HOW PATIENTS COACH THEIR THERAPISTS IN PSYCHOTHERAPY

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This article examines coaching behavior in the therapeutic relationship from the perspective of control mastery theory. The expanded concept of coaching presented here views the patient as actively engaged throughout therapy in prompting, instructing, and educating the therapist to relevant aspects of the patient's plan for disconfirming pathogenic beliefs and attaining treatment goals. Three therapy situations encountered when coaching is prominent are identified and illustrated with clinical vignettes.

Introduction

This article focuses on a clinically important topic that has not been specifically addressed in the psychotherapy literature: the different ways and reasons patients *coach* their therapists during psychotherapy. In the most general sense of the word, to coach is to train someone, to give special instruction, to help prepare someone for an examination or an event. The term coaching is used in this article to refer to those patient behaviors and communications that serve to attune the therapist to essential aspects of the patient's problems, conscious or unconscious treatment goals, and to how the therapist can best help the patient attain these goals. When coaching, patients provide special information or instruction in order to help their therapists help them effectively. With the exception of recent work by Casement (1991), no specific references to patients coaching their thera-

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pists were found. Casement, borrowing concepts from Bion, Langs, and Winnicot, suggested that patients may unconsciously prompt and guide therapists to be more helpful. He proposed that therapists need to adopt an attitude (or internal supervisor) that renders them receptive to these unconscious communications from patients. The concept of coaching presented here is derived from and unique to control mastery theory (CMT) (Weiss, 1993). The authors give a brief overview of this theory and then elucidate the phenomenon of coaching, illustrating the concept with clinical vignettes.

Overview of Control-Mastery Theory

CMT is a cognitive psychoanalytic theory developed by Joseph Weiss (1993) and empirically studied by the San Francisco (formerly Mount Zion) Psychotherapy Research Group (Silberschatz, Curtis, Sampson, & Weiss, 1991; Weiss, Sampson, and the Mount Zion Psychotherapy Research Group, 1986). A central tenet of CMT is that humans have an innate striving toward adaptation, growth, and mastery. Traumatic childhood experiences interfere with and often thwart these developmental strivings. Traumatic life experiences, according to Weiss, are internalized in the form of conscious as well as unconscious pathogenic beliefs. For instance, if a child is treated abusively by a parent the child typically develops the (unconscious) belief that he deserved to be mistreated; such a belief frequently leads to repetitive, maladaptive relationships in adulthood, and hence Weiss (1993) refers to these as pathogenic beliefs.

Pathogenic beliefs are grim and highly distressing; they interfere with the pursuit of normal developmental goals, generating inhibitions, symptoms, and self-destructive behaviors. Patients who seek psychotherapy are highly motivated to overcome pathogenic beliefs and they work in therapy to disconfirm them. According to CMT, psychotherapy is a process in which

patients—with the help of their therapists—actively seek the knowledge and experiences that will enable them to disconfirm pathogenic beliefs. One of the primary ways that patients work in therapy to disconfirm their pathogenic beliefs is by testing them in the therapeutic relationship (Weiss, 1993). Tests are trial actions carried out by the patient (often unconsciously) to appraise the danger or safety of pursuing certain crucial goals. Consider, for example, a patient whose parents were unable to tolerate her childhood strivings toward autonomy and independence. This patient developed the pathogenic belief that her independence was intolerable or upsetting to the people in her life that cared about her (friends, lovers, teachers). The patient worked in therapy to disconfirm this pathogenic belief by experimenting with behaving independently with the therapist (e.g., by disagreeing with the therapist and coming up with her own insights) to see if the therapist (unlike her parents) could comfortably tolerate her independence. (For further discussion of testing see Silberschatz & Curtis, 1986, 1993 and Weiss, 1993.)

