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Through Flow and Swirls: Modifying Implicit Relational Knowledge and Disconfirming Pathogenic Beliefs Within the Therapeutic Process

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The aim of this paper is to describe and discuss the models of the process of change in psychotherapy developed by the Boston Change Process Study Group (2010), and by the San Francisco Psychotherapy Research Group (Gazzillo, 2016; Silberschatz, 2005; Weiss, 1993; Weiss, Sampson, & the Mount Zion Psychotherapy Research Group, 1986). The first model is centered on change in implicit relational knowledge and describes the process of change as being composed of "moving along" phases interspersed by "now moments" that can become "moments of meeting" if the clinician is able to give authentic and specifically fitted responses. A moment of meeting opens up space for a change in the implicit relational knowledge of the patient. The second model is centered on the idea that patients come to therapy with an unconscious plan to master traumas, pursue healthy and adaptive goals, and disprove their pathogenic beliefs, and points to how patients test their pathogenic beliefs in the relationship with the therapist, coaching the therapist about what they need. Passing patients' tests means helping them disconfirm or undermine pathogenic beliefs that hopefully will lead to disproving them. This second model focuses on the subjective meaning of the therapeutic process as seen from the perspective of the patient. We will also try to show, using clinical examples, how these two models can be integrated and how their integration may give us a more comprehensive, tridimensional vision of the therapeutic process.

Keywords: therapeutic process, change in psychotherapy, control-mastery theory, moment of meeting, test

The aim of this paper is to compare and discuss two models of the therapeutic process: the first, that developed by the Boston Change Process Study Group (BCPSG; 2007), which is centered on change in the implicit domain of relational knowledge; and the second, the model of the therapeutic process proposed by control-mastery theory (CMT; Weiss, 1993), which is centered on the need to overcome the obstructions that prevent patients from pursuing their adaptive goals.

After describing these models, we will demonstrate the similarities and differences between the two. We will then use some clinical examples to show how they can be seen as complementary and can enrich both each other and our ability to understand what happens in psychotherapy.

Something More Than Interpretation

It is now commonly accepted that change in psychotherapy takes place thanks to "something more than interpretation" (Stern et al., 1998). For example, on the basis of a series of empirical studies, Waldron and collaborators (Gazzillo, Waldron, et al., 2018; Waldron, Gazzillo, & Stukenberg, 2015; Waldron, Scharf, Crouse, et al., 2004; Waldron, Scharf, Hurst, Firestein, & Burton, 2004) identified the overall quality of therapists' interventions and of the relationship between patient and therapist as the most important factors for a good outcome. Regardless of the type of intervention—interpretation, clarification, transference, or conflict interpretation, and so forth—it seems that the therapist's ability to "say [and do] the right thing at the right time" (Waldron, Sharf, Hurst, et al., 2004, p. 1106) is what allows the patient to improve. But of what does this right thing consist? According to the BCPSG, 2010; Lyons-Ruth et al., 1998; Stern et al., 1998, this something more than interpretation relies within the intersubjective patient—therapist processes that modify the implicit relational knowledge of the patient (and of the therapist).

The BCPSG starts from the observation that most patients, after having completed therapy, mainly remember two types of moments: the analyst's key interpretations, and some special and unpredictable moments of authentic connection with the therapist, that is, moments that changed the relationship and consequently themselves.

On the basis of these observations, these authors hypothesize that psychotherapy gives rise to two types of changes:

1. the first occurs at the declarative and verbal level and is due to the communications and interpretations of the analyst;

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2. the second, less explored in psychoanalytic theory and technique, is implicit, relational, and procedural, and occurs thanks to particular moments, that the authors define as "moments of meeting," that modify the patient's implicit relational knowledge.

Implicit Relational Knowledge: The Child-Caregiver Interaction

The hypotheses of the Boston Group stem from studies of child development by infant researchers and are conceptualized according to the categories of the theory of dynamic systems (Sander, 1962, 1991). These studies show that from the very beginning children are involved in a process of mutual interaction with their caregivers, and from these interactions build relational knowledge and strategies for surviving and adapting to their environment. From their first months of life, children's interactions with their caregivers shape and are shaped, in a circular process, by implicit relational knowledge based on the experiences of both subjects. The child and the caregiver are able to assess and respond to the emotional state and relational moves of the other (Stern, 1995), and it is this mutual adaptation between the two partners, and not the actions of any single individual, that creates the basis for the early interactive representations that are the core of the infant's implicit relational knowledge (Beebe & Lachmann, 1988; Stern, 1983). The unique configuration of adaptive strategies that emerges from this sequence constitutes the initial organization of the child's implicit relational knowledge, which continues throughout his or her life and gives rise to different and multiple schemas of being-with-the-other (Stern, 1995).

During the first years of life, most of the time that children and caregivers are together is spent in active mutual regulation of their own state and the state of the other, in the service of some goal (Tronick, 1989). The reciprocal regulation intrinsic in the first interactive exchanges between parent and child implies not a symmetry between the interacting subjects but rather a bidirectional influence. Each subject brings his or her own history to the interaction, shaping what adaptive maneuvers are possible. The repetition of these regulatory processes involves the repetition of sequences of experiences that arouse expectations and therefore generate implicit relational knowledge; what the child internalizes are not the objects themselves but the process of mutual regulation (Beebe & Lachmann, 1988, 1994; Stern, 1985, 1995; Weinberg & Tronick, 1997).

This process by which infant and parents proceed together by trial and error toward a goal is defined by the BCPSG (2010) as a moving along process. This moving along process simultaneously pursues two main goals: the first is physical/physiological; the second is intersubjective, and concerns mutual recognition of desires, motivations, and intentions (Tronick, Als, & Adamson, 1979). During the process, these two goals can suddenly be realized in a moment of meeting (Lyons-Ruth et al., 1998). These moments of meeting are the emerging characteristics of this progressive process that modify the intersubjective context and consequently the implicit relational knowledge of both partners. This concept will be discussed further below.

