# The Significance of Turning Passive Into Active in Control Mastery Theory

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*Turning passive into active was first described by Freud but was later given expanded importance by Weiss. This new conceptualization of turning passive into active as an interpersonal communication and test has made a major contribution to the clinical treatment of difficult patients. This article reviews "control mastery" theory and puts its notion of passive-into-active testing into perspective with regard to Freud's original conception as well as other conceptions, such as identification with the aggressor and projective identification. Formulation and the treatment of patients are illustrated with clinical examples.*

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The concept of turning passive into active was introduced by Freud[1] and has been refined and given expanded importance in "control mastery" theory developed by Joseph Weiss and the San Francisco Psychotherapy Research Group (originally the Mount Zion Psychotherapy Research Group).[2,3] The understanding of the patient's turning passive into active is one of the most clinically useful contributions of the control mastery model, particularly in helping to understand and treat difficult patients such as those with severe narcissistic or borderline pathology. In this article, the concept of turning passive into active will be developed in the context of Weiss's theory and illustrated with clinical examples.

## TURNING PASSIVE INTO ACTIVE

Weiss defined turning passive into active in the following way:

> The patient who turns passive into active reproduces in his relationship with the analyst parental behavior that he had experienced as traumatic; that is, he identifies with a parent and does to the analyst those traumatizing things a parent had previously done to him.[2] (p. 107)

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Like Freud,[4] Weiss said that patients repeat childhood traumatic experiences in therapy in their attempts to get better. Freud thought these repetitions in the therapy were all transferences, but Weiss said that patients repeated in two ways: by transferring and by turning passive into active.

Moreover, Weiss's view of transference differs from Freud's. According to Weiss et al.,[2] a patient transfers by reproducing behaviors that, in the patient's opinion, had provoked the traumatic parental behavior. Weiss said that transferring and turning passive into active are both carried out by all patients: "In turning passive into active he repeats [the traumatic experience] with the roles reversed; in transferring he repeats it directly"[2] (p. 108).

Weiss's significant contribution was in pointing out that these repetitions in psychotherapy, both transference and turning passive into active, are not automatic compulsions or merely resistances to remembering as Freud had hypothesized.[4] Weiss said that these repetitions were adaptive interpersonal strategies, under partly unconscious control, that he conceptualized as "testing" the therapist as "part of the patient's preparation for remembering"[2] (p. 105).

Weiss's theory emphasizes the interpersonal nature of the development, manifestations, and resolution of psychopathology. According to Weiss, psychopathology (of nonbiological origins) results from interpersonal experiences that have been traumatic. Weiss loosely defined trauma as any experience that impairs the person's normal growth and development. Some examples of traumatic experiences include a child's being excessively criticized, humiliated, physically abused, sexually abused, cheated, or exploited in other ways.

Children are also traumatized by worry and feelings of responsibility for their impaired family members. Such prosocial concern for family members' welfare, although quite adaptive for species survival, becomes problematic for the child in a dysfunctional family because of intense feelings of omnipotence and irrational guilt for causing the dysfunction or for failing to fix it. The importance of prosocial instincts and the role of guilt in the development of psychopathology were reviewed by Friedman.[5]

The impairment of the parent can be traumatic to the child because the child believes that her own progress and growth come at the expense of the impaired family member.[6] The child might hold back in identification with the parent or might permit herself limited success but then undo it out of guilt, suffering symptoms of anxiety and depression and constantly fearing the loss of all she had gained.

Weiss noted that psychopathology has not only interpersonal origins but also interpersonal manifestations, which he identified as either *compliances* with negative treatment or *identifications* with impaired parents. Compliances reflect a child's belief that the negative treatment or the negative messages received were true and well deserved. The child then feels obligated to experience life in compliance with these negative expectations by failing, repeating negative relationships, and punishing herself for successes.

Pathological identifications are repetitive behaviors, relationships, or dilemmas in a family member's (usually a parent's) life that the patient feels obligated to repeat in his own life. These identifications may reflect destructive behavior to self or others, poor parenting, unhappiness at work or in a marriage, or specific symptoms of depression or anxiety. The patient's repetition of the negative aspects of a parent's personality or experience is motivated by an unconscious feeling of disloyalty for allowing himself to do or be better than the parent. Patients who repeat in these ways have intense guilt for being separate or different from their parent, and this guilt may be intensified when the parent expresses distress at signs of the child's independence or success.

Both compliances and identifications are mediated by *pathogenic beliefs*, which can be thought of as intrapsychic structures. Pathogenic beliefs are distorted ideas or beliefs held about the self in relation to the world. Based

on actual traumatic experience, they result in psychopathology such as depression, anxiety, inhibitions, or impaired relationships. Weiss's concept of pathogenic beliefs is similar to other cognitive and interpersonal concepts such as Piaget's schemas,[7] Beck's schemas and depressive cognitions,[8,9] Safran and Segal's interpersonal schemas,[10] Bowlby's working model,[11] and Stern's RIGs (representations of interactions that have been generalized).[12]

Pathogenic beliefs and compulsions to repeat negative experiences do not simply reflect cognitions about how the world is but are often moral statements about how the world should be. Children not only learn that they are treated in a particular way, they also unconsciously infer that they should be treated that way. They believe it is morally correct to be treated the way the parents treat them (compliance) or to treat others the way the parents treat them (identification). Consciously they may argue or fight back, but unconsciously their loyalty is much stronger to the parent than to the self.

People often learn many more behavioral alternatives than they experienced with their families, but they do not feel permitted to access them. They are motivated to hold pathogenic beliefs steadfastly in place by their loyalty to family, and particularly to parents who traumatized them as children. As Friedman[5] observed, "To a degree not generally recognized, psychopathologies are pathologies of loyalty" (p. 530).

