

CONTROL MASTERY THEORY AND FAMILY THERAPY

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Control Mastery is a psychodynamically based and empirically supported theory that has, to date, mostly been used in conducting psychotherapy with individuals and couples. This article describes the principal constructs of the theory and the rationale and procedures for its application to working with children and adolescents in family therapy. Control Mastery focuses on the development of growth-inhibiting pathogenic beliefs, which are based on traumatic interactions with early caregivers and subsequently generalized to the world beyond the family and into adulthood. The individual and family are assumed to be highly motivated to overcome these troubling beliefs in therapy and work to do so primarily through an unconsciously planned process of testing them with the therapist and with each other. Therapist interventions based on a case-specific Plan Formulation Method. Altruistic motives and efforts to adapt to the family envi-

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ronment are emphasized, lending to a humanistic, nonpathologizing, and collaborative approach to treatment.

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The intent of the present article is to demonstrate how Control Mastery Theory (CMT) can be applied to the practice of family therapy. Control Mastery is a psychodynamically based theory developed over the last 47 years by Joseph Weiss and empirically tested by Weiss, Sampson, and the San Francisco Psychotherapy Research Group (Weiss, 1993; Silberschatz, 2005a; 2005b). The effectiveness of this approach has been demonstrated in psychotherapy for individuals presenting with a wide range of problems, including eating disorders (Friedman, 1985), major depressive disorder (Fretter, 1995), addictions (Lieb & Young, 1994; O'Connor & Weiss, 1993), posttraumatic stress disorder (Pole & Bloomberg-Fretter, 2006); learning problems (Galleher, 1997), and adult survivors of child maltreatment (Suffridge, 1991). It has also been applied to the treatment of children (Foreman, 1993), older adults (Silberschatz & Curtis, 1991), couples (Foreman, 1996; Vogel, 1994, 1998; Zeitlin, 1991), clinical supervision (Gassner, 1990; Rosbrow, 1997), groups (Cooper & Gustafson, 1979; Gustafson, et al., 1981); educational settings (Gustafson & Cooper, 1990, organizations (Gustafson & Cooper, 1990; Cooper & Gustafson, 1981), and large-scale social problems (Bader, 1994, 2006; Gustafson & Cooper, 1990). An impressive body of psychotherapy process and outcome research further supports CMT's effectiveness in treating individual adults and children (Gassner & Bush, 1988; Norville, Sampson, & Weiss, 1996; Silberschatz, 2005b; Weiss, 1993; Weiss, Sampson & Mount Zion Research Group, 1986). Folsom (1993), in an unpub-

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lished paper, described her application of CMT in a multigenerational family therapy case and has created a video (1996) demonstrating a Control Mastery approach to child and family therapy. More recently, Bigalke (2004), in an unpublished doctoral dissertation, conducted a pilot family study of Control's Mastery's plan formulation methodology. To date, however, there has been no published, systematic description of the use of CMT with families.

Although psychodynamic theory had a significant impact among the family therapy pioneers (Ackerman, 1958; Bowen, 1978; Framo, 1965; Jackson, 1968; Skynner, 1981), it has had relatively minor influence upon contemporary family therapy theoreticians. While there are certain notable exceptions (Bentovim & Kinston, 1991; Nichols, 1987; Scharff & Scharff, 1987; Slipp, 1991; Wachtel, 1997), there appears to be widespread belief, even among some of its adherents (e.g., Scharff & Scharff, 1987), that psychodynamically based family therapy should primarily be used with highly motivated and insightful families who can muster the money and motivation to participate in this typically long term treatment. Other reasons why psychodynamic family therapy has lost influence may include disfavor with classically based psychoanalytic assumptions that instinctual sexual and aggressive drives take priority over the desire for relationships, that clients resist change, and the prioritization of insight about the past over a systemically preferred focus on changing contemporary relationships.

In this article, we will argue that CMT is a straightforward psychodynamically based theory that can be effectively used in both brief and long term treatment to help families presenting with a wide range of problems and with various levels of motivation and resources. We will also demonstrate how CMT's de-emphasis of instinctual drives, optimistic view of therapeutic motivation, and emphasis on providing new relational experiences are consistent with the central paradigms in contemporary family therapy practice. Even more importantly, an understanding of the unique contributions of CMT to family therapy theory and practice can aid the family therapy practitioner in more effectively achieving the family's therapeutic goals. An introduction to the central concepts of CMT will provide the foundation for its application to family therapy. Case material will be used to illustrate theoretical concepts.

Control Mastery Overview

A number of previous authors have provided excellent in-depth discussions of Control Mastery Theory (Rappoport, 1996, 1997; Silberschatz, 2005a; Weiss, 1990a; 1990b). Therefore, we will only provide a general overview before discussing the theory's application to family therapy. CMT elaborates Freud's later idea (1926) that psychological problems are rooted in grim, growth arresting beliefs that have been inferred from traumatic early experiences, usually within the family or with other primary caretakers. It argues that the child gradually develops a set of beliefs, initially preverbal and unconscious, about what are safe or unsafe ways to adapt to the family environment while simultaneously attempting to meet important personal, developmental needs and desires. While highly adaptive in the striving for individual and family safety, the beliefs inferred from traumatic early experiences (trauma is loosely defined in CMT as any early experience or set of experiences that harms the child or important others) are termed pathogenic because they inhibit the pursuit of preferred goals and give rise to troubling feelings, problematic behaviors, and interpersonal conflicts. In fact, due to their role in adaptation and in maintaining required connections to family members or other caretakers, pathogenic beliefs are typically infused with the attachment based emotions of fear, anger, sadness, grief, guilt, and/or shame. Thus, providing the therapeutic safety to help clients access and process these emotional responses often plays a key role in helping to overcome pathogenic beliefs. Further, the emphasis on the child's primary motives of adaptation to the family and altruistic concern for the well being of family members, even at the child's expense, contributes to a humanistic, systemic, and nonpathologizing clinical stance.

The Formation of Psychopathology: Pathogenic Beliefs

Pathogenic beliefs may develop out of the child's compliance with parental treatment and messages. Given their dependence and lack of prior experience, children are prone to believe that the treatment they receive from their parents is deserved and that what they are told about themselves is true. From the child's perspective, there is little difference between reality and mo-

rality; if they are treated badly, most children come to believe they should be treated badly and should feel badly. The dynamic of compliance is perhaps most commonly seen in cases of child abuse and neglect as children frequently develop beliefs that hold themselves accountable for these experiences (Summit, 1983; Weiss, 1993) and, consequently, act in self-destructive ways (Coffey, Leitenberg, Henning, & Turner, 1996; Suffridge, 1991).

