July 14, 2009

Hi Summer,

WOW!!! What a lot of work went into this. It is really amazing how many different areas you reviewed—what a breadth of scholarship—and also your passion and compassion for the people behind the numbers and data comes through.

My in laws are novelists, and they once shared with me their definition of an “editor” (which might also apply to an external reviewer!).

*An editor is someone who comes down from the mountain after the battle has been fought, and shoots the wounded.*

For anyone, such as yourself, who has obviously wrestled long and hard with a topic, sometimes it may feel like that! I know it sometimes has for me in the past. Please know that that is not my intent!

In terms of Dr Kutz’s questions, in my judgment, (a) the proposed work IS of doctoral scope and significance, and (b) the methods ARE appropriate to the intended outcome.

Dr. Kutz further asks me to “state your judgment frankly. If you see points at which you believe the elements of the proposal are inadequate, it would be helpful to have your suggestions about bringing them up to a satisfactory level.

This proposal and intended study is certainly satisfactory as it is.

Having said that, I have two areas where I would like to push and challenge you to deepen your thinking. The first has to do with spine and bridge building between the literatures you’ve surveyed. This can be done in the next round of writing. The second has to do with the methods and intent of your study. This may be able to be done simultaneously with your data collection. Let me talk a little more about each below.

1. DEVELOPING A STRONGER SPINE FOR THE WRITING. You have, as noted, done an excellent job of covering several different literatures. Many of these literatures I found quite interesting (e.g., the serotonin studies) and show your groundedness in important aspects of what you are studying, and your scholarly breadth, and the knowledge that would be important in helping the people you work with as a clinician. What I suggest for your final write up of the dissertation is that you seek connections with the literatures you write about with the nature of the study itself. While some areas, such as serotonin studies might not lend itself to that, others (such as the dynamic and family formulations related to control definitely do.

What is missing in some bridge between the SCI, and its control variables, and all the other control writing. At the very least, when you write this up as a publication (which I would certainly encourage you to do, you will need a spine that connects all of these different literatures, so the reader doesn’t feel they are wondering through a vast, interesting overview of the field, without some kind of spine running through it that
connects all the literatures. I again realize this may be harder to do in the dissertation itself, where part of your task is to show expertise in all areas of a topic. However, knowing that you know those areas, I'd invite you to "take a breath" and see how you build bridges and connections between them a bit better—build more bridges between the fields you are writing about with what you're actually doing with the study. Now that you've surveyed and accumulated a huge amount of information in a scholarly way, you are in an excellent position to challenge and deepen the field, creating a spine that guides the reader through the writing to your study. This does not need to be done before you start collecting data. But I believe should be done before your next write up (and definitely when you submit the paper for publication).

On a smaller level (but still in terms of flow, editing, etc), I've made several suggestions in the paper; also, you may want to check the APA style manual in terms of headings (e.g., main A head; sub B heads; further sub C heads). There are also some cases of repetition, which if they are conscious, may be ok (to help remind the reader) but make sure you're doing them consciously. If you don't feel they're necessary, try to remove in final editing.

In the remarks enclosed in your copy of the paper I've tried to help clarify and work with the material to help point out how I think it might be made clearer (or deepened). These are just my thoughts and opinions. Some of my suggestions for improvement may not be in the direction you think helpful, and in those cases, perhaps they can be seen as where I was confused, and you can find other ways to help the reader.

In any case, as noted, none of these changes need be done before you begin your study, and collecting data, they are more for the next round of writing.

2. THE INTENT OF THE STUDY. Basically, as I understand it, your intent is to extend prior studies on control variables involved in AN, with the hope of "building bridges" from research to clinical practice. Here I'll say BRAVO! I think this is critically important and admire your willingness to tackle this.

Here is where I want to challenge you in terms of the goal of your study. How is your study really different than a replication of Lee's study? You are using cross sectional design and comparing the CONTROL PROFILES of those who are still struggling with anorexia with those who have "succeeded" in addressing that concern. How is that different from her "good" (as one group) and intermediate and poor "as another group"? I may be missing something, but this seems more a replication of a study, than what you say is an "extension and expansion."

As I wrote to you last month, and as we discussed by phone, the goal of the study, in a larger context, is to provide information which will be helpful toward evolving more effective treatments. But how will your study help do this more than Lee (or Surgenor's study) or our initial study? The hypothesis you're suggesting are already ones that have been confirmed by those studies. Again, there's nothing wrong with another replication, but as I wrote to you, what I'm wondering is if it might not be possible (and not really much extra work), to consider adding a "qualitative" component to your study. You may want to talk to Dr. Schacter, your other faculty advisor, and your statistical consultant, but here's what I was thinking. Why not take two or three (perhaps up to five) from each group (who are in most trouble; and who have the "best" control.
profile. You could at the least review their SCI 20 page clinical report and see what that suggests; and perhaps that would give you some ideas for "subsequent" interventions. It may also be interesting to interview (depending on time, logistics) those people (particularly those who succeeded, and ask as they look back, what worked. (It might be helpful also--though this would be more work--to tape record the conversation--and examine their "control" speech"—even if you don't put that in the study, it would be interesting information to have).

(Further, as I wrote, then, I'd suggest, if you haven't already taken the SCI yourself and reviewed the clinical print out, I'd invite you to do so. As noted, this is all available for free at controlresearch.net In addition, I enclosed the first chapter of the Control Therapy Training Manual (dealing with the SCI and how to read it; as well as how to "listen" to control speech."

