The Control-Mastery Perspective: A Clinical Formulation of David's Plan

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The Control-Mastery theory is reviewed, focusing particular attention on the concept of the patient's plan for therapy. A formulation of David's plan is then presented. The formulation includes David's early childhood traumas, his goals (conscious as well as unconscious) for therapy, the pathogenic beliefs (schemas) that have obstructed him, the tests that he is likely to present in therapy in order to disconfirm his pathogenic beliefs, and the insights that would be helpful to him.

I will present a formulation of the patient's problems and treatment goals from the perspective of control-mastery theory—an integrated cognitive-psychodynamic-relational model of how the mind works, how psychopathology develops, and how psychotherapy can effectively help (Silberschatz, 2005a; 2005b).

Theoretical Background

A fundamental premise of control-mastery theory is that from birth onward humans are geared toward adaptation to the environment (Weiss, 1993). For the first few years of life, the family unit comprises the child's environment, and consequently the child's most powerful motivation is to preserve her ties (attachment) to family members. The child forms theories or beliefs about self and others as part of this adaptive process. Traumatic experiences lead to the formation of dysfunctional or pathogenic beliefs

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(schemas), which are typically not conscious. Pathogenic beliefs develop as a result of a parent's consistently adverse reactions to the child's normal developmental strivings ("stress" trauma) or the child's experiencing a severely traumatic event ("shock" trauma). Patients typically develop unconscious pathogenic identifications and/or compliances with a traumatizing parent. In short, psychopathology is rooted in the grim, constricting pathogenic beliefs—and the related identifications and compliances—that the patient acquires in the traumatic experiences of childhood.

The following brief example illustrates a control-mastery perspective on the development of psychopathology. A college student sought therapy because she felt depressed, socially withdrawn, and generally lethargic. Her boyfriend recently ended their relationship, complaining that she was too distant, cold, and rejecting toward him. The intake interview revealed that the patient was raised by her mother and her maternal grandmother until the age of 8, at which time her grandmother died of a sudden heart attack. The patient was severely traumatized by the death, partly because she suddenly lost an important loving, nurturing caretaker (a shock trauma), and partly because her mother became increasingly withdrawn, irritable, emotionally unavailable, and overtly rejecting of the patient's efforts to be close. Her mother's cold, aloof attitude persisted until the patient left home for college (stress trauma). As a result of these traumatic experiences, the patient developed the unconscious pathogenic belief that her "neediness" led her mother to reject her and that she (the patient) was unlovable. The patient developed a powerful unconscious identification with her mother by adopting a cold, indifferent attitude toward her peers and friends.

Pathogenic beliefs are internalized cognitive-affective representations of traumatic experiences and they are typically extremely painful, constricting, and debilitating (Silberschatz & Sampson, 1991). Control-mastery theory assumes that psychotherapy patients are highly motivated to disconfirm or relinquish pathogenic beliefs; indeed, this represents a patient's most powerful motivation in psychotherapy. This fundamental motivation to solve problems and master conflicts is embedded in the concept of the patient's plan (Silberschatz, 2005b; Weiss, 1993). According to control-mastery theory, patients come to therapy in order to get better and they have a plan for doing so: the disconfirmation of crippling pathogenic beliefs. In therapy—as in other aspects of a person's life—plans are frequently unconscious or not consciously articulated; nonetheless, the plan organizes the patient's behavior and plays an important role in evaluating and filtering information.

Consider, for example, the case of Jill (Silberschatz, 2005b), a compassionate middle-aged woman, who sought therapy because she felt emotionally overwhelmed by her older mother who had dementia. Jill suffered from the pathogenic belief that taking care of herself meant that she was

selfish and cruel. While growing up, Jill's mother frequently accused her of being "a spoiled, selfish brat", and she unconsciously complied with this false accusation. Jill's unconscious plan for therapy was to disconfirm her pathogenic belief ("If I take care of myself or put my needs and my family's needs first, that means I am an uncaring, cruel, selfish daughter") so that she could pursue her goal of finding a suitable nursing home for her ill mother. Jill's plan led her to carefully monitor (albeit unconsciously) the therapist's reactions to her efforts to find a nursing home. She had the transference expectation that the therapist, like her mother, would see her as selfish or callous. When the therapist encouraged or supported her efforts—that is, when the therapist supported Jill's plan—she felt temporarily relieved. Throughout the therapy, she continued to monitor and assess (unconsciously) the therapist's reactions and interpretations for any indication of disapproval.

