We are particularly intrigued by your proposal to actually test the Control Therapy model outlined in our 1998 book in a population of African-American clients presenting with depression and/or anxiety.

There are two specific areas in the proposal where we would like some further clarification and would ask that you send us a couple of paragraphs (email is fine) outlining your response to these points by April 1st. This would enable us to make our final funding decision by May 1. The two areas where we would like some further clarification are:

1. We realize that you will be assessing changes in the SCI as part of your study. However, while you may have intended to do this, we encourage you to examine changes in the outcome measures (of anxiety/depression) as a function of changes in the SCI. In other words, we feel it would be very informative since you will be testing the effectiveness of Control Therapy, to examine the extent to which any positive changes in psychological symptoms are mediated by changes in any of the control constructs, which our theory would suggest. In other words, it would be helpful in your study to look at the SCI both as an outcome itself and as a mediator of symptom change.

2. There is certainly an advantage to having therapists other than just you provide the intervention to study subjects. For example, such a design can help control for therapist differences in skill level. However, we feel that the proposal would be made substantially stronger by indicating how you plan to address the issue of therapist training as well as therapist adherence to the Control Therapy protocol. This could be as simple as describing the methods you will employ for training others in this therapeutic approach and the criteria you will use to assess the degree to which therapists were actually practicing these methods in their work with study participants. We feel this will help to ensure some degree of study validity.

Sincerely,
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1. I agree there are potentially very valuable and interesting relationships to be explored between changes in the control constructs and changes in levels of depression/anxiety during a course of Control Therapy. My hope is that by creating graphs of the changes in SCI scores and then graphing changes in symptom levels --each paralleling one another over time for the same case study participant^Wthat I can ^Smap out^T and in my discussion section address patterns and possible relationships between these two types of measures. For example, for an anxious client, one who presumably is high on negative assertiveness at the outset, past studies show that delivery of Control Therapy is likely to lead to a shift toward increased us of positive yielding. This shift can be examined in conjunction with the week-by-week trends in depression/anxiety scores, in order to create some preliminary ideas about relational patterns between increases in positive yielding and the process of recovery from depression/anxiety.

In addition to examining these quantitative results, the proposed study has great potential for gathering a rich array of qualitative data. I intend to conduct qualitative interviews with study participants conducted shortly after they complete their course of treatment. Using open-ended questions addressing their experience of their therapy, I plan to gather participants^R impressions of the change process as it relates to control, depression and/or anxiety, and the interplay between the two. I also plan to gather therapist impressions of changes in participant control dynamics and depression/anxiety over the course of the therapy, through a combination of weekly client progress notes, bi-weekly supervision sessions, and post-therapy interview with each therapist.

By the end of the study, I will also have collected the videotapes for all study therapy sessions, although an in-depth analysis (such as content analysis) is beyond the time and resources available for this dissertation project. Certainly, however, the data collected could be the basis for other papers (and potential publications) in the future.

2. Therapist Training & Treatment Model Adherence

As a White therapist with specific training and experience in cross-cultural counseling, I approach the selection and training of the therapists for this project in a way that is both complex and (hopefully) straightforward. The selection of the two therapists for this study will be from our doctoral program^Rs psychology training clinic, where each candidate for work in the study will have had at least one semester of in-clinic training including live and delayed supervision, and will have achieved at least basic general counseling competence as measured by a supervisor rating form used by our clinic instructor, Dr. Portia Hunt. Ideally, I would like the therapists to be African Americans with high quality counseling skills. At least on the surface, sameness of race between therapist and counselor reduces ^Sinterference^T variables in the study. However, if for some reason I am unable to recruit such individuals, then I will select therapists (one or both) from those remaining doctoral students who have both high quality counseling skills and an ability to engage and gain credibility with Black clients. The most important element is the therapist^Rs ability to work effectively with clients.

For about two years, I have been researching the literature on control measures and constructs, e.g., Rotter, Rothbaum and associates, the Wallstons, and of course Shapiro and Astin. Dr. Hunt is an African American psychologist and professor specializing in multicultural counseling and training, with 25+ years experience providing instruction and supervision to doctoral students.

At the end of the training period, I will assess each therapist^Rs ability to adhere to the Control Therapy approach, using an evaluation form covering areas such as: ability to assess client control dynamics, ability to appropriately elicit control stories, ability to guide clients effectively through the 5-step process of change, ability to select and incorporate mind/body techniques where appropriate, etc. In addition, a second rater will view either a live or videotaped role play in order to assess therapist adherence to the treatment model. The special rater will likely be Dr. Hunt. If a therapist does not achieve acceptable competency in delivering Control Therapy, in the opinion of either me or Dr. Hunt, then s/he will receive additional instruction and practice and be reassessed in the same manner within a reasonable period of time.

Once delivery of Control Therapy is underway, to ensure adherence to the Control Therapy model from session to session, ongoing adherence checks will be conducted. I will meet with the therapists every two weeks for one hour to hear therapist reports on the client^Rs processes and their own processes in delivering the therapy. I will then use this time to give feedback on recent session videotapes. Dr. Hunt will provide me with supervision every other week and will occasionally join my meetings with the therapists, to help ensure appropriate delivery of the treatment. The study therapists will also be receiving weekly supervision with Dr. Hunt as part of their regular training as students in our clinic training program.

