PART TWO

SEEKING OPTIMAL CONTROL IN MENTAL, PHYSICAL, AND INTERPERSONAL HEALTH

If you do not know where you are going, you will never know if you have arrived.

ANONYMOUS

CHAPTER 4

Suboptimal and Normal Control Profiles: Relationship to Mental Health

As NOTED in Chapter 1, all systems of psychotherapy have a vision of psychological health, the endpoint of successful therapy, "the ought or should toward which every counselor, therapist, and healer should seek" (Allport, 1955). In this chapter we examine a control-based model of psychological health and well-being.

We begin by examining the relationship among psychopathology, mental illness, and suboptimal control. Second, we explore what a normal control profile looks like within mainstream psychology, and why this normal control profile—involving sense of control, desire for control, modes of control, and agency of control—is considered better than suboptimal control. We note how several schools of therapy stress the importance of helping the patient gain or regain a sense of control through the therapeutic process. Third, we point out the problems with a normal control profile, detailing limitations of psychology's previous conceptualizations of control and mental health. We conclude this chapter by arguing that a normal control profile should not necessarily be equated with healthy or optimal control.

SUBOPTIMAL CONTROL: MENTAL ILLNESS AND LACK OF CONTROL/DYSCONTROL

Most of the nonmandated patients we see in therapy are suffering from feelings of loss, lack of control, or fear of losing control.

Both psychology and psychiatry in general agree that dyscontrol is associated with mental illness. Early versions of this view, discussed in Chapter 1, were espoused by Menninger, who argued that mental illness occurred

along a continuum of dyscontrol: The greater the dyscontrol, the greater the mental illness. This dyscontrol could be caused by external events such as grief, or internal events such as warring components of the mind (Menninger et al. 1963; Wender et al., 1982). Psychiatric symptoms resulted from this disorganization and subsequent attempts to master it. Menninger believed that a continuum of dyscontrol was the only difference between the most severe psychiatric illnesses such as depression and less-severe problems such as mild anxiety. The greater the dyscontrol, the more severe the illness.

Both Hans Strupp (1970) and Jerome Frank (1982) noted that issues of control underlie all clinical difficulties. For example, Frank (1982) argued that individuals seek psychotherapy because of demoralization involving one or more of the following: subjective incompetence, loss of self-esteem, alienation, hopelessness (feeling that no one can help), or helplessness (feeling that other people could help but will not). He noted that these feelings are accompanied by a sense of loss of control.

Beck (1976) noted that "dominant schools of psychotherapy share one basic assumption: the emotionally disturbed person is victimized by concealed forces over which he has no control" (p. 2). Bandura (1989b) stated that "among the mechanisms of [human] agency, none is more central or pervasive than people's beliefs about their capabilities to exercise control over events that affect their lives" (p. 411).

DYSCONTROL AND THE *DSM*

Support for the idea that *control* is a central component of mental illness can also be found in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-IV;* 1994). In their introduction, the authors mention dyscontrol as one of several concepts that have been used to define mental disorders. In this chapter we have highlighted a number of those disorders and the specific references made to control found throughout the *DSM-IV*.

For example, under the heading "Substance Dependence," we find the following: "There is a persistent desire or unsuccessful efforts to cut down or control substance abuse" (p. 181). Under the heading "Anxiety Disorders," control also emerges as a central feature in several disorders. One of the defining features of panic attack is the "fear of going crazy or losing control" (p. 402). Under the heading "Specific Phobia" we find the following definition: "it may also involve concerns about losing control, panicking, and fainting that might occur on exposure to the feared object" (p. 405). Further, the *DSM-IV* states that obsessive compulsive disorder is indicated by "persistent ideas, thoughts, impulses . . . experienced as intrusive . . . the

content of the obsession is alien, not within [the patient's] own control, and not the kind of thought that he or she would expect to have" (p. 418). Finally, one feature of generalized anxiety disorder is that "the individual finds it difficult to control" the excessive worry and anxiety (p. 433).

