CHAPTER 4

Inferring the Patient’s Plan from the First Few Sessions of Therapy

When I was a student at the San Francisco Psychoanalytic Institute, a prominent teacher advised me to avoid formulating the patient’s problems, especially at the beginning of treatment. He assumed that in general it is possible to formulate a case only after a prolonged period of exploration, and so that if the therapist develops hypotheses about the patient too early, he risks the premature closure of his mind.

I now believe that this advice is wrong. The therapist should begin during his first contact with the patient to try to understand him. The therapist should attempt to formulate the patient’s pathogenic beliefs, his goals, and his plans for working to disconfirm the beliefs and to pursue the goals (Curtis & Silberschatz, 1986; Silberschatz & Curtis, 1986). If the therapist develops explicit (albeit highly provisional) hypotheses about these, he has something to work with. He may check the hypotheses against new observations and thereby confirm them, alter them, or dismiss them. Moreover, the therapist who has in mind the best hypotheses that his current knowledge supports is prepared for the patient’s tests, including tests that the patient may give him quite unexpectedly.

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

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

In attempting to determine where the patient wants to go, the therapist is thinking about him in familiar, everyday terms. Unlike the therapist who attempts to infer the patient’s impulses and defenses, the therapist who attempts to infer the patient’s goals is calling upon well-developed intuitions based on everyday experience. The therapist who is not accustomed to listening for the patient’s goals may be surprised to discover how often they are easily perceived. In our research, we have found that judges who are only moderately trained in the present theory can learn to make reliable plan formulations. Moreover, these formulations are valid, as shown by our finding that research relying on them yields a great deal of order (see Chapter 8).

EVALUATING THE PATIENT’S STATED GOALS

In attempting to infer the patient’s true unconscious goals from his stated goals, the therapist should assume that the patient’s true goals are normal and reasonable. If the patient states implausible goals, he is probably doing so in obedience to powerful unconscious pathogenic beliefs. For example, the therapist should not take at face value a patient’s statement at the beginning of treatment that he is interested in a woman who (he implies) is ungiving, demanding, and insulting. The patient’s true goal may be to leave her; however, he may be maintaining an attachment to her for various maladaptive reasons. For instance, the patient may believe that he is obliged to suffer in his
relations with women as his father suffered in his relations with the patient’s mother. Or, if his father failed to protect him from a demanding, vituperative mother, the patient may be testing the therapist in the hope that the therapist will protect him from a demanding, vituperative girlfriend. Or he may be maintaining an attachment to his girlfriend because he believes by leaving her he would destroy her. Or he may be afraid to tell the therapist that he wants to leave his girlfriend, assuming either that the therapist will reprimand him for being selfish or that the therapist will encourage his leaving her before he can tolerate his guilt about doing so.

In some cases, a patient at the beginning of therapy may be unable to state his goals directly. Throughout therapy, but especially at the beginning, he is in unconscious conflict about his wish to reveal his true goals and his fear of doing so. He would like to reveal his goals so that the therapist may help him to pursue them. However, he unconsciously believes that by revealing them he risks being traumatized by the therapist, because he fears that the therapist (whom he has not yet tested) will agree with the pathogenic beliefs that warn him against pursuing his goals.

The degree to which the patient is able at the beginning of therapy to state his true goals varies from patient to patient; it depends, among other things, on the degree to which the patient is bound by his pathogenic beliefs. A patient beginning therapy may be surprisingly insightful about his goals, but may seem to lose his insight soon afterward. At first he may be so powerfully motivated to orient the therapist to his problems that he does so despite his pathogenic beliefs. However, having oriented the therapist, he may soon begin to test him by stating false goals in the hope that the therapist will not take such statements at face value (see Chapter 8 for research supporting this assumption).

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

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

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

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

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

EVALUATING THE PATIENT’S CHILDHOOD EXPERIENCES WITH HIS PARENTS

In attempting to understand the patient’s problems from a description of his childhood, the therapist is especially interested in determining what traumas the patient suffered in childhood and what pathogenic beliefs he inferred from these traumas. As the therapist comes to understand the patient’s pathogenic beliefs, he also comes to understand his goals, which always include disproving these beliefs.

The therapist, in inferring the patient’s pathogenic beliefs, should keep in mind that a child tends to take responsibility for the unfortunate things that happen to him and to his family. These include catastrophic events, which give rise to “shock” traumas, and protracted strains resulting from pathogenic relations with parents, which give rise to “strain” traumas.

