

## TOWARD A CONSTRUCTIVIST CONTROL MASTERY THEORY: AN INTEGRATION WITH NARRATIVE THERAPY

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*The integration of control mastery theory and narrative therapy provides a critical constructivist approach to a psychodynamic psychotherapy. The root metaphor of stories, even more than pathogenic beliefs, offers a fertile landscape in which clients' problems can be deconstructed along the theoretical lines formulated by control mastery. A heightened sensitivity to cultural and intergenerational contexts adds to the power of such interventions. Perhaps even more important, new "mastery stories" can be constructed through attention to language, bodily based experience, and the therapeutic relationship. The positive outcome of this integration is greater 'pro-plan' specificity, which is the capacity to more effectively infer and support the client's goals for therapy.*

The field of psychotherapy is taking a constructivist turn toward embracing the idea that the meaning of people's lives is actively created and not simply discovered (Bruner, 1986). The clinical implications of this shift transcend and potentially integrate three dominant, but previously divergent, approaches in the field: psychoanalysis

(e.g., I. Z. Hoffman, 1983; Renik, 1993; Schafer, 1992; Spence, 1982; Spezzano, 1995), cognitive behaviorism (e.g., Mahoney, 1991; Meichenbaum, 1993; Russell, 1992), and family systems theory (e.g., de Shazer, 1988; L. Hoffman, 1990; Keeney, 1983; Maturana & Varela, 1987). By establishing a common theoretical foundation, constructivism progressively integrates these approaches and facilitates a more refined and powerful model of psychotherapy.

We believe that the work of Weiss, Sampson, and their colleagues at the San Francisco Psychotherapy Research Group (Weiss, 1993; Weiss, Sampson, & the Mount Zion Psychotherapy Research Group, 1986) stands at the crossroads of this convergence. However, up to this point, its historical roots in classical psychoanalytic thought have impeded a full embrace of its connection to constructivism and its philosophical substrate—postmodernism. In fact, the control mastery writers (Bader, 1998; Sampson, 1996) who have specifically addressed this issue have positioned themselves as modernists in opposition to this theoretical perspective. We believe that in opposing the excesses of the postmodern movement, the "baby has been thrown out with the bath water." In the course of doing so, important theoretical commonalities and therapeutic contributions have been overlooked. Alternatively, Bracero (1994, 1996) has attempted to address this issue from the postmodern perspective but has also failed to make effective linkages between control mastery and constructivism because of his focus on differences rather than on points of integration.

The purpose of this article is to first establish control mastery as a constructivist theory and, on that basis, forge a progressive, theoretical integration (Neimeyer, 1995) with other constructivist approaches. Of these approaches, we have primarily chosen the narrative therapy work of Michael White and his associates at the Dulwich

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Centre in Adelaide, Australia, to aid us in developing a methodology of change that is synergistic with a control mastery therapy, constructively conceived. In doing so, we reformulated a number of control mastery concepts into constructivist terms. However, we sought to do more than simply put "old wine into new wineskin." Case examples are offered to illustrate the pragmatic implications of this integrative model as it furthers our work in new and powerful ways. Finally, we hope that our colleagues across the constructivist spectrum will find our integrative control mastery model to be a valuable new ally in their therapeutic endeavors.

### Control Mastery Overview

Control mastery theory elaborates Freud's (1926) later idea that psychological problems are rooted in grim, largely unconscious beliefs that have been inferred from traumatic early experiences, usually within the family or with other primary caretakers. Infant researchers (Beebe, Lachmann, & Jaffe, 1998; Bowlby, 1988; Gopnik, Kuhl, & Meltzoff, 1999; Schor, 1997; Stern, 1985) have demonstrated that the child, acting much like a scientist, quickly begins scanning the family environment to monitor the behaviors of parents, siblings, and other primary caretakers in order to adapt to their interpersonal reality. Control mastery theory asserts that the child gradually develops a set of beliefs about what are safe or unsafe ways to adapt to the family environment while simultaneously attempting to meet important personal, developmental needs and strivings. Maintaining conditions of psychological safety for the self and important loved ones becomes a central motivational principle throughout the course of life, organizing intrapsychic and interpersonal development as well as the process of therapy (Pole, 1999; Sampson, 1989, 1990; Silberschatz & Curtis, 1993; Weiss, 1993; Weiss et al., 1986). The emphasis on the child's primary motives of adaptation to the family and altruistic concern for the well-being of family members, especially when they are in distress (O'Connor, 2000; Rosbrow, 1993; Suffridge, 1991; Weiss, 1993), contributes to a humanistic and non-pathologizing clinical stance.

While highly adaptive in one sense, the beliefs inferred from traumatic experiences (*trauma* is loosely defined as any early experience or set of experiences that harm the child or important oth-

ers) are termed *pathogenic* because they inhibit the child from pursuing preferred goals and give rise to troubling feelings, problematic behaviors, and interpersonal conflicts. Pathogenic beliefs most commonly occur when a child attempts to achieve a certain developmentally appropriate goal and discovers that such attempts repeatedly lead to trauma for the child or parent. For example, a child might discover that his or her moves toward greater autonomy are consistently met by parental rejection, abuse, or frailty and then might develop the pathogenic belief that autonomous desires are dangerous to self or others. Other children might experience their own dependency strivings as overwhelming to caretakers and develop pathogenic beliefs contributing to excessive self-reliance.

Pathogenic beliefs may also develop as a result 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. The dynamic of compliance is perhaps most commonly seen in cases of child abuse. Pathogenic beliefs involving personal unworthiness and self-blame are commonly inferred from abusive treatment (Summit, 1983; Weiss, 1993) and have been found to later mediate adult adjustment (Coffey, Leitenberg, Henning, & Turner, 1996; Suffridge, 1991).

Finally, pathogenic beliefs are often perpetuated over generations as children identify unconsciously with certain behaviors, attitudes, and beliefs expressed by their parents, which are later transmitted to their own progeny. For example, an adolescent with drug-addicted parents described her pathogenic beliefs that drugs were harmless and even necessary in order to enjoy life. By romanticizing her parents' drug abuse and following in their troubled footsteps, this client was able to avoid experiencing survivor guilt over being better off than her parents. She made them more like the idealized caretakers she still needed them to be, even though her identification came at the price of impaired peer relationships and school performance.

