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## **Patients' Unconscious Testing Activity in Psychotherapy: A Theoretical and Empirical Overview**

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# Patients' Unconscious Testing Activity in Psychotherapy: A Theoretical and Empirical Overview

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The aim of this paper is to present a theoretical and empirical overview of the hypothesis that patients' behavior in psychotherapy can be understood as an expression of their efforts to disprove their pathogenic beliefs by testing them in the therapeutic relationship. According to Control–Mastery Theory (CMT; Gazzillo, 2016; Silberschatz, 2005; Weiss, 1986, 1994), psychopathology stems from unconscious pathogenic beliefs developed in response to early traumas. Pathogenic beliefs associate the achievement of healthy goals with a variety of unconsciously perceived dangers. Thanks to the inborn human motivation to adapt to reality and to the power of adaptive unconscious mental functioning, patients come to therapy with a unconscious plan to overcome their pathogenic beliefs by testing them with their therapists. Tests are consciously or unconsciously devised actions aimed at disproving pathogenic beliefs. CMT describes two broad categories of tests: transference tests and passive-into-active tests. Tests require specific responses from the therapist to be passed. When therapists pass patients' tests, patients feel safer and may make therapeutic progress; when tests are failed, patients feel endangered and may get worse. Consistent with CMT assumptions, studies on testing have shown that a therapist passing a patient's tests is associated with immediate positive effects on the patient, but more studies are needed.

*Keywords:* Control–Mastery Theory, empirical studies, patients' unconscious plan, psychotherapy process, test

The aim of this paper is to present a theoretical and empirical overview of the hypothesis that one of the main activities of patients in psychotherapy is to test their pathogenic beliefs with their therapists. This hypothesis is one of the core concepts of Control–Mastery Theory (CMT; Gazzillo, 2016; Silberschatz, 2005; Weiss et al., 1986; Weiss, 1993), a relational cognitive-dynamic theory of psychic functioning, psychopathology, and psychotherapy developed and empirically tested by Joseph Weiss, Harold Sampson, and the San Francisco Psychotherapy Research Group over the last 40 years.

## The Basic Concepts of Control–Mastery Theory

CMT starts with the assumption, shared by modern biology, ethology, and cognitive sciences, that all animals are motivated—actually, predisposed by evolution—to adapt to their environment and master their problems and adverse experiences. For humans, adaptation requires, among other things, the establishment and maintenance of stable relationships with relevant others and the development of a reliable set of beliefs about reality and “morality” (Weiss, 1993, p. 4).

Another fundamental assumption of CMT is that psychic functioning is basically regulated by perceptions of safety and danger (Weiss, 1990) and that humans unconsciously perform many of the same complex adaptive functions (assessing reality, developing inferences and beliefs, making decisions, establishing and pursuing goals, solving problems, planning, etc.) that they perform consciously (Bargh, 2017; Lewicki, 1986; Lewicki & Hill, 1989) and are able to exert conscious and unconscious control of their mental functioning. This “unconscious higher mental functioning paradigm” (HMFP; Weiss, 1986), together with the centrality it gives to the safety/danger regulatory principle, is compatible with the later writings of Freud (1925, 1938) and finds support in infant research, evolutionary psychology, and cognitive research (Am-bady & Rosenthal, 1992; Bargh, 2017; Chaiken & Trope, 1999;

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Evans, 2008; Gawronski, Sherman, & Trope, 2014; Shiffrin & Schneider, 1977).

Humans consciously and unconsciously develop and test hypotheses about how the world works beginning in infancy (Gopnik, Meltzoff, & Kuhl, 1999; Stern, 1985). They develop a relatively stable and coherent set of beliefs about themselves, their environment, and their relationships (Beebe & Lachmann, 2002, 2013; Murray, 2014) in a map-making process that continues throughout life (Silberschatz, 2005). These beliefs may be implicit or explicit, and most of them can be formulated according to an “If . . . , then . . .” format. For example, on the basis of her experiences a little child may develop the belief that if she calls her mother because she is in pain, the mother will arrive soon, or that if she pulls her brother’s hair because she is angry with him, her father will get angry. In other words, beliefs store the contingencies detected or inferred by the person on the basis of her/his experiences, and the teachings s/he receives (Tarabulsky, Tessier, & Kappas, 1996).

Adverse experiences (stress or shock trauma) may result in the development of beliefs that associate the achievement of healthy and pleasurable goals with a danger for the person, significant others, or significant relationships. According to CMT, such beliefs are the cornerstone of psychopathology, and for this reason they are called *pathogenic beliefs*. Children develop pathogenic beliefs because they try to understand what they did to cause the trauma they suffered and how they can avoid or prevent a similar trauma in the future. In other words, pathogenic beliefs are developed as part of an effort to cope with traumas.

In their theorizing—particularly about traumatic experiences (Call & Wolfenstein, 1976; Zahn-Waxler & Kochanska, 1990; Zahn-Waxler, Rade-Yarrow, & King, 1979)—children are prone to draw conclusions that typically lead to feelings of irrational responsibility and guilt (Bush, 2005; Shilkret & Silberschatz, 2005). CMT (Gazzillo et al., 2017, 2018) describes five main interpersonal kinds of guilt<sup>1</sup>: *survivor guilt* (connected to the belief that being or feeling better off than important others makes them suffer), *separation-disloyalty guilt* (deriving from the belief that being independent or different from important others makes them suffer), *omnipotent responsibility guilt* (deriving from the belief of having the power and the duty to make loved ones happy and healthy, so that putting of one’s own needs in the foreground means to be egoistic), *burdening guilt* (deriving from the belief that expressing own needs means burdening other people), and *self-hate* (deriving from the belief of being wrong, bad, inadequate and feeling undeserving of protection, love, and happiness).

Consider, for example, the case of John, a young man in his late twenties who entered therapy with severe work and social inhibitions. When the patient was a child, his father was extremely domineering and competitive toward his son. For instance, he insisted that the patient learn how to play chess and then regularly challenged him to matches. When he (father) won, he crowed over his victory. However, when the patient improved to the point that he regularly won games, the father refused to play with him. From these and other experiences, the patient developed the pathogenic belief that he should downplay his aspirations and accomplishments to avoid upsetting others, a belief that gave rise to survivor guilt.