In defining dissociative identity disorder (DID; formerly known as MPD), the *DSM-IV* states that it is "characterized by the presence of two or more distinct identities or personalities that recurrently take control of the individual's behavior" (p. 477). Under diagnostic features of depersonalization disorder, we find that "a sensation of lacking control of one's actions, including speech, are often present" (p. 488).

The category "Eating Disorders" also contains several specific references to control. First, in describing the condition of anorexia nervosa, the *DSM-IV* states: "weight loss is viewed as an impressive achievement and a sign of extraordinary self-discipline, whereas weight gain is perceived as an unacceptable failure of self-control" (p. 540). Second, Criterion A2 for bulimia nervosa contains the following: "a sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating)" (p. 549).

For personality disorders in general, impulse control is listed as one of the four general diagnostic criteria. More specifically, in describing the obsessive-compulsive personality disorder, the *DSM-IV* states that there is a "preoccupation with orderliness, perfectionism, and mental and interpersonal control at the expense of flexibility, openness, and efficiency" (p. 669). Borderline personality disorder criteria include "difficulty controlling anger" (Criterion 7) and impulsivity (i.e., lack of control) in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). Finally, there is an entire section devoted to impulse-control disorders not elsewhere classified, including intermittent explosive disorder, kleptomania, pyromania, and pathological gambling.

As discussed in Chapter 3, researchers have developed more specific and precise control profiles for many of these disorders. The main point of this chapter is to show the strong connection between lack of control and mental illness, which is reflected throughout multiple diagnoses.

A Content Analysis of Speech Samples of Patients Entering Therapy

Our own research supports the relationship between lack of control and poor psychological health. In one study, we developed a Control Content Analysis Scale (Shapiro & Bates, 1990) based on the technique of coding of verbal samples pioneered by Gottschalk and Gleser (Gottschalk & Gleser, 1969; Gottschalk, Lolas, & Viney, 1986). With the client's permission, we

taped and then scored speech samples of individuals who had voluntarily sought therapy at a university outpatient psychiatric clinic. Patients being seen had a wide range of disorders, including affective disorders (major depression, bipolar disorder, dysthymic disorder); anxiety disorders (generalized anxiety disorder and adjustment reactions); psychosexual disorder (exhibitionism); substance abuse disorder; and eating disorders (bulimia). We coded their speech into three groupings:

1. Fear of losing control, losing control, and lack of control
2. Desire for control and efforts for control
3. Belief that they could gain control, gaining control, and having control

Specific results showed, as expected, that psychopathology is associated with loss of control. Across diagnoses, individuals entering therapy made significantly more statements of fear of losing control and lack of control than they did statements reflecting having control or believing they could gain control (see Figure 4.1, Shapiro & Bates, 1990; Shapiro, Bates, Greensang, & Carrere, 1991). In this study, individuals' statements of loss of control covered a wide range of different domains of their life. (see Table 4.1)

