Control-Mastery Theory and Cyclical Psychodynamics: Commentary on the Weiss vs. Wachtel and DeMichele Dialogue

Suzanne M. Gassner, Ph.D.*

Suzanne M. Gassner, Ph.D. is a Training and Supervising Analyst, San Francisco Psychoanalytic Institute; Adjunct Faculty, Psychology Dept., University of California/Berkeley; Member of the San Francisco Psychotherapy Research Group.

Summary

One of the fundamental premises of Weiss's control-mastery theory is that under favorable circumstances, people in general and patients in particular are inherently motivated to master their traumas. In direct contrast, Wachtel's work has been organized around the concept of cyclical psychodynamics. His fundamental observation is that people in general and patients in particular relate to others in just those very ways that invite, evoke and provoke confirmation of their pathogenic expectations and fears. In the Weiss vs. Wachtel and DeMichele dialogue about the unconscious plan concept, Wachtel implicitly challenged Weiss' overestimation of the patient's mastery motivation, whereas Weiss implicitly challenged Wachtel's minimization of mastery motivation. Weiss assumes that if the therapist is able to create a relationship that enables the patient to develop confidence that she will be safe from being retraumatized, this increasing security will gradually free the patient to work in treatment to master her problems and pursue her own purposes and goals. Wachtel assumes that patients have neurotic expectations that lead them to behave in just those very ways that invite others to confirm their worst fears. Therefore Wachtel also sees one of the primary tasks of therapists as being to help the patient become less ruled by her neurotic anxiety about perceived dangers. In addition, he believes therapists need to decline invitations to participate as accomplices in those interactions with patients that would serve to confirm their neurotic expectations. In an effort to advance the exchange of models and methods, this commentary discusses mutual contributions that these theoretical perspectives could make to one another. Fundamental differences in assumptions are taken up. Case material is also presented to illustrate how these perspectives can be reciprocally enriching and informative.

Introduction

This essay was stimulated by the informative dialogue between Joseph Weiss, and Paul Wachtel and Annette DeMichele about the control mastery theory's understanding of "The Patient's Unconscious Plans for Solving their Problems" (1998). Let me be clear at the outset about my own biases. I am very indebted to Drs. Harold Sampson and Joseph Weiss, the co-directors of the San Francisco Psychotherapy Research Group, for all that they have taught me and for the opportunity they afforded me to engage in research on unconscious mental functioning. Nonetheless, I found myself intrigued by Wachtel and DeMichele's critique, perhaps in part because I share with them an interest in identifying and understanding the factors that have impeded the wider acceptance of control-mastery theory. In Wachtel and DeMichele's commentary on Weiss's paper, Wachtel's own theoretical position was not laid out. I believe the significance of their response would have been further clarified had they more explicitly described their own theoretical position which Wachtel has called "cyclical psychodynamics. Based on a subsequent reading of Wachtel's work I have also concluded that Wachtel's theory of psychopathology and its treatment might be valuably expanded were he to integrate the evidence for mastery motivation into his formulations about psychopathology and technique. I further concluded that there are aspects of Wachtel's observations about "cyclical psychodynamics" that if integrated into control-mastery theory would enable us to expand further control-mastery theory and its applications. Before I present clinical material to illustrate these points I will provide an introduction to each of these two theoretical perspectives.

An Introduction to Control-Mastery Theory

Control-mastery theory emphasizes the importance of trauma in the etiology of all forms of psychopathology. By trauma we mean any experience or ongoing life circumstance which leads an individual to believe that an important goal, whether an instinctual wish or an ego striving, must be sacrificed to avoid the interrelated dangers of damaging the people one loves or being damaged by them. Patients are understood to enter treatment consciously or unconsciously motivated to achieve important life goals by mastering earlier traumas which had made those goals too dangerous to pursue. In keeping with Freud's (l926) signal theory of anxiety, control-mastery theory assumes that one consequence of trauma is that anxiety will be experienced whenever an individual unconsciously anticipates the possible danger of being retraumatized. Guided by unconscious memories of childhood traumas, people form unconscious beliefs about what constitutes situations of danger and use these beliefs to calculate the potential consequences of gratifying a particular impulse or pursuing a particular goal. We refer to these as "pathogenic beliefs". Psychopathology is characterized by a person's adherence to pathogenic beliefs in dangers that have long since past. Pathogenic beliefs can take the form of powerful, unconscious commands, which compel or prohibit certain kinds of thoughts, feelings or behaviors. This is to say that compulsions and inhibitions can be understood as efforts to avoid the dangers foretold by pathogenic beliefs.

At times, pathogenic beliefs involve faulty explanations about how one's behavior caused the trauma to occur. Sometimes these convictions develop at a later time, when the patient reconstructs what had happened earlier. Other times pathogenic beliefs are over-generalizations based on traumatic experience. Patients govern their behavior in accordance with beliefs that may have had a realistic basis in the context of a particular traumatic experience but which now are misapplied to the world at large.

The faulty ideas to which a patient subscribes have a number of additional sources. They may result from an identification with the parents' pathogenic beliefs. They may result from the child's compliance with the parents' interpretation of reality. They may also result from the distorting influences of early childhood cognition.

The control-mastery theory of unconscious mental functioning is rooted in Inhibitions, Symptoms and Anxiety (Freud, l926). In this account of unconscious mental functioning, people are understood to be capable of exercising unconscious control over their repressions. This is in contrast to Freud's earlier theory that unconscious mental life is automatically regulated by the pleasure principle. Contained in this earlier view is the tenet that people cannot exercise control over the lifting of their defenses. They can only become aware of a repressed mental impulse if the impulse or the defense warding it off have been interpreted, or if, as the result of frustration, the impulse becomes so intensified that it breaks through into consciousness (Freud, l900, l905).

In keeping with Freud's later theory of how the unconscious becomes conscious, Weiss has had a longstanding interest in observing how we may lift our defenses against mental contents and decide to make the contents conscious when we judge that we may safely experience them (Weiss, l952). In accordance with Freud's signal theory of anxiety, we typically maintain our repression of a mental content when we anticipate that experiencing the content would create a situation of emotional or interpersonal danger (Freud, l926). The *control* portion of the *control-mastery theory* label refers to the idea that a part of the unconscious mind is capable of exercising unconscious control and that in contrast to Freud's earlier view in Formulations on Two Principles of Mental Functioning (l9ll), unconscious processes are not devoid of secondary process thinking. The studies our research group has completed have demonstrated empirically that patients can exercise a certain amount of control and regulation over a particular kind of unconscious processing, namely the bringing forth of previously warded-off contents (Horowitz et al., l975; Gassner et al., l982, l986; Shilkret et al., l986; Gassner and Bush, l998).

The *mastery* portion of the *control-mastery* label refers to the premise that the unconscious ego is always ready to master an unconscious content which it has previously failed to master, *once the ego judges that the conditions of safety are likely to exist.* It is the imprint of traumatization and the need to ward off retraumatization that conflicts with and inhibits such a pursuit of mastery. Patients' convictions that they would be in serious danger of being retraumatized stops them from mastering their traumas. Such convictions cause the patient to avoid and defend against the possibility of having the required interpersonal experiences that would disconfirm her pathogenic beliefs. Weiss's theory presupposes that the patient is not only motivated to overcome her problems but that she unconsciously forms sketchy, tentative strategies for developing an interpersonal relationship with the analyst that will enable her to determine whether it is relatively safe to revisit and rework the traumas associated with her pathogenic beliefs. Weiss refers to such patient-initiated, purposive, interpersonal interactions as indications of the patient's "unconscious plan."

Control-mastery theory *does not* conceive of the patient as having anything like an omniscient understanding of how to orchestrate her therapy, as Wachtel assumes. This is a rather common misunderstanding suggesting that at times our terminology fails to communicate. Rather, we mean by the term "plan" that the patient's behavior in treatment is guided by unconscious, roughly conceived, experimental strategies for the purpose of enlisting the therapist's help in overcoming her psychopathology. As the therapist-patient relationship develops, the patient revises and modifies her strategies in response to her evolving perceptions of the therapist's characteristics.

Broadly speaking, unconscious plans are ways of achieving therapeutic goals by mastering the effects of childhood traumas and thereby overcoming the internal obstructions, that is, pathogenic beliefs that interfere with the pursuit of these goals. Weiss assumes that as long as a therapist's interpretations help the patient to disconfirm her pathogenic beliefs, and as long as the new relationship with the therapist provides new developmental experiences that disconfirm of those beliefs, the patient will make progress. The concept of the unconscious plan provides a coherent, unifying perspective that helps to organize the underlying pattern that shapes the patient's varied and wide-ranging ways of presenting herself in treatment. It also provides the therapist with a basis for understanding the stalls and impasses in treatment, and further provides guidelines for the subsequent modification of technique. As Weiss puts it, "While the analyst helps the patient to go where he unconsciously wants to go, the analyst feels as though he is pushing a large rock down a gentle but perhaps bumpy slope. The rock may have its jolts, its stops, and its starts, but it moves forward. When the analyst hinders the patient from going where he unconsciously wants to go, the analyst feels a though he is pushing the rock uphill. It is hard work, and once the pressure on the rock is removed, it may roll backwards; the ground that has been won with such difficulty may be quickly lost (Weiss, Sampson, and the Mt. Zion Research Group, l986, p. 93)."

