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Safety in control-mastery theory

ELEONORA FIORENZA, MARIANNA SANTODORO, NINO DAZZI, &
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Abstract

This study presents an overview of the development of the main psychoanalytic conceptions regarding safety, an aspect that has received increasing attention within the psychoanalytic literature. After describing the hypotheses of Sigmund Freud, Joseph Sandler, John Bowlby, and Harry Stack Sullivan, the study focuses on the ideas proposed by Joseph Weiss and on control-mastery theory (CMT), a cognitive-dynamic relational theory of mental functioning, psychopathology, and psychotherapy. Unlike other models, CMT stresses that human beings need to feel that both themselves and the people they love are safe; each person, however, may need something different to feel safe. Two clinical vignettes are used to illustrate how the therapist can understand, from the outset of the therapeutic process, how to help the patient feel safe, stressing the case-specific nature of the conditions of safety.

Key words: *psychoanalysis, safety, control-mastery theory, plan, psychotherapy.*

Clinicians from different theoretical orientations recognize that feeling safe is fundamental for effective psychotherapy (Dallos, 2006; Gilbert & Leahy, 2007; McWilliams, 2004; Rogers, 2003). Already at the beginning of the last century, Freud (1915b) suggested that it is important that the analyst, with a nonjudgmental attitude, helps the patient feel safe so that they can bring to light their unconscious conflicts and their repressed childhood memories. At the end of his study on transference love, for example, Freud (1915a) observes how common it is for a woman in analysis to fall in love with her analyst. He argues that the analyst must neither deny nor feed such transference but regard it as a useful part of the treatment:

the patient ... will then feel safe enough to allow all her preconditions for loving, all the phantasies springing from her sexual desires, all the detailed characteristics of her state of being in love, to come to light; and from these, she will herself open the way to the infantile roots of her love. (p. 178)

Considering the importance of the concept of safety in psychotherapy and psychoanalysis, the

present study discusses the main contributions of psychoanalytic theory on the topic, beginning with Freud's theory and ending with the recent contributions of control-mastery theory (CMT; Gazzillo, 2021; Silberschatz, 2005; Weiss, 1993; Weiss, Sampson, & Mount Zion Psychotherapy Research Group, 1986). Our aim is to highlight how the conceptualization of the role of safety in mental functioning and psychotherapy has undergone a profound change.

At first, safety was seen as the possibility of not experiencing any impending external or internal danger (Freud, 1926); then, with object relations theory (Sandler & Sandler, 1998) and interpersonal psychiatry (Sullivan, 1953), its meaning has been expanded to include the idea that *real objects* can function as external *regulators for the self* and not only as a source of gratification or frustration of their desires. Finally, attachment theory (Bowlby, 1988) has placed safety at the center of human relatedness as the marker of a condition that is necessary if the child is to explore the world without anxiety.

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More recently, and in line with the contributions of evolutionary psychology (Wilson & Wilson, 2008; Wilson, Van Vught, & O’Gorman, 2008) and developmental and moral psychology (Tomasello, 2016), CMT has emphasized the role of safety in connection with the perception of the wellbeing of both the self and significant others. Feeling safe has become an *overarching and unconsciously constantly sought-after goal of the self*.

Safety in psychoanalytic theory

Traces of the hypothesis that we (unconsciously) need to feel safe to do our best were already present in Freudian theory. At the end of his life, for example, Freud (1926) hypothesizes that the unconscious ego tries to defend itself from drives and experiences that it recognizes as potentially *dangerous*. In his essay “Inhibitions, symptoms and anxiety,” Freud (1926) modifies his previous theory on anxiety as a transformation of libido, proposing that this affect arises as the ego’s reaction to a situation that is believed to be dangerous. The ego is the psychic instance that is in direct contact with external reality and is dominated by considerations of safety; the ego’s main task is self-preservation, and it uses anxiety as a signal to announce impending danger. From this point of view, anxiety activates defenses to protect the ego from dangers (Freud, 1940).

Freud then analyzes the dangerous situations that are fundamental for psychic development and identifies *birth* as the prototypical event triggering anxiety, where the psyche is overwhelmed by an excessive amount of stimuli received in a very limited period. Subsequently, the child experiences the *fear of losing the loved object*, followed by the *fear of losing the love of the object*. During the Oedipal period, the central anxiety will be that of *castration*; finally, the child experiences *moral anxiety* as an outcome of the formation of the superego. Anxiety and defense mechanisms protect the ego from dangerous situations that are believed to be both possible and impending. Freud, however, rarely explicitly addresses the concept of *safety* per se, giving more importance to the *pleasure principle* or its later modification – the *reality principle* – that was based on considerations of *utility*.

