How Psychotherapy Works: The Concepts of Control-Mastery Theory

Alan Rappoport, Ph.D.

I am pleased to present Control-Mastery theory to you, the members of the Academy of Clinical Psychology. The use of Control-Mastery theory has made the process of psychotherapy more straightforward and understandable for me, more effective for my patients, and more enjoyable for us both, and I have found it to be invaluable both in the teaching of the therapeutic process and in my clinical practice. I am glad to share with you this approach to psychotherapy, which has been of such great benefit to me.

Control-Mastery theory was formulated by Joseph Weiss, M.D., in the 1960s. Weiss, a psychoanalyst, found that the Freudian model of psychotherapy did not predict and could not account for improvements in some of his patients, and he began an intensive study of these cases in order to better understand the therapeutic process. In 1972, in collaboration with Harold Sampson, Ph.D., Weiss founded the Mt. Zion (now the San Francisco) Psychotherapy Research Group, which since that time has been engaged in the development of the theory, research, and teaching. The theory Weiss created is about the origins of psychopathology and how the patient works in psychotherapy to overcome his or her problems. He proposed that in attempting to adapt to unhealthy psychological environments people develop invalid, negative beliefs about themselves and others that make them unhappy and prevent them from living effective and satisfying lives. It is these beliefs that are the basis of psychopathology. (Examples of such beliefs are "I should be unhappy as my mother is or she will feel lonely and blame me," "I must have low self-esteem so that my father will not feel threatened by me," "If I express my emotional needs to my parents or others I will be unduly burdening them".) At the heart of the theory are two concepts: that people have unconscious control over their defenses, and that they have a wish to master their problems and unconsciously organize their behavior in an attempt to do so. In psychotherapy, the therapist's task is to understand the patient's unconscious plan to solve his or her problems and to help the patient to do so.

"Control" and "Mastery"

The term "Control" refers to the ability that people have to unconsciously assess their degree of interpersonal safety and danger, and to adjust the strength of their defenses in accordance with these assessments. In psychotherapy, the function of the therapist is to provide an experience of interpersonal safety for the patient, so that the patient will feel free to lower his or her defenses and to be more open and authentic. Since the goal of psychotherapy is less defensiveness on the part of the patient, the nature of the psychotherapy process is clarified: the therapist's task is to understand what the patient is afraid of, what the patient is defending against, and to help the patient feel safe from

---

Rappoport, A. 2002. How psychotherapy works: The concepts of control-mastery theory. *Bulletin of the American Academy of Clinical Psychology*, **8**(2), 10-14.

these dangers. To the extent the therapist is able to do this, the patient will respond by being more open (e.g., more expressive, more physically relaxed, more insightful, and more able to associate). The therapy process essentially consists of repeated experiences of this kind, the effect of which is to reduce the patient's general need to be defensive.

"Mastery" refers to the idea that people are motivated to overcome their problems. People are uncomfortable when they constrict their behavior and their experience in accordance with negative beliefs, and, to the extent that a person is defensive, he or she is in pain. That pain is a motivator to be free of defensiveness, and people who come to psychotherapy are particularly highly motivated in this regard. Weiss proposes that patients have a *plan* for their psychotherapy, that is, an unconsciously organized way that they intend to go about working on their problems. In carrying out their plan, patients actively *test* the therapist as a way of determining how safe it is for them to be less defensive, and, to the extent the therapist "passes" the test, their behavior immediately becomes more authentic. Control-Mastery theory has identified two major types of tests, *transference* tests and *passive-into-active* tests.

Transference Testing

Transference testing refers to the dynamic therapists ordinarily mean when they use the term "transference", in which the patient experiences himself or herself in the historical role he or she had as child and experiences the therapist as a parent or other significant authority figure. This kind of testing has to do with the patient's attempts to find out if she or he is acceptable and lovable: "Can you accept me as I am?", "Do you value me?", "Will you hurt me?"

A sequence from the movie, "Ordinary People" (paraphrased in the following example) provides a good illustration of transference testing: The father of a boy who is being treated for depression calls his son's psychiatrist for an appointment for himself. When he arrives, he tells the psychiatrist that he does not know why he is there or what he wants to discuss. He then asks the psychiatrist to tell him some details about his son's treatment. The psychiatrist refuses, citing confidentiality. The father says, "So it's private here?" The psychiatrist says, "Yes, very private." The father takes a deep breath, sits back in his chair, and says, "You know, I think I know why I'm here. I want to talk about my marriage."

