Patients' coaching behaviours, transference testing and the corrective emotional experience: Transcending the self in psychotherapy

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This article is broadly based within a psychodynamic approach to psychotherapy, drawing on object relations theories and, more specifically, on an object relations model outlined by Frank Summers, namely, relational psychoanalysis. The article explores the notion that because attachment to the object is central to the development of a sense of identity and belonging, individuals will seek to preserve the relationship at the expense of the development of their authentic self. In this way, those aspects of themselves that they perceive to be unacceptable to others and thus often to themselves, will be buried in order to maintain the relationship. The therapeutic relationship, as an interpersonal matrix, may echo patients' problematic modes of being and relating. However, the therapeutic relationship is potentially one in which such problematic patterns of relating may be resolved rather than re-enacted. In this context, patients may experience in therapy a 'transcendence of the self' as they begin to experience how they are relating, and more importantly, how such relating may result in the arrested development of their authentic self. The article makes links between three therapeutic phenomena in which problematic patterns of relating are embedded: (a) patients' coaching behaviours, (b) transference testing and (c) the corrective emotional experience. Such links are not clearly made in the literature. Furthermore, clinical material is drawn from the author's work as a psychotherapist and is used to illustrate transference-testing behaviours and three of its components, namely: (a) testing by compliance, (b) testing by non-compliance and (c) passive-into-active testing.

The psychodynamic approach provides the overarching conceptual approach of this article. Psychodynamic theories regarding psychotherapy are broad and therefore this article draws on different aspects of theories from interpersonal or relational psychoanalysis and object relations theories, as well as from the psychoanalyst, Frank

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Summers' (2000) object relations representations regarding psychoanalytic psychotherapy.

The article explores the object relations view that attachment to the object is pivotal to the development of a sense of self and identity. In this sense, because attachment to the object is so central, patients will seek to preserve the relationship while sacrificing the development of their authentic self. Patients will commit this sacrifice by burying aspects of themselves that they feel are not approved by others, in order to maintain the relationship. This burying of such unacceptable aspects results in the repression of the authentic self and authentic experience.

Patients come to therapy because they have a problem. They feel that things can or should be different. Often these problems or dilemmas are rooted in problematic patterns of relating to others and to themselves. Such dysfunctional modes of being and relating result in patients feeling that their relationships with others are difficult and stressful.

Much has been written about the process of therapy, and how patients consciously and unconsciously attempt to deal with their problems. One of the ways in which patients unconsciously attempt to deal with their problems is through the mechanism of transference. In the therapeutic relationship, as an interpersonal matrix, patients' modes of being and relating are thus re-enacted. The therapeutic relationship can be viewed as potentially one in which such problematic patterns of relating may be resolved rather than re-enacted. The therapeutic process for the patient may facilitate the potential for the experience of new ways of relating, and what Summers (2000) terms, an experience of the 'transcendence of the self'.

This article draws attention to the notion of dysfunctional ways of being and relating, and how thoughts about the self govern how patients engage with others and the therapist, as well as the possibility of the transcendence of the self in therapy. It does this by making the links between three therapeutic phenomena in which problematic patterns of relating are embedded: (a) patients' coaching behaviours, (b) transference testing and (c) the corrective emotional experience. This theoretical link has not been made explicit in the psychotherapeutic literature and this article begins to address this conceptual gap. Patients' dysfunctional modes of being and relating are often enacted through three types of transference testing behaviours: (a) testing by compliance, (b) testing by non-compliance, and (c) passive-into-active testing. Clinical material is selected from the case notes and archival material generated by the author's work as a psychotherapist and used to represent these types of transference testing behaviours.

BASIC PREMISES

Relational psychoanalysis, sometimes referred to as the *interpersonal approach*, consists of the principle assumption that individuals are defined by their relationships with other people. From within this perspective, relationships are viewed as the

very substance of life, they define who we are. It is not just that interpersonal relationships are necessary for the formation of the psychological structure of the ego or self, but that the very nature of all individuals is inherently relational (Gill, 1983). From within a wider theoretical context, if one views Freud's drive-ego model as relatively neglectful of interpersonal relations, and the object relations theorists as emphasising them, then the interpersonal model may be viewed as possibly the next theoretical step – a model based more fully and completely on interpersonal relations (Summers, 1994).

