

**THE PATIENT'S SEARCH FOR SAFETY: THE ORGANIZING PRINCIPLE
IN PSYCHOTHERAPY**

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This article presents the Control-Mastery view that patients organize the process of their psychotherapy in their search for psychological safety with the therapist. According to this theory, people unconsciously assess their social environments for signals of safety and danger, relaxing their defenses when it seems safe to do so. In therapy, patients test to find the safety with the therapist which would free them to be less defensive in that relationship, and, ultimately, in all their relationships. Understanding how patients' activity in psychotherapy is organized by their search for safety can simplify the treatment process for the therapist and help to guide the therapist's interventions. Clinical examples are used to illustrate these ideas.

INTRODUCTION

According to Control-Mastery theory, the degree of safety the patient feels with the therapist is crucial in determining the effectiveness of psychotherapy (Weiss, Sampson, and the Mt. Zion Psychotherapy Research Group, 1986; Weiss, 1993). Weiss proposes that there is a structure to psychotherapy which arises from the patient's search for interpersonal safety with the important figures in his/her psychological history and, by transference, with the therapist. This structure is called the patient's *plan*, a flexible, largely unconscious strategy patients have for achieving their psychological goals. Control-Mastery theory views psychotherapy as the carrying out of the patient's plan to overcome dysfunctional behavior patterns, which are seen as adaptations to early, dangerous interpersonal situations. People maintain

these adaptations because they fear that the traumas they were intended to protect them against would recur if the adaptations were relinquished. It therefore follows that, in order for the pathological adaptations to be dispensed with, the person must discover that the dangerous situations no longer exist, and that it is now safe to act in healthier ways. An experience of interpersonal safety is thus essential to the patient's purposes in psychotherapy. Not only does the theory see psychological safety as a requisite for change, but it is seen as the *only* requirement for change: The theory proposes that people are *motivated* to relinquish their pathology and that they will do so to the extent it seems safe to do so. Interpersonal safety is therefore both the necessary and the sufficient condition for psychotherapeutic progress.

A number of authors have proposed that a person must feel safe with the therapist in order for therapy to proceed. Sampson (1990) reviews the history and development of the concept within the psychoanalytic tradition, and presents clinical examples supporting the Control-Mastery view that "the patient unconsciously controls his defenses...on the basis of appraisals of danger and safety" (p. 119). Rangell (1968), also an analyst, offers a model of psychological defenses based on unconscious assessments of safety and danger. He suggests that "by countering actual or potential anxiety, [therapists] elevate the anxiety threshold for the patient, thus permitting a wider range of psychic products to become available for analysis" (p. 25).

Authors with other orientations address the issue as well. Harry Stack Sullivan (1970), who proposed the *interpersonal theory of psychiatry*, gives a central role to anxiety. He discusses the *self-system*, the purpose of which is to organize security operations to prevent the lowering of self-esteem. He says that the self-system "comes into existence solely for the purpose of avoiding drops in euphoria which are related to the significant other person with whom the child is integrated" (p. 101). Kohut (1977), the self-

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psychology theorist, recommends that the therapist maintain an exquisitely attuned focus on empathy, which implies a profound concern for the patient's sense of safety: "I believe that, *in principle*, the functional basis of the analytic situation is empathic responsiveness" (p. 91, italics in original). Carl Rogers (1961), originator of *client-centered therapy*, says, about working with a person in therapy, "If I can free him as completely as possible from external threat, then he can begin to experience and to deal with the internal feelings and conflicts which he finds threatening within himself" (p. 54). Gilbert (1993) presents a *biopsychosocial* model of human behavior and theorizes about the evolutionary development and survival value of biological systems which are responsible for behaviors relating to defense and safety. He provides a discussion of behaviors related to defensiveness and safety in ordinary life and in psychotherapy.

Control-Mastery theory further develops the importance of the patient's sense of safety, making it the crucial element in psychotherapy. It suggests that the effectiveness of any intervention can be understood in terms of its effect on the patient's sense of safety, and that psychotherapy works to the extent that it helps the patient feel safe.

THE STRUCTURE OF PSYCHOTHERAPY: THE DIAGNOSTIC PLAN FORMULATION

The Diagnostic Plan Formulation expresses the therapist's formulation of the patient's plan, which is a key concept in Control-Mastery theory. The plan is the patient's organization of the therapy process. It is partly conscious and partly unconscious, and is composed of the patient's *goals* for therapy, the *obstacles* which currently stand in the way of realizing these goals, the *tests* the patient intends to enact with the therapist to determine if it is safe to move towards the goals, and the *insights* the patient wishes to achieve. Obstacles consist of *key traumas* and *pathogenic adaptations* (Rappoport, 1996a). The key traumas are incidents the patient reports which stand for a class of related psychological injuries the patient identifies as significant. These traumas resulted in certain maladaptive thoughts, feelings, and behaviors, called pathogenic adaptations, which the patient is seeking to overcome. Tests are the patient's trial actions which are designed, usually unconsciously, to

help the patient overcome his or her pathogenic adaptations. Tests depend on the appropriateness of the therapist's response for their success. The purpose of testing is to determine that it is safe to relinquish the pathogenic adaptations. Insights are understandings the patient becomes conscious of in therapy as to the origin, nature, and solutions to his or her problems, which result from successful testing. (See Figure 1 for the format of the Diagnostic Plan Formulation; the case it presents is discussed later in this article.) See Rappoport, (1996b) for a more detailed discussion of the plan.

