CHAPTER 23

Control Therapy: Contributions Of Eastern and Western Approaches to Psychotherapy

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The construct of control is much richer and more complex than previously acknowledged. For example, there are definite cultural differences. 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, Lao-Tzu, the fifth century Chinese sage, noted that ultimate control was like water, which followed the way of harmony, the path of least resistance, yielding and accepting what is.

In addition, there have been recent refinements in how we understand the construct of control. This will be discussed in greater detail later, however, here I mention just one example. Initially reinforcement processes were thought to be of two types: internal and external locus of control (Rotter, 1966). Subsequent research by Professor Haruki at Waseda University, however, has shown that there can be as many as four types of reinforcement operating between the controller and the controlled (Haruki, 1979, 1984). Therefore it is necessary to expand our vision regarding the place of control in mental, physical, and interpersonal health. To address this, Deane H. Shapiro and John Astin in their book, Control Therapy: An Integrated Approach to Psychotherapy, Health and Healing, develop a unifying theory of control which is the foundation for their control-based therapy. In this talk I outline their theory of control and then briefly summarize the actual control-based therapeutic process including assessing a client’s control profile, matching specific techniques to client needs and control profile, and highlighting new insights control can provide into the domains of mental, physical, and interpersonal health. Finally, I will discuss the application of a specific control strategy, mindfulness, and will review some current studies.

**History of control**

In the late 50’s and early 60’s psychology began to reexamine issues of human control which prior to that had been relegated to the graveyard of epiphenomena since concepts such as control, will, etc. were seen as holdovers from psychology’s more philosophical beginnings or roots. Interest in control grew out of anecdotal reports and later controlled research that revealed humans had the potential to realize quite extraordinary levels of physiological and mental control (e.g., yoga adepts, long term meditators) heretofore thought impossible by the scientific community. These discoveries were coupled with research using biofeedback technologies suggesting that humans had the ability to control a variety of autonomic processes previously thought to have been outside the realm of voluntary or conscious control.

Historically, one can see that each of the major “schools” of psychology: analytic, behavioral, humanistic, and transpersonal, has some perspective on control, its importance, how much humans have, the sources of control in one’s life. Shapiro and Astin suggest that the fundamental importance of control in human’s lives is reflected in the fact that the principle tenets of each of the major forces in psychology can be understood in control terms. For example, the analytic tradition, emphasized that individuals are governed by “unknown and uncontrolled forces,” i.e., the powerful, unconscious id (Freud, 1923). 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...”

Like the analytic tradition, the behavioral schools (particularly radical behaviorism) similarly emphasize 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. While both the analytic and behavioral traditions argue that humans are controlled by powerful internal and external forces over which they have limited control, the humanistic tradition has emphasized the importance of personal choice, individual freedom and the right and responsibility of individuals to be in control of their own lives. Finally, transpersonal psychology drawing from different spiritual/religious traditions, holds two seemingly paradoxical views regarding control:

1. In order to realize liberation or wisdom in one's life, it is necessary to gain active control and mastery of one's mind or attentional faculties, passions, desires, habits, etc.;
2. Freedom comes about through surrendering and letting go of active control efforts (Astin & Shapiro, 1997).

**A unifying theory of control**

Shapiro and Astin have attempted to show that many of the constructs of control previously identified, though important, are only part of the picture. Therefore, they have developed a unified theory of control which incorporates prior work, but also adds to it. This integrative control theory addresses the multidimensional complexity of control while showing how a single and primary cause can be utilized to explain a wide range of seemingly diverse behaviors. In this section I lay out the three main postulates of this control theory:

1. Cognitions and behaviors can be explained and understood by our desire to gain/reclaim a sense of control;
2. There are suboptimal, normal, and optimal ways to gain/reclaim a sense of control;
3. There are individual differences in control profiles.

Before discussing these postulates, I detail the four components of the construct of control.

**The four components of control**

Control is defined as, “to cause an influence in the intended direction” (Weis, Rothbaum). There are four key components of the multidimensional construct of control: sense of control, mode of control, agency of control and desire for control. Each of these individually contributes to the control profile as well as works with the others in a synergistic co-evolution creating a whole control profile.
Sense of control.

Research suggests that perceived control can be as important as actual control (Taylor & Brown, 1988). Sense of control subsumes both constructs (perceived & actual) and is defined as “a person’s perception that he or she has control, or the belief that he or she can gain such control if desired” (p.22) (Shapiro, 1994).