The innate mental tendency to interpret human behavior in terms of intentions and motives and to represent and anticipate interaction patterns with others is present well before the acquisition of symbolic capacity (Carpenter, Akhtar, & Tomasello, 1998; Meltzoff, 1995; Ruby & Decety, 2001; Tomasello, Carpenter, Call, Behne, & Moll, 2005; Trevarthen, 1979). Therefore, procedural memory anticipates and supports symbolic and verbal representations (Westen & Gabbard, 2002). From the first months of life, children appear able to recognize, remember, and expect what others and the self will do (Beebe & Lachmann, 2013; Sander, 1997; Tronick, 1989; Tronick, Als, Adamson, Wise, & Brazelton, 1978); toward the end of the first year of life, these modalities are abstracted into generalized prototypical representations that will form the basis for the subsequent construction of symbolic representations of the self and others.

The term *implicit relational knowledge* describes the kind of procedural knowledge that concerns how one relates to others and the world; it is characterized as both an affective and a cognitive knowledge that originates in childhood, in repeated or affectively relevant interactions between the child and her/his caregivers and in moments of meeting that promote a change in the intersubjective field. The more the primary environment supports the child's development, the more this knowledge will be flexible and integrated as it is continually updated in relationships with others; however, conflicting experiences and affects also become part of this knowledge, together with ways of managing them (BCPSG, 2007). For example, according to our real experiences we can feel free to express a certain emotion, or to express another emotion in a distorted way or not at all if it is considered dangerous for our relationship with others:

> The established defenses that we see in the clinical situation often have deep roots in problematic internalized ways of being with others that are a part of the implicit domain. . . . Defensive strategies are likely to constitute one component of a much broader interpersonal arrangement that has endured over a significant period of a patient's life. (BCPSG, 2007, p. 852)

These processes of relational and affective regulation are mostly implicit and are based on childhood experiences. However, each relational encounter is potentially able to change this knowledge by violating previously established expectations. An important feature of changes in the implicit relational knowledge domain is that they are perceived as being sudden qualitative changes.

Moving Along, Present Moments, Now Moments, and Moments of Meeting

In light of these observations on child-caregiver interactions, how should we visualize the relationship between therapist and patient? "The analytic process inevitably involves working simultaneously at affective, cognitive, and enactive levels to deactivate old, more negatively toned procedures and meanings, while simultaneously constructing more integrated, flexible, and coherent ways of being together" (BCPSG, 2002, p. 1059).

The BCPSG (2010) also uses the expression "moving along" to define the customary dialogue that moves forward each therapy session, for describing what therapist and patient usually do together (Stern, 2004). This term points to the therapeutic process, which is slow and nonlinear, and involves losing the way and then finding it again or finding a new way and choosing new goals. In every moment, the verbal content of the patient—therapist exchange is accompanied by an intersubjective process of meaning-

sharing. Therefore, the moving along process includes two parallel goals: the first is the reorganization of conscious verbal knowledge, and the second is the reorganization of implicit relational knowledge.

Moving along phases are driven fundamentally by the need to establish intersubjective contact with the other and, more specifically, by three main intersubjective motives (Stern, 2004):

1. *intersubjective orienting*, that is, the need to know the other and to see where each other is in the intersubjective field;

2. the *sharing of experiences*, which implies the need to be known and which allows the patient to experience a new way-of-being-with the therapist and hopefully with other people; and

3. *defining and redefining oneself*, using the reflection of the self in the other's eyes to reinforce one's own identity.

We can imagine the moving along process as being composed of a series of present moments (Stern et al., 1998) characterized by slight changes in the therapeutic relationship. The present moments between patient and therapist are similar to the interactive, mother-child present moments observed by Tronick and collaborators (Tronick et al., 1998), which are characterized by agreements and disagreements, ruptures, and repairs. Within the therapeutic process, each of these moments constitutes a step in the moving along process toward a goal; they may seem slightly discordant but, on the whole, they assume a coherent form. They are characterized by the sharing of intentions and desires, and their enactment; and, since they are repeated during the sessions with slight variations, they gradually become familiar and end up building a series of expectations about the relationship with the other, or what Stern (1995) calls ways-of-being-with-one-another. They include the procedural and unconscious knowledge that characterizes the relationship with the other: the expectations, the needs, the ruptures, and reparations (Lachmann & Beebe, 1996).

There is, then, a specific kind of emotionally charged present moments (Stern, 2004), the now moments (Lyons-Ruth et al., 1998; Stern et al., 1998), where there is a sudden change in the normal relationship between therapist and patient; the knowledge already acquired and so far consolidated is questioned and the therapist is implicitly asked to react in a way that modifies the usual picture. These now moments normally evolve in three phases:

- the *waiting phase,* characterized by the beginning of the now moment, which pervades the intersubjective field with its atypicality;
- the *strange phase,* which is characterized by a state of confusion and uncertainty; and
- the *decision phase,* in which the therapist needs, in the end, to be able to seize the moment by reacting appropriately and thus transforming it into a moment of encounter.

These now moments—present moments that unexpectedly pop up as an emergent property of the moving along process—call the nature of the patient-therapist relationship into question. For this reason, the therapist needs to act but feels that a routine technical response will not be adequate and that what is needed is a resolution that can come through interpretation or a third kind of present moment.

When the therapist is able to recognize and respond to these now moments there is a moment of meeting, which presupposes an awareness of the change occurring in the intersubjective field and a reorganization of implicit relational knowledge. These moments of meeting arise in particular intersubjective processes involving the affective, cognitive, and behavioral spheres.

A fundamental characteristic of the moment of meeting is the fact that both participants in the relationship recognize the subjectivity of the other: patient and therapist achieve an intersubjective meeting and become aware of their respective experience, achieving what Sander (1995) defines as a *specific fittedness*, reciprocally recognizing the subjectivity of the other. These moments of meeting represent a deviation from the normal progress of the therapy and presuppose a response on the part of the analyst that is based on the here and now and is independent of interpretation or other standard techniques. They involve the analyst in an active change of the intersubjective field created by the two participants. After each moment of meeting, an open space (Stern et al., 1998) emerges in which each participant can assimilate a new intersubjective mode and begin to reorganize her/his implicit relational knowledge. These moments of meeting "shift the relational anticipations of each partner and allow new forms of agency and shared experience to be expressed and elaborated" (Lyons-Ruth, 2000, p. 91).