THE PATIENT'S SEARCH FOR SAFETY AND THE DIAGNOSTIC PLAN FORMULATION

The following discussion shows how each element of the Diagnostic Plan Formulation is integrally related to the patient's search for safety.

Goals

Goals are healthy, natural behaviors people seek to regain. These ways of behaving were available to the person early in life, but were given up because it became unsafe to continue them. The person, while relinquishing these healthy behaviors, kept them in mind, consciously or unconsciously, to be regained when it became safe to do so. Goals are both lifetime aims as well as the shorter-term objectives the person hopes to achieve in therapy. Examples of goals are the ability to be intimate, to pursue one's interests, to be free of depression, to be accepting of others, to be free to express oneself openly, and to have a good sense of self-esteem.

Obstacles

Key Traumas

Key traumas represent a set of highly significant events in a person's life which convinced them to give up certain healthy behaviors because these behaviors placed them at risk. The most significant danger they posed was the weakening of the parents' attachment, good will, and love for the person, thereby resulting in a lower quality of care and, ultimately, lessening the person's chance for survival. Since the person's survival depends on the parents' good will, it must be

GOALS	OBSTACLES		TESTS		INSIGHTS
	KEY TRAUMAS	PATHOGENIC ADAPTATIONS	PATIENT'S BEHAVIOR	THERAPIST'S RESPONSE	
To not feel overly responsible for other's moods, to be free to act for himself and in his own interests without unduly worrying about others.	Father's narcissism and punishment of Barry's expressions of individuality. Was required by both parents to be solicitous and entertaining, was blamed for "selfish-ness" if he did not consider others.	Feels responsible for other's well-being. Unable to know and express his own feelings, needs, and preferences for fear of being punished. Thinks that he must serve others' needs if he wishes to relate to them.	<u>Transference:</u> Compliance: —Be solicitous, entertaining. Non-compliance: —Be silent or attend to own interests. <u>Passive-into-active:</u> —Claim that therapist should be responsible for him and not consider himself	—Do not be gratified; challenge, interpret. —Allow, support, encourage. —Do not accept unrealistic responsibility for patient, assert own needs and views.	Barry's parents' made him think he should feel responsible for others and ignore his own needs. If he meets his own needs and has his own views he need not feel guilty, selfish, or that he is necessarily hurting others by so doing.
To be able to think well of himself and assert his value to others.	Father's relentless criticism.	Thinks he's bad and worthless, and that others want and need to see him this way. Fears he will injure or threaten others if he thinks well of himself.	<u>Transference:</u> Compliance: —Criticize himself, invite criticism. Non-compliance: —Accept and validate himself. <u>Passive-into-active:</u> —Criticize therapist unfairly, especially for not being sufficiently solicitous.	—Do not be gratified; challenge, interpret. Do not criticize. —Value, support. —Be assertive, do not comply with criticism, don't lose self-esteem.	Barry's father's criticisms made him think others need to see him as bad or incompetent, and that he should see himself this way. This is not necessary or valid. He is free to see himself clearly and positively, and he need not feel responsible if others find this threatening.

Figure 1. Diagnostic plan formulation for Barry.

preserved. To the extent that one's parents' good will seems endangered, and there are no alternative sources of support, a person must choose to comply with parental demands.

Patients report key traumas in therapy to convey to the therapist the nature of the problems these events created for them, and to alert the therapist to the fact that they wish to work on these problems. Patients present key traumas in a specific order as part of their orchestration of the therapy process according to their needs, priorities, and requirements for safety. Examples of key traumas are: (a) a father's disinterest in a patient's school project which represented a characteristic disinterest on the father's part in the

child's education, (b) a parent's criticism of a patient for not being more like a preferred sibling which represented the parent's persistent disparagement of the patient, and (c) a mother's broken promise to a patient which typified the mother's undependability in regard to the patient.

Patients also report key traumas in order to help inform the therapist of their needs in terms of interpersonal safety and danger. If the patient reports being traumatized by being mistrusted, neglected, or criticized, for example, each of these kinds of mistreatment will sensitize the therapist to different issues, lead the therapist to understand the relationship with the patient in different ways, and

encourage the therapist to make certain kinds of interventions and to refrain from making others.

Pathogenic Adaptations 253

Pathogenic adaptations are the ways the person accommodated to the interpersonal dangers he or she perceived, as represented by the key traumas. Each pathogenic adaptation had the purpose of protecting the person from certain specific dangers in regard to significant caregivers. The better the therapist understands the danger from which the pathogenic adaptation protects the patient, the better the therapist can behave in ways which help the patient feel safe from this danger. Pathogenic adaptations are demonstrated in the following examples: (a) A patient who was told by her parents that she was stupid, and whose intelligent behavior went unrecognized, concluded that her parents needed her to think she was stupid. She came to believe she *was* stupid and acted in accord with this belief. (b) A patient whose mother required a great deal of solicitous attention from her, and blamed her for being uncaring if she felt inadequately attended to, came to feel overly responsible for the needs of others and to feel guilty if they seemed distressed. (c) A patient whose father sexually molested her came to believe that she deserved the molestation and in adult life found it difficult to resist the unwanted attention of men. Each of these adaptations served the function of preserving a degree of parental attachment to the child.

