CONTROL-MASTERY THEORY IN COUPLES THERAPY

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ABSTRACT

Control-Mastery theory is a cognitive psychoanalytic theory which holds that psychopathology is rooted in grim, unconscious "pathogenic beliefs" that arise from traumatic childhood experiences. Patients, guided by an "unconscious plan," work in therapy to overcome these beliefs by acquiring insight and "testing" of the therapist. Utilizing this model, the author presents an original application to the theory and practice of couples therapy, demonstrating how childhood trauma and pathogenic beliefs influence the choice of an intimate partner; how the resultant configuration of pathogenic beliefs in the partnership can predict both the evolution of dysfunctional relationships and the nature of the partners' work and testing of each other and the therapist; and how conflict, trauma, and stalemate can be therapeutically managed.

INTRODUCTION

This paper presents a systematic application of Control-Mastery theory to the field of couples therapy, in the hope of demonstrating how

this approach can increase the therapist's understanding of couple psychodynamics, that is, the choice of an intimate partner; the process by which relationships become dysfunctional; the nature of the partners' work and "testing" in therapy to overcome irrational and maladaptive beliefs; and the effective management of conflict, trauma, and stalemate.

OVERVIEW OF CONTROL-MASTERY THEORY

In the 1950s, Joseph Weiss, currently a Training Analyst at the San Francisco Psychoanalytic Institute, began to take a fresh look at the psychoanalytic process. He noted a condition that continues to the present day: Despite clinicians' apparent familiarity with Freud's later work, most analysts and analytically oriented psychotherapists typically conduct their clinical practices along the lines recommended by Freud in some of his earliest writings—his papers on technique written in 1911–1915 (Freud, 1958). At that time, Freud was immersed in drive theory and had not yet begun to develop his ego psychology, and during this formative period, assumed people have little or no control over their unconscious mental functioning. Weiss refers to this view as the "automatic functioning hypothesis." It proposes that the unconscious mind is made up predominantly of two forces: sexual and aggressive impulses seeking gratification and pushing toward consciousness, and defensive forces opposing them. The impulses and defenses interact dynamically much as do the forces in the physical world, beyond the person's control, and without regard for thought, belief, or assessment of current reality. Freud concluded that almost all the phenomena of mental life could be derived from these dynamic interactions, which are regulated by the pleasure principle.

With the advent of Freud's ego psychology (Freud, 1923/1961, 1926/1959, 1940/1964), a new view of the mind began to take shape, both the contents and the functions of the unconscious becoming broader and more complex. In this construction, though some automatic functioning might still occur, the unconscious ego (the person) controls most unconscious activities. This control is regulated in accordance with higher mental functions such as unconscious thoughts, beliefs, plans, anticipations, guilt and other affects, identifications, and wishes for mastery. The ego unconsciously utilizes criteria of danger and safety to decide whether to carry out a proposed course of action, such as "lifting" a repression, and allowing a previously warded off mental content into consciousness. The unconscious ego considers the current situation and compares it with past experiences to gauge consequences.

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For example, a patient may unconsciously decide that it is not safe to express deep feelings of need due to the perceived risk of rejection. The ego also makes use of "experimental actions" (i.e., tests of the external world) to help determine safety. Behavior is here regulated primarily by the reality principle. Weiss calls this the "higher mental functioning hypothesis." In this stage of Freud's theorizing, he brought trauma and the environment back into the foreground as important determinants of development and psychopathology.

Weiss felt that the process of psychoanalysis and psychotherapy was more accurately understood by the higher mental functioning hypothesis, and proceeded over the years to generate a new and comprehensive psychoanalytic theory of the mind, psychopathology, and therapeutic technique based on these concepts. In 1972, Weiss, in collaboration with Harold Sampson, Ph.D., formed the Mt. Zion Psychotherapy Research Group (currently the San Francisco Psychotherapy Research Group) to clinically evaluate the theory. The group has grown to include over 70 members. Their quantitative, empirical research has been reported quite extensively (Fretter, 1984; Broitman, 1985; Silberschatz, Fretter, & Curtis, 1986; Weiss, Sampson, & The Mount Zion Psychotherapy Research Group, 1986; Norville, 1989), and continues to be highly supportive of Weiss's theoretical position.

Central to this Control-Mastery theory ("control" refers to the emphasis on the person's control of unconscious mental life; "mastery" refers to the unconscious will to master conflict) is *adaptation* (Weiss, 1990a; Sampson, 1990). The recent infant observation research reported by Daniel Stern (1985) supports the view that infants, from birth, are actively involved in the interpersonal world. They test reality, and develop theories about how they, the world, and relationships work. Of all animals, humans have the longest period of dependence on adult caregivers. Infants and children are therefore highly motivated to adapt to the structural and moral realities of their parents in order to maintain this crucial tie, even if this adaptation involves the renunciation of normal developmental goals. In this manner, the growing child accrues a body of *beliefs* (both conscious and unconscious) that govern his perception of himself and others, and shape his personality and psychopathology. This development is profoundly affected by his perceived relationship with his parents. The beliefs may be either growth promoting or "pathogenic." Both represent adaptive striving on the part of the infant or child, but "pathogenic beliefs" are ultimately maladaptive and play a crucial part in the generation and maintenance of psychopathology. These beliefs are wholly or largely unconscious, and warn that certain thoughts and actions endanger the crucial parental relationship and will give rise to unpleasant affects such as

guilt, fear, shame, remorse, anxiety, helplessness, and humiliation. Constriction, repression, symptom formation, and inhibition may result.

Pathogenic beliefs are grim, and are not to be equated with wishful fantasy. These convictions are typically acquired by inference from traumatic experiences with family members. "Trauma" here refers to "any experience or ongoing life circumstance which leads an individual to believe that an important goal, be it an instinctual wish or an ego striving, must be given up in order to avoid the inter-related dangers of damaging one's love objects or being damaged by them" (Gassner & Bush, 1988). In families of severe abuse or neglect, trauma is often so omnipresent that the child may come to believe that this is what he deserves *in general*, merely for existing.

Young children endow their parents with supreme authority. Because of their dependence and lack of prior experience by which to judge, children tend to automatically assume that the way they are treated is how they *should* be treated. The child's egocentricity and lack of knowledge about causality tend to make him both feel responsible and unconsciously guilty for the traumatic events in his life. This idea is supported in the study by Beres (1958) of children placed in foster homes. Invariably, he found that the child assumed that he had been *justifiably* sent away for doing something bad. Traumatic experiences may also be distorted by the child's projections.

Pathogenic beliefs can take myriad forms. Some examples are: "I am a burden to my parents by being so inquisitive"; "I hurt my mother by becoming strong and independent of her"; "I must take care of my fragile parents to make them happy"; "If I have good things in my life, I am taking good things away from my sibling"; "people cannot be trusted"; "I don't deserve any privacy"; "I am toxic and must avoid close relationships"; "I am arrogant and selfish"; "I cannot succeed at anything"; "My mother died because I was so angry at her."

Pathogenic beliefs arise from two kinds of trauma. Kris refers to these as *strain* and *shock* trauma. In strain trauma, the damage occurs over a long period of time in a pathogenic parental relationship. Here, the pathogenic belief is typically acquired by identification, or compliance with instructions or attitudes of a parent (for example, a boy whose father chronically belittled anything he had to say developed the pathogenic belief that his ideas were worthless). In shock trauma, the damage arises from a sudden overwhelming event such as the aforementioned foster home placement, or an unexpected illness, death, or departure of a parent. The child takes responsibility for the event, and develops a pathogenic belief by retrospective inference, assuming that some aspect of his behavior caused the trauma (e.g., "I

am too disruptive; if I had been quieter at home, I would not have been sent away." "I am a bad person because I did not pay enough attention to my father and caused him to get sick").

