CONTROL MASTERY: THEORY AND PRACTICE

Control-Mastery Theory and Contemporary Social Work Practice

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ABSTRACT. Control-mastery theory is a cognitive relational psychoanalytic approach to psychological functioning that assumes that people are strongly motivated to adapt to their interpersonal world. The theory hypothesizes that unconscious pathogenic beliefs, originating in actual experiences, are an important source of psychopathology. Clients work to disconfirm their pathogenic beliefs by testing the therapist in the transference. Control-mastery theory is unusual in that it has had a multidisciplinary research component from its beginning. In its emphasis on adaptation, competence, and empirically validated practice, control-mastery theory is highly congruent with social work values.

KEYWORDS. Control-mastery theory, psychotherapy, pathogenic beliefs, transference

Social work, a values driven profession, calls on clinical social workers to draw from theories that are compatible with the profession's philosophy, ideals and view of human beings. CSWE

Smith College Studies In Social Work, Vol. 78(2–3) 2008
Available online at http://scssw.haworthpress.com

doi: 10.1080/00377310802112050

and NASW have established standards for education and practice reflecting the profession's values and mandates. Both emphasize maintaining a focus on person-in-situation transactions that include adaptation, human relatedness, competence, self-direction, self-concept, and self-esteem and the capacity to attribute meaning to life experiences. Control-mastery theory, a psychoanalytic approach that emphasizes cognitive and relational aspects of psychological functioning, offers clinical social workers an effective framework for treatment that is highly compatible with these social work values. This article presents the theory, illustrate it with case examples, discuss its developmental foundation, and consider how the theory dovetails with the clinical social work practice perspective.

ADAPTIVE AND MALADAPTIVE BEHAVIOR

Control-mastery theory originated over 50 years ago in the work of psychoanalyst Joseph Weiss, MD (Weiss, 1952, 1967, 1971). He was joined by psychoanalyst Harold Sampson, PhD and together they started the San Francisco (formerly Mount Zion) Psychotherapy Research Group to subject their ideas to rigorous research (see Silberschatz, 2005; Weiss, Sampson, & The Mount Zion Psychotherapy Research Group, 1986). The theory's name comes from two basic concepts of the theory: that people exert considerable control over their conscious and unconscious mental life and that they are highly motivated to master their unconscious conflicts. Because of his background in American ego psychology, Weiss began with a focus on the role defenses play in psychoanalysis, emphasizing the importance of the individual's assessment of safety and danger in instituting a defense and in dealing with the environment. Weiss believed that people's real experiences shaped how they faced the problems of living. People's most powerful motivation is to adapt to reality, especially the reality of their interpersonal world (Weiss, 1993). This is consistent with

> an assumption that is prevalent in modern biology, ethology, and the behavioral sciences: the adaptive imperative. All animals, according to this imperative, are motivated—indeed, they are predisposed ("hardwired") by evolution—to adapt to

> their environment. For humans (and most mammals), survival and adaptation require maintaining a stable connection or attachment to parents, family members, or other caregivers … In order to adapt to our environment we develop *beliefs* about our family, our relationships, our world, and ourselves. (Silberschatz, 2005, p. 4)

Control-mastery theory hypothesizes that unconscious pathogenic beliefs are an important source of psychopathology. They originate from the child's attempt to adapt to a traumatic experience with a loved one. The trauma may be a discrete, shocking event, such as the death of a parent, or it can be the result of an ongoing pattern of interactions. A pathogenic belief is not a wish or a fantasy, but a grim, constricting, painful idea. It is not simply a thought, but a powerful thought together with the intense affects connected to that thought. It is powerful because it predicts danger if the child pursues a normal developmental goal. Children need help and encouragement to accomplish developmental goals. If the child infers that his or her goal would threaten his or her relationship with a parent, she or he may unconsciously renounce the goal to preserve the relationship. Sometimes the child's inference is a distortion, but it may also reflect the parent's actual comments. For example, Mary, 45, an only child of a divorced, alcoholic mother, entered therapy with symptoms of agoraphobia. When she began therapy, Mary was underemployed and could only travel between her work and her apartment, a few blocks apart. She had a brief period of adolescent rebellion but then became increasingly unable to venture out into the world. Several months into the therapy she remembered that at age 18 she returned from a weekend trip to find that her mother had been assaulted. Her mother, battered and bruised, said to her, "This is what happens when you go away." This event was one of many over the course of their relationship. It illustrates the origins of her pathogenic belief that to be more independent was dangerous to those she cared about.

