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Features of Pathogenic Beliefs in the Context of Childhood Maltreatment: Implications for Therapeutic Empathy

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ABSTRACT

One reason why patients may seek therapy is to address constricting beliefs about themselves, others and the world that diminish the quality of their lives. These pathogenic beliefs interfere with the pursuit of personal goals and are often the source of considerable distress. In this paper, we discuss the perspective from Control-Mastery Theory that such beliefs were once adaptive in the context of earlier traumatic relational experience, and are often held in place by loyalties and attachment ties to important figures. Therapists can facilitate patients' efforts to disconfirm these beliefs by empathically understanding the form and function of the patient's pathogenic beliefs historically and in the present. Such understanding is termed "person empathy" and is found to contribute to positive therapeutic outcomes. With the aim of helping to facilitate therapists' empathy regarding patients' pathogenic beliefs, we describe in this paper some of the original functions and subsequent consequences of such beliefs in patients' lives.

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Introduction

One reason why patients may seek therapy is to address contrasting beliefs about themselves, others and the world that diminish the quality of their lives (Weiss, 1998). These pathogenic beliefs interfere with the pursuit of personal goals and are often the source of considerable distress. For example, the patient who believes that getting close to another leads to shame and rejection will find it very difficult to initiate and participate in loving intimate relationships. So why do people develop these beliefs in the first place, and subsequently adhere to them? In this paper, we discuss the perspective from Control-Mastery Theory (CMT) (Gazzillo et al., 2019; Silberschatz, 2005; Weiss, 1993) that such beliefs were once adaptive in the context of earlier traumatic experience, and are often held in place by loyalties and attachment ties to important figures. By understanding various features of pathogenic beliefs, including their adaptive and developmental origins, therapists may be better equipped to empathically and

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creatively help their patients overcome them. In this paper we describe the original functions of pathogenic beliefs in patients' early development along with their subsequent consequences in patients' lives. We limit this discussion to patients who experienced maltreatment by their caregivers because such incidents often result in the development of powerful pathogenic beliefs that can have longlasting adverse effects. Drawing upon principles of CMT, along with other psychoanalytic theorists (Fairbairn, 1943; Liotti, 1992, 2004), we suggest that maltreatment––particularly emotional and physical neglect and abuse––can create a challenging dilemma involving the child's need for their caregiver and need for self-protection, the experience of which may give rise to pathogenic beliefs. Clinical vignettes will be included to illustrate the utility of therapists' empathic understanding of––and therapeutic responsiveness toward––patients' pathogenic beliefs.

CMT (Gazzillo et al., 2019; Silberschatz, 2005; Weiss, 1993; Weiss et al., 1986) is a theory of mental functioning, psychopathology, and the therapeutic process that emphasizes perceptions of safety and danger in the pursuit of goals, adaptation to reality, and development of pathogenic beliefs. In the clinical context, CMT stresses that patients work in psychotherapy to achieve the goals they had to abandon earlier because they led to traumatic outcomes with their caregiver. "Goals" may be conscious/explicit or unconscious/implicit, often reflecting adaptive or healthy developmental achievements, particularly those that may contribute to the individual's subjective experience of satisfaction with life. Examples include reasonably positive and accurate self-esteem, a sense of autonomy, and the ability to achieve and sustain close and fulfilling relationships with others – though concrete goals such as having a job or choosing activities are also salient concerns from the perspective of CMT (Gazzillo et al., 2021). In the context of this paper, traumatic interactions refer to a caregiver's maladaptive or adverse treatment of the child, typically involving chronic or severe neglect of the child's needs or sensitivities, if not outright abuse. According to CMT, children may develop theories of what they did wrong to cause a caregiver's adverse treatment, and then adopt beliefs that turn those theories into rules for living that are subsequently constricting. These beliefs help the child predict their caregiver's hurtful response to pursuing a goal and guide the child to surrender the goal (Gazzillo, 2023). Later as patients in psychotherapy, individuals may be able to develop mastery over these beliefs or theories when their therapist responds in ways that counter the predictions of their pathogenic beliefs. CMT regards patients as having an unconscious plan to seek corrective experiences that could help them overcome the grim strictures of their pathogenic beliefs, and explains therapeutic success as the degree to which the therapist's responses facilitate the patient's plan (Weiss, 1998). Empirical studies into the process of psychotherapy show considerable support for this model (Bugas et al., 2021; Fimiani et al., 2022; Silberschatz, 2017; Silberschatz & Curtis, 1993).

