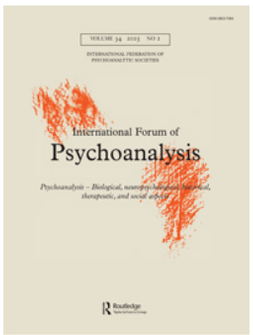

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The core assumptions of the control-mastery theory and their implications

FRANCESCO GAZZILLO, MARTA RODINI, & ELEONORA FIORENZA

Abstract
This paper aims to identify the core assumptions of the control-mastery theory (CMT) – those assumptions whose falsification would determine the abandonment of the theory itself. These concepts are the adaptive nature of basic human motivations; the sophisticated and adaptive nature of unconscious mental functioning; the overarching role of safety in the regulation of conscious and unconscious mental functioning; the prosocial nature of certain basic human motivations; the centrality of beliefs for understanding how human beings relate to reality and other human beings; and the ontological unity of the human Self. We show how the application of these assumptions to clinical phenomena that apparently contradict them has given rise to the more innovative concepts of the CMT – such as the concept of patients' tests, coaches, and plans – and has emphasized the centrality of guilt and shame in psychopathology. In contrast to the core concepts delineated above, modifying these derived concepts would not imply modifying the entire theory. Finally, we show how these concepts shape the clinical work of therapists who embrace the CMT.

Key words: *control-mastery theory, pathogenic beliefs, plan, test, coaching.*

Following the proposal of the epistemologist Imre Lakatos (1980), it is possible to identify the *core assumptions* that define a scientific research program – those whose modification or falsification would imply the necessity to abandon a theory. In this study, we attempt to outline the core concepts of the control-mastery theory (CMT) (Gazzillo, 2021, 2023; Silberschatz, 2005; Weiss, 1993; Weiss & Sampson, 1986), which is an integrative, relational, cognitive–dynamic theory of mental functioning, psychopathology and psychotherapeutic process developed and empirically validated by Joseph Weiss, Harold Sampson, and the San Francisco Psychotherapy Research Group (SFPRG) and, more recently, also by the Control-Mastery Theory Italian Group (CMT-IT). It is worth noting that the reconstruction of the CMT we propose here is a logical, not a historical, reconstruction of theory development.

The core assumptions of the CMT

The first core assumption of the CMT (Weiss, 1990) is that *basic human motivations are adaptive*, and their manifestations are shaped by the actual experiences of an individual. This hypothesis – partially derived from some hypotheses proposed by Freud (1940) and from ego psychology (Hartmann, 1939) – is compatible with recent developments in the infant research-informed psychoanalytic theory of human motivations (Lichtenberg, 1989; Lichtenberg et al., 2011), with motivational theories proposed by contemporary cognitive–evolutionistic authors (Liotti et al., 2017) as well as with recent models of basic human affective systems developed by affective neurosciences (Panksepp & Biven, 2012). In contrast, this assumption is not compatible with the classical psychoanalytic hypothesis that basic human motivations are maladaptive and that one of the main tasks of human development and socialization is to tame them.

The main clinical implication of this assumption is that patients come to therapy to achieve normal and adaptive goals and not to find gratification for maladaptive unconscious goals. When it appears that patients come to therapy in an attempt to find help to pursue maladaptive goals, this should be interpreted as a consequence of how their basic motivations were shaped by their life experiences.

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The second core assumption of the CMT is that, among the basic human abilities and motivations, there are *prosocial abilities and motivations*. Previously cited contemporary psychoanalytic, neuroscientific, and evolutionary models indicate the existence of essentially prosocial motivations such as attachment, care, play, affiliation, and cooperation. Moreover, recent evolutionary research studies and models suggest that altruistic behaviors and their emotional and psychological correlates (e.g. empathy, loyalty, equity, guilt, shame) are inborn, that they derive from our necessity to live in groups for survival and reproduction, and that their presence can be observed from the first two years of life onward (see, for a review, Gazzillo, Fimiani et al., 2020). Moreover, this assumption was also present in psychoanalytic motivational models such as those proposed by Fairbairn (1952) and Suttie (1935). This hypothesis does not imply that all basic human motivations are altruistic, but that altruistic motivations are as primary and important as more egoistic ones.[1]

The main implication of this assumption is that, in attempting to understand patients, therapists should take into account the fact that they may be doing something because they consciously or unconsciously believe that, in doing so, they are helping some of their important others or complying with what they think these people want.

The third core assumption of the CMT (Weiss, 1990) is that *human unconscious mental functioning is sophisticated, reality-oriented, and adaptive*. This idea, proposed for the first time by Freud (1926), is in line with recent empirical data of cognitive and evolutionary psychology that emphasize that many complex human mental activities are normally performed sufficiently well outside of our awareness: assessing our moment-to-moment level of safety, identifying recurring patterns, developing inferences, and formulating and testing plans are among these activities (for a review, see Leonardi et al., 2020). On the contrary, this assumption is not in line with the classical psychoanalytic idea that unconscious mental functioning is dominated by a primary process whose only aim is finding immediate gratifications without considering reality (Freud, 1899). It is worth noticing that this assumption does not imply that unconscious mental functioning follows the rules of formal logic or is perfect. The main clinical implication of this assumption is that when clinicians listen to and observe their patients, they should begin from the assumption that what they see and listen to are the results of complex unconscious mental processes aimed at adaptation.