The motivation to adapt to one's reality and to preserve the tie to one's caregiver is supported by attachment theory and the work of Bowlby (1969, 1973, 1980), Main (1995), and others (Cassidy & Mohr, 2001). Children develop expectations of all future relationships based on their interactions with their caregivers. Bowlby (1973) referred to these internal representations of their relationships as

internal working models (IWM). Children develop different IWMs and different attachment styles to preserve the tie to a specific caregiver. For example, if a mother conveys to her child that the child's normal needs are burdensome, the child is likely to develop an exaggeratedly independent style. The child may then develop the unconscious pathogenic belief that normal dependence in relationships is draining to the other person. (See C. Shilkret, 2005 and R. Shilkret & Silberschatz, 2005 for examples of pathogenic beliefs reflecting different attachment styles.)

Children endow their parents with great moral authority. As a result, the child may unconsciously believe that whatever treatment she receives is what she deserves. Political, cultural, and social realities affect all people, but for disenfranchised groups such realities are likely to lead to specific pathogenic beliefs. The effects of culture and social realities are conveyed to the child through how the family manages particular stresses created by these conditions. Children growing up in families that experience hardships such as racism, oppression, and poverty will be especially affected by how the family lives them out. Adult clients with such backgrounds will develop pathogenic beliefs that reflect the particular hardships they experience(d).

Antoine's immigrant parents not only struggled with an unfamiliar language, but also were also always on the edge of being homeless. In fact for a time he, his parents, and three siblings lived in a car. His parents worked at subsistence jobs. In adulthood, Antoine's siblings had made only modest economic gains beyond their parents. Antoine, an articulate, bright, young man, had been able to finish high school with good grades despite the family's poverty. He entered therapy after losing scholarships to two different colleges because he became very depressed at each school and was unable to finish his class work during several terms. Part of the therapy revealed his enormous guilt about pursuing college, because it could allow him to achieve what seemed to him to be more than he deserved. His pathogenic belief was that he would be disloyal to his family if he, too, did not struggle as they had.

Alice, an African American woman who grew up in the segregated South, was the middle child of poor rural parents. She had eight siblings, several of whom were sent, out of necessity, to live with members of the extended family. Her mother cleaned

houses for White families in the city, while her father worked sporadically. Her father was alcoholic and began to sexually abuse Alice when she was left alone with him while her mother worked. Alice's mother, who also drank heavily, had an explosive temper and would regularly turn on Alice during her drunken rages. Alice's mother was bright but frustrated by the limitations of her life, which included never having enough money and feeling burdened by having children of her own to care for. She often raged about how White people were to blame for all their troubles and could not be trusted. Whenever Alice, as a small child, talked about what she imagined she would do in adulthood, her mother would grow furious and attack her with statements such as "You will never amount to anything. They won't let you."

Alice's ambitions led her to move north and complete her undergraduate education. Her plan was to become a teacher. Although she was accepted to graduate school, she had great difficulty finishing her class work. She was underemployed at a minimum wage part-time job and was digging herself deeper into debt each month. In addition, she suffered from anxiety and depression.

One of Alice's pathogenic beliefs was that she should not "amount to anything"—a belief engendered by her mother's repeated admonitions. From early childhood she had experienced the impact of oppression on her family and her community through her mother's unhappiness. She interpreted her mother's attitudes to mean she should not have more than her mother did. In this way, loyalty to the group begins with loyalty to parents and family.

Alice's dream life reflected her worry that she would leave African Americans behind if she were to attain the middle-class status to which she aspired. In a dream she and her family members, as well as people from her community, rowed in a rickety boat across a swollen river. After the boat landed, Alice was the only person who walked up into a town that was peopled with prosperous White people who welcomed her. Alice saw that the others from the boat had remained on the shore never looking up. As she explored the meaning of the dream she began to feel very sad about an older sister who struggled with alcoholism. A complicating factor was Alice's guilt about discussing these experiences with a White therapist. She felt that taking a White woman into her confidence was disloyal to her

mother: "Here I am talking about how Black people don't do well to a White woman and I can feel a pain on my back where my mother kicked me during one of her rages."

