The original plan involved recruiting African American therapists. However, since no African American students were currently enrolled as student clinicians in the training clinic, competent student clinicians of a broad range of racial/ethnic backgrounds were invited to participate in the study. The clinicians in the study included one Trinidadian (of African and Southeast Asian ancestry) woman who identifies as Black, one Latino (Puerto Rican) man, one Southeast Asian (Indian) woman, four Caucasian women (including one bilingual Russian immigrant), and one Caucasian American man.

Training of Therapists

Once the selection was completed, initial training in Control Therapy for each therapist involved approximately eight (8) initial hours of instruction and involved (a) assigned readings, mainly from the book “Control Therapy, An Integrated Approach to Psychotherapy, Health, and Healing”, (b) demonstrations using role-play scenarios and discussion, and (c) practice tasks whereby therapists demonstrated skill in using basic Control Therapy principles and methods. See Appendix C for instructional handouts used in the training. The trainers put emphasis upon using the methods to their fullest potential, helping the clinicians elicit client’s cultural context via the Control Therapy model. In other words, clinicians were taught to help clients “paint a picture” of what it was like for them growing up in their particular cultural (including neighborhood and familial) context and deeply explore how those experiences impact who they are today. For example, one of the clients often felt overwhelmed; she was working on a college degree and trying to care for an ailing elderly parent, feeling pulled in different directions trying to be a good daughter who did not complain, while striking out on her own, seeking to become the first in her family with a college degree. To understand her
experience on more than a surface level involved helping her articulate the complexities of what it was like in her family of origin, those relationships today, and how she conceptualizes being a good sister, daughter, Christian, and so on. Once the clinicians gained skills in working with this material, they were then taught to connect the complex meanings back to the client’s issues related to having or gaining control.

The student clinicians also received training on administration, scoring, and interpretation of the Shapiro Control Inventory (SCI). They learned how to discuss the SCI answer sheet (e.g., reviewing the client’s levels of control in specific life areas) with clients. They also learned how to present the computer-generated results (a.k.a., “control profiles”) with clients in session. On the SCI results printout is a set of nine bars on a graph, one bar for each of the nine scales of the SCI. Each bar illustrates how far a client scored from the mean for the normative group used in creating the instrument.

The clinic director and I co-led the trainings. The director is an African American psychologist and professor specializing in multicultural counseling and training, with 25+ years experience providing instruction and supervision to doctoral students. I am a Caucasian woman with 10 years of post-master’s counseling experience and have completed all required doctoral-level coursework and an APA internship. Prior to the study, I had worked in the clinic for four and a half years, starting as a student clinician and moving on to assisting with the supervision of others in training, while carrying a small caseload. In the past year, the director, one of the study clinicians, and I have co-presented on the theory and methods of Control Therapy at two regional conferences on multicultural issues in counseling and education.
At the end of the training period, the clinic director and I assessed each therapist’s ability to adhere to the Control Therapy approach, using an evaluation form listing important elements of the approach, such as: ability to help clients review the life areas (relationships, feelings about self, time management) and describe relevant examples, ability to appropriately elicit control stories, ability to utilize culturally relevant information to deepen the exploration, and ability to guide clients effectively through the 5-step process of change. See Appendix D for the evaluation form. If at any time prior to, or during the delivery of, the treatment a therapist did not demonstrate acceptable competency in delivering Control Therapy, in the opinion of either myself or clinic director, then s/he received additional instruction and practice and was reassessed within a reasonable period of time.

In addition to learning how to use the SCI, therapists also received specialized training in administration of three other instruments. These instruments were the Center for Epidemiological Studies-Depression scale (CES-D; Radloff, 1977), the Beck Anxiety Inventory (BAI; Beck & Steer, 1993), and a Background Information Form that I created which contains demographic questions.

The Treatment Phase

Treatment Protocol

The treatment followed the principles and procedures outlined in the book “Control Therapy, An Integrated Approach to Psychotherapy, Health, and Healing” by Shapiro and Astin (1998). There, the authors describe a control-focused talk-therapy strategy that selectively draws upon techniques from a wide menu of established cognitive, behavioral, and affectively-based therapies. The approach involves a 5-step
cognitive-motivational model for facilitating change, as explained previously in the literature review. Well-established relaxation and other self-control techniques are used as relevant, in keeping with the model.

The clinicians followed Shapiro and Astin’s (1998) guidelines for delivering a 12-week course of Control Therapy. These guidelines were followed as closely as possible without becoming rigidly imposed. For each client, the assessment phase flowed into the goal setting phase and from there into whatever tasks were necessary. The pacing of sessions was dictated by client needs, not by predetermined time periods. The protocol was delivered according to these general guidelines, with one added “special session”, which will be explained below:

**Session one.** The therapist helps the client identify areas of concern. He or she helps the client identify areas where there is a desire for greater control or a desire for less control, depending on the issues. The therapist listens to client speech, working to develop rapport and the therapeutic relationship. He or she also listens for control-related aspects of the client’s personal history. The client fills out the SCI after the session and it is mailed away for scoring.

**Special session.** While the manual recommends discussing the SCI results (which are computer-scored and then mailed back) with the client during Session Two, the treatment team in this study made a small deviation which proved to be very fruitful. They delayed the discussion of the results until after at least one session in which the client got a chance to talk about his/her experience filling out the instrument. Before mailing out the SCI answer sheet for scoring, it was photocopied, so that the clinician could take the copy into the therapy session and look at it with the client. Specifically,
the clinicians directed the clients to look at their answers to the questions about specific life areas (e.g., eating behavior, sadness, stress, relationship with partner, and so on) and to talk about what specifically they were thinking about when they answered. This led to rich discussions and new realizations for the clients, and it helped clarify therapeutic goals. It was for some clients more useful than discussing the computerized printout of the results.

