What is Control Mastery Theory- The Dance of Psychotherapy (a paper written by Jessica Broitman and presented by Jessica Broitman and Ginger Rhodes Cuba 2016)

Control Mastery theory was developed by Joe Weiss (1924 - 2004) and researched by Hal Sampson (1925 -2015) and the many theoreticians involved with SFPRG. CMT offers one a foundation, scaffolding or container for understanding how psychotherapy works. Weiss suggests that patients enter treatment with a (unconscious) plan to mastery (overcome or deal with) the traumatic events, which leads to their symptoms and inhibitions. His straightforward concepts and structure offer an elegant platform from which to begin the dance of psychotherapy.

In what follows I will delineate some of the therapeutic dance steps (techniques), learned through our understanding and grounding in Control Mastery Theory, that have joined our repertoire for successfully interacting with our patients. First I will offer a brief overview of the theories of Sampson and Weiss.

In part 2, I will begin to go into detail regarding a dozen or so of the technical concepts, derived from the CMT that we've found most useful including how you infer your patient's plan and pass their tests.

Control Mastery theory is considered an object relational type of therapy, which is a type of Psychoanalytic psychotherapy which originates from the works of Sigmund Freud. Within the history of the field, the term object has been used to describe your relationship with both real people in the external world and the images/ experience of them that are established internally. This dual connection is helpful in describing the interchange between the inside and outside that occurs inside all of us and in all treatments. We are often asked why was it called Object relations ? Isn't therapy about people? Object is used as it is a tangible term and it's meaning is flexible in accord with the pts. experience of their interchanges/ interactions with their objects. These interchanges carry a unique experiential reality for our patients. An object, despite its durability, can be manipulated and modified. It can be reshaped, repaired, repainted, cut in two, even destroyed. It suggests that there are Interpsychic operations that can be performed upon objects that correspond to the experiences that the patient have.

That means that there are mental representation of others that we carry internally and that have some of the real characteristics of people, as well as their capacity to trigger behavioral responses. They have different names in different systems, such as: internal objects, schemas, introjects, personifications etc. In control mastery theory we talk about the **pathogenic beliefs** that carry the internalization of these primacy relationships. They produce a residue within the mind pertaining to these relationships with important people in the individual's life. In some way these exchanges with others leave their mark, and they come to shape our attitudes, reactions, and perceptions. It is these **early beliefs** and **feelings** that must be discovered through interactions with our patients. One could just as easily refer to theses as Schemas, conflicts, or internalized objects.

All discussion of Object Relations theories begins with Melanie Klein – (born 30 March 1882 – 22 September 1960), who is known as the mother of object relations. She was an English psychiatrist and contemporary of Freud, analyzed by Ferenczi, who was the first to apply psychoanalytic techniques to the treatment of children. She built on Freud's theories to hypothesized that the child's world contained good and bad objects, created from the projections and introjections of his caretakers. The child both loves and hates their parents and alternates between "positions": the paranoid- schizoid, and the depressive positions. While Klein first introduced the concept of object relations, Otto Rank (1920) coined the term "pre-Oedipal," and was the first to create a modern theory of "object relations" in the late 1920s.

How did Object Relations theory differ from Freudian theory?

It did in at least in at least three ways:

(1) It places more emphasis on interpersonal relationships,

(2) It stresses the infant's relationship with the mother rather than the father, and

(3) It suggests that people are motivated primarily for human contact rather than for sexual pleasure. Again- The term **object** in object relations' theory refers to any person or part of a person that infants introject onto their psychic structure and then later project onto other people. Thus, an object is something like Freud's notion of a superego, which children introject. That is, children take into their psychic structure the morals and ideals that they see in their parents. These ideas, however are often out of conscious awareness and

remain hidden from our patient's decision making while affecting the outcomes!

So we are now taught that we must determine how our patients came to be - that is, to think and feel what they think and feel, and how are these thoughts and feelings then expressed? It is now at least a two-person process of development.

Our first question as a therapist is:

How do we come to know about these crucial processes for our patients? How do we help our patient's discover these truths for themselves? How do we help their (unconscious) feelings attain form so that they can become aware of their motivations, needs and desires?

A contemporary and complementary psychoanalytic account of the ways in which "feelings can attain form" is through that of "experience-near" inquiry, a concept which is not quite the same as working within the "Here and Now". It was developed by psychoanalyst Franz Kohut (see, e.g., Kohut, 1978), and subsequently elaborated in the socio-cultural field by the cultural anthropologist Clifford Geertz (1974). I think they are useful to illustrate an important component of the dance of a object relational psychotherapy.

"Experience", for Geertz arises, in the materialization of human feeling into the symbolic forms that compose cultural systems, whether they are material artifacts or social practices. Put simply, experience-near inquiry (or treatment) is an investigation of the "forms of feeling". It would respond to the question: what forms (environment) (dance) does (our therapeutic) practice provide for human feeling so that these feelings can become available for thought and communication between therapist and pt? It asks the question of how can the spaces and experiences of human interaction be harnessed to enable a form of inquiry, a conversation, and a shared experience? That eventually enhances the treatment and promotes innovations within it. This is what Stern and his colleagues' (1998) refer to as of creating 'moments of meeting'.

Creating this state of the possibility of a safe interaction and exploration is what I believe is the goal of the "dance of psychotherapy" and what control mastery theory promotes and focuses on (Safety).

In order to progress and develop (in therapy) one must discover a method of communication with one's partner (therapist and pt). Essentially, it is an understanding of symbolization, whereby words or images are used to capture emotions and sensations so that they can be thought about and communicated to others. Symbolization is rooted in experience, and having a theory of symbolization can help to establish epistemological principles for psychotherapy practice. Alternatively this can be done through conducting trial actions and many symptoms and enactions can be understood as such in control mastery theory.

Within the British psychoanalytic tradition, and particularly within Wilfred Bion's thinking on symbolization (Bion, 1970), the process of finding forms for human feeling depends on the "container-contained" relationship, whereby the symbol provides a container for feelings. **In my metaphor this is found in the safety of dance of therapy.** Our goal is to help our patients find verbal expression rather than having to resort to enacting in order to communicate. Bion's original model for the container is provided by the nursing mother who is engaged in feeding her baby both emotionally and physically, and in so doing performs an important psychic function. This will help the infant to moderate anxiety aroused by an environment, which is as yet too complex to process. When this "feeding process" goes well the nursing mother holds her infant both in her arms and in her mind, and thus "contains" and modifies its bodily sensations and feelings. Bion uses the metaphor of "digestion" to describe a process in which she "metabolizes" fragments of sense data for the infant. In his view these would otherwise appear as "bizarre objects" which are threatening and devoid of meaning. The mother thus demonstrates to her baby that the sensory world can be experienced, thought about, and rendered coherent. While the infant is still developing its own mental structures, the mother as physical/emotional gesture enacts the containing function. However, at a later stage, images and words—a system of symbols—will develop so that the growing child can contain its own anxiety and "digest" its world for itself. We as therapists and psychoanalysts are called upon to recreate this process in order to help our patients regain lost capacities from failed attunements.

