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Patients' Tests and Clinicians' Emotions: A Clinical Illustration

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Abstract
Psychotherapists can experience various kinds of emotions in response to their patients' communications and behaviors over the course of therapy. These may be understood in the context of interpersonal dynamics associated with patients' testing activity. The concept of testing, as part of the patient's plan for therapy, is explained from the perspective of Control-Mastery Theory. Different kinds of testing behaviors, aimed at disconfirming the patient's pathogenic beliefs, may evoke different emotions in the therapist. Understanding the patient's testing strategies can help to make sense of the therapist's emotional reactions, manage countertransference, and guide therapeutic responses. This paper describes testing behaviors, according to the patient's compliance and non-compliance with pathogenic beliefs, along with corresponding therapist emotional responses. A descriptive clinical case is provided to illustrate various tests and their associated emotional reactions within a therapy session.

Keywords Countertransference · Psychotherapy · Therapist emotions · Testing · Control-mastery theory

Introduction

Psychotherapists' emotional responses can reflect important aspects of the therapeutic process (Gabbard, 2020; Hirsch, 2021). The nature or intensity of therapists' feelings may change when the patient is engaged in testing behaviors, which may take various forms (Gazzillo, et al., 2019). Understanding these emotional states in light of the patient's tests can assist the therapist in working to advance the therapy. In this paper we describe how the patient's testing activity in psychotherapy can influence therapists' within-session emotional experiences, and how understanding such feelings can illuminate the therapeutic process. A detailed clinical case will illustrate various kinds of patient tests and associated therapist emotional states.

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Management of clinicians' emotions, particularly in response to the patient or material introduced by the patient, has been a concern since the beginning of psychotherapy. Early psychoanalytic literature defined countertransference as feelings arising in the therapist in response to the patient's communications, yet influenced by the therapist's own conflicts and thus a potential impediment to successful treatment (Holmes, 2014). The concept has since expanded and countertransference is now recognized across different theoretical orientations, in a narrow sense referring to challenging emotional reactions experienced by the therapist, and more broadly as the range of a therapist's feelings evoked in therapy (Gabbard, 2020). The latter perspective often dovetails with the notion that such feelings may reflect something important about the therapeutic process, such as an aspect of the patient's interpersonal patterns or an enactment of unconscious dynamics (Hirsch, 2021). Regardless of whether viewed in a narrow or broad sense, the literature converges on encouraging therapists to develop awareness and understanding of their feelings in the service of mitigating immediate emotion-based actions (Hayes et al., 2018). Indeed, meta-analytic review of empirical research indicates that countertransference problems are associated with worse therapy outcomes, and therapist management of countertransference is associated with improved therapy outcomes (Hayes et al., 2018). Research has also suggested

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that clinicians' emotions can reflect aspects of their patients' personality functioning, likely manifest through their ways of relating with the therapist during sessions (Colli et al., 2022). For example, patients' narcissistic problems tend to evoke therapist feelings of anger, dread, and disengagement—including the therapist's sense of insecurity and reduced competence (Genova & Gazzillo, 2018).

One way to make sense of therapist emotional responses is to consider the role of patient testing behaviors in psychotherapy. Tests are trial actions and communications engaged in by the patient—often implicitly or unconsciously motivated—for the purpose of learning something from the therapist's response. For example, a patient might challenge the therapist in order to learn whether disagreements can be tolerated. Therapists' emotions can become activated by such tests, especially when involving dramatic behavior from the patient that catches the therapist off-guard or pushes the limits of the therapeutic frame. For example, a patient's repeated phone calls outside office hours—perhaps an effort to learn whether limits can comfortably be set—may induce strong feelings of frustration and anxiety in the therapist. Because patients' testing behavior can be highly idiosyncratic, sometimes intense and sudden, and sometimes subtle and drawn out, therapists' emotional responses to tests can vary considerably. However, testing may be regarded as lawful and logical, offering therapists insight into the meaning of these behaviors and the feelings they evoke. Control-Mastery Theory (CMT; Gazzillo, 2021; Weiss, 1993) provides a conceptual model of patients' testing behavior within an overall 'plan' for therapy. Moreover, the theory facilitates an individualized method of anticipating, understanding, and responding to tests and the emotional states that may accompany them.