In another developmental path, pathogenic beliefs are often perpetuated over generations as the child identifies consciously and unconsciously with the parents' behavior, attitudes, and beliefs and passes these on to their own children. Symptomatic behaviors, of all varieties, frequently contain elements of these troubling identifications (Fretter, 1995; Friedman, 1985; Lieb & Young, 1994; Weiss, 1993). While the focus on problematic identifications is not limited to CMT (e.g., Bandura, 1977), its emphasis on the role of guilt, caring, and loyalty toward caretakers in the genesis of these identifications offers the family therapist a unique vantage point in treating them. For example, "omnipotent responsibility guilt" involves an exaggerated sense of responsibility and concern for the well-being of loved ones, "separation guilt" involves a pathogenic belief that one's separateness from loved ones causes them harm, and "survivor guilt" is characterized by the pathogenic belief that by pursuing normal goals and achieving success and happiness one will cause others to suffer simply by comparison (O'Connor, Berry, & Weiss, 1999; O'Connor, Berry, Weiss, Bush, & Sampson, 1997).

Most commonly, children cope with these types of troubling guilt and loyalty by identifying with their loved one's behavior and, thus, making themselves suffer as they believe their loved ones are suffering (O'Connor, 2000). From the child's perspective, "it is better to be a sinner in a world ruled by God than to live in a world rule by the devil" (Fairbairn, 1954, p. 110). In other words, far better for the child to make their parents appear as good as possible, even if it means taking on the same problematic behaviors and beliefs as their caretakers in an effort to protect, idealize, and stay connected to them.

It may be apparent that CMT's understanding of the formation of psychopathology can also find common ground in the work of various systemic theories (Boszormenyi-Nagy & Krasner, 1986; Madanes, 1986; Nichols & Schwartz, 2006;

Palazzoli, Boscolo, Cecchin, & Prata, 1974, 1980; Skynner, 1981). These theories see the child as self-sacrificing for the sake of parents, siblings, or the family as a whole and view symptoms, typically, as efforts to solve family problems. For example, the Milan school attempts to qualify not only symptomatic but all observable behavior as being positive or good because it is inspired by the common goal of preserving the cohesion of the family group (Palazzoli et al., 1974, 1980), which nicely dovetails with CMT's focus on the unconscious, adaptive, altruistic, and loyalty motives underlying symptomatic compliances and identifications. In stark contrast with traditional psychoanalytic thinking, which focuses primarily on self-serving and often asocial instinctual motives that attempt to ignore external realities, CMT, like the Milan approach, maintains an inherently systemic view by seeing symptoms as intended to preserve the well being of all family members. By recognizing the adaptive purpose of pathogenic beliefs, the CMT approach undercuts the problematic blaming that is so pervasive in many troubled families and the pathologizing attitude that is common in classical psychoanalytic theorizing (Freud, 1920, 1933; Kanzer & Blum, 1967; Klein, 1935).

However, unlike the Milan or other contemporary family therapy approaches, the CMT approach is always case specific. It does not prioritize the use of any specific technique, such as externalizing the problem (White & Epston, 1990), focusing on solutions (de Shazer, 1988), family ritual, paradox, circular questioning, positive reframing, or prescriptions to change (or not change) behavior (Palazzoli et al., 1974, 1980). While not eschewing any of these particular methods, it can effectively employ the techniques of any other theoretical approach, provided that these techniques are useful in overcoming a particular client's or family's problematic beliefs.

Control Mastery also strongly diverges from traditional systems theory's emphasis on homeostasis (Guttman, 1991; Nichols & Schwartz, 2006) and traditional psychodynamic theorists' emphasis on resistance (Freud, 1905, 1940) by emphasizing the individual's and family's inherent motivation, at all ages, to overcome the suffering derived from pathogenic beliefs and to get on with preferred life goals. The Control Mastery family therapist assumes that families want to overcome their difficulties, their symptom-generating beliefs, and to pursue a healthier and

more adaptive family life. This focus on the family's inherent desire for mastery and health has a very hopeful and collaborative effect as the family and therapist work together to go in a direction that the family wants unconsciously and often consciously.

Finally, we have previously argued that the traditional CMT approach has unnecessarily confined its focus to the immediate family in the etiology of pathogenic beliefs and that careful attention to cultural factors can add additional therapeutic leverage and flexibility in overcoming these beliefs (Lieb & Kanofsky, 2003). We agree with Bracero (1994, 1996), in his approach to working with Asian Americans, that developmentally appropriate goals for any particular client or family will vary from culture to culture and should, ideally, be given strong consideration in formulating the pathogenic beliefs for any particular client or family. The broader culture, like the family system, is capable of reinforcing both growth-promoting as well as pathogenic beliefs, which Lieb and Kanofsky (2003) have examined through a CMT/Narrative Therapy lens in terms of the power of these stories. From the context of cultural influences, we believe that pathogenic beliefs/stories emerge:

when children must make accommodations to their parents' treatment, attitudes, and beliefs while disregarding their own, unmediated, desires and goals. In this regard, the influence of cultural factors reflects just another power differential that operates in the child's life through the dictates of religious teachings, political realities, gender specifications, social class, and ethnic norms. . . . In general, we believe the incorporation of culture in our model makes two significant contributions to our practice of control mastery: (a) to account for cultural influences on the development of pathogenic narratives and (b) to separate the person from limiting cultural discourses that impede him or her from attaining goals while reinforcing those cultural discourses that are more preferred and adaptive (pp. 195–196).

The Resolution of Psychopathology: The Patient's Plan and Testing Process

CMT holds that, in the course of therapy, clients work to overcome their pathogenic beliefs primarily through a process of consciously and unconsciously "testing" the beliefs with the therapist and particularly with significant others in the course of family therapy. The focus on testing as the major ingredient in therapeutic change is perhaps CMT's most unique contribution to the field of psychotherapy. Testing is viewed as a fundamental human activity in and out of therapy

for adapting to one's interpersonal world and achieving personal goals (Rappoport, 1997; Sampson, 1990; Sampson, 1992; Silberschatz, 2005a; Weiss, 1993). Testing is especially likely to occur in the therapeutic relationship because this relationship is particularly designed to help overcome pathogenic beliefs and generate more preferred beliefs and "stories" about the self, others, and reality (Lieb & Kanofsky, 2003). In "transference testing," the client, initially in an unconscious fashion, behaves with the therapist and others as he or she behaved or behaves with the caretakers involved in the original traumatization. The client is unconsciously hoping here that the therapist/others will not repeat the traumatization. For example, a teen who is harshly criticized whenever disagreeing with parents and develops fearful beliefs about the dangers of asserting her independent opinion might, in family therapy sessions, begin to disagree with the therapist's observations or parents' recommendations, hoping that the therapist won't be disturbed by the client's behavior. If the therapist is able to "pass" these tests (e.g., by tolerating the teen's challenge calmly and helping the parents to do the same), the client is then able to take steps toward disconfirming the belief that her own autonomy is dangerous to family harmony.

