

# How Patients Work On Their Plans and Test Their Therapists in Psychotherapy

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**ABSTRACT.** Relying primarily on Weiss and Sampson's control-mastery theory (Sampson, 1976, 1991; Silberschatz, 2005; Weiss, 1986, 1993), I briefly describe how psychopathology develops and then discuss how patients<sup>1</sup> work in psychotherapy to master their problems and conflicts. My focus is on two particular concepts: the patient's plan for therapy and the patient's testing of the therapist during psychotherapy.

**KEYWORDS.** Control-mastery theory, psychodynamic theory, psychotherapy

## ***PSYCHOPATHOLOGY AND THE PATIENT'S PLAN TO OVERCOME IT***

According to control-mastery theory, traumatic experiences play a central role in the development of psychopathology. Weiss (1993) posited two types of traumatic experiences: 1) shock trauma: discrete catastrophic childhood events such as the death or serious illness of a parent that overwhelm the child's coping capacities; and 2) stress trauma: persistent traumatic experiences from which the child can not escape, such as growing up in a dysfunctional family or being raised by a depressed parent. Children develop theories as part of their efforts to cope with trauma and in their theorizing they are prone to

draw irrational conclusions, which typically lead to self-blame and guilt (Shilkret & Silberschatz, 2005). Weiss (1986, 1993) termed these theories “pathogenic beliefs” and argued that such beliefs are the cornerstone of later psychopathology. For example: a child who had been mistreated by her parents developed the pathogenic belief that she deserved mistreatment. That unconscious belief led to psychopathology later in her life including depression, disturbed relationships, and substance abuse.

Pathogenic beliefs are internalized cognitive-affective representations of traumatic experiences. Typically, they are extremely painful, constricting, and debilitating (Silberschatz & Sampson, 1991). Control-mastery theory assumes that psychotherapy patients are highly motivated to disconfirm or relinquish pathogenic beliefs. This fundamental motivation to solve problems and master conflicts is embedded in the concept of the patient’s plan (Silberschatz, 2005; Weiss, 1993). According to control-mastery theory, patients come to therapy to get better and they have a plan for doing so: by disconfirmation of their crippling pathogenic beliefs. In therapy—as in other aspects of a person’s life—plans are frequently unconscious or not consciously articulated; nonetheless, the plan organizes the patient’s behavior and plays an important role in evaluating and filtering information.

Consider, for example, the case of Jill (Silberschatz, 2005), a compassionate middle-aged woman who sought therapy because she felt emotionally overwhelmed by her elderly, demented mother. Jill suffered from the pathogenic belief that taking care of herself meant that she was selfish and cruel (accusations her mother had frequently voiced when Jill was a child). Her unconscious plan for therapy was to disconfirm her pathogenic belief (“If I take care of myself or put my needs and my family’s needs first means I am an uncaring, cruel, selfish daughter”), so she could pursue her goal of finding a suitable nursing home for her ill mother. Jill’s plan led her to carefully monitor (albeit unconsciously) the therapist’s reactions to her efforts to find a nursing home. She had the transference expectation that the therapist, like her mother, would see her as selfish or callous. When the therapist encouraged or supported her efforts—that is, when the therapist supported Jill’s plan—she felt temporarily relieved. Throughout the therapy, however, she continued to monitor and assess (unconsciously) the therapist’s reactions and interpretations for any indication of disapproval.

Clinicians are far more accustomed to thinking about their own (the therapist's) treatment plan than the patient's plan. Nonetheless, there is considerable research evidence showing that therapists who have been trained in control-mastery theory consistently achieve high levels of interjudge agreement in inferring patients' unconscious plans (for reviews, see Curtis & Silberschatz, 2007; Silberschatz, 2005). There is also strong research support in the fields of experimental and social psychology as well as in cognitive-behavioral therapy for the concept of *unconscious cognition* and *planning* (for a review and references, see Silberschatz, 2005, p. 9). The assumptions underlying the plan model are also consistent with client-centered, humanistic, and experiential theories. For instance, a fundamental tenet in Rogers' thinking is that humans have a self-actualizing tendency. Accordingly, it is crucially important for the therapist to create conditions that allow the self-actualizing tendency to flourish. This is essentially synonymous with the control-mastery concept that patients come to therapy with an unconscious plan to solve their problems and master the traumas they have experienced. The therapist's primary role is to help the patient carry out her or his plan.

