

A TEMPLATE MODEL FOR A LECTURE

CONTROL THERAPY

*Helping individuals gain a positive
sense of control in their lives*

The last lecture

Deane H. Shapiro, Jr

Research and Teaching Funds Available: The Control Research Foundation Fund, through the Orange County Community Foundation, provides seed grants for research, and funds for lectures and classes on Control Therapy. Please go to [controlresearch.net](http://www.oc-cf.org/) or contact the OCCF at <http://www.oc-cf.org/> Control Research Foundation Fund.....for more information.

* * *

If you can keep you head when all about you are losing theirs...

*If you can stay calm and in control when those around you are
panicking and losing control, then.....*

clearly, you don't understand the situation!

(with apologies to Rudyard Kipling)

* * *

A PERSONAL NOTE: September, 2014. Please consider this "last lecture" a metaphorical message in a bottle, dropped into the waves of humanity, hopefully to be found and shared in a way that helps decrease suffering and increases wisdom, compassion, and healing.

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A Template for a lecture on
CONTROL THERAPY
*Helping individuals gain a positive
sense of control in their lives*

INTRODUCTION: Goals, process thoughts, time frame example

The material below is intended as an introductory lecture template for those in the health and healing professions (psychologists, psychotherapists, physicians, nurses, and, with some modifications, educators) as well as trainees in these fields summarizing over three decades of work on the Principles and Practice of Control Therapy . Control Therapy teaches the role of human control and self-control/self-management/self-regulation in physical health (wellness/behavioral health and self-care), mental health (with specific control profiles of depression, anxiety, eating disorders, and several other clinical populations); and relational health (e.g., couples, parent-child, work settings).

THE GOALS OF THIS LECTURE ARE TO:

1. Provide an overview of the main points of the principles and practice of Control Therapy, and its relationship to related “constructs” in psychology
 - *development, theory, postulates, definitions
 - *individual assessment including: a person’s unique Control Profile (sense of control, modes of control, agency of control, desire for control), through a multidimensional Control Inventory (SCI), with well-established reliability and validity empirically tested with thousands of individuals in research ranging from content analysis of psychotherapy, patients to neurobiological correlates with PET scans.
 - *examining assaults to sense of control, control stories and dynamics
 - *matching control-enhancing techniques to a client’s control profile, goal, and area of concern, using an assertive/change mode of control; a yielding/ accepting mode of control; or a combination of the two; considering self as agent, others/Other as agent
 - *teaching techniques to enhance self-efficacy beliefs; overcoming resistances to maximize adherence and compliance
 - *a systems model to evaluate effectiveness at each phase: assessment, goal-setting, intervention selection, teaching of interventions; to optimize chances for success in re-gaining and maintaining a positive sense of control.
2. Give therapists an opportunity to explore how the role of control in general, and CT in particular, may be applicable to their own preferred theory of personality, theoretical orientation, and system of psychotherapy. Detailing the core competences of each phase of Control Therapy
3. Raise questions that may be of interest in going forward in terms of theory, research, and practice on control.

PROCESS THOUGHTS

Personal teaching style. There are many different ways to give a talk, based on a person's teaching style and the audience. Therefore, the material below seeks primarily to provide an "essence" of the content that would be helpful to convey regarding CT. There are also some "process" suggestions, which may or may not be helpful. For example, at the start of the lecture, one could just begin with "This is a talk about the Principles and Practice of CT"—and lead directly into the discussion of Point One: What is Control Therapy: An Overview. A second approach would be to say we are going to be discussing the Principles and Practice of Control Therapy today, but since CT is not just about "others' lives" but our own as well, there will be some questions involving self-reflection interposed throughout the lecture I'd invite you to consider as a way to see more personally the relevance and importance of this topic.

Longer and shorter readings. This material summarizes in one place salient material from 1) the book Control Therapy (where a more fulsome discussion of theory; as well as detailed case studies on Control Therapy with anxiety; with lifestyle concerns; and with relationship can be found). 2) the Shapiro Control Inventory (SCI) Manual (where more detailed information on empirical studies of reliability and validity of the SCI can be found); and 3) the Control Therapy Training Manual where, based on the model of 'psychology from the inside out', the first three modules attempt to "teach" the principles and practice of Control Therapy such that the student becomes both his/her own therapist and client. All three of these additional resources are available at no charge at controlresearch.net.

Further, depending on the presentation format, if the lecturer/ teacher wishes to offer a short hand out on Control Therapy, the following provide an overview of Control Therapy (in order of length!) Attachment A of the Control Research Foundation Fund: Control Therapy (two pages); three pages in the Control Therapy Training Manual (FAQ from lay public/client (p. 3), by students, trainees (pp.13-14); a four page summary in the Encyclopedia of Psychology (Wiley); a 15 page summary in Appendix 11 of the Control Therapy Training Manual. All can be found and read or downloaded at no charge at controlresearch.net.

Humor, over inclusive, and questions. In this lecture, there are also some cartoons and efforts at "humor" which the instructor may or may not find helpful (or funny!). Again, clearly, the lecture will need to be tailored to the audience. This "summary lecture" therefore may seem "overly inclusive" (e.g., it includes foundational research on reliability and validity studies for the SCI) which may have only modest relevance to say, a clinical practicum class. The level of inclusiveness is intentional so that the instructor may choose those aspects which are most salient to a particular audience. Finally, some instructors may like to take questions at any time during their talk, others toward the end. Some questions that may come up and/or might be of interest are listed at the end of the lecture, as well as "concluding" comments that the lecturer may or may not feel appropriate depending on the audience.

TIME FRAME EXAMPLE. Although, as noted, each lecturer will construct the talk based on his/her experience, as well as audience, here is a suggested model for a sixty minute presentation:

What is Control Therapy?.....	8 minutes
Intro, Theory, Postulates, Definitions, Phases	
Phase One: Assessment and goal setting.....	16 minutes
Assessment.....	8 minutes
Listening to control speech, stories, Control Profile	
Goal Setting.....	8 minutes
Addressing challenges in goal setting: e.g. Control Mode Dialogue; decision making process	
Phase Two: Interventions.....	16 minutes
Matching technique to Control profile to goal...	
5 step process; Assertive/change mode	
Yielding/accepting mode; Control Mode rehearsal	
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Systems Model, Therapist Competencies.....	8 minutes
Frequently Asked Questions,	10 minutes
Concluding Remarks.....	2 minutes

Note: A short table of contents is provided (p. 2) to give an overview; and a longer several page one with more details follows. The “lecture” itself beings on page 15.

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Competence teaching the 5 steps for the assertive, change mode of control

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ADDITIONAL COMPETENCIES:

Teach clients skills in integrating the two positive modes of control, and to do so in a way that honors and respects the client's preferred learning style.

Help the client maintain compliance.

Monitor the process of therapy with a systems model

Therapeutic relationship:

Has a range of interpersonal verbal skills, from yielding to assertive,

and can skillfully choose the most effective style for a given circumstance

Is able to address areas of therapist/client disagreement, "power struggles"

(transference or counter- transference) with awareness and skill.

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- *The First Comparison, Contrast, and Integration of meditation and behavioral self-control techniques.*
- *Positing, Development and Empirical investigation of four modes of control: positive and negative aspects of the assertive/change and yielding/accepting modes.*
- *Control Mode Dialogue*
- *An integrative theory of human control*
- *SCI Control Profile: 3rd generation multidimensional inventory*
- *Matching Control Profile to Control Enhancing Interventions*
- *Systems Model of Control Therapy.*
- *Content Analysis: “Deconstruction of Techniques”. Control Mode Rehearsal*
- *Control as Common Link in Human Behavior*

CAN CONTROL THERAPY COMPLEMENT OTHER APPROACHES?

- Relevance of Control in Different Therapeutic Approaches*
- An overview of contemporary control-related constructs*
- Control therapy: session breakdown by phases-- aspects in common with other therapeutic approaches*

THERE ARE SO MANY TECHNIQUES. ...

- How to know which technique to choose*
- Is there any psychotherapeutic technique that is not compatible with CT?*

DOES CONTROL THERAPY REQUIRE THAT EVERY CLIENT’S PRESENTING PROBLEM BE FIT INTO A “BOX” IN WHICH CONTROL IS THE MOST SALIENT ISSUE?

- Even if control issues exist, is it always necessary to discuss the issue in control terms with the client?*
- A further note on theory:*

DIDN’T YOU SAY IT WAS BEST TO TEACH A TECHNIQUE TO THE CLIENT THAT WE HAD PERSONALLY PRACTICED? HOW CAN WE AS THERAPISTS PERSONALLY PRACTICE ALL TECHNIQUES

- Does Control Therapy have a bias toward the assertive change mode of control?*
- Does Control Therapy have a bias toward the yielding, accepting mode of control?*
- Life as a developmental dance?*
- A further (and final) comment on theory.*

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- The breath cycle revisited*
- The limits of human control, the importance of trying, compassion as a context.*
 - Facing suffering—within and without*
 - Healing the world;*
 - Touching the human soul.*

WHAT IS CONTROL THERAPY: AN OVERVIEW

Slide

- *Think of times when you have had a positive sense of control in your life.*
- *What does a positive sense of control feel like? How do you “know it”? In your body? Your thoughts? Your feelings? Relationally? At work?*

The greatest benefits that psychological treatments can bestow [are] the tools with which to cope effectively with whatever future situations might arise. To the extent that treatment equips people to exercise control over events in their lives they are less vulnerable to distress and debility.

--Albert Bandura

(described as one of the most influential psychologists of all time)

--Start worrying. . . details to follow.

My grandma Nana's view of life....

Control Therapy is based on the premise that all of us want to have a positive sense of control about our lives and feel happier and healthier when we do. According to control theory, one of our greatest human fears is losing control, and one of our strongest motivations is to have a degree of control over our lives. Therefore, the reason individuals seek counseling is often because there are one or more areas of concern in their life where they feel things are not in as much control as they would like, and where despite their best efforts, those areas are causing them pain and suffering. These areas could include physical health, work, relationships, and personal issues, such as our habits, our feelings, and our thoughts.

Each of us—client, student, teacher—also knows from first-hand experience that we receive assaults to our sense of control as we go through life. All of us have hardships and wounds in life, a myriad of potential specific content concerns that may cause us stress and heartache on an individual level. For example, in the Chinese painting below, each monkey is looking at what we may assume to be some “stressor” outside the picture. Although the content may change for each of us, there is always some stressor metaphorically “out there” (e.g., getting back “results” from the doctor; a challenging financial situation; relationship issues; and loss, such as death or divorce). The monkey in the foreground has its mouth open (arrgh!), eyes wide open looking fearful. The monkey in the background at first glance might not seem to be seeing the same stressor, yet if you look careful, you'll notice the eyes are focused, and the fist is clenched in a “ready position” if need

be. Although stressors “out there” can cause us to feel fearful, we can also develop the centered and calm readiness of the background monkey when we confront these inevitable life challenges.

Start slide



End slide.

Some suffering in life is what we might call unnecessary, brought about by poor choices, lack of skillful responses to events, and/or not having learned appropriate cognitive, emotional, and behavioral self-regulation strategies. However, some suffering is necessary and unavoidable, part of the inevitable existential suffering inherent in being alive. Much of this suffering involves dealing with situations that are outside of our active control--universal root issues—the messengers Buddha called them: illness, aging, death-- that all humans have to face.

The human species can have an extraordinary capacity for coping and resilience, and an amazing capacity to find ways to act, think, and feel that make difficult, even horrible losses and challenges seem bearable. Responses to stress and challenges are both personal and cultural, and there is no simple or single way or “right solution.” Therefore, it would be simplistic, if not foolhardy, to try to suggest a unitary “best wisdom” for dealing with adversity and seeking to gain or regain a sense of control.

Within that context of individual variation and matching control enhancing strategies to the person and situation, CT believes that each of us has an ability to

Slide

- *learn to pause, reflect, consider and reconsider our thoughts, actions, and behavior*
- *learn to choose, if we wish, to interrupt and override reflexive cognitive, emotional, and behavioral impulses and sequences*
- *Learn to create alternative ways of responding---behaviorally, emotionally, and/or cognitively -- that we feel are more in our (and*

others') best interest, and which help us gain, or regain a positive sense of control

End slide.

The Goal and Process of Control Therapy: Theory, postulates, definitions.

The goal of Control Therapy is to help people gain or regain a more positive sense of control about their lives through their actions, thoughts, emotions, and awareness.

Control is defined as the ability to cause an influence in the intended direction, and ***sense of control*** as beliefs and expectancies, as well as the attainment of that “intended direction” through self and/or others as agent, and through using either assertive/change and/or accepting/yielding modes. ***Desire for control*** is the motivational vector for seeking to gain, maintain, and/or regain a sense of control.

Further, if you look at how we humans attempt to positively and nuancedly cope with necessary and unnecessary suffering, in general it involves taking the *alphabet of universal building blocks we as humans have available to us---our thoughts, feelings, body, behavior—and utilizing them in some combination of the positive assertive change and the positive yielding, accepting modes of control; and with some combination of self efforts and other efforts.*

In so doing, we can develop the “wisdom” to recognize what we can actively control “with courage”, and to accept “with serenity” what we cannot. Variations of this balance allow us to deal with both root and content issues as resiliently and skillfully as possible

The meta goal of Control Therapy is to help us reduce and minimize both necessary and unnecessary suffering and to maximize ways of gaining and regaining a positive sense of control.

After reviewing the history of control constructs in both psychology and philosophy, and based on the bio-psycho-social theory of human control, three postulates were developed that undergird Control Therapy. We will be discussing them in a bit more detail in a few minutes showing how they relate to control theory (and your own theories of personality and systems of psychotherapy). For the moment, however, it can be helpful to list the three postulates and show in overview form how they undergird the goal and process of Control Therapy

slide

- 1. Gaining and maintaining a sense of control is a major motivational force across the human life cycle.***
- 2. There are both high and lower levels of control-related goals, desires and strategies by which people seek to gain a sense of control***
- 3. There are individual differences with respect to how and why control is sought***

end slide

As a basic premise, Control Therapy would argue that issues of control (and self-control) exist, whether or not we recognize them explicitly (**POSTULATE ONE**).

Control Therapy didn't create control issues; rather, it helps clients to recognize what is--the "control factor."

POSTULATE TWO, building on Postulate One, notes that *control issues can exist even when a person says they don't, or doesn't recognize them*. Thus, there are times when a sense of control in and of itself may not be positive—e.g., when it is maintained through denial, defensiveness, avoidance of issues, a self-deceptive illusion of control. Recognition of the possibility of a detrimental sense of control is critical to begin the process of actually gaining (or regaining) a higher level of positive control (**POSTULATE 2**). Several examples of this are given in the book *Control Therapy* and the *Control Therapy* training manual: e.g.,; the mother-in law who says she's not being controlling in just "helping" her future daughter in law plan the wedding; the person who said he didn't have a problem with alcohol because he didn't drink before 9 a.m; the vignette about a person who even though s/he uses wires and twists them over the limbs of the plant to stunt and shape its growth, says he is "not controlling the bonsai" (*Note to lecturer*: you may choose to give other examples here from your clinical experience.)

Following from **POSTULATES 1 and 2** is that *denial, defensiveness, and other misuses of control can be motivated by the very desire to be (or appear) in control*. Because it can be uncomfortable to admit when we're actually "out of control" and need help we may self-deceive, and say we're really in control or there is no problem, when there really is. (**POSTULATE 1**).

Recognizing that each person is unique, and there is individual variation (**POSTULATE 3**), the task, then, is to help the client move from less healthy and maladaptive ways of seeking to gain and maintain control to healthier and more skillful ways (again, within an empathic context): e.g., how does this concern affect your sense of control? how do you normally try to gain a sense of control in relation to the presenting concern; how is that working for you?; would you be willing to explore other ways that help you to further regain a positive sense of control? (**POSTULATES, 2,3**).

The meta-goal of Control Therapy, therefore, is, as noted, to help individuals achieve a positive sense of control. Sometimes this can best be achieved through the goal (and practice) of an assertive/change mode; sometimes through the goal (and practice) of a yielding accepting mode; and sometimes through a combination of both; sometimes with self-agency, sometimes with other agency. The Control Therapy approach believes in the importance, where appropriate, of integrating the two positive modes: wedding active change methods with a healthy focus on acceptance; self and other agency To do this, Control Therapy teaches clients how to formulate goals and develop interventions that are matched to the specific client's unique Control Profile and clinical concern in a way that maximizes the chance of therapeutic success in gaining or regaining a positive sense of control. (**POSTULATES 1, 2,3**)

*

*

Control Therapy has its roots in self-regulation strategies, both Western (e.g., behavior self-control, cognitive therapy) and Eastern (Zen Buddhism and Vipassana, mindfulness meditation). which was first written about in the mid 1970's (American Psychologist, 1976). Although this panoply of techniques from different psychological and religious/spiritual traditions held promise, what was needed was

systematic analysis and integration at both the theoretical and clinical levels. Control Therapy attempted to do exactly this, refining and integrating the wisdom and techniques from Western and Eastern traditions, to develop a systemic and wholistic theory and integrated therapeutic approach. Let us look at each in turn.

CONTROL THEORY.

Slide:

It is the theory which decides what we can observe

Einstein

A geologist without a theory is just a person counting rocks

Darwin

- How much choice and free will do you believe individuals (or you as an individual) have over thoughts, feelings, and behavior?
- Where is the primary source of control in our life: the environment, the person's choice; biology? When things are not in control, what is the primary cause?

End slide

The control story of the two wolves.

slide

A native American granddaughter/grandson says to his/her grandfather/grandmother :

"I feel like I have two wolves inside me.

One is a good wolf (kind, gentle, caring) and one is a bad wolf (greedy, mean, angry).

Both are battling within me. Which one wins?"

To which the grandparent replies: "The one you feed." ☺

end slide.

Control Story (One aspect): your views of your preferred Personality Theory, System of Psychotherapy and the role of control in each.

Each school of psychotherapy has to address the issue of human control. Classical Freudian, id psychology said we are governed by "unknown and uncontrolled forces," an innate amoral id. Freud argued that the function of the ego was to learn to give individuals greater control over (i.e., rein in) these powerful pleasure-seeking and aggressive id impulses: "Where id was, ego shall be..."

Ego Psychology/ Humanistic (Client Centered) systems of therapy focus on the innate self-actualizing "good" nature within us. Existentialists see humans as more a

“tabula rasa” –existence precedes essence. Yet, like humanistic approaches, existentialists see humans as having the right and responsibility to be in control of their own life, and focus on personal choice, individual freedom, and self-determination.

Radical behaviorism emphasized that humans have significantly less control over their own behavior than they believe and argue that external or environmental factors rather than unconscious forces are what govern the course of humans' lives. Cognitive-behavioral schools have a personality theory similar to existentialists, and therefore focus on learning: what skills are improperly learned, what need learning, and emphasize self-control, recognizing cognitive “traps” of mental habits and relearning cognitive and emotional skills.

Transpersonal approaches highlight mastering one’s unskillful emotions, controlling attention--the “dancing monkey” mind, and, at the same time, seeing limits of an egoic “controlling” self.

All of these “theories” can also be understood as “stories” about that psychologists and theorists choose to “tell” about human nature.

In the Native American story above, what school of psychotherapy does the grandparent’s answer best represent? What control story is the grandmother telling?

How does the grandparent’s answer fit with your own view? Questions to explore: Do you believe we have good within us (i.e., the good wolf?; (If so, is this good innate? learned? i.e., nature/nurture); what about “bad”/unskillful qualities (the bad wolf?) Again, are these innate, learned? Which theories/systems of therapy do these views about the nature of goodness/badness represent? In each of these views, what would be the role of “personal control”?

What about the role of learned skills, existential choice? “ie., the one you feed.” How do we “know” which one to feed? Are we initially amoral (Freud’s id) and we have to learn skills; might we have learned “bad” habits, poor skills (e.g., cognitive behavioral); do “should, oughts” of society get in the way of “authentic choices” (existential, humanistic)?

Note the dimensions of self-control mentioned or implied in this story: “*awareness*” of the two aspects of self; “responsibility” for “choice”; *motivation* to choose the *goal* of the good wolf, and skills and determination to follow through.

How much free will do you believe we humans have to “control ourselves?” and make personal choices regarding our cognitive, emotional, behavioral habits?

How have you formed your view, your “story”(e.g., personal experience, self-reflection, scientific data, comfort level)? Are you an inductive thinker: i.e., look at several facts, and then draw an overarching theory? Are you a deductive thinker, who likes to create an overarching theory,--big picture-- and then see how well the data “fit” the theory (and then modify, refine the theory accordingly?)

Each of us may have different styles and preferences along an inductive/deductive continuum. Yet, both styles are important in theory development in general, and in particular, a theory of human control. Reflecting on your style of theory development can help you explore more nuancedly the theory (and stories) you evolve and believe regarding how control affects the way you see the client, assess their concern, and understand the barriers to human change and success. The approach taken here to Control Theory has been a combination of the two. The parts can help refine by data and

empirical observation the theory and make sure the “whole” is broad enough to encompass the area of inquiry under investigation. the theory can give an overview, understanding, and context to the parts. In essence, the whole and parts help inform each other.

Different psychological theories and constructs regarding control.

The construct of control and theories about control are ubiquitous. In *Control Therapy*, Table 1.1 (pp 8-9) there is an historical overview of the construct of personal control, (will, self-control) from the Greeks through Aquinas, Kant, Hegel, Hobbes, Locke, Hume, Spinoza, Descartes to William James. Below are two tables, one of uni-reciprocal and omni deterministic biopsychosocial models of control; followed by an overview of contemporary control-related constructs (References are all detailed in *Control Therapy*).

Theories of the source of human control range from radical behaviorism, which suggests that we are controlled by our environment to biological determinism, which argues that there is “control upward”—biology (genes) determine actions, thought, and behavior. Existentialists argue that behavior is a function of the person, and that individual is responsible for choosing and developing control. In addition to each of these “uni determinism” models, there are views which suggest that control is a function of a mutual interaction between the individual and the environment; that consciousness can influence biology (reciprocal determinism); and even that consciousness, the environment, and biology are all important as sources of control (omni-determinism).

To this we need to add developmental-life cycle and gender socialization factors. Control-related desires and choices occur within both developmental and social contexts and can therefore be influenced by factors such as gender socialization; sex-based biological hormonal differences and particular developmental stages.

Start slide

UNI-, RECIPROCAL, AND OMNI-BIOPSYCHOSOCIAL MODELS OF CONTROL :TABLE 1.3

Radical Behaviorism

Behavior as function of environment; control determined by environment (Skinner, 1953, 1971; Goldiamond, 1965) within limits of nervous system.

Existential Will

Behavior as a function of the person; person chooses and is responsible for developing control (May & Yalom, 1989; Bugental, 1976) within existential limits and givens.

Biological Determinism

Control upward: Biology determines actions, thought, behavior (Sperry, 1988; Wender et al., 1982; Wilson, 1975; Dawkins, 1985; Crick, 1993; Churchland,1995).

Reciprocal Determinism

Control as a function of mutual interaction between individual and environment (Bandura, 1978; Delgado, 1969); consciousness can influence biology (Pribram, 1988; Sperry 1985,1988); control as emerging properties of brain function (Sperry, 1985, 1988).

Omni-determinism

Control as a function of multiple variables; analogous to a systems/ cybernetic model (Minuchin, 1974; Schwartz, 1983)

End slide.

Where do your views on the “source” of control fall within the above framework? Our views of these topics may be influenced both by scientific theory and research, as well as by our own experiences and resultant control stories. Try to pinpoint your beliefs (and the reasons for them) as carefully as you can. Take a few moments to reflect on where you think these views came from. How much are they based on prior life experiences? How much on research data? How much on a theory of human nature that you feel congruent with?

As can be see below, different models of control are reflected in different therapeutic approaches.

The biopsychosocial theory we propose involves “reciprocal” influences. Biology and genes have a causal role (what Nobel Laureate Roger Sperry called “control upward”: the smaller controlling the larger: behavior, thought, etc.). We also believe that culture and environment have a causal role in our behavior and thoughts (e.g., America has been called a “mastery” culture involving self-determination, individual effort, and standing forth [positive assertive values]; whereas Japan has been called a fitting-in culture involving group cooperation and getting along). There is certainly “a” truth in that different cultures can affect our views, values, and behavior.

However, by learning certain skills, consciousness and individual choice also can be causal (Sperry’s “control downward”) and in turn can have an influence on our biology and culture. Thus, though there are biological and genetic influences on control, human will and consciousness, values, and beliefs can be causal determinants affecting both biology and environment. Humans can learn through "attentional training" and values clarification to exercise choice through both self-control and environmental control. To do so, humans need to recognize (become conscious of) the power of biopsychosocial forces and begin to make control choices more consciously. It is important to become aware of automatic instinctual responses, and develop the capacity to practice higher levels of conscious choice regarding our control-related goals, desires and strategies.

The theoretical basis of Control Therapy builds upon and integrates several literatures including self-efficacy, learned helplessness and optimism; competence; dyscontrol; reactance; will to meaning; will to superiority; cybernetic feedback models and disregulation; internal and external locus of control; self-determination; and self-control/delay of gratification.

Note to lecturer: This slide is meant to give an overview of different approaches and how control is involved. It may be helpful to just give a few examples from different perspectives, to make that point.

Slide.

AN OVERVIEW OF CONTEMPORARY CONTROL-RELATED CONSTRUCTS

Analytical

Freud (1923): Id governed by uncontrolled forces

Hendrick (1943): Will to mastery
Adler (1964): Will to superiority
Rank (1950): Psychology of will and will therapy Farber (1966):
Will training; theories of will White (1959): Concept of
competence
de Charms (1968): Pawn and originator Menninger (1963):
Dyscontrol and mental health
Mahler (1968) and Klein (1932): Control through differentiating from
environment; Object relations

Cognitive/Behavioral

Bandura (1977): Self-efficacy
Rotter (1966): Internal external locus of control Seligman
(1975): Learned helplessness
Mischel (1972): Control as delay of gratification Pavlov
(1960/1927): Freedom reflex ICobasa(1979):Hardines
Kaufer (1979): Personal control
Mahoney, Thoresen (1974), Cautela (1969): Self-control
Beck (1976), Meichenbaum (1977), Lazarus (1981), Ellis (1962):
Cognitive approaches Schwartz (1983):
Disregulation

Humanistic/Existential

Schutz (1958): Control in interpersonal behavior May (1961):
Control as power, choice
Rogers (1951): Self-determination
Frankl (1980): Will to meaning
Becker (1973): Death as loss of control

Transpersonal (Astin & Shapiro, 1997)

Zen (Smith, 1983):Self-power and other power
Chuang-Tsu (Lao-tzu, 1936): Letting go of attachments and desire
Judeo-Christian (Syme, 1986), (Bouwsma, 1976): Controlling passions
Islam (Lapidus, 1976): Self-rule and surrender to Allah
Yoga (Yogananda, 1946): Control of the mind and body

Social Psychology and Other

Lefcourt (1973): illusion of control
Langer (1975): Mindfulness, illusion of control
Averill (1973): Behavioral, cognitive, decisional control
Rodin (1986): Control-enhancing options from environment
Antonovsky (1979): Coherence
Taylor (1983,1989): Cognitive adaptation, positive illusion
Burger (1979): Need for control
Lazarus (1981): Coping
McClelland (1961, 1975): Need for achievement; power motivation
Glass (1977): Too high desire for control
Brehm (1966, 1981): Reactance
Kamiya et al. (1971), Miller (1969), DiCara (1970), Schwartz 1979, 1983):
Physiological self-regulation

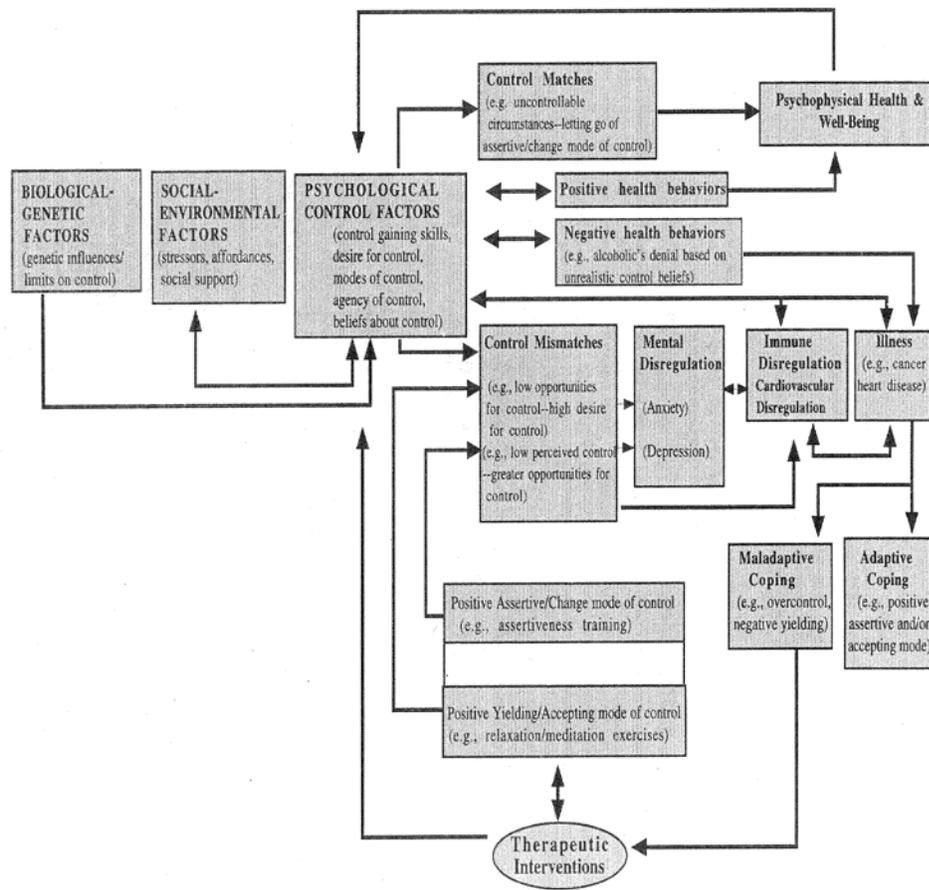
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CONTROL THERAPY: THEORY AND POSTULATES

Flow chart of a biopsychosocial model, including therapeutic intervention. Our biopsychosocial model of control is represented in the following flow chart. This flow chart also shows the role that therapeutic intervention—(Control Therapy) can play in the process.

Note to lecturer. This flow chart model, showing potential reciprocal relationships, and different feedback loops, can initially appear a bit daunting. It may be helpful to point out to the participants a few main salient ideas: e.g., the biological/genetic; social/environmental; and psychological control factors effects on each other; adaptive and maladaptive coping; control mismatches; the two modes of control as part of the therapeutic interventions. This is just to give an overview of the model, which for those interested in the more depth, can consult the original article.

Figure 2
Biopsychological Model of Control



(From American Psychologist, 1996)

Postulates of Control Theory and Therapy

(Note to lecturer: It might be helpful initially just to read the Main Postulates, as you present the slide with refinements. Then you might further explore this by showing how these postulates are embedded in the

POSTULATES OF CONTROL THEORY AND THERAPY: TOWARD AN INTEGRATED APPROACH.

POSTULATE 1: Across domains of life, the behavior and cognitions of individuals can be explained by and are often an expression of their need to gain, maintain, and/or reestablish a sense of control.

- 1.1. There are control-related developmental and life-cycle issues across multiple domains—personal, interpersonal, and cosmic—that all people, irrespective of culture, have to address.
- 1.2. When sense of control is lacking in one domain, it can be reestablished through one or more of the following: increasing or decreasing desire for control, developing behavioral competencies (either for self-change, altering the environment, or focusing control efforts in a different domain), altering cognitive appraisals/beliefs in order to reframe the situation, or transforming affect.

POSTULATE 2: There are lower and higher levels of control desires, goals, and strategies.

- 2.1. When sense of control is not established, there are negative mental and physical health consequences.
- 2.2. Although a normal control profile emphasizing active, instrumental control and the use of attributions and defenses to maintain a sense of control is more positive than suboptimal lack of control, there can also be negative consequences associated with normal strategies used to gain and maintain a sense of control.
- 2.3. Higher, more optimal levels of control are reflected in a balanced and flexible use of assertive and yielding modes; the ability to gain control from both self and other; situation-appropriate levels of desire for control; and the directing of control efforts toward furthering the well-being of both self and others.

POSTULATE 3: There are individual differences in people's desire for control and the means whereby they gain a sense of control.

- 3.1. Biological–genetic, psychological, and sociocultural (i.e., biopsychosocial) factors interact to influence people's desire for control, ability to gain control, and means whereby such control is gained.
 - 3.2. There are differences in how and to what extent control is exercised, depending on the particular stage of development one is in and one's gender.
 - 3.3. Although there are biological and environmental influences on behavior, humans can learn, through attentional training and values clarification, to exercise choice through both self-control and environmental control.
-

Postulates embedded in and undergirding the description of Control Therapy. Control Therapy seeks to “translate” these postulates into practical guidelines and language which the therapist can use with a client. As an example, the material at the start of this lecture on “What is Control Therapy” is actually based on an integration of the answers to the Frequently Asked Question “What is Control Therapy” in the Control Therapy Training Manual. One answer is given for the lay person/client, p. 3), one answer for therapists, trainees, and students. Below are the two answers, with notations of where and how the postulates are embedded and undergird the answers.

Note to lecturer: The two FAQs may provide more detail than realistically can be covered in a lecture, but they do provide a good illustration of how the postulates are related to CT, so feel free to draw on this material to make this point how you see best.

IN FAQ 1 (CLIENT): WHAT IS CONTROL THERAPY?

Control Therapy is based on the belief that all of us want to have a positive sense of control about our lives and feel happier and healthier when we do (POSTULATE 1). Therefore, the reason individuals seek counseling is often because there are one or more areas of concern in their life where they feel things are not in as much control as they would like, or where they feel they (or others) are too controlling (POSTULATE 2). Despite their best efforts, these areas are causing them pain and suffering. These areas could include physical health, work, relationships, and personal issues, such as our habits, our feelings, and our thoughts (POSTULATE 2.1, 2.2).

The goal of Control Therapy is to help people gain or regain a more positive sense of control about their lives (POSTULATE 1). Over the course of eight to twelve sessions, we work together to find out what are your areas of concern, and what are your goals for those areas that would help you achieve a more positive sense of control (POSTULATE 1.1). For example, are you seeking to alter and change a situation, or to learn to accept and live with more serenity with what is? (POSTULATE 2.3). Based on your concerns, your goal, and your unique Control Profile, we then match and tailor the strategies and techniques most suitable to help you reach your goals (POSUTLATE 3.3). Together we’ll evaluate your progress toward your goals and seek to ensure that your concerns are addressed.

Looking at the client FAQ 1, you can see that Postulates One and Two are embedded in lay language in the first paragraph, and the idea of individual differences—Postulate Three (reflected in the development of the SCI and an individual “Control Profile”) -- is embedded in the second paragraph.

FAQ 1 (THERAPIST/TRAINEE: WHAT IS CONTROL THERAPY?)

All of us would like to have a positive sense of control in our life. Each of us—client, student, teacher—also knows from first hand experience that we receive assaults to our sense of control as we go through life. Some of these are the result of inevitable existential suffering inherent in being alive (POSTULATE 1). Others are what we might

call “unnecessary suffering” brought about by poor choices, lack of skillful responses to events, and/or not having learned appropriate cognitive, emotional and behavioral self-regulation strategies (**POSTULATE 2**). In addition, according to control theory, one of our greatest human fears is losing control, and one of our strongest motivations is to have a degree of control over our lives (from *Control Therapy*, p. 31) (**POSTULATE 1**).

Therefore, according to control theory, we seek to gain or regain a sense of control by our actions, thoughts, emotions, and awareness (**POSTULATE 1.1**). Sometimes we try to accomplish this by changing and altering a situation (and ourselves); sometimes by learning to accept, yield, and develop a peace and harmony with “what is” (**POSTULATE 2.3**).

Each of these ways to gain a sense of control can be accomplished by the use of self efforts (self as agent) and/or by help from others (others as agent, including our beliefs about the nature of the universe). What is important is that we match and tailor techniques and interventions to a client’s clinical concern, his/her goal, and his/her individual control profile (**POSTULATE 1.1, 2.3, 3.3**)

CT believes that although there is individual variation, (**POSTULATE 3**) each of us has an ability to

- learn to pause, reflect, consider and reconsider our thoughts, actions, and behavior
- learn to choose, if we wish, to interrupt and override reflexive cognitive, emotional, and behavioral impulses and sequences
- learn to create alternative ways of responding---behaviorally, emotionally, and/or cognitively -- that we feel are more in our (and others’) best interest, and which help us gain, or regain a positive sense of control (**POSTULATES 1, 2, 3**)

By integrating theory, research and practice, Control Therapy addresses these issues through an eight to twelve week course of sessions in order to help individuals learn to gain or regain a psychological “sense of control” in the “intended direction”-- by the most skillful means possible. This short term approach provides a systematic way to determine when to use which types of control strategies with a specific client given that person's unique control profile and consistent with that person's particular counseling goals (**POSTULATES 1-3**).

As you can see from the above discussion of biopsychosocial foundations and postulates, Control Therapy believes that individuals are indeed influenced by the environment and biology. The Chinese word “fate” means heredity and environment. However, as can be seen (Postulate 3.3) Control Therapy is based on the premise that through education and learning, individuals can exercise choice—i.e., we don’t need to let circumstances define us. This is similar to the word “education” in Chinese: “having the self-soar!” As can be seen from Postulate 1.2 there are ways to gain and regain a sense of control; and positive ways to do so (Postulate 2.3).

We now turn to the two phases of Control Therapy to look at interventions that can help to gain and regain a positive sense of control.

CONTROL THERAPY: TWO PHASES.

(Overview)

The first phase is assessment and goal setting. The second phase is intervention: Matching the control enhancing techniques to a person's Control Profile and clinical concern.

FIRST PHASE OF CT: ASSESSMENT AND GOAL SETTING.

Slide



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end slide

Assessment: Through careful listening to a client's speech (including "control speech" such as in the above slide!) areas of concern and assaults to a person's sense of control are identified. The client also completes the Shapiro Control Inventory (SCI) to develop a personalized Control Profile. The SCI is a reliable and valid standardized multidimensional psychological assessment tool that provides a "**Control Profile**" showing *sense of control* in the general domain, in specific life areas; , preferred style for gaining control: i.e., assertive/change mode of control; yielding/accepting mode of control; and agency of control (self and/or other). as well as desire for control (the motivational vector).

Clients are also helped to explore their control stories (the ways individuals frame, explain, and understand events in our world—why things happen; and what our role and responsibility is). Through assessment by the SCI, self-observation, listening to control speech, and examining their control stories, clients are helped to recognize their control profiles, assaults to their

sense of control, and what forces are shaping their lives, including personal (i.e., behavioral, cognitive, and emotional), interpersonal, and environmental.

Goal setting. Based on the area of concern, the client and therapist work to develop goals for those areas that would help the client best achieve a more positive sense of control. These goals may include learning to alter and change a situation, (and ourselves) (the positive assertive change mode); and/or to learn to accept and live with more serenity with what is (the yielding/accepting mode of control). Each of these ways to gain a sense of control can be accomplished by the use of self efforts (self as agent) and/or by help from others (others as agent,) including, depending upon a person's beliefs system about the nature of the universe) a belief in a higher power, Other (capital O as agent).

SECOND PHASE OF CONTROL THERAPY: MATCHING INTERVENTIONS TO PERSON AND TO CONCERN.

Based on the client's concerns, the goal, and a person's unique Control Profile, Phase Two matches, tailors, and teaches control enhancing strategies and techniques most suitable to help individuals reach their goals. This can involve teaching clients to gain more positive assertive control over those areas which are amenable to some degree of change; and to learn skills helpful to accepting those aspects of life which they either cannot or should not try to change. This phase also involves skillful matching of the client's control profile to agency of control as well as mode of control, and to "teaching" strategies in a way that honors and respects the client's style of learning.

Throughout each phase, there is a system's model to help evaluate progress toward client goals and seek to ensure that these concerns are addressed in a way that optimizes the chances for the client's regaining and maintaining a positive sense of control.

Thus, in summary, Control Therapy helps individuals learn to gain or regain a psychological "sense of control" in their lives. This short term, two phase approach provides a systematic way to determine when to use which types of control strategies with a specific client given that person's unique control profile and consistent with that person's particular counseling goals. Research has shown that there are individual differences in people's Control Profiles in terms of their preferred modes for facing this central issue of gaining and maintaining a sense of control; and that for a specific clinical problem, matching clinical control-enhancing interventions to the individual's Control Profile maximizes the opportunity for therapeutic success.

PHASES OF CONTROL THERAPY

PHASE ONE: ASSESSMENT AND GOAL SETTING

ASSESSMENT. The material below provides an overview of the Assessment, Phase One of Control Therapy. There are four ways in which a client's control profile and dynamics are assessed: listening to control speech, the SCI (Shapiro Control Inventory); exploring client control stories, and self-observation. We begin by examining the four aspects of a person's Control Profile: sense of control; modes of control; motivation (desire for control); and agency of control: self and other/Other.

SENSE OF CONTROL

slide

- Do you feel you have too little control in your life? In which "domain(s)"? e.g., physically, cognitively, emotionally, interpersonally; at work?
- Do you sometimes feel you are seeking, desiring, or actually have and are exerting too much control? Again, in which domain(s)?

Dominant schools of psychotherapy share one basic assumption: the emotionally disturbed person is victimized by ... forces over which <s/he feels s/he> has no control."

--Aaron Beck (one of the founders of Cognitive Therapy)

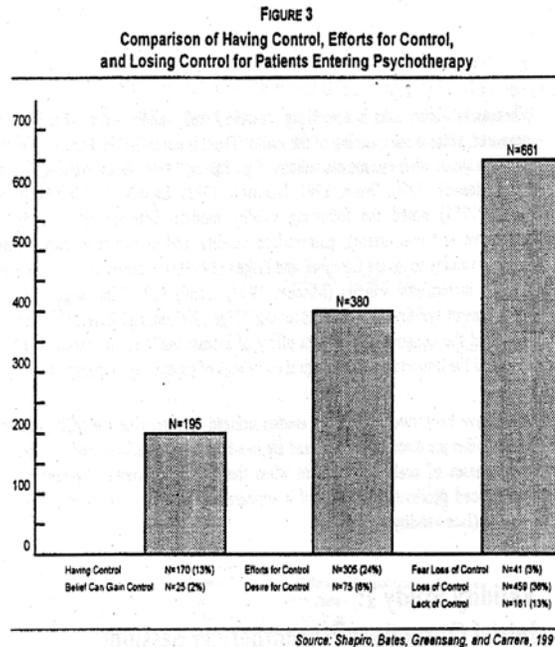
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Content Analysis of Speech Samples: Comparison of Having Control, Efforts for Control and Losing Control in Patients Entering Psychotherapy. (Validity Study One).

If you were to do a content analysis of a patient's speech who is entering therapy when asked the question "So what brings you here?" what do you believe you would find? Would the patient make more statements about being out of control and fearing loss of control, or more statements about having and being in control? As you might imagine, when a study was done through a systematic content analysis method of coding speech samples of patients' initial psychotherapy sessions in terms of how they responded to the neutral prompt "What brings you here today" the results were as follows:

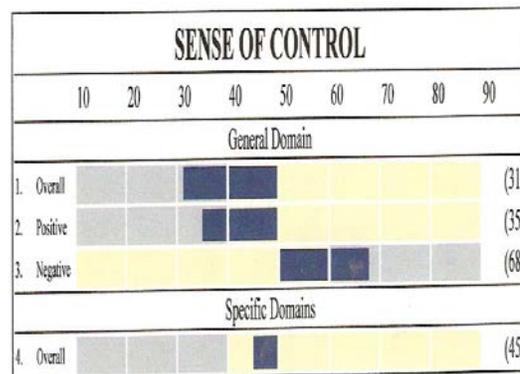
As can be seen from the Figure below of patients entering psychotherapy including affective disorders (major depression, bipolar disorder, dysthmic disorder); anxiety disorders (generalized anxiety disorder and adjustment reactions); psychosexual disorder (exhibitionism); and substance abuse disorder, psychopathology is associated with loss of control. Among these subjects, there were significantly more statements reflecting *fear of, loss and lack of control* (e.g., I'm afraid I might lose control of my emotions; I fear being enfeebled; I'm losing my power base at work; I can not perform as well as I once did, I have no choice,

no options) than there were statements of *positive sense of control and belief one could gain a positive sense of control*.(e.g., I am learning to control my anger much better; I have a lot of choice over how I structure my day). *Efforts for control* included statements such as, I've started a daily exercise program; I'm trying to get more influence at work. Subjects made *desire for control* statements such as I wish I could control my temper, I want to be more of a decision maker in our family.



Sense of control on the SCI. One major area of a person's control profile is their sense of control. There are four scales on the SCI (scales 1-4) that measure an individual's current sense of control status, both positive (to what extent they believe they have the skills and competencies to gain and maintain a sense of control) and negative (losing control, feeling others have too much control). The scales cover sense of control both in the general domain, and in domain-specific areas (e.g., mind, body, relationships, work, self).

Below is an example of a patient's Sense of Control profile.



Here is a simple way to read the above figure. The numbers at the top (10-90) represent standardized scores, with a mean of 50 and a standard deviation of 10. A client's score is compared to a healthy normal comparison group that was psychiatrically screened to provide an empirical reference standard against which to interpret the subject's scores.

Light gray shaded portions on the graph indicate score ranges that are considered to be of potential clinical concern. Thus, it is important to note when the dark bar (dark blue for those who have a color copy) enters those gray areas. (The light yellow area, for those who have a color copy is a "healthier" direction). For this client, a fifty four year old male, overall sense of control (general domain) is low (Scales 1-3).

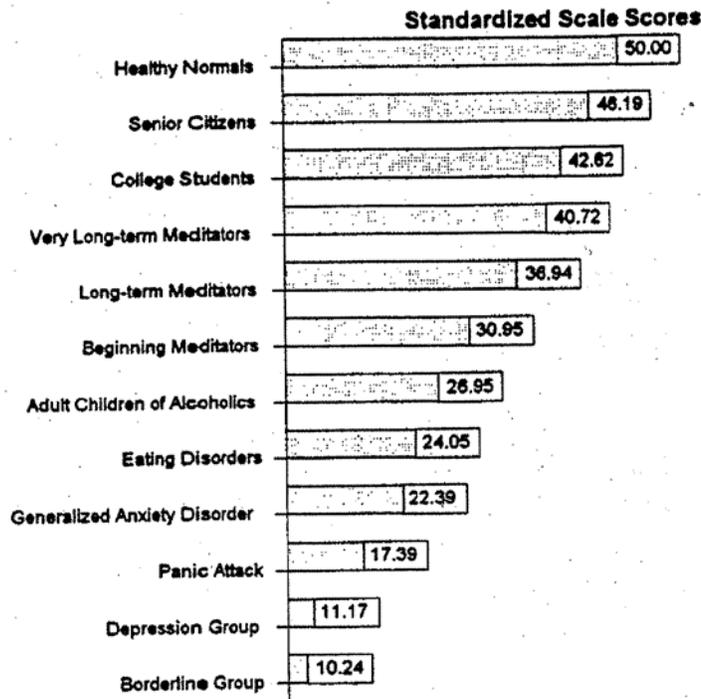
The **positive sense of control scale** consists of 11 items, including self-efficacy beliefs about one's ability to change what s/he wants; whether the person can calmly accept what cannot be changed; whether s/he is able to set goals; take appropriate responsibility for meeting those goals; has the self-control to achieve the goals.

The **negative sense of control scale** consists of five items, measuring whether the client feels s/he is losing or has lost control in spheres of life where s/he once had control; lacks control of his/her environment; and feels s/he is controlled too much by others. These combine to form an overall "sense of control scale).

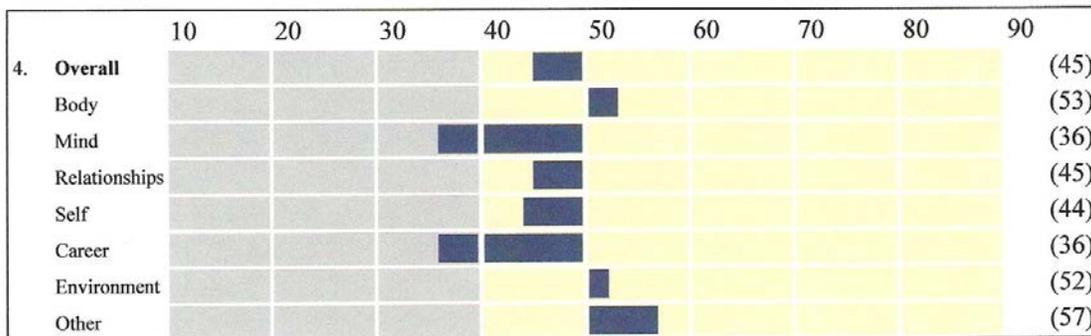
Below is a chart showing the overall sense of control profiles (standardized scores) for some of the different groups for which data has been collected including healthy normals, senior citizens, meditators (beginning, long term, very long term); adult children of alcoholics, eating disorders, generalized anxiety disorder, panic attack, depression, and, borderline personality disorder.

Control profiles of Different Clinical and Normative populations. Data from these groups allow comparisons of different control profiles for clinical and normative populations, as well as comparisons between different control profiles of clinical populations. For example, the depression group has the lowest positive sense of control (compared to the anxiety, panic attack and borderline groups, including the lowest score on the following items: perceived self efficacy, ability to set clear realistic and meaningful goals, ability to take appropriate responsibility for that over which I have control, and "I make appropriate effort and have sufficient discipline to reach my goals." Interestingly, the depression group didn't have much fear of losing control (perhaps because they felt they had so little) and the panic attack and generalized anxiety groups had the highest fear of losing control. (We will shortly discuss differences in modes of control between these two groups, and more detailed summaries are provided in the readings). The important point to recognize here is that by being able to develop control profiles for different populations in a nuanced manner, it is then possible to develop and individually tailor control enhancing strategies to address client concerns.

Figure 6
Overall Sense of Control, General Domain, Scale 1,
Standardized Scale Scores and Raw Scores



Domain specific sense of control In addition to the overall sense of control scales, the SCI has a domain specific sense of control scale comprised of twenty-five life parameters. On a clinical level, the SCI shows which “domains” may be of concern.



As can be seen from the above, the mind and career areas are in the gray area suggesting these are areas where the person feels less in control, and therefore worthy of further clinical investigation. Further information on the domain specific sense of control scale looks at overall feelings of control in each domain, whether that area is a concern, and if

so, how the client might wish to address it: e.g., change the situation, or learn to better accept it. This leads us directly into a discussion of the different modes of control (topic 3) after a brief discussion of the neurobiological correlates of sense of control (topic 3). (This could be a choice point in the lecture, in which the presenter may decide to go directly to 3, or to spend a few minutes discussing topic 2.5

Neurobiological Correlates of Sense of Control. As noted briefly in the introduction, and as will be discussed further toward the end of this talk, CT is based on a biopsychosocial model of control. Investigating the biological correlates of control, one study investigated the functional neuroanatomy of the relationship between having control and losing control (Validity Study Two). Normal male subjects were injected with 18 F D-deoxyglucose during rapid eye movement or non rapid eye movement sleep. When subsequently awakened, subjects reported their dreams and mentation which were tape recorded, transcribed and then coded along dimensions of perceived control.

Slide

Table 1. Having Control and Losing Control: Correlations with Rate of Local Cerebral Glucose Metabolism

Having Control	REM & NREM	REM	NREM
	n=12	n=7	n=5
Frontal cortex structures			
Frontal cortex, right			.97**
Rectal orbital gyrus, left	.64*		.96**
Medial frontal cortex, right	.73**		.98**
Limbic structures			
Amygdala, left	-.59*		
Other structures			
Temporal cortex, right	.64*		
Basal ganglia, left	.59*		
Paracentral cortex, right		.83*	
<hr/>			
Fear, Losing Control	REM & NREM	REM	NREM
	n=12	n=7	n=5
Frontal cortex structures			
Frontal cortex, right			-.89*
Limbic system			
Amygdala, left	.74**		
Amygdala, right	.71**	.90**	
Amygdala	.65*		
Hippocampus, right	.81**		-.93*
Other structures			
Calcarine cortex, right	-.65*		
Cerebellum, left	-.59*		
Cerebellum, right		-.79*	
<hr/>			
condition	n	p=.05*	p=.01**
REM and NREM	12	r=.58	r=.71
For REM	7	r=.75	r=.87
For NREM	5	r=.88	r=.96

end slide.

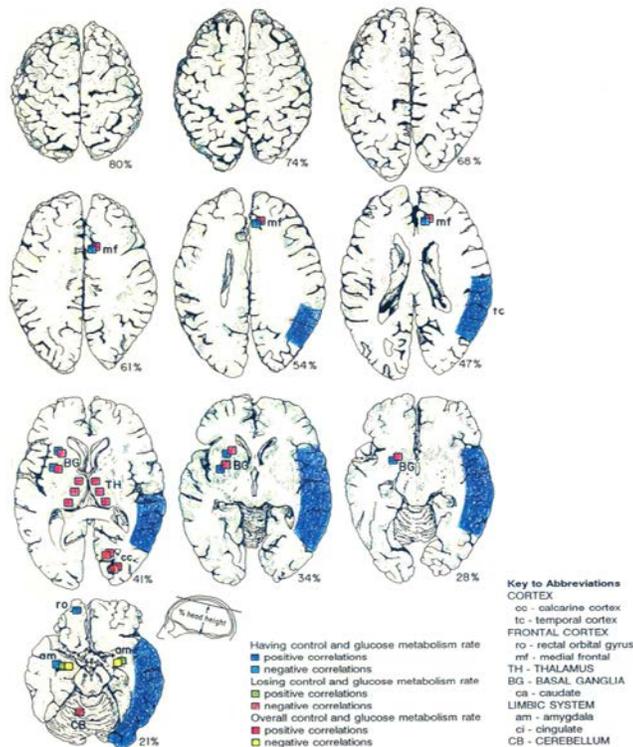
Non parametric correlations between these verbal reports and localized cerebral glucose metabolic rates obtained from Positron Emission Topography (PET) scores revealed significant positive and negative correlations throughout the brain.

As can be seen from the table above and brain scans below, having control was positively associated with activation of frontal cortex components and negatively correlated with limbic system activation. Showing internal consistency, there was a significant positive correlation with between loss of control and limbic system activation, and a significant and a significant negative correlation between loss of control and the frontal cortex (right).

Slide.

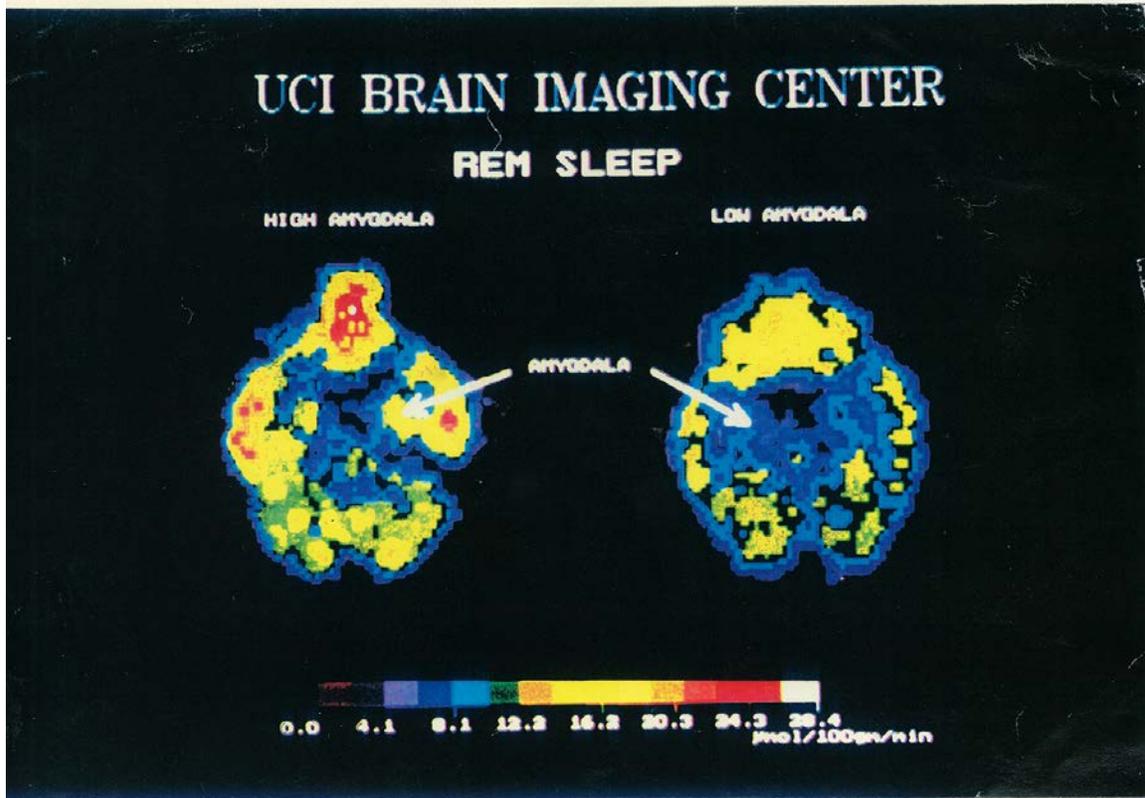
HAVING CONTROL, LOSING CONTROL: CORRELATIONS WITH RATE OF LOCAL CEREBRAL GLUCOSE METABOLISM

Correlations between relative metabolic rate during dreaming and having control, losing control, and overall global "sense of control" for the 10 positron-emission tomography (PET) levels assessed. The cortical surface areas (32) and medial areas assessed with regions of interest (126) were evaluated. Each PET slice was visually matched to the Matsui and Hirano atlas (1978) which is redrawn here. Slice height is in percentage of head height above the canthomeatal line.



End Slide

Qualitatively, below are two dreams, one which received the highest positive overall sense of control score; and one which received the lowest positive sense of control score and a slide showing the high and low glucose metabolic rate of the amygdala as a function of high and low sense of control during dreaming



End slide

Dream With Lowest Overall Positive Sense of Control

My dad was chasing me around the house swinging a pick at me. I was just trying to help out my mom. The pick kept going lower and lower. It was dark. I was scared. Our house seemed to be on the other side of the street. The houses were the neighborhood where I grew up my first sixteen years of life, but I was as old as I am now. Then my brother was flying down the street, soaring higher than a telephone pole and trying to catch green fluorescent tennis balls. I was fearful that he was going to get hurt. We all ended up at a meeting with business men. I was faking that I hurt my leg at this meeting. Somehow they found out that I was faking it. There was one *guy* who was really heavy and a crooked type *guy* type that you could not trust over nothing. Then I did some flying around. All the places just appeared all of a sudden.

Dream with Highest Overall Positive Sense of Control Score

I went into the house where I used to live ten years ago. I remember recognizing the house ... it was really homey ... the Lakers were there, Kareem Abdul Jabbar and Magic Johnson. The Lakers and the people in the house were festive because they won the championships ... we were in a good mood. Their speaking was "Oh, hi, good to see you." We then went outside and I ended up in this mission thing where I was flying around. I felt good just flying around. I was trying to catch a car or dune buggy or something ... there were dark colors of night, purples, blues, dark reds, browns, grays. It was the thrill I was feeling.

This ends the discussion of "Sense of Control" as one aspect of the Control Profile. Now let us proceed to the second aspect of a control profile, the four modes of control.

MODES OF CONTROL

slide

- *Does a sense of control always involve making changes to meet your needs and desires (an assertive, change mode of control)?*
- *Can it sometimes involve learning to accept and be at peace and in harmony with “what is” (a yielding, accepting mode of control)?*

*courage to change
the serenity to accept*

--Reinhold Niebuhr.

end slide

Overview. The second part of a Control Profile is the four modes of control. This work, developed in the late 1970's (*cf Precision Nirvana, 1978*), involves four scales on the SCI (Scales 4 to 8) which reflect characteristic cognitive and/or behavioral styles of responding to control-related issues: positive assertive (change), positive yielding (acceptance), negative assertive (overcontrol), and negative yielding (too little control or helplessness).

An **assertive, change mode of control** can be positive (striving for excellence, self-improvement) or negative (overcontrol, perfectionism). Similarly, a **yielding, accepting mode of control** can be positive (at peace with self, gratefulness for what you have) or negative (passivity, helplessness). This gives us the following four-quadrant model—as shown below.

The positive assertive scale (quadrant one) measures an individual's self-description in terms of ability to use an active, altering mode of control to change the environment, others, and/or oneself. It includes descriptive words and phrases such as 'decisive,' 'communicating needs,' and 'leading.' The positive yielding mode (quadrant two) involves knowing when a sense of control can better come from letting go of active control. Its descriptive words include 'patient,' 'trusting,' 'accepting.' Negative assertive (quadrant three) is sometimes referred to as "overcontrolling." It involves efforts at active change, pushing inappropriately, often in an aggressive or hypervigilant manner, based on inaccurate (sometimes even irrational) assumptions such as the notion that continuing active assertive efforts (in certain uncontrollable situations) will eventually lead to the desired outcome even when so far such efforts have failed or only made things worse. Descriptive words include 'dogmatic,' 'aggressive,' 'manipulative.' The fourth mode of control, negative yielding (quadrant four), involves thoughts and behaviors that reflect a sense of helplessness and lack of control when in fact control might be realistically asserted. Descriptive words include 'indecisive,' 'manipulated,' 'timid.'

start slide

A FOUR-QUADRANT MODEL OF MODES OF CONTROL

<p>POSITIVE ASSERTIVE</p> <p><i>Assertive, Change Mode of Control</i></p> <p>(Quadrant One: Q1)</p>	<p>POSITIVE YIELDING</p> <p><i>Yielding, Accepting Mode of Control</i></p> <p>(Quadrant Two: Q2)</p>
<p>NEGATIVE ASSERTIVE</p> <p><i>Overcontrol</i></p> <p>(Quadrant Three: Q3)</p>	<p>NEGATIVE YIELDING</p> <p><i>Too Little Control</i></p> <p>(Quadrant Four: Q4)</p>

end slide

Let me ask you to free associate to the term “control”... what comes to mind? For some, it may be terms like “empowerment” and “taking charge.” These are clearly Positive Assertive Quadrant One; for others, terms like manipulation, control freak, coercion, power trip might arise, which represent Negative Assertive, Quadrant Three. What we often find in this exercise is that all of us have both positive and negative associations with the term control, and these can be understood in a more nuanced way by distinguishing between positive assertive and negative assertive.

Now, please take a moment to free associate about the opposite of control—i.e. lack of control. For example, terms like helpless, vulnerable, and powerless are characteristic of Negative Yielding, Quadrant Four. Interestingly, when we think of the **opposite** of control, in our culture, we often think of quadrant four, negative yielding terms, which is why the quadrant two box, positive yielding control, often remains empty in this exercise.

Positive Yielding: The Way of Water. A frequently asked question is “*Isn’t positive yielding/acceptance, even though you call it positive, really passivity or fatalism, a kind of giving up?*” To answer this question, it can be helpful to make a distinction between negative yielding (quadrant four) and positive yielding (quadrant two). For example, in the philosophy of Lao-Tzu, the highest form of control is symbolized by water, which, when confronted by an immovable rock, does not try to bulldoze through the rock, but

accepts the rock's position, yields and goes around. Lao-tzu points out that this "way of water" is actually very powerful—witness the way water eventually wears away rocks.

Another example is the Chinese story of the origins of the philosophy of Judo, which is purported to have been discovered while watching snow fall on two different trees. A larger tree stood solid, strong, and unyielding while the snow piled upon its branches. After a while the snow became so heavy that the branches cracked under the weight. Meanwhile, the smaller tree also grew heavy with snow, but its branches were limber and merely bowed and yielded to the greater weight, gradually bending to the ground, casting off the snow, and returning to their original position. The smaller, more flexible branches survived the winter; the tree that yielded proved the stronger in the end.

Take a moment and think if there is an example in your own life when positive yielding/acceptance might be a wise course of action: "the serenity to accept." Western expressions that emphasize this mode include: don't make a mountain out of a mole hill: in other words, keep a perspective on what is important, and be able to let small things go. In terms of body self-image, for example, might there not be wisdom at a certain point in life in developing self-acceptance of who we are (e.g., our height!); or giving way to a driver who has seized the right of way unfairly in a situation which otherwise might result in an accident. Sometimes, to yield and accept in a situation can show great wisdom, and decrease our pain and suffering, in a way not at all related to fatalism or giving up in a negative sense. Positive yielding can decrease stress and unnecessary suffering, and increase calmness, serenity, and a positive sense of control.

The modes of control can be both a goal and a means to the goal. Just for clarification, it should be highlighted that utilizing a positive mode can be both a goal, and a technique. For example as a goal, a client might say, "I want to clearly and nonreactively express my dislike of the way my mother in law belittles me. I want to do this with calmness, yet firmness, using right speech." This is a therapeutic goal framed primarily in positive assertive change terms. The intervention to achieve this goal might include role playing, relaxation techniques, and practicing right speech to improve communication with mother-in-law, techniques involving both positive assertive and positive yielding modes of control in the service of reaching the chosen goal.

Cultural and Gender Sensitivity.

It is also particularly important to be sensitive to issues of culture and gender in terms of how we assess whether control actions are viewed positively or negatively.

For example in the United States, the active, assertive mode of control is emphasized, such as in the aphorism, "The squeaky wheel gets the grease." In Japan, a more yielding, accepting mode of control involving group harmony is often emphasized, such as in the aphorism, "The nail that sticks out gets pounded" or "The person who raises their voice first loses the argument."

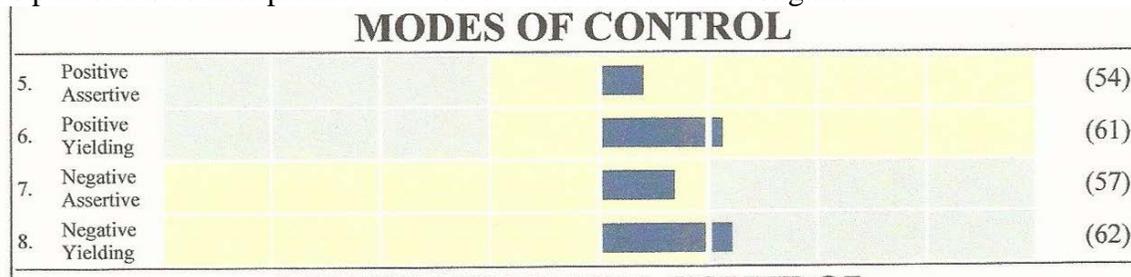
Further, have you experienced or can you think of examples where the same assertive behavior might sometimes be viewed or labeled differently depending upon whether it was done by a man or a woman (e.g., leadership, positive assertive quadrant one versus bossy, controlling, quadrant three?). Conversely, can you think of examples where positive yielding and acceptance

might be seen as healthy wisdom and restraint in a woman, and as inappropriate passivity and timidity in a man?