Shock Traumas

The patient who suffers a sudden catastrophe in childhood tends to experience it as a punishment for something bad he has done. Since he considers it a punishment, he may become unduly guilty, and since he believes himself responsible for it, he may develop a belief in his omnipotence. The more severe the catastrophe, the more guilty and omnipotent he may believe himself to be. In addition, he may infer from the sudden unfortunate turn in his fortunes that catastrophe may strike at any time. He must therefore keep himself vigilant and thus prepared for another blow by fate.
For example, the patient mentioned in Chapter 1 who was sent away from his parents for several months when he was 2 1/2 assumed that he was being punished for demonstrating too much initiative and independence. After the trauma, he became markedly more passive and compliant, and he remained that way into his adult life. He also inferred that he should not be relaxed and happy. During his analysis, whenever he began to feel relaxed, he would warn himself about the danger of relaxation by producing a dream of catastrophe.

A man whose mother died when he was 15 inferred that he had caused her death by his anger toward her. Subsequently, he became quite inhibited in his expression of anger lest he damage the person at whom he was angry. When he came to treatment, he was unable to experience normal anger toward his wife and children.

**Harriet A.**

Another patient, Harriet A., was severely traumatized when her father deserted the family. He left when the patient was 14 and was killed 2 years later in a car accident. The patient unconsciously took responsibility for her father's departure and death. She assumed that if she had been a better, more loving daughter, her father would have remained in the family and would not have been killed. Before her father's death she had enjoyed life; she was becoming popular in high school and was beginning to date. Harriet unconsciously assumed that her happiness had caused her father's death, and so inferred that she should not be happy, lest she bring about another catastrophe. She suffered a personality change. She became less outgoing. In college she made few friends and spent a great deal of time writing poetry. In her marriage Harriet felt omnipotently responsible for her husband. She tried patiently to satisfy his unreasonable demands and accepted his reprimands submissively. In a long therapy which began when she was 35, Harriet was helped to overcome her pathogenic belief in her responsibility for others. She became more assertive with her husband. She also overcame her survivor guilt to her mother. She ceased being depressed and became more active and outgoing.

A child who is exposed to continuing overwhelming trauma may develop the belief that there is no help for him. He may
attempt to ease the pain by withdrawing and anesthetizing himself. For example, a child whose father died when she was 9 was left in the care of her mother, who became depressed and alcoholic. The child felt responsible for her mother. She also felt lonely. She could not talk to her mother or to anyone else about her grief over her father's death. Since the trauma was overwhelming and continuing, she became hopeless and reacted by withdrawing and losing touch with her own affects. In addition, she came to see her family as abnormal and different from the families of her schoolmates. The patient perceived her schoolmates' families as having two happy parents, whereas her family had one depressed parent. She felt ashamed of her family and hence of herself. She tried to deal with this shame by anesthetizing herself to her feelings and attempting to be cheerful and carefree like her schoolmates.

The Child's Compliance with Inadequate Parents

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

If the child perceives his parents as depressed, needy, or fragile, he may take responsibility for their happiness and go to great lengths in his efforts to make them happy. For example, a male patient at age 6 became sexually interested in a depressed, languid grandmother. His interest in her was not to gratify himself but to revive her. If a child who believes himself responsible for the happiness of a mother fails in his efforts to make her happy, he may believe himself a failure. A patient whose mother was chronically unhappy and blamed the patient for her unhappiness concluded that he did not deserve to live; he became suicidal.
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If a child’s parents are unconcerned about him yet demand that he show solicitude and respect to them, he may become depressed, for he may infer that it is his lot to give but not to receive. If a child’s parents persistently criticize him for various faults, such as selfishness, arrogance, or stupidity, he may consciously repudiate the criticisms, but unconsciously believe them. As a result, he may come to believe unconsciously that he is not a good person.

If one of the parents is a severe alcoholic, the child is likely to feel both rejected by the parent and worried about him. He may, as a consequence of such trauma, experience a sense of shame. If the family denies the alcoholism, he may experience even more shame. He may also develop the idea that he is not supposed to perceive things as they really are (see Brown, 1985, 1988).

If a child perceives his parents as volatile and capricious—if, for example, they surprise him by unpredictable fits of anger—he may develop the belief that he is always in danger, and so may become hypervigilant. If the child’s parents fail to protect him and so expose him to dangers beyond his capacity for coping, he may come to believe that the world is dangerous and that he does not deserve protection. He may become withdrawn or anxious, or subject to attacks of panic (Gassner, 1989).