Fortunately, many children come to discover that their pathogenic beliefs are false and maladaptive as part of normal "growing pains," but some do not, primarily because they are afraid to test them out. Further, pathogenic beliefs may color a person's vision so profoundly that contrary evidence cannot be seen—an example of what H.S. Sullivan called "selective inattention." And since pathogenic beliefs are typically wholly repressed, the child (and later, the adult) cannot consciously work at "disconfirming" them, and may have no conscious motive for this work. For example, a woman who unconsciously suffers from the belief that she is responsible for her ailing mother and has no right to a happy, separate existence may consciously enjoy her constant companionship with her.

In human life, the plethora of maladaptive characterological styles, symptoms, repressions, and inhibitions all can be seen as relating to underlying pathogenic beliefs, through compliance, identification, rebellion, or various forms of compensation and compromise. In the above example, the woman is compliant to her pathogenic belief. Another woman with the same belief might strongly rebel and desert her mother, rail at her possessiveness, but experience intense unconscious guilt as a result. Still a third woman with the same pathogenic belief, but *held with less conviction*, might be able to separate from her mother, but would feel compelled to call several times a day to see how she was. Yet a fourth woman might develop a symptom, such as a driving phobia, that would make it impossible for her to leave her mother at all. These particular examples all happen to involve separation and survivor guilt, which are given particular recognition in Control-Mastery theory.

Unconscious guilt plays a central role in the maintenance of most psychopathology. A child may feel guilty toward a parent for virtually any reason, and guilt can even arise at infancy. The infant or child unconsciously believes that everything the parents do is what *should* be done, even if consciously he repudiates the behavior. Oedipal guilt is seen as just one of many forms, and might best be understood as a special form of survivor guilt. The pathogenic belief underlying survivor guilt holds that to allow oneself more of the good things in life than other family members is to betray them; there is only a finite amount to "go around."

Various internal and external factors determine the strength of this belief. These include the intensity of the child's "greed" and the reality circumstances of other family members. Other things being equal, the

child coming from a devastated family is more likely to suffer from survivor guilt.

An individual burdened by survivor guilt may appease his conscience by "leveling" himself with the family by self-sabotage, renunciation, making himself miserable in the face of good fortune, or making himself envious of those who actually have less than he does.

Separation guilt (often called separation-individuation guilt) also involves the assumption of irrational responsibility for others. The pathogenic belief here is that the child would hurt a parent by becoming strong and/or independent of the parent. Internal and external factors involved here are: the strength of the child's independent strivings; his sense of omnipotence; the child's projections of dependence onto a parent; and importantly, his actual experiences with that parent. Other things being equal, a child whose parent(s) is unhappy and discourages independence will be more likely to develop separation guilt. An individual thus burdened may appease his conscience by having difficulty leaving his parents and may devise ways to keep them central in his life. Few of us have managed to avoid at least a "touch" of survivor and separation guilt. The experience is often described as irrational family "loyalty."

Such patients unconsciously (and, in part, consciously) suffer from these pathogenic beliefs and their ramifications, and are very motivated to change them. Yet success is risky, as it involves facing the painful affects arising from the beliefs and the dangers they foretell. At bottom, crucial parental love and protection is jeopardized, and herein lies the motivation for resistance in psychotherapy.

During the course of treatment, the patient works to disconfirm his pathogenic beliefs in two ways: (a) by unconscious testing of the therapist, and (b) by acquiring insight into them, either through his own efforts or from therapist interpretation. In individual therapy, patients can test in two ways: (1) When *transference testing*, the patient behaves in a way similar to what he believes caused his parent(s) to traumatize him, hoping that the therapist will *not* replicate the trauma. For example, Richard (the names of all patients, here and in the following examples, have been arbitrarily chosen), a patient who had come to believe that his father rejected him because he acted too assertively, tests the therapist by being assertive, hoping he will not be rejected. Another way he might transference test would be to act unassertively and take note if the therapist seemed to prefer him that way. (2) When *turning passive into active*, the patient switches roles, and behaves the way he believes the traumatizing parent did, hoping that the therapist (who is placed in the role of the patient as a child) will *not* be traumatized as he was. Our illustrative patient might behave in a critical, rejecting

way when the therapist makes an assertive statement, hoping that the therapist will not feel rejected, become defensive, or back down.

The research confirms that when a test is *passed*, the patient takes a step toward disconfirming the pathogenic belief. He typically becomes less anxious, bolder in exploring the material of the session, and more relaxed and positive. He may also bring the pathogenic belief closer to consciousness, begin to overcome certain inhibitions or symptoms, or lift repressions formerly maintained in obedience to the belief. If the test is *failed*, however, the opposite occurs: he takes a step toward reconfirming the belief. He typically becomes more anxious, more inhibited in exploring the material, less relaxed and positive, may regress behaviorally and symptomatically, and may intensify his repression of the belief, associated feelings, and ideas (Weiss, 1990b; Weiss et al., 1986).

A person with a pathogenic belief suffers from overgeneralization of his family experience. The patient who turns passive into active is looking for a healthy role model. If our patient's test is successfully passed, he is able to temporarily identify with the therapist, and to become less endangered by the rejection of his internalized parent. He demonstrates to himself that at least one other person does not react as he did as a child, and he becomes less constrained by the beliefs he had inferred from the parental rejection. Similarly, when a transference test is passed, the patient finds one person who does not treat him as his parents did, and loosens his conviction about the inevitability of retraumatization.

The Control-Mastery research supports the idea that patients come to therapy with a "plan," largely or wholly unconscious, for disproving their pathogenic beliefs and attaining the goals originally renounced due to these beliefs. The plan is not a detailed map, but includes general goals—the "rough" order in which pathogenic beliefs will be tackled and the kinds of testing strategies that will be utilized. The plan, at various periods in a person's life, is profoundly affected by his assessment of safety and danger, level of suffering, appraisal of his interpersonal world (e.g., his therapist), and the strength of his compliance to the pathogenic beliefs. With familiarity and training in the Control-Mastery model, it is possible to reliably infer at least the broad brushstrokes of the patient's plan in the initial sessions. The therapist then strives to make his behavior and interventions "pro-plan": he does his best to pass tests, tries to avoid behavior that would be retraumatizing, attempts (through each intervention and interpretation) to make conscious and help disconfirm some aspect of the pathogenic belief, and otherwise aids the patient in moving toward his goals. When the therapist is in a pro-plan mode, the patient moves forward in the manner

described above when a test is passed. Obviously, no one is perfect, and therapists inevitably slip off the track from time to time. However, patients often have "fallback" positions prepared in advance for failed tests, and will retest in an easier or different mode. At times, they unconsciously "coach" the therapist to get back on a pro-plan track. Analysis of transcripts and tapes of a number of therapies carried out by therapists of various theoretical persuasions has shown that pro-plan behavior on the part of the therapist is a crucial variable in therapy outcome (Silberschatz, Fretter, & Curtis, 1986).