Control Mastery Theory: A Brief Introduction

CMT is a cognitive-dynamic relational theory of mental functioning, psychopathology and psychotherapy developed by Joseph Weiss and Harold Sampson (Silberschatz, 2005; Weiss et al., 1986) and empirically investigated over the last 50 years by the San Francisco Psychotherapy Research Group (SFPRG; Silberschatz, 2017) and more recently also by the Control Mastery Theory Italian Group (CMT-IG; Gazzillo, 2021). CMT holds several basic assumptions that are broadly aligned with contemporary developments in cognitive and evolutionary psychology (e.g., Bargh, 2019; Leonardi et al., 2021). First, that the overarching aim of mental functioning is to *adapt to reality*, *pursue healthy goals*, *solve problems* and *master traumas*. Second, that such activities (e.g., establishing goals, planning behaviors, assessing reality, making decisions) can be performed at an implicit or unconscious level of functioning. Third, CMT assumes that the human mind can and is motivated to exert *control*, both consciously and unconsciously, over its processes and content and does so according to a safety principle. Thus, human beings need to feel safe and may pursue their goals only if they feel safe enough to do so.

In line with attachment theory and research (for a review, see Sutton, 2019), CMT regards the establishment and maintenance of good-enough relationships with significant others as an adaptational priority—especially with caregivers during early developmental phases. These relationships contribute to the development of beliefs about reality, one's way of being in the world, and relationships with others. Such beliefs may be both conscious/explicit and unconscious/implicit or procedural, and can generally be formulated according to an "if…then" format (e.g., "if you are successful, others will be hurt"; "if you have expectations of others, you will be disappointed").

According to CMT, functional psychopathology stems from and is sustained by *pathogenic beliefs*, typically developed during childhood, formed in adaptation to adverse experiences and traumas that disrupt their sense of safety or interfere with their development (Fimiani et al., 2020; Silberschatz & Aafjes-van Doorn, 2017). People generally attempt to understand traumatic or adverse experiences, including how they may have contributed to them and how they may avoid such experiences in the future. Although it is highly adaptive to develop explanations for adverse experiences, children are typically not well equipped to do so accurately. Children depend on their caregivers and need to see them as powerful, wise and good. Thus, disagreements between children and caregivers often lead children to think that they are wrong—even morally wrong—and that their caregivers are right. Moreover, children tend to attribute more responsibility to themselves than is actually the case, at the same time overgeneralizing such conclusions (for a review, see Gazzillo et al., 2020). Consequently, children may develop beliefs about themselves in relation with others that are unrealistic and distorted.

A pathogenic belief is defined as a belief that inhibits the pursuit of a healthy and adaptive goal, typically because the pursuit of the goal is associated with danger—either for the self, for an important other, or an important relationship. The danger may be both internal (e.g., anxiety, fear, shame, guilt) and external (e.g., being reproached, losing the love of an important person, hurting a loved person). Pathogenic schemas—pathogenic beliefs entwined with emotional and behavioral patterns—tend to be grim and constricting, obstructing the pursuit or enjoyment of healthy goals (Aafjes-van Doorn et al., 2020). Thus, people are highly motivated to disprove them. Yet pathogenic beliefs are perceived as protecting against dangers, preserving attachment relationships, and reflecting parental authority. Attempts to disprove them may therefore cause painful

negative emotions such as fear, anxiety, shame and guilt. In this way, inner conflict can be understood as a conflict between the motivation to be free from pathogenic beliefs and the perceived need to comply with them. Nevertheless, people attempt to disprove their pathogenic beliefs principally through observation and by *testing* them in their relationships with important others (Gazzillo, et al., 2019). This also occurs in psychotherapy when patients engage in communications, attitudes and behaviors (consciously or unconsciously) devised to disprove their pathogenic beliefs, often in relation to the therapist. According to CMT, there are two main testing paradigms: transference tests and passive-into-active tests.

A *transference test* in psychotherapy involves the patient's observation of whether the therapist's response to her/him is different from the traumatizing way the patient was treated by others. For instance, a woman who was traumatized by severe mistreatment by her parents during childhood subsequently developed the belief that she was bad and unworthy. She might test this belief in therapy by describing herself as bad, unworthy and despicable, or by behaving as such toward the therapist, hoping that the therapist will not believe that she is this kind of person. Alternatively, she may present herself as being nice, clever and full of resources, hoping that the therapist will support this positive view of herself. A patient can thus use transference testing by behaving as though the pathogenic belief is true, or by behaving in a way that opposes (often tentatively) the pathogenic belief. The first instance represents a transference test *by compliance* with the pathogenic belief, while the latter is a transference test *by non-compliance* with the belief.