At the least, I want to challenge you to think a bit more deeply about what you say is your goal: the clinical implications that might come from this to help treatment, and how what you’re doing might add to our understanding beyond what already exists. I realize this is challenging, but I felt that given your deep understanding of the field, your passionate commitment to AN care and treatment, that you are really in an ideal spot to be able to ask and explore these questions.

In conclusion, please understand that I realize that these questions may be a (at least one!) life’s work. I don’t want to unduly burden you in terms of the enormous amount of work you’ve already done, nor impose burdensome or insurmountable logistical obstacles. However, I was thinking (hoping) that through adding a bit more of a qualitative aspect to the study, and pushing yourself to think through a bit more deeply the connection between all the different literatures you have mastered, you might be able to help push the field forward a bit more.

So, fine job. I definitely recognize how much work you have done, and how competently you have done it. Please see these comments as given in the spirit of hoping to be helpful—not to create any additional wounds!

Good luck!

Warmly, Dr. S
In thinking about your proposal this week, and after talking with you and Dr. Schacter, I have a couple of thoughts that I thought may be helpful to express as you are finalizing your proposal. First, just a practical thought. I'm not sure whether you are aware that the SCI can now be taken on line (for free) when given by licensed clinicians or those doing research. The site automatically scores the instrument (which can be used for research purposes) and provides a 20 page clinical observation print out (which can be used clinically). If that will help you, please feel free to use it: www.controleresearch.net.

The second thought has to do with the goal of your study. My understanding, from talking to you and Dr. Schacter, is that you are using a cross sectional design (with about 50 in each group) and comparing the CONTROL PROFILES of those who are still struggling with anorexia with those who have "succeeded" in addressing that concern. That seems a worthy and interesting study. As we discussed, the goal of the study, in a larger context, is to provide information which will be helpful toward evolving more effective treatments. We discussed having this part of your "discussion."

What I'm wondering is if it might not be possible (and not really much extra work), to consider adding a "qualitative" component to your study. You may want to talk to Dr. Schacter, your other faculty advisor, and your statistical consultant, but here's what I was thinking. Why not take two or three from each group (who are in most trouble; and who have the "best" control profile. You could at the least review their SCI 20 page clinical report and see what that suggests; and perhaps that would give you some ideas for "subsequent" interventions. It may also be interesting to interview (depending on time, logistics) those people (particularly those who succeeded, and ask as they look back, what worked. (It might be helpful also--though this would be more work--to tape record the conversation--and examine their "control" speech"--even if you don't put that in the study, it would be interesting information to have).

I'd suggest, if you haven't already taken the SCI yourself and reviewed the print out, I'd invite you to do so. Also, there is a copy of the SCI manual there available for free download, if you don't already have it. In addition, I'm enclosing the first chapter of the Control Therapy Training Manual who have been developing the last few years (dealing with the SCI and how to read it; as well as how to "listen" to control speech."

Hope these ideas are received in the spirit in which they are intended--which is to be helpful--and I hope they don't cause you to feel too "out of control!" :) But I thought they might be useful to share with you before you complete your proposal.

Now, if you still want me, I'd be happy, as I said, to serve!

[Signature]

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My dissertation research is on Psychological Sense of Control and Recovery from Anorexia Nervosa. I have been inspired by your work on control theory and the Unifying Theory of Human Control, both of which form the core theoretical foundation of my research. Additionally, I am utilizing the Shapiro Control Inventory as the main instrument in my study. The Chair of
This study utilized Shapiro and Astin's (1998) Unifying Theory of Human Control as an integrative framework for understanding a sense of control as it relates to eating pathology.

I would like to thank Deane Shapiro who served as my External Examiner. It was his theory that inspired me and I am grateful for his enthusiasm and support of my research.
of nine psychiatrically screened "normal" volunteers with no history of past or current psychiatric illness. The other group consisted of 50 unscreened undergraduate college students recruited from a class on the environment. The purpose of the study was to extend research on the Shapiro Control Inventory (SCI) to individuals with eating disorders and further elucidate a sense of control profile of the population. Results indicated that symptomatic individuals showed the greatest endorsement of over-control items with the highest scores on negative assertive and negative yielding modes of control. The eating disordered group had the lowest scores on overall sense of control, positive sense of control, domain specific sense of control, positive assertive mode of control and positive yielding mode of control. Further item analysis suggested that the eating disorder group felt most out of control (and the percent that expressed concern) about eating (100%), stress (80%), relationship with a significant other (80%), and the way they feel about themselves (90%). The eating disorder group scored equal to or higher than the "normal" comparison groups on specific domain items of exercise, spending, thoughts, attention, drugs, alcohol, violence and gambling. This group endorsed a belief in their own "skills and abilities to reach my goals," and "have sufficient discipline to reach my goals." The researchers concluded that individuals gain a sense of control through internal (self) and external (other) agency. They indicated that the development of a control profile might help identify where control problems occur and lay groundwork for targeting, specifying and refining treatment interventions of both a preventative and rehabilitative nature.
definitions of recovery to the absence of eating disorder symptomatology. Few outcome studies have focused on qualitative changes in the individual's psychological and psychosocial functioning beyond the reduction of concerns with body image and weight.  