Weiss (personal communication, 1991) highlights how the Control-Mastery theory of technique differs from the still highly influential drive-oriented theory of technique Freud espoused in his *Papers on Technique* of 1911–1915. In traditional theory, the analyst's task is to demonstrate to the patient how his psychopathology has roots in particular infantile gratifications, and to reveal these gratifications so that the patient can give them up. Since the patient unconsciously does not want to relinquish them, the therapist must try, with tact, to induce the patient to go where, unconsciously, he is determined not to go. By contrast, Control-Mastery theory holds that the therapist's primary task is to demonstrate to the patient how his psychopathology has roots in particular pathogenic beliefs, and the feelings of fear, anxiety, shame, guilt, and remorse produced by them. By so doing, the therapist is trying to help the patient to disconfirm the pathogenic beliefs that the patient himself is working unconsciously to disconfirm. In this approach, the therapist is trying to help the patient to go where unconsciously he *wants* to go.

In an initial encounter with this approach, therapists sometimes believe that the emphasis on pathogenic beliefs, testing, and plans must produce a highly cognitive, intellectualized experience for both patient and therapist. This is not the case. Typically, the experience is phenomenologically rich, affectively charged, and involves all the creative and empathic capacities of the therapist. In fact, the therapist's pro-plan behavior, particularly the passing of tests, offers a specific and powerful corrective emotional experience.

THE CHALLENGE OF INTIMACY

As we make our way through the life cycle, we are constantly assessing ourselves and our surroundings for possible opportunities to test and disconfirm our pathogenic beliefs. We are governed by issues of safety and danger. In dangerous circumstances, where we unconsciously sense the likelihood of retraumatization, we remain compliant

to the dictates of these beliefs. If our unconscious assessment is that of relative safety, we may begin to "work," to test these beliefs. Both motives are constantly in attendance: our wish to grow and actualize our plan, and our need to comply with our pathogenic beliefs. As interpersonal beings, it is normal and healthy to seek out intimate partners. Yet our beliefs may forbid this utterly, or warn of grave dangers. An intimate relationship more intensely replicates aspects of our families of origin than any other type, and we make a major emotional investment when we enter one. Depending on our predilections and choices of partners, we have an ideal opportunity to unconsciously sculpt situations designed primarily to maintain compliances or to encourage growth. Intimate relationships are "ideal" for this process because of their constancy. Compliances are more easily maintained through the ongoing "cooperation" of the partners. Conversely, partners actively "working" to disconfirm have continuous opportunities to test, and when tests are failed, to be able to unconsciously reshape the test and retest soon, rather than having to contain the unpleasant affects of shame, guilt, loss, and anxiety that result. This encourages more active testing. (This is a main advantage of more frequent sessions in psychotherapy—not only in couples work, but in individual, group, and family therapy as well.)

If one examines the *series* of intimate relationships, a broad spectrum becomes evident. There are those whose relationships remain stereotyped throughout; due to entrenched compliances, only the actors can be changed, not the underlying script. At the other end of the spectrum are those who show dramatic shifts over time to healthier configurations as a result of the progressive disconfirmation of pathogenic beliefs. Since the testing phenomenon is so central to this process, the types of testing in which couples engage are now considered.

TESTING IN COUPLES

Cooper and Gustafson have written quite extensively about small group theory and group therapy from a Control-Mastery perspective (Cooper & Gustafson, 1979; Gustafson & Cooper, 1979; Gustafson, Cooper, Lathrop, Ringler, Seldin, & Wright, 1981). Their descriptions of testing in groups are particularly useful in understanding couples (Cooper, Gustafson, & Dawson, 1986). Couples utilize these tests with varying results in their everyday lives, both partner to partner, and as a couple in contact with others. Frequent examples occur in the couple therapy situation. If tests are being passed, the therapist typically intervenes little, if at all. If the patients appear to be failing, the

therapist typically intervenes to avert retraumatization. The various tests are defined below; clinical examples of the various tests and their therapeutic implications will be considered in subsequent sections.

Transferring and turning passive into active have already been described. It is important to bear in mind that in the therapy situation, these tests may be between the partners, or between a partner and the therapist. In *couple process testing* (analogous to Cooper, Gustafson and Dawson's *group process testing*), the partners, who share the same pathogenic belief, unconsciously cooperate to test the therapist. In this case, pro-plan behavior to pass the test is the same for both partners. In *vicarious experiencing*, one partner tests the therapist while the other, who shares the same pathogenic belief, sits silently but benefits or suffers from the therapist's response as does the active partner. *Plan contradiction*, as defined here, exists when pro-plan behavior for one partner constitutes anti-plan behavior for the other. It is also important to bear in mind that at any point in time, a partner's plan may be to be "compliant" rather than to "work" to disconfirm the pathogenic belief. This can make the *short-term* plan different from the *long-term* one. Plan contradiction is a couple "state" of varying degrees of retraumatization. At times it seems to be chronic and unremitting; at times it occurs accidentally because of the partners' inability to always sense how far it is safe to go on certain issues; and at other times it is unconsciously engineered and presented as a test of the therapist. In any case, there are both traumatic and testing aspects. A "steering contradiction" (Cooper, Gustafson, & Dawson, 1986) is presented to the therapist, who typically feels pressure to "side" with one partner. The management of plan contradiction is a major concern of the couples therapist, since the incidence and severity of this situation so profoundly affects the couple's experience of harmony and satisfaction. Clinical examples appear in subsequent sections.

MODES OF INTIMATE CONNECTION BETWEEN PARTNERS

Despite the conscious consideration that may bear upon the "attraction" to a potential partner, much of the actual connection occurs on an unconscious basis. A number of modes of connection may coexist in a given relationship, and may change over time. These modes of connection need not be between "whole partners," but rather aspects of personalities. They are usefully grouped according to whether or not they involve *repetition*, that is, the direct re-creation of the original trauma or gratification.

I. Repetition

In this mode, there is a repetition for one or both partners. "Passive/active" behavior is manifested: each places a reciprocal interpersonal demand on the other. A rescuer finds someone who must be rescued; an abuser links with someone who insists on being abused, and so on. Individuals who "repeat" their childhood traumas in a relationship are typically at greater risk than those who do not; they risk regular retraumatization (plan contradiction) when they are being compliant to their pathogenic beliefs, and frequent episodes when they are in the "working" phase. Repetition often involves separation, survivor, and oedipal guilt. Types and examples of repetition follow.

A. Transferring—Choosing the Transference Object
Consider a few examples:

> Sharon was chronically ignored or belittled by her father as a child, and developed the pathogenic belief that she deserved to be rejected. Greg was similarly rejected by *his* father, and developed the same pathogenic belief. Greg, however, attempts to compensate and remove himself from the traumatized position by identifying with his father ("identification with the aggressor") and becoming a rejecting man. Greg and Sharon meet and connect. From Sharon's standpoint, she is transferring. (We shall consider Greg's standpoint, "turning passive into active," later.) Their opportunities for successful testing are limited. For example, if Sharon attempts a transference test by denigrating herself, hoping that Greg will tell her she is being too hard on herself, the test is likely to fail, since Greg is "driven" to be rejecting. If she attempts a passive into active test by putting Greg down (hoping that he will not be bothered by it and take it personally), again she is likely to fail, since Greg will redouble his efforts to maintain his role of rejector and retraumatize her. She may attempt to protect herself by fighting back (temporarily identifying with her own abusive parent), but this often leads to further escalation.

In couples therapy, the therapist experiences this plan contradiction, and ideally:

avoids the pressure to take sides;
stops the traumatization;
demonstrates how this situation has come about;
explores the pathogenic beliefs underlying the behavior for each partner;
models empathy for each which promotes empathy in the partnership, and diminishes the tendency to impute negative intent.

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In escalating fighting situations, the therapist must intervene strongly and directively to stop the retraumatization. These are the general guidelines for managing any form of plan contradiction.