In the example of the abused child, for the child not to feel deserving of abuse would make the parents wrong in the child's mind. The child would feel more comfortable seeing himself as wrong than seeing the parent that way. Viewing the parents as wrong would make the child feel intensely disloyal, which is why children comply with their parents' hurtful views and treatment of them. As Fairbairn[13] observed about this tendency in children, "It is better to be a sinner in a world ruled by God than to live in a world ruled by the Devil" (p. 66).

Not to repeat the unhappy parents' miserable experiences would make the patient feel terribly guilty for outdoing the parents and leaving them behind. That is why children identify with their parents' negative attributes. For a child of a healthy parent who promoted the child's progress, it would not be a problem to outdo a parent. But for a child of an impaired parent who competed with the child, who inspired guilt for leaving or outdoing the parent, it is very hard to separate, grow up, and do better without the psychological cost of tremendous guilt.

Of course, children's behavior often reflects realistic fears of parental retaliation or withdrawal of support. When children can modify their behavior on the basis of a clear assessment of their parents' motivation and behavior, they are being adaptive. What is pathological is when children cannot see their parents clearly and cannot protect themselves politically within the family—that is, not get into trouble, not fail in school, not get depressed. Compliances and identifications are based on distortions that suggest that the parents are correct and the child is wrong. For a child to be politically savvy in a dysfunctional setting would be a great achievement. If children can learn to fit into the expectations of the dysfunctional system without self-blame or self-destructive behavior, they are far ahead of the game.

Weiss theorized that patients try to resolve their psychopathology by using an interpersonal strategy—initially outside the therapy, but more intensely inside the therapy if the therapy is seen as a safe place to work. The patient continually assesses safety by testing the therapist, posing questions and reenactments relevant to the pathogenic beliefs the patient is working on in relation to the therapist. This testing is sometimes conscious but is often unconscious. For example, a gay patient consciously assessed safety by asking his prospective therapist what experience the therapist had with gay patients, exploring potential biases or limitations in the therapist that would interfere with the patient's feeling safe and confident in the therapy.

More often, however, a patient tests unconsciously from the beginning of therapy. For example, a patient who had the pathogenic belief that he was incompetent and undeserving because his critical father treated him that way got lost and came late to the first appointment. This behavior unconsciously tested whether the therapist would be irritated and dismissive, which would have confirmed the patient's pathogenic beliefs that he was undeserving of getting help from the therapist because he was so incompetent. The therapist was neutral and supportive, not irritable and dismissive. This stance allowed the patient to feel safer to deepen the therapeutic work, and it began to undermine his pathogenic belief that he was undeserving.

The pattern of testing and the relation of the testing to the underlying goals or issues the patient is trying to work through has been called the patient's therapeutic strategy or "plan." Weiss asserted that testing the therapist establishes conditions of safety in the therapy to allow the patient to become aware of his traumatic past, to become clear about his pathogenic beliefs and replace them with more accurate versions of self and others, and thereby to free himself of symptoms and inhibitions consequent to pathogenic beliefs.

Weiss's view of the patient as adaptively testing the therapist consciously and unconsciously differs from Freud's "automatic functioning model" of why patients tend to repeat dramas from their childhood. Freud[4] talked about patients repeating childhood dramas as "acting out" or as a "compulsion to repeat." He said that patients repeat as a form of resistance to remembering. What they repeat are inhibitions, unserviceable attitudes, pathological character traits, and symptoms.

Freud emphasized two characteristics of repetitions: they are all transference phenomena, and they have their pathogenic roots in the patient's childhood libidinal drives, which he called "pathogenic instincts"[4] (p. 154). Freud theorized that the patient's strategy was to repeat in relation to the therapist, rather than remember, the discharge of libidinal drives. Freud viewed the analyst's goal as helping the patient remember rather than act out by allowing the transference to flourish and be experienced by the patient and then interpreted by the analyst.

In *Beyond the Pleasure Principle*,[1] Freud further developed his ideas on the "repetition compulsion" to include not only transference repetitions in therapy, but also child's play and traumatic neuroses. In considering child's play, Freud used the term "passive into active" for the first time.

Freud described a child's game he had observed, which he called "*fort*" (gone) and "*da*" (there). An 18-month-old child would throw his toys away from him and say "o-o-o-o," which was interpreted by his mother and Freud as "*fort*" (gone). Later Freud observed that the child had a spool with a string attached, which he would toss away, uttering "o-o-o-o" and then bring back with the string, uttering a joyful "*da*" (there). Freud understood this game as related to "the child's great cultural achievement, the instinctual renunciation which he had made in allowing his mother to go away without protesting. He compensated himself for this . . . by himself staging the disappearance and return of the objects within his reach"[1] (p. 9). Freud noted that the child played this game with great pleasure, especially on recovering the spool. He noted that the child could not possibly feel that the mother's departure was pleasurable or even neutral. How then could this game be explained by the pleasure principle? Freud went on to observe, "At the outset he was in a passive situation—he was overpowered by the experience; but, by repeating it, unpleasurable though it was, as a game, he took on an active part"[1] (p. 10).

Freud considered the possibility that this sequence illustrated an "instinct for mastery" but then discounted it and posited that the pleasure in the game came from the child's fantasied revenge over the parent, attained by throwing her away in the form of the spool. The revenge was seen as instinctual gratification. Freud concluded that this and other ex-

amples of turning passive into active in child's play still should be explained by the dominance of the pleasure principle. Freud rejected "the theoretical importance of the instincts of self-preservation, of self-assertion, and of mastery"[1] in favor of the death instinct (p. 33).