Pathogenic beliefs are often tenacious because they warn the individual that violating the belief will somehow threaten their attachment bonds, themselves, and/or an important figure (Rappoport, 1996; Silberschatz, 2005). These beliefs shape the person's perceptions and are regarded as authoritative, contributing to confirmation bias whereby external reality is often seen through the lens of pathogenic beliefs (Gazzillo, 2023). Nevertheless, patients who seek psychotherapy are thought to be motivated to try to disconfirm pathogenic beliefs because they are linked with considerable suffering (Gazzillo, 2023; Weiss, 1998). They may do so through testing whether their beliefs are applicable in their relationship with the therapist (Gazzillo et al., 2019, Rappaport, 1997; Sampson, 1990). A test is a trial action aimed at determining whether the statement or prediction of a pathogenic belief is true, typically enacted for the purpose of disconfirm the belief so that the individual may feel safer in pursuing their goals. A patient tests a pathogenic belief in therapy by presenting information – usually unconsciously – that allows the therapist to respond in ways that either confirm or disconfirm the belief (Gazzillo et al., 2019). Via testing ––and through the therapist's empathically informed responsiveness––the patient may be able to obtain corrective experiences that help them to defy pathogenic beliefs without actually endangering their attachment relationships, and in so doing they may develop new insight and learning (Weiss, 2005). The CMT perspective regarding the patient's intrinsic motivation to overcome pathogenic beliefs, and their use of therapy to facilitate this objective, implies that the therapist's main objective is to intervene through their techniques, attitudes, and conduct to offer the patient information which contradicts and allows insight into their pathogenic beliefs. Thus, it is the collaborative task of patient and therapist to identify the patient's pathogenic beliefs, the traumatic circumstances under which they were formed, and to facilitate the patient's efforts to conclude that these beliefs are no longer necessary in the patient's current life.

Therapists can facilitate this learning process by empathically understanding the past function and current consequences of the patient's pathogenic beliefs. Such understanding has several benefits. First, it will help the therapist better appreciate the original relational traumas the patient endured that made their pathogenic beliefs so useful. Second, the therapist can more readily empathically resonate with the patient's perception of danger in defying these beliefs in the present. Third, such an understanding can inform how the therapist might optimally respond to help the patient become more hopeful about their goals and less inhibited in their personal development. In short, therapists' understanding of pathogenic beliefs represents a window into critical organizing principles of their patients' lives. This kind of perspective and understanding of the patient's psychology has been referred to as "person empathy" (Elliott et al., 2011) and is regarded as an important contributor to positive therapeutic outcomes. Indeed, individual studies have shown that

patients' perceptions of their therapist's empathy tend to be associated with improvement in symptoms (Snyder & Silberschatz, 2017; Vitinius et al., 2018; Watson et al., 2014), a finding that has been further underscored by meta-analysis (Elliott et al., 2018). Such findings indicate the value, from an empirical perspective, of therapists working to facilitate their patients' sense of being profoundly understood.

Why pathogenic beliefs develop

CMT proposes that children who are faced with dangerous situations are motivated to develop strategies designed to avoid such dangers in the future (Silberschatz, 2005; Weiss, 1993). Danger can come in a variety of forms – from external events that place demands on the child that outstrip their coping resources at the time (i.e. "shock trauma") to relational contexts that frustrate the child's needs for secure attachment and interpersonal safety (i.e. stress trauma) (Hesse & Main, 2000; Reid & Kealy, 2022; Silberschatz, 2008). Upon surviving such a danger or trauma, the child might develop a theory or belief as to why it happened and what they can do to prevent it from happening again.

Children have limited information they can consider to develop their beliefs. For example, a five-year-old child who sees his father regularly explode into rages at his mother could be flooded with feelings of fear, anger toward his father, confusion, and worry about he and his mother's safety. The child has to make sense of what is happening without the broader knowledge and psychological capabilities needed to accurately understand the forces that are beyond his control and contributing to this volatile and dangerous situation (e.g. his father's own inner world and contextual factors that lead him to react with rage rather than communicate in a constructive manner). Rather, a young child may rely only upon the limited information available about the causality of these events, and with a developmentally appropriate tendency to assume personal responsibility for events outside their control (i.e. egocentric thinking) (Gazzillo et al., 2019). Thus, the child in this example might conclude that he was to blame for his father's outburst and then search himself for the reason(s) why. The child might conclude that he was not paying close enough attention to his father's happiness, which led to the angry outburst. Next, the child will determine what he can do to prevent the danger of his father's rageful reaction from happening again. This strategy may come in the form of an "if-then" statement (Gazillo et al., 2022), such as "*if* I pay more attention to myself than my father *then* he will fly into a rage." Pathogenic beliefs can also function as declarative statements such as "I am defective" or "I deserve less than others."