Control mastery further asserts that individuals come to therapy highly motivated to overcome the suffering derived from pathogenic beliefs and that they want to pursue their preferred life goals. This guiding focus on the client's inherent motivation for health represents the *mastery* component of the theory and has a very hopeful and

collaborative effect on treatment. It is understood that the client and therapist work together toward a direction that the client, unconsciously or consciously, chooses. We believe that the mastery motivation is universal and evolutionary based, while its specific expression is contingent on the particular historical and cultural context.

Control mastery holds that, in the course of therapy, clients work to overcome their pathogenic beliefs primarily through a process of consciously and unconsciously “testing” their beliefs with the therapist. Testing of pathogenic beliefs is viewed as a fundamental activity in and out of therapy for adapting to one’s interpersonal world and achieving personal goals.

There are two types of testing. In *transference testing*, the client, initially in an unconscious fashion, behaves with the therapist as he or she responded to the caretakers involved with the original traumatization that led to the formation of pathogenic beliefs. The client is seen to be unconsciously hoping that the therapist will not repeat the traumatization. For example, a client who was regularly criticized during childhood for expressing vulnerable affects, and thus learned to repress these affects, might test the therapist by expressing sadness or crying during early sessions. In this case, the therapist will be able to “pass” these tests by responding empathically to the emotional material. In doing so, the client begins to disconfirm the pathogenic belief that the expression of vulnerability is wrong and dangerous. In the other primary form of testing, *passive-into-active testing*, clients switch roles and treat the therapist or others in the traumatizing ways they were treated in the development of their pathogenic beliefs. The unconscious goal of passive-into-active testing is that the person being tested will not be traumatized and succumb to the same pathogenic 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.

While therapist interpretations may also be used in control mastery therapy to help overcome pathogenic beliefs, reflecting its humanistic and relational approach, the therapeutic emphasis is less on interpretations and more on providing a therapeutic experience that runs counter to the client’s pathogenic beliefs and expectations. When interpretations are used, they are directed toward describing the pathogenic beliefs that inhibit the pursuit of the client’s goals, the various

contexts contributing to the development of the beliefs, and the ways that the client may be testing the therapist and others in efforts to overcome these troubling constructions.

Control mastery theory hypothesizes, with increasing research evidence, that clients form unconscious plans to master the effects of prior trauma and overcome pathogenic beliefs (Fretter, Bucci, Broitman, Silberschatz, & Curtis, 1994; Curtis, Silberschatz, Sampson, Weiss, & Rosenberg, 1988; Curtis, Silberschatz, Sampson, & Weiss, 1994; Rosbrow, 1993; Weiss, 1993; Weiss et al., 1986). The unconscious plan is a fairly flexible strategy for how clients will work in therapy to overcome their unique system of pathogenic beliefs. Unconscious plans include the client’s therapeutic goals, the unconscious testing strategies the client might use, and the insights he or she might seek in attempting to achieve these goals. The therapist’s goal throughout treatment is to infer the client’s unconscious plan and to intervene in a *pro-plan* manner. It is not the therapist’s a priori formulation of the problem that defines the client’s plan; it is the client’s response to interventions that ultimately craft the work of psychotherapy. Consistent with postmodern sensibilities that guard against the arrogance of authority, the control mastery emphasis on demonstrable client progress encourages a humility and accountability to the client that keep the focus on the client’s goals and plans.

### Constructivism

We believe that control mastery can be effectively reformulated as a constructivist approach to psychotherapy by virtue of the fact that its tenets are inherently consistent with the core constructivist principle that individuals do not simply observe the world. Instead, individuals actively participate in creating meaning.

However, the constructivist foundation of control mastery has been, up until this point, largely unacknowledged or disavowed because of a failure to distinguish between two types of constructivism: radical and critical constructivism. The key distinguishing element of these two philosophical variants is primarily in their ontological position (the nature of reality), not in their epistemological position (the nature of knowledge). Radical constructivism is related to the philosophical idealism exemplified by Bishop Berkeley (Rosen, 1996) and holds that there is no ob-

jective reality beyond the individual's personal experience or through social discourse (social constructionism). In contrast, critical constructivism, which has also been labeled efferent constructivism (Pepper, 1942), reluctant postmodernism (Leary, 1994), and soft constructivism (Mahoney, 1991), holds that there is indeed an objective reality that exists independently of human minds.

Critical constructivists emphasize the centrality of subjective structures or schemas in fashioning the individual's adaptation to, and understanding of, his or her various environmental realities (Dorpat & Miller, 1992; Lichtenberg, 1984; Slap & Saykin, 1983; Stern, 1985; Stolorow & Atwood, 1979). According to Mahoney (1991), a cognitive behaviorist, critical constructivists view the acquisition of these personal representations of reality as occurring through a social process of interaction with the environment. In this way, what is operatively true for each individual is based on coconstructive processes performed with significant others in his or her world. This is fortuitous, from a clinical perspective, because it implies that these constructs are also amenable to change through a social process. According to Rosen (1996), critical constructivism asserts that "constructs that are repeatedly disconfirmed lead ideally to revision and reconstruction" (p. 12).

Thus, critical constructivism is clearly in line with control mastery's understanding of psychopathology and how psychotherapy works. Pathogenic beliefs exemplify these originally adaptive, socially coconstructed, and ultimately problematic subjective structures that are ideally disconfirmed through the processes of testing and interpretation in psychotherapy. Given this apparent theoretical compatibility, it is somewhat surprising that control mastery writers (Bader, 1998; Sampson, 1996) have so vigorously carried the banner of modernism in opposition to the postmodern movement, especially as it is expressed in contemporary psychoanalysis. Unfortunately, this critical position forecloses integrating what constructivism has to offer control mastery practitioners.