Joseph Sandler¹ was the first Freudian author to discuss safety in the context of Freudian psychoanalytic theory and give it central importance. His aim

was to create a psychoanalytic model clearly connected to clinical practice and systematic psychoanalytic observation (Bolland & Sandler 1965). For Sandler (1960), perception is not simply the passive reflection in the ego of stimulations that come from the sense organs but *an activity* that the ego puts in place to protect itself from trauma and to master the stimuli that come from unorganized sensory data. Perception plays an integrating role and is accompanied by a specific feeling of safety. This necessary “background of safety” is mainly related to the *familiarity* and *constancy* of the objects in their environment, even if in an unsatisfying environment, which are usually more easily perceived by the child than unfamiliar ones. Sandler and Sandler (1998) give, then, the ego the fundamental task of *maximizing the sense of safety* and *avoiding distress*, and point out that the search for safety is a superordinate construct that organizes mental functioning: the need to ensure wellbeing and safety turns out to be more powerful than the drive to satisfaction. Thus:

the successful act of perception is an act of integration which is accompanied by a definite feeling of safety—a feeling so much a part of us that we take it for granted as a background to our everyday experience; ... this feeling of safety is more than a simple absence of discomfort or anxiety, but a very definite feeling quality within the ego; ... we can further regard much of ordinary everyday behaviour as being a means of maintaining a minimum level of safety feeling; and ... much normal behaviour as well as many clinical phenomena (such as certain types of psychotic behaviour and the addictions) can be more fully understood in terms of the ego’s attempts to preserve this level of safety. (Sandler, 1960, p. 352)

To better explain this, the authors hypothesize a *value investment of the object*, defining it as an emotional state that a particular mental representation is connected to and that shapes the attractiveness or repulsion of that representation. Object representations can thus have not only a drive investment, but also a *safety or wellbeing investment*. In anxiety-generating situations, the individual has the superordinate motivation to seek out an object relationship that in their representational world is associated with safety, whether it is a fantastic or a real object, or an object that can be connected to other pleasurable or unpleasurable affects.

Moreover, according to Sandler and Sandler (1998), the human mind tends to *actualize* mental representations connected to the feeling of safety by

¹In 1952, Winnicott wrote an essay on the “Anxiety associated with insecurity,” where he talked about the fact that an infant can feel “insecure” because of deficits in the holding they receives from their mother.

actively, albeit unconsciously, involving other people as co-actors in these enactments (cf. the concept of *role responsiveness*) so as to establish an “identity of perception” (Freud, 1899) between these internal representations connoted with safety and the present external reality. If Freud has always supported the idea of the centrality of the search for pleasure as the basis of mental functioning, it now seems that the paradigm has changed because *the existence of a superordinate principle – the maintenance of safety – is postulated as the regulatory principle of mental functioning*.

The idea that feeling safe is crucial (and that this affect is unrelated to the gratification of libidinal drives) is also at the core of Bowlby’s attachment theory, which was conceived in the 1950s and developed in the following three decades.² Bowlby integrates concepts of clinical psychoanalysis with discoveries and constructs of ethology (Harlow, 1958; Hinde, 1959; Lorenz, 1935; Tinbergen, 1951), cybernetics (Wiener, 1950), and developmental and experimental psychology (Piaget, 1936; Pribram, 1967; Young, 1964), and theorizes the existence of attachment as an autonomous *behavioral system*.

The psychological purpose of attachment is to increase individual safety, whereas its biological purpose is to provide protection through the physical proximity and psychological availability of an older, stronger, and wiser caregiver in situations of danger. The attachment system is activated by internal or external stimuli, and the child carries out *coordinated, environmentally labile behaviors directed toward a goal*, defined as attachment behaviors (such as clinging and following), aimed at gaining physical proximity to the caregiver. In other words, attachment behaviors ensure that the child will be close to a person who can protect them and are turned off when the child is close to the caregiver.

According to this theoretical framework, the most important feature of parenting is to provide a *secure base* (Ainsworth, 1967) for children, which implies that the attachment object(s) must be available and ready to respond when called and must be encouraging, giving help, and actively intervening when necessary. Moreover, the child needs to explore and become familiar with the world as well as develop autonomy, and they can do this only if they have a *safe haven* to return to if needed.

Based on the real relationship with their caregivers, the individual builds internal working models

(IWMs) that are representations of themselves and the attachment figure and that encode how the relationships between them operate. IWMs serve to regulate, interpret, and predict one’s own behaviors, thoughts, and feelings and those of the attachment figures. In this way, when a child is cared for by a caregiver who is available and attentive, they will feel secure enough to go out into the world because they know that in situations of danger or stress, they have a strong and wise person whom they can ask for help.