The pioneering work of Harry Stack Sullivan (1953, 1970) has been credited with developing the interpersonal or relational approach to psychoanalysis, but it is contemporary theorists such as Merton Gill (1981, 1983), Jay Greenberg and Stephen Mitchell (1983) (who parted conceptual company later on) (Greenberg, 1991; Mitchell, 1988), Irwin Hoffman (1991), Edgar Levenson (1981), and Edward Teyber (2000), who have developed variations of relational psychoanalysis.

The position of relational psychoanalysis, as outlined by Mitchell (1988), is that the young child learns the range of possibilities and limits of relating to others first from the parents. Such relating is anchored in the child learning what she or he needs to do interpersonally in order to reduce the anxiety that comes from the imagined or real loss of contact with parents. Through this compliance, the child obtains the acceptance and love he or she needs from the parents. From within this perspective, these modes of engagement with the world become the child's template for all subsequent relationships. Out of these patterns of relating, the child begins to construct a self. 'Each person is a specifically self-designed creation, styled to fit within a particular interpersonal context' (Mitchell, 1988, p. 277). Problems in living are viewed as rooted in these (now limiting) relational patterns or relational configurations, formed in childhood. These relational patterns are not easy to discard, as they were a means of safely reducing the anxiety of loss of contact (and thus loss of self identity). Instead, they continue to play a role in the now adult's life. 'It is the degree of rigidity of the relational configuration, that is, the extent of attachment to the archaic childhood objects that determines the extent of maladjustment of the personality. Flexibility of the self-organisation, the freedom to experience different relationships in different ways, is Mitchell's concept of mental health' (Summers, 1994, p. 321).

The relational psychoanalytic viewpoint of treatment or therapeutic intervention would therefore include helping the individual to begin to experience a wider sense of self. This is done by experiencing a new relationship, and thereby altering the individual's relational world. The relational perspective focuses less on the exclusive use of interpretation in the classical psychoanalytic sense (making the unconscious conscious). Instead, the therapeutic process involves the broadening of the relational possibilities of the individual, as well as the structure of the individual's relational world beyond the restrictions of childhood limitations (Summers, 1994).

Fundamental to the psychotherapy approaches mentioned above is the notion that individuals endure key traumas or traumatic experiences. These key traumas shape and demarcate our sense of self, and create the roots with which we dig into the soil of our psyches, and from which we structure the next moment, the next encounter, the next experience. This psychological structure or structuring of the psyche contains the prejudices that confine and determine our perception of self, as well as our interpretation of the other and the world. These key traumas, or what I term *self-defining moments* (defined below), are expressed in unconsciously orchestrated interpersonal (and mostly problematic) patterns of contact. The notion of trauma implies that there is psychological damage and that this damage often results in problematic modes of relating. It is often these problematic patterns of relating that bring the patient into therapy in the first place. Such dysfunctional patterns of relating are expressed in the relationship with the therapist. Self-defining moments are not always necessarily problematic. However, if they arise out of a key trauma, they can become problematic in that they can be the roots of dysfunctional patterns of relating.

With reference to the object relations model of psychoanalytic psychotherapy proposed by Summers (2000), which includes the premise that because attachment to the object or other is so crucial for the emergence of an enduring sense of self, such attachment may be at the expense of the development of an authentic self. In this way, unacceptable parts of the self are 'buried' in order to maintain the relationship (Summers, 2000). Summers (2000) emphasised the travesty of this psychological act of burying the self in the service of maintaining much-needed relationships – value is given to the maintenance of the relationship rather than to the development of potential and the realisation of an authentic self. In other words, the development of the self is sacrificed in the service of the relationship. Summers (2000, p. 91) argues that 'pathological symptoms are indirect communications of potential ways of being and relating that have been unable to find a direct avenue of expression in the world'. Symptoms are thus messages from the 'buried self'.

> In this model, the needs of the self are not conceptualized as a particular type of experience, such as autonomy or agency. The concept of self realization embraces the inherent movement toward the development of a broad range of psychological capacities, the combination of which is different in each individual. This motive is fuelled by inborn affects and the capacity to magnify them into categories of experience. Psychic well being is a function of the degree to which the individual is able to realise inborn potential, and the development of these capacities is, in turn, dependent on the relationship to the object (p. 62).