According to CMT, children form beliefs that allow them to make sense of and operate optimally in their world, even if doing so might

come at some cost to the child's own development. Beliefs formed to avoid dangers or traumas are likely to become pathogenic––creating suffering and dysfunction––if they involve the child attributing their pursuit of a healthy developmental goal (e.g. "Asking for what she wants from others") as the cause of their endangerment or trauma (Fimiani et al., 2020). In other words, the child may associate their own developmental needs and strivings with a sense of foreboding, calamity, or impending danger (e.g., "I will be rejected"). Although our focus is on the traumas of caregiver abuse and neglect, there is actually a wide range of experiences beyond a child's control, from interpersonal difficulties with peers (e.g., being ostracized or bullied) to social structural problems (e.g., racism or poverty), that could potentially exert traumatic effects and contribute to the development of pathogenic beliefs.

Subsequent consequences of pathogenic beliefs

As implicit understandings of oneself and important others, pathogenic beliefs tend to persist into adulthood, influencing individuals' decision-making, interpersonal relationships, and sense of identity (Curtis & Silberschatz, 2005). Equally important to empathically understanding the traumatic origins of pathogenic beliefs is recognizing the extent of their current consequences in the patient's life. In broad terms, such consequences can involve avoiding, interrupting, and/or undermining patients' attempts to find and maintain satisfaction in relationships, work, and personal pursuits.

Case Example #1[1]

> Kim was in her mid-thirties when she came to treatment. She reported suffering significant childhood emotional neglect. She described her mother as excessively anxious and self-preoccupied and her father as emotionally remote; Kim felt neither were appropriately attuned to her needs. Kim coped with this absence of emotional nourishment by developing pathogenic beliefs about interpersonal engagement and attunement. She and her therapist inferred that she concluded something like, "If I get close to others then I will be gravely disappointed." Her life circumstances seemed to reflect her adherence to this belief, in that she spent most weeknights and weekends by herself, assuming that no one would really want her company. Her occasional enthusiasm for social interactions was often cut short by her own discouraged attitude and subsequent depression. Thus, Kim structured her life to avoid the old "danger" of disappointment that her pathogenic belief would predict.

Case Example #2

> Alan was in his twenties when he came to treatment because he felt anxious and aimless. He reported having had a chaotic and abusive upbringing. To avoid physical abuse he felt he had to put his father's needs ahead of his own. Doing everything in his power to make his father happy seemed to have provided him with some protection; his father was less inclined to accuse Alan of not "respecting him enough". Alan's pathogenic belief reflecting this chronic dynamic could be phrased as "My needs are less important than others'".
>
> In his current life, Alan excelled at meeting demands but had little sense of what happiness might look like for himself. He would often work late rather than delegate responsibilities to others. In his personal life, he would anxiously anticipate and meet the needs of his partner and friends. When he was not with them, he feared that his partner or friends had turned against him.

These two vignettes offer a simplified illustration of the development of pathogenic beliefs in response to trauma, and the consequences of living with pathogenic beliefs in a patient's current life. Such consequences dramatically constricted these patients' quality of life and were a major reason for their seeking of therapy. CMT suggests that the success of their therapies could be measured by the degree to which they are helped to identify, understand, and disconfirm their pathogenic beliefs––thereby mitigating the associated consequences and suffering (Gazillo et al., 2022). From this perspective, psychotherapy is seen as a way in which patients can make sense of their pathogenic beliefs and their origins in traumatic experience, for the purpose of developing new possibilities and pursuing adaptive life goals.

Facilitating safety for patients via empathic understanding of the function and consequences of their pathogenic beliefs

Feeling understood is a vital aspect of emotionally intimate and connected relationships (Reis & Shaver, 1988; Reis et al., 2017), including––for the patient––the psychotherapeutic relationship (Elliott et al., 2011). When a therapist has a grasp on the patient's developmental history, and how the patient has made sense of that history in ways that now compromise their quality of life, the therapist may be better able to respond in ways that demonstrate an appreciation and understanding for the patient's fears from the past along with hopes––some of which may be unconscious––for the future. Building on and empirically validating Carl Rogers (1975) foundational work on empathy in psychotherapy, Elliott et al. (2018) have called this kind of communicated empathic understanding *person empathy* or "a sustained effort to understand the historical and present context or background of the patient's current experiencing. The question is: How have the patient's experiences led

him or her to see/feel/think/act as he or she does?" (p. 402). Thus, it is important to have and to communicate an understanding of the patient that takes into account their historical stressors, associated perceptions and meanings, and efforts to cope or adapt.