You might have realized that this metaphor has passed into popular culture as we take time to "digest" what we do not understand by

bringing to bear a system of symbols, which allows us to think about experience.

So the next question emerges: how do we put our understanding of the nature and creation of thoughts, of feeling, into the practice or dance of object relational psychotherapy?
I have found that the theories of Joe Weiss, Hal Sampson and SFPRG offer the clinician a theory and a way to create such a container for the state of mind required for such a meeting of the minds, with its oscillation of thought and experience, this amazing dance of psychotherapy.

2- Control Mastery and its object relational concepts

Training and Supervising Analyst from the Institute of Contemporary Psychoanalysis Robert Stolerow, has called Joe Weiss' Control Mastery Theory a breath of fresh air in a field dominated by unsupported doctrine, as it is "a experience-near, relational, and rational approach to psychoanalytic therapy that is based on empirical research into the therapeutic process".

Joe Weiss has said CM is an object relations theory in that it "assumes that the pt develops his problems in relation his first objects and may resolve them in relation to another (how psychotherapy works p203)".

Joe was a psychoanalyst and very influenced by Freud. In particular in he based his theory on the following four pivotal articles:
1- Freud in 1920 in *Beyond the Pleasure Principle* wrote about the pts unconscious motivation to master his trauma.
2- In 1926 in *Inhibitions, Symptoms, and Anxiety* Freud:
a) Moved away from having no regard for reality to adapting that there is a perceived danger and threat that induces the patient to develop inhibitions and symptoms in order to remove the himself (the ego) from the danger.
b) Said that therapy provides a playground where the pt. can be free to display and enact all that is hidden - repeating in order to remember.
c) Patients use the transference to heal - resolve fears and work through traumas.
d) The concept of a pathogenic belief comes from Freud's explanation of castration anxiety in *Inhibitions, Symptoms, and*

Anxiety as a conviction acquired by inference from experience- the story of little Hans and the horse.
3) Freud further clarified his shift away from the automatic hypothesis in (interpretation of dreams) to the higher mental functioning hypothesis and lastly:
4) In the Outline (1940) :
a) Here pts think, judge and determine what actions may be safe or put them in danger. Pts will keep mental contents unconscious until they feel it is safe to bring them forth. Pts attempt experimental actions to determine their safety. Many have continued this line of reasoning including: Kris (1950) , Sandler and Joffe (1969) and Rangell (1966) and Dewald (1976)
b) Symptoms are no longer understood as simply compromise formations but rather as a way to avoid danger.
c) Trauma is seen as a central part of Freud's new theory of repression. A child is said to ***condemn inside himself any strivings, which threaten his ties to his parents!***
d) These beliefs, observations and inferences are the basis of the conscious and unconscious beliefs that are used in daily life.
e) The pt works actively therapy to disprove theses beliefs in relation to the therapist

One can now understand that our patients are enacting their past relationships with us, telling me the story of their trauma through how they treat me and how they come to perceive I am treating them with the hope that I will help them to master their past traumas. Our task is to help our patients learn the meaning of these enactments, to help them find the way to understand their symbolizations, to gain insights and help them to find their way back from their internalized realities and digest and metabolize their thoughts and feelings more productively. To find a path to happiness and productive lives. Control Mastery Theory is one therapeutic approach and theory that can help one do this.

3- A broad outline of the work of Sampson and Weiss called Control Mastery theory-

Joe Weiss began over sixty years ago to formulate the cognitive psychoanalytic model of psychopathology and psychotherapy today known as Control-Mastery Theory (CMT). With the choice of this name, that often misleads those who hear it for the

first time, Joe and Hal wanted to emphasise the adaptive nature of unconscious mental processes, and the patient's motivation to control and finally master their own attitudes and behaviours' (Weiss, Sampson, 1982).

CMT can be defined as a cognitive-psychodynamic-relational theory because it developed originally within a psychoanalytic framework, but it also integrates cognitive, psychodynamic and relational perspectives at the conceptual level (Migone, Liotti, 1998).

Weiss, Sampson and the San Francisco Psychotherapy Research Group (SFPRG, a group of clinicians and researchers previously known as the Mount Zion Psychotherapy Research Group, MZPRG) started studying and developing these ideas about the therapeutic process, empirically investigating psychotherapies (Weiss, 1986; Sampson, Weiss, 1986), and ending up in the formulation of the CMT.

The CMT is a theory of how the mind operates, how psychopathology develops, and how psychotherapy works. It provides a set of concepts that can help clinicians in understanding and in formulating patient's problems and goals in therapy and in learning how to work with the patient towards achieving those goals. CMT was not born as a new school of therapy, nor a new set of therapeutic techniques (Silberschatz, 2005).

Weiss formulated CMT when, during his collaboration with Sampson, they were studying the transcripts and notes of Weiss's and other therapists' cases conducted following Freud and other theoretical viewpoints. Weiss and Sampson wanted to understand which elements make a therapeutic relationship a successful one. They focused on the identification of significant therapeutic progress to understand how patients access change in psychotherapy.

Their assumption was that in a therapeutic relationship there are processes happening between the therapist and the patient that the existing theories did not yet specify (Comello, 2003). Weiss and Sampson started from the conviction that while every case is case-specific, nevertheless some elements of the treatment can be considered as common, and therefore studied to improve psychotherapy (Sampson, 1995).

Freud's idea was that the unconscious mind is made of impulses and defenses regulated automatically by the pleasure principle, rendering them beyond the patient's control, thoughts, or beliefs. In contrast to this, Weiss formulated the hypothesis of a

higher mental functioning. He assumed that people function both unconsciously and consciously in very similar ways: thinking and making inferences through testing reality, and making decisions and building plans about their lives as a result of these unconscious and conscious processes (Weiss, 1993).

Weiss assumed that people are powerfully motivated to understand their reality and to adapt to it. While doing so, they develop, starting in early childhood, beliefs about their reality including beliefs about themselves and their interpersonal world, by inference from experience. Some of these beliefs might be "pathogenic", or considered maladaptive, if they impede a person from functioning and prevent that person from pursuing desirable goals in their life (Sampson, 1990b). According to CMT every child needs its parents for survival, safety, love and security. In order to get along with the parents, a child learns and infers as much as possible about their parents: the way the parents relate to the child and how they expect the child to relate to them. It is in the child's nature to develop ideas about their parents' needs and desires: what they want, expect and will allow. A child has a tendency towards feeling guilty for any impulse, attitude, goal or affective state, which the child believes might be against their parents (Weiss, 1993).

