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**THE DEVELOPMENT OF PATHOGENIC BELIEFS  
THAT RESULT IN CHRONIC DEPRESSIVE DISORDERS:  
A CONTROL MASTERY FORMULATION**

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## **Abstract**

This paper presents a preliminary exploration of the development of pathogenic beliefs that result in chronic depressive disorders. Psychodynamic conceptualizations of endogenous depression are reviewed and an overview of control mastery theory is presented. Conditions are described that may result in the formation of specific depressogenic pathogenic beliefs. Further research is indicated to examine the process by which these core beliefs are identified and disconfirmed in a therapeutic setting, thereby enabling patients to experience greater affective range and to pursue healthy life goals.

## **Conceptualizing Depression**

Depression is defined as an affective disorder, and is characterized by inhibition and repression of expression and even experiencing of emotions. Its primary symptoms include feelings of sadness and emptiness, social isolation or withdrawal, anhedonia, lack of goal-directedness, a sense of helplessness and hopelessness. Depressed people are acutely aware of the poverty of their intrapsychic and interpersonal lives, but feel unable to make significant changes. Dysthymia, defined as long-term mild to moderate depression, is particularly insidious because it becomes almost characterological, with depressive attitudes and affect entrenched in one's way of viewing and being in the world. While many depressed people function adequately in the world, and are not always visibly depressed to others, depression can be quite debilitating to those who suffer from it, keeping them from attaining satisfying goals and relationships and severely

impacting their ability to enjoy and participate in life. The writer William Styron (1990) describes his long-standing battle with severe depression, which culminated in his seeking hospitalization to prevent himself from acting on his suicidal impulses. His account demonstrates how pervasive, debilitating and even life-threatening chronic depressive disorders can be.

While it is currently commonly acknowledged that there is a biochemical component to at least some depressions, it is difficult to sort out the biochemical from the environmental. Gabbard (1994, p. 220) reviews several studies that indicate that early life stressors may create a heightened neurobiological sensitivity to subsequent loss or abandonment. These studies likewise suggest that this neurochemical sensitivity may be ameliorated by psychotherapy and by sustained corrective experiences. While recognizing the biochemical component, this paper conceptualizes chronic or endogenous depression from a psychodynamic standpoint, as resulting from inadequate early relationships and early life experiences of loss, abandonment or perceived rejection.

Freud (1917) discussed the psychological phenomenon that he named melancholia, or "pathological mourning," which he described as resulting from incomplete or inappropriate mourning of a loss. This is to be distinguished from a healthy process of grieving or bereavement. According to Freud,

"The distinguishing mental features of melancholia are a profoundly painful dejection, cessation of interest in the outside world, loss of the capacity to love, inhibition of all activity, and a lowering of the self-regarding feelings to a degree that finds utterance in self-reproaches and self-revilings, and culminates in a delusional expectation

of punishment." (1917, p. 244)

The symptoms of mourning are the same, Freud notes, except for the absence of disturbance in self-regard. And while the duration of mourning may vary, it typically lasts for only a finite time, after which a healthy interest in life resumes and the libido attaches to other objects. Melancholia is thus characterized by an inability to grieve, to proceed with the complexity of the mourning process. The griever is thus frozen in the painful state that Freud described, and will remain there until the loss is fully acknowledged and properly mourned.

Freud also noted that the loss of a significant object, whether through death or another type of abandonment, is likely to evoke anger on the part of the griever for having been left. But because the lost object has internalized, there is now "an identification of the ego with the abandoned object" (Freud 1917, p. 249) such that the griever turns the anger inward toward herself, where the lost object now resides. Freud described "the marked self-depreciation common in depressed patients as the result of anger turned inward" (Gabbard 1994, p. 223).

Bowlby (1980) likewise distinguishes between sadness and temporary depression on the one hand, and chronic depression on the other. He notes that depression occurs when there is a cessation of "active interchange between ourselves and the external world, either in thought or action" (1980, p. 246). Depression will continue until "new patterns of interchange have become organized towards a new object or goal" (1980, p. 246). Lack of successful striving toward goals is thus seen as a

crucial component of depression.

