HOW DOES PSYCHOTHERAPY WORK? FINDINGS OF THE SAN FRANCISCO PSYCHOTHERAPY RESEARCH GROUP

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ABSTRACT

Ideally, psychotherapy research should reflect the complexity of the therapy process and have significant bearing on practice. As an example of such an ideal, the work of the San Francisco Psychotherapy Research Group is described and the Control-Mastery theory of Joseph Weiss and Harold Sampson is discussed. Two empirical studies, one from an earlier phase of the research and the other a more recent one using the Plan Formulation method are described, noting the development of the group's research over a 20-year period. Finally, a long-term psychotherapy case is summarized to illustrate the application of these ideas in practice.

The work of the San Francisco Psychotherapy Group for over 20 years has exemplified the interplay of clinical research and clinical practice. Detailed discussions of cases have led to testable hypotheses and formal research studies; the findings of those studies, in turn, have led to refinements in practice. The purpose of this article is to summarize the work of this group, focusing on the interaction of research and clinical case formulation. A brief summary of the theory will be presented, followed by a description of two empirical studies of psychotherapy process. These studies are chosen to illustrate the development of the group's work over the past 20 years. Finally, a clinical case will be described, illustrating the application of some of these ideas in clinical practice.

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OVERVIEW OF THE THEORY

We offer first a brief summary of Control-Mastery theory, which was developed by Joseph Weiss in collaboration with Harold Sampson, leaders of the San Francisco Psychotherapy Research Group. In this theoretical stance, it is assumed that people exercise significant unconscious *control* of their mental lives and of their behavior. It is further assumed that clients come into therapy with a powerful desire to *master* their problems (see Bush & Gassner, 1988, for a discussion of the relation of these ideas to social work values). The theory is a modification of psychoanalytic ego psychology and is linked to Freud's later writings, especially the modifications of the theory of anxiety. The role of trauma and unconscious guilt in psychopathology and therapy is emphasized. It is assumed that motives for mastery and self-control often take precedence over other motives, including those for drive gratification. The child's real experiences and real relationships are assumed to be crucial in determining psychological development. These views are quite compatible with many ideas in object relations theory, as well as with many interpersonal approaches. They are also compatible with current research in normal infant development, including the work of Daniel Stern (1985), and also with recent research on children's prosocial behavior and the early origins of guilt (e.g., Zahn-Waxler & Kochanska, 1990; Zahn-Waxler, Radke-Yarrow, & King, 1983; Zahn-Waxler, Radke-Yarrow, Wagner, & Chapman, 1992).

Control-Mastery theory assumes the importance of trauma in the etiology of all psychopathology. Some traumas may be chance events, such as the illness or death of a loved one. Due to the child's relative egocentrism, she may assume that the unfortunate event is due to her own occasional negative feelings toward the loved one. Even lacking such negative or hostile feelings, the child may come to infer that she has no right to a better life than a suffering family member. Other traumas derive from the interactions between the child and her loved ones. For example, if a particular child's goal is to develop close peer relationships but that goal happens to be threatening to a needy father who demands that the child be exclusively interested in him, then the child may renounce the goal of developing close peer relationships. That is, the child needs help and encouragement to accomplish important developmental goals; and the younger the child, the more parental help is needed to accomplish such goals. If such assistance is not forthcoming, the child may infer that the parent does not wish her to develop in that direction. And given the young child's understanding of cause and effect, she may

ening to her relationship with the parent. She thus may renounce the goal in order to preserve the relationship. These too are examples of "trauma" in Control-Mastery theory. Often they are not single, high-intensity events; rather, they are persistent patterns of interaction of moderate intensity—the dense texture of everyday life. Important in this notion of trauma is not simply the reality event itself but also the experiencer's construction of the event's meaning.

To return to the example, the problem, unfortunately, does not disappear once a goal has been renounced. In the child's mind, the connection may have been made between a developmental striving and someone else or the self being hurt. The child has now developed what we call a *pathogenic belief* (here, about her power to hurt her father); and this unconscious belief may continue to exert great force and to influence her behavior. She might develop a school phobia. Or she might have great difficulty leaving home to go to college. Or she might not be interested in making friends. A pathogenic belief is not a wish. It is a grim, constricting idea that the person has formed from experience. It includes the thought plus all affects connected with the thought. Pathogenic beliefs can develop for any normal motive. Young children are particularly vulnerable to the development of pathogenic beliefs because of their relative cognitive immaturity and lack of experience with other relationships with which to compare their current situation. In the example of the girl whose father seemed to get upset by her wanting a friend, it is possible that if that young child had a close relationship with another adult, she would not be so vulnerable to being traumatized by her father's reaction. She might know from her relationship with her mother or grandmother, or whomever, that not all adults feel that way about her wish. Although we look to early childhood for the origins of many pathogenic beliefs, a pathogenic belief can develop at any age if the circumstances are traumatic enough. For example, most Holocaust survivors were not severely disturbed as children, and yet the extreme horror to which they were subjected often led to the development in adulthood of pathogenic beliefs such as, "Because others in my family have died, I do not deserve to live" (Niederland, 1981).