Freud saw psychopathology as originating in pathogenic instincts; that is, the child feels humiliated, frustrated, hopeless, and in expectation of punishment because of his inherent, impossible instinctual wishes. Weiss, in contrast, saw psychopathology as originating in pathogenic beliefs developed as a consequence of real, specific interpersonal traumatic interactions with other people. Freud always maintained a limited view of the traumatic effect of real relationships and experiences compared with the role of the instincts as a cause of neurosis in the child's life.[1,14]

Freud downplayed the role of mastery in repetitions, whether they represented turning passive into active, the repetition compulsion, or transference. Freud hypothesized either libidinal gratification to explain passive-into-active child's play or regressive instincts to explain the repetition compulsion. In contrast, Weiss asserted that the patient's purpose in repeating by turning passive into active is not to gain revenge or any other libidinal gratification. It is to master the traumatic experience by doing it to the therapist and watching his response in hope of identifying with his strength and skill.

Erikson[15] emphasized the role of mastery in child's play, concluding that the child Freud described in the "fort-da" game turned passive into active to master his mother's absence and his increased autonomy. Erikson gave as another example the toddler, barely able to stand without falling, who takes pleasure in building tall towers out of blocks and knocking them over so as to master standing and falling. Erikson posited that "the child's play is the infantile form of the human ability to deal with experience by creating model situations and to master reality by experimenting and planning"[15] (p. 10).

Anna Freud described a phenomenon very similar to turning passive into active, calling it *identification with the aggressor*[16] (pp. 117–131). She reported a case of August Aichhorn's in which a schoolboy would grimace in response to his master's reprovals. The schoolmaster thought the boy either was consciously making fun of him or had a facial tic. Aichhorn noticed that the boy's grimaces were a caricature of the angry expression the teacher had while scolding him. Freud concluded that the boy was trying to master his anxiety by involuntarily imitating the teacher.

Freud went on to describe a little girl who was afraid of ghosts and made peculiar gestures, pretending she was a ghost when she was in the dark hallway so she would not be afraid. Anna Freud noted that there are "many children's games in which through the metamorphosis of the subject into a dreaded object anxiety is converted into pleasurable security. . . . By impersonating the aggressor, assuming his attributes or imitating his aggression, the child transforms himself from the person threatened into the person who makes the threat"[16] (p. 121).

Although Anna Freud saw that these role reversals had the purpose of mastering anxiety about being helpless, she did not have a concept of role reversal in psychotherapy as an interpersonal strategy in which the patient tested the therapist for the purpose of undermining pathogenic beliefs. Anna Freud expanded and changed her concept of identifying with the aggressor, a simple role reversal, to that of identifying with an authority's expected aggression, which would be a punishment for guilty wishes. The child would then project his guilty wishes onto his parent and punish the parent, completing the role reversal. These formulations are more consistent with drive theory and more distant from control mastery's concept of turning passive into active.

The concept of *projective identification*, a natural extension of Anna Freud's notion of identification with the aggressor, tries to account for the intensity of the drama enacted by the patient and the feelings experienced by

the therapist. Ogden[17] noted that projective identification is simultaneously a defense, a mode of communication, a form of object relationship, and a pathway for psychological change.

Ogden's conceptualization of projective identification is similar to the control mastery concept of turning passive into active in two ways: 1) the therapist is pressured via the interpersonal interaction to think, feel, and behave in a manner congruent with the way the patient feels and 2) the patient pays attention to how the therapist psychologically processes the experience and internalizes the therapist's capacities to think and feel in a healthier way.

The conceptualizations differ in that Ogden posited that the intrapsychic component, the central and initial process in projective identification, is a projection, a getting rid of unwanted feelings, a defense against unwanted impulses of anger or destructiveness. Control mastery theory posits that the patient's intrapsychic work is not a projection of feeling but rather an attempt to modify a pathogenic belief. According to control mastery theory, the ugly drama that is being played out between patient and therapist is not seen as an expulsion of inner feelings but as a reenactment of a traumatic experience.

The following examples illustrate how passive-into-active testing can be identified, conceptualized, and responded to therapeutically according to control mastery theory.

## Passive-Into-Active Testing in Control Mastery Theory

**Example 1: "Cheating."**

A female patient was raised in a family where she felt cheated, deprived, and blamed as a child. Her mother withheld birthday presents from her when angry and often failed to live up to promises, such as taking her on outings or supporting dancing lessons. If she complained or protested the unfair treatment, her mother made her feel guilty by acting hurt or angry. Her mother complained that the patient demanded too much and was "bleeding" her with neediness. The patient grew up feeling undeserving. As an adult, she could not enjoy mutual relationships, had trouble promoting herself professionally, and was always in debt.

In therapy, the patient started to let the bill accumulate. First there was a plausible excuse as to why the payment was late. Then the patient complained that she really wasn't getting such good quality care. She added that the billing mechanism of the therapist was faulty and difficult to comply with. She said the therapist was ridiculous to expect payment for several missed sessions, and she refused to pay for one session because the therapist's comments were not "worth anything." The patient railed against the therapist for being selfish, undeserving, too interested in money, and unsympathetic about the patient's own emotional needs and financial difficulties.

In this example, the patient was traumatized as a child by being cheated over and over by her mother. She was made to feel undeserving of better treatment. She was also made to feel guilty for complaining or expecting redress for being cheated. In therapy, she turned passive into active by doing to the therapist exactly what was done to her. She cheated the therapist and made the case that the therapist deserved it and, even worse, was a monster for asking to be paid.

Turning passive into active in therapy has several adaptive functions. First, on a cognitive basis, it reenacts the original traumatizing relationship as an illustration and demonstration of what the patient experienced at the hands of the parent. It allows the patient and the therapist to look at and appreciate the drama that the patient as yet has been unable to face.