It is also valuable for the therapist to pass the transference and passive into active tests of each partner, since he is not burdened by their pathogenic beliefs. The couple process test is not available in situations where the behavior is passive/active.

The following example illustrates a situation where the underlying pathogenic beliefs are not the same:

> Sharon subsequently chooses Don, whose father instructed him as a child to be "tough and ugly" with others because he himself had been abused and unprotected and wished to spare his son the similar trauma. Don complied with his father and developed the pathogenic belief that he must be tough and rejecting of others. From Sharon's standpoint, she is again transferring. Don is neither transferring nor turning passive into active. He is not repeating a traumatic situation, but is acting in compliance to his pathogenic belief.

Here the pathogenic beliefs are paired in what I call the "passive/ active" configuration. But since the resultant *behavior* is again passive/active, the same remarks about testing apply. It is very important, however, for the therapist to note the underlying configuration of pathogenic beliefs, so that plan contradictions can be handled properly and insight acquired by both partners about the history and dynamics of their individual contributions.

Consider a case involving separation guilt and survivor guilt:

> Jack's mother was chronically depressed and unhappy, and complained about her burden of child care. Jack developed a series of pathogenic beliefs: "I am responsible for my mother's depression"; "I cannot be happier than she"; "I cannot leave her—I must care for her." Noncompliance to these beliefs produces the painful affects of separation and survivor guilt. To avoid these feelings, he marries Eleanor, a depressed, complaining woman.

Jack repeats his trauma by choosing the transference object. The behavior is again passive/active: he is driven to restore a woman and be complained about, and he connects with a woman in need of restoration who complains about him. The same remarks about testing generally apply.

In addition to transference as an attempt to deal with pathogenic beliefs (through varying degrees of compliance and the "will to master"), *transference as gratification* must also be considered: a positive, gratifying experience is repeated rather than a trauma. For example, Ned, a young man who had a collaborative, fun-loving relationship

with his father, chooses a wife with these characteristics. This type of repetition is conflict-free and constitutes part of the healthy "glue" that holds relationships together.

B. Turning Passive into Active—Identifying with the Transference Object

This is the other form of repetition, typically less "risky," since in this role the trauma is being *meted out* rather than *received*. This can be illustrated if we take Greg's standpoint in the earlier example of Sharon and Greg. Here, Greg identifies with his father and rejects himself in the form of Sharon. In the preceding example of Jack and Eleanor, Eleanor would be turning passive into active if she had a depressed, complaining mother with whom she guiltily identifies. Since the behavior remains "passive/active" in this mode, the range and fate of tests is the same as in transferring.

The focus here has been on the "high risk" in a repetition type of connection, but there is also the possibility of "high gain." If a partner chooses well (or luckily) and ends up with a partner not in high compliance, there will be a good opportunity to rewrite an old script. Parallel to the transference situation, in addition to turning passive into active as an attempt to deal with pathogenic beliefs, *turning passive into active as gratification* also must be considered: a positive, gratifying experience rather than a trauma is repeated with the roles reversed. For example: Sam treasured his mother's patience and love in explaining the meaning of literature to him. He becomes enamored of Sally, and treats her with the same love and patience he had received, and gets fulfillment from being a "good parent" to her. If Sally has no prohibiting pathogenic beliefs, this area of their relationship is conflict-free.

II. Nonrepetition

If turning passive into active is safer than transferring, then nonrepetition is safer still. Here the partners avoid directly immersing themselves in the original traumatic situation, at least with respect to the personality traits involved. They neither choose nor identify with the transference object. Several types of pathogenic belief connections are seen in this mode.

A. Choice of Partner Based on Similar Areas of Pathogenic Beliefs

Partners may employ this mode out of a range of unconscious assessments. At one pole is a sense that working to disconfirm is too dangerous and is best mutually avoided (high compliance). At the other is a belief that the similar areas of involvement will increase the likelihood

of empathy and thus aid the work of disconfirmation (low compliance). Within these similar areas, the pathogenic belief pairs may be *shared*, that is, the same, or *polarized*.

1. Polarized pathogenic beliefs. In this connection, the partners' pathogenic beliefs occupy the poles of a *concept*. An example is "strength," in which the beliefs might be "I must be strong" and "I must not be strong." Note that there is no immediate reciprocal interpersonal demand such as that produced by the analogous passive/active connection: "I must dominate" and "I must submit."

Taking "rejection" as an example, the polarized pathogenic beliefs might be "I must be rejected" and "I must not be rejected"; passive/active pathogenic beliefs might be "I must reject" and "I must be rejected." Polarized pathogenic belief connection offers easy compliance for those seeking it. Plan contradiction is not a chronic state as in passive/active behavior—there is low interpersonal demand, and each typically benefits from the other's position in a complementary way. Indeed, it is one of the ways that "opposites attract." There is opportunity for vicarious fulfillment, though this may shift as a partner changes. The following is an example in which some "work" is occurring:

> Ben grew up with a profoundly disturbed father who would not tolerate any extremes of emotion. He acquired the pathogenic belief: "I must constrict my feelings." He hopes to disconfirm this and be able to safely expand his affective range. Trish's background was very different. Her mother was chronically depressed, passive, seemingly lifeless, and Trish found that she could activate her by being explosive with her emotions—having tantrums, crying spells, laughing jags. She felt responsible for her mother and developed the pathogenic belief that these behaviors were necessary, that is, "I must be expansive with my emotions." Part of her plan is to be able to safely learn to constrict her feelings.

In this polarized situation, transference tests typically pass, both in life and in couples therapy. For example, if Ben risks testing Trish by expanding his feelings a little, the test will probably pass if the demand is just for tolerance. Trish has been awash in extreme affects all her life, and is unlikely to be disturbed. The test would be more likely to fail, however, if the demand were for Trish to respond in *kind*, since if she is in a "working" phase, she will be trying to constrict. Confronted with this apparent plan contradiction in a therapy session, the therapist should help reshape the test to reduce the interpersonal demand and reassure the partners that no real plan contradiction exists through explication of both plans.

Turning passive into active is more problematic. If Ben attempts to constrict Trish's emotions, hoping that she will not comply as he did

as a child, the test will probably fail if Trish is "working," since she would *want* to constrict and will accept Ben's invitation. If Trish happens to be in an entrenched compliant phase, the test might pass, but could not be counted on over time, and would not have the quality of passing that a person with no conflicts in this area could offer. The therapist should not be surprised to see plan contradiction develop with passive into active testing, and should explicate the problems of this maneuver. There may be excellent opportunities, however, for the *therapist* to pass the transference and passive into active tests of each partner.

Ben and Trish might employ a couple process test of the therapist, to see if it is safe to open up the subject of their shared area of pathogenic beliefs which concern affective range and style. It might have more of the quality of a plan contradiction test if they unconsciously produced an argument about the relative merits of constriction and expansion. Here, in addition to the intervention recommendations offered previously, the therapist should also demonstrate his comfort in a continuum of emotional possibility—to help the partners loosen up their fixed views of the world. Vicarious experiencing can also be valuable. In this instance, the therapist's talking with Ben about the values of working toward the *choice* of being constricted or expansive also benefits Trish.

2. Shared pathogenic beliefs. In this situation, there are even stronger opportunities for compliance through mutual avoidance, or working to disconfirm through empathy. Consider the example of Rachel and Tom:

> Rachel was chronically abused physically and emotionally by her mother during childhood. Tom suffered significant abuse at the hands of his much older brother, and his parents did not intervene. They both acquired the same pathogenic belief: "I deserve to be abused," and eventually formed a relationship.

