

## A Control-Mastery View of Case Consultation

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*Case consultation is an important part of deepening a clinician's therapeutic skills. However, consultation is not theory neutral: Each theory of therapy guides consultants according to their particular theoretical orientation. Control-mastery theory assumes that clients come into therapy desiring to solve their problems and have a tentative unconscious plan for working in therapy. These assumptions have been supported by 40 years of research data. Although control-mastery theory is written in everyday language without jargon, it takes considerable time to learn to apply the theory because each plan formulation is case specific. Consultation relies on the examination of detailed process notes, within and across sessions, as well as the therapist's affective reactions to the client. Initially, it can help the therapist formulate the client's unconscious plan and determine the types of interventions that will be most helpful. Consultation is also useful during ongoing therapy to help the therapist maintain (or regain) the focus on the client's unconscious plan, especially when it is derailed by transference enactments.*

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Atul Gawande, an experienced surgeon, wrote an article (2011) describing the improvement in his surgical technique and outcomes when he consulted with a more senior surgeon. He was surprised at the difference that “coaching,” as he referred to it, could make. Practitioners of psychotherapy and psychoanalysis have long known about the benefits of consulting with a more experienced clinician. However, unlike surgery, psychotherapy consultation is not theory neutral. There is no general theory of case consultation

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because each psychotherapeutic theory approaches clinical practice, and the teaching of clinical practice, from its own theoretical framework. This article explores how control-mastery theory views case consultation (see also Gassner, 1990).

### CONTROL MASTERY AS A THEORETICAL FRAMEWORK

Control-mastery theory is a cognitive psychodynamic relational theory developed by Joseph Weiss in collaboration with Harold Sampson (Silberschatz, 2005; Weiss, 1993; Weiss, Sampson, & The Mount Zion Psychotherapy Research Group, 1986). The theory's name comes from two basic concepts: (1) that people exert some control over their unconscious mental life and (2) that they want to master their conflicts. Control-mastery theory assumes that psychopathology originates in unconscious pathogenic beliefs that form in reaction to traumatic experiences with parents or other important caregivers. Pathogenic beliefs are not fantasies or wishes but rather grim painful thoughts that predict relational danger. Because loving parents are crucial for the development and well-being of their growing children, children pay close attention to the parents' words and deeds and are vulnerable to being traumatized by anything that suggests the parent does not appear to support the child's development (e.g., the parent ridicules the child's wishes to be autonomous, or, conversely, her wishes to be close to the parent). In reaction to such traumas, children develop pathogenic beliefs to make sense of the powerful affects they experience in response to the traumatic events. These explanations may be irrational but are understandable given the child's limited experience with relationships, and egocentric thinking. The child's pathogenic beliefs may also reflect her or his compliance with the parent's own pathogenic beliefs. For example, a child may develop the pathogenic belief that she or he is too much of a burden to explain the mother's depression and inability to care for her or him. This is even more likely to occur if the mother actually blames the child for her depression.

Children want their parents to be strong and powerful and will be upset by anything that seems to diminish the parent. Children will be particularly upset if they feel they have done something to hurt or provoke (or in any way diminish) the parent. Because of their concerns about their parent(s), children are vulnerable to two kinds of guilt. Separation guilt occurs when a child feels that becoming independent of the parents or other important caregivers will upset them. Survivor guilt reflects the child's pathogenic belief that what he or she has achieved has come at the expense of one's parents or siblings. For example, anorexia may develop from a person's pathogenic belief that she or he has gotten too much of the family's limited psychological resources, and that the only way to atone for getting too much is

to stop taking in anything at all (see Friedman, 1985, for examples of this pathogenic belief).

Because control-mastery theory hypothesizes that people are powerfully motivated to solve their problems, we assume that people come into therapy not for infantile gratifications, or to maintain infantile object ties, but to master the traumas that have kept them from reaching their normal developmental goals. Therefore, clients are almost always working to get better. Clients come into therapy with an “unconscious plan” for solving their problems. An unconscious plan is not a formula or a blueprint. It is a rough guide for what a client unconsciously intends to do. It consists of the client’s goals (which may be conscious or unconscious), obstructions to the goals (usually a pathogenic belief of danger if the person pursues the goal directly), and strategies for reaching the goals (generally the types of tests the client will carry out and the insights that will be helpful in achieving the goals).

