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Unconscious Plans or Unconscious Conflict? Commentary on Joseph Weiss's Paper

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Unconscious Plans and Unconscious Conflict Reply to Commentary

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The idea that people plan their behavior is considered common sense for most human activities. This commonsense view, however, is not extended to the behavior of the patients in therapy. Patients' behavior is thought to be governed to some extent by unplanned unconscious forces. In this paper, I challenge that view. I assume that the primary motive of patients in psychotherapy, including psychoanalysis, is to solve their problems by disproving the pathogenic beliefs that underlie them, and it assumes, too, that patients make and carry out plans for solving their problems. Patients' plans are for testing their pathogenic beliefs with the therapist in the hope that the therapist will not react to their tests as their beliefs predict. In research studies carried out by the San Francisco Psychotherapy Research Group, we demonstrated that we can reliably infer patients' plans from their behavior at the beginning of therapy and that patients work consistently in accordance with these plans throughout the therapy. Support for this thesis appears in infant research, evolutionary psychology, academic cognitive research, and linguistics. The view of the therapeutic process proposed here bears on the current discussion of the therapist's use of authority and integrates several current trends in the theory of therapy.

IN THIS PAPER, I ATTEMPT TO SHOW THAT THE PRIMARY UNCONSCIOUS motive of patients in therapy is to solve their problems and that throughout therapy they make and carry out plans for solving them.

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I support these ideas using a variety of sources including formal, quantitative investigations of the patient during psychotherapy, including psychoanalysis (Weiss, Sampson, and the Mount Zion Psychotherapy Research Group, 1986; Weiss, 1990, 1993a, b). I also indicate how these ideas bear on certain issues in the theory of therapy.

The concepts about the patient's unconscious mental life that I develop here differ radically from those proposed by Freud in his "Papers on Technique" (1911–1915). In the early "Papers," Freud assumed that the primary unconscious motive of patients is to resist therapy in order to continue to be gratified by their symptoms. In addition, Freud assumed that patients function unconsciously much differently than they function consciously. In Freud's early formulations, patients are not capable of unconsciously making plans and working to carry them out; they are only capable unconsciously of seeking gratification. Indeed, the unconscious mind is organized along different lines than the conscious mind—it is fluid, it functions in accordance with the primary process, and it is regulated by the pleasure principle.

Freud greatly changed his early ideas about the nature of unconscious mental functioning.[1] Indeed, my concepts of unconscious mental functioning are compatible with certain ideas that Freud presented in parts of his late writings (1926, 1940). Nonetheless, to make my ideas clear and to emphasize their significance, I have contrasted them with those of Freud's early views, which, although superseded in theory, remain highly influential.

My concepts about patients' working to solve their problems are closely connected to my ideas about the nature of their problems. I assume that patients' psychopathology stems from certain maladaptive beliefs about reality and morality and that patients acquire these beliefs in infancy and early childhood from traumatic experiences with parents and siblings. The beliefs, here called pathogenic, give rise to anxiety, guilt, and shame. They impede patients' functioning, adversely affect their self-esteem, and prevent their pursuit of such highly adaptive goals as happiness, success, and good relationships. Patients suffer unconsciously from these beliefs and are highly motivated unconsciously, and sometimes consciously, to disprove them. They work throughout therapy to do this by testing the beliefs in relation to the

[1]For a detailed discussion of the development of Freud's thinking about unconscious mental functioning, see Weiss et al. (1986).

therapist and by using the therapist's interpretations to become conscious of the beliefs and to recognize them as false and maladaptive. Patients may work for long periods of time, perhaps throughout an entire analysis, to disprove just a few interrelated pathogenic beliefs.

The Persisting Influence of the 1911–1915 Theory

A perusal of clinical discussions contained in current psychoanalytic journals indicates the persistence of the 1911–1915 theory. Freud's early idea, that the unconscious is fluid, is sometimes taken for granted, and Freud's concepts about unconscious belief, plan, and goal (1940, p. 199) and about the wish to solve problems (1920, pp. 32–35; 1926, p. 107; 1937, p. 235), which he developed in his ego psychology, are seldom invoked. True, the concept of unconscious plan is sometimes implied, but in such instances the implied plan is to resist therapy, not to solve problems.

The following anecdote illustrates my contention that an implied unconscious plan to resist therapy is sometimes acceptable to clinicians, whereas a plan to solve problems is not. Several years ago, I informally discussed with colleagues a patient who insisted that he was doing his best to come to treatment but often came late or failed to come at all. He would argue convincingly that he had attempted to make his appointments but had been held up unexpectedly by an event that required his immediate attention. My colleagues agreed that the patient's behavior was not a matter of chance. When pressed, they acknowledged that it must have been unconsciously planned. It takes planning to just miss one's appointments. although my colleagues acknowledged the patient's unconscious planning, they assumed that it was motivated by an unconscious wish to resist treatment.

In contrast, I assumed that the patient's missing his sessions reflected his working to solve his problems by testing the therapist in an attempt to disprove the pathogenic belief that the therapist was not interested in him and did not care if he came to his sessions. The patient, according to my formulation, had inferred the belief (from experiences of parental neglect) that authorities were unconcerned about him. During his adolescence, the patient would stay away from home for several days at a time, yet his parents scarcely seemed to notice. They would question him about where he had been and would be satisfied with any explanation, however implausible.

The therapist helped the patient to disprove his pathogenic belief that he was uncared for. The therapist did so by passing the patient's tests; he confronted the patient with the frequency of his missed sessions and challenged his excuses for missing them. The patient showed considerable relief. He relaxed, began to come more regularly, and more vividly remembered experiences of parental neglect. The patient's reaction to the therapist's encouragement is strong evidence that the patient, by missing his sessions, was testing the therapist as part of his working to disprove his pathogenic beliefs. If the patient had been missing sessions to resist the therapy, he would not have felt relieved when the therapist challenged his excuses. He would have experienced the therapist as undermining a defense against facing problems and so would have become not more relaxed but more tense and anxious.

The patient's conflict was between a wish and a fear. He wished to come to treatment but stayed away at times not only to test the therapist but also because he feared rejection. His fear of rejection was an obstacle that he wished to clear away. His behavior may be compared to that of a man who wants to cross the street but is deterred by a vicious dog. His wish to cross the street is central. His fear is based on an unwanted obstacle. Indeed, he will cross the street as soon as the obstacle is removed (Bernfeld, 1941; Weiss, 1995).

The Explanatory Power of the Plan Concept

The concepts of pathogenic belief, testing, goal, and plan have great explanatory power.[2] To perceive behavior in the patient in these terms is to see the therapy as a coherent and continuous story in which the patient as protagonist works to disprove his or her pathogenic beliefs by testing them in relation to the therapist and in which the patient pursues the goals inhibited by the pathogenic beliefs.

This may be illustrated by the following brief schematic report on the behavior of Mrs. C, a 26-year-old married social worker, during

[2]For extensive quantitative empirical research supporting the explanatory power of these concepts, see Weiss et al. (1986) and Weiss (1990, 1993a, b). See also Fretter (1984, 1995), Broitman (1985), Bugas (1986) Davilla (1992) Silberschatz and Curtis (1986), Silberschatz, Fretter, and Curtis (1986), Linsner (1987), Fretter, Bucci, Broitman, Silberschatz, and Curtis (1994), O'Connor, Edelstein, Berry, and Weiss (1994), and Norville, Sampson, and Weiss (1996).

the first 100 sessions of her analysis. This report summarizes the findings of a number of formal, quantitative investigations carried out on verbatim transcripts of Mrs. C's analysis over a period of six years by the Mount Zion Psychotherapy Research Group.[3] In each of the following paragraphs is summarized an entire research project done by a team of investigators over a one- or two-year period.

In an initial study on which the subsequent studies depended, independent judges inferred reliably from the transcripts of the first 10 sessions of Mrs. C's analysis that Mrs. C was burdened by unconscious guilt stemming from the pathogenic belief that she was better off than her family and that, in being better off than they were, she was hurting them. Mrs. C also believed that she would hurt her family by being different from them, independent of them, or opposed to them. She feared she could push them around. She felt an exaggerated sense of responsibility for them. The judges predicted that Mrs. C would test these beliefs by opposing the analyst or by making demands on him or by implying superiority to him in the hope that he would not be hurt by such behaviors. They predicted that, when Mrs. C experienced the analyst as not being hurt by her, she would feel relieved and so would permit herself to become bolder, more insightful, and more relaxed. They also predicted that, over a period of time, Mrs. C would develop insight into her unconscious guilt and would work throughout the first 100 sessions to become more independent of her family, her husband, and the analyst and more able to oppose them (Caston, 1986).

Mrs. C. behaved as predicted. She tested the analyst in order to assure herself that she could not push him around. She made demands on him, and she was immediately relieved when the analyst did not yield to her demands. She became less tense and anxious (Silberschatz, 1986). That Mrs. C was relieved when the analyst did not yield to her demands shows that her testing was unconscious. She consciously wanted the analyst to yield to her.