As indicated, key traumatic events that may or may not give rise to self-defining moments that are problematic, shape and define the sense of self and provoke a dramatic shift in the organisation of the self structure. This new self structure, if it is

based on a problematic self-defining moment, is expressed in what I term *disparaging critical decisions*, that is, negative decisions made about the self and the other. Such disparaging critical decisions give rise to self-disapproving pathogenic beliefs that are central to clients' problems (Beck, 1976; Beck & Freeman, 1990; Teyber, 2000). Such disparaging critical decisions and beliefs, which create a restrictive psychic organisation of the self, crystallise and remain subversive and disloyal to the deeper process of self-realisation. These self-condemning critical decisions therefore betray the healthy pathway of the emergence of potential that the buried self seeks.

As a result of what Summers (2000) refers to as the 'burial of the self', a one-sided and incomplete development of the self emerges. This buried self appears to be similar to the Winnicottian notion of a 'false self' (Winnicott, 1960b). Summers warns, however, that the notions of a 'false self' and 'true self' are frequently misconstrued. Sometimes the 'true self' is inaccurately implied to be like a '*homunculus*' somehow 'lying in waiting' inside patients, impervious to environmental forces. 'The distinction between true self and false self is meant to refer to the fact that some ways of engaging the world are genuine expressions of who the person is and others are protective of authentic experience' (p. 93). 'True self' does not mean that there is a single way to be that can be equated with the self but refers to any of a variety of possible ways of being that relate to authentic experience. The aims of psychoanalytic psychotherapy, within the object relations model as proposed by Summers, is the facilitation of potential ways of being. The therapist's task is to find the potential of the patient that is not yet fully visible, not a 'fully developed self', lying in waiting beneath the surface of social adaptation.

It seems that this 'false self' acts as if it was the authentic self, and most patients will initially present this false self in therapy. Such patients enter therapy, unconsciously holding onto their constructed false self, unaware of the buried self, and act and relate in therapy from within this limited and condemning self structure, as they do with others outside of therapy.

Winnicott (1971) suggested that the analytic relationship is a 'transitional space'. Winnicott's notion of transitional space refers to the idea that the transitional area of human experience is a specific developmental phase of 'intermediate experience', neither fantasy nor reality but illusion, a blend of both spheres. His concept was rooted in the belief that patients in some sense know that their therapist is 'an other', someone who has real and different qualities, but treats the therapist as though he or she were an object of the their creation. Summers (2000, p. 92) posits that the 'analyst's task is to provide sufficient space in the relationship for the patient to create the analytic relationship in the way he needs'.

According to Summers (2000), this view of the analytic process signals a shift from interpretation to adaptation. Rather than being confined to verbal understanding, Summers (2000, p. 92) argues that the therapist's role embraces whatever is needed to promote the development of arrested potential. 'There is no illusion here

of a blank screen, but the analyst's role includes the provision of a certain "formlessness" in the setting. That is, the analyst's task is to be flexible enough to adapt to the experience the patient needs to create. Too much "form" or structure restricts the space the patient can make use of in order to realise the yet unborn self.'

In this context, the therapist must therefore read patients' behaviours as an expression of a need and then adjust him- or herself as far as possible to provide an experience the patient can use to articulate new ways of relating.

In summary, all initial modes of relating and being (relational templates) in the therapeutic space are unconsciously poisoned by the disparaging critical decisions and self-beliefs which are detrimental to the development of an authentic self. In this regard, there is little opportunity for what Summers (2000) refers to as 'the transcendence of the self'. This notion of the transcendence of the self is understood as the process in which the limiting and limited self, or the self which is unpotentiated and lop-sided in its development, can safely begin, under certain conditions, such as in psychotherapy, to express itself more fully, more authentically, taking risks with new behaviour, and in so-doing, rise above or transcend limitations, and realise and release its hidden and buried potential.

Since adult patients' psychological survival depends on maintaining much-needed relationships, this false self *re-enacts* patterns of limiting interpersonal relating or problematic or faulty relational templates (Teyber, 2000) within the therapeutic space (Winnicott, 1971). When this happens, there is often a confirmation of the early self-disapproving pathogenic beliefs and critical decisions while ignoring evidence that would disconfirm such beliefs and decisions.

A brief note on relational templates: Teyber (1997) describes relational templates as 'ingrained relational responses and expectations' (p. 18). These are relational patterns or 'relationship themes that are more pervasive . . . across the different narratives the client relates' (p. 50). 'Faulty' or 'problematic' relational templates are understood as repetitive self-defeating relational patterns.