During psychotherapy, the clinician has to provide safe conditions that allow patients to explore the painful and unhappy aspects of their life and enable them to reorganize and update patterns derived from early painful experiences in light of new experiences. According to Bowlby (1988), “If the therapist does not give the patient a certain degree of safety, the therapy cannot even begin” (p. 136). Differently from Sandler, however, Bowlby stresses the relevance of *real experiences*, both in child development and in therapy, in providing conditions of safety and in the development of the representational world; further, he stresses how the roots of this search for safety lie in the evolutionary history of mammals.

The American psychiatrist and psychoanalyst Harry Stack Sullivan, founder of interpersonal psychiatry, underlines the importance of interpersonal safety. In *The interpersonal theory of psychiatry* (1953), he makes clear the importance of interpersonal relationships and the concept of safety by theorizing the concepts of the *self-system* and *security operations*. According to Sullivan, from the early years the child manifests a need for contact that is no more than the purely human necessity of closeness and manipulation by other human beings, and is completely unable to get by without a caregiver. Children request the satisfaction of their physical-chemical needs, and this induces in the mother a tension experienced as a need for tenderness and as an impulse to perform activities that bring relief to the child. The caregiver’s activity aimed at providing relief to the child’s needs is immediately experienced as the beginning of a tender behavior and, from that moment, those needs whose satisfaction requires the cooperation of another person assume the generic character of a *need for safety*.

By contrast, anxiety is an obstacle to the formation of interpersonal situations that are necessary for the

²Two authors who may be considered forerunners of Bowlby’s theory of attachment and whose views radically differed from the Freudian perspective were Hermann (1943) and Suttie (1935). Hermann describes the instinct in primates (including humans) to cling to caregivers, especially in situations of danger and stress. Suttie argues that the innate need for sociality is the infant’s only means of survival and is independent of genital appetites. In *The origins of love and hate*, Suttie (1935) suggests that the need for tenderness in a small child is a primary need that was not based on hunger or sexuality. The child needs the protection, care, and tenderness of the mother, and when they are deprived of their mother’s loving behavior, they lose their sense of safety.

satisfaction of needs. Anxiety arises from interpersonal relationships because it is induced in the child by the mother and has the characteristic of disintegrating interpersonal situations created for the satisfaction of needs. Anxiety prevents the person from making decisions regarding the best thing to do to bring relief because it limits the ability to satisfy needs. Therefore, the only solution is to apply a *safety mechanism*, such as *apathy* – that is, a state in which the child suspends all their tension:

This tension and the activities required for its reduction or relief—which we call security operations because they can be said to be addressed to maintain a feeling of safety in the esteem reflected to one from the other person concerned—always interfere with whatever other tensions and energy transformations they happen to coincide with. This in no way denies the usefulness of security operations. They are often quite successful in protecting one's self-esteem. Without them, life in an increasingly incoherent social organization would be exceedingly difficult or impossible for most people. (Sullivan, 1948, p. 109)

Therefore, for Sullivan, the need for interpersonal safety is equivalent to the need to free oneself from anxiety and have a *normal enough* life.

Based on what we have seen so far, the individual looks for safety – within relationships with significant others – for their wellbeing. This involves feeling free of negative emotions and being protected from dangers to the self.³

With the passing of time, increasing emphasis has been placed on the interpersonal aspect of safety and the importance of intimate relationships with real others as the primary source of safety. More than on the balance among intrapsychic forces, safety depends on the actual interactions between the child/patient and their caregivers/therapists. Further, safety is more important than pleasure as a regulation principle of mental functioning. In fact, the entire focus of psychoanalytic thinking shifts from the pleasure-driven regulation of the relationships among different psychic structures (e.g., id, ego, superego, and internal objects) to the safety-based regulation of the different states of the *self* with their relative experience-based *expectations*.

CMT (Gazzillo, 2021; Silberschatz, 2005; Weiss, 1993; Weiss et al., 1986) shares the idea of the centrality of safety as the core regulatory principle of mental functioning but stresses how, to feel safe, human beings need to *believe* not only that they are

not in danger, but also *that the people they are close to and their relationships with them are not in danger*. In line with contemporary evolutionary theories that regard human beings as fundamentally prosocial (Tomasello, 2009), CMT stresses the mutual and altruistic component of the sense of safety: human beings feel deeply threatened when they believe that a significant other (internal or external) is suffering or that their relationship with them is in danger.

Safety in control-mastery theory

Weiss (2005) states that “Our pursuit of a sense of safety is rooted in biology and is to a considerable extent unconscious” (p. 31), and we perform this task every day, in every moment, and mostly unconsciously.