Modes of control

Research and clinical experience suggest that there are two primary modes that people use to gain, maintain, or reestablish sense of control: an active, altering mode and a yielding, accepting mode. Most Western psychological research on control focuses on the active altering mode of control to influence or change a situation (Shapiro, 1982, 1983, Thompson, 1981). The other mode of control, characterized by a yielding or accepting orientation toward one’s circumstances in life, has received greater emphasis in Eastern psychology. However, both these modes contain positive and negative aspects; problems frequently occur when we try to retain a sense of control through either excess active altering or extremely passive (helpless) yielding. Thus, a Four-Quadrant Model of Control - depicting Active Control, Positive Assertive (Q1), Letting Go Control, Positive Yielding (Q2), Over Control, Negative Assertive (Q3), and Too Little Control, Negative Yielding (Q4) - was developed to capture the depth and subtlety of the different modes of control (see Figure 1).

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Figure 1 Four-quadrant model of control

Agency of control

Agency refers to the source (i.e., self and/or other) from which people gain a sense of control. Individuals can gain a positive sense of control both by believing that they are in control as well as by believing that someone else is in control – who is more powerful and benevolent.

Desire for control.

As a final dimension of control, and the basis for the first postulate, control may be represented by a “control motivational vector” whose direction is toward gaining, maintaining, and reestablishing control. The human quest for control is one of the major driving forces behind all human action, behavior and thought.

Suboptimal and normal control profiles

The second postulate details suboptimal, “normal”, and optimal ways to gain/re gain a sense of control. Both psychiatry and psychology in general agree that dyscontrol is associated with mental illness. Many of the DSM-IV disorders are defined in part by the explanation that the patient evidences “unsuccessful attempts to control” (e.g., substance abuse) or is “losing control.” Suboptimal control results when there is a mismatch between personal variables and the environment (e.g., helpless when could/should make a change, over-controlling when circumstances are out of your control). When sense of control is not established, there are negative mental and physical health consequences.

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

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 (Lewinski, 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 attributes identified by Peterson and Seligman (1987) 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.

Problems with the Normal Control Profile

However, because lack of control is associated with mental illness, is it justifiable to equate positive psychological health using a linear model that more control is better? 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.

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.

Toward optimal control

The control theory attempts to move beyond traditional notions of control and psychological health by positing optimal control strategies. The foundation of optimal control is recognizing that through awareness, conscious choice is possible. 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.

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, awareness of when desire for control has become excessive or misplaced, and an ability to gain a sense of control without relying on reality distorting defenses and attributions.

At a more subtle level, 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 through conditioned and reflexive attachments and desires, as well as fears and avoidances. What causes suffering in the Buddhist view is the desire to get conformed to a particular notion of how things should be, as opposed to how they really are. As Jackson (1995) noted:

In the course of everyday life we spend the majority of our time immersed in self-centered thoughts: Why did this happen to me? What would make me feel better? If only I could make more money, win her heart, make my boss appreciate me. The thoughts themselves are not the problem; it’s our desperate clinging to them and our resistance to what’s actually happening that causes us so much anguish. The point of Zen practice is to make you aware of the thoughts that run your life and diminish their power over you. (p.149)

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 must go beyond goals of personal competence, autonomous self-identity, and positive ego development (Walsh & Vaughan, 1994). Such control efforts should also be 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).

To summarize, to achieve a balanced, integrated and optimal sense of control requires that individuals learn to: 1) Systematically observe their mind, 2) Acknowledge, take responsibility for, and accept their feelings, 3) Recognize the opportunity to pause and choose whether to change or modify reactions and habits, to notice instances of too much as well as too little control, 4) Work on letting go though forgiveness and acceptance (Q2), or on changing and addressing difficulties by channeling the negative effect of self-defeating fear, anger and craving into positive action (Q1).
Individual differences

The third postulate views control on a continuum that acknowledges individual differences. There are three important influences that must be incorporated into assessment and intervention. First, are biopsychosocial factors (e.g., cultural-environmental, biological-genetic, psychological) and their multidirectional interaction. Second we must include 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. Third, although 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. Humans must rise above or 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.