Depressive disorders are often characterized by a sense of helplessness in relation to one's life and world; and especially about one's capacity to establish and sustain important relationships. Bowlby (1980) cites three types of early life experiences that may result in such a disorder: the experience of never having had a stable and secure relationship with one's parents; having been told over and over that one is unlovable, inadequate or incompetent; or having sustained actual loss of a parent.

Guidano (1987) identifies three common dysfunctional patterns of attachment that result in depressive disturbances. The first two overlap with Bowlby: actual loss of a parent during childhood, and the experience of never having been able to attain a stable and secure emotional attachment. The third is inversion of the parent-child relationship, whereby the child becomes responsible for the care of the parent. According to Guidano, these dysfunctional attachment patterns cause a child to experience a lack of control over her environment, which is perceived overarchingly in terms of losses and failures. Continuous anticipation of such losses and failures is seen as a way of managing or forestalling the strong emotions aroused by the ongoing trauma to which the child is exposed. Depression can thus be viewed as an adaptive mechanism, however painful, that allows the child (and later, the adult) to function in an environment that she knows will not provide her with support or success.

In the models presented by Bowlby and Guidano, depression is the result of how one thinks about oneself, the world, and one's interactions with others. This is consistent with Beck's (1967) theory that depressive disorders result from negative cognitive schemas. However, Beck makes no attempt to explain the etiology of such schemas, nor do cognitively based psychotherapies attempt to explore such origins.

Object relations theory understands depression as representing

"the ego's identification with 'bad' aspects of the parents which could not be reached through real exchange with the parents in the external world and thus were taken inside. . . . The re-creation of the sorrow, suffering, and defeat are forms of renewal of and devotion to these ties. Reluctance to betray these attachments through new relations and allegiances impedes constructive change in living. . . ." (Greenberg and Mitchell 1983, p. 174).

Control mastery theory is a psychodynamic theory with a strong cognitive component. This model does not posit a theory of depressive disorders, but rather locates the source of all distress and psychopathology in pathogenic beliefs. These are deep unconscious beliefs about oneself and the world which derive from early childhood experiences with parents or other caregivers. Thus a formulation of chronic depression from a control mastery perspective is compatible with the views presented here.

#### **An Overview of Control Mastery Theory**

Control mastery can be described as "a cognitive-interpersonal psychoanalytic theory which assumes that psychopathology results from unconscious pathogenic beliefs" (Bush 1993, p. 11).

Pathogenic beliefs are compelling, grim unconscious beliefs that

Pathogenic Beliefs - Chronic Depression

warn a person that he will endanger himself or others if he pursues normal, healthy developmental goals. These beliefs develop in childhood as a result of early experiences and relational patterns with parents or other primary caregivers. Pathogenic beliefs persist throughout adulthood, steering a person away from successful pursuit of the goals which he early on determined were dangerous to strive for.

Pathogenic beliefs may develop as a result of patterns of interaction with parents, such as a parent repeatedly criticizing or becoming angry at a child for being too energetic, or too assertive. In such cases the child may form a belief that being energetic or assertive will cause her to be rejected or disliked by others, and she will thus unconsciously repress her energetic or assertive impulses. Alternatively, pathogenic beliefs may result from a traumatic event such as the death or abandonment of a parent. In this case, the child may unconsciously feel responsible for the parent's death or absence, especially if she had harbored any negative or hostile feelings toward the parent. The child may then come to believe that her hostility or anger, or simply some "badness" on her part, endangers others. This belief persists not because it is plausible, as in the first sequence by which pathogenic beliefs develop, but rather because the perceived consequences of her real or imagined behavior are so extreme (Weiss and Sampson 1986, p. 71). The child may also come to believe that any attempts on her part to rectify a bad situation will be futile, since no amount of wishing or "being good" was able to save the parent.