In a passive-into-active test the patient actively, though typically unconsciously, positions the therapist in a similar role to one that the patient previously occupied in a challenging or adverse relation. As with transference tests, passive-into-active testing can be either aligned with or contrary to the patient's pathogenic belief. *Passive-into-active tests by compliance* with the pathogenic belief are characterized by the patient treating the therapist in a way that the patient experienced as traumatizing. In the example above, the woman who believes she is bad and unworthy might 'mistreat' the therapist by accusing her/him of being bad, inadequate and stupid, hoping that the therapist will not be unduly upset by these accusations. In this kind of test, patients want the therapist to provide a model of how to deal with the traumatizing behavior without developing the same pathogenic belief(s). In other words, the patient unconsciously hopes the therapist will be able to maintain her/his self-esteem in the face of mistreatment. This same patient may engage in passive-into-active testing *by non-compliance* by supporting the self-esteem of the therapist (e.g., through positive regard) to show how she wanted to have been treated during childhood, hoping that the therapist will accept such behavior. In this way she could learn that it is reasonable to expect support and positive regard from an important other. Thus, by observing the therapist's response to either kind of passive-into-active testing, the patient can begin to disprove pathogenic beliefs formed in adaptation to earlier adverse experiences.

When patients actively test their pathogenic beliefs and schemas in therapy, they may act more provocatively or irrationally than usual—and therapists tend to experience strong emotions and feel pulled toward acting on their emotions. In transference tests, for instance, patients are identified with their childhood traumatized self. Correspondingly, the therapist is positioned in a parent-like role, which can lead the therapist to feel more "adult" than the patient. By contrast, in passive-into-active tests, patients may be identified with a potentially traumatizing parental figure. In this instance, the clinician is positioned in a potentially traumatized child role, which may evoke more "childish" emotions in the therapist. The clinician feeling such emotions more strongly than usual, often combined with a sense of pressure to act, may be a useful indicator that the patient is testing in some manner.

In addition to their function in disproving pathogenic beliefs, tests allow the patient to assess the level of safety in the therapy relationship. If the therapist responds to testing behavior in a way that reinforces the patient's pathogenic beliefs, the patient may feel endangered by the idea that the relationship may not provide the conditions necessary to overcome them. Patients may feel an increase in their sense of safety when their tests are "passed" by the therapist (i.e., disconfirming of their pathogenic beliefs). Empirical research has shown that when therapist responds in ways that pass a patient's test, the patient generally becomes less anxious, less depressed, more involved in the therapeutic process, and more insightful and motivated to pursue her/his goals (for a review, see Gazzillo et al., 2019; Silberschatz, 2017). By contrast, when a test is failed by the therapist, the patient may become more anxious and depressed and less involved in the therapeutic process, with the patient changing the topic or becoming silent or confused, and the therapy may seem to stall. Given the myriad ways in which therapists work, patients may try to adapt their testing strategy to the therapist's personality, model of therapy, and clinical setting. This might involve "coaching" (Bugas et al., 2021), whereby patients attempt to convey—implicitly or directly—information about their goals and the kinds of responses and attitudes that would counter their pathogenic beliefs.

From the perspective of CMT, patients enter therapy with a set of needs and priorities regarding what they need help with and how they want to work in therapy. Referred to as the patient's *plan* (Gazzillo et al., 2019), many aspects of such may remain outside of their awareness (i.e., involving unconscious motivation and unconsciously devised behavioral strategies). Components of the plan include: the patient's

healthy and adaptive *goals*; the *pathogenic beliefs* that obstruct those goals; the *traumas and adverse experiences* that contributed to pathogenic beliefs; the ways in which pathogenic beliefs might be tested within the therapy relationship (*tests*); and the kind of understanding or experience (*insight*) that would be helpful in these regards. Research has shown that patients' plans can be reliably formulated on the basis of clinical material and therapist inferences (Silberschatz, 2017). The Plan Formulation Method (Curtis & Silberschatz, 2007; Gazzillo et al., 2019) is a standardized procedure for understanding the patient's goals, pathogenic schemas, and traumas—orienting clinicians to the patient's potential testing strategies and needs for insight and responsiveness. Because plans are specific to each individual patient, plan formulations help therapists decode complex and contradictory information in the service of personalizing therapeutic responses according to each patient's needs (Gazzillo, Dazzi, et al., 2021; Gazzillo, Dimaggio, et al., 2021).

