



# Control-Mastery Theory

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## GLOSSARY

**anti-plan intervention** An anti-plan intervention (including an interpretation), is an intervention that may impede patients in their efforts to carry out their unconscious plans. For example, a person who is working to become more independent may be set back by the interpretation that he or she is afraid of his or her dependency (see unconscious plan).'

**pathogenic belief** A belief that is in varying degrees unconscious and that underlies the patients' problems. It warns persons suffering from it that if they attempt to solve their problems, they will endanger themselves or others. For example, persons may be impeded in their quest for success by the pathogenic belief that if they are successful they may hurt others.

**pro-plan intervention** An intervention (including an interpretation) that patients may use in their efforts to carry out their unconscious plan. For example, patients who want to be successful but believe that their success will hurt others may be helped by the interpretation that they are holding themselves back lest they hurt others.

**survivor guilt** The kind of guilt felt by persons who believe they have surpassed others by obtaining more of the good

things of life than others. Pathogenic beliefs are often concerned with survivor guilt toward parents and siblings.

**unconscious plan** The patients' unconscious plan (which in some cases may be partially conscious) specifies where patients want to go in their therapy. The unconscious plan is usually broad, loosely organized, and opportunistic. It is not a blueprint. It takes account of the therapist's personality and of changing life circumstances. An example is a person's planning to overcome his or her fear of rejection so that he or she may develop closer ties to others.

**unconscious test** An experimental action, ordinarily verbal, that the patient produces in relation to the therapist. The patient's purpose is to disprove his or her pathogenic beliefs. Patients hope that the therapist will pass their tests and so help them to disprove these beliefs. For example, patients who believe that they will be rejected may threaten to stop treatment, hoping unconsciously that the therapist will indicate or imply that the patient should continue.

## I. INTRODUCTION TO THE THEORY

Control-mastery theory is a theory of the mind, psychopathology, and psychotherapy. It was introduced by Joseph Weiss, and was investigated empirically and developed by Weiss, Harold Sampson, and the San Francisco Psychotherapy Research Group (formerly the Mount Zion Psychotherapy Research Group).

Control-mastery theory assumes that patients are highly motivated, both consciously and unconsciously, to solve their problems, to rid themselves of symptoms, and to seek highly adaptive and important goals, such

as a sense of well-being, a satisfying relationship, or a meaningful career. Patients are in conflict about wanting to accomplish these things. This is because they suffer from pathogenic beliefs that tell them that by moving toward their goals they will endanger themselves or others. Throughout therapy, patients work with the therapist to change these beliefs and to reach their forbidden goals. They work to disprove their pathogenic beliefs by testing them in relation to the therapist, hoping that the therapist will pass their tests. In addition, patients use therapist interventions and interpretations to realize that their pathogenic beliefs are false, and a poor guide to behavior. The therapist's task is to help patients in their efforts to disprove their pathogenic beliefs and to move toward their goals.

## II. THEORETICAL BASES

As our research and the research of academic psychologists have demonstrated, people perform many of the same functions unconsciously that they perform consciously. They unconsciously assess reality, think, and make and carry out decisions and plans. They unconsciously ward off mental contents, such as memories, motives, affects, and ideas, as long as they consider them dangerous. They unconsciously permit such contents to become conscious when they unconsciously decide that they may safely experience them.

Patients develop the pathogenic beliefs, which underlie their psychopathology, usually in early childhood, through traumatic experiences with parents and siblings. These beliefs, which are about reality and morality, may be extremely powerful. This is because for the infant and young child, parents are absolute authorities whom the infant or the young children needs in order to survive. Young children are highly motivated to maintain their all-important attachments to their parents. In order to do this they must believe their parents' teachings are valid, and that the ways their parents treat them are appropriate. For example, a young boy, who experienced himself as neglected by his parents, developed the pathogenic belief that he would and should be neglected, not only by his parents, but also by others.