### **Examples of Pathogenic Beliefs**

Pathogenic beliefs begin as specific to a situation or relationship, but over the course of time generalize to situations and relationships that are perceived as similar. For example, an energetic, lively child has a depressed mother who can not tolerate her level of energy and who constantly tells the girl to be quiet, stay out of her way and not disrupt the mother. This child may develop a belief that her liveliness is harmful to her mother, and that if she expresses it she will be rejected by her mother. Over time that belief may generalize, so that she comes to believe that her playfulness is a bad quality in and of itself and that she must keep it suppressed if she wants to sustain any relationships (Engel and Ferguson 1990, p. 20).

A pathogenic belief often connects a normal developmental goal with dire consequences. A child whose widowed mother is depressed and lonely and clings to her young son for comfort may develop the belief that he will harm her, and suffer guilt himself, if he attempts to pursue friendships or activities. The child might forgo such pursuits, remaining overly attached to his mother. Over time this pathogenic belief will generalize, such that as an adult striving to develop other intimate relationships, he may believe that he will harm others or lose relationships if he attempts to exercise any independence or puts his own needs above those of others. He will therefore refrain from doing so in his relationships, and will thus repress his desire for autonomy or attainment of goals that he perceives to be "selfish."

## The Therapeutic Process

Control mastery theory posits that patients in therapy are strongly motivated, both consciously and unconsciously, to disconfirm their pathogenic beliefs. The therapist's task, then, is to help the patient to identify and disprove her pathogenic beliefs and to pursue the goals that these beliefs stand in the way of (Weiss 1993, Weiss and Sampson 1986). In therapy, patients continually assess their psychological safety, lifting repressions and producing formerly warded-off material only when they feel adequately safe to do so. Psychological safety in this model is seen not only a requirement for facilitating change, but as "the only requirement for change: the theory proposes that people are motivated to relinquish their pathology and that they will do so to the extent it seems safe to do so" (Rappoport 1997, p. 250).

Patients assess safety in the therapeutic process primarily by setting unconscious tests for the therapist.

"Weiss theorized that patients come into therapy with an unconscious therapeutic strategy or plan to overcome their pathogenic beliefs by testing them in therapy, in relation to the therapist, by transferring and turning passive into active. Weiss asserted that testing the therapist established conditions of safety in the therapy to allow the patient to become aware of his traumatic past, to become clear about his pathogenic beliefs, and replace them with more accurate versions of self and others, and thereby free himself of symptoms and inhibitions consequent to pathogenic beliefs." (Foreman 1991, p. 21)

To the extent that the therapist is able to pass the patient's tests, the patient will become less anxious, have access to greater depth of feeling, and will be more likely to experience the emergence of warded off material. When a therapist fails

tests, on the other hand, the patient will be likely to experience increased anxiety and defenses, with a decrease in the emergence of warded off content (Eagle 1984, p. 97).

### **Patient's Unconscious Plan for Therapy**

According to control mastery theory, patients enter therapy with an unconscious plan by which to disconfirm their pathogenic beliefs and relieve their psychological symptoms and distress. The model "views psychotherapy as the carrying out of the patient's plan to overcome dysfunctional behavior patterns, which are seen as adaptations to early, dangerous interpersonal situations" (Rappoport 1997, p. 250). According to this theory, each patient's plan is specific to her particular pathogenic beliefs, but consists generally of testing and working with the therapist to disconfirm these beliefs and to remove obstacles to pursuing normal, healthy goals. However, it seems likely that in fact patients present with an unarticulated hope rather than with a clear unconscious plan. Patients test in the context of their pathogenic beliefs, then, because these beliefs are the way in which people organize their mental structure and mode of relating.

### **Centrality of pathogenic beliefs**

Guidano (1987) noted that depression is adaptive in that it allows one to function in a restrictive environment that does not support expression or striving. This view is consistent with control mastery theory's stance that people are highly motivated to adapt to their interpersonal worlds, and that the development of pathogenic beliefs is an adaptation to perceived reality.

Such beliefs typically develop out of an accurate assessment of the parent's expectation or behavior, and provide the child with guidelines by which to behave in order to maintain ties with the parent. Later in life these beliefs are no longer necessarily accurate; it is then that people begin to assess the safety of disconfirming their pathogenic beliefs.