If the child is sexually abused by a parent, he will blame himself for the abuse and develop a sense of shame. If the parent denies the abuse, the child will infer that he must not remember it. His sense of reality may be impaired. If the abuse occurred at an early age, the child is confronted with the following problem: In order to adapt to his world, he must both forget the abuse and remember it. He must forget the abuse in order to adapt to the members of his family, who insist on denying it, for he cannot be friendly and close to a parent who he knows is abusing him. However, he must remember the abuse in order to prepare for further abuse. If abused while quite young, he may deal with this problem by dissociating, or in certain instances by developing several personalities—one or more of which has no memory of the abuse, and one or more of which remembers it.
The Child's Identifications with Inadequate Parents

In attempting to infer how the patient was affected by his parents, the therapist should keep in mind that for the child his parents are role models. It is from his parents that the child learns how to relate to others. Thus it is extremely difficult for a child to develop abilities that his parents have not developed.

Stuart C.

For example, Stuart C., whose parents had little sense of authority, was himself scarcely able to exert authority. Neither parent could explicitly prohibit him from doing whatever he wanted. His mother could only indicate her disapproval by questioning him. For example, she would ask, "Why do you want to go to the movies?" or "Why do you like to play football?" and so forth. His father would respond to his requests by telling him to ask his mother. In order to protect his parents' authority, Stuart kept himself indecisive. In his adult life he continued to have trouble making and carrying out plans, and, like his parents, was scarcely able to exert authority. In his analysis, Stuart was helped to overcome his indecisiveness. He married, had several children, and became more successful in his work.

Another patient suffered in childhood from parents who were not able to maintain close, satisfactory relations with him. For example, as soon as he and his mother would become involved in a pleasant conversation, she would display discomfort and change the subject or leave the room. His father was even more difficult. He implicitly refused to take the patient seriously; rather, he would tease him by seeming to misunderstand him. As an adult in analytic treatment, the patient noticed that he was uncomfortable when tempted to feel close to another person. For example, he was uncomfortable with women who were respectful and loving. He would become embarrassed and would be tempted to tease them.

If a child perceives his parents as ashamed, he too is likely to develop shame. A patient mentioned in Chapter 2, whose parents revealed their shame about his brain-damaged brother
by carefully avoiding any reference to the brother's condition, himself became ashamed of his brother, and ultimately of himself, for coming from a family he considered shameful.

**Survivor Guilt**

In inferring the patient's pathogenic beliefs from his account of his childhood, the therapist should keep in mind the prevalence of survivor guilt (Modell, 1965, 1971). Most persons suffer from survivor guilt. They assume that in some ways they have been treated better by fate than their parents and siblings, and that their favorable treatment was at the parents' and siblings' expense. A person who suffers from survivor guilt may fail to take advantage of his opportunities, or, if he does take advantage of them, may find some way of punishing himself for doing so.

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

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

A patient may first become aware that he suffers from survivor guilt by inference from experience. He may observe that he develops symptoms either after he is successful or after a close friend or relative suffers a setback. He may only later
realize that he feels sorry for certain members of his family and that he considers his advantages unfair. For example, a patient whose parents were extremely anxious when they were away from home developed an embarrassing facial tic whenever he felt adventurous. At first he had no understanding of this symptom. He began to understand it by observing that he developed the tic only when he was enjoying himself in ways his parents could not. It was many months later that he became aware that he felt sorry for his parents in these circumstances.

Separation guilt is also extremely common, if not universal (Modell, 1965, 1971; Loewald, 1979). The patient who suffers from separation guilt believes that if he becomes independent of his parents or siblings, he may upset them. In extreme instances the patient may feel that he has no right to a life of his own. He may, as a consequence of an unconscious belief that he does not deserve to be a separate independent person, convince himself that he enjoys being dependent.

**THE THERAPIST’S AFFECTIVE RESPONSES TO THE PATIENT**

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

*Kenneth Y.*

During the first few sessions with Kenneth Y., the therapist noticed that he felt himself especially skillful, intuitive, and likable. He inferred from this that Kenneth was unconsciously taking care of him. He assumed that the patient felt omnipotently responsible for others. The therapist’s hypothesis was supported by the patient’s description of the way he had dealt with his depressed mother. He had bolstered his mother’s fragile self-esteem by making himself highly attentive, deferential, and appreciative. The therapist’s hypothesis was further supported several weeks later on an occasion when the therapist was late. The patient apparently
feared that the therapist would feel guilty, and so was especially ingratiating. In particular, he stated that he had arrived only shortly before the therapist. The therapist reacted by telling Kenneth that he seemed worried about him. Kenneth showed relief and became slightly more straightforward.