The strength of children's attachments to their parents, and of the pathogenic beliefs acquired in their relations to their parents, is shown by the observation that adults, who in therapy are attempting to give up their pathogenic beliefs, often feel disloyal to their parents. If adult patients believe they have surpassed their parents by giving up the maladaptive beliefs and behav-

iors that they learned from their parents, and by acquiring more of the good things of life than their parents, they are likely to experience survivor guilt (surpassing guilt) to their parents.

## III. THE THERAPEUTIC PROCESS

The therapeutic process is the process by which patients work with their therapists to change their pathogenic beliefs and to pursue the goals forbidden by these beliefs. Patients test their pathogenic beliefs by trial actions (usually verbal) that according to their beliefs should affect the therapist in a particular way. They hope that the therapist will not react as the beliefs predict. If the therapist does not, they may take a small step toward disproving the beliefs. If patients experience the therapist as passing their tests, they will feel safer with the therapist, and they will immediately change in the following ways:

1. They will become less anxious.
2. They will become bolder.
3. They will become more insightful.

Patients in therapy work in accordance with a simple unconscious plan that tells them which problems to tackle and which ones to defer. In making their plans, patients are concerned with many things, especially with avoiding danger. For example, a female patient who unconsciously believed that she had to comply with male authorities lest she hurt them, felt endangered by her therapy with a male therapist. She feared that she would have to accept poor interpretations or follow bad advice. Her plan for the opening days of therapy was to reassure herself against this danger. She tested her belief that she would hurt the therapist if she disagreed with him. First she tested indirectly, then progressively more directly. The therapist passed her tests; he was not upset, and after about 6 months' time the patient had largely overcome her fear of complying with the therapist, and so became relatively comfortable and cooperative.

## IV. THE THERAPIST'S APPROACH

The therapist's task is to help patients disprove their pathogenic beliefs and move toward their goals. The therapist's attempts to accomplish this are case-specific. They depend on the therapist's assessments of the

patient's particular beliefs and goals, and the patient's ways of testing his or her pathogenic beliefs. For example, if a patient's primary pathogenic belief is that he or she will be rejected, the therapist might be helpful if he or she is friendly and accepting. If the patient's primary pathogenic belief is that he or she will be intruded upon, or possessed by the therapist, the therapist may be helpful by being unintrusive.

## **V. EMPIRICAL STUDIES (INCLUDING STUDIES OF THE PATIENT'S PLAN FORMULATION)**

The San Francisco Psychotherapy Research Group (formerly the Mount Zion Psychotherapy Research Group) was founded in 1972 by Harold Sampson and Joseph Weiss to investigate and develop the control-mastery theory by formal empirical research methods. A number of our studies were carried out on the transcripts of the analysis of Mrs. C, which had been recorded and transcribed for research purposes. Several of these studies were designed to test our assumption that patients unconsciously control the coming forth of unconscious mental contents, bringing them to consciousness when they unconsciously decide that they may safely do so.

In one such study, Suzanne Gassner, using as data the transcripts of the first hundred sessions of Mrs. C's analysis, tested our hypothesis against two alternative hypotheses. According to one alternative, the patient brings forth repressed unconscious contents when the contents (in this case impulses) are frustrated, and so intensified to the point that they push through the patients' defenses to consciousness. According to the other alternative, the patient brings forth repressed contents when they are disguised to the point that they escape the forces of repression. The three hypotheses may be tested against one another because they make different predictions about what patients feel, while previously repressed contents that have not been interpreted are becoming conscious.

According to our hypothesis, patients have overcome their anxiety about the repressed contents before they come forth and so will not feel particularly anxious while they are emerging. Moreover, because they have overcome their anxiety about the contents, they will not need to defend themselves against experiencing them as they are coming forth, and so will experience them fully. According to the hypothesis that the contents come forth by pushing through the defenses, the

patient will come in conflict with them, and so feel increased anxiety while they are coming forth. According to the hypothesis that they come forth because they are disguised (or isolated) the person will not feel anxious about them as they are emerging, and because they are disguised, will not experience them fully.