In a second study, Mrs. C also behaved as predicted. When she experienced the comments of the analyst as indicating that he was comfortable with her being oppositional or different from him (and

[3]The Mount Zion Psychotherapy Research Group (now the San Francisco Psychotherapy Research Group) is codirected by Harold Sampson, Ph.D., and the author. For a lengthy, detailed report of the research concerning Mrs. C, see *The Psychoanalytic Process* (Weiss et al., 1986).

thus as countering her belief that she would hurt him), she was relieved, as shown by her becoming bolder and more insightful (Caston, Goldman, and McClure, 1986).

In a third study, we showed that, during the first 100 sessions of her analysis, Mrs. C became, as predicted, progressively more able to fight with and oppose the analyst and others, indicating that she was becoming less constrained by her belief that she would hurt him (Curtis, Ransohoff, Sampson, Brumer, and Bronstein, 1986).

In a fourth study, we demonstrated that, during the first 100 sessions, Mrs. C became, as predicted, progressively more aware of her previously unconscious guilt and exaggerated sense of responsibility for others (indicating that she was becoming less threatened by her fear of hurting them) and that she accomplished this without the aid of interpretation (Shilkret et al., 1986).

We showed clinically, but did not demonstrate by formal research, that Mrs. C showed flexibility in her working to disprove her pathogenic beliefs. For example, toward the beginning of the analysis, Mrs. C behaved flamboyantly in order to test whether the analyst would approve of her being strong and uninhibited. When she experienced the analyst as not encouraging her flamboyance, and thus as not passing her tests, she dropped this kind of test and used another kind to assure herself that she could be strong. She began to make demands on the analyst in order to convince herself that she could not push him around. She had learned from experience that the analyst was almost certain to pass this kind of test.

We also showed clinically, but did not demonstrate by formal research, that, when the analyst focused on a topic unrelated to Mrs. C's pathogenic beliefs, Mrs. C was unresponsive. For example, during the first 100 sessions, Mrs. C's grandmother died. Mrs. C had loved her grandmother, but, in the analysis, she demonstrated little inclination to grieve for her. Moreover, she was unresponsive to the analyst's interventions concerning her failure to grieve. These interventions were not in accord with her plan, which was to get away from her family. Her mourning her grandmother would have brought her closer to them.

As the example of Mrs. C illustrates, patients' plans are flexible. However, they are not completely unconstrained; they are directed to goals that patients do not readily relinquish. If patients experience the therapist as unalterably opposed to important goals, the patients may be severely set back or may comply with the therapist and

relinquish these goals, as in childhood they relinquished them out of compliance to their parents. Or they may quit treatment and pursue their goals on their own, or with a different therapist.

Ordinarily, patients are especially reactive to interventions that bear on their goals and relatively nonreactive to interventions that do not bear on them. However, there are exceptions. Patients may sometimes react favorably during a short time to interventions that do not bear directly on their current goals. However, they will soon resume their work on their original goals. This should not be surprising. It happens frequently in everyday life. Suppose, for example, that a man who is spending a great deal of effort trying to develop a relationship with a certain woman discovers that he has just inherited money from a distant relative. He is likely to be pleased and think briefly about the inheritance before again focusing on the woman.

Additional Support for the Plan Concept

The most general support for the plan concept comes from the consideration, put forth forcefully by Miller, Galanter, and Pribram (1960), that it is impossible to conceive of any human psychological behavior that is not done in accordance with a plan. Although people may try to behave without purpose or plan, they cannot do so. Moreover, after people have devised basic plans and goals either in life or in therapy, they tend to retain them. This is adaptive. It would be quite costly and highly inefficient for people to change their basic direction frequently.

The idea of conscious and unconscious planning extends to everything the patient says to the therapist. Each statement, thought, or emotion that the patient reports is consciously or unconsciously intended (among other purposes) to elicit a particular response or range of responses. One person cannot talk to another person without such expectations, for such expectations are an inherent part of human communication.

The idea of unconscious planning applies even to patients who seem to have no direction. They may be testing the therapist as part of their working toward a particular goal. An example of this was reported by Renik (1995), although Renik did not refer to the patient's behavior as testing. Renik's patient seemed to meander without purpose. When

Renik pointed this out, the patient told him that she was attempting to assure herself that Renik would not impose an agenda on her. Subsequent work in the analysis confirmed this.

Patients' adaptive plans for working to disprove their pathogenic beliefs should be distinguished from the maladaptive, self-destructive plans they make in obedience to these beliefs. Such plans express patients' poor self-esteem or the unconscious shame, guilt, or remorse that stem from pathogenic beliefs. The patient behaves differently when the therapist challenges a maladaptive plan than when the therapist challenges an adaptive plan. When the therapist challenges a patient's maladaptive plan, such as a plan to relinquish a cherished ambition or to make a bad marriage, the patient is relieved. When the therapist challenges an adaptive plan, the patient becomes depressed.

Support for the Plan Concept from Cognitive Psychology, Linguistics, Evolutionary Psychology, and Infant Research

The concepts proposed here about unconscious pathogenic belief and plan are compatible with investigations carried out by cognitive psychologists over the last 20 years. This research provides powerful evidence that humans have an enormous capacity both to acquire information nonconsciously and to act nonconsciously on the basis of this information. Lewicki, Hill, and Czyzewska (1992), in a review article, cited evidence from a number of studies for the assumption that a person is able nonconsciously to acquire information and to act in accordance with this information. Moreover, a person's nonconscious information-processing is much more sophisticated than his conscious information-processing. People have the capacity nonconsciously to solve difficult problems that they cannot solve consciously, and, in solving them, they think much more rapidly than they can think consciously.

According to Lewicki et al. (1992), people are able nonconsciously to make strong inferences from complex data and, on the basis of repeated experiences, make broad generalizations. They form their impressions of others nonconsciously, rapidly, and without conscious knowledge of how they do so. They may become conscious of the results of their nonconscious thinking but not of the nonconscious thinking itself. It is on the basis of such nonconscious cognition that a person falls in love.

The kind of nonconscious cognition used to develop impressions of others is precisely the kind of cognition that I assume the infant and child use in forming impressions of parents—including the traumatizing impressions that give rise to pathogenic beliefs. It is also the kind of cognition that patients use to evaluate the analyst's comments as well as the analyst's reactions to the patients' tests.

Our findings concerning the patient's reactions to the therapist's interventions demonstrate the speed and accuracy of nonconscious information-processing. For example, after the therapist offers the patient an interpretation that he can use in his efforts to carry out his plan, the patient, within seconds, becomes less tense as measured by the voice stress measure, even though the interpretation may be rambling and difficult to understand (Kelly, 1989). In addition, the patient almost immediately becomes bolder and more insightful (Broitman, 1985; Caston et al., 1986).

Patients not only have the cognitive capacity nonconsciously to solve problems, they have the motivation to do so. The most general evidence for this comes from broad biological considerations. These support the assumption that the wish to adapt and indeed to improve adaptation is inborn and inherent in higher organisms. The wish to adapt has great survival value and so has been bequeathed to us by evolution.

It is highly implausible that evolution would produce the kind of mind that Freud postulated in his early theorizing (1900, 1911–1915). This mind is severely handicapped at the task of adaptation. In Freud's early theory, people have no control over some of their most powerful impulses. They are at the mercy of powerful, fluid, and shifting unconscious forces. Their conscious thoughts and decisions are epiphenomena, and they are not endowed with an instinct for self-preservation.

More specific evidence for an inborn drive to adapt is supplied by infant research (Stern, 1985). Stern (1985) wrote that infants, only a few weeks after birth, begin to make and test hypotheses about their caregivers in an attempt to learn how to develop secure relationships with them. The behavior that Stern described is very much like the testing carried out by adults in therapy. Such behavior, as the example of the infant indicates, does not depend on language or on a highly developed conscious mental life. The infant's ideas about himself and his caretakers, in Stern's terms, are stored as RIGS (that is, Repetitions of Interactions Generalized). The assumption that language is not

necessary for thought is supported not only by infant research and cognitive psychology (Lewicki et al., 1992) but also by linguistics (Pinker, 1994).

Stern's (1985) finding that infants work to develop a good relationship with their mothers throws light on the question, "Do patients unconsciously know what is good for them?" According to Stern, infants know what is good for them. Moreover, our formal research indicates that adults do too, for it demonstrates that adult patients are relieved when the therapist challenges their self-destructive ideas and plans. (Patients, although relieved when their self-destructive plans are challenged, may nonetheless retain them for some time, in compliance with their pathogenic beliefs and in order to continue their testing of the therapist.)

The Problem of the Patient's Compliance with the Authority of the Analyst

That patients endow their analyst with considerable authority has been demonstrated by our research. We have shown that patients, including those who appear skeptical and willfully defy the analyst, are nonetheless intensely reactive both to the analyst's interventions and to the analyst's responses to their tests. They react immediately to the analyst's helpful responses, including his interventions, by becoming more relaxed, bolder, and more insightful. If patients did not endow their analysts with authority, the analysts would not be able to help them.