A brief background note on the development of these four scales. An initial set of several hundred words were generated by mental health professionals reflecting the four quadrants. These were narrowed down to under 100, and given to mental health professionals who were asked how well the words reflected a person, man, or woman with high and low self-control. Factor analytic studies were conducted to categorize the responses.. Quite discrete factors were identified which reflected the four quadrants of the model. A second strategy in developing, refining and finalizing the modes of control scales was to use inter-rater reliability. Six experts were selected, consisting of three pairs—in each case one woman and one man-- in the fields of “East/West psychology; sex role psychology; and Type A behavior) were asked to rate the words which previous research had indicated distinguished the four quadrants. Only words in which a minimum of 5/6 agreed were included in the final scales.

Mode profiles: clinical.

You can see in the slide below the modes aspect of a control profile. This is the same subject whose *overall sense of control* we saw in a previous slide This person has a high positive yielding sense of control (in a good way) but also a high negative yielding score as part of his control profile that would warrant further investigation.



Research on the four clinical groups discussed earlier, that the modes can help distinguish between different clinical disorders. For example, the generalized anxiety disorder group had the highest negative assertive quadrant three, the depressed group the lowest positive assertive quadrant one; and the borderlines group the lowest positive yielding quadrant two score.

Content analysis of mode speech.

It is helpful to listen to client speech (as well as one’s own) for examples illustrating the four different modes.

Below is a slide showing

EXAMPLES OF CONTROL SPEECH FOR THE FOUR MODES OF CONTROL

QUADRANT 1—POSITIVE ASSERTIVE: ACTIVE, ALTERING, MODE

1. *Active Assertive Positive.*

This refers to words that show instrumental activity in a positive way toward the accomplishment of something—goal oriented, self-starter, independent. They involve a concept of doing, of activity, of motion.

EXAMPLES: I am going to go on a diet to try to lose weight.
I'm working hard to influence my senator to vote to ban CFC.

QUADRANT 2—POSITIVE YIELDING: LETTING GO, ACCEPTING MODE

2. *Yielding, Letting Go Positive.*

This refers to the positive aspects of acceptance, yielding, softness, gentleness, and nurturing. There is more a sense of stillness here, of quiet, of softness, of being.

EXAMPLES: I am able to accept that I am never going to lose weight.
I have learned to accept that I can never change her.

QUADRANT 3—NEGATIVE ASSERTIVE: OVERCONTROL

3. *Active (Overassertive) Negative (Overactive/Overcontrol).*

This refers to too much activity, too high control, a sense of aggressiveness, a certain ruthlessness, a Machiavellian quality, a high agitation, an insensitivity, and a selfishness.

EXAMPLES: I am unable to delegate responsibility and end up trying to control everything.
She is an overprotective parent.

QUADRANT 4—NEGATIVE YIELDING

4. *Overyielding, Negative (Too Little Control).*

This refers to too low activity, a mushiness, an overpassivity, a diffuseness, undifferentiatedness, helplessness, and hopelessness.

EXAMPLES: I accepted his offer, but then felt like a victim.
I let everybody boss me around.

Neurobiological correlates of the Four Modes.

Using content analysis of dream speech samples, these modes were correlated with neurobiological correlates, as can be seen in the slide and table that follow:.

As can be seen from the slide and Table 3, below, positive assertive (quadrant one) and quadrant two (positive yielding) are both significantly associated with midbrain activity (REM and NREM combined; NREM alone). But only quadrant one positive assertiveness is associated with frontal cortex activation in the medial frontal cortex left (REM alone) and in the medial frontal cortex right (REM and NREM combined.) Showing internal consistency, quadrant one positive assertiveness is negatively correlated with the hippocampus (REM & NREM combined; REM alone for left and right); and quadrant three, negative assertive is positively correlated with the overall hippocampus (REM alone, NREM alone) and with the left hippocampus (REM & NREM combined and REM).

FOUR QUADRANT MODE OF CONTROL: CORRELATIONS WITH RATE OF LOCAL CEREBRAL GLUCOSE METABOLISM

Correlations between relative metabolic rate during dreaming and having control, losing control, and overall global "sense of control" for the 10 positron-emission tomography (PET) levels assessed. The cortical surface areas (32) and medial areas assessed with regions of interest (126) were evaluated. Each PET slice was visually matched to the Matsui and Hirano atlas (1978) which is redrawn here. Slice height is in percentage of head height above the canthomeatal line.

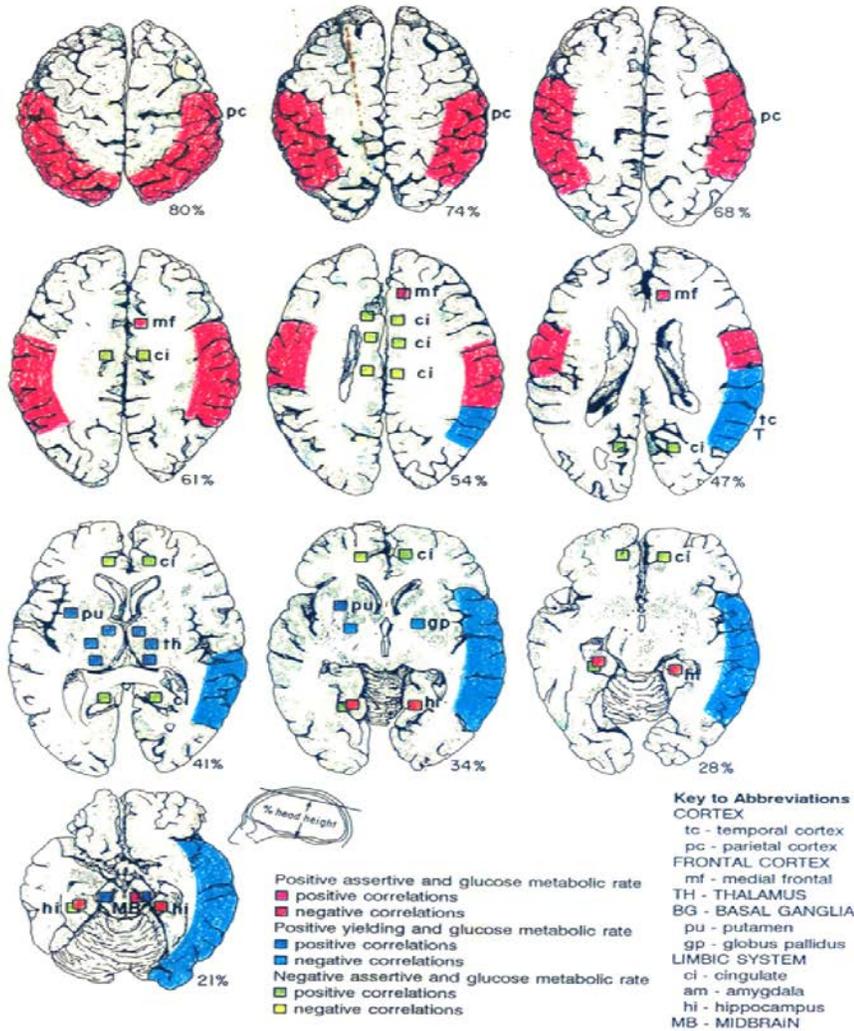


TABLE THREE
FOUR QUADRANT MODE OF CONTROL:
CORRELATIONS WITH RATE OF LOCAL CEREBRAL GLUCOSE METABOLISM

Quadrant One: Positive assertive	REM & NREM	REM	NREM
Frontal Cortex			
Medial frontal cortex, right	.61*		-.95*
Medial frontal cortex, left		.76*	
Limbic system, Left	-.64*		
Hippocampus, Right	-.68*	-.82*	
Hippocampus, Left		-.81*	
Hippocampus	-.71**		
Other			
Midbrain, Right	.61*		.89*
Parietal Cortex, Left	.58*		.88*
Parietal Cortex, Right	.73**		
Globus pallidus		.82*	
Globus pallidus, right			-.91*

Quadrant two: positive yielding	REM & NREM	REM	NREM
Thalamus, Right	.74**		
Thalamus	.61*		
Midbrain, Left	.62*		
Midbrain, Right	.65*		
Midbrain	.78**		.92*
Putamen, Left	.60*		
Globus Pallidus	-.68*		
Globus Pallidus, left			-.89*
Cerebellum, right			.89*
Medial temporal cortex, right		.78*	
Temporal cortex, right	-.81**		

Quadrant three: Negative assertive	REM & NREM	REM	NREM
	n=12	n=7	n=5
Frontal cortex			
Rectal orbital gyrus, Right		-.81*	-.90*
Limbic system, right		-.81*	
Cingulate cortex, left			.94*
Cingulate cortex, right	.81**		.91*
Cingulate cortex	.77**		.96**
Posterior Cingulate Cortex, Left		.86*	
Posterior Cingulate Cortex, Right		.92**	
Hippocampus, Left	.73**	.78*	
Hippocampus		.80*	.92*
Occipital cortex			
Occipital Cortex, Left		.83*	
Occipital Cortex, Right		.76*	
Precuneus, Left		.81*	
Other structures			
Putamen Left			-.89*
Putamen, Right		-.81*	
Globus Pallidus, Right		-.84*	
Globus Pallidus		-.77*	

Quadrant four: Negative yielding	REM & NREM	REM	NREM
	n=12	n=7	n=5
Frontal cortex, right			-.96**
Rectal Orbital Gyrus, Right			-.99**
Anterior cingulate cortex, left		.76*	

condition	n	p=.05*	p=.01**
REM and NREM	12	r=.58	r=.71
For REM	7	r=.75	r=.87
For NREM	5	r=.88	r=.96

Although this research is only preliminary work, it does show different neurobiological correlates and brain activity for the different modes of control.

Control mode dialogue. Before turning to the third part of the Control Profile, the motivation (desire) for control, I'd like to introduce the "Control Mode Dialogue" an exercise involving personally experiencing how you might understand and conceptualize the four different modes of control. Without too much thinking, please create

representation for you of what negative yielding looks, feels like: (e.g., color, sound, animate, inanimate object). Now negative assertive. Positive assertive. Positive yielding. We will return to this exercise when we discuss goals.

MOTIVATION (DESIRE) FOR CONTROL

begin slide

- *Do you feel you have too little control in your life, and desire more? In which “domain(s)”?* e.g., physically, cognitively, emotionally, interpersonally; at work?
- *Do you sometimes feel you are seeking, desiring, or actually have and are exerting too much control? Again, in which domain(s)?*

end slide

As a way to introduce this topic, I’d like to invite you to take a moment to reflect on the two questions above. Please close your eyes, and imagine a situation in which you would like to have more control. Now, turn inward, and ask yourself, How do you know you have a desire for control in this area? Is there a bodily sensation, cognitions, images? Note how you receive information about your desire for control. Thoughts, feelings? We’ll discuss and refine this process further in the self-observation section, but for now, just notice the sensations, feelings, thoughts that are your “teachers” and provide this knowledge for you.

Now, if you would please imagine a situation in which you feel you are exerting too much control. Once again, please note how you know this—is it a bodily sensation, a thought, a feeling, an image? Again, please take just a few more seconds to notice how you know. When you’re ready, please open your eyes gently and slowly.

Desire for Control scale. The third aspect of a client’s Control Profile is the Desire for Control (Scale 9 of the SCI). This scale looks at how important active control is to the client, and includes items such as I make a great deal of effort to try to stay in control of my life; I fear losing control; others have too much control over me; it is important to give the appearance to others that my life is in control; I like things around me to be ordered and dislike ambiguity and the unknown.; before making a difficult decision, I like to gather as much information a possible; having power is important to me; I want to control my anger better? The desire for control scale has gray shaded areas in two directions. This is because research has shown that a person can have too high or too low a desire for control. As can be seen from the slide below, for this individual, the desire for control is in the normal range.

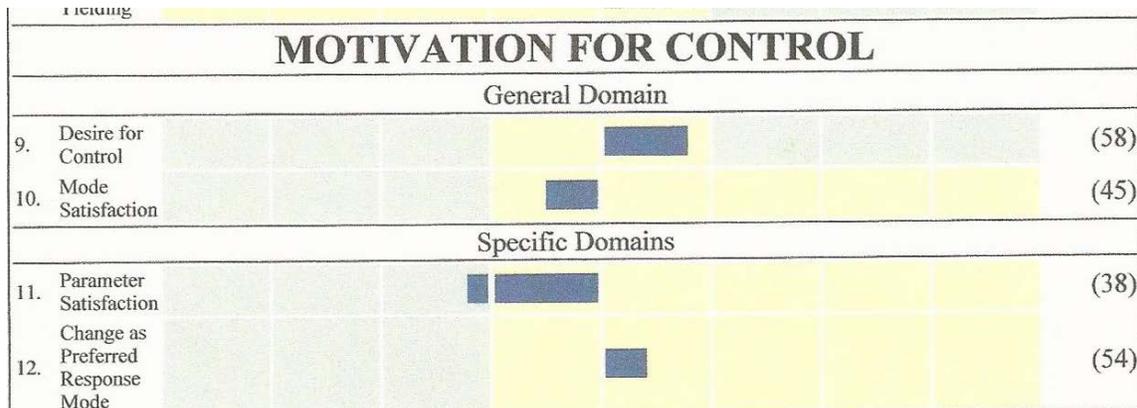
The Desire for Control Scale is part of the larger issue of a client’s “Motivation for Control.” Motivation for control is important both as assessment of where the client is—part of the Control Profile-- and also provides some potential information about the client’s goal—where s/he would like to go.

Motivation for Control: Additional Refinements. Information about Motivation for Control comes from several places in the SCI. (as can be seen from the slide below). In addition to the desire for control scale, there is mode satisfaction (refinement 10 below).

This assesses how satisfied the client is with the his/her modes of control profile, and whether s/he wants to stay the same, be less that way, or more that way. For this client, mode satisfaction is trending lower, but still normal. Further exploration of this person's SCI showed that when the client did want change, he wanted to increase positive assertive and positive yielding, and decrease negative assertive and negative yielding.

Parameter satisfaction (Refinement 11) explores how satisfied the client is with his or her sense of control in different domain specific parameters of life. The overall parameter satisfaction score is based on how many of the twenty-five domain areas in Scale 4 the client says are "Not a Concern." As can be seen from the slide below, for the client, the black line goes into the gray area. Additional details regarding which areas are of concern are important can be addressed in more detail with the client based on the client's profile.

The preferred response mode (Refinement 12) assesses what is the way (assertive/change, yielding acceptance or both) the client would prefer to utilize to address domain specific areas of life that the client experiences as not in sufficient control. As can be seen below, this client's preferred mode of response is slightly toward positive assertive, and well within the "normal range."



There are also items on the SCI that focus on the issue of overcontrol and the desire to have less control (e.g., belief one is too aggressive and overcontrolling; feeling one exercises too much self-control).

Together this information provides the third dimension of a Client's Control Profile.

We now turn to the fourth and final aspect of the Control Profile: Agency of Control

AGENCY (Locus) OF CONTROL: Self and other/Other

start slide

- *What are ways **you** seek to gain and maintain a positive sense of control in your life? (Self as agent);*
- *What are ways that **others** can help you to gain a sense of control in your life? (Other as agent, including, where appropriate, your beliefs about the nature of the universe).*

end slide

Rotter, Walston (and Taylor) and Locus of Control: A Brief intro. The final part of the control profile is the “agent” (or locus) of control, whether from self efforts and/or the efforts of others. This concept is well developed in psychology, and introduced in systematic fashion by Julian Rotter’s internal, external locus of control scale. This scale, developed in the 1960’s, provides a single output forced choice (internal or external locus of control). For example,

9. a. I have often found that what is going to happen will happen.
- b. Trusting to fate has never turned out as well for me as making a decision to take a definite course of action.

A second generation test, Wallston’s health locus of control, looked at a single domain—health—but did not make responses a forced choice, allowing for both self agency (I can help keep myself healthy) and other agency (the doctor is in control of my health). This was an important conceptual improvement because it recognized that self and other as agents of control were not mutually exclusive.

Shelley Taylor in her work with cancer patients found that those who had a positive sense of control utilized one or both of these strategies: self-agency strategies involved saying they were going to change their diet, eat healthier, exercise more and do those things which they could to address their cancer. Those who had a positive sense of control from others believed that their doctor and health care team were “in control. Taylor called this “control from a powerful benevolent other.” In other words, someone else was in control, but that person was on their side, and knew more about how to address the concern.

Both Rotter’s and Wallston’s work hints at and contains aspects of one’s view of the nature of the universe. That can be seen in 9a of Rotter’s question above, and more explicitly in Wallston’s test, which has a “chance” health variable: i.e., no matter how much I do, or my doctors do, sometimes we get just get sick-- i.e., random events which might be construed as fate. But what is missing in Rotter’s, Wallston’s, and Taylor’s formulations are additional views that clients may have about sense of control and the nature of the universe.

Listening for speech reflecting agency of control. Below is a chart listing seven

groupings of self as agent and other as agent. This was used as part of the content analysis coding, and is shown here because it can be useful in helping us listen more carefully to our client's and our own speech utilizing self and other as agent (and object) of control. It is worth taking 30 seconds or so just to note in overview form the different variations that are possible in exploring self and other as agent.

start slide

SELF AS AGENT			OTHER AS AGENT			
Group 1: Self Control			Other Controlling Self (Positive: Group 4) (Negative: Group 5)			
Self as Object	Self as Agent	Species	Self as Object	Other as Agent	Species	Self as Object
Examples:	I	cannot control	my eating, my feelings.	Examples:	God	gives strength to me. (Group 4)
	My thoughts	control			AA	helps me stop drinking. (Group 4)
					My spouse	dominates my behavior. (Group 5)
					The noise	makes my mind crazy. (Group 5)
Group 2: Self Controlling Other			Group 6: Other Controlling Other			
Other as Object	Self as Agent	Species	Other as Object	Other as Agent	Species	Other as Object
Examples:	I	cannot control	my spouse.	Examples:	She	dominates her spouse.
	My thoughts	thoughts	control God.		The economy	controls all human life.
Group 3: Self as Agent, No Object			Group Seven: Other as Agent, No Object			
No Object	Self as Agent	Species	No Object	Self as Agent	Species	No Object
Examples:	My body	is out of control.		Examples:	God	controls.
	My thoughts	are running wild.			She	lacks control.

end slide

Nature of the universe; beliefs regarding agency of control. You will note in the slide above there are several examples regarding self and other agency that refer to the nature of the universe: e.g., God gives strength to me; AA (a higher power) helps me stop drinking. All of us, including our clients, have views (sometimes more thought out, sometimes less) about the issue of how much control we have in the universe. For some clients this will be more salient, for others less. However, it is an area to which the therapist should at least be open (and also aware of his/her own beliefs). For example, how might the client's views of the nature of the universe be relevant as they address their area of control related concerns? You the therapist, student/trainee, likewise have views about these topics. How does that affect your approach to your client's concerns, your interactions with their views?

There is a continuum of beliefs regarding self and other/Other power in both theistic and non theistic traditions. Huston Smith writes that Buddhists talk of self and other power. There are aspects of Judaism, Christianity, and Islam in which one turns one's self over completely to faith and trust in God. Below are some "sayings" which reflect different views:

Slide

*Be patient. ...God isn't finished with me yet. (*God as Agent*)

*Who we are is God's gift to us; who we become is our gift to God.

Native American saying: (*Co-agency*)

- GOD loves you as you are; and too much to have you stay that way!
(*This is Positive yielding and positive assertive modes ☺. Question: how do you see this? Is this also an example of co-agency? Or Divine Agency?*)
- *God will not change the condition of a people until they change what is in themselves (Koran); verse 13.11 (*co agency*)
- *The Lord helps those who help themselves (*co agency*)
- * God's winds always blowing, you must raise your sails. Ramakrishna (Hinduism) : (*co agency*)
- *the opening line of the serenity prayer:
God grant me....
the courage to change (positive assertive mode)
the serenity to accept (positive yielding mode)
(Question: *how do you "hear" this prayer: is the point that all agency ultimately comes from God? Or is this also co-agency?*)

End slide

If a person comes from a theistic perspective, it may be worth exploring how much trust and faith that person is willing to place in "Control by a benevolent OTHER"—i.e., God. For those in a theistic faith community, the belief in a "benevolent Other" can provide support, encouragement, and trust in accepting *what is*, especially when self efforts seem to falter. Individuals with a theistic view may be more willing to let go into "God's hands" as a way of accepting.

In terms of forgiveness, this attitude may be facilitated by spiritual beliefs and community. For example, in Christianity, we find modeling of "Other" efforts: Jesus forgives our sins, and teaches us we must forgive the sins of others. In Judaism, the teaching is that what is between God and humans, God forgives; but what is between humans, you must address directly, both asking for and extending forgiveness to another.

A theistic view may also facilitate the assertive/change mode: providing faith and determination: e.g. those who hope in the LORD will renew their strength. They will soar on wings like eagles; they will run and not grow weary, they will walk and not be faint. There can also be a sense of "co-creating" with God's guidance, living and acting on the values of one's faith community.

When a client's views originate in non-theistic traditions that do not identify a specific benevolent Other, such as Buddhism and Taoism, those belief systems can also provide encouragement. In terms of the yielding accepting mode: to trust the path of the Tao, and to take refuge in the Buddha, the dharma, and the sangha (the community). In terms of the assertive/change mode, these views can help in terms of providing encouragement for "right speech" right action."

There are also views— for example, humanistic existentialism-- in which agency is entirely up to humans. Existentialism asserts that there is no God to save us. We live in a random, meaningless universe so we have to create meaning ourselves. The existentialist writer Andre Malraux wrote it is up to humans to create meaning in order "to deny our nothingness." If a client's view of the universe is existentially random and indifferent (ie., no Taoist Way of Harmony; no Buddhist "isness"), then the task falls more on the individual's shoulders to stoically learn to control reactions to events, and accept the "throwness" and randomness of fate on the one hand (positive yielding

through self-agency), and to feel courage in “denying our nothingness,” making “authentic choices” in how we live our life (positive assertive through self-agency). In combining both modes, this person, like Sisyphus, can be inspired to both push the rock up the mountain knowing it will only roll down again, and still, as Camus says, to “imagine Sisyphus happy.”

To conclude this discussion of agency and the nature of the universe and control, let me ask you to consider two questions:

Do you have a theistic (belief in God: e.g., Judaism, Christianity, Islam, Hindu) or non-theistic (e.g., existential, Buddhist, atheist, Taoist) view of the nature of the universe?

From a control perspective, given your belief above, what is the role of control for humans in your belief system about the nature of the universe..

There are two stories, both about a person chased by a ferocious tiger, which explore beliefs about self and other agency. In one story, found in the Zen Buddhist tradition, a person is chased by this ferocious tiger.

He runs until he reaches a cliff, then starts to crawl down, hanging from a frail vine. Far below are crashing waves dancing off jagged rocks. Two mice, one black, one white, begin gnawing on the vine. The man looks up at the fierce tiger’s sharp teeth, and down at the deadly rocks. Then he notices a strawberry growing out of the cliff. The story ends with the words,
“How sweet it tasted.”

Faced with the vagaries and challenges of life, we can learn to make choices, utilize our self-control, self as agency, and focus our attention in a way that allows us to choose to enjoy the sweetness available.

A second story, told in theistic traditions, has the same person, same tiger, same cliff, same jagged rocks, same mice eating away at the thin flimsy vine to which the person clings. At this point, the stories diverge.. Whereas the first story was about self-control, self as agent (from a non-theistic Zen tradition” this story is about seeking a sense of control through total surrender and acceptance: Not my will, but Thy will be done.” (positive yielding, quadrant two) (Other as powerful benevolent Source of control). It also playfully reminds us that such total acceptance is not always easy amidst life’s vicissitudes, sharp rocks and ferocious tigers:

The person looks up to the heavens, and says,

“Is anybody up there?”

A booming voice rings out, “Have faith. Trust and let go.”

The person looks down at the steep cliff, the raging waters and jagged rocks below, then looks back toward the heavens and says :

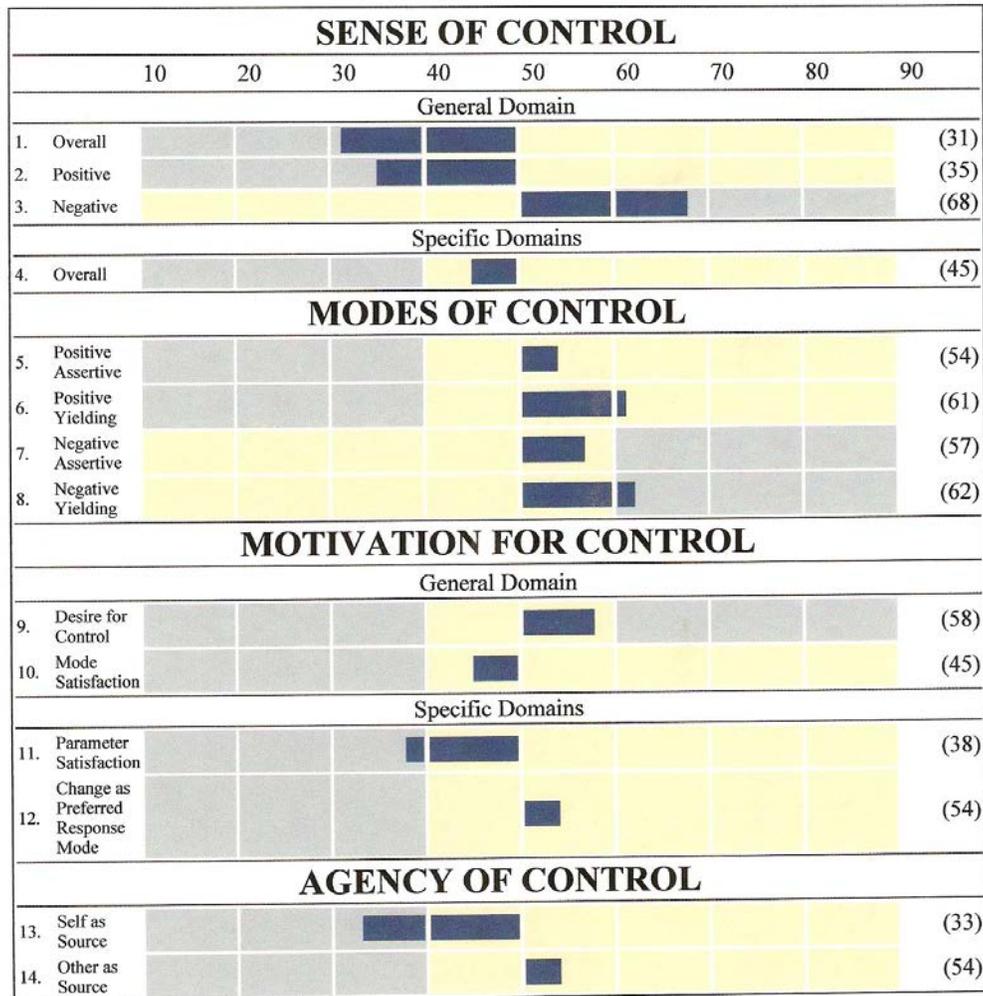
“Is anybody else up there?”

SCI and Agency.

The SCI provides information on both self and other as possible sources of control. Other is also refined into friends and family; government and society, religious and spiritual beliefs.

For the client whose profile we have been illustrating, his entire control profile is shown below.

1 SCI CONTROL PROFILE



You'll note in 13 and 14 that his sense of control from self efforts is low, entering the gray shaded area. (Note, for each client who takes the SCI, there is a 20 plus page print out summarizing the results. Here is the material from the print out, regarding agency:

This individual reports experiencing a sense of control as coming from his own efforts to an extent less than a normal, screened group. However, he reports that control is coming from others to an extent comparable to or higher than that of healthy normals. It is suggested that the clinician investigate why the subject has such a low degree of control from self. There may be too much of a feeling of a

need for or reliance upon others, to the exclusion of one's own efforts. This profile is frequently seen in persons with depression or low self-esteem. On the other hand, this profile may reflect a healthy feeling of interconnectedness, control by a higher power, and/or a religious belief. This specific profile is not necessarily a concern, but should at least be investigated further by the clinician.

Note to lecturer: If appropriate, the following exercise might be included at this point as a way to relate the four modes (and agency) to the breath cycle, (and to give the audience a chance to catch their breath!)☺

*

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*

A BREATH BREAK!

We've now completed the four dimensions of the SCI Control Profile. Before proceeding to the research basis—reliability and validity studies—for the SCI Control profile, this might be a good time for a “breath” break...let me invite all of us to take a conscious “cleansing breath.”

Let's start with a deep conscious inbreath. Now notice there's a pause at the end of the inbreath, and then allow yourself to breath out. Ahhhh....Now, we don't want any opportunity to go to waste so let's explore for a moment how the breath cycle can be an interesting way to explore the four modes (and with a nod to agency!)

BREATH CYCLE AND THE MODES. The breath cycle can be a useful learning device for understanding experientially the different modes of control.

POSITIVE ASSERTIVE. Take a conscious in-breath. You are in control of that breath. As we mature, we no longer need to be passive, helpless victims of fate. The in-breath can symbolize the positive assertive mode.

NEGATIVE ASSERTIVE. Now keep breathing in. More. Still more. If we continue to take in air in an active way, we find that no more will go in. We have reached the limit of assertiveness. What was positive becomes negative.

POSITIVE YIELDING. What needs to happen next in the breath cycle? We have to let go. Ahhhh. Breathing out (positive yielding) can be an antidote to negative assertive.

NEGATIVE YIELDING. If we continue to breathe out, we find that eventually what was positive and necessary becomes passive (even life threatening), i.e., negative yielding.

As a simple tool, our natural breath cycle (in-breath, pause, out-breath, pause) can be a reminder of the four modes.

Regarding agency, notice that the language we've used presumes the “self” as agent during the breath cycle, and voluntary, “willful” breathing: e.g., “Take a conscious breath in.” But we also know that at night breathing occurs, even though we aren't “consciously” doing so. Who is the agent then? ☺ Ok, now onward.

**RESEARCH BASIS FOR THE CONTROL PROFILE:
Reliability and Validity Studies**

We have now completed our discussion of the SCI, which provides a Control Profile, one way of assessing a person's control issues and concerns. We have also discussed the importance of listening to "control speech" as another assessment tool. Before turning to two additional means of assessment (Control stories) and Self-observation, I'd like to make a few further comments about clinical research regarding the reliability and validity of the SCI. These are included here because in psychology these criteria are foundational for a psychometric instrument. There were 12 reliability and validity studies done with the dimensions of the control profile. We have mentioned two (the control content analysis of speech samples of patients entering psychotherapy; and the PET scans showing neurobiological correlates of sense of control and modes of control).

(Note to instructor/lecturer: Again, this is an area of choice point in terms of how much emphasis on this area is appropriate given the audience).

Alpha Reliability, test-retest reliability, and scale intercorrelations

Reliability studies in psychometric testing ask the question, how well is something measured. Without reliability, there can be no validity. The determination of the SCI's reliability was undertaken in a commonly accepted manner, and showed that items in a scale are internally consistent with each other (alpha reliability) and that the questions are understood in a consistent fashion by individuals over time (test-retest reliability). As can be seen from the table below, all nine of the SCI scales have both quite respectable internal consistency, and based on a retaking the test five weeks later, quite respectable stability.

Reliabilities for the 9 Shapiro Control Inventory (SCI) Scales

SCI Scales	Alpha Internal Item Consistency	Test-Retest <i>r</i> (five week)
Sense of Control		
General Domain		
1. Overall sense of control	.89	.83
2. Positive sense of control	.89	.81
3. Negative sense of control	.70	.70
Specific Domain		
4. Overall domain specific	.75	.93
Four Quadrant Mode of Control		
5. Quadrant 1 Positive Assertive	.88	.80
6. Quadrant 2 Positive Yielding	.77	.67
7. Quadrant 3 Negative Assertive	.82	.78
8. Quadrant 4 Negative Yielding	.70	.84
Desire For Control		
9. Overall desire for control	.76	.82

An intercorrelation of the nine SCI scales shows high correlations between the overall sense of control scale and the two scales from which it is constructed (positive sense of control and negative sense of control). Other than that obvious high correlation, the SCI scales show a small to moderate intercorrelation with each other, with no scale accounting for more than 36% of the variance of another scale. The degree of overlapping variance indicates that each scale provides unique information.

SCI Scale Intercorrelations

Scale	1 GDOV	2 POS	3 NEG	4 SDOV	5 Q1	6 Q2	7 Q3	8 Q4	9 DESI
1. GDOV	1.00								
2. POS	.96	1.00							
3. NEG	-.83	-.63	1.00						
4. SDOV	.50	.51	-.35	1.00					
5. Q1	.66	.66	-.48	.34	1.00				
6. Q2	.23	.30	-.04	.07	.25	1.00			
7. Q3	.13	.10	-.17	-.09	.40	-.02	1.00		
8. Q4	-.52	-.43	.55	-.36	-.30	.15	.26	1.00	
9. DESI	.13	.16	.03	.02	.28	-.12	.50	-.43	1.00

Key:

1. GDOV = General Domain Overall Sense of Control Scale
2. POS = Positive Sense of Control Scale
3. NEG = Negative Sense of Control Scale
4. SDOV = Specific Domain Overall Sense of Control Scale
5. Q1 = Quadrant 1 Positive Assertive/Change Mode of Control Scale
6. Q2 = Quadrant 2 Positive Yielding/Accepting Mode of Control Scale
7. Q3 = Quadrant 3 Negative Assertive Mode of Control Scale
8. Q4 = Quadrant 4 Negative Yielding Mode of Control Scale
9. DESI = Desire for Control Scale

Discriminant validity studies: Eating Disorders, Adult Children of Alcoholics;

Two studies were then undertaken with a clinical sample—restricted eating disorders (anorexia nervosa and bulimia nervosa), and an at risk sample: adult children of alcoholics—to examine the question of discriminant validity as it relates to treatment utility of assessment. Both studies showed discriminant validity and also that the scales of the SCI significantly differentiated the populations from sex matched and age matched/balanced normal comparison groups.

Discriminant, divergent and incremental validity between the SCI and Rotter's Locus of Control Scale and Wallston's Health Locus of Control Scales. Normals, Depression, Generalized Anxiety, Panic Attack, Borderline.

Another series of studies involved divergent, discriminant, and incremental validity of the SCI compared to Rotter's Internal External Locus of Control Scale and Wallston's Health Locus of Control Scales. Five groups were administered the above tests, four clinical groups (depression, generalized anxiety disorder, panic attack, and borderline personality disorder) and a normal screened group.

Discriminant Validity. The first objective was to determine whether the SCI, as well as Rotter's and Wallston's scales, can discriminate among the groups in question, and in particular between normals and different clinical groups. This is a critical question because if the SCI cannot discriminate normals from clinical groups, it has no clinical utility. The results (Table below) indicated the SCI does indeed discriminate among normals and several clinical groups. Analysis of variance revealed that all nine of the SCI scales were able to significantly differentiate among groups. Of the nine scales, four differentiated among groups at $p < .0001$; 3 at $p < .001$; and 2 at $p < .01$. Rotter's Internal/External Locus of Control Scale differentiated among groups at $p = .0445$; and Wallston's three scales did not differentiate among groups.

TABLE 11
Control Scales: SCI, Rotter's, Wallston's

Populations:		Normal	Border- line	Depression	Panic Attack	Generalized Anxiety	Overall <i>p</i>
SCI General Domain Sense Of Control							
1) Overall Sense Of Control							
	mean	5.59	3.92++++	3.98++++	4.22++++	4.43+++	<.0001
	sd	(.44)	(.69)	(.98)	(.83)	(.92)	
2) Positive Scale							
	mean	5.68	4.00++++	3.98++++	4.17++++	4.47+++	<.0001
	sd	(.45)	(.81)	(1.17)	(.96)	(1.03)	
3) Negative Scale							
	mean	2.60	4.27++++	4.04++++	3.73+++	3.61++	<.0001
	sd	(.57)	(1.02)	(.88)	(.94)	(1.09)	
SCI Specific Domain Sense Of Control							
4) Overall							
	mean	5.15	3.79++++	3.69++++	3.90+++	4.10++	<.0001
	sd	(.46)	(.58)	(.76)	(.88)	(.87)	
SCI Mode Of Control							
5) Quadrant 1 Positive Assertive							
	mean	2.90	2.32+++	2.06++++	2.16++++	2.42+	<.001
	sd	(.55)	(.41)	(.54)	(.59)	(.65)	
5) Quadrant 2 Positive Yielding							
	mean	2.67	2.07+++	2.16+++	2.24++	2.22+	<.01
	sd	(.54)	(.42)	(.46)	(.48)	(.55)	
7) Quadrant 3 Negative Assertive							
	mean	1.79	2.43+++	2.02	2.06	2.64+	<.001
	sd	(.48)	(.63)	(.41)	(.48)	(.58)	
3) Quadrant 4 Negative Yielding							
	mean	1.50	2.19++++	2.20+++	2.23++++	2.13++	<.001
	sd	(.42)	(.53)	(.62)	(.60)	(.59)	
j) SCI Desire For Control							
	mean	4.66	5.37++	4.97	4.94	5.19	<.01
	sd	(.74)	(.62)	(.75)	(.62)	(.78)	
Rotter's Internal/External Locus of Control Scale							
	mean	8.09	10.95+	11.33+	9.74	10.59	<.05
	sd	(3.90)	(3.97)	(2.47)	(3.54)	(4.35)	
Wallston's Multidimensional Health Locus of Control Scales							
Internal		29.09 (3.42)	27.03 (6.51)	25.43 (6.86)	24.90 (8.43)	26.53 (4.78)	NS
External Powerful		21.82 (12.87)	16.83 (6.98)	18.02 (5.85)	16.76 (7.01)	17.82 (6.38)	NS
Chance		17.09 (4.76)	16.45 (5.49)	17.35 (5.98)	16.21 (6.74)	17.76 (5.65)	NS
Clinical versus Normal:		+ $p < .05$	++ $p < .01$	+++ $p < .001$	++++ $p < .0001$		

DIVERGENT VALIDITY.

This study was to determine whether the SCI measured something different from Rotter's and Wallston's tests. If the SCI scales were highly correlated with Rotter and Wallston's tests there would be no reason to have developed a new instrument. Results showed a low correlation among scales. The highest correlation of the 9 SCI scales was Negative Sense of Control, Scale 3, and Rotters' ($r=.38$). This correlation accounts for less than 15% of the variance, is below the .6 correlation (see Cronbach, 1970) stated as needed to be clinically significant, and is well outside confidence limits (.27-.45) for the population correlation coefficients given the sample coefficients (Beyer, 1976, p. 392). The correlations suggest the SCI is measuring something different from the other tests. This low correlation across scales was expected as Rotter's and Wallston's tests assess *if* a contingent statement regarding control is true (in the abstract) but not *whether* it is true for that person as do the SCI sense of control scales. Further, whereas Rotter's and Wallston's tests appear to reflect a generalized expectancy along a quadrant 1 positive assertive and quadrant 4 negative yielding continuum, neither of them even attempts to measure quadrant two, positive yielding or quadrant three, negative assertive.

Correlations Between the Shapiro Control Inventory (SCI) Scales and Rotter's and Wallston's Locus of Control Scales (Co pairs N=164)

SCI Scales	Rotter's*	Wallston's		
		Internal	Powerful Other	Chance
General Domain				
1) Positive	-.31	.25	.02	-.14
2) Negative	.38	-.20	-.07	.07
3) Overall	-.37	.26	.04	-.14
4) Domain Specific				
Overall	-.34	.18	.04	-.07
Mode				
5) Positive Assertive (Q1)	-.23	.14	-.08	-.31
6) Positive Yielding (Q2)	-.25	.07	-.08	-.19
7) Negative Assertive (Q3)	.12	-.02	.07	-.05
8) Negative Yielding (Q4)	.23	-.07	.08	.18
9) Desire	.15	.05	-.04	-.03

* On the Rotter, the lower the number, the more internal the locus of control.
 For N=100, a correlation of .20 is significant at $p=.05$
 For N=100, a correlation of .25 is significant at $p=.01$.

INCREMENTAL VALIDITY: Sensitivity and Specificity

By showing that the SCI significantly discriminates among groups (objective one) and that the SCI measures something different than Rotter's and Wallston's locus of control scales, (objective two), it was then possible to see whether the three control assessment instruments could provide incremental validity: both sensitivity - distinguishing normals from clinical disorders; and specificity - distinguishing between clinical groups.

Discriminant functional analysis with jackknifed classification results were calculated only for the SCI scales and Rotter (because the Wallston tests has no discriminant validity (objective one). Depending upon sample size, two tailed Fisher

Exact and Yates corrected chi square were run in order to determine whether differences among scales were significant.

Sensitivity. In terms of sensitivity, 5 of the SCI scales were more accurate than the Rotter in predicting normals, reducing between one third to two thirds of the Rotter error. The highest accuracy was 90%, achieved by the SCI scales of positive sense of control and negative sense of control.

Specificity. In terms of specificity, the SCI was more accurate than Rotter's in correct diagnosis of borderline patients on all 9 scales. The SCI negative sense of control was most accurate with borderline patients (56.4%) compared to Rotter's 2.6% accuracy. For GAD patients the SCI was more accurate than Rotter on 8 of 9 scales. The SCI positive and negative sense of control and desire for control scales were most accurate (25%) compared to Rotter's 0% accuracy. For depressed patients the SCI was more accurate than Rotter on 2 scales: the SCI scales of positive sense of control (53.1%) and positive assertive mode of control (50%) were most accurate followed by a tie between Rotter and the SCI general domain overall sense of control scale (46.9%). Rotter was more accurate than 5 of remaining SCI scales). For panic attack patients the SCI was more accurate on 2 scales. The most accurate scale was the SCI positive yielding mode of control (14.6%) and the SCI desire for control (14.3)% followed by a tie between Rotter and the SCI domain specific sense of control scale with 6.1% accuracy.

Thus, for objective three, in terms of sensitivity, five of the SCI scales were more accurate than Rotter's in predicting normals, reducing between one third to two thirds of the Rotter's error. In terms of specificity, the SCI was more accurate than Rotter's scale in correct diagnosis of borderline personality disorder on all nine scales, generalized anxiety disorder on eight scales, depression on two scales, and panic attack disorder on two scales.

Additional validity studies have looked at the relationship of the four modes of control to psychological health (for "person," "man," and "woman" in an 11 city US study (*concurrent and construct validity*); a prospective longitudinal study of the modes of control with Type A individual with one myocardial infarction (*validity through treatment utility*); (validity study 7); two different case studies of stress related disorder with clients presenting nearly opposite clinical "mode" profiles" and the implications for matching treatment to Control Profile (validity through treatment utility of assessment: validity study 8); one case study using the SCI and the MMPI (validity study 9); divergent and convergent validity with the SCI modes and the Eysenck personality questionnaire (Validity study 10); construct validity with long term meditators and the positive yielding mode of control (validity study 11); and discriminant validity through contrasted groups of meditators and Type A individuals (validity study 12). These studies are all published and detailed in summary form in the SCI Manual (as are all the studies detailed above).

Note to lecturer: This may be an appropriate time to mention that since we have been discussing the Control Profile from the SCI, for those who would like to take the SCI and learn about their own Control Profile, it is available for health care professionals (and their clients) at no charge at Controlresearch.net

Now, we turn to Control Stories, a third way (besides listening for control speech, and the SCI), of assessing a person's control dynamics.

CONTROL STORIES.

slide

***I've given up my search for the truth,
now all I want is a good story!***

--Ashleigh Brilliant (with gratitude and apologies)

Once, in Kansas City, a friend walked up to his colleague who was wildly waving his hands. "Why are you doing that," he asked his friend.

To keep the elephants away. I do it once a day."

"But there are no elephants in Kansas City."

"See," his friend replied, "it works!"

end slide

What is a control story? Control stories are a third way to assess a person's Control Profile. These stories are formed by the units of control speech, and coalesce and evolve into a narrative—consciously or unconsciously—(and with varying degrees of "truth" and "accuracy") by which individuals

- frame, explain, and understand events in our world—why things happen;
- seek to explain chaos and disorder—internally and externally;
- reflect attitudes and views about the amount of influence we believe we (and others) can and should have over events in our lives;
- explain our level of motivation and commitment, as well as our ability to develop self-regulation of our thoughts, emotions, and behavior.

Control stories further tell us whether, when, and how we are feeling in control, out of control, and the means by which we believe we can best gain and maintain a sense of control.

These stories are a chance to create explanations that make us feel more in control, and make events more understandable. "Naïve" unexamined control stories are based on our early childhood experiences and parenting, personality, salient control-related life events in "love and work", and cultural and religious attitudes. In effect, our control story "not only creates beliefs about reality, but defines that reality." (CT, Chapter 9, p. 155).

Control stories can become fundamental, core belief systems and self-narratives we use to shape and define our lives--past, present, and into the future. Everyone has them. As noted, in addition to being conscious or unconscious, they also may be in varying degrees accurate or erroneous (or a mixture of both).

Control stories can help explain the world, creating meaning throughout the developmental life cycle, addressing the individual's need for a sense of cosmic

perspective, and framing existential human concerns of identity (who am I?); direction (where am I going?), and meaning and purpose (why am I going there?). Control stories can also play a key role in determining a person's motivation, including his/her motivation for change. In fact, major thematic stories, once they take hold in a person's mind, then become like "perceptual filters" through which the person receives input from the environment, interprets it, rejects some of it, and accepts other parts of it

Recognizing problematic control stories. Below are a couple of examples of how a control story can create difficulties for someone. A person who remembered her parents as continually harping on her to do better internalized the message that she wasn't doing "good enough"... so that in adulthood her control story becomes, "I always second guess myself. I do not feel I am adequate to competently exert control in the world in an effective manner." Another example is a person who was reinforced for performance and came to tell the control story that "I am not lovable as I am; I can only be loved for accomplishment" and therefore relies exclusively on the assertive mode—doing—in order to gain a sense of control through competence and productivity. The problem is this person felt unlovable "just as he is."

Experiential exploration of control stories: We humans create stories to reduce uncertainty and ambiguity and to give us a sense of control. For example, we see a semi-random collection of stars in the sky, and call it the "Big Dipper" and then proceed to tell stories about the constellations. Sometimes these imaginal stories are harmless, or serve a positive, reassuring function. Sometimes these stories can be wrong: e.g., the earth is flat, the sun revolves around the earth.

The first step in exploring control stories is to make them overt and bring them into conscious awareness.

The next step after raising awareness of a personal control story or stories is to ask if these stories about oneself and the world are as true, accurate, and helpful as they can be. Do not assume all control stories are problematic. Control stories can be helpful and adaptive. Sometimes they are adaptive in some situations, but not in others. Or they may have been adaptive in a past situation, but they could be a hindrance in the present.

I'd like to take a few minutes to invite you to further explore a few aspects of your control story. We have already explored certain aspects of your control story: remember, the simple topic of your view about the nature of the universe and the role of control in it. :) "Personality theories" are actually control stories, hopefully more refined than "naïve" control stories. For example, are we innately good (humanistic psychologists); innately amoral (classic Freudian Id psychology); tabula rasa (behavioral, existential). It might be worth considering how and where you, as clinician and health care professionals, developed your personality theory: how much from scientific research, how much from life experiences, a "felt" knowing?

On a personal level, below are questions related to different aspects of the Control Profile—desire for control, modes of control, and agency of control, that you, in turn, could address to your client, as appropriate.

Desire for control. How would you answer this if...then clause. Just quickly notice what response comes to mind....

IF ONLY I COULD GAIN MORE CONTROL.....

(fill in your greatest desire in one of your life domains: e.g., body, relationship, financial, etc),
THEN I WOULD BE.....
(fill in the feeling).

This question can be helpful in exploring the aspect of your control story that connects a desire for control in some area and the belief, whether conscious or unconscious, between gaining a sense of control in that area, and your emotional well-being and happiness. Generally we desire control in our life because we feel it will make us happy. Note what the area was that you wanted to change, and why. "I want to be... richer, wiser, taller, stronger. Or, I want to have.... a relationship, house, etc." See if this thinking doesn't apply to your desires for control. What is your belief about the relationship between control and personal happiness?

How important is it for you, personally, to have control in your life? What might be experiences in your childhood or upbringing that may have contributed to your desire for control.

Further stories about desire for control can include beliefs about when desire for control is good and positive, when it is bad and inappropriate, when we have too much desire, when too little.

Modes: The modes you prefer (and dislike) is also part of your control story." For example, here are some questions to take a moment to explore slide:

1. What is your personal preference: the assertive/change mode of control , or the yielding, accepting mode of control?

Take a moment to consider why you feel a preference for one mode over the other.

2. Which negative mode seems worse to you: negative assertive or negative yielding (If you had to choose between being considered by others as a passive wimp (quadrant four) or an over-controlling tyrant (quadrant three), which would seem better and which worse to you? Why?

3. Are there any childhood experiences you have had, or other "significant events" which you believe might have influenced your preferences (and aversions) in questions 1 and 2 above?) What does your culture say about which mode is preferable? Your religious, spiritual beliefs?

Agency of Control. Beliefs about agency are also part of one's control story. How would you answer the question, again quickly, **Who (or what) controls your life?** Often the first answer to the question is "I do." (self as agent). Other answers include "money, duty, fame, my parents, my significant other, my children, my work, my boss, food, pain, pleasure, my passions, God, etc). Are there some who gave multiple answers, including self and other, depending upon the situation?

Do you primarily gain your sense of control from your own "self" efforts, or the help of others? Which do you feel is better? Please consider why you believe as you do, based on your own upbringing and experiences.

Evaluation of a control story. In general, we don't really begin to think about evaluating a control story until a concern or problem arises that challenges it. Part of evaluation involves recognizing a control stories, and then exploring whether that preference is currently serving one well in the present. It may be worth asking in your own life, and certainly in your client's lives, whether there may be times when a different control story, or the flexible use of control stories regarding mode, agency, and desire for control might better serve you? Locating this present-day meaning stemming from early and/or crucial experiences allows us to step back and examine our control stories and reflect on how they guide our choices today. When we discuss goals in a few minutes, we will look at ways to evaluate (and if we wish, later edit and change) our control stories. For now, the important point in assessment is just being more aware of the nature and type of control stories.

Note to lecturer. This is again a choice point in the lecture. We've now completed the third aspect of assessment, and you could go directly to the fourth aspect: self-observation (topic 8). However, there are two additional topics about control stories that are important and interesting, which, if there is enough time, might be mentioned here.

The first has to do with Self-control and control stories, including your (and your client's) views of who is the "self" in self-control, and what are the dimensions of self-control. These dimensions are part of the SCI "Sense of Control" Scale, and are important in terms of evaluating which ones the client has skills in, and which might be further explored.

The second topic has to do with providing the therapist an opportunity to explore in a bit more depth their own control story (theory) about personality, their preferred system of psychotherapy, and the role of control in each.

Self-control and control stories. We all have control stories about our level of self-control. At a simple, descriptive level, increasing self-control involves doing something that you are not doing, or that you want to do more. Or, it means working to stop doing something that you are doing that you wish you were doing less! To look at this in your own life, ask yourself (and realize these are questions that you could ask your clients):

What would you like to do that you're not doing?

What would you like to not do that you are doing?

How you answer these questions are mini-control stories.

In addition, sometimes we may feel like we are exercising too much self-control. One meditation student, while working on relaxing and just "allowing breathing" pulled back in tension, and said, "I don't feel like I have the self-control to just let go of active control." This is this student's story about her level of self-control.

Therefore, an additional question for you, and for your clients, is:

Are there areas where, in order to realize your vision for yourself -- you would like to exercise increased self-control and/or become more comfortable with not having active control?

Clearly, the issue of self-control, where we want it, and why, is also part of our control story.

Six Dimensions of self-control. Research has shown that there are six dimensions of self-control. One way to help pinpoint these six areas more carefully is to listen to speech (your own speech and that of others) reflecting these dimensions. The following table provides high and low examples of each dimension. These dimensions are part of the SCI Positive Sense of Control scale (questions 13-18). Each person has a control story about where they fall on each of these dimensions (high to low examples are provided below). As we review these in the slide you may begin to think about the control stories you have about the relevance and importance of each of these dimensions in your life. These are also important dimensions to assess in your client to see, as noted above, which ones the client has skills in, and which might be further explored to understand their control stories about each.

slide

Six Dimensions of Control and Self-Control

1. CHOICE

This dimension suggests volitional efforts in which external demands (shoulds, oughts) are minimized. Choice implies alternative degrees of freedom and the ability to evaluate as well as posit goals. Averill (1973) has referred to this as "decisional control."

REFERENCES: Furlong, 1979; Lefcourt, 1973; Nolan, 1972; A

EXAMPLES: I want to make a clear choice about this. (High)

I don't feel like I have any options in this. (Low)

2. GOAL

One's goal (or vision) is what choices are made toward (i.e., "control and self-control for what?"). Goal is defined as the desired objective toward which effort (discipline) is directed.

REFERENCES: Bandura, 1977; Thoresen & Mahoney, 1974.

EXAMPLES: I definitely want to control my temper. (High)

I don't know what I really want to do. (Low)

3. AWARENESS

The ability to discriminate cues in the internal and external environment and the ability to note how those variables affect a person. Awareness can be of a particular cause/ effect change, a style of striving, a recognition of the goal (#2), and/ or an awareness of choice and options.

REFERENCES: Furlong, 1979; Lefcourt, 1973; Nolan, 1972; Shapiro, 1983; Thoresen & Mahoney, 1974.

EXAMPLES: I am learning how my thoughts affect my feelings. (High)

I don't understand why I act the way I do. (Low)

4. EFFORTS/DISCIPLINE

Efforts/ discipline is used here to include effort, delay of gratification, self-sacrifice, and determination. Webster's defines discipline as "training that molds, corrects, or perfects the mental faculties or moral character... .. Control gained by enforcing obedience or order." (1981, p. :322)

EXAMPLES: I am willing to do whatever it takes to stick to this program (high)

I don't have the energy to make much effort (low)

5. SKILL

Webster's defines skill as "the ability to use one's knowledge effectively and readily in execution of

performance" or "a development of aptitude or ability." (1981, p. 1079).

REFERENCES: Bandura, 1977

EXAMPLES: I know how to act assertively. (High)

I don't know how to change. (Low)

6. RESPONSIBILITY Responsibility is defined as a cognition in which one assumes unidirectional, casual attribution about the effect one's own behavior and thoughts have or could have on the environment and/ or oneself.

REFERENCES: Globus, 1980; Knowles, 1977; Shapiro & Shapiro, 1979.

EXAMPLES: It's up to me to control my behavior. (High)

It's my parents' fault that I act like this. (Low)

end slide

A Homeric tale to help you explore your own control stories regarding “self-control.”

In the *Odyssey*, Homer described Odysseus' preparation to navigate the bewitching effects of the sirens, whose lulling sounds inevitably caused sailors to steer toward them and crash their ships on the rocks. Knowing this, Odysseus had his oarsmen tie him to the mast and place wax in their own ears.

Does this represent self-control? Why or why not? Quickly think what your “gut” reactions is. What do you imagine was Odysseus' self-control story?

Those who argue that this does not represent self-control say that Odysseus doesn't have either sufficient personal skill or discipline to handle the sirens' call. Those who argue that he *is* demonstrating self-control say he has awareness of the situation and his limitations, has a clear goal, exercises a conscious choice about how to proceed toward his goal, and takes responsibility for both his limitations and his actions. Both of these are control stories of the listeners.

This “tale” can help us examine our own control story about what “self” -control means. The six dimensions of control (awareness, choice, responsibility, goal, effort, and skill) are building blocks that underlie all human control strategies. Although all six are needed, they do not all necessarily have to come through self-agency. [Odysseus has four of them. And he is aware of what he doesn't have—skill and discipline—and therefore asks others for help]. Which self-control strategies we choose to emphasize, and how we go about implementing them (whether through self or other agency) are influenced in part by our control stories.

What is instructive in the above “tale” is it might help each of us (and our clients) nuance our own stories about what “self” control means. We might learn to recognize and assess, which dimensions we (and our clients) have abilities to address, and which, we don't; and further, as for Odysseus, there may be certain areas where we need to ask help from others.

Control Stories about “Who is the ‘self’ exercising control? The final point regarding self-control and control stories is how to assess a person's control story through careful listening to their speech to help understand their view of the role of “self” in self-control, and how that relates to the six dimensions. Different ways individuals characterize self can include Global self: I, me, etc; as well as specific aspects of self—e.g., mind, thoughts, feelings, body, behavior.

Sometimes these stories about self are well thought out, sometimes less so. For example, in your control story (theory of “self-control”) do you believe that thoughts control emotions? Emotions control thoughts? How much control do you believe we have over what we choose to attend to? Is motivation innate? How much of it can be learned and cultivated? And, even more, who is the “self” who either does or does not exercise agency—if thoughts can control emotions, “*Who* controls our thoughts?!”

Is our self more than thoughts, emotions, awareness? Sometimes we (and our clients) refer to the self in a global sense (“I” choose to do this; “I” am responsible.). Sometimes we (and our clients) will use aspects of the self when referring to their control story: e.g., my emotions control me; my thoughts are more important than my emotions.

Through careful nuance of the different dimensions of self-control (as in the Odysseus story), and through careful listening to our and our client’s speech, we can better assess the control story we and they are telling regarding “self” and the dimensions of “self” control. Below is a Figure showing different dimensions of “self” in coding speech samples in content analysis research. In a less formal way, this sort of careful listening can be helpful in helping us and our clients identify certain speech patterns representing aspects of their control story—when they are taking responsibility, when deferring it to others (and when you assess that as positive, and when as less skillful). : These examples provide insight regarding the speakers’ control stories about who are what controls their “self,” and have implications for how they view the six dimensions of self-control.

slide:

"SELF" CATEGORIES

DESCRIPTION AND EXAMPLES OF “SELF” AS AGENT AND AS OBJECT

GLOBAL: This refers to the entire “self”; the person in his or her totality.

Code words include “I,” “me,” and so on.

EXAMPLES: I control him. (Self as agent)

She ordered *me* to stop. (Self as object)

MIND: To be coded as a descriptive term when used by the person giving the speech sample.

EXAMPLES: My mind controls my body. (Mind as agent)

Voices control my mind. (Mind as object)

BRAIN: This term is coded either when the word “brain” is used by the person giving the speech sample or when there is reference to a certain part of the brain.

EXAMPLES: My brain waves control him. (Brain as agent)

God controls my brain. (Brain as object)

COGNITIONS: Refer to thoughts, statements, beliefs.

EXAMPLES: My thoughts control my feelings. (Cognitions as agent)

Meditation has helped me slow down my thoughts. (Cognitions as object)

FEELINGS: Refer to emotions, mood states.

EXAMPLES: My anger made me lose control and hit her. (Feelings as agent) I feel

I can control my sadness. (Feelings as object)

BEHAVIOR Refers to actions, bodily movements, deeds.

EXAMPLES: My behavior affects others. (Behavior as agent)

The government interferes too much with my private actions.

(Behavior as object)

BODY: Refers to weight, illness, body parts (e.g., eyes); also coded here are statements about genes, heredity, etc.

EXAMPLES: My genes make me aggressive. (Body as agent)

I am having trouble controlling my weight. (Body as object)

end slide

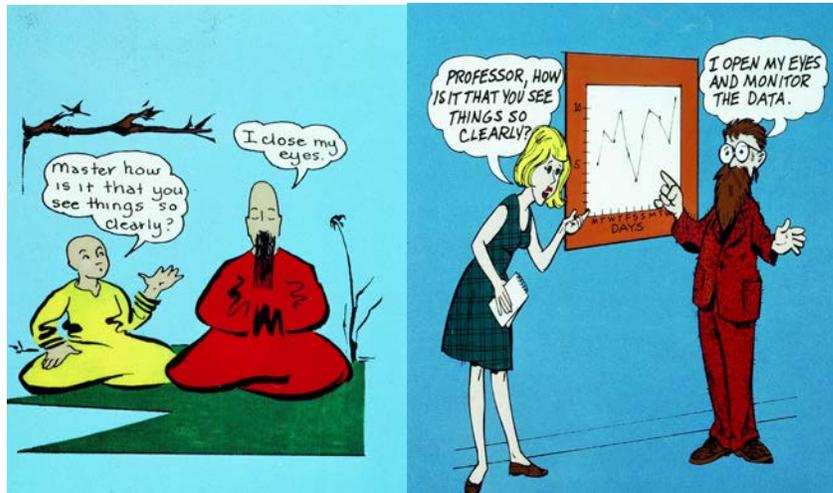
Again, this material is merely an effort to help refine and listen to client speech in a way that helps give clues to the client's story about

- *the global "self" and its ability to exert "influence" over itself and the world around;
- *the person's views of who or what is "influencing" the self,
- *when influence from others is positive, when troublesome
- *the most salient aspects of "self" for that person (e.g., body, behavior, cognitions, etc)
- *the interaction of those aspects with each other in terms of which is "more" in control;
- which aspects of the self are viewed as trustworthy, which troublesome
- and finally the relevance of a person's speech (and story) for assessing and understanding the six dimensions of self control for that person.

We now turn to the fourth aspect of assessing our client's: awareness, through self-observation.

**SELF OBSERVATION:
MORE PRECISE (AND COMPASSIONATE) AWARENESS
IN ASSESSING THE CONCERN**

slide



Most of us don't take the time or expend the energy to monitor our lives, so we remain puzzled by occurrences that seem haphazard. If we monitor our actions and feelings carefully, we will notice patterns. They may be complex patterns, but patterns nonetheless.. -- L. Barbach

end slide

The importance of awareness. All therapeutic approaches acknowledge the importance of awareness as a necessary (and some schools say sufficient) aspect of therapy. However, there are differences into where the awareness should be focused (e.g., past experiences and events, future goals and aspirations, the here and now present.). Further there are different views of how "natural" awareness is. For example, Skinner argued that people are not naturally self-aware and only develop it when external events force them to. Freud, similarly, felt humans were very resistant to develop self-awareness of certain aspects of their behavior, and would use resistance, denial, and other defenses to avoid observing themselves honestly and clearly.

CT would say "yes" to the above differences. As in the story Fiddler, Tevya says, He's right; she's right. To which a friend says "they can't both be right." And Tevya responds, you're right, too!"

CT's "Yeses!" are tempered by nuance and careful distinctions as follows. We have pointed out the potential importance of examining awareness that is historically focused (e.g., origins of control stories). In next section, we discuss the importance of awareness of future goals and plans. In terms of here and now awareness as part of assessment, CT seeks to combine the precise, nuanced cause and effect clarity of behavioral self-observation. and the spacious, open handed, compassionate awareness involved in mindfulness meditation.

If you are willing, let me invite you to practice each of these types of awareness in the following exercises. These are both exercises that can be shared with your clients., CT's belief is that personal practice can both create empathy for the client's experience, and also model a "practice what we preach" effort. After briefly practicing each, the important points of their potential integration will be noted.

Mindfulness Meditation. At its simplest, mindfulness meditation is a type of self observation which involves "just noticing" "bare" awareness of what is happening in the here and now. The meditator is told that as thoughts, feelings, sensations arise, not to judge them—there is to be no evaluation-- not to further explore them, but merely to notice and let them go. The goal is the paradoxical "goal of no goal"—to stay in the present moment, nothing to achieve, no place to go. One of the powerful advantages of this type of awareness is that giving instructions that reinforce removing "judgment" may allow a less defensive and more open receptivity to whatever is going on in the mind and body. There can be an attitude of "curiosity"—just noticing, e.g, huh, I'm having that thought, that feeling, let me notice it and then let it go. Shauna Shapiro (who created the instructions below on mindfulness for the Control Therapy Training Manual) has added the intentional attitude of bringing compassion to one's mindfulness practice, so that there is even a gentler noticing of thoughts and feelings that arise.

If you're willing we can try a brief mindfulness meditation right now, using diaphragmatic breathing. There are several ways we can breathe. One is where we actively try to control it. For example, draw a big breath in through your nose. Now exhale forcefully. Good. Notice whether your chest rises during the process. Now, in this exercise, we are going to try to let the air come at its own pace—without any active control on your part. For example, your breath comes at its own rhythm during the night when you sleep. You don't have to control it. Further, when we sleep at night, our body naturally breathes from the diaphragm. Therefore, DIAPHRAGMATIC BREATHING is really something that our body already knows, and we are just trying to "learn" to do it well awake .Research has shown that when we breathe from our diaphragm (belly) our brain goes into a relaxed state (EEG alpha) and that when we breathe from our chest (thoracic), our brain goes into a more excited state (EEG beta). Now for mindfulness meditation:

- Adopt an alert, yet relaxed body posture.
- Set an intention for your practice (and then let it go).
- Bring your attention to your body sitting.
- And then notice that you are breathing.
- Really experience the movement of the breath coming into the body and the breath flowing out of the body.
- Try not to control the breathing, but simply experience it. Feel the coolness of the air as you breathe in through your nose.
- Breathing in, allow your belly to naturally rise and expand, breathing out, allow your belly to sink back.
- When your mind wanders, name what it wanders to and come back to the breath, using it as an anchor.
- Remember to bring a nonjudgmental, accepting and kind attention to whatever arises, moment by moment.

A Reminder: Emotions or thoughts that arise in the field of awareness are just noticed, including any tendencies to push away unwanted thoughts or feelings, or rush toward positive ones. Rather the “goal” is to just allow whatever is arising to be there. If fear, sadness, or anger arises, and you notice a desire to run away from these states, try to just continue your gentle breathing, while noticing the desire to flee, but without judging, seeking to maintain a compassionate, non-judgmental awareness of whatever thoughts and feeling may be present.

Behavioral self-observation is an “awareness” and assessment strategy common to nearly all cognitive and behavioral therapeutic approaches. Some methods look at the relationship between cognition and affect (based on cognitive theory regarding how beliefs create affect). Others, based on Skinner’s functional analysis, look at the relationship between a) antecedent environmental events (e.g., who is present, where) and b) a person’s behavior, and c) the consequences (e.g., reinforcement, punishment) of that behavior, sometimes referred to as the ABC model.

The self-observation model used in Control Therapy includes both. It is based on the simple A-B-C (antecedents, behavior, consequences) of Skinner but includes cognition and affect. A target area, such as an internal thought or feeling, or an external behavior, is selected for monitoring, and the individual records in systematic fashion not only the target behavior, but also: A) the antecedents: where the individual is, who is present, and events, actions, verbal statements, feelings that occur *before* and in some way may *trigger* the target behavior. C) how things change as a result (i.e., consequences). In terms of the area being monitored, the therapist should emphasize the importance of precision: frequency, latency, intensity, duration.

A sample form is shown below. Alternatively, a person can devise his or her own means of recording, such as a free form journal. Again, like fingers pointing to the moon, the goal here (the moon) is what is important—i.e., some form of monitoring to gain greater self awareness—the means (the finger) less so.