According to CMT, psychotherapy is an occasion for the patient to disconfirm pathogenic beliefs by testing their beliefs in the relationship with the therapist. In CMT the process of testing is explained as a mostly unconscious way for the patient to feel safe in the therapeutic dyad, and to bring up materials connected to traumas and beliefs that the patient wants or needs to work on. Testing should be helpful for the therapist to collect information about problematic experiences of the patient. The patient, through testing, should eventually feel safer and introduce more details and thoughts about traumas and beliefs (Sampson, 1990a; Rappoport, 1997).

CMT addresses the discussion about tests through a case-specific approach. It does not propose new techniques for dealing with particular patients, but rather a model for conceptualizing how a person's problems develop and the ways the patient will need to test the therapist to disconfirm pathogenic beliefs. Key tests are those that are most critical to the patient because they are central to the predominant pathogenic beliefs that the patient is working on to disconfirm so as to access change (Pole et al., 2002; Silberschatz, 2005).

Concepts like “pathogenic beliefs” and “test” are central to this approach. In essence the idea is that people develop beliefs about themselves, which can be maladaptive on different levels; they try in therapy to test and disconfirm these beliefs. (Valentina Gandhi, 2015). From these basic ideas I have learned a way to understand how therapy works and how to organize my therapeutic dance steps. I will now to offer you some of the technical concepts derived from the CMT that I’ve found most useful.

Techniques of psychotherapy

1-The Function of the Frame: It is how a Good Therapist makes their Patient Feel Safe!-

Freud’s 1911 model suggested setting a consistent frame or background from which the patient could develop a plan for working in their treatment (testing). First and foremost is the concept that the therapist’s task is to create a safe holding environment. To attend to and infer for each individual pt what this might be. My basic job is to be an ally to my patient. To be that container from which digestion, metallization and metabolizing can occur. This process of creating a safe space in which therapy can take place is at times referred to as building a **secure frame,** or in my metaphor, **“the dance”.** A structured frame is most important for patients who were intruded upon or violated. It may not be as important for patients who are very rejected. There is no magic number of sessions needed per week (1-4) or specifically perfect length for a session. The use of a couch or chair can be pt. specific. Pts. can be comforted by consistency but again flexibility can show strength and comfort with your authority.

I will be helping my patients disprove their pathogenic beliefs in order allow them to be free to pursue the goals forbidden by the beliefs. The patient and the therapist have the same purpose, disconfirmation of these beliefs. The efficacy of my techniques is judged by whether it disconfirms or confirms a pathogenic belief. I can judge my success by whether my patient becomes less anxious, more secure, more insightful, or bolder - which may lead to increased testing.

I have been taught to act polite and friendly. It’s not a manipulation; it will not gratify dependency needs, which might prevent the patient’s facing dependency needs. Patients will not lose their motivation for work in treatment because they feel good. I do not need to worry about patients externalizing their problems via

blame. Requests for changes do not have to be seen as hostile acts; rather they can be rejection tests, or invitations from our patients to blame or humiliate them.

In psychotherapy, one makes oneself deeply vulnerable to another human being, and may allow many disturbing feelings and thoughts to be expressed. This is absolutely necessary to healing. But to allow himself to do it, a patient will need to have a strong feeling of trust in their therapist; they will need to feel **safe**. ***This is the central component of Control Mastery theory.***

The "frame" is the environment of therapy. It includes the physical surroundings, the emotional environment, the psychotherapeutic structure, and the relationship (or dance) between patient and therapist. A secure frame is a private psychic space in which the patient feels safe, "held" and supported. A secure frame is an environment in which every detail reflects structure, containment, safety, and support. Psychodynamic therapists believe that the secure frame is a vital element of the therapy. Others disagree about its place in the scheme, but certainly if the frame is *not* secure, you will find it difficult to accomplish much that is meaningful, whatever type of therapy you pursue.

Psychotherapists now know that boundary violations in the therapeutic setting are problematic, but most can't tell you why. Therapists will say it is because of the loss of objectivity and potential for exploitiveness. True, but there is so much more to it.

One perspective, returns to our image of the child and its mother and is developmental in nature: a child needs to be in a protective boundary within the family, within the symbiotic boundary with the mothering object, and feel protected within the self-boundary. If the boundary is violated with too much stimulation, aggression, seduction or exploitation, the child will have traumas and developmental arrests. They can, as Bion would remind us, lose the capacity to symbolize. When a therapist uses his or her patient for personal needs, the patient loses a healing therapist, just as a child loses a parent. The world doesn't feel safe, and the damage sticks to the patient's personality.

The question of what should be included and excluded in the therapeutic frame is not an easy one to answer. The frame itself is to some extent determined by a clinician's theoretical framework and work setting, along with serious consideration of the client's needs and ego strength. For example, a traditional psychoanalyst may view

a therapist's self-disclosure as something that negatively impacts transference, whereas an existential therapist may see it as essential to the therapeutic process. Control Mastery therapists will use the patient's plan to guide what kind of frame will be needed to create a sense of safety.

Flexibility in the therapeutic frame can be an important component of successful psychotherapy. In using the term "flexibility", I am referring to measured and well-considered self-disclosure, and a willingness to alter various aspects of the traditional therapeutic frame when it is deemed to be in the patient's best interest, with an understanding of how it is likely to affect them, and a willingness to observe and correct with the real data from your relationship with your patient. I am not referring to inappropriate self-disclosure, touch, or dual relationships, or any illegal act. If done mindfully and safely, alteration of the therapeutic frame in the service of a client's progress and healing can produce potentially profound outcomes.
Patients adapt to the therapist's approach, style, and personality. Patients who feared challenging authority would be particularly helped by the 1911 model, as would patients who have trouble protecting themselves from the intrusiveness of others or fear seducing the therapist or overwhelming and worrying the therapist. So another way to consider the issue that I like is using the term "Boundary Crossing" instead of "violation". (From Misuses and Misunderstandings of Boundary Theory in Clinical and Regulatory Settings -Thomas G. Gutheil, M.D. & Glen O. Gabbard, M.D). (http://kspope.com/ethics/boundaries.php#copy)

"Boundaries are not intended to create a remote and rigid way of relating between therapist and patient. On the contrary, external boundaries are established so that psychological boundaries can be crossed through a variety of mechanisms common to psychotherapy, including empathy, projection, introjection, identification, projective identification, and the interpretation of transference. Langs's concept of the frame and Winnicott's notion of the "holding environment" address similar concerns."

Gutheil & Gabbard have suggested that boundary transgressions can include a "boundary crossing," a benign variant where the ultimate effect of the deviation from the usual verbal behavior may be to advance the therapy in a constructive way that does not harm the patient. Some of these may be fully appropriate

human responses to unusual events that might involve physical contact. One should consider the way in which cultural differences, timing, and transference combine to create a context for an action, which may be felt as a boundary transgression by the patient or the therapist.