PATIENTS COACH THEIR THERAPIST IN PSYCHOTHERAPY

The notion that patients coach their therapist in psychotherapy was first introduced by Casement (1985, 1990) who borrowed concepts from Bion, Lang, and Winnicott, and suggested that patients may unconsciously prompt and guide their therapist in the direction that they most need in order for therapeutic progress to occur. Casement proposed that therapists need to adopt an attitude of empathic receptivity to these unconscious communications from patients, and to be attuned to how best to facilitate a new experience that could begin to break the old patterns of negative beliefs that result in problematic relational templates. Weiss (1993) developed this notion that patients coach their therapist in psychotherapy, locating it within a control mastery theory (CMT) framework. Weiss demonstrated how patients coach their therapist and suggested that patients are much more self-aware of what they need and

how they can get their need met. However, this study and other similar studies (Bugas & Silberschatz, 2000; Silberschatz, Curtis & Nathans, 1989; Silberschatz, Curtis, Sampson & Weiss, 1991) do not build the links between patient coaching behaviours, transference testing and the corrective emotional experience. It is this aspect of the therapy process that I focus on below.

In the process of psychotherapy, patients will bring to therapy memories of their key traumas or self-defining moments. Therapy is a story-telling process, and in the telling of the story the nature of the problems these events or defining moments created for patients become apparent. Patients tell their tragic and often sad stories in such a way that most therapists are usually moved by the events and respond empathically. However, patients also tell these stories in such a way that there is an unconscious message embedded within the core theme(s) of the stories and that alert their therapist to what might be their core needs in therapy and how best their therapist can be receptive to meeting such needs. Patients unconsciously coach their therapist, communicating to him or her what they need to experience in therapy – what kind of new relationship they need from him or her that will disconfirm their pathogenic beliefs and critical decisions about themselves (Bugas & Silberschatz, 2000). There is an unconscious hope that at least this time, in this relationship, it can be different.

The definitions and meanings of transference: Transference as 'transitional space'

Transference is possibly one of the most important but most misunderstood concepts in therapy. This misunderstanding has arisen from the fact that the field of psychotherapy has used the term to convey different meanings, and over the years several competing definitions have emerged. Two of these definitions are described here. Proposed by Freud (1912), the first definition limited transference to the transfer of drive-based wishes from childhood. Traditionally, transference has referred to the feelings, thoughts and ways of being, as well as the perceptions that are rooted in patients' drive-originated wishes and that are transferred to the therapist. The classic psychoanalytic model is based on the notion that the therapist is neutral (a blank screen) and whatever emotional reactions patients have towards the therapist are distortions or misinterpretations that have been unrealistically transferred to the therapist from past relationships. Most patients do have preconceived notions and do relate to the therapist (and others) along old, familiar ways of relating and being. These are enduring aspects of patients' inner life, and are often evoked in the therapeutic relationship. When these types of traditional transference mechanisms occur in therapy they distort patients' perceptions of the therapist (Teyber, 2000).

In contrast and in reaction to the traditional view, the second and more commonly used definition within relational psychoanalysis is broadened to include *all* of the feelings, perceptions and reactions that patients have towards the therapist, both

realistic and distorted. These reactions to the therapist can be either highly distorted or accurate and reality-based (Teyber, 2000).

The object relations concept of transference, broadly located within this second definition of transference, understands transference as 'transitional space' (Winnicott, 1971), which broadens the transference arena to whatever affects and meanings compose patients' experience of the therapist. Summers (2000) argues that any effort to confine the impact of the therapeutic relationship to drives is unhelpful, reductionistic and limiting. In this object relations definition of transference as transitional space, transference is an illusion, a 'blend of reality imbued with personal meanings, that is, a transitional experience' (p. 94). The 'as if' quality of the transference reflects the dual nature of the patient's experience of the analyst: Patients know that, as mentioned above, some of their affective responses to the person they perceive the analyst to be may be a result of distortions, but these patients treat the analyst according to their feelings anyway.

The creation of the object is inherent in the notion of transitional space. The reality of the therapist is included in patients' experience, so that patients never simply 'transfer' or re-enact an object relational pattern from the past but, according to Summers (2000, p. 95), 'enact it in some new way with the therapist, thus creating a new version of the old relationship'. Summers warns that this novel aspect of the relationship must not be confused with its repetitive aspect. In this regard, Summers writes that the definition of transference as transitional space gives significant value to both the newly created relationship and the repetitive components that tend to define the therapeutic issues to be addressed and resolved.