We propose that therapists can help their patients feel understood by adopting an orientation toward appreciating the developmental conditions and contexts in which their pathogenic beliefs originally developed. This understanding––that pathogenic beliefs arise out of adaptation to adversity in the context of important relationships––can help the therapist to (1) avoid repeating similar traumatic interactions; (2) facilitate experiences within the therapy relationship that help master earlier traumas and associated pathogenic beliefs; and (3) respond to the patient in ways that convey empathy for and foster insight regarding the patient's adaptations. Taken together, these aspects of the therapist's behavior are thought to contribute to psychological safety, which in turn allows the patient to advance their plan for growth, mastery, and the pursuit of adaptive goals (Gazzillo, 2023; Weiss, 1998). It is important to note, however, that particular behaviors will facilitate safety in different ways for different patients, and at different timepoints, depending upon their individual goals, pathogenic beliefs, and associated traumas.

An appreciation for the developmental context of pathogenic beliefs also helps the therapist recognize that modifying them is likely, at least for some patients, to be incremental. The patient who is working to disconfirm a pathogenic belief is trying to change ways of thinking, feeling, and behaving that have held a longtime organizing influence. The patient may need to carefully test whether it might be safer than before to pursue goals that their pathogenic beliefs have warned them against. In responding to the patient's tests, the therapist may demonstrate a different possibility or outcome than that predicted by the patient's pathogenic belief. The therapist may also explore and explain the origins of the patient's pathogenic belief in an effort to promote insight. For some patients, such exploration could enhance reflectiveness, as they observe how their perceptions of self and others may have been filtered through pathogenic beliefs. This may in turn allow for consideration of alternative understandings, including those which may be more self-affirming. We propose that the therapist's empathic understanding of the original functions of the patient's pathogenic beliefs provides an important undergirding to exploratory and insight-oriented interventions. While it is important to contextualize the features and functions of pathogenic beliefs within each individual's unique developmental circumstances, several broad themes may be salient and useful to consider.

Key features of pathogenic beliefs in childhood

To support therapists' empathic understanding, we describe some theorized functions of pathogenic beliefs in patients' psychosocial development, along with their potential consequences and possible therapeutic implications.

Pathogenic beliefs protect the child's attachment needs

A child needs to experience their caregiver's attachment to them, yet this is jeopardized when their caregiver is abusive or neglectful (Liotti, 1992, 2004). Because the child has little direct influence over the caregiver to be more available and loving, the child must then psychologically contort themselves, attributing the difficulty to their own badness (Fairbairn, 1943), and find ways to somehow evoke whatever degree of engagement their caregiver is able to provide. Children may do this by assessing how their caregiver responds to their actions and attitudes. When only some of these yield favorable or less harmful caregiver responses the child may narrow their range of behaviors and attitudes to those which produce such responses. As Rappoport states: "to the extent the child believes that certain behaviors make the caregivers feel less connected to them and less well intentioned towards them, they tend to relinquish those behaviors" (p. 28, Rappoport, 1996). Pathogenic beliefs allow the child to present themselves in ways to the caregiver that have the highest likelihood of evoking that caregiver's goodwill. In so doing, the child protects their need to feel their caregiver's attachment to them as best as possible.

> Mark came to therapy for generalized anxiety and difficulty sustaining his achievements. He seemed to hold the pathogenic belief that "If I succeed then I will provoke others' envy and contempt". He reported having grown up with a father who was cruel and seemingly envious of Mark's abilities and achievements. When Mark came home in seventh grade announcing that he had made the school basketball team his father sneered and called him a "dumb jock". When Mark focused on his studies and brought home high marks on his exams his father would call him "an egghead". Mark realized that success only seemed to make his father dislike him all the more. Mark also saw that if he seemed directionless and/or distressed then his father would treat him less harshly. Mark's father seemed to experience Mark's expressions of his abilities as a source of envy that prompted contemptuous outbursts. In response, and in line with his pathogenic belief, Mark inhibited his self-expression, personal achievement, and confidence.
>
> The consequences of Mark's pathogenic belief seemed pervasive and grave. He concealed his ambitions and barely allowed himself to imagine success. Although he was a talented and capable salesman at work, he told himself that he was lucky not to be fired yet. When he earned a promotion he felt anxious rather than proud. He expected others to envy and despise him for "outdoing" them by getting promoted. These dynamics could be explained by his pathogenic belief. In adherence with the belief, Mark found himself behaving as though he did not deserve his promotion. He began to find the simplest of his work tasks to be difficult, and became anxious that he would offend people when he

wrote them emails. Consequently, Mark fell behind on his tasks and was eventually reprimanded for his loss in productivity. While this temporarily reduced his anxiety about succeeding and standing out from peers, Mark's personal and professional growth was curtailed, and he felt some distress about not making use of his abilities.

