PART THREE

CONTROL AND THE THERAPEUTIC ENCOUNTER

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CHAPTER 8

Knowing Thyself: Therapist Control Dynamics and Orientation

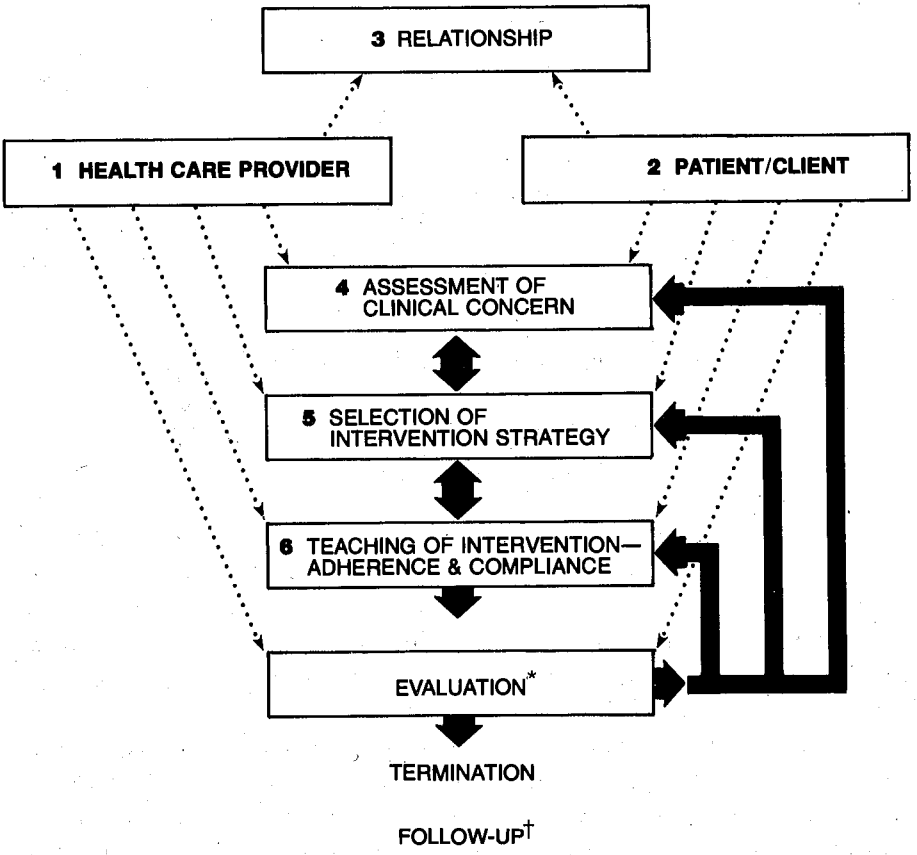
ANY TIME there is human interaction, control issues are present (Schutz, 1958; Shapiro, 1998), as humorously suggested by the cartoon on page 129. Control dynamics in the therapeutic encounter reflect control profiles of both client and therapist.

Part Three is the final component of our journey of transformation metaphor: the techniques to enable individuals to reach the goals discussed in Part Two. Techniques, broadly conceived, are what the therapist uses to assess the client's control stories and dynamics, help the client identify control-related concerns (Chapter 9), and facilitate the development of assertive and yielding modes of control (Chapters 10–11).

Figure 8.1 illustrates a systems model showing the six dimensions involved in the clinical use of a control-related strategy (Carver & Scheier, 1981; Schwartz, 1983; Shapiro, 1983a; Von Bertalanffy, 1968). In systems theory, multiple dimensions are identified to describe the boundaries of the system, and their interconnections are shown. As can be seen from Figure 8.1, control techniques (Dimension 5) occur within a context, the first dimension of which is the therapist (Dimension 1).

The topics this chapter covers are represented in Figure 8.1 by the dotted lines emanating from the therapist dimension:

1. Relationship (Dimension 3). Relationship emerges from the therapist/client encounter. Each therapeutic orientation has beliefs about the relative importance of that relationship.
2. Assessment (Dimension 4). As noted in Chapter 1 and Part Two, all therapists implicitly or explicitly have a view of positive health, nor-



*Evaluation of clinical efficacy should be a standard part of any psychotherapeutic and health care treatment, regardless of orientation. If evaluation is not positive, the systems model, involving feedback loops between different dimensions and from the evaluation to each of the various dimensions (heavy dark lines) can help determine precisely which ones may be facilitating treatment outcome and which not. For example, if a technique does not appear to be working, there may be a reassessment of the clinical concern, the therapist teaching style, and/or the strategy itself.

†If evaluation is positive, follow-up should again be a standard aspect of treatment.

NOTE: By following this feedback model in an intensive case study approach, clinicians can contribute valuable information toward helping generate hypotheses for future research.

FIGURE 8.1

DIMENSIONS RELEVANT TO THE CLINICAL USE OF A CONTROL STRATEGY—AN INTERACTIVE SYSTEMS THEORY MODEL

mality, and disease etiology. These views determine how the therapist assesses the client's concern.

3. Techniques (Dimension 5). The therapist also has beliefs about the limits and possibilities of client change, and therefore interventions appropriate to help the individual reach the goal of positive health.
4. Teaching (Dimension 6). Attention not only needs to be paid to the specific interventions, but to the ways in which those strategies are taught by the clinician or health care provider in order to maximize adherence and compliance.