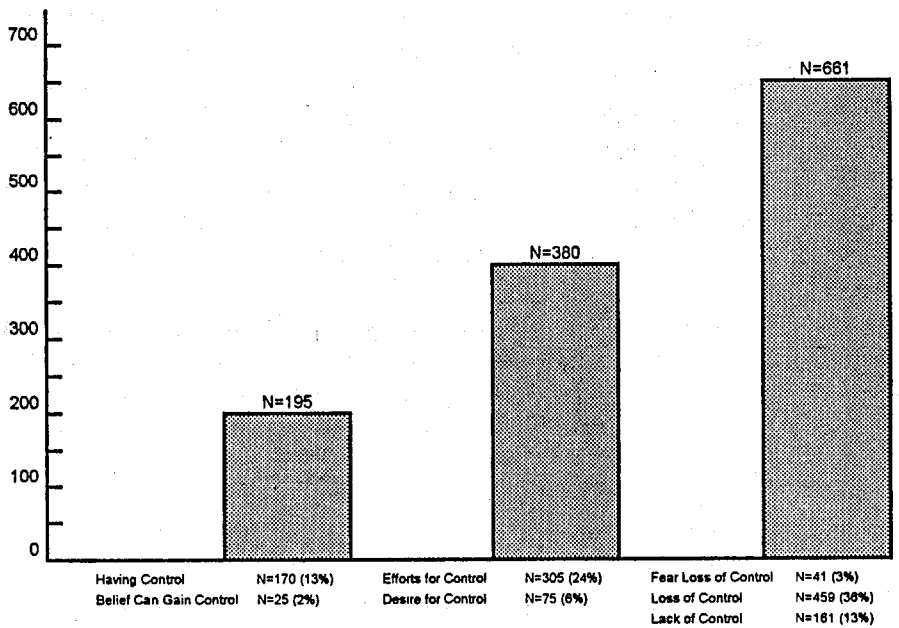

FIGURE 4.1
COMPARISON OF HAVING CONTROL, EFFORTS FOR CONTROL, AND LOSING CONTROL FOR PATIENTS ENTERING PSYCHOTHERAPY

TABLE 4.1
DOMAINS WHERE INDIVIDUALS EXPERIENCED LOSS OF CONTROL

Personal Self

Minds and emotions:

"I seem to have lost my ability to concentrate. Thoughts just wash over me and I am like a puff ball being bounced by the wind."

"I get angry at the slightest provocation. I know it is insignificant when a car passes me, but there is just an enormous rage in me . . . like I have been personally attacked and want revenge."

Mind/behavior:

"I know that exhibiting myself to youngsters is wrong. But I get a sexual urge which is tender and I don't want to harm them, but I am unable to stop myself."

"I wake up at night and want to make sure the table setting is laid out correctly. I want each linen in its proper place. I set them correctly before I went to bed, but I am unable to go back to sleep unless I double-check."

Interpersonal Domain

Intimate relations:

"I feel my spouse tries to totally control my life. He feels that because he earns more income, he has a right to determine all aspects of how I live and who I see."

"I am trapped by the relationship. I feel like I need breathing room to express myself and my wishes."

Parents/children

"My daughters run our life. They do not listen to us, they do not obey us, they do not even show any considerateness."

"My parents were always the boss. What they said was law. I don't want to be that strict, but I am afraid I am not giving my children enough discipline."

Societal Domain

Work

"I am running myself ragged at work. I am caught between a demanding boss and ineffective employees."

Economy

"The recession is destroying me. The government keeps raising taxes, my vote doesn't mean anything, there is nothing I can do."

Planet and Cosmos

"Some people are able to laugh about it—Los Angeles has four seasons: fire, riots, mudslides, and earthquakes. But I cannot stand the uncertainty. I am a religious person, but I am now losing sleep, always afraid. Nothing makes any sense to me."

Freud's projection hypothesis suggests that when individuals are out of control, they project their feelings onto the world. Along these lines, individuals in our study who expressed a high frequency of out-of-control statements about their own lives were also more likely to see the world itself as out of control, even when they were *not* directly involved. For example, when talking about friends, they would focus on friends whose relationships were deteriorating. In other words, not only can an out-of-control event or situation cause a person to feel out of control, but a person feeling out of control may be more likely to attend to out-of-control events and situations, confirming his or her worldview and internal state. In either case, it is clear that feelings of loss and lack of control are associated with pathology and mental illness.

NORMAL CONTROL PROFILE: (RE)GAINING CONTROL AS A GOAL OF THERAPY

Conversely, mental well-being is associated with feeling a sense of control (Bandura, 1989a, b; Beck, 1976, 1989; Seligman, 1991; Taylor & Brown, 1988, 1994). Along these lines, Frank noted that all schools of psychotherapy attempt to bolster a patient's sense of control, mastery, and self-efficacy by providing them with conceptual schemes that both label and explain symptoms and experiences of success (Frank, 1982).

From this perspective, a higher level of mental health involves going from a low or absent sense of control to a positive sense of control. This movement is vitally important, for without a sense of control, we are threatened with feelings of incompetence, alienation, and chaos. We do not have a belief in our ability to effect change or to create order. In Beck's terms, an important therapeutic task is to help individuals recognize those forces that may be "victimizing" them and over which they feel they have no control. The second task is to learn the different positive modes of control with which to address those forces. As Bandura noted, to the extent that treatment equips people with the ability to exercise control over events in their lives they are less vulnerable to distress and debility.