As any of you who have tried to self-monitor, or worked with clients to do so, it is not necessarily easy or consistent, and often there is some resistance. So, how we frame the reasons for self-monitoring is important. Here is one way to explain self monitoring to a client: e.g. “One important type of awareness is gaining more precise information about a problematic behavior so that you can learn about yourself and how you are affected by the world around you. It would be really helpful if we could gain more information about your areas of concern in the “natural” environment when it is occurring. Would you be willing to work on trying to gather this information more precisely this coming week? Also, it is important to try to be as precise as possible: For example, if you were monitoring “when I feel stressed” you would want to pinpoint what stress means to you, where you feel it (e.g., in your body, your thoughts); how intense it is; how long it lasts.

Slide:

SELF-OBSERVATION FORM: For each occurrence.

What is being observed: (Be as clear and precise as possible - e.g., physical sensations, thoughts, feelings, behavior, verbal statements, etc)

Please discuss the following for each occurrence:

Intensity (1 = slightly out of control to 5 = very out of control) _____

Time of day observed _____ Day of the week _____

Physical sensations—before; during; after

Thoughts and emotions that preceded the concern being monitored; during? after?

Who was present?

What was going on in the environment?

Consequences of the “behavior”: How did the situation/you change? What happened?

End slide

Start slide

SELF OBSERVATION: A WEEKLY OVERVIEW FORM

Name _____ Week Monitored _____

Concern being monitored _____

BEFORE AFTER

Where, Who was present, doing what; thoughts, body sensations, feelings?*	How did situation change as a result: externally, internally?*		Sun	Mon	Tues	Wed	Thurs	Fri	Sat	TOTAL PER TIME SLOT
		7-9								
		9-11								
		11-1								
		1-3								
		3-5								
		5-7								
		7-9								
		9-11								
		11-7								
		TOTAL EVENTS PER DAY								

End slide

This self-observation provides situation-specific variation and nuance about different aspects of the Control Profile. It is important, as noted, to try to have the client be as specific and careful as possible about the area monitored. The therapist can explain this is like turning up the “attentional” power of a microscope.

Integrating mindfulness meditation and behavioral self-observation. As previously noted, the roots of Control Therapy began with seeking to explore, understand, and where appropriate integrate eastern self-control strategies of meditation and western behavioral self-control strategies. As can be seen from the above, both sets of strategies place a prime importance on self-observation. In CT, the elements of curiosity, bare awareness, and “just” noticing” are emphasized when applied to the practice of behavioral self-observation. This allows for a potentially less resistant, less defensive willingness to carefully and nuancedly monitor one’s behavior. Further, since behavioral self-observation is involves careful precise attention to an area which is one of concern to the client, it can be helpful to bring the qualities of kindness, patience, and compassion to whatever is being observed. This can allow a client to learn to self-observe in a more nonjudgmental and kindly manner. Further, meditative mindfulness as an awareness strategy is actually teaching a person to learn how to notice and “accept what is”; and therefore is also a helpful strategy for those whose goal (next section) is learning a positive yielding mode of control toward their concern. as a reminder to be kind and curious toward oneself, not judging and blaming.

Behavioral self-observation is important because it allows for a careful exploration of cause and effect between thoughts, feelings, sensations, and looks at how antecedents and consequences influence thoughts, feeling, and behavior. This is critical information to help learn about the “patterns” that Barbach speaks of in the quote at the start of this section. In behavioral self-observation, thoughts and feelings are not just noticed and “let go.” They are actively investigated, evaluated, and used as a basis for setting a goal (described in the next section). When “awareness” alone is not sufficient to address clinical concern, this information is essential and foundational as part of the therapeutic “change” process, as we will see in the section on goal setting, and then in Phase Two, Interventions.

Thus, in Control Therapy, an effort is made to combine the two techniques of awareness—meditation and behavioral self-control-- by bringing the precise attention of behavioral self observation to help gain further information about the area of clinical concern, and to do so with the qualities of kindness, patience and compassion of mindfulness awareness to whatever is being observed, whether in oneself or others.

A brief exercise on behavioral self-observation: observation of an aspect of one’s Control Profile.

Self-observation is generally a “homework” assignment given to the client to practice during the week. Its purpose is to gain practical and precise in vivo information gathered in the here and now .natural environment about an area of concern

As a way to “simulate” an aspect of self-observation, I’d like to invite you to turn your awareness (mindfully!) to a specific area of the Control Profile. Although this

won't give you here and now information, (since it will be based on post hoc retrospective recall), it can help give a flavor of the process of self-observation, and might be a good way to model it in a clinical session with the client as practice, before the client actually leaves the office to go engage in it during the week. Further, this exercise will not be about a specific concern, but rather about your preferences and tendencies in terms of a Control Profile—Sense of Control, Modes of Control, Desire for Control, Agency of Control. The exercise also can help familiarize you with an additional way to gather information about either your own or a client's Control Profile. . . .

Note to instructor. Several different areas of the Control Profile that might be observed are noted below. Feel free to choose one which you think might be of interest to the group (or let them choose the one that most interests them).

As you sit, please allow your eyes to gently close and bring your attention to one of the following areas. Please attend to how you *know*, recognizes, and experience that area in as careful and nuanced way as possible, noting bodily sensations, feelings, thoughts, images. . . Also, try to imagine with as much specificity as possible, the antecedents to what you are monitoring (who was around, where were you) and how you acted, felt as a result of what you monitored (e.g., how did the situation change as a result).

Topic #1. POSITIVE SENSE OF CONTROL GENERAL DOMAIN. Just for a moment try to imagine yourself feeling a positive sense of control. Try to bring a refined awareness to your feeling and thoughts. What does a positive sense of control feel like? Where in your body do you notice different sensations? What are the thoughts you are having? Any images? Try to identify the antecedents: What are you doing? Where, and with whom? Are you exerting high or low effort? What are the consequences? (feelings of wellbeing, competence etc.).

Topic #2 NEGATIVE SENSE OF CONTROL. How do you know when you feel things are “not in control”? Thoughts, feelings, bodily sensations? What are *antecedents* that seem to trigger these feelings of not being in control? Some may be small, such as a pen running out of ink, a person cutting in front of you on the freeway, your computer not functioning properly, or a busy signal when you make a phone call. Others may be more significant. Notice as carefully as you can, where are you; doing what; and with whom?

Now try to investigate in a very precise way your “target *behavior*”—negative sense of control in response to these antecedents. What are cognitive cues that you are feeling a negative sense of control? What are you saying to yourself? What are your bodily cues? What emotions do you notice? What is the intensity of those feelings (e.g., one butterfly in your stomach, 10 butterflies)? Are there any images?

Finally, how do you react when you have this feeling of negative sense of control— what are the *consequences*? You may wish to note how you handle situations and events where you are feeling out of control in ways that are not helpful to yourself or others, as well as ways that you feel are helpful.

Topic #4. MODES OF CONTROL.

Positive Assertive. What were times you recall when you used a positive assertive mode to gain control; What were the feelings this mode creates in you? What

type of situations do you remember acting in a positive assertive way? What were the outcomes?

Negative Assertive. You may choose to think about quadrant three, *overcontrol* examples. When do you recall feeling you were being too controlling? How did you know? What cues do you notice in the feeling of “overcontrol” – e.g., body cues, cognitions, feedback from others? Think about the antecedents and consequences of these overcontrolling examples. (You may also wish to imagine an example when you felt someone was acting too controlling toward you. What did you notice about them? About your reactions--how did it make you feel?. How did you respond?

When you practice the above two exercises (Positive assertive and negative assertive) , can you begin to notice an “edge,” a place where positive assertive seems to cross a line into negative assertive? An analogy might be doing a stretching exercise as in yoga. There is a place where a stretch is pushing ourselves in a good way, and a place where we push ourselves too much. When does your seeking for active control seem positive, and when does it start to feel like micromanaging and overcontrolling?

Positive Yielding. Finally, you may choose to recall instances when you acted in a *positive yielding way*, and accepted a situation over which you might have been able to exert active control, but didn't feel it was in your best interest. What did acceptance feel like to you? How did you experience acceptance cognitively? Emotionally? Where in the body did you experience this yielding? What would be an example (e.g., letting an extra car go in front of you even though it might be “your” turn. You may also remember times when you didn't have active control over a situation, but rather than feel passive and helpless, you framed it in a way which allowed you to feel sense of control through positive acceptance (e.g., it's not that important; don't sweat the small stuff, etc).)? Be sure to think about the antecedents and consequences of this positive yielding.

Negative Yielding. When in your experience has “letting go” crossed the line into feelings of laziness, passivity, victimization? Think about these situations as well, including what was going on before the negative yielding, and what happened after. It may be helpful for you to think of a continuum of words you use to describe different forms of “yielding (e.g., positive or negative). You may also wish to notice words you use to describe different situations along a positive and negative yielding continuum. For example, in an interpersonal situation, by “allowing another person's actions” are you being: *accepting, unconditionally loving, non-judgmental, tolerant, passively indulgent, enabling?* Note the different feelings that each word engenders.

You may also explore times when you felt a positive assertive action might have been called for, but didn't act on it and ended up feeling a quadrant four *negative yielding mode*. When you didn't act, but felt you would have wanted to, you might explore the reasons for that (e.g., fear of being rejected, misunderstood, or drawing attention to yourself).

Topic #5 DESIRE FOR CONTROL. How do you know you have a desire for control? Think about times in the past when you have wanted more or less control of a situation. Is there a bodily sensation, cognitions, images? Again, note the antecedents, the situation, circumstance, people involved. For example, was it important for you to give the

appearance to others that your life is in control? Did you like things around you to be ordered and disliked ambiguity and the unknown? Did you want to control your anger better, etc.?

Do you notice that your “desire for control” increases or decreases when “antecedent” conditions seem to be more out of control? How do you tend to respond (consequences): e.g., do you “micromanage” more when you have an increased desire for control? Or do you become more passive and helpless when you have a decreased desire for control?

Topic #6. AGENCY OF CONTROL Finally, you may choose to remember times when you gained a positive sense of control from your own efforts; and/or when you gained this positive sense of control from “others.” If from “others,” what was the source: e.g., family, friends, a higher power? Or you may wish to note when you felt you were relying too much on others, when you felt you should be making the effort yourself. Or, conversely, you could recall a time when you felt you were relying too much on yourself, and were not able or willing to ask for help from others (cf., quadrant four, negative yielding, above).

Note to instructor: After taking a couple of moments to allow the audience to participate in this exercise, it can be helpful to ask them to bring the exercise to a gentle close. Invite them to try to note any experiential learning or insight gained from the exercise about their own control-related profile, and then, as they are willing, to allow their eyes to slowly open.. This exercise can be a good compliment for a client who has taking the SCI. It helps them learn about the antecedents and consequences involved in a Control Profile in a more situation specific way, as well as to potentially be more in touch on an experiential level with the different aspects of one’s Control Profile. If time, and again, depending on the nature of the lecture format, this could be an opportunity for people participating to share what they learned with the group, or in dyads.

Now that we have explored the different ways to assess the client’s concern—developing a Control profile through the SCI, as well as listening to client’s speech, their control stories and dynamics, and then through self-observation, it is possible to move to the next step in the process: self-evaluation and goal setting.

THE ROLE OF EVALUATION AND GOAL SETTING IN CONTROL THERAPY

slide

“One reason things aren’t going according to plan is that there never was a plan”

-- Ashleigh Brilliant

The essence and joy of the goalless position:

“In order to hit the target, shoot first, and whatever you hit, call it the target.”

-- Ashleigh Brilliant

END SLIDE.

The essence of the two approaches—mindfulness meditation and behavioral self-observation, self-evaluation, and goal setting -- is well captured in the above two statements by Ashleigh Brilliant.

In a mindfulness meditation approach, as we have just seen, there is no ‘formal’ evaluation of the thoughts, feelings, experiences that arise. They are just noticed with bare awareness and let go. A mindfulness meditation approach doesn’t seek to understand and analyze cause and effect, and invites the meditator to just notice and then “let go” of thoughts, feelings, sensations that arise. There is no effort, attempt, or purpose in “counting” quantifying, accumulating, and evaluating “data.” Further, there is no goal, other than the goal of just noticing what is....whatever comes up, is, “*the target.*”. You can’t miss!

Behavioral self-observation type of awareness, as we say in the last section, is reductionistic, involve precision about what is being monitored, clarity about antecedents and consequences, . looks at cause and effect, and seeks to count and quantify the “data” (whether cognitive or behavioral). For those of you who have practiced any type of precise self-reflection, as you have probably discovered, we often have a naïve awareness that is not very precise or accurate: we don’t “know” ourselves as clearly and carefully as we may assume. Behavioral self-observation is an important skill in gaining this precise awareness and self-knowledge. Further, this self-observation is the beginning of a “behavioral chain” such that the data that is accumulated is then evaluated. Cause and effect, cues and consequences are noted, and based on this information and evaluation, a goal is set. That way, there is a “*plan.*”

Which type of awareness approach is best?

The “dialogue” between these two approaches in contemporary psychology in some ways replicates the debate about the “best” type of awareness (evaluation, and goal setting) that occurred in ancient China between Confucius and Lao-Tzu thousands of years ago during a time of chaos in that society: To count or not count, to reduce or to holistically flow. Confucius argued that the problem was that people weren’t being systematic and analytical enough in their awareness. Therefore he argued that what was needed was more precision and clarity in language and word choice, and more refined analysis. This would lead to better discrimination, more systematization, and greater understanding. (Yes, he was an early advocate of behavioral self-observation!).

Lao-tzu, on the other hand, argued that the problem was that people were being too analytical, and that more precision was as wrong a solution as trying to divide a flowing river into segments. The river just flows, as one. Therefore what was needed was a more holistic, less evaluative, less systematic and more “fluid” type of awareness, and the goal of no-goal, just flowing with the current.

The approach in Control Therapy, as noted, is that both approaches are important and valuable, and that both involve skills that can be useful, either alone or in combination. That is why, in the assessment phase, as noted, CT combines and compliments the type of awareness involved in behavioral self-observation by the type of observing awareness of mindfulness meditation. A non judgmental compassionate “bare awareness” may make it easier for clients to be less defensive about noticing uncomfortable material that arises. .

Different views of awareness’ curative power: is awareness sufficient? Some approaches (e.g., classical Freudian id psychology, Gestalt, mindfulness meditation) posit that awareness in and of itself is curative. Other approaches (e.g., behavioral self-observation) suggest awareness can be curative, but isn’t necessarily sufficient. CT believes that occasionally “pure” awareness may be sufficient for healing and “cure” in and of itself. . When it isn’t, additional steps are necessary, specifically self-evaluation and goal setting and developing further interventions beyond “bare awareness.’

Slide:

“If you have the wisdom to perceive a truth, but not the manhood (sic) to keep it, you will lose it again, even though you have discovered it.”

Confucius

End slide

CT would prefer a more gender neutral term to connote the way to retain perceived truth This term would encompass the aspects of self-control: e.g., motivation, skills, commitment, etc However, Confucius’ point is instructive: for those times when awareness alone is not enough for therapeutic success, then the next step in Control Therapy is to evaluate the information gained through the assessment phase, go through a decision-making process with the client and help them set a goal.

<***Note to instructor:*** the information above is placed here, after the experiential exercises of mindfulness meditation and behavioral self-observation, so that the audience has an experiential “feel” for the two approaches before this material is presented. However, depending upon the instructor’s preference, it could also go after —the Importance of Awareness- earlier.>

Self-evaluation and goal setting: Two different models. How CT seeks to integrate them. CT, following the approach of behavioral self-evaluation, takes the further step of exploring what has been observed to see whether it is an area a person is comfortable with or whether it is something the person would like to address further, and change. Mindfulness meditation teaches simply witnessing what arises with no effort to evaluate, change, interpret, or judge. Mindfulness meditation is an effort to live in the present moment without any goals. It could be said to have a

paradoxical “goal of no goal”: keeping a present centered awareness, being in the here and now. Cultivating this type of awareness is appropriate when the client chooses to attend more carefully to a concern, but not to change it.

On the other hand, in the behavioral approach, a very specific goal is set as to how a client wants to change in the future: what “behavior, thoughts, or feelings” should change; to what extent; and under what conditions. Control Therapy attempts to integrate aspects of mindfulness and a cognitive behavioral approach in the evaluation phase. In effect, CT says to a client: “I invite you to seek to practice this process of self-evaluation with a certain gentleness and kindness, rather than harsh judgmentalness. During both the self-evaluation and goal-setting phases, try to keep a kind-hearted, calm, and curious mindset, and explore in a compassionate, thoughtful (versus unforgiving, severe, or self-punishing) way yourself and what you are working on.”

Control Therapy believes that we (and our clients) are more inclined to honestly and clearly observe and evaluate our behavior and actions when we practice loving-kindness and understanding towards oneself. On the one hand, this helps us to avoid imposing a rigid good-bad, type of judgment; on the other hand, it helps keep us from slipping into minimizing and denial (e.g., “maybe my overeating is really no big deal”).

Self-evaluation involves making a decision about how comfortable the client is with the status quo, things as they are. Perhaps the goal will be how to learn to “accept what is” in a gentler, more compassionate way, with no behavioral change. Bare awareness and acceptance of what is may be sufficient. Or, as the client looks at the area of interest and the information observed, he or she might decide that this is an area where s/he would like to change and grow.

If a client decides to change, this goal of change can be approached with a compassionate, non-shaming attitude. It is possible to bring a clear, compassionate discernment, a discrimination with gentleness and a light touch, while also seeing clearly what is skillful and healthy and in one’s best interests. For example, as the therapist you might say to your client:

“If an attitude or feeling or behavior is a concern, this can be a time to gently explore whether it really still serves you. For example, you might acknowledge how the behavior or feeling or attitude has helped or protected you in the past; or has grown out of a painful experience having at its root perhaps some good intention. But it may time for you to make a change. If you do determine that an area is one where you would like to make some ‘improvements.’”

This sets the stage for a further exploration of precision in goal setting.

Precision in goal setting in Control Therapy—“Creating a plan.”

In Control Therapy, the goal is to help the client gain a positive sense of control about the area of concern. This can be done through either choosing a goal of assertive/change to make things better; or a goal of yielding/ acceptance to come to a greater peace about what is.(or some integration of the two).

The goal that is set is based on the client’s control profile, the client’s areas of concern, the client’s beliefs about a concern’s controllability, and the client’s personal control stories. Further, in choosing a precise, narrow goal, the therapist and client will want to make sure that this goal is consistent with the client’s overall value framework and life goals.

There are many advantages in having the skill of creating and clarifying a precise goal: It helps clients clarify and focus on the goal they feel will best address their area of concern. The very act of setting a goal can be empowering to the client, helping them shift from a focus on the concern which has been “victimizing” them and making them feel out of control (where they are) , to envisioning what their goal would be to address the concern (where they would like to be) . By setting a precise goal, the client can learn to continue the clarity and nuance of self-observation about their concern and have that reflected in the goal. In so doing, the client takes responsibility for choosing her goal, and, at the best, creates an opportunity to hold herself accountable for its implementation (Phase Two, Interventions). The precision of the goal can also help the therapist explore, where necessary, if the goal seems too high or unrealistic (e.g., I want to lose 8 pounds in one week). A precise goal also provides a marker so that if the goal is met, whether that goal was sufficient for therapeutic success can be evaluated

Since “precise” goal setting is common in cognitive behavioral approaches, it is only briefly mentioned here as one important skill for clients to develop as part of Control Therapy:

Creating a precise goal. As discussed, goal setting occurs after information has been obtained from “baseline” self-observation—which involved being able to “count” what is a concern *What is the behavior (internal or external—i.e, cognition, behavior, feeling)) that is being focused on in a way that it can be “observed and measured” by the client (e.g, frequency, duration, intensity, latency)* At the end of the self-observation phase, the data is evaluated and a goal is then set.

For example, in the data set presented below, the person was monitoring feelings of anxiety. The feeling of anxiety she initially described was “being bounced around by all powerful forces, themselves neurotic.” Through precise self-observation she began to notice antecedents to the “behavior”: early morning and before English class were periods when she felt increased anxiety.

At the end of the self-observation phase, a precise goal was set: including specific decrease of frequency, duration, and intensity of the anxious feelings. This aspect of precise goal setting involves: *To what extent does the client want to make changes (including increasing acceptance): This involves both a shift in frequency (does the client want the behavior to increase or decrease, how much, and under what conditions – i.e., when and where does the client want the behavior to change)* . For this person, the goal was to decrease the frequency of anxious feelings from the baseline phase of 17.5 times per week to less than 10. To decrease the intensity of anxiety from 4 to 5 (on a 5 point scale) to 3 or less; and to decrease the duration which could last from a half hour to several hours of rumination at baseline, to under twenty minutes.

To finish up with this example, after the goal was set control-based interventions were matched and tailored to the client, a self-management contract was established, and the client implemented the intervention and continued to self-observe, as noted below: As you can see, the client’s anxiety decreased noticeably, and the client felt that her concern (anxiety) had been successfully addressed through the goal she had set. (This case also provides an example of using an N=1, A-B research design with A being the baseline phase and B the intervention phase. (Here statistical analysis of Owen White’s work on median slope procedures. for fitting trend lines to N=1 data. The median slope of the baseline phase here was $\times 1.2$ (increasing) and

for the intervention phase was $\div 1.037$. The slope changes were significant and there was a significant decrease in feelings of anxiety during the intervention phase.

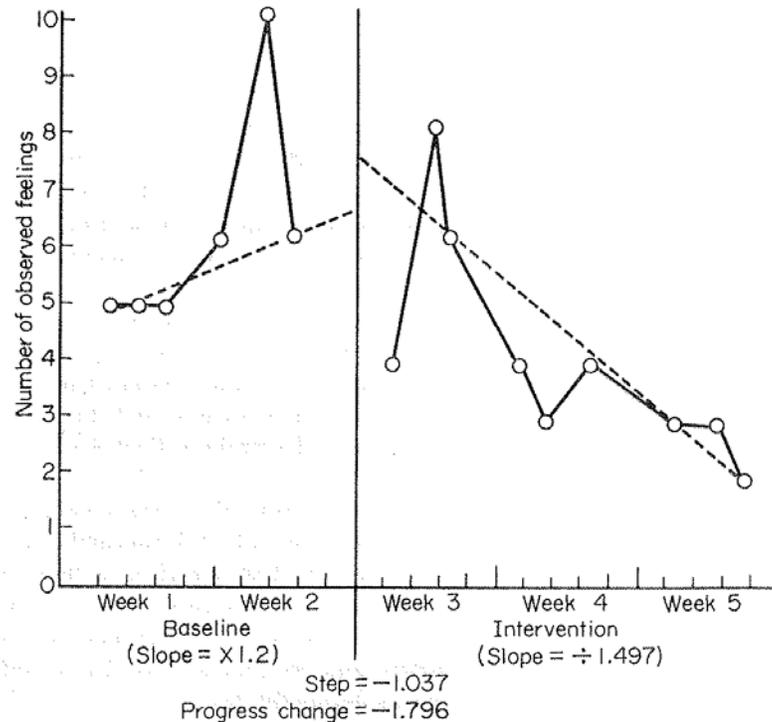


Fig. 1. Daily self-observation of anxious feelings.

ANECDOTAL DATA:

- 1st Week: ...overpowering feelings of being bounced around by some sort of all powerful forces, themselves neurotic. (sic)
- 2nd Week: I find the anxious periods can be timed-upon awakening and before English class in the evening. As if I'm conditioned to be anxious at those times. (sic)
- 3rd Week: By focusing on breathing, I realize the trivia of my anxiety.
- 4th Week: Self-control is growing as I feel I am starting to beat anxiety. I fall into breathing meditation much more automatically. At first informal meditation involved concentration on my breathing, but I don't even need to do this anymore. Just the recognition that I am anxious is a signal to dismiss my thoughts and worries. It's something like just recognizing that I am becoming anxious is a signal for calm.
- 5th Week: I can direct myself out of anxiety very well now. Enormous improvement.

From Psychologia, 1978; reprinted in Precision Nirvana, p. 230.

Note to instructor: In the Control Therapy Training Manual specific examples are given for this process of self-observation, self-evaluation, and goal setting, including an overt behavior (physical activity); an internal feeling (stress); and an interpersonal dynamic (relationship with spouse). The manual also provides examples of goal setting for different aspects of the Control Profile: Sense of Control, Desire for Control, Modes of Control, Self and Other agency. The instructor may wish to refer to those, or to choose examples from their own experience where precise goal setting has been helpful.

In one further example, we use a straightforward example of goal-setting in the physical domain to illustrate the process. Let's say from talking to the client and from Scale Four (the Domain-specific Scale on the SCI where the client notes for her own life, how in control each of twenty five different areas is, whether that area is "of concern" to her, and if it is a concern, whether she would like to address it by changing the situation, or accepting it) that the area of concern identified is physical activity, which is "slightly out of control" and that the client's initial belief, without yet taking baseline information, is that s/he wants to engage in active "change" to address the concern.

Physical activity is a relatively easy area to monitor as is something external like weight, or number of cigarettes smoked. (More complicated examples of what to monitor, and how to monitor certain internal cues and cognitions are described in the Manual.)

Let's say that for the self-observation baseline phase, the client decides to operationalize physical activity as "walking. Through self-observation, she discovers that in terms of *frequency* she takes one walk of fifteen minutes (*duration*) in a week. For *intensity*, some measure would have to be devised: (e.g., a leisurely pace, moderate pace, faster pace). Let's say for now the client walks at a leisurely pace.

During the self-evaluation phase, the client decides, based on this information, that s/he is not satisfied with her walking and wanted to "change." The goal then becomes to gain more control by assertive action through modifying her walking. Based on self-observation, the client knows she currently walks once a week for fifteen-minutes at a leisurely pace. Her precise goal could be as simple as "I want to increase my walking to twenty minutes three times a week (frequency) at a moderate pace (to what extent) anytime of the day or evening over the next six weeks (under what conditions)."

The behavior here is clear, as is the time and frequency. But how will the client know what she means by "moderate pace" (versus leisurely or fast)? Will she base it on her "pulse" count? The rapidity of her breathing? She could get a pedometer to measure the number of steps she takes when she feels she is walking "at a moderate pace" and have that as a goal. Or she could even get a chest strap heart rate monitor which can measure the different "intensity" zones of her pace and target heart rate.

Learning how to systematically observe and monitor one's own behavior, thoughts and feelings; then pausing to reflect on and evaluate what has been observed; and finally, setting a clear, congruent goal, is foundational for developing the ability to engage in self-change (and/or self-acceptance). Creating this sort of multidimensional plan, including self-observation, evaluation, and goal-setting can have a profound and positive effect on self-awareness and self-understanding, as well as offer valuable insights into a particular area of concern and offer a clear focus which the client feels will help ameliorate the area of concern.

We now turn to times when selecting a goal is more difficult for the client.

WHEN SELECTING A GOAL IS MORE DIFFICULT

Slide

*Not everything that is counted, counts;
and not everything that counts can be counted.*
—Einstein.

End slide

Sometimes the process of choosing the goal for an area of concern is relatively straightforward, as in the above example. . However sometimes it's not. Potential "challenges" to setting a precise goal include the following: 1) the client having difficulty in deciding whether to choose the goal of changing the area of concern or of learning to accept the situation/concern as it is, with more serenity. 2) the client having difficulty prioritizing and choosing a particular area of concern, clients who have trouble formulating and setting goals, 3) the client resists precise goal-setting because she feels that "quantifying" the goal into something measurable feels too narrow given the depth and scope of the concern. 4) the client finding it hard to choose a goal because even though there is a concern, it may involve a known and familiar "control story" and to choose a new one seems a) unimaginable; as well as b) scary and unfamiliar. 5) Finally, one further resistance that might occur in setting a goal involves the client's needing to shift his/her self image from being a person who has a concern by which s/he may feel "victimized" to a person who is willing to take responsibility for creating a plan to address the goal. The very setting of a precise goal may feel uncomfortable because once a goal is set, the client might then feel held accountable to his/her own self-chosen goal, and a measurable standard at which they may fear they could fail.

Further it is important for the therapist and client to ensure that the client's short term goals mesh with their long term goals, and to make sure that the goals selected are congruent with the client's vision of him/herself and who s/he wishes to be.

To address these issues, there are certain exercises in Control Therapy that can be helpful. 1) The Control Mode Dialogue. This is to help the client explore her own control stories regarding the modes; 2) A decision-making priority list; 3) An exercise involving further exploration of a salient event in the client's life and the control story that resulted; how this story might have served the client in the past; and the process for potentially choosing a new "chapter"/story that might serve the client better in the present. These exercises and --the "**Client Worksheets**"—can be an important part of the process of Control Therapy. They can help both in the process of choosing the goal, making sure it is congruent with the client's values, and in helping to address in a preventive way, resistances that may arise regarding the goal that has been selected

CONTROL MODE DIALOGUE: ENVISIONING WHICH MODE TO CHOOSE

This exercise is an opportunity for clients to explore in more depth their views and beliefs about the different control modes based on their prior control stories and dynamics related to the four modes and to clarify the relationship of the modes to the goal. Further, the exercise can help clarify goals, based on the client's control profile and the current situation and concern. The process also helps pinpoint any resistances the client might have to considering either of the positive modes as means of reaching her goal.

Earlier, I asked you to think of a representation for each mode. I'd like to take a few moments now to invite you to experience the Control Mode Dialogue.

***Note to instructor:** This example is provided if you feel it is needed as a "model" for the audience, or you may wish to just ask them to go through each of the steps, and may decide it is not necessary to add the material from this specific client. Each step A-G could be made into a slide. Here are seven steps outlining the process of CMD :A) create a representation of the negative modes (e.g., color, sound, animate, inanimate object); B) choose a preference regarding the negative assertive or negative yielding mode, and explore why; C) have the two "representations" of the negative modes engage in a "dialogue;" D) work toward choosing a positive mode goal; E) create representations for the two positive modes: explore initial resistances and preferred mode; F) further explore resistances: dialogues between negative yielding and positive assertive; negative assertive and positive yielding; G) move toward reconciliation, appreciation, and say good bye to the negative modes; explore the positive modes, alone and integrated>*

<A detailed example of the CMD process with client/therapist dialogue and client dialogue with herself is found in the Control Therapy Training Manual, Module 2, pp. 68-76. The following exercises material (steps A-G) gives a flavor of the process.>

A. Create a representation of the negative modes. (e.g., color, sound, animate, inanimate object) . This you have already done earlier.

As an example, a client, Jane, a 44 year old female attorney, came to therapy complaining of feeling stressed and anxious. In particular Jane had concerns about her interactions with her mother-in-law, who was always criticizing her and putting her down. When doing this exercise, she saw her negative assertive side as a fierce, tough, callous drill sergeant; and her negative yielding side as a rag doll lying helplessly in a hospital bed.

B. Choose a preference regarding the negative assertive or negative yielding mode, and explore why.

Jane:, Well, my own mom is very possessive and overcontrolling, and my mother-in-law is so interfering. So I guess if I had to make a choice, I would say that I am more afraid of being too controlling. I'd rather just see things work out. I don't like the anger in me, and I don't like feeling stressed all the time, especially around my mother in law It just doesn't seem to be a healthy use of my energy. I guess that's a long way of saying that I'd rather be in the hospital bed than be putting someone there!

C. Have the two “representations” of the negative modes engage in a “dialogue”

JANE: The rag doll patient says regarding the mother in law, “I give up. Nothing I do is good enough. What’s the point? I’ll just lie here and wait for her to finish. No use fighting. That hurts more; better to just take it and pretend I’m somewhere else.” But after a while, the drill sergeant says, “She can’t do this to me! I want her to get out of my life and stay away! I can’t stand her butting in. If she wants to ruin my life, then I need to give her a taste of her own medicine!”

C1 Any insights gained from this dialogue? This exercise can help us recognize that there are multiple perspectives and that each mode of control, even the negative ones, may be trying to protect us in some way. It can be helpful to learn to befriend these different perspectives, even as preparation for choosing a positive goal.

For example, Jane realized from this dialogue the positive role that each of these negative control aspects of herself was trying to play. The rag doll side helped ensure that she did not put herself in scary, dangerous situations where she could be hurt and which caused her enormous stress. In her hospital bed she was safe. The rag doll also served as a counterbalance to the unrelenting, hard-driving drill sergeant side. In some ways, the rag doll was trying to keep the drill sergeant safe, removing her from battle.

The drill sergeant, on the other hand, felt she had worked hard to be taken seriously and “I don’t appreciate others just walking in and telling me what to do.” The drill sergeant was there to make sure the mother in law didn’t just run over her, and was ready to push back to give the mother in law some of her own medicine. Stress is just a part of life, and can make you stronger. She saw her task as standing up for the passive, lazy rag doll, and motivating and disciplining it not to cave into the mother-in-law’s comments. The toughness and warrior-like ferocity were necessary to compensate for the lifelessness of the rag doll, including the rag doll’s fear of responsibility and the accountability that comes with it.

D. Working toward choosing a positive mode goal:

The Control Mode Dialogue up to this point is an exercise designed to help each of us (as well as our clients) learn how to make peace with and move toward “letting go” of the negative modes. *The negative modes are not goals.* It is unlikely a person would say, “Oh, I want to be negative assertive” or “I want my goal to be negative yielding.” These negative modes are (often reflexive) reactions to situations or feelings about how we’ve acted in situations. What is important to recognize thus far in this exercise is that the negative modes are efforts to “control the world,” and that they can be understood at some level as trying to help protect and serve the client’s best interest. However, even though their *intentions* may be good, the “methods” of the negative modes are generally not especially effective or skillful. Learning and understanding their purpose and intent (i.e., once the two “negative modes” can (anthropomorphically!) feel understood and appreciated), helps lessen “sub-conscious or non-conscious” resistance toward selecting and clarifying the best goal(s) for the situation.

JANE: I guess I'd like to be less passive, less the rag doll, and put some boundaries on my mother in law and tell her she has to act with more respect toward me, less punishing and negative. She's just a bully. (She pauses and smiles). But I'd like to do that without being a bully back and acting just like her—without being my drill sergeant warrior. But I want respect. And I want her to know how angry I am at the way she treats me.

Once Jane was able to formulate in general terms this positive assertive goal, the therapist then worked with her regarding a more precise formulation of the goal and ways to anchor it in specific positive assertive behaviors—which will be discussed in the section on Techniques. The important point here is the first step of being able to create a positive goal. It is also important to look at any resistance that there may be in choosing the goal, as discussed in the next step (E).

But I want respect. And I want her to know how angry I am at the way she treats me.

E: Create representations for the two positive modes:

You have also created representations for the two positive modes. This is a chance to have them dialogue with each other.

Jane described her positive assertive side as a judge in robes seated behind a high desk in a courtroom with a confident, amused smile. Her positive yielding/accepting side emerged as a puppy, playing with children, a little cocker spaniel that was warm, loving, and accepting of everyone.

E1. Exploring initial resistance to using those modes in the area of concern.

JANE: Positive acceptance just seems like letting her get away with it, being a little puppy rather than a mature woman. With my mother-in-law, I just feel completely at a loss, like my hands are tied, and nothing I do ever works. It's hard to imagine being positive yielding without falling back into negative yielding.

On the other hand, when I think of trying to be a calm, forceful judge, it's hard for me to imagine a situation where I could stand up to her without it escalating into a shouting match. I don't think she would respect me as an authority figure, with the right to make requests of her. She would just accuse me of being tyrannical and overcontrolling. Then I'd feel guilty, like I'm pushing her away and causing her a lot of pain. So, I guess it's hard for me to imagine being positive assertive without it degenerating into a negative assertive encounter.

How the negative assertive q3 might see the “yielding modes. Note: Jane's situation is a common one. Often clients with a high quadrant three (negative assertive) profile might see positive yielding as being identical to negative yielding, being weak or wimpy, more limp, acquiescing rag doll than playful, kind puppy, and fear that the “puppy,” for all its playful non-judgmental love, may be being taken advantage of.

How the negative yielding mode q4 might see the assertive modes. Likewise, a client who is high negative yielding (quadrant four), the rag doll may feel they lack the skills to be positive assertive, the right to be so, or fear they will fail miserably if they try, or be castigated as over controlling if they succeed. Both the “judge” and the drill

sergeant may seem intimidating and daunting, and both uncomfortable (and not that different as options.)

In working with the audience's own dialogue in this area of q1/q3 and q2/q4, as well as with clients, it's instructive to note how each person determines the "tipping point" at which positive assertive seems to slip into negative assertive, or positive yielding begins to feel like negative yielding. What influences that tipping point? Is it the situation; how the actions are responded to? Feedback from others, i.e., how others label and view the behavior? An internal feeling?

E2. Have the two positive modes dialogue with each other. The therapist had Jane create a dialogue between her two positive modes, the judge and the puppy. In one of the scenarios, the judge was feeling quite exasperated and hassled, not only by the load of work before her, but also by the vicious adversarial comments of the opposing attorneys, and the disrespectfulness of the defendant. Just then the puppy came into the courtroom. The judge immediately smiled, lightened up, became calmer, and noticed she was able to listen more compassionately and carefully to the case before her (without getting so hooked by the negative emotions). The puppy in turn had no fear of the judge, and treated her with good humor and affection.

F. Further exploring resistances: additional dialogues between the different positive and negative modes

Note what situations "cause" you to feel negative yielding or negative assertive. How do you feel when you act positive assertive and it doesn't "work," i.e., doesn't produce the consequences or outcomes you hoped for? Do you revert to negative yielding (helplessness) or negative assertiveness (attempting to overpower)? How do you feel when you act positive yielding and it doesn't work: e.g., you act kind and forgiving, and other person does not react similarly? Does positive yielding slip into negative yielding feeling?

Please pay careful attention to the interactions between modes, including the dialogue of the negative modes and the tendency to alternate from one to the other: e.g., from "I feel passive helpless" (negative yielding) to "I'm not going to let myself be taken advantage of" (negative assertive). Notice when you seem to slip from positive yielding into negative assertive (to keep from feeling negative yielding): e.g, when we see ourselves as kind and giving, or "turn the other cheek" and forgive and accept, (Positive yielding) and feel the recipient isn't sufficiently appreciative, we may say angrily, "I'm not going to be a patsy" and find ourselves tightening and becoming negative assertive and/or feel passive helpless and a victim (Negative yielding).

THE THERAPIST helped Jane's negative modes dialogue with her positive modes in order to continue examining resistances to using the latter. He asked her how her drill sergeant side would respond to the idea of acting in a positive yielding, puppy dog manner.

JANE: My jungle warrior self (negative assertive) is having a fit at the idea of my smiling and being calm, even playful (positive yielding) in response to my

mother-in-law confronting me. I hear that side saying, “Don’t be a wimp. You’re no different than that comatose rag doll in the hospital bed (negative yielding), and that’s where you’ll end up if you let that woman keep pushing you around and verbally beating you up and ordering you around. Can’t you see I’m trying to protect you from being hurt?”

Likewise, Jane constructed a dialogue between the competent judge and the hospitalized rag doll.

JANE: The rag doll says, “Are you kidding? You’re not going to try to talk to your mother-in-law reasonably, are you? Sure, you have control in a courtroom, but she’s not a defendant. She’ll just escalate and you’ll end up fighting and getting a verbal tongue lashing after which she will once again declare herself the winner and you a horrible person. How do you think I got here?”

G. Moving toward reconciliation, appreciation, and saying good bye to the negative modes; exploring the positive modes, alone and integrated.

In this final step, it can be helpful to have the negative yielding mode talk to positive yielding and negative assertive talk to positive assertive to try to refine and nuance the distinctions between them, tease out the distinctions between them. It can also be helpful to have the two positive modes ask the negative modes for permission to try new way of acting and being.

In Jane’s exploration of positive and negative assertive, she noted that the sergeant said anger must be met with anger, but the judge countered that anger can be contained with firmness but not so much emotional engagement. The positive assertive side, the judge, then asked the drill sergeant for permission to be assertive but avoiding the aggressive anger of the sergeant.. The drill sergeant replied “Sure, war is hell, and there’s way too much bloodshed. I’m exhausted by all the fighting. I don’t know if judicial authority will work, but give it a chance!”

In terms of positive and negative yielding dialogue, the rag doll said the only way to protect herself was complete withdrawal, but the puppy expressed a desire to have a connection with the mother-in-law, but just not take her so seriously. The rag doll admitted she liked the puppy’s friendliness, and though she feared for her innocence, she’d be happy to give her an opportunity to see if she could soften the mother in law.

The negative representations realized that, despite their best intentions, Jane was still getting hurt, and so were her mother-in-law and husband. Jane asked if the negative modes she’d relied on previously in dealing with her mother-in-law would be open to some alternatives, including what conditions would have to be present for them to try something new. The rag doll admitted she actually admired the judge’s ability to stand up for herself, and the sergeant said maybe if anyone could soften the mother in law, it would be a cute puppy.

During the ensuing dialogue, Jane’s “judge” and “puppy” thanked her hospitalized rag doll and drill sergeant for their efforts to protect her. The drill sergeant and rag doll acknowledged that they felt appreciated and understood. Having acknowledged and expressed thanks for the intentions of the negative modes, Jane was then able to turn toward addressing how the two positive modes might be helpful in her situation.

In the Control Mode Dialogue, the final step is exploring how the two positive modes might be utilized together.

In this case, Jane realized she had two goals for herself regarding her mother in law. First, from a positive assertive standpoint—and the judge’s wisdom, authority, and fearlessness-- she wanted to ask to be treated with respect, and to share her concerns in a calm, clear, unintimidated way (but without resorting to negative assertive screaming or yelling).

But Jane was still concerned that if she learned all these new assertive skills, and the mother in law still didn’t change ...

JANE. But then what would I do? Won’t we just be back in the same situation?

THERAPIST. How else might you take care of yourself? What would positive yielding, quadrant two mean for you in that situation?

Jane realized that she had a second goal, which integrated with the first: from a positive yielding standpoint –and the puppy’s wisdom--she wanted to bring compassion (for her mother-in-law’s hurt and pain), as well as lightness, even humor to the conversation, not taking her mother-in-law’s antics so seriously. She wanted to minimize unnecessary pain to her mother-in-law, and to reduce “entangling engagements.” Further, still from a context of positive yielding, she wanted to recognize that no matter how well—calmly, kindly—she stated her concerns, she couldn’t control how her mother-in-law would react.

The therapist pointed out that sometimes no matter how well you present a concern to another, or draw a boundary, or make a request, there is no guarantee the other person will not respond defensively, hostilely, and angrily, and launch a counter attack. When someone reacts poorly to our best, most skilful efforts, ***one of the things we all have to learn is what is in our active control, and what is not.*** No matter how skillfully we try to address in an issue in a positive assertive manner, we don’t have ultimate active control over how the other person will respond.

Jane wanted to be able to honor herself for acting in an assertive way while at the same time being respectful toward her mother-in-law. And, from a compassionate place she wanted to be able to thank her mother-in-law for listening as best she could, and to appreciate whatever increased kindness and respect the mother-in-law was able to offer. She also realized that part of her goal might be to learn how to not take personally and “shrug off” any negative statements of the mother-in-law and to stay calm, centered, even forgiving during the process. Jane felt that this combination of goals gave her the best opportunity to develop “the best possible” relationship with her mother-in-law, while still keeping her own self-respect and inner dignity.

Summary comments on the control mode dialogue

Jung suggested that an important part of psychological growth involves acknowledging, non-defensively taking responsibility for, and to a certain extent accepting and integrating the shadow side of one's personality. The Control Mode Dialogue helps our clients delve deeper into their mode control stories, including their views of the "negative" modes. It's very hard to set a goal to learn and grow if we don't first acknowledge "who we are," including parts of our selves that we may consider less desirable.

As you have seen in the case of Jane, this dialogue and exploration can be useful in helping you and clients to realize that, at some level, each of the modes serves a function, even the negative ones. This may seem counterintuitive initially, but after reviewing the above case, as well as experientially going through this exercise yourself, you may now have a clearer understanding of what this means. Understanding why we are relying on negative modes can help us be more willing to focus with less ambivalence and more certainty on choosing a goal, and to see how each of the two positive modes can become components of that goal.

The CMD can also help clarify any confusion that may occur in mistaking negative assertive for positive assertive, and negative yielding for positive yielding based on prior control stories. Thus, rather than simply reacting automatically, the hope is that by going through the CMD process, in the end, with each mode understood and validated, our clients can feel an internal healing and then more freely choose the best positive mode(s) as a component of their goal in a given situation.

The "representations" in Control Mode Dialogue are merely one way to facilitate a dialogue, exploration, and refinement of the relationship between and among the modes. Of course, the therapist and client can choose to do engage in a Control Mode Dialogue exploration in whatever way seems most congruent to the client.

Therefore, the Control Mode Dialogue can help clients recognize and move through resistances to utilizing the positive modes in identifying a precise goal (what behavior, to what extent, under what conditions)

In this case, Jane noted, "I want to clearly and nonreactively express my dislike of the way my mother and law belittles me. (*the behavior*). I want to stay calm when I share my concerns, and calm no matter how she responds. My goal is to engage in this process every time I feel belittled by her (*under what conditions, to what extent*)"

Once such a goal is selected, the stage is set for developing, learning, refining and practicing specific positive assertive and positive yielding mode interventions for this client and this situation (PHASE TWO)—in order to more effectively gain and maintain a sense of control. (In this case, first in vivo through Control Mode Rehearsal) and then in the natural environment. But before we turn to interventions, there are two other exercises that can be helpful in helping a client who is having trouble with goal setting.

DECISION-MAKING PROCESS: HELPING CLIENTS PRIORITIZE DOMAINS, SELECT GOALS AND CHOOSE MODES.

Often the client feels there are too many areas of concern, and it is hard to pick and prioritize among them. It can also sometimes be intimidating to choose a goal because of the depth and scope of the concern: the problem just seems too big and overwhelming to create a meaningful goal. The four step process below can be helpful in making these determinations. It can also be helpful to use an image or analogy about problems, for example, a web in which they may feel entangled. If you cut one strand, it can still trap its victim. But if you keep cutting one, then another, then another, eventually there will be freedom from the restraint. As well, each time there is a successful effort to cut one strand, it makes it easier to cut the next. Therefore, choosing a goal that is realistic and attainable, even if it seems initially too small can be a good learning experience. .

start slide

1. **List areas of concern, broad and narrow.** Have the client brainstorm broadly and also specifically, in terms of “areas of concern,” and note those areas on the left side of a blank page. Then, have the client make two columns after each area, stating in the first column what aspect of that area is in the client’s active personal control, and what aspects are not.

2. **Check with SCI, Scale 4 areas of concern. Integrate.** Now, to make sure the above list is inclusive, have the client consult the Domains section of the SCI. They will see that there were certain domains which they stated were “not a concern.” Have the client make a list of the other domains, ones for which there is a concern. You and the client should then compare the list from Step 1 with this list from the SCI and integrate the two lists.

3. **Rank order the lists. How “out of control” is each? .** The client can then rank order them from most to least important. The client may choose to start with the area most “out of control”, or to start with something “slightly in control” or even “moderately in control” since the client already feels some mastery in that area.

4. **Choosing a goal of a mode (positive assertive change and or yielding acceptance) for addressing the concern.** When a person takes the SCI, the Domain Scale 4 asks for areas of concern; and then asks for each those areas of concern, how would you like to deal with it: change or accept. This is the client’s initial “simple” take on the issue. Subsequently, you will have worked with the client to observe an area of concern in more detail. If appropriate, you will also have explored with the client their feelings and thoughts about the 4 modes of control through the Control Mode Dialogue. Have the client think about each concern listed in step two, and for each, determine which mode(s) the client currently uses to handle that issue, and then consider which mode(s) might help the client better address it. In this step, you can revisit the client’s views of the following: how much lack of active control can the client “tolerate” in his/her environment, relationships, emotions, body, etc. Examine which areas can or should *not* be actively controlled, in other words, which would be better addressed by positive yielding

(acceptance). Help the client consider “What is in my power to do, with what effort, for what reason, and for what benefit?” The point of this is to help the client recognize that not all concerns can or should be approached using active change strategies.

Adapted from page 214, CT.

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CONTROL THERAPY VIEWS OF DECISION MAKING

A process note on decision making. The decision making process described above is obviously critical when applied to a client’s specific concern. Further, the entire process of decision making is critical throughout the course of CT (and life!). Therefore, the therapist might want to make a process note to the client regarding how the lessons learned here about decision making, and one’s own style, can be applicable in many areas of life.

If you remember at the start of the lecture, we stated CT believes that although there is individual variation, each of us has the ability to

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- ***learn to pause, reflect, consider and reconsider our thoughts, actions, and behavior,***
- ***learn to choose, if we so wish, to interrupt and override reflexive cognitive, emotional, and behavioral impulses and sequences***
- ***learn to create alternative ways of choosing to respond---behaviorally, emotionally, and/or cognitively - that we feel are more in our (and others’) best interest.***

End slide

Each of the bulleted points (and bold words) above is clearly about the importance of the process of decision making and making choices (through pausing, reflecting, examining alternative ways of responding). It is during the time of pause that we can assess and reassess where we are, where we want to go, and how well we are moving along our chosen path. There is a saying (from Paul Reps) in Zen:

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***When you sit, sit,
When you walk, walk
Above all don’t wobble.***

End slide

What is implied in this saying is the essence of self-control:

Decide what you want to do, and do it.

Critical to the development of self-control and the use of self-control strategies is the concept of choice, or decisional control. The domain the client focuses on, the goal selected in terms of mode: change or accept (or both); the building blocks utilized to formulate an intervention to address the goal and concerns are all decisional choices.

CT believes that we make better choices by being aware of our decision-making process, and the factors that influence that decision-making.

One of the principles of Control Therapy is that it is always a skillful strategy and attitude to believe that there is a way to gain a positive sense of control in any circumstance and situation.

This principle is itself a “choice” in the existential sense. William James stated that his first act of free will was to believe “as if” he had free will and believe in human choice. CT posits that we need to have certain skills and options in order for us to truly use our “choice” and free will most wisely. That is why it is important to spend time with the client exploring views about different control modes, agency, domains and, in the next section, building blocks. As the therapist can make clear, the client has the opportunity to decide which domain area is the one to begin working on first; where and how to focus attention; and which cognitions and images are to be employed for what goal.

To decide what we want to do, we need to be aware of when we are acting by habit and reflex. We also need to be aware of the many choice points that exist at each moment. We have to be willing to take responsibility for our actions and choices. Finally, we need the skills to perceive increased alternatives. As Abraham Maslow said, if the only tool you have is a hammer, all problems look like head of an undriven nail. To do what we want to do, we need the self-management and self-regulation skills to carry through with our decision.

Of course, this explanation makes the model seem so much simpler than it sometimes is. This is an empathic point that can be made to the client! Sometimes we do indeed “wobble” about our decisions (and also, once we have made them, in the learning process of trying to carry them out.). That is why we have added a footnote to Reps’ saying:

“When you wobble, wobble well!”

There are times when we need to step back, pause, and consider our decision-making process and choices, before we once more proceed forward. We need to learn to develop increased awareness about ways we are influenced by others and life situations, and to notice our habitual and reflexive ways of responding. Then we can decide, after a conscious, considered, reflective, pause, what is the best way to respond.

To take an interpersonal example, how might you respond if someone were to say something to you that is critical, accusatory, commenting on what they see as “bad behavior” in you, treating you with what you see as “disrespect”?

Often we feel threatened in this situation, and thus our reaction will be reflexive, defensive, angry, attacking back. If we can learn to pause, we can then put the issue in perspective, re-center, consider our alternatives and how we would like to respond. We will almost invariably choose a more carefully thought-out, less counter-attacking, wiser

response. The pause gives us an opportunity to consider alternative solutions (along the gradient from maximum yin to maximum yang).

Further, as in the story of the person chased by the tiger, hanging over a cliff, with sharp rocks below, yes, there must have been some wobble, then a conscious decisional choice about where to focus one's attention:

Ah, how sweet the strawberry tasted.

Therapist self-reflection on personal decision making process. It's important for a therapist to know their own decision-making style for several reasons. First, so that the therapist has conscious experiential practice in understanding his/her decision making style. It is easier to teach what one knows, and can model. Secondly, so that they can guide the client in the decision making process more effectively in therapy. And thirdly, can be more confident they are making the best choices for their client in the therapy sessions. Therefore, let me take a few moments to discuss decision making in general, and to raise questions for you as therapists to consider.

In making decisions. one of the first things we want to do is to pause and still ourselves enough so that we can hear all the competing voices and options available in a clear, calm way. It's easier to see clearly what is going on if the lake is calm and still, rather than if the waters are murky, churning, and stirred up.

A process of decision-making which honors all the different aspects of our self (body, mind, feelings) and others, is to listen to each individually, and then put them together as a whole. For example, in contemplating an action, we can make a list of all the pluses and minuses of a given course. We can even rank how important each plus and each minus seems to be (e.g., on a one to ten scale). This is bringing a cognitive, rational component to the decision making process, while also recognizing that the judgment of "importance" is influenced by our emotions. You can add up all these numbers, and see which choice "wins." Then, before making a final decision, set all these ruminations aside, and again take a few cleansing breaths. Lao-tzu says,

*Do you have the patience to wait till your mud settles
and the water is clear? Can you remain unmoving
Till the right action arises by itself?*

The process does not need to be either/or (i.e, wait til action arises; OR consciously choose). We can use our analytical minds, our emotions, our bodily cues, and the advice of others. We can lay out different options. Then we can sit in a calm, centered way, pausing to see what arises from the clear space we've created. We can learn when we feel congruent and clear about a choice (what our body feels like, what our "mind" feels like; what we feel). We can notice where and when our body "contracts": that constriction can be a cue that something is "off"; that we are not centered, and therefore not ready to make the choice; or perhaps that there is something in the choice that needs exploring.

In this way, by observing our own process, we can learn how we can most skillfully make the best decisions and choices of which we are capable. In investigating your decision-making process, you can also examine the following:

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- What is your tolerance for ambiguity—how long are you able to wait before making a decision? Do you have a tendency to seek closure too soon? To procrastinate and wobble too long?
- How able are you to examine gradations and nuances, and how much do you wish for clear black and white answers? How able are you to hold different ideas, thoughts, emotions, feelings, cues in a “big mind” at the same time?
- How much information is helpful to you in reaching a decision? Do you sometimes feel you have too much information so that you feel overloaded and confused? When should you seek more information before deciding? When do you feel overwhelmed? When do you feel you are overanalyzing?
- How well do you respond to pressure in working toward a decision? When is pressure a helpful goad to maintaining focus? When does pressure impede your decision-making process?
- Is it important for you to feel you have choices and options?
- How much choice do you like? Some people are happy with having a lot of choices. Others are confounded by too many choices. When do you feel there are too many options? Not enough options so that you feel trapped and forced? What is your decision-making pace? Are you more the hare, or the tortoise?
- Are you more of a concrete person or more of an abstract person? Is it easy for you to see the whole picture and put parts together? Do you tend to feel more comfortable focusing on the details?
- How much do you turn to others for guidance and help in making a decision; how much trusting your own judgment?

End slide

As part of learning about your own decision-making style, it is important for you to learn what is an optimal decision-making style for you. To what extent is it in your interest to rely on your preferences above, and to what extent it is useful to build up the weaker ones? How much do you want to rely on guidance and advice from others; how much on your “self”? How much do you want to rely on your intellect and logic; on your emotions; cues from your body? When do you want to override emotions, intellect, bodily cues, or others? The decision making process gives you an opportunity to see how well you are able to develop a combination of analysis and feeling, emotion and thought, body and mind, self-exploration and guidance and support from others that might be beneficial and result in optimal choices. Each of us has to decide which of the foundational building blocks we “trust” and can utilize in making decision. Part of wisdom is learning through experience to evaluate your own limits and skills, to evaluate the different situations, and to find the best mode match of which you are capable. One way to start developing this wisdom, is, to “know your own Control Profile.”

Of course, engaging in this decision-making process, no matter how thorough and well done, does not necessarily ensure a successful outcome. Almost all decisions are made on the basis of incomplete information, and involve a certain amount of chance, risk, and luck. But, as noted, if we stay conscious about the process and the outcome, we can face our fears of making the wrong choice, take responsibility for our decisions, feel comfortable in knowing that we have made the best choice of which we were capable at the time, and commit to a course of action (or inaction!). Then, as we continue to evaluate our progress, if we find our choice wasn't optimal, we can learn from our mistakes, and use that knowledge to enhance the process the next time.

Finally, it should be noted that the above rather thorough self-exploration of the variables involved in the decision-making process is not something that a therapist would necessarily engage in with every client. However, we have examined the process here in some detail because we feel it is important that the therapist him/herself be aware of the complexity of factors that can be implicated in their own decision-making process. This in turn can help make the therapist more sensitive to the potential differences, as well as strengths and weaknesses, in the decision-making styles of their clients.

* * *

CONTROL STORIES—The goal of a new chapter?

One further way of formulating a goal is to explore the aspect of a client's control story that identifies a nodal event from which the client learns a lesson about loss of control, and/or gaining, re-gaining, or maintaining a sense of control. This exercise explores that nodal event, the feelings associated with it, the conclusions drawn from it, and the lesson learned. The exercise ends with exploring whether a new goal, chapter, or addition to the control story might be helpful in the client's current phase of life.

Note to instructor: This information may be shared didactically and/or experientially with the audience : e.g.

Again, I invite you to engage in this exercise, both as a way of exploring it for yourself, and for later introducing to your clients, as appropriate.

What happened was _____. Generally, the event you describe in your control story will be something that was "true." Let's take it as a "fact." What is interesting is how, from your current perspective, you evaluate that fact: What do you remember feeling? What conclusions did you draw? What did this story teach you about maintaining a sense of control in life?

I remember feeling _____, Let's also take your feelings as "fact." The current evaluation might involve exploring whether there are other ways that now, as an adult, you might a) have felt in the same circumstances if they were to happen today; b) even if not, are there ways you might want to address, modify, and/or soften those feelings: e.g., less fear, more forgiveness, more trusting of yourself?

I concluded that life is/can be _____. Is it possible, given additional life experiences that you have had since this event, that there is a more nuanced approach and understanding you could have now in terms of how you view life?

Therefore, to gain a sense of control, I _____. Based on the event, your emotions about the event, and your generalizations about “life,” you then evolved and created ways to protect yourself and to gain and maintain a sense of control. Those ways to gain a sense of control—modes, desire, agency—may have served you well then. The question is whether questioning these strategies, and looking for other options and skills, might serve you better now.

A new goal, chapter, addition to the control story? If there are aspects of your control story that you feel might be worth changing following the above analysis, what would be your goal? Ideally, how would you like your control story to read? For the woman who felt she was always second guessing herself, she might want to add a component such as, “I’m doing the best I can. I need to be more trusting.” For the person who felt unlovable unless doing, it might be helpful to add, “I can be valued for what I accomplish, and I can be valued for who I am at my core, just as I am.” If you feel there are problematic areas in your control story, make a note of them, and begin to explore how you’d like them to change.

When exploring control stories with oneself and/or with one’s clients, note how these stories can range from the micro (e.g., beliefs about self-efficacy in a certain area—ability to influence one’s mother in law) to the macro (beliefs about the role of human agency in life!) One way to explore present-day control stories (either your own or your client’s) is to reflect on whether you regard these beliefs as absolute truth or provisional truths; and whether you feel these control stories, even if they once served a useful function, may need to be reconsidered and evaluated for their current helpfulness. If so, think whether a new chapter or editing the old chapter might be helpful as a goal.

THE RELATIONSHIP OF PSYCHOLOGICAL HEALTH AND CONTROL

We have now completed Phase One of Control Therapy: Assessment and Goal Setting. Before we move on to Phase Two, Interventions, it is useful at this point to take a step back and further explore our own (and psychology's) views about the role of control in psychological health.

As you remember, when we were discussing the client's control stories, we also took time to examine your own control stories (theories) as they related to your preferred Personality Theory, System of Psychotherapy and the role of control in each. (section 7.6). Each System of Psychotherapy has a view of human nature—who we are (remember the wolves discussion) as well as a view of psychological health—who we can become. Who we can become is really the overarching “goal” of therapy. So, just as we have been discussing how the client formulates their goal, it is instructive for each of us to examine in a systematic, conscious way our own views of what constitutes the goal of therapy, and, for our purposes here, how control may be involved.

Let us begin by looking at five different schools of therapy; then examining psychology's view of suboptimal, normal and optimal control and its relationship to psychological health; and finally, briefly raising questions for you to think about regarding your view of optimal control in each of several domains.

Comparison and Contrast of Five Schools of Therapy : Goal of Therapy.

Below is a slide representing several different theories, each of which has a view of the extent and limits to which control is useful. For example, a biomedical model argues there is no such thing as self-control; a psychodynamic (id) model argues that the ego needs to gain progressive control of the id impulses; a cognitive-behavioral orientation emphasizes the learning of appropriate (self)- control skills; etc. (These theories and their relationship to control are discussed extensively in Control Therapy, Chapter 3; and in Appendix 7 of the Control Therapy Training Manual there is an overview of contemporary control-related constructs). This material is also included at the end of this lecture in a handout.

Each of these views suggests how much control humans have (view of human nature) and can (or should) have as means and/or end in terms of the goal of therapy
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Subject	Biomedical	Psychodynamic	Cognitive-Behavioral	Humanistic-Existential	Transpersonal
View of Human Nature	Primarily biological/ physiological processes.	Ruled by unconscious amoral id.	Blank slate. Determined by environmental stimuli, or cognitive representations of stimuli.	Innately self-actualizing (H). Existence precedes essence (E).	Interconnected. Capable of going beyond ego identity.
Goal of Psychotherapy	Normalize chemical imbalances.	To make the unconscious conscious, “where id was, ego shall be.”	Competently respond to environment. Reinterpret illogical cognitions.	Foster self-actualization (H). “Choices” create authentic self (E).	Go beyond identification with limited ego. See interconnection with others and world.

end slide

As can be seen from the above, different therapists can have a broad range of perspectives yet they all see some aspect of control as important in their theoretical orientation. Therefore, as we continue to discuss assessment, goals, and interventions, it is worth considering how aspects of Control Therapy might be helpfully incorporated by those with a variety of theoretical approaches.

A control-based view of psychological health: Suboptimal, normal, and optimal.

(Note to lecturer: This material helps refine and further explore the three postulates. You may wish to point out as you go through it, where aspects of each postulate is found (e.g., our desire for control, the importance of a sense of control (1); when and where that is skillful and positive, when not (2); within the context of individual variation, how individuals can learn to develop increased positive sense of control (3).)

Suboptimal and normal. Traditional Western psychology argues that loss of control and learned helplessness are unhealthy and suboptimal. Both psychiatry and psychology in general agree that dyscontrol is associated with mental illness. Many of the DSM disorders are defined in part by the explanation that the patient evidences "unsuccessful attempts to control" (e.g. substance abuse) or is "losing control". When sense of control is not established, there are negative mental and physical health consequences. (cf Postulate one)

While mental illness is associated with loss of control, mental well-being (the normal control profile) is associated with feeling a sense of control, even including an illusion of control (Bandura, 1989a, Beck 1976, 1989, Seligman, 1991, Taylor & Brown, 1988, 1994 .

Traditional mainstream psychology has a linear view that increasing control or belief in one's control is associated with positive health. It is argued that even illusory control (i.e. times when we feel we have behavioral control, but actually do not) can be beneficial to our well-being. Research indicates that psychologically healthy normals overestimate the amount of control they have in situations, are more optimistic about the possibility of their achieving control than their ability warrants (Lewinsohn,, Mischel, et al, 1980, Seligman, 1991, Taylor & Brown, 1988); attribute their success to high skill and ability, with luck having little to do with it; overestimate their invulnerability and underestimate risk (Weinstein, 1984, 1993), and make explanatory attributions to protect their sense of control when behavioral control efforts are not successful.

Three attributions identified by Peterson and Seligman (1987) to maintain a sense of control when efforts are not successful are: attributing the outcome to situational factors ("There were mitigating circumstances," "My luck was bad"), a universal human condition ("The goal was too difficult and no one could have accomplished it", "I am still as competent as anyone around"), or a temporary situation (fatigue or lack of preparation rather than a stable condition of lack of skill or ability). Other strategies normals use include minimizing the significance of a situation, and denying or putting out of mind problems that do not seem amenable to control. In other words, we often seek to control the world not only by our overt behavior, but also by our cognitions about and perceptions of reality.

This position that positive illusions foster mental health by removing feelings of lack of control continues to be a major influence on the field of psychology. In summary, therefore, a healthy, "normal" control profile is considered one in which a person has a sense of control, believes and acts as if he or she can influence the course

of events, often to an exaggerated degree, and feels that he or she is a competent and special self capable of effecting control on her own.

Overall the research supports the relationship between having personal control, a strong, autonomous identity, and physical and mental health. These findings give credence to the dominant Western psychological paradigm regarding control, which can be summarized as follows: Having active, instrumental control is positive, and the more control you have (or believe you have), the better (Evans et al, 1993, Thompson, 1981).

Problems with Normal Control However, because lack of control is associated with mental illness, is it justifiable to equate positive psychological health with more control using a simple linear model? In other words is the absence of dyscontrol truly the same as positive psychological health? This question arises with the definition of health in general. The field of medicine and health care is currently acknowledging that health is not merely the "absence of illness." So too in this model of control must we expand and develop our definitions and paradigms. (cf Postulate 2).

Although a normal profile is better than a suboptimal profile, there are numerous problems with what psychology considers a normal control profile, and the failure to adequately consider these potential difficulties has led to an overly narrow definition of what constitutes healthy psychological functioning (Clover & Block, 1994). "Healthy normals" build elaborate perceptual, cognitive, and affective defenses, as well as behavioral habits, in order to give themselves an illusion of control. These defenses can distort an accurate appraisal of reality, cause us to engage in denial and other defenses that can create unhealthy illusions of competence. External attributions of failure can keep individuals from learning about their mistakes and making appropriate growth-oriented changes. The low level of awareness in normal control profiles keeps individuals from recognizing the unconscious reactive and reflexive nature of many of their control desires and efforts, so they continue to pursue them without considering some of their negative consequences.

Western psychology by and large has tended to overlook the potentially negative effect of normal control strategies and efforts. The theory, research, and practice of Control Therapy agree that "normal" control is better than suboptimal. However, it maintains that "normal" control strategies can also be problematic. For example, they can keep individuals from being aware of the unconscious, reflexive, and reactive nature of many of their control desires and efforts; are often insular and self-serving; and can keep people from learning about their mistakes.

Therefore, a concept of optimal control is needed.

Toward an understanding of optimal control.

Recognizing naïve awareness.

Slide

The first stanza of a Zen poem:

“When one *is unenlightened*,
snow is snow and water is water.”

End slide

From the perspective of “optimal control, we begin with the premise that even in “normal” awareness, which allows us to navigate our daily life relatively successfully, we often don’t have as much control as we believe we do. We may think things are normal and “in control”—i.e., water is water and snow is snow.