The fourth core assumption of the CMT is that the more fundamental regulation principle of unconscious mental functioning is a *safety principle* (Fiorenza et al., 2023; Weiss, 2005): we want to feel safe in pursuing our goals; when we do not feel safe in doing so, our main unconscious goal is to regain a sense of safety. The centrality of a sense of safety in ego regulation was proposed for the first time by Freud in his *Outline of Psychoanalysis* (1940); later, other psychoanalytic authors emphasized the centrality of safety in human functioning from different perspectives, with the more important ones being Sullivan (1953), Sandler (1960), and Bowlby (1982). Moreover, the centrality of safety as a fundamental regulation principle of human mental functioning has been recently emphasized by evolutionary psychologists and by the polyvagal theory proposed by the psychophysiologist Stephen Porges et al. (1994). However, more than these other perspectives, the CMT emphasizes how our sense of safety also has an *altruistic component* – it depends not only on how safe we think we are but also on how much we believe that our important others feel safe with us.

These first four assumptions imply that human beings need to feel safe and are consciously and unconsciously motivated and capable of *controlling* the access to consciousness and behavior of their psychic processes and contents, solving their problems, and *mastering* their adverse experience and traumas – that is, those experiences that acutely, systematically, or chronically disrupted their sense of safety. The importance of a drive to mastery was emphasized for the first time by Freud in 1920.

[1]Recent developments in emotional neurosciences and ethology-derived models of human motivations (Liotti et al., 2017; Panksepp & Biven, 2012) stress the primary nature of a "rage system" aimed at removing the obstacles to the satisfaction of the person's needs, and of defensive, antagonistic and predatory aggression. These hypotheses do not contradict the CMT idea of the primary nature of human prosocial motivations because all these theories, as we have seen, also stress the presence of primary prosocial motivations. However, in understanding the maladaptive manifestations of these human "aggressive" motivations, CMT, as we will see later, stresses the relevance of the developmental experiences that shape these manifestations and of the pathogenic beliefs that mediate them. Maladaptive aggressiveness can be explained as a consequence of the compliance with a pathogenic belief (for example, abused, neglected, and mistreated children can develop the pathogenic belief of being "bad" and then act as "bad" people); as a form of non-compliance/rebellion with a pathogenic belief (for example, they can become aggressive in the attempt to defy the pathogenic beliefs that they do not have the right to ask for what they need because they are too demanding and their needs are a burden to others) or as the consequence of an identification with an aggressive caregiver, for example an identification based on the pathogenic belief that being better than that caregiver would mean humiliating them. Finally, as stressed by Richard Wrangham (2019), from an evolutionary perspective, the worst manifestations of human destructiveness, such as genocides, are not motivated by a "warm" or impulsive aggressiveness, but by the "cold" ability of human beings to plan and execute complex collective destructive actions usually motivated by "moral" reasons. Needless to say, less destructive actions and scenarios, such as sadistic and masochistic actings and fantasies, can be read also as attempts to disconfirm pathogenic beliefs (see Bader, 2003).

The main clinical implication of this safety assumption is that clinicians have to pay attention to all the bodily and psychological signs of safety and danger of their patients and must attempt to understand what their patients need to feel safe; this is because it is only if they feel sufficiently safe that patients can be therapeutically productive and work to get better.

The fifth core assumption of the CMT (Gazzillo et al., 2022; Weiss, 1997) is *that each human being relates to their reality according to the system of beliefs that they have developed on the basis of their actual experiences*. From an epistemological perspective, the CMT embraces a position of *perspective realism*: a reality exists, and when people – each with their inborn peculiarities – meet their reality, they develop a system of beliefs that enable them to anticipate and make sense of what happens to adapt and preserve a sense safety while pursuing their life goals. These beliefs can be conscious, explicit, and verbally articulated or unconscious, implicit, and procedural, and store the contingencies detected in the environment and between the self and the environment. This assumption is in line with those psychoanalytic models that emphasize the role of actual experiences in shaping the structures that organize human psychological functioning (e.g. Bowlby, 1982; Fairbairn, 1952; Sullivan, 1953), while it is less compatible with those models that emphasize the role of conscious and unconscious fantasies in psychic life (Klein, 1957). Moreover, the abovementioned assumption makes the CMT non-compatible with postmodern approaches that adopt a pure constructivist perspective.

The main clinical implication of this assumption is that to understand patients and what they need, clinicians must understand their systems of beliefs – that is, how they make sense of their reality and the actual developmental experiences that shaped these beliefs. Among these experiences, particular importance is given to adverse and *traumatic relational experiences*; moreover, helping patients get better implies helping them *become conscious and modify the beliefs* that make them suffer.