Control-based therapy: An overview

Many clinicians and theorists have argued that one of the main reasons clients enter therapy is because they are feeling loss or lack of control (Bandura 1989, Beck, 1976). The seven main principles of the control-based approach are to 1) clarify assumptions about personal control; 2) address assaults to client’s control profile; 3) examine the control profile of the individual; 4) clearly identify and then monitor the client’s area of concern; 5) help the client determine his or her goals; 6) increase conscious choice and awareness; 7) evolve individually tailored cognitive and behavioral strategies for helping the client (re)gain a sense of control thorough one or both modes of control, as needed.

The question is what combination of control-enhancing strategies are most effective for a particular individual with a specific control profile and with a particular control-related problem. In the control-based approach, two positive modes of control are taught: an assertive, active change strategy in which individuals learn to identify, monitor, and gain active control over those aspects of their lives under personal control, and a yielding, accepting mode of control in which individuals learn to positively accept with serenity (without helplessness and feelings of resignation) those aspects of their lives that are not under personal control (Shapiro & Astin, 1998).

Assessing the theory: Developing a Control Profile

The Shapiro Control Inventory (SCI) is a clinically reliable and valid multidimensional control assessment instrument that can help the clinician in diagnosis, case conceptualization, treatment planning and therapy evaluation. In so doing, it provides a foundation for a control-based approach to psychotherapy and health care in two ways. First it can differentiate between control profiles of various clinical populations. Second, by developing a more sophisticated way to measure an individual’s control profile, it can help the clinician select interventions most suited to a particular client. (Shapiro & Astin, 1998). This instrument measures the four components of control (sense, modes, motivation, agency). The SCI helps address the crucial question: “Which control-related intervention is most effective for a particular patient with a specific control profile and a particular control-related problem?”

For example a recent study using the SCI identified two different profiles associated with high cardiovascular risk (Shapiro, Lindberg, Daniels, Breuer, & Astin, 1994). As can be seen in Figure 2, both patient 1 (with cardiovascular risk 4 times the U.S. average) and patient 2 (with cardiovascular risk 3.5 times the U.S. average) have low domain-specific sense of control scores (represented by the black bar entering the gray area). However, from this point, their control profiles differ markedly from one another. Patient 1’s profile shows an elevated score on both the desire for control scale and the negative assertive “overcontrolling” scale. Further, he shows a low score on the agency dimension others as a positive source of control (i.e. an unwillingness to rely on or trust others for help in gaining a sense of control). Patient 2, by contrast, has a normal desire for control score, but an elevated score on the negative yielding scale (too little control) and a low score on self as a positive source of control.

The profile of these two patients suggests that different control profiles can be associated with higher cardiovascular risk. Therefore, different control-related therapeutic interventions would be needed, depending on the person’s control profile. For example, individual-specific matching of control-related interventions involves teaching patient 1 ways to decrease negative assertive overcontrol, decrease desire for control, and increase the ability to gain a sense of control from others through techniques such as meditation and relaxation training. The intervention for patient 2 would involve decreasing feelings of negative yielding (helplessness and too little control) and increasing feelings of agency of control from self through techniques such as assertiveness and self-efficacy training.

Strategies and therapy suggestions

Assessment is crucial to entering the next phase which is matching control-based techniques to the clients control profile. Control-based therapy typically includes 8-12 sessions which have been detailed in Shapiro’s and Astin’s book (see Shapiro & Astin, 1998). Research suggests that the process of gaining control can be broken down into five basic components as follows: 1) desire or motivation for control, 2) belief in one’s ability to gain control (i.e., self-efficacy beliefs), 3) right/responsibility (believing one is entitled to feeling a sense of control as well as responsible for achieving it), 4) skills -- actual ability to gain a positive sense of control, 5) success -- importance of recognizing, honoring, and reinforcing one’s successful control efforts.
facilitating client self-awareness into their own control dynamics some of the following techniques are suggested:

a. self-monitoring/self-observation of out of control experiences (noting antecedents, consequences).

b. self-awareness exercises based on mindfulness meditation that increase moment to moment awareness of one’s own affective, cognitive and somatic experience.

c. visualization exercises such as imagining each mode as a personality and then having these personalities dialogue with one another; control mode rehearsal in which one imagines responding to some out of control circumstance with one of the positive modes of control exploring resistance and barriers to change and dialogue with these.

While many clients may be working on developing more assertive control, and others more yielding/accepting control, the underlying theme and goal of control therapy is to facilitate clients’ development of a balanced and flexible use of both modes of control. This balance is beautifully captured in the well-known prayer of Reinhold Neibuhr:

God grant me the serenity to accept the things I cannot change
The strength to change the things I can
And the wisdom to know the difference.