What implications do these ideas have for therapy? For one thing, the goals of many clients, in treatment as in life, are to overcome their traumas and the pathogenic beliefs these traumas have generated, and thereby to solve their problems. In psychodynamic therapy this is accomplished largely through the specific interactions between therapist and client as well as through the conscious and unconscious inferences the client draws from these interactions. The client will *test* the therapist

to see if it is safe to bring forth material that was previously traumatizing. The evaluation (conscious or unconscious) of safety is a crucial consideration for the client to assure herself that she won't be retraumatized by bringing forth renounced ideas or affects. The various types of testing clients may engage in will be elaborated later, in the context of the clinical illustration.

More generally, Control-Mastery theory assumes that each client has a *plan* when coming into therapy, and that large parts of this plan are not conscious but can be inferred by the therapist. This plan is composed of the following components: (1) the *goals* the client wishes to accomplish in the therapy; (2) the *obstructions* (or pathogenic beliefs) that keep the client from reaching those goals; (3) the *tests* that the client will need to carry out to determine if it is safe to pursue certain goals; and (4) certain *insights* that will be helpful to therapeutic progress. Clients generally have a hierarchy of goals—if a therapist does not seem to be very helpful with one goal, a client may switch to another. Generally, clients' plans are not rigid or fixed; rather, they are tentative and conditional, and they are modified and elaborated as the therapeutic work proceeds. But clients are not infinitely flexible. If the therapist starts to fail important tests routinely, the client may lose confidence in the treatment. We also like to try to formulate the client's plan with relatively little evidence, after only a few sessions. This forces the therapist to think seriously and systematically about what the client is trying to accomplish and how. It also allows for the opportunity to use the evidence of subsequent sessions to confirm or disconfirm the original hypotheses; this serves to refine and articulate the therapist's developing ideas about the client's plan.

AN EARLY EMPIRICAL STUDY

In the past two decades, most aspects of the theory of psychotherapy process just outlined have been subjected to formal empirical test. In fact, the theory evolved into its current form largely as a consequence of the results of those research studies. That wealth of research cannot be summarized here. However, in order to give some sense of the evolution of the group's work over the past 20 years, we provide two illustrations: First, an earlier study is described. Second, a recent study, using the notion of the client's plan as outlined above, is presented.

For approximately the first 10 years of the project, the majority of the empirical studies involved the data from a single case, Mrs. C. (The early theory and this research is reported in Weiss, Sampson, & the Mount Zion Psychotherapy Group, 1985.) This was a full psychoanalysis

the analysis was completed before our group began to study it.

Mrs. C. was a married woman in her late 20s. Among several presenting problems, she complained of feeling chronically tense, self-critical, overly anxious, and unable to relax and interact comfortably with other people. She was also unable to enjoy sex with her husband. She described her fear of "simply being a nonentity," of existing as a maid to her husband, and of not occupying an equal position in the relationship. At work she felt driven by a strong sense of obligation and duty. She also felt more distant from co-workers than she thought she should be. Mrs. C. had an older and a younger sister and also a brother about six years younger than she. She described her family as controlled, unemotional, and unaffectionate. She felt she had internalized her father's disapproval of sensuality, and characterized him as a tyrant who rarely showed physical affection but who often punished her in violent outbursts of emotion. Mrs. C. felt she was much like her mother—efficient, overly organized, and afraid to show emotion. Like her mother, she felt unable to relax and enjoy herself. She also expressed long-standing resentment toward her mother for not having protected her from her father's rage.