In therapy, Mark's therapist understood his goal to be to succeed without the fear of others' negative reactions. His therapist inferred that his pathogenic belief stood in the way, conveying compassion and empathy towards Mark for the historical circumstances that led to this belief. The therapist proposed interpretations that suggested Mark's difficulties at work may have some roots in earlier adaptation to traumatic experience. Rather than agreeing with Mark's claim that he was "incapable", his therapist emphasized how Mark had historically needed to suppress his capabilities in order to ensure some modicum of goodwill from his father.

In addition, the therapist held an attitude of consistent curiosity and appreciation for Mark's strivings. He expressed happiness for Mark in moments when he reported, often in a dismissive or cursory manner, an accomplishment in his work or personal life. In such moments the therapist would slow Mark down so they could both attend to his accomplishment and consider the feelings he was having. Mark would report feeling a mix of excitement, pride, and dread. Over time the dread diminished as he gradually and consistently experienced the therapist's appreciation for Mark's ambitions and successes.

Mark's mention of his accomplishment in passing was understood to be a test of his pathogenic belief with the therapist. By blithely stating such things Mark could determine if his therapist would grow contemptuous like his father. The therapist's welcoming attitude towards Mark's success contradicted his pathogenic belief, allowing Mark to determine that his pathogenic belief at least did not apply in the therapeutic relationship. Over time, Mark's criticism of himself lessened in intensity and frequency, and he began to generalize from his experience in therapy. He seemed to grow in confidence that his therapist, and other people in his life, would not automatically turn against him if he made use of and fully expressed his abilities.

It seemed important to the outcome of the treatment that Mark's therapist understood the trauma-based protective function his workplace paralysis reflected. Mark seemed to have been suffering from a fear of being rejected by colleagues––resulting in self-diminishing or self-sabotaging behavior––rooted in a need to protect himself from contemptuous attacks predicted by his pathogenic belief should he express and enjoy his abilities. As such, to therapeutically intervene in a way that challenged his anticipation of rejection––without empathic understanding of the developmental context of this dynamic––might have left Mark feeling less understood in his distress. His therapist's emphasis on the function served by the pathogenic belief allowed Mark to reflect on the fear of contemptuous attack he would feel when he succeeded, and to explore the childhood origins of this fear. Mark was then able to develop a more compassionate understanding of the ways he had been trying to protect himself––by complying with the pathogenic belief––from what he feared. Thus, the therapist's person empathy for how and why Mark had to

adopt this pathogenic belief attuned to Mark's fear of what would happen if he did not expect rejection rather than seeing the problem as the rejection itself.

Mark's case example illustrates how a child might act to diminish their own quality of life if doing so facilitates connectedness––as in the reduction of hostility or promotion of goodwill––with a needed caregiver. By testing his pathogenic belief in therapy, Mark may have learned a different way to be close to others, in that he found that the therapist's goodwill toward him was not dependent on Mark diminishing himself.

Pathogenic beliefs influence the child's behavior to get along with their caregiver

In severe cases of abuse or neglect, children may find it emotionally dangerous to express their healthy developmental strivings or take in positive information about themselves. According to CMT, children may develop pathogenic beliefs to inhibit their pursuit of healthy developmental goals that are perceived to threaten their relationship to their caregiver (Fimiani et al., 2020). Consider, for example, a caregiver who becomes overly sensitive to or severely threatened by challenges to their authority, and who reacts with inordinate anger or vindictiveness if the child protests one of the caregiver's directives. Their child may well become distressed by such treatment and may adopt a belief to help them avoid such outcomes. A belief such as "If I say what I really think then I will offend others" will influence the child to act in ways that their overly sensitive and controlling caregiver might find acceptable. While this belief may result in the child sacrificing their nascent initiative or autonomy, it may allow for the preservation of the caregiver's precarious sense of authority and therefore their willingness to remain available to the child.