Testing

Patients test to determine the extent to which their pathogenic adaptations are required of them by their therapist and to assess how safe it may be to dispense with these adaptations. They behave in ways which they have specifically (usually unconsciously) designed to elicit this information. Patients manage the level and rate of testing so as to keep their interpersonal risk at a tolerable level. Therapy is a risky business for patients, since they are exposing themselves to the possibility that they will be retraumatized in ways which were particularly harmful for them. They are as careful as they can be to maximize the likelihood they will benefit from the treatment, and to minimize the dangers of being harmed by it.

To the extent that a test has a successful outcome (the therapist *passes* the patient's test), the patient shows immediate signs of an increased sense of safety. Such signs include greater physical relaxation (e.g., more relaxed posture, deeper, more even breathing, more graceful movements), less vocal stress, more fluid use of language, decreased defensiveness, increased self-acceptance, self-confidence, and/or self-esteem, increased emotional expressiveness, the introduction of new, significant material into the therapy (e.g., dreams, memories, associations), the appearance of insight, and increased boldness of testing. To the extent that testing is unsuccessful, the patient immediately feels less safe, and the opposites of the above responses will be apparent. Such reactions on the part of the patient can serve as an excellent guide to the therapist as to whether he or she is passing tests.

Patient Behavior

There are typically three ways by which the patient tests for the safety to give up pathogenic adaptations: *testing by compliance* and *testing by non-compliance* (both types of *transference* tests), and by *passive-into-active* testing. (Transference testing refers to situations in which the patient enacts the role s/he had as a child and assigns the therapist the role of the parent; in passive-into-active testing, the patient acts as the *parent* did and treats the therapist as *he* or *she* was treated.) These tests may be engaged in overtly as actual behavioral interactions between patient and therapist, or they may be done covertly by the patient's simply observing the therapist's behavior. I refer to the covert form of testing as *testing-by-observation*. Below are testing strategies as they appear in overt testing followed by testing-by-observation.

Overt Testing

Testing by compliance. In this form of transference test, the patient complies with what he or she presumes are the needs of the therapist and attempts to determine whether the therapist seems gratified by this behavior. (*Complying* means attempting to meet the needs of others in order to avoid the negative consequences of not doing so, such as punishment, withdrawal of affection or nurturing, or blame.

Examples of complying include being supportive of others without regard to one's own needs, accepting invalid characterizations of oneself as true, and feeling inappropriately guilty and responsible for another person's experience.) If the therapist does not seem gratified by the patient's compliance, the patient feels safer to relinquish the behavior.

As a child, Barry had been required to entertain his parents and relatives and be concerned with their needs and moods to the exclusion of his own. In therapy, Barry initially acted solicitously toward his therapist, inquiring into his health and how his life was going. He also said he thought he should keep the conversation lively and entertaining for the therapist. When the therapist called this behavior to Barry's attention, Barry said he felt compelled to do it and said he found it quite difficult to stop. The therapist did not act gratified by Barry's overly considerate behavior and interpreted it as a continuation of the function he served in regard to his parents. Barry took both the therapist's behavior and his interpretation to mean that it was safe to be less solicitous of him. He found the therapist's responses encouraging and made use of them by becoming increasingly free to use the therapy for his own purposes.

Compliance tests are the safest for the patient, and for this reason are the kind of tests used most frequently early in treatment. This is because the patient believes he or she is *meeting* the anticipated needs of the therapist and so is most likely to assume that he or she is safe from the dangers which might ensue from not complying. If the therapist does not seem gratified by the patient's pathogenic adaptations, and by behavior and/or interpretation conveys to the patient that these adaptations are not required nor desired, the patient often will move to a bolder form of testing, *testing by noncompliance*.

Testing by noncompliance. In this form of transference test, the patient does *not* comply with what he or she believes to be the needs of the therapist and attempts to determine whether the therapist seems *threatened* by such behavior. To the extent that the therapist does not seem threatened, but, in fact, seems to support the healthier behavior, the patient feels safe to continue the behavior and encouraged to go further. This strategy requires that the patient have more confidence in the therapist than does the previous one, since, when using it, the patient is deliberately not

attending to the therapist's needs and therefore anticipates the possibility of being retraumatized. For this reason, testing by noncompliance is typically not engaged in during the initial phases of treatment, but occurs to an increasing degree over the course of a successful therapy. This, of course, is what we mean by progress in psychotherapy.

Barry, encouraged by the therapist's support for his independence and apparent lack of need for his solicitous attention, began to engage in brief periods of silence during his therapy sessions. He said this concerned him because he was probably not doing what the therapist thought he should do (i.e., talk about his problems). The therapist said he did not require that Barry talk and supported Barry's right to behave as he wished. As a result, the length and frequency of Barry's silences increased for several weeks, and then they diminished, and Barry became freer to follow his own inclinations both in therapy and at work.

Passive-into-active testing. In passive-into-active testing, the patient treats the therapist in the same harmful and threatening ways in which the patient was treated as a child. The patient hopes that the therapist feels safe enough to protect himself or herself from the traumatic effects of such treatment, as the patient was not able to do, and can respond to the patient's behavior in a nondefensive way. The patient's purpose is to learn, from the therapist's example, how to feel similarly safe not to comply with such treatment. (See Foreman [1996] for an in-depth discussion of passive-into-active testing.)

