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CONTROL THERAPY

Control therapy is an integrated approach to psychotherapy and health care that combines theory, research, and practice. It is based on the premise that issues of control (e.g., fear of loss of control, desire for control, power struggles) underlie most concerns brought to therapy (Frank, 1982; Strupp, 1970; Shapiro, Schwartz, & Astin, 1996). A reliable and valid standardized psychological assessment inventory (the SCI, or Shapiro Control Inventory) was developed to both measure the theory and provide an individual client "control profile" (Shapiro, 1994). Finally, control-based therapeutic techniques, including an assertive change mode of control, and an accepting/yielding mode of control, are "matched" to the client's control profile and taught as interventions. The theory, test construction, and interventions have been developed and empirically

tested over a period of twenty-five years involving research and clinical work with thousands of individuals in over a dozen countries.

A UNIFYING THEORY OF CONTROL

The theoretical basis of control therapy builds upon and integrates several literatures, including self-efficacy (Bandura, 1977), learned helplessness and optimism (Seligman, 1975, 1991); competence (White, 1959); dyscontrol (Menninger, Mayman, & Pruyser, 1963); reactance (Brehm, 1966); will to meaning (Frankl, 1980); will to superiority (Adler, 1964); cybernetic feedback models and dysregulation (Schwartz, 1983); internal and external locus of control (Rotter, 1966; Wallston, Wallston, & DeVellis, 1978); self-determination (Deci & Ryan, 1985); and self-control/delay of gratification (Mischel, 1974; Mahoney & Thoresen, 1984).

Control theory is based on an unifying biopsychosocial theory of human control and self-control and has three postulates that can be summarized as follows: (a) all individuals want a sense of control in their lives; (b) there are healthy and unhealthy ways by which they attempt to gain or regain that sense of control; and (c) there are individual differences in control profiles of individuals and in how they face this central issue of maintaining a healthy sense of control in their lives (Shapiro & Astin, 1998).

DEVELOPING A CLIENT "CONTROL PROFILE": ASSESSING THE THEORY

A client "control profile" is based on clinical assessment with the SCI, which has undergone extensive reliability and validity testing (including an investigation of neurobiological correlates of control using Positron Emission Tomography; Shapiro, 1994; Shapiro et al., 1995). The 187-item, nine-scale SCI inventory is a clinically reliable and valid multidimensional instrument that measures four primary and interrelated components of clients' control profiles: (a) desire for control (i.e., where they want control, why they want it); (b) current sense of control in both general and specific domains; (c) the modes by which they seek control (assertive/changing and yielding/accepting); and (d) use of both self and other agency in gaining control. Research shows that this method of assessing client control profiles is the most sensitive inventory yet devised to differentiate among clinical disorders, and between clinical and normative populations (Shapiro, Potkin, Jin, Brown, & Carreon, 1993).

Assessment also includes methods for listening to client speech, including the client narrative (their "control story"), control-related beliefs and assumptions, and assaults to the client's sense of control which brought them into the therapy session. Assessment also includes having clients identify and monitor their area of concern (e.g., domains where they feel a lack of control).

In goal-setting, clients examine their preferred style or mode (assertive/changing or yielding/accepting) for regaining control, and are helped to determine whether that mode best "matches" the current situation. In other words, is the issue something best addressed by learning greater self-control, learning to change the situation that exists, or learning to accept a situation outside of one's active control?

Through such precise assessment, the clinician can differentiate between different control profiles of various clinical populations. Further, by measuring a client's individual control profile, the clinician is assisted in matching the most effective intervention to a particular client.

CONTROL-BASED INTERVENTIONS

Control therapy consists of an eight- to twelve-week step-by-step-treatment program involving defining the area of concern, assessment, monitoring, goal-setting, determining the appropriate strategy or strategies, teaching the strategies, and evaluation. Therapeutic interventions involve detailed and well-defined clinical instructions for matching treatment strategy to the client's control profile, thus offering both standardized, replicable techniques, and providing flexibility and sensitivity to each client's individual needs and style.

Based on the goal selected, individually tailored cognitive and behavioral strategies are utilized to help clients regain a sense of control through one or both of the positive modes of control. The assertive/changing mode of control, which has historically been emphasized by Western scientific psychology, involves having individuals learn to identify, monitor, and gain active control of those aspects of their lives which are or should be amenable to change.

The yielding/accepting mode, which has historically been emphasized by non-Western philosophical and psychological traditions, helps clients learn the value of surrendering, accepting, and letting go with serenity (i.e., without feelings of helplessness or resignation) of those aspects of their lives that are not under personal control, or of inappropriate active control efforts. Practical instructions in each mode are explained, as well as ways to integrate and achieve balance between the two positive modes.

A CONTROL-BASED VIEW OF PSYCHOLOGICAL HEALTH: SUBOPTIMAL, NORMAL, AND OPTIMAL

Traditional Western psychology argues that loss of control and learned helplessness are unhealthy and suboptimal. Normal control is defined as gaining control (even including an illusion of control) and is equated with mental health. This traditional view argues that instrumental control is good, and that "the more control the better" (Thompson, 1981). "Healthy normals" often maintain control through illusory, overinflated perceptions of control (Taylor & Brown, 1994), and they use defense mechanisms such as making external attributions for failure (Seligman, 1991).

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. Optimal control, according to control therapy, involves:

- 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.
- 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).

BENEFITS OF CONTROL THERAPY

Control therapy has been shown to be effective in both assessment (sensitivity and specificity) and treatment (clinical outcome), with a wide range of *DSM* diagnoses and health-related concerns (Shapiro & Astin, 1998). Clinical areas investigated include generalized anxiety disorder, panic attack, depression, borderline personality, eating disorders, and adult children of alcoholics. Control issues have also been investigated in "Type A" individuals with myocardial infarction, women with breast cancer, and individuals at high cardiovascular risk (see Shapiro, 1994 for summary; Astin et al., in press).

There are several advantages to control therapy and to the unifying theory upon which it is based. First, a unifying theory helps clinicians understand control as a central component underlying all schools of therapy: the analytic view that humans are governed by "unknown and uncontrolled forces"; the cognitive/behavioral schools' emphasis on self-control; and the humanistic/existential focus on personal choice, individual freedom, and self-determination.

Secondly, in addition to the theory's universality and parsimony, it also can be operationalized, thereby providing an empirical foundation for assessing a client's control profile. Based on individual variations in control profiles, specific techniques can be matched to client needs and clinical problems (Evans et al., 1993).

Third, based on a systems approach to clinical issues, control therapy provides for systematic feedback at each step of the clinical process. Such feedback allows specific common client difficulties in gaining or regaining a sense of control to be pinpointed, and explicit guidelines are provided for helping clients deal with problems such as resistances, lack of motivation, unclear goals, and poor self-efficacy beliefs.

Finally, control therapy examines the importance of therapists becoming aware of their own control dynamics because of the potential effect those dynamics may have on the therapeutic encounter. It also examines matching the therapists' method of "teaching" interventions to the client's control style: e.g., teaching control strategies in a "self-directed way" to those clients with a higher "desire for control" profile; increased therapist-directed teaching for those clients with a lower desire for personal control and more willing to gain a sense of control from an "other."

SUMMARY

To recap, Control Therapy is based on a unifying theory of control, and provides a multi-dimensional psychological inventory to both measure the theory and assess a client's "control profile." Further, drawing from both Eastern and Western psychological traditions, Control Therapy involves specific assertive/change and yielding/accepting modes of control intervention techniques; and the matching of these techniques to a client's control profile, goals, and clinical problem. 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.

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