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Personalizing Psychotherapy for Personality Disorders: Perspectives From Control-Mastery Theory

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While several empirically supported models for treating personality disorder (PD) are available, researchers and clinicians have continued to advocate for the personalization of psychotherapy to the particular needs and characteristics of the individual patient with severe personality pathology. Control-Mastery Theory (CMT; Gazzillo, 2016; Silberschatz, 2005; Weiss, 1993; Weiss, Sampson, & The Mount Zion Psychotherapy Research Group, 1986) provides a useful framework for understanding personality pathology, and for guiding treatment with individualized case formulation. The present article introduces the basic concepts of CMT and their application in personalizing psychotherapy for patients with severe PDs. According to CMT, patients come to therapy in order to disprove the pathogenic beliefs that obstruct their pursue of healthy and adaptive developmental goals. These pathogenic beliefs were developed to adapt to early traumatic experiences, but end up causing further suffering, inhibitions, and symptoms. For this reason, patients test these pathogenic beliefs within the therapeutic relationship in search of corrective emotional experiences that disprove them. Among patients with severe PDs, such beliefs may be reciprocally contradictory and may be enacted in therapy in multiple different ways, often challenging therapists to respond appropriately. CMT suggests that therapists' formulation regarding a given patient's plan—including the nature of the patient's goals, traumas, pathogenic beliefs, and testing strategies—allow for a personalized approach that will optimize therapy effectiveness.

Keywords: personalizing psychotherapy, control-mastery theory, severe personality disorders, patients' plan, testing in psychotherapy

Research continues to support psychotherapy as the dominant approach to treating personality disorders (PDs; Bateman, Gunderson, & Mulder, 2015). Mostly focused on borderline PDs, reviews of clinical trials suggest that psychotherapy for PD contributes to reduced psychiatric symptoms, suicidality, and health care utilization (Cristea et al., 2017). Indeed, a number of different treatment models have been found effective in Randomized Controlled Trials (RCTs), including dialectical behavior therapy (DBT; Linehan, 2014), transference-focused psychotherapy (TFP; Yeomans, Clarkin, & Kernberg, 2015), and mentalization-based treatment (MBT; Bateman & Fonagy, 2016). As encouraging as these developments may be, many patients struggle to obtain access to specialized treatment (Grenyer, Ng, Townsend, & Rao, 2017), and others still may be less responsive to interventions from particular models. Indeed, consistent with other disorders, premature treatment termination among patients with PDs remains high (Barnicot, Katsakou, Marougka, & Priebe, 2011), and many patients continue to experience significant social impairment following the completion of treatment (Bateman et al., 2015). Effect sizes of empirically supported treatments for PDs tend to be small (Cristea et al., 2017). Thus, despite significant advances, ongoing efforts are needed to continue to improve psychotherapy for PDs.

Personalized care provides a broad mandate for working toward better outcomes in PDs[1] treatment through the individualization of

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[1] In this article we will talk about the need of a personalized therapy for patients with severe personality disorders. However, we think that also treatments for patients with clinical (former Axis I) disorders would be improved by an individualized approach (see also Gazzillo, Dimaggio, & Curtis, 2019). In fact, one and the same disorder may have different meanings and functions in different patients, and the data about the efficacy and effectiveness of empirically validated treatments for both clinical and personality disorders show that, in the best case, half of the patients drop out from treatments or did not respond and 2 years after the end of the treatment the large majority of patients relapse (for a good review see Shedler, 2018; Westen, Novotny, & Thompson-Brenner, 2004). Moreover, the problem of the very high levels of comorbidity among both clinical and personality disorder diagnoses (around 80%; see, for example, Kessler, Chiu, Demler, Merikangas, & Walters, 2005) show the severe limitations of disorder-specific psychotherapies if applied in real clinical practice.

therapy to the particular needs, sensitivities, and preferences of the individual patient. Psychotherapy has always been a highly personalized method of healing (Norcross & Wampold, 2011). However, the movement to scientifically evaluate the efficacy of psychotherapy has arguably shifted attention toward specific, empirically supported treatments (ESTs)—typically involving a hierarchy of specific intervention strategies—for particular disorders. While the demonstration of efficacy of PD treatments has been an advance, evidence regarding the major ESTs for PD suggests an equivalent degree of effectiveness among them (Cristea et al., 2017). Thus, it seems unlikely that PD treatment may be greatly improved by the further development of specific treatment models. Indeed, the vast heterogeneity among patients with PDs—in terms of severity, trait profile, and comorbidity with other disorders—has led to advocacy for treatments that are more personally tailored as a way of improving outcomes for individual patients. These include stepped care approaches that match patient severity with particular ESTs (Choi-Kain, Albert, & Gunderson, 2016), and module-based integration of different EST components targeting specific symptoms and behaviors (Livesley, Dimaggio, & Clarkin, 2016).

Case formulation is also increasingly seen as a way of tailoring therapy to the individual characteristics, needs, and preferences of each patient with PDs (Kramer, 2019), allowing for more personalized treatment within EST models. A DBT formulation, for example, might emphasize the analysis of problematic behaviors—manifesting in unique ways for each patient—and the identification of person-specific behavioral treatment targets (McMain, Leybman, & Boritz, 2019), while a MBT formulation might focus on individual differences in reflective functioning and patterns of attachment, influencing the stance adopted by the therapist (Karterud & Kongerslev, 2019). While such models inform how a therapist can "prescribe" certain aspects of a treatment model to the individual, they do not necessarily inform the clinician of the idiosyncratic ways in which a particular patient might work in therapy. Moreover, case formulation based on a particular EST risks the omission of salient treatment goals and processes that lie outside the model's prescribed change mechanisms.