In the next example, the therapist used his reactions to the patient during the first hour in making a preliminary formulation of the patient’s plan.

**Thomas C.**

Before his first interview with Thomas C., the therapist heard from the family physician who referred him that Thomas had trouble making himself work. He came from a poor, hard-working family, and both his parents and his wife were worried about his difficulty working. However, during his first session, Thomas, a computer programmer, did not mention his problem about working; indeed, he was relatively uninformative. He chatted informally about various topics. He gossiped about certain mutual acquaintances and talked about the fascinating advances that computers would make possible. He used the therapist’s first name and sat in a relaxed posture with his leg over the arm of the chair.

The therapist experienced the patient’s casualness as pleasant, confusing, and slightly provocative. He wondered, “Why is the patient so casual? Why is he not talking about his problems?” The therapist was tempted to ask the patient about this. However, he suspected that the patient was being nagged by his parents and wife to work harder, that he probably resented this, and that he was testing the therapist to determine whether the therapist would nag him as they did. Perhaps the patient was struggling to disprove the pathogenic belief that he must at all times be serious, hard-working, and goal-directed.

The therapist therefore decided to reciprocate the patient’s casual, friendly attitude; during the first session and throughout the therapy, he refrained from pressing the patient to work in treatment. The patient’s response confirmed the therapist’s assumption. A few sessions after beginning treatment, Thomas reported that he had tackled a project that he had been avoiding. About a month later he revealed more about his childhood. He stated that his parents had been grim, controlling, and rejecting. As the rest of the therapy confirmed, the patient in childhood had felt
both rejected and deprived of autonomy. He now had difficulty working because he experienced work as depriving him of freedom. He was afraid that the therapist would confirm his pathogenic belief that he deserved rejection and did not deserve freedom. He was reassured against this belief by the therapist's response to him. As he realized that the therapist would not try to make him work, he became more able both to relax and to work; his ability to relax and enjoy himself made working feel less burdensome.

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

This may be illustrated by another example, in which a patient during his initial phone call asked the therapist a number of searching questions about his qualifications. During the call the therapist had the unpleasant feeling that unless he was careful, the patient would criticize him. The therapist inferred that in his childhood the patient had suffered hostile criticism from a parent, and that in the phone conversation he was turning passive into active. His assumption proved correct: The patient later reported that his father had been quite critical, and that he (the patient) had been so compliant that he had felt almost paralyzed in his father's presence. He feared that the therapist would criticize him and that he would comply. During the phone call the patient was not only protecting himself from the therapist, but was also testing the therapist's capacity to tolerate being criticized. He unconsciously did not want to commit himself to a therapist who could not stand up to him.

Yet another patient, in his initial phone call, provoked in the therapist a sense of mild bewilderment and rejection. He began in a friendly way by telling the therapist that the therapist was well recommended and by readily setting up a first appointment. However, immediately afterward he began to express grave doubts about the time, effort, and money involved. Like the patient described above, this patient was turning passive into active, both to protect himself from the danger of rejection and to assure himself that the therapist could tolerate the patient's rejecting him.
In the case of Zora T., the therapist, while listening to the patient, had the unpleasant feeling that the patient's problems were almost insuperable.

Zora T.

In her first hour, Zora T., an emigré from Israel, described her situation in bleak terms. She was one of many children whose father had abandoned the family when she was 5 and whose mother died of premature senility at age 38. She was now a widow living alone in a small apartment. She felt weak, had hypertension and asthma, had trouble getting out of bed in the morning, and had no social life. Nor did she get along with two of her three daughters, one of whom was an addict, the other retarded. Several of her grandchildren were not doing well. Her retarded daughter did not know how to mother her own children and would not accept help.

The therapist's initial reaction to Zora's story was to feel burdened. The patient seemed so weighed down with real as opposed to psychological problems that the therapist developed the feeling that he would be unable to help her. He thought to himself, "This patient can't use psychotherapy—she needs money and a good internist."