The second function of turning passive into active is interpersonal, as a test of the therapist. The patient tests two things: 1) if it is safe to work on this problem in therapy and 2) if it is right to overcome this problem. In assessing safety, the patient reenacts the childhood drama and ascertains whether the therapist has the strength to tolerate both her own and the patient's thoughts and feelings that

result from the traumatic experience. Practically, the patient cannot successfully turn passive into active outside of therapy because people usually do not tolerate that. Or if such behavior is tolerated, it often becomes destructive to relationships. Rarely outside the therapeutic setting can a person work on such traumatic events in this way without being destructive or getting rejected. Even in the therapeutic setting, patients are often rejected by therapists who do not recognize the adaptive nature of the patient's testing behavior.

The second component of the test, whether it is "right" to change, tests the pathogenic belief that the patient deserved to be treated so badly and deserves to suffer currently. Control mastery theory states that traumatic events in pathogenic relationships cause psychopathology that is mediated by pathogenic beliefs. In the example above, the patient's psychopathology included depressive feelings, self-destructive behaviors, impaired relationships with others, low self-esteem, and inhibitions about financial and personal success. These symptoms were mediated by the patient's pathogenic beliefs that she deserved to be cheated, deserved to have very little, and was bad if she got what she consciously thought she deserved because she would have to drain good people to get it.

In therapy, the patient watches closely the therapist's response to turning passive into active. If the therapist responds to the traumatic behavior in the same way the patient did at the hands of the parent, the patient cannot be helped. In the above example, if the therapist gets depressed, is unable to ask for what he deserves, believes he is bad for asking for his fee, develops debt problems, and starts cheating the patient and others, then the patient cannot get help challenging the pathogenic beliefs she is saddled with. If the therapist can tolerate the experience without losing his dignity, becoming depressed, or developing the same pathogenic beliefs the patient has, then the patient can take heart and challenge her own pathogenic beliefs.

Interpersonally, the patient can see that someone can have the same traumatic experience and not "personalize" it, not take responsibility for the pathological interaction in the way that children feel they have to do. The patient can identify with the therapist's strengths, borrowing the capacity to consider other hypotheses about reality than the patient's own distorted pathogenic beliefs.

## IMPLICATIONS FOR TREATMENT

The most important helpful response the therapist can make is to tolerate the passive-into-active test without being damaged. It is difficult to emotionally ignore passive-into-active behaviors such as incessant blaming, a teenager's finding every physical flaw, a depressed patient's indicting the therapist as worthless and impotent to help, or a tortured patient complaining that the therapist's personality flaws and empathic failure are the central cause for the patient's suffering. The therapist cannot and should not be oblivious to the drama being played out by the patient.

The patient's turning passive into active is often confusing and painful, and it inspires soul-searching in the therapist just as the original traumatic experiences did for the patient. It must have an impact on the therapist if the patient is to get any help. Patients need to present an effective rendition of their traumatic experiences in order to make use of the therapist's creative ability not to be devastated and paralyzed as they had been. If the therapist laughs off the experience or withdraws coldly, the patient will know that the therapist cannot tolerate it or else does not want to get involved enough to help. On the other hand, if the therapist gets depressed, loses faith, or acts out of panic or guilt, the patient will become more anxious and make less progress.

It is often asked whether the therapist should interpret the turning of passive into active. Interpretation is important as a cognitive structuring of experience, but its implications need to be weighed. The therapist's helpfulness is transmitted more powerfully by

his behavior and attitude than by his words.[18] Sometimes an interpretation can be experienced by the patient as a criticism or a rebuke. Often when therapists interpret patients' turning of passive into active, their interpretations truly are criticisms and rebukes—and no wonder, since therapists experience this behavior as quite toxic and provocative. Often the interpretation is an attempt to stop the patient from being so unreasonable or obnoxious by pleading with, instructing, or scolding the patient into more pleasant behaviors. Control mastery theory says that with few exceptions, passive-into-active testing in the therapy should not be stopped or even discouraged.

If the interpretation of the process will discourage the patient from testing—if the patient feels criticized by the interpretation and discouraged from turning passive into active, which is often the case—it is better not to interpret. Just tolerating the turning of passive into active will generally pass the test, and often a patient will then provide new material without having been offered an interpretation. An example follows.

**Example 2: Telephone calls.**
A young woman insisted that the therapist not accept telephone calls during her sessions because having this occur hurt her feelings. She counted the number of times the phone rang and complained she had lost six minutes of time in the previous five sessions because of the interruptions. Even though many therapists decline to accept telephone calls during sessions, the therapist said that her policy was to accept phone calls briefly, and she did not want to change that unless their frequency increased dramatically. The patient was quite put off, and the therapist was pleasant but firm about not changing her policy in this case. She told the patient that she understood her feelings about the intrusion and agreed with her that it was unfair but that it was important to the therapist to be able to answer the phone.

The therapist privately had doubts, thinking that maybe she should make an exception in this case because the patient felt so strongly. The therapist felt guilty and pressured by the intensity of the patient's complaints and worried that she might traumatize the patient by seeming unreasonable and rigid like the patient's parents. But despite her misgivings, she held firm to her policy, guessing that the patient's pressure might be a test.

When the patient came back in the following hour, she was calm and pleasant. After a few minutes, the patient spontaneously raised the issue of the telephone, saying that after the previous session she had had a new memory. When she was a teenager, her father would tell her to get off the phone in a tyrannical and abusive way. He was very cheap, did not talk much on the phone himself, and criticized all the children and the mother for talking on the phone. The patient said she felt she had been acting like her dad in relation to the therapist in the previous hour.