In "passive-into-active testing" the client switches roles and treats the therapist or others in the traumatizing ways they were treated in the development of their pathogenic beliefs. For example, a child who is criticized by caretakers in an ongoing and traumatic fashion and develops painful beliefs involving personal inadequacy might imitate the caregivers by constantly finding fault with the therapist's interventions, that is, doing actively to the therapist what he or she has had to endure passively in the family. Depending on their unique biographical circumstance, one child who is testing in this way might benefit by a nondefensive response in which the therapist maintains a curious and neutral attitude while another child might benefit from a "strong" therapist who confidently asserts the value of treatment. CMT is always case specific, but in either case the goal would be that the client is able to demonstrate increased resilience and a greater capacity to better defend him/herself against the real and/or internalized critical parents. In other words, the unconscious goal of passive-into-active testing is that the person being tested won't be traumatized and succumb to the same patho-

genic beliefs, thus helping to overcome the client's beliefs by demonstrating that such treatment is not deserved and by modeling various ways to cope with it.

Successful passing of transference and passive-into-active tests by the therapist and significant others is the key ingredient in effective CMT individual and family therapy. In this regard, Control Mastery is also consistent with contemporary psychoanalytic relational theories that view therapeutic relationships, more than insight, as the major ingredient of change (Kohut, 1984; Mitchell, 1997; Orange, Atwood, & Stolorow, 1997; Shane, Shane, & Gales, 1997; Slavin & Kriegman, 1992). The CMT emphasis on helping family members pass each other's tests is also consistent with Family Systems Theory's primary focus on altering current family interactions as the key factor in facilitating change (Nichols & Schwartz, 2006).

In summary, CMT is based on a number of core constructs, to be elaborated below as they apply to the treatment of families. First, symptoms are maintained by unconscious beliefs that are developed in childhood by inference from experience and reinforced by subsequent relational patterns. Second, clients are strongly motivated, unconsciously and often consciously, to overcome their pathogenic beliefs and pursue healthy goals, but fear putting themselves or loved ones in danger by doing so. Any "resistance" to therapeutic progress is based on these troubling beliefs and the feelings of fear, guilt, and danger to which they give rise. Lastly, any repetitions of childhood experiences in the transference with the therapist, or with others in the course of family therapy, are unconsciously planned and purposeful (the "Control" aspect of CMT). The primary goal of such repetitions is to unconsciously test the validity of pathogenic beliefs and to obtain the therapist's and family's help in overcoming them (the "Mastery" aspect of CMT). In other words, CMT offers a key challenge to traditional psychodynamic theory by arguing that the client's/family's strongest urge is to eliminate symptoms and improve functioning and that even the most apparently "resistant" behaviors in therapy typically represent efforts to overcome these constraining beliefs. It offers a powerful extension to family systems approaches by providing a theoretically based "roadmap" for understanding the nature and purpose of problematic behaviors in the family and a clear direc-

tion as to how to help the family get to where they want to go.

Rationale for Family Therapy

Given its systemic way of understanding the formation of problems, it is somewhat surprising that CMT has not heretofore been applied to family therapy. A central benefit of family therapy from a CMT perspective lies in the therapist's ability to directly alter the traumatic interactions that both create and reinforce the child's problems. By viewing pathogenic beliefs as emotionally laden inferences from real family experiences with inevitable behavioral correlates, Control Mastery emphasizes the cyclical interaction between beliefs, emotions, behaviors, and the family system and encourages the family therapist to intervene on all of these levels within family treatment. Because problems develop within the family context, solutions are most effectively accomplished within this same context, especially when sociocultural factors are taken into account (Lieb & Kanofsky, 2003). By focusing on these multisystemic factors, family therapists can help interrupt the development of problematic beliefs in children before they become ingrained and overgeneralized to the world outside the family.

Despite occasional appearances to the contrary, children and teens are almost always worried about the suffering of their parents and siblings and want their family members to be well and happy. A significant benefit of family therapy is the reduction in various forms of maladaptive guilt and loyalty that all family members experience when they see directly that other troubled members of the family are also getting help.¹ When caretakers and siblings are able to use family therapy to make progress in their own lives, troubled children are freer to progress with their preferred goals.

¹ A number of studies have reported guilt to be adaptive and related to socially valued characteristics (Baumeister, Stillwell, & Heatherton, 1994; Tangney, 1990; Tangney & Fischer, 1995). O'Connor, Berry, and Weiss (1999), in integrating the finding of these studies with their own research, argue persuasively that "interpersonal guilt is adaptive in its role in the maintenance of social relations: however, when linked to irrational or pathogenic beliefs, it may be maladaptive and lead to distress, inhibitions, and psychopathology." p. 182.

In our observation, it is clear that it is the parent's pathogenic beliefs that interfere the most in their ability to pass their children's tests. Therefore, in order to help the child, it is typically necessary to help the parents overcome their own limiting beliefs. In simultaneously addressing the child's and the parents' interlocking beliefs, family therapy aligns the child's individual developmental goals within the family context. In this way, we can directly arrest the transgenerational transmission of such beliefs by disrupting the child's identification and compliance with their parent's maladaptive beliefs.

A case illustration of assessing pathogenic beliefs and helping family members pass the corresponding tests follows:

Joe, a father in his early 40s, called the therapist (SK) asking for help for his son, Bill, a 14-year-old who was having difficulty adjusting to Joe's divorce from his wife Betty, one year previously. Bill had developed "discipline problems" in both households and was putting out little effort in school. The therapist agreed to Joe's request that he, Betty, and Bill all attend the initial session to give the full picture, but Joe also stated on the phone that he and Betty "probably" wanted individual therapy for their son. During the initial session, Joe described Bill's intense anger at him and his increasing refusal to come for the planned alternate weekend visits. Joe would feel like hitting Bill when Bill angrily protested Joe's limits, but he remembered being beaten severely by his own father and would instead yell loudly at Bill, withdraw, and then frequently give into his demands. Betty, also in her early 40s, soon started to cry and described how neither she nor Bill were aware of Joe's unhappiness in the relationship when he told her he was involved with someone else and wanted a divorce. She acknowledged that it was still very hard for her to accept. She felt like she had somehow failed Joe and was starting to feel like a failure with Bill; Bill's anger at her over chores and schoolwork was increasing and she was also yelling a lot, eventually giving in, and "feeling exhausted." Bill stated that he could "probably do better" in school and that his dad was "too strict" and yelled too much. When asked how he felt about his parents' divorce, he said he was responsible, since both his parents told him that their attention to him had kept them from dealing more directly with each other. Betty concurred that "we spoiled him, we gave him everything he wanted," while Joe went on to state that Bill's bad temper was causing his own temper problems.