**Outcome.**

There are few empirical studies linking psychological control to AN. Lee, Chan, Kwok, and Hsu (2005) studied the relationship between control and 'intermediate term outcome' in 88 Chinese patients diagnosed with anorexia. Participants were contacted an average of nine years post initial diagnosis for inclusion in the study. No comparison or control group was included. The Morgan Russell Outcome Assessment Schedule (MROAS) was used to group patients into three categories—good, intermediate, and poor—based on nutritional, mental and menstrual status, sexual functioning and socioeconomic status. The Shapiro Control Inventory (SCI) was used to assess domain-general and domain-specific perceptions of control, positive and negative control mechanisms and the motivation for control. Results indicated that individuals reporting good outcome, 62.2% (n=46), displayed higher scores on domain general sense of control and positive sense of control. Domain specific scores in the areas of positive assertive mode of control and positive yielding mode of control were also higher than the intermediate or poor outcome groups. Desire for control was lowest within the good outcome group. The researchers concluded that better outcome of anorexia may be associated with healthier control mechanisms. They propose that the manifestation of anorexia may be a 'no-control phobia' rather than a 'fat phobia' thus suggesting an
Surgenor, Horn and Hudson (2003) examined the relationship between psychological sense of control factors and clinical variability among 51 New Zealand women diagnosed with anorexia nervosa. The participants were recruited as part of a larger clinical trial and inclusion criterion included the presence of anorexia nervosa as the primary and current diagnosis. The Shapiro Control Inventory (SCI) along with the Eating Disorders Inventory (EDI) was used to assess the variability of control factors in this population. Results indicated that women with greater eating disturbance had an increased negative sense of control and increased control through a negative-yielding mode. Their overall sense of control and domain control were reduced, and a reduction in positive-assertive mode of control and a positive sense of control was noted. Thus the greater severity of the eating disturbance the more adverse sense of control experience the women endorsed an over-reliance on negative experience and passive strategies of achieving control and an under-reliance on positive experience and active strategies of gaining control. These data indicate that specific aspects of control may be associated with specific clinical phenomena seen in anorexia. They also suggest that it is not only perceptions of control that relate to eating disorder severity but how the individual responds to control challenges on both an internal (intrapsychic) and external level.

Shapiro et al. (1993) investigated issues of control in 10 symptomatic female patients, 4 with a primary diagnosis of anorexia and six with a diagnosis of bulimia nervosa (BN). Two sex-matched comparison groups were utilized. One group consisted
CHAPTER 3

METHODS

Research Design

The questions and hypotheses presented in this paper pertain to only a small portion of the data gathered during a multifaceted treatment outcomes study. The entire body of data is simply too large and complex to be presented here, and so analysis of the remainder of the data is reserved for a future report or reports. This chapter describes only those parts of the study that relate to the questions and hypotheses presented in Chapter 1.

This paper focuses on the quantitative data gathered while a small group of African American clients participated in a treatment study using Control Therapy. I am aware that small group designs are often overlooked due to the low power that weakens the results of parametric analyses, and the common view that case studies are purely subjective and do not allow for generalizability of findings. The small group design was chosen for this study for several reasons that compensate for these common criticisms. A small sample design allows for quantitative data collection while acknowledging the complexity of psychotherapy (Paul, 1967). It addresses the concerns of those who find that group level data masks valuable process dynamics (Heppner, Kivlinghan, & Wampold, 1992). The study was designed to capture both outcome and process variables, with the aim of elucidating how Control Therapy occurs for the individuals in this study, as well as exploring trends and patterns that appear in common among them.
Furthermore, this study marks a first attempt in exploring Control Therapy with African Americans, and so a close examination of the change process is important, especially when historically, large, sweeping generalizations have been made about American minority groups. While some researchers will still dismiss the small sample study despite these advantages, it is important to remember that the data collected in this study can be pooled with future replications to create a large sample with power adequate to parametric analyses, thus allowing generalization of findings in keeping with the spirit of typical large sample investigations (Franklin, Allison, & Gorman, 1997; Heppner, Kivlinghan, & Wampold, 1992; Hill, Carter, & O’Farrell, 1983). Implications for future research, including further analyses of the larger body of data from this project, will be discussed in Chapter 5.

The Participants

There were two groups of participants in this study: a group of nine outpatient African American clients and a racially mixed no-treatment comparison group consisting of 41 unscreened volunteers, including 10 African Americans. Participants who received Control Therapy in this study presented with depression, anxiety, or a mixture of these symptom clusters, and were recruited from the clientele seeking services from the psychotherapy training clinic for doctoral students in counseling psychology at a major mid-Atlantic university. Meanwhile, the no-treatment comparison group was comprised of 37 master’s students studying counseling psychology at the university and four local community volunteers. See the consent forms in Appendix B.
The clinic was open two afternoons and one evening per week until 8 p.m. At any given time, each clinician-in-training carried a caseload of four or five clients per week, which left ample time for in-depth supervision, peer feedback, role-playing and demonstrations, case conferences, note-writing, follow-up phone calls, and related tasks, including supervision time dedicated specifically to this research project. The clinic’s emphasis was quality, not quantity.