The sixth and last core assumption of the CMT is that, from an ontological perspective, each human being is *a singular and whole subject*, even though they can experience a multiplicity of different and even dissociated states of self. This perspective is compatible with psychoanalytic models such as Fairbairn's idea of an originally unitary ego, Winnicott's (1971) concept of a true self, Kohut's idea of a nuclear Self (1977), and the ontological assumption of a unitary subject proposed by the intersubjective perspective of Atwood and Stolorow (2014). On the contrary, it is incompatible with models that hypothesize a basic dissociation of the human psyche (e.g. Bromberg, 1991).

The main clinical implication of this and the previous assumptions is that a clinician who works from a CMT perspective interprets what patients say and do as manifestations of a core unitary "Self" who is unconsciously attempting to pursue adaptive and often prosocial goals and to feel safe in a reality that they perceive through the lenses of their personal unconscious beliefs.

Original concepts of the CMT: pathogenic beliefs, coaching, testing, and plan

Many of the more original concepts of the CMT can be understood as the results of applying the previously described core assumptions to clinical experiences that apparently contradict them. The development of these concepts, to use the theory proposed by Lakatos (1980), can be seen as the result of *positive heuristics*.

The concept of pathogenic beliefs

The first original concept developed by the CMT is the concept of *pathogenic beliefs*. By this term, the CMT means beliefs that associate the pursuit of healthy and adaptive goals to dangers for the self, important others, or important relationships. Pathogenic beliefs are derived from unconscious attempts at adaptation to adverse and traumatic experiences – that is, experiences that acutely, systematically, or chronically disrupted the sense of safety of a person – by attempting to make sense of these experiences and understanding how the person could have contributed to their occurrence. Pathogenic beliefs are often developed by unconscious inferences and are aimed at restoring a sense of safety by sacrificing the possibility of effectively pursuing healthy goals. The root of this concept of pathogenic beliefs is the model of anxiety proposed by Freud in 1925: according to Freud, anxiety is the signal of a danger that the unconscious ego believes will become real if the person attempts to satisfy one of their drive derivatives – a danger that a person believes will manifest on the basis of their past experiences. However, unlike Freud, the CMT is founded on the assumption that human drive derivatives/goals are basically adaptive and realistic, and that fantasy is secondary in shaping the dangers that can come from their satisfaction.

Beginning from the assumptions that human motivations are adaptive and often prosocial, that human unconscious mental functioning is sophisticated and adaptive, that the regulation principle of mental functioning is the search for safety, and that beliefs mediate the relationship between the person

and reality, according to CMT psychopathology can be understood as a consequence of pathogenic beliefs developed in the attempt at adapting to safety-disrupting environments and experiences.

CMT authors, influenced by the attention they pay to the prosocial nature of the human psyche, have identified five broad families of pathogenic beliefs that give rise to feelings of pathogenic guilt and shame: (1) pathogenic beliefs that connect the pursuit of autonomy, physical separation, and psychological differentiation to the suffering of important others (*separation/disloyalty guilt*); pathogenic beliefs that convey that the condition of being or becoming better off than important others will make them feel humiliated or envious (*survivor guilt*) (see Fimiani et al., 2022); pathogenic beliefs that make the person feel selfish and guilty if they are not taking care of other people in distress, as if the person has the power and duty to make other people feel well (*omnipotent responsibility guilt*); pathogenic beliefs that equate showing own needs and affects and being spontaneous to burdening and overwhelming important others (*burdening guilt*) (Leonardi, Gazzillo, et al., 2023); pathogenic beliefs that the person is unworthy of love, care, protection, attention, and appreciation (*self-hate*).

Several empirical research studies have revealed that it is possible to reliably identify these pathogenic beliefs in the transcriptions of therapy sessions or with self- and clinician-report scales, that these beliefs mediate the effect of early trauma on psychopathology, and that they are correlated with several clinically relevant phenomena, such as anxiety, depression, lack of self-esteem, worry, rumination, imposter syndrome, intolerance for frustration, difficulties in mentalizing, emotional dysregulation, etc. (Aafjes-van Doorn et al., 2022; Curtis & Silberschatz, 1986; Faccini et al., 2020; Fimiani et al., 2023; Gazzillo et al., 2025; Leonardi et al., 2020, 2022, 2025).

The concept of testing

If the concept of pathogenic beliefs helps understand psychopathology according to CMT, the concept of testing (Gazzillo, Genova, et al., 2019) has been developed to explain those illogical, provocative, and excessive communications, attitudes, and behaviors that patients reveal in therapy or in their close relationships. With the concept of testing, the CMT implies communications, attitudes, and behavior that are unconsciously aimed at: disproving pathogenic beliefs; assessing the degree to which the patient can feel safe in pursuing healthy and adaptive goals obstructed by their pathogenic beliefs; mastering the traumas and adverse experiences that are the basis of their pathogenic beliefs by intentionally but unconsciously recreating scenarios that are similar to the old and traumatic ones in the hope of giving them a happier ending; seeing if they can get rid of their pathogenic forms of compliance and identification with their traumatizing caregivers.