Family Treatment: The Plan Formulation Method

CMT offers an effective, heuristic formulation methodology for directing family therapy interventions. It hypothesizes an "unconscious plan" (Curtis, Silberschatz, Sampson, & Weiss, 1994; Fretter, Bucci, Broitman, Silberschatz, & Curtis, 1994; Rosbrow, 1993; Silberschatz, 2005a; Weiss, 1993; Weiss, 1998) that takes into account

the family's conscious and unconscious motivation to work in therapy to master their problems, overcome pathogenic beliefs, and become free to pursue healthy and preferred goals. Broadly speaking, the unconscious plan is a fairly flexible unconscious strategy for how clients will work on achieving their therapeutic goals by mastering the effects of prior traumas and, thereby, overcoming the beliefs that interfere with the pursuit of these goals. Unconscious plans contain the clients' therapeutic goals as well as the testing strategies for attempting to achieve these goals.

The therapist's job throughout treatment is to effectively infer the client's/family's unconscious plan (pathogenic beliefs, tests, and related goals) and to intervene in a "proplan" direction of helping to achieve their goals. This is most effectively accomplished through the development of a case specific "plan formulation" (Bigalke, 2004; Curtis & Silberschatz, 2005; Curtis et al., 1994; Curtis, Silberschatz, Sampson, Weiss, & Rosenberg, 1988; Rappoport, 1996; Silberschatz, 2005b). A plan formulation contains five central components that can serve as general guides for the therapist to use throughout treatment. These include (a) the family's goals for treatment, (b) the obstructions (pathogenic beliefs) that have impeded the family from pursuing their goals, (c) the life traumas that led to the development of pathogenic beliefs, (d) the tests that family members will enact in therapy in order to disconfirm the pathogenic beliefs, and (e) the therapist interventions and interpretations that will help the family members understand the pathogenic beliefs, pass tests, and achieve their goals.

For maximum flexibility and effectiveness, it is typically worth the additional effort to develop individualized plan formulations for each family member given the frequent variety in the trauma history and corresponding pathogenic beliefs within the family system. For example, a particular child's troubling beliefs may be reflective of traumatic interactions with just one parent or may be inferred from an interlocking two-parent or marital dynamic. In either case, the plan formulation should always be seen as an hypothesis developed by the therapist, at times shared explicitly with family members for their feedback, but always monitored for its accuracy and usefulness as the family responds to the therapist's interventions. The plan formulation is subject to revision as further evidence and feedback supple-

ments or alters the therapist's understanding of the family's goals, pathogenic beliefs, and tests.

We agree with Folsom (1993) that while each member of the family has individual pathogenic beliefs and goals with which they enter therapy, most families work on a limited number of central beliefs and goals which relate to reducing the primary family suffering. To develop a family plan formulation that most effectively matches the family's unconscious plan, the therapist relies upon several sources of information. These include (a) the family's conscious goals and inferred unconscious goals, (b) family history with an eye toward trauma, (c) the therapist's countertransference reactions, and (d) the family's behavior in sessions response to the therapist's interventions, interpretations, and attitudes. Each of these sources, along with relevant aspects of the family plan formulation, will be elaborated below especially as they apply to the treatment of Bill's family.

Goals. In many cases the family's conscious goals for treatment are the same as the unconscious goals and set the course for therapy. In accord with its core thesis that family members in therapy are unconsciously motivated to overcome the inhibitions and symptoms that accompany pathogenic beliefs, CMT defines unconscious goals as healthy and developmentally reasonable. Conscious goals that don't seem reasonable are probably tainted by compliance to pathogenic beliefs and may thus represent testing of these beliefs. For instance, the substance abusing family which initially denies the seriousness of this problem and wants to focus on other issues may be engaging in "denial testing" (Lieb & Young, 1994), hoping that the therapist can find a constructive way to facilitate the unconscious goal of overcoming this denial and achieving sobriety. In the case of Bill's family, the father's stated goal to help his son adjust to the divorce and to feel closer to his son was seen as quite reasonable and as thus reflecting both his conscious and unconscious goals. His eventual request, however, for Bill to work on his problems alone with the therapist and to relinquish his custody was hypothesized to be a manifestation of pathogenic beliefs about himself as a failed helper as a son, brother, and father. It was thus seen as a test, disguising and contradicting both his conscious and unconscious goals.

History. The second source of information for the plan formulation involves the gathering of

family history, with an eye toward trauma. In keeping with its psychodynamic roots, this history is prioritized and is typically gathered in the first few sessions. The rationale here is to begin hypothesizing the pathogenic beliefs inferred from various trauma, how the family may begin to test such beliefs in the therapy, and what interventions might be beneficial in helping achieve the family's unconscious goals. Research indicates that clients are particularly motivated to be clear and insightful about their history early in treatment in an effort to "coach" the therapist about what issues they most want to work on (Bugas & Silberschatz, 2005; Curtis & Silberschatz, 2005; O'Connor, Edelstein, Berry, & Weiss, 1994; Weiss, 1993). Knowledge of the parents' and children's history is equally important. Even when only brief details are given, therapists can usually assume that these represent distillations of significant trauma history. This knowledge then orients the therapist in efforts to offer experiences and interpretations that run counter to the predictions of the trauma-related beliefs.

For example, in the initial sessions, Betty was much more inclined to blame herself for problems in the family than to blame Joe or Bill. While generally reluctant to discuss her family's history, she did reveal that her parents had been "as demanding of themselves as they were of me" and had expected her to work constantly in following their lead as hardworking laborers. She had been compliant with these expectations, was a successful student, and now had a highly demanding job as a legal assistant. When asked how her parents responded to her hard work and academic success, she sadly reported that they "always seemed unhappy."

In this case, Betty's history and current presentation enabled the therapist to hypothesize a central pathogenic belief of omnipotent responsibility for her parents' and eventually others' unhappiness. It wasn't a great leap for her to believe that Joe's withdrawal and Bill's anger were all her fault. In accordance with these grim beliefs, she would often try to please Bill by giving into his angry demands, as she once had tried so hard to please her parents, only to feel worse when her efforts to please weren't appreciated by Bill. What wasn't initially apparent to Betty, but became more conscious over time, was that Bill didn't really want her to give into his demands. In making frequent and outrageous demands, he was

testing a painful belief about his own omnipotent (but destructive) power (e.g., that he caused his parents' divorce, his father's bad temper, and Betty's subsequent depression) and unconsciously hoped that Betty was secure and strong enough to stand up to him. In fact, the outrageousness of some of these demands (e.g., he would often ask her to take him to the mall as she was preparing for sleep) was seen as a way that he was coaching her to not take them seriously. From this perspective, and as so commonly occurs among family members in treatment, Betty and Bill had thus been reinforcing each other's pathogenic beliefs.