In contrast to transference testing, during a passive-into-active testing sequence (which may take several sessions, or even several months, to enact) the patient typically does not display signs of increasing safety even though the therapist is passing the test. The reason for this is that such behavior is incompatible with passive-into-active behavior and would therefore reduce the power of the test, thus defeating the patient's purpose. The patient *will* exhibit signs of increased safety once the testing sequence is complete.

Passive-into-active testing is a particularly dangerous testing strategy because, when using it, the patient risks traumatizing the therapist, and thereby, perhaps, diminishing the therapist's good will. This risk is greater than in testing by noncompliance because, in the latter mode, the patient is merely refusing to cater to what he or she imagines are the

therapist's needs; whereas, in passive-into-active testing, the patient is acting in a way that he or she has actually experienced to be injurious and, thus, knows is potentially injurious to the therapist. (A patient who acts abusively towards the therapist is not necessarily doing so primarily for testing purposes. Passive-into-active *behavior*, as opposed to passive-into-active *testing*, reflects an identification with the parent and is not engaged in for testing purposes. There are components of both identification and testing in all passive-into-active behavior.)

Most patients do not use passive-into-active testing to any significant degree and work primarily in the transference mode. Given the dangers inherent in passive-into-active testing, there must be a compelling reason to use it for those who do so. Patients who are strongly identified with their parents have no choice; they must use the passive-into-active testing strategy since it is the only behavioral style available to them. For patients with more flexibility, the reason for using this strategy is that the information they hope to gain is crucial and could not be obtained in another way; therefore, the risk must be taken if they are to advance (Rappoport, 1996a). As a patient gains confidence in the therapist, passive-into-active testing may be used to advantage with less sense of risk.

Throughout his life Barry had been subjected to a great deal of unfair and invalid criticism by his father. After a year in therapy, Barry showed clear benefit from treatment. He then began to claim that the treatment was not helping him, disparaged the therapist's abilities and knowledge, and said that he should probably stop coming. He maintained for several weeks that the therapist's methods were having no beneficial effect. The therapist countered Barry's arguments by citing examples of his progress, by saying that he was being unrealistically negative about himself, and by pointing out events in his life which might be contributing to his sense of discouragement. After about two months of this process, Barry stopped claiming a lack of benefit from treatment and resumed making progress in a more collaborative and straightforward way. He also began to see himself as more competent, started to enjoy life more, and was less ready to accept unfair or inaccurate criticism of himself.

This sequence is an example of passive-into-active testing whereby the patient was trying to see if the

therapist would accept unfair and inaccurate criticism and comply with being seen as not competent, as the patient had been required to do by his father. Barry did not initiate the passive-into-active sequence until he had satisfied himself that the therapist did not require him to be solicitous. He also needed to have gained some confidence that the therapist could pass such a test, and there needed to be a clear background of improvement by the patient against which the test could be constructed. The passive-into-active sequence was time limited, and was followed by rapid progress by the patient. This process was quite beneficial to Barry, helping him feel safe to defend himself against unfair criticism and to be less self-condemning. (See Figure 1 for the Diagnostic Plan Formulation for Barry.)

During Mary's childhood her mother was extraordinarily narcissistic, highly irrational, emotionally fragile, and paranoid. When she was agitated she required Mary to accept the blame for her distress and distanced herself emotionally from Mary as punishment, often not speaking to her for days. In therapy, Mary overcame some of her sense of isolation which resulted from this treatment and gained more self-esteem. She began to trust her therapist, who enjoyed being of help to her. After about two years of straightforward and productive treatment, Mary was rejected by a love interest. In response to this event, Mary abruptly accused the therapist of giving her bad advice and very angrily blamed him for not preparing her for the rejection. After several sessions of this kind, she quit treatment, claiming to have been injured by the therapist, who felt mistreated, misperceived, and defensive. However, he tried his best to not feel irrationally responsible for Mary's loss and to continue to be empathic toward her.

In this passive-into-active sequence, Mary is repeating her mother's way of coping with difficulty. She unconsciously hopes the therapist responds to her as she could not respond to her mother, that is, by maintaining his sense of self-esteem, by recognizing the irrationality of Mary's arguments and not accepting them as valid or himself as bad, and by not feeling guilty or responsible for Mary's distress. She also wants him to continue to have good will toward her and not to retaliate. He was apparently able to do this well enough, since Mary resumed treatment with him after a lapse of several months. Following this test Mary was more able to recognize that her

mother's cruel treatment of her was undeserved, felt more independent of her mother, and was less injured by her mother's current irrational behavior.

Covert Testing (Testing-by-Observation)

In testing-by-observation, the patient simply observes the therapist's spontaneous behavior and compares it to the parental behaviors which resulted in the patient's pathogenic adaptations. This is the safest form of testing, since there is no overt action by the patient and therefore minimal interpersonal risk. The behaviors of interest may include any aspect of the interaction the patient has with the therapist, such as the therapist's affective tone, the kinds of comments the therapist makes, the kinds of questions he or she asks, personal information the therapist reveals or does not reveal, how lively the therapist is, and so on. The patient also pays attention to behaviors outside of the interaction which may be informative: how the office is furnished, what books and magazines are provided, the location and condition of the office, the therapist's dress and grooming habits, the fee and the method of billing, what holidays and how much vacation the therapist takes, and, very important, interactions the therapist has with others which the patient may overhear or observe.

