Clinical applications of control-mastery theory

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In the past year, control-mastery theory has been enriched by formal research investigations and by theoretical and clinical contributions. Studies using a new measure of survivor guilt have shown its importance in psychopathology. Quantitative research of the therapeutic process supports the idea that patients plan their psychotherapy.

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Introduction

In this article, developments in control-mastery theory, derived from quantitative and clinical research and from theoretical discussions, are described.

According to control-mastery theory, patients' psychopathologies stem from pathogenic beliefs about themselves and their relation to others, which they acquire in early childhood from traumatic experiences with parents and siblings [1–3,4•]. Young children acquire these beliefs as part of an effort to adapt to their family. These beliefs adversely affect self-esteem, maintain psychopathology, prevent the pursuit of adaptive, desirable goals, such as success or a good relationship, and often give rise to intense shame and guilt. These beliefs are about reality and morality. The moral principles that families adhere to are part of children's reality and children must learn them if they are to adapt to their family.

People are highly motivated to disprove their pathogenic beliefs and work throughout therapy to do this by testing their beliefs in relation to the therapist. Patients carry out trial actions that, according to their beliefs, should affect the therapist in a particular way. They hope that the therapist will not behave as their beliefs predict. If the therapist does not act as predicted and so passes the patients' tests, patients move forward [4•]. Patients control their repressions by the criteria of danger and safety, maintaining them as long as they feel endangered by the mental contents they have warded off, lifting them when they unconsciously decide that they may be safely experienced [5]. After the therapist passes their test, patients show an immediate response. They feel safer and less anxious, become bolder and more insightful [6].

Patients react in the same way to interpretation, which they can use in their struggle to disprove their pathogenic beliefs [7–9].

Patients work in accordance with a simple plan that tells them which problems to tackle at a given time and which to defer [10–12].

The therapist's approach and the patient's responses are case-specific

The therapist's approach is case-specific. It depends on a patient's particular pathogenic beliefs and his or her ways of testing them. Sampson [13•] illustrated this in a clinical paper. The author described a patient whose main pathogenic beliefs, which stemmed from his derisive father, concerned his fear of rejection and humiliation. The patient who at the beginning of therapy was averse to interpretation was helped by Sampson's friendly attitude. He made progress and without the benefit of interpretation retrieved memories of his father's putting him down.

Patients' responses to the therapist are case-specific [14•]. Each patient is relieved when the therapist passes a test. However, the way patients show their relief depends on how they are testing the therapist and what they have repressed.

The significance of the plan concept

Rosbrow [15•] argued for the value of the plan concept, stating that patients have a strong wish to be understood in terms of their own specific life history rather than in generic terms. The therapist who understands that the patient is working to get well, offers the patient the respect that he or she deserves.

The value of the plan concept has been highlighted [16•,17••]. Fretter *et al.* [17••] compared the plan concept to that of transference. The authors showed, in a formal research study carried out on transcripts of three brief psychotherapies, that patients make immediate, statistically significant, progress in reaction to interpretations that they can use to carry out their plans (pro-plan interpretations). The authors also showed that transference interpretations produced no greater effect than nontransference interpretations; nor were pro-plan trans-

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ference interpretations any more effective than pro-plan interpretations not involving transference.

Evidence for the plan concept was reported in an article by O'Connor *et al.* [18••]. The authors researched five psychotherapies which the patient knew in advance would be limited to 16 sessions. In each case, the patient began therapy with a relatively high level of pro-plan insight. The level of insight appeared to drop to zero in the middle part of treatment and rose again in the last several sessions. These findings support the hypothesis that patients unconsciously plan their therapy. Patients show high insight at the beginning to orient the therapist to their plan so that the therapist can help them. They appear to lose insight in the middle part of therapy as they test the therapist. They regain insight at the end in preparation for leaving treatment.

Studies of depression and addicted clients

Studies have shown the value of the control-mastery perspective in the treatment of particular syndromes. Jones *et al.* [19•] demonstrated the value of the control-mastery approach in the successful treatment of a major depression, in which the therapist focused on helping the patient overcome her survivor guilt. In a clinical paper [20•], the successful treatment of addicted clients by the control-mastery approach was reported. Addicted clients may be helped if the therapist understands that these clients are motivated to overcome their addictions but are inhibited by pathogenic beliefs warning them against recovery as well as by the direct effects of their addiction. When the therapist supports their unconscious plan to recover, patients may be helped to achieve a stable abstinence and to overcome long-standing psychological problems.