2- **Once I have begun to create a container, a safe play space, for the dance, I need to INFER my PATIENT'S PLAN**.

During my contact with my patient I am, of course, trying to understand my patient. In CMT terms I will formulate their pbs, their goals, and strategies to overcome their past traumas. I will continually check these initial hypotheses against all new observations to confirm, alter, or dismiss them. These preliminary theories help prepare me for their tests. I will develop provisional formulations using: the patient's own formulation, childhood traumas, my affective responses, and my patient's reactions to my approach, attitude, and interventions.

The plan should help me understand all, or most of what I know or understand about my patient. The pts goals will be based on everyday normal expectations. There are both Stated and Unconscious goals: true goals are normal and reasonable vs. compliance's with pathogenic beliefs.

For ex. : the pt is unlikely to really want to stay with a mean, critical spouse. They may unconsciously feel, however, that they should suffer as the parent suffered.

Patients are often in conflict, due to a wish to reveal their plan balanced against a fear that in doing so they risk re-traumatization. How bound your pt is to a pathogenic belief may determine how clear they are in presenting their goals. Tests may reveal specific goals. Patients are motivated to orient you and may do so *vis a vis* testing. They may give you mixed information to see what you pick up on. They may hide their problems in bits of information. They may express the opposite of what they want but give you a clue, such as a weak argument. They may display fears of rejection by acting rejecting, such as "therapist shopping." They may act too crazy or difficult to treat. One needs to evaluate their traumas to sort it out!

3-**EVALUATING my PATIENTS TRAUMAS- in order to develop my patient's possible plan.**

Children take responsibility for everything that happens to them, they see their parents as supreme authorities. They may suffer from either shock or strain traumas or both. I have been taught to learn as

much as possible about my patient's past and current history to understand what they have internalized, come to believe, and adapted to.

I am looking for both the shock and strain traumas.
Shock Trauma or sudden catastrophes. - Patients believe they are being punished for bad action. They become guilty and omnipotent. They see danger everywhere. Vigilance is required and it is impossible for them to relax.
Strain Trauma or continuing protracted trauma occurs within a pathogenic relationship over time. Patients come to believe that there is no hope or help for them.

4-**Children's compliances and identifications – how pathogenic beliefs are formed-**

CMT notes how much children are highly motivated to be liked, to obey, and to be accepted by their parents. Children must maintain their tie to their parent to survive. Children will develop unconscious guilt about wanting to pursue any developmental goals that they perceive as weakening their ties to their parents – by, for example, harming them or provoking punishment from them. Children greatly exaggerate how their impulses, feelings, thoughts, and actions affect others or bring harm to themselves. Because they are egocentric, children have difficulty understanding that the people around them have feelings, attitudes, and behavior patterns, which have reasons independent of them.

They accept and believe they deserve the treatment they receive. They try to fulfill the expectations they infer their parents have for them. They take responsibility to care for and cure parents. They blame themselves for failures to succeed and develop deeply held and often-unconscious beliefs regarding why. If they can't make a parent happy, they may come to believe they don't deserve to live. If their parents seemed unconcerned about them, yet demanding, they may come to believe that they must give a lot without any expectations of receiving. If they are criticized, they come to believe they are not a good person. An alcoholic home can produce rejection, worry, and shame. A vicious and capricious parent can lead a child to be hyper-vigilant, always fearing danger. A child who is unprotected may be subject to panic attacks and not feel as though they deserve to be protected. Sexual abuse often leads to shame and impaired reality, and a need to not remember that can

result in dissociation. Children are developing hypotheses for why they are treated the way they are. Weiss calls these **"pathogenic beliefs".**

Pathogenic beliefs stem from a number of sources including identifications with a parent's pathogenic belief or in compliance with a parent's interpretation of reality. The kind of beliefs a child develops depends on the nature of his specific motivations at the time the beliefs were created. It also depends on how the child believes his parents reacted to his motivations. For example, it depends on which of the child's traits or attitudes seemed to upset his parents, and how they displayed their displeasure. The child's beliefs may be incorrect inferences about their parents' motives, misunderstandings, or they may be accurate assessments and perceptions of the real situation. For example, an ill child who is kept in may incorrectly infer that his parents want him to remain dependent on them. PB's aren't the only factors in a person's symptomatology or character development and distortion. One has impulses and goals, which are also playing a part as well as the gratification that a person might receive from adhering to the compliances from his family.

Examples of Pathogenic Beliefs:

Several examples of pathogenic beliefs are presented below. Each example, however, reflects only one of the many, varied beliefs a child may develop. Guilt based on a person's fear of harming others in the pursuit of his or her own goals may be divided into several distinct, although related, types of guilt. Of special importance are survivor guilt and separation guilt, both of which involve an exaggerated sense of responsibility for others (Modell, A. (1984a) (1984b)).

a) Separation guilt – Consider for example, a child who observes his parents becoming depressed or worried after he becomes more independent or displays more strength. That child may develop the pathogenic belief that his parent would be upset, hurt, or depressed if they were to become still more independent or feel even stronger. They might develop symptoms, such as a phobia, which would require them to stay close to home. In Control Mastery terms this person would be conceived of as suffering from **Separation guilt**. This stems from the belief that a parent would be hurt by the child's attempts to separate and have an independent life. Separation guilt is another type of guilt arising from the fear of harming others as the

result of pursuing one's goals. Separation guilt was described by Modell (1965) as "the belief that one does not have a right to life . . . For the right to a life really means the right to a separate existence . . ." In some cases, according to Modell, "separation is unconsciously perceived as resulting in the death of the object" (p. 328). Weiss (1986) and Bush (1989) expanded this to include the guilt that people may feel, not only for separating, but also for being different from an important person in their lives. Separation guilt is characterized by the belief that one is harming one's parents or other loved ones by separating from them or by differing from them and thereby being disloyal.

b) Survivor guilt- A child whose parents deprive themselves and appeared to become upset if the child achieves things for himself, might come to believe that his parents do not want him to have more in life than they did. He may deny himself good things in life so as to avoid getting more than his parents. In Control Mastery terms, this person would be conceived of as suffering from **Survivor guilt**. This is based on the belief that there is only a certain amount of the good things in life to go around. Therefore the child fears that his achievements are stolen from his family members.