TRANSFERENCE TESTING BEHAVIOURS AND THE CORRECTIVE EMOTIONAL EXPERIENCE

Transference tests are patients' trial actions which are usually unconsciously designed to help them overcome their disparaging critical decisions and self-defeating pathogenic beliefs about themselves and the world.

Tests depend on the 'appropriate response' of the therapist for their success. 'Appropriate response' refers to the response which patients need from the therapist and which begins to challenge patients' disparaging beliefs about themselves and the other. In other words, patients test their therapist to determine the extent to which their decisions and beliefs are true. In the therapeutic relationship, patients continue to act from within problematic relational templates, and test to see if such modes of relating are also required of them by their therapist. They do this in order to assess how safe it is for them to let go of the limited interpersonal patterns and adaptations. Transference testing is thus done with the aim to determine whether it is 'safe enough' to relinquish problematic interpersonal adaptations (Rappoport, 1997; Weiss, 1993).

The patients' search for safety becomes paramount in making decisions with regard to relaxing or maintaining their defences. Patients test their therapist to find the

safety they need, which would free them to be less defensive (Rappoport, 1997), less resistant, and assist them in breaking the dated patterns of self-disapproving beliefs and problematic relational templates. In this context of testing, therapy becomes a risky business as it can potentially expose patients to more damage or re-traumatisation (Rappoport, 1997). In order to find out if it is safe to be less defensive, and whether their deeply embedded relational expectations can be relaxed this time with this person (their therapist), patients will act in ways that are designed to elicit this kind of information from their therapist. If their therapist (unwittingly) re-enacts patients' relational expectations, therapy will often stall or end prematurely (Teyber, 2000).

If a transference test has a successful outcome, patients show immediate signs of an increased sense of safety. Such signs include greater relaxation (relaxed posture, deeper breathing), less vocal stress, more fluid use of language, and a less defensive posture (Rappoport, 1997), which allows for a greater sense of self-acceptance and emotional expressiveness. If transference testing is unsuccessful, that is, when therapists fail the tests and re-enact old problematic relational responses, the opposite of the above responses will be apparent – patients become defensive, emotionally withholding or tightly controlled, and no new material is introduced into the therapy.

This unwanted re-enactment occurs when patients elicit responses from their therapist that are thematically similar to those they have come to expect from others, based on past experience. This eliciting behaviour is enacted with the aim of obtaining a different response to the familiar relational scenario that they have come to expect (Teyber, 2000). However, it is not merely a different, more helpful and undamaging response that they are hoping for, but a new relationship in which their own potential can be fulfilled and their hidden and buried self realised (Summers, 2000).

Therapists need to work together with their patients to establish a different pattern of interaction or mode of being and relating that does not recapitulate the old relational scenario. If therapy is to lead to change, the therapeutic process must enact a resolution of patients' conflicts, rather than a repetition of them. As indicated, patients need an experience that will begin to disconfirm their beliefs about themselves, but they also need to begin to create an experiential knowledge that although old conflicts may have been aroused, and old expectations fearfully encountered, this time, in this (therapeutic) relationship, it can be different, and they can experience a new and different relational response or outcome from the therapist, which is contrary to what they have come to expect from others. This therapeutic action is known as the 'corrective emotional experience'. Alexander and French (1946) were the first to document this notion.

Alexander (1954) recognised that patients frequently use the analytic experience in order to deal with unresolved conflicts under new circumstances. He therefore pointed out that, if the therapist's reactions to a patient are too similar to those of the parents, this can lead to a mutual involvement in the patient's transference neurosis.

He noted that when the transference neurosis has developed, the therapist feels himself or herself to be placed in a role of the patient's choosing. In this context, he advised that therapists should consciously choose to respond in ways that are opposite to the manner in which the patient's parents had behaved, arriving at this role by a 'principle of contrast'. This original notion, as articulated by Alexander, of the corrective emotional experience is one that is contested (Casement, 1985, 1990). Casement notes that deliberately adopting a role in relation to the patient, and thereby manipulating the therapeutic setting, becomes a way of influencing what the patient experiences in the therapy. In this sense, the original understanding of this therapeutic action infringes on the patient's autonomy, and is antithetic to the therapy process.