The therapist inferred from his feeling burdened that Zora might have been severely traumatized in childhood by worry about her overwhelmed, overworked, prematurely senile mother, whom she was unable to help. He assumed too that Zora was testing him, hoping that he would not feel burdened by her. The therapist resisted the temptation to feel burdened, remained upbeat, and accepted the patient for treatment.

The patient's behavior in the next hour tended to confirm the therapist's initial hypothesis. In this hour Zora presented a completely different picture. She was more cheerful. She described her problems at work, where she was in charge of a number of office workers who used computers to process taxes for the federal government. She was the most knowledgeable person there. She resented her boss for ignoring her advice and for taking credit for her work. As she talked, she made it clear that she had an important job, was highly respected, and enjoyed her work.

The rest of her therapy confirmed that Zora's problems stemmed primarily from her relationship to her sick, overburdened mother. (She suffered secondarily from rejection by her
father. She hinted at this in the second session in discussing her relationship with her boss.) Zora had believed in childhood that she should relieve her mother of her burdens, and that since she could not do this she was a failure. She also suffered from survivor guilt: She believed that if her mother was so burdened, she herself had no right to be happy. In her first session she tested the therapist by tempting him to feel burdened by her and worried about her, as she had felt with her mother, and she was relieved when he did not do so.

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

**THE PATIENT’S REACTIONS TO THE THERAPIST**

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

Sometimes the therapist may gain confidence in his approach when the patient reacts to just a single passed test or a single pro-plan interpretation. This may be illustrated by the case of Kenneth Y., described above. The therapist inferred from his feeling so capable during the first few sessions that Kenneth was unconsciously worried about him and attempting
to bolster his (the therapist’s) self-esteem. When a few weeks later Kenneth showed relief after the therapist pointed out Kenneth’s worry about him, the therapist gained confidence in this inference.

Another example of this occurred early in the therapy of Zora T., the patient who during her first hour described her situation as bleak. The therapist, assuming that Zora was testing him in the hope that he would not feel burdened by her misery, maintained an optimistic attitude. In the next session Zora confirmed the correctness of the therapist’s approach by being more cheerful and by revealing that she had an important job and enjoyed her work.

Still another instance occurred early in the therapy of Thomas C., the patient who during the first hour chatted casually with the therapist and offered little or no information about his problems. The therapist inferred that Thomas was testing him in the hope that unlike his stern parents, the therapist would not be worried about his casual approach. The therapist behaved as casually as Thomas. A few sessions later Thomas confirmed the correctness of this approach by reporting that he had begun to work harder, and a month later by revealing that in childhood he had felt constrained by his stern parents.

OTHER CASE EXAMPLES

In the following examples I show how the therapist during the first few sessions develops hypotheses about the patient’s plan, including his pathogenic beliefs and his goals.

Janice D.

From the beginning of treatment, Janice D. was aware of some parts of her plan but not of others. Janice, a young woman of Japanese ancestry, began her first session with a female therapist by stating that she was seeking treatment in order to obtain support for her decision not to return to her husband. She continued that her husband was a severe alcoholic, loving when sober but abusive when drunk. He was in Canada, hiding from the police for having
killed a man in a drunken brawl. However, he was planning a secret visit home in a few weeks, and Janice feared he would persuade her to return to him.

In her opening remarks, Janice revealed her immediate goal for therapy, but was not conscious of the pathogenic beliefs that she feared would prevent her from realizing it. However, in the first few sessions Janice provided the therapist with enough information to infer one such belief, which was that she deserved to be abused. She stated that she had been severely beaten by both parents from an early age, but only “when I was bad,” and also that she had been in numerous affairs with abusive alcoholic men. A few months before she began treatment with her present therapist, Janice had been seeing an elderly male therapist who told her that in her married life she was recreating the experiences of her childhood. She had felt tortured by this therapist and had dreamed that she wanted to kill him. She also had dreamed that she wanted to kill her husband.

From all of this, the therapist inferred the following: Janice had first acquired the belief that she deserved abuse from being abused at an early age by her parents, her first and most absolute authorities. This inference was supported by Janice’s statement that her parents only punished her when she was bad, for by this statement she implied that she deserved their punishments. Janice had felt tortured by the previous therapist because she had experienced his interpretations as blaming her for her unhappy marriage, and thus as confirming her pathogenic belief that she had been “bad” and so provoked her husband to mistreat her.