We contend that Bader (1998) and Sampson's (1996) critiques are applicable to radical constructivism but not critical constructivism. Unlike the radical constructivism espoused by contemporary psychoanalysts (I. Z. Hoffman, 1983; Renik, 1993; Spezzano, 1993), critical constructivism,

like control mastery, is open to an empirical approach to the study of psychotherapy. There is a copious body of research that is firmly based in constructivist psychotherapies (L. S. Greenberg, 1986; Kelley, 1955; Martin, 1992, 1994; Piaget, 1971; Rennie & Toukmanian, 1992; Rice & Greenberg, 1984). The common bond among constructivist researchers is the understanding that each psychotherapy follows internally lawful and rational processes, which may not be true in any absolutist sense. In other words, how psychotherapy works may be studied on scientifically replicable grounds, although specific interventions cannot be prescribed across clients or across moments in any one therapy. From this perspective, control mastery therapists adopt the highly postmodern stance that each and every intervention is case specific.

Bader (1998) and Sampson (1996) also challenged the postmodern psychoanalytic position that accurate empathy is always questionable because the material for analysis is an irreducible intermingling of both the patient's and the analyst's intrapsychic constructions (Renik, 1993). On the contrary, they pointed out that a wide body of control mastery research has suggested that the client's unconscious plan can be reliably inferred by a group of independent observers (Weiss, 1993). In addition, as Ecker and Hulley (2000) indicated, even though a critical constructivist position incorporates a blend of relativism and objectivism in which objective reality can never be directly known, "a person's unconscious constructs behave phenomenologically as well-defined and highly durable mental objects that are discovered in therapy, not invented, and are then manipulable in accordance with equally well-defined principles. Any two competent therapists would usher a particular therapy client into discovering the same constructs necessitating the symptom" (p. 84).

In summary, we believe that control mastery represents a constructivist approach to psychotherapy that has been unacknowledged up to this point. Both its clinical emphasis on subjective structures and its case-specific empirical foundations are highly consistent with the major tenets of critical constructivism. We now turn our attention to a particular constructivist approach, narrative therapy, in order to develop an integrative framework that does more than reconceptualize control mastery theory but also suggests different implications for clinical practice.

## Narrative Therapy

Narrative therapy offers control mastery theory a new root metaphor: stories. This root metaphor generates a methodology of change that can vividly animate control mastery work. Unlike the metaphor of pathogenic beliefs, which connotes fixedness (Rappoport, 1996), stories promote fluidity. The aim of narrative therapy is to focus on the person's unique story of his or her experience, realizing that these stories are, in fact, constructions and are not universal, immutable truths. Each and every action is a "performance of meaning" (Bruner, 1986) that simultaneously re-authors past experience and frames subsequent experience.

Stories are seen as being socially constructed through engagements, or discourses, with the culture. Furthermore, the unique historical moment of the culture fosters certain stories and neglects or marginalizes others. Narrative therapy focuses on the tendency for privileged, dominant stories in the mainstream culture to silently obscure descriptions that are at odds with those dominant descriptions of reality. Because of imbalances in power, individuals can become oppressed by certain dominant discourses, and their capacity to generate more preferred stories remains choked or limited.

The key therapeutic practice of narrative therapy involves a radical shift that externalizes the person's problem as a property of the social discourse, not of the individual. Thus, the tasks of psychotherapy are twofold: first, to deconstruct the dominant discourses and second, to construct more preferred stories. This work is accomplished by both deconstructing the story of how the externalized problem affects the person and constructing the story of how the person affects the problem. These new accounts of the influence of the problem and the influence over the problem occur in the "landscapes" of action and consciousness. Narrative therapists tend to favor intervening through questions in order to bring forward redescriptions of behaviors, thoughts, emotions, intentions, identities, and relationships in increasingly vivid ways. These practices have a number of salutary effects. One consequence is to depathologize the client. Also, by deconstructing the contexts and conditions in which problems occur, the person is able to fully separate from the problem. Finally, the telling of those occasions when the person had influence over the

problem "thickens" an alternative, more preferred, narrative construction. The richer the alternative descriptions, the more effectively they constitute identity and experience.

## The Integrative Model: Overview

When two therapeutic approaches share a common underlying theoretical basis, they can be progressively integrated (Norcross, 1990). In this case, we can utilize the constructivist underpinnings of narrative therapy and control mastery theory to generate such an integrative model. As control mastery therapists, we continue to subscribe to the injunction that we must strive to pass our clients' tests; our integrative approach utilizes a narrative, and at times a more linguistic methodology of change, to facilitate that therapeutic goal more effectively.

We conceptualize that the therapist is participating, at any given moment, in one of three story lines that clients are telling about themselves through their words and actions. One of these story lines is the problem story, which significantly limits their well-being. Participation in this pathogenic story, using control mastery language, is *anti-plan* and is not helpful. In contrast, participation in the other two story lines is *pro-plan* and facilitates attainment of the client's goals. The first of these *pro-plan* story engagements we call the *deconstructive work of psychotherapy*, and the second we term the *constructive work of psychotherapy*.

Control mastery theory provides a coherent and effective framework for deconstructing the client's pathogenic story. Our integrative model seeks to reformulate this work into constructivist terms and calls on narrative techniques and tenets to further enhance it. However, from our perspective, narrative therapy makes an even more important contribution to control mastery theory with its postmodern emphasis on the creative or constructive work of psychotherapy. Until now, control mastery theory, rooted in the modernistic emphasis on discovery and explanation, has not emphasized this equally, or perhaps more, powerful method of being *pro-plan*. However, we have found that it is extremely helpful to participate in our clients' constructions of their "mastery stories," which can evolve as alternatives to their pathogenic beliefs/stories. It is our thesis that the limiting effects of pathogenic stories will lose their hold as we facilitate more preferred

stories that are as elaborated and compelling as the pathogenic stories.