But actually, our control beliefs and feelings frequently are naïve, conditioned,

and reflexive. We can't really have true free will until we realize how conditioned we are i.e., just how reflexive and automatic many of our actions and desires are. The beginning of optimal control occurs when we have awareness of times when desire for control has become excessive or misplaced, and develop an ability to gain a sense of control without relying on reality distorting defenses and attributions.

To a great extent, all of us live lives controlled by pronounced reactivity, reflexive defenses, and untrained minds. Without awareness, we may never become aware of these unconscious automatic reactions and defenses. We may believe we have free will and are making informal choices, when we are merely reacting to our biology, past experiences, and cultural conditioning. We may never gain the insight to recognize our maladaptive behavioral habits and cognitive thought patterns that hurt both ourselves and others. Defenses are often insular and self-serving, and are the cause of misdirected efforts to control others and the environment, causing destructive consequences on personal, interpersonal, environmental and societal levels. At a more subtle level, the beginning of optimal control involves becoming aware of the often unconscious thoughts, feelings, desires, conditioning that often influence or "control" our behaviors. To gain this optimal control involves paying systematic attention to one's motivation for control, to notice subtle, unconscious, reactive, control-related habits and desires. This attention involves recognizing how it is possible to bring about self-created suffering though conditioned and reflexive attachments and desires, as well as fears and avoidances.

Positive, optimistic self-efficacy ("as if" belief): Beyond naïve awareness.

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Second stanza of a Zen poem

“When one seeks enlightenment,
snow is no longer snow and water is no longer water.”

End slide.

The very act of exploring one's preconceptions, worldview, normal daily habits, and moving from unconscious automaton (stanza one) causes confusion. There may be doubts that a third stanza even exists, that things will get better.

Seemingly paradoxically, although we may not initially have as much “skillful” positive control as we believe we do (with our naïve awareness), with more careful awareness and practice, we have the potential to develop even more positive control than initially we believed possible.

With practice, humans can affect considerable control over many aspects of their lives —both through the assertive mode and the yielding, accepting mode; and can learn to become more aware, take more responsibility for their choices, and increase control over their thoughts, feelings, and behavior in a health-enhancing way. (cf Postulate three). The point of awareness practices, such as self-observation and mindfulness, is to make us (client, therapist you aware of the thoughts that run your life and diminish their power over you.

The foundation of optimal control is recognizing that through awareness, conscious choice is possible. Optimal control involves learning where and when control goals, desires and strategies have become reflexive, limiting and potentially destructive. It

involves appropriately matching control desires, goals, and strategies to situations. Optimal control further consists of a balanced and flexible use of assertive and yielding modes of control, an ability to gain a sense of control from both self and other sources/agents.

We may not be able to develop perfect self-control, but even a little bit more can make a difference. Simply because we are limited in our ability to exert positive control in each mode does not mean that the effort is not worthwhile. If we can only improve two, three, or four degrees, that can make a substantial difference in our lives and the lives of others. Think of the difference a few degrees make in our body temperature: e.g., 98.6 to 102.

Finally, as noted, one of the principles of Control Therapy is that it is always a skillful strategy and attitude to believe that there is a way to gain a positive sense of control in any circumstance and situation (Module 3.3, p. 197).

In and through. At the start of Module 1 of the Control Therapy Training Manual there is a playful paraphrase of the Socratic injunction: “Know thy... Control Profile, control stories, and control dynamics.” Control Therapy argues that, in general, and while honoring each client’s individual style and readiness, concerns are most skillfully addressed through awareness (i.e., “in”) rather than through avoidance, distraction, or denial. Going “through” involves trying to address the concern through change, acceptance, or some combination of these two. To take stress as an example, Control Therapy approaches this concern first through “awareness”-- what is the stressor, what is the client’s control profile, the extent to which the client is vulnerable to stress, the client’s “usual” focusing strategies All of this is “in.” Going “through” involves decisional control, values and beliefs, self and other as agent, setting a goal, and developing appropriate interventions, as needed and useful: a) to address internal feelings of stress b) to address the external stressors c) to cultivate gratefulness and joy. More specifics of interventions to create “in and through” are further discussed in the interventions section below.

Healing beyond the personal self. Finally, moving toward optimal control involves directing control efforts not solely toward furthering the well-being of oneself but toward the promotion of health and well-being in others and the world at large. At some point developmentally, the focus of control can go beyond goals of personal competence, autonomous self-identity, and positive ego development (Walsh & Vaughan, 1994). Such control efforts may directed toward generativity, compassionate service for healing others, and interpersonal and collective well-being (Fowler, 1981; Kohlberg, 1981; Levenson, 1978; Maslow, 1968, Shapiro, 1983, Shapiro & Schwartz, 1998; Tart, 1986, Walsh & Vaughan, 1994).

Thus, to summarize, according to Control theory and Control Therapy, optimal control involves:

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- Increased conscious awareness of one's control dynamics, including affective, cognitive, and somatic experiences, to learn when and how the desires and efforts for control are expressed; when control beliefs, goals, desires, and strategies are reflexive, limiting, and potentially destructive; and when they should be increased, decreased, or channeled.

- A balanced and integrated use of assertive/changing and yielding/accepting modes of control matched to situation and goals, desires, and temperament. : As a “mantra,” Control Therapy believes the wisest course is to examine our selves, our biases, our goals and, from a centered place, try to arrive at the best goal for the situation, time, place, person, developmental phase, and concern being addressed
- The ability to gain a sense of control from both self (self-regulation of cognitions, affect, and behavior) and from others (gaining a sense of control from a "powerful benevolent other," whether from a doctor [see Taylor, 1983] or from one's view of the nature of the universe, including religious and spiritual beliefs).

End slide

And yes, there is a third stanza to the Zen poem. It is identical to the first stanza. In Zen, one returns to the awareness of the first stanza with a freshness and openness to the here-and-now present,-- on the other side of naïve awareness--seeing the flower for the five hundredth time with the same joy as one saw it the first time.

In terms of our control model, we would say that with practice, one learns to be both conscious and calm, recognizing the naïve awareness and reflexive control desires and strategies that “seem” natural (first stanza); and then, seeking to “grow” to a higher level of wisdom, (seeking enlightenment—second stanza). Finally, through having learned skills to allow one to see with a higher (deeper, more precise, and more holistic) level of observation and consciousness, and possessing control-enhancing techniques and skills, one “grows” and transforms into a new level of “optimal control, developing more skillful, higher level control desires, goals and positive sense of control.

Coping with challenges: A breast cancer 20 year follow up on sense of control, psychological health, and morbidity/mortality.

This section has explored the goal of control, including therapists’ views of the relationship between control and psychological health based on the assumptions of different schools of therapy; and a control-based view of suboptimal, normal, and optimal psychological health. Earlier in this talk, when we discussed reliability and validity studies, we looked at research on therapists’ views of the relationship between the four modes of control and psychological health. I’d like to end this topic with a comment on research involving a 20 year follow up to a breast cancer study looking at the role of control in coping with this disease both in terms of psychological health, and morbidity/mortality.

In the initial study, quality of life, mood, and psychological control were assessed in 58 women diagnosed with breast cancer at three time points: within 6 weeks of initial diagnosis; and then at 4 months and 8 months post-diagnosis. The goal of this study was to examine sense of control, mode of exercising control, and desire for control at diagnosis and the relationship of these variables to psychological adjustment and quality of life post-diagnosis. Test measurement instruments includes: a) *anxiety*, with a subscale of the Hopkins Symptom Checklist¹⁰; (b) *depression*, with the Center for Epidemiological Studies Depression Scale (CES-D)¹¹; and (c) quality-of-life, with the Functional Living Index–Cancer (FLIC).The Shapiro Control Inventory (SCI), was

utilized to examine overall sense of control, desire for control, and four distinct modes of control: (a) positive assertive (taking charge, being assertive); (b) negative assertive (e.g., overly controlling); (c) positive yielding (e.g., acceptance, equanimity); and negative yielding (passivity).

Findings indicated that those women who at diagnosis evidenced a high desire for control coupled with less use of an accepting mode of control (ie, the ability to let go of active control efforts) showed the poorest psychological adjustment post-diagnosis. In contrast, those women high in both desire for control and use of a positive accepting mode of control showed the best psychological adjustment. These findings lent partial support to our theory that a balanced use of active and yielding or accepting control efforts may lead to optimal psychosocial adjustment and quality of life in the face of life-threatening illnesses such as cancer.

A 20-year follow up was carried out to examine possible associations between sense of control, psychological mood, and quality of life and breast cancer recurrence and survival.

No significant relationships were observed between mood (anxiety or depression) post-diagnosis and either mortality or cancer recurrence. However, overall sense of control at 8 months post diagnosis predicted recurrence ($p=.04$), with higher sense of control being associated with *less* likelihood of recurrence, after controlling for age, and tumor grade and size; while high *desire* for control predicted greater likelihood of cancer recurrence.

Based on the results from the earlier work, investigators examined whether use of the positive yielding mode of control (accepting, trusting) might help mitigate the negative effects of excessive desire for control on cancer recurrence. In fact, women who were high in desire for control but also scored high (above the median) in the yielding mode of control were *not* more likely to experience a recurrence. In contrast, women evidencing high desire for control and low yielding/accepting control were more likely to experience a recurrence.

Previous studies examining the potential influence of control coping responses on stress and disease outcomes such as cancer have tended to frame the issue on a continuum from active/assertive control (eg, “fighting spirit”) on one end and passivity (“helpless/hopeless”) on the other. The work just described, however, suggests that this framing of the construct fails to consider the potential negative consequences of maintaining a fighting-spirit attitude in the face of life challenges that are not within one’s control (eg, overcontrol) while also failing to distinguish between unhealthy passivity and healthy or adaptive acceptance, thereby overlooking the potential psychophysical benefits of surrendering active control efforts.

Future studies may wish to explore in a controlled randomized trial, with a larger sample, the effects of a targeted therapeutic intervention addressing relevant issues of control: 1) increasing a positive sense of control; 2) finding an appropriate level of desire for control; 3) and obtaining a greater overall sense of control, through some combination of positive assertive/change and positive yielding/acceptance modes of control). And then to assess the effects of such an intervention on psychological well-being, as well as morbidity and mortality.

Now we’ve completed our discussion of Phase One of Control Therapy: the Assessment and Goal Setting Phase, let us turn to Phase Two of Control Therapy: Interventions.

PHASE TWO OF CONTROL THERAPY:

INTERVENTIONS: CONTROL ENHANCING TECHNIQUES

MATCHING STRATEGY TO CONTROL PROFILE, CLINICAL CONCERN, AND GOAL.

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Control Therapy attempts to provide the client an experience grounded in the client's motivation, encouraging their self-exploration, honoring their unique cultural positions and world view, refining and addressing their self-stated goals, and tailoring interventions to help them meet those goals. In so doing, it helps clients learn how to focus on their own thoughts, behaviors, and feelings within the context of their lives and then learn how to positively influence the world and themselves in healthy and healing ways, whether through positive assertive, positive yielding, or an integration.

end slide

Interventions are the second phase of Control Therapy. There are four important points that guide interventions in Control Therapy.

The first comes from Gordon Paul's excellent and often quoted statement about psychotherapy effectiveness,* that the most important question is: *What specific treatment, by whom, is most effective for this individual with that specific problem and under which set of circumstances?"*

By finding a way to assess a person's specific control profile and their particular concern of assault to their sense of control, it is possible to develop and match techniques to the person and their concern with some care and precision. We've discussed how the SCI shows sensitivity and specificity between and among different clinical groups. This is important information for devising large scale interventions with specific clinical populations. However, in clinical practice, we work with an individual. Even within different clinical groups, we have seen that there can be unique variation in control profiles. For example, earlier in validity study 8 we presented two cases of stress with exact opposite mode profiles.

One of the competencies of a therapist doing Control Therapy is the ability to learn to select an intervention that is the best match for the client's control profile and goals. The intervention should be the best blend and balance between positive assertive change and positive yielding acceptance, self and other agency, thereby most effectively addressing and reducing the assault to the client's sense of control.

The second has to do with the techniques themselves. Techniques will be presented here that are helpful for obtaining a positive sense of control through a five step process, for a) the yielding accepting mode of control; b) the assertive change mode of control and c) where appropriate, the balance and integration of the two modes. This will help you get a flow for each of the five steps and what resources are available for each: 1)

* Paul, GL, (1967) Strategy of outcome research in psychotherapy, *Journal of Counseling Psychology*, 31, 109-118)

initial desire/motivation; 2) right and responsibility; 3) self-efficacy beliefs; 4) motivation and commitment to practicing skills; and 5) gaining and evaluating “success.”

Thirdly, the control enhancing techniques in Control Therapy are formulated from the universal building blocks available to humans: cognitions/thoughts; feelings/emotions; imagery; body/behavior. Control Therapy is less interested in what a technique is called, and more interested in deconstructing techniques into these building blocks to see what is unique about a particular technique; in what ways these building blocks can be “constructed” to most effectively enhance a person’s sense of control; And, related to point one, how these “constructed” techniques can be matched to that person’s particular control profile, including which building blocks the person finds trustworthy, which less so.

Finally, interventions are taught in the context of relationship. Here we present the interventions, but in the section presenting the systems model, we spend time exploring the importance of relationship, as seen by different therapeutic approaches.

Matching: An example.

Individuals at high risk for coronary disease. Comparing two SCI control profiles:

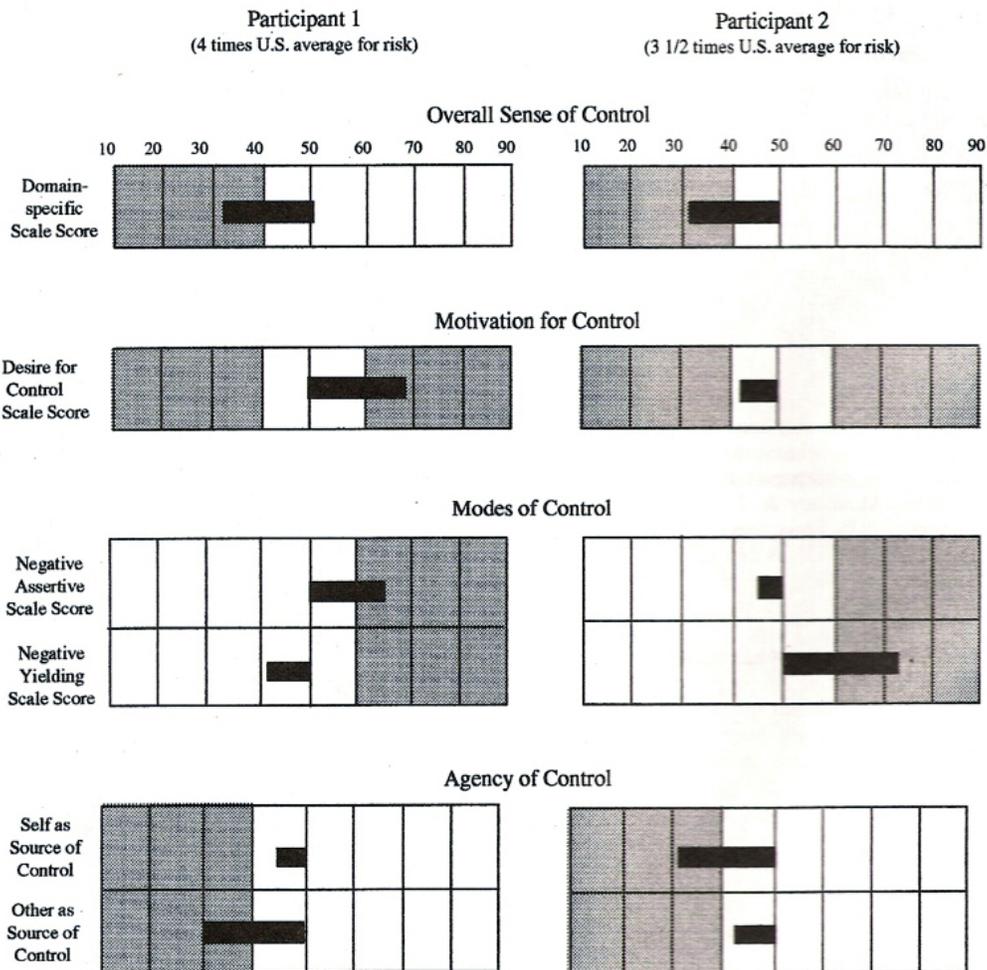
Below is an example of individuals with equally high cardiac risk, but with quite different control profiles. These examples illustrate the importance of matching control enhancing interventions to the unique control profile of the person with whom we’re working.

Note that though each of these individuals feels a low sense of control, there are differences in desire for control, modes, and agency. These two profiles show the importance of matching, and emphasize the point that there is no one-size-fits-all approach to people feeling a low sense of control. Rather, it is important to have a multi dimensional approach to understanding a client’s (or one’s own) control profile

If you look at the two different control profiles of these patients at high cardiovascular risk in the figure below, it is clear that it is necessary to tailor and match different control enhancing interventions to each. Participant one differs from the normal range in these ways, as indicated by the gray areas on the slide: a high desire for control, high negative assertive, and low belief in others as a source of control. Participant one needs to learn to have less desire for control, reduce his/her negative assertive mode style, develop positive yielding skills, and learn to trust others more. Participant two, on the other hand, is high in negative yielding; and has a low self as a source of control. This individual needs to learn to rely on him/herself more and develop more positive assertive control skills. Given these profiles, how might a therapist “teach” each person the skills needed to best address their control deficits and build a more optimal sense of control?

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CONTROL PROFILE OF TWO PATIENTS AT HIGH CARDIOVASCULAR RISK



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We now turn to the five step process for teaching the yielding/accepting mode of control, and the assertive/change mode of control.

TEACHING THE YIELDING/ACCEPTING AND ASSERTIVE/CHANGE MODES OF CONTROL: A FIVE STEP PROCESS.

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According to Control Theory, each of us seeks to gain or maintain a positive sense of control in our life. When there is a concern—something seems out of control, we fear losing control, or there is an area where we desire more control—there are two positive modes that can help us achieve that sense of control: either we act assertively to address the issue or we utilize a yielding mode to accept the situation. In either case, we use interventions based on a combination of the fundamental building blocks at our disposal; mind, body, behavior, environment, others, based on the individual's control profile and goals

end slide

There is a five step process to teach either the assertive/change or the yielding/accepting modes of control. In Phase One of Control Therapy, based on the client's initial concern, Control Profile, self-observation and self-evaluation, the therapist has worked with the client to set a goal to address the concern. This goal involved learning greater assertiveness to change a situation; or greater yielding to accept the situation.

Once the client has set a goal, the therapist can then work with the client to develop specific intervention techniques involving addressing the concern and reaching the goal through an assertive/change mode of control, or by a yielding, accepting mode. The first three steps below—1 desire, 2 right and responsibility, and 3 self-efficacy beliefs may be thought of as a critical “architectural” foundation to maximize the likelihood that the techniques for the modes (Step 4) will be successful (Step 5).

These five steps include the following:

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- 1) **DESIRE FOR CONTROL:** Therapist works with the client's initial motivation and goal to gain a sense of control through either positive mode.
- 2) **RIGHT AND RESPONSIBILITY:** Therapist works with clients to assess whether they feel they have the right (and responsibility) to gain a sense of control through either mode.
- 3) **SELF-EFFICACY BELIEFS:** Therapist discusses and if needed works with client's self-efficacy belief in his/her ability to learn to practice and succeed using either mode of control.
- 4) **COMMITMENT AND SKILL:** Therapist is able to effectively teach client the building block techniques for each mode of control, and to help the client maintain commitment (adherence and compliance) in practicing the techniques.
- 5) **SUCCESS:** Therapist works with client to evaluate and ensure that the clinical goals set in Phase One are reached.

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Due to time limitations, the material presented here will only briefly review the five steps for each mode. More detailed technique presentation, as well as client/therapist dialogue and discussion regarding each stage, can be found in the book Control Therapy and the Control Therapy Training Manual.

It should also be noted that the five steps are presented as linear. There is some “architectural” justification for this—as each step provides a “foundation” for the next: e.g. the desire and intention to change/accept adds a motivational component which increases the likelihood of successful learning of new skills. The person also has to feel they have a right (and responsibility) to address the assault to their sense of control. Further self-efficacy beliefs can enhance commitment and skill learning. On the other hand, there can be reciprocal influences and feedback between steps in this process: e.g., learning skills (step 4b) can also increase self-efficacy beliefs (step 3), self-efficacy beliefs (step 3) can enhance feelings of personal responsibility (step 2b), etc.

STEP ONE. DESIRE FOR CONTROL: “I WANT....”

Working with the client’s initial motivation/intention to gain a positive sense of control.

Desire for control, as we have pointed out, is a “motivational” vector. It suggests that the client wants something to be different in his/her life.

Once a client has set a goal, it is important to explore with the client how high their intention and motivation is to reach that goal. The therapist can work with the client to try to pinpoint the client’s motivation as clearly as possible. For example, if starting an exercise program, is it to improve your health? Because your doctor told you to? So you can look in the mirror and feel proud? For an interpersonal relationship? To work on creating your body “as a temple of the soul?”

Assessing Motivation to work toward healthy acceptance (or healthy change). .The therapist can invite the client to explore the following four questions

1. The most important reasons for your wanting to develop more acceptance in this area (or more change).
2. In what ways does this control issue negatively impact your life (i.e., what are the negative consequences if you do not become more accepting). (if you do not act assertively to make change)? What happens if no effort is made to improve the situation?
3. How motivated are you to gain increased acceptance (increased change) in this area? Let’s imagine a four point scale with 4=*very much*, 3=*somewhat*, 2= *a little* and 1=*not at all*. On this scale, where would you fall? (See also Intention to Change/accept, form below)
4. On the same scale, how motivated are you to learn and regularly practice self-control strategies for the yielding, accepting mode of control? (or for the assertive, change mode of control).

One way to explore these questions further is through the Intention to Change (Intention to Accept) worksheet. Once this has been completed and the above four question explored, the therapist can work with the client, as needed, to develop affirmations—cognitive statements to support the yielding/accepting mode of control (or the assertive/ change mode of control). Below is the worksheet, and then some examples of affirmations.

Intention to change/accept : for areas of concern: *This form can be used to compliment the above four questions, and to assess intention to change (e.g., one's feelings, thoughts, behavior) as well as intention to accept (e.g., oneself, one's body, one's relationship).*
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INTENTION TO CHANGE/ACCEPT

In the following, please note whether there are any areas (e.g., in the domains of mind, body, relationships, work, etc) which you would like or intend to change or accept. In those areas where you have a slight to very strong intention to change/accept (i.e., in which you circle 2, 3, 4, or 5), please write down as specific a goal as possible. Two examples are provided of how you would specify goals, one of change, and one accepting.

1	2	3	4	5
No Intention	Slight Intention	Moderate Intention	Strong Intention	Very strong intention

Please underline or circle the relevant word (change/accept):

Example 1: I plan to change/accept my nutritional habits this year.
 Intention = 3
 Specific goal: Reduce red meat from 5 to 2 times per week.

Example 2: I plan to change/accept my height
 Intention = 4
 Specific goal: Every time I have a negative thought about my height, I will counter it with a positive, accepting statement.

(1) I plan to change/accept _____

Intention = _____

Specific goal: _____

(2) I plan to change/accept _____

Intention = _____

Specific goal: _____

(3) I plan to change/accept

Intention = _____

Specific goal: _____

end slide.

Affirmation for the yielding/accepting mode of control. . Below are some affirmations that may be helpful for maintaining and increasing desire for the yielding, accepting mode of control, which can be edited and adapted to a client's particular goal and area of concern:

slide;

- I want to learn to act and believe that I do not always need to be in active control.
- I want to learn to trust that things will be all right if I am not managing everything, and that the world will not fall apart if sometimes I let go of my active efforts and relax.
- I'm ready to learn that I don't need to have a façade of always being strong and totally confident.
- I'm ready to learn to stop worrying so much about how I look or act in every situation.
- I want to learn to accept my limits, and to realize that I can do only so much before I need to pause.
- I want to learn to accept and love myself just as I am (general affirmation).
- I want to learn to accept and love my (specific affirmation: body part, height, weight, etc).

end slide

Affirmation, exploration for the assertive, change mode of control. Below are some affirmations that may be helpful for maintaining and increasing desire for the assertive/change mode of control, which can be edited and adapted to a client's particular goal and area of concern:

- I want to learn to develop the courage to act in a way that helps me change my current situation. .

- I want to learn to not sit passively by and watch things happen when I know I can impact them in a positive way.
- I want to learn to test my limits, and am willing to try new ways of acting and behaving.
- I want to learn to improve myself, and make the changes that I know are in my best interest.

Ready to move to step 2? At this point, the therapist and client have reviewed the intention to accept/change form; reviewed the above four questions about motivation and desire for learning a particular mode of control and explored affirmations that may help buttress the client's initial motivation. If each agree that the client has appropriate and sufficient desire and initial motivation to learn, develop, and practice the selected mode of control, and that the mode of control serves the client's personal goals, growth and higher self, then they are ready to turn to Step Two, Right and Responsibility.

STEP TWO: RIGHT AND RESPONSIBILITY.

The second foundational step in the five step process is exploring whether the client feels s/he has the right and responsibility to address the area of concern and the assault to his/her sense of control. Let's look at each.

RIGHT "I HAVE A RIGHT" TOTo address an area of concern in order to help gain or regain a sense of control, does your client feel they have the "right" to make changes in a certain area; or to become more accepting about a certain area?

In this step you and the client would explore the goal, and consider how the client feels about his/her rights in the situation. If the mode being considered is assertive/change, and the client is dealing with an intrapersonal issue (losing weight) or interpersonal issues (asserting yourself with a bully at work), the question would be: Do you have a right to exert active control in these circumstances?

If the concern is yielding/acceptance i.e., , accepting one's limits, then the question would be does the client feel s/he has a right to simply accept what is For example, does the client feel s/he has a right to decrease the desire for active control, and to be more accepting of the situation or behavior that is of concern: e.g., one's weight, one's exercise program, one's commitment to work, family.

Sometimes this step can be quite simple, and the client says, "Yes, of course I do" and then the therapist and client can move on to the issue of responsibility.

If there are challenges in this step...Sometimes the therapist may feel that a discussion is important in this step to explore what are "appropriate rights" and when are they too high or too low. For example, too high a right might be the narcissistic belief that the world owes us something (e.g., entitlement); too low a right would be too little belief that we have a right to anything or a fear that we have no rights (e.g., I don't have a right to ask for what I want; or a right to be happy, etc.). Appropriate rights would be a belief that we almost always have a right to ask for what we want from ourselves, and

from others and the world ,(positive assertive) but to remember that we don't always necessarily have a right to get everything we ask for! (positive yielding/acceptance).

Messages during upbringing? If there are difficulties in this step, the therapist might also work with the client to look at what messages the client received growing up about the right to exert active control or yielding control. Was there a belief that active control was appropriate (in some situations and others not? Was asserting active control appropriate with certain people and not others? Was assertive control seen as “bullying” bossy, not appropriate?

What about “yielding and accepting?” Were there certain situations where it was reasonable to accept what was rather than try to change it? Was it okay to take time to just “day-dream” and “be?” Did you hear messages that “winners never quit, quitters never win.” “Don't be complacent, don't rest on your laurels.” “When you're resting, someone else is getting ahead?” Was yielding and accepting seen as passive and wimpy?

(The previous work on Control Mode Dialogue could be helpful here).

Hopefully it is clear that unless the client feels s/he as a right either to be more assertive, or more accepting, it is not really possible to effectively go further along the five step process, and time should be spent becoming comfortable with this step.

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Affirmations regarding “rights” for the yielding/accepting mode might include:

- I have a right to learn greater equanimity and self-acceptance.
- I have a right to accept myself as I am

If the client realizes that sometimes s/he has too high a belief in his/her “right” to get what s/he want (ie., a sense of entitlement that doesn't serve the client well), then it might be helpful to work on “softening” this sense of “right.”: e.g., to notice when the client is feeling inappropriately “entitled” and shift statements from “I have a ‘right’ to gain active control in this area

- I have preferences and desires, but can accept that I don't have a ‘right’ to necessarily receive everything I desire.
- I don't have a right to have every need of mine met. I can learn to increase my acceptance of situations where I don't have every need met when and how I want it.

Affirmations regarding rights for the assertive/change mode of control

- I have a right to greater active control in the area I'm focused on.
- I have a right to think of myself and to have my needs honored.
- I have a right to try to control my thoughts and feelings and reactions to events.
- I deserve to exercise positive control in my life.

end slide

These statements can be tailored to each client's specific area of concern. Have the client try to experience each statement as s/he says them: "Breathe in as you make the affirmation. As you breathe out, feel its truth for you."

RESPONSIBILITY: I AM RESPONSIBLE FOR...

Related to right is the question of responsibility. Does the client feel s/he has not only the right, but the responsibility to address the assault to her/his sense of control.

Sometimes, again, the answer is a simple "Yes, of course I'm responsible."

However, sometimes, the answer is not so simple (and even the above simple answer may need nuancing. For example, questions to be asked about the assault to the client's sense of control include:

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1. What aspects of the assault to your sense of control can you be (or are you) responsible for?
2. What aspects of this area are outside of your active control and for which you are therefore not responsible?
3. Do you believe you can be responsible for your **reactions** (thoughts, feelings, speech, behavior) to the aspects that are out of your active control? (e.g., how you might react to your spouse's angry behavior if you cannot get him/her to modify that behavior).

end slide

The therapist may also wish to explore with some clients when they take undue or inappropriate responsibility: e.g. a feeling that "everyone depends on me" and "things would fall apart if I didn't do all that I am doing." Does the client have a fear of turning over some of the responsibility to others? Or does that seem "irresponsible" to the client? Is the client taking inappropriate responsibility—e.g., for another person's substance abuse problem—so that care and concern become enmeshment and collusion?

Sometimes a client may not take responsibility for his/her feelings and reactions, but instead will blame others or circumstances. "He made me angry." "She hurt my feelings". "No matter what I do, fate intervenes to mess things up." "It's not my fault, I can't get a break!" "I just have to look at food and I gain a pound." "It's all my parents' fault that I am the way I am. They really screwed me up."

Here, increasing personal responsibility in the relevant areas may be appropriate. The Gestalt therapy literature makes the distinction between saying "I can't" when "I won't," or "I don't want to" is more accurate. The latter phrase involves taking personal responsibility for one's actions.

Some more complex situations regarding responsibility: Many adult children at some point in their life feel that their parents weren't perfect, and made mistakes for which they as children were too young to be responsible. However, healthy development involves learning how those mistakes affected them, and taking responsibility for one's reactions and feelings in the present.

A more complex area is the one of abuse. A person can feel like a victim because he or she was physically or emotionally abused—either as a child, or in an adult relationship-- something for which they were not responsible. However, with therapy

and time and distance, they may come to realize that they can take responsibility for not continuing to see themselves as a victim because they refuse to be consumed by hatred, to punish themselves, or to let others take advantage of them.

Regarding physical and mental health, there is a debate about the extent to which a person has responsibility. For example, in terms of weight, there are individual differences in metabolism, set points, and body builds, over which we have limited control. On the other hand, there are other areas—eating and nutrition, exercise—where a person can take responsibility for actions and behavior.

Finally, many factors may influence a person's choice to take an action yet ultimately, regardless of the choice, it is important for the client to take responsibility for it. For some, the desire for increased control, is internal, self-directed; for some, a portion of the motivation might come from others (e.g., loved one's concern about your health; the doctor told me I "should"). Might some people do better when they feel self-directed; while others like being "motivated" by others.

However, even if "others" are an impetus motivating the client, it is important ultimately to help the client take responsibility and make the choice whether to act toward change (or acceptance). For example, when clients feel that others want them to change (or to accept), part of them may even feel "pressured", "bullied", "mentally coerced", "bribed," or "guilted" into change (or acceptance). Before proceeding, it is imperative to explore these feelings to ensure that the client is not proceeding down the five steps progression only in response to pressure from others. However, after considering others' concerns, if the client agrees that there is some truth in them, and that it is in their interest to change (or accept), then the client needs to take responsibility for that decision. That means the client needs to be aware of subsequent self statements and feelings that may involve self-pity or blaming others for their efforts to change or accept. The therapist can explore this to ensure that the client is willing to acknowledge that s/he is choosing to pursue whatever goal is set, intends to do it well, and is responsible for the decision to proceed.

The yielding, accepting mode of control. In addressing the assault to a client's sense of control, if this yielding accepting mode of control has been chosen as the goal, questions regarding right and responsibility that can be addressed to the client (of course tailored to the client's concern) include: Do you have a right to be more accepting of how you look? Of your weight? Your physical features? Who you are as a person? Your personal limits and boundaries? Who is responsible, if not you, for creating these feelings of acceptance within you?

Slide

Affirmations regarding responsibility and the yielding, accepting mode of control

- I have a responsibility, to create times of safety where I can let go, relax, and just be.
- It's okay for me to let go and not try to push beyond my limits.

- I realize that not everything in life is under my personal active control. I am not responsible for changing or solving all the world's problems.
- It is not being irresponsible to take time just for myself to relax and replenish, to not always try to improve and perfect myself and others.
- There are some situations where I have the responsibility to learn to let go and allow others the chance to grow and make their own decisions.
- When faced with an immovable wall, I have the responsibility to learn the yielding, accepting mode of control. Hitting my head repeatedly against the wall will only give me a headache.
- I have a responsibility to learn to love and accept myself just as I am.

Responsibility and the assertive, change mode of control.

Affirmations *Below are affirmations for the assertive/change mode of control which can be shared with your client. Of course, you can have the client edit and adapt them in ways that would seem life-affirming and healthy for the client's own particular situation and concerns.*

- I am not a victim. I have rights as a human being, and a responsibility to stand up for myself.
- I have only so much time and energy; if I fail to protect these resources, no one else will.
- Only I can decide whether I want and am willing to truly make changes in my life.
- I am responsible for my reactions to events.
- I am responsible for how I let other people treat me.
- I am responsible, within the limits of my ability, to effect positive changes in my life. Where I am not able, I am responsible for seeking help and guidance.
- I have a right to be the master and shaper of my own destiny—I can and must take responsibility for directing the course and direction of my life.

end slide

Having explored these issues of right and responsibility and come to sufficient understanding and agreement, the therapist and client are ready to move on to Step Three: Self-Efficacy. Even if the client has the desire, and feels s/he has the right, and the responsibility to address the assault to his/her sense of control, does s/he feel s/he has the ability to actually be effective in addressing that assault?

STEP THREE: SELF-EFFICACY BELIEFS . "I CAN."

To what extent does your client believe s/he has the skills, or can learn the skills, to gain a positive sense of control in his/her life? These skills may include exerting influence to change some aspect of the external environment or situation, including other

people; or changing one's own behavior, speech, and/or thoughts and feelings. These skills may also include accepting some aspect of one's external environment, a particular situation, or another person as well as accepting aspects of oneself. How much does your client believe in his/her ability to control his/her thoughts, feelings, and behavior in order to utilize a healthy yielding, accepting mode of control, or an assertive change mode? Is the client's language strong or tentative? Clear or equivocal?

Here is a simple clinically useful, heuristic one question about a client's self-efficacy beliefs regarding "success" specific to the goal set.

"How strongly do you believe that you will succeed in learning and practicing the skills needed to achieve the assertive change goal (or the yielding accepting mode) in addressing your concern." Clients can rate their confidence on the following 7-point scale:

- 1 – I know I will succeed.
- 2 – I am almost positive I will succeed
- 3 – I am pretty sure I will succeed
- 4 – I have some doubts about my ability to succeed, but probably will
- 5 – I don't think I will succeed
- 6 – I'm almost positive I won't succeed
- 7 – I know I won't succeed

If the rating is anything other than a "1", it can be helpful to work with clients to identify what they think may hinder their progress, including any fears they may have about how they might sabotage themselves. For example, if the client knows that they tend to become impatient and give up when trying a new skill, would they be willing to try to learn strategies to anticipate and counteract thoughts about abandoning their efforts.

For further self-exploration, the client can complete the worksheet below entitled "Assessment of Self-Efficacy Beliefs" to pinpoint more specific areas (building blocks) of potential low self-efficacy beliefs, as well as potential strengths to build upon.

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ASSESSMENT OF SELF-EFFICACY BELIEFS

Name: _____ Date: _____

SELF-EFFICACY. This form explores beliefs that may influence your ability to meet your goal. If your goal is quadrant one, change oriented, then please circle or underline the word change for each question, and answer accordingly. If your goal is to be more accepting (of your or others' thoughts, feelings, behavior) then please circle or underline the word accept for each question and likewise answer accordingly.

If you have more than one goal, and each involves change or accept, more copies of this form can be printed and utilized!

You will note that questions 1-5 are self-efficacy beliefs about your current ability; questions 6-9 self-efficacy beliefs about your ability to learn new skills.

Question 10 involves self-efficacy beliefs about your ability to integrate the modes.

- 1 In general, do you believe you have the ability to control (change/accept) your thoughts?

Strongly believe	Somewhat believe	Somewhat disbelieve	Strongly disbelieve
1	2	3	4

2. In general do you believe you have the ability to control (change/accept) your feelings?

Strongly believe	Somewhat believe	Somewhat disbelieve	Strongly disbelieve
1	2	3	4

3. In general do you believe you have the ability to express, identify and achieve your wants and needs? (change what is); to decrease your wants and needs and be more accepting of what is?

Strongly believe	Somewhat believe	Somewhat disbelieve	Strongly disbelieve
1	2	3	4

4. In general do you believe you have the ability to control (change/accept) your behavior?

Strongly believe	Somewhat believe	Somewhat disbelieve	Strongly disbelieve
1	2	3	4

5. In general do you believe there are skills that can be learned which would enable you to increase your ability to control (change/accept) your thoughts?

Strongly believe	Somewhat believe	Somewhat disbelieve	Strongly disbelieve
1	2	3	4

6. In general do you believe there are skills that can be learned which would enable you to increase your ability to control (change/accept) your feelings?

Strongly believe	Somewhat believe	Somewhat disbelieve	Strongly disbelieve
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end slide.

Enhancing self-efficacy. It can be helpful in enhancing self-efficacy beliefs to have the client recall times in life when s/he has been able to gain a positive sense of control (through the yielding/accepting mode; or the assertive/change mode, depending upon the goal in this case). Let the client re-experience those feelings in mind and body. Also, have the client reflect on small ways in which s/he already exercises a healthy accepting or change mode of control in his/her life on a daily basis even little things one might not normally think about.

For the yielding, accepting mode: For example, in terms of the yielding, accepting mode of control, the therapist might say “Once you put a letter in the mail box, or send an email, do you just “let it go.” You have the ability to let go in a similar way in other situations. Similarly, every time you breathe out can be an opportunity to focus on positive yielding, as you “let go” and allow air to exhale. Other examples are noticing each day when you say good-bye to your loved ones and noticing each evening how you allow yourself to let go of consciousness—let go of active control-- and drift into sleep.”

Another way to build a “self-efficacy” muscle for the yielding mode is to practice learning to let go and accept in other small areas not related to the presenting concern. Have the client try to identify areas that would be fairly easy for him or her, and would result in a success experience. Here are some small examples you could share with a client: “If you see a driver take a parking space you wanted, and you “move on” congratulate yourself. When you reach a red light, try to calmly take a breath and be appreciative of a moment to “stop”. If someone makes a slightly irksome but inoffensive remark, and you decide not to engage, give yourself credit. You may notice that some of these things are occurring naturally, and you aren’t giving yourself sufficient reinforcement for them. Others may take a bit of practice, but when done successfully, they can provide an increased feeling of self-efficacy that may enhance your belief about your ability to succeed in your specific self-management project.”

For the assertive, change mode: For the assertive, change mode of control, the therapist can instruct the client as follows: “Notice the competent acts you perform throughout the day, even little things you don’t normally think about.* Oftentimes, we notice things only when something goes wrong, and we ignore the multiple things that we have already “done right” in the day. As you reflect on current areas of competence in your life, notice the statements you make to yourself, the language you use about these areas. Do your words give you credit for what you’re accomplishing? Can you identify recent successes and allow yourself to feel a positive sense of control from what you’ve accomplished?” Further, the therapist may invite the client to “Pause a few times throughout the day and consciously notice that every time you take a voluntary in breath that can be felt and experienced as a sense of the self as a competent doer, giving a positive assertive sense of control.”

Visualizing success –The therapist can have the client practice seeing him/her self acting in a way that represents a sense of control: e..g, a calm and serene attitude in various situations for the yielding, accepting mode; courageous and competent action and speech for the assertive, change mode. A detailed elaboration of this technique—

Control Mode Rehearsal (CMR) is detailed in step Four of the Five Step process . Also, the therapist can share that the research literature shows that techniques exist for each mode that, when practiced for six to eight weeks, are effective in strengthening that mode. It may also be helpful to share with clients that it is to their advantage to feel that the task they are undertaking is possible, and to maintain a hopeful, confident, optimistic attitude about our ability to succeed. Overall, it is important that the therapist create a positive (and accurate) expectation for the client about a technique's efficacy to enhance his/her self-efficacy beliefs.

Affirmations of self-efficacy for the yielding, accepting mode of control. . Below are some potential affirmations to strengthen and reinforce the client's belief that s/he can successfully adopt yielding, accepting strategies:

- I trust my ability to become more serene about those areas I cannot control, or believe that I should not try so hard to control
- I will notice all the areas of my life where I am already being successful in exercising the positive yielding, accepting mode of control. These areas give me the knowledge and strength to know that I can apply that mode to my current area of concern.
- I have the ability to counter my self-defeating doubts and fears about my ability to succeed in becoming more accepting.
- I believe that I can learn to yield and accept without feeling passive or as if I'm giving up, acting like a victim, or being unproductive.
- I can learn to be less influenced by other people's doubts about my ability to succeed, and trust my own decisions and abilities.

Affirmation of self-efficacy for the assertive, change mode of control. These affirmations can be used to create a pause, some space in order to interrupt a negative cognitive sequence involving thoughts and feelings such as, "I can't do this, I'm powerless and helpless, I've never been very good at making changes;" as well as before actually trying an intervention, to focus and create the optimal context for change:

- I believe in and trust my ability to succeed.
- I will notice all the areas of my life where I am exercising positive active control. These areas give me the knowledge and strength to know that I can make changes in new areas.
- I am a person of strength and power.
- I am confident I will achieve my goals and address this concern.
- I am competent; I will find a way. I can do this. I feel optimistic about my ability. I

- I can learn to say no to self-defeating thoughts, doubts, and feelings. If I think I can't and don't try, I'll just be proving myself right.
- I recognize that even though setbacks are possible, even likely, I believe I can persevere and overcome them. I trust I can handle them well and continue toward my goal.
- I can learn to be less influenced by other people's doubts about my ability to succeed, and trust my own decisions and abilities.
- I can practice firm, fair, and calm statements about my needs and feelings.
- I feel I will be able to make changes to help me reach my goal. For those skills and abilities I do not yet have, I trust that I will be able to develop them; and/or find others who can guide and teach me.

After reviewing these affirmations, client and therapist can then review the client's score on the single question seven point self-efficacy scale. ***“How strongly do you believe that you will succeed in learning and practicing the skills needed to achieve the assertive change goal (or the yielding accepting mode) in addressing your concern.”*** If it was less than four, was the client able to increase it through the above affirmations, CMR, and knowledge that there are effective techniques that can be utilized? The main point of this step is that before moving on to learning actual intervention skills, it is important for the client to believe that s/he has the ability to reach his/her goals and positive belief about the chances for success and mastery (e.g., 4 or higher). If the score is still lower than four, the client may need to reconsider the goal and perhaps be willing to identify a smaller, more achievable one that s/he has more confidence s/he can accomplish. Research has shown that the stronger the self-efficacy beliefs, the more likely one will succeed.

Once you and the client have determined that the client has the appropriate desire, right, responsibility, and self-efficacy beliefs, the stage is set for Step Four, Commitment and Skills for the actual interventions.

STEP FOUR: COMMITMENT AND INTERVENTION SKILLS/TECHNIQUES. slide

Commitment: “I will.”

“I find it easier to be a result of the past than a cause of the future.”

Ashleigh Brilliant

Slide

STEP FOUR A: COMMITMENT

The fourth step involves a commitment to learn and practice certain intervention techniques and skills tailored to the client's goals, concern, and control profile. Commitment can be understood as a deepening of the desire to change in Step One's “I want.”; of the “I have a right and responsibility” (step two); and of the “I can” of step three to an “I will”. “I will” implies that the client will commit to learn and practice techniques and skills to become more accepting, and/or to change. This process of commitment is not necessarily easy or quick, either in terms of ourselves or others.

Therefore, in addition to the actual skills of the intervention, the client needs the skills to maintain the commitment to the process when there are setbacks and frustrations, as well as to address self-sabotage scenarios. Learning new skills and habits can be challenging. It is important to help your clients recognize and be proud of their efforts, and honor, encourage, and reinforce their progress and determination to stay the course.

There are three aspects to addressing commitment. One is to reaffirm the concerns that brought them into therapy—why they have a desire to gain a greater sense of control. The second is to explore and acknowledge one more time (if needed) any “wobble” or ambivalence that may still remain which could sabotage their efforts. And the third is a list of affirmations that can be helpful in enhancing commitment—both proactively in terms of the goal, and reactively, when setbacks may occur.

Reaffirming commitment/enhancing motivation. To help maintain motivation, it can be helpful to have the client look back at the reasons s/he wrote down in Step One, Desire for Control, for wanting to develop a greater sense of control (through either the yielding/accepting mode or the assertive/change mode) including the negative impact if s/he does not become develop a greater sense of control, and the situation remains “as is.” Have the client remember in body and mind why s/he chose this path.

If it was the yielding/accepting mode of control that was chosen, did the client feel s/he had reached a limit in terms of active change efforts and decided the area was something that either s/he wasn't able to change, or didn't feel was worthy of change? Did the client choose the accepting mode in an effort to learn to be less judgmental, intolerant, and punishing of him/herself? Of others? Was the accepting mode a way to be kinder, more compassionate and more tolerant of him/herself, a dropping the bundle for a moment, so s/he could be less depleted and demoralized, and feel more refreshed and stronger?

Or if it was the assertive/change mode of control that was selected, did the client feel that s/he had skills and abilities that weren't being appropriately utilized, feel that s/he wasn't standing up for him/herself in a courageous and forthright manner when it would be appropriate; that there were situations about which action could be taken to make things better and that seemed important to try to accomplish.

In addition to remembering initial motivation, it can also be helpful to have the client recall (as we did in the self-efficacy section) past times the client has been successful in learning and practicing new skills, and to actually try to experience and imagine what positive success would feel and be like.

Exploring possible self-sabotage/resistances. In addition to proactively exploring and reaffirming positive motivations, it can also be helpful to have clients recognize, anticipate and explore ways they might sabotage themselves and explore possible resistances.

Questions which can be asked of the client at this step include: What might make you ambivalent about pursuing the yielding, accepting mode of control (or the assertive/change mode)? As you begin the actual skills intervention, it is important to look at the following specific aspects of your concern:

1. What might be the possible negative consequences if you do succeed in becoming more accepting (or able to effectively create assertive change?)

Even though there is a large part of the client that wants to address the concern that brought them into therapy, acting in new ways can upset the “known comfort zone” and can create new issues that may be challenging. For example, if a client succeeds in becoming more accepting, might they feel they are “giving in”; giving up, abandoning their efforts to make positive change,” or that they have “lost their dream forever” by accepting the present reality. Are they concerned that if they succeed in “accepting,” there is a part of them that may actually experience this as a defeat, that they’ve given up trying to really address the concern. Conversely, if the client learns new assertive skills, how might those in his/her environment feel about that? Might there be some “challenging” negative reactions from others? Might there be some inner discomfort in “asserting” oneself?

2. What are the potential problems, difficult times, and stumbling blocks you can foresee in trying to “let go” in this area (or trying to be more assertive)?

One common challenge is maintaining motivation for practice--“adherence and compliance”-- especially when results do not seem immediate. Learning a new skill is not easy, and requires patience, focus, and commitment. However, just because a new skill is difficult does not mean it isn’t worthwhile to learn. The therapist can explore with the client control stories with which the client may be familiar that might be helpful to maintain motivation. For example, one lesson many of us have been taught is that “quitters never win, and winners never quit.” A control story that typifies this way of thinking describes a person trying to break a stone into small pieces. He hits the stone 499 times, and each time nothing changes. Finally, with the 500th hit, the stone crumbles. The story concludes that, even though the person couldn’t see any change in the stone, it was really each “hit” that prepared the way for the breakthrough. The moral is, keep trying even if you feel discouraged and don’t appear to be succeeding. There is also a story in the “cold calling” business community that it takes one hundred calls to achieve one good outcome. Therefore, each time the person on the other end hangs up, is rude, or doesn’t respond positively, the cold caller should tell herself, “One step closer to success.”

Some people, when faced with challenges and adversity, shrink away. Others become more determined, maintaining an optimistic belief in their own ability to cope. The therapist could explore how the client intends to meet challenges and adversity—to address feelings of wanting to give up and quit; to create affirmations for renewed motivation to refocus, “digging deeper” to find inner resources, strength, determination, and even creativity to help them succeed. It is important on the path to change to acknowledge each small step heading in the right direction.

3. What excuses might you give to sabotage your own efforts (i.e., ways you keep yourself from succeeding) to “let go” and accept? (or to be more assertive and change? (adapted from CT, pp. 215-216)

If a person is trying to learn a new skill, which is different from their normal “control profile”, it may at first seem quite “unnatural.”

For example someone with a high quadrant two/quadrant four profile, who is wanting to learn to be more assertive, may feel quite awkward initially practicing assertive skills. There may be familial/cultural messages of “go along to get along.” It’s inappropriate, “bossy”, “pushy”, “egotistical” to assert your rights. There may be the feelings as in the book’s title “I feel guilty when I say no” of not pulling one’s weight, of letting others down. These beliefs and views may compound the challenge of learning a new assertive/change mode of control.

On the other hand, someone with a high quadrant one/three mode of control, with a high desire for active control, may find it quite difficult initially to practice the yielding, accepting mode of control. The notion of letting go of “productive goals” may be accompanied by fears of completely losing all control with some resulting terrible outcome. Won’t everything fall apart? There may be cultural and familial messages of “You’re not good enough, more is not enough, you’re taking the lazy way out, don’t rest on your laurels.” Although there may be a partial truth from these messages in that they can be useful, though harsh, motivators for positive assertive efforts, are they helpful for this client with this particular concern? Letting go of and accepting that which is not in our control can, in a seeming paradox, free us up to shift energies from the proverbial “hitting our heads against a brick wall” to finding new ways to gain hope and meaning, purpose and competence.

Therapist reminders: It may be important to remind the client that if a person has only one mode—an assertive change strategy or a yielding, accepting mode, --that that limits him or her in how s/he approaches the complexity and nuance of situations. By learning to accept in certain situations, and be more assertive in others, the client is actually empowering herself, giving herself a CHOICE in terms of how to spend her time and energies. Even the existential philosophers, who emphasize “denying our nothingness” and “standing forth in existence” in a way that seems to focus almost entirely on assertive change, quadrant one ways of being in the world, acknowledge that there is a large part of “reality” that is out of our control: what they call the “thrownness” of existence. .

Also the therapist can remind the client (through the Control Mode Dialogue already discussed) to be careful in distinguishing between negative yielding, which may feel like passivity, resignation, fatalism, being a helpless victim; and positive yielding, in which the client is consciously choosing an accepting mode of control as a skillful and healthy way to address a concern. Similarly, it is important for the client to remember that there is a difference between negative assertive (being bossy, overcontrolling, micro managing) and healthy assertiveness (having the courage to change what can and should be changed).

The practice of affirmations can be useful during the challenging times to help the client learn to trust that even though the client is learning a new skill, it’s one that she (and the therapist) believes will be valuable. Encourage the client to notice and let go of doubt about practicing this new mode of control.

Affirmations for commitment. Enhancing and maintaining motivation; The following cognitions can enhance motivation, commitment, and change efforts. These general affirmations may be tailored toward the client’s specific goal, and the particular

mode techniques (yielding /acceptance; assertive/change) being learned and practiced. The following cognitions can help enhance motivation, commitment, and client efforts toward learning and practicing the control enhancing techniques and skills to be used in the intervention phase (discussed in part two of Step Four). The client can practice visualizing (or role playing) successfully challenging any negative cognitions that would get in the way of their learning these new skills. Also, it may be important to once more remind the client that learning and practicing new skills can be challenging and difficult....so that there needs to be a certain compassion and kindness toward oneself during the process....even when we are not as “perfect” as we would like!

These can be practiced as affirmations and self-statements during the assertive/change techniques discussed in the second part of Step Four. The therapist can have the client practice visualizing successfully challenging any negative cognitions s/he might have that would interfere with achieving the goal. Ask the client what are self-defeating statements s/he might make. These could be written down on one side of an index card: “I can’t,” “This is too hard.” “I missed a day of exercise (ate too much) and have blown it. I might as well give up.” Then have the client flip the card over and write down honest, accurate rebuttals or responses that reflect her capabilities, the half-full side of the glass. “I worked out twice this week already. I ate well most of the day. I’m a fighter, and can try again. One mistake doesn’t make me a failure.” Invite the client to be particularly aware of how she reinforces and punishes herself. When there is backsliding, help the client to avoid harsh self-condemnation, and to develop strong encouragement of small positive steps.

- I commit to giving myself permission to learn, practice, and act in new ways that will be healthy and life-affirming for me.
- I commit to practice on a regular basis the control enhancing strategies selected for my goal (e.g, involving the yielding, accepting mode of control; or the assertive/change mode of control) in my efforts to develop a healthier mode of living.
- I recognize that failure is possible, even sometimes likely, and that I must commit to persevering in the face of these inevitable setbacks. I see myself handling these setbacks well and continuing toward my goal.
- I will challenge doubts, and potentially negative thought patterns, beliefs, and habit patterns which may hinder my efforts to practice and use these skills of (the accepting, yielding mode of control; the assertive/change mode).
- I commit to being proactive and use control enhancing techniques in my efforts to develop a healthier mode of living.
- I commit to stay focused, determined, and fully committed to my goal of developing additional skills for : (e.g., the yielding, accepting mode of control; the assertive change mode of control. I feel a sense of excitement and adventure about what I am pursuing. I see any barriers or setbacks as challenges and

opportunities enabling me to grow in strength and understanding, helping me move beyond my self-perceived limitations (*from CT, p. 199-220*).

Effort explored. Commitment obviously requires an effort. So, one potential problem would be if the client (or therapist) feels the client is using too little effort, not trying hard enough in the therapeutic process. However, sometimes a person can try too hard to increase their effort, with resultant tension and stress. Neither of these options represents an optimal one. Because of these pitfalls, it is helpful to explore with the client what “optimal effort” might mean/

For example, you can ask the client to notice what amount and type of effort seems most effective for him/her in learning new things. You can explore with the client different levels of effort that s/he has noticed are needed at different times. Sometimes a person will need to “up the ante” in terms of effort, focus, and discipline. This is the “no pain, no gain” mantra. At other times, that intensity of effort may be less skillful, and it seems that “trying harder” only makes things worse. This can be true in learning positive assertive skills, and well as skills for the positive yielding mode of control (e.g. trying too hard to learn to meditate perfectly!) Although increased effort is often needed at the start of new learning, it is helpful to also encourage the client to bring a relaxed awareness to the process. Eventually, with practice, the client can develop a feeling of almost effortless effort. Rather than “pushing the river,” the learnings take over and the client may even experience a feeling of flowing *with* the river.

Now that the therapist and client have reviewed the commitment to learn and practice (adherence and compliance) control enhancing techniques, let’s turn to the actual skills of techniques and interventions themselves.

STEP FOUR B : SKILLS:

The second part of Step Four is “skills” –teaching the client control enhancing interventions matched to the client’s control profile to meet the client’s goals. Now clearly several skills have already been taught prior to this step: e.g., skills of self-observation, goal setting, enhancing belief in one’s efficacy to accomplish the goal. However, one can have desire, intention, motivation, a belief in one’s right and responsibility, and in one’s self efficacy, but not, for example, know how to speak assertively or how to relax. No matter how much desire, right, and responsibility we may have to reach our goal of gaining a more positive sense of control, it is also necessary to have the skills to implement that goal. Therefore a separate step is included under the label “Skills” meaning specific intervention strategies matched and tailored to the client’s goal.

INTERVENTIONS/SKILLS: DEVELOPED FROM BUILDING BLOCKS.

We humans have certain potential building blocks at our disposal, what we might call the raw material, the alphabet that can be used to construct the skills of any intervention. These building blocks are

BODY

- **body/behavior (including posture, speech and actions);**

- **breath (focus and style);**

MIND

- **attentional control (where and how you focus attention),**
- **decisional control (choices that you make),**
- **cognitions (thoughts, control stories about self), images,**
- **emotions/feelings,**

SELF (Comprised of body and mind above)

RELATIONAL (OTHERS)

- **other people (guidance, social support, and reinforcement/feedback), including relations and work setting**

RELIGIOUS AND SPIRITUAL BELIEFS

- **control stories, including beliefs about others and Other--the nature of the universe (i.e., religious and spiritual beliefs).**

PHYSICAL/NATURAL ENVIRONMENT

- **the actual physical environment (including stimulus cues, environmental planning, choice of environment for different activities)**

These building blocks are the alphabet, which when put together in different combinations, create the “words,” “phrases,” and “sentences” of an intervention. Conversely, techniques can be “deconstructed” into their building blocks. From a research standpoint, this deconstruction and identification through content analysis of an intervention into its specific building blocks is helpful to a) investigate and separate the active from the inert “ingredients” of a specific technique; b) so that it is clear, when comparing different techniques, what actually is the difference in terms of the raw material—the building blocks—of the technique.

From a clinical standpoint, it is important so that, as for example in the Control Therapy approach, control enhancing interventions that are specifically tailored and matched to the client’s control profile, area of concern, and goal can be utilized. This is a critically important point. Control Therapy, as we have seen, does not advocate a “cook-book,” one size fits all approach. Rather, the therapist and client work together to explore, fashion, select and tailor control-enhancing interventions that match the client’s needs

MULTILEVELS AS CONTEXT (DOMAINS) AND CONTENT (BUILDING BLOCKS)

As you remember, in the SCI Domain Specific Sense of Control Scale, there were several different domains: e.g., body, mind, emotions, relationships, etc. that were assessed in terms of a client’s sense of control. These domains are what me might call the context toward which an intervention is directed, (listed on the horizontal axis in the figure below). The building blocks (vertical axis below) are the “content” from which the intervention is constructed.

As a brief overview example to give an illustration of the multi-levels as context (domains) and content (building blocks), suppose the client’s contextual concern involves relational intimacy and closeness, as shown in the figure below:

slide

		CONTEXT						
		BODY	MIND	EGO	PROFESSIONAL	INTIMACY	POLITICAL	RELIGIOUS
CONTENT	BODY INTERNAL: PHYSIOLOGICAL CUES SENSATIONS REFLEXES EXTERNAL: OVERT BEHAVIOR							
	MIND PERCEPTION ATTENTION COGNITIONS IMAGERY AFFECT							
	EGO (SELF) (IDENTIFICATION)							
	PROFESSIONAL (CAREER)							
	INTIMACY WITH LONG TERM SIGNIFICANT OTHER WITH FAMILY WITH CHILDREN WITH MALE AND FEMALE FRIENDS WITH OTHERS							
	POLITICAL, ECONOMIC, SOCIAL							
	RELIGIOUS, SPIRITUAL EXISTENTIAL							

end slide

For each domain, area of concern, or “context” (horizontal axis) , control enhancing interventions can be developed based on building blocks—the “contents” For example, note in this Figure the context—area of concern—is let’s say, generally speaking, the relationship (intimacy) domain.

The building blocks that can be used to construct an intervention to address an area of concern and/or optimal well-being in the relationship domain are the contents—building blocks--in the gray shaded area: e.g., what would be the role of body in addressing a relationship issue; what would be the role of the “mind”; the “self” (e.g., time together, time apart); work (e.g, balancing work and adult intimacy time); the political, economic, social situation, and finally one’s religious and spiritual beliefs (e.g, relationship as karma yoga, how one’s religious beliefs effect the relationship) (Note, although the political, economic and social system is included here, and is a potential building black on a macro scale that the therapist should, in general be sensitive too, it is not discussed in this lecture on Control Therapy).

Previously the therapist will have explored with the client whether s/he wants to better accept that domain, or transform and change it. Then, the building blocks will be “arranged”, matched, and tailored to the client as interventions to enhance either the yielding/accepting mode of control or the assertive/change mode of control.

WHAT ARE THE BUILDING BLOCKS OF DIFFERENT TECHNIQUES:

A Content analysis example of meditation and behavioral self-control strategies.

As noted above, there are different building blocks than can be used to develop interventions. Conversely, from a research standpoint, in comparing different control

enhancing strategies, it is important to deconstruct the techniques into their building blocks to see where there are similarities and differences. Clinically, this can also be helpful in that by performing a content analysis of different self-control techniques, it allows us to examine and clarify within each technique what building blocks (e.g., cognitive, attentional, emotional, behavioral) are being utilized in the construction of an intervention technique. Therefore, although there are a myriad of control-enhancing techniques, there may be considerable overlap between them once the “building blocks” of a technique are identified. Further, the building block components of any technique (e.g., meditation, yoga, etc) can be identified and then its utility determined for a specific client with a specific control profile.

In the following figure, a comparison and contrast of the techniques of meditation (formal and informal) and behavioral self-control strategies is offered as an example of such a process. The dimensions addressed include the environmental building block (environmental planning and strategies (e.g., where the intervention occurs, stimulus cues); the physical body building block (type of breath regulation nature of physical posture; and behavioral practices).; the mental building block (nature of cognitive statements and instructions, nature and type of attentional focusing and observation; content of what is observed; nature and type of self-evaluation and goal setting; images used; how thoughts are viewed, and, if appropriate stopped or changed; decisional choices (e.g., the use of preprogrammed punishments and reinforcers.

slide, next two pages.

COMPARISON AND CONTRAST OF DIFFERENT SELF-REGULATION STRATEGIES : MEDITATION AND BEHAVIORAL SELF-MANAGEMENT

Note to lecturer: A couple examples from the slide below may be utilized just to point out the process of comparison: cognitive variables, effects of observation; how behavior is observed; nature of cognitive statements and images, etc

Topics	Formal Meditation	Behavioral Self-management	Informal Meditation	Contingent Informal Meditation
Environmental Planning where intervention strategy occurs	specified setting (e.g., room or in nature); reduced external stimuli to initially help individual focus on object of meditation	<i>in natural environment where problem behavior occurs; or symbolically in neutral environment</i>	occurs in natural environment	<i>same as behavioral self-management</i>
if stimulus cues are used	stimulus cues (control): e.g. incense; or, in case of concentrative meditation, the object of meditation as stimulus cue	<i>specified cues in natural environment (programming antecedent or initiating stimuli)</i> <i>self-regulated stimulus exposure</i>	everything is a stimulus cue for "awareness"	<i>same as behavioral self-management</i>
nature of physical posture	specified body posture: lotus or half-lotus, to reduce bodily distractions	<i>symbolic desensitization occurs in relaxed posture: e.g., reclining in thick armchair</i>	no specified posture	no specified posture
if preprogrammed punishments or reinforcers	"KWAT" as preprogrammed punishment for nonalert behavior	<i>preprogramming of certain punishments or reinforcements</i>	no preprogrammed punishments or reinforcers	sometimes preprogrammed punishment or reinforcement
Cognitive Variables effects of observation	in formal Zen meditation, focusing on behavior of breathing alters the behavior: a stumbling reactive effect (step 1); soon mind wanders, i.e.,	<i>behavioral self-observation alters behavior observed (generalization one); then there is habituation to task; subject forgets to monitor; when subject stops monitor-</i>	goal is that observation have no interference or interruption of daily activities	observation used as a discriminative stimulus to interrupt a maladaptive behavioral sequence (<i>see also behavioral</i>
	habituation to task of observing (step 2)	<i>ing, behavior returns to pre-self-observation phase (generalization two)</i>		<i>self-observation)</i>
what is observed	initially just breathing is focused on (steps 1, 2, 3); eventually openness and receptivity to all stimuli, internal and external (steps 4, 5) occurs	<i>functional analysis: observation of problem behavior, antecedents, and consequences</i>	all behaviors, actions, and thoughts are observed: global awareness	only specified cues (e.g., anxiety, stress) in internal and external environment are observed
how behavior is observed: self-evaluation and goal setting	thoughts, behavior, breathing, are observed without analysis; no charting, no evaluation, no goal-setting: i.e., "detached" self-observation	<i>parameters of behavior observed: frequency, latency, duration, intensity; behavior is counted, charted; systematic evaluation is made; and goals are set</i>	observation without comment and without evaluation	<i>same as behavioral self-management; however, also try to maintain detached self-observation at same time</i>
desensitization paradigm; when occurs	relaxation (step 3) precedes feared images (step 4); in formal meditation, a "global" desensitization with no specific cues formal meditation occurs at specified times throughout the day, regardless of antecedent stimuli	<i>relaxation precedes phobic scene (cf. Wolpe, 1958, 1969)²: involves subjective hierarchy of disturbing scenes; or, relaxation follows phobic scene (real or symbolically) and is contingent on discriminating certain cues (cf. Goldfried, 1973)³</i>	continuous discrimination of cues in daily environment	relaxation follows phobic scene or certain stress cues

Topics	Formal Meditation	Behavioral Self-management	Informal Meditation	Contingent Informal Meditation
cognitive statements and images; thought stopping	observation without comment (no self-statements); and without evaluation (no thinking); covert images are allowed to "flow down the river of consciousness" and are not dwelled on; focus on competing response of breathing helps remove thoughts (step 4)	<i>covert images and self-instruction used extensively: e.g. covert sensitization (images as punishment); covert rehearsal (images and self-instructions as successive approximation): self-modeling; covert self-reinforcement; covert behavior modification: either alter self-statements, or emit relaxing instructional self-statements; to stop thoughts, covert yelling of word "stop"</i>	no cognitive statements or images involved in the performance of actions.	use of covert images, self-modeling; and self-instruction: e.g., "I am breath," "I am relaxed, in control, I can handle this"
focused attention	in formal Zen meditation, attention focused on breathing (steps 1-4); the KWAT (step 2) helps return the wandering mind to the object of focus; in Raj Yoga (cf. Anandi, ¹⁵ Chhina, & Singh, 1961) note the use of internal focusing	<i>Kanfer and Goldfoot (1966)¹⁴ discuss the use of external focusing as a technique for self-management of pain</i>	attention focused on the here-and-now action only	in contingent informal breath meditation, attention focused on breathing; in Transcendental Meditation, attention focused on covert sacred syllable
Breathing effects of; type used	breathing from the abdomen; goal is effortless, autonomic	<i>"controlled" breathing; voluntary breathing from</i>	relaxed, aware autonomic breathing from abdomen	controlled breathing in contingent informal breath meditation (cf. Shapiro, 1974a); nonfocus on breathing (but rather on sacred sound) in "contingent" Transcendental Meditation (cf. Boudreau, 1972) ¹⁶
Contributions of the Strategies to Each Other	acquisition and proper performance of formal meditation is facilitated by a wrist counter, a device used in behavioral self-observation; naturalistic observation methodology of social learning theory is useful in understanding meditation as a series of behaviors under explicit contingency arrangements	<i>clear mind gained during step 5 of formal meditation helps facilitate a behavioral functional analysis of internal and external events throughout the rest of the day; practice of discriminating a stimulus (e.g., wandering mind) gained during formal meditation should help an individual interrupt a maladaptive behavioral chain earlier and more quickly; meditation involves a "detached observation" of concerns, thereby reducing the threat of the concerns and producing optimal conditions for behavior change</i>	in terms of a clinical intervention strategy, informal meditation is made more powerful by making its performance contingent upon certain internal and external cues, and by coupling it with covert imagery, self-instructions, and focused breathing	This technique is a combination of informal meditation and behavioral self-management strategies; covert imagery, self-instructions, focused breathing, functional analysis all come from the behavioral self-management strategy; however, at the same time the technique involves the use of "detached self-observation" derived from informal meditation

End slide.