Tests and interventions: Overview. Our clinical experience and results of an initial research study (Bigalke, 2004) indicate that testing behavior is more frequent and varied in family therapy as compared to individual therapy. In family therapy, tests may occur between an individual family member and the therapist, between several family members and the therapist, and between family members with the therapist not directly involved. In CMT family therapy, the therapist attends to the parallel, isomorphic, and, occasionally, competing nature of the family matrix of testing.

Attending to this matrix and the family's unconscious plan is most effectively accomplished by orienting ourselves to the following sequence of questions:

1. What pathogenic beliefs are the child/children attempting to overcome/testing?
2. How can the therapist pass the child's transference and passive-into-active tests and, more important, help the parents become aware of the child's beliefs and help them pass the related tests of these beliefs?
3. What are the parents' pathogenic beliefs that are obstacles to passing the child's tests?
4. What interventions are best tailored to overcome these beliefs and align individual development and family adaptation? In brief, we call this process helping the parent to "think like a therapist and act like a parent."²

Passing the child's tests. For example, in what the therapist hypothesized to be an early

transference test of the belief that Bill was omnipotently powerful and caused his parents' to overreact with anger, submission, and even divorce, he initially presented in an angry and rejecting way with the therapist, stating that he didn't see the point of therapy and wanted to stop coming. Keeping in mind how his parents responded to similarly provocative behavior at home and in sessions by yelling, blaming, and eventually giving in, the therapist fashioned several strategies to respond to this test: (a) he would neither argue with Bill nor comply with his requests as both parents repeatedly did, (b) instead, he would elicit Bill's concerns about therapy, and then (c) he would adopt a position of hopefulness regarding the therapy while seriously taking into account Bill's misgivings. Rather than overtly point out the beliefs that he imagined were driving Bill's behavior, the therapist decided that the initial mode of intervention would be more relational than interpretive, and both parents seemed relieved that the therapist didn't overreact to or comply with Bill's angry protests. They soon followed the therapist's lead and began to encourage him to continue and made clear that they weren't going to allow him to stop, rather than criticizing him for "giving up" as they did initially.

Following this initial testing process, the family agreed to the therapist's recommendation of alternating conjoint sessions with Bill and each parent, and the level of anger in each home and in the sessions soon began to diminish. However, one month later, Bill's criticisms of the therapist rapidly increased and he angrily accused the therapist of making things worse. This shift in Bill's attitude alerted the therapist that Bill was involved in an active testing process. He first hypothesized that this was another transference test of Bill's omnipotent destructive power designed to see if it was safe to complain without the therapist, and ideally his parents, retaliating or submitting. Therefore, his initial intervention was to invite a full discussion of what he might be doing to make things worse. However, Bill only responded by escalating his negativity in accusing the therapist of selfishly taking the family's money for his own benefit without changing anything. At first, Joe and Betty responded by reassuring Bill about their financial solvency, but

² We are grateful to David Auld for providing us with this clinically useful catch phrase.

soon, they too began to feel discouraged about what else they or the therapist could do. Joe, especially, began to wonder if therapy was worth all the effort, since Bill continued to protest his visits with him. As he felt that Bill was giving up on him, he talked about giving up on therapy.

Reminding himself that, according to the parents, Bill's behavior was improving at home (however slightly), the therapist began to generate an alternative hypothesis: the entire family was engaged in a passive-into-active testing process. He speculated that Bill was identifying with Joe and Betty and blaming the therapist for causing Bill's problems, as Bill felt blamed by his parents for causing their problems. The therapist hypothesized that if he could withstand the onslaught of being held accountable for either causing the family's problems or not doing enough to help, without feeling like a failed therapist himself, then he could pass these passive-into-active tests and help the family overcome what appeared to be a shared family belief of guilt-filled omnipotent responsibility for causing and fixing each others' unhappiness.

With the help of the above formulation, the therapist was able to understand the family's discouragement without being undone by it. He did a lot of listening, stated that he was getting a good sense of how discouraged they'd all been feeling, but rather than work so hard to elicit criticism, this time he steadfastly and assertively maintained that he felt encouraged by their hard work. He actively pointed out clear examples of their progress at home and honored their consistent attempts to communicate honestly in sessions. All parties seemed encouraged as he responded in this manner. They agreed to continue, and the therapist prepared for the further, and necessary, progression of the family's unconscious plan to test increasingly central pathogenic beliefs at the heart of their difficulties.

Passing the parent(s) tests. As stated above, the CMT family therapist remains aware that parents typically have their own pathogenic beliefs, which frequently parallel the child's beliefs and interfere with passing the child's tests. Just as children must test in order for treatment to proceed, so must their parents. Fortunately, parents are also unconsciously motivated to test these beliefs to become better parents. A CMT family therapist views the "resistance" that so many parents initially present with as both a manifestation of trauma-related beliefs and as testing to

overcome these beliefs. For example, parents often enter treatment with an aversion to the family work in favor of handing off their child for individual therapy. This stance might reflect a number of possible pathogenic beliefs: they'll be exposed as bad parents who are fully to be blamed for their children's problems; they don't deserve treatment for their own distress about how the family is functioning; it is disloyal to family traditions or a sign of weakness to go outside the family for help, and lastly, especially in families with a problematic teenager, they are no longer important in their child's life. We consider "resistant" or "oppositional" family behaviors as forms of testing that increase the chances of therapeutic success if handled in a proplan manner.

The therapist does so by offering a different response to the parents than their own parents had in the formation of their problematic beliefs. As is commonly discussed by intergenerational family theorists (e.g., Boszormenyi-Nagy & Krasner, 1986; Roberto, 1992), initial family assessment typically reveals that current problems are closely related to problems and patterns that existed in previous generations. In this regard, the CMT family therapist's task is to help the parents stop repeating with their own children the traumas that were inflicted upon them. Children cannot break this multigenerational cycle on their own because they need to comply with parents for their psychological survival. However, the family therapist is in a privileged position to do this work. When parents test their own beliefs and the therapist is able to pass these tests, the parent is then in a position to more effectively pass the child's similar tests. In this process, the therapist helps to facilitate a transformative emotional, cognitive, and relational experience (Silberschatz, 2000c) for the entire family.

For example, to help Betty pass her son's tests regarding his omnipotent destructive power, it was crucial to understand and challenge Betty's parallel beliefs regarding her own omnipotent power to harm or heal others. The therapist, relying on the plan formulation method, hypothesized a number of ways to pass Betty's tests in order to disconfirm the beliefs that were undermining her effective parenting. First, he felt that it was important to adopt a general attitude that was not neutral but conveyed his enjoyment of her, whenever appropriate, while validating how difficult it was to work so hard with so little appreciation, both in her family of origin and

with Bill. It also proved proplan to directly challenge her self-blame for Joe and Bill's unhappiness, as he reminded her how both were contributing to the family's problems especially as they responded to their own vulnerability and self-blame by blaming others. A cultural lens was additionally helpful as we further contextualized her excessive self-blame as an unfortunate aspect of gender socialization practices that tend to hold women overly responsible for the family's emotional health. Another proplan intervention was helping her see that some of Bill's demanding behavior flowed from a desire to elicit strong limits, rather than based in any real antipathy toward her or a pathological level of entitlement. As is often the case with adolescents in family therapy, Bill appeared relieved to have his mother regain a stronger position and expressed this relief by becoming more open about his concern for his mother and even acknowledged that her saying no to some of his demands seemed "pretty fair." In this way, a "vicious cycle" turned into a "virtuous cycle" (White, 1984). Seeing the vulnerability altruistic motives behind Bill's tests helped Betty feel much better about herself (and Bill) and further enabled her to set limits and thus help overcome Bill's pathogenic belief in his omnipotent destructive power.