Unconscious strategies include, as a key component, various ways to "test" the reality basis for pathogenic beliefs. There are two major ways to test such beliefs. One, transference tests are instances where the patient relates to the therapist in the ways that she did with the parent, with the hope that the therapist will not traumatize her in the ways that the parent had. The second form of testing involves the patient's taking the role of the traumatizing parent, thereby placing the therapist in the role of the traumatized child. By turning passive into active the patient tries to master the effect of the trauma.

Passed tests help patients challenge their convictions about the reality of the dangers their pathogenic beliefs foretell. As patients discover that the therapist does not reenact with them the traumas they experienced within the context of their primary relationships, usually those with family members, they feel safer to lift their defenses against previously warded-off thoughts and feelings, and to begin to rework their childhood traumatic experiences. In addition to passing patients' tests, the therapist helps the patient by making "pro-plan" interpretations whose import is to make conscious and implicitly disconfirm some aspects of the patients' pathogenic beliefs, or otherwise to assist patients in moving toward their therapeutic goals. When the therapist provides the patient with insights into the nature and effect of her pathogenic beliefs, the patient increases her conscious control over the effects of those beliefs as well as her capacity to reality-test the dangers foretold by those beliefs.   Conversely, when the therapist fails a test, or makes interpretations that confirm the patient's pathogenic beliefs, we expect that the patient will experience an increased sense of danger and become more beleaguered, resistant and uninsightful.   The San Francisco Psychotherapy Research Group (formerly called the Mount Zion Psychotherapy Research Group) has demonstrated in a series of studies that patients become more relaxed, bold and insightful when the therapist's responses disconfirm their pathogenic beliefs. Conversely, patients become more constricted, resistant and uninsightful when the therapist's responses inadvertently confirm their patients' pathogenic belief (Weiss, Sampson and the Mt. Zion Psychotherapy Research Group, l986; Broitman, l985; Fretter, l984; Linsner, l987).   From a control-mastery perspective, when a psychoanalyst or psychotherapist working from any theoretical perspective succeeds in diminishing the patient's unconscious sense of danger, and makes interpretations which increase the patient's insight, the patient will begin to make progress in disconfirming her pathogenic beliefs. Thus the therapeutic relationship will succeed in helping the patient to emancipate herself from the constraining effects of her traumatic experiences and to overcome the obstacles that had earlier derailed her development.

Working within the control-mastery framework, a case formulation, which we label a plan formulation, attempts to answer the following questions: l) What were the patient's traumas? 2) What pathogenic beliefs did the patient developed in response to the traumas? 3) What likely kinds of tests will the patient create to learn more about her current reality and in particular the reality of the therapist-patient relationship? 4) What insights will be likely to help the patient disconfirm her pathogenic beliefs, and to apply what she learns to her current goals and interpersonal relationships?   Our answers to these questions constitute what we call a plan formulation. Plan formulations are important because they help organize the therapist to assist the patient in disproving her pathogenic beliefs so that she can resume working on the goals that these beliefs warned her against pursuing.   Caston (l986) who studied the case of Mrs. C. demonstrated that independent judges could reliably diagnose a patient's unconscious plan.   Based on work that Bush and I did while studying the case of Mrs. C. (l983) I will offer an example of one of the traumas we posited and the related components of the plan formulation we conceptualized.

The Case of Mrs. C.

Mrs. C. perceived her father as suffering from extreme narcissistic vulnerability.   In the first l0 hours of her analysis she provided the following relevant information. She described him as easily wounded if family members disagreed with him, and excessively touched when family members agreed with him. Mrs. C. sensed that her father had an urgent need to be right, to be the final authority on all matters, and to feel superior to everyone with whom he related. He behaved as if there were only one right answer or one correct solution to every problem, his answer, his solution. When family members did not agree with father's ideas, he responded with contempt and rage.

The Expected Pathogenic Beliefs

We inferred Mrs. C. would have been likely to have developed these pathogenic beliefs: l) She developed the omnipotent belief that she has the power to hurt others by disagreeing with their ideas. Therefore she would view disagreeing with others as an act of hostility; 2) She believed that it is an act of disloyalty to question the authority of others, to be objective about the deficiencies of others, or to have values, ideas and plans that differ from others. She would view such "acts of disloyalty " also as acts of aggression. She might hold these beliefs in particular with regard to men; 3) She believed that should she disagree with others, they would respond to her with contempt and anger; 4) She believed that she must keep herself dependent on the approval of others. This belief would be based both on a pathological identification with her father, and on her compliance with her perception of her father's need to be the final

5

arbiter of her self-esteem. 5) She was afraid that being proud of herself would mean that she is self-aggrandizing, out of control and foolish. This pathogenic belief would be based on a strong negative identification with her father; 6) She believed that were she to feel equal to or superior to a man, it would leave him feeling emasculated. More generally she believed that she would inevitably threaten anyone, should it become known that she were superior to that person in any regard; 7) She believed that the way to show love for someone else is to cater to their narcissistic needs, that is, to shower them with admiration, behave in ways that imitate them, and generally to idealize them; 8) She believed that she would undermine other people's sense of authority were she not to agree that their solution to a problem is the only possible solution. Mrs. C. feared that were she to see issues in terms of possibilities, to see problems as having multiple solutions, in effect were she to think clearly, creatively and with reasonableness, she would destroy the sense of authority of others.

The Kinds of Tests Envisioned

We thought that if Mrs. C. tested these beliefs in the transference she would test: l) to see how much power she has to hurt or please the analyst by either agreeing or disagreeing with his interpretations; 2) to see if the analyst objects to her efforts to dethrone her father, or if he will want her to submit to him and her father in the ways her father wanted; 3) to see if the analyst would be easily threatened by her acting equal to or, at times, superior to him; 4) to see if the analyst can tolerate her feeling that she is in the right and he is in the wrong by seeing if he can comfortably accept being called on his mistakes; and 5) to see if the analyst needs her to feel inferior to him by blaming herself for her feelings.

Should Mrs. C. turn passive into active we thought she would do so by either l) asking for reassurance and approval to see if the analyst could feel comfortable if he did not provide these responses or 2) acting contemptuous when the analyst holds a view different from hers.

It is my understanding that it is this portion of the plan concept Wachtel and others find the most controversial and I shall return to discuss the controversy later in this essay.

Insights That Would Help Mrs. C.

Finally, we expected that Mrs. C. would be motivated to achieve several insights. First, that she has distorted ideas about the narcissistic vulnerability of male authority figures. She sees them as precarious. She is very cautious about doing anything that could be narcissistically injurious, because she does not want the responsibility of wounding them, or setting them off.   Second, that she feels she should sacrifice her own autonomy and her right to assert her own ideas to protect narcissistically vulnerable authority figures. Third, that her presenting symptom of envying men and feeling ashamed of being female was in part an act of compliance to her father who needs to feel superior to females, and also an attempt to ward-off her feelings of contempt for him.

An Introduction To Cyclical Psychodynamics

Wachtel's conceptualization of cyclical psychodynamics reflects his most worthwhile and ambitious goal of integrating the contributions from family systems and cognitive-behavior therapies into a psychodynamic framework. His interest in the benefits to patients of such a synthesis has also led to his organizing an international association, The Society for the Exploration of Psychotherapy Integration. Cyclical psychodynamics "gives a central role to the repetitive cycles of interaction between people and to cycles of reciprocal causation between intrapsychic processes and the events of daily life (Wachtel, l993, p. l7)."   Whereas psychoanalytic theories are grounded in a belief in the potent capacity of history to shape our experiences throughout life, Wachtel assumes that the patterns of reinforcement in our current relationships, patterns we create based on our history, keep our psychopathology locked in place. Therefore Wachtel challenges the idea that archaic processes and structures (and this would include pathogenic beliefs) "are nearly as anachronistic as they are depicted in most psychoanalytic accounts. Rather they can be recognized to be both symbolizations and consequences of the very way of life of which they are also a determinant" (Wachtel, l993, p. l9).

People's expectations are self-fulfilling, and their expectations may lead them to invite the very responses from others they most dread. I assume Wachtel would find it congenial to conceptualize such neurotic expectations as the patient's currently held pathogenic beliefs.   As he has said, whether we use the language of "fantasies, schemas, representations, personifications, inner objects, or internalized

working models—such processes are a crucial component of the dynamics of people's difficulties" (Wachtel, l993, p. 25).

In the example that follows Wachtel describes a patient who has the neurotic expectation that it is wrong to assert one's own needs, or to be angry, beliefs that psychotherapists routinely see underlying the struggles of many patients. The vicious cycle that has the patient in its grips, according to Wachtel, can be understood as follows. The patient, in keeping with neurotic expectations appears to be a meek individual who is unable to assert himself. Wachtel understands the patient's prohibition against asserting himself, his rights and his needs, as resulting in the individual's being unable to represent his own interests or protect his needs and rights.