Because of the painful, constricting, and grim nature of pathogenic beliefs (Silberschatz & Sampson, 1991), patients who seek

therapy are highly motivated, both consciously and unconsciously, to disconfirm them and get better; and they have a more or less articulated, albeit unconscious, plan for doing so (Weiss, 1998a). A clinical formulation of a patient’s plan includes the patient’s goals; the pathogenic beliefs that have obstructed them; the traumas from which these beliefs originated and that the patient needs to master; insights that will help the patient achieve his or her goals for therapy; and how patients are likely to *test* their beliefs in therapy.<sup>2</sup> Weiss (n.d.-a, n.d.-b) proposed that patients’ behavior is best understood as an expression of overarching motivation to adapt to reality and of their adaptive and planful unconscious functioning. Weiss also pointed out that many transference manifestations could be understood as patients making adaptive use of the analyst by testing him or her.

### Patients’ Testing Activity: Theoretical and Clinical Features

One of the primary ways patients work in therapy to disconfirm their pathogenic beliefs is by testing them in the therapeutic relationship. By testing, patients actively seek, albeit generally unconsciously, experiences that will help them to disprove their pathogenic beliefs. For this reason, we can define tests as (unconsciously) devised actions aimed at disproving one’s pathogenic beliefs. Or, from another perspective, we can conceive of tests as trial actions aimed at assessing the level of safety of the therapeutic relationship.<sup>3</sup>

Testing is a risky activity because there is no guarantee that the therapist will pass the patient’s tests, and there is no way of knowing whether pathogenic beliefs will be confirmed or disconfirmed. Consequently, patients tend to be more anxious while testing because they expose themselves to the risk of having their pathogenic beliefs confirmed and being retraumatized. Thus, particularly at the beginning of therapy and in other crucial moments of the treatment, patients may coach their therapists directly or indirectly, that is, give them information on how to pass their tests, which are their goals and how to help them reach these goals, and how they hope the therapist will behave to help them feel safe (Bugas & Silberschatz, 2000; Curtis, Silberschatz, Sampson, & Weiss, 1994; O’Connor, Edelstein, Berry, & Weiss, 1994).

CMT delineates two broad testing strategies: transference tests and passive-into-active tests, and we propose that each strategy may be pursued by compliance or by noncompliance with the pathogenic beliefs being tested (Curtis & Silberschatz, 1986; Gazzillo, 2018; Silberschatz & Curtis, 1993). The aim of this differentiation is to stress how even opposite behaviors may be used to test one and the same pathogenic belief.

In a transference test, the patient observes whether the therapist responds to or treats her/him the same way the patient was previously traumatized by parents or significant others. This type of testing may be done by compliance, that is by behaving in a

<sup>1</sup> It is worth noting that not all pathogenic beliefs support guilt.

<sup>2</sup> Empirical data show that therapists with minimal training and following the Plan Formulation Method manual developed by Curtis and Silberschatz consistently achieve high levels of inter-judge reliability in inferring the unconscious plans of patients (for a review, see Curtis & Silberschatz, 2007).

<sup>3</sup> Although testing occurs in every interpersonal relationship, we will discuss only testing in psychotherapy.

manner consistent with the pathogenic belief to see whether the therapist encourages a more adaptive response, or by noncompliance, that is by behaving contrary to the pathogenic belief to see whether the therapist is critical of or upset by this behavior.<sup>4</sup> For example, a patient may test a pathogenic belief connected to his separation guilt by always being very close to the therapist and never missing a session, to see whether the therapist is particularly gratified by his extraordinary commitment and hoping that he will not be (transference test by compliance). The patient may also begin coming late or missing sessions to see whether the therapist is disappointed by his behavior, hoping that he will not be (transference test by noncompliance). What both transference tests by compliance and by noncompliance have in common is the fact that the patient gives to the therapist a parent-like role while gives to her/himself the role of the child, and this is what defines them as transference tests.

On the contrary, passive-into-active tests in general are based on reversal, that is, the patient acts as a parent and gives to the therapist the role of her/himself as a child. In passive-into-active tests by compliance, patients treat or behave toward the therapist in ways similar to how the patient was treated (and traumatized) by others in relationships or circumstances that gave rise to their pathogenic beliefs. The therapist's response to such a test can show the patient how to deal with those behaviors and attitudes without being overwhelmed by them and without developing pathogenic beliefs (Foreman, 1996; Sampson, 1991, 1992). So, passive-into-active tests by compliance are aimed at acquiring strengths and capacities the patient lacks by "doing unto others what was done unto you." For example, a patient who was verbally abused by her mother and developed the pathogenic belief that she deserves to be abused, may verbally abuse the therapist hoping that the therapist will not be as hurt as she was by this behavior, and that the therapist could teach her how to appropriately defend herself without thinking that she deserves to be abused. By contrast, when patients pose a passive-into-active test by noncompliance they typically behave in a way that is the opposite of a traumatizing parent or loved one to see whether the therapist feels recognized and appreciates this. And if the therapist benefits from their behavior, they will feel empowered to question the behavior of the traumatizing figure and the pathogenic beliefs developed as a result. In other words, in passive-into-active tests by noncompliance the patient "gives to the therapist what s/he would have liked to have received" as part of an effort to understand (from the therapist's reaction) if what s/he wanted was healthy and justified or not.<sup>5</sup> Using the previous example, the patient who was verbally abused by her mother could be consistently polite and sensitive with her therapist, even during moments of disagreement, hoping that the therapist will appreciate this behavior as the more appropriate one. In Table 1 we can see how John, the patient previously mentioned, may test his pathogenic belief "If I am successful, the people I love will be upset."