In her dream that she wanted to kill the previous therapist, Janice was telling herself something that she could not quite face in her waking life (see Chapter 7). She had been so compliant to the therapist that she had not let herself become fully conscious that she hated him for implying that she was responsible for her husband’s abusing her. It was for similar reasons that she dreamed she wanted to kill her husband. In her waking life, she assumed that she deserved his abuse and so had no right to hate him for it.

The therapist was able to confirm the correctness of the inferences cited above by noting Janice’s responses to certain interpretations. Several weeks after the opening sessions, the therapist told Janice that she had been mistreated by her husband and emphasized that she did not deserve this. Janice’s immediate response was to become more cheerful and optimistic. That night she dreamed that an old male physician had done a bad job in sewing
up her scalp wound, and now a loving nurse practitioner would help her to heal it.

In the session after the dream, Janice showed that she had made good use of her therapist’s comments by revealing that in childhood her parents had sometimes beaten her without apparent cause. A week later Janice tested the therapist by appearing to be losing her resolve to stay away from her husband. She stated blandly that she expected to remain friends with him and to see him occasionally. She was immediately relieved when the therapist challenged the wisdom of this plan.

**Francine A.**

Francine A. was similar to Janice D. in that she came to therapy because she wanted to leave her husband. However, she was unconsciously so guilty about this (she felt omnipotently responsible for her husband’s happiness) that she began therapy by stating the opposite—namely, that she wanted to work at improving her marriage. Nonetheless, Francine provided the therapist with considerable indirect evidence for her real goal. Though she tended to blame herself for her unhappy marriage, she indicated by her description of her husband that he was almost impossible to get along with. She depicted him (albeit not explicitly) as not interested in her, and as lazy, passive, ungiving, and blaming.

Francine also gave evidence that she had learned in her childhood relationship with her mother to take a great deal of responsibility for others. She remembered her mother as depressed and demanding. Her mother had expected her to spend a lot of time with her, to cheer her up, and to comfort her. When Francine did not do these things, her mother would accuse her of selfishness, and she would accept her mother’s accusations.

From the available evidence, the therapist could not be certain that Francine wanted to get a divorce. However, he inferred that her minimal goals were to stop blaming herself for her marital unhappiness, to see her husband more clearly, and to develop the right to pursue her own interests without believing that to do so was selfish. The therapist received some confirmation of this formulation from Francine’s reaction to his first few interpretations. When he pointed out her exaggerated sense of responsibility for her husband, Francine was relieved. A few weeks later, she told the therapist that she wished to devote more time to her oil painting.
Kirsten C.

Kirsten C. began her first session with a tentative statement of her immediate goal, and in addition provided the therapist with enough information to permit him provisionally to infer certain of her pathogenic beliefs. Kirsten began by saying that she had received her M.B.A. a year before. Most of the members of her class now had good jobs, but she was reluctant to look for one. She wondered whether she really wanted to work. Sometimes she thought she did not; other times she thought she did. She did not know why she was reluctant to look for a job. Maybe she was afraid of making mistakes. If a supervisor reprimanded her for an error, she might burst into tears and run out of the room.

At that point, the therapist asked the patient whether she had ever previously behaved in that way. She was silent a minute and then remembered that years before she had felt vulnerable toward her mother. She could not oppose her. She believed whatever her mother told her, even about how she (the patient) felt. For example, the patient had hated summer camp, but she would temporarily believe that she liked it after her mother told her she did.

Later in the same session, Kirsten complained that her parents were not interested in her successes. When she was accepted for the M.B.A. program at Stanford, she telephoned her parents excitedly. Her mother’s first reaction was to tell her not to yell into the phone. Later, when in business school, she had been reluctant to discuss her school work with her parents. She thought of the phrase, “I did not want to rub their noses in it.” She stated that she was not sure what she meant by that. When encouraged by the therapist to think about it, she stated that neither of her parents had enjoyed their work. She, on the other hand, wanted to be excited about her work. However, her parents would probably disapprove of her feeling excited because it would show them how unlike them she was.

Kirsten added that if she enjoyed her work she would also be different from her younger sister, who had experienced serious problems since her first year of high school. She had done badly in school and been heavily into drugs. Addiction ran in the family. The father was addicted to food and was obese.

From the information offered in the first hour, the therapist inferred that Kirsten had come to therapy because she wanted to get a job. She did not realize how strongly she wanted one, for fear that she would hurt her parents and her sister. She considered her parents weak; in order to protect her mother, she had made herself
highly vulnerable to her mother's reprimands. She feared that she would do the same with supervisors at work. She also feared that if she enjoyed work she would hurt her parents and sister by making them envious.