> The result of such a state of affairs is some mixture of being taken advantage of, being overlooked and dismissed, or simply not having one's needs noticed by those toward whom one has gone out of one's way to be accommodating, helpful and considerate. Such experiences are likely to stir anger in the patient as they would in almost anyone, but being particularly unable to tolerate anger, he redoubles his efforts to push the anger back by again being self-abnegating, unassuming, excessively cooperative and inoffensive to a fault. As a consequence he sets the stage for still another experience of not getting his due or not being treated with respect, generating still more anger in response, necessitating still further efforts to hide that anger from himself and push it back with behavior that is its opposite and creating yet another repetition of the pattern that has dominated his life. Thus the anger he struggles against now is not "old" anger that has been "in" him since childhood, although it is likely that the struggle began back then. Rather the anger he struggles to keep at bay today is anger that was generated quite recently and ironically that was generated by the very efforts he has made to purge himself of anger. A self-perpetuating process has been established that maintains itself by the consequences it repeatedly generates (Wachtel, l993, pp. l9-20).

In <u>Therapeutic Communication</u> Wachtel provides a number of examples that similarly demonstrate how neurotic patients evoke the very behaviors that validate their own perceptions of danger. His formulations are consistent with contemporary behaviorists' assumption that whatever the origin of a symptom, its persistence must be a function of the symptoms' continuing reinforcement in the patient's current life circumstances. Wachtel's's ideas about therapeutic communication are geared to teaching therapists how their interventions can help to break the vicious cycles that are the daily fare of the patient's interpersonal relations. Wachtel offers a social psychological perspective on psychopathology. He states that

> In an odd way, neurosis is a joint activity, a cooperative venture....The maintenance of neurotic patterns proceeds with the assistance of other people....To keep a neurosis going, one needs help. Every neurosis requires accomplices....It is only when one understands how others are drawn into the pattern as accomplices, how they are induced to interact in ways that confirm neurotic expectations and perceptions, that one appreciates fully both the depth of the patient's dilemma and what is required to bring about change. Focus in the therapeutic work on how patients induce others to play a complementary role in their neurosis in many instances is the key element in understanding how the patient's difficulties are perpetuated. It would not be far from accurate to say the process whereby others are continually recruited into a persisting maladaptive pattern is the neurosis (Wachtel, l993, p. 25).

It is easy to understand why psychoanalysts who endorse such a perspective would have a more optimistic view of what the processes might be whereby couples therapy and family therapy could produce fundamental and lasting structural change.

According to Wachtel, the situation that the patient creates is precisely the one he is trying to avoid. Cyclical psychodynamics conceptualizes the patient's psychological state as one in which "the defense and the defended against determine each other in a continuing cycle of confirmation and reconfirmation" (Wachtel, l993, p. 23). The patient is understood to maintain his pathology because he is afraid not to live according to what his neurotic expectations dictate. Therefore, even more important than trying to help the patient gain insight into the origins of her neurotic patterns are the therapist's efforts to

address and help the patient overcome the anxiety that locks the psychopathology in place. An omnipresent fundamental task of the therapist is to resist responding to the patient's neurotic expectations in the way that the patient invites the therapist to react. A major reason the therapist can help the patient is that she directs her attention to avoiding being drawn into the role of accomplice, someone induced to interact with the patient in just those ways that confirm her perceptions and expectations.

Some Similarities and Dissimilarities in the Two Theories

Coming from a control-mastery perspective, it is striking how many of the recommended cyclical psychodynamic communications are virtually identical with the kinds of interpretations that control-mastery practitioners make daily. These similarities reflect certain fundamental commonalities. Both perspectives propose a relational psychoanalytic perspective that is heavily cognitive. Both perspectives derive from Freud's signal theory of anxiety. All of Wachtel's recommendations are based on the importance of framing interpretations in a manner wherein their impact will reduce the patient's anxiety as much as possible, enhance the patient's self-esteem, be permission-giving, and be experienced by the patient as respectful of her predicaments. Similarly, all of Weiss' recommendations are based on developing a relationship that will enhance the patient's unconscious sense of safety, and reduce the patient's fears of retraumatization. Both theorists implicitly assume that the therapist's empathy for a patient's unconscious anxieties helps the therapist anticipate how different kinds of interpretations will be heard by the patient. Both theorists also emphasize the importance of the reality basis for their patients' anxieties. Weiss emphasizes that pathogenic beliefs are derived from traumatic relational experiences. Wachtel states that

> Appreciation of the role of accomplices in the patient's difficulties enables the therapist to be sensitive to the *reality* dimension in neurotic suffering. We are used to thinking of neurosis as entailing needless suffering, *unrealistic* suffering, based on distorted perceptions, on misapprehension of the reality the individual faces. And certainly this is largely true. But one must recognize that the very nature of neurotic ways of living creates what one might call a "neurotic reality," that is a reality in which the expectations and reactions the person encounters from others are, at least in certain respects, more in line with the assumptions that constitute the neurosis than they are with what one might describe as the average expectable environment. The patient's dilemma begins to take on a life of its own. ...Appreciation of this reality basis for the patient's anxieties—of the ways in which the patient's neurotic patterns of living become self-perpetuating and draw out from others the very attitudes and reactions that will keep his neurotic assumptions intact—can enable the therapist to confront the patient's worst fears about himself without becoming one more accomplice in the patient's private rogues' gallery (Wachtel, l993, pp. 28-29).

Despite all of these similarities, there is a fundamental incompatibility between these two perspectives. Although both theorists agree that patients are intensely motivated to avoid retraumatization, their theories make conflicting assumptions concerning the patient's capacity to be an active agent whose behavior is in part designed to master her psychopathology. Within control-mastery theory, the patient's repeated behavior with the therapist or analyst in the transference is routinely understood to be a means to test the reality of her neurotic expectations. Wachtel, in contrast, would understand the same behavior not as a test, but as the patient's unconsciously and automatically relating to the therapist in such a fashion that she/he elicits an accomplice response from the therapist which then inadvertently reconfirms the patient's neurotic expectations. According to Wachtel, oftentimes the patient may not even realize that her behavior has this effect. Wachtel warns therapists against complying with the negativity of the patient's invitation. The therapist's task is either to resist such an invitation, or to acknowledge and discuss with the patient how she inadvertently got pulled into the neurotic interchange. I suspect that oftentimes such responses would in fact therapeutically counter the patient's pathogenic beliefs. Both theorists agree that the patient is reassured when the therapist responds in such a way that the disturbed relational pattern is not repeated in the context of the therapist-patient relationship. But it is important to note that cyclical psychodynamics does disclaim the patient's capacity to be an active agent who uses repetition as a means to work toward mastering her psychopathology . Consistent with such a characterization of Wachtel's position, in Therapeutic Communications Wachtel states,

>....A cyclical psychodynamic analysis points to how we actively bring about the patterns we have come to therapy to change, and do so repeatedly...Such an analysis differs quite substantially from that embodied in the concept of "repetition compulsion" (Freud, l920). The latter concept implies that...for the purpose of attempting to master a trauma by repeating it actively we intentionally (if unconsciously) cause the trauma to recur again and again. In contrast, the cyclical psychodynamic account of how we repeat problematic patterns does not typically posit an intention to reproduce the offending situation. The intention is quite the opposite—to *prevent* the repetition. The irony in what ensues lies in how, by the very act of carrying out that intention, the patient contributes to the outcome he is trying to avoid (Wachtel, l993, p. 24).

From Wachtel's point of view, much of the patient's behavior that Weiss characterizes as testing is simply the way that the patient characteristically elicits the therapist to function as an accomplice. From his perspective, control-mastery theory fails to consider how the patient routinely, in all her relationships, stimulates the very responses that ironically confirm her worst fears. Wachtel agrees that the patient is emboldened and encouraged, her anxiety reduced, and her progress facilitated, when the therapist succeeds in withstanding the neurotic pull, and refuses to function as an accomplice who once again reconfirms her neurotic expectations. But he pointedly asserts that this predictable consequence does not provide evidence that the primary purpose of the patient's stimulating the therapist to behave as an accomplice is to have an opportunity to have her expectations disconfirmed.

In summary, control-mastery theory and cyclical psychodynamic theory agree that if the therapeutic relationship creates a sufficient sense of safety, the patient is able to set aside defenses and accept a new perspective about her previously held neurotic expectations. In Wachtel's view, however, the defensive structure is a more solid determinant of the patient's behavior in treatment. In contrast, in control-mastery theory the basic need of the patient is to find a new solution to the problems posed by her pathogenic beliefs.

At this point I believe that any clinician who assumes the *pervasiveness* of either the cyclical psychodynamic or the testing phenomena may be overstating the importance of these theoreticians' enormously valuable contributions. I suspect that the temptation of overstatement always exists for adherents of theoretical insights that are designed to correct for something important missing in our body of knowledge.