In the CMT literature to date, the concepts of "compliance" and "identification" have been used mainly to describe pathogenic behaviors or attitudes that patients developed as a result of traumatic experiences with parents or loved ones (e.g., Foreman, 1996, 2009, 2018; Weiss, 1993, pp. 76–80).<sup>6</sup> In this paper we propose to use the concepts of compliance and noncompliance (toward pathogenic beliefs) also to identify different kinds of transference and passive-into-active tests in order to be more precise in noticing and

describing several clinical phenomena. Consider for example the case of a 30-year-old female patient whose father died when she was a young child. Her mother was quite lonely and clearly wanted her daughter to remain close to home. Though the mother feared the possibility her daughter would leave, she frequently told her to "go out and make your own life—don't spend all your time with me!" She then appeared pleased when the patient stayed close to home. The daughter developed the belief that her separation and independence would be very hurtful and upsetting to her mother. The daughter's inability to leave her mother's home and go live with her boyfriend can be understood as a compliance out of guilt with the mother, even if it is the opposite of what the mother explicitly pushed her to do. For this reason, we believe that it is more precise to view it as a compliance with the pathogenic belief inferred from her mother's implicit demands of closeness. Now imagine that, during one of her sessions, this patient reports to her analyst that she renounced a job opportunity because it could have interfered with the scheduling of their sessions. This represents a transference test by compliance: the patient is trying to find out if the therapist, like the mother, needs her to put the relationship with him ahead of her need to make her own life—a compliance with her pathogenic belief developed from her experiences with her mother.

The utility of this use of the term compliance, and the continuity of this use with Weiss's thinking, may be clearly understood taking into account the case, described by Weiss (1993, p. 3), of one

boy of 2 ½ [who] was sent away for 5 months to live with an uncle and aunt, because his parents were overwhelmed by the task of taking care of his sick younger brother and were afraid that the boy would catch the disease [that his brother had]. However, the boy believed that he was sent away because his restless activity had burdened his mother. *He complied with this belief* [italic added] by becoming especially docile and passive, and he remained this way long after he came back to live with his parents.

In this case, the child's behavior does *not* reflect compliance with the mother; rather, the child is complying with a belief he developed as a result of his parents' decision to send him away.

The newly proposed concept of passive-into-active tests by noncompliance is illustrated further in the following example: A 24-year-old patient was raised by a very abusive mother who, among the other things, would scold her any time she expressed pride in something she had done: "Do not be so arrogant!" was her mother's frequent admonishment. Toward the end of her analysis, in the middle of a session where they were discussing the many ways that her life had improved thanks to her treatment, the patient said to her analyst that he should be proud of the work he had done with her. Then she looked at him, waiting for a reaction. At that point the analyst, wanting to stress her contribution to the good outcome of the treatment, replied: "I think that you have been the

<sup>4</sup> The distinction between transference tests by compliance and by noncompliance was proposed for the first time by the CMT author Alan Rappoport in 1996. For a similar differentiation see also Gootnick (2000; pp. 26–30).

<sup>5</sup> It is worth noting that there may be a strong coaching component in passive-into-active testing by noncompliance.

<sup>6</sup> There are compliances and identifications that are not pathogenic but adaptive, as when a child heeds a parent's advice about danger situations or acquires needed abilities by identifying with a parent.

Table 1  
*How John May Test His Pathogenic Belief*

Measure	Transference test	Passive-into-active test
Compliance	The patient may downplay or deny his accomplishments (in compliance with the belief that he should do so) and observe whether the therapist in fact recognizes and promotes his accomplishments (disconfirming the belief that others will be hurt by his successes).	The patient might be critical of, or act hurt or bothered by, the therapist's abilities or accomplishments (i.e., treating the therapist as he was treated) to see if the therapist feels ashamed or blameworthy (i.e., holds beliefs similar to the patient's).
Noncompliance	The patient may boast of accomplishments or abilities (in defiance of the belief that he should not do so) to see if the therapist is upset or challenged by this behavior.	The patient may compliment or praise the therapist's abilities or accomplishments (i.e., treat the therapist in the way that the patient would like to have been treated) to see if the therapist is comfortable with and feels deserving of appropriate recognition.

one who did most of the work!" The patient appeared disappointed and upset by his response and said: "So, you agree with my mother. Being proud of oneself is wrong." This response suggests that the analyst had failed the patient's test and confirmed a central pathogenic belief. Which kind of test was this? In praising her therapist, the patient was testing him to see if he could be unambivalently proud of himself, hoping that he could. To accomplish this goal, she did the opposite of what her mother used to do to her—she praised him and invited him to be proud of himself, while the mother used to scold her and discourage her feelings of pride. In enacting this test, she hoped that the analyst could enjoy her praise and demonstrate that it was legitimate to be proud. For these reasons, this was a passive-into-active test by noncompliance. So, while passive-into-active tests by compliance are based on identifications with the traumatizing parents or significant others, passive-into-active tests by noncompliance are based on a counteridentification with them.<sup>7</sup>

The aim of the patient when testing the therapist is to disprove his or her pathogenic beliefs, and this is the reason why enactments such as these ones are called tests, not merely repetitions of pathogenic schemas based on compliance (or noncompliance) or identification (or disidentification) with traumatizing others.

To sum up, we propose differentiating the different kinds of testing according to two dimensions: if the patient is attributing to the therapist or to her/himself the parental role (transference tests vs. passive-into-active tests) and if the patient's behavior and attitude shows her/his compliance or noncompliance with the pathogenic belief tested. The idea of testing by compliance and noncompliance was not part of Weiss's original writings on the phenomenon of testing. Rappoport (1997) elaborated Weiss's concept of transference testing when he distinguished between testing occurring in compliance with and in noncompliance with pathogenic beliefs. Similarly, our adding the dimensions of compliance and noncompliance to the concept of passive-into-active testing further elaborates the different ways in which this important clinical phenomenon occurs. We think that this distinction will enable clinicians to more easily identify a broader range of patient tests, even if we are aware that this distinction may need some time to be widely accepted because it implies a slightly different use of the terms "compliance" and "noncompliance," which so far have been mainly used to describe attitudes that patients develop toward relevant people of their life.

Deciding which patient behaviors constitute a test is somewhat arbitrary because in each communication and behavior there may

be a testing component and because, during testing phases, patients' usual behaviors and attitudes may change only to a degree and may even be justified by reality factors. However, we can be more confident that patients are testing their therapists when: (a) they exert a strong pull for the therapist to intervene (e.g., the patient may insist that the therapist step out of his or her role); (b) they induce powerful emotions in the therapist (e.g., the patient may be strongly seductive or aggressive, very distressed or agitated and so on); or (c) they become more self-destructive or foolish, or (d) they behave in a wild or exaggerated way (Weiss, 1993, p. 95). Finally, to think that a patient is testing her/his therapist, there needs to be evidence of her/his capacity to exert some degree of control over own behavior.