### ***THE PATIENT'S TESTS OF THE THERAPIST***

According to control-mastery theory, perceptions of danger and safety play a central role in explaining human motivation and behavior. An important part of a patient's efforts to solve problems and conflicts in psychotherapy involves bringing warded-off feelings, behaviors, goals, and thoughts into consciousness. To do so, the patient must work to overcome the sense of danger she or he would face if she or he were to experience these warded-off contents. She or he does this by attempting to create a relationship with the therapist that would protect her or him from this danger. The patient tests the therapist to assure herself or himself that were she or he to bring warded-off material into consciousness, the therapist "could be relied up to respond in a way that would afford protection against the danger" (Sampson, 1976, p. 257). Consider, for example, a patient who grew up in a family that could not tolerate his expressing any angry, critical, or negative feelings. The patient tested the therapist by tentatively disagreeing with her and by expressing mildly critical

feelings toward her. The therapist responded to these tests by pointing out the patient's tentativeness or discomfort in criticizing her and by encouraging him to say more about his anger. The patient felt reassured by the therapist's responses—that is, he felt a greater sense of safety—and subsequently brought up relevant traumatic memories of having been punished as a child for his critical feelings. Because the patient's convictions about the danger of expressing anger were deeply rooted, he tested the therapist repeatedly over a long period of time to reassure himself.

Tests are patient-initiated behaviors that require some kind of response from the therapist.<sup>2</sup> Although the testing process is typically unconscious, the patient's primary intention in testing is always adaptive. Early in therapy patients frequently test to ascertain what they can safely work on with a particular therapist. The patient attempts to determine 1) whether the therapist will support his goals, understand his problems, help him master early traumas and 2) whether the therapist has some of the qualities and strengths the patient lacks and wishes to acquire. Generally speaking, patients test their therapists to disconfirm pathogenic beliefs and to solicit help in pursuing their therapy goals. Tests are shaped by the patient's interpersonal history, traumas, defenses, personality style, conscious and unconscious goals for therapy, and specific pathogenic beliefs. Two broad categories of tests have been described in the control-mastery theory: transference tests and passive-into active tests (Silberschatz, 1986, 2005; Silberschatz & Curtis, 1986, 1993; Weiss, 1986, 1993). In a transference test, the patient attempts to assess whether the therapist will traumatize her or him as s/he had previously been traumatized by family members or other significant figures in her or his childhood. In the above example of a patient who grew up in a family that could not tolerate the expression of any angry or negative feelings, the patient frequently behaved in a mildly negative, disagreeable manner as part of a transference test, that is, to see if the therapist needed to stifle the patient's critical feelings as his parents consistently did while he was growing up. Each time the therapist did not stifle the patient's negativity—that is, disconfirmed his pathogenic belief that anger and negativity are intolerable—the therapist “passed the test.” Had she conveyed—either through her attitude, behavior, or interpretations—that she could not tolerate the patient's criticism or anger, she would have “failed the test.”

In a passive-into-active test, the patient tries to traumatize the therapist, as the patient had been traumatized earlier in life. In order to see if the therapist can handle trauma more effectively than the patient could (Sampson, 1991, 1992; Silberschatz, 2005; Silberschatz & Curtis, 1986, 1993; Weiss, 1986, 1993). These tests represent efforts at mastering trauma by “doing unto others what was done unto you.” Passive-into-active testing is also used to acquire strengths the patient lacks. The patient hopes to identify with the therapist’s capacity not to comply with or be overwhelmed by the patient’s potentially traumatizing behavior. These tests can be very helpful because they provide a vivid opportunity for the patient to identify with (and ultimately internalize) the therapist’s ability to handle traumatic experiences that the patient could not handle. For instance: a female patient was traumatized in childhood by a cold, critical stepmother who frequently treated the patient with scorn, disdain, and ridicule. As part of her work toward mastering this trauma in therapy, the patient tested the therapist by turning passive-into-active: she often reacted to the therapist’s comments scornfully and with ridicule (just as she had been ridiculed by her abusive stepmother). The therapist passed these tests by responding in a genuinely inquisitive, nondefensive manner—he was neither overwhelmed nor did he comply with the patient’s scorn, that is, he did not feel stupid or helpless as the patient had felt as a child.

Although patients are highly motivated to disconfirm pathogenic beliefs, doing so requires considerable effort and repeated testing. There is strong research evidence that shows that when therapists pass tests, patients show signs of therapeutic progress and when therapists fail tests there is a lack of progress or therapeutic retreat (for an overview of this research, see Silberschatz, 2005). However, neither theory nor research on the testing concept implies that if the therapist passes the test once or twice, the patient will relinquish pathogenic beliefs. Patients unconsciously test and monitor therapist behaviors throughout treatment, paying careful attention to the content of therapist interpretations (Silberschatz, Curtis, & Nathans, 1989; Silberschatz, Fretter, & Curtis, 1986) as well as to the therapist’s style and attitude (Sampson, 2005; Shilkret, 2006). When therapists repeatedly fail tests, the patient may alter the testing strategy or may coach the therapist (Bugas & Silberschatz, 2005) as part of an effort to get the therapist on a more productive track.