In some cases, however, when the therapist is unable to fully grasp it (Stern et al., 1998), a now moment may be missed and not lead to a moment of meeting. It can be considered to have failed when an important part of the intersubjective experience is excluded from the therapy, or when the therapeutic relationship is questioned; in some cases, these missed moments of meeting can then be reported by the patient so as to be resumed and repaired (Stern et al., 1998).

Stern (2004) claims that when a now moment occurs, the therapist is confronted with a difficult task for which s/he is not necessarily prepared because it demands something beyond a technically acceptable response. It requires a moment of meeting involving an honest response matched to the specific moment, to the specific context, to the specific relationship between patient and therapist. One of the obstacles for the therapist in producing authentic and personal responses that permit the transformation of a now moment into a moment of meeting is the anxiety s/he experiences during the now moment which, because of its unplanned nature, may disorient the therapist because her/his usual way of being-with-each-other is implicitly being called into question. In contrast, if starting from a now moment the therapist is able to cocreate with the patient a successful moment of meeting, thereby giving the patient an authentic and fitted response, therapist and patient return to their moving along but in a newly expanded intersubjective field that allows new and different ways-of-being-with-one-another (Stern, 1995). Both patient and therapist are changed and their relationship is different because they have changed one another. It is in this sense that a successful moment of meeting is one of the most crucial experiences that can change the course of therapy.

Thus, the moment of meeting is one of the key events in promoting change: it creates an experience that Stern (2004) calls

a *shared-feeling voyage* (p. 172): becomes; the idea is that the therapeutic relationship is essentially a two-person cocreated phenomenon. For this same reason, a moment of meeting can lead to several outcomes—in addition to the important therapeutic changes mentioned above, it could: (a) result in a progressive, implicit change in the therapeutic relationship that favors a desired change, a sort of microcorrective emotional experience (Stern, 2004, p. 179) that creates a context in which something new can arise; (b) pave the way for a new exploration of explicit material; and (c) pave the way for *interpretations*.

But, if the therapist's response/reaction is not adequate, a moment of meeting may result in a failed opportunity for change with negative therapeutic consequences. Sometimes a therapy can be seriously impaired or even brought to termination by such failures because the patient feels that the therapist is incapable of understanding her/him.

Unpredictability, Sloppiness, Uncertainty

According to the BCPSG, the therapeutic process has several principal features. One is its unpredictability: it is spontaneous, and neither the therapist nor the patient can know precisely what the other is going to say or do next. "For this reason psychotherapy (as experienced from within) is also a very sloppy process," writes Stern (2004, p. 156). This sloppiness (BCPSG, 2002) refers to the indeterminate, messy, or approximate nature of the exchange of meanings between two minds (BCPSG, 2005). This intrinsic quality of the process does not have a negative connotation; on the contrary, it is a crucial element for generating new possibilities for psychotherapeutic change. Through this uncertainty, the therapeutic process and the therapeutic relationship can express their creative potential, insofar as sloppiness may alter the direction of the dyad's evolution in unexpected, even previously unimaginable, scenarios. It is important to specify that sloppiness can be used in a creative way only if it is framed within a well-established therapeutic system or well-functioning dyad; without these prerogatives, the improvisational elements can provoke chaos and confusion (Table 1).

Every therapeutic process, as well as every single therapy session, consists of a series of present moments that are driven forward by the desire for intersubjective contact and an enlargement of the shared intersubjective field; it is in this sense that intersubjectivity represents a primary motive in the moving along process. While the process progresses, the dyad lives new experiences that become part of implicit knowledge in the form of new ways of being with the other. During this time, in an unpredictable and sloppy manner a special present moment may occur, a now moment, generating a crisis that needs some kind of original and authentic resolution which, if successful, creates a moment of meeting, that is, the central event leading to change in psychotherapy.

The Basics of CMT

CMT (Gazzillo, 2016; Silberschatz, 2005; Weiss, 1993; Weiss et al., 1986) is an integrative, cognitive-dynamic relational theory of mental functioning, psychopathology, and therapeutic process. Its core hypotheses were developed by Joseph Weiss in the second half of the last century and have been empirically tested and verified by Joseph Weiss, Harold Sampson, and the San Francisco Psychotherapy Research Group.

The name CMT derives from two of its basic assumptions: (a) people are consciously and unconsciously able to control their conscious and unconscious mental functioning,[1] and (b) they are autonomously motivated to solve their problems and master their traumatic experiences.

In line with recent developments in social cognition, experimental psychology, infant research, and evolutionary psychology (Bargh, 2017; Chaiken & Trope, 1999; Dijksterhuis & Aarts, 2010; Evans, 2008; Gawronski, Sherman, & Trope, 2014; Lewicki, 1986; Lewicki & Hill, 1989; Shiffrin & Schneider, 1977; Stern, 1985), CMT stresses how we are able to unconsciously perform many of the same complex mental functions that we perform consciously. We are able to unconsciously set and pursue goals, assess reality, develop and test plans, modify, change, or abandon our plans on the basis of the results of their implementation, and so on (e.g., Gassner, Sampson, Brumer, & Weiss, 1986; Weiss, 1990b; for reviews see Silberschatz, 2005, 2017). This Higher Unconscious Mental Functioning hypothesis (HMFP; Weiss, 1990b) is in line with the hypotheses developed by Freud (1920/1958, 1925/1958, 1938/1958) in the latter years of his career, but is in contrast with the idea of the unconscious of classical and Kleinian psychoanalysis.