Each patient has specific pathogenic beliefs stemming from particular traumatic life experiences. According to CMT, the primary motive of patients in psychotherapy is to solve their problems. Weiss (1993) has proposed that patients enter therapy with an unconscious plan to disconfirm their pathogenic beliefs and attain desired goals (see also Curtis & Silberschatz, 1997). Patients unconsciously make and carry out plans for solving problems by disproving the pathogenic beliefs that underlie them. They work to disprove these beliefs by testing them with the therapist in the hope that the therapist will not respond to the tests as the beliefs predict (Silberschatz & Curtis, 1993; Weiss, 1993).

Coaching and the Plan Concept

The coaching paradigm presented in this article is based on CMT's plan concept. The plan concept is a hypothetical construct used to explain a broad range of patient behaviors during therapy. It is composed of three interrelated components: goals, pathogenic beliefs, and tests.

The first component refers to the patient's goals for therapy. Goals represent potential affects, attitudes, or capacities the patient wants to achieve. They reflect the direction (or series of directions) patients want to go during therapy. Goals may be specific and concrete (e.g., to change a career) or more general and abstract (e.g., to have a fulfilling life). Migone and Liotti (1998) suggested that goals are innate dispositions and values toward different states of interpersonal relationships (e.g., attachment, caregiving, competition, cooperation, and sexuality) that have been relinquished because of pathogenic beliefs. Throughout therapy patients experience their therapists' interventions as demonstrating either sympathy, opposition, or indifference to their goals. The degree to which patients are conscious of their goals at the beginning of therapy depends to a large extent on how dangerous and forbidden they believe them to be.

The second component of the patient's plan concerns pathogenic beliefs. CMT proposes that psychopathology is a product of irrational pathogenic beliefs about self and others acquired from early traumatic experiences with parents and siblings. These beliefs warn patients that if they attempt to gratify certain impulses or seek specific developmental goals they will risk the disruption of their all-important parental ties. Pathogenic beliefs impede the pursuit of normal developmental goals and strivings, and they typically generate inhibitions, symptoms, self-destructive behaviors, and faulty object relations. For example,

Carl was an exceptionally bright, inquisitive man who was traumatized as a child by his parents' inability to tolerate his incisive questions and unrelenting intellectual curiosity. For instance, as a young child he asked his father to explain the solar system; when he pushed his father to provide more details, the father apparently felt threatened and became increasingly frustrated, irate, sullen, and emotionally withdrawn. Carl's mother blamed him for the father's reactions and pleaded with him to stop asking so many questions; with extreme disdain and harsh disapproval, she frequently chided him for being too smart for his own good. Carl developed the pathogenic belief that his intelligence was dangerous and needed to be suppressed. Thus, despite a superior IQ, he became a mediocre student and dropped out of college after his first year.

Patients suffer from these beliefs and the feelings they engender and are highly motivated (both consciously and unconsciously) to change them.

Tests comprise the third component of the patient's plan. According to CMT, psychotherapy is a process in which the patient works to disconfirm pathogenic beliefs and solve the problems they engender. Patients work by unconsciously testing the validity of their pathogenic beliefs in the therapeutic relationship. Tests are experimental behaviors and attitudes patients present to their therapists in order to appraise the relative danger or safety of pursuing valued goals. Patients may test

by either "transferring" or by "turning passive into active," (Weiss, 1993). When patients test by transferring, they repeat behavior with the therapist similar to the childhood behavior they believe provoked their parents to traumatize them. When patients test by turning passive into active, they identify with the parents and repeat the parental behaviors they experienced as traumatic. By repeating the past in either a transference or a passive into active test, patients are actively seeking experiences with the therapist that will help them disprove irrational expectations and false beliefs (Silberschatz & Curtis, 1986). Research has shown that when therapists "pass" key tests (i.e., intervene in a manner than is compatible with the patient's treatment plan), patients will be relieved and emboldened and make significant therapeutic progress; when therapists "fail" key tests (i.e., intervene in a manner that is incompatible or at cross-purposes with the patient's treatment plan), patients become anxious and constricted and retreat from therapeutic progress (Silberschatz & Curtis, 1993). While testing, the patient closely monitors the therapist's behavior and attitudes to see if they confirm or disconfirm pathogenic beliefs.