If a child's parents have experienced very little career success, the child may develop the symptom of a work inhibition. He fears that his family would be hurt if he were more successful in work than they. Freud referred to survivor guilt in the wake of his father's death, in a letter to Wilhelm Fliess, in which he noted ". . . that tendency toward self-reproach which death invariably leaves among the survivors . . ." (Freud, 1896; cited from Ernst Freud, 1960, p. 111). Survivor guilt was described by Neiderland (1961, 1981) as a psychological state common to people who survived the concentration camps of World War II. These survivors suffered from feelings of guilt for surviving loved ones who were killed in the camps. Years later, the survivors were noted to be experiencing depression, anxiety, and somatic symptoms. Neiderland described survivors as behaving as if they themselves were dead. Modell (1971) extended the discussion of survivor guilt to include more subtle forms. He described patients who inhibit themselves from success, or who engage in self-destructive behaviors, in response to unconscious survivor guilt for a parent or sibling whom they believe to be worse off than themselves. He suggested that people have ". . . an unconscious bookkeeping system, i.e., a system that takes account of the distribution of the

available ‘good’ within a given nuclear family so that the current fate of other family members will determine how much ‘good’ one possesses. If fate has dealt harshly with other members of the family, the survivor may experience guilt as he has obtained more than his share of the ‘good’.” (p. 340). Weiss has suggested that survivor guilt occurs when people believe that they are—simply by furthering their own cause—experiencing good things at the expense of others, and that their success will make others feel bad by comparison. They assume irrationally that the attainment of good things is unfair to those who have not attained them, or is at the expense of those who have not attained them (Weiss, 1986).

c) Depletion Guilt- If a child’s parents seemed drained, burdened or overwhelmed, following the child’s attempts to be close, or get help, the child may develop the belief that there was something wrong with him that caused his parents to be drained, burdened or overwhelmed by him. He might develop the symptom of a reluctance to complain or express his needs for fear of draining his parents.

d) Omnipotent responsibility guilt - Omnipotent responsibility guilt also arises out of altruism. This guilt involves an exaggerated sense of responsibility and concern for the happiness and well being of others. This person might worry a great deal about the other person or his impact on the other person without having any power to do anything about it. This kind of guilt intensifies when a parent acts weak and vulnerable or behaves in a way that leads the child to feel overly powerful or responsible

People who feel survivor guilt and/or separation guilt invariably feel omnipotent responsibility guilt. However, there are instances in which a person may feel omnipotently responsible for others without specifically feeling survivor guilt or separation guilt. Omnipotent responsibility guilt may be seen as an exaggeration of adaptive guilt, which concerns feeling anxious and disturbed about real and specific wrongful behaviors and the desire to make reparation.

e) Adaptive guilt is associated with good social adjustment and healthy personality development (Tangney 1991; Zahn-Waxler & Kochanska, 1990). In contrast, survivor guilt, separation guilt, depletion, and omnipotent responsibility guilt are often highly irrational and potentially pathogenic.

5- **Using MY AFFECTS to help me access and infer these beliefs – learning from my patients!**

Weiss (and many others) has taught that we can use our feelings as a signal to teach us the dangers a patient is trying to ward off. These are my best indicators of what my parents are unconsciously experiencing.

For ex: If I am feeling especially unusually skillful, my patient may be trying to taking care of me as they had to bolster a fragile parent; they may suffer from omnipotent worry, If they are acting unusually casual and friendly, in a provocative manner, not getting down to work, they may be testing my capacity to allow them to enjoy life. If I am experiencing unpleasant hostile intense feelings this is often a "passive into active" repetition of their childhood trauma. Time and money complaints like "it's too much trouble" could be rejection tests. When they are presenting themselves as if they are too much trouble, they can't be helped, or they are a big burden, they may suffer from a trauma of having had a worried overwhelmed parent who they were unable to help. If they are opaque, they may have a shameful hidden secret they're not ready to reveal.

Our reactions to our patients and their reactions to us will help orient us!

[If you pass these tests] You should see an increase in confidence, which should result in an increase in the patient's relief, insight and boldness. You should see a decrease in depression and anxiety or consider that you are on the wrong track. Tease out the plan from all your material. Utilize all the material you have gathered from discerning and passing these tests to formulate or refine a hypothesis about the patient's plan for getting better. Next I will talk with about how we help our patients overcome their pathogenic beliefs through the testing process and how therapy works!

6—**OVERCOMING PATHOGENIC BELIEFS:**

How do patients work in treatment to overcome these crippling beliefs? – Through Testing, Identification and Insight.

We try to adapt to the world to protect ourselves from danger and take advantage of opportunities. We do so through gaining an understanding of the dangers that surround us.

As Weiss says, "testing is a fundamental activity prominent in everyday life and in therapy." It is the manifestation of the individual's effort to adapt to their interpersonal world. Through testing they explore the world to determine its dangers and its opportunities so that they may protect themself from the dangers and take advantage of the opportunities.

All testing ultimately has to do with the patient's wish to disconfirm their pathogenic beliefs. It is an attempt to assess the validity of the potential dangers foretold by their internalized object relations, from which they formed their pathogenic beliefs. A test is an occasion for patients to evaluate reality. Everyone tests everywhere all the time!

During the testing process, patients act in accordance with their pathogenic beliefs. They test in an effort to disconfirm those beliefs. What they need to test first are that the conditions of safety be met in therapy, in order to infer if it is safe to make their beliefs conscious and work on them. If the therapist succeeds in passing the patient's initial tests then they are able to begin to work on testing their pathogenic beliefs. If the patient succeeds (through testing the therapist) to disconfirm their pathogenic beliefs, they may then feel safe to lift their repressions and denials. This would allow the patient to become more aware of their pathogenic beliefs and the impulses, attitudes, and goals they repressed based on these beliefs. Patients need to feel safe in therapy before facing important issues.

Freud first used the term passive into active (testing) in 1920 in *Beyond the Pleasure Principle* (p35). There he introduced the compulsion to repeat unpleasant actions in order to master actively an experience that previously were passively endured. Freud returned to this concept in 1926 in the *Addenda to Inhibitions, Symptoms, and Anxiety*, (p 167) where he summarized the adaptive sequence of signal anxiety. In this action the ego is warned of a danger, and fears helplessness. This promotes the ego to react actively to avert the feared course of traumatic experience. Freud believed that changing from passively experiencing a traumatic event to actively controlling the action would allow a child "to master their experience psychically." This concept has also been linked to the concept of identification with the aggressor. Rangel also used the concept of trial by action in 1968.