Two main testing strategies have been identified: (1) *transference testing*, which refers to when patients put themselves in the role of their traumatized child self and ascribe the role of their potentially traumatizing caregiver(s) to their therapist; and (2) *passive-into-active testing*, which refers to when patients identify with their potentially traumatizing caregiver and ascribes the role of their child Self to their therapists. Both these testing strategies can be mediated by communications, attitudes, and behaviors that can be in *compliance* or *noncompliance* with the pathogenic beliefs tested. For example, a male patient who has developed the pathogenic beliefs of being stupid and underserving of appreciation in his/her relationship with a violent and disparaging father can (1) say silly things or act foolishly with the therapist in the hope that the therapist will not end up considering him stupid (transference test by compliance); (2) attempt to show or stress upon how clever and bright he is, hoping that the therapist will form a positive view of him (transference test by non-compliance); (3) devaluate the therapist as his father did with him in the hope that the therapist will not be too upset and will show him how it is possible to relate to a devaluating person without developing his same pathogenic belief (passive-into-active test by compliance); (4) make the therapist feel clever and appreciated in the hope that the therapist will appreciate this to show him that it was legitimate that he needed the appreciation that he never received from his father (passive-into-active test by noncompliance).

Just as the patients' attitudes mediate many tests, a powerful tool that therapists can use to pass their patients' tests is their attitude and the atmosphere that it favors within the therapy (Sampson, 2005; Shilkret, 2006).

Testing is evidence of the adaptive nature of human motivations and the sophisticated functioning of the unconscious mind; in fact, it implies saying or doing something to see if the reaction of a therapist will be similar to the one we received (transference tests) or showed (passive-into active tests) in the past, or if the reaction of the therapist will be different, thereby implying that our tests were passed and that the pathogenic beliefs that we were testing was partially disproved.

If the therapists pass their patients' tests, patients will feel safer (less anxious, less depressed, bolder),

will work hard to attain the goals obstructed by the pathogenic beliefs tested, will feel more involved in the therapeutic enterprise, will become more able to gain new insights, and will be able to bring to consciousness previously repressed or dissociated contents and work through them. Several empirical studies have revealed that it is possible to identify tests reliably and that the hypothesized consequences of the therapist's ability to pass patients' tests are real (see Fimiani et al., 2023; Gazzillo et al., 2019; Gazzillo et al., 2025).

This conception of testing aligns with the idea of the centrality of corrective emotional experiences in psychotherapy, as proposed by Alexander and French (1946); nevertheless, it emphasizes the active unconscious role of patients, who look for these experiences in their idiosyncratic ways. Moreover, it is in line with those conceptions of transference and projective identification that emphasize how they are aimed at finding new and better objects and experiences and developing new psychological abilities (see e.g. Bion, 1952; Stolorow & Atwood, 1996); in contrast, it is not compatible with the idea that phenomena such as transference, projective identifications, or enactment are motivated by repetition compulsion (Freud, 1920), masochism, and the unconscious need for punishment (Freud, 1912, 1926) or mentalization deficit (Fonagy, 2001).

The concept of plan

The six assumptions on which the CMT is based and that we presented at the beginning of this paper have another relevant therapeutic implication. If patients seek psychotherapy, it is because there are several healthy and adaptive goals that they wish to pursue, but thus far have not been able to pursue because their trauma-derived pathogenic beliefs obstruct them. This implies that patients in therapy want to become aware of and disconfirm their pathogenic beliefs and wish to better master the traumas that gave rise to them. Moreover, as we have seen, patients try actively, albeit unconsciously, to disconfirm their pathogenic beliefs by testing them in their close relationships. Thus, it is possible to hypothesize that patients come to therapy with a generally unconscious and more or less articulate *plan* to get better (Weiss, 1998). This plan comprises healthy goals that patients want to pursue, the pathogenic beliefs that patients want to disprove, the traumas they wish to master, how they want their therapists to pass their tests, and the insight they may wish to obtain to develop a more comprehensive and benevolent perspective on themselves.

The CMT idea of the patient's plan is similar to Kohut's (1977) hypothesis of a nuclear program of the Self that is composed of skills, ideals, and ambitions, but the former is more period-specific and relationally oriented than the latter; moreover, it is highly compatible with the hypothesis recently proposed by the primate psychologist Michal Tomasello (2022), according to which the behavior of all animals, from lizards to human beings, is organized in an "agentive" manner – that is, organized by plans aimed at attaining desired goals. In contrast, it is incompatible with models attributing to clinicians the role of the person who knows what their patients need better than the patients themselves.

From a CMT perspective, the main task of clinicians is to understand and formulate their patients' plans during the first few sessions of their therapy and then to help patients implement their plans (Weiss, 1994; Gazzillo et al., 2021). An empirical procedure has been developed and empirically validated for formulating the patients' plan, the Plan Formulation Method (Gazzillo et al., 2022), and several research studies have revealed both its reliability and that the ability of the therapist to deliver interventions that support patients in implementing their plan (pro-plan interventions) correlates with patients' improvement in therapy (see Silberschatz, 2017). The plan, as formulated after the first few sessions of treatment, is a good guide for the therapist up to the end of the treatment period (Bush & Gassner, 1986).

