

THE PSYCHOLOGICAL CONSTRUCT OF "CONTROL":  
A THIRD GENERATION ASSESSMENT APPROACH

ABSTRACT FORM  
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Type the TITLE of your paper in CAPITAL LETTERS.

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THE PSYCHOLOGICAL CONSTRUCT OF "CONTROL": A THIRD  
GENERATION ASSESSMENT APPROACH

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U.S.A.

Issues of "control" abound throughout the human life cycle. Heightened or decreased "sense of control" has been seen to have profound positive or negative effects on an individual's psychological and physical health. This paper reports on the development of a "third generation" assessment instrument which has been developed as the result of a 10-year project to review the experimental, clinical and health-related literature on control. The instrument, known as the "Shapiro Control Inventory," was designed by Deane H. Shapiro, Ph.D., based on his findings. The instrument builds upon, extends, and refines prior efforts to measure human control and self-control. Dr. Broenen, who is Dr. Shapiro's collaborator on the development of a clinical reporting/interpretation system for the instrument, will describe the instrument, its clinical applications, interpretive approaches, and its origins. Potential international applications will particularly be highlighted.

## IV. CLINICAL EXAMPLES

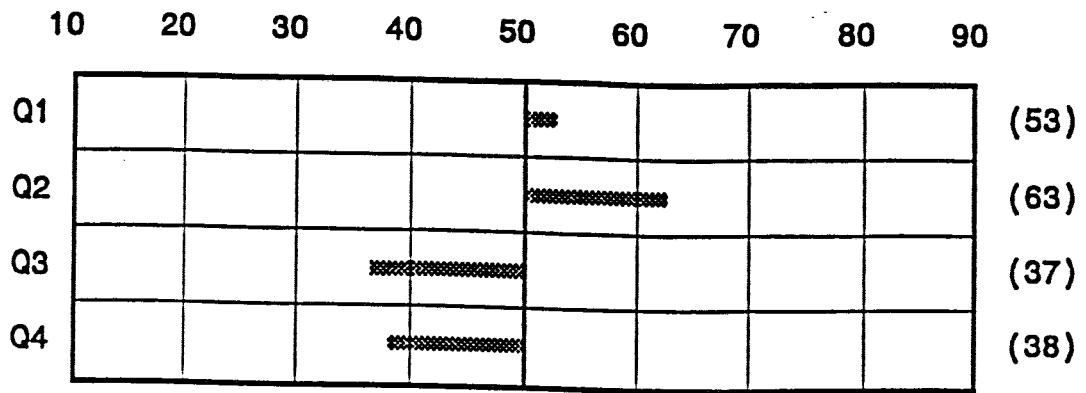
Systematic clinical field trials have not yet been undertaken with the SCI. While the instrument is in the process of being readied for publication in a research version, it has been employed in a private practice setting with appropriate cases. Following are data from a "normal" case and two illustrative clinical cases. Data presented is taken from the Behaviordyne interpretive system. (Scores are normalized, with a Mean of 50 and a Standard Deviation of 10.)

### A. NORMAL EXAMPLE

Normal mode of control profiles for both the general and specific domains are presented in Figures 8 and 9. These are for a male, age 39. His quadrant profile (Figure 8) evidences high Quadrant 1 & 2 and low Quadrant 3 & 4 scores, indicative of psychological health, and a high level of satisfaction with his general domain modes of control. His specific domain profile (Figure 9) indicates no significant deviations from the norm in any of the seven domains of self-control.

### B. A MALE WITH RELATIONSHIP ISSUES

The first case is that of a male, age 38, who was experiencing difficulties with his significant other. She tired of their relationship because of his emotional neediness and erratic behaviors. MCM results suggested a passive aggressive personality disorder with self-defeating behaviors. The SCI indicated a low sense of control in two specific domains: cognitive and relationships (See Figure 10). His mode of control preferences were seen to be inverted from the normal (See Figure 11).