This interaction illustrates many of the aspects of transference testing: The patient typically tests unconsciously (the father didn't know why he was there). The patient designs the test to provide information about how safe he is to proceed with his agenda (in this example, how safe he is to discuss his marriage with his son's therapist without fear that the information may be revealed to his son or others). When the therapist passes the test, the patient exhibits the typical signs of increased safety (physical relaxation, deeper breathing, and insight). The patient then proceeds with the next step of his plan, in this case, to consider the quality of his marriage.

The efficiency and efficacy of the process are impressive: In less than a minute, the father obtained a behavior sample of what the psychiatrist does when pressured to reveal information. As a result, he has real confidence that the psychiatrist will not reveal the contents of their conversations to others. This testing process is elegant, and it is typical of what happens throughout the course of most psychotherapy.

Passive-into-Active Testing

Passive-into-active testing, the other major testing paradigm identified by Weiss, is experienced as more adversarial than transference testing by both the patient and the therapist. In this form of testing, the patient turns the tables on the therapist and treats the therapist in the same abusive or rejecting ways the patient was treated as a child. The patient hopes the therapist will respond assertively in the face of such mistreatment, which was dangerous for the patient to do as a child. The patient's purpose in this test is to acquire the same safety to be assertive when mistreated that he or she hopes therapist will demonstrate in the current interaction. (The term "passive-into-active" comes from the idea that what the patient experienced "passively" earlier in life he or she is now engaging in actively in the present. It is related to the concepts of Projective Identification and Identification-with-the-Aggressor.) For example, a patient who was bullied by his father may bully his children and bully the therapist. Here, the patient is identified with the parent and acts towards the therapist as his parent acted toward him. Under these circumstances the therapist may feel disempowered, disrespected, unappreciated, threatened, worried, burdened, guilty, and inadequate -- all the ways the patient felt during the abusive treatment. However, the patient does not do this simply as a repetition, but does it for testing purpose as well. The patient hopes that the therapist responds in an assertive, non-defensive, and non-rejecting way, and tries to learn from the therapist's response that it is safe to act in this way, and thus free himself or herself from the identification with the parent. Passive-into-active testing requires us as therapists to value our own experience and be free to act in our own behalf, as well as valuing the experience of the patient. To the extent that we do so, we demonstrate that such healthy relationships are possible. As a result, the patient feels safer to be similarly open to others as well as assertive in his or her own behalf.

Understanding passive-into-active testing can free the therapist from the paralysis and discomfort that results from taking the unpleasant enactment personally. It can help the therapist to view the interaction more objectively, and to consider what healthy, assertive behavior the patient is unconsciously pressing for. I find that almost all cases presented for supervision involve a significant element of passive-into-active testing, since the supervisee naturally wants help most strongly with those cases he or she finds to be distressing, or feels most "stuck" with. I am continually impressed with the degree of freedom, relief, and regained ability to formulate and treat a case supervisees experience when they are freed from the conflict created by passive-into-active enactments.

Empirical Support

Over the past twenty years, the research group has produced a substantial body of work providing empirical support for the theory. We have shown that independent raters can reliably agree on a patient's plan (e.g., Caston, 1986; Curtis, Silberschatz, Sampson, and Weiss, 1994). We have demonstrated that test-passing can be empirically defined and reliably measured (e.g., Silberschatz in Weiss et al., 1986; Silberschatz & Curtis, 1993; Kelly, 1989). We have shown that test-passing predicts both immediate patient progress and outcome in psychotherapy (e.g., Fretter 1984). We have found that therapy events that increase the patient's sense of safety are typically followed by progress in therapy (e.g., Broitman, 1985, Gassner, Sampson, Weiss, and Brumer, 1982, Silberschatz, Curtis, Sampson, and Weiss, 1991). There is a great deal of additional research supporting the theory. More detailed discussions of the research and a bibliography can be found in Weiss, J., Sampson, H., and The Mount Zion Psychotherapy Research Group (1986), in Weiss (1993a), and on the research group's website, www.sfprg.org.

Conclusion

One advantage for the therapist in using the Control-Mastery approach is that it helps us to stay oriented in the treatment process. We can evaluate the appropriateness of our interventions by watching for signs of whether or not the patient feels safer after each intervention. If the patient does feel safer, we can assume our intervention was helpful, and this gives us confidence in our understanding of the case and in our treatment strategy. If the patient does not seem to feel safer after our intervention, we should try to understand the reasons for his or her response, and change our tactics, and perhaps our case formulation, accordingly. A second benefit for the therapist of this approach is that he or she is encouraged to participate fully in experiencing the relationship with the patient, and to be authentic and expressive. This makes the experience of doing therapy inherently more rewarding for the therapist, and it benefits the patient because she or he can more easily understand the therapist. The more transparent the therapist is, the more likely the patient is to feel safe and free in the treatment process; the more enigmatic or authoritarian the therapist is, the more defensive the patient is likely to feel.