According to CMT, the basic principle that we follow in order to regulate our mental functioning is not the pleasure principle (Freud, 1911/1958) but a safety principle (Weiss, 1990a), and our overarching motivation is to adapt to our environment in order to pursue healthy and pleasurable developmental goals. Among these goals, whose reciprocal relevance varies in different phases of life and circumstances (Liotti, Fassone, & Monticelli, 2017), CMT highlights attachment, care, exploration, rank, play, and sex (Bader, 2003; Weiss, 1993, p. 7).

From the beginning of our lives, we consciously and unconsciously try to assess whether and how much it is safe for us to try and pursue these adaptive goals. This motivation to adapt to our environment implies the necessity of, above all else, establishing sufficiently secure relationships with relevant others (Beebe & Lachmann, 2013; Gazzillo, Dazzi, De Luca, Rodomonti, & Silberschatz, 2019) and the necessity of developing a reliable map of ourselves, other people, our relationships, and the world (Gopnik, Meltzoff, & Kuhl, 1999; Silberschatz, 2005; Stern, 1985; Weiss, 1993). This map can be conceptualized as a system of beliefs that we try to make as coherent, comprehensive, economical, and flexible as possible. Some of our beliefs are conscious and explicit, others are implicit, procedural, or unconscious; they all store the contingencies that we detect in our experiences and may be formulated following an "if . . . then" format (Tarabulsy, Tessier, & Kappas, 1996). For example, "If I cry, my mother will come and sooth me;" or "If I smile at another person, that person will smile back at me."

Given that we start to develop our system of beliefs during our developmental period, many of our core beliefs are influenced by

[1] By unconscious "control," Weiss, Sampson, et al. (1986) meant first of all that patients, when feel safe, can unconsciously lift repressions and become aware of feelings, thoughts, memories and insights that they previously warded off from awareness because they felt threatened by them.

Table 1
The Therapeutic Process According to the BCPSG

Moving along		
A therapeutic process that is slow, nonlinear, and includes two parallel goals: the reorganization of conscious verbal knowledge, and the reorganization of implicit relational knowledge.		
Present moments	Now moments	Moments of meeting
Moments that are characterized by slight changes in the therapeutic relationship.	Emotionally-charged present moments.	Now moments that presuppose an awareness of the change occurring within the intersubjective field and a reorganization of implicit relational knowledge.

Note. BCPSG = Boston Change Process Study Group.

the cognitive and emotional peculiarities of our childhood mental functioning: the tendency to overgeneralize; the lack of experience; the need to see our parents and siblings as good and wise, and believe that they love and are happy with us; and the tendency to assume responsibility for everything that happens to us and the people we love.

When faced with adverse experiences and shock and stress traumas that make us lose our sense of safety, we try to understand why these events happened, how we could have prevented them, and how we can prevent them in the future. In such situations, given our tendency to attribute responsibility for what happens to ourselves (Bush, 2005; Gazzillo, Fimiani, et al., 2019; Shilkret & Silberschatz, 2005; Zahn-Waxler & Kochanska, 1988/1990), we tend to develop beliefs that associate our pursuit of adaptive and pleasurable goals with dangers to ourselves and the people we love. In other words, we may develop beliefs that could be called pathogenic because they are grim, constricting, and could cause inhibitions, suffering, and symptoms. These pathogenic beliefs obstruct our desire to pursue adaptive goals, or make us feel afraid, ashamed, or guilty when we try to pursue them (Sampson, 1990, 1992; Weiss, 1997).

CMT, anticipating recent developments in moral and evolutionary psychology (Gazzillo, Fimiani, et al., 2019; Haidt, 2012; Zahn-Waxler & Kochanska, 1988/1990) and in line with the hypotheses of some United States analysts (Asch, 1976; Loewald, 1979; Modell, 1965, 1971; Niederland, 1981), has deepened our understanding of five kinds of interpersonal guilt supported by pathogenic beliefs (Gazzillo et al., 2017; Gazzillo, Gorman, et al., 2018): survivor guilt, experienced by people who feel that having more success, satisfaction, good fortune, or other positive qualities than important others may hurt them; separation/disloyalty guilt, based on the belief that separating physically or psychologically from loved ones can cause them harm; omnipotent responsibility guilt, based on the belief that one must, and has the power to, make loved people feel happy, so that putting the satisfaction of own needs to the fore means being selfish; burdening guilt, derived from the pathogenic belief that one's emotions and needs are a burden to loved people, and that one's own problems and fragility cannot be expressed because it would hurt them; and, self-hate, based on the conviction that one is bad, flawed, inadequate, and worthless. Unlike the other kinds of guilt, self-hate is self-accusation directed at what one is, not what one has done or could potentially do, and its interpersonal origin derives from the fact that in the presence of ill-treating, neglecting, or abusive parents, it is safer for a child to think that s/he deserves the mistreatment rather than feeling dependent on parents who are actually bad (Fairbairn, 1943). People with self-hate see themselves as something dirty, flawed, and contaminated because this is the way they felt they were seen and treated by their traumatizing caregivers.

Given the intrinsic motivation to adapt to one's environment and pursue adaptive and pleasurable goals, people are intrinsically motivated to become conscious of and disprove the pathogenic beliefs that obstruct them (Silberschatz & Sampson, 1991). On the contrary the process of disconfirming our pathogenic beliefs is generally difficult because of confirmation bias, which drives us to find it easier to confirm than disconfirm our pathogenic beliefs. This is because of safety bias, which drives us to pay more attention to the potential losses than to the potential gains that may derive from our choices; and because of the strength of our maladaptive guilty feelings, which are expressions of our internalized relationships with our traumatizing caregivers and are supported by our pathogenic beliefs.

The principal way in which we try to disprove our pathogenic beliefs is by testing them. With the term *testing* (Gazzillo, Genova, et al., 2019), we mean conscious and unconscious attempts to disprove our pathogenic beliefs by trialing actions, communications, and attitudes to test whether the reaction of the other person to them confirms or disproves them. From another perspective, tests may be thought as a way of understanding the level of safety of a relationship, or as a way of exploring the intersubjective field between the self and relevant others in order to understand whether this field supports or obstructs our pursuit of adaptive goals.