Gassner located a number of mental contents that had been repressed in the first 10 sessions of Mrs. C's analysis, but which came forth spontaneously (without being interpreted) after session 40. She then had judges, by use of rating scales, measure the patient's degree of anxiety, and her level of experiencing, in the segments in which the contents were emerging. Her findings strongly support our hypothesis. The patient was not anxious in these segments (by one measure, she was significantly less anxious than in random segments). Moreover, her level of experiencing in these segments was significantly higher than in random segments.

Another research study was designed to test our hypotheses about the patient's unconscious testing of the therapist, and was carried out by George Silberschatz, using the transcripts of the first 100 sessions of Mrs. C's analysis. From our study of Mrs. C, we had assumed that Mrs. C unconsciously made demands on the analyst so as to assure herself that she could not push him around. We assumed that she would be relieved when the analyst did not yield to her demands. Another group of investigators assumed that Mrs. C unconsciously made demands on the therapist in order to satisfy certain unconscious impulses. They assumed that Mrs. C would become more tense and anxious when the analyst did not yield to her demands. Silberschatz, whose research design was considered satisfactory to both groups of investigators, demonstrated that when the analyst responded to Mrs. C's demands by not yielding to them, Mrs. C became less tense and anxious than before the analyst's response. Silberschatz' findings were statistically significant. These findings strongly support our assumption that the patient is unconsciously testing the analyst by her demands, rather than unconsciously seeking the gratification of unconscious impulses.

Another series of investigations was carried out by our group to test the hypothesis that patients benefit from any intervention, including any interpretation that they can use in their efforts to disprove their pathogenic beliefs and to pursue the goals forbidden by them. We assumed that after a pro-plan intervention, the patients' pathogenic beliefs are temporarily weakened. Therefore, we hypothesized that since patients maintain their repressions in obedience to their pathogenic beliefs, that after a pro-plan intervention, patients

would become a little more insightful, and a little less inhibited. We assumed, too, that anti-plan interventions would not help the patient, or might even set the patient back.

The first step we took in preparation for studying the effects of pro-plan and anti-plan interventions was carried out by Joseph Caston, in 1986. It was to demonstrate that independent judges could agree reliably on a formulation of the patient's plan. Caston broke down the patient's plan formulation into four components: (1) the patient's goals, (2) the obstructions (pathogenic beliefs) that impede patients in the pursuit of their goals, (3) the tests the patient might perform in their efforts to disprove their pathogenic beliefs, and (4) the insights patients could use in their efforts to disprove their pathogenic beliefs.

Caston gave independent judges extensive lists of goals, pathogenic beliefs, tests, and insights, along with the condensed transcripts of the first 10 sessions of Mrs. C's analysis. The judges were asked to read the transcripts, and then to rate the items in each category for their pertinence to the patient's plan. Caston found that the judges did agree on a plan formulation, and that their agreement was statistically significant.

Caston used his plan formulation to evaluate Mrs. C's responses to pro-plan and anti-plan interventions. Caston tested the hypothesis that the patient would respond immediately to pro-plan interventions by becoming bolder and more insightful, and that she would respond negatively to anti-plan interpretations by becoming less insightful, and less bold. Caston found strong confirmation of this hypothesis in his pilot study; however in the replication study he found that the hypothesis held for pro-plan interventions, but not for anti-plan interventions. Apparently Mrs. C responded favorably to pro-plan interventions but was not set back by anti-plan interventions.

In a study of the last 100 sessions of Mrs. C's analysis, Marshall Bush and Suzanne Gassner in 1986 tested the hypothesis that Mrs. C would demonstrate an immediate beneficial effect when offered pro-plan interventions, but that she would be set back by anti-plan interventions. They found strong statistical support for this hypothesis.