Without any interpretation from the therapist, the patient presented new material, consequent to the test, that illustrated specifically the traumatic interaction she suffered with her father. She was able to be conscious of the memory because the therapist passed the test in this case, even though for another patient the same firm response might have been a mistake.

Intrapsychically, control mastery theory posits that two things occur when the therapist passes a passive-into-active test. First, the patient identifies with the therapist. Second, the patient's pathogenic beliefs are undermined. In this example, the patient borrowed the therapist's capacity to resist feeling bad, guilty, responsible, and morally wrong, which was how the patient invited her to feel and how the patient had felt as a child when her father pressured and berated her. The patient believed that she deserved to be treated this way and that she should always feel guilty when she conducted personal business that might conflict with the needs of others. She challenged her pathogenic belief by watching the therapist tolerate her passive-into-active repetition of her father's traumatic behavior toward her. If the therapist did not become convinced that she was evil and selfish for maintaining her telephone policy, the patient could infer that she herself was not evil and selfish for talking on the telephone in her father's house. By challenging her pathogenic

belief that she was at fault in the past conflict with her father, she became more conscious of his behavior and how inappropriate it was.

The patient did not verbalize that this was a passed test. Patients are rarely aware that they are testing the therapist, particularly when they are turning passive into active. They are often irritated if the therapist suggests they are "testing" because they feel accused of being inauthentic. It is unusual for patients turning passive into active to make the conscious connection themselves that they are repeating in the therapy, as the patient did in this case by stating that she treated the therapist the way her dad treated her as a child. Usually the therapist has to infer the test and whether it was passed from the patient's behavior.

When they are turning passive into active, patients are particularly lacking in insight about their behavior. Their immediate goal is not to become more insightful about their own behavior but to become more aware of the behavior of those who traumatized them in the past. Indeed, these patients can be described as doing therapy by action. Later in the therapy, the patient's strategy may shift from turning passive into active to a strategy that seems more comfortable for the therapist, discussing the past and collaboratively developing insights. Some patients usefully turn passive into active throughout the entire therapy, sometimes intermittently and sometimes continuously.

There are a couple of exceptions to the general technique of tolerating the turning of passive into active without interpretation. One is a situation in which the patient's behavior is actually destructive; this occurs particularly with children and sometimes with adults. It is important always to limit destructive behavior in the office and to interpret it to help the patient gain control of the behavior. For instance, with a borderline child who threatens to hurt the therapist by swinging a broom handle or throwing large blocks, the therapist might say, "You're letting me know how it feels when your parents threaten or hurt you. But you can't do that here. The rules of the play room are that no one gets hurt."

Another instance when interpretation may be particularly helpful is when a patient feels very guilty about turning passive into active. Interpretation can offer a framework for maintaining the patient's self-esteem even if the patient's interpersonal behavior is bizarre. An example follows.

**Example 3: Leaving.**
A young man repeatedly left the therapy because he told the therapist that she was failing him in every way, that she was unempathic, ungiving, and at times cruel. He would leave and the therapist would call him or write him and invite him back. He would come back and revile her and then leave again in a few weeks. The therapist always kept his time open (and charged him for it) and encouraged him to come back and work things out. She did not interpret his behavior as turning passive into active but talked about transference issues of his feeling rejected by the therapist as he had by his parents.

The patient was reenacting the rejection he had experienced as a child by repeatedly leaving the therapist because she was so defective and morally repugnant—what he had been told about himself as a child. Eventually, he begged the therapist to give him a better idea of what was going on because it was not making any sense to him. The therapist in a gingerly way offered the interpretation that he was replaying a drama of one person rejecting another because of the second person's defectiveness. She said she believed that he had experienced this as a child with his parents and was now recreating it in his therapy so that he could overcome his terrible feelings of low self-esteem and of deserving such rejection. He responded, "I knew that—and that's why I have to leave you, because you don't help me enough." In his response, he was continuing to turn passive into active, continuing to reject the therapist for not being helpful enough to him even though she had just responded to his request.

He continued his pattern of leaving therapy and returning and made steady improvement in his life outside the therapy. The therapist's technique was generally to tolerate him, keep inviting him back, and reach out even though he rejected her and invited her to reject him. The therapist

charged for all missed sessions and telephone contact, and the patient begrudgingly paid. She occasionally interpreted his turning passive into active in order to maintain a cognitive framework for what he was doing, relieve his guilt, and actually give permission for his strategy to continue as long as he needed it.

Another technique for helping the patient understand the issues underlying passive-into-active behavior is to ask the patient how she thinks the therapist might feel about experiencing the behavior the patient has just displayed. For example, if the patient rants and raves, or refuses to pay the bill, or interrupts and vilifies the therapist, the therapist can ask what the patient thinks the therapist might feel. If the patient shows no interest in answering the question, the therapist might ask her to speculate or to sit a minute with the idea. Without directly asking the patient to face the possibility that this was a drama she presumably experienced, the therapist gently directs her to consider what the therapist, or anyone for that matter, might feel in response.

Sometimes the therapist might joke in a kindly, respectful way that he is being treated like a slave or stage a mock rebellion and refuse to buckle under to the patient's tyranny. The importance of these interventions is that without blaming or attacking the patient, the therapist tolerates and illuminates the patient's behavior. As part of the theatrics, the therapist can put his feelings into words, helping the patient put her own feelings into words by inference. The therapist should never appear critical or derisive when using humor. It is important that the exercise not be presented to the patient as a rebuke or a request to stop the behavior because it is too obnoxious. Patients need to feel safe and to have permission to use their passive-into-active strategy in order to get better. The following is an example of a patient who was hopeless about ever getting any better.