Moreover, there is no doubt that certain patients may be severely harmed by complying with false interpretations or bad advice. For example, a patient who hoped to disprove her pathogenic belief that no one cared about her tested the analyst by implying that perhaps she had received maximum benefit from treatment and should consider stopping. The analyst agreed that she should seriously consider termination. The patient, who unconsciously knew that she was not ready to stop, felt severely rejected. She stopped treatment, quit her professional job, moved to another city, and joined a commune. After several years, she got back into analysis but did not tell the second analyst how the first analysis ended until she had tested him by criticizing him and by threatening to leave and had been reassured by his passing her tests.

Even though patients may be severely damaged by complying with their therapists, as already illustrated here, therapists in some instances (to be illustrated) may best help their patients by insisting on their own point of view, even if doing so puts them in opposition to their patients. Indeed, from the vantage point of my approach, the question of the analyst's authority is not fundamental. The therapist's fundamental concern is not, "Am I or am I not assuming that my perspective is more valid than the patient's?" but, "Am I or am I not helping the patient by enabling him to carry out his plans?"

Thus, the analyst's approach is case-specific. His decision whether or not to insist on his approach depends on his assessment of the patient's plans, including the patient's pathogenic beliefs, goals, and methods of testing these pathogenic beliefs. For example, patients who suffer primarily from the belief that they have no right either to have their own opinions or to question the opinions of authorities may be hurt if they experience the analyst as insisting on his or her position. In treating a patient with this kind of problem, analysts may be especially helpful if they demonstrate their respect for the patient's approach and if they follow Renik's (1993, 1995) recommendation that they inform the patient of the observations, inferences, and theoretical ideas on which they base their position, so that the patient may evaluate it.

However, if patients suffer primarily from the belief that they do not deserve protection, they may be most helped in some cases if the analyst insists on her or his own point of view even in opposition to the patient's stated goals. This was the case in the therapy of a patient who had been a severe alcoholic, who had stopped drinking, and who was threatening to start drinking again. Both his parents and his older brother were alcoholics, and they frequently tempted him to drink. This patient unconsciously wanted to remain abstinent but unconsciously believed that, by not drinking, he was being disloyal to his parents and brother (O'Connor and Weiss, 1993). He unconsciously wanted the therapist's support to maintain his abstinence, and he tested the therapist by insisting that he now had enough control to enjoy social drinking. The therapist, who knew from the patient's history of relapses that the patient would endanger himself if he began to drink and who, in accordance with Renik's recommendation, informed the patient of this danger, insisted that the patient remain completely abstinent. After a somewhat heated discussion, the patient gave in and agreed not to drink at all. In the next session, the patient thanked the therapist for supporting his

abstinence. He became slightly tearful as he told the therapist that, in contrast to his family, the therapist was offering him real protection.

As implied, the therapist may best protect the patient from damaging himself by compliance with the therapist by inferring the patient's unconscious pathogenic beliefs and plans and by helping the patient to carry them out. The therapist may infer whether his interventions and attitudes are helping the patient by the patient's reactions to them. Patients who behave, think, or feel in compliance with another person do something that they do not want to do. If the therapist's interpretations are impeding the patients in their efforts to carry out their plans, or if the interpretations are irrelevant to the patient's plans, they may, out of compliance, agree with the therapist. However, they will show little or no excitement about the interpretations, they will bring forth confirmatory material without enthusiasm, and they will make little or no movement toward their goals. Patients who behave in these ways feel obliged as a consequence of their pathogenic beliefs to comply with the therapist but do not, except in the rare case of a very compliant patient,[4] show any enthusiasm for the therapist's interventions. Because these patients cannot oppose the therapist directly, they may attempt unconsciously to coach the therapist, or they may offer the therapist tests that the therapist is quite likely to pass. If their efforts are unsuccessful, patients may give up their efforts to reach their goals.

Patients who agree with their therapists because their therapists are helping them to carry out their plans behave as persons who are encouraged to think, feel, or believe as they unconsciously wish to think, feel, or believe. Over time, such patients show confidence in the therapist and become more expansive. They bring forth pertinent new material, advance toward adaptive and desirable goals, or test the therapist more vigorously. Such patients are feeling that it is safe for them to behave in ways that previously would have seemed dangerous.

This may be illustrated by the two therapies of a married woman in her forties who came to treatment unconsciously hoping to receive help in going to graduate school to become a clinical psychologist.

[4]We have studied just one patient who was so compliant that, according to one measure (a measure of the patient's level of experiencing), the patient reacted positively to proplan and antiplan interpretations. Nonetheless, the patient's plan was reliably inferred and, with the exception noted, predictive of the patient's behavior.

The patient's parents had encouraged her brother to take his career seriously but had showed no interest in her having a career. The patient had inferred that her parents opposed her having a career. She complied with them and so developed the pathogenic belief that she should not be concerned with her education but should devote herself to family life. Unconsciously, she remained ambitious. Her relinquishment of her career was a painful sacrifice.

This patient's main unconscious purpose in coming to therapy was to receive help in changing the pathogenic belief that she should not pursue a career. In her therapy, the patient tested the therapist by telling her on a number of occasions that she had considered becoming a psychologist but probably would not do so because she was quite happy in her family and, in addition, was too old to go to graduate school. The therapist, out of concern for the patient's autonomy, accepted the patient's story and made no effort to explore the patient's interest in psychology or her reluctance to go back to school. The patient inferred that the therapist opposed her ambitions. She dropped the subject of her career and, after a few months, changed therapists.

She tested the second therapist in the same way she had tested the first. The second therapist inferred that the patient wished to go to graduate school, and she cautiously encouraged the patient to consider doing this. After a brief period of hesitation, the patient became excited about going back to school. She energetically investigated graduate schools in psychology, was accepted by one, did well in her work, and became a successful clinical psychologist.

This patient, by her display of energy and enthusiasm, showed that she did not make her decision in order to comply with the therapist. She behaved not compliantly but as someone who at last received permission to do what she wanted to do.

Relation to Other Approaches

The theory proposed here integrates several trends in the psychoanalytic theory of therapy. It is well suited to accomplish the goal, emphasized in much current writing, that therapy should help patients to develop an intensified sense of themselves. This emphasis (which, like other technical prescriptions, does not apply to all patients) may be exemplified by Mitchell's (1993) assertion that "helping the patient to develop a real and deeply rooted sense of self

is at the center of the modern analytic experience" and that "psychoanalysis is increasingly envisioned as a process that enriches the analysand's subjectivity, a subjectivity that includes an appreciation of oneself as an independent agent among other agents" (pp. 77–78).

The therapist who works in accordance with the present theory (which assumes that patients unconsciously set the agenda and work throughout therapy to move toward their goals) helps patients to see themselves as independent agents among other agents. The therapist with this perspective accords patients the respect they deserve as full collaborators in the therapy (Rosbrow, 1993).

The failure to develop a strong sense of self stems from pathogenic beliefs. Patients may be induced by such beliefs to do or feel not what they want to do or feel but what they unconsciously assume their internalized parents want them to do or feel. Or patients, out of loyalty to parents whom they perceive as weak, handicapped, or undeveloped, may keep themselves weak, handicapped, or undeveloped in the same ways. The therapist, by helping them to disprove their pathogenic beliefs, helps them to develop a stronger sense of themselves.

The present theory is also in agreement with those authors who assume that, in a successful therapy, the patient and therapist develop a relationship in which both actively participate and that is meaningful to both (Bollas, 1987; Benjamin, 1988; Mitchell, 1993). According to the theory proposed here, patients develop their pathogenic beliefs from traumatic experiences with parents and siblings, and in therapy they seek experiences with the therapist that they can use to counter these pathogenic beliefs. They can (in most instances) best obtain such experiences in relationships in which they perceive the therapist as engaged. However, the quality and degree of engagement that the patient will find most helpful are case-specific.

An example of a successful patient–therapist relationship occurred in the therapy of the patient who came to treatment burdened by the belief that she did not deserve to have a career. The therapist, herself a clinical psychologist, was sensitive to the patient's hints that she might wish to become a clinical psychologist. When the therapist offered the patient mild encouragement to pursue her career in psychology, and the patient responded with excitement, the therapist was pleased. Moreover, the therapist helped the patient by providing knowledge about how to obtain an education in clinical psychology.

The present theory also is in agreement with those theoreticians who assume that the course the patient takes in therapy, and the self-

knowledge that the patient acquires, reflect the personalities and attitudes of both therapist and patient (Stolorow, 1986; Hoffman, 1994; Stolorow, Atwood, and Brandchaft, 1994). In contrast to these authors, I, however, emphasize that both the therapist and the patient must work within certain limitations imposed by their tasks. Patients must work to disprove their pathogenic beliefs, and therapists must help them do this. The patient who is working to disprove a particular family of pathogenic beliefs can test them in a variety of ways, each of which reflects the experiences, beliefs, and personality of the patient. By the same token, the therapist can pass the patient's tests in a variety of ways, each of which reflects the therapist's theories, ideas, personality, and experiences. The patient will work to find a means of testing that fits the therapist's personality, and the therapist will work to find a means of passing the patient's tests that fits the patient's means of testing. (Both patient and therapist, in Stolorow et al.'s, 1994, terms, work in accordance with their own subjectivities.) Under favorable circumstances, the patient and the therapist will find a satisfactory way of working together.