A child regulates their relationships with their parents according to a safety principle, and patients do the same with their therapists. As Bowlby (1988) observes, feeling safe with parents is a necessary condition if the child is to develop, and the patient's sense of safety with their therapist is a necessary condition if they are to overcome their difficulties and pursue their therapeutic goals. CMT (Weiss et al., 1986) has in fact empirically shown that people exercise unconscious control over their repressions on the basis of the unconscious appraisal of *danger* and *safety* (Sampson, 1990) and that, during the analytic process, the patient maintains repressions, symptoms, or inhibitions when they believe that not doing so would represent a danger to the self or another important person. This means that *the patient's progress in psychotherapy is regulated by unconscious appraisals of danger and safety* (for empirical evidence supporting these ideas, see Gassner, Sampson, Weiss, & Brumer, 1986; Horowitz, Sampson, Siegelman, Wolfson, & Weiss, 1975; Silberschatz, 2017; Silberschatz, Fretter, & Curtis, 1986; Weiss, 1990).

The phenomenon of *crying at the happy ending* (Weiss, 1952) is a prototypical example of this safety principle. We do not cry when a couple in a romantic movie is dealing with their problems, but we cry at the end when they are no longer in danger. Only at that point do we feel safe to fully experience and express our emotions. To allow ourselves to experience our emotions only when we feel safe to do so has an adaptive function because it helps us to more effectively deal with the problem at hand.

³Other psychoanalysts, such as Melanie Klein (1932, 1957) and Donald Winnicott (1958, 1963, 1965), highlight how the perception or fantasy of having damaged the love object/environment mother because of one's own aggression/ruthless love is a source of intense distress for the person. The child realizes that the bad object being attacked is also the good object that provides care and need satisfaction. This generates an anxiety about losing the object and the need to repair it. However, these feelings are not based on altruistic concerns: in fact, the child fears losing the object because they need it; without the living and whole object that supports them, the child's ego might become vulnerable and break into pieces.

When we feel safe, we can experience the previously inhibited painful emotions and rethink about what might have happened; this also is adaptive because it enables us to master our negative experiences. Thus, according to CMT, adaptation is the overarching motivation of conscious and unconscious mental functioning.

To adapt to their environment, human beings need to consciously or unconsciously assess reality; plan their goals; predict and assess the consequences of their actions; take decisions; identify, process, and manage their emotions; and master their traumatic experiences. This unconscious higher mental functioning (HMF) paradigm (Weiss et al., 1986) is based on Freud's (1926, 1940) later writings and has been substantially supported by studies of infants, cognition, and evolutionary psychology (for an overview, see Leonardi, Gazzillo, & Dazzi, 2021).

Our ability to adapt to our environment is based not only on the establishment and maintenance of stable relationships with relevant others, but also on the construction of a reliable set of beliefs about how things are (reality) and how we should behave (morality) in a process that continues throughout the life course (Silberschatz, 2005; Weiss, 1993). These beliefs may be unconscious/implicit or conscious/explicit (Gazzillo, 2022) and store the contingencies we have detected in our experiences, and most of them can be formulated according to an *if ... then* format. Over time, these beliefs are generalized and tend to become self-confirmatory. They determine the way we perceive reality, express our emotions, and direct our behavior, and they shape our motivations and the expression of our temperamental traits and basic motivations; thus, they are the basis on which we build our personalities.

The need to adapt to developmental *traumas* may result in the development of beliefs that associate the achievement of healthy goals with danger (both internal and external) for the person, their significant others, or their important relationships (Fimiani, Gazzillo, Fiorenza, Rodomonti, & Silberschatz, 2020; Sampson, 1992). Here, internal danger refers to the experience of negative feelings such as guilt, shame, pain, or humiliation. External danger here means something negative that happens to ourselves or to the people who are important to us. Such beliefs are the cornerstone of psychopathology, and for this reason we call them *pathogenic*.

CMT stresses that people develop pathogenic beliefs to maintain bonds and preserve the wellbeing of the self and/or important others. When faced with traumatic experiences that threaten their sense of safety – including acute shock traumas and chronic stress traumas – they try to understand why these events happened, how they might have prevented

them, and how they can prevent them from reoccurring. Given childhood tendencies to attribute responsibility for what happens to ourselves and preserve positive relationships with caregivers – maintaining their images as good and wise – adverse and traumatic experiences tend to promote the development of beliefs that associate our pursuit of adaptive goals with harming the people we love. Several pathogenic beliefs end up fueling *maladaptive interpersonal guilt* (Bush, 2005; Gazzillo, Fimiani, De Luca, Dazzi, Curtis, & Bush, 2019a).

CMT categorizes five kinds of interpersonal guilt: *separation-disloyalty guilt*, deriving from the belief that being independent, autonomous, or different from important others makes them suffer; *survivor guilt*, deriving from the belief that being or feeling better off than important others makes them suffer; *omnipotent responsibility guilt*, deriving from the belief of having the power and the duty to make loved ones happy and healthy so that putting one's own needs in the foreground means being egoistic and making loved ones suffer; *self-hate*, deriving from the belief of being wrong, bad, and inadequate and feeling undeserving of protection, love, and happiness; and *burdening guilt*, deriving from the belief that expressing one's own needs means burdening and hurting other people. As has been noted and empirically shown (for an overview, see Faccini, Gazzillo, & Gorman, 2020), pathogenic beliefs related to guilt (Bush, 2005; O'Connor, Berry, Lewis, & Stiver, 2011) originate from attachment, fear, a concern for the wellbeing of significant others, and the need to preserve a bond with them.