It is possible to distinguish two different testing strategies: transference tests and passive-into-active tests. With the first testing strategy, the person assumes the role of the traumatized child and gives to the other the role of the potentially traumatizing other. In passive-into-active tests, in contrast, the person assumes for him/herself the role of the potentially traumatizing caregiver while giving to the other the role of the traumatized child. Moreover, both the transference and passive-into-active tests may involve compliance or noncompliance with the pathogenic belief tested. In transference testing by compliance, the patient exhibits an attitude or behavior that shows her/his compliance with the pathogenic belief tested, while in the transference test by noncompliance the patient displays attitudes or behaviors that show her/his noncompliance with her/his pathogenic belief.

Let us give an example. A patient who believes that if he does not take care of other people they will be hurt and he will be

accused of being selfish, and who developed this belief in a relationship with a needy and depressed mother, could test his belief by:

1. always being caring with the therapist, in the hope that the therapist will make him understand that he does not need him to be so (transference test by compliance);

2. acting in a selfish and uncaring way with the therapist, in the hope that the therapist will not be upset by his behavior (transference test by noncompliance);

3. becoming needy with the therapist and being overtly depressed and extremely upset, just as his mother was with him (identification), in the hope that the therapist will not be as upset as he was with the mother and will not become too caring or worried (passive-into-active test by compliance); and finally,

4. inviting the analyst not to take care of or worry too much about him even if he is in pain, in the hope that the therapist will be relieved by this attitude. In this way, he would be behaving as he would have wanted his mother to behave (counteridentification), in the hope that the positive reaction of the therapist will show him that his desires were legitimate.

Even though virtually any behavior, attitude, or communication on the part of the patient could have a testing dimension, there are some indicators that may help us understand whether a patient is testing the therapist (Weiss, 1993, p. 95):

(a) s/he arouses powerful feelings in the clinician;
(b) s/he pushes the clinician to intervene; and
(c) s/he behaves in a way that is particularly absurd, illogical, provocative, or extreme.

It is worth noting that in order to construe that an attitude, communication, or behavior of a patient is a test, it is necessary to have evidence that s/he is at least partially in control of her/his behavior, that s/he could say or do something different in the same situation. From another perspective (Marshall Bush, personal communication, April 20, 2015), it is possible to construe the presence of a test where the clinician perceives an "interruption" in the normal flow of communication and the relationship between her/himself and the patient.

Given that patients expose themselves to the danger of being retraumatized when testing their pathogenic beliefs, they tend to be more anxious and less relaxed during the testing phase. Conversely, when the therapist passes their tests they tend to feel relieved, less anxious and less depressed, more involved in the therapeutic process and therapeutic relationship, and bolder and more active in pursuing their goals. They may also gain new insight, bring forth previously repressed or dissociated contents, and test the therapist more vigorously. When the clinician fails their tests, they tend to become more anxious and depressed, may retreat from pursuing their goals, and may change topic or become silent, and the therapy may end up in a stalemate (Horowitz, Sampson, Siegelman, Wolfson, & Weiss, 1975; Silberschatz, 1986; Silberschatz & Curtis, 1993; Weiss et al., 1986).

Patients also tend to give their therapists signs in order to help them understand the goals they want to achieve, the pathogenic beliefs that obstruct them, the way they want to disprove their beliefs, the kind of relationship they want to have with the therapist, and the insights they need to acquire in order to master their traumas and problems. In other words, they coach their therapist at the beginning of the treatment, at important moments during therapy, just before, during, and after testing phases, or when they need something to change in their relationship with the therapist (Bugas & Silberschatz, 2000; O'Connor, Edelstein, Berry, & Weiss, 1994).

The Planful Nature of Psychotherapy and the Opportunistic and Coconstructed Nature of Testing

In line with what we have seen so far, according to CMT patients come to therapy with an unconscious plan (Curtis & Silberschatz, 1986; Silberschatz, 2008; Weiss, 1998) aimed at pursuing healthy goals; disproving the pathogenic beliefs that obstruct them; mastering the traumas and adverse experiences that gave rise to those pathogenic beliefs; looking for specific responses, relational qualities, and attitudes from the therapist that pass their tests; and hoping to obtain some insight into the nature, origins, and sense of their difficulties. Goals, pathogenic beliefs, traumas, tests, and insight are the core components of the patient's plan.

Patients want to feel safe in pursuing their developmental and adaptive goals, so their plan may also specify which goal should be pursued first and which pathogenic belief needs to be disproved before working on the others. However, a patient's plan is not a fixed or rigid structure specifying each step of therapy. It is more like a blueprint or a compass signaling the direction to follow, the degree of detail and structure varying among different patients. In any case, empirical research conducted using its empirically validated operationalization, the plan formulation method (Curtis & Silberschatz, 2007), shows that therapists' communications and responses that support patients' plans have immediate and long-term positive effects on the outcome of psychotherapy (Curtis, Silberschatz, Sampson, & Weiss, 1994; Curtis, Silberschatz, Sampson, Weiss, & Rosenberg, 1988; Foreman, Gibbins, Grienenberger, & Berry, 2000; Horowitz et al., 1975; Silberschatz, 1986, 2005, 2017; Silberschatz & Curtis, 1993; Silberschatz, Curtis, & Nathans, 1989).

The evidence shows that it is possible to formulate a reliable patient plan on the basis of the first 2 to 10 sessions, and that the resulting plan is a good guide for the therapist in terms of the treatment required. However, this does not mean that it is possible to know in advance how the patient will specifically test the therapist, and therefore when and how she/he will try to disprove each specific pathogenic belief or pursue each of her/his goals. In fact, these "choices" are influenced by what is happening in the patient's life and by the specific intersubjective patient—therapist relationship with all its vicissitudes. Quoting Weiss (1993, p. 94): "In testing the therapist, the patient makes use of the events in his everyday life," and may adjust her/his testing strategy to the responses and characteristics of the therapist and of his or her technique and style.