The Patient's Plan and the Therapist's Emotions

According to CMT, when patients are testing they are performing an important aspect of therapeutic work (Rodomonti et al., 2021). Therapists too are often engaged in emotional work when patients are testing, in that tests can instigate various strong and sometimes challenging feelings in clinicians. The nature of the therapist's feelings may differ depending on the kind of testing strategies employed by the patient at a given time, by the pathogenic belief being tested, and by the associated trauma. Transference testing tends to evoke emotions similar to those experienced by a traumatizing early figure or similar to those that the patient would have liked the traumatizing figure to have felt. In other words, transference tests can lead therapists to feel emotions that prompt them to act in either a re-traumatizing or transformative way. The difference between these outcomes likely rests on the therapist's ability to empathically sense the patient's needs, even those "underneath" the patient's manifest behavior, in concert with an accurate formulation of the patient's plan.

Passive-into-active testing involves identification with a traumatizing figure, treating the therapist in a manner similar to how the patient was once treated. These kinds of tests often elicit in the therapist feelings similar to those experienced by the patient at one time. In this case (passive-into-active testing by compliance with the pathogenic belief), the therapist ought to tolerate and understand these feelings as representative of the patient's earlier experience, empathically resonating with the traumatized self of the patient. Doing so is not always easy, as some patients may test their pathogenic beliefs in this way quite vigorously, using challenging behavior that stirs up powerful and disturbing or negative countertransference. The concept of passive-into-active testing by compliance can help clinicians maintain a sense of optimism with the reminder that even when patients act in ways that seem "traumatizing" for the therapist, they are actually working to disprove their pathogenic beliefs and master their traumas. The therapist's management of such experience can help the patient see that her/his pathogenic beliefs are not the only kind of adaptation available in the face of such treatment. By contrast, passive-into-active testing by non-compliance with the pathogenic belief may evoke feelings in the therapist that the patient would have liked to experience during their development. In such instances the patient is relating to the therapist in a manner they wished their caregivers had been capable of during their development. This gives the therapist a sense of what the patient needed or wished for, providing an opportunity—through the therapist's recognition and acceptance of such feelings—for the patient to learn that their developmental needs were legitimate.

It is worth noting that the aforementioned kinds of testing strategies may be employed in discrete, attenuated episodes as well as in the general atmosphere of the entire therapy. The former, relying on the patient's specific communications and behaviors, tends to evoke acute emotional reactions that eventually dissipate, while the latter—some patients may test primarily with their attitude (Gazzillo, Dazzi, et al., 2021; Gazzillo, Dimaggio, et al., 2021) throughout the course of therapy—may contribute to persistent emotional states that permeate the therapist's experience of the patient.

Therapists' emotional states can provide information about various aspects of the patient's plan, including the kinds of pathogenic beliefs and traumas the patient is attempting to master, and the particular testing strategies being employed by the patient to feel safe and achieve these goals (Gazzillo et al., 2019). Thus, attention to their own emotions can help therapists refine their formulations of patients' plans. At the same time, a plan formulation can assist therapists in determining the relevance of their emotional states for the therapeutic process. In other words, inferences regarding the patient's plan can help the therapist understand whether their feelings might reflect those which the patient traumatically endured at one time, or those similar to her/his traumatizing figures, or wished-for emotions (of the patient or that she/he wished for others). In this way, the clinician's emotions must be understood within the context of what the patient is working on (e.g., the traumas and pathogenic beliefs being mastered) and how she/he is working during that period of therapy. As a window into the patient's experiences, goals, and needs, the plan formulation is particularly useful when the patient is testing in such a way that saturates the therapy with strong and disturbing emotions that challenge or perplex the therapist.

It is important to recognize therapists' individual differences and idiosyncrasies that, even independently of patients' testing activity, influence their emotional experiences in therapy. The therapist's personality, personal history, cultural and social background, and religious or political beliefs—not to mention psychological theories and training experiences—inevitably shape the nature and content of her/his emotional reactions to the patient's communications and behaviors. Moreover, the therapist's own pathogenic beliefs and schemas can have some bearing on her/his emotional responses. These factors could increase the intensity and frequency of some emotions and inhibit the appearance of others—particularly in response to specific themes, attitudes, or behaviors of the patient. In line with the literature regarding countertransference management (Hayes et al., 2018), therapist awareness of potential vulnerabilities and challenging themes could help mitigate difficulties ensuing from patients' emotionally-charged testing activity. Maintaining a focus on what the patient needs, with the assistance of a comprehensive plan formulation, is paramount when faced with strong emotional reactions to patient material and behaviors.