**Example 4: Despair.**

A 35-year-old divorced man with a college degree complained that he had a flunky job as a clerk and yet could not take steps to apply for a better job because of various fears and inhibitions, which remained powerful but vague. He said he did not want to be alone but complained of being petrified at the thought of dating women for fear that something terrible might happen. It was not clear what that would be. He worried about rejection, but in fact girls and women had always liked him. The therapy slowly progressed, but the patient felt stuck and at times despaired that the therapy would ever help him. However, he felt that if he gave up on therapy, he had no hope at all. The therapist was aware at times of feeling helpless to help, uniquely responsible for the patient's being stuck, with no clear guideposts for how to help him get better.

The therapist suspected that the patient might be turning passive into active. The patient gave a history of growing up with two very unhappy parents. His father was chronically unhappy with his work and justified it with a very pessimistic view of life in general. His mother had been hospitalized for major depressive episodes, was unhappy with her husband, and had been too inhibited to even do volunteer work at a hospital.

Without interpreting passive into active directly, the therapist explored the possibility that the patient might be acting like his parents, holding himself back in his life in the same way his parents did. The therapist explained that the patient identified with his parents because he was really very worried about and ashamed of them. Rather than risk being disloyal by outdoing them, by being successful, the patient unconsciously felt obliged to be saddled with all the same problems his parents had—specifically, be unhappy in work, unhappy in his relationship with his spouse, hopeless, and pessimistic about life.

This example points out the close relationship between pathological identifications and the turning of passive into active. Turning passive into active can be thought of as a more specific interpersonal interaction, one that takes place between patient and therapist in therapy and that is adaptive because the patient is doing it with a professional who is skilled enough to help him overcome his pathology. Pathological identifications are repetitions of past unhappy relationships in the

patient's daily life and are usually not adaptive because they are merely painful repetitions of what the person believes he deserves. The patient cannot let himself escape these identifications because of his guilt over potentially feeling superior to and therefore disloyal to the parent.

Pathological identifications outside of therapy may have had initially adaptive motives. The person who acts like an impaired parent may hope that a family member, a friend, or a spouse will help her not have to repeat the pathological interactions she witnessed in the parent. For example, a wife was excessively critical of her husband as her father had criticized her. Her husband complained that her excessive criticism irritated him. She was able to stop her behavior after his complaint and was relieved that he had brought it to her attention. Later she became aware that she was acting like her father. But often other people in the patient's life do not adaptively complain because they take the treatment personally. They do not see through the pathological identification and thus fall into patterns of responding to the patient in a way that confirms rather than challenges the patient's pathogenic belief. Then these pathological identifications and interactions become entrenched patterns, vicious cycles, rather than opportunities for growth and change.

The hopeless patient in Example 4 was suffering from pathological identifications with his parents and was also turning passive into active in therapy. The technique of interpreting the identifications was helpful as a cognitive structuring for the patient of what he was doing. But the more powerful therapeutic element was the therapist's passing the passive-into-active test by not giving up, not despairing, not believing the patient was impossible, and maintaining energy and thoughtfulness in the face of confusion and guilt induced by the patient. The patient used the therapist by identifying with the therapist's capacity to withstand the same behavior the patient was faced with as a child. The therapist maintained self-esteem, did not get depressed, and did not feel overwhelmed. The patient was able to identify with those strengths and later to produce memories of how crippled and at times ridiculous his mother and father had been, something he had felt too disloyal to face earlier. His behavior toward his 2-year-old daughter changed dramatically from being sour, critical, and lifeless to becoming more energetic, loving, and creative.

## PASSIVE-INTO-ACTIVE TESTING OR TRANSFERENCE TESTING?

Because patients reenact their traumatic past in therapy in two ways, by transferring and by turning passive into active, it is important to be able to differentiate the two strategies to understand what the patient is working on at any particular time. First, it is important to clarify how Weiss's concept of transference differs from Freud's and more modern concepts of transference.[19] Freud said that transference was an automatic repetition of the discharge of libidinal energy in the therapy that served as a resistance to the patient's remembering his childhood libidinal experiences. Freud counseled the therapist to interpret the pattern and meaning of these transferences so that the patient could better see his pathogenic libidinal roots and either give them up or use healthier defenses against them.

Weiss's view of transference bridges what Cooper referred to as the "historical" and the "modernist" models of transference.[19] Weiss sees transference testing as a true reconstruction of the past that distorts the patient's current view of the therapist. But the purpose of this reconstruction of the past, according to Weiss, is to adaptively test the pathogenic beliefs inherent in that past traumatic experience by testing the therapist interpersonally.

Weiss asserts that the therapist's behavior in response to the patient's test, whether it is a transference test or a passive-into-active test, can change the patient's view of himself. By

acting differently from the traumatizing other in the childhood drama being replayed in the current transference test, the therapist helps the patient see his past more clearly and helps free the patient from the distorted pathogenic beliefs he carries with him consequent to his past traumatic experience.

Passive-into-active testing and transference testing are similar in that they are interpersonal tests of the therapist, they are repetitions of past traumatic experiences, and they are unconscious strategies employed by the patient to adaptively correct distorted self-concepts. They are different in that transference testing puts the therapist in the role of the traumatizing other, whereas in passive-into-active testing the roles are reversed: the patient plays the role of the traumatizing other and the therapist is put in the historical role of the traumatized patient. Differentiating passive-into-active from transference testing is important so that the therapist can understand what the patient is playing out interpersonally and can devise an appropriate strategy in response that will further the patient's plan to get better.