The Control-Mastery group developed an independent case formulation about Mrs. C., one that was quite different from the formulation the analyst had employed. For example, the analyst's formulation placed emphasis on the client's envy toward her brother and men in general. The alternate Control-Mastery formulation cast this in terms of her seeing her father and other men as weak and brittle, and not really as people to be envied. From the viewpoint of this different formulation, her conscious envy of men was actually a compliance with what she unconsciously had inferred would help her father, since she unconsciously recognized he was quite narcissistically vulnerable. Her envy was a form of flattery of him, and it developed in compliance with what she thought he desired of her. To envy someone can be a high compliment if that person needs to be admired.

Many studies were conducted testing the validity of different predictions from these different formulations; this is one example. Part of the alternative formulation was the inference that the inhibitions that were troubling to Mrs. C. were largely based on unconscious fears of her power to harm others, and that these fears stemmed from pathogenic beliefs about her parents' and siblings' vulnerabilities. She believed they would be severely damaged if she held different ideas or values than they did; she believed unconsciously they would be damaged if she led a life that was less burdened and less joyless than she perceived theirs to be;

or if she were strong, assertive, able to think for herself, and self-confident, or if she were able to be close to others—all these things she had, based on certain childhood experiences, inferred unconsciously would harm her parents and siblings. In short, we hypothesized that Mrs. C. suffered from an unconscious sense of omnipotence, a sense of omnipotence that was inhibiting and constricting rather than empowering, since she feared the harm her imagined power could visit upon her loved ones.

We developed a method to test this aspect of the case formulation, using the first 100 hours of the analysis (see Shilkret, Isaacs, Drucker, & Curtis, 1986). This particular study involved developing a scale of Mrs. C.'s insight about her omnipotent ideas, with three steps. First, all of Mrs. C.'s statements during the first 100 hours of the analysis that pertained unambiguously to her irrational feelings of responsibility, guilt, and power to hurt others were selected. The second step, and the most painstaking one, was to examine each such statement and develop a scale of various levels of her own insight into her irrational sense of omnipotence. Descriptions of five levels of increasing insight were developed in this way. Finally, independent judges classified all items, and some fillers, randomly presented, in terms of this "insight into omnipotence" scale, without knowing the hypotheses of the study. In this way, it was determined, first, that the scale of levels of insight into her unconscious omnipotent ideas was reliable in terms of interjudge agreement. Then, in looking at the hours in which various levels of insight occurred, it was apparent that her insight increased over the 100 hours: at first, she had only a very vague sense of her ability to harm or even influence others; but she became more and more aware of her sense that she could harm others over the hours of the treatment.

The next question was how Mrs. C.'s insight in this area increased. The increase in insight about her omnipotence was particularly interesting because, as noted earlier, the analyst was not thinking that this was one of her central issues. A subsequent study applied the same scale systematically to all statements made by the analyst during the first 100 hours. Thus, the analyst's level of insight, if you will, into this theme, could be assessed, as compared with the client's level of insight about the same theme. In every case, the client reached a new level of insight about her irrational omnipotent ideas before the analyst did. The analyst followed the client, rather than vice versa. The client did not develop this insight through suggestions from the analyst. Rather, she did it through a complex process of testing around this issue. For example, by disagreeing with the analyst and seeing that he remained neutral and

unbothered, Mrs. C. gradually came to believe that he would not be harmed by her having different ideas than he did. This disconfirmed one of her central pathogenic beliefs, namely that she could harm others by being different or even thinking differently from them. Disconfirming this belief allowed her to feel sufficiently safe to experience greater insight and to recover memories about this theme from her childhood. In short, it was concluded that the analyst was on the right track, but not for the reason he thought he was (he was simply following the general principle of neutrality).

This study was characteristic of the work of the early phase of the project. It was tremendously useful in developing ideas from verbatim clinical material to a point where they could be brought to formal test. Some of the earlier studies directly tested competing hypotheses about various aspects of the therapeutic process, as manifest in this case; for this reason those studies might be called retrospective experiments. But this work was also extremely painstaking; it involved developing specific methods and specific scales for this one client, and was thus very time-consuming.

A MORE RECENT STUDY: THE PLAN FORMULATION METHOD

The more recent research of the group, led by George Silberschatz and John Curtis in tandem with Weiss and Sampson, has focused on short-term, dynamically-oriented psychotherapy, and other types of therapy, rather than psychoanalysis. It has also focused on developing general methods for assessing psychotherapy process, and applying these methods to a larger number of clients with a wide range of presenting problems.