According to CMT, every therapy is unique and every patient requires a different one. But notwithstanding this "case-specificity,"

every therapy should be understood as a process whereby the patient has a plan to pursue healthy adaptive goals and, in order to do so, needs to become aware of and disprove her/his pathogenic beliefs. For this reason, s/he coaches the therapist about what s/he needs and then tests her/him, hoping that the therapist will help her/him to pursue her/his plan by passing her/his tests, adopting a proplan attitude, and constructing a safe relationship with her/him.

The wish to pursue healthy developmental goals and disprove pathogenic beliefs, the need to master traumas and to test the therapist in order to feel safe, and the ability to coach the clinician, are the core elements of this therapeutic process.

Comparison of the BCPSG and CMT Models of Therapeutic Process

When we compare the two models of therapeutic process described above, several similarities and differences readily emerge. First of all, both implicit relational knowledge and pathogenic beliefs indicate a type of (mainly procedural) knowledge that originates in childhood, in primary relationships, and include a more or less integrated and flexible set of knowledge of what to expect from and how to react to the other. From this perspective, both implicit relational knowledge and core beliefs may be connected, if related to the attachment system, to the internal working models hypothesized by Bowlby (Bowlby, 1988; Gazzillo, Dazzi, et al., 2019). Neither implicit relational knowledge nor pathogenic beliefs are necessarily dynamically repressed, because both are rooted in procedural knowledge that, as such, is implicit/unconscious (but not repressed) and may also present conflicting elements. The expectations that this type of knowledge promotes in the relationship with the other give rise to a series of affects and behaviors based on inferences that stem from past relationships.

Moreover, both models also give relevance to specific "moments" of the therapeutic process in which the therapist must give a "special" response to a special "request" from the patient in order to make change possible. These moments are not the only mutative moments of a therapy because the process of therapy has the potential to be continuously mutative, but they have a special importance and emerge from the usual process flow.

The BCPSG conceptualizes these "special moments" as a particular kind of emotionally charged "present moments," the "now moments" (Lyons-Ruth et al., 1998; Stern et al., 1998), which can become moments of meeting characterized by a reorganization of the intersubjective field and of the implicit relational knowledge of the patient. The variable that can enable or obstruct the transformation of a "now moment" in a "moment of meeting" is the response of the therapist, which needs to be simultaneously specific and authentic. If a moment of meeting occurs, then a microcorrective emotional experience will occur that will create a context in which something new could arise, a moment that could pave the way for a new exploration of explicit material and for interpretations. The whole therapeutic process, according to BCPSG, is cocreated, nonlinear, sloppy, and uncertain. Its basic motivations are to establish intersubjective contact and modify the implicit relational knowledge, not only the explicit declarative knowledge, of the patient.

CMT, on the contrary, considers these special moments as "key tests" (Silberschatz, 1986) aimed at disconfirming the patient's core pathogenic beliefs. These key tests occur within a process in which the patient is motivated to reach healthy and pleasurable goals, become aware of and disconfirm her/his pathogenic beliefs, and try to coach the therapist in order to make her/him understand what s/he needs. When the patient tests her/his therapist, s/he needs to see that the therapist does not share her/his pathogenic beliefs and supports her/him in reaching her/his goals.

The clinical phenomenology of now moments is in many ways similar to that which occurs when a patient tests the therapist in order to verify, in the hope of disconfirming, the truthfulness of her/his nuclear pathogenic beliefs. In fact, these are emotionally charged situations that suddenly pervade the intersubjective field with their atypicality, generating in the therapist a state of confusion and uncertainty about the appropriate response to be offered to the patient. According to CMT too, in order for these moments to be translated into emotionally corrective experiences it is necessary that the response of the therapist is specific, that is to say it fits with the specific moment, the specific context, and the specific relationship between patient and therapist. Once a test has been passed, the patient become less anxious and less depressed, more involved in the therapeutic process and relationship, bolder in pursuing her/his goals and testing the therapist, and more able to become conscious of previously repressed or dissociated material and to elaborate it (Horowitz et al., 1975; Silberschatz, 1986; Silberschatz & Curtis, 1993; Silberschatz, Sampson, & Weiss, 1986).

In contrast, the failure to pass tests is often followed at first by repeated attempts by the patient to report and repair the break in the relationship (coaching communications and behaviors); however, repeated failures to adequately respond to the patient's implicit and explicit requests to disconfirm her/his core pathogenic beliefs can have negative therapeutic consequences, compromise the therapeutic relationship and, in extreme cases, bring the therapy to an end.

The nature of the entire therapeutic process is intersubjective and coconstructed for CMT too. However, even if it is not possible to predict the specific tests that the patient will put to the therapist, according to CMT it is possible on the basis of a sufficiently well-formulated plan to anticipate both the fundamental manifestations of the various kinds of strategies a patient may use to test each of her/his pathogenic beliefs and how the therapist should respond to them (Curtis & Silberschatz, 2007).

The proposition we wish to advance in this paper is that both the BSPSG's and CMT's descriptions of the therapeutic process point to one and the same set of clinical phenomena, while stressing two different levels of them. If we were to describe these phenomena, we would use the image of a choppy, coconstructed, ascending spiral flow that, in certain moments, is interrupted by unpredictable swirls. The flow is fueled by the different motivations of the patient and the therapist, among which a particular role is played by intersubjectivity. In order to help these swirls give way to a new, higher level, flow, the therapist must give the patient a special response.

The BCPSG describes the implicit relational level of this process; CMT explains the level of the subjective, conscious, and unconscious, meanings that this process has for the patient. The BCPSG, whose perspective derives mainly from infant research, stresses the unpredictability, sloppiness, and uncertainty of the process. CMT authors, on the contrary, having been always very careful to find empirical support for their clinical hypotheses,

stress the fundamentally lawful nature of the therapeutic process.[2] However, in our opinion both perspectives can be integrated and are useful in understanding the therapeutic process: on a microanalytic level this process is unpredictable, sloppy, and uncertain, as described by the BCPSG, just as the flow of a river is unpredictable, sloppy, and uncertain at each specific point of its course. But, on a more global level, it is possible to predict the direction and turns of a river, at least roughly, if we have a good map of the territory through which it flows and we know the weather conditions. And we need both perspectives because neither of them can be reduced to the other and both are constitutive of the therapeutic process.