Evidence for the Importance of Mastery Motivation

I will describe below clinical observations that I believe both illustrate the value of the concept of testing and more broadly illustrate mastery motivation. I do not see how cyclical psychodynamics can account for these observations. In this sense I believe that cyclical psychodynamics *understates* the rational, reflective and planful elements of unconscious mental functioning.

Clinical Evidence for the Concept of Testing

Some years before I became familiar with control-mastery theory and its applications, a patient whom I will name Rand sought treatment with what appeared to be some routine problems of late adolescence. Rand, a college student, was having difficulty in his dating relationships and was also very anxious about living up to his very high standards for academic performance. After we had been working well together for about one and a half years he began coming to his twice-weekly therapy sessions only to remain mute throughout the hours. No effort on my part to engage him in a dialogue about his experience was effective. Week in and week out we would meet at 7:00 A.M. only to spend the time together in total silence. Despite my numerous invitations, Rand seemed unable or unwilling to reflect on what was going on. Finally, after many weeks of this, I intervened in a way that didn't meet my own standard of therapeutic conduct, but which seemed to me better than any other alternative I was able to construct. I told Rand that I was feeling bored, trapped and frustrated, and that I did not want to allow resentment to become a significant element of our relationship. I asked him how he would feel if while I was in the room with him I were to read until he was ready to talk with me. He readily agreed that this would be fine. He did not show any interest in exploring the impact of what I was suggesting and instead returned to his mute state. I was mystified by our process and commenced reading for the remainder of the hour. I felt a distinct sense of discomfort since it appeared I was being paid for reading a book of my own interest. The

next hour Rand returned, again on time, and sat quietly. At one point he uncrossed his legs and I asked him if he was giving me a cue that he'd like to talk. Emphatically he said, "Oh no," and once again he remained silent. As best I can remember, following two or at most three such additional hours of silence, Rand began to talk. Although I had known that his mother had died of brain cancer while he was in high school, he now described in great detail the poignant experience of sitting helplessly at his mother's bedside during her last months of life, unable to make any verbal connection with her, and guilty about feeling trapped by what he experienced as his daily obligatory vigil. After reliving with me this very painful period in his life, Rand decided to apply for early admission to medical school, was accepted and concluded his therapy with a sense that the problems that had brought him to treatment had been resolved.

Some Theoretical Implications of the Vignette Taken from the Case of Rand

I find it meaningful to look at this case material from the vantage point of control-mastery theory. I believe that in keeping with Weiss's view of unconscious mental functioning, while Rand was engaged in a sustained period of silence he was a powerful agent working on behalf of his own treatment. Unconsciously, he knew better than I what it was he needed to do. Rand's testing was unconscious because it was connected to a trauma, and the associated pathogenic beliefs that were too distressing yet to face. Conceptualizing this sequence within the control-mastery framework I would infer that Rand was turning passive into active in order to test the reality basis of several pathogenic beliefs that he had developed in response to this trauma. He felt self-condemnation that he was an insufficiently devoted child because he resented sitting vigil with his mother. He may even have developed the omnipotent belief that his lack of devotion had contributed to his mother's death. He also felt guilty to go on with his own life when his mother's had ended so prematurely and tragically. He created a situation which stimulated resentment in me. To get on with my life I had to make some progress in overcoming my own guilt, guilt that had left me feeling that I was obligated to endure endless hours of stone silence. Although in retrospect I can see other ways, other than by reading that I might have addressed the situation, what seems most important to me is that Rand was able to identify with some capacities of mine, and this seemed to free him to lift defenses against very painful memories and feelings. Rand's passive into active test led to developments in our relational interaction, and subsequently in our discussion, that helped to free him from the pathogenic belief that he did not have the right to get on with his life. My impression is that the drama Rand created can better be conceptualized as an example of testing by turning passive into active than as simply as an instance of the defensive use of projective identification or identification with the aggressor. Rand's silent hours began following a period of work in which he seemed to be feeling a great deal of confidence in our relationship and satisfaction with his progress. He seemed highly motivated to come to these hours (unlike his therapist), and was scrupulous about getting his full fifty minutes of time with me. I believe his behavior fits with the concept of repetition as a test rather than with the concept of neurotic repetition. From anything I had learned about Rand, he was disinclined in his other relationships to withdraw from interchange and engagement with others.

Let me add that there may well have been an additional meaning to Rand's mutism. In this passive into active test, Rand was taking control of his leave-taking from me. There may well have been some mastery that he achieved by having created an opportunity to take charge of leaving me, given that his mother's death was a trauma that fate had enforced upon him. Oftentimes, patients gain mastery of traumas by having a sense of control over what transpires in the therapeutic relationship. Respecting and supporting such patients' autonomy may be more important than any interpretation or therapist-initiated interaction in helping these patients regain a sense of control over their lives. In such cases doing less is usually doing more.

I believe this vignette implies that Rand had a more active ego and brought to the treatment enterprise a greater capacity for mastery of conflict and trauma than I would infer Wachtel credits his patients as having. I also think this is a fairly dramatic example of how the testing concept can contribute to our understanding of what otherwise might simply be experienced as a patient's provocative, sadistic or controlling behavior. When the meaning of a test can be anticipated, something I was unable to do in this instance, such an understanding enables the therapist to have greater sympathy and empathy for the patient, and more tolerance for interchanges that, lacking this frame of reference, would routinely be experienced by most people simply as disagreeable or resistant. Finally, this perspective leads the therapist to ask of herself and perhaps to explore with the patient the possible links between her own subjective states and the experiences the patient may have had.

Without such a frame of reference, such provocative interchanges set the stage for negative transference-countertransference enactments or impasses. The testing concept suggests that when interactions with a patient lead to distress in the analyst, and the analyst believes that the patient has not stimulated the analyst's own pathological or distorted reactions, the analyst may likely be experiencing her patient's warded-off experiences. It should be noted that using a different theoretical framework, many clinicians employ the concept of projective identification to suggest that the analyst's most disturbing experiences are communications about their patients' deepest levels of disturbed object relations. In those instances where projective identifications are conceptualized as motivated by wishes for mastery, different terminology is being used to describe and conceptualize the same phenomenon.

I chose this particular example because I believe it illustrates how an historical event could produce persistent problems in the absence of everyday accomplices whose behaviors inadvertently validated the patient's need for the persistence of the contemporary symptom picture. Although the cyclical psychodynamic formulation integrating the psychoanalysts' attention to the potency of history with the behaviorists' emphasis on the role of continuing reinforcement has value, I think Rand's treatment illustrates that sometimes developmental traumas play a central role in their own right. The impact of Rand's trauma was not the result simply of a self-perpetuating process in which others were being enlisted in the here-and-now to function as accomplices.

Other Relevant Clinical Phenomena

Another clinical example cyclical psychodynamic theory cannot fully explain is the rare, but nonetheless observed, phenomenon of a patient's working progressively throughout an analysis in the absence of interpretation. In one such case, every time the analyst tried to make an interpretation, the patient became highly resistant. Paradoxically, she only was able to do analytic work as long as the analyst made no comments. How does one work with such patients who become more anxious and less productive in the face of any efforts the analyst makes to assist actively in the process? In our view patients who have been traumatized by excessive intrusion, or by extreme impingements on their autonomy may find that it is the analyst's inactivity that provides the best condition for them to develop a growing sense of safety, an emerging confidence that the analyst will not retraumatize them.

In our research we have found that it is not an infrequent event for warded-off material to emerge, as it did with Rand, in the absence of pertinent interpretation. In the analysis of Mrs. C., a case which our group studied extensively, she made a great deal of progress during the first one hundred hours of treatment without interpretation. Although Wachtel shares with Weiss the view that a primary task of the therapist is to help reduce the patient's perception of danger, he does not describe any cases in which reducing anxiety by being quiet and inactive is the treatment that frees a patient to move steadily forward. He has illustrated how the therapist's active interventions can refute the patient's cyclical dynamic patterns. Wachtel assumes that without the active intervention of the therapist, the patient cannot make substantial progress. It strikes me as possible, in keeping with Wachtel's ideas concerning the self-fulfilling nature of expectations, that his own theory might lead him and his followers to use interventions that would preclude allowing the opportunity to arise in which these kinds of observations would be made. If this were the case, then he would not be in a position to identify those portions of the therapeutic process in which cyclical psychodynamics were not the fundamental dynamic that was operating.

The control-mastery group is particularly interested in understanding the commonplace behavior of people who, outside of therapy, make significant psychological gains in response to various kinds of salutary interpersonal experience. Wachtel's valuable contribution focuses on the opposite problem and offers an encompassing explanation for why it is that people are not able to overcome their developmental history and instead persistently repeat it in their contemporary relations. It is those instances in which the analyst's activity involves mindfully doing nothing, and in which such a stance reduces the patient's anxiety, that the data can most clearly make prominent the mastery motivation that the patient herself brings to the treatment enterprise.