Patients want therapists to understand their plans and help them master problems. They are highly motivated to directly or indirectly communicate relevant and pressing aspects of their unconscious treatment plan to their therapists. Coaching behaviors serve to provide therapists with the information necessary to understand various components of the patient's plan. This includes information about treatment goals, pathogenic beliefs, ways the patient wants to work with the therapist, and the therapist's attitudes and interventions that are most likely to be helpful. Patients coach in order to make their plans clear to therapists, to get therapists back to the plan if they stray, and to keep therapists focused on how not to traumatize them in the way their parents did. Unconscious considerations of safety significantly influence the clarity and directness of the patient's coaching communications. Since patients vary with respect to the intensity and pervasiveness of their pathogenic beliefs, it follows that patients differ in their coaching ability and effectiveness.

Case Illustrations

Patients may employ coaching strategies at any given time during therapy. However, there are three specific occasions when coaching tends to be prominent. These are: (a) at the beginning of therapy; (b) before, during, and after presenting significant tests to therapists; and (c) when patients want to change the therapeutic relationship.

Coaching at the Beginning of Therapy

CMT emphasizes that it is the patient rather than the therapist who sets the agenda in psychotherapy. By coaching at the beginning of therapy, patients directly and indirectly convey to therapists how they would like to work with them. Coaching allows therapists to infer the goals their patients want to pursue and the pathogenic beliefs that have prevented them from attaining these goals.

Empirical studies indicate that a significant number of psychotherapy patients manifest a great deal of self awareness and insight at the beginning of treatment (O'Connor, Edelstein, Berry, & Weiss, 1994; Weiss, 1994). These findings underscore the unconscious importance patients give to orienting therapists to their plans. Indeed, some patients may begin therapy with clear and direct verbal summaries of their treatment plan:

Out of guilt, Jill felt compelled to invite her mother to come live with her even though she knew it would not work out. Her mother accepted the invitation and moved in, with the predicted disastrous results. Jill began a brief (16-session) psychotherapy saying, "My mother, my mother is driving me up the wall. I mean that's my prime concern. You know, the other things are security of my home, and financial problems. But as great as they are, and as horrible as they are, and they are surmounting like you wouldn't believe, what is really getting me down and making it harder to cope with things is, is the um, problem with my mother." Jill then said she wanted her therapist to help her overcome her guilt so that she would be able to follow through on her plan to move her mother to a retirement community. She wanted to understand the source of her guilt, and she suggested that encouragement and support would help her to attain her treatment goal.

More frequently, patients begin therapy by coaching therapists in more indirect ways. These include the use of exaggerations and striking contradictions in verbal content, attitude, and behavior:

Doris began therapy by presenting an emphatic case against herself. She claimed she was stupid, weak, and profoundly psychologically impaired. She recounted story after story that seemed to support her case. However, her behavior was relaxed, her attitude confident (even cocky), and she spoke in a coherent and intelligent manner. Moreover, toward the end of the session, she briefly mentioned that she had applied to and was accepted by a top university (one that is highly selective and difficult to get into), but had turned it down because her mother thought she was too dysfunctional to go. The

mother wanted Doris to live at home and attend a local vocational school to become a hairdresser—something in which Doris had no interest, but did anyway to satisfy her mother.

The patient's ability to directly convey pertinent information about treatment plans at the beginning of therapy is primarily determined by how bound he or she is to pathogenic beliefs (Weiss, 1993). Jill was able to communicate her plan clearly and directly to the therapist despite her pathogenic belief regarding her sense of omnipotent responsibility for her mother's welfare. Doris employed more indirect coaching methods that were still powerfully effective in orienting the therapist to her unconscious plan. She presented exaggerations and contradictions that helped the therapist to accurately infer her tendency to obscure strengths and sacrifice goals as a compliance, out of pathological loyalty and guilt, to her mother. The patient demonstrated that she wanted to begin working with the therapist by inviting him to view her as incapable and impaired in the hope that he would not accept her invitations at face value. In this way, she could begin to utilize her strengths and abilities while pursuing the goal of becoming independent of her mother.