THE THERAPEUTIC RELATIONSHIP

It is important for the therapist to be as aware as possible of his or her own professional and personal preconceptions, values, and biases toward therapeutic treatment for three reasons. First, as noted, therapists' theoretical orientations affect their beliefs about the nature and importance of relationship in the therapeutic process; help determine which techniques are selected based on the definitions of psychological health offered by their orientation; and influence how the strategies are subsequently taught.

Second, therapists need to develop increased awareness of how their own control issues affect their working with clients. Such awareness involves understanding their own control profiles and potential control-based countertransference dynamics.

Third, we need to explore the therapists' clinical assumptions and knowledge about control. This topic includes their beliefs about the relationship of control to psychological health within their own orientation; their willingness to frame issues in control terms; and their knowledge and skill level at practicing and teaching control strategies. In this section we begin our examination of therapist professional and personal issues by exploring how different therapeutic approaches view relationship; we then offer our own views of the importance of relationship in therapy; and conclude by examining potential therapist control issues in the therapeutic encounter.

Therapists' Views of the Importance of Relationship

Views of the nature and importance of the client-therapist relationship follow from the personality theories discussed in Chapter 1. For example, classical Rogerian client-centered therapy views individuals as inherently self-actualizing. Thus the therapist can trust what the client says and only needs to provide a supportive environment for healing and change to occur. Rogers (1961) stated that the necessary and sufficient variables for therapeu-

tic personality change to occur involved two people in close interpersonal contact, and the client perceiving the therapist to be nonjudgmental, having an accurate empathic understanding of the client's frame of reference, as well as unconditional positive regard for the client. Truax and Carkuff (1967), who later developed scales for measuring congruence and genuineness, nonpossessive warmth, and nonjudgmental accurate empathy, concluded from their research that these three variables are characteristics of human encounters that are therapeutically beneficial. Similarly, the existential schools see relationship as the critical variable in successful therapeutic outcome and place major value on authentic interactions and dialogue (Friedman, Maurice, 1989; May, 1969; May & Yalom, 1989).

The analytic perspective also views the relationship as an important variable. However, there is a belief in classical id psychology (in contrast to the Rogerian approach) that the client has low self-awareness and high defenses, and is basically untrustworthy due to the amoral id. Therefore, the person will be resistant to self-understanding. The therapist must learn to either confront these defenses (early Freud) or remain an aloof figurehead on which the patient can project current and developmental issues (Greenson, 1968). Major emphasis is placed on transference, defined as the repetition of reactions (e.g., feelings, attitudes) toward significant persons from early childhood unconsciously displaced on figures in the present (Freud, 1955).

Cognitive-behavioral theorists believe that individuals have learned faulty thought and behavior patterns. Therefore, the therapist is regarded more as a coach, teaching skills that need to be learned or relearned. The role of therapist–client dynamics and relationship have been emphasized much less in the behavioral tradition. Instead, the emphasis has been on the utility of the strategy. Therefore, tape-recorded or other semi-automated methods of disseminating techniques to individuals are considered appropriate and useful.

The issue of control is present in all these views of relationships. Psychotherapy talk has been specifically referred to as "social control," a process to influence an individual through social interaction toward some desired state. Not only does talk control people, but the talk itself is constrained by the social context in which it occurs (i.e., clients tend to come to understand that the use of self-reference, present tense, and meta-communication are highly valued, whereas indefinite pronouns and abstract words are unacceptable).

Looking at specific schools of therapy, Kilbourne and Richardson (1984) commented:

> In psychoanalysis a good deal of time is expended in the selection of words and in the timing of the therapist's comments to insure that the appropriate

> dosage of insight is meted out. We see an even greater concern with control and the effective management of experience in the attitudes of Skinnerians who essentially disregard the contribution of the patient to help in the resolution of their problems. Studies have also shown how Carl Rogers, the foremost advocate of non-directive therapy, systematically rewards and punishes the verbal behavior of clients that he likes or dislikes. (p. 238)

Our View of Relationship

The traditional behavioral approach has underemphasized the importance of relationship (Schapp, Bennum, Schindler, & Hoogduin, 1993; Ullman & Krasner, 1976). There are three problems with such an underemphasis. First, to teach a technique, there needs to be a certain amount of trust. For example, asking a person to close his or her eyes for an imagery exercise, progressive relaxation, or desensitization can frighten the person. Teaching techniques within a trusting relational context can only enhance an intervention's effectiveness.

Second, existential authenticity in the therapeutic encounter can be important because, as Jourard (1968) showed, therapist self-disclosure can increase client self-disclosure. Further, it models the very values it tries to teach.

Finally, the Freudian emphasis on countertransference is critical so that therapists can be aware of their reactions to different clients. Therapists are more able and willing to work with some clients than others. Further, therapists have different control profiles and dynamics, and there are better matches with certain clients than others. Such issues are often ignored, both to the therapist's and the client's detriment.

However, although relationship issues are important, we note several caveats. First, regarding self-disclosure and existential authenticity: The therapist needs to ensure that self-disclosure is motivated by the client's interest. Therapy is not friendship. If a client needs to have self-disclosure and openness modeled, such authenticity can be helpful. But the disclosure should not be for the therapist's needs, and not every case requires the same level of self-disclosure. Further, therapy is not just about egalitarian dialogue. There are, in fact, times when clients have resistances and defenses that need to be broken through and addressed; sometimes this can be done by gentle, authentic modeling, but sometimes for certain patients more confrontive approaches are needed.