From a CMT perspective, the plan of each patient is the compass that therapists must follow to help their patients: clinicians can help their patients with any kind of technique or attitude insofar as the patients they are treating feels that that technique is useful for them to pursue their goals, disconfirm their pathogenic beliefs, master the traumas at the basis of those beliefs, have their test passed, understand themselves better and from a more benevolent and comprehensive perspective, and feel safer.[2]

The concept of coaching communications

One last concept that derives from the basic assumption of the CMT is that patients can deliver to their therapists *coaching* communications (Bugas & Silberschatz, 2000; Bugas et al., 2023; Rodomonti

[2]For the application of CMT in the understanding and treatment of patients with psychoses and severe personality disorders, see Alesiani (2013), Gazzillo et al. (2020, 2022), Pryor (2005), Shilkret (2006), and Weiss (1993, pp. 101–102).

et al., 2021) – that is, communications consciously and unconsciously aimed at helping their therapists understand and follow their plan. These communications may be *proactive* (suggesting to the therapist what to address or what to do) or *reactive* (helping therapists understand if they are on the right or wrong track). Several clinical and empirical studies have revealed that it is possible to identify coaching communications reliably and that, in line with CMT hypotheses, the ability of the therapist to follow these communications correlates with the immediate improvement of the patients (Gazzillo et al., 2025; Kealy et al., 2022).

The concepts of pathogenic beliefs, testing, patients' plans, and coaching are the cornerstones of the CMT in clinical practice and are evidence of the generativity of the theory and of its ability to propose empirically sound new perspectives on clinical phenomena; however, unlike the six basic assumptions presented at the beginning of this paper, they can be refined and modified without altering the core identity of the theory. Thus far, empirical research studies have revealed that they are sufficiently sound.

It is worth noting that the efficacy of CMT psychotherapies so far has not been shown with randomized controlled trials (RCTs), which are considered the gold standard for showing that a therapy is effective, because, in order to conduct a valid RCT, it is necessary to manualize the psychotherapy implemented, which would be in contrast with the CMT idea that each psychotherapy must be shaped by the specific plan of each patient.

The empirical studies conducted so far have shown that, independently of the model followed by the therapists (psychodynamic, cognitive–behavioral, systemic-relational, and so on), the patients' improvement was favored by the fact that therapists' interventions passed their tests and supported their plan.

The clinical attitude of a CMT therapist

On the basis of all the concepts described thus far, CMT-oriented clinicians, when working with patients, begin from the assumption that each patient is a unique human being whose unconscious motivations and abilities to cooperate with the therapist and get better need to be trusted. CMT clinicians believe their overarching task is to help their patients feel safe and that, to do so, they need to understand and formulate their patients' plans and help them implement them.

Since each patient is a different person and has a different plan, each treatment must be *case-specific*. Given that the main aim of a patient is to pursue healthy and adaptive goals obstructed by pathogenic beliefs, therapists *must not be neutral*; given the centrality of relational traumas in the development of pathogenic beliefs and the centrality of patients' testing activity aimed at disproving them, the core change factor in psychotherapy is the *corrective emotional experiences* that can be lived both within and outside the therapeutic relationship. Finally, the main criterion for understanding the suitability of a therapist's intervention is the reaction of the patient to it; the primary criterion for understanding if the approach of a therapist is correct is the patient's improvement; and the only criterion for understanding if a theoretical hypothesis is correct is its verification with empirical studies.

A clinical exemplification

In the last portion of this paper, we examine the application of these concepts to understanding the first interview with a patient.[3] Caroline was a 32-year-old patient who looked for psychotherapy because she was having difficulties in completing her academic exams. Her 35-year-old female CMT therapist had over five years of clinical experience. Below is a detailed synthesis of the transcription of the beginning of Caroline's first interview.

T: So, how can I help you?

P: eh (laughs then bursts into tears) Eh, nothing, all the time it feels like this (silence) … nothing, I'm having a hard time … because I feel that my life is not going in the right direction, especially from the academic perspective. I mean, I always had a "peculiar" relationship with school, then with lots of effort and thanks to help from my parents … I went to a private school anyway because I failed already in the sixth grade (sighs) … I had a "special year," and after finishing middle school, I began high school, where I failed another year. Then, my parents decided to send me to a private school because I wasn't really … an easy daughter academically. Then, I finished high school and wanted to try college, but that perspective for me was too challenging. I knew it was not my path, and after one year, I dropped out of my studies and went to work. But I felt unhappy in any case, and I felt that there was something inside me that pushed me to measure myself in life by keeping on studying … however my

[3]The patient has given consent to the publication of this part of her first interview. Moreover, details have been disguised to protect her privacy.

parents never, never, ever made me feel bad about not continuing my studies; on the contrary …

In these first minutes of the session, the therapist had the impression that it was not easy for Caroline to show her emotional distress and communicate her needs (this could be the first implicit goal she wants to pursue in her treatment) and believed that Caroline was attempting to articulate and coach her therapist about one of her goals for therapy – that is, that she wanted to be more self-assured in her academic abilities. Moreover, she noticed that Caroline believed academic success was the main "measure" of her self-worth. Thus far, Caroline was testing her therapist in the transference: she was showing to her that she was doing her best not to cry and that she thought she was not able to be a successful student in the hope that the therapist could help her feel entitled to ask for help and capable.