It makes a big difference to your technique if you believe that a patient wants to remember (either through thoughts or actions) in order to work through their traumas, as Weiss does, (and Freud did some of the time in some of his writings), and that patients come into treatment planning to do just that. Weiss's testing concept refers to the process by which our patients learn how to handle traumatic experience, and acquire through identification with the therapist; new ego strengths, which will help them, deal with future trauma. This

expectation creates a different type of therapeutic relationship in which resistance has a very different meaning.
According to the CMT, psychotherapy is an occasion for the patient to disconfirm pathogenic beliefs by testing these beliefs in the relationship with the therapist. In CMT the process of testing is explained as a mostly unconscious way for the patient to feel safe in the therapeutic dyad, and to bring up the issues connected to the traumas and beliefs that they want or need to work on. Testing offers the therapist a way to collect important information about problematic experiences of the patient. The therapist works to understand the affects that are being created and pulled for inside the therapist by the patient's actions. The patient, through testing, should eventually feel safer and thereby be able to introduce more detail.
Testing is a patient-initiated behavior, which emerges within a particular relational context. A test invites or requires a response from the therapist. It is usually an unconscious process, but the patient may have some degree of conscious awareness of testing the therapist. According to Weiss, repeating a trauma through testing in psychotherapy is not the result of an automatic compulsion, but an adaptive interpersonal strategy, under partly unconscious control. He conceptualised "testing" the therapist as a part of the patient's process to be ready to remember (Weiss 1990; Sampson, 1991; Foreman, 1996).

CMT addresses the discussion about tests through a case-specific approach. It does not propose new techniques for dealing with particular patients, but rather a model for conceptualizing how a person's problems develop and the ways the patient will need to test the therapist to disconfirm pathogenic beliefs. Key tests are those that are most critical to the patient because they are central to the predominant pathogenic beliefs that the patient is working on to disconfirm so as to access change (Pole et al., 2002; Silberschatz, 2005).

Let's define a test: (Marshall Bush)

1 - a test is an unconsciously (sometimes consciously) planned patient behavior that attempts to solicit information about the therapist's willingness and ability to help the patient carry out his or her plan for therapy. The testing behavior may just provide an opportunity for the therapist to intervene in a helpful way or it may exert a strong demand for the therapist to respond to what the patient is doing or saying.

2 - tests vary in how discrete and noticeable they are. Some are barely distinguishable from the patient's normal behavior. Some are obvious. Some occur repeatedly or continuously throughout the therapy.
3 - the way a patient tests will be determined by their goals, childhood traumas, pathogenic beliefs and unconscious perceptions of the therapist.
4 - there are two main types of tests (and can co-occur) which Weiss identified as "transferring" and "turning passive-into-active." In the former, the patients invites the therapist to treat him or her as the traumatizing parent did. In the later, the patient treats the therapist as the traumatizing parent treated the patient. Tests can be passed or failed to varying degrees. There is a third kind of test: Testing/Treatment by Attitude. I'll talk more about that in a few minutes.

What is the purpose of testing:
Testing is the primary way in which patients attempt to
*(*1) establish if conditions of safety occur with the therapist,
(2) master their childhood traumas,
(3) disconfirm their pathogenic beliefs,
(4) overcome their pathogenic compliances and identifications,
(5) acquire psychological strengths that they lack, and
(6) solicit their therapist's help in pursuing their therapeutic goals.

7- Testing is the way patients attempt to learn:

What is a test? CMT believes that people regulate their own treatment. And that they come to therapy with a plan to get better. A test is one way for a patient to evaluate reality.

Patients think unconsciously about their problems, and they figure out ways to disconfirm these crippling beliefs. Their symptoms such as compulsions or inhibitions can be understood as efforts to avoid situations that are perceived as dangerous because of their pathogenic beliefs. A test is a way for patients to evaluate the reality. During the testing process, the patient acts according to their pathogenic belief. They need to test to see if the conditions for safety have been met. If the patient succeeds by testing the therapist to disconfirm her/her pathogenic beliefs, then she/he may feel safe to list repressions and denials. This would allow the patient to become more aware of his/her beliefs and the impulses, attitudes, goals that

she repressed for these beliefs. Patients need to feel safe before they can go on with the work they came to do.
As Bush briefly summarizes the importance of testing, testing is the primary means that a patient uses to:
1 - Disconfirm their pathogenic beliefs
2 - Master their childhood traumas
3 - Overcome their pathological identifications and compliances
4 - Clarify their therapist's intentions AND
5 - Develop new response patterns by identifying with the therapist (Bush, 2008)
And testing is the way that patients attempt to learn:
1 - How safe it is and how possible it is to collaborate with a therapist.
2 - How much the therapist will support their goals and provide helpful insights.

The intensity and duration of a test may vary a lot.

A test can basically go on for a few minutes or it can go on for almost the entire session. Even the way of testing is case-specific. Also the passing or failing a test by the therapist can be at different degrees. The test can be passed right away, partially passed, partially failed or completely failed.

How do we infer what and how our patient is testing?

Understanding my patients tests requires using everything that I have learned about them. It starts with things in the first session, including the presenting complaints, goals, traumas, relationships, experiences, pathogenic beliefs, whatever it takes to create a specific and detailed patient profile.

Much about understanding the testing process has to do with the therapist's feelings at the time of the interactions. Part of understanding any test is recognizing my own internal process at the time. Often in the testing process the client is teaching and coaching the therapist on how to behave, and what their own internal experience is all about.
1 - Notice the case specific use of the plan
2 - Test theory by observations of our patients behavior - are they bolder / do they have increased insight
3 - Tests are like all behavior: we are always testing and it serves a variety of functions
4 - Testing makes use of everyday real problems and events that would be likely to promote worry or rejection

5 - Testing arouses powerful feelings - it could be we find ourselves bored, or with contempt, it could feel seductive, to help could feel impossible, we fall silence, they may fail to pay, or could feel insulted
6 - Tests can evoke in us a pull for intervention
7 - We could feel as though the situation were a wild exaggeration
8 - And it may feel out of keeping with our patient's normal behavior

Patients may use different behaviors to test the same beliefs

1 - We may only understood after we pass the test
2 - Testing may be done with attitudes or affection
3 - May walk in with easy tests – Where do you want me to start, versus difficult tests – Not sure I want to be here. The intensity of the testing will be related to how scared and traumatized they are.

8 - How do patients use testing to get better? Let's look at the specifics of testing.

CMT believes that patients regulate their own treatment. They work in therapy to disconfirm their crippling pathogenic beliefs. Patients are made miserable by these beliefs and are highly motivated to disconfirm them. Patients think unconsciously about their problems, and make plans for disconfirming these beliefs.

Symptoms such as compulsions or inhibitions can now be understood as efforts to avoid dangers foretold by the pathogenic beliefs. One way that patients work to disconfirm their pathogenic beliefs is by testing them in relation to the therapist. This is a way for patient's to reevaluate the reality basis for the dangers predicted by the pathogenic beliefs. In testing, a patient acts in accordance with his pathogenic belief. Patients test in order to ascertain if the conditions of safety exist for making their beliefs conscious. For example, if a child believes that his parents were overly worried, he assumes that he must have done something wrong that caused them to worry. To test his belief, he will act worrisome with the therapist. He hopes that the therapist will not be worried. This would help him to disconfirm his pathogenic belief that he caused his parents to worry.