The Case of Tom

I am now going to present a case in order to demonstrate how the concept of testing can throw light on a sequence of events which might appear to be unrelated, but which can be interpreted to have coherence when the control-mastery perspective is applied to the clinical data. I hope to illustrate how the

testing component of my case formulation provided a logically integrated, intelligible explanation for my patient's difficulties, clear guidelines for my interventions, and a convincing explanation for my patient's progress.   This case formulation is *not intended for the purpose of disproving a cyclical psychodynamic formulation.* As I will indicate below, I believe that cyclical psychodynamic perspective would also lead to a coherent formulation with possibly similar implications for technique.

When first Tom consulted me, he was an attractive 34 year-old man who was tall, and somewhat stocky. He was married and the father of two stepchildren.   The older child was away at college. The younger, Jill, was living at home with Tom and his psychotic wife. In Tom's initial session he reported being in a panic because he had just been fired from his job in an accounting firm. His description of the events that led to his dismissal elucidated certain aspects of his psychopathology. According to the patient's own report, he could not tolerate clients or colleagues having a good opinion of him. He repeatedly disappointed those he had initially impressed by failing to complete promised work, by making careless errors, or by focusing on inconsequential details to the neglect of fundamental issues. Sometimes Tom knowingly took the blame for errors that he knew were not his responsibility.   For example, a client who failed to follow Tom's advice blamed Tom for subsequent problems that arose. When questioned, Tom told his employer that the problem was entirely his responsibility.   When I expressed surprise at his willingness to accept unjust blame, Tom replied with characteristic nonchalance saying, "This is just one of my self-destruct mechanisms."

Tom had to decide whether to continue practicing accounting, and if so, whether to go into independent practice. As Tom struggled to understand his conflicts about how to proceed, it became clear that he was preoccupied with worry about how his father, also an accountant, would respond to his decisions. When I commented to Tom about his apparent compulsion to undercut his potential career success, he immediately focused on his conflicts about competing with and surpassing his father.

Tom's father also worked in a large accounting firm. Tom said that his father had always regretted not having entered independent practice. Tom feared his father might feel hurt and humiliated were Tom now to begin a private practice. Tom viewed his father as someone who would be helpful if the patient were failing, but who would become disinterested and unavailable when his son was successful. Tom appeared to be discouraged by his father's reactions. He reported that his father continually offered him unsolicited, gratuitous advice, but minimized his son's actual achievements. He conveyed his surprise that others respond to him with admiration when he competes successfully.

During the initial treatment period, Tom gained some insight into his omnipotent fear that he would hurt his father by functioning successfully in his profession. As Tom became better able to control his work-related self-destructive behaviors, he felt freer to launch his own independent practice. He also decided to undergo psychoanalysis.

Some dramatic changes accompanied Tom's transition to the couch. He began revealing his ongoing fantasies about forcing his stepdaughter into a sexual relationship. At times the fantasies involved rape; at other times they were seduction fantasies.   The patient confessed to rubbing his stepdaughter's back and stomach and feeling sexually aroused by these repeated physical intimacies. He also reported fantasies of raping and beating me, as well as a dream in which I was a seductress, intent on disrupting the analytic relationship. In associating to this dream, Tom recounted an incident that had occurred when he was 22. The patient's stepmother who was at the time in her early thirties got drunk while visiting at a relative's home. Tom reported that the stepmother tried to seduce Tom, and when he refused to be enticed, she removed all her clothing. The patient ran from the house with his stepmother chasing after him until she fell down in a drunken stupor. Tom and the relatives carried the woman to a bedroom. The next day Tom's father and the rest of the family totally ignored the whole incident.

The first time during Tom's psychoanalysis that he posed the transference test of inviting me to ignore disturbing behavior was when he confessed to driving 60 miles an hour on city streets. He downplayed the seriousness of his reckless driving. After I pointed out how he was urging me to disregard his self-destructive behavior he began to remember incidents while in high school and college when he would drive home drunk and would be throwing up loudly. Both parents are reported to have totally ignored these signals. After he dropped out of college, he used drugs extensively, especially cocaine. Whenever he went home, no matter how terrible he looked, his mother complimented him on his appearance. I believe the patient had been unconsciously discouraged by this stance, and took it to mean

that she expected and required little of him. I came to learn that whether the patient was engaging in delinquent activities as a child, or later, as a college student was using hard drugs, driving dangerously under the influence of alcohol, or dropping out of school, mother and maternal grandmother had only praise for him.

During the second year of analysis, Tom revealed additional traumatic experiences. As a child, he often stayed at his paternal grandmother's estate, where her children and grandchildren convened for long and frequent visits. The grandmother and her two children (including the patient's father) constantly engaged in deeply distressing conflictual interchanges. For example, the grandmother blamed her daughter for the grandfather's fatal stroke, although the rest of the family believed his death immediately followed an argument with the grandmother. The grandmother's endless, repetitive accusations led to great commotions. Mealtimes were marked by explosive interactions. Shouting, drunkenness and tearfulness were daily routines of family life. On one such occasion, Tom's father broke every piece of furniture in the house, and another time he destroyed all the china and crystal. Another time father packed the children into the car and deliberately drove up and down grandmother's lawn, thereby destroying it. Based on the patient's associations to the family crises I offered the interpretation that he seemed to have felt unconsciously guilty about his inability to alter these events. After these previously warded-off memories and affects emerged, I was able to interpret some of the genetic origins for the patient's heretofore surprising pattern of devoting enormous amounts of effort to rescuing those around him rather than attending to his own serious problems. Tom remembered being unable to shake a sense of responsibility for everyone's chronic unhappiness, and at times attempting to cheer them up. More typically, he tried to protect himself from the emotional impact of this brutality by telling himself that these events were exciting and amusing. I pointed out to Tom that he used a bored and disinterested tone of voice in describing these horrifying experiences and that I thought he acted so blandly at times when he feared the intensity of the feelings he might otherwise experience. The patient's ability to tolerate painful feelings increased slowly and steadily throughout the duration of the analysis.

Tom told me more about the serious dissension in his family, in part because father was abusive and in part because mother was unable to protect herself from father's mistreatment. The parents divorced twice. Following each divorce, father refused to make child support payments, thus leaving mother overburdened with the financial as well as the emotional responsibility for each of four children. Tom was aware that his father had numerous affairs including one with the next door neighbor's wife.   When the cuckolded husband confronted Tom's father, the father threatened to kill him, and sat in the kitchen with a loaded weapon by his side.

After the parent's second divorce, Tom's visits with his father often involved a blurring of the boundaries between the generations. For example, when the patient was in his teens, his father began inviting him to join him at bars, where the father routinely made derisive comments about women.   Father and son also experimented together with drugs, which indicated to the patient that his father had entered a second adolescence. Without my help he was not able to connect these observations with those about his own adolescent behavior with his stepdaughter, such as actively instigating rock and roll dancing sessions with her when his wife was away from home.

During the next two years of treatment, Tom provoked shocking crises on two separate occasions. The first crisis occurred the day I returned from my summer vacation. During the session Tom blandly reported that he had been accumulating a debt of more than $60,000. He quickly changed the topic, stating that this kind of reality concern represented an avoidance of analytic work.   With exploration it became evident that he had incurred this debt because of his unrealistic and extreme sense of responsibility for the welfare of others. The patient was paying for his step-daughter's thrice weekly therapy, her twice-weekly tutoring, her private school education, and her summer camp program. He was also paying for his wife's psychotherapy and her private college education. In addition, he had loaned a large sum of money to a friend who had subsequently declared bankruptcy. The patient was also making major expenditures on behalf of his other stepchild, who was struggling with serious legal problems.

I addressed the problem as follows. I suggested that the patient would either have to find a way to solve the financial problem, or it would be necessary that he cut back drastically on his current expenses including his analysis. I told him that even though I thought the analysis was of great importance for him, I would find it unconscionable to continue the treatment if it meant that it was going to lead to his eventual

bankruptcy. Tom seemed surprised and relieved by my stance. He reported expecting me to respond much as he pictured his mother had. The transference expectation was that I would ignore the seriousness of his financial problems. After several months of work, Tom overcame his over-identification with his friend, and worked out an arrangement that met his own financial needs. As we continued to explore his compulsive me-last attitude, he was able to implement a plan that resulted in his more than doubling his earnings.

Shortly after the resolution of this financial difficulty, the second crisis occurred. Tom revealed that he was entering his stepdaughter's bedroom, ostensibly when she was asleep, and fondling her breasts. He spoke about this incestuous activity in a detached, bored tone of voice, and denied its significance, asserting that she was asleep and that it couldn't possibly do any harm. I responded by challenging Tom's denials and rationalizations and then asked him if he could commit himself to stopping the behavior entirely. He agreed to do so. Since all the family members were in treatment at this time, and since Tom had always been highly conscientious about the importance of keeping promises, I felt confident that we would subsequently be able to explore the meanings of his incestuous fondling of his stepdaughter.