HOW CLIENTS WORK IN PSYCHOTHERAPY

A central tenet of control-mastery theory is that people want to free themselves from their unconscious pathogenic beliefs so they can pursue their normal developmental goals. People may do this in a variety of ways in their everyday life. For example, an event that brings a person great happiness can help to disconfirm the person's belief that she or he doesn't deserve to be happy. But many pathogenic beliefs cannot be disconfirmed outside of a therapeutic relationship. Clients enter therapy with an unconscious plan to solve their problems, including disconfirming their pathogenic beliefs. An unconscious plan is not a rigid blueprint. It is a rough guide that can inform the therapist about how the client wants to proceed. A client's plan incorporates the traumas she or he has experienced, the pathogenic beliefs that have developed as a result of those traumas, and the goals, conscious and unconscious, she or he would like to achieve. Just as pathogenic beliefs develop from individual experiences, unconscious plans are also individualized and case specific.

Clients work unconsciously to disconfirm their pathogenic beliefs and achieve their therapeutic goals in three ways. First, similar to other analytic and psychodynamic treatments, clients can use interpretations made by the therapist to gain insight into their pathogenic beliefs. Second, clients can use the relationship itself to disconfirm a pathogenic belief. Thus, a client who was neglected and grew up feeling very unimportant can use the therapist's concern and interest in her or him to disconfirm her belief that she or he deserves to be ignored. Third, a client may unconsciously test the therapist in an attempt to disconfirm the pathogenic belief. Clients may use all three of these methods, or they may rely more heavily on one. (See Sampson, 2005 and C. Shilkret, 2006 for a discussion of clients who primarily use the relationship to disconfirm their beliefs, a process Sampson labels "treatment by attitudes.")

Testing the therapist in the transference relationship originates in the idea that the client has an unconscious plan to free herself or

himself of her or his pathogenic beliefs, and thus, unconsciously organizes a test of those beliefs. Testing is based on the idea that the client is trying to determine if it is safe to give up the pathogenic beliefs. To assure herself or himself that she or he will not be retraumatized, the client repeats a traumatizing relationship with the therapist to determine the validity of her or his unconscious predictions. There are two main types of tests in control-mastery theory: transference tests and passive-into-active tests. In transference tests the client repeats behavior from her or his history and gives the therapist an opportunity to act like her or his traumatizing parent. For example, a client who was traumatized by her father's insistence on total obedience from his children demonstrated increased assertiveness by disagreeing with the therapist and then waiting to see if the therapist reacted with anger. In this example, there is no single "right" way to respond. The therapist may choose to interpret the behavior or not, but as long as the therapist does not demonstrate annoyance at the client's assertiveness, the therapist will pass the test.

Alice, for example, gave the therapist numerous opportunities to underestimate her abilities. After she finished graduate school and took a job as a teacher, her supervisor was a White woman. She spent some time complaining about this woman, who Alice saw as less competent than herself. This began Alice's test to see if her White therapist would be offended by her indirect expression of judgment and anger at White people. When the therapist acknowledged the insidious nature of racism, Alice remembered a specific memory from her childhood in a segregated southern state. As a 7-year-old child, she and her mother had gone into a local White-owned store. When she showed an interest in a toy doctor's kit, a White woman customer scoffed at her, called her a racial epithet, and said that such a toy would be wasted on her because she obviously was not smart enough to be a doctor. She could not allow herself to recall this memory until she had tested her therapist and reassured herself that the therapist would not humiliate her for seeing herself as competent.