Testing is a crucial part of the therapy. It is the main way that clients determine if it is safe to recall the traumas that led to the development of pathogenic beliefs. Testing helps the client to challenge pathogenic beliefs and, ultimately, to disconfirm them. Clients can test the therapist in one of two ways by transferring or by turning passive into active. In a transference test, the client acts like the child he or she once was, to see if the therapist will act like the traumatizing parent. This is the usual way that psychodynamic theories view transference. In passive-into-active testing, the client enacts the role of the traumatizing parent and treats the therapist as the parent treated the child. (Identification with the aggressor is one form of turning passive into active.) However, both types of testing are carried out for the same reason: to determine if it is safe to recall previously repressed traumatic events. When the therapist passes the test, the client feels reassured, and this furthers therapeutic progress. It becomes the clinician’s task to develop a plan formulation, to understand the client’s unconscious plan and how the therapist can help the client to achieve his or her goals. Because each formulation is case specific, there are no generic techniques that can be applied. Therefore, the therapist must examine the therapeutic process in great detail to determine the specific client’s unconscious plan, how the client is working toward his or her goals, and what interventions will facilitate that progress (what control-mastery theory refers to as “proplan interventions”).

Control-mastery theory is written in simple, everyday language, and for this reason, it is often seen as simpler and therefore easier to understand and apply than it actually is. In fact, it takes about 2 years of weekly supervision from detailed process notes to become comfortable using the theory correctly without supervision. One reason for this is the complexity of doing psychodynamic psychotherapy. Another reason is the case specificity of the approach. That is, each client is seen as unique, and each formulation of a case, including the client’s unconscious plan, is unique. An example of this is the concept of testing. Although other theories may use the term, the

control-mastery concept of testing is firmly based in the theory's assumption that the client is almost always working to get better. A test in this sense would not be carried out to impede or interfere with the therapy. It then becomes part of the therapist's job to figure out how the client's specific test is being used to further the therapy, and, given that, what kind of response by the therapist would be most useful to the client. Consider an everyday example: A client is talking about the connections between her history and her present behavior; at some point, the therapist adds an additional example to support the client's insights. For many clients, the discussion of past events would not be a test at all. It would be understood as just part of the normal back and forth of therapeutic interaction. But for clients who had been ignored or neglected in childhood, this could be a significant test of the belief, "I'm not important enough to pay attention to." That client would be encouraged by the therapist's comments because she would take it as evidence that the therapist was listening and interested in her. In contrast, a client who had been traumatized by intrusive parents who always had to have the last word could feel that the therapist's everyday "supportive" comment, no matter how accurate, was a repetition of the parental relationship and not helpful. The therapist who has developed an understanding of that client's unconscious plan might let the client talk without adding any comments.

### THE IMPORTANCE OF PROCESS NOTES

One unique aspect of control-mastery theory is the research that has been carried out for the past 40 years by the San Francisco Psychotherapy Research Group (SFPRG). The research has influenced the theory as well as our understanding of therapeutic practice and supervision. For example, from the research we know that tape-recorded sessions, though useful, are not necessary for a close examination of the therapeutic process. Detailed process notes are usually sufficient to capture the important aspects of the therapeutic process (Wolfson & Sampson, 1976). Although it takes 2 years to gain enough knowledge to conduct a therapy without supervision, that is really only the beginning. The more the therapist learns, the deeper the therapist's understanding of the details of the therapeutic relationship. That is one reason therapists often choose to seek additional case consultation even after they are licensed as independent practitioners. As the therapist develops a more complete understanding of the client's problems and the client-therapist relationship, the therapist is able to remember an increasing number of details of each session. That allows the therapist and consultant to study the interactions of each session in greater depth. The detailed study of process notes is essential for determining the client's unconscious plan. Somewhat paradoxically, the more experienced the therapist the more

detailed the case consultation becomes as the therapist and the consultant examine the nuances of each case.

When a therapist presents a new case the focus of the consultation is to formulate a first approximation of the client's unconscious plan. The therapist and consultant examine the process of the first few sessions to begin to formulate the client's stated goals, the nature of the client's symptoms, the traumas the client reports, and the nature of the interaction between the client and the therapist, including the therapist's affective reactions to the client. From this information we begin to infer what the client's unconscious goals might be and the unconscious pathogenic beliefs that have interfered with the client pursuing her goals. These inferences will guide the therapist's responses. For example, if a client begins therapy with the stated goal of marrying a partner who is clearly abusive, we would assume that her unconscious goal is quite different and that some pathogenic belief has made it impossible for her to select a partner who treats her well.

As therapy proceeds, the therapist and consultant continue to study detailed process notes to assess the client's responses to the therapist's interventions; particularly to see if the therapist seems to be on the right track. For example, research has shown that clients react to proplan interventions by feeling safer, becoming less anxious, and making more therapeutic progress (Silberschatz, 2005). If, based on a tentative plan formulation, the therapist's intervention seems to result in the client becoming more anxious and less forthcoming in sessions, the plan formulation will need to be revised. The therapist and consultant examine the interactions within each session as well as from one session to another; clients often pose a test at the end of a session, and the results of passing or failing a test may not be apparent until the following session. As they continue to examine the therapeutic process, the therapist and consultant develop a more detailed understanding of the client's plan. This allows the therapist to hold the "big picture" in mind and to feel more confident in the ongoing interactions with the client. For example, a therapist who knows that her client reacts to excitement by claiming to be bored will be listening for a possible reason for excitement if a client suddenly starts talking about feeling bored.