According to control mastery theory,

"pathogenic beliefs are the essential element, the sine qua non, of psychopathology, and variations in psychopathology reflect variations in pathogenic beliefs. . . . Also, the most fundamental way of describing a problem is in terms of its underlying pathogenic beliefs. It may be useful, in describing certain kinds of psychopathology, to consider such attributes as the capacity to develop object relations, the capacity to maintain transferences, and the capacity to repress. However, such attributes are themselves reflections of underlying pathogenic beliefs" (Weiss and Sampson 1986, p. 325).

Within the framework of this model, then, depressive disorders result from specific pathogenic beliefs. These beliefs guide the way a person manages her interpersonal and intrapsychic world; how she relates, behaves and strives toward healthy goals. Certain kinds of pathogenic beliefs, if not challenged, may perpetuate depressive symptoms such as anhedonia, sadness or emptiness, feelings of worthlessness or guilt, diminished ability to concentrate, make decisions or pursue activities, and feelings of hopelessness.

#### **How Pathogenic Beliefs Develop into Depressive Disorders**

Psychodynamic theories account for the origin of depressive disorders in the context of early interpersonal disturbances, with resulting disturbances in self-perception, self-regard, and expectation from the external world. However, no theory attempts

to explain the process by which a depressive disorder develops as a result of these relational disruptions. One can trace this process by examining pathogenic beliefs that develop from depressogenic scenarios, and the specific repressions and inhibitions that these beliefs put in place which result in chronic depressive states. The components of this process are as follows: a statement or behavior by the parent, or a traumatic event; the child's perception of himself in relation to the above and the resulting belief that he forms; specific repressions and inhibitions that follow from the pathogenic belief and that result in chronic depressive symptoms.

Mancuso (1995) studied children who had lost a parent to death. She found that many of them believed that they had caused the death by being "bad" in some way. She cites Nagy's (1948) studies in which children believed that their own aggressive actions or "evil wishes" had contributed to or caused the parent's death. Several of the children interviewed by Mancuso also expressed the belief that if a parent could die, then other bad things could happen as well, thus one was powerless to pursue one's own goals, at the mercy of fate.

In these cases, the traumatic event was the death of a parent. The resulting belief was that the child's bad behavior or aggressive wishes caused the death. The specific repressions and depressive symptoms that might develop would vary according to each child's personality and circumstances. Further, Mancuso's study showed a strong negative correlation between parent-child communication and level of irrational thinking in

regard to the child's perceived responsibility for the other parent's death. The children interviewed by Mancuso also expressed generalized beliefs that their feelings upset others and that they were responsible for the well-being of others. These beliefs might cause a child to develop a pattern of repressing her anger or other emotions perceived as negative; being overly solicitous of others and putting her needs and goals secondary to those of others; clinging to others and rejecting autonomy in a fearful attempt to maintain relationships. The poverty of emotional and interpersonal life that these repressions create may result in chronic depressive symptoms such as feelings of emptiness and sadness, anhedonia, withdrawal or isolation, and feelings of helplessness and hopelessness.

#### **Clinical Examples of Depressogenic Pathogenic Beliefs**

Several clients seen by this author in clinical settings have presented with chronic depressive symptoms, typically a pervasive dysthymia overlaid with intermittent major depressive episodes. These clients reported persistence of symptomatology despite many years of intermittent psychotherapy and antidepressant medication. Examining these clients' pathogenic beliefs helps to explain the entrenchment of depressive affect and symptoms.

One client, a 44-year-old woman, had suffered from depression since adolescence. She had been treated intermittently with medication and therapy for 25 years but claimed that her symptoms remained severe. This woman's father had committed suicide when she was fourteen, just before Christmas (a traumatic event). The client's mother refused to

discuss his death and forced the family to "put on a mask" and celebrate the holidays as usual (behavior by the parent). The client had last seen her father a year before his death, and had refused to talk to him because he was drunk (another traumatic event for a 12-year-old). She developed a pathogenic belief that her father had killed himself because she rejected him; this belief extrapolated into a generalized belief that her anger or negative feelings would destroy others. Her mother's refusal to discuss the death or allow mourning instilled a pathogenic belief that expressing emotion was intolerable and would disrupt the family system. This generalized into a belief that no one could tolerate her emotions and so she had better hide them.