But let us look more closely at what exactly psychology means by a healthy sense of control.

THE COMPETENT AND SPECIAL SELF

Whether from psychoanalytic, cognitive-developmental, or humanistic perspectives, one critical aspect of healthy psychological development has been the ability to form an autonomous identity as a competent, confident, spe-

cial self (Erickson's initiation, 1959; Loevinger's autonomy, 1976; Wallston, 1989). Jahoda, in her pioneering study of mental health (1958), stressed the importance of developing personal competence for environmental mastery.

Indeed, in the *DSM-IV* dependent personality disorder specifically refers to an inability to develop this competent and autonomous self. That disorder involves (along with the avoidant personality disorder) "feelings of inadequacy, hypersensitivity to criticism, and a need for reassurance." In the dependent personality disorder there is an overreliance on others for support: "these individuals tend to be passive and to allow other people to take the initiative and assume responsibility for most major areas of their lives" (p. 665).

Relying too much on others can result in a failure to recognize one's own strengths and abilities to exercise control, simply reinforcing the notion that without others' help and support, one will feel out of control. These beliefs serve to confirm one's already low sense of self-esteem and efficacy. Further, in the interpersonal domain, this overreliance on others for gaining a sense of control (a kind of neediness) can have the effect of pushing others away, making them feel uncomfortable with or resentful about having to fill a void in the person.

For the humanists, this task of developing a competent and special self involves learning to trust one's self rather than relying on and being controlled by the shoulds and oughts of the external society. Maslow (1968) talked about self-esteem needs, which follow directly on his hierarchy after survival and safety needs. Existentialists speak of moving away from the herd mentality and through the use of a "heroic stance," developing and choosing the authentic self.

Early cognitive-developmental psychologists such as Piaget (1952) noted the importance for young children of learning to act on the environment, what neoanalysts such as White (1959) refer to as competence. Object relations theorists stress the importance of separation and individuation (Klein, 1932; Mahler, 1968). Social learning theorists refer to this task as self-efficacy (Bandura, 1977) or having an internal locus of control (Rotter, 1966).

There are really two parts to this construct of the competent and special self. The first is the self-esteem component, and the second is the relationship between that self-esteem and the ability to act competently on (i.e., have some control over) one's environment. In general, success at gaining personal competence and mastery is considered a prime determinant of self-esteem and identity. For example, Fromm (1956) went so far as to equate identity with the ability to have personal mastery: "Only if I am the true originator and creator of my own psychic acts, the true master of my own human powers, only then will I have the experience which permits me to have a sense of identity" (p. 101).

Finally, psychological theory states that we need to learn to maintain and

defend our competent and special self, believing in ourselves and our ability to exert control often in the face of adversity, setbacks, and even contradictory information (Levinson et al., 1978; Seligman, 1991; Taylor, 1989, 1994). As Freud so elegantly noted, and contemporary psychological research illustrates, our brain/mind creates stories/attributions as well as both conscious and unconscious psychological defenses to help us continue to feel a sense of control even when we do not feel behaviorally competent or do not feel that events are ordered and predictable. These strategies are ways we can either maintain a sense of control through defenses about our competence or cognitive frames that create meaning and purpose which can help improve our competence for next time.

HAVING CONTROL IS GOOD: THE MORE CONTROL THE BETTER

Overall, research supports the relationship between having personal control, a strong, autonomous identity, and physical and mental health. These findings give credence to the dominant psychological paradigm regarding control, which can be summarized as follows: Having active, instrumental control is positive, and the more control you have (or believe you have), the better (Evans et al., 1993; Thompson, 1981).

Traditional mainstream psychology has a linear view that increasing control or belief in one's control is associated with positive health. The mainstream view goes even further. It suggests that a higher-level sense of control in normals is equated with an exaggerated belief in one's ability to exercise control. Western psychology argues that this perceived control is helpful even though we may not choose to exercise instrumental control. Further, even illusory control (i.e., times when we feel we have behavioral control, but actually do not) can be beneficial to our well-being.