Since the introduction of this therapeutic action by Alexander, and owing to the controversy surrounding the original term, its meaning has been re-interpreted and modified. A revised meaning is offered by Winnicott (1971). He suggested that the patient searches for and uses the object. He recognised that there is in every patient an unconscious awareness of the experiences that need to be found, to be re-lived in the transference. In this sense, patients look for opportunities in therapy that assist them to get in touch with previously unmanageable experiences (Casement, 1985). In the transference, therefore, the therapist is used to represent an earlier relationship. The mistakes made by the therapist are also used to represent earlier bad experiences.

Many therapists, such as Casement (1985, 1990), Corey (2000), Corey and Corey (1992), Kell and Mueller (1966), Malan (1963, 1979), Mander (2000), Strupp (1980), Teyber (2000), and Yalom (1995), have subsequently written about the psychological significance of the corrective emotional experience in psychotherapy in the light of the contestation of the term. According to Teyber (1997, p. 143), a 'corrective emotional experience occurs when the therapist responds in a new and safer way that resolves, rather than metaphorically re-enacts, clients original conflicts'. Patients working through their issues or conflicts within the therapeutic space (Winnicott, 1971) may relive or re-enact experiences that they were unable to resolve by themselves (Kell & Mueller, 1966), and the therapist contributes, by permitting the patient *to create the therapist* into whatever role the patient needs in order to undergo or relive an experience which previously had traumatic results or consequences, but which now will be experienced differently in terms of providing them with a different response to that which they imagined would result. In this sense, Casement (1985, p. 172) writes:

> When there has been a lack of adequate structure, within which a patient could have more securely negotiated key developmental phases of growth, there is a *search for structure* in the therapeutic relationship. When there has been a lack of sufficient responsiveness in the person taking care of the infant's attempts at communicating . . . there is a *search for responsiveness* from the therapist. When there has been a lack of mental or emotional privacy, within which a child can begin to establish a viable separateness from the mother (or other adults), there is a *search for space.*

To expand this point from within an interpersonal approach, patients also believe actions, not only words. For example, patients who have been deprived of privacy and confidentiality, or emotional responsiveness, will often indicate from the start their fear that this will not be found even in therapy. Therapists thus need to allow their patients to create and use them (in the Winnicottian sense of 'object usage'), and also provide their patients with an experience (action) rather than mere explanation (interpretation) (Fromm-Reichmann, 1960). (This does not, however, mean that interpretation is not used or valued as part of the therapeutic process.) Passing transference tests is closely related to the corrective emotional experience in that both therapeutic actions require that therapists 'must respond to patients' conflicts in more helpful ways than the caretakers did originally' (Teyber, 2000, p. 18). 'Accurate interpretations, relevant educational inputs, and effective cognitive restructuring will be useful in almost every therapy, but they are not the primary seat of action in the interpersonal process approach . . . patients change when they live through emotionally painful and ingrained relational scenarios with the therapist, and the therapeutic relationship gives rise to outcomes different from those anticipated and feared' (p. 17).

Thus, they experience within the 'holding environment' (Winnicott, 1971) a close therapeutic interpersonal envelope of caring, a new and positive emotional response to the original key trauma. Once this corrective emotional experience has been experienced, all other intervention techniques become more effective (Teyber, 2000). However, it is important to note that 'experiencing an interaction with their therapist that is incompatible with their maladaptive relational templates does not make up for patients' childhood deprivations or disappointments' (p. 245).

In short, patients unconsciously set up transference tests for the therapist and therefore give clues to the therapist as to what type of corrective emotional experience they need. The corrective emotional experience is set up by the therapist's flexibility and openness to being used and created by the patient. Transference testing has three broad aspects, namely, testing by compliance, and non-compliance, and turning passive-into-active. These three aspects of transference testing are described below.

Testing by compliance

In testing by compliance, patients comply with what they believe are the needs of their therapist and attempt to determine whether the therapist is gratified by this behaviour. Complying behaviours mean that patients attempt to meet the needs of others (Rappoport, 1997).