*Score?*

Quadrant	% Satisfaction	% More	% Less
Q1, Positive Assertive:	37.50	62.50	0.00
Q2, Positive Yielding:	78.57	0.00	21.42
Q3, Negative Assertive:	100.00	0.00	0.00
Q4, Negative Yielding:	100.00	0.00	0.00
Overall Satisfaction:	72.00		

Figure 8. Normal Example: Derived Mode of Control Profile and Level of Satisfaction

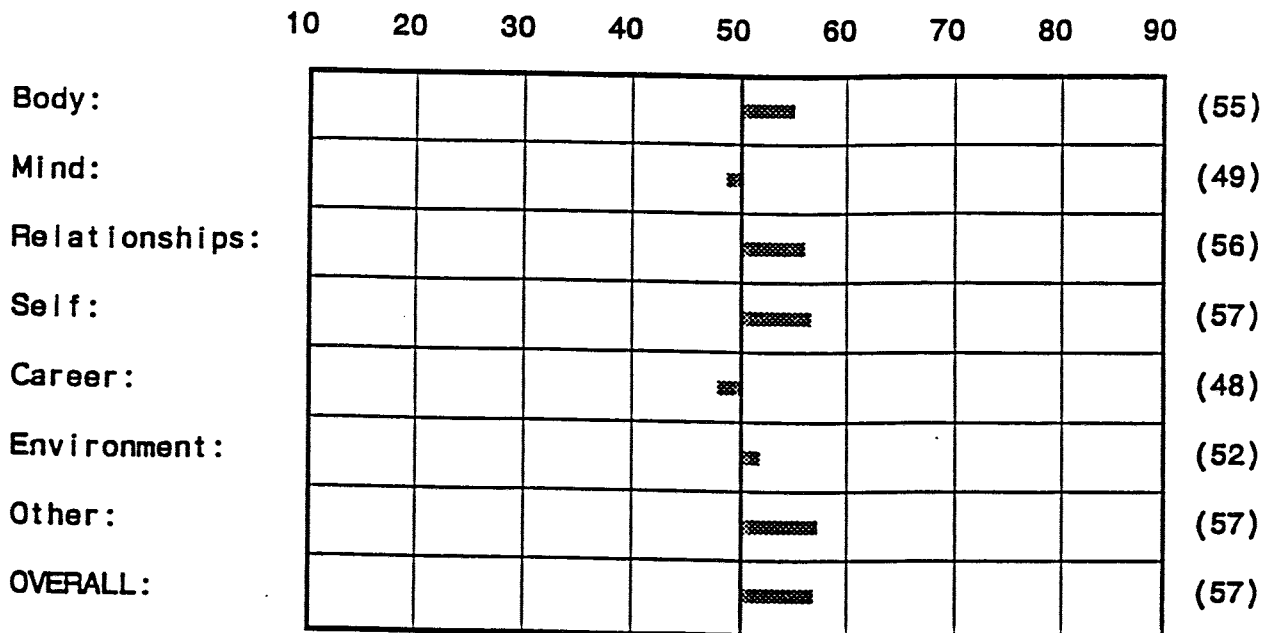
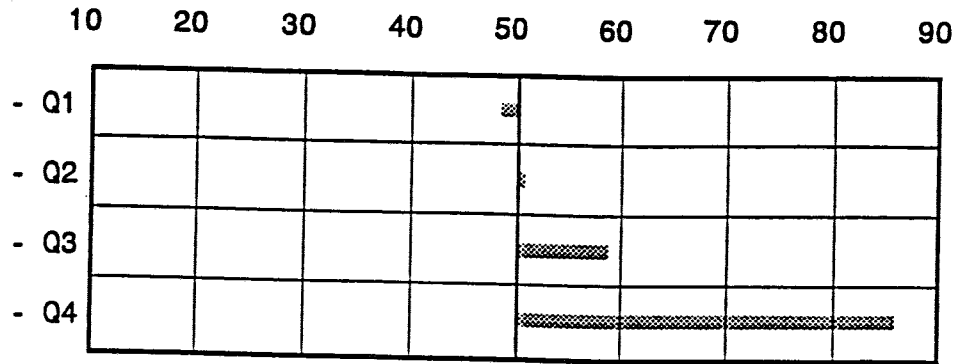


Figure 9. Normal Example: Specific Domain Control Profile



Quadrant	% Satisfaction	% More	% Less
1	37.50	56.25	6.25
2	57.14	35.71	7.14
3	50.00	0.00	50.00
4	0.00	0.00	100.00
<b>Satisfaction:</b>	<b>46.00</b>		