The research suggests that psychologically healthy or normal individuals have a greater sense of control than clinical populations. In order to overcome the feelings of loss of (or threats to losing) control that inevitably arise as part of the human condition, individuals typically employ (sometimes consciously, sometimes not) a number of coping strategies, defenses, and cognitive reframings (as well as overt behavior).

For example, research indicates that psychologically healthy normals: overestimate the amount of control they have in situations, are more optimistic about the possibility of their achieving control than their ability warrants (Lewinsohn, Mischel, et al., 1980; Seligman, 1991; Taylor & Brown, 1988), attribute their success to high skill and ability, with luck having very little to do with it) overestimate their invulnerability and underestimate risk (Weinstein, 1984, 1993), and make explanatory attributions to protect their sense of control when behavioral control efforts are not successful. Three at-

tributions identified by Peterson and Seligman (1987) are attributing the outcome to situational factors ("There were mitigating circumstances," "My luck was bad"), a universal human condition ("The goal was too difficult and no one could have accomplished it," "I am still as competent as anyone around"), or a temporary situation (fatigue or lack of preparation rather than a stable condition of lack of skill or ability).

Other strategies normals use include minimizing the significance of a situation, denying or putting out of mind problems that do not seem amenable to control, declaring in effect that they are not really problems, and turning to other areas to master, where they might be more effective.

In other words, individuals often seek to control the world not only by overt behavior, but also by cognitions about and perceptions of reality. In using these attributions and strategies, normal individuals frequently absolve themselves of personal responsibility for failure so that they can ward off internal and external threats, thereby protecting the competent and special self (Peterson & Seligman, 1987; Seligman, 1991). Seligman (1991) and Taylor (1988, 1994) argued that these strategies are effective means of maintaining positive mental health. Taylor (1989), for example, argues that normal psychological adjustment is associated with less accurate perceptions of the self and one's ability to exercise control and mastery, as well as less realistic (more optimistically biased) appraisals of the future in comparison to the more accurate and realistic perceptions and assessments of depressed individuals. This position that positive illusions foster mental health by removing feelings of lack of control continues to be a major influence on the field of psychology.

Thus, in summary, a healthy, normal control profile is considered one in which a person has a sense of control, believes and acts as if he or she can influence the course of events, often to an exaggerated degree, and feels that he or she is a competent and special self capable of effecting control on one's own.

PROBLEMS WITH A NORMAL PSYCHOLOGICAL CONTROL PROFILE

It is important to help individuals gain control to reduce dysphoric, out-of-control feelings such as depression and anxiety. Some, such as Taylor (1988, 1994) and Seligman (1991), have argued that removal of dyscontrol can be equated with mental health. Similarly, Menninger's (1963) model equates mental health with a homeostatic model of sense of control. When dyscontrol is removed and things are back in control, the person is again considered mentally healthy.

However, because lack of control is equated with mental illness and a

normal control profile is equated with having a sense of control, is it justifiable to equate normalcy with positive psychological health? In other words, is the absence of dyscontrol truly the same as positive psychological health?

The answer is no for two reasons. First, mental health is more than the absence of mental illness. Jahoda (1958) noted that to extrapolate to positive health from psychopathology is an unsupportable generalization. Even if one observes that the majority of normal individuals engage in certain behaviors and thought patterns, and those suffering from depression and mental illness tend not to engage in such behaviors and thought patterns, it is faulty to then conclude that such behaviors are representative of psychological health. Such a position rests on a definition of psychological well-being as being the absence of pathology or dysphoria and fails to consider that there may be different levels or degrees of mental health and well-being.

Second, there are numerous problems associated with what psychology considers a normal control profile, and the failure to adequately consider these potential difficulties has led to an overly narrow definition of what constitutes healthy psychological functioning (Colvin & Block, 1994). Although effective at one level, normal control strategies, desires, and goals can be problematic at another. The intent in examining these problems is not to pathologize the normal, nor to argue that we all need therapy. In the personal growth movement in the 1970s there was a popular saying: "You don't have to be sick to get better." By pointing out the limitations of our current concepts of psychological normalcy, we can learn important lessons that we can apply to growth-oriented models of therapy. In the remainder of this chapter we examine problems with the normal control profile in each of four components: agency, modes, desire, and agency.