The idea of the client's "plan" in coming into treatment has already been described. Recently, the group has refined the procedures for developing these Plan Formulations from the first few hours of the treatment, and has used this Plan Formulation method in its formal research. The method involves several steps. First, experienced clinical judges constituting a "formulation team" independently read material from early in the treatment (usually verbatim transcripts of the intake and first two therapy interviews). They then generate items representing the client's conscious and unconscious (1) *goals* for the treatment, (2) *obstructions* to reaching these goals (pathogenic beliefs preventing attainment of goals), (3) predicted *tests*, or experimental actions the client may likely conduct with the therapist in the hope of disconfirming pathogenic beliefs, and (4) *insights* that would be particularly helpful in

overcoming or disconfirming pathogenic beliefs. (Recently, the category of *early traumas* has been added to the method.) The different judges' lists, plus filler items, are then combined. The master lists so generated for each category of the plan are presented again to the judges (with items randomized); the judges then independently rate each item as to its suitability to the clinical material. Those items reliably agreed to be highly relevant to the case are then examined by a second team of judges, who eliminate redundancies; and it is this final list of items that constitutes the final plan formulation (Curtis, Silberschatz, Sampson, Weiss, & Rosenberg, 1988; Silberschatz & Curtis, in press).

While complicated, the Plan Formulation method can be thought of as a formalization for research purposes of what transpires during an ideal case conference. In fact, the case conference might be considered a method of inquiry in itself—this is when a group of clinicians gather together to discuss a case and to develop a theory about the client. The case conference often leads to new insights and sometimes even to a consensus about those insights. But the case conference method has certain drawbacks: There are almost always differences within the group, and in what is said and finally accepted, along such dimensions as the participant's experience, role, gender, age, willingness to speak in the conference, and so on. And sometimes such differences can influence what is taken to be the consensus of the case conference. The Plan Formulation method might be thought of as a formal research version of the case conference, in that it asks clinicians to formulate the case independent of these group influences, and includes a method for arriving at group consensus with each participant judging other participants' ideas (without knowing who those other participants are). A first finding is that reliable case formulations can, in fact, be derived by this method.

Once one has a reliable method for deriving case formulations that are realistic to the complexity of real clients, the case formulation can then be used as a tool to address other interesting kinds of questions. Here is one example, from the recent work. A major question addressed by the Weiss-Sampson group is what kinds of therapist interventions are effective in facilitating change in psychotherapy. There have been several studies of this question; one by Polly Fretter (Silberschatz, Fretter, & Curtis, 1986) is quite intriguing. Several versions of psychoanalytic theory argue for the potency of interpretations over other kinds of interventions in facilitating change, with particular attention given to the transference interpretation. While many clinical reports offer support for the assumption that the interpretation is especially potent, the

empirical research literature has been less convincing, with some studies finding that interpretations actually hinder progress. In this area of research, a typical strategy is to define a category of intervention, such as transference interpretations, and then to assess the frequency of such interventions as related to quality of outcome. A major problem with such a strategy (and a reason for inconsistency of prior results) is that it assumes that all interventions of that particular category are equally accurate and helpful; it often further assumes the more, the better. That is, the accuracy and helpfulness of certain types of therapist interventions are often *assumed*, rather than independently *assessed*. In contrast, Fretter's study used another new method to assess directly the accuracy of therapist interventions and their effects on process and outcome.

Three brief (16-session) therapies were studied, one case with an excellent outcome, one with a moderately good outcome, and the third with a poor outcome. Therapists were experienced in different schools of brief treatment (not all were Control-Mastery people); they were unfamiliar with the hypotheses of the study. After the therapies were completed, clinical judges, working with verbatim transcripts of the entire therapies, categorized all therapist interventions as either interpretations or noninterpretations (using a standard typology developed by Malan). Interpretations were further classified as transference or nontransference interpretations. Then, from the transcripts of the intakes and first two therapy hours, Plan Formulations for each client were derived, using a method similar to the one outlined above. In the next step, each therapist interpretation was compared against the Plan Formulation for that client in terms of how suitable the therapist's interpretation was to the client's plan for therapy. In this way, every interpretation the therapist made was judged independently as to its compatibility with the client's plan. Next, the client's immediate response to each interpretation was assessed by a standard measure of client involvement in the therapeutic work. Longer-term effect (or outcome) was also assessed, as it is done typically in this work, by a battery of standard assessment measures (administered pre- and post-therapy), as well as pre- and post-therapy interviews conducted by an independent evaluator, and 6-month and 12-month follow-ups. In summary, in this study, each therapist interpretation was assessed for its accuracy to that particular client's plan; secondly, to assess the effect of the therapist's interpretations, client speech segments immediately before and after each therapist interpretation were assessed, as well as the longer-term outcomes of the therapies.