Second, the Rogerian school overestimates the efficacy of relationship in therapeutic change. The Rogerian approach in fact is not as nonjudgmental as the theory states. Research has shown that Rogerian therapists differentially reinforce certain client behaviors—especially those in the direction of independence, taking more control, and being less dependent on others. It is

both naïve and inaccurate to believe that therapists are objective and nonjudgmental. We as therapists have beliefs, values, an orientation—and expectations about what is "health." What is important is how up front we are about the issues and whether there is negative manipulation through coercion or deception. We are constantly trying to influence our clients—by our nods, by what we reinforce, and by what we don't comment on. Rather than pretend we don't try to influence our clients, we need to honestly and openly acknowledge to ourselves (and, as appropriate, to our clients) our intent.

Finally, although the context of warmth advocated by the Rogerian approach is helpful, it is also insufficient for change and the teaching of specific control-related skills (Chapter 10) is also critical. Relationship is not sufficient for change, but can be a context for it.

THERAPISTS' CONTROL ISSUES IN THE THERAPEUTIC ENCOUNTER

The therapist needs to be sensitive to his or her reaction to the patient's mode, agency, and desire for control style, as well as the interpersonal dynamics that may arise. For example, clients high in negative yielding control may tend to become overly dependent on the clinician. Therapists must be sensitive to these transference control issues in order not to be drawn into unhealthy patterns of relating. In response to a Quadrant 4 negative yielding client, a therapist may become overly controlling and directive in trying to rescue clients. In reaction to an overcontrolling Quadrant 3 patient, a therapist might become overly passive or alternatively angry and confrontive.

On the countertransference side, therapists may want to examine their own reactions to the following:

- If you had to choose between being considered a Quadrant 3, overcontrolling, person or a Quadrant 4 person of too little control, which would you personally rather be labeled?
- What types of individuals or situations seem to be most likely to cause you to feel helpless and hopeless? to feel overcontrolling and too confrontive?
- Are you most comfortable with your assertive or yielding modes? If assertive, how do you deal with times when you are not able to help a client change or grow, or when the client doesn't get better? If yielding, how do you feel when a client begins to power struggle with you? How do you feel about acting in a confrontational manner?
- Would you prefer to deal with a patient whose primary negative mode is Quadrant 4, helpless and hopeless, wanting to be saved by an-

other, or Quadrant 3, confrontive and overcontrolling, who is constantly asking you to justify why he is there and what, if anything, you or this field can do for him?

- How do you deal with some clients' ambivalence regarding self and other control? On the one hand, they may want control from other as agent: your approval, help, and guidance. On the other hand, they may resent giving you such power and feel angry that you are making them accountable. They may feel infantilized, demeaned, and that they have lost independence by sharing their vulnerability. Although this question involves sensitivity to patients' control issues, in the context of this chapter, it is an issue of therapists' sensitivity to how they react to being double-binded by a client's ambivalence.
- How do you respond to clients who continue to stay passively mired in their problems, talking about them, but not willing to change? Do you use some type of psychological defense (e.g., denial, projection) to withdraw and distance yourself, while denying Quadrant 4 feelings of helplessness (e.g., "Some people just aren't capable of changing; I helped them enough"; "He or she simply isn't motivated enough to gain increased control"; "I'm not going to be a baby-sitter").

Questions such as these can help therapists examine their own preferred modes of exercising control, which therapeutic situations make them most comfortable, which situations are likely to cause them to feel threatened, and how they respond when they feel such concerns.

Finally, some therapists feel more comfortable temperamentally with the more nondirective yielding side of their nature. Other therapists have a more dispositionally confrontational style. An interesting question is to what extent does our dispositional mode style affect our choice of orientation (e.g., a more confrontational person becoming a family therapist or Ellis [RET] rational emotive therapist; a more yielding person attracted to the humanistic or transpersonal schools).

The important point is that the therapist's preferred mode of exercising control (assertive or yielding) may not always be in the client's best interest. For example, a therapist who prejudges clients, determines what their issues are (most of us do this to a certain extent Meehl, 1960; Lesh, 1970), and offers guidance and direction based on too little information may end up exercising control in a negative assertive manner. This therapist may also be too quick to offer advice when nurturance and self-acceptance may be more beneficial to the client. However, therapists who are unwilling to appropriately challenge clients' distortions or beliefs may remain silent and overly passive (Quadrant 4) and end up allowing the client to direct and control the course of therapy when therapist direction and guidance is needed.

THERAPISTS' VIEWS OF ASSESSMENT

There are two issues involved in therapists' views of assessment. The first is the actual means whereby such assessment is made. The second is the extent to which the therapist believes the clinical problem is of biological, cognitive, and/or environmental origin. These issues determine how the problem is assessed, affect therapists' views of the role and limits of client responsibility and personal control to address the clinical concern, and influence the nature of the techniques the therapist would select.

THERAPISTS' ASSESSMENT OF THE CLINICAL PROBLEM

All therapeutic schools have a means for assessment. That assessment is not context free, but rather grows out of and is based on the therapeutic school's view of human nature, its goal or vision of psychological health, and its beliefs about impediments to attaining psychological health. Each type of assessment is particular to the belief system espoused by a given approach.