In both of these crises, my patient appeared to be testing me to see if I, like his mother and father, would disregard the seriousness of his actions. A prominent theme for this patient involved numerous childhood delinquent and self-endangering actions that his parents simply ignored. Tom had found the absence of parental attention most disturbing. He tried to rationalize the neglect as freedom, but he was troubled by the absence of parental protection. He had inferred from his parents' neglect that they enjoyed his being a troublemaker, and that he would disappoint his father in particular if he stopped getting into trouble.

In both of these crises I told Tom that he had to stop what he was doing. In the second crisis, the patient not only stopped fondling his stepdaughter, but he was also able to tolerate experiencing himself as having been monstrous, perverse and corrupt. Tom contrasted my response to those responses he believed his mother would have made. He thought she would have said something minimizing and inane such as "that's not nice".

In these crises, Tom was also testing me in a second way. By forcing me to witness an adult behaving in uncontrolled and abusive ways, he was putting me into the position he was in as a child. Thereby he was testing and identifying with my ability to tolerate the intense feelings that he had had to repress, in particular, feelings of alarm, contempt, disgust and worry. Let me add that years later one of my hunches, based on my case formulation was in fact confirmed. He described how he had felt compelled to engage in this incestuous behavior right after reading about a new law that had been passed that required all psychotherapists to report child abuse to the state.

The theme of illicit and incestuous sexual relationships remained prominent in our subsequent work, primarily in the form of his reported dreams, fantasies, and memories. As the analysis proceeded, it became a pattern that Tom became preoccupied with the theme of illicit and incestuous relationships under two circumstances: (l) when he functioned unusually well as a parent and (2)when he witnessed destructive behavior by a family member. Tom's anxiety about doing better than others appeared to reflect his unconscious survivor guilt. Whenever he succeeded in areas where his parents had failed, or whenever he witnessed family members pursuing disastrous courses, Tom punished himself for these inequities by becoming obsessed with thoughts of sexual intercourse with his stepdaughter. He was aware that these thoughts were not arousing; rather, they were a form of self-torture that disrupted his sleep and generally left him feeling miserable.

This line of interpretation enabled the patient to exercise control over his sexuality and his other need-gratifying behaviors. After the first five years of the analysis, the work was discontinued because of some important career opportunities that led to his deciding to relocate. At the time that we stopped working together he had been able to work out an appropriate parental relationship with his stepdaughter and had become unusually successful in his profession. Tom's colorless way of presenting himself had yielded, and he was characteristically displaying much more vitality and emotional expressiveness in his relationship with me. He had divorced his very disturbed wife and was in what seemed to be a vastly better relationship with his second wife. He had overcome his feelings of responsibility for living like a "chip off the old block". His analysis had helped him disconfirm his powerful unconscious belief that controlling his instinctual impulses jeopardized his relationships with his parents and constituted an act of disloyalty

(Weatherford, l989).

Some Theoretical Implications of the Ccase of Tom

In this highly summarized case presentation I have tried to illustrate how Tom's traumas and the associated pathogenic beliefs he developed led to my devising specific interventions, interventions whose purpose was to help him master the effects of his childhood traumas. I understood Tom's incestuous interest in his stepdaughter to represent primarily Tom's way of punishing himself for his successful efforts to be a more loving and responsible parent than he viewed his parents to have been.   I inferred that Tom's behavior toward his stepdaughter expressed a pathological identification with his father as well as his stepmother.   I viewed Tom as motivated to disconfirm his pathogenic belief that he was harming his parents whenever he behaved as a responsible parent, and his guilt about this disloyalty.

The concept of testing helped me to understand and organize the meaningful pattern underlying this seemingly out-of-control behavior.   Without the concept of testing I might well have made the prima facie assumption that Tom's incestuous activity was simply drive-gratifying behavior. I had inferred, however, that Tom was suffering from an irrational sense of guilt and was engaged in a form of self-destructive behavior. This behavior reflected his omnipotent belief that he bore some responsibility for his parents' illicit sexual activities. I understood Tom's behavior as also motivated by his need to deny his disillusionment with his parents. I saw part of my task as being to demonstrate to Tom the manifestations of his pathological identifications with his parents.   The testing concept helped me to understand how Tom's misdirected love for his father motivated his sexual perversity, and how his seeming indifference represented a disguised cry for help.

Throughout Tom's treatment he repeatedly posed the transference test of inviting me to ignore his disturbing behavior. In these transference tests Tom risked being retraumatized because I, like his parents, might ignore or respond permissively to his reports of self-destructive, out-of-control behavior.

We have observed that some patients work to master trauma by engaging in low risk tests early in treatment and in response to such tests being passed, pose increasingly risky tests.   In the case of Tom he first tested my willingness to protect him from his self-destructive behavior when at the beginning of his psychotherapy he described knowingly taking unearned blame.   Subsequently, early in the formal psychoanalysis, he then nonchalantly confessed to driving recklessly on city streets. The tests became increasingly risky when he next mentioned in an offhand fashion that he had accumulated a serious debt. Finally, he confessed having an illicit and incestuous relationship.

Adapting the behaviorists' concept of desensitization, one could conceptualize such an effort at mastery as an instance of a patient generating a hierarchy of increasingly anxiety-inducing trial actions that invite the analyst to negatively reinforce her pathogenic beliefs.   Within control-mastery theory such a hierarchy of increasingly difficult tests constitute evidence of the patient's mastery motivation.   By working in this manner Tom tested the reality basis for his pathogenic beliefs.

Without the concept of testing I might have erroneously concluded that Tom was unanalyzable. I have found the testing concept particularly helpful when trying to understand the more destructive or seeming maladaptive aspects of human experience. Testing is one powerful way for patients to reevaluate the reality basis for their unconscious perceptions of danger. In response to Tom's report about his incestuous behavior I confronted the self-destructive and self-deceptive aspects of his behavior.   Tom then became able to face his own feelings that this behavior was reprehensible. He was also able to relinquish his use of denial concerning the extent of his parents' perversity as reflected by their illicit sexual invitations. Subsequently I was able to interpret the guilt that Tom experienced when he functioned as a responsible parent.   Some months after my prohibitions of and interpretations of Tom's incestuous activity he commented that my confrontations were the most important thing I had ever done for him. He reported no additional episodes in which he was tempted to fondle his stepdaughter and we were able to examine further his unconscious beliefs about the expression and regulation of sexuality relying solely on his fantasies, dreams and transference expectations.

As best I can tell, Wachtel would view the success of this analysis as in keeping with his fundamental view of a good treatment process as being one in which the therapist finds ways to disconfirm a patient's pessimistic neurotic expectations. Wachtel and Weiss would agree that relational experiences that disconfirm pathogenic expectations will reduce the patient's anxiety, and symptomatolgy and free the

patient to change his behavior.

I would guess that Wachtel would not have any major disagreement with the formulation I have offered of Tom's traumas and pathogenic expectations. From a cyclical psychodynamic frame of reference, however, the interventions that I conceptualized as instances of passing tests would be understood by Wachtel and his followers, I suspect, as examples of occasions when Tom failed to induce me to behave as an accomplice. Thereby I disallowed him to keep his neurotic assumptions or pathogenic beliefs in tact. I would expect that Wachtel would emphasize and interpret, in a case like this how the patient's self-destructive actions, based on unconscious guilt, led to his engaging in just the kinds of reprehensible behavior that further fueled his need for punishment. I would also think that Wachtel might be likely to focus some of his interpretations on inviting Tom to see how his very method of speaking in a bored, disinterested, deadened manner induced in others just the kind of neglect that he hated experiencing from his parents. Wachtel might understand the significance of Tom's use of isolation of affect as an instance of automatic defensive behavior designed to protect him from risking the even more devastating experience of making one's needs known loud and clear and then having them overlooked. Wachtel might try to help Tom see how his bland presentation elicits the very kinds of disregard that he most dreads re-experiencing. Finally, I assume that Wachtel would conclude that my ability not to be induced to interact with Tom in just those ways that would have confirmed his fearful expectations left him pleasantly surprised, but that his delight and his subsequent progress do not in and of themselves demonstrate that Tom unconsciously designed these "tests" with the hope of mastering his traumas. Thus it is that Wachtel and DeMichele state in their discussion of Weiss' work that the concept of the patient's plan for mastery "confuses a predictable consequence with an intention" (l998, p. 433).

The Therapist's Role In Helping A Patient Overcome A Cyclical Psychodynamic

Wachtel's work embraces any therapeutic approach that helps reduce the patient's anxiety by disconfirming his pessimistic, self-fulfilling, neurotic expectations. Wachtel's patient is seen as treatable if the therapist-patient dyad can engage in interchanges that reduce the patient's neurotic anxiety and disconfirm her neurotic expectations. Although control-mastery theory also leads to a technique that is designed to disconfirm pathogenic beliefs, many clinicians who work within Weiss's framework emphasize the patient's capacity to pose passable tests as the major determinant of how treatable the patient will prove to be. I am going to describe the case of Ruth, a patient whose functioning deteriorated after two years of seemingly successful, intensive psychotherapy. Following a devastating set-back in her life, she became so discouraged that I believe she lost the ability to test. In response to my patient's crisis, I made direct efforts to instigate and guide new behavior patterns, a stance that reduced the hold on her of her pathogenic beliefs. My behavioral interventions achieved their intended effect, and the downward spiraling of Ruth's depressive state was halted. Wachtel's formulations very nicely explain just this process.