**Example 5: "I hate you."**

If a patient says "I hate you," it has a very different meaning if it is a passive-into-active rather than a transference test. In a transference experience, the patient may actually have feelings of hatred toward the therapist or may want to see how the therapist responds to the expression of those feelings. The therapist may have blundered and hurt the patient's feelings, and the patient may be bold enough to respond, "I hate you." In a transference test, the patient is expressing and exploring these feelings to learn more about how noxious or threatening the current situation is so that he can more accurately plan to defend himself or adaptively alter the situation.[40] Working through these feelings in the transference helps the patient reassess what actually happened, and what should have happened, when the original trauma occurred. The patient may have wanted to tell the parent about similar feelings when he felt hurt by the parent but was made to feel that he had no right to complain. In reenacting the traumatic experience transferentially with the therapist in the role of the traumatizing parent, the patient is hoping that the therapist, unlike the parent, will tolerate his complaints and take them seriously. He wants the therapist to help him feel it is safe to understand what is traumatic in the present relation with the therapist as well as what was traumatic in the past, and he also wants the therapist to support his right not to be traumatized.

However, if the statement reflects a passive-into-active test, the drama may be very different. Again the patient may consciously feel he hates the therapist or may have no feelings of hatred at all toward the therapist. But the importance of saying "I hate you" in a passive-into-active test is in reenacting a traumatic experience of someone (probably the parent) telling the patient that he is hated. The purpose of feeling or displaying affect in passive-into-active testing is not to use feelings to adaptively plan or protect oneself as it is in a transference experience, but rather to inflict on the therapist a convincing rendition of what the patient passively endured in the past. In this case, instead of working on his right to have or express strong feelings of hatred, the patient who turned passive into active would be working on how damaged he felt when his parent told *him* "I hate you" as a child, trying to disconfirm that he deserves to feel so bad about himself.

Differentiating transference from passive-into-active testing gives the therapist peace of mind and may help her tailor the response that will be most helpful and least confusing to the patient. For example, if the therapist knows the patient's "I hate you" is a transference statement, perhaps following a clear therapeutic blunder or misunderstanding, the therapist will want to show the capacity to be flexible and recognize her mistakes, particularly if the patient's parents were not able to do that. The therapist might apologize, or clarify, or readjust her intervention to get back on the therapeutic track. If the therapist thinks the patient's

"I hate you" statement is a passive-into-active test, the therapist might take a different tack. In this instance, the patient needs for the therapist to show the capacity to withstand the assault without being damaged or losing her dignity. The therapist might be a little cooler, less apologetic, and more matter-of-fact.

Three sources of information can help the therapist distinguish transference from passive-into-active testing: 1) history, 2) the patient's response to previous tests, and 3) countertransference feelings.

The first and most helpful guide to understanding the test is knowing the patient's history and knowing what he is working on at the time in therapy. The drama in the therapy reflects the drama in the patient's life. The therapist needs to figure out who is playing what role in order to understand what the patient is working on and what optimal therapeutic approach to take. If the history indicates one or both parents made the patient feel hated, then it is likely to be a passive-into-active test. If the patient did not feel free to express strong feelings such as hatred toward the parents, then such an expression toward the therapist might be a transference test.

The second guide to understanding the meaning of the patient's test comes from watching the patient's response to interventions. Control mastery theory predicts that after passed tests or helpful interventions, patients become more relaxed, bolder, and more motivated to deepen the therapeutic work. They also bring new unconscious material into consciousness. After failed tests or unhelpful interventions, patients become more anxious and disorganized and show signs of therapeutic retreat. The existence of this pattern is supported by extensive empirical research.[2,3,21]

In the above example, if the therapist acts cool and undeterred, correctly assuming the statement "I hate you" is a passive-into-active test, the patient will probably be reassured and may bring out new material, as in the "telephone calls" example. However, if the therapist acts cool and it is really a transference test, the patient may perceive the therapist's coolness as indifference or defensiveness in the face of the patient's appropriate indignation. Then the patient may feel hurt, confused, and misunderstood and may either retreat or test again until there is some resolution.

Conversely, if the therapist correctly assumes it is a transference test and takes very seriously the patient's complaint, acting conciliatory or even a little apologetic, the patient will probably feel relieved, see this response as strength in the therapist, and deepen the therapeutic work with more memories and more affect. However, if the therapist acts conciliatory and apologetic and it is really a passive-into-active test, the patient may think the therapist feels damaged or guilty, and this will make the patient more anxious and probably result in an intensification of the passive-into-active testing until the therapist shows more toughness.

Whatever the therapist does, she should watch the patient's response to fine-tune her understanding of the case and her technical approach. According to control mastery theory, if the therapist is on the right track, the patient should deepen the therapeutic work and get better in his life outside the therapy. If the therapist is on the wrong track, the patient will either fail to get better or will get worse.[2,3,21]

Sometimes not enough history or data are gleaned from previous tests to show the therapist the meaning of the current test. A third hint about the nature of the test is the therapist's countertransference feelings in response to the test. When the patient is transferring, he is usually working with the therapist in a more mutual, cooperative manner than when he is turning passive into active. The therapist feels less on the spot and more collaborative with the patient. In contrast, when the patient turns passive into active, the therapist feels the patient is doing something to him that feels more uncomfortable and less collaborative. The therapist often feels confused, attacked, guilty, defensive, or paralyzed. Therefore, the therapist's feelings can help differentiate a transfer-

ence from a passive-into-active test.

This method is not invariable, and sometimes therapists get confused, make mistakes, or feel put on the spot even when the patient is transferring. Sometimes patients give mixed tests to the therapist with elements of both transference and passive-into-active testing.