### THE ROLE OF THERAPISTS' AFFECTS

Another important aspect of consultation is the attention paid to the therapist's affective reactions. This can provide additional information regarding the tests the client is carrying out. Sometimes this is apparent from the beginning of therapy.

For example, a therapist noted her unusual reaction of dislike for a client who began therapy with a dismissive attitude toward women and toward therapy. Assuming the client is almost always working to get better,

the therapist used her unusual reaction to begin to formulate a reason why the client needed to present himself in such a negative light. Eventually it became clear that the client expected to be criticized and rejected, and he was posing a very early test to determine if his therapist was going to confirm his pathogenic belief (see Shilkret, 2008, for a more detailed discussion of this case).

The therapist's affective reactions may not necessarily be prominent at the beginning of a therapy. The therapist may develop an adequate plan formulation and conduct a successful therapy for a considerable period of time. Later, the therapist may notice herself developing a variety of unexpected and intense, often unpleasant, affects. This often occurs when the therapist feels stuck in a passive-into-active transference. When a client turns passive into active and enacts the role of the traumatizing parent, the client may be subjecting the therapist to an intense experience of what growing up was like for that client. These interactions can be unpleasant and cause the therapist to lose sight of the plan formulation, as the client, in the role of the traumatizing parent, makes the therapist feel hopeless, incompetent, worried, and other intense negative affects that the client experienced growing up. This is another point in therapy when consultation becomes helpful even for the experienced therapist. The consultant, who is not so caught up in the interaction, helps the therapist to regain his or her therapeutic equanimity by reminding the therapist that the client is working to get better; how can we understand the client's behavior as a test to reassure him or her that it is safe to make progress? For example, in consulting with a therapist who was getting discouraged when her client did nothing but complain about her, the consultant was able to remind the therapist that the client's mother always complained and made the client feel hopeless. The consultant also observed that in the process notes it was noticeable that when the therapist remained calm in the face of these complaints the client perked up and then acted in a more confident manner. The therapist was able to use these observations to refocus her attention on the client's unconscious plan and was less troubled by feelings of discouragement.

In another case, a therapist requested a consultation when she realized that she was often preoccupied with vague worries about the client. The therapist was experienced in applying control-mastery theory, had formulated the case satisfactorily, and the client had improved. But after the first year of therapy, the therapist felt increasingly worried in ways she had trouble articulating. The client was a woman in her thirties who began therapy complaining of severe depression and the inability to form a lasting relationship with a man. She was also dissatisfied with her career. As she went from man to man, she also went from job to job. She presented herself as the passive victim of boyfriends and bosses who did not treat her well. She had no recognition that she contributed to her own unhappiness, for example, by getting involved with an alcoholic boyfriend. In giving her history, she

reported that her parents had a tense, unhappy marriage, as did her sister. Although her father enjoyed his career, her mother always seemed dissatisfied because her own career was a second choice. For financial reasons, her mother had not been able to pursue her original career interests.

The therapist had hypothesized reasonably that the client's goals were to become less depressed and to form stable work and love relationships. She also hypothesized that the obstruction to pursuing her goals was the guilt she felt at surpassing her unhappy mother and sister. The client's initial presentation as an unhappy victim was an unconscious test to determine if the therapist (in the transference) wanted her to remain identified with her mother and sister, or if the therapist would support the client's ability to act in less self-defeating ways. (As with any long-term psychotherapy, the clinical material is more complex than this one theme. However, not to complicate the material further, I am focusing on this one important element of the case.)

With this initial plan formulation, the client and therapist worked well. When the client complained about various situations, the therapist listened and was supportive. Sometimes no response was necessary. But at times the therapist pointed out that the client seemed to feel uncomfortable whenever she mentioned some success in her life, particularly if her mother or sister appeared to be struggling with a similar issue. The client usually felt less depressed after these interventions. But after a year, the therapist noticed she was increasingly worried about the client. The client would drop hints about being suicidal, allude to bad things she had done, and suggest that therapy was not helping. The client discounted whatever the therapist said—it was wrong, or, if it was correct it did not change anything. The therapist felt increasingly pressured and requested a consultation.