> Nat came to treatment in his late twenties complaining of intense anxiety when alone. He was a thoughtful, congenial, and warm person who seemed good at making others feel comfortable in his presence. Despite being well-liked and professionally accomplished, he had extreme difficulty recognizing his strengths and liking himself. His self-concept was that he was "lazy, doing the bare minimum to get by, and fooling others that he was a good person." As such, he had found it too emotionally dangerous to feel close with others in his life or maintain a visible and meaningful role in his work.
>
> Nat's father seemed like a charismatic and generous person to his community. However, behind the closed doors of their home he was emotionally and physically abusive towards Nat. His father's harshness was incongruent with Nat's need to see his father as a good parent. Nat seemed to resolve this incongruency by developing a pathogenic belief that he was fundamentally bad and deserving of maltreatment. This belief allowed Nat to avoid seeing his father as someone who was egregiously abusive.
>
> Nat was a gifted basketball player and initially enjoyed the sport at his middle school. His coach saw Nat's talent and offered consistent encouragement. Nat felt like a valuable person to his coach and proud of his abilities and efforts as a basketball player. These

feelings, however, seemed contrary to his pathogenic belief of being bad and unworthy. How could Nat be accepted by his coach and teammates if he was bad and deserved their hostility? If Nat had allowed himself to doubt this belief it would have been harder to explain and justify his father's ongoing cruel treatment of him. Indeed, if Nat had taken issue with his father's behaviour, he would likely have been further punished and mistreated. Thus, Nat's life would have been made worse if he had challenged his pathogenic belief at that time.

In unconscious compliance with his pathogenic belief, Nat began to see his coach as "full of it." Rather than see his coach as genuinely accepting, he construed the coach's behaviour as phony and ultimately hostile. He took offense at the coach taking him out of games to give him needed rest. He reacted defensively to his coach's occasional pointers on technique. His coach tried to talk to him after practices to repair their relationship but Nat would not cooperate. Eventually, his coach grew impatient and somewhat frustrated with Nat. After one game where Nat refused to listen to his coach's instructions he was benched for the remainder of the game. Nat quit and never took up basketball again throughout his schooling.

Nat seemed to deal with the danger posed by his positive relationship with his coach––the disruption of his precarious image of and relationship with his father––by complying with his pathogenic belief. This meant - unconsciously - acting in ways that unfortunately evoked the negative regard from others that his pathogenic belief indicated he deserved. Quitting the team allowed him to keep this belief intact and turn his former proponent (i.e. his coach) into an opponent – at least in Nat's mind.

Nat's therapist had difficulty seeing the basis in reality for his self-criticism. In their first three sessions, the therapist had taken a comprehensive history of Nat's life. The therapist was struck by Nat's self-criticism in the face of considerable evidence of many strengths and positive qualities. This incongruence signaled the possibility of Nat holding a pathogenic belief that he was bad and deserving of criticism, raising questions in the therapist's mind about the function of such a belief in Nat's relationship with his father.

The therapist's person empathy helped to illuminate the possibility that Nat's claims of disliking his job were tests of his pathogenic belief. Nat worked diligently and seemed to care a lot about the quality of his work. Although his manager was encouraging and impressed by his work, Nat would often discredit this feedback by finding fault in his manager. In relation to his father, Nat was forbidden from valuing himself and his pursuits. His therapist understood Nat's professed dislike of his job and his manager, and the material about his hard work and good feedback as a kind of test: would the therapist support Nat's right to criticize, endorse his obvious competence, and recognize his competence? Or would the therapist shame and undermine him?

The therapist interpreted Nat's supposed dislike of his job as a way to maintain the belief that he was unworthy and not deserving of credit for his efforts. Such interventions carried the implicit message that the therapist saw Nat as fundamentally deserving rather than bad. Nat's therapy involved many sequences of this type. For example, Nat often found fault in himself or in others whenever he was well-received and appreciated by others. In most cases, the therapist would use his historical and empathic understanding of how Nat had negotiated earlier traumas to consider that Nat may have been testing whether he deserved such good treatment. Over the course of several years Nat seemed

> to find it much easier and safer to accept what others liked about him, and in doing so became less self-critical. This was paralleled by his recognition and processing of his experience of his father's abusive treatment during childhood.

Due to compliance with his belief of being bad, Nat had great difficulty accepting and absorbing positive responses from others such as his coach and manager. Nat's therapist's understanding of the possibility that his initial distrust of his manager may have been a consequence of a pathogenic belief, rather than a reality to accept at face value, seemed to help advance the treatment. If the therapist had validated Nat's dislike of his work then his pathogenic belief might not have been challenged and worked through. The therapist's person empathy incorporated inferences about Nat having to devalue himself in relation with his abusive father in order to get along with him. This contributed to the therapist being able to challenge––through interpretations, attitudes, and the therapy relationship––Nat's pathogenic belief and his sense that it would not be safe to relinquish it and ultimately value himself. The therapist's attitude and responsiveness also implicitly conveyed the message that he would not be hostile toward Nat (as his father had been) for liking and feeling proud of himself.