Coaching and Tests

According to CMT, patients begin therapy with an unconscious plan to disconfirm pathogenic beliefs and master the problems to which they give rise. Patients work to disconfirm these beliefs by testing their validity in the therapeutic relationship (Curtis & Silberschatz, 1986; Sampson, 1994; Silberschatz & Curtis, 1986, 1993; Silberschatz, Curtis, & Nathans, 1989; Weiss, 1993; Weiss et al., 1986). Tests are trial actions by patients designed to assess the danger or safety of pursuing treatment goals. Throughout therapy, patients are primarily concerned with how therapists respond to tests. They closely monitor their therapists' behavior in response to tests to see if it confirms or disconfirms irrational expectations and false beliefs. By testing, patients work to create a relationship with the therapist that makes it safe for them to lift repressions and pursue previously forbidden goals (Weiss, 1990). However, testing is a risky activity. There is no guarantee that therapists will pass patients' tests (i.e., intervene in plan-compatible ways); indeed, they may even confirm pathogenic beliefs by failing key tests. Thus, because of the inherent risks involved, patients may coach their therapists on how to pass upcoming tests. The unconscious

(and conscious) education therapists receive from their patients' coaching behaviors often allows them to pass tests with a sense of ease and an enhanced confidence in the validity and helpfulness of their interventions. In addition, therapists' spontaneous plan-compatible interventions are usually good indications that they have been successfully coached, as the following vignette illustrates:

Neal devoted an entire session talking about his difficulties in saying no to his son's unreasonable demands. When the session was over, he tried to engage the therapist in a discussion of various self-help books. The therapist immediately reminded the patient that the session was over and they needed to stop. In the following session, Neal reported he was able to say no to his son's excessive demands.

Neal wanted his therapist to demonstrate the capacity to set limits with him so that he could begin setting limits with his son. He provided the necessary information to help the therapist understand and respond appropriately to his attempt to extend the session.

During the hour, Bill talked about his father's cold, critical, and rejecting attitude toward him when he was a child. He then began to talk about his inexplicable tendency to suddenly withdraw from the people whose company he enjoys and whom he feels are important to him. Bill began the following session saying that he had decided to quit therapy. He was reassured when his therapist suggested the two of them take whatever time was necessary to understand his sudden decision to end therapy.

Here, Bill wanted his therapist to help him overcome his fear of rejection and continue with therapy. He prepared the therapist for a sudden rejection test (i.e., he would reject the therapist before the therapist rejected him) by providing him with sufficient information to understand the test. Bill was then able to become aware of and explore his pathogenic belief that he deserved to be rejected. In both of the above cases, the therapists felt at ease and confident with their interventions.

When Carl (the man previously mentioned who believed that his intelligence was dangerous and should be suppressed) started therapy, he was significantly underemployed as a grocery store clerk and was generally unhappy with his life. In the early phases of the treatment he vigorously tested to see if the therapist would condemn his intelligence. For instance, he resumed his college education and presented numerous intellectual and academic accomplishments in a veiled manner to see if the therapist could acknowledge him. These tests were relatively easy to pass because the therapist not only recognized but also genuinely admired Carl's incisive intellect and the breadth of his abilities. As Carl developed a greater sense of safety and confidence in the therapeutic relationship, he intensified the testing process and made it more immediate

and personal. He began to read numerous articles and books on psychoanalytic theory and therapy (a field in which he saw the therapist as an authority) and then engaged the therapist in theoretical discussions. Carl was particularly astute at zeroing in on topics of considerable controversy, and on several occasions he clearly pushed the limits of the therapist's knowledge! Nonetheless, the therapist pursued these discussions in a friendly, respectful, and collegial manner, for he saw them as an integral part of Carl's testing to see if the therapist would be threatened by his inquisitiveness and his brilliance, as his parents had been. Carl was clearly pleased by the therapist's ability to comfortably tolerate and even enjoy these theoretical dialogues. After one of these, Carl began to recount several poignant memories of his parents' rageful outbursts at his asking his father to explain how gravity worked. With considerable insight and emotion, he began to articulate how inappropriate, abusive, and stifling his parents had been.