For example, classical id psychology believed that individuals, because of defenses, repression, and self-deception, would have a great deal of difficulty answering accurately "where they were." Therefore, to try to bypass the individual's conscious defenses to get a more accurate assessment, Freud used free association. Later, individuals following that perspective developed projective techniques, such as the Rorschach Inkblot Test (Rorschach, 1921; Exner, 1974) or Thematic Apperception Test, (Morgan & Murray, 1935) in order to obtain what Mischel called indirect signs of unconscious personality dynamics (1968, 1981).

Behaviorists, leery of diagnostic labels and underlying unconscious motivations, look to clients for direct signs based on clients' here-and-now self-reports. Often self-observation is used; in it the client monitors a specific behavior or thought (e.g., negative self-statements) throughout the week in the natural environment. Such observation is used to help the therapist (and client) gather information about antecedents that increase the likelihood of certain behaviors, and thoughts; and consequences—behavioral or cognitive reinforcement patterns that affect the occurrence of the target issue. Emphasis is on the here and now and the situational specificity of behavior.

Coan (1974) developed a Theoretical Orientation Inventory to examine therapist beliefs about the extent to which clinical problems are under the client's personal control (i.e., are behavior and cognitions determined by biological, cognitive, or environmental variables):

- All human motives, except for a few elementary drives like hunger and thirst; and all human behaviors except for a few simple reflexes, are learned.
- The direction of human behavior and individual differences in personality are governed to a high degree by inborn predisposition and heredity.
- Individuals have the ability to exercise substantial choice about their behavior. Goals, values, and consciousness determine to a considerable extent how we behave. Therefore, the individual's personal account of private conscious experience is one of the most important sources of psychological information.

A second set of questions explores the degree to which therapists believe human behavior is predictable:

- Human behavior is characterized in all aspects by lawful regularity and thus in principle is completely predictable
- In principle, human behavior cannot be completely predicted because people can choose to act in ways we have no basis for expecting.

Therapists' reactions to these statements are instructive both in general and with regard to specific clinical problems, for their views determine both the etiology of the problem and the amount of control they believe the person has in dealing with the problem, and thus they determine the role of individual responsibility.

Personal Responsibility: Therapists' Perspectives

Stone et al (1979) pointed out that the attribution of responsibility by the patient and health care provider is critical. To what extent does the therapist/provider believe a person has free choice, and thus to what degree is he or she responsible for his or her behavior, emotions, and cognitions?

Differences in views on these matters have been the classical dividing lines between schools. For example, biologically oriented approaches are suggesting that mental illness is caused by genetic or brain dysfunction that is not human caused, and over which humans do not have control (Wender et al., 1982). Therefore, medications are needed to restore appropriate functioning. Behaviorists assume that a person's actions are not independent of environmental influences, and that the mechanisms influencing human behavior are lawful and predictable. As such, all behavior is already under the preexisting control of naturally occurring social processes, and the task of

the behaviorally oriented therapist is to discover the principles by which a person is being externally controlled, and then help the person apply those principles to modify unwanted or develop desired behaviors.

London (1964) has noted that humanists object that "Deliberate control of human behavior is immoral because it dehumanizes man. Anything that reduces an individual's ability to make choices (whether he wants to make choices or not) is objectionable" (p. 15). The humanists' focus is to maximize individuals' choice over their own behavior, and to turn from external to internal sources of control.

Halleck (1982) presented the issue of responsibility as a paradox for most psychotherapists. Most therapists believe that the client's behavior is determined by factors outside their control (e.g., biology, environment). However, they seem to believe that the client can only change if he or she is treated as a responsible individual who can exercise free will and play a role in determining his or her future. Freud (1955) wrote "Obviously, one must hold himself responsible for the evil impulses of one's dreams" (p. 131). This is so even though the person may not be consciously aware of this unconscious content!

OUR VIEW OF RESPONSIBILITY

There are ways to integrate such seeming paradoxes, *if*, as noted in Chapters 2 and 5, we do not conceptualize control, freedom, and responsibility as an either/or, all-or-nothing proposition. Research is convincing that there are biological and cultural influences on human behavior, and to ignore those is naïve. Further, individuals do not initially have a great deal of awareness either of the extent to which they are controlled by outside influences, or even how little control they have over their minds and thought processes. Further events happen to clients that they did not cause, and they are often at the mercy of events they cannot control. Often in life people are forced by contingencies, some harsher than others (Frankl, 1962/1980). Further, no one has 100% control over his or her reactions to events, or even the reactions to one's reactions!

However, just because they do not initially have much control does not mean they cannot learn skills by which they can gain greater control, responsibility, and freedom (Brickman et al., 1982). Our position is that the client's can learn to increase their skills of choice and decision making, and can learn and take responsibility for selecting their goals. Within certain parameters, even if a person cannot control an external event, there are skills they can learn to increase their choice and ability regarding how they react to an event.

This balanced approach to responsibility can be seen in other psychotherapeutic approaches. For example, in psychodynamic therapy it is often said that a person isn't responsible for his or her actions prior to coming into therapy, but once the person is in therapy and has more awareness, the therapist insists on the patient's behaving as though the patient has the capacity to choose. Similarly, from a broad-spectrum behavioral approach, Lazarus (1971) used a process of imagery to ask patients who are dealing with painful memories to try to imagine themselves back in the same situation, not as they once were but as they are now. This emphasizes the patient's current maturity and helps him or her reexperience and master painful past times.