A Clinical Example

We will now provide some illustration of patient testing and therapist emotions by presenting a descriptive account of a single session of therapy. The therapy was conducted by a therapist in training who is in supervision with the first author of this paper. She is a 27-year-old female therapist who is completing her psychodynamic training and a specific CMT training in Italy. The patient, Andrea, is a 26-year-old female with borderline personality disorder characterized by relational and emotional instability, dissociative symptoms, skin-picking, impulsivity, difficulty in managing her rage in intimate relationships, low self-esteem and difficulty in taking care of herself. Before this session, Andrea had been in therapy with her present therapist for six months, one session per week, face to face.[1]

The Formulation of Andrea's Plan

Andrea's *goals*, as identified in the first three sessions of her therapy, were: to stop skin-picking and dissociating ("I start watching the TV or the mobile phone, or I start skin-picking, and I forget where I am, what time it is and what I have to do"); to be able to take care of her health and her hygiene; to be able to keep her room tidy; to be able to respect a study routine; to be emotionally more stable; to have better self-esteem and more trust in her academic skills; to be more satisfied with her relational and emotional life and less critical with the men she is with; and not to behave like her mother. Her main *pathogenic beliefs* were that (1) she did not deserve love, care and protection and (2) that if she had been happier, healthier and more accomplished than her mother, then her mother would have felt humiliated and deserted by her.

Andrea's pathogenic beliefs derived from several stress *traumas*. Andrea's mother was diagnosed with schizophrenia and mood disorder NOS (not otherwise specified) and since Andrea was a little child her mother had been psychologically and physically violent with her. She used to beat her any time she thought that Andrea was not "perfect" (e.g., if a pencil she was using was a bit worn down, if her hair was not well-tied, if Andrea's notebooks were not in order, and so on) and on many occasions Andrea felt totally disoriented because she was not able to understand why her mother had abruptly changed her mood and beat her. "She was unpredictable and unattainable." Moreover, Andrea's mother suffered from a hoarding disorder and their house was a mess, but every time Andrea tried to tidy up her mother beat her; Andrea's mother did not let her wash herself without the mother's aid until she was 15 years old—and was then incapable of taking care of herself, washing appropriately or taking care of her own physical and mental health.

For Andrea it has always been clear that her mother's behaviors were expressions of her deep suffering and mental problems, exacerbated by several disappointments, in particular the one suffered because she had to abandon university when Andrea was born and because she was abandoned by Andrea's father a few months after Andrea was born. When Andrea met her father, years later, he told her that when he held her, soon after her birth, he felt disgusted.

Considering her traumas, the therapist hypothesized that Andrea's problems could be considered as expressions of her *identification* with her mother (difficulties taking care of herself and her room, being critical with men, difficulties in studying and her emotional instability) and a manifestation of *compliance* with the message implicit in her mother's mistreatments and neglect and her father's abandonment (she believes that she does not deserve to be loved and appreciated).

The therapist hypothesized that Andrea might *test* her first pathogenic belief in therapy in several ways. She could describe herself and/or show herself to be unworthy, a person who did not deserve care, attention and appreciation, hoping that the therapist will keep on considering her as deserving care and appreciation (i.e., transference test by compliance with the pathogenic belief). Alternatively, Andrea could try to behave as a very good person and a

[1] The patient gave consent for publication of session material; identifying information was disguised and/or removed to preserve confidentiality.

very engaged patient, hoping that the therapist will appreciate her engagement and her skills (i.e., transference test by non-compliance). The therapist also wondered whether Andrea might mistreat and control the therapist or neglect her therapy in an unpredictable way, just as she was mistreated, controlled and neglected by her "unpredictable and unattainable" mother, hoping that the clinician will not feel hopeless and hurt—and will instead urge her to commit to her therapy (i.e., passive-into-active test by compliance). Finally, the therapist considered the possibility of Andrea testing her belief of unworthiness by being very kind and dedicated to her therapy and toward her therapist, hoping that the clinician will appreciate this and reciprocate (i.e., passive-into-active test by non-compliance).