After discussing the initial sessions and the original plan formulation, I believed that the therapist had viewed the case correctly. We then focused on the therapist's feeling of vague worry. Because the therapist was competent and usually able to articulate her concerns about clients, I thought that this was probably a passive-into-active enactment. The client was traumatizing the therapist as she had been traumatized, with the unconscious hope that the therapist would be able to deal with complaints more effectively than the client had. We then began to examine the process notes of the sessions in great detail, to determine what had led to the therapist's feelings of excessive worry. (Although the client alluded to vague hints of suicide, she denied any intent, and there was nothing in her history to suggest that she had been or might become suicidal. From this we decided that the therapist's worries were probably excessive.)

In examining the process notes, I noticed one brief comment that the client had made many sessions prior to the consultation. The client's parents, who lived 1,000 miles away, were thinking of visiting and possibly even relocating to be near the client. The client had not referred to this again,

and the therapist had gotten so caught up in worrying about the client that the comment had been forgotten. I suggested to the therapist that as part of a passive-into-active test, the client was worrying the therapist as one or both parents had worried the client as a child; this had probably been intensified by her fear that her parents might move closer to her. The therapist took this advice and, in a subsequent session, wondered with the client if the client was worried about something that was increasing her feelings of hopelessness. The client then began to talk about her parents' impending visit and how responsible she felt for keeping her mother safe. She revealed many self-defeating and self-destructive things that her mother had done since the client was a child. Her father typically only shook his head or shrugged his shoulders. At that time, her sister was too young to do anything. So the client would worry and futilely try to keep her mother safe, even though, as a child, realistically there was nothing she could do. Once that material emerged, the therapist's vague worries disappeared and she felt back on track with the client.

#### CASE CONSULTATION AND THERAPISTS' UNCONSCIOUS PLANS

The above case example illustrates another key point of control-mastery theory, the importance of the therapist's affective reactions not as an indication of the therapist's pathology but as a result of a test carried out by the client. (This assumes that the therapist's affective reaction is case specific. If the therapist has the same reaction to all clients then the therapist might need to consider personal psychotherapy.) The focus of the consultation sessions is always on the client and how to deal with the client. The therapist's reactions are used to understand the clinical process, rather than to focus on the therapist's internal difficulties. However, there are times that consultation reveals a personal problem of the therapist. As we assume that clients come to therapy wanting to resolve their difficulties, we also assume that therapists come for consultation because they want to improve their clinical skills. Therefore, if a therapist seems to be impeding her own progress (e.g., if she asks for guidance with a difficult case and then refuses to consider the advice or argues with the consultant without any good rationale), we would assume that the therapist might be testing the consultant. The consultant's work would then include formulating what the therapist's unconscious plan might be and deciding how to help the therapist achieve it. For example, a therapist consulted with me regarding a case that was not going well. We discussed how the client was testing her and how she might change her approach with this difficult client. The therapist agreed with everything I said and then continued along with the therapy, making the same mistakes, as if we had never discussed them. I knew that this therapist had followed in the footsteps of her mother, who was a well-known and well-respected



therapist. I also learned in casual conversation with the therapist that it was important to her mother to be viewed as an expert. I hypothesized that the therapist had the pathogenic belief that I, too, needed to be seen as an expert and that she, the therapist, was supposed to act incompetent for my sake so that I could correct her. Because our meetings were not therapy (and, in fact, the therapist had her own therapist), I decided to handle the situation by not criticizing the therapist or telling her what she should do. Instead, I praised her for the many correct interventions that she made, and I suggested an occasional additional intervention that she might try. Over several months of this approach, the therapist became more confident about her ability to treat her client, became less deferential to me, and became more able to listen to the suggestions that I did make.

### CONCLUSION

Case consultation is an important part of a clinician's professional development. From a control-mastery perspective, consultation focuses on the detailed examination of process notes as well as close attention to the affective reactions of the client and the therapist. This dual focus helps to orient the therapist to the client's unconscious plan for the therapy. Although the consultant may recognize unconscious conflicts in the therapist, consultation is not therapy, and the focus remains on helping the therapist facilitate the client's unconscious plan for the treatment. Consultation can also be professionally and personally rewarding for the consultant. Professionally, consultation encourages consultants to sharpen their thinking as they try to understand difficult case material and then to explain it to the therapist in a clear and useful manner. It is also personally rewarding to help a colleague improve her or his skills. I feel privileged to have had many such close relationships in my many years of providing consultations to a wide variety of valued colleagues.

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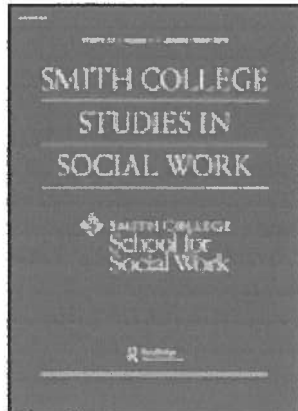
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