AGENCY OF CONTROL

Western psychology, as discussed earlier, has tended to equate healthy functioning with being self-reliant and autonomous. It has similarly stressed the importance of personal competence, self-efficacy, optimism, and an internal locus of control. Although gaining a sense of control from one's own self-efforts is an essential aspect of psychological health, self as source of control can also have negative effects. Rotter (1966) warned in his seminal monograph that a high internal locus of control score on his scale might be dysfunctional. Research has shown that there are several areas where gaining a sense of control from self can represent a form of unhealthy normal control.

First, normal individuals may overestimate their ability, and therefore fail to delegate or rely on others who may be more competent (Evans et al.,

1993). Further, having fought to develop a competent and special self, "normal" individuals are reluctant to surrender control to others, fearing their self-competence and sense of self-efficacy may be threatened (Bandura, 1977; Taylor & Brown, 1988; White, 1959). Attached to their view of self as an agent of control, they may spend a great deal of time and energy trying to defend that identity, attempting to prove that they are right, rather than listening to and learning from others' feedback. This can cause difficulties in work situations, where others' ideas may be devalued.

Relying exclusively on self as the source of control can alienate or push away others. The belief that only I can exert adequate control over situations often invalidates the efforts of others, communicating to them that they are somehow not capable of exercising behavioral or decisional control. It also can make intimacy difficult because an important part of close interpersonal relationships is being able to receive and accept nurturance, care, and support from others, sharing personal vulnerabilities, surrendering to, and trusting the other (Schutz, 1958; Shapiro & Shapiro, 1984; Wellwood, 1985a, 1990).

In addition, the belief that one alone has the power, right, or responsibility to have and keep things under control can cause an increase in psychosomatic stress and anxiety as well as fears of losing such control (Burger, 1989; Shapiro, Anton-Culver, et al., 1998; Shapiro & Shapiro, 1979).

Modes of Control

As noted in the previous section, the dominant psychological paradigm regarding control is that having active, instrumental control is positive, and the more control you have (or believe you have), the better (Evans, et al., 1993; Thompson, 1981). However, early control researchers sounded a caution regarding the benefits of active control. For example, Averill (1973) noted that even in studies that showed a decrease in stress in a majority of subjects who had control, as many as one fifth reflected the opposite pattern of response: Control over a stressor increased stress rather than reducing it.

Averill's research, as well as the research of others (Evans et al., 1993), suggests that Western psychology's understanding of control as active and instrumental has many culture-bound features and is not always facilitative or desirable (Shapiro, Evans, & Shapiro, 1987; Thompson et al., 1988; Weisz, Rothbaum, & Blackburn, 1984).

First, and most obviously, active attempts at mastery are most effective when events are actually controllable. When events are beyond an individual's personal control, problems may be exacerbated by persistent efforts at control. When low environmental affordances exist (i.e., when there is no opportunity to exert active control effectively) but the person has a high

need for control, high belief in ability to gain control, and/or high behavioral competencies, there is a mismatch, resulting in a dysfunctional use of active instrumental control. This mismatch directly counters the dominant psychological paradigm by indicating when seeking or having active control is not helpful, thereby moving beyond an overly simplistic linear function between active control and well-being (Burger, 1989).

Second, for some individuals, being offered more instrumental control (e.g., Averill, 1973) is not helpful. This condition may result from a combination of one or more of the following: a low desire for control, a high external locus of control, a low belief in self-efficacy, or low behavioral competencies. If we are to recognize individuals' uniqueness, we should not assume *a priori* that everyone who has a normal control profile must always value an assertive mode of control.

DESIRE FOR CONTROL

In order to gain assertive control, an essential first step is the motivation, or desire, for such control. Often such desire is necessary to help motivate individuals to recognize that they are limiting themselves by accepting situations that they could change. However, there are potential problems with two high a desire for active control.