The chairperson for this dissertation was also the director of the clinic in which the study was conducted. She played a central role in the training and supervision of the student clinicians who delivered Control Therapy to the clients who volunteered to participate in the study. I was a clinical assistant in the program, and I assisted in conducting the trainings and supervision for this study. Neither the chairperson nor I participated as a therapist in the study, but we did do assessment interviews. Details of the supervision of the clinicians are described later in this section.

Procedures

Pre-Treatment Preparations

Recruitment of Treatment Participants

At the outset, the clinic director and I met with the seven therapists in the clinic who had previously volunteered to participate. (Therapist selection is discussed later in this chapter.) Together, we reviewed current cases to see which clients might qualify for the study. Once a group of potential participants was identified, each therapist spent five to ten minutes at the end of their next therapy session with a potential participant to explaining the purpose of the study and what was being asked of each participant. Some clients agreed to the study at that time, and others asked to learn more by speaking with
me before deciding. Those who wanted more information met privately with me and/or the clinic director, who answered their questions. One candidate said she was still undecided; another declined to participate. In the end, 10 clients agreed to the study. Of those ten, one dropped out after three therapy sessions, and the remaining nine stayed through the phase of treatment. Clients in the study remained with the same therapist throughout the study.

Several of the clients had already attended several weeks or months of "standard" therapy at the clinic prior to their invitation into the study. This was simply a circumstance of the clinic. Standard therapy involved a blend of cognitive, psychodynamic, and developmental approaches as outlined in Teyber (1999), however, there was some variation due to each clinician's own personal theoretical orientation. The time available spanned the spring semester and the first summer session in 2005, starting in February and finishing at the end of June. It would not have been possible to achieve enough treatment participants by waiting for newcomers, as the clinic was already rather full with ongoing clients when this study was initiated. Those whose therapy was well underway at the time they were invited into the study did not change therapists; instead, their therapist adopted the Control Therapy protocol and continued working with that client. Clinic clients whose therapists had opted not to participate in the study were not invited to participate in the study.

Meanwhile, excluded from the study was anyone unable to read at a minimum eighth-grade level, since this reading level was necessary for clients to fill out the various self-report instruments. This was generally not a problem for the clientele at this clinic. No potential participants were turned away based on reading ability. Meanwhile, clients
with primary diagnoses falling outside the parameters of the DSM-IV-TR (2000) mood disorders and anxiety disorders were excluded, since the treatment was not geared toward addressing other issues. In keeping with the types of clients normally accepted at the outpatient training clinic in this study, none of the ten original participating clients presented with severe difficulties requiring close monitoring or hospitalization.

Recruitment of the No-Treatment Control Group

In early spring 2005, at roughly the same time the treatment phase was beginning, I approached two professors teaching master’s students in counseling psychology and asked if I could present some basic information about the study to their classes and invite them to participate by filling out some surveys at two points in time, once at the start of the semester and once near the end. The professors agreed to this arrangement, and the classes also agreed to hear the brief presentation. In my talk, I explained that I was exploring the use of the SCI with people of all racial/ethnic backgrounds, that this has not been done in the past, and that the instrument can potentially provide some valuable information to counselors and their clients. I also explained that the students’ participation would contribute to understanding the function of this instrument and would help generate new research questions. I provided the appropriate consent forms and gave students some time to read them and ask questions. After learning about the study, one student opted not to participate, and eight missed one of the testing sessions, leaving 37 complete sets of data when data collection was finished. An additional four participants (leading to a total of 41) were family therapists working in a nearby clinic, who agreed to help with the study out of their own interest in improving services for African Americans.
They were not able to complete the BAI and CES-D at the initial assessment, but they did complete all three instruments at the second testing.

Confidentiality of Participant Records

All information, including test results and videotaped sessions, pertaining to study participants were kept confidential and stored in a locked filing cabinet. The clinic director, volunteer clinician, and I have abided by the rules of confidentiality, not disclosing participant information to anyone outside the study team. As is customary and appropriate in the treatment of outpatient clients, identifying information was kept with client records. However, any reports referring to study data, including this one, are written such that participants’ identities are protected (no names or obvious identifiers). Pseudonyms will be used when referring to individual clients.

Selection of Therapists

The seven volunteer clinicians in this study were recruited from among the nine doctoral students enrolled in the clinical training component of the program at the time the study was being organized. They were in their second year of doctoral studies and had previously completed a terminal master’s degree in a human services discipline. Prior to joining the study, each therapist had at least one prior semester of general training in the clinic, including live and delayed supervision, and achieved at least basic general counseling competence as measured by a supervisor rating form used by the clinic supervisor/director. I invited those student clinicians into the study who could demonstrate high quality counseling skills and an ability to engage and gain credibility with Persons of Color.
Data collection for the 37 master's students in the no-treatment control group consisted of two phases: two 30-minute testing sessions one week apart during February 2005, and then two 30-minute re-test sessions one week apart starting about 10 weeks later. These participants completed the BAI, CES-D, and the SCI. The four community volunteers were tested in January and then again in April of 2005. They did not complete the BAI and CES-D at their initial assessment, but they did complete the entire battery (BAI, CES-D, and SCI) at re-test.

Instruments

*Background Information Form*

This form was created to gather an array of descriptive data about the participants in this study. It includes typical information, such as age, gender, and socioeconomic status, as well as questions about parents and the area where participants were reared. See Appendix E.