A therapist had his office painted by a professional painting contractor. The job was not performed to the therapist's satisfaction, and he called the job foreman to complain. In his behavior with the foreman, the therapist was assertive in stating his dissatisfaction with the aspects of the job which were done poorly and in his insistence that the job be redone. However, he was not rude or aggressive and did not attack the foreman personally. A few months later, the foreman called the therapist requesting to see him for psychotherapy. During the first session, he told the therapist that he was impressed with the way he had handled his complaint about the painting job and that he wished to learn how to behave in a similar manner. It turned out that the patient's father had frequently been critical and angry with the patient and others when dealing with problems, blaming them for his difficulties and becoming irrationally angry with them and alienating them. The patient believed unconsciously that his father needed his son to identify with him in this regard, and, as a result, he

had become angry and critical. He was looking for a relationship with a therapist in which it was safe to relinquish this identification; that is, he wanted a therapist who did not behave in the way his father did and would not require him to act that way.

Testing-by-observation which consists of observing the therapist's interactions with a third person might also be considered to be *vicarious* testing, insofar as the patient identifies with the third person.

Therapist Responses to Testing

Any response to a test which helps the patient to feel safer is therapeutic. There can be no generically correct responses, since how the criterion of safety is fulfilled is entirely case-specific. Therefore, questions such as, "Should I interpret a patient's lateness?" or "How should I respond if a patient requests personal information?" cannot be answered without an understanding of the particular patient to whom the question refers. In principle, responses to transference tests should indicate that the therapist does not require the pathogenic adaptations that the parents seemed to need, and responses to passive-into-active tests should show assertiveness and noncompliance with the patient's traumatizing behavior, but never be rejecting of the patient. (With most mild forms of passive-into-active testing, simply remaining nondefensive is an adequate response.)

To illustrate the importance of case specificity in the therapist's approach to patients, consider someone who was intruded on by parenting figures and not allowed adequate autonomy or privacy. Such a person is likely to feel safe and valued if the therapist does not ask many questions, allows the person to be silent when he or she wishes to be, and is relatively nondirective. In contrast, someone who was neglected in childhood, having parents who did not display sufficient interest in that person's activities, accomplishments, and experiences, is more likely to feel safe and valued if the therapist shows an active interest in the person by asking questions, making suggestions, recognizing and referring to the person's accomplishments, and initiating interactions when the person is silent.

Responses to Overt Testing

Noninterpretive responses. This category includes

responses to patients such as encouragement, empathy, acceptance, understanding, support, the giving of information, questions, comments, silence, displays of affect, and self-disclosure. Any of these responses to a test can help a patient conclude that it is safe to give up a pathogenic adaptation.

Jack, who had made considerable progress in his therapy towards his goal of feeling more self-confident and autonomous, was considering leaving treatment. He had been traumatized in childhood by an emotionally fragile father who was relentlessly critical and fault-finding, as well as being intrusive in Jack's life. These events resulted in Jack's believing that he had to find fault with himself and allow others to do so, and that he must allow others to direct his life, in order to provide for their emotional need for control. In therapy, when Jack brought up the idea of termination, he spent some time discussing his thoughts and reasons for leaving and then offered the therapist the opportunity to evaluate his ideas about stopping treatment. The therapist declined to comment and appeared untroubled by the prospect of Jack's leaving. Jack later asked to hear of the therapist's concerns for him were he to leave treatment, whereupon the therapist said he had no concerns in that regard. The therapist appeared calm and confident in the patient. At this point Jack began to cry, explaining that he was touched by this demonstration of confidence in him by the therapist. Jack was greatly relieved that the therapist did not need to criticize him nor to direct his life, and was now able to terminate his therapy feeling self-assured and independent.

If a therapist encourages a patient to act in a new way and the patient does so, the patient's new behavior may result either from an increased sense of safety or from compliance. These differing motivations may be distinguished by the qualities of autonomy and nondefensiveness associated with a greater sense of safety; compliant behavior always lacks these characteristics.

Interpretive responses. When a therapist offers an interpretation, he or she is helping the patient to feel safe, rather than imparting new information. Patients unconsciously understand the reasons for their pathogenic adaptations, but they are unable to bring the understanding to consciousness because they would feel endangered by the material. The therapist, in making the interpretation, demonstrates his or her

conviction that it is safe, both for the therapist and for the patient, to be conscious of this information.

Barbara's father had a great need for his children to comply with his wishes and to accept his advice, his views on life, and his recommendations for how they should handle their affairs. When they refused to do so, he would often try to enforce their compliance by warning them that they would make him ill by not obeying him, claiming to be in fragile health due to a supposedly weak heart. This behavior presented a significant problem for Barbara who would typically stop trying to be independent under these circumstances because she was afraid she would be responsible if her father became ill. In her adult life Barbara's ability to act in her own interest had become greatly impaired because of the unrealistic concerns for others' fragility which she had developed as a result of these experiences. However, Barbara did report that on the occasions when she stuck to her point of view despite her father's pressures for compliance, he did not get sick. She also mentioned that he had passed numerous physical exams and heart examinations with flying colors.

Barbara's therapist made the interpretation that her father had encouraged her to have an irrational sense of responsibility for his emotional needs which resulted in her compliant behavior toward him. The therapist made this interpretation based entirely on information that Barbara provided spontaneously, and the interpretation was clearly implicit in both the material she presented and the way she organized it, showing that Barbara had an unconscious understanding of the situation before she presented it to the therapist. The reason she did not have the understanding consciously was that she was afraid her father would feel threatened if she viewed their relationship in this way. What she gained from the interpretation was the safety to be conscious of and to use the knowledge she already had, encouraged by the therapist's freedom to understand it and his belief that it would be safe for her to do so. Over time, Barbara used this interpretation to reduce her sense of guilt towards her father and to feel freer to act on her own judgments and feelings.