In general, we agree with approaches that emphasize a person's capacity for decision making and that teach skills needed for greater active control in order to make choices (Wilber, 1983). These skills enable the individual to recognize that a choice situation exists and that there are alternative courses of action available in this situation, moving from the passive to active voice; possess a repertoire of skills that can be used to obtain the alternatives, and understand that certain choices and behavior will likely have certain consequences associated with them.

Thus, our model emphasizes individual responsibility and yet subscribes to a relative rather than an absolute view of an individual's capacity to choose. It shows an appreciation of the patient's limits (Quadrant 2), as well as increasing responsibility and control given to patients during the course of therapy (Quadrant 1).

Therapists' Process Interventions Emphasizing Assertiveness or Yielding

There are basically two ways in which therapists deal with client concerns regarding desire for control, personal responsibility, motivation, and beliefs in self-efficacy. One is to encourage them toward greater active control: i.e. assertiveness, self-agency, more personal responsibility. The second is to encourage them to develop greater yielding and acceptance: i.e., less self-agency and less personal responsibility in certain areas.

Thus, before teaching formal techniques, therapists are already intervening in the process of therapy by their responses to clients.

For example, when therapists feel there is more that a patient can do to change the situation, the therapist may verbally encourage the client toward Quadrant 1 assertiveness, self-agency, and change, through statements such as "What would *you* like to see happen?" "What do *you* want to see happen?" "You really do have choices for change." "You definitely can take greater control." "There is more you can do, if you are willing to . . . (try new strategies, try harder, etc.)." "You have the ability to change. It's really up to you

whether you do so." On the other hand, if the therapist does not believe the client has the ability to make assertive changes, or should not try for such efforts, statements encouraging Quadrant 2, positive yielding, letting go, moving on, forgiveness, and acceptance, can be made: "You did about as well as you could under the circumstances. Nothing more can or should be done." "No one could have done better." "There's nothing else that can be done. You need to let it go." Such comments, based on the therapist's view of this particular patient's needs and ability to change, set the stage and groundwork for the techniques selected.

THERAPISTS' VIEWS OF TECHNIQUES

As noted previously, therapists have an implicit or explicit view of how much control individuals can exert over their own lives. Based on these views (and perhaps some of their own control-related dynamics), they may feel more comfortable teaching assertive/change strategies or yielding/accepting strategies to the client. Further, their choice of interventions may reflect teaching the client self-agency, or helping the client develop control through other sources, such as pharmaceuticals.

For example, a UCI Department of Psychiatry journal club meeting reviewing weight control measures examined a study comparing fenfluoramine to a behavioral approach (Agras, 1987). Although there were some promising initial results for the group using the drug, when the drug was removed, the behavioral group did better long term. A psychiatrist colleague's comment on the weight control study was "We just have to find better ways to utilize and administer the drug, or find better drugs" (M. Buchsbaum, 1987, personal communication). In our own view, the task is to find better ways for individuals to self-regulate through cognitive and behavioral strategies. We believe that behavioral approaches are better because they can be self-administered, with almost no side effects, help the person feel in control through personal agency, and can be generalized to other situations. However, our view shows that we have as much a therapeutic and treatment bias as our colleague has a pharmacologically oriented bias, and such biases, if not carefully considered, may not be most appropriate or in the client's best interest. For example, for some clients, self-regulation techniques may involve more effort and may initially be more expensive than taking a pill. Further, would an external locus of control client prefer medication to the practice of self-regulation training? Biases become problematic because they take into consideration neither the client's profile nor the client's views on different treatments. For example, research by Baxter and colleagues (1992) comparing drug versus behavior therapy with obsessive compulsive disorder found by using PET scans that both

Prozac and behavioral techniques cause similar changes in brain activation and are equally effective. Given these findings, which approach would a therapist prefer? Why? How much of our choice is determined by what we are taught? What is in our guild interest?

Our View of Selecting Techniques

It should be clear from Chapters 2 and 3, as well as our subsequent discussion, that a one-size-fits-all approach does not work. Rather, the therapist must take into account individual client differences in behavioral competencies and control cognitions, and help the client match those to environmental affordances. In so doing, the therapist can select the most appropriate strategy given a client's control profile and the nature of the situation.

Thus, the most promising approach to issues of control appears to be a matching approach between personality variables and individual differences with a particular control-enhancing approach (Evans, Shapiro, & Lewis, 1993; Reich & Zautra, 1990). There are basically three strategies for change: change the environment; change one's behavior; and change one's consciousness, attitude, and beliefs.

There can also be combinations of these. For example, Bandura (1989b), using path analysis, showed that coping efficacy (leading to positive behavior change) followed two paths: perceived environmental vulnerability (could one effect control over the environment?) and cognitive control efficacy (could one effect control over one's thoughts?). Thus, through assessing the area of concern and the person's style, specific cognitive and/or behavior techniques can be utilized to help the person gain or regain control.