*Beck Anxiety Inventory (BAI)*

The BAI (Beck, 1987; Beck & Steer, 1993) is a 21-item self-report measure of somatic and cognitive symptoms of anxiety occurring over the course of the preceding week. See Appendix F. Items are rated on a 4-point scale, from 0 to 3. The possible score range is 0-63, with higher scores indicating greater symptom severity. Directions request that answers be given while reflecting on experience from the previous month, but studies commonly use it to gather data on the previous week, and it is typically given just before a therapy session (Moras, Telfer, & Barlow, 1993). The BAI is commonly used to assess anxiety in both clinical and research settings, including treatment research. The BAI has shown high internal consistency (coefficient alpha = .92) and test-retest
reliability over one week, r (81) = .75 (Beck, Epstein, Brown, & Steer, 1988). It has been found to discriminate anxious diagnostic groups from non-anxious diagnostic groups (Beck et al., 1988). It has shown moderate correlation with the revised Hamilton Anxiety Rating Scale, r (150) = .51 and only mild correlation with the revised Hamilton Depression Rating Scale, r (153), .25 (Beck et al., 1988), indicating good convergent and discriminant validity, respectively. Hewitt and Norton (1993) conducted a series of factor analyses, showing that items on the BAI and BDI loaded on different factors. Various other studies support the BAI's good reliability and validity (Fydrich, Dowdall, & Chambless, 1992; Borden, Petersen, & Jackson, 1991).

*The Center for Epidemiological Studies Depression Scale (CES-D)*

The CES-D (Radloff, 1977), has been used extensively in a variety of clinical and non-clinical settings, including cross-cultural research. See Appendix G. It is a 20-item self-report scale developed to assess the presence and severity of depressive symptoms experienced over the course of the previous week. The instrument takes from five to 10 minutes to complete. Items are rated on a 4-point scale, from zero to three. Except for four questions, a higher score indicates greater depression. In the calculation of the total score, the scores for these four items are reversed. Possible total scores range from 0 to 60. Generally, scores of 16 or more are considered indicative of depression. Items were selected from existing depression scales, including the Beck Depression Inventory, Zung's Self-rating Depression Scale, and the Minnesota Multiphasic Personality Inventory, and reflect mainly affective symptoms (e.g., feeling lonely or sad) with a few items tapping physiological processes (e.g., poor appetite or restless sleep) (Radloff, 1977).
In his development of the scale, Radloff (1977) reported alpha coefficients of 0.85 for general population samples and 0.90 for a clinical sample; meanwhile, split-half reliability ranged from 0.76 to 0.85. In a study examining the use of the CES-D among different ethnic groups, Roberts (1980) found alpha coefficients of 0.85 for both Black and White samples. Low test-retest reliability for the CES-D may be due to the fact the instrument assesses recent symptoms only; Radloff (1977) found retest correlations running from 0.32 to 0.67, with the majority falling between .50 and .60. The CES-D has been found to discriminate between depressed and non-depressed adults in a community sample (Weissman, Scholomskas, & Pottenger, 1977). It can also distinguish depressed from non-depressed alcoholics and schizophrenics (Weissman, Scholomskas, & Pottenger, 1977). Studies of sensitivity and specificity are also very good in a variety of clinical groups (Weissman, Scholomskas, & Pottenger, 1977). Tests of concurrent validity, in which the CES-D was compared with various clinical ratings, have yielded correlations ranging from 0.44 to 0.75 (Radloff, 1977). For example, the CES-D correlated 0.44 with the Hamilton Rating Scale for Depression for patients at admission, and 0.69 after treatment (N = 35). Meanwhile, Radloff’s (1977) factor analyses yielded four factors (depressed affect, positive affect, somatic symptoms and retarded activity, and interpersonal problems). Roberts’ (1980) factor analyses using Black, White, and Chicano samples yielded a similar factor structure.

Recent literature suggests that the expression of core symptoms of depression and anxiety are the same across American ethnic groups (Ballenger et al., 2001; Myers et al., 2002). In the present study, the BAI and CES-D appeared to appropriately and accurately measure the symptoms of the participants.
Shapiro Control Inventory (SCI)

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 H. 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. The small correlations between the SCI scales and
the Rotter and Wallston scales suggests that the SCI measures dimensions of control that
are not captured by these two instruments. There is no data addressing convergent
validity for the SCI, since it encompasses a group of interrelated aspects of control not
included in any other instrument (Shapiro, 1994).

According to the SCI Manual (1994), it appears that the samples used in the
development of the SCI were predominantly White, with some use of Asian and Asian
American samples. More research is needed on the function of the SCI with various
Limitations of the Study

The use of only one baseline (Initial Assessment) and one post-treatment (Final Assessment) measurement occasion leaves open the chance that initial scores are not as stable as assumed and outcome measures are also not as stable as they appear. However, it was important to start clients in counseling when they were most motivated and not to wait weeks while baseline measures were gathered. As for post-treatment measures, it was not advisable to stop therapy and not feasible to switch to “standard” therapy. With the clinic closing at the end of June, most of the last contacts the staff had with the clients were focused on termination and transfer issues, which may have “muddied the waters” if tests done in those final days were used to gather post-treatment data. Despite these complications, the use of only one Initial Assessment and one Final Assessment appears consistent with the typical circumstances under which clients seek and receive therapy services, and so in that light contributes to the study’s relevance to typical clinical settings.