Most of the problems we have mentioned so far can be viewed as resulting from a high need for control. This high desire for control can lead individuals to seek a sense of control through self as agent and an active control mode even when such efforts have become excessive or misplaced. In this way, the very need for control can become a blinder limiting a person's ability to see the problems with those efforts.

One set of problems involves expectations and aspirations for control exceeding one's ability or environmental affordances. A second set of problems occurs when desire for control is successful, for such desire can be endless. Reinforcement theory would predict that success in gaining control in one area would only increase the desire for more control. Further, our desires are at least initially driven by biological reflex and unexamined cultural conditioning. Evolutionary biologists note that humans believe that if only they could control 25% more resources (e.g., income, house, friends), then they would be happy (Wright, 1994). U.S. culture similarly, involves the assumption that the more goods and possessions one controls, the happier the person will be. But the 25% is an ever-receding horizon: The more control a person has, the more that person's desire for control increases. And, as noted, individuals' desire to believe they have control—free will and choice—may keep them from realizing how conditioned they are.

The negative aspect of this increased desire for and success at gaining

personal control can be seen in a materialistic consumer culture where natural resources are depleted (Elgin, 1981), competition between individuals is increased, and personal altruism is usurped by self-interest (Kanfer, 1979). These adverse consequences of the need for control and power can even be seen at the international level (Frank, 1987), where each country seeks a larger share of resources and the acquisition of arsenals to maintain that control.

Sense of Control

As we saw in the previous section, in a normal sense of control profile individuals often believe they are in control, even when they are not, based on the following: (a) an illusion of control, including exaggerated beliefs about their ability to effect control; (b) defensive strategies, such as denial and external attribution to protect their ego when they are not behaviorally competent; and (c) making order out of chaos, sometimes inaccurately.

There are several reasons these strategies can be problematic. First, when people feel that their self is attacked, they spring to their own defense. The classic Freudian defenses—denial, projection, rationalization—all give a feeling of control. Such strategies, although normal, may not be healthy. Defenses—including illusions of control, denial, and external attributions—to maintain a sense of control, prevent individuals from learning from the situation, learning about themselves, and therefore causing them to continue to make the same mistakes. For example, if people only utilize external attribution, how do they learn to discriminate those situations where failure is due to lack of effort or skill on their part?

As all clinicians know, the course of successful psychotherapy is not necessarily a linear increase in feelings of client's personal control. Rather, the very nature of therapy often involves helping the patient to relinquish unhealthy defenses, which can cause increased feelings of loss of control in the client. Yet vulnerability and feelings of loss of control can be critical for deeper self-exploration and set the stage for subsequent self-directed change or greater self-acceptance (Shapiro, Schwartz, & Astin, 1996).

Second, though an illusion of control and invincibility may enhance self-confidence and a sense of control short term, the resulting feeling that one is in control and therefore immune to risk and hazards may reduce long-term health-promoting efforts (Weinstein, 1984, 1993). It may keep individuals from anticipating threats and risks that they could do something about. Further, researchers have noted that a characteristic normal human coping response to aversive environmental conditions (e.g., ambient stressors such as pollution and noise) is to habituate, to tune out, and become less aware of those stressors (Averill, 1973). However, habituation, despite being a nor-

mal control strategy, can give a sense of control at the expense of recognizing that problems exist (about which individuals could take constructive action). It is said that the way to boil a frog is to put it in a pan of comfortable water, and then slowly turn up the temperature. The frog continues to adjust, habituate, and do nothing about the problem; it feels in control until it boils to death.

Third, many traditions, both Eastern and Western, argue that humans have much less control over their minds and thoughts than they believe. Skinner (1953, 1971) noted that self-awareness is not natural for humans and must be conditioned, and Freud's work (1959a) is based on the premise of low or nonawareness of unconscious processes. The East often refers to the mind as a "drunken monkey" (i.e., out of control), filled with a constant stream of fantasies, wanderings, judgments, and desires (Walsh & Shapiro, 1983).