Two other building blocks not discussed here (because of their variety of possibilities) but which are nonetheless obviously critical include 1) the role of others; e.g., how the technique was taught: e.g., nature of teacher, coach, "guru"; individual or group setting, etc) and 2) the views of the nature of the universe (implicit or explicit)

which contexts the teaching of the technique: e.g. theistic, non theistic, secular; existential).

Through this content analysis (i.e. deconstruction process), it is possible to compare similarities and differences in the techniques (and also to do research exploring active from inert variables within each intervention). Also, comparing the strategies at a reductionistic level can help suggest ways that they could be used to complement each other, as well as combined and integrated. Examples of such integration of different building blocks is provided in a few moments during the discussion of control enhancing techniques used in the body domain, mind domain, and through the technique of Control Mode Rehearsal.

EXAMPLES OF BUILDING BLOCKS USED IN CONTROL ENHANCING INTERVENTIONS.

The multilevel model above provides a “big picture” overview of domain concerns, and a list of building blocks that can be used to construct interventions to address those concerns. Below I give a couple of examples of control enhancing interventions (in the body and mind domains), and how these interventions are created from the building blocks. Following these examples, I will show how these techniques discussed below are utilized in an integrated technique, the Control Mode Rehearsal, for either the assertive/change mode of control or the yielding, accepting mode of control.

BODY: Bodily self-regulation and control enhancing techniques. Now let us turn to the body domain to explore different possible interventions involving bodily “self-regulation.” As an example, let’s say a concern in the body domain is stress. An intervention may be composed of building blocks from the body domain (e.g., breath, certain postures). Other building blocks may also be used: e.g., the mind, attentional focusing, self-instructions, imagery.

It is important to understand that a building block (e.g. breath) is “neutral”—i.e., it naturally occurs, often without one consciously attending to it. Breath, as building block, only becomes part of an intervention when a choice is made to consciously focus on breath: e.g., the nature and time of breathing, for what purpose, relative to a client’s concern. For example, diaphragmatic breathing which we discuss below can be an intervention (using several building blocks, including breath) to help relax the body.

In the material below, a description of different interventions are offered, starting with the body domain. These interventions are, where possible, discussed from most accepting (yin) to most assertive (yang).

BODY/BEHAVIOR

Almost any Control Mode Rehearsal technique will involve, to some extent, the building block of body/behavior. Here we are going to discuss a few (of the myriad) body focused interventions. As you will note body focused interventions can contain aspects of several different building blocks, including (obviously) the body and behavior, but also, for example, breath (focus and style); and attentional control (where and how you focus attention),

Let’s begin with the building block of breath.
slide

*Breathing in, I relax my mind and body
breathing out, I smile.
what a wonderful moment....*

Thich Nhat Hanh

end slide

BREATHING:AN INTRODUCTION.....

As an introduction to diaphragmatic breathing, let me say just a brief comment about breath and how we humans breathe! Breath is a useful intervention because a) it is always with us; b) if we didn't breathe, we wouldn't be here in our body); c) it can be done voluntarily and intentionally. . Breath is as an important building block in many therapeutic techniques, with many styles and variations (e.g., breathe through nose, through mouth, voluntary intentional breathing, allowing non interfering breathing—e.g., the “natural” breathing in diaphragmatic breathing; breathing with stomach rising, with chest rising; the coordination of breath with stretching (outbreath) staying still on in breath in hatha yoga; the two count in breath three count outbreath in cycling, breathing into and out of an area of “stress” (e.g., body scan) etc.). Breath, can also be coupled with cognitive statements, (see the Thich Nhat Hanh meditation above), and self-instructions (a smile!)....

To illustrate an example of breathing right now, for example, as we did earlier, let me invite you to draw a big breath in through your nose. We can understand, feel, and experience that as an example of the positive assertive mode of control that is an example of voluntary, intentional breathing.

Now voluntarily and consciously expel the air. “Let go” of the in breath and breathe out. This can be understood as an example of consciously practicing “letting go” which helps teach us that we (self as agent) *can* learn the skill of the positive yielding mode of control.

Now, when we aren't focusing on breath during the day, it still occurs! So, a softer way to use breathing as a learning tool is just to bring soft witnessing attention to the process of breathing. Note when an inbreath occurs (allowing your stomach to rise on its own, and notice when an outbreath occurs (now allowing your stomach to “naturally” fall back to its original position.

Through this process we can also realize that without our conscious effort, by just “allowing” the breath will enter and exhale on its own, removing the “self as doer”—letting us just be an observer. By trusting the body, we learn to deepen the practice of consciously allowing, yielding, accepting, and trusting. This also occurs during sleep, when we breathe “automatically. This provides a perfect introduction, then, to....

DIAPHRAGMATIC BREATHING

In the diaphragmatic breathing exercise, we are going to try to let the air come at its own pace—without any active control on your part. For example, your breath comes at its own rhythm during the night when you sleep. You don't have to actively control it. Further, when we sleep at night, our body naturally breathes from the diaphragm. Therefore, *diaphragmatic breathing* is really something that our body already knows, and we are just trying to “learn” to do it well while we are awake: to learn to accept and allow our body's natural wisdom.

Research has shown that when we breathe from our diaphragm (belly) our brain goes into a relaxed state (EEG alpha) and that when we breathe from our chest, our brain goes into a more excited state (EEG beta).

One of the easiest ways to practice diaphragmatic breathing is at night, just before you go to sleep. Lie down facing the ceiling, and place your hands, palm down, on your belly, with your two middle fingers just barely touching about an inch below your navel.

Now, *let* your body take a nice relaxed breath, allowing yourself to feel the air gently entering through your nose. Don't try to draw it in. Just *allow* it to come in at its own pace. You will notice that, if you are breathing from your belly, your two middle fingers will move a small distance apart as your belly rises. It's as if the stomach is gently inflating on its own.

Then, as you allow your breath to exhale at its own pace, your two index fingers will come back together and gently retouch each other.

There is no need to force your breath (e.g., puff your belly up). Just trust your body and your natural breathing style. Allow your breath to come in at its own rhythm, noticing your stomach gently rising, your fingers coming apart on the inbreath as the air enters your nose; then your fingers coming back together as your stomach gently sinks back toward the bed on the outbreath.

Notice whatever feelings you have of trying to control this breathing actively, versus letting it just be. Practice each night, taking three conscious breaths. You may notice that this exercise will help relax you into sleep!

As you become more comfortable with this way of breathing, you may want to practice it a few times during the day, as a way of "re-centering yourself."

A building block for CMR, and for learning trust of the body. This technique of diaphragmatic breathing is helpful as a skill in Control Mode Rehearsal for both the yielding accepting mode of control (which it teaches explicitly), and also as a grounding, centering exercise when using the assertive/change mode of control. Whether the client's goal is yielding accepting, or assertive change, a relaxed, effortless, calm style of breathing can be helpful.

This technique is primarily body focused. As such, it can be helpful for a client who is somatic oriented, for a client who already trusts the body, and also can help teach the client who has some distrust of the body, a way to learn to trust the body through using other building blocks, like attention, cognition, imagery.

Note how this technique, which is primarily focused on the body and breathing, also uses other building blocks: For example, there is an "allowing" consciousness and attention (just watching) without trying to change anything (based on the building block of attentional focusing --; there are self-instructions, created from the building block of cognition: [we breathe naturally whenever we're asleep, so we're just trying to keep our

“self” from getting in the way!. The therapist (the building block of “other”) can share with the client certain self-instructions for the client to then practice him/herself: e.g. Let the air breathe you, there is no need to draw it in, or force it in or out. Trust your body’s wisdom! The therapist might also invite the client to use and practice certain imagery (let your belly be like a balloon being filled)].

Diaphragmatic breathing is a “generic” relaxation technique which is as allowing and trusting and positive yielding a body technique as possible. Two additional body techniques which are slightly more “yang” and assertive include the body scan technique and progressive relaxation. Both of these techniques target both the whole body and specific “parts” within the body. The therapist, in working with the client’s concern, may explore whether among these potential body techniques, a more “yin” allowing trusting diaphragmatic strategy is sufficient. The therapist might also feel the client might benefit from greater specificity, “focus” and attention on the body, in which case the therapist might “move up the ladder” by choose increasingly “yang” body focused relaxation technique such as the two described below.

BODY SCAN. The body scan is a way to use soft attentional focusing to help clients (and ourselves) get to know our bodies better, looking for tension and areas of relaxation. To illustrate this technique here, we will only use one area of the body, although the technique does go through each body area (more detailed instructions can be found in the Control Therapy Training Manual, Appendix 3, client handouts.)

As a way to briefly practice this technique here (and as a way to teach it to a client), here are some suggestions: To begin the body scan, you can either get into a comfortable position in your chair, with both feet on the floor in front of you, arms gently resting by your sides or in your lap. Or you can lie on your back in a comfortable position. Have a blanket or sweater available in case you get cold. Gently close your eyes and begin with diaphragmatic breathing.

Then bring your attention or awareness to the toes of the left foot. Without moving or wiggling them, simply notice whatever sensations arise in that area of the body, being with the sensations without judging them. Now imagine that you are breathing into and out of this part of the body, as you continue to focus on whatever sensations may be arising there. If there is no distinct sensation present, simply attend to the absence of sensation. Go through several rounds of breathing into and out of this area.

It is natural that your attention will wander during this process. When it does, simply notice the distraction, and then gently bring your attention back to the part of the body you are focusing on, without judging yourself for having become temporarily distracted. When feelings arise (judgment, non-acceptance, gratefulness), just notice them and gently return to focusing on breathing into and out of the body part to which you are attending. You may be tempted to fall asleep during this process; try to remain awake and aware, in order to foster a sense of conscious, yet deep relaxation.

In addition to the practice of this formal body scan exercise, it can also be helpful to informally practice a quick body scan at different times throughout the day, to increase awareness of bodily cues and sensations during our daily lives (i.e., work, interactions with others, how our body feels and responds during times of stress, times when we feel a loss of control or when we feel we are trying to control and manage too much.)

Now, let your eyes gently open. Again, note how in this body focused technique, there are also building blocks of breath, attentional focusing, and self-instructions on how to deal with “thoughts, feelings, sensations.”

(PROGRESSIVE MUSCLE RELAXATION): This variation of the body scan involves going through each muscle group, alternating tensing, then relaxing. Again, below, one example is used. You can apply it to each muscle group, or target specific areas as needed:

On an in breath, tighten your right fist. Notice the tension. Keep tightening, and notice how you can make yourself tense, and where you feel it. Now, on the exhale, relax your right hand, opening your fingers. Feel the difference. Notice what it is like for your fingers to feel at ease and with the excessive tension removed.

Notice in these two techniques, the focus is on the body domain. In the body scan, the body does relatively little, whereas in progressive relaxation the body is “tensed” and relaxed. Further even though the focus is the body, other “building blocks” are involved. Both techniques involve the building block of attentional focusing, breath, and self-instructions. In the body scan it is a soft, gentle allowing focusing with instructions to just notice, as well as to consciously breathe into and out of this part of the body.. In progressive relaxation, there is the attentional building block: focusing on different specific body parts; there is the cognitive building block: e.g., self-instructions: notice how you can make yourself tense, and how you can learn to relax yourself. These self instructions help teach clients to take responsibility for recognizing stress, for learning to see when clients have some responsibility for making themselves anxious. These self instructions also involve the building block of decisional control: i.e., that clients have the ability if they so choose (decisional control) to relax themselves (the self instruction of self-efficacy). ourselves.

. Each of these body domain interventions may be appropriate and sufficient in and of themselves for the clients concern, or, if necessary, they can become a component of an overall CMR intervention.

BODY POSITION: PREPARATION FOR “ASSERTIVE” ACTION.

Centering, (e.g, diaphragmatic breathing) is helpful as part of the yielding mode body building block of CRM, and also as an aspect of the assertive mode CMR. In the assertive mode, however, one would want to have the client explore more explicitly the physical posture that would be most comfortable for them in preparation for an assertive act. The

therapist could discuss with the client that there are many physical postures that prepare us for action. Think of the ready position in tennis, or of a shortstop, or for beginning tai chi /chi gung. In these postures, knees are slightly bent, weight evenly distributed between your two feet, usually with more weight on the front third, the ball of the foot. Have the client explore what is the optimum level of “controlled” arousal for the situation: e.g., you may want to be relaxed, minimizing any unnecessary tension, a slow even breathing, eyes softly focused, ready, attentive. These ready positions allow us maximum flexibility in terms of the next step (e.g., moving right or left, up or back in tennis and baseball). By staying balanced and maintaining a calm, quiet breathing, this ready position also allow us to move gracefully and with balance from one “form” to another. For example, in tai chi these different forms involve degrees of balance and nuance between “yin” accepting energy and “yang” assertive energy, represented by different body postures and hand movements. Explore with the client what s/he thinks of when she tries to image the ideal “ready position” for the situation which concerns him/her. e.g., if you’re thinking of confronting your mother in law, do you want to be standing, seated? Do you want to be leaning forward? Where are your hands? Where do you want to focus your eyes? Imagine and practice how you want to be breathing. What in general is the most comfortable position for the client when preparing to act assertively. Have the client notice breath, hands, eye focus, where the body is being “balanced.” This attention to physical posture can be an important part of the preparation for taking an assertive action in the Control Mode Rehearsal (and in life)!

MIND :

ATTENTIONAL AND COGNITIVE SELF-REGULATION BUILDING BLOCKS AND SKILLS.

Building blocks, such as attention and cognitions, can be used as part of a variety of skill building techniques for either positive assertive/change or the positive yielding/accepting mode of control interventions to help address multiple problematic “mind domain” concerns. Here we explore one example: what are wise ways to deal with negative thoughts (and feelings) that hinder a client’s positive sense of control?

Skills in this area involve some use of the body building blocks (e.g., finding a comfortable posture; where to focus one’s eyes; relaxed, effortless breathing etc) but primarily use the attentional and cognitive building blocks are the more important ones to deal with negative thoughts and affect.

There are five different gradations of skills discussed here, from most accepting to more assertive. These are adapted from both meditative and cognitive/behavioral self-control schools. Depending upon the client’s concern, these skills can be helpful in teaching acceptance of what is, including all thoughts, even negative ones; can teach learning to and practicing letting go of thoughts and stories so one is not so caught up in them; learning to not take thoughts so seriously; learning to keep a larger attentional “mind” noticing thoughts; learning to stop thoughts; and learning to stop negative thoughts and replace them with more positive ones. This latter can involve affirmations, as we shall see, toward either the yielding, accepting mode of control, or the positive assertive mode of control, depending upon the client’s concern and goal. .

Thus, I want to make it explicitly clear that these mental building blocks, which can involve a continuum of accepting to change skills, can be implemented as a way to develop interventions that can be used for goals of either

the assertive change mode: i.e., to help the client *let go* of negative thoughts as part of change; to help the client *change* negative thoughts as part of change;

or as part of interventions directed to the yielding/ accepting mode of control: i.e., to *let go* of negative thoughts to learn to accept “what is” better; to *change* negative thoughts to accept what is better.

Just to repeat: *both* positive assertive and positive yielding *techniques* can be used to facilitate positive assertive or positive yielding *goals*.

Notice only. The most accepting skill is that which is practiced in the meditation technique of “just noticing the thoughts” without judgment (“ah, noticing negative thoughts,” “doubting mind,” etc.). Thoughts are viewed as “content” stories, and simply “observed,” allowing whatever is to be. In watching the thoughts, one doesn’t “catastrophize” and embellish; one doesn’t minimize and dismiss, one doesn’t dwell on and ruminate about them. “Don’t run toward, don’t run away from the thoughts.” Again, just observe. Also, if you want to run away, and minimize, or start to embellish and create a story, just notice that, too. Just observing whatever is might be thought of as the ultimate “acceptance” of thoughts.

This “observing and noticing” of thoughts can also be applied to feelings, body sensations, etc. For example, one useful practice is to just observe mindfully the stories, thoughts, and feelings you have in each of the “negative” quadrants—e.g., negative assertive, negative yielding. Just observe from a quiet, centered place what those quadrants are like, without running toward them, or away from them. Just sit and observe “with curiosity” and get to know the stories, thoughts, and feelings in those quadrants.

Notice and let go. Additional instructions in some schools can include “notice the thoughts as if you were under a bridge and cars are passing over the bridge-- just notice the cars, *then let them go* (don’t get into the car and drive away in it) and return to breathing.” This approach is a bit more “assertive” in terms of changing the “mind’s thoughts-- using thought (self-instructions) to work toward ceasing thoughts, and creating a more “open” mind.

There is a story of two monks who see a woman unable to cross a river. One monk picks her up and carries her to the other side. Then the two monks continue walking one way, and the woman another. An hour later, one monk says to the other, “How could you pick up a woman? You know monks don’t touch women.” The other monk replies, “I set her down an hour ago. Are you still carrying her?”

Notice, let go, return to a competing response. Whereas one school of meditation says notice, and another says notice and “let go” of negative or unproductive thoughts, still another approach involves practicing a competing response: e.g., a mantra, or series of sounds and phrases to utilize to stop negative thoughts and replace them with neutral/positive sounds and statements. When a person notices a negative thought, they merely let it go and return to the pre planned word (e.g., Ommm, peace, gratitude), etc.

This has been referred to as concentrative meditation. in which, for example, a specific auditory, visual, or kinesthetic/tactile object becomes the focus of attention. Below are examples of each of these (internal and external).

SLIDE

EXAMPLES OF CONCENTRATIVE MEDITATION

	<i>Auditory</i>	<i>Visual</i>	<i>Tactile</i>
<i>overt, external environ- ment</i>	verbal— Sufi dervish call mantra	kasina mandala cross vase abdomen	touching thumb to each finger
<i>internal environ- ment</i>	verbal— mantra koan	third eye vault of skull symbol of guru (image)	heart beat breathing

END SLIDE

Notice, Stop, “Dialogue”, Replace: *A cognitive-behavioral approach* to dealing with negative thoughts involves four steps. The first is to notice the negative thoughts, and the second is to “stop them.” This can include using stimulus cues to remind oneself to check in on one’s thoughts, and “catch” and interrupt maladaptive ones, to more vigorous efforts, including, a loud covert or overt “STOP!”, and even the behavioral use of a real “rubber band” to punish and reduce negative thoughts, and break into a cognitive sequence. Meditative thought stopping can range from the gentle instructions to “notice and let go” to more vigorous efforts such as the Zen “Kwat” (an internal harsh image of a monk bowing and then using a board to the shoulder to interrupt thoughts.

The third step is to explain (argue, convince, challenge, dialogue) with oneself about why those thoughts are negative and not helpful: e.g., “I’m catastrophizing, overreacting,” “I’ve been through this over and over, and am just rehashing old news”; “this is not going anywhere, and it’s not worth going there.” The final step in the sequences is to replace the negative, unhelpful thoughts with positive, less destructive thoughts, and ones which more accurately reflect how you’d like to think and feel. For example, on one side of an index card, you could have the client write down a negative statement about his/her body and on the other side self-accepting statements to be used as substitutions.

It is helpful to have the clients write down any self-sabotaging or negative thought related to their self-management project, area of concern.. Then have them explore what would their wiser, higher self respond to this thought? It’s been said that the one who controls the narrative wins. It is useful to anticipate negative thoughts, and to plan how one intends to wisely address them.

Affirmations: For the yielding, accepting mode of control

Below are cognitive statements—affirmations, self-instructions-- that can be used to help us accept where and who we are. Skillful use of these can be helpful. As a generic affirmation, the following can be helpful to practice:

slide

- I'm doing the best I can. There's nothing more to be done; I'm coping (solving) what's facing me as best I am able." (acceptance with gentleness toward self).
- "Rather than focusing on what is lacking or missing in my life, I choose to count my blessings, and find things I can be thankful for in my life as it is." (acceptance with gratitude)
- I will seek to focus on and appreciate those parts of my(body, life, relationships) that are working, and to develop conscious appreciation for what is.
- I can love and accept myself just as I am.
- My self worth is not based on "doing" alone..

And, as continued practice in specific areas:

- I am working on learning to deal with specific situations that are out of my active control—e.g., : a busy signal, traffic, red lights, long lines)-- as an opportunity to pause and accept what I can't change with one or two degrees greater equanimity and serenity (rather than with aggravation, impatience, and helplessness).
- Every out breath I take, I am learning to practice consciously letting go, trusting, and accepting.
- I am increasingly able to be peaceful and accepting, and not rise to every trivial annoyance.

Finally, accepting beliefs can also be facilitated by one's world view. For example, affirmations can incorporate a theistic view:

-- I trust in a higher power and that this makes sense. I accept what God gives. It is God's will.

-- Everything happens for reason; I choose to trust that this makes sense.

For those with a non-theistic view such as Taoism or Buddhism, affirmations can involve a belief and trust "in the way"; in the "isness" of things:

--You can't push the river.

--It is what it is.

--Trust the Tao (the way).

end slide

Affirmations for the assertive, change mode of control. We have already mentioned over a dozen affirmations for the assertive/change mode of control under Desire, Right/Responsibility, Self-efficacy beliefs, and commitment. Here are a few additional ones, and of course the therapist and client can add additional specific ones targeted to the client's concern.

- “I’m ready”;
- “I’m going to follow through.”
- “I am proud of myself and the courage I’m showing by being willing to make this change.”
- I can do this.

THE BUILDING BLOCK OF “OTHERS” IN FACILITATING CONTROL ENHANCING INTERVENTIONS.

Sometimes gaining a positive sense of control through either the assertive/change mode or yielding/accepting mode can be facilitated by enlisting others' help. One obvious example of this is the therapeutic session, in which a client has come seeking guidance, wisdom, advice, a safe place to share, a desire to learn healthier skills, etc.

We saw a literary example of that in the story of Odysseus and the sirens--that part of self-control (and a “self”-management project) can involve recognizing the limits of our own personal abilities. Odysseus realized that he alone through personal will couldn't overcome the sirens, and asked for help.

“Others” can be a building block in efforts to gain, maintain, or regain s sense of control: a support group of people focused on a similar problem, letting others know you are trying to make changes and asking for their reinforcement and feedback to help keep you on the path. Other people can serve as a source of self-efficacy by providing us (as well as teaching us) skills necessary (assertive/change and or yielding/accepting) as well as by being a source of encouragement and support in enhancing our commitment.

Social support can be helpful in adapting to and accepting adversity through maintaining connection, and helping us to see and feel that we are not alone. To have someone who can calmly and empathically just listen and hear, and let us talk about our losses, to let us know that it is ok to feel how we are feeling, that it is okay not to be okay can be an invaluable gift.

The question of whom does your client trust as agent--self and/or other—is an important one in terms of building blocks. Is the client's preferred style self as agent—i.e., more trusting of and would rather rely on him/her self, or is s/he more trusting of “others” and would rather rely on their guidance and advice? This is clearly important information in working with a client to develop an intervention.

BELIEFS ABOUT THE NATURE OF THE UNIVERSE AS A BUILDING BLOCK.

We discussed views of the nature of the universe in exploring self and other agency earlier in this talk. A person's belief system about the nature of the universe can also be a building block in gaining a sense of control.

NATURAL/PHYSICAL ENVIRONMENT AS BUILDING BLOCK. Although we may not consciously think of our environment as a building block, it can be quite helpful in developing an intervention. This can include consciously choosing and arranging certain environments to facilitate the goals we wish (e.g., a quiet room for meditation; an exercise bike in a convenient location.). It can also involve environmental programming strategies (e.g., removing inappropriate foods from the house). It can involve thinking of places to put stimulus cues as reminders for “encouragement” or to actually take a moment to do a “body/mind scan.” Finally, sometimes just changing physical environments - going for a walk, taking a few moments in nature - can be important in helping one regain one’s sense of control.

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CONTROL MODE REHEARSAL: An intervention created by putting building blocks together to match the client’s goal, profile, and concern

The above control enhancing skills in mind and body, composed of several different building blocks, can be utilized to develop skills and interventions directed toward either the yielding/accepting mode of control, or the assertive/change mode of control.

One way to put them together in an integrative model is through the use of the Control Mode Rehearsal, matching the client’s control profile, preferences, goal, and clinical concern. This technique builds upon and is an extension of the work we have already done with the Control Mode Dialogue (CMD). The CMD was an opportunity to clarify goals and modes.

The CMR is an opportunity to practice, through a combination of different building blocks—e.g, visualization, kinesthetic, and/or self-instruction--modeling the new skills the client wishes to develop in order to reach her/his goal. You will note that the building blocks for CMR are adjusted accordingly to tailor it depending upon whether the client’s goal is to gain a sense of control through the yielding, accepting mode of control, or the assertive/change mode of control.

CMR has two main steps:

1) The first step is to have the client try to re-create, and experience the problem scenario, noting with some precision any mental and physical cues, e.g., body sensations, thoughts, feelings. This re-creation can be done through visualization of the situation and persons involved, if the client is comfortable with visualization. CMR can also be done descriptively, i.e., having the client verbally describe who is present, where the client is, what the client is feeling.

2) The second step involves self-modeling, seeing oneself effectively handling the situation by using the physical and mental cues from step one as a “signal” to engage in the desired behavior, thoughts, and/or feelings the client would like to implement in reality. The client can either visualize this process, if s/he is good at imagery, or actually practice acting (feeling, thinking) exactly as s/he would like to when dealing with the real situation, including feeling the body calm and relaxed, making cognitions that are supportive and helpful, and saying and doing whatever supports the goal of enhancing either the yielding, accepting mode of control, or the assertive/change mode of control. .

You can explain to the client that Control Mode Rehearsal operates on the same principles sports psychologists use when helping athletes use self-hypnosis/ self-instructions and guided imagery to effectively execute a play sequence, golf swing, or other highly controlled yet relaxed precision movement. It is helpful to point out to clients that the more clearly they can approximate creating the problem situation and then practice in the safe space your office (and later at home as homework) a desired solution or solutions, the more likely they will be able to successfully reach their goal(s).

We will now go through a brief exercise involving the CMR for each mode. Please note how the different building blocks are utilized and integrated. This is an over inclusive model in terms of utilizing building blocks; not all of the each building block necessarily would be needed for the intervention for each client, but all are provided here to create a familiarity with how each might be used.

Guidelines for practicing CMR.

Creating a personalized script. What follows is a general format, but the therapist and client should work together to create a more specific script, because research suggests that it is more effective to create a personalized guided scenario tailored to the client's concerns, style, and values, than to use a preset one. When working with clients, you may want to have a detailed discussion of their problem scenario and desired behavior before doing a Control Mode Rehearsal, so they can generate material that resonates most powerfully for them. In other words, you can co-write a customized protocol using the client's own keywords and affirmations.

Perhaps we can practice this here in the lecture, if you are willing. Please recall a situation of "minor" concern that you are willing to briefly explore as a way to experience the CMR.

Brief preparatory breathing. Let me invite you to ask you to engage in a brief breathing exercise. Allow yourself to take a couple of deep breaths, exhale, and as you are willing, let your eyes gently shut.

The scenario as it is. Use visualization (for those who are comfortable with imagery; otherwise, use whatever senses are most helpful for you—somatic, cognitive)--to create the situation that is of concern, as it is. Notice in your mind's eye a situation that is causing you some concern. Try to see the situation in as much detail as possible. Where are you? Who is present? What time of day is it? Describe the scene as precisely as you can (sights, sounds, sensations, tensions).

Notice where and how you are ***breathing***. Is it somewhat shallow? In your chest?

Bring your attention to how you are ***feeling*** in this situation. Are you noticing any stress in your body? If so, please note as clearly as you can where you are feeling this anxiety. Butterflies in the stomach? Tension in the neck? Sweaty palms? Are there

other emotions? Fear? Anger? Again, notice where you are feeling these emotions in your body.

Note as precisely as you can what you are *saying* to yourself, what thoughts you are having.

When you envision the problem situation, you should try to make it as realistic as possible. This is important because it will help you recognize (in a safe environment) what feeling anxious, even slightly “out of control,” is like for you. This is important so that, in the future, you can detect these feelings and thoughts early, and use them as a cue to break the negative sequence and transition to the next phase, below.

The scenario as you would like it to be: The use of multiple building blocks.

This step involves the transition to imagining how you want yourself and the situation to be. Note how this CMR technique can include and integrate many of the building blocks, all in the service of self-modeling whichever positive mode of control you wish to emphasize: either the accepting/yielding mode of control or the assertive/change mode of control. Imagery and visualization; emotional reprogramming/ self-regulation; self-instructions (cognitions) to alter negative thought patterns and feelings, and kinesthetic (body and movement) are possible building blocks for creating a control enhancing intervention you might choose to utilize.

Diaphragmatic breathing. Now, take a few slow, diaphragmatic breaths. Allow your breath to settle into its natural rhythm and let yourself practice the diaphragmatic breathing we have discussed.

Mindfulness. If you continue to feel anxiety or tension, allow these feelings to arise. Then, just notice them mindfully, while continuing your diaphragmatic breathing. You may also wish to direct your breath gently toward the areas of discomfort, as in the body scan allowing a calm, gentle relaxation to flow through you.

The second two interventions involve cognitive and emotional self-regulation to cultivate the either the accepting/yielding mode or assertive/change mode:

cognitive self-regulation involves self instructions and affirmations;

emotional self-regulation may involve cultivating emotions reflective of either mode: for the accepting mode, emotions such as serenity, gratitude, unconditional, non-judgmental love, and forgiveness might be cultivated; for the assertive/change mode, emotions such as courage, fearlessness (managing fear), determination, competence may be cultivated. Of course, the most important thing is to talk with clients about what emotions they feel might be most helpful in working toward achieving their goal.

It would also be important to discuss with clients, if appropriate, their views of the nature of the universe, and how that might context and even be a part of the Control Mode Rehearsal, as we have discussed previously under that particular building block.

We then put the four interventions together into the ***Control Mode Rehearsal.***

Visualizing positive self-modeling. As you continue this mindful noticing and slow, gentle breathing, switch the scene in your mind so that you now see yourself thinking, feeling, and if appropriate, acting exactly as you would like to

in the situation. If someone else is present in your CMR, see yourself saying or doing exactly what you want to do, if anything, toward that person. When you switch to the desired scenario, try to be as specific and detailed as possible. This helps you visualize what success would mean to you in concrete terms, thereby modeling it for yourself.

Remember to keep your breath as an anchor, inhaling effortlessly, exhaling gently and calmly.

Positive thoughts. Remember to create positive thoughts as part of your CMR ideal scenario. Are you telling yourself that you are proud for the courage you are showing in attempting to act in accordance with your self-chosen goals? Are you admiring your willingness to become more (e.g., accepting in this area? or your courage to engage in positive assertive change). You may use positive self-statements listed above as affirmations, including “This is a brave step I am taking,” “I am doing the best that I can,” “I am feeling loving and accepting of myself just as I am, and proud of myself for how I am acting and behaving and feeling.” Create affirmations tailored to your situation that are most helpful to you.

Positive emotions. Also try to cultivate and feel the positive emotions that you want to have in the CMR situation, using a combination of thoughts and images that are most helpful for you.

Up to this point, the instructions I’ve given you can be used for either positive mode of control. I’d now like to offer some specific cultivation of positive emotions tailored to each mode of control. Let me begin with

THE YIELDING, ACCEPTING MODE OF CONTROL.

Emotional self-regulation. What emotions do you associate with the yielding, accepting mode of control? Four are explored here, as examples, but are not meant to be inclusive.

Serenity. The first is “serenity,” as in the “serenity to accept” and “letting go” of stress, negative thoughts, negative emotions. You may wish to feel this serenity through **diaphragmatic breathing**, which involves learning to accept and trust your body’s natural wisdom and gentle, relaxed breath; through **mindfulness meditation**, which teaches attentional focusing and the ability to accept all thoughts and feelings, without rushing toward them, or running away from them, a compassionate gentle observing of thoughts with non judgmental equanimity. If your problematic scenario in CMR involves dealing with stress, tension, too many responsibilities, perhaps you may think about, see, and actually feel yourself “dropping the bundle” of cares. Imagine yourself being in a place that brings you quiet relaxation (e.g, the ocean, watching a sunset, a favorite place in nature).

Gratitude: Acceptance and appreciation of what is. A second emotional state that you may wish to cultivate as part of the accepting mode of control is gratitude, appreciation and acceptance for what you have. If that is an emotional state that you feel would be helpful in your CMR to create feelings of acceptance, you might ask yourself what is there right now in your life that you are thankful for, what are “blessings” that you have right now. The emotion of gratitude helps address feelings of frustration, helplessness, annoyance, envy, and other emotions about what you don’t have or feel is

lacking in your life. Rachel Remen talks about those people “who are given more blessings than they receive.” Gratitude can be achieved through the conscious focus of attention on the positive aspects of your life, and by utilizing cognitions and affirmations such as the first one noted in the affirmations above:

Rather than focusing on what is lacking or missing in my life, I will recognize and be grateful for the blessings that I have. You may also choose for a moment to focus on your breathing, and notice how grateful we are when we think of this amazing feat which occurs even we do nothing. We can feel gratitude to our body, our lungs; and to the earth, which provides oxygen! You may imagine yourself feeling grateful for breath which keeps us alive.

(A note on gratefulness and upward and downward comparison: Sometimes affirmations of positive yielding and acceptance can involve downward comparison, as in the aphorism, “I felt sorry for myself because I had no shoes until I met someone who had no feet.” Downward comparison can be helpful to develop gratefulness. Rather than always looking for what we’re lacking, or what others have that we don’t, a useful strategy for cultivating gratefulness and acceptance for what we do have is to see, relatively speaking, how many blessings we have in comparison to those who are less fortunate. For example, in the first affirmation listed, a person could add: ... gratefulness for the blessings I have, *especially when I recognize the extent of poverty, homelessness, and suffering that others in the world are experiencing*. However, downward comparison can also be misused, as when a person tries to accept and feel better about their situation by putting others down through racism, sexism, ageism, etc. This is clearly not what is meant.)

Non-judgmental, unconditional love and loving-kindness. A third emotional state that may be part of the yielding, accepting mode of control is loving-kindness. This emotional quality can help address the desire to change, judge, or criticize. Loving-kindness can include the use of attentional focusing in a kind, loving way on a specific body part, on yourself as a whole, or on a beloved. It involves the feeling tone of caring and compassion. If there is a specific aspect of yourself that concerns you—a limitation, something about your body— in your CMR, send as much caring and love as you are able to that aspect of your self, greeting it with kindness. If your goal involves more holistic self-acceptance, you may wish to practice a CMR in which you cultivate images and make “self-statements” of self-acceptance and self-love for who you are, just as you are, without trying to accomplish, change, or actively control anything. Feel a deep caring about yourself, a willingness to nurture yourself, and to accept yourself at the most fundamental level, unconditionally, not dependent on what you perform, do, or accomplish.

Forgiveness. Forgiveness is a form of acceptance that involves changing your attitude and feelings toward what happened in the past that is not changeable, to be more accepting of it. If your goal involves letting go of past hurts you feel were caused by another (or yourself), you may wish to offer forgiveness for pain that person (or you yourself) has caused you, whether intentionally or unintentionally, by thoughts, words, or deeds. You may visualize this process in your CMR, feeling yourself letting go of unproductive anger and dwelling in the past about events that cannot be changed, and

see and feel in your mind's eye as you allow yourself to come to a greater inner peace and healing acceptance in the here and now. If you have made mistakes or caused suffering to yourself or another in the past, it is helpful to practice self-forgiveness in your CMR "for any hurts I've caused, intentionally or unintentionally, by my thoughts, words, or deeds."

As you continue your slow, gentle breathing, allow all the thoughts and feelings that contribute to peaceful acceptance and letting go to flow through and in you. If your goal involves accepting some problematic aspect of another person, you might want to see yourself in the CMR guided visualization being serene, grateful, loving, and forgiving accepting and non-reactive when the person acts in the way that concerns you. If your goal involves letting go of past hurts you feel were caused by another, and you wish to offer forgiveness, you might want to use CMR as a way to visualize the practice of offering forgiveness to another for pain that person has caused you, whether intentionally or unintentionally, by their thoughts, words, or deeds. As you visualize this process, feel yourself letting go of unproductive anger and dwelling in the past about events that cannot be changed, and see and feel in your mind's eye as you allow yourself to come to a greater inner peace and healing acceptance in the here and now. All the while you can continue to allow the slow gentle natural rhythm of diaphragmatic breathing and the gentle, kind, compassionate noticing of mindfulness.

Discussion. As you are willing, let's take a few second of breathing and then gently open your eyes and return to the room. When you do this with a client, it can be helpful to take some time to discuss the differences between the two scenarios in CMR. What were the thoughts and feelings in the scenario "as it is" compared to those in the scenario "as you wanted it to be." Notice how the second set of thoughts and emotions might serve as an antidote to the first. Further, once we become aware of the first set of thoughts and feelings—the ones that seem problematic and challenging -- they can be a cue to "change the scene" to the "scenario" as you desire it, a cue triggering a new sequence: beginning to breathe diaphragmatically, notice mindfully, and replace the problematic thoughts and feelings with the positive statements and emotions of acceptance that you desire.

ASSERTIVE CHANGE MODE:

When the Control Mode Rehearsal is directed toward the assertive change mode it involves a way to self model (visually and/or through actual role-playing) trying on new behaviors. Through guided imagery and self-instructions, the clients can image (and practice) seeing themselves building competence and confidence in the ability to engage in "assertive change" that fits their goal (e.g., slow eating, speaking up calmly and confidently to their mother in law, exercising).

Many of the mind-body exercises discussed earlier can be utilized with the client in working toward assertive/change: e.g., diaphragmatic breathing to promote relaxation, role-playing to try on new behaviors, guided imagery to relax or build feelings of competence, and self-instructions to alter negative thought patterns and feelings). These building blocks are both preparations for change AND forms of change in and of themselves—skills to help the client reach his or her goal. The therapist can work with clients in CMR to help them see themselves acting exactly as they would like,

including visualizing and feeling the body calm and relaxed, making cognitions that are supportive and helpful, and saying and doing whatever supports their identified goal. When creating the personalized script, it can be helpful to include positive affirmations we have discussed above about the client's desire, right, responsibility, and belief in one's own efficacy to accomplish what the client wishes to change.

We have already explored potential "ready" positions physically in terms of what the client feels would be best for him/her in an assertive/change scenario. Let's look briefly at some considerations of the assertive/change project—mentally and emotionally.

Mental/emotional attitude. What is the mental/emotional readiness this client feels would be best before embarking on an assertive action? Would the client want to be focused, attentive, determined, relaxed and minimizing unnecessary tension/mental contraction, while projecting a certain confidence--the psychological representation of the ready position discussed earlier.

What are cognitive statements, self-talk, and instructions that would be helpful for the client? The process discussed in the section on negative thoughts can apply here. If the client notices a negative thought, that can serve as a cue to replace it with a positive one. For example, here is a series of self-critical thoughts: "I am undisciplined, lazy, noncommittal, a procrastinator. I've always been a failure" (Quadrant 4, negative yielding). Positive replacements can include: "Careful of all-or-none thinking. I'm becoming increasingly disciplined. I am practicing small changes." "I can do this", "I'm ready"; "I'm going to follow through." "I am proud of myself and the courage I'm showing by being willing to make this change."

Visualization. The next step is to have the client see him/herself acting exactly as s/he would want. . This might involve taking a brisk walk; or eating slowly and calmly. If the goal involves another person, this step involves the client seeing herself or himself saying exactly what s/he would want to say to them, with the confidence, clarity, calmness, and forceful self-assurance that ideally the client would want to have.

Ideal response from "other"; adaption to non-ideal responses. Initially, in the Control Mode Rehearsal when a client is going to be assertive with another person, it is helpful to focus on a) the client's behavior, thoughts, feelings; and b) having the other person acting exactly as the client would want in response to the initial request or actions. The therapist can remind the client that this is all happening in their mind, so why not imagine the event as they'd want it to be initially?

However, since assertive/change sometimes involves another person, it is important to imagine different possible outcomes, some of which are less than ideal. For example, sometimes an individual may "rehearse" speaking assertively to her husband. Next, she could imagine different scenarios of how her husband might react, ranging from hostile and defensive to "less than pleasant" (perhaps more realistic but less desirable outcomes). The therapist and client can role play a) how she would ideally like to respond to these reactions: i.e., staying calm in body and mind, choosing the best possible option staying on target in terms of her goal.

From "in vitro to in vivo": Clearly, the goal is to be able to engage in the behaviors in an actual situation. The therapist and client should work together to practice

CMR a sufficient number of times so that the client feels increasingly comfortable and confident in the “self-modeling” rehearsals helps optimize the chances for success in the actual situation.

Turning a negative into a positive. An adorable video which may be shown if time is “the best hitter ever!” It suggests there is always a way to gain a sense of control, in any situation, even in seeming defeat!...

<http://www.values.com/inspirational-stories-tv-spots/99-The-Greatest>

STEP 5: SUCCESS: “I” did it!

As discussed, there are many ways to measure success. In the final section of this talk, we discuss a system’s approach to evaluating success, as well as using pre-post measures such as the SCI. Another way is to see if the client has met the clearly stated goals of Phase One.

Of course, it is possible for a client to reach his/her goal, still not be “satisfied” and decide to choose other areas or other goals to focus on. Such an outcome can certainly be appropriate as part of the continuing process of therapy. However, it is also important to take some time with the client in this step to appreciate the phenomenological experience of “success” in the specific area originally chosen.

In this step, the client has gone from *I want* to *I have a right and responsibility to I can* to *I will* to *I did it!* What does the experience of “success” feel like and mean to the client--- how does s/he cognitively and affectively experience success. Regardless of whether the client chooses another therapeutic goal, it is important to first focus on these feelings of success and accomplishment and the positive sense of control in each mode that such success produces.

Yielding, accepting mode of control. Successful use of the yielding accepting mode of control usually brings positive feelings and a sense of control through equanimity and serenity. Some describe it as feeling a weight has been lifted.... a feeling of positive letting go of the self, of the “I” as doer, and a resultant lightness. (That is why the “I” is in quotes at the start!) There is a sense of getting out of one’s own way---reducing the ego, letting “breath” happen naturally and trustingly. For others, successfully utilizing the yielding, accepting mode of control can produce feelings of self-competence and mastery at having gone from feeling out of control, powerless or helpless in a certain area, to feeling a sense of control in learning to be serene, calm, and accepting. “I” have taken time to just be, to come to a greater peace and acceptance of myself, , learned to relax, reduced my unnecessary rumination, etc.

Again, it is important to take some time with the client to notice his/her internal reactions, feelings, thoughts, and to feel grateful and appreciative for the accomplishment and wise use of the yielding, accepting mode of control

Assertive/change mode of control. Assertive change can bring positive feelings and a sense of control resulting from competence and mastery. There can be a great sense of satisfaction in having the courage, determination, and will to have gone from feeling out of control, powerless or helpless in a certain area, to feeling more in control and empowered. Robert White called this the “joy of being a cause.” Again, the therapist can

have the client pay attention to the ways that s/he has been successful in actively gaining control over the area of life s/he chose to work on, and take time to savor and enjoy the accomplishment.

* * *

Note to lecturer (and therapist). We have now gone through Phase One—Assessment and Goal Setting, and Phase Two: the five steps of the Intervention. At some point—from beginning with goal setting to after the five steps of the intervention phase have been reviewed - it is helpful to create a “self-management contract” with the client. We present an example of such a contract here, at the end of the discussion of Phase Two, though, as noted, it could be presented earlier—either in the lecture, or in the therapy process.

MAKING A SELF-MAGEMENT CONTRACT. Working with the client to make a self-management contract can be useful in several ways—making sure the goal(s) are stated as clearly as possible, helping the client take more responsibility for the intervention phase, addressing how resistances might be dealt with, enhancing commitment, and ensuring that the new skills (and the frequency) of practice are clearly understood. This “contract” can be done verbally, or formally, in writing. There is some advantage to creating the contract in writing, in that it makes it more explicit. However, sensitivity to the client’s style (e.g., see freedom reflex above) should be taken into consideration regarding the best way to achieve buy-in to the treatment plan.

Einstein once said that “**Everything should be made as simple as possible, but no simpler.**” Although he wasn’t referring to a self-management contract, it might apply! It can be as simple as needed, or more elaborate, if appropriate. It can include an action plan stating expectations and goals (a means of measuring success); identifying means to reach the goals (noting specific strategies, skills and plans developed to achieve the goals—the ones that are going to be “learned” and practiced); anticipating difficulties in attempting to achieve the identified goal; plans to address these difficulties by identifying specific ways to counteract each difficulty); identifying specific rewards/positive consequences for successful completion of the goal. Further, it can be added to and nuanced during the course of therapy. An example of such a contract is provided below.

slide.

EXAMPLE OF A SELF MANAGEMENT CONTRACT FORM

Below is a simple example of a self-management contract. It can be modified and added to as you feel helpful (e.g., ways the client might address difficulties, resistances, etc.).

Dates of contract:

I, _____ agree to (list specific goal(s)

1.

2.

3.

I plan to accomplish this goal (these goals) by (note specific strategies, skills, and plans you have developed to achieve your goals).

1.

2.

3.

I anticipate the following difficulties in attempting to achieve this project.

1.

2.

3.

I plan to address these difficulties by... (note specific strategies, skills, and plans you might develop and utilize to counteract each difficulty)

If I keep this contract I will (note how you plan to “reward” yourself) and the positive benefits you will gain.

Signature

Date

Witness

Date

end slide

--FINAL TOPICS--
**INTEGRATION, SYSTEMS'S MODEL, WEEKLY BREAKDOWN,
CT COMPETENCIES, FUTURE RESEARCH, FAQ**

We have now discussed the two phases of Control Therapy. In some ways this material presents a “simple” linear model: after developing a client control profile and assessing the area of concern, the client is able to choose a goal of assertive/change OR yielding acceptance; and then learns the five steps involved in each mode. Further, we have gone through the five steps in detail and, after exploring some challenges along the way, ended in “Success.”

This final section adds additional depth, refinement, and an overview to the two phases in five areas:

INTEGRATION: In the above material we have presented examples of the assertive/change mode of control and the yielding/accepting mode of control separately—both as goals, and in terms of the five steps utilized in each mode to reach the goal. On the one hand, this makes sense because the modes can be separate and unique. However, they also can be integrated: both in terms of goal(s) and techniques. Therefore, the first refinement involves integration in four areas:

- 1) integration of the positive assertive/change and positive yielding/accepting modes of control—as goals, and as techniques;
- 2) integration of the agent of control (self and other)
- 3) optimal control and building blocks: your views
- 4) dealing with adversity: integrating modes, agency, and control stories.

A SYSTEM'S MODEL OF THE COMPONENTS OF CONTROL THERAPY

The second refinement involves presenting the six components of a systems model of CT (1. therapist, 2. Client; 3; relationship; 4assessment, 5 selection of intervention; 6: teaching of intervention). The material presented thus far has primarily focused on the client (component 2). However, clearly the therapist is an important component, including the values, beliefs, and skills of the therapist including the therapist's view of the importance of relationship (component 3) in the therapeutic process. These are discussed in this section as well as how this systems model can

*be used to deal with “challenges” in the therapy process, including setbacks, compliance issues, client resistances; and when client and therapist disagree,

*evaluate the process and ending of therapy

At the conclusion of these two sections, a complete overview of the Control Therapy by

Phases and a session by session weekly breakdown is presented and clinical competencies for Control Therapy are detailed for each phase. Future directions for research are explored, and finally, there is a section on Frequently Asked Questions.

INTEGRATION: MODES OF CONTROL, AGENCY OF CONTROL, AND CONTROL STORIES

EXPLORING THE TWO POSITIVE MODES TOGETHER: GOALS AND TECHNIQUES

GOALS: The two modes integrated, balanced, “dancing”

A strong case can be made for the importance of presenting the two positive modes as unique and separate—as a goal, and as means to reach the goal. The modes are different, and it is helpful as a teaching tool to present them separately to ensure clarity and understanding of each. Therefore, regarding goals, as noted above in the Mode Dialogue (and in the SCI, domain specific scale 4) learning how to choose which mode is most appropriate for defining the nature of the client’s goal—courage to change, serenity to accept, “the wisdom to know the difference” -- is an important skill set.

However, this does not mean that the two modes cannot be integrated when choosing a goal. For example, recall in the Control Mode Dialogue, the client decided her goal was to speak up and let her mother-in-law know that the client felt she wasn’t being treated with respect (positive/assertive change mode). However, in that CMD, the client also developed the goal of learning to accept with serenity that she might not be able to change her mother-in-law’s behavior (positive yielding/accepting mode).

In Module Two of the Control Therapy Training manual several examples are detailed of the integration and overlap of the modes. Frequently asked questions which reflect this overlap include the following

*isn’t trying to become accepting a type of change?

*don’t you have to “let go” of what is to move on to create change?

*when a person says they want to choose the goal of having time to meditate and just “be”, don’t they also sometimes have to be assertive by letting others know that they need to create some private space, time for taking care of themselves (and just “be”).

Here are some other examples to highlight further integration of the two modes as goals. Interestingly, this is recognized visually in the yin/yang Chinese symbol  in which the white (yin) contains an element of yang (the small dark circle in it), and the dark yang contains a small white circle of yin.

The Control Therapy approach believes strongly in the importance, where appropriate, of integrating the two positive modes: wedding active change methods with a healthy focus on acceptance. To do this, *Control Therapy teaches clients how to formulate goals--again, where appropriate-- that move beyond either/or selection of a specific positive mode, and to move between using both modes.* Below are some thoughts to consider as it relates to the integration, blending, and balancing of the two positive modes of control as goal.

EACH MODE CAN CONTAIN AN ASPECT OF THE OTHER MODE.

Yielding can involve change. Learning the positive yielding mode of control can be understood as essentially developing a skill. For those who don’t use that skill, or haven’t developed it, the process of learning to yield and accept will actually involve *changing* their normal ways of behaving in certain situations.

Change can involve letting go. Just as learning acceptance can be a type of change, change can involve letting go. There is an aphorism that in order to set sail for new lands, you have to be willing to let go of sight of the land that you are leaving. Similarly, if you are swinging from vine to vine, you have to let go of the one behind in order to grab hold of the next one and continue on your journey. Change often involves unlearning (letting go of) old habits in preparation for new growth. For example, think of “negative habits” metaphorically as dead or overgrown branches on a tree. Taking a positive assertive action (trimming the branches, seeing to remove negative habits) involves “letting go” and leaving behind (positive yielding) of that which is no longer useful or helpful. That letting go, in turn, allows for the potential for new buds (and new habits) to grow.

EACH MODE CAN FACILITATE THE OTHER MODE

Change strategies can create opportunities and facilitate subsequent yielding and acceptance. Let’s take an example of people who are constantly doing for others, and not taking time for themselves. They may feel stressed, overwhelmed, harried, and decide that their change goal is to find a quiet, peaceful time each day in which they can “just be”. So, their goal is to find time for non-action and quiet relaxation. This is a positive yielding, accepting goal. However, to achieve this goal, they are going to need to use assertive strategies to set boundaries, and not continue to allow things to continue as they are. Then, of course, they will also need to learn yielding, accepting techniques, such as meditation, relaxation, enjoying without doing.

Yielding and accepting can facilitate subsequent change. Just as change can create an opportunity for acceptance, in reciprocal fashion, acceptance can often lead to positive assertive growth. As Carl Jung and others have pointed out, often the process of change begins with learning to accept ourselves. The first step toward change as we have discussed, involves a clear and honest assessment of where we are (using self-observation and assessment of our Control Profile). This includes acknowledging all the feelings and thoughts that are within us, without defensiveness, distortion, projection, or minimizing

Once we have recognized who and where we are, we may decide that we can “live with what is” and no further action is necessary. Or we may decide that we wish to set a goal of change, and engage in subsequent interventions. As the saying goes, if you are taking a trip from Kansas City to Los Angeles, where do you begin? (The answer is Kansas City—where you are!).

When we recover from a mistake, this again assumes recognizing and accepting responsibility for it-- we have made a mistake, that is where we are. Sometimes the recovery may involve forgiving ourselves (positive yielding). It may then be important to learn from your mistake and practice new skills (mental, emotional, behavioral) to avoid a similar mistake in the future (positive assertive). The goal is learn from and heal the past, where appropriate, but not to be caught by the past.

Likewise, there is the adage, when life gives you a lemon, make lemonade. Again, we might be inclined to initially think of this as a “pure” positive assertive change strategy: we take an obstacle, and transform it. That is true from one perspective. However, often in order to make change, there has to be an acceptance that there really is an obstacle—a rock blocking us; that life really has thrown us a “lemon”; or that we are

lost. This can be especially true—and a critical antidote-- for people with a more “action at all costs” mentality. It can help avoid potential wheel-spinning and acting to keep in motion at all costs: ie, to barrel through the rock, to squash the lemon, and/or, as the adage says, “When you are lost, just pick up the pace.”

In AA “hitting bottom” and learning to recognize and accept one’s powerlessness to make change solely by self efforts is seen as an essential first step. Sinking to the bottom of the well (rather than, as we are falling, madly scrambling to hold onto the sides, or defensively pretending that everything is “under control”), gives us a place to rest and regroup. We may realize that we’ve “taken a hit”, are facing a daunting obstacle and challenge, and that there is no immediate or clear way to proceed. Sometimes it is necessary to accept our situation—that we are at the bottom of the well--not necessarily as a final answer, but certainly in recognition that “this is where we are.” That acceptance can be an important part of a subsequent assertive change strategy.

There is a lovely story that illustrates this approach of surrendering as a step toward more centered action. There once was a seeker after knowledge. One day, he is walking in the mountains, carrying a heavy bundle, when he meets the Buddha (disguised as a poor peasant). The seeker greets the Buddha by saying he has been searching for enlightenment for many years, is frustrated and tired, and wonders if the poor peasant has any advice.

“Put down your bundle,” says the Buddha.

The seeker drops the bundle and in that moment becomes enlightened. He recognizes the essential need to trust in the universe, to let go of his burdens, even the burden of seeking, of trying to change himself and the world, and to just accept what is (positive yielding mode). With that, he recognizes the Buddha. After a pause, the recently enlightened seeker says, "What do I do now?" to which the Buddha responds, "Pick up your bundle and continue your journey."

Pausing, dropping the bundle, and accepting where we are, (positive yielding) can then lead to regrouping, and subsequently forging ahead, finding new direction, being resilient, committed, and determined to overcome difficulties to make successful changes in our life (e.g., positive assertive mode).

EACH MODE CAN BE USED TO ACHIEVE THE OTHER MODE

Yielding and letting go can be a strategy to bring change. There is a story told of how to catch a monkey. You place a banana in a container, the opening of which is large enough for the monkey’s hand to enter. Once the monkey closes its hand around the banana, however, the opening is too small for its hand to exit. The only way for the monkey to escape is to open its hand and let go. This principle is similar to the party favor in which you stick your fingers into each end. If you pull, the “trap” only gets tighter. To escape, you have to let go in order to free yourself from a situation in which you are trapped by holding on and grasping. These letting go stories are also similar to the ones we discussed in Module One—1) Lao-tzu’s “way of water” accepts the rock, gently flows around it, rather than confronting it head on. But water eventually wears away the rock by yielding to it! 2) The heavy snow breaks the large unyielding tree branches, while the smaller, more flexible limbs yield and bend with the weight of the snow, allowing it to fall to the ground without harm to them.

Think in your own life about ways in which a yielding, accepting mode of control has been, or might be, helpful in providing you more freedom to bring about the change in your life that you desire.

Efforts to change can bring letting go and acceptance. Sometimes, as noted, the positive assertive mode is needed in order to achieve positive yielding. Individuals may need to be assertive and set boundaries on others (positive assertive) in order to create the space and time for engaging in positive yielding (e.g., practicing meditation). Further, sometimes having tried the positive assertive mode first helps us feel more comfortable with subsequently turning to positive yielding. For example, feeling that we have done everything we could through assertive action and efforts at change can often help us feel more willing to embrace the yielding mode

As an example, suppose someone has a physical limitation/challenge which is not changeable (e.g., deafness in one ear). The person comes to realize that there is nothing that can be done, and so he resigns himself to the situation. This is positive yielding--to a certain extent. The person has to overcome self-pity, feeling a victim, and acknowledge that the deafness is “what is.” Once having accepted “what is,” the question is might it be possible to turn that deafness into a challenge to be embraced and overcome, which would allow that person to move on to develop other strengths and gifts (positive assertive): e.g., to become an exceptionally good listener with the one ear; to train himself to be particularly adept and sensitive to the use of colors. By adopting this positive assertive strategy, this person may be able to subsequently reflect on his deafness, and become even more accepting of this “limitation”—seeing it in a new light: e.g., because he lost part of one sense—hearing--, he may feel he became more skilled in another—visual; or he may create a story of the one-eared person who learned to be an exceptionally astute “listener” to himself and others.

Through the positive assertive action, as well as cognitive reframing, we may **evolve a control story, and create meaning** about a difficult event that makes it easier for us to understand and accept it. These control stories and narrative meanings can include feeling that the tragedy or difficulty we have encountered is something we learned from, helped us refine and reprioritize our values, become more empathic to others’ suffering, and in other ways influenced us to become a better person.

Thus, just as yielding and accepting can lead to change, it’s also possible that if you choose the assertive path, it may ultimately bring you back to greater acceptance.

THE TWO MODES CAN BE INTEGRATED SIMULTANEOUSLY.

Let’s say you have the goal of wanting to lose weight (active control) but find yourself impatient and not wanting to follow through on a gradual diet and exercise plan. You want to lose weight and lose it NOW. It’s possible that learning to accept yourself as you are may allow you to foster greater patience and a more realistic assertive plan, so that change can be experienced in a slow, peaceful way.

In this weight example, as in other areas in life, we certainly have a right to ask for and work toward obtaining what we want (positive assertive) but we may not always receive it (an outcome for which we may need positive yielding and acceptance). A simple example of this can be found in sports such as golf: you hit the ball the best you can. This is a positive assertive act. But from that point forward, what happens to the ball

is out of your control. This is where positive yielding is important. So too in other aspects of life.

If you are having an interpersonal conflict that is a concern, it is possible to execute the positive assertive mode flawlessly and competently, and still not get the effect from others or the world that you wish. Others, after all, have their own agency, desires, and goals: i.e., you can lead a horse to water but you can't make him drink. Therefore, sometimes it will be important as part of our goal that we want to learn to accept the possibility that even our best positive assertive efforts may not bring the results we want. Similarly, as in the weight control example above, you may want the yielding accepting mode as a context, so that you become less attached to the fruits (outcome) of your actions: i.e., I will do the best I can, and accept that's all I can do. Sometimes we feel we must act (positive assertive), even if there is little hope of success. For example, there are teachings that say that, even though we may not be able to solve the world's problems, we need to take some actions toward trying. As the Bhagavad-Gita advises, one should "be non-attached to the fruits of one's actions." All we can do is the best we can. The outcome is often out of our control, and an important skill is learning to accept with equanimity that which we cannot control, even as we try to the best of our ability to effect that outcome.

The quality of acceptance/yielding (i.e., allowing things to be as they are from a serene, peaceful core) can help one to navigate through challenging times of change and transformation. Bringing an attitude of inner peace and serene acceptance to the process of change can be helpful, particularly when one is finding that the changes he or she is embarking on are difficult.

A NOTE ON ACCEPTANCE: Two models. Just to ensure clarity, there are two models of acceptance. One model of acceptance, the most "radical" definition (and position) of acceptance is to accept what is, regardless of *what* that is. We accept, as part of the "big mind," feelings and times of chaos and lack of active control, just noticing what is. We observe with as spacious a mind as we have, negative assertive and negative yielding feelings and thoughts. This radical acceptance is perhaps most fully embodied in the practice and attitude of mindfulness meditation, which includes accepting when you are being non-accepting. It is *not* making an effort to "drop the bundle" and "let go of thoughts." Rather, it is just noticing whatever is, and accepting that. It is "Shoot first, and whatever you hit, call it the target." Whatever comes up is what comes up and that is what is.

A second model, a more "change-oriented" type of acceptance is *learning* to be more accepting. This model may be thought of as along a continuum. Rather than acceptance being an "all and everything" proposition (as in model one), it may be better characterized by stages along a continuum. (Note, this is assuming the person wishes to learn to accept—and does not address Kubler-Ross's "earlier" stages of denial, anger, bargaining, depression, "before" acceptance).

The first stage is to recognize and accept what is: e.g., a negative thought, a judgmental attitude, a "poor choice." But rather than stopping there, the next step would be to evaluate whether there is a way to learn from and address what is in a more skillful way. Would it be possible to "let go" of the negative thought and replace it with a positive one, a willingness to change your thoughts and feelings from those that are

harsher and more judgmental, to those that are kinder, more compassionate and gentle. In this model as we have noted acceptance can be a context for, as well as a facilitator of, change.

Finally, along this continuum, it should be noted that acceptance is not an all or nothing proposition. For example, the lowest level may be simple recognition and goal setting: is there a willingness, eventually, to come to peace with your circumstances? “I don’t like this. But this is what is and there’s nothing I can do about it. I have to learn to accept it.” Other levels may include: “I can tolerate this”; “I can face this”; “I can live with this”; “I can be ok with this.” “I hope to learn to accept this situation with some serenity, and until then I can accept it realizing that I’m not yet perfectly serene or at peace.”

The highest level along this continuum is calm acceptance with serenity. This level allows a more complete living in the here and now. For example, research shows that in terms of accepting death, the sooner parents whose children were dying of cancer accepted that the child would not recover, the more they enjoyed their final months with their son or daughter.

Thus, there are two different models of acceptance. One is to accept whatever is, including when you’re not being accepting. The other is acceptance as a goal, and is an evolving proposition along a continuum.

WISDOM REVISITED.

Wisdom to know the difference refers to when to have the goal of the courage to change, and when to have the goal of serenity to accept. As we have seen, in Control Therapy, interventions, Phase Two, follow from Phase One: Assessment the goal(s) selected. Thus, there are times when the use of a specific mode of control as a technique is clearly the best match for a particular person with a particular concern, Control Profile, and goal: i.e. when the goal is “courage to change” or the “serenity to accept” then the five step technique intervention process for learning either change techniques or acceptance techniques separately can be utilized, as we have detailed above in the intervention section..

Sometimes, however, the best wisdom in terms of a goal, is not an “either/or” choice between the modes, but some combination, integration, and balance between them. In that regard, it often takes courage not only to change, but also to accept. Similarly, there can be serenity in acceptance, but serenity can also be part of the change process. Thus, the two modes do not need to be separate. Sometimes wisdom involves knowing how to integrate, balance, and synthesize the two modes. When the goal involves some integration of the modes, then appropriate techniques that involve integration can also be utilized.

INTEGRATING THE MODES: EXAMPLES OF TECHNIQUES.

The material that follows begins with a simple example of using both modes of control. That is followed by several examples of mode intervention technique integration: cognitively, (including affirmations and the idea of finding the best possible response for a given situation—*dongjing*); as well as integration techniques at the body level, and interpersonally.

Positive yielding and acceptance of “what is”: ***Looking for positive assertive actions and attitudes.*** Sometimes addressing a difficult situation involves integrating the modes in order to gain or regain a sense of control.

To take a relatively simple example, imagine for a moment that you get aerobic exercise by jogging, but you can't run because of an injury. Under these circumstances, it is important to acknowledge that you are hurt, and can't run. rather than trying to push it through (negative assertive). It is important not to hide from and deny adversity, to pretend it doesn't exist. Rather, we need to be willing to acknowledge what we are feeling (in and through)—upset, frustrated in some situations, saddened, grieved, even devastated in others. Facing and feeling the emotional turmoil is an important step, rather than just trying to “put on a happy face,” saying, “Don't worry, I'll be fine.” It may mean taking time to rest, restore, and heal (positive yielding). In these situations we need need to recognize what is-- “accepting your limits” and the current situation--.

From the place of acceptance, you can then seek alternatives “around the mountain” (positive assertive). This involves developing a core mental/emotional strength, where we don't catastrophize, panic, or become unduly alarmist, even while recognizing where there is cause for concern, as well as feelings of grief and sadness. This attitude is not the same as giving into hopelessness and helplessness, or indulging a sense of powerlessness —poor me, why me? Rather, it is working toward not being overwhelmed and incapacitated by these emotions.

It may also mean actively seeking out alternative methods that might help to maintain control. In the aerobic example, that might mean swimming and biking (positive assertive). When facing adversity, part of good control-related coping is to address the specific tasks that are under our control-- what we need to do on a content level, the tasks that need to be dealt with. For example, people who interpret difficult economic situations as a challenge do better than those who only stay focused on how bad things are and how helpless they feel.

Further, it is important to minimize unhelpful “leakage” from a domain of concern to other domains. For example, in the aerobic situation described above, you may feel as if everything is out of control because you can't run, but on a content level, it is important to focus not only on what isn't working (a body part) but also to remember and focus on what is working (e.g., other body parts, your mind, your work, your relationships, etc). The same is true when the “work” or any other domain is an area of concern—try to keep that one domain from leaking into the other domains.

Conversely, we also want to make sure that we keep the other domains “as healthy” as possible to support and help the domain of concern. So, when you're going through a stressful experience (e.g., a rough economy), you would want to make sure you

try to eat right, exercise, and get enough sleep so your body supports your coping efforts; be open and attentive to friends and family so you are able to receive relational and social support; and focus on meditative or other mental strategies to relax and calm your mind.