Consider, for example, the patient whose major pathogenic belief is that he is an unattractive social misfit and who in therapy seeks acceptance in an effort to counter this belief. He may be helped by a variety of therapists, each of whom, in his or her particular ways, demonstrates an interest in and acceptance of the patient. By the same token, this patient may be harmed in a variety of ways by therapists who do not attempt to convey their interest in and acceptance of him or who attempt to convey these in ways to which he is not receptive.

Although the patient's responses to the therapist reflect both the patient's and the therapist's individualities (subjectivities), these responses may be evaluated objectively. As already noted, when patients experience the therapist as passing their tests and/or offering them pro-plan interpretations, they make immediate progress and become bolder and more insightful (Caston, 1986; Fretter, 1984; Silberschatz, 1986; Silberschatz, Fretter, and Curtis, 1986; Silberschatz and Curtis, 1993). Indeed, as we demonstrated with the voice stress measure (Kelly, 1989), patients respond to the therapist's passing their tests by immediately becoming more relaxed.

In addition to being compatible with certain current trends, the present theory retains the traditional concept of repression. According to the present theory, when patients are helped by the analyst to disprove their pathogenic beliefs and move toward their goals, they

feel safer. As they feel safer, they lift their repressions and become progressively more aware of previously repressed mental contents, including previously repressed experiences that bear on their pathogenic beliefs (Broitman, 1985; Caston et al., 1986). For example, the patient whose therapist passed her tests by encouraging her to become a clinical psychologist became conscious, without being helped by interpretation, of her family's lack of interest in her career. The sense of safety she obtained from the therapist made it possible for her to face her humiliation and sadness over her parents' lack of encouragement.

Summary

The idea that patients work unconsciously throughout therapy, in accordance with unconscious plans for disproving their pathogenic beliefs, has great explanatory power. It enables the therapist to develop a remarkably coherent picture of the patient's behavior. It is supported by findings from quantitative empirical psychotherapy research, research carried out by academic cognitive psychologists, evolutionary psychology, infant research, and linguistics.

The concepts of pathogenic belief, testing, and plan bear on the current question of the therapist's authority. They help therapists decide whether patients are complying with them and so help therapists protect their patients from self-destructive compliances. In addition, these concepts integrate several current trends in the theory of therapy.

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Unconscious Plan or Unconscious Conflict?

Commentary on Joseph Weiss's Paper

Paul L. Wachtel, Ph.D.
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THE DEVELOPMENT OF PSYCHOANALYSIS AS A DISCIPLINE HAS BEEN uneven. Advances in theory have not always been matched by advances in technique, and advances in one aspect of theory have not necessarily reverberated thoroughly throughout the body of psychoanalytic thought. In important ways, addressing this dissociation of influence is at the heart of the efforts to reform and reformulate a psychoanalytic approach to therapy undertaken by Weiss, Sampson, and the Mount Zion Psychotherapy Research Group (1986). Weiss's starting point is in the distinction between Freud's 1911–1915 theory and the ego psychology that evolved a decade later. He argues that the influence of the early theory persists, despite its having been superseded by Freud's later insights into mental functioning, and that many of the important developments of Freud's most mature theorizing still are insufficiently incorporated into the way analysts think about the therapeutic process. As a consequence, the element of resistance in the patient's behavior and his or her efforts to seek infantile gratification are exaggerated, and more progressive motivations and more mature and reality-oriented cognitive functioning are minimized.

We will return to this distinction on Weiss's part, but we begin with another divergence between "old" and "new" psychoanalysis that we believe bears equally significantly on the technical and theoretical changes Weiss proposes. We believe that this additional focus—on

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the implications of Freud's (1926) revised view of the role of anxiety in mental life—sheds further light on the perspective offered by Weiss. Although it is clearly part of the background of Weiss's thinking, it has not been elucidated by him in the same way as has the distinction between what he calls Freud's "automatic functioning hypothesis" (that unconscious mental life is regulated automatically, with no control or mediation by the person's higher mental processes) and the "higher mental functioning hypothesis" (in which significant control, even over the process of repression, is posited; Weiss et al., 1986).

In "Inhibitions, Symptoms, and Anxiety," Freud (1926) was quite explicit that his former understanding of the relation between anxiety and repression had been backward. Rather than anxiety being produced by repression, anxiety was the cause or motive for repression. This new formulation had potentially momentous implications for psychoanalytic treatment, as it paved the way for patients to be conceived not as unconsciously resisting the necessary renunciation of id impulses but rather as defending against the anxiety associated with intrapsychic conflict (see Waelder, 1967; Dewald, 1972; Aron, 1991). This, in turn, pointed to a psychoanalytic vision in which going deeper into the patient's aims and experiences could be less adversarial and more empathic (see, e.g., Wile, 1985; Apfelbaum and Gill, 1989; Wachtel, 1993).

To be sure, "Inhibitions, Symptoms and Anxiety" did not represent a total overhaul of the psychoanalytic understanding of the relation between anxiety and defense. It was clear from the first that Freud conceived of repression as motivated by intolerable feelings of psychic distress. That he did not label these distressing feelings as *anxiety* and even confusingly referred to anxiety as a somewhat different phenomenon (i.e., what resulted from repression) does not mean that he did not recognize the fundamental pain-avoidant motivation of defense. Moreover, the theoretical reversal Freud offered was a continuation of an overly linear and schematic framework that characterized *both* approaches. It would be more accurate to state that anxiety is both a cause *and* a result of repression: repressing fundamental needs and experiences renders them less capable of being fulfilled and understood and thus makes it more likely that further distress will therefore be encountered (in this regard, see Wachtel, 1987, 1993, 1997).

Notwithstanding this clarification, it may be said that Freud's reconceptualization of the role of anxiety shifted the very cornerstone

of psychoanalysis. Freud had stated on a number of occasions that repression was the cornerstone of the psychoanalytic point of view (e.g., Freud, 1914a). Consistent with that image, repression could be said to underlie all other phenomena of interest to psychoanalysts. But in positing that, in fact, anxiety lay behind or beneath repression, Freud was altering the fundamental structure of psychoanalytic thought; anxiety, we might say, logically succeeded to the role of cornerstone.

Contemporary psychoanalytic thought certainly pays considerable attention to anxiety, and surely no analyst is unaware of the change in Freud's thinking that was declared in 1926. But the history of psychoanalytic technique reveals that the potential introduced by Freud's reconceptualization has not been fully realized. The work of Weiss and his colleagues can be seen as an effort to bring both psychoanalytic thought and technique up to date on this score. They offer an approach in which the patient is not seen as harboring forbidden impulses and hiding them, "resisting" the efforts of the analyst to uncover the truth, but rather as feeling *afraid* to be fully himself or herself. In this, as in a number of other respects, Weiss and his colleagues are part of a progressive thrust in psychoanalytic thought and practice that has contributed to the renewed vitality of psychoanalysis. However, although their work provides an important contribution to the reworking and expansion of psychoanalytic concepts, they present a theory in which unconscious mental functioning seems to be simultaneously exalted and limited in scope. Our aim in this discussion is to separate the valuable core of their rethinking of psychoanalytic concepts from the problematic and idiosyncratic articulations that have contributed to their work not receiving as enthusiastic a response from the psychoanalytic community as it might have.

Part of what we believe has impeded the wider acceptance of Weiss's ideas is that he depicts unconscious mental functioning almost exclusively as rational and reflective, characterized by mature cognitive processes and planful activity. Indeed, Weiss's unconscious is so saturated in secondary process that it seems at times virtually equivalent to the traditional conception of the ego. As he elaborated more fully elsewhere (Weiss, 1994): "[The] patient unconsciously performs many of the same kinds of functions he performs consciously. He unconsciously thinks, assesses reality, makes decisions, and carries out plans. Moreover, he exerts control over his unconscious mental

life in accordance with these decisions and plans" (p. 8). In positing that the patient formulates a plan for self-cure, Weiss (1994) stated that "the patient in therapy unconsciously develops a simple plan that tells him which problems to tackle first and which to defer" (p. 10). The patient, it seems, is a maestro with a grand unconscious vision, trying to conduct an orchestra (the therapist) who often just doesn't get it.

This is not to say that we do not find something appealing about Weiss's construction. His departures from Freud's early id psychology foster a view of the patient that is more "experience-near," more empathic, less condescending or demeaning, and less a view of the patient as impulse-ridden and seeking infantile gratification. But Weiss's way of conceptualizing seems fixed in an overly dichotomous way of comparing his formulations to those of analysts and therapists whom he regards as rooted in the older model. For example, Weiss's description of more classical versions of psychoanalytic theory as based on a notion of "unplanned unconscious forces" is both ambiguous and misleading. It is true that psychoanalytic discourse has been filled with images that imply a kind of quasi-decorticate entity impelling a bewildered ego—from the "seething cauldron" image of early id psychology to references to "primitive" or "archaic" impulses in contemporary psychoanalytic parlance. But forces, as opposed to energies, are inherently directional. And, in the psychological realm, as soon as one begins to inquire why the force points in a particular direction, as it were, one is immediately in the realm of thought, intention, desire, and—if one wants to use such a vocabulary—plan. That is, what distinguishes the "plans" that Weiss discusses from the "forces" he suggests most analysts instead posit is not a difference in kind but a difference in content and in subtlety or capacity.