Figure 10. Case 1: Derived Mode of Control Profile and Level of Satisfaction

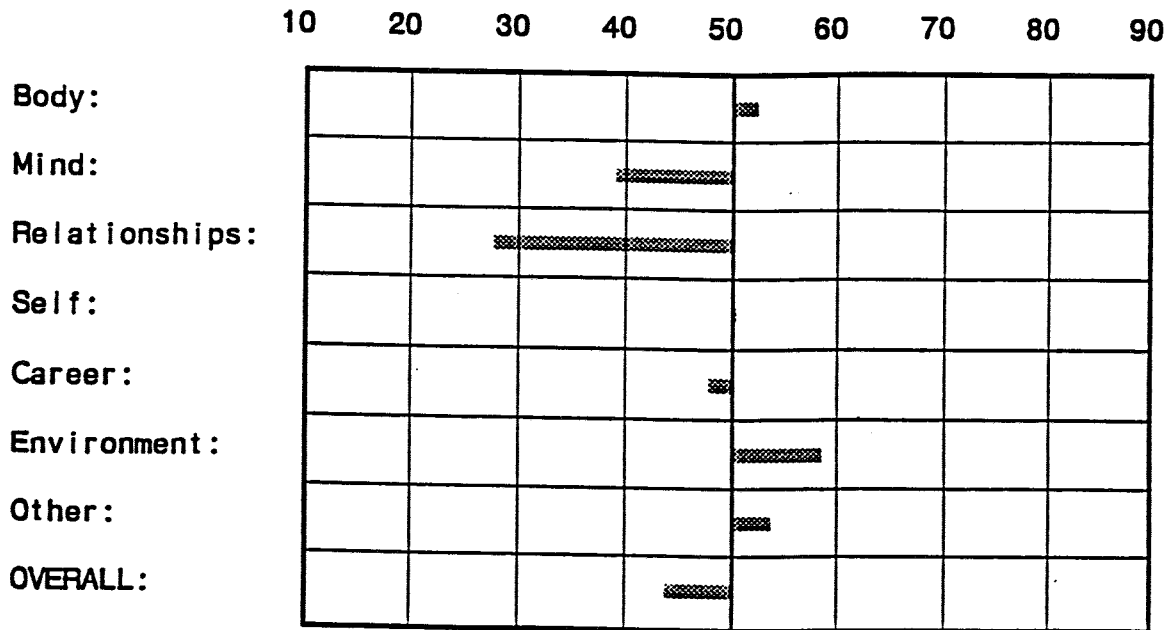


Figure 11. Case 1: Specific Domain Mode of Control Profile

In this first case, the SCI provided information which helped the clinician coach the client regarding his exaggerated sense of lacking control in the relationship, leading to alternating capitulation and equally self-defeating attempts at overcontrol.

### C. THE TROUBLED WIFE

The second case involves a female, age 48, who has been married for 25 years to an overcontrolling man. She has been in psychotherapy for over a year. She initially presented as listless and ill. MMPI testing at that time indicated that she was dysthymic and somaticizing her distress.

She was administered the SCI at intake and a year later. Data comparisons indicate an enhanced effort/desire for control (Figure 12), and an improved sense of control in specific domains (Figure 13).

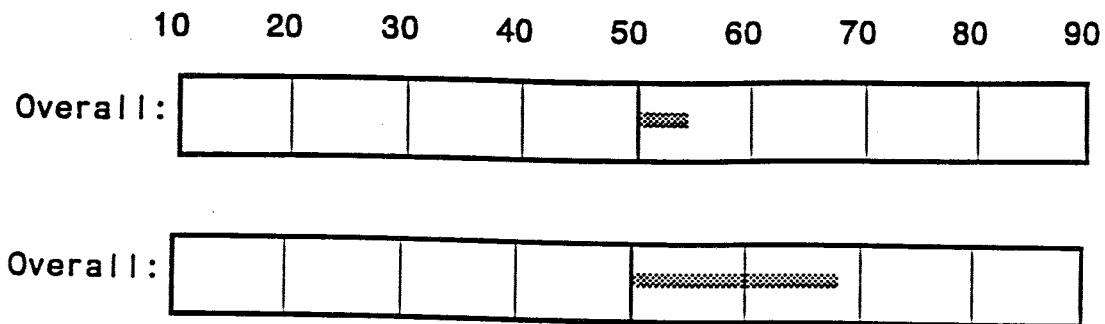


Figure 12. Case 2: Comparative Effort/Desire for Control, Pre- and Post-Treatment

The SCI helped identify specific domains in which she could gain an increased sense of control. The clinician worked with her to enhance her awareness, skills, and effort/desire for control. Progress was indicated not only in her motivation, but in her perceived results in three domains.