*Control Inventory: Background and Description (read more)*

Session two (in this study the third session). The therapist shares the SCI results with the client and guides him/her in a discussion of pertinent control information, with some focus on the client’s use of the Four Modes of Control (Positive Assertive, Positive Yielding, Negative Assertive, and Negative Yielding). If needed, the therapist can ask the client to use something called the “eyes closed” exercise, which involves attaining a relaxed state and just freely thinking about the issue (e.g., anger at a family member), envisioning an incident that typifies the concern, and identifying feelings and meanings related to the matter. The therapist engages the client in a discussion of his or her “control story”, dynamics, and assumptions. Control stories can often be encapsulated in a single statement, and are usually created in one’s family of origin. These statements are similar to Albert Ellis’s “11 irrational beliefs” (Ellis, 1999). Examples include, “The world is not a safe place, so I can never trust anyone” and “Unless I do everything myself, then things will fall apart around me.”

Where appropriate, the therapist may use “teaching stories,” which illustrate central control principles. For example, to help a client understand the value of yielding, one might tell the following story:
In India, the story is told about how to catch a monkey. One places a banana inside a vase that is small at the top and wider at the bottom. The hole at the top of the vase is large enough for the monkey’s hand to reach in and grasp the banana. However, the fist around the banana is too large to get out of the vase. The only way to get free is to let go of the banana. Active control will only keep the monkey trapped” (Shapiro & Astin, 1998, p. 195).

The homework stemming from Session Two should be some type of self-observation task on an area of concern identified by the client, such as making a list of occasions during the week when a certain problem behavior, feeling, or experience occurs and listing the thoughts that happen at these times.

*Session three (in this study the fourth session).* This session contains a number of tasks, which for some clients need to be spread over several sessions. The therapist helps the client explore the self-monitoring information (homework). Discussions may focus on the client’s rights in a situation and/or responsibility for his/her own actions/choices. If appropriate, the clinician employs one or more relaxation or mind-calming techniques, such as diaphragmatic breathing, the “body scan” whereby muscles are relaxed one by one, and the “mind scan” which is similar to mindfulness meditation, in which the person allows thoughts and emotions to come into awareness and simply notices them without judgment or doing anything about them.

From here, the work can move into clarification of goals and goal-setting. Several techniques are available. An exercise called mode dialogue may be needed to move through any resistances. Mode dialogue is a technique whereby the client thinks about the four modes of control and talks about how each manifests itself in his/her life. To help, the clinician brings into the session the table showing the Four Modes and the adjectives that comprise each one, so that the client has something to refer to. For
example, the woman overwhelmed by handling too many tasks at work and at home, might describe her Negative Assertive (Scale 7) side as a drill sergeant, her Negative Yielding (Scale 8) side as a rag doll, Positive Assertive (Scale 5) side as a fair and humane judge, and her Positive Yielding (Scale 6) side as a playful puppy dog (example in Shapiro & Astin, 1998, pp. 207-208). In the exercise, the client gives voice to each mode, speaking about the protective and helpful intentions of each one. With each one valued and validated, she can then more freely choose which mode to use, rather than just reacting. Other techniques include (a) envisioning which mode to choose, (b) use of a written self-management contract, and (c) use of what’s called “an external Rorschach vignette.” The external Rorschach vignette is a means of identifying client control stories and client strategies for solving interpersonal problems. The therapist says, “You and your partner have agreed that your partner will water the plants. You notice that the plants are beginning to wilt. What do you do?” Clients may give negative assertive/yielding responses, and discussing these can become a chance to identify typical reactions and begin to generate alternative choices.

As the therapy progresses, the therapist provides handouts on the Five Steps for Positive Assertive change and Positive Yielding, as well as a handout on how to balance the two positive Modes of Control. For our study, I borrowed these materials from the Shapiro and Astin (1998, pp. 197-203) and compiled them into a booklet entitled Readings for Taking Charge. Also during this session, the clinician may guide the client to envision the problem situation or event, then envision taking steps to deal more effectively with it in ways that are either positive assertive, or positive yielding, or a combination. The homework should be continued self-observation and daily practice of whatever mind-body techniques have been found relevant thus far in the therapy.
Session four (in this study the fifth session). Session Four begins with discussions of the client’s practice of control-based techniques both in-session and via homework. The client may at this point benefit from further clarification and enhancement of motivation, through a number of methods. The therapist may work with the client further on overcoming barriers to control (i.e., secondary gains that may cause the client to keep problem behaviors), enhancing motivation through discussing pros and cons of current behavior choices, and recognizing the limits of overcontrol. Homework is continued self-monitoring and practice of control-based techniques.

Session five (in this study the sixth session). Again, the session is likely to focus on further discussion of the client’s use of control-based techniques. As needed, the therapist helps the client enhance self-efficacy beliefs and commitment to change. This may be done through examining past successes, generating thoughts to enhance change, and/or reaffirming commitment to change. It also may mean reviewing control stories and beginning to “rewrite” them through imagery exercises. Again, the homework involves continued self-observation and practice of control-based techniques.

Sessions six and seven (in this study, the seventh and eighth). Sessions Six and Seven can be used to review progress from both the therapist’s and the client’s perspectives, with a focus upon client self-observation data. At the end of Week Seven, the SCI can be re-administered to evaluate change. Research shows that Control Therapy can be effective within four to eight sessions, but for some clients four additional sessions
may be necessary to continue the work already outlined and to gain more practice with
the various self-control techniques.

Final session – Twelve. The final session is typically used to reflect on the
process, explore progress, and consider ways that new behaviors may be generalized to
address new problems as they arise. Therapist and client can say their final goodbyes and
discuss any future boosters or follow-up as needed.