In this example, the behavior by the mother exacerbated the trauma of the father's suicide and strengthened the child's resulting pathogenic beliefs. These beliefs resulted in an inhibition of emotional expression, with a corresponding need to appear cheerful and socially proper. They also created a severe relational disturbance, such that the client was not able to seek out stable affectional relationships out of fear that her negative emotions would destroy any intimate relationships. The paucity and inauthenticity of life that these restrictions imposed created chronic depressive symptoms, including intermittent suicidal impulses in this case.

Another client, in her 50s, also reported that years of psychotherapy had not eradicated her depressed mood, difficulty striving for goals, or feelings of hopelessness and worthlessness. This woman's parents were both physically abusive

toward her, and her mother was critical and neglectful (behaviors and statements by parents). The mother also gave up her own artistic ambition to be a housewife to a series of abusive men (a behavior not directed at the child, but from which the child makes inferences about how to be in the world). The client stated that even now whenever she thought of disagreeing with her mother or asserting her own needs, she anticipated the mother slapping her across the face and accusing her of being selfish and stupid. This client developed a pathogenic belief that she could only sustain relationships if she refrained from expressing her opinions and feelings. She also believed that she was selfish if she asserted her desires or needs. Further, she believed that it was wrong and selfish to pursue her own artistic ambition. In adherence to these beliefs, this client remained passive and neutral in her relationships, and did not pursue goals relating to her art or to other career or financial goals. The repressions created by her pathogenic beliefs, and the internal and external restrictions that they imposed, resulted in chronic depressive symptoms that had proven intractable despite 25 years' intermittent psychotherapy and five years of antidepressant medication.

One 27-year-old woman complained of having been depressed since early adolescence. Through years of psychotherapy she had learned to manage her symptoms, but her dysthymia persisted, causing her acute distress. This client's father died when she was twelve (a traumatic event), and her mother continued to run the family "just business as usual," allowing no room for

grieving (behavior by the parent). Prior to the father's death, the client's outspokenness and expressions of anger had earned her the position of scapegoat and identified patient within the family (behavior and statements by parent). The client formed pathogenic beliefs that no one could tolerate either her dissident opinions, her anger, grief or depression; and, because she had not been permitted to express herself in a genuine way and had lost her parents' regard when she attempted to do so, that she was isolated and disconnected and would never be able to form satisfying lasting relationships. These beliefs resulted in an inhibition of emotional expression and a distancing from others. Yet because the client still yearned for authentic expression and intimacy, her inhibitions resulted in chronic depressive symptoms.

#### **Implications for Clinical Practice**

Weiss (1993) provides an example of a depressogenic pathogenic belief and the way in which it is uncovered and explored in a therapeutic setting. During the course of the therapy, the analyst determined that a patient held a conviction that she deserved to be rejected. She invited the therapist to reject her time after time with requests to change their schedule and with statements that she intended to end treatment. When the therapist urged her to continue treatment, the patient gained access to a memory of her mother sending her out to buy groceries despite the eruption of gunfire in the neighborhood, leading her to believe that her mother wanted her to be killed. This behavior by the parent is seen as the source of the patient's

belief that she deserved to be rejected. According to Weiss, the therapist's interventions

"focused [the patient's] attention on her belief that she would be rejected. However, she was not able to face this belief affectively or to remember its origins in her childhood traumas until the analyst passed a difficult rejection test" (1993, p. 47).

The persistence of chronic depressive disorders in many patients despite extensive treatment with both psychotherapy and medications suggests an intractability to the disorders that has not yet been explained. Within the framework of this model, one can posit that failure in the therapeutic process occurs when conditions of safety are not sufficiently established, or when key organizing beliefs are not accurately identified and challenged. The model presented provides a focus for understanding the patient's mental functioning and ways of correcting it both through interpretations and enactments. Detailed analyses of therapies with chronically depressed patients would add to the body of empirical research conducted by control mastery proponents and would demonstrate the specific ways in which pathogenic beliefs were identified and disconfirmed, with corresponding reduction in depressive symptoms.