## I. ORIGINS OF THE SCI

### A. DR. SHAPIRO'S WORK

Deane H. Shapiro, Jr., Ph.D. has dedicated more than a decade to the study of human control. His interest in meditation, holistic health and Eastern philosophy and religion led him to this pursuit. He is particularly interested in how a person cultivates exceptional psychological health, and how such a state is conceptualized in various cultures.

Almost all of the work described here is that of Dr. Shapiro. I am pleased to have the privilege of presenting it.

### B. THE CONSTRUCT OF CONTROL AND ITS IMPORTANCE

As humans, we have a basic need to have control over ourselves and our lives. Among our greatest fears is that of losing control. Control affects our sense of identity, our health, our relationships, our work, and how we face life's difficulties including illness and death. Medically, sense of control may have a bearing on arresting progressive physical diseases such as cancer.

Psychologically, impairment of control has been suggested as a central feature in clinical syndromes, such as depression, anxiety, and addiction. Conversely, enhancement of control options and behavioral repertoires is seen as a major component in achieving exceptional psychological health and well-being.

Control, however, is a complex construct. It is defined differently by different theorists. It varies with persons and situations. It tends to be culturally embedded and take on moral meanings, positive or negative.

Research into control has been productive in the past 25 years. Better-known findings include Rotter's internal/external locus of control,

Seligman's learned helplessness and Bandura's self-efficacy. But as our understanding of control deepens, so does awareness of its complexity.

#### D. RATIONALE FOR DEVELOPING A NEW INSTRUMENT

In his review of the literature, Dr. Shapiro became convinced that "clinical research has reached a plateau in terms of being able to differentiate between competing control strategies" because of semantic confusion. Early instruments were based on different paradigms. Rotter's internal/external locus of control scale (1966), the "first generation" measure, yielded one score in the general domain, indicating whether the subject has either an internal or external locus of control. Later research suggested that "internal" and "external" perceptions of control were orthogonal, with zero correlation. Wallston et al. (1976) developed a "second generation" Multidimensional Health Locus of Control Scale (1976). It was domain-specific in that it gave a score for the health domain. It provided both internal and an external locus scores. Further, external locus of control was divided in chance and powerful other. Thus, measurement of control was moving from general to several specific domains, and from a unitary construct to one that is potentially multifaceted and multidimensional.

Dr. Shapiro, convinced of the need for a "theory-driven research model based on clarification of semantics," took on the challenge of "developing a precise, multi-faceted overview of the construct(s) of control" as a necessary first step toward better understanding how the different constructs of control interact. He saw that this would enable design of a unifying theory which could be integrated into assessment and treatment strategies. He envisioned an instrument incorporating all

major perspectives on control embodied in the world's psychological literature. In clinical practice, he saw that a standardized assessment inventory could differentiate control profiles across clinical categories, thus enabling definition of preferential therapeutic control strategies. In research, the model could be used heuristically as the basis for progressively refining our understanding of the construct. Thus, the Shapiro Control Inventory, or SCI (Figure 1).

Figure 1. The Shapiro Control Inventory



## II. DESCRIPTION OF THE SCI INSTRUMENT

### A. ORGANIZATION

The SCI provides a standardized way to perform a multi-faceted, multi-dimensional measurement of control with a paper-and-pencil self-report. It has pretested clarity and uniformity of items. It can be used with both psychiatric and normal populations. It has a total of \_\_\_ items, and can be administered in about 30 minutes.

The SCI has the following goals:

1. to provide the most comprehensive enumeration currently available of the different parameters of control;
2. to measure those parameters in a standardized way;
3. to show how those parameters interact; and
4. to begin to establish profiles of three varying states--pathology, normalcy, and exceptional health--based on its findings.

The SCI has three parts:

Part 1: Aspects of Control consists of 37 general-domain questions on a 7-point Likert scale of frequency ("never" to "always") measuring "species," "agent/ object," "mode," and "dimensions" of control.

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Part 2: Domains of Self-Control addresses 25 variables which can be grouped into 7 specific domains of one's experience of self-control:

- body/somatic
- interpersonal relations
- career / money issues
- other
- cognitive/affective
- self
- environment

It asks for three responses relative to each variable:

- 1) Whether the subject feels "in" or "out" of control and to what

degree (6-point Likert scale);

2) Whether or not that state is of concern; and

3) If a concern, whether one prefers to change it or accept it.