In this example, the couple shares the same half of what would be a passive/active behavioral pairing, that is, abused/abuser (referred to here as Type A). Now consider the example of Harriet and Bob:

> Bob and Harriet's parents were similar in that they all acted as if the world was a dangerous place and their children had to be tough in order to survive. Harriet and Bob complied, and each developed the pathogenic belief, "I must be strong and tough." Attracted to each other, they began a relationship.

In this example, the couple shares the same "pole" of what would be a polarized pathogenic belief pair having to do with "strength," that is,

"I must be strong" vs. "I must be weak" (Type B).

The distinction between these two types is important with regard to testing. In Type A pairings, we would predict a higher incidence of plan contradiction for the following reasons. If Tom attempts a transference test with Rachel by being verbally self-abusive, hoping that Rachel will not chime in or simply sit quietly by, indicating that he indeed deserves the abuse, the test will probably pass. Rachel's empathy regarding the pain of abuse will help her pass. But if Tom attempts another kind of transference test, wherein he exhibits some of the kind of behavior that originally led to his being abused, in the hope that Rachel will not abuse him, the test may fail. Such failure will occur if the test is too provocative or rejecting of Rachel, causing *her* to feel abused, thereby re-creating her original trauma. Were she to feel abused, it is likely that she will defend herself by identifying with her parental aggressor and turn passive into active, thereby becoming abusive of Tom (and failing the test). Tom may then defend his position by identifying with *his* parental aggressor.

This is a very common sequence with couples who have been mutually abused, blamed, criticized, or rejected, and is a major cause of escalated fighting. The therapist must intervene to stop the traumatization, and follow the guidelines about plan contradiction. Turning passive into active re-creates the original trauma, and routinely fails in this type of pairing, unless the partner receiving the test has accomplished a significant amount of disconfirmation of the pathogenic belief.

In Type B pairings, we predict a lesser incidence of plan contradiction in transference tests due to the decreased interpersonal demand and diminished chance of re-creating the original trauma. For example, if Harriet tests Bob by seeing if he can tolerate some weakness in her, the test is likely to pass, since she is not demanding that Bob be weak. Turning passive into active, however, is more problematical. Harriet may test Bob by taking the position that he must be strong, hoping that Bob will not agree and indicate that it is O.K. to have some weakness. The test is likely to fail if Bob is in strong compliance, i.e., maintaining that he *must* be strong. As in the Type A situation, only if Bob has done significant work of disconfirmation will he be unaffected enough by Harriet's pressure to be able to pass her test by indicating that some weakness is all right. In contrast to the Type A situation, there is less likelihood of escalated fighting from a failed test.

In either Type A or B pathogenic belief pairings, each partner has testing opportunities for transferring and turning passive into active with the therapist. The couple process test finds its greatest use here.

Almost the entire range of testing that might be seen in individual psychotherapy can be replicated by the partners acting as if they were one person, for example, transferring or turning passive into active to see if the therapist finds them unattractive, burdensome, boring, too healthy, too assertive, or toxic. Vicarious experiencing is also best utilized here, where the pathogenic belief similarity is more marked than in the case of polarization.

B. Choice of Partner Based on Different Areas of Pathogenic Beliefs

In this mode of connection, the pathogenic beliefs are "unpaired." This results in a healthier, more stable form of complementarity and "attraction of opposites" than in the mode of polarized pathogenic belief pairs. In this situation, a "compliant" partner chooses out of an unconscious assessment that anything more ambitious than the vicarious realization of goals via the unconflicted partner is too dangerous. This represents the pole of "renunciation." At the other pole is "hope": The choice is made by a "working" partner out of an unconscious assessment that opportunities for healthy identification and passed tests will aid in the work of disconfirmation. As always, a continuum exists, but this is a generally healthier mode than any of the preceding, and offers numerous benefits.

In therapy, we hope to see initially paired configurations of pathogenic beliefs become unpaired. At the very least, there is vicarious realization. Consider this example:

> Jake fell in love with Susie who has no conflicts about public speaking and enjoys doing it. Jake had pathogenic beliefs that forbade his taking himself seriously and warned of the dangers of public humiliation if he risked speaking out. In the beginning "compliant" phase of his therapy, he basked in the glow of Susie's ability, but did not attempt to develop his own. However, largely due to the excellent testing opportunities, he made rapid progress.

Transference tests will more reliably pass in this mode than in any of the preceding, and Susie was happy to encourage Jake when he tested her to see how she would feel if he learned how to "hold forth" a little with their friends. And when he tested by belittling his speechmaking abilities, she immediately took issue, encouraged him, and did not become irritated. There is very little chance of provoking "passive/active" behavior with this type of test. In this mode, in contrast to those discussed previously, passive into active tests *also* have an excellent chance of passing, and Jake made good use of the opportunity. At times he would "warn" her that she was appearing before a very large crowd, and that it looked scary out there. She was unflappable, and

always did well. This was true even on occasions when he was a little sarcastic about her "investment" in her public speaking image. But even though Susie was far more immune to Jake's traumatization than a partner with any of the earlier described modes of connection would be, there was an instance in which Jake's testing became too vigorous and resulted in Susie failing the test by lashing back. I call what occurred a "crossover" plan contradiction. Susie's self-esteem was quite stable, largely due to helpful individual therapy prior to meeting Jake, but she still had some "residual" pathogenic beliefs in the area of being abused. When Jake turned the thermostat up too high on his "sarcasm" test, it recapitulated the trauma of her father's occasional sneering remarks, typically followed by physical punishment. This temporarily confirmed a *different* set of pathogenic beliefs from those Jake was testing, and caused her to strike back defensively. Making this process clear to the couple was very helpful to them, and did not vitiate Jake's ability to utilize the passive into active test. In this mode, the couple's success makes the therapist less necessary for transference and for passive into active testing.

A kind of vicarious experiencing testing also occurs regularly in the life and therapy of a couple with this mode of connection. Every time Jake observes Susie speak publicly, he does some disconfirming of his pathogenic belief. It is not as effective as it would be if he knew that *she* were actively struggling and testing, but it counts. (The couple process test is not applicable in this configuration.)

More should be said about the *crossover plan contradiction*, since it constitutes a very common form seen in therapy. Consider this example:

> Mary comes from a family situation in which she was physically, emotionally, and sexually abused and abandoned, and as a result developed corresponding pathogenic beliefs. In her relationship with Ralph, she transference tests to see if she will be rejected and abandoned by becoming progressively clingy, anxious, and demanding of reassurance. For a while, this is no problem for Ralph, who tends to comply with his pathogenic beliefs that he must be a rescuer and caretaker. However, Ralph had extraordinarily intrusive parents who severely traumatized him. He is working very hard not to comply with another pathogenic belief that he has absolutely no right to privacy. Eventually, Mary's pursuit of reassurance threatens to confirm this conviction, and Ralph defends by attempting to move away, generating more pursuit from Mary. Ralph's last ditch defense is to become angry, abusive, and rejecting, which then traumatizes Mary.

Here again there is a crossover between unpaired pathogenic beliefs, leading to a plan contradiction. In both of the previous examples, the

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partners are in "working" phase. In the following example, one member is not:

> Mel, who is in his 60s, has made several million dollars and, at this point in his life, wants to live well but carefully, obedient as ever to his pathogenic belief, "don't count on the future—conserve." Unfortunately, his wife, Lilah, 20 years younger and tortured by the pathogenic belief, "I don't deserve," is attempting to disprove this by expanding, developing, and spending money. Mel, made very anxious by this trend, tightens the purse strings, traumatizing Lilah.