Ruth suffered from a pathogenic belief that she deserved little from life. Her childhood had been characterized by emotional abuse and neglect. Her own normal needs for love, attention and protection had been severely thwarted. Ruth's family life had been dominated by the difficulties of having a psychotically depressed mother who periodically required hospitalization. Although Ruth was the youngest of four children, she took on the mantle of mother while her older siblings, all boys, continued to engage in what by outward appearances at least were normal adolescent activities.

Despite all of Ruth's desperate ministrations, mother remained severely depressed. Father was described as a hard-working breadwinner who often had to travel. The patient adored her father and benefited enormously from his encouraging her to go to college, develop a career and become self-sufficient. Tragically, father suffered a stroke and died while Ruth was attending a highly prestigious out-of-town college, and the patient left college to return home to care for mother. Despite Ruth's powerful attachment to her father, during the eight years of treatment she never described any childhood incident in which father tried to protect her from playing the role of mother's nursemaid or the family's servant. So it seemed natural to Ruth that this self-sacrificial stance was the only basis for having any right to any kind of relationship with her parents.

I want to highlight some of the unconscious pathogenic beliefs that I inferred Ruth had extracted from these traumatic experiences. In therapy it became clear that Ruth suffered from a burdensome omnipotent belief that she was responsible for her parents' unhappiness. This omnipotent belief caused her unconsciously to view herself like a criminal who deserved nothing from life. Ruth developed these beliefs

16

based on her view that she had profoundly failed both her parents. She believed she failed her mother because of her inability to cure her. She believed she failed her father by leaving home instead of staying to help reduce the enormity of the stresses that plagued his daily life. She thought these stresses led to his suffering the stroke that killed him. In sum, she felt an intense sense of responsibility for her parents' ill fates.

Ruth also suffered from a pathogenic belief that she was an incompetent person who would be unable to succeed at mastering life's challenges, and that she therefore needed to depend on others to take care of her. Ruth acquired this belief based on experiences in which she failed to solve the problems in her family life of such urgent importance for her. The problems at home had been insurmountable. As a child she lacked the perspective necessary to understand that no child could possibly have solved these problems. Instead she came to view herself as inadequate, and retreated to passivity with an underlying conviction that she was helpless and defeated.

Before describing how Ruth's therapy addressed these pathogenic beliefs, I will first offer some background information. Ruth presented as an extremely depressed patient. She displayed a submissive and long-suffering attitude. Ruth had been married to a highly successful professor-inventor, a man whose creations had enabled him to accumulate much wealth. Ruth was particularly resentful of the love and adulation that her husband's students had for him. This was in sharp contrast to the many grievances which she harbored against him. Ruth had three children who were young adults at the time she first consulted me. The patient took some moderate comfort in her children's modest successes but had often felt unduly burdened by the roles of wife and mother. Despite her obvious intelligence Ruth had not pursued additional education nor a career once her father had died. Ruth recounted several serious suicide attempts that she had made, and her dissatisfaction with a string of psychotherapists and psychoanalysts with whom she had worked both while hospitalized and on an out-patient basis. When the patient's husband divorced her, she self-destructively gave away much of her portion of the accumulated community property. She told herself that she wanted to be free of the encumbrance of the large Bostonian home in which she had raised her family and she moved to a small apartment in Cambridge. When I first met her she was living off the dividends from a stocks and bonds portfolio, the only part of the estate that she had kept.

After two years of twice-weekly psychotherapy meetings Ruth decided that she wanted to go back to court to seek what would have been a more equitable settlement. She was feeling more deserving and assertive, having acquired a good deal of insight about the self-destructive, punishing motives that had led to her original maladaptive stance. Ruth felt that the additional income would enable her much more freedom to return to school, and more importantly to return to the time preceding her father's death when she had truly been flourishing. Without the additional resources, she needed to seek some form of menial employment, an alternative that filled her with indignation.

Despite what might have been progressive about the patient's wish to seek legal redress, I worried that going to court might be disastrous. Because the patient suffered such intense unconscious guilt I feared she might be set back by a major win, and devastated by a major loss. I interpreted her irrational wish to invoke the court to judge who was good and bad, deserving and undeserving. Since she wanted to make her mental health a point at issue, I also talked about how disruptive it could be to our work were she to engage me in any role in a court battle. Ruth never showed any interest in reconsidering her decision, but agreed to protect our relationship by having no access to any testimony I would have to give. Despite numerous attorneys confirming that the patient had a strong case, and despite there being no disagreement between the mental health experts on both sides, when Ruth went to court she lost. She then became increasingly depressed and no interpretative stance I took seemed to help. I increased the frequency of our sessions but saw no evidence of progress. Suicidal thoughts began to dominate. It was emotionally impossible for the patient to accept that there was no court of appeal and no choice but to call it a day. Although it did not seem to me that Ruth had arranged to experience the disappointment of the courtroom, she now seemed obsessed with collecting signs of injustice.   Her indignation and rage were directed at her husband, her attorney and me. Her blaming stance seemed to represent a defense against her intense feeling of self-blame. Her entitled stance of what the world owed her seemed defensive against her belief that she deserved nothing. The gods, as represented by the court, had confirmed her pathogenic belief that she was bad, unworthy, incompetent and undeserving. Her self-assertive behavior had been punished.

The patient was now in a downward spiral. Her anger, helplessness, and depression were leading to her doing the very things that were making her feel worse and worse. She was provoking all the people who cared about her, and thus confirming her own belief that her relationships only compounded her problems. Her frustration at not extracting help from others was only leading her to treating others with hostility and their responses were only serving to confirm her view that relationships were not a source of comfort or help. Thus, a cyclical psychodynamic was in full force. Because Ruth had given up, she was no longer motivated or capable of engaging me in any tests of her pathogenic beliefs. The underlying beliefs had become unassailable convictions.

I began to fear that Ruth was once again going to require hospitalization, a step I dreaded taking because her prior hospitalizations had carried meanings for her similar to those of the court defeat. I began meeting with Ruth on a daily basis. Yet my words no longer seemed to make any positive impact. Moreover, she no longer held any hope that understanding could make a difference. In her mind I too had become one of the villains who had failed her.

Now I was feeling helpless to stop the patient from deteriorating, much as she had been with mother. I saw no evidence that her stance was a form of passive into active testing. Rather than leading to growing self-awareness and insightful reflection, her mental state was continuing to deteriorate. I felt I needed to find a means to help her combat her pathogenic belief, despite her demonstrating no motivation to fight these self-defeating convictions. I told her that despite her claims to the contrary, she was living her life as if she deserved nothing. I suggested that we try an experiment. I told her I wanted her to find some way to give herself a daily treat, and that I wanted to hear the details of that experience. Eventually, and with much reluctance, Ruth agreed. Despite the patient's many claims concerning how much the world owed her, it became dramatically clear to her now that she found it extraordinarily difficult to give herself anything. The easiest thing she could tolerate was treating herself to an ice cream cone, something her mother had also found comforting. Gradually she allowed herself to shop at Filene's bargain basement and buy some inexpensive items–a scarf, a belt. After a couple of weeks, the patient was feeling vastly better. The vicious cycle had been broken. She began buying fabric and sewing small articles of clothing for her grandchildren. She even was able to make herself a dress. Her acting the part of being deserving seemed to lead to her beginning to regain a belief that she was deserving. The fact that she was doing this in compliance with her therapist relieved her of the responsibility for these small indulgences. My daily meetings combined with my attentiveness to the details of her daily life also seemed to help her counter her conviction that she was so unworthy, unimportant and undeserving. As she began once again to feel a positive connection to me she was able to remember previously warded-off memories of her husband's futile attempts to help her give more to herself. Eventually she was even able to begin to take some realistic responsibility for the negativism she had brought to her family life. Years later, when Ruth was no longer a patient, she wrote to tell me about how she had pulled herself out of another depression, one occasioned by a major financial loss. Her solution was to give something to herself each day. She made daily arrangements to create opportunities to bring more interesting people into her life, and was thus able to overcome her depression.

One of the fundamental differences between the control-mastery and the cyclical psychodynamic perspectives concerns the conceptualization of who is the agent for change, and who has the primary role in overcoming the patient's psychopathology. Both theories assume that the patient is motivated and capable of monitoring her interpersonal relations such that she will be alert to evidence that her pathogenic expectations are not being confirmed. The studies of our research group have repeatedly demonstrated that when therapists are "pro-plan", that is, when they disconfirm a patient's pathogenic expectations, the patient becomes less anxious, more insightful and her work moves forward (Silberschatz, l986, Silberschatz et al., l986, Caston et al., l986, Bush and Gassner, l986). These findings are consistent with the expectations of both control-mastery theory and cyclical psychodynamics. Our research has also demonstrated that when the analyst or therapist passes the patient's tests, the patient progresses. Wachtel might conceptualize these interchanges as instances in which the therapist succeeds in not behaving as an accomplice.