If the patient succeeds by testing the therapist, to disconfirm his pathogenic beliefs, Weiss suggests that he may then feel safer to lift his repressions and denials. This would allow the patient to become much more aware of his pathogenic beliefs and whatever impulses, attitudes, goals, or affective states he has repressed in obedience to these beliefs. Typically patients do not want to face core issues until they are reassured that it will be safe to do so. For example, a patient

who was impaired by the belief he deserved to be blamed by his parents may not remember being blamed until he assures himself that the therapist will not blame him in the same manner that his parents did.

Two Kinds of Tests

As I said earlier there are two kinds of main tests, transference tests and tests by turning passive into active. The difference in the kinds of testing has to do with the difference in the relationship between parent to child and child to parent. I will describe them both.

1-*Transferring*:

The patient invites the therapist to treat him or her as the traumatizing parent (or significant person) did. In these transference repetitions, a patient reproduces with the therapist those behaviors that he believed provoked his parent's traumatic reactions. He invites the therapist to react in the same traumatizing way his parents did. For example, a patient who in childhood believed that his parents enjoyed lecturing him, might invite the therapist to worry about him to see if the therapist appears to enjoy lecturing and telling him what to do. If the therapist does worry or lecture, the patient might infer that the therapist likes being the authority and feeling needed. He then fears that he would threaten the therapist when he comfortably pursues his own goals. The patient hopes that he will not affect the therapist in the same way that he fears he had affected his parents. If this appears to be the case, the patient may then move toward disconfirming his beliefs that he caused his parents' traumatizing reactions.

The child's wish to stay connected to the parent accounts for the ease of the transference test. The child wants to be and stay connected to the parent and will try to stay connected and get along. He brings this into the treatment so that he will be cooperative with the therapist and try to give them what she thinks the therapist wants. Healthier individuals tend to come into treatment with Transference tests. They have enough faith in others to wish and hope that someone will be on their side. But they also want someone to help then and believe that they can, so they make themselves likeable in different ways so the therapist will be on their side and want to help.

People who have had more traumas, feel more damaged and don't find the world a very accommodating place tend to test more

vigorously and come in with tests that are more difficult because they don't think that the world will help them. Some have not been treated well at all and are concerned that the therapist will treat them the same way, so they come in swinging. They often use the second form of testing.

2- *Turning passive-into-active*:

Here our patient treats the therapist as the traumatizing parent (or other significant object) treated the patient. This test is often used to cope with a stressful life situation. If the patient enacts drama after drama and presents crisis after crisis, it is likely that he is presenting the therapist with the opportunity to experience and feel firsthand those situations, which were traumatizing to the patient as a child. The pull into action must be experienced as a challenge in order to evoke a role model. In turning passive into active, the patient treats the therapist in the same manner that they had been treated and found traumatic. The patient hopes that the therapist will not be traumatized and instead will be better able to deal with the behavior than the patient was. The patient may then identify with the therapist's capacity to withstand bad treatment such as indifference, false accusations, blame and attacks.

Passive into Active testing has some similarities to projective identification-

The concept of projective identification is a Kleinian term first introduced by Klein in 1946 and later elaborated by Balint in 1952 and 1968, Rosenfield in 1952, 1954 and 1971, and Bion in 1959 (called "attacks on linking" by Bion). Ogden brought it into the popular American psychoanalytic culture in 1982.

There are three main ways that this concept has been used.
1 - One of the ways the term has been used is the idea that one is getting rid of feelings that are unpleasant.
2 - Another use emphasizes the creation of the feelings in another in such a way that the other experiences the unwanted feelings. Some do not believe that you have to actually receive the feelings for this to be happening which seemed like simple projection to me? Some see it as an aggressive act intended to destroy.
3 - Ogden (and others) also used the term as a form of communication between the therapist and patient. Betty Joseph in 1987 offered the possibility that it can be used (whether or not intended) as a way to understand your patient's communication.

Weiss used it to refer to an intentional interaction, for the purpose of mastery, (even if unconscious), where a patient wants to show you something that he or she can not find the words to tell you. The purpose is so that you can help them deal with a trauma. This is very different idea than an attempt to get rid of the feelings or destroy an object you are envious of. Weiss' theory posits that the patient wants to get better and is trying to do so through a variety of strange actions such as showing you in action what was wrong in their early experiences.

Passive into Active tests are more difficult – the patient takes the role of the adult/abuser/parent and gives the role of herself to the therapist. So the therapist has the experience of the patient in both action and feelings. This is when it is not so much fun to be a therapist. You feel as the client does which is often uncomfortable. Often you are having the experience of how the client was treated as well as the emotions that go along with it. From these experiences you can extrapolate the pathogenic beliefs, or the treatment or the feelings of constraint. Our patients are trying to learn from our reaction – if I treat you the way I was treated how will you (the therapist) respond to this stuff. Can you remain calm and stand firm - can I do what you are doing? You are not complying to what I had to comply to – are there are other ways to respond?

Some examples of passive into active tests:

1. Patient arouses very powerful feelings in the therapist -- does not have to be angry but can also be overwhelming, confusing and depressing.
2. Patient makes the therapist feel that no matter what they say or do – it is not correct.
3. Therapist fears that if they do the wrong thing, the patient will leave treatment. The test leaves you walking on eggshells.
4. Patient wildly exaggerates a feeling or thought – displays actions or feelings that are out of keeping with their usual behaviors

Testing by Attitudes"

Weiss and Sampson identified a third type of testing, "**testing by attitudes**". The patient may attempt to disconfirm pathogenic beliefs by displaying a persistent attitude towards the therapist. They can be positive or negative personality traits, but the patient uses them to infer the therapist's stance towards the patient's goals, pathogenic beliefs and childhood traumas. The therapist's attitudes

can play also a therapeutic role in the interaction with the patient, showing and leading to possible change.

Sometimes patient can use different testing to work through the same pathogenic belief. Or can switch the meaning of a test needing a different outcome. Sometimes the meaning of the test is not always clear. – Sometimes it is never clear and sometimes it is clear only after the test is completed.

In addition to testing, patients also work in treatment by making use of the therapist's interpretations to become conscious of the pathogenic beliefs and to realize that they are false and maladaptive. This increases the patient's control over the effects of their beliefs. They may then become less constrained by the beliefs and less vulnerable to the kinds of trauma to which they were exposed by the beliefs.

Control-Mastery theory emphasizes the cooperative working relationship between therapist and patient to disconfirm his pathogenic beliefs. The patient is highly motivated to disconfirm his crippling beliefs in order to recover the capacity to pursue life goals.

9-"What happens when you pass a test?

Gasser reported on Weiss's research, that as patients feel increasingly safe and lift their defenses, they then gain insight. Along these lines, successful treatments are those during which the therapist is able to pass many of the patients' tests and make pro-plan interpretations in order to increase the patient's' insights so that they may move toward living the way they would like, according to their plan.