Owing to the painful, constricting, and grim nature of pathogenic beliefs (Silberschatz & Sampson, 1991), people are highly motivated to become aware of and disconfirm them (Curtis, Ransohoff, Sampson, Brumer, & Bronstein, 1986) mainly by *testing* them. CMT defines such testing as (unconsciously) devised communications, attitudes, and behaviors aimed at disproving one's pathogenic beliefs or as trial actions aimed at assessing the level of safety of the therapeutic relationship (Fimiani, Gazzillo, Gorman, Leonardi, Biuso, Rodomonti, et al., 2022; Gazzillo, Genova, Fedeli, Dazzi, Bush, Curtis, et al., 2019b). We test our pathogenic beliefs within interpersonal relationships, including therapeutic ones, to obtain a sense of safety and understand how reliable those beliefs are, as well as the extent to which we can feel free to reach our healthy goals.

From a certain perspective, we can also say that patients in psychotherapy are always testing because they are always interested in understanding whether their therapists share their pathogenic beliefs. However, certain indicators make it more

probable that a patient is testing the therapist. Among these indicators, we find that: (1) the patient makes implicit or explicit requests to the therapist, (2) the patient pulls the therapist to say or do something, (3) the patient stirs up strong emotions in the therapist, and (4) the patient behaves more irrationally or provocatively than they usually do (Weiss, 1993, p. 95).

According to CMT, there are two main testing strategies: *transference* testing and *passive-into-active* testing. A transference test involves the patient's observation of whether the therapist's responses to them are different from the traumatizing ways the patient was treated by others when they try to pursue adaptive goals that they are afraid may cause a danger. A patient can use transference testing by behaving as though the pathogenic belief is true or by behaving in a way that opposes (often tentatively) the pathogenic belief. The former represents a transference test *by compliance* with the pathogenic belief, whereas the latter is a transference test *by non-compliance*.

In passive-into-active testing, the patient actively (albeit typically unconsciously) places the therapist in a role similar to the one the patient previously occupied in a traumatizing situation or relationship. As with transference tests, passive-into-active testing can be either aligned with or contrary to the patient's pathogenic belief. Passive-into-active testing *by compliance* with the pathogenic belief is characterized by the patient identifying with a traumatizing caregiver and treating the therapist in a way that the patient experienced as traumatizing. The patient wants the therapist to provide a model of how to deal with the traumatizing behavior without developing the same pathogenic belief(s). In a passive-into-active test *by non-compliance*, the patient treats the therapist as they would have wanted to be treated; hoping that the therapist will appreciate that behavior that legitimizes their thwarted infantile needs. Thus, by observing the therapist's response to either kind of passive-into-active testing, the patient can begin to disprove pathogenic beliefs that were formed in response to earlier traumas and adverse experiences (Gazzillo, Kealy, & Bush, 2022a, 2022b).

If the therapist responds to testing behaviors in a way that reinforces the patient's pathogenic beliefs, the patient may feel endangered by the idea that the relationship may not provide them with the conditions necessary to overcome their pathogenic beliefs. By contrast, they may experience a greater sense of safety when the therapist *passes* the test (i.e., their pathogenic beliefs are disconfirmed). Empirical research has shown that when the therapist responds in ways that pass the patient's test, the latter

generally becomes less anxious, less depressed, more involved in the therapeutic process, and more insightful and motivated to pursue their goals. When the therapist fails the test, the patient may become more anxious and depressed and less involved in the therapeutic process, and may change the topic or become silent or confused. The therapy may then stall (for overviews, see Gazzillo et al., 2019a; Fimiani, Gazzillo, Gorman, Leonardi, Biuso, Rodomonti, et al., 2022; Silberschatz, 2017).

When considering the patient's traumas and pathogenic beliefs and the testing strategies connected to them, the therapist can also understand which *attitudes* may be more appropriate to take. It should now be clear that patients will be helped by a therapist's attitude that is different from both that of the traumatizing parents and that assumed by the patients to adapt to their parents. In other words, the therapist can use their attitude to both provide the patient with corrective emotional experiences and act as a role model (Sampson, 2005). According to CMT, even *dreams* (Gazzillo, Silberschatz, Fiamini, De Luca, & Bush, 2020) and *sexual fantasies* (Bader, 2003; Rodomonti et al., 2021a) reflect a person's efforts to pursue healthy goals and feel safe, disprove pathogenic beliefs, solve problems, and master traumas.