We have found that the narrative therapy metaphor of “reauthoring stories” offers a therapeutic framework that significantly enhances our control mastery work. We have come to favor this framework over the organizing framework of “disconfirming pathogenic beliefs” because it creates a wider and richer therapeutic space within which change can happen. While we agree that pathogenic beliefs underlie psychological problems, we have found that a focus on this superordinate structure is, for many clients, not mutative in its effect but simply remains an intellectual label. It is too great a distillation of experience to be meaningful in ways that promote change. Using a narrative metaphor, it is akin to summarizing a complex novel into a few salient themes. By borrowing the landscapes metaphor from narrative therapy, our work becomes actively focused on the deconstruction of the pathogenic stories and the construction of mastery stories. In the course of therapy, we strive to thicken the pro-plan stories by building rich topographies in the landscapes of both action and consciousness through our words, attitudes, and actions. While control mastery theory provides the compass, narrative therapy provides additional means to follow its direction.

Having articulated the general principles of our integrative model, we turn our attention to its pragmatic application. For expository purposes, we first focus on the deconstructive work of psychotherapy and subsequently on the constructive work. However, in practice, the therapeutic work often weaves back and forth between these two pro-plan story lines.

### **The Deconstructive Work: Focus on the Pathogenic Story**

Clients enter therapy with an unconscious plan to restory their pathogenic beliefs. These beliefs, while largely unconscious, have a profound organizing effect on the client’s direct experience of his or her world. They could be understood as superordinate constructs (Kelley, 1955), deep structures (Guidano, 1991), organizing principles (Stolorow & Atwood, 1979), or core ordering processes (Mahoney, 1991). They are responsible for selective attention to new experiences, biases in attribution of meaning, reconstructive errors in memory recall, and expectations of outcomes.

Thus, they coalesce into predictable behavior patterns and themes. In short, pathogenic beliefs became complete macronarratives (Goncalves, Korman, & Angus, 2000) of self and others.

The deconstructive task of psychotherapy is to collapse manifestations of the pathogenic story upon itself. From this perspective, it is the conversation between the client–author and the therapist–reader in which the inherent oppositions in the “author’s texts” become apparent and open to reconstructions (Doherty, 1990; Leary, 1994). “Our function as therapists then becomes that of literary critics—interpreting the narrative of the client while co-constructing with him or her another story” (Goncalves, 1995, p. 198). The key to collapsing the pathogenic story lies in the therapist’s constructivist attitude, which asserts that the problem is not the person, it is the story. Furthermore, the client does not have a singular story (Schafer, 1992; White & Epston, 1990).

A case illustration of deconstructing the pathogenic story follows.

Scott presented in treatment with the complaints that he was dissatisfied in his marriage, unsure of his career path, chronically depressed, and intermittently explosive. He was the middle child in a family with a rageful father and an emotionally withdrawn mother. Scott watched his father sadistically humiliate his youngest brother on many occasions. He himself was also subject to extreme verbal abuse. He was encouraged to feel weak and inadequate when he was expressing vulnerability, sensitivity, hurt, or fear. At the same time, his expressions of strength, competence, and anger were seen as attempts to usurp his father’s authority and were actively suppressed by his father. His father died when Scott left home to go to college, and he became increasingly disengaged from his family. Scott did quite well academically and went on to establish a successful career in the financial world. He married a woman he met in college whom, at the time of initiating therapy, he described as depressed and his marriage with her as “lifeless.”

When Scott entered therapy, he was captured in a grim pathogenic story that he consciously experienced as “the Truth.” This story was saturated with oppressive themes of power (White & Epston, 1990) and guilt (Weiss et al., 1986), which precluded him from leading the kind of life he preferred. We participated in the deconstructive story line whenever we worked to expose the internal tensions, hidden contradictions, and concealed assumptions (Derrida as cited in Neimeyer, 2000) in these dominant narratives. In Scott’s case, the deconstructive work of psychotherapy was to collapse the pathogenic narratives onto the hidden narratives of loyalty and adapta-

tion not only to early family figures but also to broader cultural and gender specifications.

Deconstructive conversations unmask the compliance or identification operations that “stick the client” to their pathogenic narratives. In furthering Scott’s goals, the therapist participated in conversations that were designed to instill a curiosity about his father’s messages and how they could be distinguished from his own direct experience. What had been the consequences to him and his relationships of believing that his father’s story was the truth? Alternatively, what had been the consequences of questioning his father’s messages?

An example of this “anticompliance” deconstructive work occurred when Scott talked about rarely joining his colleagues for lunch. His initial understanding of this pattern was that he did not have time for long lunches, and he was not “much in the way of company, anyway.” After looking at the many exceptions to these assumptions, Scott was invited to explore their origins. He began to recall how often he felt his father’s displeasure for “just goofing off” and how socializing with his male friends was discouraged and often prohibited. He related another story about his father’s frequent rages when he failed to clean the garage to a level of a “white glove inspection.” From his vantage point as a child, with its constructive bias toward egocentrism (Piaget, 1971), Scott had developed, but was beginning to question, a pathogenic narrative that his father’s rage was a result of his failure to meet his father’s expectations and that his worth as a human being was equal to the outcome of his labors. We explored how this narrative was currently manifested in his excessive concern about displeasing his boss, feeling overly responsible for his company’s productivity, working many overtime hours, and general isolation from peers.

In another pathogenic narrative, Scott had come to comply with his father’s message that being emotionally intimate, especially with women, was a threat to his capacity to be strong and autonomous and signified inadequacy. The deconstruction of this narrative led Scott to recall how he was repeatedly and condescendingly told that closeness to his mother made him a “mama’s boy.” Thus he came to see how he had followed his father’s example and stayed loyal to his messages by keeping hurt, fear, self-doubt, and sadness to himself in his own marriage. He also began to consider how this behavior might be con-

tributing to the “lifeless” climate in his marital relationship and his wife’s disconnection from him.

Compliance operations can be further deconstructed through an exploration of any “sparkling moments” (Monk, Winslade, Crocket, & Epston, 1996) that further challenge the compliance-based narratives. For example, Scott was invited to consider the following questions: Were there times in your life when you questioned the story that being intimate with women was a danger to your strength and autonomy? Have you met any men, whom you respect, that seem not to have agreed with that story? What are the times when you have questioned your father’s messages about self-worth being totally dependent upon your capacity to work? How did you begin to risk questioning his messages?