In this article we argue that an approach to case formulation based on Control-Mastery Theory (CMT)—a broad framework for understanding the therapeutic process—can be especially helpful in the personalized treatment of severe PDs.[2] CMT (Gazzillo, 2016; Silberschatz, 2005; Weiss, 1993; Weiss et al., 1986) is a nonprescriptive, relational, cognitive-dynamic theory of mental functioning, psychopathology and psychotherapy process that seeks to explain how patients work in therapy to accomplish their goals and ameliorate psychopathology. Rather than specifying interventions based on an a priori hierarchy of treatment priorities and mechanisms, CMT may be used to guide the therapist to understand the individual patient's goals and obstructions to reach goals, and to make sense of idiosyncratic and often puzzling ways in which the patient may utilize the therapy process. Moreover, a CMT-informed perspective can be integrated with ESTs and other model-based paradigms, and may be particularly useful in illuminating clinical dilemmas and guiding therapists toward individualized responses to confusing and challenging scenarios that frequently arise in the treatment of PDs (see also Gazzillo, Dimaggio, et al., 2019).

The Basics of Control-Mastery Theory

CMT core hypotheses were developed by Joseph Weiss and have been empirically tested and verified by Joseph Weiss, Harold Sampson, and the San Francisco Psychotherapy Research Group over the past 50 years. 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; and (b) they are autonomously motivated to solve their problems and *master* their traumatic and adverse experiences.

In line with recent developments in social cognition, experimental psychology, infant research, and evolutionary psychology (Bargh, 2017; Dijksterhuis & Aarts, 2010; Weinberger & Stoycheva, 2019), CMT stresses humans' ability to unconsciously perform many of the same complex mental functions that are performed consciously. According to this higher mental functioning hypothesis (HMF), we are able to unconsciously set and pursue goals, assess reality, develop, test, and modify or abandon our plans on the basis of the results of their implementation, and so on (e.g., Gassner, Sampson, Brumer, & Weiss, 1986; Weiss, 1990; for reviews see Silberschatz, 2005, 2017). According to CMT, the basic principle that we follow in order to regulate our mental functioning is a *safety principle* (Weiss, 2005), and our overarching motivation is to *adapt* to our environment in order to pursue healthy and evolutionary based *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, 2002; Weiss, 1993, p. 7).

From the beginning of our lives, we consciously and unconsciously try to assess the degree to which and how it is safe to 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; Sampson, 1990, 1992) and the necessity of developing reliable knowledge about reality and morality, about ourselves, other people, our relationships, and the world (Gopnik, Meltzoff, & Kuhl, 1999; Silberschatz, 2005; Stern, 1985; Weiss, 1993). This knowledge can be conceptualized as a system of *beliefs* that we try to make as coherent, comprehensive, and economical as possible. While many beliefs are conscious and explicit, others are implicit, procedural, or unconscious. Such beliefs 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 their emerging formation during early childhood, many core beliefs are influenced by the cognitive and emotional peculiarities of childhood mental functioning: the tendency to overgeneralize, the relatively limited perspective and experience, the need to see parents and siblings as

[2] Severe PD in this article refers to patients who experience inconsistent representations of self and others, chaotic relationships, difficulties in regulating impulses and emotions with a prevalence of negative emotions, difficulties in self-esteem regulation, tendency to act out, mentalization difficulties, difficulties in setting and pursuing long-term goals, and temporary and limited difficulties in reality testing.

good and wise (and to 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 (Bush, 2005; Gazzillo et al., 2020; Shilkret & Silberschatz, 2005; Zahn-Waxler, Kochanska, & McKnew, 1990).

When faced with *adverse and traumatic experiences* that threaten our sense of safety—including acute "shock" traumas and chronic "stress" traumas—we try to understand why these events happened, how we could have prevented them, and how we can prevent them in the future. Given childhood tendencies to attribute responsibility for what happens to ourselves and preserve positive relationships with caregivers—maintaining their images as good and wise—adverse and traumatic experiences tend to favor the development of beliefs that associate our pursuit of adaptive 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 contributing to inhibitions, symptoms, and suffering. These pathogenic beliefs obstruct one's pursuit of adaptive goals—evoking fear, shame, or guilt as such goals are approached (Silberschatz & Sampson, 1991; Weiss, 1997). Indeed, interpersonal guilt tends to be particularly entwined with pathogenic beliefs, due to the critical importance of preserving good relationships with caregivers and other family members during early childhood.

CMT, anticipating recent developments in moral and evolutionary psychology (Gazzillo et al., 2020; Haidt, 2012; Zahn-Waxler et al., 1990) and in line with the hypotheses of several psychoanalytic authors (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, 2018): *survivor guilt*, involving the sense 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 and becoming independent 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 one's 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. While affectively similar to shame, self-hate functions as a form of interpersonal guilt in aiming to preserve positive relations with our images of close others. Originating in the context of neglectful or maltreating parents, self-hate involves the child believing that s/he deserves maltreatment, because it is safer to do so than to feel dependent on parents who are actually bad (Fairbairn, 1943). People with self-hate see themselves as dirty, flawed, or contaminated, having inferred that they were seen and treated as such by their traumatizing caregivers.

Given the fundamental motivation to pursue adaptive and pleasurable goals, people are intrinsically motivated to become conscious of and disprove the pathogenic beliefs that obstruct them (Weiss, 1993). The process of disconfirming pathogenic beliefs, however, is made difficult because of *confirmation bias*, in that it tends to be easier to confirm than disconfirm pathogenic beliefs. Moreover, a *safety bias* motivates toward paying more attention to the potential losses than to the potential gains that may derive from personal choices. Due to interpersonal guilt—entwined with internalized relations with caregivers and family members—the disconfirmation of pathogenic beliefs is also often associated with considerable perceived losses in terms of damage to one's images of, or actual relationships with, close others.