Given that human beings constantly work to adapt to reality and pursue a sense of internal and external safety, every human activity is regulated by a *plan* comprising goals and strategies (Miller, Galanter, & Pribram, 1960; Weiss et al., 1986). Patients come to therapy with a set of needs and priorities and an idea of how they want to engage with the work. In other words, they begin their therapy with a plan (Gazzillo, Dimaggio, & Curtis, 2019c) that they convey to their clinician at the beginning of the treatment. The components of this plan comprise the goals that patients want to pursue, the pathogenic beliefs they want to disprove, the traumas and adverse experiences they need to master, the way they want their therapist to help them (e.g., by passing their tests and building the kind of relationship they are looking for), and the knowledge they may want to acquire to feel better. Empirical studies have shown that the plan can be reliably formulated during the first sessions of treatment and that the therapist's supporting interventions can correlate with the patient's improvement both immediately after the intervention and at the end of therapy (Gazzillo et al., 2022c; Silberschatz, 2017).

Finally, studies have shown that patients work hard to help their therapists understand their plan through *coaching communications*, both direct and explicit and allusive or implicit (Bugas & Silberschatz, 2000; Bugas, McCollum, Kealy,

Silberschatz, Curtis, & Reid, 2021). Coaching communications are intended as a way of helping the therapist understand what patients need to feel safe, and if they act on them, patients may improve.

To conclude, CMT, in line with other models (Bowlby, 1988; Freud, 1926, 1940; Sandler, 1960; Sullivan, 1953) and recent neuroscientific findings (Le Doux, 2012; van der Kolk, 2014), stresses the centrality of safety: the human mind works both consciously and unconsciously to adapt to the environment, monitoring what happens inside and outside the self as it pursues its goals according to a safety principle (Weiss, 1990). However, although the centrality of pleasure has been partially abandoned in favor of safety in psychoanalytic theory, the latter is still conceptualized as a “selfish affect.”

From this perspective, CMT significantly differs from other approaches, as it argues that the sense of safety is always mediated by (unconscious) beliefs about the level of wellbeing and happiness of both the self and other loved ones – to the point where people might self-sabotage to not feel threatened and not threaten the relationships with their significant others. Here, CMT is in line with the hypotheses proposed – among others, by Michael Tomasello (2009, 2016) – about the inborn nature of human altruism and the human inborn proclivity to take care of important others’ wellbeing to feel and *de facto* be safe.

Thus, according to CMT, the main task of the therapist is to make their patients feel safe, and to do so, the therapist must understand what each specific patient needs to feel safe given their goals, pathogenic beliefs, traumas, and testing strategies. In other words, the therapist needs to understand and support the plan of each patient.

Clinical implications and exemplifications

CMT enables the therapist to articulate, on a case-by-case basis, how they can help to make their patients feel safe. To do so, the therapist should accurately formulate the patient’s plan at the beginning of the treatment. During the treatment, they should: (1) support patients in pursuing their goals; (2) disconfirm patients’ pathogenic beliefs; (3) help patients master the traumas and adverse experiences that are at the basis of their pathogenic beliefs; (4) pass the patients’ tests and adopt a pro-plan attitude that is different from the attitude of the traumatizing parents and the attitude adopted by the patient to deal with them; (5) assist patients in understanding

the origins of their pathogenic beliefs, their functions, and how they shape their problems, and in realizing that they are no longer true; and (6) follow the patients’ coaching communications.

Empirical research in psychotherapy has suggested that being empathic, providing unconditional acceptance, avoiding any form of judgment, being warm, fostering the patient’s positive expectations, and repairing the ruptures of therapeutic alliances, for example, contribute toward good therapeutic outcomes (Norcross & Wampold, 2011; Wampold & Imel, 2015). From a CMT perspective, however, this may not apply to all patients and at all moments of a therapy because each patient has different traumas, different pathogenic beliefs, different goals, and different ways of testing. The therapist must be able, therefore, to understand each patient’s plan to provide them with the help they need. A couple of clinical exemplifications may help clarify this point.

Sara⁴ and the need to be protected by a strong authority figure

Sara is a 28-year-old white woman who wants to have psychotherapy because she feels depressed and lonely. Her therapist is a 40-year-old white man specialized in psychoanalysis and CMT with more than 15 years’ clinical experience.

During the first session, Sara says that she would like to graduate but has trouble concentrating and studying; she does not know what to do with her life, and her self-esteem is quite low. She helps her mother with her job but does not like it. She often takes cocaine on weekends to feel happier; she is mourning the end of a relationship. She was with her boyfriend Luca for 4 years, although she fell out of love with him after 2 years because she came to consider him as “too fragile, not very educated, and sexually not very attractive.” In the last year of the relationship, Sara decided to spend 6 months abroad, saying to Luca that she thought their love story had ended, but when she came back to Italy, she discovered that he had fallen in love with another woman and she was “devastated.”

