Control-Mastery: A Contemporary Psychoanalytic Theory You May Never Have Heard Of

By Sandra Howarth, LCSW

Control-Mastery? Although I was feeling reasonably satisfied with my practice and my patients' progress at the time I first encountered Control-Mastery Theory, I saw nearly all of my patients improve dramatically when I started applying the theory. According to Jessica Broitman, Ph.D., the name "Control-Mastery" denotes the emphasis on the patient's ability to **exercise some control over his mental life and unconscious mind,** and acknowledges his wish to **master traumatic experiences** that have inhibited his development. This theory, which is compatible with many other theories, gives us powerful tools to understand the nature of the patient's transference and to use this relationship for change. Joe Weiss founded this theory, and together with Hal Sampson started the San Francisco Psychotherapy Research Group (SFPRG). Members of this group have published an impressive array of research and articles supporting this theory. (See **www.sfprg.org** and **www.controlmastery.org**.)

How the theory works. We see patients as having an ***unconscious plan*** for growth, wholeness and health. Often they have acquired ***pathogenic beliefs*** when early environments have not supported growth strivings. They enter therapy, or perhaps even several therapies, hoping that the therapist will convince them that their pathogenic beliefs are not accurate. To this end, patients ***test*** the therapist, unconsciously, but deliberately. If the therapist ***passes the client's test***, the client's ***pathogenic belief*** is ***disproven***, and thus the therapist's intervention is said to be ***pro-*** [the patient's] ***plan***.

The therapist is readily able to see if her/his hypothesis about the patient's ***plan*** facilitates a ***test-passing*** response, simply by noticing if, in the moments afterwards, the patient becomes more open, expressive, and disclosing (the therapist ***passed*** the patient's ***test***) or more constricted, quiet and flat (the therapist ***failed*** the patient's ***test***). As with other theories, our hypotheses and their implications for treatment are constantly revised in the service of the patient's progress. It is striking, however, to note how smoothly things can go once the therapist has an accurate idea of the patient's plan and has developed a confident stance to facilitate it.

Clients offer us ***transference tests***, generally opportunities for us to show an alternate response to behavior that complies with the parent's characterization of the child during developmental years. Thus a client who as a child kept a narcissistic parent entertained may approach the therapist offering good entertainment value during sessions. The client will be unconsciously but definitively noting whether the therapist accepts the entertainment (failing the test) or expects something different from the client (passing the test).

More difficult to manage are ***passive into active tests***. The patient gives up the childhood passive role and assumes the parent's active role, thus behaving toward the therapist as the patient's parent historically behaved toward him/her. We experience similar painful feelings to those endured by our patient as a child. Passive into active tests are pretty easy to identify because they make us uncomfortable. To pass these tests, we try to model a way of responding to the [unwelcomed] behavior in ways that a healthy person would choose. If we succeed, we have helped the patient immensely by offering a grounded way of responding to such provocation, one that will be useful to the patient, and the patient's plan, in the future.

This is not as difficult as it might seem. As a prop, I use the "reasonable person" standard familiar from our legal system. If confused or uncertain, I ask myself what a reasonable person

would do in these circumstances, and attempt to do it. Incidentally my own behavior has benefited over the years from this “fake it till you make it” approach.

A Cinematic Illustration. Alan Rappoport, PhD, offers an example of a test that will be familiar to those of us who have seen the 1980 film *Ordinary People*, about a family responding to tragedy. Mary Tyler Moore’s performance as an icy mother and wife is memorable for anyone who’s seen the film. At one point Donald Sutherland, the father and husband in the film, visits the psychotherapist (played by Judd Hirsch) who has been working with his son. They start out awkwardly, with the father obliquely asking for information about his son’s progress several times, and the therapist gracefully parries these questions without offering information. The father has said he doesn’t know why he’s made the appointment. After a silence, the father says “So – it’s pretty private in here…” and the therapist nods, yes. The father suddenly offers, “Maybe I do know why I’m here…I need to talk about my marriage.”

By floating an unconscious test, the father has determined conclusively that the therapist will honor confidentiality. The therapist passed his test, thus making it safe for him to open up about his own wounds. Note that the confidentiality information has been obtained more convincingly than it could have been in open questioning. As human beings, we believe what we see people do far more readily than we believe what they say. This example also illustrates that the testing process is a positive, adaptive process used by clients. Thus, interpretation is seen as somewhat beside the point in Control-Mastery Theory.

The Role of Guilt. The theory recognizes a pivotal role played by guilt. Michael Friedman’s article “Toward a Reconceptualization of Guilt” (*Contemporary Psychoanalysis.* October, 1985, 21(4) 501-547) convincingly lays out the research foundation for the idea that people are hard wired to be altruistically concerned about other people, in fact much more so than is commonly understood. The 12-26-04 tsunami has provided some poignant examples of this.