With regard to Andrea's second pathogenic belief—that her happiness and achievement would threaten her mother—the therapist considered several possible testing strategies. First, she hypothesized that Andrea could describe herself and/or behave as if she was like her mother, incapable of pursuing a satisfying career, or unable to take care of herself or cultivate a satisfying love relationship—hoping that the therapist will not believe that she is like her mother and will help her to do better. The therapist also hypothesized that Andrea could show herself to be very dedicated to the tasks of achieving in her work, of taking care of herself and having a satisfying love relationship, hoping that the therapist will support her and help her in these efforts. Passive-into-active tests were also formulated, in that Andrea could attempt to make the therapist feel guilty for her own mental stability, success, happiness and ability to take care of herself—in the hope that the therapist will not be upset or discouraged. Alternatively, Andrea could overtly endorse her therapist's desire to be happy and satisfied, hoping that this will be appreciated.

The therapist also formulated several insights that Andrea would benefit from. First, that her tendency to dissociate, her difficulties in taking care of her health and hygiene, and her challenges with emotional stability and academic ambitions are expressions of her identification with her mother. Second, that Andrea's difficulties in abandoning this identification stem from the fear that if she becomes healthier and more satisfied her mother will feel humiliated and deserted. Furthermore, that Andrea developed this belief because as a child she thought her mother suffered in seeing that Andrea could be different and better than her—and because her mother accused her of being the reason she abandoned university and was abandoned by her husband.

Insights were also formulated regarding Andrea's compliance with messages from her parents. The therapist hypothesized that Andrea would be helped by understanding that she mistreated her skin in the hope of making it perfect, just like her mother mistreated her, saying she was doing so because of her imperfection. Moreover, the therapist sought to help Andrea understand that her belief about being unworthy of love and appreciation was linked with chronic criticism and neglect by her parents. The development of this belief was compounded by Andrea's difficulty in thinking that they were wrong, because of her need for parental care.

The Session

At the beginning of the session, Andrea told her therapist that one of the job projects she was working on was a great success, but rather than focusing on her success she focused on the fact that she was tired, that this project implied a great amount of work, and that it was unfair that her colleagues were not involved in it so all the workload, and all the merits, fell on her. The therapist felt *a bit saddened* by the fact that Andrea seemed unable to enjoy her success even though she had worked hard to obtain it. Being aware of Andrea's belief of not deserving to be more accomplished than her mother, the therapist thought that she was giving her a transference test by compliance. For this reason, the therapist said to her that she deserved the success and could be proud of herself, given that she was the only author of that project, and stressed that she had not damaged anyone with her success. Incidentally, the belief of not deserving her success was one of the beliefs that the therapist had worked on during her own personal analysis. Andrea replied that she felt more effective in her job and more satisfied with herself than in the past and that this change had happened after a fight with a colleague. This colleague was very determined and competitive, was able to "steal with the eyes" the abilities of her coworkers and thus was able to anticipate what there was to do and to do it. Andrea added that at the beginning she felt disoriented by the colleague's way of doing things, but she subsequently accepted the competition and eventually won it. And now she felt much more focused and stronger.

While listening to this narrative, the therapist thought, on the basis of the first part of the response of the patient, that she was on the right track, but then *felt a little "disturbed" by this competitive atmosphere* of Andrea's narrative because she personally did not like competitiveness. However, thinking that the patient was working to disprove the belief that she did not have the right to be better off than another person without feeling guilty, the therapist decided to support the patient with nonverbal cues (smiling, nodding her head yes). In other words, the therapist thought that Andrea was still testing the same pathogenic belief but now with a transference test by non-compliance: Andrea was implicitly asking the therapist if she had the right to win a competition with another woman. At that point, Andrea added that in the past she had been quite different from that colleague, always very sensitive to the needs of other people, but then things changed and now she does the best that she can but is less dedicated to others.

When the therapist asked her what determined this change, Andrea replied that when she was a teen she had felt "betrayed" by her Boy Scout leader. She had been a member of the Boy Scouts from 8 to 14 years old and her leader was an older girl around 20 years old who was "bright, charismatic, lively and ironic". Andrea was "platonically in love with her" and wanted to become like her. However, one day her leader said to her that she could not go to church with make-up on, and cleaned her face—that was one of the very few times her mother had made her face up. A week later, the leader herself came to church with make-up on and when Andrea stressed the contradiction between what she had said and done to her the previous week and what she had done the very next week, the leader replied that her make-up was waterproof. Andrea felt a victim of injustice, felt mocked—something she cannot stand—and felt that her leader was like her mother. After that, the leader did not give her the promotion she deserved, sent her to another group and decided that she had to be the last one to receive a prize that she deserved more than the other girls. Andrea felt betrayed and felt she had lost her safe place.