During the second session, Sara told her therapist about her past. Her parents got divorced when she was 2 years old, and although she had kept seeing her father regularly, she had the impression that her parents considered her “a burden.” After a few years, her mother fell in love with another man, Fabio. The three were together for 10 years, but

⁴All clinical case names are pseudonyms to ensure patient privacy. The patients described have given their therapist consent to use their material for this study, and the clinical material has been disguised.

when her mother and Fabio broke up, Fabio did not want to know about Sara, and this convinced her that nobody would be interested in her and that she had been a burden even for him. Moreover, after the end of the relationship, her mother became severely depressed and could not help her daughter during her troubled adolescence, when Sara started taking drugs and having problems at school.

Soon after having told the therapist this part of her story, Sara added that she had had therapy before. It lasted only a few months because she realized that she “could dominate” the previous therapist. When the therapist asked her for an example, Sara told him that during one of the very first sessions, she had said to the therapist that she did not want to talk about the relationship between her mother and Fabio, and the therapist accepted this. “She was not able to keep up with me,” Sara commented.

In musing about these communications, the therapist thought that Sara had made sense of her traumas by developing the following pathogenic beliefs: she did not deserve love and protection (self-hate); she was a burden to the people she needed to care for her (burdening guilt); and if she had been more satisfied with her love life than her mother, her mother would have thought she was disloyal to her (disloyalty guilt). He hypothesized also that Sara was “devastated” by the fact that her former boyfriend had fallen in love with another woman because it was a confirmation of the belief that she did not deserve love and should not be more successful in love than her mother. These same beliefs were the root cause of her difficulty in finding her way in life, her low self-esteem, and her abuse of cocaine. Moreover, he thought that, in describing what she did not like about the previous therapist, Sara was coaching him by telling him what she needed to feel safe: she needed a therapist who showed an interest in her and was able to “confront” her and stop her from doing dangerous things. She needed a strong authority figure.

During the first year of her treatment, and notwithstanding some initial protest, Sara *was* helped by her therapist’s firm attitude toward her cocaine abuse and her tendency to postpone her exams: she had to stop using any kind of substance for at least 1 year if she wanted to carry on with the therapy, and she had to study and try to pass her exams even if she was under the impression that she was not ready. She managed to accomplish both tasks within 12 months.

Laura and the right to have her agency respected

Laura was an 18-year-old girl who was “brought to therapy” by her grandmother because she had

started having panic attacks. Her therapist was a 30-year-old white woman with 3 years’ clinical experience in psychoanalysis and CMT.

At the beginning of the first session, Laura’s grandmother tried to explain her granddaughter’s problems and her character. However, Laura made the therapist understand that she wanted her grandmother to leave the therapist’s office to feel free to say what she wanted but was afraid that she would be hurt, so the therapist asked the grandmother to leave Laura and her alone.

After her grandmother had left, Laura’s attitude completely changed. She began to vivaciously talk about the fact that she was having difficulties in completing high school because, after the third year, she realized that she did not like what she was studying; on one occasion, she had had a panic attack in school. She had thought about leaving, but she was afraid that it was too late. She then talked about some of the difficulties she was having with both her boyfriend and her friends: she said she is a very direct person who always says what she thinks and feels, but she is afraid that people might take offense.

Laura added that whenever she went out with her friends, she was afraid she would meet her mother; she was ashamed of her mother. When Laura was born, her mother was a heroin addict. Laura never knew who her father was. She had been living with her grandmother since she was three years old, and her mother had not been with her for most of those years. She remarried when Laura was six years old and had two other children from the second marriage; then she got a divorce because her husband physically abused her and had hospitalized her in a psychiatric unit for some months, even though “she was not crazy.” After the divorce, the ex-husband pushed Laura’s mother to take cocaine. At this point, Laura said that this was why she felt ashamed of her mother and was afraid of being negatively judged by other people based on her mother’s appearance and behavior.

Laura then said she was not sure if she wanted to go “another time” to a psychologist. When the therapist asked her why, she explained that she had seen two psychologists before, but the first one did not seem interested in her and was often late for their appointments, and the second one treated her like a little child even though she was a teenager. She then asked the therapist whether they could decide together if it was a good idea or not to start therapy, and when the therapist replied “of course,” Laura seemed relieved and said, “So I have the right to decide!”

She then began to describe her relationship with her mother when she was a little girl. Laura’s mother treated her “like a puppet” and brushed

and washed her hair “too vigorously,” even if Laura did not want her to. Laura said that the fact that her mother disappeared for years and reappeared when she was pregnant had a bad effect on her. The therapist interpreted this communication as confirmation that she had made the right choice in saying to Laura that she was free to decide whether to begin therapy because she needed to be treated as someone of interest and an adult human being, not “a puppet.”