The term ***survivor guilt*** came to us originally from Darwin, who identified the phenomenon of guilt felt among those who literally survived the death of others. This concept became more familiar to us after the Holocaust, when it was observed frequently among surviving family members whose loved ones had not survived prison camps. In more recent decades, the concept of survivor guilt has broadened quite a bit (O’Connor, Berry, et al.,“Survivor Guilt, Submissive Behavior, and Evolution Theory: the Down-Side of Winning in Social Comparison,” *British Journal of Medical Psychology* (2000), 73, 519-530). Contemporary research shows that survivor guilt (less commonly referred to in the literature as ‘inequity guilt’ or ‘outdoing guilt’) encompasses guilt about feeling better off than others, or about any sort of advantage a person may think they have when compared with other people. For example, superior ability or greater health, wealth or happiness may cause a person to feel guilty. O’Connor, Berry, et al. propose “that survivor guilt has been selected by evolution as a psychological mechanism supporting group living (p. 519).”

In individual psychotherapy from a Control-Mastery perspective, survivor guilt, though altruistically evolved, is often too much of a good thing. Such guilt is clearly linked in the research literature with submissive behavior, including depression and failure to progress toward goals. The motive thought to be responsible is concern about harming others by outdoing them. (This wholly separate motivation for submissive behavior may be contrasted with another, better known motive, fear of *being* harmed by another who is stronger or more aggressive.)

Once armed with this perspective, examples of self-suppression are not hard to find, and are quite relevant to the treatment we provide. For example, during a first session a 43-year old patient told me that she had refrained from joining all of her high school classmates as they excitedly told each other which colleges had accepted them. She had been accepted by Harvard (not actual school). I understood this as submissive behavior based on the then-adolescent’s

unconscious awareness that her success might harm another's sense of happiness or well-being. (This same case illustrates the common sense aspect of hypothesizing patient plans. Though my patient had achieved exceptional status in both an athletic and a professional arena, her unconscious plan was to unlearn the habit of holding herself back, which would allow her to outdo even her own existing achievements). As therapists, we can pass tests related to survivor guilt by demonstrating pride in our accomplishments and by staying away from the expressions of false modesty routinely offered in our culture.

Separation guilt is a related obstacle to plans for growth. Parents or family members may behave as if a patient's desire to move to a different community to marry or attend college is unacceptably hurtful. Similarly a spouse or partner may behave as though harmed when work or an individual pursuit necessitates a separation. Depending on early history, even ending a phone call can present difficulty to a patient. As with survivor guilt, separation guilt often constitutes a pathogenic belief that the client hopes to disprove with the therapist's help.

Basic Badness refers to the third pervasive source of guilt recognized in this theory. It is largely the equivalent of low self-esteem, and is familiar to those of us who have known a rejecting environment early in childhood. We develop a pathogenic belief that says we are not accepted because we are inadequate—we're just *basically bad*

How to hypothesize what the patient's plan might be. Of course this is a key task for the Control-Mastery therapist. Though simple, the theory may seem daunting at first. Joseph Weiss' classic primer *How Psychotherapy Works* (1993, New York: Guilford) mentions that the patient's unconscious plan – the one we need to grasp – might be the exact opposite of what the patient consciously offers as a presenting problem. Although I've had great results from the time I started making use of consultation to understand the patient's plan, it took some time before I was confident of my own ability to understand this plan – especially knowing that the plan might be equivalent to the presenting problem or, alternatively, its exact opposite.

Weiss outlined the methods for hypothesizing about the plan quite plainly: observing the patient, knowing the patient's history, and applying common sense. Apparently the first time I read this material I glossed over the last method, thinking it so general or so obvious as to be meaningless. But a second reading allowed me to leap forward in intuiting patient plans, because this time I paid special attention to the "common sense" component.

Control-Mastery is an optimistic theory. It assumes that clients strive to become the best version of themselves that they can be. When the therapist can see the presenting client against a backdrop of developmental psychology and be watchful of tests related to the three guilts, the patient's plan fairly springs forth fully-grown. The plan is to overcome obstacles which are in the way of continued growth and individuation.

Patients are motivated to assist us in passing their tests. Control-Mastery Theory notes the phenomenon of ***coaching***, wherein the patient drops sometimes very broad hints to assist the therapist in producing a pro-plan response. Patients are also quite resilient. Should we fail a test, which of course happens routinely, patients may be counted on to offer us more chances. Once therapy is proceeding well, and tests are routinely passed, the patient may up the ante by making tests more and more difficult for the therapist to discern. All of this keeps therapy stimulating and lively for both patient and therapist. When a therapist passes fairly difficult tests by not replicating the early, injurious responses received by the patient, the patient is able to gain deep confidence that her/his former pathogenic beliefs were inaccurate and be able to think, feel and behave differently in the world.

Would you like to learn more? This contemporary psychoanalytic theory has been used for at least three decades and has been rigorously empirically validated. Until recently, the founders

and proponents of Control-Mastery Theory have focused on research and publishing, rather than on acquainting the therapeutic community with their concepts. However the SFPRG is beginning to be more active in disseminating these ideas through outreach, postgraduate education and training, and starting a low-fee clinic for the training of interns in San Francisco. The website (www.sfprg.org) has articles, lists a schedule of trainings and gives details about the annual worldwide Control-Mastery Conference which will be held in March.

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