To understand the testing dimension of a patients' communications, it is very important to know the patient's goals, pathogenic beliefs, traumas, and preferred testing strategies (i.e., a formulation of the patient's plan, see Curtis & Silberschatz, 2007). However, sometimes one can only understand the meaning of a test after having observed the patient's reaction to the therapist's response to her/his test. Consider the following example: Paul, a man in his sixties, told his therapist during the intake session that he wanted to become more sensitive toward his wife's needs in order not to lose her. When the therapist asked why he felt he was not sensitive, Paul said that his wife had been very upset by the fact that he had refused to relocate for the sixth time in the last 10 years! At that point, the therapist questioned the idea that he was not sensitive enough and said that he thought that his problem was probably that it was difficult for him to say no to the people he loved. After this communication, Paul relaxed, smiled, and said that he was well accustomed to taking care of other people and putting aside his needs. He attributed this to his experiences after his father had died when he was 10 years old and his mother asked him to take care of her and help her to take care of his siblings. In this case, passing the patient's transference test by compliance (by questioning his idea of having to become more sensitive toward his wife) enabled the therapist to begin to understand the patient's goals, pathogenic beliefs, and childhood traumas.

<sup>7</sup> From a different perspective, the psychic processes at the basis of passive-into-active tests by noncompliance are similar to the ones described by Anna Freud (1992/1936) when she wrote about "altruistic surrender."

Passing patients' tests is not always a simple task (Weiss, 1994) because the same behavior may be used to disconfirm different pathogenic beliefs and/or may be an expression of different strategies for testing the same pathogenic belief. In these cases, therapists can describe and explore the dilemma they experience with their patients or may follow certain basic recommendations for orienting themselves.<sup>8</sup> When the patient uses similar behaviors to test two different pathogenic beliefs, one of which is connected to burdening guilt or self-hate, the therapist should give priority to the one associated with burdening guilt and self-hate. To illustrate, Clara, a patient in her twenties, believed that she had to put other's needs ahead of her own in order not to burden the people she loved (burdening guilt) and that she always had to take care of other people in order not to hurt them (omnipotent responsibility). During the Christmas vacation of her first year of therapy she repeatedly called her therapist because she felt lonely, inadequate, and wrong. Clara's behavior might be considered both a transference test by noncompliance with her belief that her needs were a burden for other people and a passive-into-active test by compliance with her belief that she had to take care of other people. The therapist thought that Clara's behavior was primarily a transference test by noncompliance and decided to satisfy Clara's requests. After a while, Clara stopped calling and started to feel closer to her therapist. This change in Clara's attitude toward the therapist was taken as evidence of the fact that her behavior was primarily a transference test by noncompliance and that her therapist's behavior helped Clara feel that her needs were not too burdensome to the therapist in the way she thought they were to her parents. If the patient's behavior of repeatedly calling her therapist had been a passive-into-active test by compliance, it would have meant that the patient was doing to the therapist what others had done to her in the past: demanding too much and making the therapist feel guilty in the same way that she had been made to feel guilty in the past, so that she couldn't say "no" without feeling guilty. If this were the case, the therapist's calling Clara would have resulted in her experiencing increased anxiety and likely making more phone calls.

When the same behavior or attitude may be an expression of both a transference test and a passive-into-active test, the therapist may rely on the feelings aroused in him by the patient to understand the prevalent testing strategy adopted by the patient (Weiss, 1993). During transference tests, the therapist tends to feel safe and strong because s/he is endowed with the authority that a parent has for her/his child, whereas during a passive-into-active test the therapist may feel confused, frightened, or guilty as the patient felt in front of his or her traumatic parent, or may feel in some other way infantilized and treated as a child. If the feelings aroused are insufficient or not clear enough to direct the therapist, however, it is advisable to prioritize the transference testing dimension because it is the testing strategy which puts the patient in greater danger of being retraumatized.

Moreover, there are times when patients test their therapists not with discrete behaviors, but by displaying a *global and persistent attitude*. In these cases, the therapist should develop an overall attitude designed to help the patient to disprove his or her pathogenic beliefs (Sampson, 2005; Shilkret, 2006). For example, if a patient with strong feelings of survivor guilt such as John shows a persistently sad and submissive attitude because he is unconsciously afraid that the therapist would be upset by a happier and

stronger attitude, the therapist should question his submissiveness and sadness showing that the therapist does not need him to be compliant and in pain and can appreciate his vitality, boldness, and self-confidence while being vital, bold, and self-confident her-/himself.

Therapists can verify whether they passed or failed tests by observing patients' behaviors soon after their response or in the following weeks. If the test has been passed, patients will tend to feel safer and may become less anxious and depressed and more relaxed; they may produce new memories, develop new insight, become bolder and more collaborative, may make progress, or pose bolder tests. When tests are failed, patients will tend to feel in danger and may become more anxious, silent, and depressed, will be unlikely to recover new memories or gain new insight, may change topic and may temporarily retreat from their goals. The therapy may end up at a stalemate. In general, these reactions tend to be shown immediately following a passed transference test, while more time is frequently needed to evaluate responses to passive-into-active tests which tend to be longer-lasting.

During the therapeutic process, failing a patient's test is not unusual. And if the therapist regularly fails specific kinds of tests, the patient may try to adopt a testing strategy that better fits the therapist's personality and style. For example, Clara's therapist failed several passive-into-active tests by compliance related to her omnipotent responsibility by becoming overly concerned for her. Clara then changed strategy and started testing this belief with transference tests by noncompliance: over a period of several sessions, she told her therapist that she was fed up with taking care of her chronically complaining, depressed friend. When her therapist was able to pass most of these tests supporting her decision not to take care of this friend, in the following year of her therapy Clara usually tested her omnipotent responsibility in this way. Cases such as this one show (a) that patients are motivated to disconfirm pathogenic beliefs and do their best to adjust their testing strategy to help the therapist to pass them and (b) how testing is a goal-oriented, adaptive, and intersubjective unconscious activity. However, if the therapist systematically fails the key tests of a patient, that is, the tests connected to pathogenic beliefs that play a central role in the patient's psychopathology, the patient may experience a severe setback to the point of quitting treatment (Weiss, 1993).