Understanding Severe Personality Pathology Through the Lens of Control-Mastery Theory

According to CMT, much of the core psychopathology of severe PDs may be accounted for by several factors related to developmental adversities, traumas, and pathogenic beliefs. While research has consistently shown a robust relationship between childhood adversity and personality dysfunction (Lobbestael, Arntz, & Bernstein, 2010; Widom, Czaja, & Paris, 2009; Yen et al., 2002), not all individuals with PD have experienced overt abuse or neglect. In some cases, PDs report to may arise from a chronically awkward fit between individual temperament and environment, over time reinforcing dysfunctional beliefs about self-other relations. However, many patients with severe PDs suffered from severe relational stress traumas during critical developmental periods, stress traumas which were often also associated with focal traumas such as sexual and physical abuse, and emotional abuse and neglect (Howell & Blizard, 2009; Mosquera & Steele, 2017). These traumas are seen as having caused a severe impairment in the sense of interpersonal safety, contributing to frequent states of hypervigilance associated with a difficulty in downregulating emotions (Berenson, Nynaes, Wakschal, Kapner, & Sweeney, 2018; Bertsch et al., 2017; Fertuck, Fischer, & Beeney, 2018; Masland & Hooley, 2019; Schilling, Moritz, Schneider, Bierbrodt, & Nagel, 2015). Moreover, such traumas engender pathogenic beliefs that support a strong self-hate (Faccini & Gazzillo, in press). In other words, individuals with histories of severe and complex traumas tend to believe—often implicitly or unconsciously—that they do not deserve love, affection, appreciation, and protection, and they expect that other people will mistreat, neglect, and disparage them. For this reason, they are often very sensitive to actual or perceived neglect, rejection, and abandonment, tend to interpret loneliness as a consequence of an abandonment, rejection, or neglect due to their low self-worth, and may be inclined to fears of being abandoned, mistreated, neglected, or rejected by important others (e.g., borderline PD).

Many (but not all) patients with severe personality pathology show disorganized or "cannot classify" attachment, and tend to recur to dissociation for dealing with the contradictory interpersonal schemas typical of this kind of attachment (Beeney et al., 2017; Diamond et al., 2014; Gazzillo, Dazzi, et al., 2019; Liotti & Farina, 2016; Miljkovitch et al., 2018). From the perspective of CMT, disorganized attachment reflects the development of a *multiplicity of reciprocally contradictory pathogenic beliefs* deriving from the chaotic and contradictory behaviors and attitudes of the caregivers. In other words, within such fraught and chaotic early relationships, the developing child may not be able to develop a coherent picture of oneself, other people, and close relationships. Rather, in order to achieve the healthy goal of having a secure and stable enough close relationship with their caregiver, these patients

must renounce other healthy goals such as protecting oneself, developing a life of one's own, having good self-esteem, being happy, having satisfying relationships, experiencing personal accomplishments, and so on. For example, a parent could convey the message—through repeated interactions and implicit or explicit communications—that if the child asks for something, the parent would be burdened or overwhelmed, but if the child were autonomous, the parent would feel useless. Or these children could have received the message that if they did not perform, the other would humiliate them, but if they performed, the other would feel inferior and hence suffer. The contradictory pathogenic beliefs emergent from such interactions would create a powerful bind for the individual and contribute to seemingly incongruous patterns of behavior. One of our hypotheses (Gazzillo, Dazzi, et al., 2019; Gazzillo & Mellone, 2016) is that severe personality pathology is often the expression of such contradictory pathogenic beliefs, accounting for considerable instability and incoherence of the representations of the self and others that are typical of severe PDs. Moreover, from this perspective, dissociative compartmentalizing (described by other authors with the concepts of splitting or fragmentation of self and object representations; Yeomans, Clarkin, & Kernberg, 2015) may be regarded as reflecting the impossibility of creating a coherent set of beliefs and schemas from such contradictions. According to Weiss (1993, p. 77):

> If the child is sexually abused by a parent, he will blame himself for the abuse and develop a sense of shame. If the parent denies the abuse, the child will infer that he must not remember it. His sense of reality may be impaired with the following problem: in order to adapt to his world, he must both forget the abuse and remember it. He must forget the abuse in order to adapt to the members of his family, who insist on denying it, for he cannot be friendly and close to a parent who he knows is abusing him. However, he must remember the abuse in order to prepare for further abuse. If abused while quite young, he may deal with this problem by dissociating, or in certain instances by developing several personalities—one or more of which has no memory of the abuse, and one or more of which remembers it.

Emergent from such inimical experiences, the multiplicity of pathogenic beliefs—and their associated affects—combine with the attitudes and behaviors deriving from *identification* (Foreman, 2018) or *counteridentification* with relevant others. Identification and counteridentification are seen as means by which children adapt to their environment. For example, a child who is often physically abused by a parent who accuses him of being bad may become as physically abusive with his peers as his father is with him. Alternatively, especially if he has other caregivers who are more benevolent and caring with him, is to counteridentify with his father, being always kind and supportive with his peers as he would like the father be with him. The combination of various identifications and their associated attitudes and behaviors with pathogenic beliefs—including those which contradict each other—and their associated affects contributes to the tumultuous and often incomprehensible relational behaviors characteristic of severe PDs.

Testing for Disconfirming Pathogenic Beliefs

One of the main ways in which people try to disprove pathogenic beliefs is by *testing* them in their interactions with others (Gazzillo, Genova, et al., 2019). Testing refers to conscious and unconscious attempts to disprove pathogenic beliefs by trialing actions, communications, and attitudes to test whether the reactions of others either 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 one's 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 transference and passive-into-active tests may involve *compliance or noncompliance with the pathogenic belief tested*. In testing by compliance, the individual exhibits an attitude or behavior that shows her/his compliance with the pathogenic belief tested, while in the testing by noncompliance the individual displays attitudes or behaviors that show her/his noncompliance with the pathogenic belief. These testing strategies may be enacted in various interpersonal scenarios, though CMT is particularly concerned with their emergence in treatment. Indeed, CMT suggests that testing is a primary way in which patients attempt to work on their problems in psychotherapy, and that therapists—regardless of the EST or principle-based model they may be using—can greatly improve the personalization and effectiveness of their interventions by understanding the particular ways in which a given patient may test his or her pathogenic beliefs.

The following example illustrates how the aforementioned testing strategies may be employed by a patient in psychotherapy. A patient who believes that she does not deserve protection because she had been physically abused by her parents during her childhood may:

1. Tell the therapist how she keeps on choosing abusive partners and is not able to disentangle herself from these relationships, hoping that the therapist will help her understand that she does not deserve to be abused (transference test by compliance);

2. Be continually hypervigilant and overreactive toward potential or real maltreatments, hoping that the therapist will support her right to protect herself (transference test by noncompliance);

3. Become aggressive with the therapist, just as her parents were with her, in the hope that the therapist will not be as upset as she was and will demonstrate how to protect oneself from abusive others (passive-into-active test by compliance); and finally,

4. Be very protective and kind with the therapist, in the hope that the positive reaction of the therapist will show her that her needs for protection and kindness were legitimate (passive-into-active test by noncompliance).