Responses to Covert Testing

To have the best chance of passing covert tests, the therapist should be relatively open and nondefensive,

since he or she is not necessarily aware of the characteristics the patient is observing, and it is not possible to tailor one's spontaneous responses to meet the patient's needs. It is for just this reason that patients do observation testing: the information gained by it is likely to be accurate.

Therapist Behavior Which Is Not Relevant to the Testing Process

A great deal of the therapist's behavior is not significant to the patient in regard to the testing process. The issues which frighten or reassure the patient are quite specific, and behavior which does not relate to them is irrelevant. This is the reason that therapists of many different theoretical orientations and a wide variety of personal styles may be of help to the same patient. For example, if a patient is concerned about whether she is valued by the therapist, the therapist's neatness or religious affiliation is unlikely to affect the patient's sense of safety in this area. If a person is concerned about whether the therapist is competitive, the therapist's school of thought or degree of interest in the arts will not be of great significance. As long as the patient's needs are met, the therapist has great latitude to be relaxed and natural and, in fact, should be so, thus providing a convincing demonstration of nondefensiveness.

Insights

Insights occur when a person feels safe to have them. A person does not have insight into his or her problems because the person believes that such insight would be threatening to some significant person in his or her life. When the pathogenic adaptation was first being made, the person was aware of the psychological issues involved, that is, had conscious insight (to the extent his or her cognitive development permitted). The person relinquished the insight, along with the healthy behavior, because it was unsafe to retain. One of the most convincing signs of a passed test is the spontaneous attainment of insight following the test.

In her therapy Gail was working on feeling free to work hard, have great energy, be creative, stay focused on her interests, value her accomplishments, and not worry that she was overexerting herself or that others might find fault with her for working hard. Her father

had been relentlessly critical of her and actively discouraged her from attending to her own wishes and needs in favor of paying attention to him, and her mother was chronically inept, was often unable to accomplish even the simplest of tasks, and encouraged the patient to act in the same ways. During one therapy session, Gail told the therapist about how busy she had been that week, putting a lot of time into her business, into exercising, and into several projects. She said that even though she had been feeling sick, she had persisted in these efforts. She then characterized herself as neurotic for these actions and said she knew she was working too hard. She claimed she was putting too much emphasis on making a great deal of money in her business (which she called an obsessive identification with her father), and said she should be relaxing more and not be so driven. The therapist was well aware of her real goals and understood these self-criticisms to be tests. He was consistent during the session in characterizing her behavior as healthy and in her own interest. At the end of the session, Gail said that her former therapist, whom she had experienced as critical of her and unhelpful, would have encouraged her to slow down.

At the following session, Gail reported that, despite a bad cold, she had kept up her vigorous pace of exercising and working on her projects and her business. She also said she was not overeating, which had been a significant problem for her, and that she was getting enough sleep. She said she had been very influenced by the conversation with the therapist during the last session, and said that she felt different about herself. She then said that she thought she had previously found it hard to pursue her interests because of fears of "going beyond" her parents, and of becoming "too much" for them. She recalled fears of going crazy or of dying if she worked too hard or became too accomplished, which she now understood as ways of limiting herself so as not to threaten her parents. She experienced these last concepts as new, and she presented them with a sense of discovery and new understanding.

THE FUNCTION OF THE THERAPIST

In assisting patients to carry out their plans, the sole function of the therapist is to help them conclude that neither their own nor others' welfare is served by their maintaining their pathogenic adaptations; that is, that

is safe for *the patient* to relinquish them, and it is safe (and typically beneficial) for *others* that they do so. Operationally, this means that they need not feel guilty if someone claims to be harmed by their noncompliance with that person's needs or demands, and that they are free to protect themselves against the hostile or traumatizing behavior in which the person may engage in order to force compliance. All of the therapist's behavior should be organized around this principle, demonstrate his or her conviction in it, and be designed to convey it to the patient.

The therapist may intervene in a variety of ways which have beneficial effects, for example, educating, giving advice, providing assistance of one sort or another, offering encouragement, and making interpretations; however, with respect to their value in helping the patient overcome obstacles to healthy behavior, all his or her interventions are used by the patient in terms of their effects on the patient's sense of safety.

Alicia was in therapy to overcome the effects of brutal treatment by her father and neglect by her mother. Alicia had complied with her parents' treatment of her by developing a sense of herself as worthless and deserving of mistreatment, and she was often severely depressed. During her therapy, Alicia had to undergo several surgeries to correct certain medical problems, and she was often unclear about various aspects of these procedures. The therapist took her confusion about her medical treatment as an opportunity to intervene by bringing medical and anatomy books to the sessions. He and Alicia went over these books together until they both had a clearer understanding of her problems and the proposed treatments. The therapist also expressed interest and concern about the outcome of these procedures, and asked about them before and after they were done. He helped Alicia with her interactions with the various physicians, calling them himself on occasion to inquire about matters that Alicia did not understand or felt unable to bring up with them. In addition, he called and visited Alicia after the surgeries. All of these interventions were helpful to Alicia in a variety of ways, but the therapist made them in the context of the therapy because they helped Alicia feel safe to think of herself as a worthwhile person who was free to pursue and receive good treatment from others. Over time, Alicia became more able to think about and understand her medical conditions and their

treatment, ask questions of her physicians, engage proactively in her medical care, and try to correct situations which were not to her satisfaction. She also developed a better sense of self-esteem and was depressed less often.