From a clinical perspective, the idea that the therapeutic process may be seen as the expression of patients' attempts to carry out their plan to disprove their pathogenic beliefs has significant explanatory power and sheds a new and more optimistic light on clinical phenomena that have previously been conceptualized as acting-out, resistance or expressions of a repetition compulsion. Moreover, as we have seen, patients test therapists because they want help in disproving their pathogenic beliefs, and if this happens, patients may experience a real corrective emotional experience and make significant therapeutic progress. Therefore, it is important to empirically verify the soundness of these hypotheses.

<sup>8</sup> It is worth specifying that each clinical decision strictly depends on the patient's unconscious plan, as well as on the pathogenic belief on which the patient is working in that specific phase of therapy and on the testing strategy adopted.

### Empirical Evidence of the Impact of Passing or Failing Patients' Tests in Psychotherapy

This section will focus on a review of the empirical studies designed to demonstrate that (a) patients' behavior in therapy often reflects their efforts to disprove their pathogenic beliefs by testing them in the therapeutic relationship and (b) passing or failing tests has an immediate impact on patients' affect and behavior. In spite of the clinical relevance of these hypotheses, in the empirical literature we found just four published empirical studies on this topic. We will describe these studies in some detail to show the complexity of their methodology and the soundness of their conclusions.

The first study (Horowitz, Sampson, Siegelman, Wolfson, & Weiss, 1975) explored the hypothesis that when a therapist passes a patient's tests, the patient immediately shows less discomfort and feels safer, allowing the emergence of previously warded-off contents. To test this hypothesis, two psychologists were asked to read the process notes of the first 100 sessions of a psychoanalysis and identify sequences in which the patient tested the therapist. In accordance with the formulation developed for this case, the raters had to look for all the episodes<sup>9</sup> in which the patient openly disagreed with the analyst, expressed anger toward him, or made demands. The raters identified 23 "critical episodes," which were abstracted from the notes along with the therapist's response to them and "following episodes" (i.e., patient speech following the therapist's response). Afterward, three different clinical psychologists read the transcript of each critical episode along with the analyst's response to judge whether the therapist passed or failed the patient's test. According to the case formulation, if the analyst did not reply to the patient's criticisms or demands, the test was passed. On this basis, the 23 critical episodes were divided into two groups: 16 instances in which the therapist said nothing and seven in which the therapist made some comment. To assess the level of the patient's discomfort, the authors derived an index from the Mahl's Discomfort Quotient measure (DQ; Kasl & Mahl, 1965), which considers disruptions in a person's speech as reflecting discomfort at the time of speaking. DQ was measured for each critical episode and following episode. From the results of this study, it emerged that of the 16 instances in which the analyst passed the patient's test, the patient showed an increase in DQ during the critical episodes and a decrease in DQ in 15 of the following episodes. In the seven instances in which the analyst did not pass the test, the patient showed a rise in DQ in six of the following episodes.

Next, two psychologists explored whether the sequences in which (a) the patient tested, (b) the therapist passed the test, and (c) the patient's DQ dropped, occurred mainly during sessions in which the patient brought up warded-off contents. To do this, the authors first assessed the empirical validity of a method for discerning warded-off contents (called W contents, emerging in W hours) from the non-warded-off contents (called N contents, emerging in N hours).<sup>10</sup> The results confirmed that the 15 episodes showing a drop in DQ after the therapist passed the patient test occurred mainly during W hours (11 in W hours, four in N hours), whereas the six cases that showed a rise in DQ mainly occurred during N hours (five in N hours, one in W hours). This difference was statistically significant ( $p < .05$ ). Moreover, the data showed that W contents generally emerged after a test was passed. Spe-

cifically, almost all the tests (85.7%) that occurred in W hours preceded the emergence of warded-off contents. On the other hand, N themes did not depend on therapist passing the patient tests.

To sum up, this study supports CMT hypotheses that when patients test therapists they tend initially to feel more discomfort because of the risk inherent in the testing activity, but then this discomfort tends to decrease if the therapist passes the test and to increase if the therapist fails it. Moreover, it also supports the hypothesis that when therapists pass tests, patients feel safer because their pathogenic beliefs are disproved, and tend to bring up previously repressed contents.

Silberschatz, Sampson, and Weiss (1986) conducted another single case study to assess the accuracy of the unconscious automatic functioning (AF) hypothesis compared with that of the unconscious higher mental functioning (HMF) hypothesis (Silberschatz et al., 1986). This research was conducted on the recorded and transcribed first 100 hr of Mrs. C.'s psychoanalysis, a treatment conducted by an experienced analyst. According to the AF hypothesis, a patient's behavior is primarily the expression of unconscious wishes seeking gratification, and so the analyst should frustrate patient demands and requests in a neutral and investigatory manner. In this way, the patient will feel more distressed or angry. In contrast, according to the HMF hypothesis the patient's behavior is primarily the expression of adaptive efforts to solve problems and master traumas. Thus, when this patient makes demands of the therapist, s/he unconsciously wants to test the pathogenic beliefs preventing him/her from achieving realistic and healthy goals. According to this model, when the analyst does not accede to her requests and demands, the patient would feel reassured and relieved. The case of Mrs. C. enables a good comparison between the AF and HMF hypotheses, because in line with both theoretical frameworks the optimal response of the analyst would be to remain neutral by not responding to the patient's demands. According to the AF hypothesis, however, the analyst's neutral attitude would frustrate the patient, whereas according to the HMF hypothesis the analyst would have passed her tests. And because the two theories make different predictions about the immediate effects of the therapist's response on the patient's behavior and affects, the case of Mrs. C. makes it possible to test which hypothesis better fits the observations. If the AF hypothesis is correct, then the patient should feel more distressed and anxious when the therapist, remaining neutral, frustrates her requests; on the contrary, if the HMF hypothesis is correct, therapist neutrality, passing the patient's tests, enables the patient to feel less anxious and depressed, and more relaxed and bolder.