Clinicians are far more accustomed to thinking about the therapist's plan (i.e., a treatment plan) than the patient's plan. Nonetheless, there is considerable research evidence showing that therapists who have been trained in control-mastery theory consistently achieve high levels of inter-judge agreement in inferring patients' unconscious plans (for reviews, see Curtis & Silberschatz, 2007; Silberschatz, 2005c). There is also strong research support in the fields of experimental and social psychology for the concept of unconscious cognition and planning (for references to some of this literature see Silberschatz, 2005). The assumptions underlying the plan model are also consistent with client-centered, humanistic, and experiential theories. For instance, a fundamental tenet in Rogers' thinking is that humans have a self-actualizing tendency and that it is crucially important for the therapist to create conditions that allow the self-actualizing tendency to flourish. This is essentially synonymous with the control-mastery concept that patients come to therapy with an unconscious plan to solve their problems and master trauma and that the therapist's primary role is to help the patient carry out their plan (for further discussion of similarities between Rogerian and control-mastery theory see Silberschatz, 2007).

There are three ways that patients work on carrying out their plans to disconfirm pathogenic beliefs: Patients may:

1. Use new knowledge or *insight* conveyed by the therapist's interpretations,
2. Use the *therapeutic relationship*, and
3. *Test* pathogenic beliefs directly with the therapist

In delineating these three different patient strategies, I do not mean to imply that they are mutually exclusive; indeed, patients frequently use all three ways of working. The first two—insight conveyed through interpre-

tation and the therapeutic relationship—are familiar to clinicians of various theoretical orientations, as they have been extensively described in the psychotherapy literature. However, the concept of the patient testing the therapist is a distinctive contribution of control-mastery theory and therefore warrants further explication.

According to control-mastery theory, perceptions of danger and safety play a central role in explaining human motivation and behavior: "One of our most powerful motives and one frequently overlooked by theoreticians is the quest for a sense of safety. Our pursuit of a sense of safety is rooted in biology and is to a considerable extent unconscious" (Weiss, 2005, p.31). An important part of a patient's efforts to solve problems and conflicts in psychotherapy is bringing warded-off feelings, behaviors, goals and thoughts into consciousness. In order to do so, the patient must work to overcome the sense danger she would face if she were to experience these warded-off contents. She does this by attempting to create a relationship with the therapist that would protect her from this danger. The patient tests the therapist to assure herself that were she to bring warded-off material into consciousness, the therapist "could be relied up to respond in a way that would afford protection against the danger" (Sampson, 1976, p. 257). Consider, for example, a patient who grew up in a family that could not tolerate his expressing any angry, critical, or negative feelings. The patient tested the therapist by tentatively disagreeing with her and by expressing mildly critical feelings toward her. The therapist responded to these tests by pointing out the patient's tentativeness or discomfort in criticizing her and by encouraging him to say more about his anger. The patient felt reassured by the therapist's responses—that is, he felt a greater sense of safety—and subsequently brought up relevant traumatic memories of having been punished as a child for his critical feelings. Since the patient's convictions about the danger of expressing anger were deeply rooted, he tested the therapist repeatedly over a long period of time in order to reassure himself.

Tests are patient initiated behaviors that require some kind of response from the therapist (Silberschatz, 1986; Silberschatz, 2005b; Weiss, 1993). Although the testing process is typically unconscious, the patient's primary intention in testing is always adaptive. Early in therapy patients frequently test to ascertain what they can safely work on with a particular therapist. The patient attempts to determine whether the therapist will support his goals, understand his problems, help him master early traumas, and whether the therapist has some of the qualities and strengths that the patient lacks and wishes to acquire. Generally speaking, *patients test their therapists in order to disconfirm pathogenic beliefs and to solicit help in pursuing their therapy goals.* Tests are shaped by the patient's interpersonal

history, traumas, defenses, personality style, conscious and unconscious goals for therapy, and specific pathogenic beliefs.

Two broad categories of tests have been described in the control-mastery theory (Silberschatz, 2005b; Weiss, 1993). In a transference test, the patient tries to assess whether the therapist will traumatize her as she had been traumatized in childhood (e.g., a patient who was mistreated might test to see if the therapist will mistreat her). In a passive-into-active test, the patient traumatizes the therapist as she had been traumatized as part of an effort to master the trauma (e.g., the patient may "mistreat" the therapist in order to see how the therapist responds to mistreatment).