Mindfulness as a control strategy

One important strategy to cultivate this “wisdom” to know when to use the quadrant one (positive assertive) or quadrant two (positive yielding) is mindfulness. Mindfulness stems from the Vipassana/Theravada Buddhist tradition. Mindfulness practice involves concentrated moment to moment focused attention, attending to cognitions, emotions, and proprioceptive sensations as they arise. Kabat-Zinn (1994, p.4) defines mindfulness as, “paying attention in a particular way; on purpose, in the present moment, and nonjudgmentally.” Research has demonstrated that mindfulness may be an effective intervention for anxiety disorders, chronic pain, psoriasis in its own right (Kabat-Zinn, 1982, Kabat-Zinn, J., Massion, A.O, Kristeller, J., Peterson, L.G., Fletcher, K.E., Pbert, L. Lenderking, W.R., & Santorelli, S. 1992, Miller et al, 1995, Bernhard, Kristeller, Kabat-Zinn, 1988), as well as being an effective complement to more traditional medical and psychological therapies (Teasdale, Segal, Williams, 1995).

In a recent study exploring the effects of mindfulness on control, Dr. Astin (1997) found that college students practicing mindfulness evidenced significant change in quadrant 2 (yielding) as well as change in the intended direction in quadrant 1 (assertive) skills. This is a particularly interesting finding. Based on the classic notions of yielding control in the West, one might hypothesize that these subjects would have subsequently shown some decrement in quadrant 1, assertive skills, as a result of their increase in quadrant 2 skills. This finding suggests that quadrant 1 and quadrant 2 skills are not mutually exclusive/either or as they have more traditionally been conceptualized.

Fig. 2: Control Profile of High cardiovascular Risk

Note: All scores are standardized with a mean of 50, and each 10-point increment represents 1 standard deviation. The solid block bars represent the participants’ scores on each control dimension, and any bar falling in the gray shaded area represents a control score of at least 1 standard deviation in a non-psychologically healthy direction.

Control-based therapy recognizes the importance of each of the above steps and focuses both client assessment and interventions at each one. For example, it is important to assess clients’ motivation to change or gain greater control, their belief that they can realize such change, and the extent to which they feel they have a right to such control in their lives. Along with therapist assessment of clients in the above areas, control therapy emphasizes the importance of clients beginning to self-assess. The development of greater self-awareness regarding mode preferences, areas or domains where a sense of control is lacking, ways in which control modes are used negatively or maladaptively to gain a sense of control is critical in the therapeutic process. Toward this end of
in the West.

In another recent study conducted at the University of Arizona, we (Shapiro, Schwartz, Bonner, 1998) explored the effects of teaching mindfulness-based stress reduction to medical and premedical students. Using this control-technique we found significant positive psychological change. Findings indicated that participation in the seven week course effectively 1) reduced self-reported state and trait anxiety, 2) reduced overall psychological distress including depression, 3) increased scores on overall empathy levels, and 4) increased scores on a measure of spiritual experiences. These results replicated in the wait-list control group after receiving the intervention, held across different experimenters, and were observed during exam period. This study strengthens the hypothesis that using mindfulness control strategies may effect beneficial psychological change. Further, medical students face numerous control related situations, they have an immense amount of control and ability to influence, however they are also encountering numerous situations completely out of their control. Thus, learning both the quadrant 1 (change) mode as well as the quadrant 2 (acceptance) mode is crucial for both their own health as well as the health of their patients.

Concluding remarks

Control Therapy is based upon a theory which elucidates and makes clear the different components of control. It further has developed a way to assess a patient’s control profile, and to match specific control-related techniques to that profile. Finally, it recognizes the crucial role of intention in therapy and the healing process (Shapiro & Schwartz, 1998). Shapiro and Astin have integrated and expanded upon the richness and wisdom of both the Western and Eastern traditions, creating a foundation for a new, visionary control theory and therapy which can promote intrapersonal, interpersonal and planetary health and healing.

In closing I leave with you the following lines by Astin which capture in poetic form the fundamental importance of balance in control-therapy (Astin, 1994).

“The Balance”

Between the feeling and the thinking
And the being and the doing
There’s a balance you will find
Between the heart and mind.
It’s a mountain strength of will
And a patience so still
It’s a time to surrender and let go
A time to hold fast to what you know
A time to accept what this life brings
And a time to change the course of things

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