Weiss does depict a more competent or adaptive patient than do many psychoanalytic accounts. But both Weiss's *and* more standard versions of psychoanalytic thought assume that our behavior and inner experience are guided by meaningful, purposeful images and expectations. The alternative to an unconscious plan does not seem to us to be "unplanned unconscious forces," which implies almost randomness. Conversely, unconscious intentions, needs or aims can be organized and goal directed and yet not constitute a plan for self-cure.

Indeed, central to our reservations (as it is of course to what Weiss regards as most important and valuable in his approach) is his concept

of the patient's unconscious plan. It is not the concept of a plan or an unconscious plan per se that seems problematic. That idea has a useful history, with roots not only in psychoanalytic thought but in the study of cognition and neuropsychology. Miller, Galanter, and Pribram's (1960) approach to "plans and the structure of behavior," for example, was a basis for Pribram and Gill's (1975) useful reconsideration of Freud's (1895) "Project for a Scientific Psychology," and in a variety of other ways as well the concept of unconscious plans comports well both with contemporary cognitive science and with the implicit basis of all psychoanalytic conceptualizations. Rather, what we question about Weiss's portrayal of the patient's unconscious plan is that it implies a kind of prescience on the part of the patient that does not seem warranted or, to put it slightly differently, that it confuses a predictable consequence with an intention.

To expand this last point, we believe that Weiss and his colleagues are correct that, when the therapist passes what they call "tests," the consequence is that certain of the patient's unconscious expectations are disconfirmed and that repeated occurrence of such disconfirmation is a central feature of the therapeutic process. But we are extremely skeptical that the patient has orchestrated all this (even unconsciously). Rather, returning to "Inhibitions, Symptoms, and Anxiety," we suggest that a better understanding is that the patient fears—and expects—that the therapist will do just what everyone else in his or her life has seemed to do and that the patient is, in essence, *pleasantly surprised* when this does not happen. This is obviously quite different from a view of the patient as having first devised a plan for creating a situation in which particular expectations can be disconfirmed and then hoping that the therapist will know how to play his or her role.

This does not mean that patients do not on some level hope that their therapists will be different. Were there not some such hope, it is unlikely that patients would even come to therapy, much less continue. But that is a far cry from an unconscious plan to solve their problems.

We recognize that the contention could be made, perhaps even with some justification, that we are quibbling here about semantics. In certain respects, what Weiss and his colleagues mean by "plan" is probably not that different from our own conception of the therapeutic process. And yet it seems to us that in accordance with the very intentions and values evident in the work of the Mount Zion group—to introduce greater clarity and researchability into the field of

psychoanalysis and to question ambiguous and misleading formulations—it is essential to look very closely at whether the concept of "plan" as they use it contributes to such clarity.

The point is not that patients cannot plan or that elaborate plans cannot proceed unconsciously. Weiss makes an important point when he maintains that therapists are often willing to impute unconscious intentions when it comes to resistance but are more skeptical when it comes to more "positive" motivations. However, the problem is that Weiss's formulations are unnecessarily convoluted; a good close shave with Occam's razor would improve them. Much of what good therapeutic functioning entails is indeed discerning the patient's unconscious pathological expectations and working not to confirm them. But that does not require that the therapist assume that the patient has an unconscious plan for his or her own treatment. To be sure, a "plan" may be seen as implicit in the nature of the patient's participation in the process: *if* things don't unfold the way they always seem to, perhaps I will begin to believe something different and then live differently. But to make such a rubric a content of the patient's unconscious seems unnecessary and certainly not required by any of the observations Weiss and his group have amassed.

In fact, the very same clinical evidence that Weiss sees as reflecting a "plan" or "tests" may instead be construed simply as the manifestation in the transference of the patient's primary conflicts and repetitive patterns. Indeed, one might readily assimilate many of Weiss's observations into Freud's (1914b) account, in "Remembering, Repeating and Working Through," of the ways that early patterns are implicitly remembered by being enacted in the transference: "The patient does not say that he remembers how defiant and critical he used to be in regard to the authority of his parents, but he behaves in that way towards the physician. . . . As long as he is under treatment he never escapes from this compulsion to repeat; at last one understands that it is his way of remembering" (p. 150). How does one clinically (and empirically) distinguish between planning to test a belief and remembering through repeating it, between trying to disprove a belief and living out that belief, between executing a treatment plan and simply bringing oneself, with all one's conflicts and complexity, to the sessions?

To be sure, it is important to distinguish between formulations stating that the patient brings forward "defiant and critical" attitudes regarding parental authority and the kinds of formulations Weiss employs. Freud's formulation can be construed as implicitly siding with parental

authority; Weiss tends to side more with the legitimacy of the patient's attitudes and to emphasize the patient's efforts (to the point of self-sacrifice) to *protect* the parental figure.[1]

But in usefully correcting for a subtly paternalistic and demeaning attitude woven into many traditional psychoanalytic interpretations of the patient's motivations, Weiss seems to swing the pendulum too far. The importance in unconscious mental functioning of conflicting and mutually incompatible urges seems to recede, as does the darker side of human experience. One need not view the more destructive or seemingly maladaptive aspects of our motivational structure as necessarily a direct expression of our instinctual nature; Kohut (1977) eventually viewed them as "disintegration products," and one of us (Wachtel, 1993) has addressed them as the ironic product of vicious circles—the result of suppressing and running from what is potentially healthy and then getting caught in a life pattern that is frustrating, contradictory, and generative of precisely what one fears.[2] But however one conceptualizes these features of our psychological organization, we must come to grips with them. Weiss at times seems instead to slide over them, highlighting in almost single-minded fashion the heroic efforts of patients to cure themselves and the altruistic motives that brought on their trouble to begin with.

An Alternative View of the Clinical Evidence

When Weiss, discussing a patient who frequently came late or missed sessions, states that he "assumed that the patient's missing his sessions reflected his working to solve his problems by testing the therapist in an attempt to disprove the pathogenic belief that the therapist was

[1] It is important to note that Weiss differs not only in his formulation of the patient's aims and attitudes but, even more, in his conception of the therapeutic process itself. He stresses not turning repetition into remembering—but rather what is in essence a corrective emotional experience in the present. We shall discuss this issue below.

[2] Our point here is not that Freud is wrong and that these alternative formulations are correct. In large measure, the debate is ontological or metaphysical, and clinical observations cannot distinguish between the different conceptions. Rather, we wish simply to make clear that addressing these "darker" reaches of the mind does not automatically imply endorsing an id psychology conceptualization of their origin.

not interested in him," this seems to us an instance of what family therapists call *positive reframing* (Wachtel and Wachtel, 1986), a kind of lily gilding that, to borrow from Bruner (1973), goes well beyond the information given. To be sure, constructivist versions of psychoanalytic thought (e.g., Spence, 1982; Hoffman, 1991, 1992; Stern, 1992) allow a good deal of interpretive leeway, and one could make a case that Weiss's formulation is one version of what the clinical data allow. It seems to us, however, unnecessarily convoluted and loaded with extraneous and questionable assumptions.

According to Weiss, "if the patient had been missing sessions to resist the therapy, he would not have felt relieved when the therapist challenged his excuses. He would have experienced the therapist as undermining a defense against facing problems and so would have become not more relaxed but more tense and anxious." But that does not mean that "the patient's reaction to the therapist's encouragement is strong evidence that the patient, by missing his sessions, was testing the therapist as part of his working to disprove his pathogenic beliefs." Weiss is operating from a dichotomous decision tree in which, if the supposed more classical formulation is unsatisfactory, then his must be right. In fact, the observation he describes is not very strong or compelling evidence at all for his concluding that the patient was "working to disprove" his pathological beliefs. The "pleasant-surprise" alternative—that the patient anticipated rejection and was missing sessions in order to ward it off but was delighted when it turned out his expectations were disconfirmed—would *also* lead to his becoming more relaxed and coming more regularly, and it would not require making the additional assumption that the patient had this outcome in mind to begin with and was giving the therapist the chance to show he was different.

In a similar vein, in the case of Mrs. C, it seems unnecessary to posit that she had a plan to cure herself by testing the analyst and giving him an opportunity to prove her wrong, and the observations reported do not require this formulation. We should note that we see much to agree with in Weiss's account of Mrs. C. In many respects, his formulation of the case is more practical, experience-near, and readily graspable by the patient than are many psychoanalytic accounts. But, again, articulating the unconscious conflicts that drive her behavior and recognizing how understanding of Mrs. C's fears and expectations can aid the analyst in acting in a way that does not confirm them, and how the analyst's unanticipated behavior can

contribute[3] to modifying those expectations, is at least equally consistent with the data and involves fewer additional (and largely unprovable) assumptions.[4]

Some of the same issues are illustrated in Weiss's contention that "Mrs. C behaved flamboyantly in order to test whether the analyst would approve of her being strong and uninhibited." It is exceedingly difficult to differentiate empirically between such a formulation and the simple statement that she was in conflict, both wishing to act in a stronger and more uninhibited manner and fearing the consequences of doing so. It is misleading to claim that the more elaborate assumption has been demonstrated (either on the basis of formal research or on the basis of less systematic or less formal clinical observation) when in fact the latter formulation stands head to head with it, surviving every observation.