Part 3: Modes of Control solicits two responses to each of 49 words or phrases (e.g., "explorative") descriptive of four specific modes of control (e.g., "positive assertive"):

1) How accurately each word or phrase describes him or her (4-point Likert scale); and

2) His/her level of satisfaction with that state and, if dissatisfied, whether s/he would choose change, and, if so, whether to have more or less of that characteristic.

## B. THE FOUR PARAMETERS OF CONTROL

### 1. Species.

"Species" describes the nature of the control process linking the agent and object. Dr. Shapiro developed this scale through analysis of words in the literature. It involves a continuum of refinement of one's perceived degree of control--from having control to lacking control. It includes both static (e.g., sense of control) and dynamic (e.g., efforts for control) elements. The species are, so to speak, "vectors" either toward or away from a state of control. Table 1 summarizes the scale.

By creating a standardized framework of all control-relevant categories, the Species section enables examination of their inter-correlations. This can enable clinical hypotheses-testing. For example, it might be hypothesized that, for anxiety patients, fear of losing control is correlated with efforts to gain control, but that this is not true for depressed patients.

Table 1. Species of Control

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1. **HAVING (OR GAINING) CONTROL.**  
Feelings or beliefs about being in control, a sense of control, increasing one's control.
  2. **BELIEF IN THE ABILITY TO GAIN CONTROL.**  
Beliefs in one's ability, but without reference to effort being applied (#3) or without any results (#1).
  3. **EFFORTS TO GAIN CONTROL.**  
Represents points on a continuum of intensity, from making some efforts to enormous striving.
  4. **NEED, OR DESIRE, FOR CONTROL.**  
Also encompasses a continuum of intensity, but does not include either efforts (#3) or belief (#2).
  5. **NOT WANTING (MORE) CONTROL.**  
A desire to have less (or at least not more) control; suggests letting loose of control.
  6. **FEAR OF LOSS OF CONTROL.**  
The actual event of losing control (# 7 and #8) has not occurred, but there is a fear it might.
  7. **LOSING CONTROL.**  
An acknowledgment of actually experiencing a loss of control-- such as, of one's abilities, powers or emotions.
  8. **LACK OF CONTROL / OUT OF CONTROL.**  
No sense of control. ~~This~~ Contrasts with #7, in which some sense of control remains, although diminishing.
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Another example could be with regard to the inter-relationships of three variables: actual control (AC), perceived control (PC), and self-efficacy. It might be hypothesized that:

$AC > PC =$  learned helplessness, low sense of self efficacy.

## 2. Agent/Object

Research has shown that a "sense of control" can come from multiple agents, such as: the self, another, or the environment. Self-control concern can be sensed in specific domains. This section identifies the entity exercising control (agent) and the entity receiving the effect of the control (object), as well as the subject's perception of the flow of causality, whether from the self toward others, or the reverse.

In Part 1, this parameter is approached from a general-domain perspective. Questions ask whether one's sense of control generally comes from the efforts of others and/or from one's own efforts. If from others, what is its source: family and friends, government and society, and/or a higher power? In Part 2, agent/object is examined from the perspective of the seven specific domains.

In applying findings, one can combine agent/object and species data for both general and specific domains. For example, it can be determined what agent(s) give an individual a sense of control, and in what domains. It indicates whether one desires control over oneself or others. Also, it can indicate whether one feels in control in particular domains but not in others, which could have diagnostic implications.

## 3. Mode of control

Mode of control is the way the subject acquires and maintains a sense of control. Previous research has shown that there are two basic--and quite different--ways in which one can gain a sense of control. One

involves active efforts to change the situation. This mode has been referred to by Wolpe as a "mastery" model, by Weisz as "primary coping," and by Lazarus as "problem-focused instrumental coping." The other contrasting approach involves learning to accept the situation as it is. This mode has been referred to by Meichenbaum as a "coping" model, by Weisz as "secondary" control and by Lazarus as "palliative coping." Dr. Shapiro decided that a third-generation instrument needed to measure these varying approaches.

He also decided that the mode assessment required another refinement aimed at eliminating the implicit cultural bias in some conceptualizations, such as mastery vs. coping, instrumental vs. palliative, primary vs. secondary. He was particularly aware of the fact that many cultures value a psychologically healthy control mode, not of active efforts to change, but of yielding and "letting go." This orientation is based on the belief that a greater sense of control may be gained from peaceful acceptance rather than from continuing efforts to change a situation, particularly one which we cannot control. In pursuit of this goal, research yielded a total of four discrete quadrants of control describing the both the assertive and yielding styles, each in a positive and a negative modality. They are graphically presented in Figure 2 and narratively described in Table 2.