Shame and guilt

Pathogenic beliefs often give rise to shame and guilt. O'Connor [21••] conducted pilot studies using a new measure of guilt, the Interpersonal Guilt Questionnaire. The subscales of this measure, including survivor guilt, separation guilt, and omnipotent responsibility guilt, are internally consistent and correlate significantly with other measures of related constructs. The author supports the hypothesis that (1) people with severe psychopathology have higher levels of guilt and shame than other people; (2) people who have been severely traumatized in childhood have more guilt and shame than people who have not (children assume that they get what they deserve); and (3) people with much survivor guilt (that is, who are guilty of being better off than others) tend to be depressed and ashamed. Shame may serve to protect a person from survivor guilt.

Conclusion

Clinical investigations and formal research support the hypothesis that patients unconsciously plan their therapy. Research has been done on the efficacy of the control-mastery model for treatment of a major depression and also for the treatment of addicted clients. Research using questionnaires has pointed to the origins of shame and guilt in childhood trauma and the prevalence of these affects in psychopathology.

References and recommended reading

Papers of particular interest, published within the annual period of review, have been highlighted as:

- • of special interest
- •• of outstanding interest

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This article offers a brief review and summary of control-mastery theory and research up to 1993.
5. Freud S: **An outline of psychoanalysis.** In *Standard edition of the complete psychological works of Sigmund Freud,* vol 23. London: Hogarth Press; 1964:141–207.
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11. Silberschatz G, Fretter P, Curtis J: **How do interpretations influence the process of psychotherapy?** *J Consult Clin Psychol* 1986, **54**:646–652.
12. Curtis J, Silberschatz G: **Clinical implications of research on brief dynamic psychotherapy: I. Formulating the patient's problems and goals.** *Psychoanal Psychol* 1986, **3**:13–25.
13. • Sampson H: **Treatment by attitudes.** In *Process notes. San Francisco Psychotherapy Research Group* 1994, **1**:8–10.

A clinical article that is clear, well argued, and illustrated by an interesting example.

14. • Silberschatz G, Curtis JT: **Measuring the therapist's impact on the patient's therapeutic progress.** *J Consult Clin Psychol* 1993, **61**:403–411.

The authors report a formal, quantitative study of the patient's testing of the therapist and the patient's responses to passed tests.

15. • Rosbrow T: **Signficiance of the unconscious plan for psychoanalytic theory.** *Psychoanal Psychol* 1994, **10**:515–532.

A theoretical discussion in which the control-mastery theory is compared with other contemporary theories. The author argues cogently for the use of the plan concept.

16. • Weiss J: **The analyst's task: to help the patient carry out his plan.** *Contemp Psychoanal* 1994, **3**:236–254.

Through case examples and formal research, concepts that the patient develops a plan for therapy and that the therapist's task is to help the patient to carry out their plan are developed and illustrated.

17. •• Fretter P, Bucci W, Broitman J, Silberschatz G, Curtis JT: **How the therapist's plan relates to the concept of transference.** *Psychother Res* 1994, **4**:58–72.

In this interesting and well argued article, the authors report on a series of formal investigations on the effects of the therapist's interpretations. The authors show that the results are more fully explained by the plan concept than by the concept of transference.

18. •• O'Connor LE, Edelstein S, Berry JW, Weiss J: **Changes in the patient's level of insight in brief psychotherapy: two pilot studies.** *Psychotherapy* 1994, **31**:533–544.

The authors present a research investigation of the changes in the patient's level of insight in brief psychotherapy. The results are inherently of great interest and support the concept of unconscious planning.

19. • Jones EE, Ghannam J, Nigg JT, Dyer JF: **A paradigm for single-case research: the time series study of a long-term psychotherapy for depression.** *J Consult Clin Psychol* 1993, **61**:381–394.

The authors articulate a paradigm for single-patient research and show the potential of intensive single-patient designs for uncovering causal effects in psychotherapy.

20. • O'Connor LE, Weiss J: **Individual psychotherapy for addicted clients: an application of Control-Mastery theory.** *J Psychoactive Drugs* 1993, **25**:283–291.

The authors argue for the usefulness of the control-mastery model in the treatment of addiction.

21. •• O'Connor LE: **Empirical studies of shame and guilt: development of a new measure, the interpersonal guilt questionnaire.** *Process notes. San Francisco Psychotherapy Research Group* 1994, **1**:12–15.

A new measure of guilt developed by the author that correlates with standard constructs of guilt (and which is internally consistent), highlights the importance of survivor guilt in psychopathology.

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