In the first step of this study, nine raters were asked to identify every episode in which the patient appeared to be pulling, explicitly or implicitly, for some response from the analyst. To minimize systematic bias, as well as to generate a maximum number of episodes, each judge read different parts of Mrs. C.'s analysis and at least two raters read each hour independently. In the end, they

<sup>9</sup> An episode is defined as an uninterrupted sequence of patient talk that concerns one theme, ending when the theme changes or the therapist interrupts with a comment.

<sup>10</sup> From the results, it emerged that the judges' ratings were highly reliable and case specific (for a detailed description see Horowitz et al., 1975).

selected a pool of 87 episodes, to which were added 15 random episodes for control purposes (making a total of 102 segments). In the second step, two pools of independent judges—one composed of five analysts who worked according to the AF hypothesis, and one composed of four analysts who worked in accordance with the HMF hypothesis—read a brief description of the patient and viewed the 102 segments capturing the patient's pull and the therapist's response. The AF raters were asked to rate the degree to which the analyst's response was a neutral nongratification of the patient's transference wishes using a seven-point scale ranging from 0 (*clearly nonneutral*) to 6 (*clearly neutral*).<sup>11</sup> The HMF raters were asked to rate the degree to which the analyst passed the patient's test using a seven-point scale ranging from 0 (*explicit example of failing the test*) to 6 (*excellent example of passing the test*).<sup>12</sup> In the third step, to compare only those instances that clearly conformed to both the theoretical perspectives, two new sets of judges—one composed of three AF judges, the other of three HMF judges—were asked to read the 102 segments to respectively identify those instances in which the patient was seeking to gratify a key unconscious wish and those in which the patient was carrying out a key test. The AF judges identified 59 key unconscious wishes,<sup>13</sup> whereas HMF judges identified 46 key tests.<sup>14</sup> In the end, 34 segments met the requirements of both hypotheses. These 34 segments had already been rated with respect to the analyst's intervention frustrating the patient/passing her test, with a correlation between the two groups' ratings of .81 ( $p < .001$ ). In the fourth and last step, to assess the impact of the therapist's interventions on the patient's following behaviors and affects, segments of the patient's speech occurring before and after the transference pulls/tests (for the 34 segments selected) were rated on the Experiencing Scale, the Boldness Rating Scale, the Relaxation Scale, and the Affects Scale.<sup>15</sup> The segments were presented in random order and without context, and each measure was scored by a different pool of trained raters.

The results of this study showed that when the analyst did not satisfy the patient's key transference demands/passed the patient key tests, the patient became significantly ( $p > .05$ ) less anxious ( $-.34$ ), more relaxed, flexible, and spontaneous (.35), bolder in tackling issues (.41), and more positive in her attitude toward others (.36). These findings are consistent with the HMF hypothesis that the patient's transference demands were a test of her pathogenic belief, and the analyst's not acceding to her demands was a reassurance against the danger associated with the pathogenic belief. These findings do not support the AF hypothesis that the patients' transference demands were powerful unconscious wishes and the analyst's not satisfying them was therefore a frustration of those wishes. To sum up, in addition to confirming the findings from the previous study (Horowitz et al., 1975)—when the therapist passes the patient's test the patient become less anxious, more relaxed, bolder, and more positive—this study suggests that the HMF model is better able than the AF model to predict and explain patient's behavior during the therapeutic process.

In another single case study, Silberschatz (1986) used the first 100 hr of Mrs. C.'s psychoanalysis to verify the hypothesis that when the therapist passes the patient's test, the patient immediately becomes less anxious, more relaxed, and more productive.

In the first step of this study, three judges—all of whom were familiar with the concept of testing—read the typescripts of the

102 segments (each segment included the patient's test and the therapist's response) using a brief case formulation of Mrs. C. as a guide, to identify those segments that represented the patient's key tests. They selected a pool of 46 key tests.<sup>16</sup> In the second step a new pool of four psychologists, also familiar with the testing concept, was asked to read each of the 46 segments to rate the extent to which the therapist passed the patient's key tests using a seven-point scale ranging from 0 (*it is an explicit example of failing the patient's test*) to 6 (*it is an excellent example of passing the patient's test*). According to Mrs. C.'s case formulation, the therapist passed her tests by remaining neutral.<sup>17</sup> Finally, to verify the impact of the therapist's intervention on patient's behaviors and affects, different groups of raters read the patient's speech before and after the analyst's interventions using the Experiencing Scale,<sup>18</sup> the Boldness Rating Scale,<sup>19</sup> the Relaxation Scale,<sup>20</sup> and the Affects Scale.<sup>21</sup> Each segment was presented to the raters in random order and without context, and each tool was scored by a different pool of trained raters.

The results showed positive and significant correlations ( $p < .05$ ) between the degree to which the analyst passed the patient's tests and the patient's level of experiencing (.33), boldness (.32), relaxation (.35), and love (.37). Moreover, there were negative and significant correlations ( $p < .05$ ) between how well the therapist passed the test and changes in the patient's level of anxiety ( $-.29$ ) and fear ( $-.34$ ). These results suggest, as predicted, that the analyst's passing the patient's tests was associated with immediate positive effects on the patient, who became less anxious, friendlier toward the analyst, more productive in the analytic work, and more

<sup>11</sup> The reliability of the mean of  $K$  judges' ratings was  $r_{kk} = .74$ .

<sup>12</sup>  $r_{kk} = .78$ .

<sup>13</sup>  $r_{kk} = .86$ .

<sup>14</sup>  $r_{kk} = .75$ .