The therapist can use the criterion of safety to evaluate any intervention. For example, suppose the intervention in question is whether or not the therapist should accept a gift from the patient. Classical psychoanalytic theory would suggest that the gift should not be accepted because offering a gift is "acting in the transference," which tends to keep the patient's motives unconscious. It suggests the correct approach is to refuse the gift and to analyze and interpret the behavior to help the patient become aware of his or her motivations. However, using the criterion of safety produces case-specific determinations. If a patient has been taken advantage of, having been required to serve the needs of others by being accommodating and placating, the offer of the gift might be intended to determine whether the therapist needed the same kind of accommodation as did historical figures. In such a case, the patient may feel reassured if the therapist does not accept the gift. However, if a patient has been traumatized by being rejected, made to feel worthless, and not being allowed to contribute to the lives of important figures, it might be of great help to such a patient for the therapist to accept the gift. The patient is likely to feel safer upon seeing that he or she is able to offer something which the therapist values. Analysis and interpretation would provide further benefit after the gift is received, but it is likely that such analysis would not be beneficial if the gift were not accepted. The patient would probably feel wounded by the refusal of the gift and would be likely to view attempts at analysis as "just words" if the therapist's actions seemed to devalue her as he or she was devalued in the past.

CASE EXAMPLE

As a child, Beth was not able to interest either of her parents in herself or in her activities. Beth's mother was preoccupied with a multitude of irrational and unrealistic fears for her own and her children's safety and with her lifelong feelings of isolation and depression. When Beth sought her love and understanding, or was emotionally expressive in almost any way, she usually responded by being punitive, angry, or controlling. Beth's father immersed himself in his work because of his own interpersonal inadequacies and as an escape from his wife's problems. He generally tended to accommodate to his wife's fragility and irrationality and

required his children to do likewise. Beth grew up feeling lonely, isolated, and unimportant. Since her mother became easily enraged or upset, Beth developed an acute awareness of the things that might present difficulties for her. She used this awareness to adjust her behavior to meet her mother's needs, to try to help her, to soothe her, and to avoid doing or saying anything which might upset her. Beth often lied to her mother about her activities so as not to perturb her, and as a way of avoiding the constraints she placed on Beth because of her excessive fears. Understandably, Beth felt very burdened both by her mother's needs and by the efforts she made to accommodate to them, and she became a serious, unexpressive, and self-effacing child. She was polite, cooperative, and quiet around most adults, but, in her adolescence, she developed a life which she kept secret from her family in which she did adventurous and even risky things, sought new experiences, and met a wide variety of people. As a young adult she had difficulty in developing satisfactory relationships. She was often exploited by others, found it hard to be assertive, was frequently depressed, and did not feel as if she fit in. She was so unable to behave assertively with her mother that she deliberately did not have a telephone in her home in order to limit her mother's ability to contact her. (See Figure 2 for the Diagnostic Plan Formulation for Beth.)

In her therapy, Beth presented a number of tests to determine how much she had to worry about the therapist's fragility and incompetence, and how safe it was to be herself and not be excessively concerned about the therapist. She began with compliance testing by being very polite, undemanding, and unexpressive of her needs in regard to the therapist. She also reported a number of interactions with others that demonstrated her compliance with the needs of authority figures, such as listening to the problems of her former therapist and trying to help him. The therapist interpreted all these behaviors as expressions of transference; that is, that Beth was being compliant so as to help others and to not upset them. These statements made Beth feel safer to act more directly in her own interest. She felt safe enough to try testing by noncompliance by being more fully herself and not worrying so much about the needs of others, and she gradually became more assertive and expressive in the therapy. As she did so, such as when she became tearful regarding a relationship loss, the therapist did not become alarmed or troubled by her expression of feeling, did not try to reassure her (which she would have taken to mean that the therapist was threatened by her emotionality), and did not avoid her feelings. She maintained a calm, empathic, and investigative attitude, which would be likely to show Beth that it was safe for her to be emotionally expressive with the therapist. In response to these passed tests, Beth became more fully expressive in therapy. She displayed a wider range of emotion, including laughter, determination, anger, sadness, and tenderness. She seemed more relaxed and spontaneous, less tense and guarded, and more easily interactive with the therapist.

Beth did not test in the passive-into-active mode in regard to this issue. Perhaps she unconsciously decided that it would not be safe to do so, or perhaps she did not need to do so in order to accomplish her goals. Had she used this modality, she would have tried to make the therapist feel responsible for her and worry about her fragility and incompetence. She might also have criticized the therapist for not being sufficiently attentive to her needs. The therapist's task in such a situation would be to not act inappropriately responsible for Beth or worry about her and to remain in good spirits, be expressive, and be open.