This case illustrates how the therapist's own initiative may lead to the patient's increased capacity to disconfirm pathogenic beliefs. Although this example highlights the therapist-generated activity that helped to disconfirm the pathogenic beliefs of a suicidal patient, the broader purpose for describing the case of Ruth is to illustrate that a patient need not test for the therapist to play a significant role in disconfirming

the patient's pathogenic beliefs.

Discussion:

What is fundamentally incompatible about the Weiss's and Wachtel's perspectives involves the question of the relative responsibility the therapist or the patient have in directing the treatment. Within control-mastery theory the patient is understood to be a *powerful agent* who is highly motivated to master her problems. Wachtel, in keeping with the generally active stance recommended by behavior therapists, conceptualizes the therapist as the primary agent for change, the person who brings about such change by collaborating with the patient and guiding the treatment In keeping with this fundamental difference, the two theories make different assumptions about the motivation underlying patient repetition. Wachtel's patients are assumed to repeat as part of a self-defeating effort to avoid retraumatization. Repetitions are understood to be the very expression of the patient's neurotic expectations. Repetitive patterns are locked into place because the patient extracts from others reinforcements for her neurotic expectations. Weiss' patients are understood to repeat sometimes as a part of a therapeutic process, sometimes because they are giving voice to their pathogenic beliefs, and sometimes because they are unconsciously ruled by guilt. When patients repeat as part of a therapeutic process, they are seeking to disprove their pathogenic beliefs, and thereby master their traumas.

Sampson (1994), who has played a pivotal role in the whole evolution of the control-mastery movement, has recently introduced the concept of treatment by attitudes, a concept that bridges certain aspects of these two differing perspectives. Sampson has described one of the ways that therapists inevitably impact patients' pathogenic expectations. He points out that the attitudes that a therapist conveys about a patient, as the patient experiences them, are powerful determinants of the patient's progress. He asserts the importance of using a case formulation to determine and convey those attitudes which would help to contradict the patient's pathogenic beliefs about herself and her interpersonal world. He has described how treatment by attitudes produces lasting intrapsychic changes.

Control-mastery theory would be enriched were its proponents to expand their category of "pro-plan" interpretations to include efforts to illustrate to patients the very ways that their pathogenic beliefs become self-fulfilling. This clearly is a kind of insight that helps patients combat their pathogenic beliefs and gain control over their self-destructive behavior. Our group has not focused yet on how to infer whether a patient interchange is motivated primarily by the unconscious goal of disconfirming her pathogenic beliefs or a defensive need to contain anxiety. To what extent does such a differentiation have an implication for technique? Cyclical psychodynamic formulations invite our group to ask ourselves to consider the interventions we might make for the purpose of disconfirming a patient's pathogenic beliefs, during those periods of treatment where there is no clear evidence that the patient is testing her pathogenic beliefs. The introduction of treatment by attitudes is an example of one such technique.

Cyclical psychodynamic theory would be enriched, I suspect, were its practitioners to consider how patients' motivation for mastery might better be enlisted in the service of treatment goals. As one specific aspect of this question, Wachtel's group could consider the value of determining when therapist inactivity and the respect for patient autonomy might help patients break their pathological, relational patterns. If cyclical psychodynamic therapists expected patients to be capable of being powerful agents who work in treatment to overcome their psychopathology, they might observe some self-fulfilling results of such an attitude.

Despite the major differences between the two theories, I view Weiss and Wachtel as kindred spirits. Within both perspectives the combination of patient-therapist interactions and interpretations that disconfirm pathogenic expectations are the means by which the clinician helps the patient overcome her psychopathology. Both theorists view the disconfirmation of patient's neurotic expectations as the essence of a progressive therapeutic process.

References

Broitman, J. (l985). Insight: The mind's eye. An exploration of three patients' processes of becoming insightful. *Dissertation Abstracts International*, 46 (8). (University Microfilms No. 85-20425)

Bush, M. and Gassner, S. The Immediate Effect of the Analyst's Termination Interventions on the Patient's Resistance to Termination. (1986). In *The Psychoanalytic Process: Theory, Clinical Observation*

& Empirical Research.   Weiss, J., Sampson, H. and the Mount Zion Psychotherapy Research Group., l986, 299-319.

Caston, J., Goldman, R., McClure, M. The Immediate Effects of Psychoanalytic Interventions. (1986). In *The Psychoanalytic Process*: *Theory, Clinical Observation Empirical Reserach.* Weiss, J., Sampson, H. and the Mount Zion Psychotherapy Research Group, l986, 277-299.

Fretter, P.B. (l984). The immediate effects of transference interpretations on patients progress in brief psychodynamic psychotherapy. *Dissertation Abstractions International,* 46, (6). (University Microfilms No. 85-l2ll2)

Freud, S. The interpretation of dreams (l900). *Standard Edition*, 4, l-338; 5, 339-627. London: Hogarth Press, l953.

Freud, S. On psychotherapy (l905). *Standard Edition*, 7, 255-568. London: Hogarth Press, l953.

Freud, S. Papers on technique (l9ll-l9l5).*Standard Edition*, l2, 83-l7l. London: Hogarth Press, l958.

Freud, S. Inhibitions, symptoms and anxiety (l926). *Standard Edition*, 20, 77-l75. London: Hogarth Press, l959.

Gassner, S. and Bush, M. (l983). Unpublished paper.

Gassner, S., Sampson, H., Weiss, J. and Brumer, S.(l982) The Emergence of Warded-Off Contents. *Psychoan. And Contemporary Thought*, 5: 55-75.

Gassner, S. and Bush, M. Research on Unconscious Mental Functioning in Relationship to the Therapeutic Process.   In M. Bornstein and J. Masling (Eds.).*Empirical Studies of the Therapeutic Hour*. Washington, D.C.: American Psychological Association, l998.

Horowitz, L., Sampson, H., Siegelman, E., Wolfson, A. & Weiss, J. (l975) On the Identification of Warded-Off Mental Contents: An Empirical and Methodological Contribution. *J. Abnorm. Soc. Psychol*., 84: 545-558.

Linsner, J. (l987). Therapeutically effective and ineffective insight: The Immediate Effects of Therapist Behavior on a Patient's Insight during Short-Term Dynamic Therapy. *Dissertation Abstracts International,* 48, (l2b). (University Microfilms No. 88-0l,73l).

Sampson, H. (l994), Repeating Pathological Relationships to disconfirm Pathogenic Beliefs. Commentary on Steven Stern's "Needed relationships". *Psychoanal. Dial.,* 4: 357-36l.

Sampson, H. (l994), Treatment by Attitudes. *SFPRG Process Notes,* 1, 8-l5.

Shilkret, C., Issacs, M., Drucker, C. & Curtis, J. (l986). The Acquisition of Insight. In *The Psychoanalytic Process: Theory, Clinical Observation & Empirical Testing.*. Weiss, J., Sampson, H. and the Mount Zioin Psychotherapy Group, New York: Guilford Press. 206-221.

Silberschatz, G. (l986). Testing Pathogenic Beliefs. In *The Psychoanalytic Process: Theory, Clinical Observation & Empirical Testing.,* Weiss, J., Sampson, H. and the Mount Zion Psychotherapy Research Group, 256-267.

Silberschatz, G., Sampson, H. and Weiss, J. Testing Pathogenic Beliefs versus Seeking Transference Gratifications. In *The Psychoanalytic Process: Theory, Clinical Observation & Empirical Testing*. Weiss, J., Sampson, H. and the Mount Zion Psychotherapy Research Group, *267-277.*

 Wachtel, P.L. (1993) , *Therapeutic Communication: Principles and Effective Practice.* New York: Guilford Press.

Wachtel, P.L. (1997), *Psychoanalysis, Behavior Therapy, and the Relational World.* Washington, DC: APA Books.

Wachtel, P.L. and DeMichele, A.   Unconscious Plan or Unconscious Conflict? Commentary on Joseph Weiss' Paper. *Psychoanal. Dial.*, l998, 8, 429-442.

Weiss, J. (l952). Crying at the happy ending. *Psychoanalytic Review*, 39, 338.

Weiss, J., Sampson, H. & the Mount Zion Psychotherapy Reserach Group, ed. (l986), *The Psychoanalytic Process: Theory, Clinical Observations & Empirical Research*. New York: Guilford Press.

Weiss, J. (l993), *How Psychotherapy Works*. New York: Guilford Press.

Weiss, J. (l998). Patients' Unconscious Plans for Solving Their Problems. *Psychoanal. Dial.*, 8, 4ll-428.

Weiss, J. (l998) Unconscious Plans and Unconscious Conflict. Reply to Commentary. *Psychoanal. Dial.* 8: 443-453.

Weatherford, S. (l989) Unconscious Guilt Feelings in Psychopathology and Psychotherapy. *Bull. of the Menninger Clinic*, 53: l08-ll5.

Suzanne M. Gassner, Ph.D.
l49l Hopkins Street
Berkeley, California 94702