Cognitive affirmation examples. Below are cognitions that integrate active and yielding modes that can be used as interventions to achieve various clinical goals. These can be taught to the client, and modified as appropriate given the nature of the client's area of concern and goal. As we share them here, let me invite you to notice the effect these cognitions have on both your mind, and your body/feelings. These cognitions can be proactively stated on their own, or as responses to replace "negative" thoughts. For example, a negative thought might be as follows: "My progress is too slow; I must see more results." Here is a possible replacement: "I'm learning to accept myself as I am" (Quadrant two, positive yielding). "Even if progress is slow, it is only making me better (Quadrant 1, positive assertive). Here is a different example of a negative thought: "I am a victim" (Quadrant Four, negative yielding); and a positive replacement: "When I was abused, it was not my fault. I *was* a victim. But I'm now an adult; I've accepted that I can't change the past (Quadrant Two, positive yielding) but I am no longer a victim. I'm a courageous survivor who will not allow myself to be treated disrespectfully" (Quadrant One, positive assertive).

slide

- I will do my best (positive assertive) within my limits and abilities.....and that's all I can ask of myself (positive yielding).
- I'm learning to accept and forgive myself when I'm not as accepting as I'd like to be. Yes, I do fall off the path, lose a perspective, and get upset about not being able to control things that I know are not that important. I'm a work in progress. And that's ok. I am also resilient enough to get back on the path, gently and firmly, after I become aware of my lapses.
- Through creatively and wisely using the positive assertive and yielding modes in combination, I trust and believe that, in facing a difficult, challenging situation or circumstance, there is a way for me to gain or regain a positive sense of control. I have a choice about how I respond and react, behaviorally, emotionally, and cognitively, including the control stories and meaning I create to understand the situation.
- Even as I work on making changes in one area that feels out of control (positive assertive), I realize that there are many areas of my life where I already have a great deal of personal control. By also choosing to focus on these, I'm learning to feel grateful for what is working in my life, as well as developing the courage and confidence to believe I can be effective in addressing new areas of concern where I'd like to make changes.
- I am learning to do for myself as best as I am able (positive assertive), and am learning to accept help and guidance from others (positive yielding). No one can do it for you, you cannot do it alone.

- I fall off the path a thousand times, the trick is to get back on the thousand and first time. (This affirmation emphasizes non-defensive acceptance of limits—both in developing the assertive and the yielding modes—and willingness to keep trying--positive assertive).
- I am learning to accept my limitations and mistakes (positive yielding), learn from them (positive assertive), to forgive myself and others (positive yielding), and move on (positive assertive or positive yielding, depending on the definition of 'moving on').
- I am developing flexibility and balance to use and integrate both modes of control.
- When a door closes, a window opens. <This statement can be used to create positive yielding and acceptance in the here and now, while focusing optimistically on healing, change and positive opportunities for the future.>
- Wisdom is learning to get what you want (positive assertive) and want (be grateful for) what you have (positive yielding). <Or, in the words of the Rolling Stones, "You can't always get what you want, if you try, sometime you find you get what you need": i.e. sometimes it can be helpful to learn to be open to what life gives us, accept and learn from it.>

End slide

The Technique of Dongjing (Finding the best assertive/yielding response for a given situation). Sometimes the best response for a given situation is not EITHER an assertive/change mode OR a yielding/accepting mode, but an integrated combination of the two modes. A helpful way to teach this idea of integration to clients is to work with their preferred representational system (visual, kinesthetic, cognitive) and match your teaching style to that system.

Below we give an example of such an integrative teaching. Interestingly, in the English language, there is no one word that encapsulates the concept of this integration. But in Chinese there is. The word is *Dongjing*. *Dongjing* is a marvelous word, the equivalent of which does not exist in the English language. It means finding the perfect proportion of yin (yielding/acceptance) and yang (assertive/change) for a given situation. There are three intriguing aspects to this word. First, the word is based on the assumption and belief that if we come from a centered place (i.e., *xujing*), we can always find the exact right response. That belief can give a sense of control and self-trust. Secondly, having a word in the language embeds the idea of looking to integrate the assertive mode and the yielding mode in the culture and in people's psyches. Finally, the idea of *dongjing*, the best possible *response* in a given situation, shows how closely *mode intervention* is tied to *mode goal*. As you will note in the following discussion, sometimes by laying out different intervention possibilities, we help refine and clarify what our goal is in the situation, as well as the best way to achieve that goal.

Matching explanation to client style. There are several “metaphors” that can be used to help understand and achieve the wisdom of finding the right alternative for a given situation. The therapist should work with the client to help them pick the metaphor that best fits with their preferred “representational” way of learning.

- For those who are more visual and spatial, the idea of “blending paints” may be helpful e.g., red (assertive) and blue (yielding) to get to get just the right shade of color e.g, purple). Or the classic yin/yang Chinese symbol  can be used, with the white representing yang, assertive and the dark yin, yielding, accepting. For a more assertive action, imagine the white sections growing larger; and conversely, for more acceptance, imagine the dark sections growing larger until the “best” integration for a given situation is reached.
- For those who are more kinesthetic, the idea of balancing hot and cold water coming from a shower to get the right temperature; (or think of Goldilocks and the three bears: one porridge is too hot, one too cold, and one just right!)
- For those who are more analytical, and value linear/ cognitive, verbal explanations, the actual concrete use of “dongjing” can be helpful, discussed below.

Dongjing may be understood as representing several possible alternatives from a maximum of yang/assertiveness to a maximum of yin/acceptance. When confronted with some situation (from embarking on an exercise program to bringing up a sensitive issue with another person), it can be a helpful exercise to imagine what the maximum positive assertiveness (perhaps bordering on negative assertive) and maximum yielding response (perhaps bordering on negative yielding) would look like. Middle response would be more balanced (assertive and yielding).

An illustration of creating dongjing options: Poop-- The Tao is in the excrement. To discuss more refined gradations of the dongjing model, let us use the "form" or example, of a person who is causing us some grief. First, we would want to mindfully notice this issue, develop xujing, a centered stillness. This task involves recognizing and reflecting on (a) the issue that wobbles us; (b) why we are wobbled; (c) seeing the issue in perspective and centering ourselves.

The second task is dongjing, Which of the various response options feels most right to you in your situation? Choosing the optimal yin/yang, assertive/yielding mode for the situation, involving gradated options in tone, voice, and action. This task involves recognizing our own personal dynamics, such as a fear of being too passive (quadrant four), or a fear of being over-controlling and unkind (quadrant three) as discussed in the “Control Mode Dialogue.”

Let us suppose the specific issue is how to share with someone that their dog is pooping on our flowers, in the yard where our children play.

From a still calm, void place, we can then layout our dongjing options. Below, in a simplified version of classical Chinese philosophy, we represent maximum assertiveness as three solid bars and maximum of yin/acceptance as three dotted bars.

There are eight possible combinations of gradation. <The controlling, most important line is the bottom one, then the middle, then the top, as will be seen by the examples below>

The bars are only meant to be tools. Some may find them helpful. One advantage of them is that they help clarify the construction of small increments of response. Others may find a 1 (maximum yielding, accepting, yin) to eight (maximum assertive, change, yang) to be too complex. Further, depending on whether you are more visual or kinesthetic, gradation in other modalities could be developed.

Laying out the model as shown in the Figure below this provides up to eight potential groupings from which to decide on the best calibrated response for a given situation. Once we have laid out the options, we can then decide which of the various responses feels most right in this situation, That will be influenced by the frequency of times we have previously made a request, our views of the seriousness of the issue, and the nature of the person to whom we are making the request.

If an imagined response feels too yielding/passive, this model can help us see what would it like look if we added one more yang bar. If it feels a bit harsh, we can imagine what it feels like if we take away a yang bar and add a yin bar. Going through this process offers the highest likelihood of expressing the kind of skillful action and wisdom most appropriate to a given situation—no more “yang” than is needed for a given situation and with the best possible centeredness and caring context. The therapist can work with the client in Control Mode Rehearsal to explore refined and nuanced ways of integrating the two modes for their own particular area of concern. might apply to your own self-management project?

**EXPLORING BLENDED OPTIONS OF ASSERTIVE AND YIELDING:
XUJING AND DONGJING**

From Constructivism in the Human Sciences, Vol. 8 (2), 2003

The Tao is also in the Excrement: A Dongjing Example.

- 8 MAXIMUM YANG (Three solid bars)
 _____ DOG WASTE MUST BE PICKED UP FROM THE AREA
 _____ WHERE OUR CHILDREN PLAY. IT IS NOT SANITARY; THE
 _____ LAW FORBIDS IT; WE WILL PROSECUTE. CLEAN IT UP!
- 7 YIN ____ ____ WE KNOW YOU WANT TO BE A RESPONSIBLE PET
 YANG _____ NEIGHBOR, THEREFORE WE STRONGLY
 YANG _____ REQUEST THAT YOU CLEAN UP AFTER YOUR DOG
- 6 YANG _____ WE APPRECIATE YOUR KIND ATTENTION
 YIN ____ ____ TO CLEANING UP AFTER YOUR DOG'S
 YANG _____ WASTE. PLASTIC BAGS ARE PROVIDED.
- 5 YIN ____ ____ YOUR EFFORTS TO HELP KEEP OUR CHILDREN SAFE AND THEIR PLAY AREA HEALTHY
 YIN ____ ____ ARE MUCH APPRECIATED. THANK YOU FOR PICKING UP AFTER YOUR DOG, AS THE
 YANG _____ RESPONSIBLE AND CONSIDERATE PET OWNER WE KNOW YOU MUST BE
- 4 YANG _____ WE WANT TO ALL BE PEACEFUL COOPERATIVE NEIGHBORS, SO WE WOULD APPRECIATE
 YANG _____ IF YOU WOULD HELP US OUT BY PICKING UP AFTER YOUR DOG. WE'D BE HAPPY TO
 YIN ____ ____ DISCUSS THIS WITH YOU IF YOU'D INTRODUCE YOURSELF TO US. PERHAPS WE COULD
 BETTER SEE EACH OTHER'S PERSPECTIVE

- 3 YIN ___ ___ FLOWERS ARE BEAUTIFUL. DOGS ARE LOVELY PETS. HOW CAN WE BE OF SERVICE IN YANG _____ HELPING YOU ENJOY YOUR DOG; AND HELPING US KEEP OUR CHILDREN'S PLAY AREA YIN ___ ___ FECES FREE? YOU PICK UP? WE PICK UP? WE PROVIDE DOGGIE BAGS? PLEASE HELP US WORK TOGETHER SO THAT ALL MAY LIVE IN HARMONY
- 2 YANG _____ WE LIKE DOGS, FLOWERS, CHILDREN. WE KNOW IT MUST SEEM LIKE A SMALL ISSUE YIN ___ ___ AMIDST THE WORLD'S CRISES, BUT WE'D GREATLY APPRECIATE YOUR CARE AND YIN ___ ___ ATTENTION TO YOUR DOG'S WASTE, WHICH YOU MAY NOT REALIZE IS BEING DEPOSITED IN OUR FLOWER BED, WHERE OUR CHILDREN PLAY
1. MAXIMUM YIN (three yin broken bars)
- ___ ___ ALL IS PART OF THE TAO. CHILDREN LEARNING TO BE
 ___ ___ AWARE AND WATCH WHERE THEY STEP IS AN IMPORTANT
 ___ ___ LESSON. DOG WASTE IS FERTILIZER TO CREATE MORE
 FLOWERS. DOING NOTHING IS LIVING IN HARMONY, NO
 REQUEST, NO PROBLEM.

ADDITIONAL INTEGRATIVE TECHNIQUES: Body and Interpersonal

Note to lecturer. Below is a body example of integration (hatha yoga), as well as several interpersonal examples (yoga dyad exercise, tai chi dance, interpersonal four mode dialogue). If the lecture has time, or there is a workshop component, these may be enjoyable and interesting to have the audience do (the hatha yoga as a stretch break; the interpersonal exercises in dyads). These examples can help a client learn the integration of the two modes at a visceral body level, as well as practice the integration in challenging interpersonal situations. Here we merely present the techniques as useful learning interventions. However, as part of Control Therapy, the wise therapist would want to explore how they would fit for use with a particular client with a particular control profile and specific goal.

A body example. (What follows is how therapist could present this material to a client, or the lecturer to the audience): Here is an example of a technique, hatha yoga, involving the body that “embodies” the integration of both modes. This technique gives you an opportunity to experience at a body level the integration of the two modes. As you practice the exercise, note what you are feeling in your body and in your mind.

As you begin to experience the integration of the two modes through this exercise, I invite you to consider how such an integration of change and acceptance working together might be applicable (as metaphor and as experience) in other areas and levels of your life: e.g., learning to become more centered even while actively trying to make changes?

Yoga (hatha). The practice of accepting and changing simultaneously is embodied in hatha yoga. We will discuss one yoga posture (asana), as a way to share the principles of acceptance and change involved in the practice. Often a yoga posture begins with lying flat in shavasana (the corpse position). There one practices diaphragmatic breathing, just being quiet and accepting.

At the start of the yoga posture, (a seated toe-touch described in detail in Appendix 3.17 of the Control Therapy Training Manual), on the out-breath, *slowly* begin to stretch into the posture, leaning gently toward your toes. On the in-breath, relax, hold

your posture, and re-center. On the next out-breath, allow yourself to gently continue the stretch again (positive assertive) a little further.

Note here the importance of stretching slowly and gently. If you push too hard (negative assertive), your muscles, rather than relaxing into the posture, and stretching more, will actually overstretch, then reflexively tense and pull back.

On the next outbreath, seek to stretch a little further, while realizing the goal is to remain calm and centered, and learn what the limits of your stretch are. Again, pause on the inbreath, relax, center, maybe do a body scan to see where there is tightness, and breathe into that area. If you have hit your edge, return to the shavasana (corpse), lying-down posture, and allow a few more diaphragmatic breaths. You will notice that with practice, you may not only increase your stretch, but also do so with equanimity.

If at any point during the exercise you feel yourself getting frustrated because your limbs don't stretch as far or as much as you want them to, don't continue to push and struggle harder. Rather, just notice your thoughts, and go through a gentle breath cycle.

Through this process, you can learn what your outer "edge" is at the present moment, minimizing injury to yourself while also maximizing the potential you have for growth. The process teaches us how to set goals, and also how to let go and surrender. We come to realize that in order to change, we don't need to be hard on ourselves or not accept ourselves (e.g., we don't have to hate our body, or be angry at it, in order to improve it). It can be both/and: desire to change and grow, and a context of acceptance, caring, and compassion. The goal here is to learn to stretch, change, and grow in a positive assertive way (quadrant one) while keeping the equanimity and self-acceptance of the quadrant two, yielding mode.

Interpersonal examples. Next are two interpersonal body exercises—the yoga dyad and the tai chi dance—and one “four mode dialogue” that can be experienced as ways to integrate the assertive and yielding modes. As you practice these exercises, try to notice two things: 1) how the two modes work in concert with each other; and 2) how these exercises might be helpful to you (and/or your clients) in integrating the two modes in interpersonal relationships.

For example, as you think about your own life on the interpersonal domain in general, are there “control” issues that you notice? Do you sometimes feel that you are giving more than receive? That external demands of others are limiting the time you have for taking care of yourself? How much helpful guidance and a sense of control do you feel you can and do receive from others? The first exercise, the yoga dyad, addresses issues of receiving and giving energy—both giving to others, receiving from others, and giving to ourselves.

Again thinking about interpersonal “control” issues, do you sometimes notice that you have “control” battles with others over a myriad of different content issues? Do you sometimes feel the other person is being too pushy and demanding? That you are? Do you sometimes feel too passive? How much active control do you believe you can and should have over others? This second exercise, a tai chi dance, explores a way in which each person can be both “assertive” and “yielding” at different times, as part of a contextual harmony. We first present this dance as a body movement, then add a “verbal” component to show how it can be used in addressing “disagreements” “negotiations” and “conflict resolution.”

These exercises can be helpful when there is an interpersonal component to a client's concern, and may also be useful as one more way of understanding and experiencing the integration of the two modes.

Yoga Dyad Exercise. Find a partner and stand facing each other, feet shoulder width apart, knees slightly bent, arms at your side, palms facing your partner,

elbows straight. Now, as you take an in-breath through your nose, slowly bend your elbows and raise your palms toward the sky, until they reach waist level. As you do so, imagine and feel yourself receiving energy. Now, turn your palms outward (toward your partner) and let your palms touch—and imagine and feel yourself giving the energy you have just received *to* your partner.

(During the first round when you do this, it's helpful to focus at the point primarily on the giving of energy to your partner. In the next round, it can be helpful to focus primarily on the feeling of receiving energy *from* your partner (even as you are giving energy to your partner), In the third round, you might try to experience both at the same time!).

Next, while you take another in-breath, raise your hands, fingers pointing to the sky (right hand at two o'clock, left hand at ten o'clock), palms facing each other. Again, feel yourself receiving energy, breathing through your nose. Now, turn your palms toward yourself, cross your wrists at face level (so both palms are facing you), and give energy to yourself as you let your crossed wrists slowly go from your face over your heart, down across your abdomen, and let your arms once again return to your sides.

Now repeat the exercise two more times, with slow, gentle breaths.

Discussion. At the end of the three cycles, take some time to process with your partner what you experienced. In this exercise, what did it feel like to give energy to another; to receive energy from another? To self-nurture by giving energy to yourself?

This exercise teaches us about receiving and giving energy. All of us need to receive energy—from our biological breathing, from others, from the universe*. Some people are more “takers” who need to learn to give to others. Others give too much; they need to learn to receive and give to themselves. This exercise offers a nice balance between the two.

In your own life, where do you believe you fall on the continuum? What are ways you give energy to others? Receive energy from others? Give energy to yourself? This exercise can be thought of in relationship to “others” ranging from your significant other, friends, community, society, and the world and environment around you.

Tai Chi dance.** Stand facing a partner, your right feet adjacent, and your left feet placed behind your bodies. The right hands, palms open and shoulder height, are also touching, but not too tightly, as if they are holding a piece of Kleenex between them. One person starts, pushing forward with the right hand (assertive mode) while the other lets their hand yield. The one in active control has the responsibility to listen to the

* This exercise can be done in and of itself, independent of its original cultural context. Depending on your view of the nature of the universe (see Control Therapy Training Manual, Module Two), it may be helpful to know that the word yoga means “union” (with the Divine). Another variation of this exercise involves receiving energy on the first in breath from “Mother Earth”; and during the second in breath from “Father Sky” (borrowing from the Native American tradition). You may wish to practice this exercise incorporating this variation, to see what it feels like to receive (and give) feminine and masculine energy.

** * As in an “Individual” Tai Chi form, the weight is evenly balanced on the balls of the feet, with a focus on the *dan tien* energy center below the navel. In individual tai chi, as you begin doing a “form,” the body weight slowly shifts from one leg to the other and the hands go through different motions (representing different combinations of yin and yang). If you interested in learning tai chi, an excellent practical book is Douglass, Bill (2002), *The Complete Idiot's Guide to Tai Chi and QiGong*, 2nd edition; Alpha Books: Indianapolis, Indiana); see also the superb overview by Jou, Tsung Hwa; *The Tao of Taijiquan*, Tai Chi Foundation, Scottsdale, Az. 85254.(89th printing, 2001)

partner, so when the partner gently signals they have yielded to their comfortable limit, the energies shift and the yielding hand begins the assertive mode, gently pushing forward; and the one who had been in active control moves into the yielding mode.

This process teaches trust and communication in a physical way. It allows us to see what it's like to work with another, to be the leader (who is attentive and listening to the receiver); and the follower, who accepts direction while knowing that at any time s/he can become the leader.

Once you have experienced this “dance” several times so that you are comfortable with the non-verbal process, a “verbal component” can be added. This verbal component can be about a topic or concern under discussion, such as each person's preferences or viewpoints about a topic of concern. While moving her hand forward, one person says, “Here is what I'd like (or my preference, or my point of view).” (If there is no specific issue being discussed, such as in this dyad exercise, the verbal statements can be done generically just for practice). The other person receives this message, kindly hears it, paraphrases it, (e.g., “I hear that your preference (viewpoint, concern) is that....”) Is that right? as he moves his hand forward and seeks clarification and corroboration. The first person acknowledges that she has been heard, while moving her hand forward, adding any additional details as need. The second person then states his feelings and desires as he moves his hand forward and she receives his message, concern, point of view. She then becomes the leader, paraphrasing and seeking clarification of this perspective. This cycle, done within a context of caring and partnership, illustrates the yin/yang energies of assertive and yielding interpersonal dancing for the benefit of both.

Discussion. After the exercise, spend some time discussing how it felt to lead (and listen); and how it felt to receive. What were your limits of acceptance - how far back would you allow your hand to go? When did you start to feel the need to shift? When you did shift, how softly and centeredly were you able to do so? Did you notice some desire to push strongly, to make sure your partner understood you wanted to shift the mode? How receptive was your partner to the energy shifts? How receptive were you?

This exercise helps demonstrates the utility of the positive modes in relational trust and intimacy - connecting with a partner as an I-Thou rather than I-It – as well as a way to negotiate and dialogue about different points of view while staying connected, and having anchor points through which trust can be built (e.g., I hear your perspective, here's my perspective, I see it somewhat differently---versus “you're wrong!”—which, in tai chi dance terms, would be a strong arm push).

Please take a few minutes to discuss how and where the lessons from this exercise might be applied to your own life.

Interpersonal four mode dialogue. In addition to the tai chi dance above, another helpful way to explore the mode process that may be occurring interpersonally during a conflict or “control battle,” and to help each person hear more clearly each other's perspective, is to have each person engage in a dialogue (modeled after the control mode dialogue) where there are four chairs, each representing one of the quadrants.

If a person is feeling “bullied” they would take *the negative assertive chair*, and talk to the *negative yielding chair*, sharing all their feelings from that perspective, talking to the quadrant four, negative yielding chair: “You're so

passive, you never go along with anything I suggest. You're always resisting my ideas."

Then the partner who is being accused of being too bullying would sit in the negative yielding seat, talking to the negative assertive one: "You're always trying to bully me into doing what you want. You never let me make any of the decisions."

After each partner has had a chance to show they understand the other person's viewpoint, they each take turns in the positive yielding, then in the positive assertive seat, sharing how they would like to be addressed, and act as if they are speaking to a "beloved" who is on the same team. In this way, each person hears the other person, and both contribute to ideas of how to positively address a conflict, a seeming "control battle."

CT posits that interventions for both change and acceptance can involve others and self as agent. Interventions can also focus on others and self as the "object" of the intervention. However, even when an intervention involves "other" as the object of control, we may also need to work on ourselves as additional "objects" (i.e., self-control of our mind, body, emotions).

Note to Lecturer. The above material has provided three specific interpersonal integrative examples of the assertive/change and yielding/accepting mode. The material below follows by providing a further discussion of the integration of self and other, both interpersonally, and in terms of self-control. It also discusses how both modes can be facilitated by self and other as agent. This is a good place to share this material if there is time. Otherwise, the lecturer may choose to move on to the next section, on the Component of the Systems' Model of Control Therapy.

INTEGRATION OF AGENCY:

Who is the agent and who is the object of an intervention?

Further integration and discussion.

The tai chi dyad dance above is an interesting example not only of integrating the assertive and yielding modes, but also of integrating agent and object of control. Recall that we first addressed this topic in a Table discussing the seven groupings of agent and object of control. Both in goal setting, and in intervention selection, it is important to know the agent and object. The therapist and client need to work together to decide and be clear regarding with whom the client is intervening. For example, if the client's goal is to lose weight, then the client is both the agent and the object (i.e., self-control). If the goal is interpersonal (change your spouse's negative comments), the primary point of intervention is the "other"—getting someone else to behave differently.

Recall the Venus de Milo joke — the importance of not asking something of someone else that they are not capable of doing or giving. In that situation, the "object" of the intervention may not be only the other person, but also the client themselves, who may need to find other ways to get their needs met.

This may involve teaching clients to manage their reactions if their goals are not met: e.g., we can make wonderful changes, say things kindly and courteously, and our spouse may still say mean things, and /or not accede to our request. In these circumstances, we would need to manage our thoughts and emotions, and to curtail inappropriately negative comments. Thus, the self would be both agent and object, both seeking to work on and improve the relational context.

Integrating Self and other as agents in meeting our goals. We've also explored—recall the Odysseus example and Huston Smith's discussion of self and other power: i.e., that there are views in which both self and other can be "agents" in achieving our goals. For example, this principle can apply to situations where the goal is to let someone else take charge (to yield to the other as agent). If we let go of control in an area (i.e., let doctors treat the cancer; let God carry out His/Her will; asking for help in caring for a loved one) then we are teaching ourselves to manage our discomfort about depending upon someone else. We are choosing (self-control) to give up some active control, and to yield. Again, we are the agent (the one who accepts help, who dares to try something scary) and the object (recipient of that help), even if the other is also an agent in the situation.

As an assertive example of this, let's look at the above example of trying to change a spouse's negative comment, in which, clearly, part of the "object" of the intervention is the spouse. But, as noted, it is only because of the relational context that we undertake such an effort. Further, as we've pointed out, part of this intervention also involves self: self as agent, and self (behavior, mind, emotions, attention, cognitions) as objects: —teaching ourselves to manage our emotions, speak from a centered, firm place, and request positive behavior from the spouse. This is standing up for one's self, asking for what we want, speaking from an attitude of strength and being grounded.

Think how these examples apply to our ongoing discussion of "Who or what controls your life?" We have suggested the paradox: *No one can do it for you* (i.e., you have to take personal responsibility for your choices and actions) *and you cannot do it*

alone (we are part of a web of life, with which others are intimately connected). It's both/and.

Working on both/and. The tai chi dance is one example of consciously working on that both/and. Think for a moment about the shift between agent and object manifest in the tai chi dance and the lessons that can be learned from this movement. In part of the dance, you are the self who is the agent, pushing forward assertively. Yet even as you are this self-as-agent, you are listening respectfully and carefully to the other person (the object of your control efforts), and pushing in a way that is calm, careful, gentle (utilizing self-control: self as agent, but also self as object). Then, the other person, who has been yielding, lets you know they want to become the agent of control. Then, from their perspective, you become the “object” of their assertive control efforts. But it is also true that for this shift to occur, you need to utilize decisional control, and make a choice to move to the yielding mode of control with calmness, grace, and serenity (self-control, with you as agent, you as object). You also know that when you feel you have yielded as much as you are willing and able, you can once again shift the modes and the agency. Thus, when you are the agent of control, the “object” is *both* the other and your self. And when you are the object of another's control efforts, you are also the agent and the object of your own control efforts.

It is important to learn to become conscious of how we treat and act toward the “other” or object of control—whether that object of control is another, or ourselves. Can we keep a contextual, compassionate kindness, even when we are sharing in a firm, confident way our goals and desires?

Learning from others, learning from self: Who we surround ourselves with. To paraphrase a teaching from one of the classical Buddhist texts, it is said that there are two types of people in the world. When you are around one type, you feel a lack of energy, tired, contracted. When you're around the other type of person, you feel light, energized, and joyful. The text says that we can learn lessons from both types of people. That means we don't run away from difficult people, blaming them for our problems. We stay as long as we need to see what we can learn. But once we have learned our lesson from those who “deplete” us, it is time to thank them, say good-bye, and then surround ourselves with those who have positive and supportive energy.

Each of us needs to become aware of situations and people that cause us to feel uncomfortable, depleted, more “out of control.” One example might be in a relationship with someone who makes “demands” on you that you are not able or do not feel capable of fulfilling (cf the Venus de Milo statue in the joke). When your body feels tight or constricted by what someone has said, take some time later to examine their speech--what did this person say and explore why it bothered you. Did you feel heard and understood? Did you feel belittled and criticized? Did you feel the other person overreacted and shut you down? Was there a lesson in the interaction that *you* could learn—not just about the other person, but about yourself? About how you reacted? Or about what you might have been able to do more skillfully? What might this person have to teach you as a life lesson, just by being in your life, no matter how difficult that lesson might be to receive?

The text suggests that once you have learned the lessons that this type of person has to offer you, it may be time to move on, and to find people who do not treat you in ways that are disrespectful and depleting.*

Interestingly, the text goes on to say that both types of “people” are also within each of us. In other words, there is a part of us that depletes us, and a part of ourselves that energizes us. Again, we don’t want to “run away” from these parts of ourselves. We can learn lessons from both parts of ourselves. But once we learn our lessons from those aspects of ourselves which are not being kind, compassionate, or helpful to us, it is wise and skillful to say good-bye and let it go, instead filling ourselves internally with more positive, wholesome aspects of self.

Praise and criticism: Self and other. We have spent considerable time observing and assessing how we talk to ourselves, and exploring ways to “talk” to ourselves that are helpful, including self-evaluation, goal-setting, self-instructions, and affirmations. One of the most important aspects of our “self-talk” is how we praise and criticize ourselves. Supportive comments and constructive feedback are also essential aspects of interpersonal relationships.

In Module Two, we suggested monitoring ways in which you prefer to be reinforced and praised (including verbal and non-verbal). Here we explore some general guidelines that may be helpful regarding verbal praise and constructive criticism. We discuss these in terms of interpersonal relations, but they also apply to individual “self-talk.” Ask yourself, how do you feel about giving constructive criticism to others? Receiving constructive criticism from others? Giving global praise to others? Receiving global praise?

Global Positive. Relationally, most of us like to receive global praise (“You are wonderful.” “I love you so much.” “You are such a special, amazing person”). We like to feel accepted contextually and non-judgmentally as we are, a quadrant two positive acceptance. Global praise is good for this purpose. It is praise just for “being”, and allows us to feel accepted and loved for who we are “as is.” These kinds of remarks help create a positive context for relationship, feelings of safety, security, and love.

Specific Positive. Research has shown that specific (in contrast to global) praise can be helpful for encouraging and rewarding efforts to learn new tasks as well as praising successful specific actions and/or quadrant one positive assertive change. For example, rather than say, “You’re a good boy (global praise) for raking the leaves (specific action),” you’d want to say, “Thank you for raking the leaves. That was really helpful.” Or “I admire the way you are sticking to your exercise program” or “Thank you so much for listening to me so carefully. I really feel heard.”

Specific Criticism, not global criticism. Although receiving “negative” feedback, no matter how nuanced and calibrated, is never much fun, there are ways to do it that can increase the chances of its being well-received and heard.

* This “wisdom teaching” can be meant literally and/or metaphorically. We may not always want (or be able) to literally walk away from difficult people. But, after we have learned our lessons from those who are not “nourishing” to us, we may want to create some emotional and interpersonal distance (including forgiveness), so that we don’t get stuck in unhelpful patterns that don’t any longer have something to teach us.

First, it should be noted that *global criticism* is not helpful and should be avoided (e.g., “you are horrible”; “you’re a mess”; “you’re such an angry person”; “you’re so selfish”). Secondly, it can be helpful to context the criticism. Lloyd Homme suggested the “sandwich” technique: saying a positive, then the negative feedback, then another positive in conclusion. Third, the negative feedback should be specific. For example, “I feel sad when you turn away and begin watching TV when I am talking to you. I wonder if we can discuss this.”

So, putting all these ideas together, an example of effectively giving criticism and feedback might be as follows: “I really enjoy the times when we share with each other. You are my best friend. (Positive). Sometimes it seems we aren’t communicating as well as I think we can. For example, I feel sad when you turn away and begin watching TV when I am talking to you. I wonder if we can discuss this. I bring this up only because I feel so close to you and hope you know how much I adore you.”

WHAT IS YOUR VIEW OF OPTIMAL CONTROL? AND OPTIMUM BUILDING BLOCKS TO ACHIEVE IT?

If I had an hour to solve a problem, and my life depended on the solution, I would spend the first five minutes determining the proper question to ask....many people are looking for answers and not asking the wisest questions.

--Einstein.

This lecture opened with an invitation to

Think of times when you have had a positive sense of control in your life,, and then asked the question:

What does a positive sense of control feel like? How do you “know” it? In your body? Your thoughts? Your feelings? Relationally?

Now, as we move toward the end of the lecture, it's worth taking a moment to explore a refinement of these questions in a bit more detail.: namely, what is your view of optimum control in each of the different domains; and what is your view of optimum building blocks to achieve it? The answer to the first question we might consider the goal, or vision; the answer to the second is the means to achieve the goal.

Note to Lecturer: you may wish to refer briefly to the Domain and Building Block figure on p. 119.

OPTIMAL CONTROL WITHIN AND ACROSS DOMAINS

Consider what it would be like as a goal to have an optimal sense of control (and optimal control in terms of the modes and agency) in each of the different SCI domains. What would optimal control be like for you in the body domain; mind (thoughts, attention); emotions; and relationally? Which building blocks would be most helpful to you in achieving these optimal goals? For example, how much of an optimal sense of control might come from having the flexibility to use positive assertive (change) as well as positive yielding (acceptance) strategies depending upon the particular situation and circumstances one is encountering? Would an optimal sense of control come from knowing how to access both self and other agency, again depending on circumstances? Because Control Therapy is based on an education model, these questions are interesting both in terms of your view of what might be possible in therapy for your clients, but also what might be possible in your own life.

Having some sense of what optimal control is in each domain helps determine which building blocks, modes, and agency can best be utilized as interventions toward those goals. Below we raise questions about optimal control in each domain.

Body domain. How much positive assertive/change mode is possible and desirable in the body domain: e.g., change through exercise, healthy eating, self-care, flexibility exercises, strength training; how much is positive yielding/accepting needed to achieve an optimal sense of control: e.g, appreciating who you are: height, eye color, body type ; trusting the body's natural wisdom to “breathe.” Regarding stress, when

might we want to increase our positive stress (eustress): excitement, focus, arousal; and when might we want to learn to relax unnecessary tension? How might the two modes of control best blend and balance in dealing with Buddha's messengers of illness, aging, death? How much involves self-control, how much support and help from others?

Mind domain:

Thoughts What would optimal control be in terms of your thoughts: how much would optimal control involve changing your thoughts to gain a greater sense of control? How much would optimal control involve learning to just “notice” and accept your thoughts with bare awareness? When are your thoughts a strength? When troublesome: e.g. overthinking?

Attention. What might optimal control of attention look like? Might this involve examining where we focus and how we focus (depending upon the situation)? Might we want to have different attentional skills to draw on in addressing problems: e.g., precise self-observation; being able to set a goal; non-reactive mindfulness—being able to rest in the here and now, to not be always “trapped” by goals set.

Emotions. In considering emotions, how much is it wise to just notice with bare awareness and not reactively accept different emotions, how much and when is it wise to learn to change (increase, decrease) certain emotions in more skillful ways? When might you experience too much emotional reactivity; when not enough emotional expression? When should you trust emotions (e.g. the heart is better than the head), when are emotions not as trustworthy (e.g., the head better than the heart?) What might be optimal emotional control with different emotions: e.g., fear, love, anger.

Relationship Domain. Regarding control and relationships a cute cartoon shows the Venus de Milo (the armless statue of the goddess) and a person standing next to it saying, “The one thing I really want from you is a hug.” This is a humorous statement that can be used to help clients understand one aspect of negative assertiveness in relationship – always asking for what the other cannot provide. More broadly, how much does a close intimate relationship involve accepting and loving the person as they are; how much does it involve working on shared growth and change to reach one's full self and relational potential? What is involved in an optimal relationship in terms of addressing “control issues” and decision making styles; “tai chi dancing” with communication styles in a context of love? How do the two modes integrate and balance in love and intimacy?

Self. In your view, how important for a vision of optimal control is the development of a “competent and special self” capable of self-determination and mastery? Are there ever times that the “self” might get in the way, when it would be optimal to “let go” of trying to be the competent and special self?

Self and other agency. What might you consider the optimal continuum between self and other agency? Do the following seemingly paradoxical lines help or confuse in thinking about this topic:

” No one can do it for you;
you cannot do it alone?”

Kipling said: If you can trust yourself when all doubt you, but make allowance for their doubting, too.” Recall also the Odysseus tale about self and other control; as well as the discussion of self and other power by Huston Smith regarding spiritual and philosophical traditions. Here is one thought regarding the above lines. See if it makes sense, or how you would create a personal optimal balance regarding self and other agency:

“No one can do it for you (i.e., we have to take responsibility for being aware, for making choices, for choosing our goal, for exerting the discipline and skill within our capabilities and potentials); and you cannot do it alone (there are times when we need to recognize our interdependence on others and seek “a little help from our friends”).

INTEGRATION, BALANCE ACROSS DOMAINS.

How might all the different domains relate for you in the scenario of “optimal control?” Might there be optimal control in each, as well as integration and balance across each? Ah, why not, it’s our vision! However, as we know, this may not “always” be the case! On the positive side, sometimes when things are going well in one domain (e.g. a positive sense of control in the body domain) that might enhance the sense of control in the relationship and work domains. At other times, when one domain (e.g., the work domain) is not in control, it may be important, as we previously discussed, to “wall it off” so that the feelings of loss of control there don’t leak into other domains, affecting in a negative way the body, mind, or relationship domains. Also, it may be important to find a domain or area that you can control in difficult, and challenging times. For example, you may not be able to control the situation, but you can learn to work on controlling your breathing, choose where you focus your attention.

Thus, might the concept of “working toward optimal control” involve both how to best integrate different domains (e.g., work, relationship, private self <body, mind, emotions>) and have them work together while also knowing each domain in and of itself?

For those who want more reading regarding optimal control in each domain, please see the Chapters in Control Therapy on “Beyond Normal: Toward Optimal Control and Psychological Well-being (Chapter 5); Control and Physical Health: Coping, prevention, and wellness, including the further reaches of control and the body (Chapter 6); and Control and Healthy Relationships (Chapter 7). Also, in the Control Therapy Training Manual, Module 3.3 (198-213) On Optimal Control in body, mind (attention, thoughts); emotions; and relationships

Two Bonus Questions regarding sense of control. The question we opened this section (and lecture) with was when have you had a positive sense of control in your life and how do you “know” it (in your body, relationally). Let’s flip the question, and ask, when things are not under control, how does that feel, and how do you know it? Some people report cognitive distress, a sense of racing thoughts, feeling overwhelmed, helpless or having too much to do. Others experience a loss of control primarily somatically...” etc.

One strategy for dealing with the dysphoria of things (and our self) sometimes not being in control is to create a soft, compassionate container of a “witnessing mind”—in other words to just notice “things do not feel in control now. Sometimes a helpful way to

start the process of regaining a positive sense of control is to honestly and clearly and softly acknowledge that things aren't in control, using an expansive mental strategy such as mindfulness meditation, which we have previously discussed, and a couple additional strategies/stories, which we discuss below.

Generally, the way people answer these questions about loss of control and the suggested strategies we have developed fit our theory and postulates. We like the feeling of a positive sense of control, and when things are not under control, it feel dysphoric. Fortunately, there are skillfully ways to gain and regain a sense of control.

Bonus question one: Ok, now for a bonus music-based question. Janet Jackson's song "Control" fits our model of control:

*I don't wanna rule the world, just wanna run my life Ooh
So make your life a little easier
When you get the chance just take
Control, ooh ooh*

But how about the The Pointer Sisters song "I'm so excited"?

*I'm so excited, and I just can't hide it
I'm about to lose control and I think I like it*

In your own life, think about times when you may have felt you have too much control. Likely this involves some aspect of "negative overcontrol": e.g., micromanaging, too much responsibility, too many decisions; maybe even feeling trapped by always trying to be in control (including of one's self, one's mind, one's body, healthy eating, etc). Have there been times when you have lost control and "kind of like it"? Short term? Long term? Are there healthy and unhealthy ways to "lose control"? Could it be that "losing control" when looked at in a more refined way, means letting go of the assertive change mode, and "just allowing", acting "spontaneously," "going with one's impulses," a Q2 playfulness? Can there be any negative consequences to this loss of control? (ie., in retrospect, some aspect of negative yielding?) Are there healthy ways you've learned "let go of active control" and "drop the bundle," to "just be"? What are ways you give yourself permission to healthily "lose <active> control"? Do these involve positive yielding?

While reflecting on this question, think about a) how your response relates to your view of "optimal control" (the purpose of this section); and b) how your response might fit into your own refinement and thinking about a theory of human control.

A second question involves the sense of control achieved from "pushing the envelope", seeking challenges vs. liking comfort, safety, and security. You'll note on the SCI that one of the questions to rate is "I seek risks, excitement, adventure." Another is "I like things around me to be ordered and dislike ambiguity and the unknown." In general, which do you prefer? Can you see that different people could gain a "sense of control" from either one? Could a person who endorses the first phrase feel "trapped" and confined by situations which appear too ordered, safe, and routine? Could a person who endorses the second feel "out of control" by too much activity, lack of structure, risk taking? Are there positive as well as potential downsides to each? Could each be part of the same person, though in different degrees? Again, as in the above bonus question, how does your reflection on this question a) relate to your views of optimal control (for you); and b) how would these different styles fit into your own refinement and thinking about

a theory of human control?

WHICH BUILDING BLOCKS ARE TRUSTWORTHY, WHICH TROUBLESOME?

We have discussed different building blocks that can be used to create an intervention. As we have seen, for both your client (and yourself), there may be preferences for different building blocks. It is important in the process of therapy, and personal self-reflection as well, to begin to understand when different building blocks are trustworthy for you, and when they are not. This material is covered in some detail in the Control Therapy Training Manual, Module 3.3, pages 213-234) and includes topics of the body, mind, attention, emotions, and other: when each is trustworthy, and when troublesome. Here we give just a few examples.

BODY.

Trustworthy. Sometimes the body is wise and can be incorporated into an intervention as a helpful building block—such as the natural bodily wisdom of diaphragmatic breathing. It can be helpful to learn to accept and trust the body’s natural wisdom as a way to develop a calm, centered body. When we are awake by “getting out of the way” and letting the body just “breathe itself”—trusting the body and allowing and accepting breathing.

Troublesome. However, do you find times that your body does not feel trustworthy? For example, sometimes our body feels “tired” and doesn’t want to commit to a program such as exercise. Further, while there are times when signals we receive from our body are helpful in terms of correctly identifying hunger, at other times we may need to override and distrust those signals, both in terms of what we’re hungry for (e.g., thrice daily chocolate!) as well as other substances—smoking, certain drugs, immoderate use of alcohol—that the body may “crave” but that may not be in the interest of optimal bodily control and well-being. Whereas sometimes the cues from the body are too strong, at other times we may inappropriately “cut off” from our bodies cues, and need to pay greater attention to hear them.

Help from other building blocks. In each of the above examples, the body, rather than being a building block, may be a “domain of concern” and we may need to use other building blocks to address the problem: e.g., our mind (attentional focus, decisional control, self-instructions), our relationships (for reminders and moral support), and our emotions (feeling proud when we resist an unhealthy choice).

THOUGHTS.

Trustworthy. Have you noticed times when your thoughts were wise positive cognitions helped you override negative bodily cues? For example, sometimes we have a reflex bodily physiological “fight” response when driving: e.g., when someone pulls in front of us without using the turn signal. Our mind, however, may be able to tell us that this isn’t an emergency requiring “fight”. We can use our cognitions to change our bodily feelings (and our emotions). We might be able to pause, interrupt, and even change the physiological response and potential emotional sequence. We might imagine, for example, that the person is rushing home to a sick child. These thoughts may help “calm” our initial “fight” reaction. Or we might say, “Let it go. I’m safe, s/he’s in a hurry,

I'm not, that's not the type of person or energy I want to engage with." The Dalai Lama says he always tries to give the benefit of the doubt to the other person, to choose to think thoughts of compassion for that person who is in such a hurry

Troublesome. On the other hand, sometimes our thoughts may not be helpful. For example, are you aware of times when cognitions didn't seem to work well for you, or even had the opposite effect? This phenomenon has been referred to as the law of reverse effects. For example, for the next five seconds, "DON'T think of PINK ELEPHANTS." 1...2...3...4...5. What did you notice? The very thing we try not to think about, we do. The same thing can happen when someone is trying to lose weight. To say, "Don't eat that last donut!" may only make that person want it more. "DON'T think about those luscious thick gooey chocolate éclairs you shouldn't eat!" may not be the best diet-control strategy.

What are other examples of when your thinking process may not be in your best interest—e.g., black-and-white thinking without nuance? Irrational beliefs? Unfounded beliefs? Negative thoughts? (vs negative evaluation). As discussed in *Precision Nirvana* (pp. 202-203), a negative evaluation is a judgment made where action can be taken; a negative thought is continuing to think unhelpful thoughts when no action is planned or possible and, even though there is nothing you can do about a situation, you continue to rehash it without making any progress). Have you been able to identify situations where you sometimes overreact cognitively: making a speed bump in your life into something much more serious—i.e., catastrophizing, making mountains out of molehills? In these instances where the "mind" is troublesome, there are certain strategies that can be used, including help from other building blocks.

Help from other Building Blocks. In the above pink elephant/éclair example, sometimes we need to draw upon other mental strategies—e.g., to use a distraction or a competing response technique: such as think of blue squirrels; think of the éclairs as some odorous foul smelling excrement, or think of a beautiful beach where you are doing yoga! With these types of strategies, you would be using mental building blocks of decisional control (deciding that you want to build a distraction technique), plus attentional focusing, and visual imagery.

When we become aware that our thought patterns are troublesome, we can use several different building blocks, as suggested above in the discussion of the law of reverse effects (with pink elephants and éclairs) (and as we have also discussed in the previous section under *Dealing with Negative Thoughts* (see Step Four, *Yielding Mode*). To briefly review, a body building block can help give us a stable firm posture; or we can use the body and exercise, such as a brisk walk or jogging to "clear our mind."

Attentional techniques that we have discussed, such as mindfulness and self-observation, can help us observe our thoughts. We can then use thought-stopping techniques to notice, dismiss and let go of negative, unproductive thoughts. We can distract ourselves by looking at a pretty flower or imaging a positive visual image. We can repeat a cognitive mantra to replace/block the thoughts.

We can develop positive affirmations to replace the negative thoughts. As we have noted, these can take the form of the positive yielding mode: e.g., I'm doing the best I can, feel gratitude for what you have,--count your blessings, put things in perspective: e.g. "It's not worth going there, and getting caught up in a briar patch." Replacement

cognitions can be based on the positive assertive mode: taking doubting or pessimistic thoughts and using them as cues to develop positive, affirming ones: “Stick with it, it’s worth it; you’re making slow, steady progress. No success is ever attained without effort and risk. You’re on the right path.” Affirmations can also be integrative, combining positive assertive and positive yielding, as we discussed earlier in this section: e.g., I’m doing the best I am able to make changes (positive assertive) within my limits and abilities.....that’s all I can ask of myself and I can feel proud and accepting of where I am now (positive yielding).

We can turn to others for guidance, feedback, and wisdom to see where there may be “faults” in our thinking and control stories (such as defensiveness, inappropriate rationalizations, denial, self-deluding thoughts). This may involve, as noted above, developing and rewriting an alternative control story narrative.

Further, as previously discussed, depending upon belief systems about the nature of the universe, some may turn to the spiritual to address negative thoughts, including prayer, asking for guidance, and expressions such as “God loves me, God is holding me” or “trust the Tao” depending upon beliefs.

EMOTIONS AS A BUILDING BLOCK.

Trustworthy. Have there been times when you have had a “heart reaction” or an emotional intuition and it turned out that it was “truer” and wiser than your thinking processes, and you wished you had (or were glad you had) followed it? How comfortable are you in trusting your emotions in your decision making? It is helpful to explore carefully when your emotions have been trustworthy, and are helpful as building blocks for the other domains.

For example, positive motions can certainly help cultivate commitment and adherence to exercise programs in the bodily domain; and love, joy, forgiveness can certainly enhance interpersonal relationships. Anger, sadness and fear can be helpful warning signs that a problem is occurring that needs to be addressed. Although some many people might call these “negative” emotions, if we look at them with bare awareness, these emotions are telling us we’re not in control—that some aspect of ourselves or our lives feels out of control. These “negative” emotions can be understood as a “wake up call”—to look, see, and investigate what’s going on. Though they may cause us to feel vulnerable, they are also telling us that something needs to be attended to.

From this perspective, emotions can be a motivator cue that something needs to be attended to, and also a motivator to do something to address a situation. . In this way, negative emotions too can become part of the building blocks of an intervention. Finally, we have explored in Section One of Module Three how emotional self-regulation can be a helpful building block in developing both the positive assertive and positive yielding modes of control.

Troublesome. When have you noticed that your emotions can cause difficulties? Although emotions can be a cue that there is a problem, think in your own life whether there have been times when your emotions (e.g., anger, stress, fear, jealousy) may have overwhelmed you and made it more difficult for you to act as wisely as you would have liked? Are there times when you have created “more heat” than “light.” When emotions rather than bringing clarity, have clouded your judgment?

Have you ever experienced a lack of trustworthiness in your emotions? For example, have you ever had the experience of not being hungry (e.g., bodily wisdom), but you ate anyway—for emotional reasons? There can be times when the wisdom of our body is overridden in an unhealthy way by our emotions.

Have you ever noticed this emotional “untrustworthiness” in other domains and situations as well? For example, do you sometimes notice that you have an emotional reaction that seems out of proportion to the actual event (e.g., impatience while waiting at a stoplight or for an occupied bathroom at a restaurant, or in line at a store)? The emotions can then “drive” your thoughts—e.g., this is taking forever, I’m in such a hurry, this is unfair. (Those thoughts, of course, can in turn exacerbate the impatient feeling). The point to be aware of here is that emotions can influence what we think, and set off a negative sequence.

Do you take more to heart, or feel more strongly, a mistake or criticism than you do

positive comments? Even though it may be reflexive, is that necessarily a wise or helpful emotional reaction? This is yet another example of how our emotions can create problems for us.

Using other building blocks to help address when emotions are troublesome. CT begins with the premise that “It is important to honestly and clearly be aware of and acknowledge what you are feeling.” We need to be able to observe what we are feeling, without censoring or judging, but rather with openness, curiosity, sensitivity, even compassion.

Awareness. How able are you to stay with and just observe emotions of helplessness, self pity, feeling victimized, anger, rage, jealousy, hopelessness? Observing and being present with your difficult emotions does not necessarily mean “giving into” them or creating cognitive elaborations to fuel them—e.g., allowing one “slight” that makes you angry to remind you of other slights, exacerbating anger; or having one “loss” remind you of other losses, deepening sadness. Nor does it mean identifying emotions only to dismiss or suppress them. Rather it means actually seeing and recognizing what is there, neither running toward it, nor running away from it. This “mindful” approach allows all emotions, with their nuances and gradations, to be seen clearly, as in a mirror: i.e., what is. This attitude is helpful in developing an attitude of “curiosity”—“Let me just explore what’s going on, what this feels like,” getting to know your emotions.

Once you are able to clearly discern “what is,” the next step is to evaluate whether you want to stay there. To answer that question involves the building block of awareness—recognizing when certain emotions are helpful and when they are less trustworthy. We may also recognize through this observation the process by which we can create unhelpful (and often endless variations) of stories to “feed” and “fuel” our unhelpful emotions.

Once it is determined that there are unhelpful emotions (and resulting stories), interventions can then be used to express, transform and/or accept the emotions in question. Interestingly, through this process of just “observing” and learning about our emotions, we may come to the realization that although we tend to feel our emotions will last forever, usually they don’t, particularly if we are able to observe them directly at the “root” level beneath the story-telling. Often, after a time, feelings pass away or transmute into other feelings. Sometimes the very act of mindful awareness can be

curative in this regard Mindfulness meditation has been compared to a “global” desensitization, where, in a relaxed state, the contents of “whatever is on one’s mind” arise and are just observed.

Additional Building Blocks. At other times, the process of working with difficult emotions can build upon attentional observational techniques, and continue through self-evaluation, goal setting, and finally adding further building blocks as interventions. As we have discussed regarding techniques such as the control mode rehearsal, the emotion can be used as a cue, triggering positive modeling (imagery) of how you would like to act and feel; self-instructions (cognitive building block): and physical relaxation (body building block).

This can also be done *in vivo*. To take the simple example of waiting at the stop light, in this situation we may feel impatience. To address this negative emotion, we can mindfully observe our feelings; notice where in our body we are feeling “impatient” sensations and bring body scan attention to relax those sensations; remind ourselves not to let cognitions exacerbate our negative feelings by self-instructions such as “Stop lights never last longer than two minutes. Take this as a peaceful time to pause.” You can add “positive images” by thinking about something pleasant. In this way, building blocks of body and mind (decisional control, cognitions, imagery) can be used to address the emotional impatience.

Sometimes the focus may be on how cognitions exacerbate emotional reactivity. For example, have you ever noticed a bodily sensation (stress, pain) and then became “stressed” about the feeling? What initially might be experienced simply as sensation can become worse as a result of our cognitive reaction and commentary, e.g., “My body’s a mess. Things are completely out of control. What if it never gets better?” Some philosophical and psychological traditions make the distinction between “pain” (a sensation in the body), and “suffering” (emotional pain worsened by cognitions and ensuing heightening of the sensations--, e.g., catastrophic or fearful thinking). In this case, the “story” told about physical pain creates additional suffering, and the attentional and cognitive building blocks, as we have previously discussed, can be helpful as part of the intervention to stop the negative cognitions and reduce “unnecessary” emotional suffering.

ADDITIONAL STRATEGIES ACROSS DOMAINS

One goal of optimal control is to help us learn to keep a perspective, to not get so caught in stories that create unnecessary emotional and cognitive stress. To help us soften our body, cognitions, and emotions, and bring them more “under control” . here are four helpful stories/teachings and a haiku poem from the wisdom traditions Note that visual cues, cognitive ones, and even taste can all be used as teaching tools--as well as “synesthesia!”

Life’s bitterness and suffering: A Zen master story.

A student went to a Zen master, saying how should he deal with life’s bitterness and suffering. The master asked the student to put a handful of salt in a glass of water and then to drink it.

“How does it taste?” the master asked.

“Bitter,” spit the apprentice.

The two walked in silence to the nearby lake and the master said, “Now, pour a teaspoon of salt in the lake, and drink from the lake.”

As the water dripped down the young man’s chin, the master asked, “How does it taste?”

The apprentice smiled. “Much less bitter.”

The master sat beside this serious young man, who so reminded him of himself, and took his hands, offering:

“Pains in life are pure salt; no more, no less. However, the amount of bitterness we taste depends on the container we put the pain in. So when you are in pain, the only thing you can do is to enlarge your sense of things . . . Stop being a glass. Become a lake.”

* * *

What the teaching above shares from a “taste” standpoint, the following two stories utilize visual teachings.

Big Mind game. One variation of mindfulness meditation taught by Joseph Goldstein is the “Big Mind Game” in which through just observing, we can notice the impermanence of thoughts, emotions, physical discomforts—watching them unfold and pass through. In the “Big mind game” we imagine our mind that is “vast like space, where experiences both pleasant and unpleasant can appear and disappear without conflict, struggle, or harm.” (--Majjhima Nikaya). Any feeling, thought, sensation, is merely a star that lights up in the sky. Sometimes we take the star for the sky, becoming caught in the drama of only one story, emotion, sensation, to the exclusion of everything else. Try to imagine your mind as vast empty space, and an issue that is of concern (an itch or pain in the body, a thought, a feeling) as one star in that sky. Just watch it light up with greater or lesser intensity. But while softly noticing, also notice all the other stars. Don’t get lost in any one star (story), just notice the sensation of star, neither running from it, nor approaching it. Allow the mind to remain as a vast, empty sky. When a star lights up (e.g., the work domain), we can notice it without having that star outshine all the other stars. We neither rush toward it or away from it. Rather, we just sit quietly and notice as different stars “shine” and then fade, while trying to keep the still, open expansiveness of the night sky which holds it all.

Golden face of the beloved. There is a beautiful saying by Ramakrishna, an Indian Hindu sage who invited his students to

***Observe the golden face of the beloved rising
over the horizon
of your limited perceptions.***

Try experiencing this statement at a time of “stuckness.” See the “stuck” situation, the one that is your current story, emotion, or thought. Then try to imagine and visualize the “golden face” of the beloved rising over (around, through) that stuckness (limited perception). See if there can be a softening and lightening of the mood, a feeling of hope, optimism and “waking up”---new possibilities.

And a Basho Haiku poem.

Over the darkened sea,
Only the shrill voice of a flying duck is visible,
In soft white.

To instructor, it may be helpful to read the poem once, then invite the audience to close their eyes and to just see what they experience when they hear the poem? After so doing, you may ask:

What were your feelings as you heard it? Any thoughts? Does the poem make sense? Although there is no “right or wrong” here is one way of looking at the poem.

The darkened sea in the first line may be understood as the individual seeing and feeling his/her aloneness in the dark, confusing world we live in, where suffering is so prevalent, we are separated from others, and we need to rely on ourselves to survive. With these feelings, alone by the darkened sea, the voice that is heard is “shrill” and frightening. It is “other” and we need to be careful of those who are “other.”

But then the poem shifts. From the perspective of ordinary awareness it doesn’t make any sense: how can a voice be visible? But in this poem Basho has shifted to a meditative “altered state” of consciousness, an experience of synesthesia, where all the senses are open (like seeing colors while listening to music). When this shift occurs within Basho, the world that he “sees” changes for him. The shrill voice becomes a kinesthetic feeling (soft) and the darkness at the start of the poem shifts to “white” in the last line. We could liken this “soft white” to an inner “purr.”

What this poem elegantly conveys is that there are different “states” of consciousness: an ordinary awareness where we see with our eyes and hear with our ears; and an altered state experience in which those boundaries are more porous. Basho is conveying an “awakening” experience. By a shift in consciousness, there is a transformation in his attitude, the very nature of perception in how he sees and experiences. Basho becomes connected to the world, not afraid of it; fear and shrill becomes soft; darkness becomes “light.” Noting has changed “outside” but the inner changes allows him to feel and see the world in a different light, with a different attitude.

* * *

BUILDING BLOCKS CAN AFFECT EACH OTHER. Although different theorists, therapists, (and yoga teachers) may believe that there is a primary unilateral controlling building block—e.g., body, emotions, cognitions....., notice what your own experience is. As we have seen, sometimes a building block may be helpful to facilitate a sense of control in a given domain; sometimes that same building block may be “troublesome” and itself become the domain which needs to be addressed by other building blocks. As we have explored previously, do you notice that sometimes your thoughts (building block) can be helpful in controlling your body (domain)—e.g., cognitive self-instructions can calm your body? Sometimes it is your feelings that positively control your thoughts—e.g., you have an emotional reaction that you trust more than you do your intellectual ruminations, and you skillfully bring your thoughts into line with your feelings. Do you notice that sometimes it is your body (building block) that is calm and wise (e.g., when you practice diaphragmatic breathing) and helps to settle your thoughts and still your labile feelings (domain)?

Separate and together. Just as in the case of domains, might an aspect of optimal control involve learning how building blocks work both separately, and together? In other words, we might learn how emotions, thoughts, body, attention are connected, sometimes in helpful ways, and sometimes in ways that need to be “uncoupled.”

Parts and whole. You will note that much of the teaching in CT therapy seeks to be sensitive to this issue of larger, integrative perspective (holistic view) and narrower, specific detailed view. Below is an example from Tai Chi, which illustrates this model of learning. At a holistic level, Tai chi involves a flowing, graceful, interconnected, and integrated series of movements. To learn this, one has to learn individual “parts”: arms, feet, balance, eyes, shoulders, hips, etc. Sometimes the practitioner must learn to move different body parts simultaneously in similar directions, sometimes s/he must learn to “disconnect” body parts and move them in different directions (coupled, uncoupled). The interesting “trick” is how to integrate the holistic flow, which is the end goal, with attention specific to specific body parts. Both are part of the learning process, albeit at different stages. As we have seen, the mind’s attentional focus can be both wide angle, and narrow concentrative. There may be individual variation in a practitioners (or client’s) preferences for one style more than another, along a continuum. The therapist needs to be sensitive to the client’s preferences and different styles of learning. Thus, in teaching a new skill to the client, there is always a dance between “holistic” big picture and a “detail” reductionistic approach to learning based on the client’s style.

NOTE TO INSTRUCTOR: Below is a specific example of the interaction and reciprocal influences of building blocks, and their effect on domains. It involves the teaching of “parts and whole”; coupling and uncoupling. Please feel free to substitute any example of your own that you believe helpfully illustrates these points.

A Tai Chi example. The following illustration, drawn from DHS’ tai chi practice, suggests how the different building blocks (body, mind, attention) we have been exploring may affect each other in order to help us gain or maintain a sense of control.*

Expectations, thoughts, before beginning a practice *I’m curious what my body and mind are going to be like during the practice. I’m glad I’m going to be practicing. This is really a time to notice closely how the parts of my body are working and feeling. It’s almost like going in for a lubrication of my joints—I know after I finish they will feel more limber and agile.***

When I notice doubting or tired thoughts that ask me if I really want to practice this week, I thank them for sharing, and then let them go. I tell myself that I know that the exercise, once I start, will propel me forward. I also know that after I finish, I always feel better and am glad I’ve done it. I’ve never been less happy or disappointed

* Learning any new skill can be an opportunity to become more aware of “learning how we learn.” For example, in tai chi, the “holistic” flowing motion of each form, for me, was a product of learning movements for individual parts of the body--hands, head, shoulders, hips, feet all doing different things--and then putting them together. This was also a helpful metaphor to see how I seek to create a “whole” from different building blocks, each one both separate and unique, and also potentially able to join and fit with each other.

** One building block that should be stated explicitly at the start of each intervention is a cognitive one: noticing your thoughts and expectations—what you say to yourself right before you begin an exercise.

after doing tai chi. I tell myself I'm lucky I have the time and space to do this, and in such a beautiful setting. (Cognitive thoughts to motivate toward the practice.)

Body building block. Some days my physical balance is lovely, like a gift of grace. I seem to float, effortlessly, my fluidity and centeredness nearly impeccable. My feet feel rooted in the ground for stability, when appropriate, and yet also able to softly and lightly rise for kicks when needed. Weight shifts from one foot to another feel like they are done with the care and precision of sand pouring from one side of an hour glass into the other. This good balance gives me a sense of control on the body level, which filters up to the mind level and indeed to my view of life. (The body building block giving me a sense of control in the mind domain and giving me a sense of my "self" as competent and in control).

Mind building block. Other days, my physical balance is really not good at all, but my mind is still and calm, and my attention focused on the tan tien (energy center below the navel) is clear and consistent. I can observe "body not in control" and still have a general feeling of being calm and in control (The mind building block [attentional focusing, cognitive self-instruction] helping to give a sense of control regarding the body domain).

"Witnessing mind." On still other days my body is not in balance and my mind (thoughts, attentional focusing building blocks) is not calm either, but rather like choppy water, with emotional waves of frustration, anger, annoyance, anxiety, even sadness. But sometimes on those days there is still a "detached" part of me--the big mind game-- that can simply observe "unbalanced body, unbalanced mind" like stars in the night sky. This mindful style of observation—with equanimity—allows me to feel "All is okay, this is just the way it is today," providing a sense of control at a more "meta" level* .

Decisional control: Shifting attention outside the self. Then sometimes, none of the above works. There is unbalanced body, unbalanced mind, unbalanced observer. Everything gets swirled around and I feel like I'm being flushed down a toilet into the sewer!

When that happens, I often shift my focus from myself to what is around me. I feel thankful to be there with my beloved partner (feeling a sense of control from an interpersonal building block). I also focus on the beauty of the natural surroundings, ocean waves, birds singing, the colors of the flowers (using decisional control to shift my attentional focus to other sense modalities - auditory—listening to the birds, the ocean waves on the rocks; visual—watching the seagulls floating and gliding in the wind—and trying to feel that same ease modeled by the birds-- to give a positive sense of control).

Emotional Control. When my mind and body are calm, it helps create a greater emotional equanimity. But emotions and feelings do arise during tai chi. What is interesting is that tai chi (Guang Ping Yang style) has three forms that specifically relate to how to address emotions. The first is "embrace tiger return to mountain." I understand this form as taking the emotional negativity, the "tigers" within me, and

* In Zen it's said that one way to "control a cow is to give it a large field." When I am able to maintain and experience the big mind game—the mind as a vast spacious universe—then thoughts and feelings are merely cows—stars in the night sky to mix metaphors—that are allowed to be present, but don't disturb the surroundings!

“embracing them” with gentleness and kindness, and then returning them to the “sacred” mountain. (Yes, I use Sinai!—cross cultural tai chi!:). For me this helps lessen emotional reactivity. A second, later form is “flee the tiger” and another form is “shoot the tiger.” I experience these as alternative ways to deal with emotion, once you have clearly and compassionately recognized and learned what you can from them. Sometimes you just have to “let the emotion go” (flee it) as it’s not a skillful emotion.. Sometimes you have to give it a “kwat”—a thought stopping “no”—“shoot the tiger.” ☺

Interpersonal: *I learned from teachers, and often while practicing I hear their advice and encouragement, see their grace, as well as feel and remember the camaraderie of those in the class. Sometimes I do the practice alone, sometimes with others, particularly my wife. Doing it with her provides an initial motivation and an enjoyable sense of sharing an experience both during and after the practice.*

Contextual beliefs: Other as building block; Nature of the universe.

Sometimes I find myself gaining a sense of control through letting go of “self” efforts and allowing my self to be held by core contextual beliefs about the nature of the universe. From a non-theistic (Taoist) perspective, I image and experience xujing, the cosmic void of the universe before form, and I realize that all the forms and levels are just “games” that emerge from this void.

At other times what “catches” me is a theistic perspective, remembering a story Reb Zalman Schacter-Shalomi told.

He was counseling a woman and reminding her that we are all children resting in the hand of God. The woman closed her eyes, and tried to feel and experience this. Then, in fear, she opened her eyes and said,

“God just threw me out of God’s hand. Now what?”

*“That’s okay,” Reb Schacter-Shalomi laughed, “Because wherever you land will also be God!” **

* Each person brings certain expectations to learning a technique. And each “teacher/therapist” has certain beliefs about the utility of the technique they are teaching. Thus, all techniques are utilized within a context. An issue that is beyond the scope of this lecture is how important is the original philosophical context in which the techniques were initially formulated—e.g., yoga within Hinduism, tai chi within Taoism and Chinese philosophy, mindfulness meditation within the Vipassana Buddhist tradition. Similarly, some prayers and affirmations may have originally come from monotheistic religious traditions. What can be stated is that the *content* of these techniques (e.g., attentional focusing, cognitive self-instructions, visualizations), can be utilized within a Western psychotherapeutic context and framework. In this lecture, we have noted in each case the content of the techniques and the building blocks that comprise them. However, we are not unaware that the context of the technique—the philosophy, original intent-- can influence their use and meaning. That is why the topic of beliefs about the nature of the universe was discussed in this lecture (under self and other agency) and why in the Control Therapy Training Manual, considerable time is spent in Module Two providing the student/trainee an opportunity to investigate their a “sense of control” own philosophical and therapeutic beliefs about human nature and the nature of the universe.

DEALING WITH ADVERSITY: INTEGRATING MODES, AGENCY, AND CONTROL STORIES.

We have talked about the challenges—setbacks, problems-- during the process of therapy (e.g. the initial reactive effect of self-observation; the feeling that things are “getting worse” when trying to learn a new skill). More in depth discussion on dealing with setbacks can be found in the Control Therapy Training Manual, Module 3.2.

Here we would like to mention several different types of control stories that can help us gain, maintain, and/or regain a sense of control during and after times of adversity. These stories can involve different combinations of integrating modes of control and agency of control.