From within an object relations perspective, as described by Summers (2000), modes of being and relating in the world are adaptations at the expense of the development of the authentic self. The much-needed relationship becomes more important than the realisation of the self and interpersonal behaviours are understood as manoeuvres that preserve the needed relationship. From within this perspective, such behaviours are enacted in the therapeutic relationship in order to avoid loss of

contact and the experience of 'annihilation anxiety' or 'unthinkable anxiety' (Winnicott, 1951, 1960a). Sullivan (1970) suggested that the avoidance of anxiety in relationships, including the therapeutic relationship, is the most fundamental motivating force of behaviour. Similarly, object relation theorists, such as Klein (1957, 1958, 1959), Kernberg (1976), and Fairbairn (1944) proposed that the fear of annihilation anxiety gives rise to the development of a self-structure. In order to protect against the 'unimaginable terror' (Winnicott, 1951) and the anxiety of the loss of a sense of self (annihilation anxiety), patients will engage in cycles of primitive defences of projection and introjection, denial and splitting.

Examples of compliance include meeting the needs of others with little regard to one's own needs, feeling inappropriately guilty and responsible for others, and accepting invalid criticisms from others about oneself. Passing this kind of transference test means that therapists must not seem gratified by such compliance. If patients perceive that their therapist is not satisfied by such compliance then the patient feels safer to relinquish the behaviours (Rappoport, 1997). They experientially learn from the therapist that their compliance adaptations are not required in this relationship. They experience a corrective emotional experience. Below is a short slice of the case material of a patient, Alison, drawn from my work as a psychotherapist, and which illustrates this point:

> As a child, Alison had been required to take care of her mother's emotional needs and be concerned with her moods to the exclusion of her own needs. Her mother was demanding and expected Alison to attend not only to her emotional but also physical needs. Alison had to wash her mother's hair as well as her mother's undergarments, and had to provide regular cups of tea, even though she was only five years old at the time. As Alison grew older, the demands increased, and she not only had to take a greater responsibility in maintaining the household, but she also had to please her mother by doing well at school and coming first in class each year. As an adult Alison continued to take care of her mother. Alison initially acted solicitously towards me in therapy, seeking to know, not just once but repeatedly during the same session, how I was feeling and how my last session went and whether this was actually a good time for me to be with her now, or would I want to rather change the time of therapy and she could come when it felt best for me. When I pointed out this behaviour to her she replied that she thought she needed to always inquire about my moods, and she felt that she needed to find out if there was anything she could do for me. She said that she felt unable to stop this way of relating to me. I did not act gratified by Alison's exaggerated concerns for my mood or whether this was a good time for me to meet with her and interpreted this behaviour as rooted in her compliant behaviour towards her mother. Alison learnt through my non-gratification of such behaviour that it was potentially safe to be less solicitous with me.

Compliance tests are the safest forms of transference testing for patients to engage in (and, for this reason, are the kind of tests most used). This is because patients believe they are meeting the needs of their therapist, doing what they think he or she requires (Rappoport, 1997). This is done in order for them to maintain the relationship and thus contact with their therapist. Such patients have learned that compliance has a pay-off as it leads to the preservation of the much-needed relationship. This means that patients bring this problematic relational template into the therapeutic relationship. Once patients experience that such compliance is not necessary (in which case their therapist would pass the test), they will often graduate to a 'bolder form of testing, that is testing by non-compliance' (p. 254).

Testing by non-compliance

According to Rappoport (1997), testing by non-compliance involves patients' non-compliant behaviours (in terms of what they believe to be the needs of the therapist) and attempts to determine whether the therapist seems threatened by such behaviours. These actions should not be construed as rebellious. Rather, they are healthy and are an attempt to create a new relationship with the therapist in which the therapist is not destroyed or annihilated but survives.

Rappoport down-plays this aspect of therapist survival and does not elucidate the notion of the corrective emotional experience which is, from an interpersonal approach, the principle source of therapeutic change. Once patients are aware that such non-compliance does not threaten the therapist, who remains non-defensive and open, they begin to feel safe and eventually terminate such behaviour. The therapist has passed the test when patients have experienced a new way of relating and being.

> Alison, encouraged by my non-gratification of her concerns for my needs and what my moods were, or whether this was a good time for me to have a session with her, began to engage in brief moments of not wanting to know how I felt or asking if this was a good time to have a session. This was anxiety provoking for her as she was aware that she was not doing what she thought I wanted. I told her that I did not require that she be concerned about my needs or mood, and supported her to behave in a way that felt more genuine to her. As the weeks passed, Alison asked less frequently in each session how I felt. Eventually she asked only once in a session, and then one day she came to therapy and never inquired once as to how I felt, or if this was a good time for me to see her.

