3.2b. Exploration of Specific Domains, using the SCI Answer Sheet

Didactic: Control Inventory: Description & Background

At this point, since trainees are just coming off their first "taste" of the SCI, trainers may want to give some information about the creation of the SCI and it's psychometric properties, so that trainees may understand how it is used and how it compares to other measures of control. A much fuller discussion of the instrument can be found in the manual for the SCI [reference here].

The SCI (Shapiro, 1994) is a 187-item standardized paper and pencil test for assessing an individual's sense of control in several dimensions. See Appendix X. It was designed for use as both a clinical and research tool. It is written at an 8th-grade reading level and according to Shapiro (1994), takes on average 25 minutes to complete, yielding nine scale scores and five supplemental scores (Shapiro, 1994). However, many of the participants in this study spent from 35 to 45 minutes completing the instrument. The SCI was developed to improve upon existing control-based instruments, such as Rotter's Locus of Control Scale (1966) and Wallston's Health Locus of Control Scale (Wallston, Wallston, & DeVellis, 1978).

SCI Scales 1-4 include Overall Sense of Control (derived from 16 items), Positive Sense of Control (11 items addressing such things as self-efficacy and motivation for taking control), Negative Sense of Control (5 items reflecting loss of control or too much control from others), and Domain-Specific Sense of Control (25 items regarding discrete life areas such as eating habits, family of origin, work habits, time management, etc.). Scales 5-8 are referred to as the Mode of Control Scales: Positive Assertive (16 items), Positive Yielding (14 items), Negative Assertive (14 items), and Negative Yielding (5 items). The mode scales are central to the Control Therapy approach and are explained in detail in the literature review for this report. Scale 9 is a measure of a person's Desire for Control (comprised of 11 items).

All the SCI items are presented in organized groupings. Some items require choosing from 1 (Never) to 7 (Always). Some items range from 1 (Very out of control) to 6 (Very in control). Some range from 1 (Describes me NOT WELL at all) to 4 (Describes me EXTREMELY WELL). Still others require choosing from among three distinct choices: A (Not a Concern), B (Prefer to make an active change/alter), and C (Prefer acceptance of the situation). The last section of the instrument asks participants to consider a list of adjectives (e.g., patient, rational, indecisive) and choose from the following: A (I would like to be LESS like this), B (I would like to stay the SAME), and C (I would like to be MORE like this).

The test can be administered pre-treatment and post-treatment. The developers of Control Therapy indicate that changes on the SCI are typically detectable after seven sessions of Control Therapy (Shapiro & Astin, 1998). The SCI is not meant for use as a weekly inventory. The SCI scales have shown adequate internal consistency (coefficient alpha ranging from 0.70 to 0.89), and test-retest reliability ranged from $r = 0.67$ to $r = 0.93$ after a 5-week period (Shapiro, 1994). Twelve studies have been conducted to establish the validity of the SCI (Shapiro, 1994), and they are described in the manual for the instrument. A selection is presented here: The SCI has shown that it can be used to discriminate among normals and several clinical groups, performing better than the Rotter scale and the Wallston scale.

HOW DOES THE SHAPIRO CONTROL INVENTORY WORK?

The instrument allows clients to lay out clearly where they feel in control and where in their lives they feel a lack of control. It also structures them into clearly stating whether, in a particular problem area, they would like to actively gain more control or work at letting go of their current efforts at trying to gain control. It forces them to make a conscious choice. From here, the clinician can work with the client to discuss these problem areas and how they would like to address them through the therapy. In this way, the client and clinician can begin the therapy process in a structured way, but not one in which the clinician is dictating treatment goals. Instead, the responsibility for defining what area(s) need to be addressed comes from the client and the direction (acceptance or active change) also comes from the client. Each step involves the client "in the driver's seat" so to speak, with the clinician guiding the general process.