<sup>15</sup> The *Experiencing Scale* (Klein, Mathieu, Gendlin, & Kiesler, 1970) assesses the extent to which a patient focuses on his/her feelings while simultaneously reflecting on it for problem-solving purposes on a 7-point scale ranging from 0 (*the patient is minimally involved, remote from his/her feelings, and unable to understand their implicit meaning*) to 6 (*the patient is aware of his/her feelings and internal process, is involved in his/her experience, and is able to explore it*). The judges' assessment reliability was  $r_{kk} = .88$ . The *Boldness Rating Scale* (Caston, Goldman, & McClure, 1986) assesses the degree to which the patient is able to confront or elaborate painful material, on a 5-point rating scale ranging from 0 (*the patient is anxious, inhibited, and expresses dissatisfaction about his/her handling of the material*) to 4 (*the patient is able to plunge in head on and confront a variety of issues even if they are painful and distressing*). The judges' assessment reliability here was  $r_{kk} = .64$ . The *Relaxation Scale* (Curtis, Ransohoff, Sampson, Brumer, & Brontstein, 1986) measures the patient's degree of freedom and relaxation on a five-point scale ranging from 0 (*the patient is strongly defensive and timid, and his/her associations come with great difficulty*) to 4 (*the patient is able to associate freely, easily, and flexibly and s/he is able to explore the connections between his/her thoughts and feelings*). The judges' assessment reliability on this scale was  $r_{kk} = .72$ . Finally, the patient's emotions within her speech before and after the therapist's interventions were categorized according to an affect classification system (Dahl, 1979; Dahl & Stengel, 1978) using four affect categories: love, satisfaction, anxiety, and fear. The judges' assessment reliability ( $r_{kk}$ ) here ranged from .63 to .94.

<sup>16</sup>  $r_{kk} = .82$ .

<sup>17</sup> The reliability of their ratings was  $r_{kk} = .89$ .

<sup>18</sup>  $r_{kk} = .88$ .

<sup>19</sup>  $r_{kk} = .64$ .

<sup>20</sup>  $r_{kk} = .72$ .

<sup>21</sup>  $r_{kk}$  ranged from .63 to .94.

relaxed. To sum up, this study supports the results of the previous two studies (Horowitz et al., 1975; Silberschatz et al., 1986), showing that the CMT hypothesis concerning the patient's testing of the therapist has significant explanatory power.

The fourth and last study (Silberschatz & Curtis, 1993) was conducted to show that the therapist's disconfirmation of a patient's key pathogenic belief leads to an immediate increase in patient productivity in the therapy session. However, unlike the earlier studies, this one is the first based on two brief psychotherapy cases (16 sessions) rather than on a long-term psychoanalysis. The patients involved—Diane and Gary<sup>22</sup>—had different problems and backgrounds but were very similar with respect to the general nature and severity of their psychopathology and pathogenic beliefs. Their therapies were conducted by experienced clinical psychologists and psychiatrists trained in different schools of brief dynamic therapy who were unaware of the study's hypotheses. At the end of therapy, both patients showed excellent improvement.

The research design involved five steps. The first step consisted in formulating the patients' unconscious plan (i.e., goals, pathogenic beliefs, traumas, ways of testing, insights). Gary's and Diane's plan formulations were developed as a part of a prior study aimed at establishing the reliability of CMT dynamic case formulations (Curtis, Silberschatz, Sampson, Weiss, & Rosenberg, 1988; Rosenberg, Silberschatz, Curtis, Sampson, & Weiss, 1986). In the second step, five experienced clinicians independently read the transcripts of each therapy session and identified all the instances in which the patients might be testing the therapists. The judges identified 45 tests for Gary and 69 tests for Diane. Then, each segment was randomly presented to a new pool of experienced judges who, using the patient's case formulation as a guide, were asked to rate the extent to which it represented a key test on a seven-point scale ranging from 0 (*the segment was not an example of a key test*) to 6 (*the segment was an excellent example of a key test*). Only those segments with a mean score  $\geq 3$  were considered key tests and included in the data analysis, resulting in 40 key tests for Gary<sup>23</sup> and 65 for Diane.<sup>24</sup> In the fourth step, the same judges rated the degree to which the therapists' behavior in response to the patients' tests confirmed or disconfirmed their pathogenic beliefs on a 7-point Likert scale ranging from 0 (*the therapist strongly fails the test*) to 6 (*the therapist strongly passes the test*).<sup>25</sup> Finally, the patients' immediate therapeutic progress was assessed by rating their verbalizations immediately before and immediately after each testing sequence. The segments were presented randomly to three pools of trained judges who respectively rated each of them using the Experiencing Scale,<sup>26</sup> the Boldness Scale,<sup>27</sup> and the Relaxation Scale.<sup>28</sup>

Positive and significant ( $p < .01$ ) correlations were found between therapists passing the tests and the Experiencing Scale in both cases (.35 for Diane; .40 for Gary). When the therapist passed a key test the patient's level of experiencing increased, and when the therapist failed a key test the patient's level of experiencing decreased. Similar results were obtained for the Relaxation (.37) and Boldness (.45) scales for Diane, but not for Gary. According to the authors, these different results may reflect the different testing strategies of these patients. Specifically, Diane engaged primarily in transference testing expressed by bold and insightful behaviors during therapy, whereas Gary engaged in more passive-into-active testing characterized by monotonous, pessimistic, and

noninsightful behaviors. For these reasons, the authors concluded that the Boldness and Relaxation Scales were inappropriate for studying Gary because, with his specific testing strategy, he would be unlikely to show much immediate change in these dimensions soon after this kind of test was passed.

The findings of these studies on testing confirm that patients' behaviors may be better understood as expressions of humans' fundamental motivation to adapt to reality and master traumas to achieve healthy developmental goals (Weiss, 1998a, 1998b). In fact, in line with CMT hypotheses, the level of patients' discomfort tends to follow a typical pattern during the testing activity: it tends to increase during the testing activity because the patient is not sure whether the therapist will pass his or her test and is afraid that the therapist will confirm his or her pathogenic belief; subsequently, it tends to decrease if the therapist passes the test and to increase if the therapist fails it (Horowitz et al., 1975). Moreover, the data confirm that there are other immediate effects of passing or failing tests on patients' behavior and affect. Consistent with CMT assumptions, when the therapist passes tests, the patient's sense of safety increases and the patient tends to become less anxious, more friendly toward the therapist, more relaxed, bolder and more productive in the therapeutic work (Silberschatz, 1986; Silberschatz & Curtis, 1993; Silberschatz et al., 1986), and to unconsciously lower his or her defenses and bring up previously repressed content (Horowitz et al., 1975). To sum up, these findings appear to confirm the significant explanatory power of the CMT hypothesis concerning patients' unconscious testing activity.