**Example 6: Rejection.**

Rejection tests, similar to the one described in the "Leaving" example, frequently have elements of both passive-into-active and transference testing. Rejection testing is a very common strategy of teenagers in therapy who have been belittled and rejected by their parents. They tell the therapist "You're no good. You just want to take my parents' money. I'm never coming back." These patients often miss, come late, and devalue the therapy both verbally and behaviorally. Therapists sometimes make a mistake by concluding that such a patient can't be helped because "he doesn't want to get better." The patient's rejecting behavior can be better seen as a rejection test, and the test takes both transference and passive-into-active forms.

As a passive-into-active test, the patient rejects the therapist in the same way the parents rejected him, with vitriol and scorn, moral indignation, and specific criticisms about the therapist's unworthiness, greed, laziness, and so on. The therapist needs to tolerate this, and the strongest way to demonstrate tolerance is to invite the patient back in, to reach out in the face of this verbal "abuse." Typically with teenagers like this, the therapist should leave the time open, convince the parents that the therapy should continue, and strategize with the parents (or the authorities, if they are involved) to force the child back into treatment. Outwardly the child will be outraged and rebellious at these coercions. But the child will actually be tremendously gratified and relieved that the therapist has not been damaged and still offers the therapeutic opportunity to work on feelings of self-esteem damaged by being rejected.

But at least as important as the passive-into-active test is the transference test aspect of this rejecting behavior. In addition to rejecting and reviling the therapist, the patient is inviting the therapist to reject and revile him. It would be an understandable impulse for the therapist to say, "Get out of my office. You're ungrateful. You don't really want help. You don't deserve my help. You aren't capable of getting any better." This is probably what the child has already been told by his distraught parents and what he fundamentally believes about himself. If the therapist accepts the patient's self-presentation as a deadbeat ingrate, she will have failed the transference test and will again have confirmed the patient's pathogenic beliefs. If the therapist reaches out, insists on seeing the patient, and stands up to the parents by reasserting the child's worthiness to continue to receive treatment, then the child can start to question his pathogenic beliefs and move forward in his therapy and in his life.

In this example of the rejection test, the same intervention passes both tests. In not rejecting the patient and reaching out in the face of rejection, the therapist shows strength and integrity by passing the passive-into-active test, and she shows interest and compassion by passing the transference test. In other "mixed tests," the therapist can try to find a strategy that covers both bases. Sometimes the therapist has to be flexible and switch strategies over time to demonstrate different capacities to the patient, as in the following variant of the rejection test.

**Example 7: Refusing to pay the bill.**

A patient acted badly, rejected the therapist, missed sessions, and eventually refused to pay for the sessions she missed. Initially, the therapist invited the patient back, emphasized how important the therapy was to her, and held the time open even when she missed. This was actually very helpful to the patient, who responded well, paid the bill, and dramatically improved in her relations outside the therapy at work and at home. Later, the patient refused to pay for certain therapy hours and started testing in new ways by demanding more and more flexibility from the therapist, such as repeatedly switching therapy

hours. The therapist, who initially tried to be accommodating, shifted gears and became less flexible in switching therapy hours as the schedule became too complicated. The unpaid bill became more of an issue, and the therapist threatened to stop the therapy unless the bill was paid. The patient responded to these interventions by eventually paying the bill, seeming more connected to the therapy, and further improving in her outside life.

This patient was testing a wide range of issues with the therapist. Initially she tested father transference issues of how accepting and devoted the therapist would be to her, since her father was abusive and rejecting. She needed the therapist to show the capacity to be committed to her even if inconvenienced. Later, the patient subtly shifted her testing strategy to be overbearing and demanding like her mother, which was a passive-into-active test. She needed the therapist to show the capacity to be tougher and not give in too much. Initially, she needed the therapist to show the capacity to reach out to her. Later, she needed the therapist to show the capacity to let her go.

In general, it is recommended that in mixed or confusing tests, the therapist should err on the side of failing a passive-into-active test rather than a transference test. Generally the patient makes herself more vulnerable in transference testing than when turning passive into active. If the therapist fails a passive-into-active test by appearing weak, for example, the patient will not be too damaged, but will become anxious and test again. In transference testing, if the therapist repeats the transference trauma often enough the patient will be damaged again as she was in the original family trauma. If the therapist fails either kind of test, the patient usually tests again and again, giving the therapist more chances to get it right. After failed tests, there are usually many opportunities for discussion and reparations of mistakes, and these can become powerful passed transference tests. Clinical wisdom as well as empirical data suggest that the less often the therapist fails tests over the course of a therapy, the more straightforward and unambiguous will be the patient's therapeutic gains.

## CONCLUSION

This article has outlined the development of the concept of turning passive into active from Freud's initial observations of child's play to Weiss's control mastery theory. Weiss theorized that passive-into-active phenomena as well as transference phenomena are actually interpersonal tests of the therapist, adaptively posed as part of an unconscious strategy or plan of the patient to undermine pathogenic beliefs and resolve psychopathology in psychotherapy. Weiss's view of passive-into-active testing as an adaptive interpersonal strategy, the goal of which is to master and undo the effects of previous traumatic experience with the help of a therapist, stands apart from other conceptualizations in which this behavior is viewed as either an expression of aggressive drives[1] or a projection of unacceptable impulses.[16,17] By understanding the patient's difficult behavior in this way, the therapist can adopt a therapeutic strategy that allows him to remain an ally to the patient who does not seem willing or able to be in a therapeutic alliance.

The concept of the difficult patient turning passive into active challenges the notion that these patients cannot form a therapeutic alliance with a therapist, suggesting rather that they form a different kind of alliance that can be successfully used to benefit the patient. This is a particularly useful concept in formulating strategies with children, adolescents, borderline patients, and others who are more prone to "therapy by action."

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