Although patients are highly motivated to disconfirm pathogenic beliefs, doing so requires considerable effort and repeated testing. There is strong research evidence showing that when therapists pass tests, patients show signs of therapeutic progress, and when therapists fail tests there is a lack of progress or therapeutic retreat (for an overview of this research, see Silberschatz, 2005c). However, neither theory nor research on the testing concept implies that the patient tests the therapist once or twice, and if the therapist passes the test the patient will relinquish pathogenic beliefs. Patients unconsciously test and monitor therapist behaviors throughout treatment, paying careful attention to the content of therapist interpretations (Silberschatz, Fretter, & Curtis, 1986; Silberschatz, Curtis, & Nathans, 1989) as well as to the therapist's style and attitude (Sampson, 2005; Shilkret, 2006). It would be misleading to assume that the fate of a therapy is sealed simply by whether a therapist passes or fails tests early in treatment. There is considerable variability in the extent to which therapists pass or fail tests (Silberschatz & Curtis, 1993). Typically, successful treatments include some failed tests, and unsuccessful treatments include examples of tests that were passed. When therapists repeatedly fail tests, the patient may alter the testing strategy or may coach the therapist (Bugas & Silberschatz, 2005) as part of an effort to get the therapist on a more productive track.

A Formulation of David's Plan

Just as traumatic experiences and pathogenic beliefs are uniquely formed in the patient's early relational history, the patient's plan for disconfirming these beliefs in the therapeutic relationship is case-specific and must be formulated in an individualized way for each patient. A control-mastery approach to plan formulation begins with a summary of key childhood *traumas*. The patient's *goals* for therapy are identified next. These are adaptive goals, some of which are conscious and some of which

may be unconscious and therefore need to be inferred. Next we focus on likely impediments or *obstructions* to goal achievement. These obstructions are formulated in terms of the patient's unconscious pathogenic schemas, which include pathogenic beliefs, identifications, and pathogenic compliances. Next we try to anticipate how the patient is likely to *test* his or her pathogenic beliefs in the therapeutic relationship and what the patient will need from the therapist in order to disconfirm pathogenic beliefs, compliances, and identifications. And finally, we formulate new information, knowledge, or *insights* that are likely to help the patient disconfirm pathogenic schemas (see Curtis & Silberschatz, 2005 for an extensive discussion of the plan formulation method).

Trauma

The central traumas in David's life were his dysfunctional early family life and his mother's illness and subsequent death when he was 14. He described himself as having been a very bright, energetic, ambitious child, but when he was 10 years old (and his mother became ill) everything changed: he shifted from pursuing his aspirations to taking care of others. His mother had been the strong, forceful figure in the family; his father was weak, ineffective, and alcoholic. When she became ill and died, David stepped into the caretaker role. He stopped pursuing his dreams and seemed to give up on the idea of having a happy life. He chose a wife who appears to be a combination of his forceful, dominant mother and his weak, dysfunctional father. He expressed considerable guilt toward his father, saying he couldn't let himself have a better marriage than father had. In short, he created his own dysfunctional family, which in many respects replicated his family of origin.

Goals

1. To set limits with his wife and to feel less responsible for her (this might include divorcing her).
2. To feel less critical of himself.
3. To do more of what he wants, to give his goals and aspirations a high priority (i.e., to be more appropriately selfish).
4. To acknowledge his competence, even to the point of boasting.
5. To feel proud of himself.
6. To be more social.
7. To feel comfortable being a strong, successful man (unlike his father).

Obstructions (Pathogenic Beliefs)

1. He believes people are fragile and need to be taken care of (e.g., he is convinced that his wife would fall apart if he left her).
2. He believes he's not allowed to have a better marriage/family than his father.
3. He believes that ambition and enjoyment can't be sustained.
4. He feels that he is responsible for others' feelings and well-being (omnipotent responsibility).
5. He believes that marriage/family life is awful—that is, inevitably full of conflict and strife.
6. Based on an unconscious identification with his unhappy family of origin, he is convinced that he doesn't have a right to enjoy life or to be happy.

Tests

1. He will put himself down to see if the therapist is bothered by his strength, intelligence, or competence.
2. He will test to see if therapist can tolerate his being happy.
3. He will be flagrantly and inappropriately self-critical as a test to see if the therapist wants/needs to criticize him or put him down.
4. He will "coach" the therapist by telling her that his previous therapist had encouraged him to stay in a dysfunctional marriage, making clear that he was happy when he separated from his wife.

Insights

1. His wife's problems are not his fault or responsibility.
2. His self-criticism is a way of placating his weak father.
3. He has a powerful, unconscious identification with his weak father.
4. He unconsciously complies with mother's (and wife's) criticism.
5. He is afraid that leaving his wife would destroy his family as his family of origin was destroyed.

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