Quadrants 1 and 2 represent "positive" styles. The Quadrant 1 style refers to employing an active, assertive mode to change a situation. For example, if one is concerned about weight, he or she decides to begin a diet. A Quadrant 2 style refers to a yielding mode in which a person chooses to accept a situation willingly, such as being overweight.

Quadrant 1 POSITIVE ASSERTIVE (Active Control)	Quadrant 2 POSITIVE YIELDING (Letting-go Control)
Quadrant 3 NEGATIVE ASSERTIVE (Overcontrol)	Quadrant 4 NEGATIVE YIELDING (Too Little Control)

Figure 2. A Four-quadrant Model of the Modes of Control

Table 2. Modes of Control

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**QUADRANT 1. POSITIVE ASSERTIVE: Active, altering mode.**

Instrumental activity positively directed toward the accomplishment of something. Suggests being goal-oriented, a self-starter, independent. Involves the concepts of doing, of activity, of motion.

**QUADRANT 2. POSITIVE YIELDING: Letting go, accepting mode.**

The positive style of acceptance, yielding. Softness, gentleness, nurturing. A sense of stillness, of quiet, of being rather than doing.

**QUADRANT 3. NEGATIVE ASSERTIVE: Overcontrol.**

Refers to too much activity, too great a degree of control. A sense of aggressiveness, a certain ruthlessness, a Machiavellian quality. High agitation, insensitivity, selfishness.

**QUADRANT 4. NEGATIVE YIELDING: Over passivity, dependency.**

Suggest too little activity, overpassivity. A diffuseness, "mushiness," undifferentiatedness. Helplessness and hopelessness.

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Contrasting with these are the negative modes represented by Quadrants 3 and 4. If one is acting assertively but is "trying too hard," that person is functioning in a Quadrant 3 (negative assertive) mode. For example, the overweight person who tries too hard to diet, repeatedly fails, and gets angry. Finally, one who accepts an undesirable situation--like being overweight--passively and complainingly is employing a Quadrant 4 mode.

The SCI's mode of control data on a subject can be compared to yield clinically useful insights. The endorsed mode of control profile from Part 1 can be compared with the derived mode profile from Part 3 to indicate the subject's congruity relative to perceived control styles. Part 2 provides precision regarding the severity of concern the subject may have in each domain and indicates flexibility of control strategy by domain.

#### 4. Dimensions

Research shows that self-control, like control, has many components, any which may be present for a person at a given time and situation. Dimensions are refinements of the term "self-control." Based on previous research on self-control, Dr. Shapiro formalized operational definitions for six dimensions: 1) choice, 2) goal, 3) awareness, 4) effort/discipline, 5) skill, and 6) responsibility. They are described in Table 3.

Clarifying the dimensions of self-control for a particular individual who presents for therapy begins to provide the clinician some precise knowledge and understanding of the relationship between the individual's presenting clinical problem, the species category which applies, and the individual's deficient component of self-control. That information can then be utilized to develop, refine and tailor clinical interventions directed specifically toward the identified area of deficit.

*Become part of*

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Table 3. Dimensions of Self-Control

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1. CHOICE:

Volitional efforts in which external demands ("shoulds", "oughts") are minimized. Implies alternative degrees of freedom and the ability to evaluate as well as posit goals.

2. GOAL:

The vision toward which a choice is made. Answers the question, "self-control for *what*?" The desired objective toward which effort (discipline) is directed.

3. AWARENESS:

The ability to discriminate cues in the internal and external environment and to note how those variables affect one. Awareness can be of: a particular cause/effect change, a style of striving, a recognition of the goal (#2) and/or of options (#1).

4. EFFORT/DISCIPLINE:

Discipline includes effort, delay of gratification, self-sacrifice, and determination. Discipline is defined as "training that molds, corrects or perfects the mental faculties or moral character" and as "control gained by enforcing obedience or order" (Webster).

5. SKILL:

"The ability to use one's knowledge effectively and readily in execution of performance" or "a development of aptitude or ability" (Webster).

6. RESPONSIBILITY:

A cognition in which one assumes a unidirectional, causal attribution about the effect one's own behavior and thought have or could have on the environment. A "moral, legal, or mental accountability" (Webster).