On the surface, these testing strategies may appear relatively straightforward. In practice, however, particularly with patients with severe PDs, testing can be complex and nuanced as patients attempt to address multiple (and sometimes contradictory) goals and pathogenic beliefs. Indeed, it can happen that the same behavior of a patient may imply different tests: For example, a patient who mistreats the therapist may be proposing a passive-into active test by compliance of the pathogenic belief "I deserve to be mistreated" and, at the same time, a transference test by compliance of the pathogenic belief "I do not deserve to be appreciated." In a case such as this, in order to pass the first test the therapist might be confrontative, to provide a model to the patient of how one can feel deserving of protection against mistreatment. However, this attitude might fail the second testing dimension, which in order to be passed could require the therapist's accepting and understanding attitude. In order to understand how to respond, the therapist must determine which is the prevalent testing dimension involved in this behavior in that particular moment of the treatment. In general, it is probably better to give priority to the transference testing dimension of a behavior because transference testing is generally more dangerous for the patient: In proposing a transference test the patient put her/himself in the role of his or her traumatized self, and risks the therapist responding in a manner akin to earlier traumatizing figures (see Weiss, 1993, p. 105). Another option could be to discuss this dilemma with the patient, trying to understand with her/him what s/he needs. Adding to the complexity of such testing sequences is the possibility that the therapist's responses aimed at passing patients' tests may be received with mixed feelings by the patient. These mixed reactions may have multiple meanings, from being indicators that the response of the therapist was only partially experienced as passing the test, to being indicators that the patient is further testing the therapist (below we outline indicators of whether a test has been passed or not).

It is worth stressing that patients' testing activity is often mediated by their *attitude* (Weiss, 1993). And in order to pass patients' tests mediated by attitudes, it is important that therapists are able to assume an optimal attitude, that is, an attitude that disproves patients' pathogenic beliefs (Sampson, 2005). For example, if a patient who was always despised by his parents adopts a despising attitude with the therapist as passive-into-active test mediated by his attitude, the therapist should adopt a self-confident attitude in order to help disprove the patient's self-hate.

Although virtually any behavior, attitude, or communication on the part of the patient could have a testing dimension, there are some indicators that can help to determine 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; (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, and that s/he could potentially say or do something different in the same situation.

Because testing risks the exposure of the patient to the potential of being retraumatized (i.e., the confirmation of pathogenic beliefs), patients tend to be more anxious and less relaxed when testing pathogenic beliefs in relation to the therapist. Conversely, when therapists respond in ways that pass their tests, patients tend to feel relieved, less distressed, more involved in the therapeutic process and therapeutic relationship, bolder, and more active in pursuing their goals. They may also gain new insight and bring forth previously repressed or dissociated contents, or they may test the therapist more vigorously to further disprove the pathogenic belief. When therapists respond in ways that fail their tests, patients tend to become more anxious and depressed, may retreat from pursuing their goals, and may change topic or become silent (Gazzillo, Genova, et al., 2019; Horowitz, Sampson, Siegelman, Wolfson, & Weiss, 1975; Silberschatz & Curtis, 1993; Silberschatz, Fretter, & Curtis, 1986; Weiss et al., 1986). Indeed, repeated failed tests may result in stalled progress or even premature termination.

It is worth emphasizing that test passing is not a one-time occurrence; patients test their pathogenic beliefs from the beginning to the end of a therapy (see, e.g., Bush & Gassner, 1986). In different moments of their treatment, they may test different pathogenic beliefs and may use different testing strategies; sometime they may propose the same kind of test in different moments of a therapy, so they may be helped by the same kind of response. At other times the same behavior may be used for testing different pathogenic beliefs, requiring the therapist to change the response in order to pass that test. Given the tenacity of pathogenic beliefs—perhaps especially among patients with severe PDs—the therapist's continued, sustained passing of tests is needed to loosen their constricting effect on the patient. The necessity of repetitively passing the tests proposed by a patient to disprove her/his pathogenic beliefs may be thought as part of the working-through process described by Freud for the first time in 1914 (Freud, 1914).

Testing in the Treatment of Patients With Severe Personality Disorders

The concept of testing sheds further light on the instability and inconsistency of the relational behaviors and the tendencies to act out intense emotions and impulses that are frequently observed among patients with severe PDs, explained by other dynamic models (e.g., TFP; Yeomans, Clarkin, & Kernberg, 2015) using the concepts of splitting, role reversal, and projective identification. While models such as TFP emphasize sequences of clarifications, confrontations, and interpretations to address such phenomena, the perspective from CMT would suggests an individualized consideration of the patient's unique and idiosyncratic testing strategies, and the therapist's role in responding (which may include, but would not be limited to, expressive interventions) in ways that pass tests and enhance the patient's sense of safety.

Due to early traumatic experiences, patients with severe personality pathology tend to experience a very low sense of safety, particularly in close relationships. They tend to feel afraid, often perceiving danger, due to the pervasiveness of their pathogenic beliefs that fuel negative expectations about how other people will behave with them and what they deserve in life (self-hate). As a consequence, as soon as a new relationship starts, individuals with severe personality dysfunction need to strongly test the other person. They may feel an urgent need to test this as soon as possible, very much, and in different ways. Moreover, such tests are often "acted-out" because they are connected with strong emotions of fear and anxiety, and when a person is deeply afraid or anxious, the only thing s/he can do is to try to secure her/himself as soon as possible. Another reason why these patients tend to

act-out is because their early family environments often did not facilitate communication about what was felt and thought; rather, the emotions and impulses of different family members were in many cases simply acted out. From this perspective, patients' acting-out tendencies and difficulties to mentalize may be understood also in the context of deep survivor and disloyalty guilt toward their families, whereby thinking and communicating about emotions may be believed to be or experienced as a betrayal, a burden, or a humiliation for their relevant others (Bader, 2002, pp. 260–263).