#### **Limitations of the Model**

Adhering exclusively to any one theoretical model necessarily results in a limited perspective. Control mastery provides a useful way of conceptualizing a patient's mental functioning and of conducting the therapeutic process. However, because the model is rooted in Freud's early theory of the unconscious and

repression, adequate understanding of control mastery requires familiarity with Freudian theory as well as with various psychodynamic theories derived from Freud. A clear knowledge of object relations and transference/counter-transference dynamics is requisite to understanding the complex concepts of pathogenic beliefs and testing within the therapy. The control mastery literature tends to present these concepts in an overly simplified fashion that belies their actual depth. Ideally, a control mastery formulation would be an organizing principle within a broader context of psychodynamic theory. While inferring the pathogenic beliefs held by depressed patients, it is useful to hold in mind concepts central to the understanding of depression, such as incomplete mourning, introjected anger, and learned helplessness, to see how they fit into the patients' core belief systems. Although control mastery allows for the incorporation of such conceptualizations, it does not inherently direct one toward them.

### **Ethical Considerations**

A therapist must always consider whether a specific approach is indicated for a particular patient. In treating chronically depressed patients, key concerns include whether antidepressant medication is indicated and whether there is a risk of suicide or extreme decompensation. Patients with severe disabling symptoms may need immediate relief in the form of medication or hospitalization and may not be able to participate right away in a psychodynamic therapy. A therapist should look first for evidence of biochemical disturbance or clear precipitating

circumstances and should not impose a model blindly where it may not be indicated.

### **Vision of Human Change Process**

Control mastery theory holds an essentially optimistic view of human nature and the capacity for change. The model states that people's primary motivation is to adapt to their interpersonal worlds. Pathogenic beliefs develop as adaptive mechanisms that enable people to survive in hostile environments. Once it is demonstrated that these beliefs are no longer adaptive or necessary, people work to disconfirm them and to pursue healthy goals. Change is seen first in the therapeutic relationship: anxiety decreases and emergence of warded off material increases. There is then a decrease in symptomatology, with changes occurring in the patient's world outside the therapy. The patient develops a greater capacity to pursue life goals and affectional relationships. Change, then, is reflected in both reduction of depressive affective symptoms and in increased participation and enjoyment in normal life activities and pursuits.

### **Epistemological Assumptions; Implications for Worldview**

One of the primary assumptions of control mastery theory is that the unconscious exists and that its contents can be known. The model assumes that a therapist can accurately identify a patient's unconscious beliefs and their origins. This is true of all psychodynamic theories, whether the mental contents are categorized as pathogenic beliefs, object representations or narcissistic needs. Extensive empirical research has been

conducted of analyses using control mastery formulations (Weiss and Sampson 1986); such research is both laudable and tautological in that it operates within a closed system. This dilemma exists in all models that accept the concept of the unconscious, which can never be objectively proven or quantified.

There are also developmental assumptions inherent in control mastery theory, in that the model assumes that early life events have a significant and often unconscious effect on the shaping of the personality. Specifically, "the notion of pathogenic belief in control mastery is a key developmental proposition" (Shilkret 1992), in that the theory assumes that the development of pathogenic beliefs is central to the formation and organization of personality. Control mastery also is rooted in a constructivist stance, in that it assumes that people are motivated to construe and understand experience in their own terms (Shilkret 1992, Sampson 1992) and to act according to their unique understanding or construction.

### **Summary**

This paper presented an overview of psychodynamic understanding of chronic depressive disorders and of control mastery theory. The formation of specific pathogenic beliefs was posited as key to the development of endogenous depressions. Possible paths by which such beliefs develop were described. Further research is invited to illuminate the process by which pathogenic beliefs are identified, brought to consciousness, and disconfirmed in the therapeutic relationship. Such research could prove invaluable in treating hitherto intractable chronic depressive disorders.

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