The results of the study were quite striking. In none of these three

cases did transference interpretations result in greater immediate client progress, as compared with nontransference interpretations. (In fact, in one case, there was a greater increase in progress after nontransference interpretations.) In contrast, when therapist interventions were assessed in terms of accuracy to the client's plan, improvement (or lack thereof) was accurately predicted in all three cases. That is, highly plan-compatible interpretations were followed by an increase in progress and a deepening of the client's work, while plan-incompatible interpretations were followed by a decrease in client involvement. Further, transference and nontransference interventions which were equally plan-compatible had equal effects on client progress. Perhaps even more striking were the results in terms of the outcomes of the therapies. The cases with very good and moderately good outcomes had had 89% and 80% highly pro-plan interventions respectively (with very few anti-plan interventions in each case). In contrast, in the case with poor outcome, only 50% of the therapist's interventions had been highly pro-plan, while 6% had been anti-plan and 44% of the therapist's interventions were ambiguous (neither strongly pro- or anti-plan). Although only suggestive, it may be that a large number of incorrect interventions is not needed for poor outcome. Also, it might be that a large number of ambiguous interventions may be difficult for the client to interpret consistently. The conclusion from this set of results is not, of course, that transference interpretations are bad; it is, rather, that transference interpretations are good only sometimes—when they are accurate to the client's plan for the treatment.

Of course, variables beyond Plan Compatibility and the other measures of the Weiss-Sampson group may also be important in client progress and therapy outcome. (See Silberschatz, Curtis, & Nathans, 1989, for a study of Plan Attainment; and Sampson, 1992, for a summary of recent research.) Other work has compared these techniques with those of other psychotherapy researchers and with conceptualizations derived from other perspectives entirely, such as a cognitive-behavioral perspective (Persons, Curtis, & Silberschatz, 1991).[1] Arguing from an interactionist framework, the work argues that neither client nor therapist variables considered separately will be maximally efficient in predicting change. That is, the meaning of the particular therapist intervention for a particular client must be considered, and this can be accomplished only by case-specific methodologies, however painstaking that might be. Practitioners will certainly agree with this approach; the approach, however, is methodologically complicated. But, as suggested above, the method of generating and evaluating Plan

Formulations go quite a distance in systematizing and streamlining the process of case formulation.

A CLINICAL CASE ILLUSTRATION

After this brief sampling of research directions, we turn now to a brief case example. In doing so, we hope to illustrate further some of the ideas of the theory and to convey a sense of the interchange between clinical practice and research investigation. As described above, the research of the group is highly case-specific; and it is from the detailed study of individual cases that research questions are generated in this work. The same ideas can be applied to clinical material, although it may not be organized in the same way as formal research. Also, while the Plan Formulation is a general orientation to the client's goals and traumas, as a case unfolds, memories emerge that are unique to that person. For example, Mrs. C. found it difficult to relax because she felt responsible for the happiness of others. She felt that men were weak and needed to be bolstered by her admiration. She had developed the pathogenic belief that arguing with men would devastate them, and her goal was to overcome this belief and to feel freer to state her own opinions and not to worry about the reactions of others. Because Mrs. C. was very well-functioning in many areas, she was able to test her analyst by disagreeing with him (in small ways at first, and then in more important ways), and to see that he was not bothered by this. This enabled her to disconfirm her pathogenic beliefs, and to gain insight into the origin of these beliefs by remembering how upset her father got when she disagreed with him. In contrast, another client, Ms. R., experienced traumas and the resulting pathogenic beliefs that led her to carry out very different tests in her therapy. It will be seen that, although the therapist was able to formulate a fairly accurate plan for Ms. R based on her presenting complaints and the first two sessions of therapy, one could not have predicted the specific memories which emerged.

Ms. R. began treatment (with C.J.S.) at the age of 25 with the presenting complaint of severe anxiety attacks. She had had three years of both individual and group therapy before she came to see me, during which time her anxiety attacks had worsened and she had developed multiple phobias including agoraphobia. She also worried that she ate too much, drank too much, smoked too much, and couldn't stop taking tranquilizers. Although it appeared that she had become increasingly troubled during her previous therapy, she spoke glowingly about her therapist. The only other noteworthy point during her first session was that she reported that she was unable to remember anything about her

childhood before the age of 16. When I commented on that, she said that it must mean that nothing much had happened to her before that time, that her childhood was probably a pretty normal one. At the end of that session she agreed to meet the following week.