It is important to note the vast individual differences in the ways that patients with PDs employ tests to help them overcome their pathogenic beliefs, and the myriad social outcomes that may ensue from their testing behaviors. Others may not appreciate the individual's tests as adaptive, and in fact may respond in hurtful or counterproductive ways that confirm rather than disprove pathogenic beliefs (likely reinforcing much of the social dysfunction associated with PD). Using the vantage point offered by CMT, however, therapists can be aware of the patient's various efforts—through multiple and different types of tests—to obtain a sense of safety and combat his or her pathogenic beliefs, and respond in helpful and often novel ways for the patient. Most therapists probably have an intuitive sense that acting-out behaviors call for constructive responses, and many may well end up passing many of the patient's tests simply by responding according to established principle-based or empirically supported models. For example, a therapist's adherence to the mentalizing stance suggested within a MBT (Bateman & Fonagy, 2016) framework may pass a patients' tests of the belief that thinking about emotions and mental states would mean to betray or abandon his or her parents (as in the example above). Although the therapist may not conceptualize the patient as testing this belief, the therapist's consistent focus on, and modeling of, reflective functioning could legitimize the patient's attempt to become more able than his or her parents to deal with emotions and mental states. A similar result might be achieved by a DBT therapist teaching the patient skills to improve their affect regulation abilities (Linehan, 2014). In both cases, beyond the imparting of specific information, therapists employing these kinds of interventions may convey the message that the patient deserves to have greater emotional awareness and to function better than their families in this regard. Without conceptualizing patient–therapist interactions from the perspective of testing, however, therapists using these approaches could in some cases unwittingly reduce a particular patient's sense of safety and reinforce his or her pathogenic beliefs. We speculate that the high drop-out rate and only modest treatment effects for treatment of PD may be in part due to the complexity of testing strategies of these patients and the unfamiliarity of many therapists with the concept of testing. Either way, as we will see in the next paragraph, the usefulness of this kind of interventions depend on how much they are felt by patients as supporting their therapeutic goals. Let's think, for example, about a patient who is talking with his therapist about an emotionally charged negative experience with the unconscious goal to be helped by his therapist to master it, and the therapist, following MBT indications, shifts the focus of the dialogue from the contents of the experience to how the patient made sense of what happened in order to help the patient better mentalize it. This change of focus might be easily felt by the patient as antitherapeutic because it contrasts the goal that the patient is trying to pursue, which is mastering that negative experience and not improve his mentalization skills.

The concept of testing can help both explicate the phenomenology of severe PDs and understand the processes used by patients to work on their problems in psychotherapy. Indeed, CMT would suggest that consideration of testing is a major pathway to personalizing psychotherapy and optimizing therapeutic effectiveness for patients with severe PD, even within a specific EST or principle-based treatment. A therapist could, for example, employ an interpretive approach (e.g., TFP) or a didactic approach (e.g., DBT) while formulating the patient's tests and anticipating the best ways of passing them that would be consistent with, or complementary to, the treatment model. From the perspective of CMT, however, understanding how a given patient may test the therapist, and which kinds of responses would increase a particular patient's sense of safety and confidence in countering pathogenic beliefs, is seen as more important than any specific a priori intervention strategies.

The Patient's Plan

CMT considers patients to enter psychotherapy with an *unconscious plan* (Curtis & Silberschatz, 2007; Weiss, 1998) aimed at pursuing healthy and pleasurable goals, disproving the pathogenic beliefs that obstruct them, mastering the traumas and adverse experiences that gave rise to those pathogenic beliefs, and looking for specific responses, relational qualities, and attitudes from the therapist that pass their tests. This plan also includes the patient's hope to obtain some insight into the nature, origins, and sense of their difficulties. Thus, 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. In this way, a patient's plan is like a blueprint or a compass signaling the direction to follow, the degree of detail and structure varying among different patients. The therapist's inferences regarding the patient's plan—which is necessarily idiographic—allow for the therapist's attitudes, behaviors, and formal interventions to be highly personalized in helping the particular patient to feel safe, disprove pathogenic beliefs, and pursue adaptive goals.

Empirical research conducted using an empirically validated operationalization of the plan concept, the plan formulation method (PFM; Curtis & Silberschatz, 2007), shows that it is possible to formulate a reliable patient plan on the basis of the first 2 to 10 sessions, and that the plan formulated in this way can serve as a useful guide for the therapist: Therapists' communications and responses that support patients' plans have immediate and long-term positive effects on the outcome of psychotherapy (Curtis & Silberschatz, 1986; 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). It is worth noting that, while the correlation between the "plan compatibility" of an intervention and the outcome of psychotherapy is linear, positive and significant, the relationship between the adherence of therapists to a treatment manual and outcome has been found to take the shape

of an inverted U: Only an intermediate level of adherence to the manual correlates with good outcomes, and in some studies no relationship between manual adherence and outcome was observed (see, e.g., Tschuschke et al., 2015; Webb, DeRubeis, & Barber, 2010).

As useful as a plan formulation may be in guiding treatment, by no means does it orchestrate the therapy into a series of anticipated maneuvers. Despite a careful formulation of the patient's plan, the therapist may not necessarily 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.

Applying Plan Formulation in the Treatment of Patients With Severe Personality Disorders

One way in which an idiographic formulation of the patient's plan, including consideration of testing, may be particularly useful is in helping the therapist to make sense of and appropriately respond to troublesome interactions in therapy. Therapists commonly report difficult countertransference reactions to patients with severe PDs (Genova & Gazzillo, 2018; Rossberg, Karterud, Pedersen, & Friis, 2007); a reasonably accurate plan formulation can mitigate negative responses to such feelings and prevent therapists from becoming overwhelmed. Indeed, a plan formulation can help the therapist to evaluate the degree to which a patient's acting out behavior in therapy may reflect testing strategies that are unconsciously employed to master pathogenic beliefs and traumas, but which have the effect of evoking powerful affective responses in the therapist. By highlighting the patient's traumas, goals, and therapeutic needs, the plan formulation can help the therapist remain empathic to the adaptive side of his or her provocative and challenging behaviors. Indeed, from the vantage point of CMT, patients with severe PDs may be especially inclined to act out in therapy—drawing the therapist into enactment scenarios—because they need and seek corrective emotional experiences to a greater extent than insights. Actions speaks louder than words, in that these patients need to *experience* that they are safe with their therapists; in order to overcome their fears they need to test them strongly, repeatedly, from the beginning of the therapy relationship, and in various different ways.