Rappoport (1997) proposes that this strategy requires that patients have more confidence in the therapist than does the previous one (compliance tests) since, when using it, patients are deliberately not attending to the therapist's needs and therefore anticipate the potential for being further traumatised or re-traumatised.

Passive-into-active testing

In passive-into-active testing patients treat the therapist in the same harmful ways in which they were treated by their parents during childhood (Rappoport, 1997). Patients unconsciously hope that their therapist will feel safe enough to protect and guard them from the traumatic effects of such harsh treatment. Simply stated, patients make the therapist feel what their parents made them feel when they were children. Patients do to the therapist what was done to them. This kind of transference testing, as with the other two kinds, is designed to probe for the possibility of a sense of enough safety from which they can begin to attempt to challenge their old critical decisions about themselves and their problematic modes of relating and being.

Rappoport (1997) suggests that 'passive-into-active testing' potentially is more harmful as it could result in the therapist not surviving and in being traumatised. Such patients treat the therapist in a way that they know from past experience was harmful for them, and thus they know that their actions are potentially harmful to their therapist. The following case material selected from my work as a psychotherapist illustrates this notion.

> As a child, Douglas had been systematically subjected to a great amount of harsh and unfair criticism from his father. He had felt humiliated and ineffectual. He came to therapy complaining of depression and a loss of direction in his life. He was currently a very successful and rich businessman. However, none of his achievements at university or in business seemed to bring him any joy or pride. Furthermore, he experienced his current female partner as constantly disapproving of him. He felt trapped, anxious and worthless. After several months of working on his issues in therapy, he seemed to be less depressed and to be improving. He reported how he felt less trapped in his current relationship, more empowered, and less anxious about things generally. Then one day he began to claim that therapy was a waste of money and not really helping him. He also began to belittle me, ridiculing my knowledge and therapeutic abilities, as well as questioning the authenticity of my professional registration. I realised that, based on his psychological history, he was trying to make me feel what he had felt in the relationship with his father. He was testing me, turning passive-into-active. He was trying to see if I would accept the unfair criticism and feel as humiliated and incompetent as he had with his father. I believe that he had waited several months before turning passive-into-active, as he perhaps unconsciously needed to know if I would be able to survive the attack and potentially pass the test. By waiting, he could build up the relationship with me and gain some confidence in me.

It is risky business to engage in this kind of transference-testing behaviour. There are components of identification with the parents who were the principle participants in the early dramas which gave rise to patients' critical decisions and pathogenic beliefs about the self and which are enacted in relationships. Such

identification and the passive-into-active testing reflect a deep unconscious belief that what was done to them as children was somehow deserving. Such patients often feel an immense sense of unworthiness and usually establish and maintain abusive relationships which continue to echo their belief of unworthiness.

Patients who use this strategy of testing have a desperate unconscious need to create a situation with the therapist that could potentially lead to therapeutic progress.

CONCLUDING REMARKS

Transference – what patients convey both verbally or non-verbally to the therapist – holds within its conceptual framework the possibility of the discovery of not only how patients' problematic perceptions and self-defining moments frame their behaviours towards others and themselves, and how such problematic modes of being and relating are re-enacted in therapy, but the possibility that such dysfunctional patterns of relating can be overcome and transformed. Through patients' transference-testing behaviours, and their unconscious actions of coaching the therapist, as well as the therapist successfully passing the transference tests, a psychic developmental process, which most likely would have been blocked and buried in early childhood, may be re-awakened. Such re-awakening may result in the emergence of the buried authentic self. In addition, patients may experience a new relationship and the possibility that this time, in this new relationship, things can be different. In this context, they may experience a transcendence of the self. Patients often only experience this new way of relating for the first time with the therapist who has allowed himself or herself to be created and used in the service of meeting their unmet needs. Summers (2000) reminds us that therapists must have a vision of the patient that fits who the patient is but that also goes beyond the reality of who the patient has been in order to envision the possibilities of who the patient can be. Therapists need to have a vision of patients' potential, even if patients cannot see it for themselves. Unless this vision is embraced, patients will continue to act in old problematic ways of being and relating that cannot allow for the realisation of the self.

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