Some Clinical Examples

A first clinical examples from Stern (2004, p. 166) will help us to illustrate the basic concepts of the BCPSG in practice, as follows. A patient had been in analytic therapy on the couch for a few years, and from time to time had said that she was concerned that she did not know what the therapist was doing back there.

The Patient:	Without warning enters, lies down, and says "I want to sit up and see your face." Suddenly, the patient sits up the couch and turns around, so therapist and patient find themselves looking at each other intently.
Both:	Remain silent.
The Therapist:	Without knowing exactly what she was going to do, softened her face slowly and smiled, then leaned her head forward slightly and said "hello!"
Both:	Remained locked in a mutual gaze for several seconds.
The Patient:	Laid down again and continued her work from the couch, but more profoundly and in a new key, introducing new material.

In this case, in sitting up the patient performed a spontaneous action: she could not know that she was going to do so in that specific session, nor could the therapist have anticipated it. They found themselves in a new interpersonal and intersubjective situation in which an important change in their relationship was possible, the preexisting nature of their relationship could have been renegotiated and the usual way of being-with-each-other questioned: that was a now moment. The "hello" of the therapist, with her facial expression and head movement, represents a moment of meeting because the therapist provided an authentic personal response perfectly adjusted to the specific situation that she was living with her patient; it was a specific fitted match. Other kinds of responses, such as "What are you thinking now?" or "What do you see?" while technically adequate, would have appeared inadequate for the specific contest and the specific moment described. The hello was a nodal point in the therapy of that patient because her analyst showed her that she was "on her side" and "truly open to her." Moreover, it must be recognized that this moment was never verbalized, nor was it ever interpreted during treatment—it remained in the field of the implicit. This is the BCPSG's reading of this example.

Given that we have no information about the trauma and pathogenic beliefs of that patient or about what patient and therapist were working on in that moment of their treatment, it is very hard to make educated, CMT-oriented guesses about that now moment. However, just to illustrate how the exchange could be described in CMT terms, we can hypothesize that the patient had a pathogenic belief such as: if I did not comply with other people's requests, they would be hurt and would reject me. When the patient sat up and turned her face to the therapist, she was testing that pathogenic belief. And the welcoming "hello!" of the therapist, together with her tone of voice and facial expression, passed the patient's test, showing her that the therapist accepted her spontaneous gesture, her noncompliance with the analyst's requests. Thanks to this experience, the patient felt safer and for this reason was able to participate more intensely in the therapeutic process and bring forth new material.

Now, let us look at another clinical examples. Mark, a patient in his forties, was in the third year of three-times-a-week psychoanalytic psychotherapy with a male control-mastery psychotherapist. One of his main goals was the ability to feel free to do what he wanted without being too worried about the needs of the people he loved. Mark was afraid that if he did not always take care of the people he loved, they would be hurt and would make him feel bad. This pathogenic belief derived from his childhood relationship with his mother, a complaining woman whose depressive tendencies were exacerbated by the loss first of her mother and then of her husband, the patient's father, and who expected her children, above all, Mark, always to be available and happy to do what she wanted. Not only did they have to do what she asked of them, but when they did she was completely unrewarding toward them: "You did what you had to do."

Mark started the session talking about how painful it was for his sister to live with their mother. She had to take care of her and give her attention all day, every day. Then he moved on to talking about the numerous daily requests made by their mother, who seemed not to take into account the fact that he had to work and expected him always to be free and available for her. If he was not, she made him feel bad and egoistic. While talking about this situation, Mark was slightly ironic, half incredulous and half accustomed to the behavior of the mother, making it clear to his therapist that he was now completely aware of these dynamics and their impact on him, and that he felt more justified and free to say no to his mother without feeling too guilty. The therapist replied mainly with his facial expressions and some brief comment stressing how absurd his mother's behavior was; he tried to communicate the same irony that he had seen in Mark. In CMT terms, the patient was working to better master those events that reminded him of the stress traumas that were the bases of his main pathogenic beliefs.

[2] Contrary to the CMT hypotheses on the therapeutic process, the hypotheses on therapeutic change of the BCPSG, even if rooted in the systematic observations and empirical data of infant research, so far have not been empirically verified. This is one of the main strengths of CMT. However, this does not mean that BCPSG hypotheses cannot be empirically verified, and that judges cannot be trained to identify now moments, therapists responses to them and moments of meeting, and to then assess the reliability of judges' assessments and the relationship among these elements of the therapeutic process.

Then, Mark started to talk about the fact that he was disappointed by his girlfriend, who was using her own psychotherapy not to talk about herself and her problems but only to talk about the difficulties in her relationship with him; he added that he was also annoyed by his girlfriend's and her therapist's suggestion that they consider starting couples' therapy. His tone became a little bit more sad, annoyed, and disappointed, and his therapist commented: "You feel that your girlfriend, just as your mother, blames you for her suffering; but you *know* that this is not true, that they have their own problems, and so you are fighting against this guilt." With his comment, the therapist was trying to support Mark in not assuming responsibility for the suffering of the people he loved.

From the perspective of the BCPSG model, in that first phase of the session therapist and patient were moving along.

At that point, Mark abruptly turned toward his therapist and asked to him: "Doctor, I have a question for you. If I were attracted to a sixteen-year-old girl with a beautiful, sexually mature body, could I be considered a pedophile?" The climate of the session became more tense, and there was a slight sense of arousal, but the background irony had not subsided. This was a test. And a now moment.

The therapist, after few seconds of silence, reflection, and inner self-regulation of the tension created by that question, replied: "No, I don't think so. You are attracted to various kinds of women and it is hard to imagine not being attracted by a young and beautiful body." And smiled.