At the end of each adherence check meeting, I will complete an evaluation form similar to the one used in the initial training phase. If the therapist is out of compliance with the treatment model, then additional supervision sessions will be scheduled weekly or twice weekly in order to help the therapist regain the appropriate conceptual framework and intervention approach. If compliance is not met within four weeks, then treatment with this client will continue, but the data will not be included in the results of this study. Such cases will become regular cases within the flow of clinic service delivery, and the highest ethical standards will be maintained. As with all cases at the clinic, Dr. Hunt will monitor all such sessions to make sure the client is being treated appropriately and effectively given his/her clinical issues. However, if the therapists involved in the Control Therapy study meet the initial competence requirements it is unlikely that any straying from the model will be difficult to remedy. On the other hand, if client needs emerge that should be addressed right away through another treatment approach, then certainly I would do what is ethical for the client and allow them to receive the appropriate treatment at our clinic or facilitate their referral elsewhere.

Introduction

Research on anxiety and depression suggests that sense of control is a central component underlying the different symptom expressions (e.g., Moras, Telfer, & Barlow, 1993). To date, Control Therapy has been found to be effective in relieving symptoms for clients with depression and/or anxiety, primarily with samples of White clients (Shapiro, 1990; Shapiro & Astin, 1998). With the aid of the Shapiro Control Inventory (Shapiro, 1994), the therapist and client together examine various aspects of client^Rs sense of control. The therapist then utilizes specific process interventions aimed at helping the client decide whether to take active steps to make a change in a certain life domain or to accept a situation as it is. Whatever the decision, the therapist employs a five-step process to help the client carry out this goal. While a similar process is applied across clients, the content, such as issues, goals, and reasons for change, are all generated from the client^Rs own material.

Control therapy shows promise as an effective treatment for not only White clients, but also for African American clients. The field of multicultural counseling has been searching for relevant approaches to working with African Americans. Approaches that have been found to work with this population are a) structured and closely reflect client expectations for help, b) directive without imposing the therapist^Rs agenda on goals to be accomplished, and c) behavioral while capturing other aspects of the client^Rs life, such as religion, community, and other contextual dimensions (McKitrick & Jenkins, 2000; Steenbarger, 1993). Approaches that best qualify fall within the area of family therapy and other systems models. The individual approaches that best fit are the cognitive-behavior therapies; however, these therapies are not naturally aligned to address clients^R cultural contexts. Control therapy, by its integrative and client-focused approach, provides a ^Spackage^T which allows the therapist to provide an experience that is likely to engage African American clients in a structured, directive, behavioral, and yet very contextualized and client-driven manner.

Methods

Participants will be African Americans presenting with depression and/or anxiety and recruited from the clientele seeking services from a doctoral-level psychotherapy training clinic administered by the Counseling Psychology Program at Temple University in Philadelphia, Pennsylvania. Prior to entry into the study, potential participants will receive an explanation of the study, including risks and benefits. Therapy sessions will be videotaped.

The researcher, who is a 6th-year doctoral student, will conduct an intensive single-subject design, repeated with several additional participants, totaling between 6 and 10 persons. The intervention will consist of a twelve-week phase of Control Therapy delivered on an outpatient one-session-per-week basis.

For each participant, the SCI will be given prior to Session 1, after session 7, and after session 12. In addition, the current study will also utilize a baseline measure and repeated weekly measures for 12 weeks in order to track depression using the Beck Depression Inventory and Hamilton Rating Scale for Depression, and/or anxiety using the Beck Anxiety Inventory and Hamilton Anxiety Rating Scale. The therapist and trained raters will both fill out the relevant Hamilton scales for each participant after each session.

Therapists will be recruited from among the African American doctoral students in training at the clinic. Four raters will be recruit from among doctoral and master^Rs students in the counseling program. At least two raters will be African American. The raters^R will view short segments of each therapy session and then fill out the Hamilton Scales accordingly. Thorough training sessions for therapists and raters will be provided prior to the start of the study.

Measures will be taken to ensure that the therapy is delivered

appropriately according to the approach outlined in the book by Shapiro & Astin (1998). The investigator will also work to ensure that both the therapy and rating scales are utilized in a culturally competent manner. The chairperson and major consultant for this project, Professor Dr. Portia Hunt, is a seasoned clinician specializing in multicultural counseling.

The study is projected to begin in April and to continue through November 2004. Some amount of client attrition is expect, but given that roughly 40% of the clinic^Rs clientele are African American, it is reasonable to predict that from six to ten participants will be able to complete the 12-week program in that amount of time.

In the final report, demographic data will be presented for each participant. In addition, graphs will show symptom changes over 12 weeks on the BDI and/or BAI, as well as changes on the Hamilton Scale(s). Shorter graphs will show changes on the SCI^Rs nine scales, from pre-treatment to mid-treatment to post-treatment, for each participant. Case descriptions and relevant statistics for determining significance of outcome scores will also be included, where appropriate.

Results

Using a ^Ssmall n^T case-study method, this study seeks to answer the following question: Does the intervention of CT reduce the frequency and severity of symptomatic complaints in a clinical African American sample presenting with depression and/or anxiety? This question is important to practitioners in urban environments seeking new ways to make their services relevant to their Black clientele. As explained earlier, the features of CT appear to have special appeal for African Americans, who as a group seek psychotherapy less often than Whites (Steenbarger, 1993), drop out sooner (Steenbarger, 1993), and according to some studies tend to benefit less (than do Whites) if they remain (Sue, Zane, & Young, 1994). Secondarily, this study also seeks to examine the function and relevance of the Shapiro Control Inventory in the treatment of African American outpatients.

ps, in your table, you have pre and post test for the CT group, and pre for the two comparison groups; did you also get post for the comparison groups? Just a way to control for the "time" variable.....(ok, that's all....now, have a great thankssgiving!!!!