Again, note the crossover effect between unpaired pathogenic beliefs. Finally, the following is an example in which neither partner is in "working" phase:

> George has pathogenic beliefs around the issue of trust, and carefully avoids much contact with people. He is initially very attracted to Trudi, until he finds that her pathogenic beliefs around being omnipotently responsible for other people force her to constantly rescue and bring them home. The resulting conflict is painful for both.

As always, the therapist's understanding of how the plan contradiction is created is central to resolving it. A common feature in the crossover type is the gross misinterpretation by the partners of the other's intent, e.g., George sees Trudi's behavior as hostilely invasive; Trudi views George as cruelly isolationist.

C. Noncompliant Choice by Avoiding the Transference Object and Disobeying Pathogenic Beliefs

This is an often still healthier mode of connection, where the partner(s) is able to avoid the pull to recapitulate a traumatic situation, and functions "as if" there were no pathogenic beliefs involved. This is not an entirely "conflict-free" mode, but does represent the ability to resist, covering a spectrum from "empty rebellion" (with powerful unconscious compliance) to resolution. Partners can at times be fooled into structuring inappropriate tests:

> Beverly, who believes she deserves to be criticized, is drawn to Rory, who presents a persona that seems impervious to put-downs. When Beverly tries a passive into active test, criticizing Rory, she is shocked when his shell caves in and he becomes defensively angry, thereby failing the test.

The closer Rory is to true resolution of the pathogenic belief, the more predictably he will pass the tests. A final observation regarding all these forms of "nonrepetition": it could be argued that the term is more descriptive than psychodynamic since, though these forms do not entail

the *direct* recapitulation of the parental relationship, they *do* ultimately relate back to the parents via the pathogenic beliefs.

D. Connections Based on Conflict-Free Areas of the Partners' Personalities, Unencumbered by Pathogenic Beliefs

Pessimists doubt that much of this occurs. Granting the impossibility of two perfect human beings coming together in a perfect fit, it *is* possible for conflict-free *areas* to connect. Indeed, this is responsible for much of the joy, spontaneity, effortless interest, and enjoyment in a partnership.

A broad range of modes of connection have been considered (see Appendix), stressing the unconscious "planful" nature of the choices involved. It should not be construed, however, that the plan is a *blueprint*. At any point in time, a person has a hierarchy of goals, and in choosing a partner, he will attend to some more than others. This is not an exact science, and perfect therapeutic fits are unlikely. Inevitably, certain resulting configurations of pathogenic beliefs are part of the package rather than unconsciously engineered—the frequency of crossover plan contradiction attests to this. Nonetheless, these configurations are then subject to the issues discussed.

THE THERAPEUTIC PROCESS

From the first moment of contact, the couple will be scanning and testing to determine whether the therapeutic setting is safe enough to even begin to work. Despite the sparse data, the therapist attempts to understand and pass these tests, at times having to adopt a "middle of the road" posture to avoid a more serious failure. And when some tests are inevitably failed, the therapist has an opportunity to model the appropriate shift of behavior, and if necessary, to make a reparation. The therapist with an elaborate and fixed structure of therapy is more likely to fail tests—the couple has to fit a Procrustean bed. A powerful aspect of Control-Mastery theory lies in its flexibility and case specificity. For example, although I generally prefer to begin by seeing a couple together, there have been times when the urgency and anxiety of the telephoning partner was such that I agreed to the request to begin with an individual session. Sometimes a couple will request, or I will sense from the description of the problem over the phone, that it is important to begin with a double session.

I generally suggest that we start with an "initial exploration" of one to several meetings (patients often find the clinical word "evaluation"

toxic; "exploration" better describes the mutuality of this encounter). I explain that at the end of the exploration, I hope to be able to make a recommendation regarding the advisability of ongoing work; whether I think we should work together, or if one of my colleagues would be better suited; and the pros and cons of concomitant individual therapy. I acknowledge that during this time, they will be able to get an idea of how comfortable they are talking with me. This middle-of-the-road course is almost invariably palatable; it helps avoid potential traumatic recapitulations of possessing them, rejecting them, or my presuming omnipotence or desirability.

Early testing and historical information about past trauma helps me make tentative hypotheses about:

> my optimal level of activity;
> how flexible I should be;
> how best to handle affects;
> how firm to keep the time boundaries;
> how to handle the issue of therapist transparency;
> how directive I should be in handling behavior in the session;
> the most conducive overall atmosphere for collaborative work.

We start from "where they are," and I hope to help the couple feel they can unfold their interpersonal life in the office.

Couples initiate therapy for a number of reasons. The mounting trauma of plan contradiction in its various forms is a common precipitant. This is often created by growth or regression in one of the partners, which destabilizes the system. The chronic pain of compliance to pathogenic beliefs is another; a couple's mutual avoidance of intimacy may eventually estrange them beyond tolerance. Or the partners in an abuser/abused couple may damage each other to the point where they call for help. Other maladaptive and symptomatic behavior may be present, for example, substance abuse, compulsions, sexual infidelity. Areas that may not be tied to pathogenic beliefs may become conflicted: incompatibilities of philosophy, values, and interests may emerge. Life cycle issues may intrude, with trauma from ageing, ill health, financial woes, departure of children, or employment problems.

Once the presenting crises have been provisionally handled (or at least identified), and the chief complaints noted, it is important to obtain a thorough family and developmental history from each partner. If they are able, there is great value in doing this in a conjoint situation. The therapist can create bridges, comment on differences, encourage comments from each partner, make initial interpretations, and generally enhance empathy. However, if the atmosphere is too

risky, for example, if the partners tend to use past information about the other as a bludgeon, the therapist may elect to have some individual sessions with each. Admittedly this entails a danger of creating lopsided alliances and at times hearing "secrets" that can impede the therapy, for example, a long-term, ongoing affair. Yet at times, having these private sessions can be crucial:

> After a first visit conjointly, Bill phoned me with an urgent request that I talk with him individually. There was something he felt was vital for me to know. After a brief discussion in which we both acknowledged the potential disadvantages of this secrecy, we elected to speak for some minutes over the phone. He revealed his lifelong homosexual fantasies and the intense shame he felt about them. He was greatly relieved by my empathic response to him and my matter-of-fact reaction to his fantasies. The conversation enabled him to share this with his wife a few sessions later. She handled it with sensitivity and tact, and the therapy took a significant step forward.

As the partners relate their individual histories, the therapist tries to infer the major trauma, the resulting pathogenic beliefs, and the developmental goals that were renounced. From this the therapist attempts to predict the tests the individual is likely to utilize in order to disconfirm the pathogenic beliefs, and the types of insights that will be most helpful. The couple therapist is aided in this formulation by the here-and-now data in the office.

It is then necessary to elucidate the nature of the *couple's* interaction. In the conjoint setting, the therapist obtains a history of the couple's relationship—how the partners met, what each was looking for, their initial responses to the other, what they liked and disliked, and how things have evolved. He also considers areas perhaps not tied to pathogenic beliefs, and life cycle issues. The therapist draws on his knowledge of the couple's *modes of intimate connection*, which may further his understanding of the motivation and ramifications of the relationship. He can begin to chart how the pathogenic beliefs of each partner "line up," and predict, as discussed earlier, the likely types of testing, and the insights that will be most helpful. Pathogenic beliefs can be impressionistically rated for degree of compliance, and the incidence and severity of plan contradiction anticipated. I call this chart the "Couple Pathogenic Belief Configuration," an important indicator of relationship pathology (a narrative couple case illustration, including a Couple Pathogenic Belief Configuration, is available as a supplement from the author by request). The chart may be sketchy at first and require significant modifications, but will eventually provide a detailed, rich, and useful picture of the couple's connection. I find it helpful to group the pathogenic beliefs under familiar headings, such

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as "rejection/acceptance," "neglect/protection," "mistrust/trust," "dominance/submission," "survivor guilt," "distance/closeness," "responsibility and omnipotence" and so on (Sager, 1976, coming primarily from a traditional analytic and systems orientation, has described couple parameters based on intrapsychic and biological determinants). Ongoing reference to this chart helps keep the therapist's behavior pro-plan.