In her efforts to determine whether it was safe for her to have a good sense of her own value, it was very important for Beth to find out whether the therapist valued her. She needed to know if

the therapist had a genuine interest in her and whether or not the therapist felt burdened by her. She had to design some way to test the sincerity of the therapist's interest for, since she believed all therapists are supposed to show interest in their patients, how was she to tell the extent to which her interest was genuine? Beth embarked on a long series of tests by noncompliance: She began to write about her background and her history, and brought these writings to the therapist "in case you might like to read this." They started out at a page or two, and increased in length to a maximum of about fifteen pages. The therapist welcomed these writings, encouraged Beth to bring them, read them all, and brought up information from them from time to time during the sessions. When Beth discussed some of her professional accomplishments and mentioned her résumé, the therapist said she would like to see the résumé to understand Beth's career better. Beth mentioned some photography she had done in college and asked the therapist whether she would be interested in seeing it. The therapist said she would be very interested in the photos, and reminded Beth once or twice that she had promised to bring them in when they did not appear after a few sessions. (Not bringing in the photos was testing by compliance). The therapist spontaneously expressed interest in Beth's professional activities, even though she was not familiar with her field, and asked her to explain some of the technical aspects of it in which she was genuinely interested. She also encouraged Beth to bring in some of the technical papers she had written as a way of getting more familiar with her work. She read these papers as well as she was able and discussed her questions about them, and her interest in them, with Beth.

There did not seem to be any passive-into-active tests regarding the safety to feel worthwhile. Such testing would entail Beth's ignoring, neglecting, or devaluing the therapist as her parents did to her, perhaps by not responding to her interventions, being late to sessions, or acting indifferent to the treatment process.

As a result of the therapist's responses to her tests, Beth began to feel safer to think well of herself and to have a greater sense of self-worth. She felt more relaxed with the therapist and was able to reveal more of her accomplishments, intelligence, and abilities. She ended several personal relationships in which she had not been well valued. She responded more assertively when she was not treated well by others, and she took more action at work to insure that her value to her employer was appropriately recognized.

CONCLUSION

When using the Control-Mastery approach, the therapist typically starts a new case by paying particular attention to the key traumas which the patient reports. The therapist then infers the kinds of difficulties these events are likely to have caused for the patient and, if these conceptualizations correspond to the pathogenic adaptations the patient actually displays or describes, the therapist can be confident that he or she is developing a reasonable initial formulation of the patient's problems. Once the therapist has an idea of the key traumas and pathogenic adaptations, the patient's goals and tests can be readily inferred. The therapist then makes trial interventions based on his or her concept of the tests to see if such interventions make the patient feel safer.

GOALS	OBSTACLES		TESTS		INSIGHTS
	KEY TRAUMAS	PATHOGENIC ADAPTATIONS	PATIENT'S BEHAVIOR	THERAPIST'S RESPONSE	
To be able to freely express herself, not to feel compelled to conceal her thoughts and feelings to protect others.	Mother's punishment of Beth's expression of her feelings and needs. Mother's becoming upset in response to Beth's expressiveness. Father's requirement that Beth accommodate to mother.	Expects others to be fragile and need careful handling. Believes her thoughts and feelings are too powerful and must be concealed so as not to upset others.	<u>Transference:</u> Compliance: —Be bland, compliant. Non-compliance: —Be expressive, assertive. <u>Passive-into-active:</u> —Act fragile, easily upset; criticize therapist's self-expression.	—Do not be gratified; challenge, interpret. —Support free expression. —Do not accommodate to her "fragility," remain expressive despite criticism.	Beth's parents wanted her to be unexpressive and subservient toward her mother. She need not feel responsible for others' inadequacies. She is not unduly powerful and can be open without fearing she is a danger to others.
To recognize what she has to offer, to value herself, to feel worthwhile.	Mother preoccupied with herself, felt burdened by children, father unavailable. Unable to interest either parent in herself.	Believes her thoughts, feelings, and interests don't matter to others; feels invisible and unimportant, thinks she is a burden to others.	<u>Transference:</u> Compliance: —Act and feel unimportant. Non-compliance: —Act and feel important. <u>Passive-into-active:</u> —Do not respond to therapist as a person.	—Do not be gratified; challenge, interpret. —Value, support, validate. —Be assertive, do not lose self-esteem or feel invisible.	Beth's sense of unimportance came from her parents' inability to relate to her, not from any deficiency of her own. It is OK for her to feel worthwhile and to value herself.

Figure 2. Diagnostic plan formulation for Beth.

If the patient does respond to these interventions by feeling safer, the initial formulation is taken to be a good working hypothesis and is further refined as the case progresses; if the patient does not seem to feel safer following the trial interventions, the formulation is revised to account for the patient's actual behavior and new interventions are tried. Usually, a patient

works on the same issues for quite some time, so that once a formulation is arrived at it can serve to guide the therapist for either the entire treatment process or a major portion of it.

If the therapist orients himself or herself according to the issue of safety, the therapeutic task can become relatively simple. Only one guiding principle need be

kept in mind, and ongoing observations of how safe the patient seems to feel provide continuous feedback regarding the helpfulness of each intervention. This does not mean to suggest that all therapy can be simple to do. Practical difficulties, of course, remain: the lack of a sufficient understanding of the patient to make an accurate judgment of what would make the patient feel safe, the inability to make a powerful enough intervention due to therapy format limitations, countertransference issues (especially during passive-into-active testing) which prevent the therapist from understanding what the patient needs or behaving in the way that the patient needs, the lack of sufficient resources to support adequate treatment, and a myriad of others. But doing psychotherapy is much easier *in principle* than is often thought, and the conceptual simplicity of the Control-Mastery approach can aid the therapist in the search for helpful responses to these practical problems.

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