### CASE ILLUSTRATION

I now present a brief case example to illustrate how traumatic experiences lead to pathogenic beliefs and how the patient works to disconfirm these beliefs by testing the therapist.

Zoe,<sup>3</sup> a woman in her late forties, came to therapy in a state of acute crisis because her 6-year relationship with Peter was ending. She had not been eating or sleeping and was extremely anxious, bereft, and distressed. Although she described Peter as the “love of her life,” she made it clear that she had to do all the work in the relationship and that if she didn’t it would fall apart. She was extremely self-sacrificing and clearly the “care taker”; Peter had no career, little money, and seemed to be highly narcissistic and quite needy. In these regards, he resembled Zoe’s self-absorbed, domineering husband from whom she had separated (but not divorced) to pursue the relationship with Peter. Peter expected the patient to accept his having affairs with other women. The present crisis was precipitated by his telling her he had fallen in love with someone else and intended to marry her.

The patient’s proclivity toward self-sacrifice and taking care of others originated in her early family relationships. Although her family appeared to be like all the other happy, church-going families in the small community in which she grew up, hers was clearly a dysfunctional family. She described her father as very narcissistic, and because she worshipped him, he seemed to prefer her company to her mother’s. The only way Zoe could get close to him was by being “his pet,” someone he could show off to others. Mother was described as a depressed alcoholic who resented the patient for being close to her father. There seemed to be no room for Zoe to express her wishes, needs, or feelings—father’s self-centeredness didn’t allow it nor did mother’s fragility and withdrawal. Father explicitly directed her not to be angry at mother, encouraging her instead to be understanding. The patient said that she has spent her whole life “being understanding.”

#### *Case Formulation*

The aim of the formulation is to understand what the patient wants help with and how the therapist can best provide that help. A control-mastery approach to case formulation begins with summarizing the

patient's adaptive goals, some of which are conscious and some of which may be unconscious. Next, key childhood traumas are described followed by a description of pathogenic beliefs that the patient developed as a result of these traumas. And finally, the therapist attempts to anticipate how the patient is likely to test her or his pathogenic beliefs in the therapeutic relationship, and what she or he will need from the therapist to disconfirm her or his pathogenic beliefs (for a thorough description of our approach to case formulation, see Curtis & Silberschatz, 2005, 2007; Silberschatz, Itzhar-Nabarro, & Badger, 2007).

Zoe's consciously stated goals in seeking psychotherapy were to feel less anxious, distressed, and overwhelmed and "to get a better handle" on her relationship with Peter. We inferred that her unconscious goals were to be less of a caretaker and to develop the capacity to attend to her own feelings, to take her needs and ambitions more seriously, rather than to be so preoccupied with the needs of others. In other words, she wished to be less "understanding" and to have greater access and to feel more entitled to experience a wider range of feelings, particularly her angry feelings.

The primary traumas in this case center on her disturbed parental relationships. Zoe's early relationship with her narcissistic father impeded the development of her ability to focus on her self and her needs. Zoe's mother provided no real help or comfort. Instead, she resented Zoe for being close to father, which stimulated intense guilt. Growing up in this dysfunctional family left Zoe feeling lonely, anxious, and extremely worried, especially about her depressed, alcoholic mother.

The patient's relationship with her narcissistic father led to the unconscious pathogenic belief that she must comply with others' needs and completely subjugate herself to be loved. This belief obviously shaped the men she chose as partners and contributed to the feeling that she needed to accept mistreatment and "remain devoted to her man, no matter what." Her relationship with both parents—but particularly the relationship with her depressed, alcoholic mother—led to the pathogenic belief that she is responsible for the happiness and well-being of others. Her father's strong directive to be understanding rather than critical of her mother gave rise to the pathogenic belief that she should never be authentic

because her feelings—particularly angry, critical feelings—are dangerous.

Zoe tested the therapist as part of her effort to disconfirm these pathogenic beliefs. During the first several months of therapy, many of her tests were passive-into-active tests. She tested the therapist to see if he would feel excessively responsible for her (as she felt toward others) by calling him multiple times a day and leaving messages to call her back immediately. Her excessive phone calls represented clear examples of passive-into-active testing in that she was working to see if she could make the therapist feel overly responsible in the same way she had felt burdened and responsible as a child. The therapist consistently passed these tests by demonstrating that he did not feel omnipotently responsible (as she did) and that he could set appropriate boundaries (as she could not).