This vignette illustrates the interplay between coaching and the testing process. Early in the treatment, Carl informed the therapist about his parents' inability to respond to his intellectual prowess; in so doing, he was educating the therapist about how to pass important tests. As Carl developed increasing confidence in the therapist, he began to intensify the testing process in order to disconfirm his most deeply held pathogenic beliefs.

Sometimes, while testing, patients become uncertain as to the plan-compatibility of their therapist's responses:

A patient who feared that the analyst would reject him tempted the analyst to do just that by announcing abruptly that he had decided to discontinue the treatment. When the analyst remained silent, the patient became increasingly anxious. He feared that the analyst would permit him to terminate, and so he coached him by saying, "Whenever I do something impulsive, I regret it later." (Weiss et al., 1986, p. 104)

When therapists' interventions are consistently antiplan, patients may escalate their coaching activity and utilize any relevant material to make their therapists more attuned to their plans:

Jill (the patient from the first vignette, who wanted to overcome her guilt so she could place her mother in a retirement community) provided clear and direct communication of her treatment plan to the therapist during the first two sessions of therapy. However, he continued responding with antiplan interventions. She began the third session by presenting a dream about a man who misunderstood her and was unable to help her solve a problem.

Therapists who persist in failing critical tests place their patients in difficult and traumatic situations. Under these circumstances, the very act of coaching may become a key test:

Fran began brief (16-session) therapy with the unconscious goal of extricating herself from a destructive marriage. The therapist, however, viewed her as having problems with inti-

macy. His interventions focused on her dependency needs, fears of abandonment, and desire for a closer relationship with her husband. Because of Fran's exaggerated sense of responsibility for others, she felt compelled to mostly comply with her therapist's interventions in order to protect and restore him. Late in the therapy, she began a session by boldly stating that she had just returned from a great vacation and was able to enjoy it because she went without her husband and did not feel burdened by having to take care of him.

This vignette illustrates Fran's last attempt to get her therapist to be helpful. She presented the therapist with information that challenged his formulation of the case. Unfortunately, he was not receptive to the patient's coaching behavior and persisted in making the same antiplan interventions regarding her unconscious conflicts over dependency needs and fears of abandonment. The Fran case had the poorest outcome of the brief psychotherapy cases studied by the San Francisco Psychotherapy Research Group (Silberschatz et al., 1991).

Patients may also coach after passed tests. This coaching behavior informs therapists that their interventions are helpful and that the patient wants to continue working in the same manner for a time:

Alice had been working in therapy on extricating herself from an abusive relationship with her boyfriend. In the session after she had ended the relationship, Alice said she was worried about how the boyfriend was taking the breakup. She felt he really needed her and was probably devastated by her leaving. She began to consider going back to him. The therapist interpreted Alice's concern about her boyfriend as a product of her exaggerated sense of responsibility for his welfare. She became immediately less anxious and began to talk about her admiration for independent women. She then added that a friend of hers had to break up many times before she could finally leave her abusive boyfriend.

Alice's last two comments informed the therapist that his interventions were helping her move in the direction she wanted to go, but that she had more work to do on the problem of leaving her boyfriend. She wanted the therapist to continue responding to her tests in the same plan-compatible manner.