In further family of origin exploration, the therapist also learned that Joe had experienced both severe abuse and neglect by his own father, leaving Joe frequently alone to cope with his mother's depression. His mother often turned to him to complain about her terrible marriage and to coparent his younger sister. In response to these unbearable demands and in identification with his father, Joe developed a pattern of demonstrating extreme anger and then withdrawal within subsequent relationships, including with Bill and Betty. Joe's chronic isolation before and after the divorce also left Bill frequently alone with Betty, who began to suffer from her own post divorce depression, repeating the generational cycle. Bill, like his father before him, responded to his father's physical and emotional absence by angrily criticizing Joe and complaining about visiting him. Not seeing Bill's underlying hurt, Joe, in turn, only withdrew more. Early in treatment, he requested that the therapist see Bill individually because he didn't think he could be of any further help and went on to voice the belief that Bill would be better off if he gave up his shared custody.

Given Joe's trauma history, the therapist hypothesized that his general withdrawal and his request to exclude himself from treatment and custody represented testing of painful beliefs, developed out of compliance and identification with his parent's behavior and treatment of him, that (a) fathers and sons should not be close, and he didn't deserve a closer relationship with his son than his father had with him; (b) no one was interested in him and that he didn't deserve help for himself; (c) he was a failure as a helper, since his son generally refused to see him and his mother and sister remained chronically depressed throughout their lives. These beliefs were then further reinforced by gender norms in his surrounding cultural milieu, which primarily reinforced a father's provider role and stigmatized males who expressed emotional vulnerability and/or turned to others for emotional support. In summary, the therapist hypothesized that pathogenic beliefs related to survivor guilt, omnipotent responsibility guilt, and feeling undeserving were prominent for Joe. Unfortunately, Joe's beliefs were interfering with his ability to respond to Bill's transference tests of his father ("Do I deserve to spend time with you even if I'm as difficult as you suggest?") and passive-into-active tests in which he was rejecting Joe as he felt hurt and rejected by him during Joe's 2-year retreat. Joe's pre and post divorce withdrawal along with Betty's concurrent tendency to mourn this absence with her son led Bill to believe that his mother would be left alone with her sadness if he were to regularly spend time with his dad (separation guilt) and underscored the pathogenic belief that Bill was unimportant to his father.

In attempting to pass Joe's tests and to overcome the related pathogenic beliefs, the therapist offered a different experience than Joe had with either parent. To counter beliefs that Joe was undeserving of help for himself and unworthy of a closer relationship with his son than Joe had with his own unhappy, abusive, and disengaged father, the therapist was particularly attentive, saw him individually on occasion, demonstrated interest in his life outside of parenting, and was careful to refrain from accepting his early invitations (transference tests) to become critical or dismissive when he described his angry and neglectful behavior toward Bill. Instead, the therapist empathized with the painful legacy of neglect, abuse, and guilt that he had carried with him and how, given his father's example and the

gender norms within his community, he understandably struggled to find effective ways to cope with this emotional pain and also interact with his son. To counter Joe's omnipotent responsibility guilt (i.e., that he was a failure as a helper), the therapist strongly encouraged Joe to continue in conjoint therapy with Bill; he emphasized that Bill needed his regular involvement, and that the therapist would work to help him respond effectively to his son's rejecting behavior. In evidence that the beliefs had been accurately inferred and the corresponding tests had been successfully passed, Joe was visibly relieved by these interventions, admitted that he didn't want to repeat the kind of relationship he had with his own father, and agreed to continue in conjoint family sessions with Bill.

Interpretation. Insight into the nature of pathogenic beliefs, usually through therapist interpretation or suggestion, is the second central mechanism by which clients are seen to overcome these beliefs in all modalities of CMT. Reflecting its optimistic view that clients' most powerful unconscious motivation in psychotherapy is to disconfirm or relinquish pathogenic beliefs, interpretations within a CMT perspective emphasize the goals the client or family are trying to accomplish, as opposed to what they are resisting. Interpretations may also include mention of the obstacles the child/family faces in reaching their goals (the pathogenic beliefs), the tests the child is using to overcome these beliefs, and the historical and cultural contexts leading to the development of the beliefs. Perhaps most importantly, interpretations allow parents to feel empowered by providing them with a lens through which they can understand their child's heretofore noxious or worrisome behavior at a deeply empathic level and allow them to generate their own interventions to address relevant beliefs and tests.

For example, the therapist interpreted Bill's distancing and rejecting behavior toward Joe as representing, in part, a troubling belief that Bill was unimportant to his father and a test of Joe's interest, given Joe's ongoing pattern of withdrawal and isolation. With the therapist's assistance, Bill readily acknowledged this belief, along with his accompanying feelings of hurt and sadness. Joe was clearly moved and responded empathetically. The therapist further interpreted how difficult it might be for Joe to respond to Bill's tests given Joe's history of feeling rejected

by his own father and how these painful feelings might understandably be triggered when Bill seemed to push him away. Finally, the therapist suggested that if Joe could respond to Bill's apparent rejection with pursuit rather than further withdrawal, he could help Bill overcome his painful belief, attain Bill's deeper goal of a close relationship with Joe, and interrupt this multigenerational pattern. While Joe alternately accepted and struggled with these interpretations, Bill subsequently tested the belief in a family session by angrily walking out on his father. Initially discouraged, Joe fell prey to his pathogenic beliefs and became paralyzed to act, but with the therapist's interpretation of Bill's test, Joe decided to pursue Bill down the street and encouraged him to return for further discussion, a significant turning point in their relationship.

Countertransference. The therapist's countertransference reactions are a third valuable source of information for the plan formulation. The valuing of countertransference information is consistent with most contemporary psychoanalytic relational schools (Ogden, 1979; Orange, Atwood, & Stolorow, 1997; Scharff & Scharff, 1987; Shane, Shane, & Gales, 1997), which see it mostly as data to be prized for its communication function as opposed to an impediment to treatment. Silberschatz (2005c) has particularly emphasized CMT's overlap with relational and interpersonal models of psychotherapy with its emphases on attending to countertransference reactions and providing new relational experiences in order to bring about therapeutic change. Even if families are unable to give a coherent or reliable history or articulate clear goals, family therapists can often get a clearer sense of the history of trauma, inferred pathogenic beliefs, and useful interventions by paying attention to their countertransference reactions and using these to help pass family members' tests.

