INTRODUCTION

Overview. The first section of the introductory material states the purposes of this manual (clinical training and standardized research protocol); responds to the client Frequently Asked Question "What is Control Therapy"; lays out the format of the manual; and the voice of the manual. The second section details the goals and behavioral objectives of the Control Therapy Training Manual.

INTRODUCTION
(pp 1-8)

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INTRODUCTION, PURPOSE AND FORMAT

INTRODUCTION AND PURPOSE

The **primary purposes** of this manual are to provide

1) A clear and accessible guide for training clinicians in the use of Control Therapy.

2) Standardized procedures necessary for treatment research to be replicated.

We have written this manual in response to the numerous researchers, clinicians, and trainers who have asked us for a practical way to learn how to implement Control Therapy in both clinical and research settings. Most of them contacted us after reading the book "Control Therapy: An Integral Approach to Psychotherapy, Health, and Healing" [1] which was published in 1998 after more than 20 years of research into control-oriented change processes. The book provides theoretical background, case examples, practical exercises, over a thousand references, and a broad framework for doing control-oriented therapy.

But many clinicians and researchers asked for additional information. Some simply wanted advice and guidance to ensure they were accurately implementing the ideas set forth in the book. Others wanted a step-by-step format for self-learning, for training others in the approach, and/or guidelines to ensure consistency of treatment when Control Therapy is utilized in research projects comparing therapeutic treatments

In response to those inquiries, this manual provides a concise framework for helping teachers train students in Control Therapy and helping researchers have a clear, structured methodology for ensuring Control Therapy is applied and taught in a consistent fashion as a treatment protocol.

In writing this manual, we have removed much of the theoretical and research foundations that underlie both the Shapiro Control Inventory (SCI), and Control Therapy itself. This manual is intended to complement, but not replace either the SCI Manual [2] (hereafter cited as SCI, p. x) ; or the larger work on Control Therapy (hereafter cited as CT, p. x). We encourage the users of this manual to refer to both the Control Therapy book as well as to the Manual for the Shapiro Control Inventory as resources.

Throughout the manual are a series of Frequently Asked Questions (FAQ). Below is a question often posed by clients: "What is Control Therapy?" As part of teaching by modeling, we answer this question in "lay language" as a therapist might talk to a new client. For example, below is a response a therapist might use (in his/her own words, and allowing for dialogue, of course) to FAQ #1. (A complete list of FAQs is provided in Appendix 5)

WHAT IS CONTROL THERAPY?
(Client FAQ #1)

Control Therapy is based on the belief that all of us want to have a positive sense of control about our lives and feel happier and healthier when we do. Therefore, the reason individuals seek counseling is often because there are one or more areas of concern in their life where they feel things are not in as much control as they would like, or where they feel they (or others) are too controlling. And, despite their best efforts, those areas are causing them pain and suffering. These areas could include physical health, work, relationships, and personal issues, such as our habits, our feelings, and our thoughts.

The goal of Control Therapy is to help people gain or regain a more positive sense of control about their lives. Over the course of eight to twelve sessions, we work together to find out what are your areas of concern, and what are your goals for those areas that would help you achieve a more positive sense of control. For example, are you seeking to alter and change a situation, or to learn to accept and live with more serenity with what is? Based on your concerns, your goal, and your unique Control Profile, we then match and tailor the strategies and techniques most suitable to help you reach your goals. Together we'll evaluate your progress toward your goals and seek to ensure that your concerns are addressed.

FORMAT OF THE MANUAL

The format of the manual is designed so that it can be used as part of a teacher-facilitated training in a classroom, practicum, internship, and/or workshop setting. Within that context, we believe that one of the best ways to help trainees learn how to teach and utilize this material with clients is for them to experience it themselves.

We believe that experiential, personal learning and self-reflection not only facilitate conceptual understanding, but also enhance self-growth. Therefore, the modules of Part One—Assessment, Goal Setting, and Interventions—are designed to help the "student" learn by engaging in experiential (as well as didactic) learning. In this way, the student is both the therapist and the client. Part Two then addressed how to take this self-learning and apply it to others.

Part One: "How to do it": Experiential and Didactic Learning. Part One is focused on the student/ trainee/ reader and consists of three modules:

1) **Assessment: Understanding your control profile**. This section gives a broad overview of gaining greater self-awareness through assessment, focusing primarily on the SCI results and how to interpret them; and also looking at self-monitoring, listening to control speech, and control stories.
2) **Self-observation, self- evaluation, and goal setting**. Exploring your own control stories from the macro to the micro, as well as how your personal theoretical orientation addresses issues of human control and dyscontrol.

3) Intervention selection. Clinical interventions are detailed in a step-by-step manner; explanations are provided on how to match self-control strategies to your own control profile, goals, and personal dynamics. (Training Module 3 consists of three parts).