While she was listening to Andrea, the therapist noticed how Andrea's leader behaved like Andrea's mother and *felt disoriented and hurt* by that behavior and *felt rage toward* that Boy Scout leader. The therapist thought that Andrea was still testing, using transference by non-compliance, the same belief in that she (the therapist) would feel what a good parent who protected her daughter would have felt, an experience that Andrea never had. At the same time, she thought that Andrea was trying to master that traumatic experience by talking about it in therapy.

At that point Andrea started to cry and said that it was unjust; she had thought that the world of the Boy Scout could be something different and better than the "real world", but then she realized that it was only smaller. At that point she decided not to do anything anymore and she became depressed for four years. Then she added that during the Boy Scout period she was a victim of her mother's problems because her mother did not dress her well and did not send her on time, so the other scouts made fun of her and she felt that she never really belonged. But she loved nature and she idealized the leader, as she later would idealize other people who "were in my life but were not completely part of my life; when my mother beat me, or made me sleep on the ground, I found some consolation in thinking about those people".

At that point, the therapist said to Andrea that she was looking for a healthier female presence than her mother—someone who could protect and support her—and thought that this could be true also for Andrea's relationship with her. However, the therapist decided not to mention this latter understanding of the transference; she thought it was more important to enable Andrea to have this experience and feel that she deserved it than to interpret it. At the same time, the therapist *felt worried about the possibility of disappointing the patient* and thought that this fear was something that derived from her own personal difficulties in fully accepting being successful and appreciated. Andrea replied that this was the first and probably only time that she had given that role to a woman because, in general, she prefers males, such as one of her mother's boyfriends. And she added that another problem was that when she finds a man who is fond of her and thinks that she is clever and nice, she ends up devaluing him.

The therapist, at this point, pointed out to Andrea that this was what they were talking about also in the previous session, and Andrea added that "the worst is when I feel that the other person has a good opinion of me and makes me perceive his fragilities". She described, for example, how she was disturbed for a long time by images of one of her university professors having his head broken. This professor had been very kind to her: he was able to understand that during her exam with him she had had a moment of "mental blackout" and, remembering Andrea's questions and observations during the lessons, he gave Andrea a very good mark. Andrea then added that on many occasions she found herself a "victim of terrible images produced by my brain" where she saw people who were gentle with her having severe injuries. Then she remembered that when she was young and went to church she often imagined undressing herself, running into the church naked and swearing. "It is as if I can stretch my mind to the point of no return, but without passing that point. And I have always thought that it is very easy to lose my own mind, and I can easily understand those people who ended up killing their parents or their children. It is quite easy."

On listening to Andrea's words, *the therapist felt a little scared by the troubling imagery and violent fantasies presented by the patient*. Thinking that Andrea wanted to understand if the therapist thought that she could really lose her mind, the therapist decided to say to her: "But it is very different to think something and to do something, and I do not think you would be able to DO things such as these".

If seen within the context of the overall session, it may be hypothesized that Andrea was identifying with her mother in her imagination and was testing the therapist with a transference test by compliance. In other words, she was asking the therapist: Am I mad like my mother? Will I become as she is? The therapist's feelings were an indicator of her empathic identification with the patient who, when she was a child, had to deal with a "crazy" mother. It is also possible that Andrea had felt guilty because, in having her project accepted, she had surpassed the mother, and then identified with her mother to atone for this guilt.

Andrea replied that she had had these thoughts since she was a little child. Before the Boy Scout experience, she

could imagine that a fragile person she knew was hurt but not that she was the person who hurt others. Then Andrea started to talk about her relationship with her boyfriend and said that things between them were not going well. She said that they fought because she felt he had not been empathic with her: when she told him that she was very angry because she was not allowed to give clients in her office any personal information about herself, her boyfriend asked why her boss wanted this and did not simply agree with her. Andrea could not stand the fact that he wanted to understand the situation better before condemning other people.

The therapist kept *feeling "disoriented" and a little upset* by how Andrea behaved with her boyfriend but was able to recognize in herself a similar tendency to become "dominating" when she felt threatened. Then, on the basis of what happened also in the previous session, the therapist felt conflict within herself: on the one hand, she thought that the patient wanted to feel supported in her right to achieve more than her mother in her romantic relationship; on the other hand, she had the impression that Andrea was "tormenting" the boyfriend in an attempt to have him do what she thought was right. And she was not sure which should have been the focus of her communications. Moreover, *the therapist felt "controlled" by the patient* and always *under pressure*: she had to be the perfect therapist or the patient would have criticized her. And she usually did not feel this way with other patients.

