Control-Mastery Theory in Group Therapy

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Control-Mastery theory is a cognitive-relational psychoanalytic theory of the mind, psychopathology, and therapeutic technique founded by Joseph Weiss. In collaboration with Hal Sampson and the San Francisco Psychotherapy Research Group, this theory has been systematically researched and validated over the past thirty years. The basic tenet is that psychopathology is rooted in grim, unconscious "pathogenic beliefs" that arise from traumatic childhood experiences. Patients, guided by a largely or wholly unconscious "plan", work in therapy to disprove these beliefs by acquiring insight and "testing" the therapist.("Control" refers to the emphasis on the person's control of unconscious mental life. "Mastery" refers to the unconscious will to master conflict.)

The growing infant and child is highly motivated to adapt to his surroundings and maintain ties to the adult caregivers, even at the cost of his personal growth. He endows them with absolute authority, and assumes excessive responsibility for what goes on around him. For example, if John is criticized by his father for being too rambunctious, he may develop the pathogenic belief that his natural energy is damaging, and become overly-subdued. This is adaptive in his family of origin, but maladaptive as he moves into the world. Betty, chronically rejected by her mother, may develop the pathogenic belief that she is defective and deserves to be rejected, and may provide opportunities for rejection. Susie, who got angry at her brother the day before he drowned, may develop the pathogenic belief that her anger is lethal.) Other examples: "I am toxic and must avoid close relationships," "people can't be trusted," "I must take care of my fragile parents and make them happy." Pathogenic beliefs can take myriad forms, and usually include a moral layer; children assume that they deserve the trauma that comes their way, and unconscious guilt plays a central role in the maintenance of most psychopathology

Throughout the life cycle, in and out of therapy, we look for opportunities to disconfirm our pathogenic beliefs. If the situation seems safe enough, as in an effective psychotherapy, we may abandon our usual state of being

"compliant" to the dictates of our beliefs, and begin to "work" on them. At bedrock, the perceived risk of this work is the rupture of the relationship with the adult caregivers, and the loss of their protection. Control-Mastery therapists view a patient's pathogenic beliefs and adaptations with great respect.

In individual therapy, the patient works to disconfirm his pathogenic beliefs in two ways. He may acquire insight into them, either through his own efforts, or therapist interpretation. Or he may test them, a process that is usually unconscious. In *transference testing*, the patient behaves in a way similar to what he believes caused his parent(s) to traumatize him, hoping the therapist will not replicate the trauma. Betty, from the above example, might offer the therapist an opportunity to reject her. The other testing possibility is *turning passive into active*, where the roles are reversed. In this case, Betty would identify with her mother, and reject the therapist, and hope that he would not be as traumatized as she was. The research confirms the therapeutic value of both insight and passed tests.

Early on in the therapy, the therapist attempts to get enough history to permit, when combined with the here-and-now experience of the patient, an initial formulation of the "plan", including the traumas, pathogenic beliefs, goals, and likely tests and insights that would be helpful. The formulation is *case specific*. The research shows that "pro-plan" behavior on the part of the therapist is the most crucial variable in therapeutic outcome. With this in mind, Control-Mastery theory is compatible with a broad range of techniques and styles, and utilizes all the creative, collaborative, and empathic capacities of the therapist in the furthering of the patient's plan.

In a therapy group, patients have increased sources for insight—other patients, the therapist, and themselves. And there are more testing possibilities. In addition to *transferring* and *turning passive into active,* we see *group process testing*, where patients who share a pathogenic belief test another person or subgroup, and *vicarious experiencing testing*, where a person or subgroup gives the test while another person or subgroup, sharing the pathogenic belief, observes and vicariously is benefited or harmed by the test result. At times two members, or subgroups may be in *plan contradiction*, where pro-plan behavior for one is anti-plan for the other. This implies some level of re-traumatization, and is a great opportunity for the group and a challenge for the therapist to explicate the process. At other times *plan contradiction* may be unconsciously engineered by the group as a

test of the therapist, often around themes of demoralization, chaos, and polarization. Throughout, the therapist is constantly looking for ways of increasing the psychological safety of the group; encouraging patients to move from “compliance” to “working”; refining his understanding of the members’ plans; facilitating the passing of tests and the acquisition of insight; acknowledging his own inevitable errors in a therapeutic manner; and managing the recapitulations of early family experiences by titrating the amount of re-traumatization.