Identification-based narratives have a different quality because there is less conscious separation between the imposed story and the story that was grounded in more immediate experience. Clients whose behavior is either consciously or unconsciously identified with family members typically present as less troubled by their pathogenic stories than clients whose loyalty ties are maintained through compliance-based dynamics. The deconstructive work, in these cases, requires more effort to unbalance the pathogenic story. The first step is to landscape the parallel between the client’s actions and attitudes with those of the pertinent family member in both action and consciousness. In Scott’s case, he agreed with the therapist’s observation that he seemed to be “channeling” his father or “following in his father’s footsteps” when he adopted certain misanthropic attitudes. While “weakness” in a man was considered “bad,” power was equally dangerous because strength was equated, through his father’s example, with hurting others, emotionally or physically. In short, one could be either a victim or a victimizer, and Scott unconsciously concluded, over time, that it was safer to be the latter than the former.

When clients become more aware of their identifications, we use further questions, interpretations, and empathic focusing to begin to collapse the stance of “I’m just like him” by locating the dissonance between the client’s own point of view and his or her family member’s perspective. For example, Scott was invited to explore and soon recalled how frightened, helpless, and guilty he had felt as a child when he watched his father

physically abuse his mother and brother and verbally abuse him. We also noted his strong commitment to never becoming physically abusive toward his wife, as his father had been with his mother.

When deconstructing identification-based narratives, we also use what we call “alternative points of view” interventions. We will ask the clients who in their past, present, or hypothetical future would hold a perspective of them that is at odds with the identification-based perspective they hold of themselves. We often will use our immediate relationship with the client to offer our own subjective perspective, which is intended to loosen the hold of the maladaptive identification. For example, the therapist, at one point in the course of treatment, commented to Scott, “When you challenge my thoughts in the way you just did, I experience you as being very different from your father because, unlike him, you clearly know how to be strong and assertive without being abusive or oppressive.”

#### *Significance of Language in a Methodology of Change*

Historically, control mastery theory has deemphasized the importance of language in the change process, favoring instead an emphasis on corrective experiences and attitudes in disconfirming pathogenic beliefs. In contrast, the constructivist movement in psychotherapy, and post-modernism in general, has highlighted the linguistic nature of reality and thus directs our attention to the primacy of conversations in promoting change. Our integrative model follows the narrative therapy position, which like control mastery theory, deemphasizes the use of interpretations (and their inherent performance of greater authority) but instead highlights the utility of questions in loosening the hold of pathogenic narratives. Questions, from this perspective, are used to generate experience and are not simply used to secure information (Freedman & Combs, 1996). The act of questioning the client’s pathogenic constructions, by itself, creates disequilibrium in these stories by introducing an element of doubt that these stories are incontrovertibly true. Furthermore, questions, as opposed to interpretations, privilege the client as the source of knowledge about him- or herself. In short, the constructivist contribution of utilizing questions to generate experience moves the therapeutic work

beyond disconfirmation and corrective experience to creation and meaning making.

For example, questions were used to help Scott unpack a pathogenic self-portrayal as being incompetent and weak in comparison to his father. For instance, if he were so weak and his father so strong, as assumed, why did his father need to exert such despotic control? Did Scott ever sense his father’s fragility? What effect did that experience have on Scott? Did Scott *fully* believe that being afraid in a truly dangerous situation was a reflection of being weak and flawed? How would his father have reacted to Scott’s more boldly confronting his father’s irrational positions? How would others in the family have been affected if Scott took this stance? How accessible was this position given Scott’s age, gender, and culture?

However, unlike narrative therapists who seem to rely exclusively on questions to facilitate change, our control mastery stance is more case specific. We have worked with clients who shut down in the face of repeated questions, experiencing them as interrogations or demands to produce the “right answer.” Therefore, the deconstructive work also utilizes other methodologies to separate the person from the problem and to strengthen the client’s authentic voice.

#### *Role of Empathy/Focusing in Strengthening Authorship*

We believe that pathogenic narratives are commonly created from parents’ failure to attune their “storying” of the child to the child’s actual felt experience. When these empathic failures are persistently egregious, the child will accept these imposed stories through compliance and identification in order to preserve the essential ties with his or her caretakers. While it was adaptive in the early family environment to subscribe to these dominant stories, they inevitably become pathogenic later in life. These flawed and incomplete narratives limit individuals’ capacity to interpret adult experience, but it is the narratives’ “alien” quality that compels them to seek help because, as we argue, people are inherently motivated to assume greater authorship of their lives or, in control mastery language, to master their pathogenic beliefs.

We view the empathic approaches of Rogers (1961), Kohut (1977), Stolorow, Atwood, and Brandchaft (1994), and Gendlin (1996) as further means to directly privilege the client’s authorship

status. Cognitive constructions must be grounded in felt experience in order to attain their highest level of “truth” value, which from a constructivist perspective can never be totally defined on a purely objective basis. Various critical constructivist authors highlight the centrality of bodily based experience in fostering meaningful change for the client (Mahoney, 1993; Soldz, 1996). As Mahoney asserted there is a “bodily origin of ‘higher mental activities’ ” (p. 190).

The connection between constructed experience and felt experience is essential, otherwise our clients will feel fragmented by the multiplicity of interpretations available to them. We must cocreate with our clients what is true for them, not by presenting a prefashioned story based on our theory but by touching an incontrovertibly resonant chord within them. By using their felt experience as this touchstone, we participate in strengthening their genuine authorial voice.