The therapist has the chance, through suitable interventions and passing the patient's tests, to help the patient in disconfirming some aspects of his or her pathogenic beliefs or moving towards his or her therapeutic goals. Previous research showed that when a therapist "passes" a test, the patient could make a therapeutic progress; if the therapist "fails" the test, the patient becomes more anxious and doesn't show therapeutic progress (Silberschatz, Curtis, 1993). While testing, the patient monitors the therapist's reaction to see if they disconfirm or confirm a pathogenic belief (Bugas, Silberschatz, 2000)

When the therapist succeeds in disconfirming the patient's pathogenic beliefs, it increases the patient's conscious control on these beliefs. If the therapist fails the disconfirming process, and risks the confirming of a pathogenic belief, it is expected that the patient

will experience an increased sense of danger and become more resistant and less insightful (Bush, Gassner, 1988, Gassner, 1990). If the therapist responds to the traumatic behaviour repeating the pattern that the patient adopted with their parent, the patient cannot be really helped in moving forward and in experiencing new ways of dealing with the trauma (Foreman, 1996). If the patient is very motivated in feeling better, and he or she normally is in a therapeutic process, he or she will eventually test the therapist again (Fretter et al., 1994).

A study conducted in 1993 by Silberschatz and Curtis on the cases of Diane and Gary, based on tape-recorded and transcribed therapy sessions, reported results indicating that the patient became more productive, relaxed and expressed more positive emotions when the therapist helped disconfirm their pathogenic beliefs by passing a test (Silberschatz, 2005).

According to Weiss, on this topic, therapeutic progress may occur even when the therapist fails tests or inaccurately analyses a patient's pathogenic beliefs. A therapist may be using a different theoretical model and pass the patient's most critical tests too. The idea behind this is that patients will try to get the maximum benefit from the treatment, so even when the therapist is not working efficiently, the patient might set back in their progress, but this might be only temporary. In such a case the patient will adapt his or her testing to the therapist's style and theory. The benefit our patients receive from therapy can happen not only when we are pass tests, but also through understanding and experiencing the patient's behavior, pathogenic beliefs, transferences and resistances (Bush, 1989).

How can you tell when you have passed a test?

CMT is based on the idea that when a test is passed, the therapist will know it because:

1. Classically the therapist know that they have passed a test when the client begins to feel more relaxed, shares new material or switches away from the intensity of what has been going on.
2. Transference tests work more like the above
3. Passive into active tests can work like that but can also become something else. A person who has been traumatized, does not trust might just as easily be relieved that the therapist passed the test, but might also have to increase the intensity of the test and so they

escalate the intensity of the Passive into Active test and make the therapist feel worse not better.
Jumping back and forth between P-A and Trans happens often. The more damaged the individual the more there will be testing in both directions at the same time. This can be either sequentially or simultaneously. This process can get confusing for the therapist because it can be difficult to understand which test to address. This is where understanding the plan be helpful. The plan will support that the patient is actually working on the issues brought up by one of the parts of the testing versus the other and will help the therapist know that the knowledge held in the other part of the testing needs to be held for a while.

Failing and Passing a test.

After a minor failure – sometimes the patient will just give the therapist another chance at the same test. Or sometimes the patient will coach the therapist about how to do it the next time. Sometimes the patient will ignore the therapist. And just talk for them. Sometimes a patient will go back to an earlier test to make sure that the therapist is on his side. This way they go back to an earlier pathogenic believe and might not harm herself by the thought that the therapist is not on their side.

With a healthier patient, who has more trust, the failure of a test can easily be overcome. With a more damaged person – it is often more difficult. At those times the patient does something harmful because they are complying to a pathogenic belief that is destructive. The therapist's role is an active one that is based on their understanding of the individual and the way in which the testing process occurs. Change in this theory happens because of the discussion /interpretations /interactions as well as the behavior and non-verbal processes that occur. All aspects of what the therapist brings into the office are a part of the process or dance of psychotherapy.

Failing a test

Talk with your patient about it. Try to understand and correct it. Look for some coaching. Use the plan to explore what happened.

<u>11- So the question arises: what does all of this this say about Neutrality?</u>

These concerns came from Freud's early desires to be rational - in response to hypnotism. Weiss views one's conflicts as being over goals and pathogenic beliefs. Therapists must <u>take the side of</u>

the patient's goals. Surface issues are not seen as resistances, rather tests of pathogenic beliefs.

What about reassurance, or the use of your authority? Any particular stance could be helpful or patronizing, infantilizing or humiliating, all depending upon whether the patient was rejected by his parents or intrusively demanded to perform. You must be case specific and be willing at times to go to unusual extents to help your patient feel connected. Sometimes this could include daily phone calls. Patients who are not protected will require you to use your authority to protect them.

A CORRECTIVE EMOTIONAL EXPERIENCE might be in your patient's best interest!

The CMT therapist should consider offering a corrective emotional experience in a context within the patient's history. This will not strengthen the defenses or gratify the impulses; it will not deny the patient's motivation to heal because of the concept of testing. You have a new way to understand what the patient is trying to accomplish. This is not a role-play. Expressions of empathy are appropriate; acting detached or withdrawn is as much of a role-play as being flexible and changeable.

12-Where did RESISTANCE ANALYSIS come from and go?

It was originally based on the view that

1) productions are compromised formations which are always incomplete
2) patients can't lift their own repression
3) gratification of dependency will remove their motivation to improve
4) optimal anxiety is best.

Weiss believes that you must help the patient realize that the dangers they fear, as foretold by their pathogenic beliefs, are not real. The patients will face their dangers and disconfirm their beliefs by testing them. They will set their own agenda.

So how does unconscious material become conscious?

Patients, when they feel safe, will lift oppressions on their own and will evaluate present and past situations in the light of the new relationship they have created with you. Your best guide to the accuracy of your interpretation is the patient's reaction to it.

Your patient's pathology has developed primarily in relationship to your patient's parents; it is crucial for your patient to see and

understand how they were treated, how they interpreted it, how they complied with it, and how they internalized it. They must learn that they did not necessarily deserve the treatment they received.

Are we no longer interested in understanding IMPULSES AND DEFENSES?

Patients need to understand why they have such impulses and defenses. They are often in the service of adaptation rather than a primary character flaw. You must help your patient put their impulses and defenses in the context of their pathogenic beliefs. For example:

- If you're hostile to your wife, you may be ruining your marriage by fighting out of loyalty, as you saw that your dad did with his marriage.
- If you're overly dependent you may believe that others want you to need them to make them feel important.
- If you're withdrawn you may have had self-centered parents who you were unable to elicit interest from, teaching you shouldn't bother to try.
- If your patient asks to see another therapist we don't necessarily worry about splitting the transference, the patient is likely to be testing their freedom to separate from the therapist. If we interpret it as a dilution of the treatment, the patient might infer the therapist is fragile and narcissistic.

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