To a great extent, all of us live lives controlled by pronounced reactivity, reflexive defensiveness, and untrained minds. Without awareness, we may never learn to address the problems associated with desire for control, continuing to believe we have free will and are making informed choices, when we are merely reacting to our biology and culture. Further, we may never gain the insight (Freud, 1961) or "outsight" (Ferster, 1968) to recognize our maladapative behavioral habits and cognitive thought patterns that hurt both ourselves and others.

For example, Berkowitz (1994) noted that it is assumed that anger arises as a result of perceived threat or the belief that one has been intentionally mistreated or because of some minor frustration. But he notes that negative affect can produce angry aggressive feelings. Without awareness of this process, the hostile "and aggressive tendencies created by the negative mood are less likely to be restrained and are likely to be expressed openly in a harsh treatment of the available target" (p. 502).

Fourth, even when no real order exists, humans make up stories that are inaccurate but to which they tenaciously cling. For example, the human brain constructs stories to give a sense of order when objectively there is no order. Neuropsychologically, we put into patterns a collection of random dots, such as a circle. We give names to stars (e.g., the Big Dipper). Similarly, we have created theories such as the earth being flat and the center of the solar system. Such perceptions give a sense of control. But these stories and theories are descriptive at best (Big Dipper) and may in fact be inaccurate, biased, and harmful (flat earth) and reflect the human desire to be central and special (center of solar system). Humans often cling to their self-created order with rigidity and inflexibility, fearful of losing a sense of control, and punish those (e.g., Galileo) who challenge their beliefs. This process is true both individually and collectively.

Fifth, on an interpersonal level, "normal" individuals gain a sense of control and bolster their ego through downward social comparison, favorably

comparing themselves to others. Although such comparisons are part of normal control strategies and can be helpful in some areas (Taylor, 1983), social comparisons can also lead to one being overly critical and judgmental of others and cause harm in the form of ethnic, gender, racial, or biological discrimination (Goleman, 1989).

SUMMARY

Recall postulate 2 from Chapter 2: "There are lower and higher levels of control desires, goals, and strategies." In this chapter we examined in more detail its first three subpostulates. Subpostulate 2.1 states:

> When sense of control is not established, there are negative mental and physical health consequences.

In the first section of this chapter, we examined when suboptimal control occurs and its relationship to mental illness. Subpostulate 2.2 stated:

> Normal control occurs when individuals have a sense of control, rely primarily on the "competent and special" self as agent of control; utilize primarily the assertive mode of control; and have a high desire for control and optimistic belief about the ability to gain control.

In the second section of this chapter we noted how Western psychology has tended to equate (re)gaining control as the goal of therapy; it has operated on the assumption that having control is good, and the more active control one has, the better. Such strategies can be effective in terms of helping individuals maintain a sense of control (even if sometimes illusory and not objectively true), thereby reducing dysphoric feelings such as depression and anxiety.

In the final section of this chapter we examined Subpostulate 2.3:

> While a normal control profile is more positive than suboptimal lack of control, there can also be negative consequences associated with normal strategies used to gain and maintain a sense of control.

We have noted that individuals build elaborate perceptual, cognitive, and affective defenses, as well as behavioral habits, in order to give themselves an illusion of control. These defenses distort an accurate appraisal of reality, cause us to engage in denial and other defenses that can create unhealthy illusions of competence. External attributions of responsibility can keep individuals from learning about their mistakes and making appropriate growth-oriented changes. The low level of awareness in normal control keeps individuals from recognizing the unconscious, reactive, and reflexive

nature of many of their control desires and efforts, so they continue to pursue them without considering some of their negative consequences. Finally, defenses are often insular and self-serving, and are the cause of misdirected efforts to control others and the environment, causing destructive consequences on personal, interpersonal, environmental, and societal levels.

Because of all the problems with a normal control profile, it is important to distinguish normal or typical control efforts (which often have unexamined negative features to them) from optimal strategies for gaining control. The traditional model of control and mental health is primarily homeostatic: The goal is to gain and maintain a sense of control. But such a model fails to recognize and/or posit the "ought" of control: the more optimal, higher levels of control desires, strategies, and goals toward which control might, or even should, be directed.