For example, Scott entered therapy with a construction that receiving help from others signified another aspect of personal deficiency. A more detailed view of the landscape of this story focused on his dissatisfying sexual relationship with his wife and how, in particular, he felt more uncomfortable receiving pleasure from his wife than giving pleasure to her. In focusing on this experience, he related how his discomfort was especially salient when she was giving him a foot massage. Using Gendlin’s (1996) focusing technique, he centered this experience as a “knotty feeling in my gut.” By magnifying this sensation and using it as a guide, Scott located the tension between his own desire to receive pleasure from others and a story he adaptively inferred in his family of origin that desiring pleasurable interactions from his very harried mother led her to feel inadequate and maternally deficient. The knotty feeling in his gut also contained a message from his father that deriving pleasure from the relationship with a woman made him vulnerable to manipulation. Following this moment in therapy, Scott began to rewrite the lovemaking script with his wife in a way that felt truer to his own perspective.

### **Contextualizing the Pathogenic Story**

We believe that the deconstructive work of psychotherapy must not only collapse the content of the pathogenic story and strengthen the latent authorial voice of the client, it must also take into

account the wider contexts in which the pathogenic stories acquired their persuasive hold on the client. By adopting a wide-angle lens on the story, we can more effectively separate the person from the problem and facilitate more compelling mastery stories.

While we concur with the control mastery emphasis on the family of origin’s role in the development of pathogenic stories, we also hold that for many clients deconstruction and reauthoring are enhanced by broadening the context to address cultural and multigenerational influences. In certain cases, keeping the focus largely on these broader contexts is the most effective (proplan) approach for achieving therapeutic goals. The extent to which we focus on this broader context in our clinical approach is, as always, considered on a case-specific basis.

### *Cultural Context*

The proposition that cultural factors shape pathogenic beliefs is a direct extension of control mastery’s central, but unspoken, focus on the operations of power within the family. As the child scans the family environment to form adaptive and coherent stories, the broader culture is capable of reinforcing both problematic and non-problematic stories. Pathogenic 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. These cultural pressures, which we believe have not been adequately addressed by control mastery theory to this point, can be extremely powerful in determining what constitutes “normal” development within a local culture and thus exert enormous influence on the individual’s narrative constructions. For example, Rothbaum, Weisz, Pott, Miyake, and Morelli (2000) described how even the presumably universal norms around what constitutes secure and insecure infant attachment (Ainsworth & Marvin, 1995; Cassidy & Shaver, 1999; Main, 1990) are culturally dependent rather than absolutes of development. Furthermore, they provided significant evidence that “what constitutes sensitive, responsive caregiving is likely to reflect indigenous

values and goals, which are apt to differ from one society to the next” (Rothbaum et al., 2000, p. 1096).

Narrative therapists, while not ignoring the influence of the family, have from the outset given much greater weight to the influence of culture when deconstructing problem-filled stories. We concur that careful attention to cultural factors can add an additional element of therapeutic leverage and flexibility beyond that offered by a unitary focus on family-of-origin contexts. 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.

Bracero (1994), in his attempt to integrate cultural issues with control mastery theory, reformulated the case of a young Japanese man through the lens of Asian cultural practices, which emphasize familial harmony over individuality. He ultimately critiqued control mastery theory for being so culture bound that it is not applicable to individuals from non-Western backgrounds. While correctly raising therapists’ consciousness to the relative neglect of cultural considerations, we believe that his critique is unfounded for two reasons. First, the most crucial point of control mastery’s case formulation methodology is that formulations are useful, or pro-plan, to the extent that they lead to desired outcomes for the client, not on the basis of a priori theorizing (Curtis et al., 1994; Curtis et al., 1988; Weiss, 1993). Second, our thesis is that issues of loyalty, adaptation, altruism, identification, compliance, and the inherent drive to create stories are universal, even though the client’s manifestations of these issues are personal and culturally specific.

A culturally sensitive application of control mastery theory was found in the work with a Korean college student who was the oldest daughter in her family. She presented in treatment as being chronically petulant with her family and flunking out of school in response to her parents’ overt expectations that she sacrifice her personal life to take care of her aging father. The initial formulation was that her goal for treatment was to help her feel less guilty about leaving home and succeeding on her own. Pursuing this

story line only led to an increase in symptomatology, which was understood as a comment on the anti-plan nature of these interventions. During the course of therapy, a new story emerged. She was not interested in protesting the cultural practices of her Korean community and decided that she wanted to care for her father. However, she realized that she could do so in a way that did not follow an oppressive identification with her mother, who had taken on a similar role in her family of origin but with a great deal of bitterness. Instead, she fashioned her own story in which she assimilated the bicultural aspects of her life and enacted this expression of love in a way that allowed her to feel like an adult and not a recalcitrant teenager.

In contrast, the deconstructive work of Scott’s psychotherapy liberated him from the broader discourses in our culture concerning oppressive male power, fashioning the “culture as the culprit,” not simply his father, and allowed Scott to evaluate, for himself, how well these messages actually served him. Alan Jenkins (1990), who works from a narrative therapy perspective with men who physically abuse their partners, asks these men how they feel about themselves when they coerce their partners into agreement. These men, like Scott when he first entered therapy, live almost fully within dominant cultural stories about what constitutes power and weakness as a man. This framework was instrumental in helping Scott to stage a protest against these negative definitions of masculine empowerment in favor of choosing forms of empowerment that were much more consistent with his preferred ways of being in his marriage.

#### *Multigenerational Context*

Both control mastery theory and narrative therapy have underemphasized the role of multigenerational transmission processes in the development of pathogenic constructions (Kanofsky, 2002). Consistent with other transgenerational family theories (Boszormenyi-Nagy & Krasner, 1986; Stierlin, 1977; Whitaker, 1976), we argue that pathogenic stories are frequently perpetuated over generations as the child complies or identifies with the parents’ behavior and beliefs and passes these on to his or her own children. We try to help our clients notice how they are part of a multigenerational web of beliefs and behaviors, some of which have served them well while oth-

ers may be interfering with their preferred goals. This new focus increases clients' awareness of their conscious and unconscious loyalties, reduces guilt and shame as the deeply embedded problematic behaviors are further understood, and additionally helps clients separate from limiting discourses and choose their preferred mastery story lines.