Control strategies that should be effective and are not occur when there is a mismatch between client and teaching strategy (i.e., teaching hetero-hypnosis to a person with a high internal locus of control), the wrong strategy is used in a situation (e.g., a person trying to assertively control that which is unsolvable), or the person has only a limited range of control strategies and therefore does not have the ability or flexibility to change strategies. One aspect of matching involves finding what type of technique is most appropriate for the client (e.g., assertiveness training for someone high in negative yielding, yielding or meditation training for someone high in overcontrol).

The therapist also needs to assess whether the client believes a technique can help him or her gain control and then whether the client is comfortable with the technique. For example, Barber and Calverly (1964) noted that calling a self-control technique *hypnosis* improved the likelihood of successful outcome for some individuals, but not for others. Clients with a more scientific perspective may feel more comfortable with the instrumentation of biofeedback, and uncomfortable with a relaxation technique if it is called

meditation. Others may prefer the term meditation and be put off by instrumentation. As the Chinese proverb says, "The finger points to the moon. The moon is the goal. There are many fingers." We want to select (and describe) the technique that the client feels most comfortable with, and that also leads toward that which is in the client's best interest.

TEACHING OF TECHNIQUES

Another aspect of matching involves how the therapist teaches the technique. For example, even those using objective, standardized behavioral techniques (such as tape-recorded progressive relaxation instructions) need to be sensitive to issues of transference. For example, whether the therapist's voice is male or female, authoritative or soothing, may influence the client's receptivity to the instructions. Some clients (e.g., external locus of control) may want an authoritative voice. Others with an internal locus of control and/or a high desire for control would do better with instructions that emphasize their personal responsibility and choice. The following is an example of two different types of hypnosis instructions. The first—self-hypnosis—is directed to a client with a high desire for control, and emphasizes that the client is in control at all times and has the choice to stop or continue at any step:

> There is an exercise that may be helpful for your concern. Would you be willing to explore it?

At this point the therapist needs to pause and wait for the client's agreement, or discuss any concerns the client might have before proceeding:

> In this exercise, you are in control at all times and can stop at any time. You will be instructing yourself and choosing to focus your attention.

Note the use of words and phrases such as "You are in control at all times. . . . You will be instructing yourself and choosing to focus your attention." And in the following direction, note the phrases "if you are willing," and "allow yourself":

> Now, if you are willing, let your eyes gently rest on a spot on the wall. . . . If you notice they are becoming tired, or would like to gently let them close, allow yourself to do so.

Hetero-hypnosis works better with a person low in desire for control and high in other agency. For such a client, preferred phrases from the therapist would involve the following:

There is an exercise that will help you. In this exercise, there is nothing you have to do but relax and allow the exercise to have its positive effect.

Now, focus your eyes on a spot of the wall. You will notice that your eyes are beginning to get tired and you want to close them, so just let them now begin to close.

Both these strategies have the same goal: to help give clients increased control over their lives over the course of therapy. The differences in teaching style is utilized in order to maximize the chances of the technique being effective.

But there is an interesting paradox in both situations. In the self-hypnosis situation, it is true that the therapist is providing the client a technique for increased control. But initially, the therapist is utilizing an illusion of control by telling the client that the client is in control. The therapist is in fact the one doing the teaching, and doing so in order to teach the client a technique that the therapist believes is in the client's best interest. In the hetero-hypnosis situation, the therapist is teaching the client cognitions and thoughts that can help the client gain greater self-control. But initially that self-control is coming from other control (Homme, 1965).

CONTROL-BASED ETHICAL CONSIDERATIONS

We have discussed the therapist's views of different dimensions in our systems model based on the underlying assumption that the system is a closed boundary. Although that assumption can be helpful in examining the therapeutic encounter, it is also clear that there are systems within systems. For example, the therapists are also members of larger contexts such as professional organizations, the society, the specific practice setting (e.g., private practice, health maintenance organization, preferred provider organization, hospital, university clinic), and for some religious and spiritual orientations, each of which may influence the therapist's values and beliefs.

For example, being a member of a health maintenance organization may raise ethical issues as to what extent the therapist feels he or she can be effective in a limited number of sessions. However, there also may be control dynamics raised in the therapist about having the number of sessions limited by an outside authority (i.e., the freedom reflex). The therapist needs to ensure that his or her own control-related dynamics are not being conflated with these ethical considerations.

A second issue relates to where responsibility lies for the problem. Is it the person's fault, for which they need to take responsibility, or is it circumstances beyond their control? As we have shown in Chapters 1 & 2, research is clear that environment has a strong effect on mental and physical health,

for example, depression rates go up when the economy goes down, and women try to lose weight so their bodies fit into culturally approved shapes. Research also shows that genetics and biology can influence mental and physical health, from weight control to depression and alcoholism. If a therapist takes a strong environmental or biological view, then the focus is less on seeing these concerns as client weaknesses or faults and concomitantly less on helping the client change these weaknesses (i.e., less a person-blame model; Caplan & Nelson, 1973). Rather, more effort would be focused on helping the client avoid self-blame and inappropriate responsibility by countering the client's core belief that he or she is more in active control in some areas than is accurate.

For example, Kalb (1987) pointed out that often single women come to therapy looking for what is wrong with them, noting that most self-help books emphasize that women are in control: They can be what they want and do what they want. Therefore, if they end up with a poor mate choice, they feel it's their own fault, there must be something wrong with them, and the task of the self-help book is to diagnose why they have chosen the wrong partner. Yet Kalb commented that meeting a mate may be much more in the realm of chance than choice, and that such knowledge may help reduce self-blame feelings and encourage self-acceptance.