Prior to the next session, she called to say that she didn't know what to do. After her appointment with me she had seen another therapist (she knew about this appointment at the time she saw me, but hadn't mentioned it), and she indicated that she liked that therapist much better than she liked me, so she wasn't sure which one of us to see. Now this is very unusual. Usually, if a client is going to see another therapist, she calls you up and says, "I'm going to see someone else; goodbye." She doesn't ask you what she should do. So I took this as a test in which she was slightly critical of me and then invited me to reject her. I viewed this as a rejection test because when clients invite rejection, they often do it in ways that would make it appear reasonable if the therapist did so—it is a way of letting the therapist off the hook. This dynamic is often in evidence when clients are worried that they will be too great a burden for the therapist. They suggest ending the therapy after a bit of progress, but long before the client's problems have been resolved. By focusing on the genuine, although incomplete, progress, the client reassures the therapist that the therapist has done a good job, disguising her own fear of rejection. Therefore, I suggested that she keep our appointment and that we could discuss it then, which she quickly agreed to do. When she came in for her second session, her focus was on how nice the other therapist was—much nicer than I. When she told this to her friends, they all agreed that she should see the nicer therapist, but for some reason, she just wasn't sure. I asked in what way she felt the other therapist was nicer. She said the other therapist had held the door open for her when she came into the office, while I preceded her into the office and I expected her to close the door behind her herself. I took this as confirmation that this was a drama around rejection, and not a serious complaint that I hadn't been nice enough to her.

The initial formulation involved two pathogenic beliefs. One was that she deserved to be rejected. This inference was based on her invitation for the therapist to reject her almost before the therapy had begun. I did not know why she felt she deserved to be rejected, but I assumed it was probably connected to a second pathogenic belief, that being independent was wrong. Two ideas supported my conclusion. First, being independent includes the ability to think critically of others, and she was so uncomfortable criticizing me that she immediately invited rejection. The second factor was her presenting complaint of multiple phobias.

One result of these phobias was to limit her severely in terms of where she went and what she did. She said that she had to live and work in the same town because she was phobic about crossing bridges. She also had to work near her home because she would sometimes get claustrophobic on buses. This limited her work opportunities, and indeed, she was bright, but underemployed. Because she did not have much money and because she was phobic about traveling, it was hard for her to have fun. In general, Ms. R. led a very constricted life and was not truly independent. I inferred that there must be some significant danger connected to being independent (rather than speculating that she wanted to be dependent). One reason for the assumption of a real danger was her inability to remember her childhood. Of course, I did not subscribe to her explanation that she did not remember anything because there was nothing much to remember. Rather, I assumed that there must be truly awful memories that would lead to her repressing almost everything prior to age 16. Because of her belief that it was wrong to be independent, she was always in danger of feeling compelled to give in to people and doing what they wanted.

After two sessions the Plan Formulation was that her goal was to overcome the severe inhibitions that kept her from enjoying her life. The obstructions to her doing so included the pathogenic beliefs that she deserved to be rejected and that leading an independent life was wrong and probably dangerous. And at least one of the tests that she would use to disconfirm her pathogenic beliefs was by turning passive into active and seeing how the therapist reacted to being rejected by her.

The last inference requires some further explanation. Although client-therapist relationships are very complex, we feel they generally follow one of two types. There is the usual way transference is viewed in analytic theory—that is, the client reenacts an old relationship, giving the therapist the opportunity to act as the parent did (for example, Mrs. C., who disagreed with her analyst to disconfirm the belief that he would act as her father had). However, there is another type of client-therapist interaction in which the client turns passive into active and takes the role that the traumatizing parent took, thereby treating the therapist the way the parent treated the client. This was the kind of test that Ms. R. gave from the beginning. That is, she tried to reject the therapist (by saying I wasn't very nice and later on by criticizing me in other ways); then she watched carefully to see if I felt as traumatized as she felt when she had been subjected to that treatment. This is why she invited rejection; to make sure that I was unbothered by her disagreeing with and criticizing me. To demonstrate that I was not bothered by her criticism, I told her

during that second session that it was hard for her to have reservations about me and still continue in therapy. She agreed with that, and decided to continue seeing me. She then immediately began to discuss her difficulties with men. Not surprisingly, she revealed a similar problem with men—she felt unable to be critical of men, and so she always had to give in and do whatever a man wanted her to do.