At that point, Laura stopped talking and said, “But this is something I do not want to talk about.” She was again testing to see whether the therapist would let her choose. When she said that it was fine if she did not want to say anything more about that particular subject, Laura was relieved and said that she was very annoyed by the fact that her mother never “explained” to her that she had another family and wanted more children when Laura was “adult enough to understand.”

As was clear from the start of her therapy, to feel safe Laura (unlike Sara) needed to feel that the therapist had given her the right to decide whether to start the treatment and what she would talk about during the sessions; she needed to feel that she would be treated as an adult and that her agency would be respected. She had developed the pathogenic beliefs that if she decided for herself and showed people what she thought, felt, and wanted, those she loved (her grandmother, mother, boyfriend, and friends) would feel hurt (disloyalty guilt) and that she did not have the right to be considered better than her mother (survivor guilt). She tested the first belief (with transference tests by non-compliance) by asking the therapist if she could decide whether to start therapy and the topics to talk about. She warned the therapist with several coaching communications that she needed to be respected and treated like an understanding adult. Thus, unlike Sara, who needed to feel that the therapist was able to be the “dominating” figure (at least during some of the treatment), Laura needed a therapist who did not “impose” herself.

Different histories, different pathogenic beliefs, different goals, and different testing strategies imply different conditions of treatment if the patient is to feel safe; psychotherapy is a case-specific enterprise.

Conclusion

During the past few decades, the feeling of safety has been placed at the center of the psychoanalytic stage. It has assumed the overarching position previously attributed to the feeling of pleasure in the regulation of psychic functioning and interpersonal life. This change has been accompanied by a growing

awareness of the need to focus much more on the role of past and present *real* relationships than on internal dynamics for psychic development and well-being, as well as by the growing attention dedicated to the self, whose states has taken the place of the different structures of psychic apparatus.

However, most psychoanalytic authors endorse a *self-centered* vision of safety; we need to have specific kinds of relationships to feel that *we* are out of danger. Moreover, there is a tendency to look for specific “ingredients” of the therapeutic attitude that help patients feel safe. CMT has added to this picture the importance of the perceived wellbeing of the people we love and care about in our sense of safety, supporting a *more altruistic view of the unconscious mind*, and proposes a model of psychic functioning, psychopathology, and psychotherapeutic processes that is *deeply case-specific*. It stresses how different people may need different kinds of relationships, responses, and attitudes if they are to feel safe. Moreover, CMT offers empirically supported concepts and tools for understanding what each specific patient needs to feel safe in therapy and pursue healthy goals.

Notwithstanding its clinical and empirical strengths, CMT has been criticized as an optimistic theory that does not sufficiently take into account the unconscious, aggressive, and self-sabotaging side of human psyche. However, CMT does not deny human inborn aggressiveness, whose existence is also supported by neuroscientific evidence (Panksepp & Biven, 2012). It simply stresses how this human inborn proclivity to experience *rage* when people feel that their needs are thwarted is shaped by real experiences, particularly the experiences lived during the developmental period, and how its manifestations are mediated by the world of the beliefs of the person; in many circumstances, rage derives from a rebellion against a pathogenic belief that makes the person feel hopeless, or is a manifestation of compliance with a negative image of the self developed in the relationship with an important other or of an identification with an aggressive caregiver (see Gazzillo et al., 2019a).

Regarding the role of the unconscious in CMT, it is enough to stress how most pathogenic beliefs are unconscious, their development is unconscious, and the testing and coaching activity is generally unconscious. In other words, CMT gives enormous importance to unconscious mental functioning, but as we have seen, it highlights a more sophisticated and adaptive view of unconscious mental functioning, which is in line with recent empirical evidence (for an overview, see Leonardi et al., 2021).

Finally, in CMT, the self-defeating and self-sabotaging side of the human mind, which in other

psychoanalytic models is interpreted as a manifestation of human aggressiveness (see, for example, Klein, 1957), is viewed as an effect of unconscious maladaptive guilt connected to unconscious pathogenic beliefs developed to adapt to traumas and adverse experiences (Bush, 2005). In general, those phenomena that classical psychoanalysis interprets as resistances, transference repetitions, enactments, or projective identifications are considered by CMT as, among other things, tests – that is, as deriving from unconscious pathogenic beliefs and pursuing the unconscious aim to disconfirm them. In other words, in line with the concepts of other psychoanalytic models (Lichtenberg, 2005; Loewald, 1980; Stolorow, Atwood, & Brandchaft, 1994), CMT considers these as a manifestation of the unconscious search for a “new object” so as to ensure safety in pursuing own healthy goals. From this perspective, CMT proposes a more progressive and “optimistic” view of human mental functioning and of patients’ contributions to the therapeutic enterprise (Rodomonti et al., 2021b).

Disclosure statement

The authors report there are no competing interests to declare.

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