Positive Assertive Stories. One type of story involves the positive assertive mode. In medical humanities, this is often referred to is a restitution story. We like these positive assertive stories that restore the original equilibrium: individuals overcoming chaos, difficulties, setbacks; fighting their way back to health. These are courageous and hopeful stories of individuals triumphing over adversity and obstacles to achieve success—either through self efforts, other’s efforts (e.g., the Doctor,) or a combination.

Such stories certainly fit with our culture’s view of the self as a “doer and achiever”--indomitable optimism, American individualism, the self- made person shaping the future (and herself!). You can be what you want to be. We resonate with the characters in the Chinese symbol for crisis: danger plus opportunity. Yes, there are challenges and things may be frightening, but we can use this as an opportunity for new growth. It’s not how many times you fall down, it’s how many times you get back up and keep trying. We look optimistically for the silver lining in every dark cloud. A positive assertive control story says that everything is going to be ok, maybe even better than before. What is needed is to keep going forward, not quitting, developing a tough-minded endurance, a quiet strength, an emotional resilience, a persistence, a never-give-up determination.

When a positive assertive control story is not enough.

Sometimes we don’t have sufficient active control, no matter how heroic our efforts, and a loss can’t be restored or can be restored only imperfectly. In these circumstances, we have to acknowledge and to a certain extent accept a “new reality.” This does not mean we don’t grieve and rage. It does mean that sorrow and anger aren’t our final steps. It can be both/and: Feeling the pain, allowing the grieving process, summoning the ability to take that emotional turmoil, grief, and chaos, and channel it productively, changing what we can to go forward, accepting what we must, healing what we can physically and emotionally as best we are able. Successful coping may involve knowing we have done everything we can in an assertive mode, and then it’s a matter of acknowledging that sometimes we’re “in the dark,” that we are tired and need to rest, that there’s nothing more we can do, and we have to trust, hope, wait patiently, allowing healing to occur in whatever form that may take.

Dr. Rachel Naomi Remen tells the story of a talented athlete who developed bone cancer and had his right leg amputated above the knee to save his life. In art therapy, he drew a vase with a black crack in the center, a broken vase

that could never hold water, could never function as a vase again. When he drew the picture his anger was palpable, the crayon even tearing into the paper. During the next two years, however, he began volunteering with other patients who had suffered similar medical events, sharing his experience and working to help them understand and cope with their own losses. In this endeavor, he proved to be quite effective and helpful. In his final session with Dr Remen, he took the picture of the vase he'd drawn two years ago, and began drawing thick yellow lines emanating from the black cracks. When she asked what they signified, he put his hand on the cracks, and said simply, "This is where the light comes through."*

Acknowledging and accepting loss: Stories that create meaning. There are, or will be, times in all of our lives when we can't restore what was through active control efforts--like the young man above who was not able to restore his amputated leg. Then, searching for a positive assertive control story, a literal restitution story, only brings anger and bitterness. What this young man had to do was to experience the chaos and pain— first, to live within a chaos story, where things are not in control at all (quadrant four, negative yielding). He then evolved into what can be called a journey story, in which we come to accept that things have changed forever, and we try to proceed with a curiosity and openness to face the challenge to see where these new circumstances lead us (positive yielding plus positive assertive).

Sometimes that journey story can lead to a "transcendent" story. In the case of this young man, he was able to learn to accept that although he could not restore a specific body part, he could use what he had learned to become a more compassionate person, showing greater kindness, generosity, and empathy to others—letting the light come through. He was able to transcend the specific body domain, take a wider view of suffering, and even at times to touch the sacred. He was able recommit to life, and to embrace a moment of transcendence in his revisioning of the broken vase. Positive yielding involves learning to accept the ongoing or new reality—even if that means acknowledging and directly facing the chaos. Positive assertive involves trying to turn that new reality into something that is positive: e.g., I may not be able to control what happened in the past, but I can create something from the pain and loss of the past to motivate me to do something meaningful and productive in the present, such as helping and giving something of myself to others.

Sometimes control stories are what we use to create meaning out of chaos. A classic and poignant example of this meaning-making occurs in Victor Frankl's book *Man's Search for Meaning*, which chronicles his time in a concentration camp during World War II. Frankl couldn't change the fact that he was imprisoned—ie., the event was out of his active control. But he could change his attitude about the event to create some sense of meaningful order as he envisioned a more hopeful future.

Another such story of meaning-making is told by a family whose daughter had been senselessly and brutally murdered. They created a scholarship in her

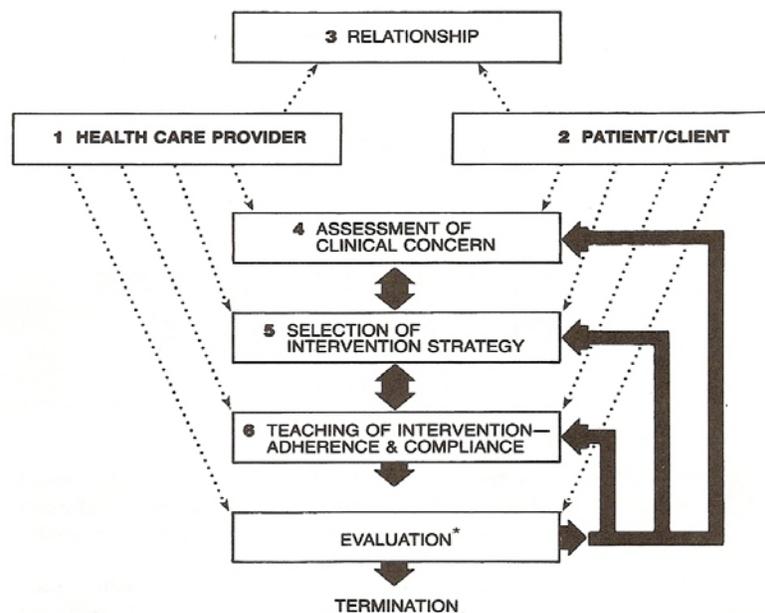
* Rachel Naomi Remen, *Kitchen Table Wisdom*, Riverhead Books New York, 1996, pp 114-118

name to help others, then held an “event” celebrating her life. This family wanted to make sure that they chose the ending of their daughter’s story, that evil didn’t have the last word, that the good and the light of her life could continue to shine. Although we may not be able to control events, we have some control in facing adversity in terms of choosing how we want to create the ending of the story.¹

¹ Some might argue that, in certain situations, acceptance with serenity is not a helpful or appropriate goal.. They may be concerned that such an attitude might lead, for example, to diminishing the connection (and sadness) at losing a loved one. Clearly, each person has to decide for themselves what is the wisest, most skillful way to deal with loss, and to what extent one can “accept and move on” but still do so with compassion and honoring the memory of the person lost. Others might feel that for certain horrific events, forgiveness and acceptance might diminish memories they feel important to keep alive—e.g., remembering the Holocaust as a way to prevent it from ever happening again. Here too, each person must decide whether one can forgive, but not forget; and whether coming to an acceptance of a terrible tragedy necessarily precludes active efforts to ensure it is never repeated.

A SYSTEM'S MODEL OF THE COMPONENTS OF CONTROL THERAPY

Therapy is a complex system comprised of several parts, notably the 1. therapist, 2. the client, and 3. the relationship between them. The client and therapist each bring their own emphasis, perspective and worldview to the therapeutic encounter, and these views in turn exert influences on assessment, intervention, evaluation, and termination. The system's model presented below was developed to help us understand these various components, their interactions, the two phases of Control Therapy; and to provide feedback loops for evaluating when progress is not going as smoothly as the therapist and client would like. The systems model of CT can be used as a framework to deal with "challenges" in the therapy process; including setbacks, compliance issues, client resistances; when client and therapist disagree, as well as to evaluate the process and ending of therapy



This model also helps us explore the question posed by Paul noted earlier: *What* specific treatment, by *whom*, is most effective for *this* individual with *that* specific problem and under *which* set of circumstances? Thus far we have discussed in some detail how to assess the client's perspective (component two); the assessment of clinical concern (component four); the nature of interventions (component five). Here we discuss the therapist (component one); the relationship (component three); provide more detail on matching and teaching control enhancing interventions (components four and five) including a discussion of when client and therapist disagree (e.g., on assessment of clinical concern, goal, selection of intervention) and then discuss the evaluation feedback loop. (More detailed information on each of the six components can be found in the book *Control Therapy* Chapter 8 and the *Control Therapy Training Manual*, Module 4.)

THERAPIST/Health care provider.

Let's start by raising questions which might be helpful in having the therapist reflect about their views and beliefs about control, as well as their "control style" in therapy. The therapist is a central component of the therapeutic process, and the therapist's beliefs have a significant influence on therapy. Just as the client needs to develop awareness of his/her "control style, beliefs, and dynamics" so does the therapist. In the context of Control Therapy, here are some important questions that the therapist can profitably reflect on related to their own beliefs, dynamics, control stories, including your views about the efficacy of self-regulation strategies.

Questions for therapist self-reflection about control. These questions explore therapist self-knowledge of his/her own control profile, desire for control level, preference for self and/or other agency, preferred modes of control, and control dynamics and stories. For example, How comfortable are you as the therapist with the concept of control? What domains do you as the therapist personally struggle with related to issues of control? How high is your desire for control In areas where you have less control than you would like? How would you try to address those domains?

Here are some other questions that may be worth reflecting on related to you and your client :

- To what extent do you as a therapist, believe there are techniques which can help an individual learn skills to more effectively take responsibility for, make choices about, and regulate their thoughts, feelings, behavior? How much does that view vary across client? Across clinical concern?
- What are your feelings about the effectiveness/desirability of
 - the assertive/change mode of control?
 - the yielding/accepting mode of control?
 - do you have a bias toward or against either the accepting mode or the assertive change mode?
- Is it better, in general, to rely on self or others as the agent of control? For you? For this client?
- How much will-power and self-control do you have? Would you like more, or less? How well are you able to practice self-control strategies? How do you feel about others who seem to have more (or less) self-control than you?
- If you, the therapist, are personally skilled at using self-control strategies, how do you feel about a client who isn't that effective? How do you deal with your own frustration and feelings of lack of competence at having someone not learn these skills as quickly as you believe they should? If you aren't able to use self-control that effectively in certain areas of your own life, how do you feel about your efficacy in teaching, and the client's efficacy in learning such strategies?

- What is your view of the use of medication in relation to self-control? Do you feel it can help a person gain increased control? When might it be appropriate? When not? If there were research showing that either medication or personal control enhancing strategies (if practiced) would work equally well (e.g., in OCD, to address diabetes, heart disease), which would you recommend—for yourself? For your client?
- How much desire for control in general do you have? You client? Have you had experience with “challenging” clients in which there are potential “power struggles” and control issues—e.g., transference, countertransference? How can you most effectively address those?

Therapeutic goal: Addressing symptom “versus” underlying issue? Your view . What is your view of a client’s presenting problem? Different schools have different understandings: e.g., is it a symptom of something else; an indirect sign, a direct sign; important in and of itself?

Control Therapy does not accept, as the existentialists have suggested, that every concern is really an underlying fear of death; or that every relationship issue is really a fear of our ultimate existential loneliness. Existential root issues (e.g., facing mortality, addressing loneliness, seeking to find meaning) are clearly control-related concerns that all humans face, and try to gain a sense of control about in their own ways. If a client enters therapy wishing to address such root issues, of course they can and should be the focus of the clinical work. Further, CT does not assume, as do some classical Freudians, that every issue is only a symptom of a deeper problem, and is best seen as an indirect sign to help identify an underlying “cause.”

Nevertheless, both these schools of thought contain important insights, which CT incorporates. For example, it can be important to look “beneath” the content area when a) the client has success in one area, but is still dissatisfied; b) the same type of content issue continues to surface, even after the initial one is addressed c) the client rejects all interventions and insists there are no content solutions to the problem (whether change or acceptance), and/or d) the client’s affect is out of proportion to the content area being addressed; e) if content issues cannot be successfully addressed as initially conceptualized.

NATURE OF THERAPEUTIC RELATIONSHIP.

The specific questions above leads to the larger question about your view about the role and nature of the therapeutic relationship. What are your views about what type of therapeutic relationship is most helpful? How you see your role as therapist will depend upon your theoretical orientation, including your view of the client (personality theory), and the nature of the clinical concern. It is important to explore your view of the therapist’s role as clearly and completely as you are able.

Each system of psychotherapy has a viewpoint. Classical Freudian id psychology felt the therapist needed to be a detached observer, who would, when appropriate, confront the patient in order to overcome resistances. If you believe in a psychodynamic worldview, you may believe that there are amoral internal forces as well as other inner dynamics of which the client is unaware. Your task is to help them overcome their

resistances to seeing what is going on within, and become more aware of their intrapsychic processes.

Client centered approaches, believing the person is innately good, offer non-judgmental warmth and accurate empathy, so the clients can uncover who they already are. For example, if you believe in a “humanistic” transpersonal orientation, you may feel that the person already has the answers within her, and your “job” is merely to remind her of that fact. “You know what to do. Trust yourself and look within. The wisdom is already within you. I’m just here to encourage and remind you.”

If you believe in an existential, behavioral world view of human nature, then you may see yourself as a “coach.” Existentially, it may not be your “job” to provide answers, as much as help them develop strategies so they can come up with their own answers, and take responsibility for their own choices. answers and choices in life (existential). Existentialists highlight the importance of authentic, mutual relationships, viewing clients as fellow travelers on a journey. Behaviorally, if you see patterns that don’t serve the client well, or skills that they are lacking, then you may believe that part of your “job” is to bring these issue to your clients’ attention, and help provide them the insights or skills that are needed. Cognitive-behaviorists often see themselves as coaches, teaching new skills.

Control Therapy, there may be a place for all of these relational views and skills, at different points in therapy, and depending upon the client. Sometimes we may need to reinforce and honor a client’s innate self-worth (Rogerian warmth, empathy, validation); sometimes, teach new skills (cognitive/behavioral coach); at other times, share authentically about the mutual journey (existential); and at still other times, be willing to work skillfully, even assertively, with denial and avoidance. Control Therapy would suggest that none of these positions need be mutually exclusive.

For example, the simple act of teaching a simple self-regulation relaxation technique may seem benign to the therapist. However, to some clients, the idea of closing their eyes in front of a relative stranger may feel threatening. Therefore, developing trust and openness through careful listening skills, cultural and ethnic sensitivity, and showing empathy is often a critical context for teaching a self-regulation mode of control technique. Therefore “relationship” and “teaching” can be mutually helpful. Further, it is important that therapist realize s/he is constantly modeling for the client examples of (hopefully good) self-regulation and control of behavior, speech, and affect.

Finally, there will be times when the client and therapist disagree. Within a healing, trusting context, it is important that the therapist have a gradated range of skillful responses from positive yielding to positive assertive skills.

Respecting each client’s uniqueness. Control Therapy attempts to provide the client an experience grounded in the clients’ motivation, encouraging their self-exploration, honoring their unique cultural positions and world view, refining and addressing their self-stated goals, and tailoring interventions to help them meet those goals. In so doing, it helps clients learn how to focus on their own thoughts, behaviors, and feelings within the context of their lives and then learn how to positively influence the world and themselves in healthy and healing ways, whether through positive assertive, positive yielding, or an integration of the two.

MATCHING CONTROL ENHANCING INTERVENTION TO CLIENT CONTROL PROFILE, CLINICAL CONCERN, AND GOAL.

We discussed under Phase Two the intervention section of Control Therapy, the importance of matching the interventions to the client’s control profile and goal. That is, of course, critical. We also showed there how different individuals, with the same clinical concern (e.g., cardiovascular risk) could have quite different control profiles, and therefore would need different control-enhancing interventions.

Here, we discuss some additional nuances that can be helpful in the “matching process—both in terms of intervention selection, as well as ways of teaching the intervention.” Specifically, we cover the following: a) teaching interventions congruent with a person’s control profile—regarding agency of control and “freedom reflex; b) matching building blocks to a client’s preferred style. In the following section, we then explore when therapist and client disagree, and when a therapist feels additional techniques are needed that are not as congruent with a client’s style.

Teach interventions congruent with the client’s control profile, dynamic, and freedom reflex. In addition to matching intervention to assessment, it is also important to match, insofar as possible and comfortable for the therapist, the intervention in a manner that is most congruent with the client’s preference. This includes sensitivity to the client’s preferred agency of control, and a related concept, the client’s “freedom reflex.”

Freedom reflex. The term “freedom reflex” comes from the work of the Russian psychologist Pavlov. Pavlov is best-known for his associational learning studies (dogs, saliva, steaks, and bells). In a footnote he noted that to conduct the experiment, he had to put the dogs in a harness, and that the dogs exhibited different degrees of resistance to being harnessed. Pavlov called this the freedom reflex.

Below is a “Freedom Reflex” scale which is a heuristic means of exploring the extent to which a person reflexively resents and feels pressured when s/he feels s/he is being told what to do.
slide

FREEDOM REFLEX SCALE

This scale explores how willing you are to ask for and to receive help and guidance from others.

Name: _____ Date: _____

1. Are you willing to accept guidance and teaching?

Strongly
willing
1

Somewhat
willing
2

Somewhat
unwilling
3

Strongly
unwilling
4

2. Are you willing to be told what to do?

Strongly willing 1	Somewhat willing 2	Somewhat unwilling 3	Strongly unwilling 4
--------------------------	--------------------------	----------------------------	----------------------------

3. Do you feel out of control when the only choices you have are generated by others?

Always 1	Sometimes 2	Seldom 3	Never 4
-------------	----------------	-------------	------------

4. If someone tells you the right way to do something, how do you feel?

Very bothered 1	Somewhat bothered 2	Very little bothered 3	Not at all bothered 4
-----------------------	---------------------------	------------------------------	-----------------------------

5. If someone tells you to do X, will you automatically tense up and/or do Y?

Always 1	Sometimes 2	Seldom 3	Never 4
-------------	----------------	-------------	------------

6. How easy is it for you to accept personal criticism?

Very easy 1	Somewhat easy 2	Very little easy 3	Not at all easy 4
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7. I like feeling I have options in any situation.

Very 1	Somewhat 2	Not very much 3	Not at all 4
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8. Are you willing to admit to others that you need help?

Strongly willing 1	Somewhat willing 2	Somewhat unwilling 3	Strongly unwilling 4
--------------------------	--------------------------	----------------------------	----------------------------

End slide

Now let's look at how this freedom reflex scale might be used to teach control enhancing techniques with a client. If a person has a "high" freedom reflex, it may be important to bring that to light as part of the intervention, to ask for the client's "partnership" in figuring out how to share techniques in a way that would be most helpful, and to let them know they have complete freedom to choose which techniques to adopt. "I think it may be helpful for you to consider... but it's got to be your choice." "You're in control of this process at all times. I'm just here as a support, and, if you wish at times, to be a guide and facilitator." To someone with a

low freedom reflex, on the other hand, the therapist might say, “If you follow this plan regularly, it will really help you.”

Clinically, it is interesting to compare the freedom reflex to Odysseus’ request to have his oarsmen bind him as they neared the sirens. In terms of the six components of control and self-control (choice, goal, awareness, effort/discipline, skill, responsibility), which are the ones for which different clients ask help from others (as did Odysseus), which are the ones they do themselves (“self-bind, e.g., remove “siren-like” food from the house etc.).

From a research standpoint, it would be interesting to see how much this clinically derived scale co-varies with self/other agency; self-efficacy beliefs, and desire for control.

Example. High (and low) self agency. As we have seen from the Figure of individuals at high cardiovascular risk, people can be high or low on “self” agency and “other” agency. This can have implications for how a technique is taught to the person. For example, in teaching a technique such as “hypnosis” to someone with high “other” agency as a source of control, the therapist may find it is helpful to use more directive language: e.g., hetero-hypnosis (“Your eyes are feeling heavy. You now want to close them.”). However, if a client has high “self-agency,” then presenting this technique as self-hypnosis may be the preferred style: e.g., (“You are in control of this technique, and can stop at any time. Notice if your eyes are feeling heavy, and if you wish, you may allow them to gently shut”).

Example: Self building blocks: ---mind/intellect/cognitions, 2) emotions, and 3) body/somatic.

One major variable in matching, constructing, and teaching a control enhancing intervention to a client’s control profile is the issue of self and other agency, as noted above. A second issue is to help the client refine their “self” “building blocks”: of 1) mind/intellect/ cognitions, 2) emotions, and 3) body/somatic.

For example, let me ask you some questions, which you in turn can ask your clients. What is your predominant sense, in other words, the sense you tend to rely on or favor? For example, are you more inclined to play back a video in your head (visual), or hear a soundtrack (auditory)? Do you remember the movements of your body and the feel of tools in your hands (kinesthetic)? Of course, most people have access to all of the five senses, but most of us are stronger in one sense than the others. When you think of “trusting yourself,” how do you decide what to do if your mind/intellect tells you one thing, and your heart (emotions) another? Which do you trust the most? Are you a “heart” person, listening to and trusting your heart and emotions? Are you a “body” person, trusting your “gut,” what your instinctual body sensations tell you, listening to your body’s natural wisdom? Do you put primary trust in your thinking processes, having most confidence in what you rationally perceive to be “best” for you? Each client will likely have preferences regarding building blocks (e.g, somatic, cognitive, imagery, relational), some of which may feel more trustworthy, others more troublesome.

As an analogy, there are several different schools of yoga, and for the purpose of our discussion here, let’s say the goal of yoga is “union” with the divine, and that each

school has the same goal of helping its practitioners achieve this goal. One type of yoga is primarily body focused (hatha); another, emotion focused (bhakti); another is focused intellectually/cognitively (jana). Assuming each of these “means” has the same goal, the question becomes which practice would you (or your client) feel most comfortable with—e.g., heart, body, cognitive (of the yoga schools). Based on your knowledge of yourself, which “type” would seem most helpful for you? What is your (and in turn, your client’s) strongest and preferred building block? In general, except as noted below in the section on when client and therapist disagree, it is helpful to use that building block as a starting point in the control-enhancing intervention construction.

As we saw in the discussion of how to explain dongjing to a client—finding the best balance of assertive and yielding modes of control for a given situation -- it is helpful to present the material in a way that utilizes teaching methods (e.g., kinesthetic (hot and cold water); imagery---integrating paint colors; cognitive: the yin and yang lines) that are the most understandable to that person.

An example of stress and “matching”: attentional focusing

Sometimes our most “sensitive” building block is the one we need to focus on when it becomes “troublesome.” For example, in terms of stress, some people feel stress primarily *cognitively*: lots of racing thoughts; others may experience stress *kinesthetically*—in their body: e.g., sweaty palms, butterflies in the stomach, tightening in the neck. Some of us are more internally *visually* oriented than others. When stressed, these people may see a distressing image (falling from a mountain, being lost in a dark cave, splashing frantically in a body of water).

Recall the slide of different types of concentrative meditation we discussed earlier under the section of ***Notice, let go, return to a competing response***. These different styles of concentrative meditation have different foci reflecting different building blocks. Some schools focus visually on an internal or external image; others focus on a self-created sound (mantra) or an external sound; still others pay attention to a particular part of the body (e.g., the rising and falling of the stomach while breathing; touching the thumb to each finger while repeating a phrase).

Research suggests that one way to address and “block” a sensory style that is generating stress—and where we may be stuck in unhelpful patterns--is by using the same style in an intervention. For example, for a person who experiences stressful images, strategies that involve kinesthetic and cognitive techniques may not be as effective as imagery ones. Specifically, it may be more effective to choose imagery, such as meditating on a candle flame (internal or external), or imagining a positive scene (e.g., a beach, or other natural setting) to help remove a negative image, rather than to talk your way out of it, or do a progressive relaxation.

For “somatic” individuals, body-focused strategies such as those noted above, or progressive relaxation, or exercise such as jogging to reduce stress may be more effective than cognitive ones such as a mantra (repetition of a word) or imagery (focus on an internal candle). If imagery were used with a primarily somatic individual, it might be more effective if it involved the body: e.g., imagining and feeling the warmth of the candle, or noticing the sun warming the individual, or experiencing the coolness of a breeze. For clients with a primarily cognitive experience of stress, thoughts can often be

best blocked by other thoughts (such as a replacement cognition—word, or phrase, self-instructions, or an auditory mantra—a sound or phrase that is repeated).

How one experiences stress and which preferred building block to use is not meant to imply that all individuals have only one preferred style. As Gary Schwartz wryly noted, some people experience stress both with imagery and cognitions, and for them a helpful strategy can be counting sheep; for those who experience stress somatically and cognitively, it may be helpful to say a verbal mantra while they jog!

The main point here is that it should be clear that we are not advocating a one size fits all approach, but rather a careful and nuanced matching. Because people are different, and in this case, experience stress in unique ways, therefore what might work for you might not be as effective for a client with a different way of experiencing stress. Also, it should be noted that we are merely presenting this discussion of matching a specific sensory intervention to a specific stress-related building block as only one aspect of a comprehensive approach to stress management (e.g., see Control Therapy Training Manual, Module 3.3); and Control Therapy book, Chapter 12).

TEACHING A CLIENT A NEW SKILL, INCLUDING WHEN CLIENT AND THERAPIST DISAGREE:

Don't tell me to relax.

It's only my stress that is holding me together.

--Ashleigh Brilliant

Earlier we discussed two control profiles of individuals at high risk for cardiovascular disease. The point made there was that although both felt a low sense of control, their profiles regarding modes, agency, and desire were quite different, so that the therapist would need to match techniques tailored to what each patient needed. We noted that “participant one needs to learn to have less desire for control, reduce his/her negative assertive mode style, develop positive yielding skills, and learn to trust others more. Participant two, on the other hand, is high in negative yielding; and has a low self as a source of control, and needs to learn to rely on him/herself more and develop more positive assertive mode of control skills.” This is wise therapeutically—and makes the critical point about matching control related interventions to a client’s unique control profile. Further, as discussed above, it is important to try to match teaching of control enhancing techniques in a way that is sensitive to and respects the client’s profile and preferred learning style and what the client believes are preferred, trustworthy building blocks (see examples above of hetero and self-hypnosis, stress focus, ways of representing dongjing, yoga).

Thus, up to now, we’ve been talking about developing the intervention based on building blocks, modes, and agency preferred by the client. But what about when the therapist feels additional skills (e.g, new positive mode; additional “agency” style; other “building blocks” might also be useful), and incorporating a new skill that is *not* initially as comfortable, trustworthy, or familiar to the client.. Using the yoga example, sometimes a highly intellectual, cognitive person may be served best by a cognitive approach; other times, however, a highly intellectual cognitive person can have a “breakthrough” using a different modality e.g., emotional (bhakti), karma (service), or

hatha (body) that helps get them “out of their mind.” ☺ In the cardiovascular example, the therapist would want to teach the clients skills that are not their natural strength.

When and under what circumstances would it be appropriate for a therapist to encourage the client know to expand their “style”? What might be the most effective way to convey that information? We first address that question, then explore how to work with a client who is reluctant to adopt an unfamiliar skill. As any therapist knows, not all clients are initially receptive and excited to change styles of acting and being. What happens when the client disagrees, or is resistant to what might the therapist feels might be in the client’s best interest?

Four general principles of the Control Therapy approach regarding helping the client learn a new, less comfortable skill. The Control Therapy approach would be to initially try to work with the client’s style and profile. If the therapist feels that additional control enhancing skills are necessary, here are four general principles:

- 1) Hold them in safety—metaphorically. Let them know you understand how they might feel---that learning a new skill can be challenging; recognizing how their worldview and building blocks give her a sense of control because of their familiarity and “knownness”;try to have them feel your empathy and trustworthiness.
- 2) Review with them that even though their current preferred (mode, building block, agency) is a strength and style in certain situations, as they themselves note, it can be problematic, in other situations, some disadvantages that don’t serve the client well
 - 3) Try to use the client’s preferred style as a foundation to teach the new skill: e.g., “You have a great assertive mode—you’re a strong self-starter, learn easily and well, and I believe we can use those skills to learn a new skill, the yielding mode of control.” If a client is more negative yielding, it would be important to provide them a lot of encouragement, while also teaching responsibility, reinforcing the courage it takes to act more assertively, and to realize when acceptance is not positive but negative. Note the importance of patience on the therapist’s part in sharing information and perceptions about the client—including empathizing with the difficulty the client may have in hearing your perspective, understanding it, and working with it.
 - 4) Be up front with the client that sometimes in learning a new skill, it gets worse before it gets better; e.g., “To successfully go from crawling to walking (learning a new skill) it may feel uncomfortable at first, we may “fall” a lot; and together we’ll work to ensure you get back up and keep practicing until the new skill becomes more comfortable, and you can see its positive effects.” Ensuring that this sharing is done in as respectful and honoring a style as possible.

The fourth point is important to emphasize regarding dealing with adversity and setbacks. Research shows that in both self-observation and meditation there can be an initial

“adverse” reactive effect. Note to lecturer: One way demonstrate this is to ask the audience in the next ten seconds, to “swallow three times.” 1...2.....3... At ten seconds, ask them what they experienced. Often there will be a tightness in the throat, difficulty swallowing. Yet, you may point out, until they began to observe swallowing, they were doing it quite well!

Similarly, when a client begins to observe their behavior, such as how many negative statements I make about myself, it may “create” more negative statements initially. When a client, (or anyone) first tries to focus on breathing during meditation, there may similarly be challenges “catching one’s breath.”

Metaphorically, the sense of control we had while “crawling” may decrease as we learn to walk. When learning a new skill, a client’s sense of control may initially decrease. There may a feeling of “I’m working harder, putting more effort, and things seem to be getting worse.” This is part of the process, in order to gain a new, higher level, more effective sense of control. The therapist should be sensitive to these “challenges” in helping the client deal with setbacks in learning new skills.

Examples where client and therapist may disagree. The above four principles, from seeking to have the client feel safe, and presenting the new skills as wisely and compassionately as possible, can run into challenges from the client. These challenges may be about learning a new skill, but there also may be potential disagreements between therapist and client on several issues—ranging from assessment and goal to learning new skills. Below we look at several examples where therapist and client may disagree.

What if....

- you believe your client has too high a desire for control, and toward a goal that you are not comfortable with? Or too low a desire for control to effectively meet their goal (issues with step one, desire for control).
- What if your client believes their goal should be positive assertive, you feel that’s really negative assertive and positive yielding goal would be better?
- What if your client wants to accept and thinks that is positive yielding; you think they would be acting negative yielding and that positive assertive goal would be better – (*issue of goal selection*)
- You feel the client is taking too much responsibility for situations over which they have (or had) no control? Or, conversely, are not taking sufficient personal responsibility for their situation and concerns (and are denying, blaming others)? (*issue of step two, responsibility*)
- You feel the client has more ability than client believes; or conversely, you feel the client is too optimistic, has too high self-efficacy beliefs, is setting too high a goal.(*Issue of step three, self-efficacy beliefs*).

- If research shows that for a given clinical concern, you can achieve the same results through medication or a self-regulation strategy, which would you prefer? Do you have a bias regarding which your clients “should” prefer? What is the client wants medication, not self-control (*issue of intervention selection*).
- What if your client wants “other” agency: you believe they need more self-agency. Or vice versa?

These issues are addressed in detail in Chapter 8 of the book *Control Therapy*, and Module 4 of the *Control Therapy Training Manual*. Therefore, here we will look specifically at b) a moment of therapist self-reflection regarding how comfortable s/he is in dealing with disagreements from the client and willingness to “challenge” the client’s preferences; b) underlying dynamics of transference/ countertransference issues around “power and control” that may be going on in the therapeutic process and c) potential graduated responses the therapist might regarding control-related issues in therapy, and dealing with client disagreements, and d) one example of this process utilizing issues related to desire for control..

Therapeutic Approach and willingness to “disagree” with the client: For therapist self-reflection; sensitivity to “control issues” in therapeutic process. The therapist needs to be sensitive to and aware of issues of transference and counter transference in the therapeutic relationship. These may arise from disagreements between client and therapist, as discussed above, but there may also be underlying specific control issues (e.g., power struggles) that can occur in the therapeutic encounter which can exacerbate “disagreements.” Earlier we showed a form “Freedom Reflex” for the client to take. It might also be interesting for the therapist to take, too. How high is my desire for control within the therapeutic encounter? How “centered” (i.e., non-reactive, non-defensive) am I when I have a client who has a high desire for control? When a client becomes confrontive (negative assertive)? When a client is passive and helpless (negative yielding?)



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Further therapist self-reflection on relationship. Each therapeutic orientation, as we have discussed, has a specific view of the role of the therapist. What is yours as it relates to how much and what type of control it is skillful for you as a therapist to utilize in therapy? How much active, “executive” control should a therapist exert during the course of therapy? How much is the role of the therapist to be a good empathic listener, whose job is to facilitate, but stay out of the way of the client’s organic growth and unfolding? Your orientation and beliefs will influence the style and intensity of the feedback you believe is helpful for your client.

Within the context of a trusting relationship, at what point and how do you feel it’s beneficial for the therapist to be clear and assertive with a client when the therapist disagrees with the client’s views? If you feel and believe that there are some areas it might help the client to explore further, how might you raise the topic? Do you have a gradated range of responses, from positive yielding to positive assertive that you feel you can call on in different situations? Which view of the therapist are you most comfortable with? How much is that view based on the research literature regarding what makes the best therapist? How much is that view based on what is most congruent with your personality style? For example, if you want to be perceived as a nice person (i.e., sympathetic, a friend) how willing would you be to challenge and confront your client, even if it meant the client might become angry with you? Conversely, if you are “naturally” by temperament more detached and analytical, how comfortable would you be becoming more involved in a caring way with the client?

In thinking about how to manage disagreement in the therapeutic relationship (and to facilitate the relationship in general), the therapist needs to ask him/herself these questions: Do I have the positive assertive skills to conceptualize the case, and executive skills for directing and structuring sessions? Do I as therapist know when to engage in positive yielding, and follow the client’s lead? The question for each of us is how much of our own style “draws” us to certain therapeutic approaches and orientations, where we feel more comfortable and have more of a “sense of control”? It is useful to explore when our own personal preference and style are helpful to a client, and when these might not necessarily best serve a client’s needs and goals. In the latter case, when is it helpful for the therapist to learn to stretch one’s limits and develop additional skills? And when is it appropriate to realize that a particular client’s concerns may be outside our ability to work with, and it would be fairer and more appropriate to arrange other treatment resources?

Having a gradated range of skillful responses. With that understanding as context, we suggest that it can be useful for you as therapist to have a series of gradated therapeutic responses (dongjing) which balance yang and yin, so that you can utilize the appropriate response, from confrontive and challenging (maximum yang) to soft, compassionate, yielding (maximum yin), including nuanced options in between, depending on your orientation and beliefs. (Note that all these examples presume and are most effective within a therapist/client relationship of empathy, understanding, and trust).

If you feel and believe that there are some areas it might help the client to explore further how might you raise the topic?

Soft therapeutic responses that also have an element of assertiveness.

(Again, we presume these responses are all employed within an empathic, understanding context, such as “That sounds rough. It doesn’t seem as though s/he is responding very kindly to you. I can see how much that upsets you”).

“Can you think of some different ways you could give this person feedback, while still being respectful...?”

“Would you be willing to consider...?”

“Let me invite you to look at...”

“A possibility that I believe may be worth exploring...”

“We all tell ourselves stories. I hear the story you are telling yourself, and if I told that story, I’d feel just the way you do, too.” (This is both empathizing, at one level, but also subtly shifting the ground, suggesting that stories may have at least an element of choice—“if I told that story...”). Might there be other ways to look at this....?

More assertive responses might include:

“Do you feel you are doing anything that contributes to your concerns?”

“What might you do differently that could help address this issue?”

“I wonder what you were thinking (or trying not to think about) in the hours before your panic attack?”

“You blame her and want her to change, and essentially you feel helpless in the situation. Is there anything you personally might do to feel less like you’re being victimized—what might be under your personal control?”

“I’d like to encourage you to consider what the other person might have been feeling?” (to try to help the client step outside his/her story, and see it from another person’s point of view).

Still more assertive responses (if the client gives no response or says they notice “nothing” going on, or nothing for which they may be responsible):

“I hear how awful you feel he is. I’m wondering what you might learn about yourself in terms of how you respond to his words and behavior?”

“Do you realize that those are really not skillful behaviors (thoughts, stories). Can you see how they are bringing you and others a lot of unnecessary suffering?”

“This might be hard to hear, but what I see is...<e.g.,> micromanaging your teenage daughter’s life may actually be contributing to her rebelliousness. How would it feel for you to consider prioritizing the most important areas, and exploring whether you could let go of some active control in areas that are less essential?”

“I’d like us to focus a bit more on what may be your contribution to the problem?” (focus on self-agency, personal responsibility)

“It seems you want someone to rescue you ... let’s look at that wish and how well it serves you. What is your responsibility for your own self-care?”

“Do you feel you’re over reacting?”

“Here’s a different perspective; although this is only my opinion, to be as honest as I can, I disagree with how you are seeing it. I think you’re making a mountain out of molehill. Let me try to share why, and see if this view might make any sense to you.”

“I’d like to urge you to go a bit deeper here. What else do you think might be going on to cause such a strong reaction in you?”

Notice how there can be a gradation of responses from “let me invite (ask) you; to “let me encourage you” to “let me urge” you to consider. This can all be

done within a context of offering advice, suggestions, and without dictating. It can also be done, as we discussed in the Tai Chi dance, in a way that negotiates and dialogue about different points of view while staying connected, and having anchor points through which trust can be built (e.g., I hear your perspective;, here's my perspective; I see it somewhat differently----versus "you're wrong!")

Awareness of your own style and comfort level. Can you, the therapist be both yielding/accepting (not from fear of confrontation or passivity) as well as challenging without becoming angry and impatient? How comfortable are you as a therapist acting in a "controlling" forceful way in order to teach a client? Can you do this without feeling you are too pushy or overcontrolling?

Are you comfortable appearing to be doing nothing while the client "demands" help? Or do you start to feel too passive and helpless in the session?

These are all "general" control related competencies that are an important part of therapist self-awareness and self-exploration. Each of us needs to learn the range in which we are comfortable, and then, as we are able, stretch our limits a few degrees, so we have more options to use in helping those with whom we work.

Our goal through the use of this range of competencies is to be able to have the skills to allow clients to feel safe and trusting through our ability to listen, be empathic, and compassionately reflect their point of view; and to have the skills, within that context, to challenge our clients, when appropriate, to help them decrease their suffering and grow in understanding and wisdom.

An example of disagreement: desire for control, and modes of control

Earlier we discussed how the therapist and client can prioritize goals, and have discussed "Desire for control" as the first step in the five step intervention process. It is worth briefly addressing here when the therapist believes the client's desire for control may be misplaced, either too high, or too low, and/or coming from an unskillful end goal.

Too high assertive desire? For example, in terms of too high a desire, we have seen that, quadrant three, overcontrol, can have too much or inappropriate desire for assertive control. It is helpful to have clients notice, as they think about their goal and why they want to achieve it, the control-related language used to describe their desire. Are they using words like "must," "have to," "need": "Things must change.....I need more control over..." Are these terms positive assertive—reflecting a useful and energized motivation; or are they negative assertive, and suggest an overreaching, a too compelling and "driven" motivation?

If the therapist feels it's the latter, he or she might ask the client, what do you feel is the appropriate amount of healthy desire for you in this situation, and how is that reflected in your speech and cognitions? Just because you may be able to exert active control in a situation, does that mean you should? Are your highest goals and values best served by using an assertive change approach? Is your desire for increased assertive control in this area healthy?

The therapist can then say, "If you feel you have too high a desire for control, if you feel your desire is too intense and is misplaced in terms of where and how you want to exert active control, (e.g., it may not be something worth going after)--then you may be

on the wrong track. Are any of your “needs” actually wants? Are these “wants” ones that you feel are truly worth pursuing? When is your desire for assertive control causing you to get upset over trivia—to fix or micromanage things that perhaps are best accepted? If you are concerned that your desire for control is too high, you may either try to “center” yourself as you seek to stay on the assertive mode track, or you might decide you may need to switch to the yielding mode track as a way of ameliorating your excessively high desire for active control. Try to be as clear and honest with yourself as possible.

Too low desire for positive assertive? Conversely, the therapist may feel the client is not sufficiently motivated toward a positive assertive goal. The client may seem somewhat ambivalent. For example, part of the client may want to make assertive changes, but another part may not want to rock the boat—why not just continue to accommodate others’ needs and “people please?” Why should the client make the effort to figure out what s/he really wants and take responsibility for it? Perhaps there is a fear of trying something new, or of making a mistake and having to take the blame if things don’t work out.

The therapist can explore with the client whether there are ambivalent phrases in the client’s control speech, e.g., “I think I’d like to gain more control, but I’m not really sure.” “I’d like it to happen if it’s not too much effort.” “I think maybe I’d like...” “It would be nice if...” Pointing out phrases like these may cause the client to consider whether, for his/her area of concern, s/he may have “too low” a desire for the effort necessary to seek to increase his active control, and therefore be insufficiently willing and motivated to take assertive action. The therapist can work with the client by asking: “Do you feel you are insufficiently motivated at this point to put the necessary time and effort into this positive assertive goal? If not, what choices might you have? You can either choose to switch to the positive yielding track, or decide you need to increase and strengthen your desire and motivation and stay on the assertive mode track.”

Ambivalent desire: positive yielding. As we have discussed in the section on the Control Mode Dialogue, sometimes clients may have ambivalent feelings about engaging in a positive yielding mode of control intervention. For example, in order to utilize the yielding, accepting mode of control with negative thoughts, (e.g., I’m lazy and too docile—negative yielding) and to replace them with positive ones, (e.g., I’m serene and take appropriate space for quiet time—i.e, positive yielding), it may be important to have the clients examine any biases in their control stories that may make this difficult—and whether the control story is problematic and needs to be changed and rewritten.

Choosing a more positive yielding control story and/or affirmation may bring a person face to face with biases that might make one feel we are acting weakly if we accept what is. This may come in part from control stories in our culture which suggests that we need to be strong, rugged individuals with a fighting spirit. We don’t want to be thought of as passive, weak, a door mat to be walked on, a victim, someone who “gives up.” If the therapist feels positive yielding is in the client’s best interest in a certain situation, the Control Mode Dialogue may need to be revisited. What might be control stories the client may be fighting as s/he tries to learn to be more accepting? Is there a concern/fear that acceptance means “giving up on yourself: that your body “is what it is”; that your relationship is as good as it’s going to get; that your vision of yourself as

better and more perfect and more ambitions may not happen? The therapist may help the client explore in more detail ways to counter resistances: e.g., “This is not ‘wimping out’ this is not choosing from passivity and fear—but is coming from a strong place of seeing clearly.” The therapist can also point out the positive benefits that might come from a positive yielding mode of control—greater serenity, willingness to stop hitting one’s head against a metaphorical wall that will not budge, a willingness to let go of what is holding one back from allowing new “growth” to occur.

False “acceptance” and no desire to change. Control Therapy argues that, in general, concerns are most skillfully addressed by being faced, rather than by avoidance, distraction, or denial. Facing a concern can involve addressing it through change, acceptance, or some combination. We might call this going “IN AND THROUGH” in order to gain a positive sense of control. There are times, however, when a client might be protecting a “lower level” sense of control which is not positive. —e.g., denial, defensiveness, avoidance of issues, a self-deceptive illusion of control.

There is a difference (as we have discussed) between positive acceptance (quadrant two) and “giving up” or “fatalism” (quadrant four). Positive yielding and acceptance is very different from denial, inappropriate minimization, or indifference, which is a negative yielding, a negative acceptance of a situation which should not be accepted.

For example, in some ways denial, in which a person “accepts” and has a sense of control about a situation by pretending nothing is wrong, is the very opposite of positive acceptance. The person who says, “I accept my drinking because I’m not an alcoholic, I never drink before 9 a.m.,” is in denial. The person who condones his/her problematic behavior through downward comparison with others—“I only cheat a little”; “At least I’m not a mass murderer”—is rationalizing and seeking to accept poor personal conduct in order to keep from facing and addressing it. Neither is acceptance the same as indifference: “I don’t care.” “It was a worthless prize [person, event] anyway. It means nothing to me.” Therapeutically, and personally, it may be necessary to break through unhealthy denial and minimizing, overcome a masking indifference to become aware of and address concerns about an area.

Some final comments on desire and modes. Seeking wisdom to know the difference. In working with the client regarding desire for control and the modes, the therapist can be empathic to the client’s concerns and ambivalence, and make sure the client feels those concerns are understood. The therapist can point out that it may involve a process of trial and error, learning from mistakes, self-reflection, self-exploration and self-evaluation, to determine the point at which s/he begins to feel that positive yielding becomes negative yielding; and positive assertive becomes overcontrolling, negative assertive.

With practice, it becomes easier to distinguish between healthy (realistic, affirming) yielding and unhealthy yielding (passivity, depression, self-pity, victimhood, inappropriate minimizing); between healthy (courageous, self-determining, optimistic) assertive control and unhealthy (manipulative, entitled, overly micromanaging, unrealistic) instrumental control.

As noted above, sometimes we may err on the side of accepting things that are not healthy for us to accept, often from many years of conditioning, about which we may not even be aware. This would not be positive yielding, but negative yielding. For example, a woman being abused by her partner may wish to ignore her despairing feelings so she can survive another day in her situation. Perhaps she does not feel safe enough to face her condition or is not aware of her choices and the resources available to help her make a safe plan for change. Clearly these feelings of helplessness and lack of options need to be addressed in therapy. Positive assertive skills would be needed, and the development of “the courage to change”: to develop a courageous, positive, optimistic belief in one’s abilities and capabilities to both set goals, and achieve them: in this case, at the least, to leave an abusive relationship.

Conversely, as also noted above, sometimes, on the other hand, there are situations where we seek to make changes that are beyond our limits and capabilities, trying to actively control too much and engaging in “magical” thinking that “where there is a will, there is a way.” “I can do anything and be anything I want.” “Nothing can stop me from reaching my goals.” Too high and optimistically unrealistic a belief in our own self-efficacy may also be harmful (negative assertive overcontrol, quadrant three). This can occur when we keep doing the same thing, trying even harder, and keep hoping for a different outcome. The result may be that we continue to hit our heads against a wall, creating pain for ourselves (and others). A better idea may be to look for other creative options (both means and goals) that might be more appropriate, as well as learning the “serenity to accept” that which we cannot (or should not) try to actively control.

The therapist can explore with the client that the issue is how do you know when it is appropriate and wise to continue your efforts, when to give up would be quitting prematurely? How do you know when it is time to accept that a particular change path is not working? Sometimes, as noted, the task involves one of will—the willingness to continue to practice and “do the homework” with regularity and consistency (hitting the stone five hundred times; meditating on a daily basis; practicing changing and replacing negative thought patterns with positive ones) even when we aren’t seeing immediate results. Should we try harder with more effort (“Winners never quit. Keep hitting the stone, it will eventually break”)? Should we recognize that it is time to go around the rock, to try more softly, with *less* effort? In the face of challenges and adversity, when is it resilience to pick oneself up and get back in the game; when is it wisdom to seek a different game? The therapist can note that there are no easy answers to these questions, and that they are different for different people. But with conscious reflection, lessons can be learned.

Perhaps a story of a seeker after knowledge is helpful as a way to end this section:

A person asks a wise person the secret of happiness.

"Good choices," the wise person says.

"But how do we learn to make good choices?" the seeker queries.

"Experience," the sage whispers.

"But how do we gain experience?" the supplicant probes.

"Bad choices."

*

*

MONITORING THE PROCESS OF CONTROL THERAPY WITH A SYSTEMS MODEL. The systems model can also be used to deal with “challenges” in the therapy process, including setbacks, compliance issues, and to evaluate the process and ending of therapy. The process of learning new skills, whether assertive/change or yielding acceptance, is not necessarily easy or quick, either in terms of ourselves or others. Therefore, in addition to the actual skills of the intervention, skills to maintain commitment to the process when there are setbacks and frustrations are also needed.

The systems model can be helpful in providing evaluation of and feedback about progress at each phase toward client goals and seeking to ensure that these concerns are addressed in a way that optimizes the chances for regaining and maintaining a positive sense of control.

For example, if a client doesn't reach their goals, is the issue one of assessment and goal setting? Were the goals too high? Does the client, upon further reflection, feel it was the “wrong” goal?

Where in the five steps of the intervention might the problem lie: e.g., desire, right, responsibility, self-efficacy beliefs, commitment? Is the issue lack of effort? (adherence and compliance?) Lack of skill? Are there better ways to nuance and refine the techniques and better match them to this client? Are there better ways to “teach” these techniques to the client? Is the client doing the best they are capable of? If so, how can you help the client work on accepting the limits of their ability?

Further, this model can help therapist explore situations in therapy where clients initial goals are satisfactorily achieved, and after “success” the client may raise additional concerns. If so, these can be addressed in similar fashion by returning to the processes of assessment described in the early sessions.

AN OVERVIEW OF THE PHASES OF CONTROL THERAPY AND AN 8-12 WEEK SESSION BY SESSION BREAKDOWN

We have now completed a basic overview of Control Therapy. Below is a summary of CT based on a “typical” 12-session format. Of course, therapists should use their clinical judgment in pacing the therapy for each client. The breakdown into sessions described below is meant to illustrate just one possible time-frame, **NOT** to dictate a rigid format. Further refinement and details (including weekly “homework”) is available in the Control Therapy Training Manual (Module 4) and the book Control Therapy (Chapter 12, which also includes case studies including mental health and CT (a case of stress and anxiety as the present problem); and physical health and CT: A case of lifestyle modification. Chapter 13 of CT presents a case of Couples Therapy and CT).

PHASE ONE: ASSESSMENT AND GOAL SETTING:

Where the client is, where the client would like to be

- gaining client trust,
- assessing the client’s control profile, giving feedback from the SCI
- listening to and understanding the control issues that are of concern to the client,
- exploring and discussing client control stories and dynamics
- helping the client formulate goals.

Session 1. (*Trust, rapport, exploring areas of concern, control profile*) The therapist starts by giving the client an opportunity to share why s/he has come for therapy. The therapist works to develop rapport and build therapeutic trust, and while listening empathically, seeks to gain information that helps the client identify areas of concern (i.e., where there may be assault’s to the client’s sense of control). The therapist listens for key words and phrases from the control content analysis scales, including control-related aspects of the client’s personal history, and begins to get a feeling for the client’s control stories and dynamics. The therapist might summarize by saying something such as “I can see you are feeling (somewhat) out of control in your life in general, and in certain areas in particular. I can tell from what you’ve said that this is distressing to you, and I look forward to working with you to help address your concerns. This week it would be helpful if you could observe an area of concern (work this out with the client) which seems most important to you. This is an opportunity for us to gain more information from actual situations in your daily life where your concern shows up. Would you be willing to do that this week?”

Session 2. (*Self-observation, evaluation, goal setting control stories, and dynamics*) This session can begin with an exploration of what the client learned from the self-observation experience. If the client seems ready, then self-evaluation and goal setting can be addressed. For example, the therapist could say, “Based on your responses, it appears that you would like to address your area of concern by...(e.g., an assertive/ change mode; learning to better accept with serenity). Let’s work together now to refine how you can go about doing this. First, in order for us to reach our goal,

we have to make sure we know what the goal is. Let's see if we can agree on the specifics of what you're hoping for." Depending upon client interest and goals, the practice of diaphragmatic breathing may be taught, as well as the mind scan (*mindfulness* meditation), and body scan. These can be explained both as relaxation techniques in and of themselves, and also as ways to help observe more carefully one's own body and mind as part of the self-observation work.

Sessions 3-5 (The final aspects of Phase One). The third session contains a number of tasks, which for some clients need to be spread over several sessions. The therapist helps the client explore the self-monitoring information (homework) including the client's rights in a situation and/or responsibility for his/her own actions/choices. Any questions about the mind-body relaxation techniques can also be discussed. The session can then further clarify goals and goal-setting. Several techniques are available, as noted in the previous Training Module, including (a) envisioning which mode to choose, (b) client handout for decision-making, (c) use of a written self-management contract. Sessions 3-5 are also an appropriate time for the therapist to go over the Five Steps for Positive Assertive Change and Positive Yielding (Appropriate handouts can be given to the client, as helpful. The therapist can also have the client work with the breath cycle as a way of grounding the four modes in the body, as discussed earlier in this lecture: i.e., voluntary in breath (positive assertive); continuing to take an in breath (negative assertive); letting go of breath for the out breath (positive yielding); continuing to let go of breath (leads to negative yielding).

PHASE TWO: INTERVENTIONS

- matching techniques to clinical concern to control profile and goal.
- teaching techniques in a way that is congruent with the client's style
- evaluating the therapy process at each stage to ensure progress is being made.

Intervention Phase (Sessions 6/7) The Intervention Phase, which we will call Session Six but which can really occur as early as Session 3 (in the simple model), can begin with a review of the self-observation material, and, once the goal has been agreed upon, can move to an exploration of the Five Steps for Gaining Control. The therapist can focus on which pathway best matches the client's goal and control profile. Specific building blocks -- cognitive, attentional, behavioral, and emotional -- can be selected, tailored, and taught toward achieving a positive assertive mode, a positive yielding mode or toward an integration.

A self-management contract can be drawn up, and the client's homework for the coming week clarified. Any questions about techniques can be further explored. The therapist should ensure that s/he is teaching the techniques in a way most congruent with the client's style (e.g., preference for self or other agency, learning style, etc).

Session 7/8: Evaluating intervention progress. Again, we are following a "typical" progression, which will need adapting to each client's pace and dynamics. This

session can begin with a discussion of the client's practice of control-based techniques during the past week.

As needed, the therapist helps the client enhance self-efficacy beliefs and commitment to change. This may be done through examining past successes, generating thoughts to enhance change, and/or reaffirming commitment to change. It also may mean reviewing control stories and beginning to "rewrite" them through exploring alternative scenarios, chapters, and outcomes. The homework involves continued self-observation and practice of control-based techniques.

Sessions 9-12. Depending upon when the intervention phase began, these sessions can be used to review progress from both the therapist's and client's perspectives, with a focus upon client self-observation data. Research shows that Control Therapy can be effective within four to eight sessions, but for some clients four additional sessions may be necessary to continue the work already outlined and to gain more practice with the various self-control techniques. When there are problems and issues, a system's feedback loop, discussed below, can be used to evaluate

* assessment of clinical concern; * selection of the intervention; and *teaching of the intervention, including issues of adherence and compliance.

Once the goals with which the client began therapy have been successfully met, issues of termination can be discussed. The SCI can be re-administered to further evaluate progress. The final session is typically used to reflect on the process of self-change, validate progress, and consider ways that new behaviors may be generalized to address new problems as they arise. The final session can also be used as a way to "consciously" say good-bye as part of the ending of the therapeutic relationship. The therapist and client can also discuss any future booster sessions or follow-up as needed. The Figure below summarizes in an overview the technique material

Begin slide

OVERVIEW OF TECHNIQUES WHICH CAN BE UTILIZED IN DIFFERENT PHASES OF CONTROL THERAPY**

Note: references () are both to where the material is covered here in the Training Manual-- e.g., TM 1,

Appendix 1; and where it is found in the book *Control Therapy: (CT.)*

ASSESSMENT AND GOAL SETTING: PHASE ONE

Identifying Areas of Concern: Assault to Sense of Control

Shapiro Control Inventory (SCI): Control profile: Desire, modes, agency (TM 1, App 2, CT Ch. 3)

Content analysis of language—control speech (TM 1, TM 2, CT Ch. 9, CT App C)

Self-observation (TM1)

Increasing Awareness: Insight and Oversight

Control stories: Sources of, exploring (TM 1.4; TM 2.2; TM3.1 CT Ch. 9& 11)

** The distinction between intervention phase, and baseline (assessment, goal setting phase) make sense at one level. However, the very act of going to a therapist, assessing oneself, self-monitoring, can also be considered techniques and an intervention of sorts. We realize this even as we sort techniques into two phases in the above Figure.

Control dynamics and assumptions (TM 2, CT Ch. 9)
 Self-observation, self-evaluation (TM 2; Manual homework; CT Ch. 10, 11)^
 Eyes closed mode dialogue: Awareness of preference (TM 2.4; CT Ch. 11) ^
 Six dimensions of control and self-control: (TM2)
 Right and responsibility (TM 3.1; CT Ch. 8, 10, & 11)
 Diaphragmatic breathing (TM 3.1, Appendix 3.11; CT Ch. 10) ^
 Body scan (TM 3, p. 64; Manual Appendix 3.12; CT Ch. 11)^
 Mind scan [In TM3 “attentional control” including mindfulness and big mind game, TM4;
 and “Appendix 3.10 (mindfulness): mind scan” ; CT Ch. 11)^
 Exploring decision making process (TM 3.3)^

Clarifying Goals

Control Mode dialogue with resistances (TM 2.3; App 3.8; CT Ch. 11)^
 Envisioning which mode to choose (TM 2.3; CT Ch. 11)
 An external Rorschach vignette (TM 3.2; TM4, 116; CT Ch. 8)
 Breath cycle and the four modes (TM3.1)
 Decision making: prioritizing domains & modes. (App 3.9; CT Ch. 11)^
 Client handout for short and long-term goals (Appendix 3.2; CT Ch. 12)^
 Self-management contract (Manual Appendix 3.7; CT Ch. 11)^
 Questions to Facilitate Discussion of Mode Control Stories (App 3.6.; CT Semi-structured
 Interview, Appendix B),
 Eyes closed: Clarifying issues, affect, meaning (TM3. TM4; CT Ch. 11)
 Finding the root issue (TM 3.1; TM4, 4 ; Chapter 12, Case 1, p. 240)

INTERVENTIONS: PHASE TWO

Clarifying and Enhancing Motivation

Proactive exploration of barriers to control (TM 3.1; CT Ch. 11)
 Enhancing motivation for positive assertive mode (TM 3.1; CT Ch. 11)
 Recognizing limits of over control (TM 3; CT Ch. 11)
 Enhancing motivation for positive yielding mode (TM 3.1; CT Ch. 11)

Enhancing Self-Efficacy Beliefs and Commitment to Change/Accept

Self-efficacy beliefs (TM 3.1; App 3.3 Intention to change/accept CT, Chapter 11) ^
 Examining past successes (TM 3.1; CT Ch. 11)
 Thoughts to enhance change/acceptance (TM 3.1); CT Ch. 11)^
 Reaffirming-commitment to change/acceptance (TM3.1; CT Ch. 11)
 Visualizing success in each positive mode Control Mode Rehearsal) TM 3.1

Matching Techniques to Client

Selecting techniques (TM 3.2; TM 4; CT Ch. 8)
 Five steps for assertive change mode of control (TM 3.1; CT Ch. 10)
 Five steps for the yielding mode of control (TM 3.1; CT Ch. 10)

- Dealing with negative thoughts (TM 3.1)
- Integrating and balancing two modes (TM 3.2; CT Ch. 10)
- Rewriting and editing control-stories (TM3.2.1); CT, Ch. 9)
- Control Mode Rehearsal (TM 3.1; App 3.14; CT Ch. 10)
- Positive Control Modes in Relationship (TM3.2) ; CT Ch. 13)
- Yoga dyad, Tai Chi Dance (TM 3.2)
- Xujing (centering) and donging (finding best response) TM 3.2
- Concentrative meditation objects of attention (TM 3.3)
- Matching Teaching Style to Client**
- Importance of relationship (TM 4,; CT Ch. 8)
- Addressing client's control needs in session (TM 4; CT Ch. 11)
- Meeting clients where they are (TM 4; CT Ch. 8 & 11)
- When therapist and client disagree: gradated responses (TM 4; CT Ch. 8)
- Teaching of techniques (TM 3.2, TM4; CT Ch. 8 & 11)
- ^= Client handouts and forms in Appendix 3

END SLIDE

The above section provided an overview of a 12 week model of Control Therapy, followed by a chart summarizing techniques and interventions in CT. Under Interventions, we have explored several different techniques that can be used for the assertive/change mode, the yielding /accepting mode, and in combination; as well as ways of integrating self and other as agent (and object). The intent has been to help guide the therapist in how to choose a technique and teach it in a way that is a good match for the client's control profile, goal, and concern

On the one hand, the number of techniques presented here is over-inclusive, and clearly not every technique presented here will be used with every client. This has been an attempt to provide an overview of some important techniques that may be used in constructing an intervention and is meant merely to be a guide to therapists to construct an intervention that best matches the client's control profile, concern, and goal. On the other hand, what has been discussed here does not represent all possible techniques available, and it is hoped that, using the structure and principles of Control Therapy, as well as an understanding of building blocks, the therapist can also feel empowered to create additional specifically tailored control enhancing techniques that the therapist feels are in the best interest of the client.

A summary handout, where appropriate, at termination Below is a generic template of a model handout that can be given to clients who have successfully used Control Therapy at termination, to summarize for them the process they went through and how it can be used after therapy as other challenging arise. Of course, it can be adapted to the particular needs of the particular client.

Start slide

“Control Therapy in a ‘Cliff Notes Form”

Here is a handout that summarizes in brief form some salient points we have covered. It may be helpful as a reminder and model just on the off chance “life” throws additional “control challenges” at you in the future.

1. *Centering Oneself.*

Take a breath.

Body Scan-- Ready position physically

Mind scan/mindfulness

Gratefulness: Creating a context for the interaction/situation.

2. *Assessment/ Exploration*

--**Situation/concern.** What is the nature and *content* of the situation of concern? How severe, acute, important?

--**Other.** If another is involved, what do you know about the other person’s interactional style, trust level, and openness to honest feedback?

--**Self.** What do you know about yourself and your control dynamics, profile, and story that is relevant to the situation?

3. *Goal Setting: Intention.*

If everything goes perfectly, what would be the best possible outcome for this situation? i.e., What is your goal for addressing this situation or concern?

4. *Intervention:*

Creating options for the response (dongjing) that best matches your goal.

Once you have completed your exploration/assessment, and have your goal, what is the best combination of assertive and yielding modes (dongjing) that you can create to help you achieve your goal? (Create a few options from most assertive/change (yang) to most yielding/accepting (yin) with graduated options for blending and integrating the two modes.

(Use your preferred sense style: e.g., feel blend of hot and cold water; visualize yin/yang or colors of paint blended; linearly/cognitively note the gradations of yang ____ and yin ---).

Select what you feel is the best option. (no more “yang” than needed.)

Take some time to practice your intervention: e.g., the five steps for the assertive mode; the yielding mode; and/or their integration including the Control Mode Rehearsal as practice.

Implement your choice using right speech and right action. The principle of right speech and right action is to make sure that what you say and how you behave are as clear and fair as possible. This means using speech and action that are no more “yang” than necessary to achieve your goals and intentions, and that seek to minimize hurt and harm to the other person—and to yourself.

5. *Evaluation.* Did you achieve your goal? If so, how does that feel to you? If not, what did you learn: e.g., about the other person, yourself, the strategy you used? What changes might you make for next time, or for the next phase of the process.

End slide.

CLINICAL RESEARCH OVERVIEW/COMPETENCIES FOR CONTROL THERAPY.

To summarize to this point, one of the goals of this lecture is to share the principles and practices of Control Therapy so that clinicians can work with clients who are suffering and who might be helped by Control Therapy. Control Therapy is an 8-12 week clinical intervention. The overarching goal of the therapy is to help people feel a greater sense of positive control, including minimizing unnecessary pain and suffering and increasing feelings of happiness, compassion, productivity, and meaning. These lofty goals are addressed through a series of precise training experiences detailed in practical step-by-step terms. By the end of the training, the student should have developed competencies in the following four areas: *Assessment* (where a person is), *Goal Setting* (where a person wants to go), *Intervention* (techniques for reaching the goal), and *Evaluation* (determining whether the goals have been met).

In this lecture we have explored the two phases of Control Therapy and therapists competencies needed for each phase. There is a Clinical Competency Checklist (five point scale) in the Control Therapy Training Manual. Each question includes a 5-point Likert scale.

<i>Never</i>	<i>Rarely</i>	<i>Sometimes</i>	<i>Frequently</i>	<i>Nearly Always</i>
1	2	3	4	5
Needs Improvement		Making Progress	Very Good	Excellent

Observer ratings of 1 and 2 mean “needs substantial additional training”; 3 means “making progress, but still needs more training”; and 4 (very good) and 5 (excellent) mean “meeting competency criteria”.

This checklist has several uses. Trainees may complete it as a self-assessment at the start and end of training. Trainers may use it to rate trainees’ progress. It may be used early in training, one or more times during training, and after training is finished. Administering it at least twice (pre-post) will allow trainees and trainers to gauge progress, to note which areas are a strengths, and which areas need further development and attention.

In addition to its didactic function, the checklist can also be useful for ensuring accurate and uniform application of Control Therapy in a research setting. By going through the competencies of Control Therapy for each phase, it should be clear there is nothing esoteric or hard to learn. Trainees unfamiliar with Control Therapy may have some initial apprehension, wondering if this approach has any links to skills and theories they’ve learned in the past. Most students are happy to learn that Control Therapy invites therapists to make full use of their existing conceptual frameworks and interpersonal skills.

Further, as has already been highlighted, the competencies in Control Therapy discussed below assume what research suggests are baselines competencies and certain basic skills, essential qualities required for any therapist no matter what the specific therapeutic approach. These include active listening to others, empathy and ability to form a therapeutic relationship, awareness of general transference and

countertransference issues; awareness of one's own thoughts, bodily cues, and feelings; knowledge of theories of personality and systems of psychotherapy; multicultural skills such as knowledge of one's own culture, of others' cultures, and the ways race and culture impact worldview. These are context and foundational for what we now discuss in terms of Control Therapy competencies. Where appropriate, we also delineate specific competences regarding the above, related to Control Therapy, including working with the client to evaluate progress and address challenges; helping the client address resistances and self-sabotage; addressing discouragement about lack of progress, and helping to foster motivation; aiding the client in revising goal(s) or considering newly emerging goals; introducing other techniques and concepts as the need arises or goals change; and knowing how to initiate appropriate termination and follow-up.

Note to Lecturer. Below is a summary of those competences for each phase of Control Therapy. It may be helpful to show these in slide form, and perhaps highlight a few examples in each phase to give a "feel" for the competencies.:

PHASE ONE: ASSESSMENT:

"Where the client is".

Therapist competencies: Helps the client identify assaults to client's sense of control, learn about their "Control Profile"; explore control stories and dynamics, listen carefully to control speech; in self and others; and learn self-observation. All of these activities are ways to increase self-awareness and self-exploration.

Help individuals learn about their unique control profile: including overall sense of control, assaults to their sense of control, desire for control, fear of loss of control, and the ways they seek to gain and maintain a sense of control through both *modes of control* (positive assertive, positive yielding, negative assertive, and negative yielding); and *agency of control* (do they get a sense of control from self and/or others).