Coaching to Change the Therapeutic Relationship

Therapists help patients change by offering proplan interpretations and passing tests. Proplan interpretations (i.e., interpretations that are compatible with the patient's plan) enable patients to gain insight into their pathogenic beliefs and the problems to which they give rise. By passing key tests, therapists help patients feel safe enough to

confront the dangers foretold by their pathogenic beliefs and to pursue the goals these beliefs have prevented them from attaining. In this way, direct plan-compatible experiences with the therapist lead to significant therapeutic progress (Sampson, 1992).

Passing tests often requires a great deal of flexibility in the therapist's approach. During the course of treatment, patients may want to test in a variety of ways, or work differently toward achieving a new goal. When patients' unconscious plans necessitate changes in the therapeutic relationship, they frequently coach therapists on the specific experiences, capacities, and knowledge they will need to make progress.

Neal's therapist had been working with him in an analytic, interpretive mode when the patient began an hour presenting new material about his father's inability to protect him from his abusive, alcoholic mother. In the following session, he reported that he had resumed an old, dangerously destructive pattern of behavior. The therapist responded by actively enjoining the patient to cease the self-destructive behavior.

The above vignette illustrates Neal's need to have his therapist demonstrate the capacity to effectively protect him. This allowed the patient to feel safe enough with his therapist to stop the self-destructive behavior and become aware of the false belief that he did not deserve protection. Information given in the preceding session enabled the therapist to understand the new test and provide the patient an almost effortless proplan intervention.

Dan began treatment focused on overcoming an urgent relationship problem with his lover. Except for a few interpretations (which the patient found helpful), the therapist was mostly silent during this time. After the relationship problem was resolved, Dan began talking about his inability to pursue his interests in film. He presented new material concerning the parental indifference and neglect he experienced in childhood, and then resumed talking about his work inhibitions. The therapist began to actively engage the patient in discussions of film and encouraged him to pursue his goal of becoming a film director. During this time, the patient made steady progress in undoing his work inhibitions and pursuing his goal. Moreover, he developed key insights into his problems with few interpretations from the therapist.

Here, Dan coached the therapist on his need for encouragement and reassurance in order to confront the dangers predicted by his pathogenic belief. He had inferred from his parents' neglect and indifference that his interests and ideas upset and repelled them and were dangerous to pursue. The therapist's active engagement and encouraging attitude countered the belief. It was clear from the successful treatment outcome that the patient benefited greatly from the new experiences acquired in the relationship with his therapist.

Conclusion

Previous psychodynamic formulations of therapists learning from their patients have focused on the patient's unconscious perceptions of, and constructive responses to, the therapist's countertransference-based behavior. Searles (1975) and Langs (1975) contended that patients are powerfully motivated to help (or cure) their therapists. The concept of coaching presented here is different from these previous formulations in that, while coaching, patients are not concerned with helping therapists with their (the therapist's) unresolved intrapsychic conflicts. Instead, coaching behaviors serve to inform and educate the therapist about relevant and pressing aspects of the *patient's* unconscious treatment plan.

An essential (and refreshing) characteristic of CMT is that hypotheses derived from its underlying propositions have been, and continue to be, rigorously studied by formal empirical research. The reliability and predictive validity of the plan concept has been demonstrated in numerous studies (Curtis & Silberschatz, 1997; Curtis, Silberschatz, Sampson, & Weiss, 1994; Silberschatz & Curtis, 1993; Silberschatz et al., 1991; Weiss, 1993, Chapter 8; Weiss et al., 1986, Section 11). Empirical studies of psychotherapy conducted by the San Francisco Psychotherapy Research Group have demonstrated high interrater reliability for patient plan formulations (Curtis & Silberschatz, 1997). Moreover, these studies show that the degree to which therapists' interventions are compatible with patients' plans is predictive of both patient progress during therapy and therapy outcome. The idea of patients coaching their therapists is deeply embedded in the plan concept. Indeed, coaching refers directly to the communication of specific components of the patient's plan. Close examination of psychotherapy transcript material shows that coaching plays a vital role in orienting therapists to patients' unconscious plans at the beginning of therapy, and then helps to keep them attuned to and acting in accordance with the plans throughout treatment. Even therapists who are not familiar with CMT and its plan concept may be significantly influenced (albeit unconsciously) by their patients' coaching behaviors.