Meanwhile, the use of a small sample in this study means that power is low for parametric analyses; however, the data gathered provide a meaningful beginning for future quantitative research in an area where no such data at all exist at the present time. In fact the present study bridges both worlds of the scientist and practitioner in unique and complementary ways, such that the viewpoint of the clinician (practice) and the requirements and structure of the researcher (scientist) are well integrated and informing of one another. The use of the small sample is discussed further in Chapter 4.

It is possible that the use of psychologist trainees instead of more seasoned clinicians might have had some undesirable impact upon the quality of the counseling
services; however, in my experience the students in the clinic were generally on par or better than many clinicians I have known in my career as a supervisor and clinician myself. The training provided is much better than at many training programs, and the focus upon skill development using live supervision may actually enhance the quality of service beyond that which is typically found in mental health centers, where quality control is more loosely managed.
Hi Summer, Thanks for your thoughtful and careful responses—-it sounds like EVERYTHING IS IN CONTROL—-go for it!!! I've made a few comment in your email below in caps....these are just for your to ponder for your final write up; no need to respond now to me....

HiÂ Dr. Shapiro,
> Â
> Iâ€™ve had a chance to spend some time thinking about your comments and suggestions. I wanted to reply and let you know how I was planning to incorporate them into the dissertation itself. THANKS FOR THE FEEDBACK.
> Â
> In terms of developing a â€œstronger spineâ€ or a â€œbridgeâ€ I will continue to work on this by integrating the material. All of your feedback on my draft itself is very helpful and I plan to work with that in an attempt to clarify sections and tighten my writing. CHECK! In terms of the editorial stuff (headings, etc.), Iâ€™ve been planning to work on this but was waiting for the 6th edition of the APA publication manual to come out as I understood there are revisions to headings among other things.
> MAKES SENSE.
> Â
> You asked how my study was different from a replication of Leeâ€™s. I plan to find a better way to articulate this and clarify it in the dissertation but here is a short answer. It is similar, but there is much controversy in the field in regards to applying DSM diagnostic criteria and conceptualizations of pathology to non-Western individuals. Previous studies have shown that non-Western manifestations of anorexia (while similar) have distinct characteristics that differ from manifestations of anorexia seen in Western countries. SO IS YOUR STUDY SEEKING TO "TEASE" THESE OUT? OR PROVIDE A COMPARISON? These cultural variables influence participants, studies and their outcomes. Recent studies coming out of China, Hong Kong and Japan reveal increasing similarity to symptom presentation seen in Western countries (DOES THIS SAY THERE ARE NOT THAT MANY DIFFERENCES CULTURALLY?—SEE BELOW) but the application of our nosological system is still a topic of debate. A study done by Soh, Surgenor, Touyz, and Walter (2007) compared eating disorder symptoms and psychological control between Northern Australians and Chinese Singaporeans. They found that irrespective of culture, individuals with eating disorders shared similar distortions in control. However, the manifestation, and extent of specific aspects of control pathology varied from that of healthy participants, and was found to be culture dependent. OK, SO THIS SAYS THAT THERE ARE CULTURAL DIFFERENCES. HOW DOES THAT JIBE WITH THE ABOVE? (YOU DON'T HAVE TO ANSWER ME NOW, BUT YOU DO NEED TO BE CLEAR IN YOUR FINAL WRITE UP). That said, the contributions by Lee and other colleagues in our field is invaluable but there are these important differences between our studies. I'M NOT QUITE CLEAR YET--ARE THESE DIFFERENCES, AS NOTED, TEASING OUT WHAT MIGHT BE "CULTURAL DIFFERENCES"; AS WELL AS THE COMMENTS YOU MAKE BELOW?
> Â
> The three studies similar to mine all utilized a different methodology:
> participants were those who had a current diagnosis of AN and were
> participants in a clinical trial (Surgenor, 2003), those participating in
> an Outpatient ED program (your study, 1993), or participants who had
> received psychiatric treatment (Lee’s study, 2005). The aim of my study
> is not to look at those who are acutely ill, or those who have received
> treatment, but rather to examine whether individuals who have recovered
> exhibit different levels of control in comparison to those who remain
> symptomatic. (WHETHER OR NOT THEY HAVE HAD TREATMENT? OR THE FACT THAT
> THEY AREN’T CURRENTLY IN TREATMENT OR HAVE NECESSARILY HAD IT, DO I
> UNDERSTAND YOU? That said, I am curious to see if there is a difference
> between those who have received treatment versus those who have not.
> JUST OUT OF CURiosity, DO YOU FEEL THAT THERE MIGHT BE A SUBSET WHO HAVE
> RECOVERED, BUT NEVER RECEIVED TREATMENT? AGAIN, NO NEED TO ANSWER ME NOW
> But,
> > ultimately I’m interested in the strengths (OF THE CONTROL PROFILE?)
of those who have recovered
> > and what it is that has enabled them to do so (IN TERMS OF THEIR CONTROL
PROFILE, OR WHAT THEY SAY IN RESPONSE TO AN OPEN ENDED QUESTION? THE SCI
BY ITSELF WON’T NECESSARILY TELL YOU WHAT THEY FEEL ENABLED THEM TO DO
SO—YOU’LL HAVE TO INFER IT (E.G., THEY HAVE LESS DESIRE FOR CONTROL;
THEY ARE MORE POSITIVE YELLDING); THAT IS IMPORTANT; BUT I’D SURE LIKE
AN OPEN ENDED SPEECH SAMPLE TO LET THEM USE THEIR OWN WORDS; I THINK
YOU’RE RIGHT (BELOW) THAT AN INTERVIEW GIVEN YOUR METHODOLOGY WOULD BE
TOO CUMBERSOME, BUT I THINK YOU MIGHT BE ABLE TO DO IT EASILY BY
REFINING YOUR OPEN ENDED QUESTION JUST A BIT MORE (AGAIN, SEE BELOW).
when we know that so many
> with anorexia remain symptomatic.CLEAR, AND VERY INTERESTING QUESTION.
> A
> In terms of adding a qualitative piece, Sherry and I have talked about
> this from the beginning. At the end of my Background Questionnaire there
> is an open-ended question that asks the following: "Are there anything
> else you can say about your experience with anorexia that might be helpful
> to this research? I’D BE HAPPIER IF YOU MADE IT MORE SPECIFIC TO YOUR
OWN STATED GOALS: (I.E., WHAT IS IT THAT HELPS THOSE THAT RECOVERED
(PARTICULARLY ISSUES OF CONTROL THEY ADDRESS), AND HOW THEY DID IT—IN
THEIR OWN WORDS—E.G., AS YOU LOOK BACK, WHAT WOULD YOU SAY ARE THE MOST
IMPORTANT "VARIABLES" (THINK OF A BETTER, LESS ACADEMIC
WORD—CONTRIBUTIONS, HELPFUL EXPERIENCES, ETC) THAT HELPED, ARE HELPING
YOU GET TO WHERE YOU ARE TODAY? E.G., A.C.A.A. IT WOULD BE INTERESTING
WITHOUT MENTIONING CONTROL IN YOUR OPEN ENDED QUESTION, IF ANY "CONTROL"
SPEECH CAME UP: THAT COULD THEN BE ADDED AS PART OF A QUALITATIVE,
ANECDOCTAL PART OF YOUR RESULTS/DISCUSSION. It is my hope that this will
provide an added
> source of information and allow the participants to "speak."