At this point, the patient relaxed, smiled, and changed his posture in the armchair in order to sit more comfortably. The test was passed. A moment of meeting took place.

The patient went on:

> However, my favorite sexual fantasy is to have sex with a woman with big breasts. At the beginning of intercourse, she does not want to have sex and I have to force her. But eventually she likes it. What does this mean to you?

It was the first time in his therapy that this patient spoke about one of his sexual fantasies, and this was a further sign that his test had been passed: the patient felt safer and was able to say something new and intimate. At the same time this question can be seen as a new test, a new now moment.

The therapist replied that he thought that the patient found this fantasy arousing because big breasts in a woman was a "symbol" of her capacity and willingness to give, not only to make requests (she was different from his mother). Moreover, the pleasure that the woman experienced at the end of the fantasy was a sign that he did not always need to take care of other people, and that pursuing his goals did not mean hurting them. The patient agreed. There was a moment of meeting.

The last part of the session was smooth and relaxed. Patient and therapist were back at their "going along."

We hope that these two clinical vignettes clarify how the model of therapeutic process proposed by the BCPSG helps to elucidate the process of change at the implicit level of human relationships, in the changes in prevailing categorical emotions and vital affects, and at the implicit level of human communication and interaction. At this level, nothing can be known in advance; the participants to the exchange need to be there together and reciprocally adjust their facial expressions, their movements, their postures, their tones, the intensity of their voices, their reactions, and their silences, with the therapist having the task of being more attuned and regulating his or her own states and those of the other person.

These same clinical phenomena can also be described and understood using CMT concepts, which enable us to clarify the level of their subjective meanings and prepare us for the themes/pathogenic beliefs that need to be recognized and disproved. Even if it was impossible to know in advance that the first patient would sit up and look at the analyst in that session, and that the second patient would ask exactly that question in that session, the plan formulation of the two patients allowed the clinician to know in advance that the first patient needed to feel that it was possible to accept and love her even if she did not comply, and that the second patient needed to feel free not always to be preoccupied and worried about other people's well-being.[3] Putting these two models together, in our opinion, means having two lenses that enable us to understand the process of change in psychotherapy more profoundly: if we compare the therapeutic process to a ballet, the BCMSG model can help us to fully appreciate and describe the music and movements, while CMT helps us to understand the story unfolding in front of our eyes.

Conclusion

It would be reductive to describe the unfolding of a powerful and potentially revolutionary human meeting such as psychotherapy by looking at it from only one perspective or considering only one of its levels. In this paper we have tried to show how the model of the process of change in psychotherapy proposed by the BCPSG to describe what happens at the implicit relational level, and the model of the therapeutic process proposed by CMT to describe change at the level of subjective meanings, can help us to develop a more complete and tridimensional perspective of the clinical experience.

At the core of the first model is the idea of moving along periods driven by intersubjective needs and interspersed by a special kind of present moments initiated by the patient, the now moments, which can become truly mutative only if the therapist is able to respond to the patient in an authentic and specifically fitted way. If this happens, the now moments become moments of meeting that change the intersubjective field of the therapy and the implicit relational knowledge of patient and analyst. But at this level, we are dealing with coconstructed, sloppy, and unpredictable events.

CMT, on the contrary, proposes a vision of the therapy as a process guided by an unconscious plan: the patient tries to pursue pleasurable and healthy goals, master her/his traumas, and disprove the pathogenic beliefs derived from them. In this process, the patient coaches the therapist about what s/he needs, and then tests her/him in order to see whether s/he is safe to pursue her/his goals and whether the therapist shares her/his pathogenic beliefs. In order to pass these tests, the therapist must genuinely understand the specific meaning of the communications, behaviors, or attitudes of the testing patient, and to understand it from the patient's perspective. A reliable formulation of the patient's plan is a considerable help to the therapist because it gives her/him an overall

[3] Mark's therapist had formulated the plan of his patient at the end of their third session.

picture of what the patient is looking for (goals), what is obstructing her/him (pathogenic beliefs), where these obstructions come from (traumas), how the patient might test her/him (tests), and what the patient needs to understand about her/himself. Formulating a patient's plan means guiding our own empathy and harnessing our clinical sensitivity. But the plan does not say what specific kind of tests the patient will pose to the clinician, or when s/he will pose it.

It is our belief that these two models of the therapeutic process can be usefully integrated because they describe the same set of phenomena—the flow and swirls of the change process—from two different perspectives, elucidating two of their core levels—the implicit and the explicit: the sound and shape of the flowing river of the therapeutic process.

摘要

本文旨在描述和讨论由波士顿变化过程研究小组(BCPSG, 2010)和旧金山心理治疗研究小组(Gazzillo, 2016; Silberschatz, 2005; Weiss, 1993; Weiss, Sampson, & Mount Zion 心理治疗研究小组, 1986)所开发的心理治疗中的改变过程模式。 第一个模式以隐性的关系认识的改变为中心,并描述了改变过程是由"向前移动"的阶段组成的,其间穿插着"当下时刻",如果医生能够给予真实和特别合适的回应,这些"当下时刻"就可能成为"相遇时刻"。 一个相遇的时刻为患者的隐性关系认识的改变打开了空间。 第二种模式的中心思想是, 患者带着一个无意识计划来到治疗中,想要掌控创伤,追寻快乐和适应性的目标并反驳他们的致病信念,第二种模式指出患者是如何在与治疗师的关系中测试他们的致病信念的,指导治疗师来了解什么是他们所需要的。 通过了患者的测试,则意味着帮助他们驳斥或削弱致病信念,可望有朝一日能推翻它们。 第二种模式集中于治疗过程的主观意义,如同从患者的视角来看治疗过程。 我们也会用临床的例子来说明, 这两种模式是如何整合的, 以及它们的整合如何能给到我们一个更全面更立体的对治疗过程的认识的。

关键词: 治疗过程, 心理治疗中的改变, 控制-掌控理论, 相遇时刻, 测试

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