The formulation of the patient's plan neither prescribes nor proscribes the use of specific techniques (Gazzillo, Dimaggio, et al., 2019): Different kinds of techniques proposed by different therapeutic models may be useful for different patients in different moments of their therapies, insofar as patients experience them as supporting their plan (the term "proplan" refers to the compatibility of an intervention with the patient's plan). For example, if a patient at the beginning of therapy is testing the pathogenic belief that he does not deserve to be protected by acting out in ways that are dangerous for himself and/or for other people, the adoption of a specific therapeutic contract such as the one proposed in TFP for dealing with problems associated with acting-out behavior may be a powerful way to pass these tests. By contrast, if a patient acts out in testing the pathogenic belief that he is a bad person who ruins the life of people close to him, a therapist who focuses interventions on the patient's aggressiveness and destructiveness may be experienced as antiplan, and potentially confirming of this pathogenic belief.

Moreover, patients tend to understand and use the interventions of their therapists according to their plan, so that an intervention offered by the therapist with a specific aim may be proplan or antiplan according to how the patient interprets it. For example, a patient may be hurt by a therapist who says to her: "I think that you will be able to solve your problems" if the patient is testing the pathogenic belief that she does not deserve to be loved by people. In fact, for this patient the fact that therapist says "*you* will be able" means that the therapist is not willing to work with her at solving her problems; if things would not have been so, the therapist would have said "*we* will be able to solve your problems." And if a patient is testing the pathogenic belief that she deserves to be mistreated, an intervention aimed at helping her to better mentalize the emotions and intentions of a person who was rude toward her may be experienced as antiplan. In this instance, the patient may interpret the effort of the therapist to help her acquire a broader perspective on that interaction as evidence that the therapist is implying that the mistreating person may have had good reasons to "mistreat" her. On the contrary, an interpretation proposed with the aim of helping the patient to better understand how *her* unconscious mind works may be experienced by the patient as evidence of the therapists attention to what *she* says and thinks, an attention that helps disprove her pathogenic belief about not deserving attention and care. As well, by interpreting the therapist shows that he is not punishing the patient as she had expected on the basis of her pathogenic belief. Thus, the plan is the lens through which the patient filters the reality of his or her therapy.

Finally, the notion that an intervention may be compatible with a patient's plan ("proplan") or not renders the distinction between supportive and expressive interventions—and between cognitive and behavioral interventions—far less relevant. According to CMT, the main distinction to be made is between proplan and antiplan interventions (see also Weiss, 1993, p. 52), and what is proplan for a patient in a specific moment of her/his therapy is different from what is proplan for other patients or in different moment of his or her therapy.

While having a good plan formulation can help the clinician provide a more effective therapy (see Silberschatz, 2017), open-minded, flexible, and attuned therapists of various theoretical persuasions, or those adopting a multimodel approach (Pines, 1990), may nevertheless conduct a largely proplan therapy and thus be very helpful to patients. Indeed, it is worth noting that the first empirical validation of control-mastery hypotheses on the therapeutic process derived from the empirical assessment of the transcriptions of sessions of a classical psychoanalytic treatment delivered by a therapist who was completely unaware of those hypotheses (Weiss et al., 1986). Such findings, however, imply that therapists who utilize a plan formulation to understand a patient's tests may be more likely to consistently pass them, and to provide responses that support the patient's individual goals. We do not know of any other guide for individualizing psychotherapy with the same empirical support of the plan formulation method derived from CMT.

To sum up, from the perspective of CMT, psychotherapy for severe personality pathology is characterized by the patient (a) seeking to master the effects of multiple and severe developmental relational traumas; (b) experiencing a very limited sense of safety

in close relationships, which is brought to bear on the therapy relationship; (c) having strongly held pathogenic beliefs which may be in reciprocal contradiction with one another; (d) seeking to mitigate pervasive self-hate; and (e) posing multiple strong tests enacted through different testing strategies, often from the beginning of the treatment. These can manifest in multiple and very different ways depending on the individual patient. The following two clinical examples illustrate these features in the treatment of patients with severe PDs.

Claire: Multiple Contradictory Pathogenic Beliefs Tested in the Same Session

Claire was a 23-year-old female patient with borderline PD and heroin addiction who sought psychotherapy because she had to "restart from 0." A few months earlier she had put an end to a 7-year romantic relationship with a same-age boyfriend who had introduced her to heroin addiction and poly substance abuse. Claire had no close friends, spent most of her time with homeless people, had not been able to attend the academic courses of the university she was enrolled in, and most recently had engaged in promiscuous sexual behavior. She was trying to address her heroin addiction through attending a substance use counseling agency, but persisted in using several illegal drugs and alcohol as a means of dealing with very painful feelings of existential anxiety and loneliness. She said she did not know who she was, had no clear idea about what she wanted to do with her life and felt to be "rubbish," a person that nobody could love or be interested in. For this reason, she oscillated between desperate attempts to make a good impression to other people, and periods of withdrawal aimed at protecting her public image when she was afraid that other people could see her flaws and would then reject her. Her basic mood was characterized by a mixture of depression and anxiety, with brief moments of intense enthusiasm and hope, and she had rage outbursts in response to the behaviors of others that she interpreted as rejections or abandonment, or which stirred up her guilt.