In Scott's case, a multigenerational understanding of his father's authoritarian style was instrumental in relieving him of the longstanding burden of his anger and helped to lessen it through a process of forgiveness (Enright, 2001). Understanding the forces that shaped his father, including his father's own history of being abused by his father, helped Scott gain a wider perspective that did not excuse or condone his father's behavior but did lead to a more compassionate understanding of this man who had hurt Scott so badly. By making the multigenerational context explicit and understanding the embedded nature of the familial patterns, this approach allowed Scott to "stand up for" himself, as opposed to standing against the family, and further reduced the guilt of allowing himself to overcome destructive family legacies.

### **The Constructive Work: Focus on the Mastery Story**

A constructivist view of our clients allows us to see them as the containers of multiple stories. A constructivist outcome of psychotherapy, then, is that our clients grow to appreciate that their world is open to many interpretations and that they are not shackled by rigid and archaic descriptions that have confined them in the past. However, for these new constructions to be ultimately useful, they must have heuristic value. The constructive work of psychotherapy is based on the generation of preferred stories and the capacity to test these hypotheses about the world in such a way as to lead to optimal adaptation. Otherwise, there is the danger of solipsism, fragmentation, and disquieting selflessness. In this blend of modernism and postmodernism, the outcome of psychotherapy is that our clients become both compelling authors and good scientists.

Clients carry pathogenic stories that, when dominant, lead to unhappiness. However, they also carry nascent mastery stories or, more accurately, inchoate fragments of these stories that are their preferred descriptions of their lives. These

stories have a quality of self-authorship by virtue of having been created in the client's direct, unmediated experiences. They are hidden by the dominant, pathogenic narratives and are thus often unconscious and unintegrated, to use the psychodynamic terminology, or are unstoried, to use the narrative term.

Our task is to bring forward these alternative narratives into the landscapes of consciousness and action. Given the constructivist bias of the model, we pay particularly close attention to those reports and in-session enactments in which the client is not living out his or her pathogenic stories. This emphasis is perhaps the most dramatic way that our work differs from traditional control mastery technique, which tends to be more focused on explanation, being more modernistic in its roots. In contrast, the constructive work of our integrative model is creative and solution focused as we continually track exceptions to the rules prescribed by the pathogenic stories and highlight accounts in which the client reports or enacts "unique outcomes" (White & Epston, 1990).

The more we can enrich these alternative descriptions of experience, which must be grounded in the felt sense of "what is true" and then tested in the world, the more differentiated they become from the pathogenic stories. It is in this distinct differentiation that these preferred constructions will most powerfully guide future expectations and behavior. While the deconstructive work separates the person from the problem, the constructive work separates the preferred, mastery stories from the unpreferred, pathogenic stories. It is crucial to emphasize that these alternative mastery stories are not simply "feel good" descriptions but are only useful to the extent that they represent reality in a way that promotes greater adaptability.

To return to Scott, the constructive work highlighted those times when Scott, somewhat surprisingly at first, noticed that his feelings of weakness did not lead to shameful withdrawal or explosive anger. Previously we looked at deconstructing a story of his past that was logically inconsistent within the dominant, problematic descriptions of himself. Now we look to enrich a mastery story of the past, present, and future in which he is operating outside of the dominant descriptions. Typically, we use questions to bring these descriptions forward. In the landscape of consciousness, a few of the questions asked were

as follows: What else does this feeling of weakness mean to you when it is not meaning submission or danger (which he answered, “Vulnerability”)? How did you express vulnerability in your childhood, even though it was rarely safe to do so? What qualities did you have as a child that supported this more compassionate view of yourself? How do you support this view of yourself today? In the landscape of action, the questions were as follows: When did the expression of these vulnerable feelings bring you closer to others rather than shamefully separate you from others? Having made some beginning steps to define yourself and your feelings in these different ways, how will you resist succumbing to the older, stronger messages? Who, in your current life, is most capable of supporting you in this project?

#### *Evidence Base for Constructing Mastery Stories*

Mastery stories are most fully constructed when built on the client’s recognition of those occasions when past, present, or hypothetical future experiences disconfirm their pathogenic stories. Through corrective experiences in the therapeutic relationship, interpretations, questions and focusing, we strive to “catch” our clients when they are expanding their alternative stories in the full landscapes of meaning. For example, Scott experimented with what happened when he declined to work overtime and found, to his relief, that he was not solely responsible for keeping his workplace afloat. Instead, his omnipotent sense of responsibility was mitigated by discovering that he felt a great deal of satisfaction for setting appropriate limits at work. More poignantly, he began to talk about subsequent interactions with his boss, which indicated that his boss was very resourceful in finding solutions to business problems and was not as injured by Scott’s autonomous actions as Scott believed when influenced by his worrisome, pathogenic story.

#### *Thickening the Story in the Therapeutic Relationship*

Clients’ preferred stories thicken in the landscape of consciousness and action through their interactions with others. In accordance with control mastery’s psychoanalytic foundation, we pay particular attention to the therapeutic relationship as an important landscape because this relationship is specifically designed to generate preferred

stories. It is natural that the enactment of these preferred stories will occur frequently and with great affective immediacy in this setting, if the therapy is going well.

When clients enact tests in relation to the therapist, there is an opportunity to thicken their mastery story or, conversely, confirm their pathogenic story. When our participation is in service of the former, we are passing their test. In the latter case, we are failing their test. In terms of transference testing, the constructivist emphasis is on transference testing by noncompliance (Rappoport, 1997) in that we pay particular attention to those times when the client is relating to us in ways that are inconsistent with their pathogenic stories and thus are the sparkling moments of their emerging mastery stories.