Part Two: Client Focused. **Part Two** of the manual (Training Module Four: Control and the Therapeutic Encounter) shifts the focus to applying the skills learned in Part One to working with clients. This part contains one module comprised of five sections: 1) a systems model of six components involved in the process of therapy**,** 2) a session-by-session breakdown of a typical course of Control Therapy, 3) issues for the therapist involving client assessment and goal-setting, 4) addressing intervention selection, along with therapist adherence to CT, and 5) homework for the trainees. In addition, a treatment adherence checklist to assess therapist competence and skill development is provided in Appendix 1.

<***Note to researchers:*** For those using the manual as a research training tool, we have placed specific material regarding undertaking a formal research project all together in Appendix 6. This was done to improve the flow of the clinical teaching process.>

THE "VOICE" OF THE MANUAL. As noted, we are writing this manual so that it can be used by a clinical trainer/practitioner/researcher in the framework of a class, training workshop, or practicum/internship setting. Therefore, one voice is speaking directly to the trainer/professional/teacher conducting a class or workshop. An example of this is the way we begin Training Module One with "Activity 1.1" which we offer as a suggestion for the way an Instructor can structure the class and begin the module.[*] We also offer some "Experiential Activities" and "Dyadic Practice" exercises to provide instructors with some suggestions and "choice points" to help them pace and deliver the material in a way that is customized for their "audience." These are, of course, only suggestions, and we leave it up to the trainers/instructors/teachers (as discussed under "Many Fingers Pointing to the Moon" below) to adapt this material in whatever way they feel it can best be conveyed to their students.

Within the above context, a second voice we use is speaking directly to the "student/trainee/reader": i.e., the graduate student, internship/practicum trainee, or even experienced clinician learning CT for the first time. Thus, for the majority of the manual we found it less cumbersome, and more natural to speak directly to the individual involved in the "self-change" project and experiential exercise: i.e., instead of speaking to the trainer about the trainee, we say "you the reader" (For example, above we use the phrase "Understanding ***your*** control profile").

A final voice that appears models how a therapist might frame or discuss an issue with a client (e.g., Client FAQs) in which we speak as if we are a therapist talking directly to

[*] For those who are reading this manual on your own—e.g., experienced clinicians, research professionals, graduate students—to learn more about Control Therapy, then you will of course be both the "instructor/trainer" and the "student/trainee" and apply these activities directly to yourself.

a client. In this way, we give examples of what the clinician might want to actually say in a specific therapeutic situation.

MANY FINGERS POINTING TO THE MOON; MANY PATHS UP THE MOUNTAIN.

A Chinese proverb says, "Many fingers point to the moon." The moon here (in the narrow sense of this manual) is how to most efficiently and effectively convey the practice of Control Therapy. The proverb goes on to say, "Be careful not to confuse the finger with the moon."

In that spirit, we realize that there are many different teaching and learning styles. We have chosen to begin by focusing on the trainee in Part One, with the intent to begin the experiential learning early. Some trainers and trainees may feel more comfortable beginning with a more detailed didactic overview before turning to the personal. If so, they may wish to begin the training sessions with the material in Part Two (e.g., a systems model overview of the components of Control Therapy ; the specifics of Control Therapy: sessions by phases; and the adherence competency checklist in Appendix One.

What we are presenting is a model that has worked for us, but to which we are not wedded and is only one "finger." We leave the exact balance between inductive learning and deductive pedagogy to the reader's discretion.

GOALS AND TRAINING/ BEHAVIORAL OBJECTIVES OF THE CONTROL THERAPY TRAINING MANUAL

Control Therapy is an 8-12 week clinical intervention. The overarching goal of the therapy is to help people feel a greater sense of positive control, including minimizing unnecessary pain and suffering and increasing feelings of happiness, compassion, productivity, and meaning. These lofty goals are addressed through a series of precise training experiences detailed in practical step-by-step terms. By the end of the manual the reader should have developed the following ten control-based skill sets in the following four areas: ***Assessment*** (where a person is), ***Goal Setting*** (where a person wants to go), ***Intervention*** (techniques for reaching the goal), and ***Evaluation*** (determining whether the goals have been met).

I. ASSESSMENT. Learning how to initiate a control-focused interview using a control assessment instrument as part of a therapeutic relationship, the therapist will be able to:

1. Help individuals learn about their unique control profile: including overall sense of control, assaults to their sense of control, desire for control, fear of loss of control, and the ways they seek to gain and maintain a sense of control through both *modes of control* (positive assertive, positive yielding, negative assertive, and negative yielding); and *agency of control* (do they get a sense of control from self and/or others).