Claire was the younger of four children; her father was a weak man who spent most of his time at work; her mother was a depressed, narcissistic, and aggressive woman who did not miss any occasion to humiliate and blame her children. Since Claire was 4-years-old, her mother called her a whore, said that she was ugly, rude, and incapable of doing anything by herself, and accused her of lacking any moral value. When Claire looked for emotional support, her mother made her feel weak and burdensome, but when she tried to do something by herself, she accused her of being arrogant. Moreover, Claire's mother always pushed her to perform and be perfect at school and in her appearance, but when Claire was able to attain good grades or cultivate an attractive look, her mother positioned herself to be in competition with her daughter, saying things such as: "If I had had the opportunity to study, I would have been better than you." Or "I have always thought you could have done something good if only you had followed my advice, but now do not become big-headed." Almost every day of every week, there was a moment when Claire's mother had an emotional crisis and withdrew in her bedroom shouting and crying against her husband and children. She repeatedly avowed that they were the cause of her unhappiness and did not want them to come into her room, but when some of them decided to go out to get away from this atmosphere of pain and rage, she reproached them for being selfish and uninterested in her wellbeing. Moreover, Claire's mother had never been able to protect Claire, who was sexually molested by an uncle when she was 8-years-old, and by a priest when she was 14-years-old. The mother never discovered the first abuse, and did not intervene when she learned of the second abuse. Similarly, the mother did not prevent Claire against spending time with her addicted former boyfriend. As a consequence of such traumatic experiences, Claire developed a set of pathogenic beliefs giving rise to a deep self-hate: She believed she was "rubbish," that if she had died nobody would have cared, that she did not deserve any appreciation or protection. Moreover, she developed several reciprocally contradictory pathogenic beliefs which reflected the contradictory messages received from her mother: She believed that she should have always been perfect in order to be appreciated, but she also believed that if she had any successes, her mother (and her siblings) would have felt humiliated (survivor guilt). Claire believed that if she had sought help from another, this person would have felt that she was a burden as well as being incapable (burdening guilt and self-hate), yet if she had been able to do things by herself, she would expect to fail (self-hate) or to hurt the other person because the other would need to feel needed by her (separation guilt).

With regard to the multiplicity of strong tests—enacted with different testing strategies and in rapid sequence—the following example from Claire's therapy was typical: During one session of the first year of her three-times-per-week therapy, Claire shifted from a transference test by noncompliance of her survivor guilt ("Is it a problem for you if next week I will come only for one session, because I have to study for the Friday exam?"), to a transference test by compliance of her burdening guilt ("At the beginning of the session you accepted that next week I will come only for one session because you want to get rid of me"), to a passive into-active-test by compliance of her self-hate ("You are the cause of my suffering. When I came here today I was fine, but now feel as if I am dead inside and I do not want to say anything more"). In order to pass her tests and help Claire feel safer, her therapist had to first say that it was fine for him if she wanted to skip two sessions the following week because he trusted her judgment that she was capable and that she deserved to pass her exam; then, he had to clarify to her that he would also have been there for her in the hours of the other two sessions—that he did not experience her as a burden. And, finally, he had to remain calm and kind when she was accusing him of being the cause of her suffering, suggesting afterward that she was identified with her mother and was trying to make him understand the pain, helplessness, and guilt she felt when her mother behaved in that way with her and her siblings. In other words, in this sequence Claire needed to disprove her pathogenic belief related to survivor guilt by learning that if she tried to achieve, her therapist—differently from her mother—would not have been hurt; she directly tested this belief by asking the therapist if he thought that she could dedicate herself to her exam. Then, she tested the belief that if she asked to be cared for she would be a burden to others, and she did so by implicitly asking the therapist if he had accepted her request to skip sessions because he wanted to get rid of her. So she first asked if it was legitimate for her to achieve, and then asked if she could depend—two seemingly opposite requests that can become understandable on the basis of Claire's plan. Finally, she needed the therapist's help to master some of the traumatic consequences of

the relationship with her suffering and blaming mother, and she tested these feelings of shame and guilt by inducing them in the therapist—through accusing him of tormenting her—in the hope that he would model to her how to deal such feelings without being too upset.

David: The Variety of Manifestations of Self-Hate

David was a 32-year-old man who sought psychotherapy after having had a previous 11-year therapy and having used antidepressant and anxiolytic medications for 7 years. David had received the diagnoses of narcissistic PD, generalized anxiety disorder, major depressive disorder, obsessive–compulsive disorder, and paraphilia. However, David's multiple problems could be conceptualized as the products of a strongly held pathogenic belief of being inferior, inadequate, and doomed to failure (self-hate).

David developed this belief from a chronic stress trauma he suffered in his relationship with his mother and his older brother. Since early childhood his mother persistently compared him with his brother, regarding him as too shy, introverted, anxious, and slow; she conveyed the message that to have any hope for success in life, he should have been like his brother—more self-confident, happier, faster, and extraverted. David always felt that his mother did not appreciate him for how he was, and that she did not understand him. At the same time he always thought that his mother was right, and that his being introverted, reflexive, and slow was a deficit, something that made him inadequate and inferior to other people. His depressive symptoms were the consequence of this belief; his anxiety was an expression of his being afraid to fail in anything he would try; his obsessive–compulsive symptoms—mainly centered around the need to do things perfectly and to have everything under control—stemmed from his desperate attempt to become as his mother would have liked him to be. As well, David's paraphilia was an eroticized enactment of the essential features of his relationship with the mother: He got excited by submitting to transsexual prostitutes who had to humiliate him while he was sucking their penis. He thought that in this case, he could control the situation and make it stop when he had enough. Moreover, within this scenario he felt that he could not disappoint his "partners."