This does not mean that personality and skill issues related to control cannot help maximize individuals' chances to change and grow in a healthy direction. Such growth may in fact facilitate the establishment and maintenance of a relationship. However, it does mean that the therapist must be sensitive to what is and is not within a person's control. Focusing only on what is wrong with the person and overemphasizing personal control in situations in which luck and other societal factors are involved may not always be helpful.

Another specific control-related ethical issue relates to modes of control and societal gender roles. Freud (1938/1969) commented that his efforts were in vain when "trying to persuade a woman to abandon her wish for a penis . . . or when one is seeking to convince a man that a passive attitude to men does not always signify castration" (Schwartz, A.E. 1979). In our mode-of-control terms, Freud was trying to get his female patient to be less assertive and his male patient to be more accepting of positive yielding. As therapists, what are our views on these issues?

GRABBING THE BRASS RING: ASSERTIVENESS TRAINING

A teaching case was presented several years ago in the San Francisco Bay area about a couple who came to therapy. The husband, a well-known scientist, had been offered an attractive position on the east coast to head a

multimillion dollar institute in his area of specialization. He was excited about the prospect of going, but noted that his wife was somewhat shy and afraid she wouldn't be able to adjust to the change.

She grew up in southern California, and had lived there most of her life. Seven years earlier, her husband had been offered a prestigious job in the Bay area, and she had voiced similar concerns about moving. They had sought the help of a behaviorally oriented therapist, who had given her assertiveness training. Equipped with her new skills, she had successfully adjusted to life in the Bay area.

The case presentation concluded by noting that the wife had once again taken a brush-up course on assertiveness skills to help her overcome her fears of newness and risk, and had thus agreed to take the plunge. A 1-year follow-up showed that, although it was not easy for her to adjust, she was slowly beginning to find her way into the new community.

The case was presented as a successful demonstration of behavioral therapy and assertiveness training. From one perspective, it was. But the case also raises some ethical concerns. Assertiveness training (Quadrant 1) and acceptance training (Quadrant 2) are value neutral. But unless values are explicitly stated, as noted in Chapter 4, techniques will merely reflect the larger society's values.

For example, why was the wife's fear of risk and newness the focus of the intervention? Why wasn't the distinguished scientist taught yielding skills, to learn to accept his current (very prestigious) position and to recognize that not every opportunity leading higher on the social ladder needs to be followed? True, this case was presented in the mid-1970s, and there might be substantial differences in the way it would be handled today, involving more sensitivity to power issues and joint decision making. However, nearly 15 years later, Jacobsen (1989) still noted that antiquated patriarchical marital models manifest themselves in a power differential that almost always favors men. He asked to what extent the therapist has the ethical responsibility to "tamper with gender based intimacy structures in ways promoting egalitarianism" (p. 32) because by not raising such issues and going along with the couple's system, the therapist may be reinforcing societal norms of differential power for men and women.

When Should the Therapist Challenge Client Beliefs and Goals?

The dotted lines in Figure 8.1 indicate that both therapists and clients have views that affect the assessment of the clinical concern and the techniques selected. When is it appropriate for the therapist to hear the client's concern and frame of reference and then to share appropriate techniques, and when should the therapist challenge that frame of reference? For example, if a

seriously obese person comes into therapy to learn how to accept his or her weight, should the therapist simply teach the client acceptance strategies, or should the therapist challenge the clients' assessment of the problem and his or her preferred mode of control for dealing with it?

As therapists, each of us has to determine based on our orientation and values, when a client is taking too little responsibility and accepting a situation inappropriately, or is taking too much responsibility and trying inappropriately to change a concern.

For example, a patient with multiple sclerosis at first wanted us to help her understand how she had caused this disease. We felt this was a case of taking too much responsibility for something over which she had no control. Within a few sessions, we had helped her shift her focus from a person-blame model, which gave her no control but a great deal of guilt, to a new and more realistic goal for which she could take responsibility and toward which she could make changes: learning what she could do to remain as healthy as possible and with as joyful an attitude as possible. (Specific means for assessing, operationalizing, and monitoring are discussed in Chapter 10.)

A few sessions later, she wanted permission to take away some responsibility because "the responsibility for feeling healthy, joyful, and optimistic makes me feel guilty whenever my condition worsens or I have any sadness." We then worked with her on accepting her pain and sadness, too, as part of the therapy.

Another case in which we felt a person was both too accepting of the situation and simultaneously taking on too much personal responsibility in the wrong area was a woman in an abusive relationship. She commented that "we create our own reality, and we only get what we ask for." Therefore, she wanted to learn to accept the situation she was in, and at the same time wanted to address her reactions to the situation—her anger at her spouse. "I feel responsible for my own anger. The problem is that I am not accepting enough. I need to work on my anger reactions to his behavior." Rather than help her accept her situation, we encouraged her to recognize and acknowledge the pain her punishing spouse was causing her, and that she had a right to be angry. We felt what she needed to learn to accept was not the abusive situation, but her right to be angry. The next task was to help her deal with that anger, to channel it in ways that were constructive for her in either working to change her spouse or change her situation.