I like
> your idea of taking the top five people with the best control
> profile and comparing them to the people in the most trouble. I need
> to talk with the others on my committee about how to incorporate this
> piece. GOOD. THAT SHOULDN’T BE TOO HARD, CUZ YOU’LL HAVE THE DATA
ALREADY. I’m hesitant to incorporate the interview component this go
> around: I feel like it would be difficult given my method of data
> collection. THAT MAKES SENSE. I UNDERSTAND, AND AGREE....That said, I
see this as being an incredibly beneficial and
> important study and I would prefer to pursue the interview aspect in a
> future study.AGAIN, MAKES SENSE, BUT THEN IT WOULD SEEM ALL THE MORE
IMPORTANT TO TRY TO GET THAT INFO FROM YOUR OPEN ENDED
QUESTIONNAIRE—MORE SPECIFICALLY TARGETED TO WHAT HELPED THEM IMPROVE
(OH WHAT DO YOU THINK HAS BEEN THE MOST HELPFUL TO YOU---SO THAT EVEN
THOSE WHO HAVEN'T YET RECOVERED, COULD BE INCLUDED....
> Â
> I hope that I've touched upon the main points that you've addressed.
> VERY WELL!
> Please let me know if there's anything that you would like included that
> I've not covered. GOOD TO GO! I will definitely work further to
> define and refine
> the clinical implications that will come from this research and how if
> differs from that of others when drafting the actual dissertation.
> YOU'RE VERY CONSCIENTIOUS...I APPRECIATE THAT, AND THINK THIS CAN BE A
> REALLY INTERESTING ADDITION TO THE FIELD.... GOOD LUCK!! WARMLY, DR. S
> Â
> Thanks,
> Summer
>
> Â
>
Hi Summer, I went back and read your instructions/ Informed Consent Form. After meditating on that and the "open ended question", I had some additional thoughts.

My suggestion in the last email was to add something more specific about "what was helpful to you in the recovery/recovering process." And specifically suggested it might be helpful to not mention control, to see if that came up in their "open ended response." My thinking at the time was it would be interesting to see if, unprompted, they wrote about the importance of control.

Although that view has some merit, I now disagree with myself! Here's why. First, it will be clear having taken the SCI that control is of interest to you. But more importantly, your instructions make that explicit.

In your informed consent, you say the following (which I extracted):

The title of the study is "Psychological Sense of Control and Recovery from Anorexia Nervosa."

The results will be useful in furthering the understanding of control as it relates to anorexia and recovery. Results will also be useful in the future design of clinical programs to improve psychological treatment and will aid clinicians in their understanding of this complex syndrome.

If you choose to participate in this research, you may develop greater personal awareness of the role that control plays in your eating symptomatology.