Pathogenic beliefs help the child cope with their emotional pain on their own

A child who experiences maltreatment by a caregiver can face painful feelings of worthlessness, fear, and helplessness. Moreover, the person they would reach out to for comfort may well be the same caregiver whose behavior contributed to those painful feelings, resulting in a vicious cycle of seeking comfort and finding hurt (Fairbairn, 1943; Liotti, 1992, 2004). Pathogenic beliefs may be developed under such circumstances as an aspect of the child's attempt to cope without asking more of their caregiver. In essence, the child may come to believe that they must provide their own care and soothing, rather than rely upon a caregiver who has been abusive or neglectful. Moreover, rather than see their caregiver as hurtful and unreliable, the child may believe that they must repair their own perceived deficits in the hope of eventually securing desired responsiveness from the caregiver. Thus, while allowing the child to see their caregiver in a positive light, such beliefs may help protect the child from the cycle of seeking help followed by hurt. The caregiver's limitations are obscured in favor of the child being responsible for their own emotional support, whilst also being at fault for not being "good enough" to please or support the caregiver. Carried into adulthood, pathogenic beliefs under such circumstances can facilitate the individual's emotional self-containment, though with a potential consequence of excessive self-reliance and an undue attention to the needs of others. As Winnicott's notion of a false self suggests, the individual can seem to have achieved the

developmental outcome of being independent but has rather sequestered their own emotional needs underneath an outward stance of by tending to what they perceive others require of them (Winnicott, 1965).

Sarah was a successful teacher and artist in her late thirties who was in therapy for anxiety. She functioned very competently in her job and as a mother and wife. However, she often found talking to others to be "too much", had difficulty getting to and staying asleep, and was bothered by feelings of dread and panic. She was reluctant to ask others for help but readily did whatever she could to help others. She seemed to hold the pathogenic belief that she only had worth to the extent she met others' needs.

Growing up, this belief helped Sarah navigate her mother's hostility towards her. Her mother demanded Sarah's attention, admiration and validation, often attacking Sarah's character for being "selfish" if these demands were not met. By contrast, when her mother felt adequately prioritized by Sarah she would be in a good mood.

Sarah's pathogenic belief oriented her to be alert to and ready to meet her mother's needs. This yielded more moments of earned harmony than Sarah may have otherwise experienced with her, but it also seemed to lend justification to her mother's attacks, in that Sarah felt she must have deserved punishment for not meeting her mother's emotional needs. By shifting her focus to others' needs, this belief may have adaptively distracted her from painful feelings associated with her mother's narcissistic functioning.

In the first few months of therapy Sarah expressed frustration at her mother's continued intrusions, including frequent unannounced visits with the expectation of becoming Sarah's immediate priority. In their conversations, Sarah would keep the focus on her mother's well-being: What did her mother find interesting and want to talk about? Sarah felt guilty if she considered setting a limit with her mother. Sarah's therapist inferred that her continued accomodations signalled compliance with a pathogenic belief that had once been adaptive in Sarah's childhood relationship with her mother. The therapist was initially keen to raise this in session. He suggested that she seemed to take responsibility for her mother's well-being, emphasizing how this stance may have protected and helped her as a child. In response to this intervention, Sarah seemed to consider that her needs might actually be as important as her mother's. However, she found it far too anxiety-provoking to act on these considerations during interactions with her mother. The threat of her mother's rebuke and her own guilt was too prohibitive.

This pattern of interaction between patient and therapist continued over several months. Sarah remained fearful of setting a boundary with her mother. This persistent outcome led her therapist to reconsider his approach of challenging her suppression of her needs in favor of her mother's. By reflecting further about her psychology (i.e., person empathy), the therapist reasoned that Sarah may not have felt an adequate degree of safety to challenge this pathogenic belief at such time. The therapist wondered if the dynamic between them could reflect the situation Sarah's pathogenic belief had once attempted to solve. Perhaps Sarah inferred that the therapist needed her to behave differently with her mother. Now the therapeutic relationship might mirror aspects of her relationship with her mother, with Sarah feeling like she would only be valued by the therapist if she followed his wishes (i.e., agreed with his interpretations and behaved differently). If this was indeed the case, Sarah would first need to feel safe enough to prioritize her point of view over her therapist's.