T: What do you mean? What were they telling you about that?

P: Eh, I was always told that if that wasn't my way there was no problem, so it was never a problem for them. But the fact is that after a while I (continues crying) … excuse me, can I get one of your handkerchiefs?

Here, the therapist thought that Caroline was testing her to see if she was entitled to ask for what she needed. And that Caroline was "protecting" her parents by stressing that they were not the cause of her academic difficulties.

T: Sure!

P: After that period, I started working [the patient describes a series of unfulfilling job experiences, and then adds that during the COVID-19 pandemic] … I decided to start studying biology and am now in the fourth year. However, with so many difficulties (her voice breaks), I found many obstructions during these years because I have so many gaps … can you understand?

The therapist believed that Caroline was attempting to master her past difficulties related to studying and at the same time, with her last sentence, she was testing her to see if she thought that she did not have the abilities necessary to achieve academic success, as it was something "missing" or "broken" in her. For this reason, the therapist replied,

T: What do you mean by "so many gaps"?

P: That I don't know how to study. Because the school I went to didn't really teach me how to study and how to get organized … I really have a hard time passing my exams now; this is difficult for me, I swear to you. I am anxious because I feel like I have never studied enough. I am tired, and at the same time I don't want to give up. So … I find myself like this (cries), I can't study, I can't sleep at night … I am overly worried that I would not have been able to study and (voice breaks), then also with Simon, my boyfriend … (silence – holds back crying) sorry, it also bothers me to cry because it's not something I need to cry about.

The therapist thought that Caroline was providing her with more details about goals (coaching). Moreover, she thought that Caroline was testing her in the transference.

T: If you are crying, there is probably a reason; and you are free to cry as much as you want here.

P: Yes, right (laughs, crying) … I can do it. I was saying my boyfriend helped me a lot because he had a similar path at school, but recently, he gave me an ultimatum, "You have to tell your parents!" They don't know about my current situation, and they certainly don't expect that I still miss 15 exams! I can't find the courage to tell them, I can't.

T: Why? how do you expect them to respond to you?

P: I … (Cries), I don't know if they would help me … I would like to solve this problem by myself, maybe telling them that I am a little bit late, but I cannot tell them the whole truth. Obviously, Simon disagrees. Really, I see that everyone is going on with their lives and are able to do so. My sister, for example, she is studying political science, by the way, and she is doing great. She studies all day, wakes up at 7:30, and repeat. I can't do it, I swear to you, I mean I am … maybe not able to.

At this point, the therapist thought that by talking about her difficulties related to studying, Caroline was attempting to articulate and test the pathogenic beliefs that her telling the truth about her situation would have overburdened her parents and that she was a failure, that she was inferior to other people. For this reason, she decided to ask,

T: Where does this thought come from, the belief that all the other people are able to make it while, deep down, you feel like you are not? Where does this idea that you are a failure come from?

P: (Cries) Eh … I have always felt like a failure … the relationship with my parents has been always a little … (silence) I mean, what can I say? I suffered a lot in the past … maybe the first time that … I was … 18 years old, the priorities were different, I saw myself ugly, fat, I didn't have a boyfriend. I focused everything there, but I felt that it is much, much deeper … I have always wanted everything to come easy, always. Yes, that's my problem, always. I want to lose weight but without dieting, I want to graduate but without committing … Yet, it's not that I'm a girl afraid of working

… In all my jobs, I've been told I'm good, I've been given lots of responsibility early on, which I felt was rewarding. But studying is different because … about this … the relationship with my parents has always been bad, I know. Because I wasn't doing well in school anyway, but nobody cared. I'm sorry to say no one cared because they paid for my tutors, but the point is that I was always alone at home (crying). My dad was always working. My mother used to work part-time and then used to go to gym. And, for example, during my lower school, which was the worse time of all, I spent much time alone at home and being alone all the time was … at best, my dad would come back and make me a quick lunch, or I just grabbed whatever was available while watching cartoons (cries).

The therapist noticed that Caroline had begun talking about the traumas at the basis of her pathogenic belief of being a failure: she felt alone and ugly and also felt neglected by her parents; thus, she ended up believing that she was undeserving; moreover, she was struck by some of Caroline's sentences (I have always wanted everything to come easy … I want to lose weight but without dieting … I want to graduate but without committing) because they sounded like typical parental criticisms. However, she believed that in that moment the more important thing was to help Caroline feel that she was entitled to talk about her traumas and express her feelings.

T: It hurts to remember these things.

P: Yes (cries), then, my parents, I mean my dad, I don't want you to think that he is a violent man, but he is an "old school parent."

T: Meaning?