References

CASEMENT, P. (1991). *Learning from the patient*. New York: Guilford.

CURTIS, J., & SILBERSCHATZ, G. (1986). Clinical implications of research on brief psychodynamic psychotherapy: I. Formulating the patient's problems and goals. *Psychoanalytic Psychology*, *3*, 13–25.

CURTIS, J. T., & SILBERSCHATZ, G. (1997). Plan formulation method. In T. D. Eells (Ed.), *Handbook of psychotherapy case formulation* (pp. 116–136). New York: Guilford.

CURTIS, J. T., SILBERSCHATZ, G., SAMPSON, H., & WEISS, J. (1994). The plan formulation method. *Psychotherapy Research*, *4*, 197–207.

LANGS, R. (1975). Therapeutic misalliances. *International Journal of Psychoanalytic Psychotherapy*, *3*, 77–105.

MIGONE, P., & LIOTTI, G. (1998). Psychoanalysis and cognitive-evolutionary psychology: An attempt at integration. *International Journal of Psychoanalysis*, *79*, 1071–1095.

O'CONNER, L., EDELSTEIN, S., BERRY, J., & WEISS, J. (1994). The pattern of insight in brief psychotherapy: A series of pilot studies. *Psychotherapy*, *31*, 533–544.

SAMPSON, H. (1990). How the patient's sense of danger and safety influences the analytic process. *Psychoanalytic Psychology*, *7*, 115–124.

SAMPSON, H. (1992). The role of "real" experience in psychopathology and treatment. *Psychoanalytic Dialogues*, *2*(4), 509–528.

SAMPSON, H. (1994). Repeating pathological relationships to disconfirm pathogenic beliefs—commentary on Steven Stern's "needed relationships." *Psychoanalytic Dialogues*, *4*(3), 357–361.

SEARLES, J. (1975). The patient as therapist to his analyst. In P. Giovacchini (Ed.), *Tactics and techniques of psychoanalytic therapy, Vol. II: Countertransference* (pp. 103–135). New York: Jason Aronson.

SILBERSCHATZ, G., & CURTIS, J. T. (1986). Clinical implications of research on brief dynamic psychotherapy: II. How the therapist helps or hinders therapeutic progress. *Psychoanalytic Psychology*, *3*, 27–37.

SILBERSCHATZ, G., & CURTIS, J. T. (1993). Measuring the therapist's impact on the patient's therapeutic progress. *Journal of Consulting and Clinical Psychology*, *61*, 403–411.

SILBERSCHATZ, G., CURTIS, J. T., & NATHANS, S. (1989). Using the patient's plan to assess progress in psychotherapy. *Psychotherapy*, *26*, 40–46.

SILBERSCHATZ, G., CURTIS, J. T., SAMPSON, H., & WEISS, J. (1991). Research on the process of change in psychotherapy: The approach of the Mount Zion Psychotherapy Research Group. In L. Beutler & M. Crago (Eds.), *Psychotherapy research: An international review of programmatic studies* (pp. 56–64). Washington, DC: American Psychological Association.

WEISS, J. (1990). The nature of the patient's problems and how in psychoanalysis the individual works to solve them. *Psychoanalytic Psychology*, *7*, 105–113.

WEISS, J. (1993). *How psychotherapy works*. New York: Guilford.

WEISS, J. (1994). The analyst's task: To help the patient carry out his plan. *Contemporary Psychoanalysis*, *30*, 236–254.

WEISS, J., SAMPSON, H., & The Mount Zion Psychotherapy Research Group. (1986). *The psychoanalytic process: Theory, clinical observation, and empirical research*. New York: Guilford.