## Conclusions and Future Perspectives

According to CMT, psychopathology stems from unconscious pathogenic beliefs derived from traumatic experiences that obstruct the pursuit of desirable goals, and patients who seek therapy are highly motivated to disconfirm them. During therapy, patients work according to an unconscious plan to disconfirm their pathogenic beliefs by testing their validity in the therapeutic relationship. By testing, patients unconsciously plan and carry out trial actions intended to verify whether the therapist will react in the way predicted by their pathogenic beliefs. If therapists pass their patients' tests, patients feel safer and frequently make progress toward their healthy goals. In general, patients may benefit from all therapeutic interventions that support their unconscious plan (proplan interventions). The therapists' passing or failing of their patients' tests plays a central role in the therapeutic process, because by testing patients may experience a *real* interpersonal situation where their pathogenic beliefs are disconfirmed.

Studies on testing conducted so far support these hypotheses, but they are only four studies and they have several limitations. The limited number of these studies is due to the complex and

<sup>22</sup> These patients were randomly selected from the larger sample of patients in the Mount Zion Brief Therapy Research Project, a study that involved a sample of patients considered suitable for brief treatment.

<sup>23</sup>  $r_{kk} = .75$ .

<sup>24</sup>  $r_{kk} = .50$ .

<sup>25</sup> The judges' assessment reliability was  $r_{kk} = .81$  for Diane, and  $r_{kk} = .77$  for Gary.

<sup>26</sup>  $r_{kk} = .83$  for Diane;  $r_{kk} = .77$  for Gary.

<sup>27</sup>  $r_{kk} = .72$  for Diane;  $r_{kk} = .62$  for Gary.

<sup>28</sup>  $r_{kk} = .73$  for Diane;  $r_{kk} = .79$  for Gary.

time-consuming nature of the enterprise: to test CMT hypotheses about testing, it is necessary to develop a reliable formulation of the plan of each patient, to develop a specific procedure to reliably identify his or her tests, the features that a response should have in order to pass or fail the patient tests and the nature of the changes that each specific patient should show after his or her tests are passed. Moreover, to assess reliably each of these dimensions requires multiple sets of trained raters.

About the specific limitations of the studies conducted so far, then, we can point out that they are based on a somewhat limited testing conception because three of them operationally define a patient's test as a situation where the patient makes demands on the therapist, and in three of four studies the therapist passed the patient tests by being "neutral." However, the concepts of testing and of passing a test are broader and case specific; in no way is the concept limited to the patient making demands and the therapist remaining neutral. In fact, as we have seen, patients' testing strategies may be classified as either a transference test or passive-into-active test, both by compliance or by noncompliance, and their phenomenological manifestations and therapist responses vary according to the pathogenic belief tested and the trauma suffered by the patient. Consequently, there are many instances in which the therapist remaining neutral will fail patient tests. Future studies can overcome this limitation by individualizing a reliable assessment procedure that, on the basis of the specific plan of each patient, enables the raters to identify tests and rate therapist responses in a case-specific way.

Second, as we have seen in Silberschatz and Curtis's (1993) research study, generic process measures for assessing patient changes within the session may not be sensitive enough to the individual features of a given case (e.g., Gary's case). Future studies should elaborate a reliable procedure to infer which are the specific reactions of a patient which may help us to discriminate whether his or her tests have been passed or not by the therapist.

Third, the levels of the correlations between the ability of the therapist to pass the patient's tests and the changes identified in the following patient's communications are moderate (from .30 to .50). One could ask why they are not higher given the importance that CMT gives to passing patients' tests for helping them get better? First of all, they are not so low if we take into account, for example, that the levels of correlation between therapeutic alliance and outcome (the most extensively studied aspect of psychotherapy) varies from .21 to .28 (see Wampold & Imel, 2015). Second, and more importantly, the reported correlations between testing and patients' responses focus in the *immediate* effects. It is very likely that the intensity of a patient's immediate reaction to the therapist's passing or failing tests varies in the different moments of a treatment according to the nature of the pathogenic belief tested, the levels of safety or trust created by the therapist, the patient's particular defense mechanisms, if the test proposed by the patient is conscious or not and so on. Consequently, the focus on immediate effects may have suppressed the magnitude of the correlations. When Silberschatz and Curtis (1993) aggregated the effects of the therapist passing or failing tests on the patient (averaging the ratings for a session as a whole) the results were substantially higher: the correlation between the session averaged Experiencing score with the averaged test passing rating was .67 for Diane and .62 for Gary.

Finally, replications of empirical studies like the ones reviewed in this paper but conducted by different research groups and on different kinds of psychotherapy will be very useful for strengthening the empirical support of CMT hypotheses about the role of testing in psychotherapy. A recent process–outcome study (Silberschatz, 2017) focusing on the plan compatibility of therapists' interventions—not on testing per se—found a statistically significant and substantial relationship between the degree to which therapist interventions disconfirmed pathogenic beliefs and treatment outcome. The results of that study strongly support CMT hypotheses but a similar study focusing on testing is needed to further evaluate the testing concept.

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## 摘要

本文旨在提出一个理论的和实证的综述,对于这样一个假设:心理治疗中病人的行为可以被理解为这样一种表达,即他们努力反驳自己的致病性信念,通过治疗关系中检验它们。根据控制-掌控理论(CMT; Weiss, Sampson 以及锡安山心理治疗研究小组, 1986; Weiss, 1994; Silberschatz, 2005; Gazzillo, 2016),精神病理起源于无意识的致病性信念,而这些致病性信念是为了应对早期创伤而发展出来的。致病性信念将健康目标的达成与多样化的无意识感知到的危险连接在一起。由于人类有适应现实的先天动机,也由于适应性的无意识心理功能的力量,患者带着一个无意识的计划来到治疗中,想要战胜他们的致病性信念,与治疗师一起测试这些信念。这些测试有意识或无意识地被设计为旨在反驳致病性信念的行为。CMT描述了两大范畴的测试:移情测试和从被动到主动的测试。这些测试要求着治疗师给出特定的回应才能通过。当治疗师通过了患者的测试,患者会感觉更安全,可能会有治疗进展;当测试失败了,患者会感觉遭到危险,可能会变得更糟。与CMT的设想一致,对于测试的研究表明,通过患者测试的治疗师与患者取得直接的积极效果相关,但对此需要更多研究。

关键词: 控制-掌控理论, 患者的检验活动, 患者的无意识计划, 心理治疗进程, 实证研究

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