A particularly dramatic instance of the therapist failing a passive-into-active test occurred when the therapist notified her of his upcoming two-week vacation. Zoe had been working on her lifelong pathogenic pattern of feeling excessively responsible for others at great expense to herself. The therapist's vacation announcement gave her an opportunity to vigorously test the therapist to see if he would feel excessively responsible for her as she felt for others.

She complained bitterly about his taking a vacation, let him know that the timing was awful, and wondered how she would survive while he was away. Initially, the therapist failed this passive-into active test because he did feel intensely guilty, irrationally responsible, and showed an inclination to be self-sacrificing—he would have changed his vacation plans had his children's schedule allowed it! His guilt-ridden response was notably unhelpful because it made Zoe concerned that the therapist would be unable to help her feel less responsible for others. She subsequently tested him even more vigorously by “upping the ante,” asking for his cell phone number so that she might call him “just to check in every day.” He passed the test by declining her request and thereby demonstrated that he could set appropriate limits, would not be irrationally self-sacrificing, and could take care of his own needs.

Zoe posed numerous transference tests in which she worked to disconfirm her pathogenic belief that she must comply with others or subjugate her needs to preserve her relationships. For instance, she tested the therapist by behaving in a flagrantly obsequious,

subservient manner to see if he would take advantage of her or be excessively gratified by her compliments and submissiveness. She then began testing to see how the therapist would react to her expressing critical feelings, especially of men. The therapist decisively passed tests in which she expressed critical feelings toward Peter (and other narcissistic men who had taken advantage of her). However, when she expressed critical, angry feelings toward one of her women friends, he somehow got off track.

As part of her work on feeling more comfortable and entitled to her angry feelings, Zoe told the therapist about an episode in which she felt angry at her best friend. To disconfirm the pathogenic belief that being in a relationship required her to subjugate her feelings and assume the role of the dutiful caretaker, she needed the therapist to support and encourage the expression of her annoyance with her friend. Instead, he conveyed the same pathogenic message she received from her father: "You should be more understanding."

This example again shows the therapist clearly failing the patient's test. In a subsequent session the patient "coached" the therapist as part of an effort to get him back on track: she reminded him that her father had always told her she should not be angry at her mother and that, instead, she needed to be more understanding. Later in that session and in subsequent sessions the therapist was more supportive of her expressing anger and the patient was increasingly able to be appropriately critical and to feel more entitled to be angry.

With sporadic exceptions, the therapist generally helped Zoe work on her unconscious plan: he passed many of her transference and passive-into-active tests, which helped her to disconfirm her pathogenic beliefs. A strong therapeutic alliance was evident, and she made very substantial progress. About 18 months into the therapy, she posed a significant transference test by suggesting that she terminate therapy because she was so much better. Because of her lifelong pattern of taking care of or admiring others, she rarely (if ever) had the experience of being the source of someone's admiration or pleasure. Moreover, as a child when she was her father's pet, her mother expressed harsh disapproval and overt resentment of her. Her suggestion to terminate treatment represented a crucial transference test to see if the therapist could admire her, feel proud of her, and also continue to provide the support and encouragement she needed to

expand her world. By suggesting that she continue treatment, the therapist clearly showed that he felt neither threatened nor disapproving of her being the center of attention.

### SUMMARY

Psychopathology stems from traumatic childhood experiences that frequently lead to the development of unconscious pathogenic beliefs. Patients enter psychotherapy with an unconscious plan to disconfirm their pathogenic beliefs. There are three primary ways they can do so: 1) by using the therapeutic relationship per se; 2) by using new knowledge or insight conveyed by the therapist's interpretations; or 3) by testing the therapist directly. There are two different testing strategies: 1) in a transference test the patient tries to assess whether the therapist will traumatize her as she or he had been traumatized in childhood; 2) in a passive-into-active test, the patient traumatizes the therapist as she or he had been traumatized, as part of her or his effort to master the trauma. Patients are highly motivated to disconfirm their pathogenic beliefs. Typically they must test the therapist throughout the treatment to do so.

### NOTES

1. I use the term *patient* in the original sense of the word—one who suffers—rather than in the current medical model usage (see Silberschatz, 2005, p. xvi).

2. I am limiting my discussion here to tests in psychotherapy. However, it should be noted that conscious and unconscious testing occurs in all relationships; indeed, Weiss (1993) argued that testing is the primary way that people explore their interpersonal worlds.

3. This case is drawn from a training DVD, *Psychotherapy Case Formulation from the Perspective of Control-Mastery Theory*, that my colleagues Susan Badger, Zohar Itzhar-Nabarro, and I developed.

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