Kirsten felt omnipotently responsible for her parents, suffered from separation/individuation guilt toward her mother, and felt survivor guilt toward her entire family. She was avoiding getting a job in order to protect her parents. This formulation, tentative and general as it was, proved a good guide to technique. As the rest of the therapy demonstrated, it was essentially correct, although incomplete and lacking in detail.

**PLANS IN BRIEF TIME-LIMITED PSYCHOTHERAPY**

The patients our group studied in brief time-limited (16-session) psychotherapy selected themselves for brief therapy. They responded to an advertisement offering brief therapy to persons who would agree to have their therapies recorded for research purposes. The therapies were to be carried out by experienced therapists at a modest fee.

In the 10 brief therapies I studied informally from transcripts, the patients made limited plans suited to the time limitations of their therapies. Their plans were much more limited than those made, for example, by patients entering analysis. One patient planned to receive help in overcoming her guilt about leaving an abusive spouse. Another patient planned to obtain help in overcoming the separation guilt she felt toward her mother, so that she could obtain a satisfactory job.

During treatment, the brief therapy patient works to carry out his plan in the same ways that the patient in long-term therapy does—that is, by testing his therapist, and by using his interpretations to gain insight into his pathogenic beliefs and goals.

As discussed at greater length in Chapter 8, we used formal quantitative methods to study the therapies of four patients who were treated in brief therapy (Edelstein, 1992; O'Connor, Edelstein, Berry, & Weiss, 1993, in preparation; Weiss, 1993, in press). In each instance, the patient made his plans (goals) clear
to the intake worker and then, in the first therapy session, to the therapist. In the following sessions, he seemed to lose insight into his goals, and he also made false (anti-plan) statements about himself. In the middle of his therapy, each of the four patients seemed to lose all insight into his goals. However, toward the end of therapy, the patient once again made his goals relatively clear.

For example, one patient strongly implied during her first session with the therapist that she wished to become less involved with her sick husband and to get a job. Then she began to raise objections to getting a job, claiming that she had never been trained for any sort of work, and thus was unfit to work. Toward the end of therapy the patient again became clear about her wish to obtain a job, and she assumed that she deserved to obtain one. In the last two sessions, she spoke with evident pride about obtaining several interesting jobs.

Our research findings in these four cases strongly support the idea of unconscious planning. Our findings may be explained by the idea that the patient wishes to achieve as much as possible in the time allotted to him. Therefore, in the first therapy session he makes his goals clear to the therapist, so that the therapist can help him to pursue them. Afterward he tests the therapist by seeming to lose insight into his goals or by raising objections to his seeking them, hoping that the therapist will continue to support his pursuit of them. As he gains confidence in the therapist, he tests him more vigorously by losing more insight. Toward the middle of treatment, he appears to lose all insight into his goals. Then, toward the end of his treatment, knowing that he will soon not have a therapist whom he can rely on to pass his tests, he stops testing through losing insight. Indeed, in some instances he tests by acknowledging progress, hoping that his therapist will be pleased by his progress.

In a fifth therapy that was studied after this book was written, the patient also lost insight during the course of her therapy. However, a parabolic curve did not significantly fit the raw scores due to greater variability in insight throughout the therapy. The plot of smoothed scores, however, indicated that the pattern was also parabolic, though less dramatically so. The quadratic regression closely approached significance ($p = .052$ for the quadratic term in the regression).
In a study of three brief therapies (Fretter, 1984; Silberschatz, Fretter, & Curtis, 1986), we demonstrated that the proportion of pro-plan to anti-plan interpretations given to the patient was related to the success of the therapy as determined 6 months after the termination of treatment. The patient who received the highest proportion of pro-plan interpretations did the best. The patient who received the next highest proportion of pro-plan interpretations did the second best. The patient who received the lowest proportion of pro-plan interpretations did the worst.

In the brief therapies that we studied, as in long-term therapies, the patient sets the agenda. In both and long-term therapies the patient, by his statement of his goals at the beginning of treatment and by the ways that he tests the therapist during treatment, permits the therapist to infer how the patient unconsciously wants to be treated, and thus how the therapist may best treat the patient.

\footnote{Fretter's work was supervised by Curtis and Silberschatz.}