On the other side, sometimes as therapists we may feel clients are taking too little responsibility for their feelings and actions. Halleck (1982) observed that the therapist should be extremely sensitive to client statements implying lack of control such as "I cannot help myself" and "I always lose control of my emotions in these situations." He suggested that rather than speak of certain undesirable behaviors as resulting from loss of control, it is

preferable for the therapist to think in terms of the factors that go into the patient's evaluation of his or her risks and benefits.

He gave the example of a patient who said, "Last night I completely lost control of myself and shoved my wife again" (Halleck, 1982, p. 302). If a therapist accepts this loss-of-control attribution, he or she is encouraging the patient to assume a stance of nonresponsibility toward his own action. Rather, the therapist should point out to the patient that he, in fact, gained something from shoving his wife, such as expressing his feelings and relieving his tension, and that one way he might want to deal with his problem is to find other, nonviolent, ways of expressing those feelings and relieving tensions. Further, he probably would be less likely to have shoved his wife if he feared she would hit back or would call the police. All these statements encourage the client to take greater active control over his life, and see how he is the decision maker in his behavior.

We believe that the very nature of therapy is the "influence business" (or, although it may sound somewhat harsh, the control business). Therapists, regardless of theoretical persuasion, try to control (cause an influence in the intended direction) their clients to some extent (i.e., get clients to take more control of their lives, become more self-actualized, turn from external to internal standards of evaluation). The question we are addressing is how to best affect that influence. For example, if a client feels that a therapist is coercing him or her into certain ways of acting, the client will rebel at that manipulation (Davison, 1973), no matter how noble the goal (e.g., independence, autonomy). Thus, we believe in meeting the client where he or she is while at the same time acknowledging that we are, to some extent, trying to influence him or her.

Knowing Our Own Control-Related Motivations

There are many reasons why individuals choose to become therapists. Satir (1992) noted that the need for control is one of the motivations. She observed that in therapy, "there is a lot of control in the hands of the practitioner" (p. 3) and that this can become problematic if the therapist has a need to control the client, as in the following: "What is always important is whether or not whatever the therapist is doing represents power to [him or her]" (*ibid*). She pointed out that at times the "nature of helping relationships is allowing yourself to be vulnerable, giving up, so to speak, your power to the other person" (*ibid*).

Therapists, like all individuals, use defenses to maintain their feelings of power and control. One example of when there may be a feeling of loss of control has to do with termination issues. For example, Gleser and Ihilevich (1969) examined defenses the therapist used over termination, such as emo-

tional withdrawal before the final session, thus maintaining a reserved or aloof posture, or attacking the client under the guise of confrontation or interpretation. The therapist may also separate anxiety from the process of termination by invoking a general principle that, for example, termination is an activity in which the client has the opportunity to practice or master future goodbyes. Such a projection may keep therapists from working on their own feelings of loss and letting go.

Some therapists, again like other individuals described in Chapter 7, may also have a control-related fear of intimacy. If such issues are not addressed, they may lead to inappropriate behavior within the therapeutic encounter. Research has shown that many of the therapists who are guilty of sexual contact in therapy sessions have described themselves as frightened of intimacy (Cummings, 1985). Therapy can become a place where these therapists can engage in intimacy (including inappropriate sexual intimacy) from a position of power. Cummings talked about defenses therapists who had had sexual contact with their clients used: repression (e.g., 80% of the therapists were unable to recall events that led up to the sexual relationship), and rationalization, (e.g., the patient needed the assurance that she was attractive and desirable). Such defenses hide the therapists' own fears of loss of control, and emphasize the importance for therapists to know themselves.

PREPARING TO MEET THE CLIENT

It is important for therapists to adopt some personalized pretherapy rituals and strategies that can help them prepare for working with each client. Such preparation can combine both assertive and yielding modes. We offer some guidelines here based on our personal experience and our training and supervision of others.

Those of us who are more assertive by nature (Quadrants 1 and 3) may need to prepare ourselves by practicing some types of positive yielding strategies. For example, it can be helpful to spend a few minutes sitting in quiet meditation, simply breathing, relaxing, and centering. We may work to be receptive to each client, trying as much as possible to put aside preconceptions and judgments of who they are, to see and hear them from where they stand. We also work to be guided by the highest wisdom of which we are capable to do what is in the best interest of each client.

For those of us who have more of a yielding disposition, we might want to practice some assertive preparation. For example, we would review our notes, study any relevant literature for a case, and also, with certain clients, imagine ourselves acting in positive assertive, even confrontive, ways that we feel may be helpful for working with that client (while still maintaining a centered clarity).

SUMMARY

By examining the therapist side of the equation in our systems model, we have seen that as therapists, we need to have several skills. First, we need the skills to know ourselves, making a conscious effort at self-exploration of our own personal control profile and dynamics and how this affects countertransference issues; the assumptions of our professional orientation and its influence on views of relationship, assessment, and techniques selected; beliefs about personal control and how these affect opinions about when a client is exercising too much responsibility and when too little, and the values and ethics by which we practice.

Second, the therapist needs relational skills involving both assertive and yielding modes of control (e.g., nonjudgmentalness, authenticity, self-disclosure, warmth, confrontiveness). Finally, therapists must take this self-knowledge and apply it in a way that most effectively enables them to teach clients the appropriate control-enhancing techniques. To do so, therapists must be able to carefully and sensitively assess the second dimension of our systems model: the client. Such an assessment includes the client's control profile (discussed in Chapter 3) as well as control dynamics and control stories of the client.