Weiss contends that the studies of the Mount Zion research group "demonstrated that we can reliably infer patients' plans from their behavior at the beginning of therapy." Those studies do show that a group of skilled and well-trained observers can reliably infer *something* about the patient, but whether what they are reliably inferring is a "plan" is another matter. The plan concept is the guiding framework of the research group, and so what they are observing is framed in those terms. But it would be more conservative (and, we believe, probably more accurate) to state that they had inferred the patient's unconscious fears or expectations. We say "more conservative" because an evaluator of the research who did not begin with the assumption that patients come into therapy with unconscious plans could agree that the researchers had discerned expectations and fears—a conceptualization that, as far as it goes, Weiss and his colleagues would agree with as well—without having to add that a "plan" had also been discerned.

Here we believe it is important to distinguish between two different aspects of Weiss's theory that can be misleadingly equated. Although

[3] As Weiss points out, the disconfirmation is rarely if ever achieved by a single experience. His point that "patients may work for long periods of time, perhaps throughout an entire analysis, to disprove just a few interrelated pathogenic beliefs" is a restatement, in his own particular theoretical language, of the ubiquitous necessity of working through.

[4] It should also be noted that the data Weiss selects to report do not enable us to evaluate what contribution is made by the analyst's [illegible]

questioning Weiss's conceptualizations of patients' plans to cure themselves, we find his formulation of the essence of psychopathology to be much more clear and useful—that patients' difficulties stem from unconscious maladaptive beliefs about reality and about moral imperatives, that they usually acquire these beliefs early in life from painful experiences with parents and other important early figures in their lives, and that the anxiety, guilt, and shame associated with these beliefs impede and restrict patients' pursuit of full, rich living and good relationships.

However, notwithstanding our general agreement, we do have two reservations about even this formulation. One is that it is a bit one dimensional—and, ironically, ultimately insulting to the patient (i.e., "plan-incompatible")—to view the patient's core beliefs as simply "maladaptive." There are ways in which the very same beliefs that keep the patient from achieving maximum satisfaction and effective functioning also are a foundation for those satisfactions he or she does manage to achieve. Simply to dismiss as pathological the beliefs that have lain at the heart of the patient's approach to the world is demeaning in precisely the way that Weiss has been in the forefront of leading us away from.

Second, and related, it is very important to be clear that whatever roots these beliefs may have had in infancy and early childhood, they are not just anomalous products of the past. Patients' ways of living will almost inevitably lead again and again to experiences that seem to "prove" their validity, for, acting on the basis of those beliefs, patients will elicit behavior from others that is compatible with their expectations (Wachtel, 1987, 1991, 1993, 1997). In that sense, these "unrealistic" beliefs become "realistic" in the context of the patient's cumulative life experience. A therapeutic approach that does not acknowledge this odd quasivalidity will not feel as experientially on target to the patient and will therefore be less effective in helping the patient to develop an alternative valid worldview that is more expansive and affirmative of the full range of her psychological possibilities (Wachtel, 1993).

Interpretation or Corrective Emotional Experience?

Perhaps one source of the odd language and convoluted theorizing manifested by Weiss and his colleagues is the need to distance their

approach from that of Franz Alexander. It is not difficult to discern a significant link between their approach and the "corrective emotional experience." That concept—in reality, a crucial advance that has been (silently) incorporated not only by Weiss but by Kohut and by many writers in the object relations tradition—became virtually taboo in psychoanalytic circles for a number of reasons. In part, the reasons were sociological and economic; Alexander's work challenged the monopoly that institute-certified psychoanalysts had on the applications of psychoanalytic discoveries to psychotherapy, and he actively promoted the teaching of psychoanalytic ideas in psychiatric residency programs outside the control of the institutes. In addition to engendering barely disguised turf wars, Alexander's presentation of his ideas and his particular personality obscured how his concepts could be usefully applied by others. Although we believe it took some considerable selectivity to see Alexander's approach simply as authoritarian, reports by those who knew Alexander personally suggest that there was in fact such a strain in his personality, and certainly this was a key element in how Alexander's work was perceived—the analyst as "manipulating" the transference, as insincerely pretending to be what he thinks the patient needs, and so forth. Weiss rescues the concept (without speaking its name) by presenting the varied stances that the analyst may take in relation to different patients as what *the patient* had in mind all along—with our job being to "get it," to understand the way the patient is wanting us (even telling us, if we are perceptive enough to hear) to behave.

Thus, Weiss argues (in essence much like Alexander) that, for some patients, "who suffer primarily from the belief that they have no right either to have their own opinions or to question the opinions of authorities," it is important for the analyst to be careful not to assert her point of view too vigorously, but to take the lead completely from the patient, whereas for others, who "suffer primarily from the belief that they do not deserve protection, they may be most helped in some cases if the analyst insists on his or her own point of view even in opposition to the patient's stated goals." This way of thinking goes considerably beyond the rather general notion that "the relationship" is curative or that becoming a benign introject is essential to cure. Here Weiss states quite explicitly that the therapist needs to behave in a way calculated to counter the patient's pathological expectations. It would be difficult to be more Alexander-like in therapeutic strategy.

Weiss also takes a view of the role of insight and the overcoming of repressions that parallels Alexander's view quite strikingly. He suggests,

for example, that, "when patients are helped by the analyst to disprove their pathogenic beliefs and move toward their goals, they feel safer. As they feel safer, they lift their repressions and become progressively more aware of previously repressed mental contents." Thus, like Alexander, Weiss indicates that insights frequently *follow* the experience of safety created by a corrective emotional experience with the analyst. Insights need not be the primary motor of change but can be a kind of side effect of change produced through direct experience with the analyst—but an important side effect that can further extend and consolidate change. It is significant in this regard that Weiss understands Mrs. C as becoming progressively more aware of her previously unconscious guilt "without the aid of interpretation."

Despite these similarities to Alexander, however, Weiss has managed to escape the vitriol Alexander encountered. In part, this probably reflects simply a change in the *Zeitgeist*. The institutes of the American Psychoanalytic Association no longer "own" or control psychoanalysis, and Weiss, moreover, is not alone in trafficking in this forbidden product. The corrective emotional experience remains the insight that dares not speak its name, but it is thriving nonetheless. Proponents of strict abstinence and neutrality and of the idea that all change must derive from insight and all analysis be rooted as much as possible in interpretation alone no longer constitute the unchallenged dominant voice of psychoanalysis.

But Weiss does not leave his defense against the accusation of Alexandrian heresy solely to the withering away of the passions Alexander originally incited or to the slow process of change in psychoanalytic conceptions of the therapeutic process. In essence, he quite skillfully argues (if implicitly, so as not to call Alexander into the room if it is not necessary) that he does not manipulate the transference as Alexander did, because all he is doing is following the patient's lead, aligning himself with the patient's own plan for cure. What could be authoritarian or manipulative about that? Indeed, in this light, one might suggest that what is really being stressed by their idiosyncratic language and conceptualization is not that it is the patient's *plan* but that it is *the patient's* plan.

Whether or not the odd language and conceptualization offered by Weiss and his colleagues are related in any way to a desire to distinguish their approach from Alexander's, we are struck both by this similarity and by the inelegance of their framing of what is all and all very interesting and important work. We are aware that much of our discussion has a somewhat critical tone, but we offer these comments precisely because we feel that the work of Weiss and his colleagues is important enough to take seriously and valuable enough to be worth trying to improve further. Too few psychoanalytic thinkers have subjected their clinical hypotheses to controlled study. That Weiss has operationalized a psychoanalytic theory of pathogenesis and therapeutic action places him among the ranks of pioneering psychotherapy researchers. We have tremendous respect for the Mount Zion group's research enterprise, and we feel there is a great deal to be learned not only from their methods but from their creativity and initiative. We do, however, take issue with the idiosyncratic nature of some of their theoretical tenets and, in particular, with their conception of the patient's unconscious "plan" and their use of terms such as "plan compatible" and "plan incompatible" to describe the therapist's behavior. Our translation cum critique is offered as essentially a friendly amendment to the innovative ideas Weiss and his colleagues have introduced into the ever-evolving realm of psychoanalytic thought.

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Unconscious Plans and Unconscious Conflict

Reply to Commentary

Joseph Weiss, M.D.

I THANK WACHTEL AND DEMICHELE FOR THEIR FRIENDLY DISCUSSION OF my paper and for the interesting questions they raise. Their questions give me an opportunity to expand my ideas. I'll begin with their peripheral concerns and move toward their central concern—namely, their reservations about the plan concept. I'll also return to a discussion of Mrs. C.