The therapist said that, in her opinion, it was possible to have different opinions and, at the same time, be able to understand each other, an intervention that was based on the therapist's attempt to take into account both elements that were in conflict in her mind. Andrea replied, in an annoyed way, that she had to explain to her boyfriend that she felt humiliated by the fact that she could not say anything about herself to the clients and that *she wanted to feel that the boyfriend was able to put himself in her shoes and to understand her right to be angry, nothing more*. Then she added that all the people she talked to about this topic had said that she was right and that after the discussion she felt a sort of "claustrophobia" because her boyfriend wanted to spend the afternoon with her and she did not want to anymore. "His desire to stay with me is illogical. I want to have with me a person who is both caring and bright, and he showed me to be not so bright because he wanted to stay with me even after our fight." Then Andrea added that, two days later, her boyfriend was disappointed by the fact that she did not show up when they agreed to see each other, and she felt "oppressed" by his sadness and disappointment.

The therapist interpreted as a coaching communication the fact that the patient said she wanted other people to empathize with her without adding anything, and so decided to say to her: "I can understand you felt oppressed". At that point Andrea said that she could not stand her boyfriend's presence in the same bed and that she was angry with him because he knew these things, he knew that he was going to lose her, but he did not change his way of thinking or replying to her. Then Andrea concluded the session by saying that she envied a couple of friends because even though they were not perfect, they were able to overcome their difficulties; the girl of that couple had always liked her boyfriend and doing things with him, whereas she could not say the same about her own boyfriend.

The therapist did not reply to the patient but continued to feel controlled by Andrea and afraid that sooner or later the patient would discover some of her limitations and difficulties and would "attack" her for them. And she thought that in the final part of the session she was a bit lost. She was not sure what to do: on many occasions, she had thought that Andrea's boyfriend was nice and understanding with her whereas she was often critical and moody, but the clinician was afraid that if she had not supported her patient in her recriminations toward him then the patient would have felt that she did not deserve to be satisfied with her romantic relationship.

During the supervision, the therapist realized that if she had considered her own feelings and the overall context of the session and the patient's plan, she could have seen how Andrea, both in the relationship with her boyfriend and with her, identified with her mother: she was asking both of them to be "perfect", according to what she thought was "perfect"; she was punishing the boyfriend when he was not perfect, just as her mother punished her when she saw her as not perfect. The therapist also recognized that Andrea was communicating, through her attitude toward the boyfriend and the therapist, that she would have done the same to her, something the therapist "noticed" with her feeling of being "controlled" by the patient and "under pressure". This identification was also indicated by the "envy" that Andrea said she felt toward her couple of friends, an envy similar to what Andrea thought her mother felt toward her.

In other words, Andrea was testing her therapist (and her boyfriend) by a passive-into-active test by compliance, mediated by her attitude; Andrea was putting the therapist in the role of herself as the child of a critical, envious and controlling mother who wanted her daughter to be perfect and was ready to punish her if she did not do what she thought she *had to do*. She was identifying with the mother because she unconsciously believed that she would deeply hurt her mother if she was healthier and more emotionally satisfied and successful than her. The therapist's feelings were the "royal road" to this dimension of the patient's communications that became more evident in the following sessions.

Conclusions

CMT concepts such as the patient's plan and tests of pathogenic beliefs and schemas can help clinicians make sense of their emotional reactions in therapy sessions. Therapists' emotions, ranging from nurturant and positive feelings to disturbing negative affects, may be understood as reflecting the interpersonal dynamics associated with patients' testing activities. The different kinds of testing strategies, together with the specific pathogenic beliefs and traumas of the patient, may evoke particular emotions in the therapist that may advance the therapeutic process if understood and responded to within the context of the patient's plan. In the course of a therapy—even within a single session—the therapist might experience similar feelings to those once felt by the patient, feelings that the patient once wished for, feelings experienced by traumatizing figures, and feelings that the patient would have liked important others to have felt. A formulation of the patient's plan, including her/his goals, pathogenic beliefs, and traumas, can help the therapist anticipate the kinds of tests the patient may present. This may allow the therapist to be somewhat prepared for emotional reactions when they occur, remaining focused on their meaning and on the kinds of responses needed by the patient in that moment. From the perspective of CMT, the therapist's feelings may be entwined with the patient's testing—part of the patient's effort to disprove pathogenic beliefs and achieve therapeutic goals.

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