Explore with clients their control stories and dynamics,

- *Listens for and identifies control-related material in client's speech (client feels out of control, fears losing control; domains in which the client has problems with control);

- *teaches client how to listen to his/her own (and others') control-related speech;

- *explain to the client how to reflect on his/her own control stories and dynamics, including the use of a personal control journal (where appropriate);

- * identifies key themes in the client's story; works with the client to explore past ways of gaining control; helps client discuss which control modes the client believes s/he has used successfully/unsuccessfully in the past. including assumptions and beliefs, ranging from the micro to the macro,

- *the therapist should be able to do this while maintaining a sensitivity to cultural, ethnic, and gender issues regarding modes, desire for control, and agency of control.

Conceptualize concerns as they relate to control: Through listening to client control-related speech, and exploring the items from Scale 4, the Domain Specific Sense of Control, the therapist will help the client identify the life domains (e.g., exercise, relationships, feelings about one's self) where they feel a lack of control, and which they believe are a concern. If necessary, the therapist will help clients prioritize their concerns.

Teach clients self-observation: Through identifying and then monitoring the clients areas of concern, the therapist can help clients see how they are affected by personal style (cognitive, affective, behavioral), interpersonal interactions, and physical environments. This includes both precise self-observation, and general observations (as in a control journal). ***Therapist competency:*** . Teaches the client learn how to self-observe a problem behavior/concern: <internal or external: frequency, intensity, duration, latency; antecedents and consequences>

PHASE ONE: GOAL SETTING: *Where the client wants to go*

Work with clients to set realistic and appropriate goals.

* Helps the client evaluate the self-observation information--assists the client in learning how to self-evaluate with gentleness and kindness rather than judgmentalness and self-criticalness/self-blame.

*Based on evaluation of the self-observation information, as well as the client's preferred mode of control (Scale 4), ideal modes of control (Refinement 10), desire for control (Scale 9), and control stories, the therapist and the client will develop goals that are realistic, and congruent with the client's overall life plan and values.

*These goals would involve whether the client wishes to gain a sense of control through change or acceptance aspects of personal (cognitive, behavioral, affective), interpersonal, or physical environments.

*ensure that these goals specify the behavior (internal or external), under what conditions, and to what extent.

* explores with client how short term goals mesh with long term goals; making sure the goals that are selected are congruent with one's vision of one's self and who the client want to be .

Dealing with client resistances to setting a goal. Potential challenges:

* helping clients who have difficulty or can't decide whether they want to address an area of concern by being assertive and making changes, or by yielding and acceptance; or both through utilizing questions to Facilitate Discussion of Mode Control Stories; Therapist shows the ability to use the "Control Mode Dialogue" to assist client in addressing issues and clarifying goals Therapist is able to address and discuss client's ambivalence about and resistance to setting a goal.

*if the resistance to setting a goal may be related to the fact that so doing involves taking responsibility for the situation, and making a conscious choice to address it through change or acceptance, therapist should be able to discuss this as well. Therapist can sensitively explore with the client that resistance to choosing a goal may stem from

the fact that taking responsibility may feel more uncomfortable to the client than doing nothing, and simply “complaining about it without having to act.”

*helping client prioritize among many goals; dealing with multiple, conflicting goals, or unrealistic goals; clients who have trouble formulating and setting goals,

*able to discuss (and if needed use appropriate handouts): e.g., *client handout for decision-making : prioritizing domains and choosing modes p.* ; prioritize control-related concerns <from SCI, Scale 4, Part Two.

*regarding client resistance to narrow, reductionistic “counting”: the therapist is able to explain to the client the purpose and rationale of a countable goal: what behavior (internal or external), to what extent, under what conditions? ---i.e., a way to learn more precise and nuanced information, a way to see “where we are” so we can measure progress.

PHASE TWO OF CONTROL THERAPY: INTERVENTIONS: ***How to reach the goal: Matching control profile, clinical concern, and interventions:***

****Match the intervention(s) to the control profile and goals. Therapist competence:***

Is able to present and teach control-enhancing intervention techniques to the client in a way that best fit the client’s control profile (e.g., preferred agency) and learning style (e.g., cognitive, visual, kinesthetic); and are tailored, targeted, and matched to the client’s concern and goal.

Therapist competencies for five steps for the yielding, accepting mode of control.

*. Explains Step 1 – Desire for control: Works with the client to determine where and why (motivation) he/she wants more yielding, accepting mode of control.

* Explores with client issues of whether client feels s/he has the right to be more self-accepting in the area of concern

* Examines with client his/her ability to take personal responsibility for become more self-accepting, including willingness, as appropriate, to choose to let go of inappropriate, excessive, or unrealistic responsibility.

* Discusses and if needed works with client’s self-efficacy belief in his/her ability to learn to practice and succeed in the yielding, accepting mode of control.

* Is able to effectively teach client the building block techniques for the yielding/accepting mode, individually and integrated (e.g., Control Mode Rehearsal), as appropriate.

* Works with client to maintain commitment and adherence to the goal, and the practice of the yielding, accepting mode.

Therapist competencies for the five steps for the assertive, change mode of control.

*Explains Step 1 – Desire for control: Works with the client to determine where and why (motivation) he/she wants to gain more of the assertive change mode of control.

* Explores with client issues of whether client feels s/he has the right to gain more assertive control in the area of concern.

* Examines with the client any issues around taking appropriate personal responsibility for becoming more assertive and making changes in the area of concern.

*Discusses and works with client's self-efficacy belief in his/her ability to learn to practice and succeed in gaining more active control through the assertive/change mode.

*Is able to effectively teach client the building block techniques for the assertive, change mode of control, individually and integrated, (e.g., Control Mode Rehearsal), as appropriate.

* Works with client to maintain commitment and adherence to the goal, and the practice of the assertive, change mode.

*** MAKING A SELF-MANAGEMENT CONTRACT. (SELF MANAGEMENT CONTRACT, P. 18, (Discussed in Module 2.1; 3.2) Appendix 3.7**
The therapist helps the client establish and agree to a self-management contract or action plan, including expectations and goals (a means of measuring success); identifying means to reach the goals (noting specific strategies, skills and plans developed to achieve the goals); anticipating difficulties in attempting to achieve the identified goal; plans to address these difficulties by... (noting specific strategies, skills, and plans developed to counteract each difficulty); identifying specific rewards/positive consequences for successful completion of the goal.

Additional Therapist competencies:

The above therapist competencies address Phase One: Assessment and Goal Setting; and Phase Two: Interventions: The five steps for the: assertive/change mode of control and the yielding accepting mode of control.

Additional therapist competences addressed below include the ability to:

Teach clients skills involved in integrating the two positive modes of control, and to do so in a way that honors and respects the client's preferred learning style.

* Able to explore with client, as appropriate, how the assertive/ change mode and the yielding/accepting mode, can be used in balance and integrated as a combined goal.

* Utilizes metaphors and teaching methods (e.g., auditory, kinesthetic, visual) that match the client's preferred learning style

*Has the skill to work with client's preferred style when appropriate (see above), but also to share with client when therapist feels additional skills (e.g, new positive mode; additional "agency" style; other "building blocks" might also be useful.

Help the client maintain compliance. This involves therapist efforts to help enhance the clients' effort, determination, commitment, perseverance, and motivation to accomplish their goals, including addressing potential client self-sabotage and ambivalence.

* Works with the client to address challenges, resistances, self-sabotage, or discouragement about lack of progress (e.g., things getting worse before getting better).

* Helps client clarify and enhance motivation for change/acceptance process

*Helps client enhance self-efficacy beliefs and commitment to "change"/ accept

Monitor the process of therapy with a systems model The therapist is able to use the systems model of Control Therapy to evaluate and problem solve if client does not achieve initial success. This includes: monitoring and evaluating feedback at each stage of the therapeutic process to determine efficacy of treatment.

* Where there are continued concerns, resistance, or problems with adherence, the therapist will work with the client to make adjustments (in goals, interventions, how the techniques are taught, further exploration of control stories) to maximize treatment success.

*Initiates with the client additional exploration and discussion of control stories and dynamics, including helping client to reedit, and rewrite, control stories as appropriate;

* Helps client revise the goal(s) or consider newly emerging control-related goals.

* Introduces other control-related techniques and concepts as the need arises or goals change;

* If client does not achieve success, therapist is able to evaluate using the systems model of CT to determine where the problem lies: e.g., <assessment, intervention selection, how the therapist is “teaching” the techniques (most suited and matched to this client?) addressing issues of adherence/compliance, further exploration of control stories/dynamics and initiate changes in the course of therapy as needed to maximize treatment success (overall competence).

IV. EVALUATION: Competencies related to Evaluation/follow up.

Is the therapist able to systematically and effectively evaluate therapeutic process.

* **Has a systematic way to assess treatment success** (e.g., SCI, (pre and post therapy); positive changes in self-monitoring of target behavior) to ensure client’s gaining and maintaining a positive of sense of control both at the end of therapy and at appropriate follow-up; uses additional written post-tests/ client journal observations as part of a single case study design

* **Generalizability:** Helps the client consider how control-related concepts and skills applied to the presenting problem may be helpful with other (future) problems (i.e., self-management)

* **Follow up:** Makes plans with the client for follow-up contact to determine if treatment gains have been maintained and initiates CT “booster” session(s) as appropriate

Final therapist competencies:

These are some final therapist competencies to assess:

KNOWLEDGE (EXTERNAL):

*knowledgeable about control research and clinical literature related to mental and physical health;

*able to identify appropriate treatment populations and clients who will benefit from CT

KNOWLEDGE (SELF)

*aware of his/her own control-related dynamics and stories;

*aware of when s/he is upset (“off center”) during the therapy session when s/he is being assertive;

*aware of when s/he is upset (“off center”) during the therapy session when s/he is being yielding/accepting

THERAPIST/CLIENT RELATIONSHIP

*Is able to explain control-related concepts and issues effectively in terms understandable to the client; effectively uses positive assertive (Q1) skills in structuring, focusing, and guiding the session;

*is able to follow the client’s lead (Q2) when appropriate;

*has a range of interpersonal verbal skills, from very yielding to very assertive, and can skillfully choose the most effective style for a given circumstance

* is able to address areas of therapist/client disagreement, “power struggles” (transference or counter- transference) with awareness and skill.

FURTHER RESEARCH DIRECTIONS FOR CONTROL THERAPY PRINCIPLES AND PRACTICE

Control Therapy is an integrated approach to psychotherapy and health care that combines theory, research, and practice. Its test construction has been developed and empirically tested through research over three plus decades involving thousands of individuals. Smaller interventional pre/post case studies have demonstrated positive effects of Control Therapy with a wide variety of clinical populations. Studies of control have been conducted in more than a dozen countries, and the SCI translated into several languages. The research has shown that there are individual differences in people's Control Profiles in terms of their preferred modes for facing this central issue of gaining and maintaining a sense of control; and that for a specific clinical problem, matching clinical control-enhancing interventions to the individual's Control Profile maximizes the opportunity for therapeutic success.

However, continued refinement and bridge building between theory, research, and practice is essential. To that end, the Control Foundation, established in 2004, provides seed grants for those interested in doing research on Control Therapy. Theory can help inform assessment and clinical practice. Clinical practice (in the trenches, N=1 studies) can help assess the utility of the theory, and further inform it.

Below are three overview models that might be helpful in conducting such research: 1) a flow chart for Control Therapy Research; 2) baseline competencies of therapists doing Control Therapy as part of a research study; 3) refining research questions.

Several promising and important directions for future research include comparative group studies of Control Therapy with specific clinical populations, first "compared" to a placebo control; then compared to other "treatments". These clinical populations could include furthering the work already discussed in this talk on depression, anxiety disorders, panic attack, generalized anxiety, eating disorders, and addiction. Future research could also focus on furthering the work on the application of control theory and therapy to issues of physical health targeting issues such as breast cancer, cardiovascular disease, lifestyle and behavioral change. Research has and will continue to refine and nuance the proportion of variance in human behavior (and personality) due to biology (genes, psychophysiology), to environment (social, cultural) and to human "choice" (motivation, skill and personal responsibility. How much individual variation is there among individuals in clinical and health areas? The more information we have about these conditions, the better able we may be to determine how to apply "self-regulation," different positive modes of control, and control enhancing efforts interventions to help our clients.

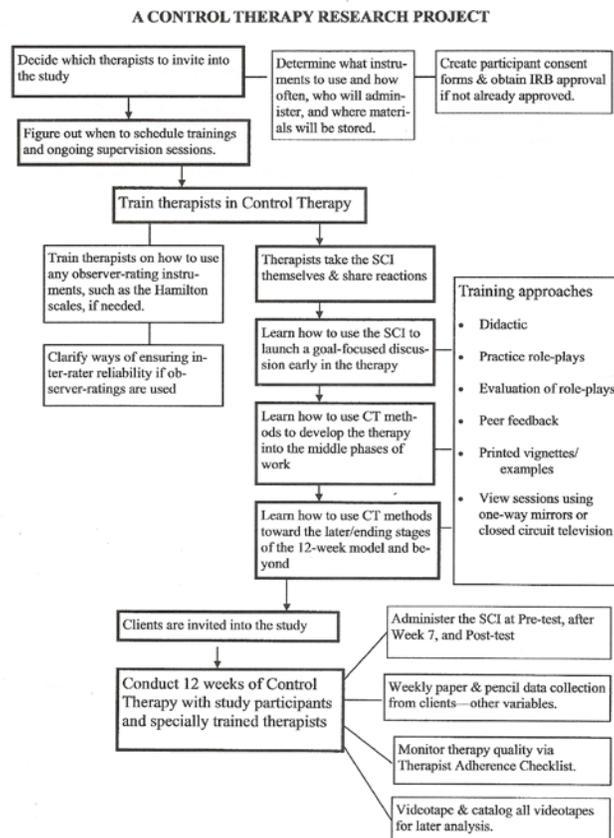
At a fundamental level, "Control Therapy" is based on an educational model of learning and seeks to affect individual psychological health and well-being—and not just in the therapeutic setting. It would be valuable to do research on the effects on the health care and educational professionals-- therapists, clinicians, medical and nursing students; - when they are taught and trained in the principles of Control Therapy. in educational settings—i.e., Further, applying the principles and practice of CT to interpersonal health, couples relationships; child rearing, parent child relationships, educational applications in classrooms and teacher training programs, and to the vision/attainment of positive

psychological health and wellbeing is a relevant and worthwhile application of CT principles and practices..

The SCI has been translated into simple Chinese and is available at controlresearch.net. Also, currently in preparation are a traditional Chinese version of the SCI ; a Spanish version; a Korean version ; and a Hebrew version. It would also be important to continue to expand this research cross-culturally to further understanding of how control therapy principles and practices translate to different cultures..

The Control Research Foundation welcomes proposals for a broad array of potential projects. The Foundation encourages empirical investigations of Control Therapy to ensure that existing research on the clinical effectiveness of Control Therapy is replicated and extended. Control Therapy is an evolving process, seeking and striving, through empirical study and evaluation by researchers and clinicians, to find ways that can enhance and improve the health and well-being of clients. Further, from a real world standpoint, as a relatively new kid on the therapeutic block, Control Therapy will benefit from additional research comparing it with more established approaches, in order to demonstrate its effectiveness as a treatment of choice for specific clinical populations.

Sample flow chart for a control therapy research project. Below is a flow chart developed by Dr. Elizabeth Soucar that may that may be helpful to the researcher in terms of therapist recruitment and training, as well as client recruitment (Examples of human subject consent forms, and permission to videotape are provided in Appendix 6 of the Control Therapy Training Manual.



Therapist /trainee selection and orientation for research purposes in control therapy

In conducting research comparing Control Therapy with other treatment options, the following are essential:

- Make sure there is a baseline assessment of competencies of all therapists/trainees (e.g., listening skills, etc., as and noted above.
- Make sure there is equivalent quantity of training between Control Therapy intervention trainees and other treatment trainees.
- Assess that trainees reach a competency threshold in Control Therapy (cf. Appendix 1 Control Therapy Training Manual (and discussed above) and in the other treatment options being compared.
- Make sure there is standardization of treatment for Control Therapy and other treatment during the study's intervention phase.

In explaining Control Therapy to prospective and/or potentially interested trainees, before they have had the opportunity to take a training course using the Control Therapy Training Manual, it may be helpful to share material from FAQ 1 (pp. 13-14) from the manual, which provides an overview of "What is Control Therapy?"

Refining the research questions while keeping a larger (holistic) perspective.

What is helpful about Paul's question: *What* specific treatment, by *whom*, is most effective for *this* individual with *that* specific problem and under *which* set of circumstances?" in terms of research is both its specificity, and the fact that it allows us to keep a broad, holistic perspective regarding the specific hypotheses we are investigating.

From a research standpoint, each of the six components of the systems model discussed above, can be used to help refine and explore Paul's question. For "*this individual*," the client variables (component 2) can be explored, including each client's control profile obtained through the SCI. For "*by whom*," therapist variables (component 1), including orientation, beliefs (demand characteristics), and experience can be addressed. For "*that specific problem*," it is important to explore the nature of the clinical issue (component 4, assessment), the client goals, and the desired outcome. "*Specific treatment*" can address all the "control-enhancing" techniques used as part of the intervention (component 5), and how they are tailored and matched to the client. *Which set of circumstances* can include relationship variables (component 3) and "teaching" (component 6)-- "matching" therapist style of teaching the techniques to the client's preferred learning style, as well as issues of adherence and compliance.

Specifying these components in a research project allows us to address and refine the first order empirical question of therapeutic effectiveness regarding Control Therapy: matching specific control-enhancing techniques to a particular individual with a specific control profile, clinical concern, and goal.

Then, specific second order questions can be addressed. For example, in terms of researching a self-control technique, such as meditation, implicated in both positive yielding, and sometimes positive assertive strategies, the following expansion and refinement of Paul's question was developed as shown below:

Figure 6.4.1
 What *effects*¹ does the *teaching*² of a self-control technique (e.g., *meditation*)³ have on an *individual*⁴ who *practices*⁵, and *why*⁶?

1. Effects	2. Teaching	3. Meditation
1.1 Self-regulation 1.1a Toward a working definition 1.1b Stress 1.1c Addictions 1.1d Hypertension 1.2 Comparison with other self-regulation strategies 1.3 Altered state 1.3a Toward a working definition 1.3b Subjective experiences 1.3c Concurrent validity 1.4 Comments on adverse effects	2.1 Clinician/psychotherapist/teacher 2.1a Orientation 2.1b Demand characteristics: beliefs, hopes 2.1c Experience 2.1d How it is taught 2.2 Relationship 2.2a Trust, confidentiality 2.2b Resistance 2.2c Non-technical transference/counter-transference 2.2d Length of contact 2.3 Other "teaching" factors 2.3a Modeling 2.3b Style—e.g., successive approximation, reinforcement, etc.	3.1 What is meditation? 3.1a Toward a working definition 3.1b Types of meditation 3.1c Levels of meditation 3.1d Cultic vs. non-cultic 3.2 What are the components of meditation? 3.2a Antecedent/preparatory 3.2b The behavior Posture Attention Cognitions 3.2c Post-meditation components
4. Individual	5. Practice	6. Why
4.1 Individual profile 4.1a Initial expectation/motivation/beliefs 4.1b Commitment 4.2 Who is attracted to it 4.3 Who drops out 4.4 Who continues 4.5 Who continues and has positive experience	5.1 Adherence/compliance 5.2 Depth of experience 5.3 Length of practice	6.1 Mediating mechanisms 6.2 Physiological 6.2a General: trophotropic response, hypometabolic state 6.2b Specific: muscular, oxygen 6.3 Attentional 6.4 Cognitions 6.5 Non-specific discussion of uni-, reciprocal, and omni-determinism models

From reference¹⁰ *Meditation*, pp. 10-11; JHP, p. 105

This Figure allows us to see in overview fashion the multiplicity of variables that may be involved in using a self-control technique, such as those utilized in CT, and to explore both first order questions: does it work, and for whom; and second order questions, seeking to differentiate active from inert variables of the intervention.

Further, as noted earlier, it is important to specify the "building blocks" (cognitive, emotional, attentional, etc.) comprising each technique. In so doing, nuanced distinctions of comparisons of techniques along multiple dimensions can be explored and additional second order questions can further refine active variables by percent of contribution through path analysis, as well as look at mediating mechanisms and moderating variables.

Clearly, not all these questions can be addressed in any one research study. However, in developing a body of research, it is important to have an overview of the variables involved. This approach has three advantages. First, it allows us to have a comprehensive map within which to review and examine a multiplicity of studies examining a range of seemingly unrelated variables involving control. These studies can involve different variables: e.g., research looking at control as a personality variable (i.e., internal/external locus of control); control as a motivational variable (e.g., desire for control); and control as a belief system (e.g., self-efficacy). And these studies can be conducted in physical and mental health domains: e.g., a study on control and anorexia and too high a desire for control; a study comparing CT to another intervention with

breast cancer patients on styles (modes) of coping; studies examining feelings of lack of control in depression; or fear of loss of control in anxiety disorders.

Secondly, having an overview model allows us to ask first order questions about CT and its effectiveness, as discussed above; and then to develop a detailed fine tuning and refinement of individual questions that help to further address and fill in information with more specificity regarding the above variables. Finally, it helps us keep the forest in mind (the broad overview) even as in a particular research project, we may be focusing on a specific (albeit important) tree.

Additional control therapy resources, seed grants for research, curricular development.

As mentioned, the Control Research Foundation Fund, established in 2003, has seed money for research projects and curricular development on Control Therapy. This information can be found at controlresearch.net.

The resources discussed in this lecture are all available for free at that website, including the Control Therapy book, the Control Therapy Training Manual, the Control Content Analysis Manual for Coding Client Speech, and the SCI. For those who would like to take the SCI and learn about their own Control Profile, it is available for health care professionals (and their clients) at no charge. Just go to Controlresearch.net, and then click SCI homepage. It takes about 5 minutes to set up an account, and 20 minutes to take the inventory. A few seconds after you have completed the test you will receive a one page graphic of the scales (shown above) and a 20 page print out giving you a description of your Control Profile (a sample of which was detailed above with agency).

FAQ: FREQUENTLY ASKED QUESTIONS

NOTE TO LECTURER: You may wish to allow time for questions at the end of the talk. Here are some questions that have been asked in the past, which you may wish to consider, or if not asked, suggest as topics for discussion. These questions are placed here, before the final comments. However, at your discretion, they could also go after the “Some Concluding Comments.”.

WHAT IS UNIQUE ABOUT CONTROL THERAPY?

This is an important question. One way to answer it is to provide a brief comment on CT’s roots, and its unique aspects, which may make it a treatment of choice (see research issues above). Secondly, a way to answer this question is to show the benefits of CT. However, it also seems important to note, in answering this question, that CT owes an historical debt to other approaches; as well as to comment on how and why CT can be potentially useful as a complement to other therapeutic approaches going forward.

UNIQUE CONTRIBUTIONS OF CT.

There are several unique aspects of Control Therapy that may make it a treatment of choice. In this section, we want to highlight those qualities. At the same time, we also want to acknowledge in the next sections the potential for integration and complementarity between Control Therapy and other approaches.

**The First Comparison, Contrast, and Integration of meditation and behavioral self-control techniques.* As noted in the beginning of this lecture, the roots of Control Therapy began in the mid 1970’s with the publication of an article in the *American Psychologist* exploring the scientific and clinical interface between self-regulation strategies both Western (e.g., behavior self-control, cognitive therapy) and Eastern (Zen and Vipassana, mindfulness meditation). This was the first time historically that these two self-regulation approaches had been discussed and explored for similarities, differences and clinical applications.

**Positing, Development and Empirical investigation of four modes of control: positive and negative aspects of the assertive/change and yielding/accepting modes.* Exploring the goals and context of these eastern and western techniques led, in the late 1970’s, to the positing and conceptual development of four modes of control, including identifying positive assertive/change and positive yielding/acceptance as important aspects of positive psychological health and well-being. The modes of control represented and embodied a way of understanding human control that was not culturally limited, but involved delineating positive assertive, positive yielding, negative assertive, and negative yielding responses to various situations, interactions, and encounters.

**Control Mode Dialogue*, which addresses the two negative modes (negative assertive and negative yielding) was developed to help recognize, understand, and transform those modes into positive ones.

***An integrative theory of human control.** A unifying theory of control and its accompanying postulates both helps undergird Control Therapy, and also helps clinicians understand control as a component involved in some fashion in all major schools of therapy.

***SCI Control Profile.** By operationalizing the theory, a clinically useful, reliable and valid means of assessment was created, providing an empirical foundation for assessing a client's control profile (including desire for control, overall sense of control in the general and specific domain, agency of control, and modes of control). Further the SCI has shown to be effective in assessment (sensitivity and specificity) with a wide range of diagnoses—e.g., Generalized Anxiety Disorder, Panic Attack, Depression, Borderline Personality. Based on individual variations in control profiles, specific techniques can be matched to client needs and clinical problems.

***Matching Control Profile to Control Enhancing Interventions.** Further, through the control profile and Control Mode Dialogue, a method of refining the client's goal, and then of *matching* that control profile and goal to an individually tailored control-enhancing clinical intervention was generated.

Control Therapy has developed guidelines and principles, based on theory, research, and practice, on how and when to utilize control-enhancing techniques based on a unique individualized Control Profile. A five step model for the assertive/change mode, and the yielding/accepting mode was developed, including 1) desire for control; 2) right and responsibility for control; 3) self-efficacy beliefs; 4) commitment and skills; and 5) success.

***Systems model of Control Therapy.** A systems model of Control Therapy, offering feedback for and evaluation of each of the dimensions of the therapeutic process, was developed. This systems model helps ensure the best possible working relationship between client and therapist with regard to assessment, goal setting, matching interventions to the client's control profile and goal, ensuring that teaching of interventions is most skillfully matched to a client's style, and to facilitate ongoing feedback during the therapeutic process to help maximize success.

***Content Analysis: "Deconstruction of Techniques".** Regarding techniques, as we have seen, one aspect of the CT approach is its capacity to perform a "deconstructing" content analysis of different self-control techniques into component parts or building blocks. By "deconstructing" interventions into these building blocks, it is possible to suggest ways that they can be used to complement each other, as well as combined and integrated. This method became the basis for the **Control Mode Rehearsal** technique, as well as its contingent practice in the natural environment.

From a therapeutic perspective, the above were, and remain pioneering efforts at integration and synthesis. Several therapeutic approaches now utilize some combination of the assertive/change and acceptance/yielding models of self-control and incorporate ways to integrate both eastern and western self-control strategies: e.g., Acceptance Commitment Therapy, Dialectical Behavior Therapy, Mindfulness-based Cognitive Therapy.

Control as common link in human behavior. One of the advantages of Control Therapy, which we have indicated at the start of this talk, and which you may continue to realize in your own self-exploration (e.g., listening to control speech, investigating your control story, and if you have done or choose to do at some point a self-management

project), is that the concept of control is something involved in normal everyday life, conversation, and experience. Therefore, CT offers the client the opportunity to frame clinical concerns in non-pathologizing language. Further, control language provides a common link between clinical disorders, normal psychological health, and positive well-being. Therefore, client desires, goals, and strategies can be viewed along a continuum from less skillful (causing increased suffering to self and others) to more skillful: decreasing suffering and optimizing well-being in both self and others.

***A control-based understanding of suboptimal, normal, and optimal control.**

Finally, Control Therapy articulates a control-based vision of mental, physical, and interpersonal health involving suboptimal, normal, and optimal control profiles. Thus, although Control Therapy was designed to specifically address individual mental and physical health problems, it can also be used as a means to help promote "growth," including intrapersonal, interpersonal and even societal health, healing, and well-being.

* A further comment about the *integrative theory of human control*. We have reviewed the theory and postulates of efforts toward an integrative control theory undergirding Control Therapy, based on several postulates and a biopsychosocial model. That work was done to add to and improve on prior models and constructs. In science there is an effort to make incremental improvements and build on the excellent work of others. The work on control theory here attempted to do just that, and in turn, the hope is that others will continue to refine and build even better and more effective models and therapies. Therefore, the following table is provided with a sense of "bare awareness" to attempt to point out the hopefully positive additions this model makes to previous work.

slide

LIMITATIONS OF PREVIOUS CONTROL CONSTRUCTS ADDRESSED BY OUR THEORY

Control-Related Theory, Construct, or Model	What Our Integrative Theory Adds to the Model.
Rotter's (1966) internal/external locus of control	Measurement of sense of control, motivational vector and domain-specific sense of control.
Wallston's et al. (1978) health locus of control	Measurement of sense of control, motivational vector, and general domain sense of control.
Bandura's (1977) self-efficacy	Measure of motivation and concept of "other" efficacy.
White's (1959) competence	Discussion of control of emotions, cognitions and delay of gratification.
Menninger's et al. (1963) dyscontrol	Negative consequences of having/gaining control are addressed.
Seligman's (1975, 1991) learned helplessness and optimism	Positive yielding mode of control is addressed.
Becker's (1973) death as loss of control; cosmic significance as way to regain control	Acknowledges Eastern views of impermanence and acceptance as ways of coping with death.
Frankl's (1980) will to meaning as way to gain cognitive control	Behavioral control (e.g., Averill, 1973) and competence (White, 1959) are included.
Adler's (1964) will to superiority	Positive yielding mode as way to gain a sense of control is considered, as are non-ego based developmental stages and control strategies.

CAN CONTROL THERAPY COMPLEMENT OTHER APPROACHES?

CT COMPLEMENTING OTHER APPROACHES. Even though there are unique aspects to Control Therapy are unique, Control Therapy is built upon other therapeutic approaches. Therefore, in positing what is unique and original to Control Therapy, it is also important to note the debt CT owes to its philosophical and psychological precursors, a debt which is honored by the over one thousand citations and references in the book Control Therapy to those schools of thought and approaches upon which it has been built and from which it continues to evolve.

Thus, CT is not a final ultimate panacea, or a closed system. Rather, ideally therapists representing other therapeutic perspectives will see aspects of Control Therapy that can be helpful and incorporated into their own therapeutic work

As the Table below suggests, control can be incorporated as an element in many therapeutic approaches. Therefore, therapists from other theoretical orientations may find that the above work on Control Therapy can help them reflect on and provide insights into how control processes may be operating within their own therapeutic theories and clinical interactions. The Control Profile and control stories may help clinicians think about their clients in ways that facilitate additional insights and understandings.

The modes of control may be helpful as a new way to understand how clients can achieve a sense of control (i.e., through the two positive modes of control). Specific control-based interventions and combinations of building blocks (e.g., the Control Mode Rehearsal; the effort to find the best gradated assertive/yielding response (i.e, dongjing) may also be helpful as part of their clinical armamentarium. Finally, the integration of theory, research, and practice which serves as the foundation of Control Therapy, and the Control Therapy System’s Model for Feedback and Evaluation, can be helpful in understanding and refining Paul’s insightful remarks about the importance of matching a specific treatment to an individual client with a particular diagnosis.

Relevance of Control in Different Therapeutic Approaches

The Figure below outlines the different session groupings in Control Therapy and shows where Control Therapy is “in line” with various schools of psychotherapy that are familiar to most therapists.

CONTROL THERAPY: SESSION BREAKDOWN BY PHASES
Aspects in common with Other Therapeutic Approaches

CONTROL THERAPY	OTHER THERAPETUIC APPROACHES
THERAPEUTIC PROCESSES	
PHASE ONE	
<p><u>ASSESS CONTROL PROFILE</u> Engagement in relationship Problem exploration & selection Take SCI in or before session 1 Discuss answer sheet, Scale 4, Page 3 Share SCI test results / control profile</p>	<p>Client-centered (contextual/relational) Experiential (use of imagery) Psychodynamic (listen for developmental control stories) Gestalt (experiential, e.g., mode dialogue)</p>

<p>Psycho-education on control concepts Control Stories, Control Dynamics</p> <p>SELECT GOALS</p> <p>Self-evaluation: options relative to what was found via SCI and self-observation</p> <p>Self-observation in session and as homework (Session 1 onward)</p>	<p>Adlerian (social connectedness) Cognitive (irrational thoughts) Constructivist; narrative therapies (rewrite stories)</p>
<p>PHASE TWO</p>	
<p>INTERVENTIONS</p> <p>Preparation for change (address belief in ability, right, responsibility, etc.) Homework to prepare for change (Session 2 onward) Client makes commitment to change Match techniques with Goals & Control Profile: Assertive Mode, Yielding Mode, Integration Teach relevant self-control skills Address any remaining obstacles to change Continue self-monitoring homework Homework using self-control techniques aimed at effecting the desired change.</p>	<p>Motivational Interviewing (The 5 Steps for Positive Assertive/Yielding Change) Behavioral assessment Skills assessment & training Dialectical Behavior Therapy A.C.T. Acceptance and Commitment Therapy Mindfulness-based Cognitive Therapy</p>
<p>Practice new skills Reinforce small successes Change process continues (Modulate goals) (Continue planning) (Continue/modify action) Evaluate (post-test) Terminate Follow-ups as needed</p>	<p>Behavioral/cognitive/affective</p>

FAQ: YOU’VE GIVEN US A LOT OF INTERESTING TECHNIQUES, BUT HOW DO WE KNOW WHAT TO USE FOR A SPECIFIC CLIENT? When should we use mindfulness or body scan or control mode rehearsal, or yoga or tai chi.? Is there any psychotherapeutic technique that is not compatible with ct?

This is an excellent question--actually it’s two questions! Let’s start with the first:

How to know which technique to choose. Given the vast array of therapeutic approaches and techniques, sometimes knowing which to choose with a client may seem overwhelming, like facing a hodge-podge smorgasbord. Darwin is purported to have said that without a theory, a geologist is only a collector of rocks. One of the goals of this lecture in a small way, and the Control Therapy Training Manual in a more in depth way, is to invite you who are here to explore and clarify your own theory of human nature, and psychotherapy in general, and to examine your own core beliefs about how the human ability to gain and maintain a sense of control fits into those beliefs.

Specific intervention protocols for depression, anxiety, and other specific clinical disorders (addictions, eating disorders) are based on the individual control profile of the client. Since research has shown that there are different control profiles for these clinical disorders, the interventions follow from the profiles, and can be uniquely tailored to the person and clinical diagnosis based on the guidelines, principles, and interventions outlined.

Control Therapy, through the careful linking of theory, research, and practice, provides a framework, a meta-structure, a set of principles for selecting and tailoring techniques and interventions (based on and matched to the person’s control profile and the goal). CT is a way of analyzing a concern, problem, and clinical issue from this multilayered framework linking beliefs about human behavior (broadest level) with specific assessment tools (e.g., SCI; middle level) that then suggests interventions (specific level). In this way, CT attempts to facilitate, in the context of a healing, collaborative, therapeutic relationship, the choice of which particular control strategies to teach to a particular client with a particular problem, and to teach those strategies in a way most appropriately matched to the client’s learning style.

The five steps provides a clear structure in which techniques are embedded and gives a nuanced and larger context for the process of change, including preparation and readiness for change, issues of personal responsibility, self-efficacy beliefs, as well as skills for addressing resistances and maintaining commitment. In so doing, CT offers a set of skills for helping the therapist (and client!) use wise and informed flexibility—giving guidelines and structure, but avoiding a one-size-fits-all, cookie-cutter pitfall. CT also seeks to build on a client’s strengths, looking for coping skills the person already has, offering practical interventions to gain and regain a sense of control no matter the presenting problem-- helping the client become both more comfortable seeing “what is” and also, as appropriate, preparing the client for change. Further, through a systems feedback model, CT provides ways to evaluate progress and pinpoint specific potential difficulties during the therapeutic encounter, as well as follow-up evaluation to ensure success is achieved and maintained. In this way, techniques are selected and taught that best match a client’s control profile, concern, goal, and style of learning.

Is there any psychotherapeutic technique that is not compatible with CT? The short, simple answer is no. The more complex answer is it depends! What is critical from the perspective of Control Therapy is the rationale for when and why a technique is used. For example, as we saw in discussing Phase One: Assessment, several different types of skills can be utilized: —structured assessment, listening to speech, stories, self-observation-- in order to help a person become more aware of their control-related habits, patterns, and dynamics. In Phase one: Goal Setting, CT utilizes self-evaluation and goal setting borrowed from behavioral approaches, tempered with meditative approaches, in order to help a person set a control-related goal based on their concerns. In Phase Two, the intervention phase, Control Therapy draws from several different potential techniques as interventions.

As we have discussed regarding building blocks, all therapeutic approaches draw from a common “alphabet” of building blocks that we can use to construct an intervention: the body, the mind (attention, choices, images, cognitions, beliefs), emotions, behavior, other people, and environment. CT doesn’t build all interventions from scratch...but it is important to know why the building blocks from any intervention are being used (whether CT draws from an already existing one) or develops and fashions a new one (e.g., CMR).

Thus, CT draws from these building blocks, this alphabet, and, as we have said, puts them together into “words,” “phrases,” and “sentences” matched and tailored to create an intervention specifically designed to best address a person’s control profile, area of concern, and goal. Specifically, we would be intervening to address a desire for control which was too high or too low; to transform a negative assertive or negative yielding tendency with a positive assertive and/or positive yielding intervention; and to ensure that self as agent and other as agent were utilized effectively and skillfully. This can involve helping a person notice default and unproductive modes of thinking, change or accept self-cognitions and thought patterns, reinterpret and transform emotions, develop greater emotional self-regulation and equanimity, change perceptions, notice unproductive habit patterns, and modify unskillful behaviors.

Control-enhancing interventions which increase self-control and a positive sense of control can be profitably “borrowed” from other psychotherapeutic approach and be applicable in a CT context when they are appropriate for a particular person with a particular control profile and a specific control-related goal.

DOES CONTROL THERAPY REQUIRE THAT EVERY CLIENT’S PRESENTING PROBLEM BE FIT INTO A “BOX” IN WHICH CONTROL IS THE MOST SALIENT ISSUE?

This is a critically important question, and the short answer has to be ***“Of course not!”*** Our first task as therapists is to hear the client’s concern in the client’s own words, and be sensitive and empathic to what the client is feeling. The very antithesis of that would be to force a client’s views into our preconceived constructs in order to validate our own perspective. “Bullying” and forcing the client to adopt a control framework are not positive options. Nor is trying to “pigeonhole” every client concern into “a control issue.” Thus the therapist should not try to force a client into a control framework; nor should the therapist try to “bully” a client into seeing control issues in her life even if the

therapist believes such issues clearly exist. If a clinician feels s/he is engaged in a power struggle with a client, and is trying to force a method upon the client (whether it be how to frame an issue, or which technique to use), this can signify some counter transference issues that the clinician should address through self-exploration or with a supervisor.

Control Therapy suggests that it is “skillful” for the therapist to be listening attentively to the concern, to note whether there is actual “control speech” used by the client; and also to be aware of whether or not there may be obvious control issues implicated of which the client is not aware. The assumption of CT is that control issues exist in most if not all problems and concerns presented (see Postulate One). However, clients may not be aware of these control issues (e.g., denial, repression). Further, clients may not be comfortable framing an issue in control terms if they think there is a pejorative aspect to it—(i.e., they do not wish to appear “overcontrolling” (e.g., negative assertive quadrant three) (see Postulate Two). For example, the mother in law who says in response to her daughter in law’s concern that the mil is always interfering: “I’m not being controlling, I’m just trying to help.” <And of course in daily life, there is the politician who says I have no desire for power and control, I just want to be of service.

Life is multidimensional, and even if there is a control issue involved, this doesn’t mean it is the only motivational variable, and does not need to negate other possible motivations. The context of the above discussion we hope makes clear that we do not believe that control issues exist necessarily as the *sole* variable and motivation in a problematic concern. However, as the postulates state, even behavior which can be framed as “just trying to be helpful;” “only trying to be caring” may contain an element of control: i.e., attempting to cause an effect in the intended direction. The mil in the above example may see her efforts as caring, positive assertive mode of control; the daughter in law may see the mil’s efforts as negative assertive, quadrant three, overcontrolling. Depending upon whom the therapist is working with, the task may be to help frame the different perceptions between positive and negative assertive, and work on the “control battle” occurring between the two. Control is both a content issue (as in this case, positive assertive “vs” negative assertive); as well as a process issue (here, a control “battle” between mother-in-law and daughter-in-law over perceptions of content). We hope the above shows that control is often an aspect, if not the root, of the clinical problem for which the client is seeking help; and helping the client recognize and understand this is part of the art of therapy.

Even if control issues exist, is it always necessary to discuss the issue in control terms with the client?

It is important to use words and metaphors that speak to the client where they are, finding the “best” therapeutic style for raising these issues; and finding positive ways to present and frame control issues in language comfortable for the client. The skillful therapist seeks a balance, so that the client doesn’t feel s/he is being force-fed a predetermined schema; yet the therapist also doesn’t avoid the topic of control just because it may be uncomfortable for the client to address.

The issue of how and when to frame issues in control terms is an interesting one. As we have previously discussed, it can be helpful to speak in terms and metaphors that

are congruent with the client's cognitive/ affective representational system. Further, not every control issue has to be described as a "control" issue. For example, in terms of the positive assertive mode of control, is the client more comfortable with terms like "becoming empowered"; "taking charge"; "opportunities for self-choice, self-determination?" In terms of the positive yielding/accepting mode of control, terms like "letting go" or just "accepting" "yielding" (without reference to it's being a mode of control).

In terms of techniques, again, the important point is the proverbial moon (the goal), not how something is called (e.g., the fingers). For example, if a therapist wanted to teach a person "meditation" to help relax them, and the client wanted to learn relaxation, but objected to anything of an Eastern derivation, what the therapist could do is teach them "focused attentional breathing." This would be a way to get to the moon (relaxation, stress management) by relabeling the finger.

What if the client doesn't "buy into" the control model? How does the therapist respond to a client who says, I have no control issues (e.g., I don't drink before 9 a.m.; the mother in law who says I'm only being caring and bringing these issues up for your own good, I'm not at all controlling)? What does the therapist do when the client has resistance to self-exploring: e.g., I'm not sure I want to take the SCI; self-monitor, set a goal, engage in practice of control-enhancing strategies, etc.

These are content control questions, and good ones. However, let me try to frame the issue in a larger contextual sense—these questions are ones every therapist, regardless of therapeutic orientation, may face with clients in the process of therapy. Sometimes clients do not wish to self-explore; to learn about their own behavior, or to take responsibility for their actions. These content issues can apply to any therapeutic approach—whenever a client doesn't want to "buy into" therapy. What is interesting is that though the content may vary—e.g., areas where the client and therapist may disagree—the meta issue is really one of a potential "control struggle"—and the issue is how does a sensitive therapist work through potential transference, countertransference issues, and develop the proper balance of empathetic understanding, and gentle(ish) prodding—as we have discussed in a range of responses--paraphrase; Socratic questioning, further exploring, more direct degrees of assertiveness-- to help the client in ways the therapist might feel are in the client's best interest.

Is control the most salient issue? Your view?

The greatest single issue to be worked out in an intimate relationship is power.. Who is going to control whom, who is going to decide what, who will get whose way and who will have to compromise? ...Almost every relationship must negotiate the power struggle stage

--Lonnie Barbach, For each other: Sharing sexual intimacy, 1984, p 47

Now, even if control issues exist, and need to be addressed, we can address the question of whether control is the "sole" or most important issue? One way to explore that is to ask yourself what you believe is "ultimately" important to us as humans? For example, Freud said it was "love and work."

Here are some possibilities which will probably rank high on anyone's list: *Meaningful order* (i.e., uncover, discover, create one's life's purpose; search for "meaning" in challenges, disorder, adversity); *belonging* (love, community, connectedness; being valued); *competence* (achievement, work, contribution, "joy in being a cause.")

Let me invite you consider whether our control theory is potentially a parsimonious theory and way to understand and "umbrella" each of these constructs—i.e., we each desire a "sense of control" in the above areas; and gaining or regaining control in its various forms (assertive, yielding, self, other) might also be a critical means for achieving those goals. This does not mean that other approaches might not highlight these (or other) important human constructs as paramount (e.g., life's purpose, love, meaning) with sense of control and control "means" subsumed under their primary therapeutic formulation.

A second way to consider this issue is to look at Maslow's needs—basic physiological needs for food, water, sex; the need for safety; the need for love and belonging; the need for self-esteem (and self-actualization). Although control is not mentioned as a "need", how important is control in the attainment of each of the Maslovian needs: e.g., gaining access to food, water; to safety, to love and belonging (including both positive modes of control as we have discussed); in terms of self-esteem (competence/mastery and self-acceptance)? In other words, might control be an important variable both in and of itself, and as a means to achieving other "needs" in life?

What we have attempted to do is to show illustrative examples of how Control Theory and the postulates of the theory underlie and serve as a foundation for Control Therapy. We encourage all those interested in the relationship of theory to practice (and research) to wrestle with the theory and postulates, and to critique, refine, detail, and evolve them as you explore the implications and applications of control theory in your own clinical practice, and its relationship to salient constructs you believe important to our human wellbeing.

DIDN'T YOU SAY IT WAS BEST TO TEACH A TECHNIQUE TO THE CLIENT THAT WE HAD PERSONALLY PRACTICED? HOW CAN WE AS THERAPISTS PERSONALLY PRACTICE ALL TECHNIQUES?

Discussion: You're right! It IS best, AND no one can test all interventions personally and in depth. Where does that leave the conscientious therapist?

There is an old Chinese saying that "the finger points to the moon." Commentary says a) don't confuse the finger with the moon (i.e., the technique with the goal); and b) there are many fingers that can point!

The goal of CT—the moon—as we have seen is to help a client gain a positive sense of control in their life. The techniques are the "fingers." CT, as this lecture has hopefully shown, attempts to ensure that any technique that is used in an intervention has been carefully chosen to maximize the chance of helping the client "see the moon." Therefore, the intent has not been merely to present techniques, but to provide a conceptual framework within which to fit the interventions, so it is clear when and why to use them, tailoring and refining them based on the client's control profile and goal. CT does not believe in "cook-book" answers, but rather

guidelines and principles that a therapist can use to come up with strategies and skills tailored to each of your clients.

For you, as therapist, it is important to “practice” what you preach as best you can, so that you can model techniques for your client and be able to teach them “from the inside out.” To do so, we must “know ourselves”--, how we gain a positive sense of control in our lives. Therefore, it is important for the therapist to reflect on his/her own learning style, and be open to learning new tools that might become part of both your personal as well as your clinical armamentarium. That is why the format of the first three modules of the Control Therapy Training Manual attempts to teach Control Therapy by having the student/trainee engage in self-exploration of the process themselves: self as client, and self as therapist: e.g. take the SCI; examine their own their own control stories and dynamics; practice self observation and mindfulness meditation, pick a goal for self-exploration, practice Control Mode Dialogue, go through the five step process, as well as an exploration of several different integrative mode techniques.

By becoming familiar with these techniques, you can then determine whether they might be helpful for a particular client. If you didn’t feel sufficiently proficient or practiced in a technique, but felt it might be helpful to the client, you could, of course, refer the client for more specialized training (e.g., mindfulness meditation) in a particular area. Further, it is important to recognize that the techniques and styles (i.e., fingers) that might be helpful for you are not necessarily the ones that would be helpful for the client in reaching the “moon”—gaining a positive sense of control.

Finally, although there are a myriad of therapeutic techniques (fingers), these techniques, as discussed, are actually composed of only a few building blocks - body, mind, (thoughts, attention, cognitions, imagery), and self/other agency. When presenting techniques, therefore, an attempt has been made to “deconstruct” them to show their component building blocks, as well as the goal and intention of the technique in CT terms and why it is being used. This way it is possible to compare the “essential” aspects of each technique discussed with others that you might consider exploring and using as a control-enhancing intervention. Thus, not every technique need be practiced by the therapist, but an experiential understanding of the essential components and building blocks of techniques is important so that the therapist is as comfortable as possible with how each of the building blocks contributes to a positive sense of control in his/her life; and how it can best be utilized for the client’s benefit: i.e., whether the technique (and its components) are suited to the client’s strengths, well matched to their control profile, and appropriate for their goal.

A further note on theory: This question can also lead us back to “theory” once more. In terms of building blocks, what is your strongest building block: e.g., cognitive, emotions, attentional, body, relational? Based on your own experience, have you “evolved” or gravitated toward a particular theory: e.g., have you concluded that “cognitions create emotions”; or “attention is key”; or “the body” is the foundational stabilizer for cognitions and emotions?” As Jung observed, the personality theories we create and the systems of therapy we embrace are not unrelated to our own personalities. What have you learned, or what do you know about yourself and your

own personal style, that might have influenced your choice of theoretical orientation and system of therapy? (A personal aside from DHS: Although beyond the scope of this lecture, this question is definitely one upon which I have spent considerable time in self-reflection—as my personal memoirs will attest!)

Do you believe the theory you've formulated is "universal" and true for "all people"? How much of your theory is based on your own personal self-knowledge and preferences? Might you allow that different individuals have different preferences and styles? And that each of these preferences and styles can be "a truth": e.g., cognitions can create emotions, but emotions can also create thoughts; the body helps stabilize the mind; and the mind can help stabilize the body. This is an invitation to reflect on the theory you may have built (or gravitated toward, or chosen) either consciously or unconsciously based on your personal control dynamics, and to be sensitive that this theory may or may not apply to your client's preferences and styles

**DOES CONTROL THERAPY HAVE A BIAS TOWARD THE ASSERTIVE CHANGE MODE OF CONTROL?
DOES CONTROL THERAPY HAVE A BIAS TOWARD THE YIELDING, ACCEPTING MODE OF CONTROL?**

These are interesting questions, particularly because these questions were asked at different times by different individuals. The short answer is a) it depends; b) sometimes; c) yes!

As a "mantra," Control Therapy believes the wisest course is to examine ourselves, our biases, our goals and, from a centered place, try to arrive at the best goal for the situation, time, place, person, developmental phase, and concern being addressed. Sometimes that will be an assertive mode, sometimes a yielding, accepting mode, and sometimes a combination (dongjing). <It's interesting that these two questions each see CT in opposite ways: one person may bring a bias toward positive yielding, and feel CT may be biased toward positive assertive; another may bring a bias toward the assertive mode, and feel CT may be biased toward positive yielding and acceptance. Although that may say something about CT, it may also say something about the perceptions and biases of the one who asks the question.:)

A developmental dance? One way to look at these questions is to think of life as a developmental "dance" between the assertive change mode and the yielding accepting mode, self and other agency. As the Chinese characters (heredity and environment) for fate suggest, when we are born we have few "assertive" actions available to us (only our infant cry). One of the tasks and goals for this phase is to learn to gain greater competence and active control over our environment and ourselves. This assertive/change mode, as a goal, involves developing a corresponding self-efficacy belief: that we can gain control of our thoughts, our emotions, and our world. It's even been suggested by some that the "illusion" of active control and belief in our ability to "make things happen" can be a good thing during certain developmental periods as we strive to make our way into the world.

However, what may work well in one domain—e.g., assertiveness at work—may be less effective in another domain—e.g., the same assertive style in relationship. Further, in facing certain uncontrollable events, and at different developmental periods (end of life, for example) the assertive change goal may not be sufficient, and may need to be balanced, integrated, and/or complemented by a yielding accepting goal.

Further, even as we learn these positive assertive lessons, there is also wisdom in learning how we handle defeat, rejection, adversity, and not getting what we want. Certainly one aspect of wisdom/psychological health involves being increasingly comfortable with not having active control, losing control, and recognizing one often can't be in control of circumstances, thoughts, feelings, sensations, or other people, our work environment, our world, the cosmos. We also need to learn the balance in different situations between self-effort and help from others as agents.

Each of us has to come to an understanding about how much self-acceptance and serenity we feel we can have when we are not in active control. How comfortable are we, or would we like to become, when we realize we're not in control of our emotions; of our thoughts; of events? How much of a lack of active control—including ambiguity, uncertainty, the unknown-- are we willing to tolerate and accept in a relationship; in our work environment; in the community; in the world?

As we get older and have less control of our body, our mind, our children, lose loved ones, face our own mortality, we may need to develop greater positive yielding and acceptance of others as agents and helpers. We also need to develop a “wisdom” about how positive acceptance of inevitable losses can be balanced by doing “everything” we can in a positive assertive way to maintain an active and healthy body and mind; and to continue to work toward making improvements in ourselves (right mindfulness, right intentions), our relationships (e.g., right speech, right action), our environment, and our world.

A further (and final) comment on theory. We have discussed theory throughout this lecture, beginning with Einstein, Darwin, and the wolves; as well as our reciprocal influences biopsychosocial model and postulates that undergird CT at the start of the lecture. We've asked you to reflect on your views of free will, as well as your preferred building blocks and the theory you have regarding cognitions, emotions, attention, and body. We have also asked you to consider your view about how salient a variable control is among potential “organizing principles.” Now, we'd like to ask you to reflect for a moment on the assertive and yielding modes of control. How much of these do you believe were evolutionarily and biologically based? How much are they cultural preferences (interacting with evolutionary possibilities/tendencies)?

Though this is starting to move beyond my pay grade, it seems reasonable to consider that in addition to our evolutionary heritage of fight or flight, there may also have been an evolutionary advantage to the positive assertive mode in the sense that this mode helps us see what needs to be changed to make life better for us as a species. This can be encapsulated in the first part of the Promethean Myth: learning to overcome helplessness and negative yielding, not to accept what is but to change and make it better: to till the land to grow food; to create drugs to cure illness; to build bridges to forge rivers. In other words, to change the world to make it better. This is also the “wanting

25% more,” to set higher goals, to seek more. This can be adaptive evolutionarily....to a certain extent.

That of course is where the second part of the Prometheus story comes in. Prometheus is punished for stealing fire from the gods. This begs the question, can we seek to actively control too much in a way that is harmful? It is Icarus flying toward the sun in Greek mythology and the Tower of Babel story in the Bible, both stories in which human hubris causes negative consequences. An unbridled assertive urge may not be evolutionarily adaptive.

Might the positive yielding mode be a counterbalance to the assertive urge that evolved evolutionarily? Might it also at times be adaptive to learn to accept, accommodate, and be content with what is? We certainly have seen that there are cultural differences (eg., in the US, the “squeaky wheel gets greased” [positive assertive]; in Japan “the nail that sticks out gets hammered” [to draw attention to oneself is negative assertive]). We have discussed the origins of jujitsu in the “yielding” of supple branches that allow the snow to fall off them. In the Chinese yin/yang symbol we have a model of integrating the two modes, in a way that works harmoniously.

These are merely questions raised to invite the audience to further explore, refine, and advance a deeper understanding of the aspect of control theory related to the assertive and yielding modes.

Thank you for your indulgence. Now for some concluding comments.

SOME CONCLUDING COMMENTS

Note to lecturer: In these concluding comments there is a final breath exercise, followed by a discussion of some issues that are personal for each of use-therapists, teachers-- as well as. The discussion goes beyond "client suffering" and links CT to fundamental questions about human suffering, healing the world, balancing striving within a context of acceptance and compassion. Of course these comments may be used or adapted in whatever way you feel is appropriate.

THE BREATH CYCLE REVISITED. We have discussed the breath cycle as it related to the modes (and agency), and to several different types of breathing (e.g., diaphragmatic, etc). It is possible to extend and deepen that exercise of the breath cycle as a metaphor of the life cycle, and its possible implications for "daily practice" in our lives. Each moment is a chance to learn and reflect. Each breath is an opportunity to be curious about what is happening in the here and now, an opening to new experiences. The following is an exercise therapists can share with their clients, and it's one that can be shared here at the end of this lecture.

In breath.

First in-breath. Imagine you are a newborn baby that has just come out of the womb. If you had self-awareness, you might wonder if you were going to be able to breathe! (as your doctors and parents worry). You are totally helpless, and it is due to the beneficence of the environment (the presence of oxygen) and the development of your lungs, that you can take your first in-breath. Interestingly, the Chinese word for fate has two characters, one meaning environment, one heredity. We are at the mercy of "fate" with our first breath. For those of a theistic persuasion, you would still be personally helpless, though believing your fate is in God's hands. Our feeling with that first in-breath would likely be one of gratitude, appreciation for our body's natural wisdom and for the environment's grace; theistically, for God's beneficence. The breath cycle also helps us realize our interdependence. We may take a breath. But we need oxygen to be present. That in itself is something for which we may wish to express gratitude. And by extension, we may express gratitude for all the "others" who keep us alive, support us, and nourish us in the "web of life."

Daily practice. One way to carry this attitude into daily life is, as some spiritual traditions suggest, to wake up every morning with a gratefulness prayer or affirmation.

Competent to navigate the world. Every time we voluntarily breathe in, we can also imagine ourselves practicing a positive assertive action competently, a reminder to learn to trust our "self" and our ability.

Out breath. But all of us have to address times when we don't have active control. We all have to let go of each breath. Therefore, every time we breathe out, we can imagine ourselves letting go with serenity.

Daily practice: Forgiveness: Letting go. Again, one way to carry this attitude into daily life is, as some spiritual traditions suggest, a nightly prayer of forgiveness, before going to sleep. In this prayer we ask forgiveness from others, we forgive others, and we forgive ourselves for hurts caused intentionally or unintentionally by thought, word, or deed. (If we are not yet ready to forgive totally, we might begin with

a *successive approximation* such as “May I start to want to begin the work of the process of forgiveness”).

Last out-breath. Now swing to the other end of the continuum. Imagine that you are about to exhale your last out-breath. Before that last out-breath, presumably you would have wanted to have lived life as fully as possible. With a final letting go, we would have wanted to have made amends and be at peace with our life. We would want to forgive all who have hurt us, and be willing to let ourselves go.

Based on our personal philosophies and control stories, each of us has to decide the context and manner in which we take our last breath and face death. For some, this letting go can be facilitated by our views about the nature of the universe—letting go into the non-theistic “Way” of the Tao, the xujing cosmic void, the isness of Buddhism; or into the theistic “One.”

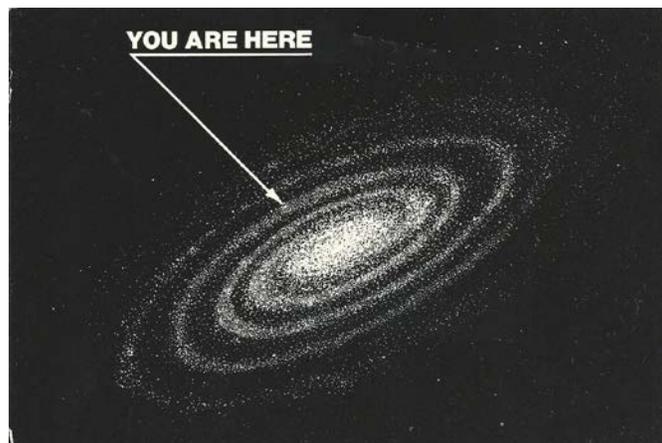
In the meantime, before our death, the act of facing that last out-breath while there is (we hope) still a next in-breath to follow, may help us consider and reflect on how we can best live our lives during the time we are physically here on earth. In the teachings of Don Juan, this is called keeping death as an advisor over our left shoulder. In Buddhism, Buddha’s last words were said to be: All conditioned things are of a nature to pass away. Practice diligently.”

THE LIMITS OF HUMAN CONTROL, THE IMPORTANCE OF TRYING, COMPASSION AS A CONTEXT.

Control Therapy is an approach to helping individuals (and ourselves) gain a positive sense of control in their lives. In ending this lecture, it might be helpful to pause and consider a “larger” picture.

If we take a few steps back—ok quite a few!—and look at the stars and galaxies, and imagine the earth rotating on its axis around the sun, it’s amazing that we have the chutzpah to believe we have any control at all in the world! It certainly might explain why we—and our clients—seek a greater sense of control!

slide



The arrow in this slide points to the sun, one of several hundred billion other stars in the Milky way, pictured here. Our sun is 30,000 light years from the center of the Mikly Way. The universe contains at least 100 billion other galaxies. Each galaxy contains at least 100 billion stars.

end slide

It's important to remember that in the process of therapy—and life itself—we are small creatures on a small planet in a small solar system in a small galaxy. This is not a reason for fatalism and helplessness. But it is a reason to honestly and compassionately face our limits.

On the one hand, we as therapists, want to “practice what we preach,” striving to become exemplars of optimal control in each of the domains of life. In Zen, as we have discussed, the instruction is “When you walk, walk; when you sit, sit; above all don't wobble.” We want to follow Gandhi's advice to “Be the change you want to see in the world.” The Gita says, “Let there not be a hair's breadth between will (what you decide) and action (how you act).” This applies to being centered and calm, and also to acting in the ways of the world. The Gita integrates these two skills by saying that one who can “*see action in inaction*” (even while calm centered, as in meditation, recognizing that blood is coursing through the body, the heart is beating, the mind is awake); and “*inaction in action*” (even while we act, we attempt to stay centered and calm), “*that person is wise among all.*”

This is all sage advice, yet as each of us have probably experienced for ourselves, there is no such thing as “perfect” self-control. There are limits to our ability to stretch and grow in a positive assertive sense just as there are limits to how much we are able to yield and accept. We are human, after all! And we do wobble. There are times in life when we simply don't know the correct course of action. As noted, we think a footnote to the Zen saying might be needed: “When you wobble, wobble well!” (Or as best we can).

Further, as we wrote long ago in the *New England Journal of Medicine* on the Psychology of Responsibility: “no matter how purely we eat and drink, no matter how carefully we guard the air we breathe, no matter how much we become involved with our doctors and they with us, no matter how well we meditate, ...the mortality rate will still be 100 percent.”

Facing suffering—within and without. Further, as the Buddha pointed out, each of our clients, as well as each of us eventually will have to face the three messengers of aging, illness, and death in our own lives, as well as in the lives of loved ones. All of us have, or will have wounds, places where we've been broken, and at times feel crushed.

We all know the challenges of overcoming our individual “selves” and connecting with others. Yet, no matter how well we do the “tai chi dance” of relationship, no matter how well we forgive, and dialogue successfully, from one perspective, in this earthly plane, all such efforts end: marriage ends either in divorce, or, even with the most devoted love, in death. Our bodies, no matter how well we care for them, are doomed to decay and fail. It is the irony recognized by the playwright Chekov, a physician who knew that even as you try to cure a patient, it is only a temporary reprieve. We humans have awareness of the suffering of life. Part of our task is to learn how to cope, deal with, and come to terms with necessary losses that are part of life. This involves mourning, grieving, and ultimately trying to come to some kind of peace and equanimity with the “thousand sorrows.”

Yet, it is said “a thousand sorrows, a thousand joys.”

We also can have awareness of life's beauty and preciousness. This is all we have. How can we keep our focus on what is important and valuable in life? Like the person in the Zen tale faced with the fierce, teeth-baring tiger above and the sharp, jagged rocks

below, we have the ability to pause, make a choice, and taste the “sweet” strawberry in the here and now. We also have the choice to courageously move forward with our lives. We can recall Hemingway’s Old Man saying, “Man can be destroyed, but not defeated.” We can learn to adapt, grow, and, as best as possible, find ways to let the “light shine though the cracks” of places where we have been wounded and broken.

We have the opportunity to learn the lesson that Miriam taught, after the Israelites had crossed the Red (Reed) Sea when fleeing the slavery of Egypt. Egypt (*mitzrayim* in Hebrew) means “narrow places.” Crossing the sea can represent, metaphorically, leaving our internal “narrow places” where we are enslaved, and crossing into a higher sea of consciousness. Yet, as we know from the Biblical story, the Israelites still had forty years of wandering in the wilderness to face in order to reach the “promised land.” Miriam’s lesson? She led the Israelites in dance. We have the choice to take a break from effortful focus on difficulties, hard times, and suffering, to pause and celebrate, to dance in our hearts and minds along our journey.

We also have the capacity to face mindfully and directly difficult and challenging aspects of reality; and, without avoiding or denying, to choose, as Victor Frankl said, “our meaning.”

This is not to say that facing such challenges and adversity is easy. Rather, it may be impossible to face all the challenges life sends us with perfect self-control. Sometimes we’ll wobble, but we should try to wobble as well (and compassionately) as we can, and choose as healing and wise a response as we are able.

Healing the world.

Sometimes, as therapists, we may feel overwhelmed by the pervasiveness of suffering in our clients. This may also be true when we look at the suffering in the world -- poverty, homelessness, war, and disease. Once we break through denial, it is understandable that we can become overwhelmed at the enormity of this suffering. There is suffering in this world that is part of the human experience, and no amount of control efforts can ever completely ameliorate that.

However, as many spiritual traditions suggest, while it is not entirely up to us to solve the problems of the world, it is our responsibility to make some contribution toward solving them. One way to address this is through the metaphor of yoga stretching. If we do not stay slow and centered in a stretch, we can push too hard and injure ourselves. From a centered place, however, each of us may be able to find ways to stretch toward one or two degrees more involvement with the posture (and with life’s suffering). In dealing with Buddha’s messengers, each of us may be able to develop one or two degrees more of acceptance. Each of us has to find the balance between acceptance (quadrant two) and stretch (quadrant one) that feels wisest and most compassionate to us.

Simply because we are limited in our ability to exert positive control in each mode does not mean that the effort is not worthwhile. If we can only improve two, three, or four degrees, that can make a substantial difference in our lives and the lives of others. Think of the difference a few degrees make in our body temperature: e.g., 98.6 to 102.

As therapists, there is some part of us that is optimistic about our ability as humans to change and grow in positive ways, or else we wouldn’t be in the health and healing professions. We seek to affect positive control and reduction of suffering in ourselves and others wherever we can. We seek to live and act and

model the values we believe in and would like to share with our clients (and, as Gandhi suggests, with the world).

We are all fellow travelers on a temporary journey through the hourglass. Compassion and love are needed as a context for our efforts to teach, learn, and practice positive control in our lives.

Touching the human soul. Learning Control Therapy and teaching Control Therapy to others is a way to help reduce the suffering in others, a step toward healing the world. For those that wish to continue on this journey, I hope you find this expedition an insightful, meaningful, worthwhile, and enjoyable learning experience, both for yourself and for your clients and/or the participants in your research.

I'd like to add one further comment. Carl Jung once said, "Learn your techniques well and be prepared to let them go when you touch the human soul." We might refine these sentiments just slightly, using the Chinese proverb we've discussed about the finger and the moon. Techniques are just fingers. All therapeutic approaches, including Control Therapy, are just fingers. Our goal and vision—our moon—is to touch human souls, to be that which we teach, to help others in a wise, thoughtful way, to reduce unnecessary suffering in those with whom we come into contact. Theories and techniques may be helpful toward pointing the way. But they are not the way.

We want to make sure that when we look back at our lives, -- when the grains of sand of our life have run out-- we have been as true as possible to our vision of why we entered the health and healing professions as possible. Thus, it is incumbent on all of us to remind ourselves and each other of our larger vision, and help light the way, by our thoughts, speech, actions, and deeds. Together, we seek a deepening, evolving wisdom for ourselves and our world.

And, as you serve as a healer for others, may you also take time in your own life for yourself...to taste the strawberry... and to dance.

I wish you-- wherever you are on your journey through the hour glass-- blessings of peace, health, and healing. And, to paraphrase Rumi's poetic words,

May we all, wherever we are,
learn to be the soul of that place.

The lecture ends. The next phase begins. Traveling mercies.