As Wachtel and DeMichele point out, my perspective has been shaped by Freud's revision of the theory of anxiety in "Inhibitions, Symptoms and Anxiety" (1926). Freud's revision of this theory changed the psychoanalytic concept of psychic conflict. Freud (1926) assumed such conflict is between a wish and a fear. A patient is afraid to pursue a particular goal because she unconsciously assumes that doing so is dangerous. In childhood, she perceived the danger as real and external. Later, she internalized it as a belief. Consider Freud's paradigmatic example. A male patient in childhood experienced as real and external the danger that he would be castrated for his sexuality, and so he became frightened of his sexuality and impeded in his pursuit of sexual goals. Subsequently, he internalized this danger by developing a belief in castration as a punishment. (Freud almost always wrote about castration anxiety as stemming from a belief and not from a fantasy.) Henceforth, the patient's conflict was internalized. He continued to pursue sexual goals and continued to be impeded in this pursuit by anxiety stemming from the belief in castration.

Freud's (1926) revision of theory paved the way for Alexander's conception of the corrective emotional experience (Alexander and French, 1946). If repression and hence psychopathology are held in place by a belief derived from experience, then new experiences that run counter to the belief may help the patient change the belief and so prove to be corrective.

I agree with Alexander about the importance of the corrective emotional experience (Weiss, Sampson, and the Mount Zion Psychotherapy Research Group, 1986, p. 330; Weiss, 1993, p. 23). As Wachtel and DeMichele point out, I assume that the patient may receive a corrective emotional experience when she experiences the analyst as passing her tests or as offering her pro-plan interpretations. We have shown in our research that, after a passed test or a pro-plan interpretation, the patient's anxiety, guilt or shame stemming from her pathogenic beliefs is diminished (Weiss et al., 1986; Weiss, 1993). She immediately becomes more relaxed; she lifts her repressions, and she becomes more insightful (Fretter, 1984; Caston, Goldman, and McClure, 1986).

Incidentally, I assume that the patient is pleasantly surprised when the analyst passes a test or offers a pro-plan interpretation. Even though the patient may have unconsciously devised the test, she cannot be sure that the analyst will pass it. The patient would not benefit much from tests that she was certain the analyst would pass, for by such tests she would not find out anything new about the analyst.

As regards the dark side of human nature, its prominence and its importance are obvious enough. Greed, lust, perfidy (and other of the seven deadly sins) are prevalent. I may, however, disagree with Wachtel and DeMichele about the source of this human darkness. I assume that dark motives, although based on inborn human tendencies, are held in place by pathogenic beliefs derived from childhood identifications with parents or by childhood compliances with parents.

For example, a patient almost ruined his marriage by rageful fits directed at his wife. These were modeled after the rageful fits that his father aimed at his mother and that ruined his parents' marriage. The patient maintained these fits in compliance with several pathogenic beliefs, including the belief that he had no right to have a better life than his father.

Another patient who was obnoxious and nasty first developed these dark traits in compliance with his mother, whom he experienced as wanting to blame him for any tension that developed between them. He believed that, by his nasty, obnoxious behavior, he was permitting his mother to maintain her sense of moral superiority and to avoid self-blame.

My focus on the patient's search for light stems from my view of the therapeutic process. Although not denying human darkness, I assume that part of each patient (including the patient whose dark side is prominent) seeks the light and that it is the therapist's task to find out how the patient is doing this and to help her to accomplish this. (A member of our research group who has interviewed numerous serial killers tells me that this formulation does not apply to them.)

In my experience, patients are not demeaned by the idea that they suffer from pathogenic beliefs. Pathogenic beliefs are not the patient's core beliefs. They constitute a subset of the totality of the patient's beliefs, and they are the beliefs that the patient herself is working to change.

When patients realize that their pathogenic beliefs are derived from their childhood attempts at adaptation, they are encouraged. They are helped to feel less ashamed. They are enabled to see their problems not as the consequence of dark inner strivings that they cannot understand but as the consequence of attempts on their part to adapt to an unsatisfactory childhood environment. They come to understand that, although their pathogenic beliefs were adaptive in early childhood, these beliefs are not adaptive in their present life.

As Wachtel and DeMichele point out, a patient who is guided by certain pathogenic beliefs may behave in such a way as to prove these beliefs to be true. For example, a patient who believes that, if she is friendly, she will be rejected may be unable to develop close friendships and so may find her belief in her rejectability confirmed. So, in this case, the patient's pathogenic beliefs are maladaptive, but, in the sense just described, they are true.

According to Wachtel and DeMichele, my language and my concepts are highly idiosyncratic and convoluted. My language differs from Wachtel's and DeMichele's because I am making use of concepts about the patient's behavior that differ from theirs. However, my language expresses my concepts directly and simply. Moreover, it is not as idiosyncratic as Wachtel and DeMichele assume. Freud (1940) wrote about unconscious tests which he referred to as *trial actions* (p. 199). He also wrote about the patient's unconsciously contemplating a course of action (p. 199). Others have subsequently taken up these ideas. For example, Rangell (e.g., 1968) has written extensively about the patient's unconscious testing; he has also written, but not extensively, about unconscious planning (1971).

Although I consider my formulations simple, direct, and close to common sense, I experience Wachtel and DeMichele's attempts to paraphrase my ideas as convoluted and odd. For example, Wachtel and DeMichele assume that I believe the patient has a plan for self-

cure. This formulation is unsatisfactory because it leaves out a crucial element in the patient's plans—namely, the role of the therapist. This is because the patient's plans always include the therapist. The patient's plan is not to cure herself but to work with the therapist in an effort to solve her problems.

I believe that the human being is always making plans. She makes plans (that may to some extent be unconscious) in every situation in accordance with the goals she intends to pursue in those situations. Thus, the patient who comes to the therapist for help makes plans for working with the therapist to obtain help.

Wachtel and DeMichele assume I believe that . . . "the patient is a maestro with a grand unconscious vision, trying to conduct an orchestra (the therapist) who often just doesn't get it." This formulation does indeed seem odd. I do not believe that the patient's making plans requires the high intelligence and the control over many elements that a maestro exerts over his orchestra. I do not believe that the therapist just doesn't get it. Although my ideas may be different from those of many therapists, I have respect for most therapists' wisdom and sensitivity.

Making plans is nothing like conducting an orchestra. As Stern (1985) told us, infants, by testing hypotheses about their caretakers, work to develop a good relationship with their caretakers. The infant knows what is good for her and works to attain it without benefit of a highly developed mental life. Rather than assuming that making plans is difficult, I assume that it is scarcely possible not to make plans.

Wachtel and DeMichele say that the patient in analysis may be simply displaying her primary conflicts and repetitive behavior or may be just being herself with all of her complexities and conflicts. Of course the patient is being herself. She is the same person in therapy as in everyday life. However, among the complexities of the person in everyday life are her tendency to make plans and to test people who are important to her. The human being is set up to make plans for testing her environment, and much of her testing, but not all, is unconscious.

Testing and planning are ubiquitous and highly adaptive. A person must know as much as she can about those who are important to her, and a person feels disoriented without a plan, even if the plan is just to waste time. A person's planning gives coherence to her behavior.

Consider as an example of planning and testing a child's testing of her parents. The child, as is well known, tests limits with her parents.

This testing may be unconscious. She must know which of her behaviors they will find acceptable and which of her behaviors they will disapprove of. She also tests her parents to find out how they will react to her attempts to pursue her developmental goals. She must know how they will help or hinder her in these pursuits. A person tests others throughout life. The man tests the woman he would like to take out, the employee tests her boss, husbands and wives test each other.

The great capacity of the human being for the unconscious testing and assessing of others is illustrated by the phenomenon of falling in love. A woman patient who at the time didn't speak much English was picked up while hitchhiking in Golden Gate Park. Although the couple's communication was impeded by language problems, they fell in love over the next hour. According to the woman, who married the man and moved to the United States, her first impressions of the man, though incomplete, were roughly accurate. She could scarcely describe the way she made her inferences about the man. These were largely unconscious. However, she did interact with the man and no doubt drew inferences from their interactions.

Why do Wachtel and DeMichele not credit the patient with the capacity to test? Although I admire Wachtel's work, I believe that, in the area under discussion, Wachtel and DeMichele (like many others) are constrained by the continuing influence of early psychoanalytic theory, which does not credit the patient with much agency or with an unconscious wish to get well.

Wachtel and DeMichele quote Freud's (1914) description of the therapeutic process in Remembering, Repeating, and Working Through: "As long as he is under treatment he [the patient] never escapes from this compulsion to repeat; at last one understands that it is his way of remembering."

In my view, the relationship between repeating and remembering discussed by Freud is well explained by the concepts of the patient's testing of pathogenic beliefs. As the patient succeeds in testing her pathogenic beliefs, she is able to weaken their hold on her and safely remember the frightening traumatic experiences from which she derived these beliefs. Here is an example.

The patient is a 45-year-old writer whose parents, both professionals, were self-centered and neglectful. When the patient was a young child, his parents gave him much more responsibility than he was capable of handling. For example, when the patient was four, he fell off their

porch and injured himself. Although his parents were close by, they were not paying attention. For another example, the patient at five was sent across the country on an airplane by himself. During the flight, he felt extremely anxious.