P: Meaning that the few times we did homework together … (cries), if I did just one thing wrong, it was the end (silence) … and nothing … that was the situation. However, I understand that those were different times, old-school parents.

T: Meaning? Can you give me an example of what was going on if you got something wrong?

P: But nothing … it was mainly a few slaps … more than one really … the problem was mostly verbal though … anyway …

T: What did he say to you?

P: Eh, that I didn't understand, that I was stupid, that I didn't get it. I'm sorry, because I still judge him now; however, I'm sorry because he realized what he did over the years and apologized to me several times. … but we we never sat down and talked about these things because as soon as this happens, I cry, and it's not something that I like. So, I don't … I don't know … I've always been a crier, always (laughs while crying).

The therapist opined that Caroline needed to talk about these traumas to better master them and noticed that anytime she showed that she was open and sensitive to Caroline's suffering, both verbally and non-verbally, Caroline felt relieved and continued talking. The therapist was passing Caroline's burdening tests. Moreover, she noticed that Caroline oscillated between describing her father's mistreatments and blaming herself for them to protect her father's image. Finally, the therapist noticed that when Caroline said at the beginning of the interview that her parents did not push her to continue studying, she was trying to say that they did not support her efforts to learn how to study and to enjoy studying.

T: No, the point is not that you are a crier; the point is that it was painful.

P: And … when I cried, nothing changed, nothing at all; I was virtually crying by myself! Then, maybe at night … I remember living in a small apartment; my sister and I slept in a bunk bed in one room, and my parents slept in the living room on a sofa bed. And I remember that we used to fight in the evening. It happened a lot of times because … anyway, the problem was … I mean, I was a difficult child because I wouldn't eat anything at dinner. I don't know why, but I wouldn't eat anything; so, every night, there was a fight about this, about the food, about the things I didn't eat. My father would get angry and beat me, and I cried. Then, late at night, he would come to me and say, "I'm sorry, I'm sorry," and I would say, "No, no, it's okay, don't worry, don't worry about it," because I was tired, I just wanted to sleep. And I remember these scenes very well, but now he is not like that … now he is much better because now I have grown up, so things are different now … My mother … at that time she didn't say anything; my mother never said anything. At least, today he says, "Caroline, I know that we have made lots of mistakes with you," and my mother immediately says: "Oh, but you exaggerate so much; it seems like we mistreated her," because maybe then she felt … I mean, I understand that, on the one hand, for a mother to hear such things feels bad, no? So maybe she feels hurt … I don't know …

The therapist thought that Caroline was coaching her with an increasing number of details about her traumas and, at the same time, she felt guilty for criticizing her parents and was testing the therapist to see if she could put her emotional needs and her perspective in the foreground. Therefore, the therapist replied,

T: And wasn't this bad for you? Poor dad because he works and he's tired and burnt out by your school problems and by your eating problems; poor mom because she is hurt by what you say. But you were a child, alone the whole afternoon, getting beaten and yelled at if you didn't eat and didn't do your homework well … That hurts, and it was bad! Why should you feel guilty? There is no such thing as a difficult child! From what I can see, their way of reacting to you has made you feel that your feelings and needs are a burden to other people and that you are worthless.

P: (Crying) Yes, on the one hand I know this … it's true, but my mother also had a difficult relationship with her mom; in my opinion, that also has something to do with this [the patient describes that her maternal grandmother never accepted her mother, hypothesizing that this could be the reason why her mother was so "selfish and cold"] … once I read that the first friendships of a child, at school for example, derive from the relationships that their parents establish with the parents of the child's schoolmates. I don't know if that's true; I read it in a pamphlet, but this made me think that I was always a very shy child; I always had a lot of difficulties socializing. Even now, socializing is a problem for me. And I always remember that when my mother came and picked me up at school, she was always in a hurry and very busy, so she could not create any close relationships with the parents of the other children at school … She didn't want to be there with me … I used to see that other children's mothers would organize snacks together at the park, spending their time together with the other children. I never had that experience. My parents don't even know the names of my friends, let alone their moms (cries) … anyway …

T: Don't say "anyway" – Caroline, what you are telling me is very important and painful. You felt that your father mistreated you and that your mother did not want to stay with you, and from what I can see, this, for you, meant that you were not important, that you were a burden, that you were unworthy of love and attention, that you did not have any positive quality. And this hurts a lot!

P: Several things hurt me yes, that's true … although I think that they tried to do their best … I don't even want to blame them because I understand that when one has had such experiences in one's life, it is difficult to come out from them … maybe we are lucky enough to have the possibility of undergoing psychotherapy, while my mother has not had that luck … But, in my opinion, she's been a little bit of a … I don't mean to say a neglecting mom, because she's always been interested in me, in her own style … she has been gruff, this is true, but she has done everything she can for us, always … she is not an easy person, but … . whenever I have to say something to my parents, I always expect something like an anger outburst, but at the end of everything …

At this point of the session, the therapist realized that it was possible that Caroline felt guilty also because she had the opportunity to be listened to and helped by a therapist while her mother had not had the same opportunity – that is, the opportunity to have a good mother–daughter relationship for herself.