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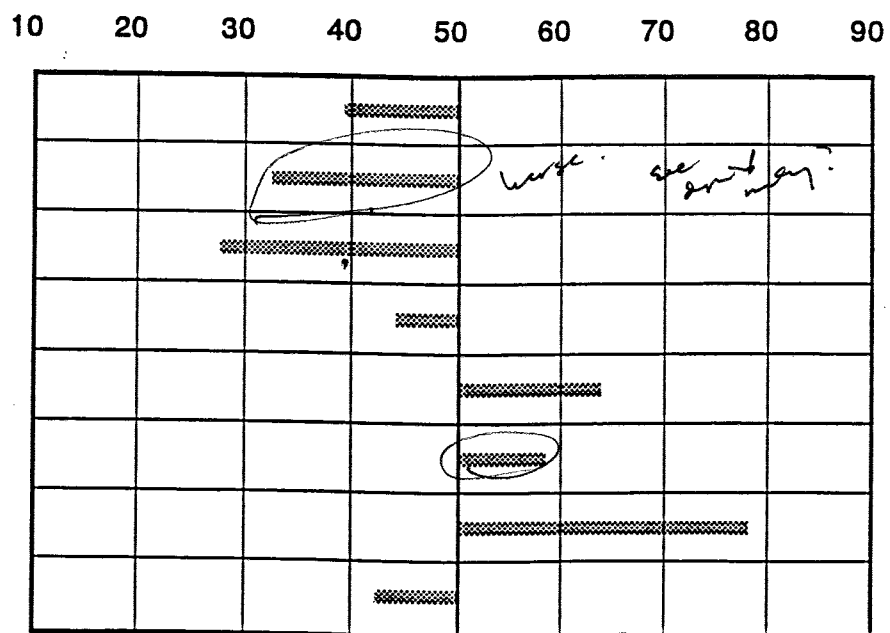
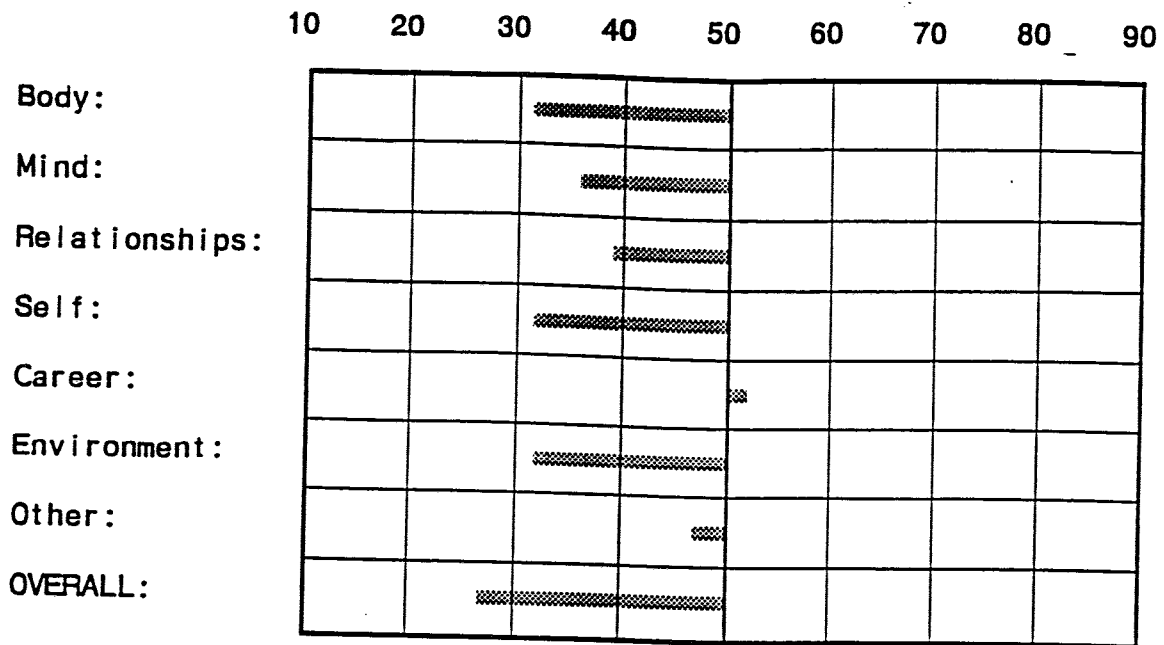


Figure 13. Case 2: Comparative Specific Domain Sense of Control, Pre- and Post-treatment

#### D. UTILITY FOR CLINICAL CASES

We believe these two cases illustrate how the SCI can be used to augment or help confirm diagnostic hypotheses, suggest therapeutic approaches, and measure progress against therapeutic goals.