With this possibility in mind, the therapist shifted his focus to reflecting and empathizing with Sarah's experience. Instead of challenging Sarah's insistence on meeting her mother's demands, he conveyed empathy for her hope that she might "do enough" to win her mother's acceptance. After an extended period of working in this manner, Sarah's pathogenic belief was tested in a dramatic way. During one session, Sarah discussed traumatic memories of being physically abused by her mother, becoming increasingly distressed in doing so. The therapist became concerned about her elevated distress and feared that she might shift into a dissociative state unless he intervened. He asked if she could rate her distress level from zero to ten, to which Sarah replied that she was at a seven. The therapist asked her to engage in diaphragmatic breathing until she could rate her distress level at four or below. He then asked if they could return to her memories but with the goal of regulating her distress levels. They struck an agreement to stop and breathe in this way if she found her subjective distress going higher than four. Her therapist thought he had done "good" trauma-informed work in helping her to recount and integrate what she had experienced at a manageable level of arousal.

At the next session, Sarah said that she had felt muzzled in the previous session. She found the therapist's directiveness to have stiflied a story that she had wanted to tell in her own way. Sarah saw the therapist's intervention as an interruption that reflected his sense of what was good for her as being more important than her own ideas. The therapist thanked her for bringing this to his attention and indicated that she had helped him understand how his approach had negatively affected her. He took ownership for his concern about her becoming overwhelmed when recounting traumatic experiences, and indicated that in the future he would trust her to gauge and manage her own distress during sessions. Shortly after this interaction, Sarah told her mother that it was not a good time for a visit when she showed up unannounced. Sarah seemed to feel safer and more capable to assert her needs with her mother after having done so with the therapist.

Sarah's therapist exercised person empathy by pivoting from his initial stance and reflecting further on the circumstances surrounding the development of her pathogenic belief. Instead of promoting her right to set boundaries with her mother he followed her lead and mirrored her experience, thereby allowing her subjectivity to become the priority in a way that she had seldom previously experienced. Through this experience, which occurred over time and culminated in a significant test, Sarah felt gradually more entitled to the other's empathic responsiveness and learned that she did not have to give up a piece of herself to involve someone else in her life. It is possible that the profound testing of her pathogenic belief may not have occurred without the incremental building of safety via the therapist's extended empathic mirroring.

In cases where a patient once had to adapt to abusive or neglectful caregivers, the therapist may need to respect the function served by the pathogenic belief as an essential way for the child to survive and navigate their world. Therapeutic progress may be facilitated by exercising person empathy and flexibility in how the therapist responds to the patient's expressions of their pathogenic belief. In this case the therapist's initial direct challenge of Sarah's pathogenic belief––while technically congruent with her therapeutic goals––did not result in her feeling

freer or safer to set limits with her mother. Nevertheless, the therapist's shift to a more unobtrusive but supportive stance may have helped to gradually challenge her pathogenic belief, thereby eventuating in greater capacity to set limits in interpersonal relationships.

Conclusion

Understanding the functions and consequences of pathogenic beliefs can help support therapists' empathic attunement and responsiveness to patients who experienced childhood maltreatment. By grasping these features, the therapist may be better able to respond to patients in ways that reflect an appreciation of the circumstances surrounding them, the functions of pathogenic beliefs in developmental contexts, and their emotional and interpersonal implications. Exploring and speaking with patients about such matters offers the potential for new understandings and eventual relief from the constricting nature of pathogenic beliefs. Moreover, the therapist's empathic understanding of the context through which the patient's pathogenic beliefs emerged may clarify how the therapist might respond in personalized ways that facilitate the patient's safety to test and disconfirm pathogenic beliefs.

CMT puts forward a model of how patients work productively in therapy that is applicable across therapeutic approaches. The therapeutic process involves the therapist attuning to and facilitating the patient's efforts to test and disconfirm these beliefs (Gazzillo et al., 2019). Research has shown that patients make progress in therapy when therapists respond in ways that are compatible with the patient's plan for overcoming their pathogenic beliefs and achieving their goals (Silberschatz, 2017). While research has also affirmed empathy as an important ingredient in psychotherapy (Elliott et al., 2018), further research is needed to elaborate on the role of the therapist's specific empathic grasp of the patient's pathogenic beliefs, and the effectiveness of interventions that flow from such empathic understanding. Novel approaches to this could include coding therapy sessions for therapists' empathy to inferred pathogenic beliefs, or comparison between therapist and patient ratings of a patient's pathogenic beliefs––using a measure such as the Pathogenic Beliefs Scale (Aafjes-van Doorn, et al., 2021)––in relation to therapy outcomes. Therapists can also take their own empirical approach on a case-by-case basis, by examining whether their empathic understanding is leading them toward interventions and responses that advance an individual patient's effort to overcome pathogenic beliefs that formed in the context of childhood maltreatment.

Note

1. Case reports in this paper are composites of real case examples with information changed to maintain the patients confidentiality. The authors took liberty to adjust some facts in the patient's histories to best illustrate the point. These adjustments did not compromise the external validity of these descriptions.

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