For example, Scott eventually left his job to pursue an entrepreneurial endeavor that severely squeezed his resources to such an extent that he began to worry about needing to terminate treatment because of financial reasons. During the course of exploring this issue, Scott tentatively asked if it were possible to reduce his fees so that therapy would be more affordable. This request was, for Scott, a remarkable expression of trust and intimacy in which he was making himself vulnerable to rejection or humiliation for not being completely self-sufficient. He was, in that request, being noncompliant with his pathogenic story that he was undeserving of nurturance and, furthermore, it was “unmanly” to ask for and receive help. At the same time, it felt like simply reducing his fee might fail to pass a different test, a transference test of whether the therapist would comply with the pathogenic story involving a pervasive doubt in his capacity to succeed in his enterprise, a story originally inferred from his father’s perfectionist expectations of Scott’s work. The therapist openly discussed these concerns with Scott and offered to charge him an affordable weekly amount and carry the balance while Scott was getting his company off the ground. Scott was visibly relieved with this negotiated solution. More important, we built on this experience by referencing it when Scott engaged in even the subtlest interactions that involved asking for and receiving support from others. We then tracked how his expectation of negative outcomes lessened as he continued to build this mastery story.

The client’s mastery story can also be thickened in the therapeutic relationship when the

therapist passes passive-into-active tests by not being traumatized by the client who, out of identification, assumes the role of the traumatizing agent. Traditionally, noninterpretive responses are encouraged in these instances because interpretations of the identification tend to be quite wounding (Foreman, 1996). Our challenge has been to find a linguistic method to landscape this experience more fully without the client feeling blamed by our descriptions of their behavior. For this reason, at times we use the narrative technique of externalization when we formulate that the client is turning passive-into-active. This intervention lends itself well to working with these types of enactments because the client is, in effect, externalizing his or her traumatic experience onto the therapist and then striving to cocreate a positive effect over it.

For example, not long after Scott began his business enterprise, he contracted a medical disorder that had the potential to result in severe disfigurement. He understandably became very depressed. However, the magnitude of his depression soon grew into significant suicidal ideation. Efforts at cognitively restorying this event were experienced as unempathic while a more purely empathic approach seemed only to deepen his dysphoria. His response to the event seemed intractable and left the therapist feeling anxious, worried, and decidedly unhelpful, providing the therapist with an opportunity to experience the depth of Scott's helplessness, not only to the current event but even more so to the cruel, irrational environment of his family of origin. Rather than make this interpretation, or abandon a basic empathic attitude, "helplessness" was coconstructed as an entity that "robbed him" of his capacity to approach this problem in a less catastrophizing manner. Scott responded to this conversation with renewed vigor and adjusted to the surgical procedure quite adaptively.

The primacy of the therapeutic relationship in enabling change, while not a focus in narrative therapy, is very consistent with other constructivist systems (Guidano, 1991; Lyddon & Alford, 1993; Mahoney, 1991). With this in mind, we believe that testing in the therapeutic relationship has important cognitive and relational aspects, both of which are crucial to the deconstruction of the pathogenic story and construction of the mastery story line.

### *Pro-Plan Specificity*

We argue that the traditional control mastery case formulation methodology (Curtis et al., 1988; Curtis et al., 1994; Weiss, 1993) be expanded beyond the contents and forms (e.g., compliance, identification) of the pathogenic narratives, as well as the client's testing strategies (transference or passive-into-active) and their therapeutic goals, but also include the therapeutic modality of intervention (deconstruction or construction) that is being used to reauthor these narratives. Our clinical experience corroborates that each modality of intervention is differentially effective with different clients and with the same client at different times. The choice of modality that we work in at any particular moment in therapy has significant implications for the immediate outcome of our interventions. Our constructivist leanings, which emphasize creation over discovery, orient us to work first on facilitating the mastery story. However, there are some clients for whom such an approach is anti-plan as they hear it as a disavowal of their pain. The answer to the question of which preferred story line, the deconstructed one or the mastery one, will be most pro-plan at any given moment in therapy is not in the province of the therapist. It resides in the client who is always guiding us through his or her verbal and nonverbal communications. Control mastery, virtually alone among psychodynamic theories, formally locates the authority to deem interventions as "correct" in the client, not the therapist. It is the client's verbal and nonverbal response to each intervention that is the most important indicator of whether or not the therapist is on the right track (Dorpat, 1996; J. R. Greenberg, 1991; Weiss, 1993; Weiss et al., 1986).

### **Conclusion**

The integration of different therapeutic systems can lead in two possible directions. One path is into the thicket of syncretism (Lazarus, Beutler, & Norcross, 1992) in which the nonsystematic melding of therapies results in a confused miasma of techniques, attitudes, and assumptions of human functioning. The other path has a more preferred destination. The integration of two schools that share sufficient theoretical underpinnings can result in a powerful synthesis that greatly enriches the practitioners' work.

We believe that the work of Joseph Weiss and the San Francisco Psychotherapy Research Group, of which we are members, can be significantly enhanced by the work of Michael White and other practitioners of narrative therapy. Both therapeutic systems share a constructivist orientation, and it is through this theoretical similarity that narrative therapy can so fruitfully inform control mastery. Both approaches also share an essentially humanistic attitude and strive to de-pathologize individuals.

Our integrative model utilizes narrative therapy to vitalize control mastery theory in a number of ways. Therapy, from this perspective, works along two major lines: (a) through the deconstruction of the client's life-limiting narratives and (b) through the active construction of more preferred narratives. Through the strengthening of the client's authentic authorial voice, located in his or her direct felt experiences, we showed how the case-specific approach of control mastery theory could be enhanced when informed by narrative therapy's systematic attention to different landscapes in the client's story and by the narrative emphasis on linguistic strategies for opening paths to the preferred mastery story. In this way, narrative therapy offers a language of change that can be used to great effect when integrated with powerful control mastery formulations. Finally, we argued that control mastery theory has needlessly confined its focus to the immediate family in the etiology of problems. In broadening our lens to include transgenerational and cultural influences, control mastery therapists develop even more flexibility to help clients overcome pathogenic stories and coconstruct preferred outcomes.

Our development as therapists and the work we do with clients is, in itself, a story still being told and, as such, there are a number of unplotted future directions. One of these is whether a systematic methodology can be developed to select when it is most advantageous to work deconstructively or constructively at any given moment in psychotherapy. Another future direction flows directly from the postmodern emphasis on the multiplicity of stories that potentially shape individuals' lives. From this perspective, we view group therapy as a particularly rich setting for change given its field of simultaneous perspectives.

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