Unlike Claire, David did not have multiple and contradictory pathogenic beliefs, but only one core pathogenic belief concerned with profound self-hate. However, like Claire, he tested this pathogenic belief from the very beginning of his treatment and in various different ways. For example, he spent 35 of the 50 min of his intake interview comparing the new therapist with the previous therapist. David said that the new therapist was less experienced, poorer, had uglier clothes, and an uglier office, adding that he was not sure that this therapist could help him (passive-into-active test by compliance). The therapist replied that it was clear that in that room there were two people, one comparing the other to another person and finding the first one inferior; but he was wondering to himself—and asked the patient—if David had never been in the position of the one who was assessed and found to be less than another person. At that point, David relaxed and replied that that was the story of his life, and described the relationship with his mother and brother. In the second session, David spent most of the time describing all his symptoms and the reasons why he thought himself to be inadequate (transference test by compliance), with the therapist listening, trying to put himself in the patient's shoes, clarifying what David was saying and communicating that he understood how painful it was for him to feel that his mother deemed him inadequate. In the third session, David again adopted a passive-into-active by compliance testing strategy. He arrived at the therapist's office, sat down and said "I am not going to say anything more today. You already know anything I can say to you, and now you must say something that can help me because this is your job." When the therapist said that he needed to know what he was thinking in order to say something, David replied that he had already said everything he thought, and now he was waiting for the therapist to say something useful. At that point, the therapist suggested that he was behaving like his mother, asking the therapist to do something different from what he could do in order not to be found inadequate. David replied that the therapist was doing the same thing, asking to him to do something different from what he wanted to do in order to be a good patient. The therapist was slightly disoriented by that response, and thought that from a certain point of view David was right. "So, we should find a way of working together that may work for both of us." At that point, David relaxed and showed signs of optimism.

Other Treatment Implications

Contributions from CMT regarding the conceptualization of severe personality pathology are compatible with other theoretical models (e.g., interpersonal theory, attachment theory, U.S. relational theory) in highlighting the role of early traumas in the development of schemata (i.e., pathogenic beliefs and their affective and behavioral consequences) regarding self, others, and interactions, the role of attachment and prosocial motivation in psychic development and the role of corrective emotional experiences in psychotherapy (Alexander & French, 1946). However, CMT adds an important emphasis on the patient's inner motivation to master the beliefs that obstruct their adaptive goals, along with the countervailing interpersonal guilt—including self-hate—that holds pathogenic beliefs in place. More importantly though, CMT provides a framework for understanding how patients with severe personality pathology attempt to address their problems in therapy through the testing of pathogenic beliefs and the traumas that engendered them. This understanding may be used per se or integrated within therapies derived from ESTs and other theoretical models, in that therapists may consider how the interventions suggested by their model may be compatible with the patient's plan at any given moment, and to increase their flexibility within the treatment model in order to better pass the patient's tests. Given the tendencies of patients with PDs to act out in treatment and employ multiple types of strong tests, personalized therapy for PDs should, from the perspective of CMT, rely upon an individual plan formulation that can guide the therapist through such complexity. The possibility of developing a reliable case formulation at the outset of therapy, following the PFM, can enable clinicians to have clear indications about how to individualize the treatment to the specificities of each patient's goals, pathogenic beliefs, traumas, and tests. Empirical studies conducted to date—while not focused explicitly on patients with severe PDs—have demonstrated that interventions that are compatible with the plan of the patient correlate with positive therapy outcome (see, for a review, Silberschatz, 2005, 2017). Having an accurate, personalized case

formulation to rely on from the very beginning of a treatment is particularly useful with patients with severe personality pathology, in that during a single session the patient may test multiple pathogenic beliefs in different ways. The PFM provides indications of how to pass these different tests and about the specificities of the corrective emotional experiences and insights that these patients need in order to disprove their pathogenic beliefs and achieve their adaptive goals (Gazzillo, Dimaggio, et al., 2019), many of which may be directly related to improved social functioning.

In addition to emphasizing patients' testing strategies, the CMT literature indicates that, in particular with patients with severe personality pathology (see, e.g., Sampson, 2005; Shilkret, 2006), the overall attitude of the therapist is one of her/his more powerful tools for conducting an effective therapy. According to CMT, the attitude of the therapist should vary according to the pathogenic beliefs tested and the testing strategies adopted by the patient session by session and moment by moment. Moreover, patients with severe personality pathology need therapists who are able to be flexible and self-controlled, as well as capable of being supportive, protective, self-confident, and self-protective. Flexibility and self-control are necessary to optimally adjust one's own attitudes to the different pathogenic beliefs and testing strategies of each patient, which are central in the different moments of a session and throughout the therapy. Empathic, supportive, and protective attitudes may be necessary for contrasting the self-hate and mistrust of patients testing with transference testing strategies, while the self-confidence and self-protectiveness of the therapist may be of help when self-hate is tested with passive-into-active strategies. In other words, a self-confident therapist who is able to protect him/herself will be less upset by these patients' devaluations and attacks, and can better provide a modeling experience whereby the patient may identify with this aspect of the therapist's functioning.

Finally, reading the problematic behaviors and attitudes of patients with severe personality pathology as reflecting the ways in which they are testing their pathogenic beliefs—trying to disprove them in order to advance their adaptive goals—enables the therapist to remain optimistic, compassionate, and trusting of patients' desire to master their problems even in those difficult moments or "crisis" situations that are almost unavoidable in the therapies of patients with severe personality pathology.

摘要

尽管目前有几种可应用的治疗人格障碍的实证支持的模型，研究人员和临床医生在继续提倡给那些有严重人格病理的个体病患的特殊需要和特性提供个性化心理治疗。 控制-掌控理论(CMT; Gazzillo, 2016; Silberschatz, 2005; Weiss, 1993; Weiss, Sampson & 锡安山心理治疗研究小组, 1986)提供了一个有用的框架来理解人格病理学，并以个体化的个案概念化来指导治疗。本文介绍了CMT的基本概念，及其在重度人格障碍患者的个性化心 理治疗中的应用。根据CMT，患者来治疗是为了推翻那些致病信念，那些致病信念妨碍 了他们追求健康和适应性的发展目标。这些致病信念是为了适应早期的创伤经历而发展出 来的，却最终导致进一步的痛苦、抑制和症状。因此，患者在治疗关系中测试这些致病信 念，以寻求矫正型情感体验来推翻它们。在严重的人格障碍患者中，这样的信念可能是相 互矛盾的，可能会以多种不同的方式代入到治疗中，常常挑战着治疗师做出适当的回应。 CMT 建议治疗师针对特定患者的个案概念化——包括患者的目标、创伤、致病信念以及测 试策略的这些性质——能考虑到个性化的方案，那会将优化治疗的效果.

关键词：个性化心理治疗，控制-掌控理论，重度人格障碍，患者计划，在心理治疗中测试

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