Both transference and passive-into-active tests typically evoke countertransference reactions, but passive-into-active testing may elicit especially strong feelings in the family therapist. Behaviors that feel very disturbing to the therapist can often inform the therapist in action rather than words about the family's history of trauma. In the case of Bill's family, countertransference feelings were an invaluable guide toward formulating an effective intervention in response to their passive-into-active testing. As the therapist initially felt blamed, responsible, and guilty for not

being more helpful to the family, he was able to infer that family members felt similarly, both historically and currently, and were looking for the therapist's help in processing their own feelings and beliefs related to omnipotent responsibility guilt.

At the same time, countertransference reactions may also involve the idiosyncratic subjectivity of the therapist. Intersubjective (Orange et al., 1997; Renik, 1993) and social constructivist theorists (Hoffman, 1991, 1992; White & Epston, 1990) have provided a helpful corrective to the omnipotent ideal of therapist "expert knowledge," as they have pointed out the limitations of understanding therapeutic material as purely the product of the client/family. No doubt, the specific qualities of the particular therapist will exert some effect on what pathogenic beliefs are tested, how they are tested, and the order in which they are tested. With this qualification in mind, CMT holds that countertransference reactions are an adaptive manifestation of the human ability to accurately empathize with the inner life of others (Bader, 1998; Curtis & Silberschatz, 2005), even when representing some aspect of the therapist's personal psychology, and should thus be mined for their communicative value.

The family's response to interventions. Any theory that hypothesizes unconscious motives runs the risk of the therapist assuming omnipotent responsibility for the direction of therapy. Therefore, more important than any other factor in completing the plan formulation is the therapist's careful ongoing observations of the family's response to therapeutic interventions to assess how accurately the family's pathogenic beliefs, tests, and goals have been understood and their ongoing progress in treatment. The CMT focus on demonstrable client/family progress encourages a humility and accountability to the therapeutic process that is intended to prevent the therapist from getting carried away with their own untested therapeutic assumptions.

The CMT emphasis on monitoring responses to the therapist's interventions and on conducting ongoing research studies to assess the validity of the theory embeds Control Mastery within the empiricist tradition of academic psychology. The San Francisco Psychotherapy Research Group has examined multiple indices of therapeutic progress, many which are commonly used in psychotherapy outcome and process research as well as a number that have been developed spe-

cifically by the San Francisco Psychotherapy Research Group to more effectively test the explanatory power of CMT's fundamental hypotheses about unconscious mental functioning, psychopathology, and psychotherapy.

Among other results, the findings of the San Francisco Psychotherapy Research Group indicate that when the therapist is acting in accordance with the client's unconscious plan, clients may demonstrate one or more of the following reactions: become less anxious (e.g., more relaxed posture, deeper breathing), less defensive, more confident, more emotionally expressive, more connected affectively to the therapist, more insightful, introduce new previously repressed material (e.g., memories and dreams), and bolder in and outside of therapy in testing their beliefs and pursuing their goals (Silberschatz, 2005b; Silberschatz, Curtis, Sampson, & Weiss, 1991; Weiss, 1993; Weiss et al., 1986). The reliability of the Plan Formulation Method has also been repeatedly demonstrated in studies of individual adult and child psychotherapy (Caston, 1986; Curtis et al., 1994; Foreman, Gibbins, Grieneberger, & Berry, 2000; Silberschatz, 2005b; Weiss et al., 1986) and in the initial empirical study of a family therapy case (Bigalke, 2004). The method has been successfully applied to a wide variety of cases treated under diverse theoretical models (Curtis & Silberschatz, 1997).

Assessing the accuracy of the therapist's understanding of the family's "treatment plan" occurs on multiple levels. Some clients and families openly convey their pathogenic beliefs to the therapist (e.g., "You can't trust anyone outside your family."), but what remains unconscious are the historical or other contexts that generated such beliefs. For example, the trauma based roots of Joe's pathogenic belief in his inability to help Bill and his tendency to isolate remained hidden until they were unearthed during family of origin exploration.

With many other families, awareness of pathogenic beliefs is repressed early in treatment. In these cases, aspects of the hypothesized unconscious plan may be readily shared with some families for their feedback. This was the case with Bill's family who generally appreciated the therapist's efforts to articulate their joint and individual unconscious goals, pathogenic beliefs, and tests, and used these insights to move toward their goals. For example, the therapist's interpretation that Bill's avoidance of Joe represented a

troubling belief that Bill was unimportant to Joe and that Bill really wanted to be closer to his father was initially puzzling for Joe, despite Bill's agreement with this idea. However, the therapist knew he was on the right track with his formulation when Joe was able to increasingly pass Bill's rejection tests and eventually stated to Bill that he loved him and wanted to work through their disagreements and see him "no matter what." In other words, Joe used both insight and testing within the therapeutic relationship to overcome his own and Bill's limiting beliefs. Final confirmation that the therapist's interventions were "proplan" was evident at the end of treatment when Bill stated, "I feel very special to my dad" and was seeing him regularly.

There are other cases in which the families don't readily profit from the sharing of the therapist's formulation. In fact, in many of these situations, these challenges are corrective and steer the therapist back on to a more useful course. Still other families might disagree with the formulation or become defensive because the therapist's efforts to hypothesize unconscious processes are too threatening or premature. These families respond more effectively to a noninterpretive approach that is still attentive to the plan formulation. For example, the therapist's initial interpretation to Betty that Joe's refusal to see his father was perhaps partially motivated by his worry about her being alone with the sadness over the loss of her marriage, however accurate, led her to feel even more worried and guilty about hurting him. A more effective intervention to address Bill's separation guilt toward Betty was helping her set limits both with Bill and with some demanding work colleagues, thus freeing up more time and energy for her to socialize and exercise after work. As this occurred, she suggested on her own initiative that Bill had been caught in the middle of her conflict with Joe and had probably taken too much to heart the feelings of hurt, anger, and betrayal that she struggled with. Her increasing capacity to pass Bill's tests in word and deed by setting firm limits and giving him the message that she didn't need him for her own companionship both improved their relationship and allowed Bill to connect more closely with his father. In the CMT model, insight into unconscious beliefs, tests, and goals, and conscious agreement with the therapist's plan formulation, while helpful in many cases, is not con-

sidered essential for families to achieve their goals.

We believe that the work of family therapy is complete when the family's central unconscious goals have been completed. This typically means, as with Bill's family, that the parents/caretakers have been helped to sufficiently overcome their own pathogenic beliefs related to parenting and are in a position to understand their children's pathogenic beliefs, pass the accompanying tests, and thus free children to pursue their preferred goals. In this case, the treatment was completed in 23 sessions over a 6-month period. A plan formulation for Bill's family can be found in the Appendix.