Our research group also studied the immediate effects of pro-plan and anti-plan interpretations in brief psychotherapies. Polly Fretter, Jessica Broitman, and Lynn Davilla studied three 16-session psychotherapies to determine whether pro-plan interpretations had a beneficial effect. They used a new version of Caston's method of obtaining a plan formulation that had been

developed by John Curtis and George Silberschatz. In addition, unlike Caston, they did not study the effect of all interventions, but only of interpretations (that is, interventions designed to provide insight).

Fretter showed that following a pro-plan interpretation, the patient was less defensive, and so developed a statistically higher level of experiencing. Broitman demonstrated that after a pro-plan interpretation, the patient became more insightful, as measured by a generic insight scale. Her finding was statistically significant. Davilla, whose findings were statistically significant, demonstrated that the patient, following a pro-plan interpretation, moved toward his or her goals as defined in the patient's plan formulation.

Our group also studied the long-term (as opposed to the immediate) effect of pro-plan interventions. In the three cases investigated by Fretter, Broitman, and Davilla, it was demonstrated that the patient who was offered the highest percentage of pro-plan interpretations did the best, as measured by a series of outcome measures, administered 6 months after the termination of treatment. The patient who received the second highest proportion did the second best, and the patient who received the lowest percentage did the worst.

We also investigated the immediate effect of pro-plan interpretations on the patient's pulse rate, skin conductance, and body movement, in three brief psychotherapies (these are not the same therapies studied by Fretter, Broitman, and Davilla). Nnamdi Pole demonstrated that pro-plan interpretations had an immediate effect on the patient's pulse rate: the pulse rate decreased. His research also showed that the patient sometimes responded very rapidly to pro-plan interpretations: The patient's pulse rate would sometimes fall before the therapist finished an interpretation, and before the patient consciously acknowledged the validity of the interpretation.

Our research group has also studied brief psychotherapies to test the hypothesis that a patient shows an immediate favorable reaction when the therapist passes her tests. Curtis and Silberschatz, in the study of two brief psychotherapies, demonstrated that immediately after a passed test, the patient showed a higher level of experiencing than before the passed test. In another study, Tom Kelly demonstrated that the patient responded to a passed test by an immediate decrease in tension, as measured by a voice stress measure. In a study of one patient, Jerry Linsner showed that after a passed test the patient demonstrated an increase in pro-plan insight as defined in the patient's plan formulation. In a study of three patients, Jack Bugas demonstrated that after a passed test

the patient demonstrated a greater capacity to exert control over regressive behavior.

In our clinical work we observed that pathogenic beliefs are often concerned with survivor guilt. Lynn O'Connor and Jack Berry conducted a series of investigations concerning the role of survivor guilt in psychopathology. These studies were conducted by means of a new pencil-and-paper questionnaire, the Interpersonal Guilt Questionnaire (IGQ), developed by O'Connor and others to measure survivor guilt and several other forms of guilt. The investigations, which were statistically significant, demonstrated that survivor guilt is highly correlated with feelings of shame, and also with feelings of fraudulence and pessimism. It correlates with a tendency to be submissive, and it is high in persons suffering from depression. It is high in recovering addicts and children of alcoholics. It predicted recidivism in a group of women on probation in Massachusetts.

## VI. SUMMARY

The control-mastery theory assumes that patients' problems stem from grim, frightening, unconscious, maladaptive beliefs. These beliefs, here called "pathogenic," impede the patient's functioning, and prevent the patient from pursuing highly adaptive goals. Patients suffer from these beliefs, and are highly motivated both to disprove them and to pursue the goals forbidden by them. The patient works throughout therapy in accordance with an unconscious plan to accom-

plish these things. The therapist's basic task, which follows from the above, is to help patients to disprove their pathogenic beliefs and to pursue their goals. The theory has been supported by numerous formal quantitative research studies.

## See Also the Following Articles

### Further Reading

- Curtis, J., Silberschatz, G., Sampson, H., Weiss, J., & Rosenberg, S. (1988). Developing reliable psychodynamic case formulations: An illustration of the plan diagnosis method. *Psychotherapy*, 25, 256-265.
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