In sum, therapy is motivated and structured by the patient. The therapist does not choose the goals of treatment nor the issues to be addressed. This is all done by the patient, both consciously and unconsciously. The therapist's task is simply to understand what the patient is working on, in what way the patient needs to feel safe with the therapist in order to proceed, and to do his or her best to provide that safety. This way of doing therapy is much easier and more enjoyable than one in which the therapist attempts to set the goals and organize the process of treatment. In such circumstances the patient will still try to accomplish his or her agenda, but the participants are more likely to be at cross purposes, the process for both of them will be less straightforward and less enjoyable, and the outcome is likely to be of less benefit to the patient.

More information about Control-Mastery theory is available in *How Psychotherapy Works* (Weiss, 1993b), in Rappoport (1996 and 1997), and on the website of the San Francisco Psychotherapy Research Group, www.sfprg.org.

References:

Broitman, J. (1985). Insight, the mind's eye. An exploration of three patients' processes of becoming insightful. Doctoral Dissertation, Wright Institute. *Dissertation Abstracts International*, **46**(8). University Microfilms No. 85-20425.

Caston, J. (1986). The reliability of the diagnosis of the patient's unconscious plan. In *The psychoanalytic process: Theory, clinical observation & empirical research*. New York: Guilford Press, 241-255.

Curtis, J.T. and Silberschatz, G. Plan formulation method. In T.D. Eells (Ed.), *Handbook of Psychotherapy Case Formulation*. New York: Guilford Press, 1996.

Curtis, J.T., Silberschatz, G., Sampson, H., and Weiss, J. (1994). The plan formulation method. *Psychotherapy Research*, **4,** 197-207.

Fretter, P. (1984). The immediate effects of transference interpretations on patients' progress in brief, psychodynamic psychotherapy. Doctoral Dissertation, University of San Francisco. *Dissertation Abstracts International*, **46**(6). University Microfilms No. 85-12112.

Gassner, S., Sampson, H., Weiss, J., and Brumer, S. (1982). The emergence of warded-off contents. *Psychoanalysis and Contemporary Thought*, **5**(1), 55-75.

Kelly, T. (1989). *Do therapist's interventions matter?* Unpublished Doctoral Dissertation, New York University.

Rappoport, A. (1996). The structure of psychotherapy: Control-mastery theory's diagnostic plan formulation. *Psychotherapy*, **33**, 1-10.

Rappoport, A. (1997). The Patient's Search for Safety: The Organizing Principle in Psychotherapy. *Psychotherapy*, **34**, 250-261.

Silberschatz, G. (1986). Testing Pathogenic Beliefs. In *The psychoanalytic process: Theory, clinical observation & empirical research*. New York: Guilford Press, 256-265.

Silberschatz, G. & Curtis, J. (1993). Measuring the therapist's impact on the patient's therapeutic progress. *Journal of Consulting and Clinical Psychology*, **61**(3), 401-411.

Silberschatz, G., Curtis, J., Sampson, H., and Weiss, J. (1991). Mount Zion Hospital and Medical Center: Research on the process of change in psychotherapy. In L. Beutler & M.

Crago (Eds.), *Psychotherapy Research: An International Review of Programmatic Studies*. Washington, D.C.: American Psychological Association, 56-64.

Weiss, J. Empirical studies of the psychoanalytic process. (1993a). *Journal of the American Psychoanalytic Association*, **41**, October.

Weiss, J. (1993b). *How Psychotherapy Works: Process and Technique*. New York: Guilford Press.

Weiss, J., Sampson, H., and The Mount Zion Psychotherapy Research Group. (1986). *The Psychoanalytic Process: Theory, Clinical Observations, and Empirical Research*. New York: Guilford Press.

Alan Rappoport, Ph.D., is in independent practice in Menlo Park, California. He has been associated with the San Francisco Psychotherapy Research group for twenty years, during which time he has been involved in various research projects of the group, written articles on the theory, and taught it to professionals at a variety of conferences and seminars. Dr. Rappoport may be reached at 1010 Doyle St. #13, Menlo Park, CA 94025. Phone 650-323-7875, e-mail: arappoport@alanrappoport.com. Reprints of his articles are available from him.