At the beginning of his therapy, the patient did not speak of these events. However, he frequently gave the therapist what I call "protection tests." He spoke casually of some rather foolish things that he planned to do. Or, he reported foolish, self-destructive behavior that he'd already carried out. For example, he developed a potentially serious physical symptom but did not have it checked out by a physician for diagnosis. He made unsatisfactory arrangements with his tenants, which led to his being cheated financially. He failed to invest an inheritance appropriately, and so forth. Each time the patient made the therapist aware of his failure to take care of himself, the therapist called his attention to the failure and implied that the patient should take better care of himself. The patient in each instance was relieved.

As the patient became aware through testing that the therapist was willing to protect him, he began to believe that he deserved to be protected. He also came to realize that his parents had been neglectful. He realized that he was not to blame for falling off the porch or for feeling frightened on the airplane trip. As he stopped blaming himself for these childhood traumas, he could safely remember them more vividly and with appropriate affect, and he could also remember other, similar traumas.

A good example of a patient's testing the therapist vigorously before telling him about a traumatic event occurred in the first session of the therapy of a 30-year-old woman. The patient at the beginning of the first hour selected a chair across the room from the therapist, about 20 feet away, and spoke in a rather soft voice. The therapist asked the patient to move closer so he could hear her. The patient smiled and moved so close to the therapist that their knees almost touched. The therapist said, "Not that close," and the patient moved back to a normal distance. Later in the session, the patient told the therapist that she had been seduced by her previous therapist. The patient was able to tell the present therapist about a traumatic experience with her previous therapist after she had given him a seduction test and the therapist had passed it. This gave her some reason to believe that he would not attempt to seduce her. She tested the therapist dramatically in the first hour in an attempt to assure herself of his reliability before committing herself to therapy. The patient became

conscious of her testing after the therapist had passed her test. She said, "I guess I was trying to find out whether you were anything like Dr. X."

Other evidence for unconscious planning is the patient's coaching of the therapist when she's not sure the therapist will pass her tests. For example, a patient who suddenly threatened to stop treatment seemed dismayed when the therapist didn't say anything. She then coached the therapist by saying, "Whenever I do something impulsively, I'm likely to screw up."

Just as patients sometimes become aware of previously unconscious testing, they sometimes become aware of previously unconscious long-term plans. In "Patients' Unconscious Plans for Solving Their Problems," I illustrated this with the case of a woman who became aware, after the therapist had passed certain of her tests, that she wanted to go to graduate school. Another example concerns a patient who, during the first two years of his analysis, worked mainly to finish his education and obtain his Ph.D. During the second two years, he worked to develop a good relationship with a woman. He married while in treatment. Toward the end of the analysis, the patient, looking back, made clear that he had been guided by a plan that was not entirely conscious—to finish his education and then find a wife. He explained that he was comfortable with a woman only if he could approach her from a position of strength.

Sometimes when the therapist fails a test, the patient makes the same kind of test more obvious. Other times when the therapist fails a test, the patient changes the kind of test that she is giving. She gives the therapist tests that she assumes the therapist is more likely to pass.

It's now time to return to the discussion of Mrs. C. Wachtel and DeMichele interpret Mrs. C's flamboyantly smoking a cigar as the expression of a conflict. They assume Mrs. C wanted to be stronger but was afraid of the consequences. I agree. Wachtel and DeMichele also say the plan concept is not needed to explain this instance of flamboyance. I agree here, too. There is no need for such a concept in explaining a single piece of behavior. However, the concepts of testing and planning may throw considerable light on sequences of events either in a single hour or over a period of time.

The concepts of testing and planning throw light on Mrs. C's behavior during the first 100 sessions of her analysis. They help account for Mrs. C's single-minded pursuit of her goals and for her ignoring

analytic interpretations that were not consonant with her goals. For example, she ignored the analyst's comments about her failure to grieve for her grandmother. As I explained "Patients' Unconscious Plans," one of Mrs. C's goals was to become more independent of her family. Her grieving for her grandmother would have hindered her pursuit of this goal.

The plan concept helps account for Mrs. C's accomplishing a great deal during the first 100 sessions without benefit of interpretation. During these sessions, Mrs. C became aware of her exaggerated sense of responsibility for others and of her guilt and worry about her family. In addition, she became more able to be oppositional and more loving.

During these sessions, Mrs. C also became able for the first time to have orgasms and to enjoy sex with her husband.[1] This was an important accomplishment. It was because of her failure to enjoy sex that she first sought analysis. Wachtel and DeMichele dismiss my assumption that Mrs. C worked to achieve these things by saying that I'm confusing predictable consequence with intention. It is of course conceivable that Mrs. C achieved all of these things without intending to do so. However, the things that Mrs. C achieved were highly desirable. They reflected a decrease in her neurotic conflicts. They were the very things that Mrs. C wanted to achieve and that our research group predicted from the first 10 sessions she would work to achieve. If Mrs. C wanted to achieve these things, seemed to be working to achieve them, and did in fact achieve them, largely without benefit of interpretation, why would Wachtel and DeMichele deny her agency? I assume that Wachtel and DeMichele are taking their position on theoretical grounds, and that they (like many others) simply do not believe that a person has the prescience to unconsciously make and carry out tests and plans.

Although Wachtel and DeMichele say that I am confusing intentions with predictable consequences, I believe that Mrs. C's accomplishments would not be seen as "predictable consequences" by investigators who are not guided in their thinking by concepts such as I propose.

The concepts of testing and planning help account for Mrs. C's flexibility in moving toward her goals. (Such flexibility is a hallmark

[1]I did not report this accomplishment in "Patients' Unconscious Plans for Solving Their Problems." I did report it in my discussion of Mrs. C in *The Psychoanalytic Process* (Weiss et al., 1986).

of having goals and making plans.) Mrs. C wanted to be stronger but was afraid that, if she were stronger, she would hurt others. She first worked to feel stronger by behaving flamboyantly to test the analyst. When the analyst did not encourage this behavior and so failed her test, Mrs. C stopped being flamboyant. She tried a new tack. She became demanding, hoping to assure herself that she could not push the analyst around. The analyst passed these tests well. He was quite unaffected by Mrs. C's demands and did not give into them. As Mrs. C perceived the analyst's comfort with this kind of test, she relied more and more heavily on it. If Mrs. C were simply compulsively repeating a childhood pattern, she would not have shown this flexibility. She would have continued to be flamboyant, regardless of the analyst's lack of encouragement.

Wachtel and DeMichele assume that the patient is not guided by long-term goals. Therefore, they believe that our judges are not inferring goals but something else. In making this assumption, Wachtel and DeMichele are relying on their theory, which does not credit the patient with unconscious long-term goals. They ignore the fact that patients often tell the therapist their goals in the first few sessions. If patients don't mention these goals directly, they strongly imply them or provide strong evidence for them.

Patients attempt to reveal their goals at the beginning of therapy so that the therapist will know how to pass their tests. After that, patients may seem to lose clarity as they proceed to test the therapist. (For empirical evidence of this, see Weiss, 1993, pp. 181–187; O'Connor, et al., 1994.)

I could provide numerous examples of patients revealing their goals during the first few sessions of therapy, but I give only two. The first concerns a patient who told the therapist during the first few sessions that he wanted to overcome his fear of women. He wanted to get closer to his girlfriend but feared that she would reject or humiliate him. He proceeded then to work at accomplishing this.

The second example concerns a patient who strongly implied at the beginning of treatment that he wanted to leave his girlfriend but was afraid he would hurt her a great deal. Although he didn't state directly that he wanted to leave her, he strongly implied this. He was highly critical of her. As he described her, she would be a very unsatisfactory partner. In addition, he told the therapist that he was excessively worried about hurting people he was close to. The therapist's inference that the patient wanted to leave his girlfriend

proved correct. The patient worked to overcome his exaggerated worry about her and eventually did leave her.

Armed with a good hypothesis about the patient's goals, plans, and beliefs, the therapist may perceive the ensuing therapy with considerable clarity. She may perceive the patient as benefiting by becoming bolder and more insightful during periods when the therapist is passing her tests. The therapist may perceive the patient as reacting to the therapist's occasional failures to pass her tests by coaching the therapist or by making her tests more obvious. The therapist may also perceive that, when the patient is put off course by the therapist's interpretations, the patient may find a way of again bringing her concerns into focus.

I believe that the idea that the patient is a powerful agent in the therapy explains the success of a wide variety of therapeutic approaches based on different theoretical assumptions. We would expect that some approaches would be much more successful than others, and yet this does not seem to be the case (Luborsky, Singer, and Luborsky, 1975; Lambert, Shapiro, and Burgin, 1986; Seligman, 1995). The success of a wide variety of therapeutic approaches may be explained by the patient's capacity to find ways of testing her pathogenic beliefs with therapists of many different persuasions. If the patient is not too rigid, she has a good chance of finding a way of testing her pathogenic beliefs that fits the personality and theoretical approach of the therapist with whom she happens to be working.

Whether the patient has the prescience unconsciously to make and carry out tests and plans can be decided only empirically. It cannot be decided by reference to theory or authority. Therefore, I hope that Wachtel and DeMichele and the readers of this paper will examine their patients (or their transcripts of therapies) through the lens of the concepts proposed here to determine empirically whether these concepts fit their data and whether the concepts turn out to be helpful.

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