In our experience, CMT's emphasis upon integrating family history does not work very well when caregivers are totally resistant to exploring and utilizing family of origin issues. In these cases, pursuing early trauma history can be so emotionally threatening or culturally incongruent that this mode of assessment runs the risk of rupturing the therapeutic alliance. There are other cases, such as foster care, where early family history is ambiguous or unknown. Assessing family members' pathogenic beliefs in these situations is more complicated and forces the therapist to rely even more exclusively on in-session behavior and countertransference reactions, as opposed to trauma history, in developing a plan formulation. With these families, therapists must be even more flexible in utilizing interventions from various family therapy approaches while maintaining CMT's empirical attitude of sticking to the data of family response as the ultimate arbiter of the plan formulation's effectiveness. We have found, for instance, that Narrative Therapy is highly compatible with CMT from both a theoretical and technical perspective (Lieb & Kanofsky, 2003). Because Narrative Therapy emphasizes developing new and more preferred stories (White & Epston, 1990) to account for those occasions when families are not being constrained by their more problematic stories or beliefs, it is particularly useful with families resistant to exploring family of origin-based trauma. An emotion-focused approach (Greenberg, 2002; Johnson, 2004; and Johnson & Boisvert, 2002) may also be very useful in these situations given its here-and-now focus and its overlap with CMT in emphasizing attachment motivation, intrapsychic experience, systemic interactions, and on providing emotional safety and transformative

relational experiences within the therapeutic setting.

Future Directions

While our clinical experience, as demonstrated above, clearly supports the effectiveness of the Plan Formulation Method in family therapy, there is clearly a need for future research to validate these clinical impressions. The careful research exploring the relationships between passed tests, proplan interventions and interpretations, and immediate and long-term client progress in individual psychotherapy (e.g., Silberschatz, 2005b) can certainly be replicated in studies of family therapy with various process and outcome measures of family functioning. Further, evidence that it is possible to develop a reliable Plan Formulation Method in family therapy (Bigalke, 2004) can now “move the field of family therapy to a qualitatively different position enabling it to more rigorously compare theories of family therapy in a systematic and clinically meaningful way” (Bigalke, 2004, p.103). For example, because the Plan Formulation Method enables the assessment of parallel but theoretically different formulations (Curtis et al., 1994; Persons, Curtis, & Silberschatz, 1991), it would also be possible for family therapy researchers to explore the power of each formulation to predict changes in the process and outcome of a particular family therapy. We expect that these research methods would further demonstrate the effectiveness of CMT in treating the wide range of problems treated by family therapists.

Summary

While retaining some of its psychodynamic roots, CMT offers the family therapist a methodology of change in the form of the Plan Formulation Method that is more optimistic, non-pathologizing, and collaborative than more traditional psychodynamic approaches. In this approach, families are assumed to be strongly motivated to overcome their problems and attempt to elicit the therapist’s help in their efforts to achieve mastery over these problems and prior trauma. With its focus on the development of childhood based pathogenic beliefs as an adaptive and often altruistic effort to accommodate to interpersonal family reality and preserve needed attachments, CMT maintains important connections with developmental, family systems, cogni-

tive, attachment, contemporary psychoanalytic, and evolutionary psychological theories. The development of the case specific plan formulation serves as a bridge between the family’s conscious and unconscious motivation to overcome pathogenic beliefs and the therapist’s attempt to join forces with this growth seeking motivation. With the plan formulation as a guide, interventions from a wide range of therapeutic approaches can be used to help overcome the family’s pathogenic beliefs. CMT offers the family therapist a flexible, integrative, and empirically based paradigm to aid in his or her efforts to help the family achieve their therapeutic and life goals.

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Appendix

Family Plan Formulation

Pathogenic Belief: Fathers and sons should not be close/ deserve rejection from each other.

Family Traumas: Neglect and abuse of Joe by his father. Joe's tendency to yell at and isolate from Bill before and after the divorce. Bill's tendency to criticize/reject Joe

Unconscious Goal: Father and son to develop a close relationship.

Tests: Transference Tests: Father and son invite rejection from each other. Father states that he shouldn't participate in therapy and should give up custody. Son invites therapist to reject him by denying his need for therapy. Passive-into-active tests: Father and son appear to reject one another and to reject the therapist.

Interventions: Therapist encourages conjoint father-son sessions, elaborates cross-generational pattern of father-son distance and resulting pathogenic belief (that sons and fathers should not be close), interprets testing of this belief, remains interested and hopeful in face of family discouragement; helps elicit mother's support for father and son to be close.

Pathogenic belief: When a parent is unhappy, it is the child's fault for causing the unhappiness and their responsibility to fix the parent's unhappiness (omnipotent responsibility guilt); the child doesn't deserve happiness when the parent is unhappy (survivor guilt).

Family traumas: Betty's parents' chronic unhappiness. Joe's parents' ongoing marital conflict and distance. Joe's mother's demand for him to be her confidante and to assume responsibility for his younger sister. His mother's and sister's life-long depression. Betty and Joe's tendency to hold Bill responsible for their divorce, Joe's tendency to blame Bill for causing him to be angry.

Unconscious goal: To overcome shared pathogenic belief that children are omnipotently responsible for the unhappiness of their parents and don't deserve to be happier/more successful than their parents.

Tests: Transference tests: Son states to therapist his responsibility for his parents' divorce and demonstrates his perceived responsibility to help with his mother's sadness by comforting her when she cries and by refusing to visit with his father. Father discusses his perceived responsibility for not helping his mother and sister more with their depression when he was young and for causing his father's abusive discipline by being disobedient. Mother holds herself fully responsible for Bill and Joe's unhappiness. Passive-into-active tests: Parents blame son in sessions for various parental problems, including the divorce and father's bad temper. Son blames therapist for making the family problems worse. Family invites therapist to feel like he's not doing enough to help.

Interventions: Therapist addresses son's perceived responsibility for causing and fixing his parents' problems by challenging parents' attempts to unfairly blame son for their problems. Therapist elaborates and challenges cross-generational pattern of children being held overly responsible for causing and fixing parents' problems. Therapist responds non-defensively to passive-into-active tests in which he is blamed by son for making family problems worse. Therapist attempts to further relieve son of omnipotent responsibility for his parents by helping parents directly with their various concerns (e.g., effective limit setting with their son, helping mother set limits at her workplace, helping father and mother relieve omnipotent responsibility and survivor guilt related to their respective families of origin). Therapist interprets and elicits various altruistic motives underlying son's behavior, including his hopes that both parents hold to their limits with him and others, that father take care of his health and not isolate from him and others, that mother socialize more often.