The next big test came up around the issue of medication. As previously mentioned, she had begun by presenting herself as out of control regarding medication. She said she wanted tranquilizers and, after some discussion, I told her I did not think it would be useful and I would not provide them for her. She insisted she had to have them, and then said she knew how to get them herself. I said that I was sure that she did and that I could not stop her from doing that, but that I would not give them to her. She was very angry and threatened to quit (again the threat of rejecting me if I did not do what she wanted), but then became thoughtful and said that maybe it was more hopeful this way, because maybe I intended to really do something about her fears rather than just tranquilize her. She then told me that her previous therapist had given her tranquilizers; but because he worried that she might take too many, he had insisted that she tell him when she took every pill. I took this to mean that she had felt infantilized and intruded upon by him (even though she never said this), and that that was probably a mistake because it went against her wish to be more independent. (This decision was not part of a general stand against medication, however. The decision to medicate is always case-specific.)

After this somewhat stormy beginning, the therapy settled into a predictable routine during which two themes emerged. The first theme was her continuing dissatisfaction with me. Whatever I did was not good enough. I wasn't helping her. I was cold and uncaring. During this time she frequently threatened to quit. She had consultations with other therapists, and went to quasi-therapeutic meetings (e.g., EST). She once told me that all her friends were in therapy, and every single one of them was seeing someone who was nicer than I was. This kind of complaining went on for months. However, during that time a second theme started to emerge—her guilt over leaving others out. For example, she worried about her roommates and felt guilty doing anything on her own, or with just one girlfriend, because she was afraid that her roommates would feel upset at not being included. She also worried about the men whom she dated. Her initial presentation was that she was worried that these men would leave her. However, they all sounded like rather weak and passive men who acted very needy. At one point I suggested to her that she felt

that she was *supposed* to worry about and care for them, and that she felt guilty leaving *them* out (despite her often repeated conscious worry that they would leave her). It was striking that her mood immediately lightened, even though she was not sure I was right; the following week she told me that she liked the previous session, although she did not know why (and, as was characteristic of her, she could remember very little of it).

This pattern continued for a few years, with her complaining about my lack of help (to see if I felt guilty and responsible for her), alternating with sessions in which she analyzed her guilt at not wanting to feel so responsible for others. What was particularly striking was that all during this time of constant complaining she actually improved. Her symptoms lessened (and there were other symptoms not mentioned here, in the interests of space), and she became more competent both in her work and in her personal life. However, she never attributed her improvement to the therapy. She never even mentioned the improvement directly. I only knew about it because she had to give me certain information. For example, at the end of one session which she spent complaining that I wasn't helping her and she wasn't getting any better, she got up to leave and said, "Oh, I suppose I should give you my new address." Of course, I said yes; and she gave it to me and left the office. I then knew that she was improving because her new address was out of town. Obviously, this meant that she was no longer phobic about long distance buses, one of her presenting symptoms. In addition, she decided to take a vacation, and she flew to a far-off resort. She bought some new clothes, and in general she seemed happier.

Her inability to speak of her improvement reflected another pathogenic belief, that she was not supposed to see things clearly. Ultimately, it originated in a belief she developed during childhood, that seeing things about her family was forbidden, and that it would be disloyal to recognize what was really going on at home. That was one of the reasons her memory was so poor—for example, her inability to remember anything significant before the age of 16.

Two dramatic vignettes demonstrate the way Ms. R.'s pathogenic beliefs were manifested in treatment, how she tested them in the therapy, and what happened when they were disconfirmed. In the first vignette, after making progress in the ways just mentioned, Ms. R. announced that she was moving away because she had decided that all her problems were environmentally caused. She felt they were all due to the stress of living in a big city; if she moved to a small town in the country she would be fine. I told her that it was important for her to continue in therapy, and

that she should not move at this time. This was followed by two sessions in which she screamed at me that I was ruining her life by keeping her here and making her look at her past. But after that she began for the first time to talk about the responsibility she always felt for her mother; she also began to remember bits of her history. She talked about the violence in her family, and how her mother seemed unable to protect her and her siblings from their father. The mother's response was sometimes to do nothing and sometimes to run away, but always in a disorganized, futile way that solved nothing because she always came back. This had been going on for as long as Ms. R. could remember; it left her feeling very frightened and responsible for the well-being of her mother and younger siblings because her mother could not seem to protect herself or her children. She then went on to discuss how she got upset if she thought she could force me to do something, because then she felt that I could not protect her. From this perspective at least one reason emerged why her previous therapy had not been helpful. She felt she had coerced her therapist into giving her medication. She then saw him as weak; in order to restore him and make him appear stronger, she became weaker, that is, more phobic. (This was her unrealistic conclusion, based on a pathogenic belief that she made him weaker. From his perspective he probably felt that he was helping her by providing medication to an intensely suffering client.) Subsequently, Ms. R. had another opportunity to move away and decided to wait until she had finished her therapy.