During the last part of her first session, Caroline provided the therapist with more details about her goals, pathogenic beliefs, and traumas. Nevertheless, as we will show now, the core components of her plan were already present in the first part of her first interview.

The formulation of Caroline's plan

Goals

- To improve her self-esteem
- To be more satisfied with her life
- To graduate
- To be less anxious about her academic abilities
- To feel entitled to ask for what she needs and to show her emotions
- To be able to live by herself

Obstructions

- I do not deserve to be cared for and loved; I am worthless (self-hate)
- If I ask for what I need and show my emotions, I will burden other people (burdening guilt)
- If I have a life happier than my mother's life, she will feel humiliated and envious (survivor guilt)

Traumas

Caroline grew up with two neglectful parents who never really cared about her, her needs, and her feelings and were always absorbed in their preoccupations (e.g. she spent entire afternoons alone, watching TV and eating junk food). Her father beat her and blamed her for her scholastic struggles, making Caroline feel stupid and incapable. Her mother was a selfish and gruff woman who never had enough time to spend with her (e.g. helping her socialize with her schoolmates), which made Caroline feel unworthy of love and attention. She also perceived her mother as less fortunate than her because her mother had a troubled childhood.

Tests

"I do not deserve to be cared for and loved; I am worthless" (self-hate).

- *Transference testing by compliance*: Caroline will present herself as being unworthy and not deserving of care and love in the hope that the therapist will help her realize that it is not true, thereby making her feel loved and valued.
- *Transference testing by noncompliance*: Caroline will be able to demand care and attention and present herself as capable, hoping that the therapist will support her in doing so.
- *Passive-into-active testing by compliance*: Caroline could criticize her therapist and make herself feel wrong, incapable, and unworthy of interest and love in the hope that the therapist remains self-confident.
- *Passive-into-active testing by noncompliance:* Caroline will show interest in her therapist, making her feel capable and loved, hoping this will please her.

"If I ask for what I need and show my emotions, I will burden other people" (burdening guilt).

- *Transference testing by compliance*: Caroline will avoid expressing needs and emotions (e.g. she apologized for crying) in the hope that her therapist will invite her to express herself.
- *Transference testing by noncompliance:* Caroline will freely express her emotions and ask for what she needs, hoping that the therapist will support her.
- *Passive-into-active testing by compliance*: Caroline will make her therapist feel like a burden; she may downplay the therapist's needs and emotions in the hope that her therapist remains calm and free to express herself.
- *Passive-into-active testing by non-compliance:* Caroline will be receptive to the therapist's needs and requests, hoping to make the therapist happy.

"If I have a life happier than my mother's life, she will feel humiliated and envious" (survivor guilt).

- *Transference testing by compliance:* Caroline will sabotage opportunities to be happy and fulfilled, hoping that the therapist will help her avoid doing so.
- *Transference testing by noncompliance*: Caroline will show that she is devoted to her personal happiness and fulfillment, hoping that the therapist will support her.
- *Passive-into-active testing by compliance*: Caroline will be envious of her therapist's happiness and satisfaction, hoping that this will not hurt the therapist.
- *Passive-into-active testing by non-compliance*: Caroline will be supportive and appreciative of the therapist's happiness, hoping that the therapist will value it.

Optimal therapeutic attitude: warm and affectionate, confident in her, welcoming of her needs and emotions; self-confident, comfortable with her own feelings, needs, and well-being.

Insights

Caroline may want to become aware that, thus far, she has not been able to improve her self-esteem, be less anxious about her academic abilities, graduate, and go and live by herself because she believes that she does not deserve love and care and that she is worthless. She may also want to understand that she developed this belief to adapt to the neglect and mistreatment she suffered from her parents.

Further, Caroline may want to understand that she cannot freely express her emotions and needs because she believes that if she did so, she would burden other people. She may want to understand that she developed this belief because this is how she made sense of her parents, who often appeared "overwhelmed" and "irritated" by her needs and reactions.

Caroline may also want to understand that she cannot be more satisfied with her life because she believes that doing so would humiliate her mother, who had fewer opportunities to achieve fulfillment and happiness.

Conclusion

In this paper, we showed that there are six assumptions at the core of the CMT: the adaptive nature of basic human motivations; the prosociality of some of these motivations; the complex and adaptive nature of human unconscious mental functioning; the centrality of safety in mental functioning; the centrality of beliefs in human relationship with reality; and the existence of a unitary Self.

We then showed how the application of these assumptions has given life to some of the more innovative and empirically validated concepts of the CMT: the concepts of pathogenic beliefs, tests, plan, and coaching.

Finally, we clarified how these concepts shape therapists' attitudes during the treatment and showed their application with a clinical exemplification.

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No potential conflict of interest was reported by the author(s).

Patient anonymization

Potentially personally identifying information presented in this article that relates directly or indirectly to an individual, or individuals, has been changed to disguise and safeguard the confidentiality, privacy and data protection rights of those concerned, in accordance with the journal's anonymization policy.

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