapist's making a transference interpretation, such as "You're afraid to tell me about your success for fear I will belittle it." However, the patient may benefit just as much if the therapist responds to the patient's reporting his success by saying, "That's good news." In both instances the patient will realize that the therapist is not motivated to belittle him. Just which approach is better for a particular patient depends on many factors. The patient who wants the therapist to be careful, deliberate, and analytic may prefer the former approach. The patient who feels put down by interpretation may prefer the latter.