So, duh, they probably will know what you're looking for in the open ended question!! And I think that is a good thing. I guess what I'd say is that since you are trying to find how control operates in AN, and what might be the best "control" enhancing treatment, why not, in this preliminary study, ASK THEM! You raised so many interesting questions in your introductory write up (e.g., paradox of control, family and control, self-control, etc); it would be wonderful to give them a chance to say what was most important thing you learned about control, or that was most helpful to you, or...however you want to phrase it; this could tie in with what you already have: eg., anything you want to offer us what would be helpful to our study (and maybe add a few lines such as the ones above, or the ones that interest you the most re: control....just to get them talking). Anyway, that's all. But I thought it was worth letting you know of the discussion myself and I were having. I now leave it in your and your committee's capable hands, and now back to some quiet meditating...ommmmmmm :)_ Warmly, Dr. S
Hi Dr Shapiro,
Thank you so much for your feedback and suggestions. I feel as though you've given me a gift that will not only add clarity to my current dissertation but will inform my research and writing in years to come. The amount of time you spent was very apparent and I'm so grateful for your help. Please know that I appreciate your honesty, your enthusiasm and the fact that you've highlighted areas where I can clarify and tighten my research. Also, your sensitivity as to what an enormous task this is clearly came through.
It has been a pleasure working with you and I will send a copy of my bound dissertation your way just as soon as it's done...
Thanks again for your support, Summer
The additional analysis:
Examination of the top five control profiles from the recovered group will be compared to the lowest five control profiles in the symptomatic group. Data will be obtained from the individual Comprehensive Clinical Reports generated from the participants' scores on the Shapiro Control Inventory.

The narrative question:
Reflecting on your experience with anorexia, is there anything you would like to share about your relationship to control (e.g., self-control, external control)? Please answer in as much detail as possible.
Hi Summer,

CONGRATULATIONS!!

This is a fascinating study, and I learned a lot from it. The amount of work you put into it clearly shows, and this will definitely make an important contribution to the literature. I want to strongly encourage you to publish this in journal form and I see the seeds of an important book for you to write on a control-based approach to AN as you continue your clinical work. (Although I know right after working on a dissertation, the idea of EVER writing anything again may seem just slightly problematic!) A possible title:

AN: THE PARADOX OF CONTROL?
Exploring the Integration of Theory, Research, and Treatment

By the way, I want to thank you for your kind acknowledgment in the dissertation:

< I would like to thank Deane Shapiro who served as my External Examiner. It was his theory that inspired me and I am grateful for his enthusiasm and support of my research. >

As George Bernard Shaw said, (paraphrase), be careful what you wish for!!! You may now be feeling "hmm, does he have to be sooooo enthusiastic?!?! Please know that I have taken so much time going over your study, because I truly believe it is VERY valuable.

As you can see, there are several attachments I’m enclosing. The first is an overview of what I feel are positive aspects and suggests for your dissertation for Chapters One through four. What I’d say is that the first four chapters are really clear and well-written, and is “First rate!”. I have only a few suggestions detailed in this attachment (for chapters one-four). Although I don’t know your work pace, schedule, etc, my sense is this would take me approximately two hours to address the suggestions.

The second attachment is for Chapters Five and Six, again with positives and suggestions. Chapters five is extremely promising and rich, and I am VERY excited by it. However, Chapter five (and six) are not yet up to the standards you set in the first four chapters. I have tried to suggest some clear, practical ways to address this. My sense is it is very doable. You have all the material there. But it will take some additional effort (again, if I were doing it, we’re probably talking 20-25 hours). I would say this is effort that would be well spent, because as you note, this is really the main contribution of your dissertation. It is unique, and even as I read what is there, I am, as noted, really ENTHUSED. This is new and important material. But it needs a spine, and some more “big picture” thought on your part. I have tried to give some suggestions as best I was able. I hope you find them helpful.

I realize this may seem “challenging” and even a bit frustrating after putting in so much work and being so close. On the one hand, part of me is “sorry” for bringing it up. I wrestled with if I should. I want you to know at some level I am sensitive to how you must be feeling. (tired anyone!!?!?) But I invite you to take a breath, now exhale…. (ahhhhh….), to know that I AM on your side, that you are REALLY close to the end, and that this extra work really is important and
exciting and worthwhile. I honestly believe it is worth the extra effort, and you are in a great place to really help the field move forward substantially.

(ok, now you can take another in breath!?!😊)

In conclusion, let me say I really am impressed with what you have done. I leave it in your capable hands (with your advisor Dr. Hatcher) and your internal readers’ to go over the last two chapters to make them as good as the first four. I’m sending a copy of this to Dr. Hatcher (but I don’t have the email addresses of the other two core committee members Drs. Bendell and Newton). I am also sending a copy of this to Dr. Kutz in which I answer her two questions in the STRONG AFFIRMATIVE: 1. Is the completed dissertation a scholarly work at the doctoral level? ABSOLUTELY!

2. Does the dissertation fulfill its own claims of originality, procedures, and results? WITH ATTENTION TO THE ACCOMPANYING SUGGESTIONS, ABSOLUTELY. AN EXCELLENT PIECE OF WORK AND CONTRIBUTION TO THE FIELD.

<I also included in my letter to her the following three sentences). I trust your skill, competence, conscientiousness, and dedication. When you are satisfied, with the last two chapters, I know they will really be good. Therefore, you have my sign off.

All I ask is that once you have bound the dissertation, please send me a copy. And once you have published it, please send me a copy of that, too.

In the Jewish tradition, we have just completed the “Days of Awe” and are starting a New Year. One of the rituals there is to dip an apple in honey and wish oneself and others a “sweet year.” Indeed, I wish you a sweet year

with blessings of peace, health, happiness, and joy....... 

. Namaste....... Dr. S