Motivation for change is a crucial dimension of the couple's plan. Are both partners really interested in shifting the relationship? How ambitious are they? The degree of compliance to pathogenic beliefs is an index of difficulty in changing, but is not synonymous with motivation. The Couple Pathogenic Belief Configuration charts areas of pathology and potential for growth, but a couple will not tackle all of these at once, and may unconsciously elect to avoid certain areas. This avoidance may be temporary, gradually lessen over time, or represent a total renunciation. It is important for the therapist to have an optimistic attitude, but not aspire to omnipotence. Couples often present as demoralized and depleted. The therapist needs to provide energy and encouragement to work and explore.

Sometimes the prognosis for the relationship is obvious. A couple may present as basically solid, healthy, and loving, but want to work out some areas while they stay together. Another couple may clearly want to work through their prohibitions about separating. And still another couple may be in plan contradiction on this issue, with one partner committed to staying and the other to leaving. But there will always be situations which remain unclear for some time both to therapist and patients. The most perplexing situation will often arise when one or both partners suffer from considerable separation and/or survivor guilt. Consider this example:

> Kathleen felt omnipotently responsible for her depressed, alcoholic mother who needed Kathleen to be dependent upon her. Kathleen was also deeply affected by the lack of closeness between her mother and father. She developed pathogenic beliefs that she had no right to a life independent of her mother (separation guilt), or a happier life than she had, or a better marriage (survivor guilt). She married Stanton, a respected physician who was chronically depressed and sour like her mother, but not an alcoholic. However, he had some real capacity for fun. A major aspect of their intimate connection is a transference repetition. She repeats not only her dependency on her mother, but the unhappiness as well. She makes significant progress in therapy, and becomes progressively dissatisfied with the marriage. Stanton finds psychotherapy humiliating and is reluctant to work on disconfirming the pathogenic beliefs that underlie his depression. He complains of her constant criticism. They have two children that they both care deeply about. Kathleen is seriously considering divorce. How is the separation and survivor guilt

operating at this point? One scenario is that she has done enough work in disconfirmation to be able to feel that she deserves a partner with more potential for healthy interaction, and therefore divorce would be pro-plan, and staying on would be self-sabotage. But another plausible scenario is that she admittedly chose a partner with psychological difficulties, but also with some strengths, and she has been unable to notice these and nurture them *because* of her separation and survivor guilt. She focuses on the negatives out of loyalty to her mother. Her divorce in this scenario would be an act of compliance to her pathogenic beliefs and would be anti-plan. It will take time and ongoing exploration to determine what she truly wants.

To avoid potential conflict of interest, I generally remark early on to a couple that it is my hope and belief that therapy will be helpful to each of them and will clarify opportunities for healthier ways of relating, but that the process of exploration may indicate that they have a better chance for happiness and fulfillment by separating. Although some partners find this unsettling at first, most are reassured that I do not have an a priori "stake" in the outcome of the relationship.

At the end of the "initial exploration" we come to an agreement about the shape of future therapy. If the "biochemistry" is right, we will typically elect to work together. Often, one or both partners is already in individual treatment. If not, I frequently recommend it. Generally, I will confine my regular therapeutic hours to seeing them conjointly. I am particularly careful to do this with couples who are mistrustful, constantly blame each other, and present their "case" to me as a judge. However, in other situations where there is more mutual trust, less blame sensitivity, and the relationship seems very solid, I may become involved in individual work as well. The maintenance of an equal working alliance is very important. The relationships with the individual therapists are important, too. Ideally, I have permission from both partners to share information as the treatment process unfolds. Whereas the more traditional analytic model would tend to view this as diluting the transference and increasing the resistance, the Control-Mastery model sees this as potentially increasing the overall safety for the patients and facilitating the passing of tests and acquisition of insight. If the therapists feel collaborative and are in accord with the direction the work is taking, there is less chance for competition, misunderstandings, and the patients' feeling divided loyalties. I have found this collaboration very fruitful, whether I have been doing the couple or the individual work. There have been times, however, when either patient or therapist wished to keep the individual therapy sealed off, and the couple therapy still proceeded effectively.

As the therapy process evolves, the partners have the *task* of integrating their *individual* plans with a *couple* plan for how they will work.

This depends largely on the nature of the Couple Pathogenic Belief Configuration and their conscious and unconscious assessment of it. Issues of safety, danger, and interpersonal urgency will dictate the order in which issues are approached. Generally, the therapist follows the couple's lead, but there are times when it is important to intervene strongly and oppose or defuse a particular line of discussion, most frequently when retraumatization appears imminent. Partners frequently misjudge each other's capacities, and find themselves in plan contradiction.

The couple can *focus* on a number of areas: the "here and now," their current life outside the office, their past experience as a couple, and their previous histories and families of origin. Couples show different styles and capacities of focus. I find it a good prognostic sign for individual growth and couple clarity if they are able to explore and share each other's family histories. They may focus on process or content, while the therapist attempts to maintain a useful balance. Another positive predictor is the partners' increasing ability to comment on their own process. At times the focus is on one partner, essentially involved in individual psychotherapy, while the other is (hopefully) listening empathically and perhaps contributing. At other times the couple is interacting, with the therapist commenting as necessary, and at still other times the process and focus is triadic (e.g., when the therapist deals with plan contradiction tests).

The *therapist's task* is to help the partners disconfirm their pathogenic beliefs and clarify their relationship by facilitating the passing of tests, the acquisition of insight, and in general maintaining a pro-plan atmosphere. The therapist's levels of activity, directivity, and transparency will be dictated by the specifics of the couple. At times the therapist may be helping the partners develop better communication skills (e.g., translating, modeling empathy, interrupting pathogenic processes). At other points he may be making interpretations, passing tests, monitoring boundaries, collaboratively exploring, brainstorming, or, if appropriate, laughing with the couple over some absurdity of modern life. A Control-Mastery approach always encourages the development of the therapist's individuality and creativity. Innovations are less apt to be "wild" since they can be provisionally checked out internally by the therapist asking himself: "Would this intervention be pro-plan?" Throughout treatment, the therapist continues to refine his understanding of the partners' plans, and to shape his behavior accordingly. This pro-plan behavior is at the heart of a successful working alliance. The longer and stronger the working alliance, with its history of passed tests, the greater tolerance the patient will have for the occasional failed test.

The *pace* of treatment is extremely important. Therapists unfamiliar with the tenacity of pathogenic beliefs and the powerful role of unconscious guilt may find themselves encouraging patients to move ahead faster than they can tolerate. The result is a "backlash" of guilt, shame, and other unpleasant affects. In the couple situation, this is particularly problematic. Consider this example:

> Reuben and Stacey share pathogenic beliefs involving separation guilt toward their mothers. In a couples session, the therapist exhorted Reuben to take a stand against his mother's plea for him to visit her. He complied with the therapist, but suffered a backlash of guilt, temporarily becoming even *more* responsible for his mother and discouraging of Stacey's own attempts to separate. Stacey, who was vicariously encouraged by Reuben's apparent forward movement, was traumatized by his radical shift. (The effect on Stacey is the same as if Reuben had mounted a passive into active test of her. We have seen how this kind of testing between partners sharing the same pathogenic belief routinely leads to plan contradiction.)