The other major way of testing the therapist in the transference is by turning passive into active. The client unconsciously acts like the traumatizing parent and treats the therapist as the client had been treated. The client's unconscious wish is that the therapist not be traumatized, and so demonstrate to the client a different way of dealing with traumatizing interactions. Because the client is in the

"safe" position, that is, enacting the role of the powerful parent and not the role of the traumatized child, this kind of test can be much more powerful. In fact, control-mastery theory posits that if the therapist experiences a strong, negative feeling with a client (e.g., confusion, worry, guilt, etc.), it is likely that the client has turned passive into active (Weiss, 1993). For example, Alice would often express dissatisfaction with the way the therapist responded to her frequent phone messages. The therapist became aware that she was feeling pushed around and resentful during these incidents. By turning passive into active in this way, Alice reenacted with the therapist the feeling of being constantly criticized by her mother. The therapist's ability to tolerate her criticisms and dissatisfactions without becoming upset allowed Alice to disconfirm her belief that she was a bad and worthless child.

Clients often use both types of tests, although the nature of their traumas influences the tests they use. For example, some clients may not feel safe enough in the beginning of treatment to engage in transference testing (for fear that the therapist will, indeed, act like the traumatizing parent). Consequently, they may test primarily by turning passive into active. Other clients may unconsciously view passive into active testing as too harmful, fearing that the test might traumatize the therapist so severely that she would be unable to help. Accordingly, the client might carry out transference tests in the beginning of therapy. Some tests may be brief and relatively clear, whereas others may be carried out over long periods of time. (See C. Shilkret, 2002, for an example of a 4-year long test in which the client persisted in complaining about the therapist and inviting the therapist to reject her.)

Because plans are rough guides and not blueprints and because clinical material is complex, tests are not always clear. Because control-mastery theory hypothesizes that clients want to disconfirm their pathogenic beliefs, they are unconsciously highly motivated to enhance their therapists' ability to understand the test being posed, so the therapists can pass it. This sometimes results in the client "coaching" the therapist (Bugas & Silberschatz, 2000). For example, a client who had been badly neglected as a child was making a reasonable case for why she was ready to terminate. The therapist began by thinking that termination was premature. However, she began to be swayed by the client's logic. At that point, the client had

an unrelated association that she rarely finished the full course of any medicine prescribed for her. Although the client was unconscious of any connection between the memory and the current discussion, the therapist immediately viewed it as coaching; a reminder that the therapist should not agree to a premature termination because it would be another instance of allowing the client to be neglected and, by identification, to be self-neglectful.

One way in which control-mastery theory differs from some other psychoanalytic theories is in its inclusion of an ongoing multidisciplinary research component. "Clinical observations lead to the development of the theory, which gave rise to a large program of research. The results of the research studies in turn shaped subsequent clinical discoveries and theoretical elaboration" (Silberschatz, 2005, p. 189). Research has been carried out demonstrating that the client's plan can be reliably formulated for a psychoanalysis (Caston, 1986), for brief (16 session) adult therapies (Curtis & Silberschatz, 1997), and for child therapy (Foreman, Gibbins, Grienenberger, & Berry, 2000). The concept of testing has also been studied empirically, the ability of raters to identify tests in an analytic transcript as well as the effects of passed and failed tests. (See Silberschatz, 2005 for a summary of the numerous research studies of the San Francisco Psychotherapy Research Group.)

In summary, control-mastery theory is congruent with several of the basic values of social work. It assumes that behavior is adaptive, even behavior that might be seen as maladaptive by the client or by others. The child develops solutions to real problems that later might not work in the individual's own best interests in different contexts. Further, the motives that are most problematic are altruistic rather than narcissistic ones. The young child, in particular, attempts to make things better to preserve a relationship with a caregiver or other loved ones. These unconscious guilt-derived behaviors might interfere with the child's own normal strivings and even result in her or his renouncing important developmental goals to preserve an important relationship or shore up a parent who appears weak or brittle. The client's unique past history of trauma must be understood to be most useful to her or him in therapy; that is, the model requires a case-specific approach. Psychotherapy is thought of as a unique partnership between therapist and client, one in which the goals, often unconscious, are those of the client, not the therapist. In therapy, the

client works to overcome pathogenic beliefs about herself or himself and her or his relationships by actively, but often unconsciously, testing the beliefs with the therapist in the hope that the therapist will not be traumatized as she was earlier, or with the hope that the therapist will respond in a better way than a parent did earlier. In this way, the client attempts to overcome the pathogenic beliefs. The propositions above have been largely empirically validated, a further value of the social work profession. At root, control-mastery theory is one of hope rather than resignation about the repetition of psychopathology.

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