## V. RESEARCH OPPORTUNITIES

Opportunities for extension of the SCI's value appear to exist in two major directions. First, in terms of refinement of the theory. Hopefully, one can appreciate the potential of the SCI serving as the basis for an integrated model of psychotherapy which incorporates all the concepts developed in the literature, thus offering a major breakthrough for clinical researchers and practitioners. Second, in terms of broadening the applications throughout all the world's cultures and into many specializations within the broad fields of physical and mental health.

### A. TOWARD AN INTEGRATED, CONTROL-BASED MODEL OF PSYCHOTHERAPY

Future research should be directed into several important areas which could help more closely connect the broad, metalevel aspects of a control theory to the practical, detailed clinical applications of a control-based model of psychotherapy. These include efforts at bridging several different literatures, particularly the literature ranging across Eastern and Western self-control strategies.

The "dynamics" of control also need to be addressed. For example, with a client in a clinical setting, a self-control history seems increasingly important to understand the parents' views of control and discipline, as well as the client's own history of control efforts. Issues of "self" and identity also need to be better incorporated within this model. For example, there may be a way to concretize negative self-image with respect to one's views of control. Also, do certain individuals have a greater "need for control" than others? In addition, more attention needs to be focused on patient/therapist control issues, including seeking to

define the best ways for a therapist to deal with resistance, and to teach self-control strategies.

Additional efforts at refinement and precision on these issues, as well as on the quadrant model and other aspects of the instrument, would help clinicians be better able to pinpoint the type of stress being experienced by a client, its cause, and the control-related issues involved. This, in turn, should help clinicians more effectively select (and teach) the most appropriate self-control interventions.

## B. PROMISING APPLICATION AREAS

A number of general areas of potential investigation and application for the SCI indicate promise. These include:

- Multicultural studies--exploring cultural assumptions embedded in various societies' views about control and self-control.
- Medicine, both preventive and rehabilitative--examining the role of stress-related control issues in precipitating and aggravating illness and inhibiting recovery.
- Marriage and family counseling--to explore control strategies used by each member in the system. Mode of control profiles for each could be individually and collectively analyzed.
- Organizational development--identifying control profiles of leaders, or all members in an organization, to identify problem areas and determine a program to enhance functioning.
- Human development--examining control issues which evolve throughout the life cycle, and appropriate control strategies for dealing with them.

These are only a few examples that come to mind easily when noting the pervasive role of control in all human experience. Our expectation is that some individuals hearing this presentation--hopefully from as wide a variety of cultures as possible--will envision specific opportunities for research and clinical applications. We stand ready to assist and support such initiatives to whatever extent is practical. Let us hear your ideas. Thank you.



# C A L I F O R N I A PSYCHOLOGICAL ASSOCIATION

Affiliated with California Chapters and the American Psychological Association

November 26, 1991

Robert A. Broenen Psy.D.  
19925 Stevens Creek Blvd No 111  
Cupertino CA 95014

File: T1-PD-01

Dear Presenter,

Again, congratulations on being selected as a presenter for the 1992 California Psychological Association Annual Convention. This is your official scheduling notification.

You have been scheduled to present "Human Control and Self-Control: Theory, Research, Assessment and Therapy" on Friday, ~~March 20~~ <sup>(2)</sup> ~~at the Postoffice~~ A

## MEMORANDUM

Date: February 21, 1992

To: Deane, Len and Murray

From: Bob

Re: SHAPIRO CONTROL INVENTORY PANEL AT CPA  
CONVENTION FRIDAY, MARCH 20

Here are the FINAL arrangements for our panel.

Attached is the confirming letter from CPA giving time and location.

Here's what we'll do:

Bob:	Introduce panel and topic.	5 min.
Deane:	History and rationale. Research findings with special populations.	20 min.
Len:	Clinical examples of SCI use (3): - a normal - an obsessive - a depressive pre/post treatment or husband and wife example.	15 min.
Panel:	Questions from floor.	10 min.
		----- 50 min.

Murray, would you please plan to sit as a panelist, not prepare a formal presentation, but be available during the Q/A to answer questions?