Even under the best of circumstances, there is some backsliding as people move forward. It is useful for the therapist to anticipate this in order to minimize demoralization and trauma. Honoring the different growth rates, compliances, and degrees of pathology is also important, while still encouraging both partners to work on whatever they contribute to the problem area. The couple's forward movement is limited by the "slower" partner.

Survivor guilt is a ubiquitous force in modern life; almost all of us have experienced it to some degree. Yet in therapy it can be very elusive. Patients suffering severely are often totally unaware; it is simply the atmosphere they breathe. It is a "great imposter," and many couple conflicts, apparently due to other issues, are actually fueled by survivor guilt. Initially patients may be able to see only the footprints and cannot give more than intellectual credence to the concept. Some patients resent this interpretation at first, feeling disqualified and robbed of the certainty of their conscious feelings. Actually experiencing the guilt as the underlying pathogenic beliefs are explicated is both relieving and painful.

Control-Mastery theory can offer a broad perspective concerning the role of *affects* in couple therapy. Consider, for example, the functions of *anger*: anger may appear as a *defensive response* to imminent or actual trauma. This may be adaptive or maladaptive depending on the degree and context. Anger may function as a *test*. For example, a patient who came to believe that her anger provoked parental rejection may mount a transference test to see if her partner can tolerate these feelings. Or she might turn passive into active, and be very rejecting

of any irritability on the part of her partner, and notice if this shuts down his feelings. A couple sharing the same pathogenic belief about anger might couple process test the therapist. Or one partner might remain silent and benefit from vicarious experience of the partner's test. Or finally, the partners might present the issue of anger to the therapist in a plan contradiction test. A partner may manifest anger out of a *guilty identification* with an angry family member. Anger may present as a *compliance* to a pathogenic belief (e.g., a man is "characterologically" angry because his mother constantly remarked, "You're an angry little boy!"; he thus inferred that she wanted him to be angry). Or the anger may represent a *defiance* of a pathogenic belief (e.g., a normally submissive woman who struggles with the pathogenic belief that she has no right to express anger fights back against the belief and becomes enraged at her partner). What about the possibility of anger representing the *gratification of an aggressive drive* (e.g., sadism, rage)? Therapists basing their clinical thinking on Freud's earlier work assume that this behavior is a selfish (narcissistic) infantilism unaffected by reality and regulated primarily by the pleasure principle. Control-Mastery theory allows for inborn impulses, and the healthy gratification that comes from angrily protecting oneself, but holds that symptomatic, maladaptive, angry behavior is unconsciously maintained by pathogenic beliefs. In dealing with anger and other "negative" affects in the session, the therapist makes a great effort to translate the interaction in order to show positive intent wherever possible, and to demonstrate the family history that makes this behavior understandable and less wounding to the partner.

A frequent trigger for escalating anger is the "Rashomon" phenomenon, wherein each partner has a significantly different memory of an event or interaction. This often presents as a plan contradiction, and the therapist feels pulled to become judge and jury. Rather than yield to this, the therapist helps the partners understand why, given their histories, these kinds of misunderstandings are inevitable. He empathizes with how difficult it is for each partner to imagine that he or she is viewing the experience through his or her own specific lens, and helps both of them to work toward accepting this relativity. The adaptive intention should be pointed out, and eventually the role of the underlying pathogenic beliefs.

As the therapeutic process proceeds, the prognosis for the relationship should become more clear. Among the many factors are: the degree of current positive regard; areas of healthy connection; history of positive experiences; motivation; hope; the Couple Pathogenic Belief Configuration; and the prevalence and intensity of plan contradiction, current pain, symptoms, maladaptions, depletion, separation and survivor guilt issues, and life cycle issues.

The point of appropriate *termination* of therapy is often more difficult to assess than in the individual therapy situation. There are a number of scenarios. The partners may feel they have essentially accomplished what they set out to do and, if the therapist agrees, a termination phase is entered. There is always a testing component to the subject of termination. The therapist may feel it is premature and point this out, which is reassuring to partners struggling to believe that they had a right to get as much as they could from therapy. Or a therapist may sense that it is time to finish, while the couple remains in therapy out of separation guilt. In this case, he may bring up the subject and encourage departure. However, the partners may have somewhat different "end points," and this may have to be negotiated. The most traumatic difference, of course, is where one partner decides to end the relationship while the other wishes to continue to work. The therapist needs to attempt to protect both partners, while allowing that either partner ultimately has the right to unilaterally call a halt to the relationship. Frequently, termination applies only to the couple modality, and they will continue in their individual work. Or the couple work may segue into individual therapies. Here, as in all other areas, the therapist attempts to help the partners make decisions that will best further their plans.

APPENDIX

Modes of Intimate Connection Between Partners

I. REPETITION
   A. Transferring—choosing the transference object.
      1. Transferring in compliance with pathogenic beliefs, often involving separation, survivor, oedipal, and other guilt.
      2. Transferring as "will to master," to disconfirm pathogenic beliefs, often involving separation, survivor, oedipal, and other guilt.
      3. Transferring as gratification.
   B. Turning passive into active—identifying with the transference object.
      1. Turning passive into active in compliance with pathogenic beliefs, often involving separation, survivor, oedipal, and other guilt ("guilty identifications").
      2. Turning passive into active as "will to master," to disconfirm pathogenic beliefs, often involving separation, survivor, oedipal, and other guilt.
      3. Turning passive into active as gratification (includes "identification with the aggressor").

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II. NONREPETITION
   A. Compliance to pathogenic beliefs without choosing or identi-fying with the transference object.
      1. Choice of partner based on *similar areas* of pathogenic beliefs (same or polarized) out of an unconscious assessment that working to disconfirm is too dangerous.
      2. Choice of partner based on *different areas* of pathogenic beliefs out of an unconscious assessment that anything more ambitious than the vicarious realization of goals is too dangerous.
   B. Noncompliance to pathogenic beliefs without choosing or identifying with the transference object.
      1. Choice of partner based on *similar areas* of pathogenic beliefs (same or polarized) out of an unconscious assessment that the greater likelihood of empathy will aid in the work of disconfirmation.
      2. Choice of partner based on *different areas* of pathogenic beliefs out of an unconscious assessment that opportunities for healthy identification and passed tests will aid in the work of disconfirmation.
   C. Noncompliance by avoiding the transference object and disobeying pathogenic beliefs.
   D. Connections based on conflict-free areas of the partners' personalities, unencumbered by pathogenic beliefs.

Notes: (1) Many modes of intimate connection may coexist, and change over time.
         (2) "Nonrepetition" is more descriptive than psychodynamic, since all categories except for IID relate via pathogenic beliefs to the adult caregivers.
         (3) The modes of connection need not be between "whole partners."
         (4) IIA1 and IIB1 represent the polarities of renunciation and hope; similarly, IIA2 and IIB2. A spectrum exists, and partners often shift over time.
         (5) IIC describes a spectrum from "empty rebellion" (with powerful unconscious compliance) to resolution.
         (6) These modes are usually partially or totally unconscious.
         (7) "Compliant" and "noncompliant" are not absolute terms, and are used to indicate the predominant motive. *Both* exist to some degree in virtually all intimate connections.

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