The second vignette was equally dramatic. Ms. R. had been complaining that I wasn't helping her, when she suddenly started shouting that she hated me and wished that I were dead. She then stopped and said, "I can't believe that doesn't bother you." She said that it would certainly bother her if someone said that to her. I then asked if someone had ever said it to her and she suddenly remembered an incident from about age 6. She had been arguing with her mother when her mother lost control and put a pillow over her face and started to smother her while saying, "I hate you and I wish you were dead." This was really the culmination of many incidents that had led Ms. R. as a child to develop the pathogenic belief that if one were independent (that is, if one disagreed with someone and had one's own ideas), it would be too much for the other person and could lead to something terrible happening. She then described something about her family that had made the pathogenic belief all the more compelling for her. Ms. R. had an older brother who was always fighting with the parents. The parents could not figure out any way to control him and sent him off to boarding school. Her brother never returned home again. When he got old enough he left school and joined the Army. From

the client's perspective as a young child, her mother's threat was a real one—her mother could make her disappear just as she had her brother. Therefore, Ms. R. had to give in to the wishes of others in order to preserve herself. Her pathogenic belief that independence led to rejection ruled her life and was an important factor in the development of her symptoms as well as the ways she interacted with others, including her therapist. This was not the end of Ms. R.'s therapy, but it was a turning point. She became more aware of her fear of rejection and how it led her either to give in to the other person or to reject the other person first. In retrospect, it became clear just why being independent was so dangerous for her. Although it had been inferred that, for her, independence was dangerous from the beginning of therapy, one could not have predicted the specific memories that accounted for the pathogenic beliefs that dominated Ms. R.'s life. It should be added that she had other pathogenic beliefs as well, and she used other tests to disconfirm them. For example, she had many conflicts about her career, which have not been discussed in the interests of space.

CONCLUSION

We have tried here to demonstrate the ways a Control-Mastery clinician looks at clinical material and starts to develop a Plan Formulation for a client. The clinician may not develop a formal and full Plan Formulation for each client (and it would be difficult in clinical practice to obtain the reliability judgments ingredient in the formal research); but the general process of thinking about clinical material is the same as illustrated in the research studies. It is very useful in clinical practice to be thinking, for example, about the client's possible pathogenic beliefs, tests likely to be presented, and so on, as early as possible in the treatment. It should be emphasized that these formulations based on early material are not set in concrete. Rather, as used in clinical practice, components of the Plan Formulation should be seen as a set of working hypotheses, to be tested against subsequent clinical data.

To conclude, we would argue that any therapist has a theory about a client, even if only an implicit theory. The therapist's theory of the client is based on the his or her own prior experience and education, as well as beginning information about the client. Ideally, such a theory of the client is modified and refined continuously by evidence from the therapy. In this sense, the ongoing cognitive activity of the therapist is analogous to the researcher's hypothesis and use of evidence to modify or disconfirm that hypothesis. Or, conversely, researchers might look to the cognitive

activity of therapists to see realized the ideal of research investigation: the therapist's initial case formulation or hypotheses about the client, modified and articulated as a function of evidence from the ongoing therapy.

NOTE

[1]These ideas have also been important in the research of several Smith Social Work doctoral students. For example, Joseph Courtney developed a method to assess the goals clients bring to group therapy and the kinds of tests they carry out with the group leader and with other members of the group. Jo Nol has noted the strong compatibility of the Control-Mastery theory with certain lines of feminist scholarship, such as that from the Stone Center; and she is studying themes in women clients' plans for therapy from this point of view. Ellen Nigrosh and Robert Shilkret are developing a method to assess college students' "Plans for College," thus taking the theory beyond the psychotherapy arena. In this work, assessments are made of students' conscious and unconscious goals for their college experience and the obstructions or pathogenic beliefs that may prevent them from reaching their goals. We hope ultimately to study how students overcome these obstructions in accomplishing their goals.

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