2. Explore with clients their control stories and dynamics, including assumptions and beliefs, ranging from the micro to the macro, as appropriate: from how they understand who they are in the world, to where and how they feel they have a right and responsibility to act. The therapist should be able to do this while maintaining a sensitivity to cultural, ethnic, and gender issues, regarding modes, desire for control, and agency of control.

3 ***Conceptualize control related concerns in a clear way.*** Through the use of listening to client control-related speech, and exploring the items from Scale 4, the Domain Specific Sense of Control, the therapist will help clients identify the life domains (e.g., exercise, relationships, feelings about one's self) where they feel a lack of control, and which they believe are a concern. If necessary, the therapist will help clients prioritize their concerns.

4. Teach clients self-observation: Through identifying and then monitoring the clients areas of concern, the therapist can help clients see how they are affected by personal style (cognitive, affective, behavioral), interpersonal interactions, and physical environments. This includes both precise self-observation, and general observations (as in a control journal).

II. GOAL SETTING

5. Work with clients to set realistic and appropriate goals. Based on evaluation of the self-observation information, as well as the client's preferred mode of control (Scale 4), ideal modes of control (Refinement 10), desire for control (Scale 9), and control stories, the therapist and the client will develop goals that are realistic, and congruent with the client's overall life plan and values. These goals would involve whether the client wishes to gain a sense of control through change or acceptance aspects of personal (cognitive, behavioral, affective), interpersonal, or physical environments. The therapist will help the client ensure that these goals specify the behavior (internal or external), under what conditions, and to what extent.

III. INTERVENTIONS

6. Match the intervention(s) to the control profile and goals. The therapist will learn to select an intervention that is the best match for the client's control profile and goals. The intervention should be the best blend and balance between positive assertive change and positive yielding acceptance , thereby addressing and reducing the assault to the client's sense of control.

7. Teach interventions congruent with the client's control profile and dynamics. This includes sensitivity to the client's preferred agency of control, as well as preferred mode of control.

8. ***Help the client maintain compliance.*** This involves therapist efforts to help enhance the clients' effort, determination, commitment, perseverance, and motivation to

accomplish their goals, including addressing potential client self-sabotage and ambivalence. This objective also involves constant monitoring and evaluation of the therapeutic process (see 9 below).

IV. EVALUATION

9. ***Monitor the process of therapy with a systems model*** for evaluation and feedback at each stage of the therapeutic process to determine efficacy of treatment. Where there are concerns, resistance, or problems with adherence, the therapist will work with the client to make adjustments (in goals, interventions, how the techniques are taught, further exploration of control stories) to maximize treatment success.

10. Commitment to follow-up including written post-tests as part of a single case study design, as well as phone contact, and/or additional "booster" sessions as needed.

MONITORING THE ENTIRE PROCESS: ADHERENCE CHECKLIST TO DETERMINE THERAPIST COMPETENCY AND SKILL DEVELOPMENT IN CONTROL THERAPY

We have provided in Appendix 1 a checklist to measure trainee learning and competence in meeting these objectives and delivering Control Therapy effectively. This Adherence Checklist has relevance both for the clinician training phase and treatment research phase.

BEGINNING THE EXPERIENTIAL JOURNEY BY TAKING THE SCI

Before proceeding further, we would like to ask you to take the SCI before continuing, if you haven't already done so. The easiest way to do this is to go to the website **controlresearch.net.** There, an account can be set up, the test can be taken, and the results obtained, *all at no charge*. It takes less than ten minutes to set up an account (a one time occurrence), and the test itself can be taken in approximately twenty minutes. Once completed, the Comprehensive Clinical Report (approximately twenty-five pages) based on your test is immediately available to you.

Ideally, we have our students complete the SCI before the first class or, if that is not possible, before they have received more than minimal information about Control Therapy and the SCI. In this way, students can experience a control-based self-assessment without having any information in advance that might bias their answers. This experience can be helpful to students in three ways: 1) the memory of this experience is useful when they administer the SCI to their clients; 2) It creates self-knowledge through generating a personal Control Profile; 3) that control profile can be a foundational cornerstone for the rest of the "journey" through the manual: i.e., goal-setting, intervention, and subsequent evaluation of progress and change.

This concludes the introduction. We hope we have provided the beginnings of the road map. And now, you - teacher, trainer, trainee, student - by taking the SCI,

have begun the experiential journey. We hope you find the trip a helpful, insightful, and enjoyable learning experience.

PART ONE

CONTROL THERAPY: HOW TO DO IT

TRAINING MODULE ONE

ASSESSMENT

WHERE ARE WE?
ASSESSMENT OF ONE'S SELF

KNOW THY…
CONTROL PROFILE,
CONTROL STORIES
CONTROL DYNAMICS

OVERVIEW MODULE ONE: This module begins with a series of open-ended questions experientially exploring what a sense of control means to the reader. "Control" and "sense of control" are defined, followed by a Trainee FAQ "What is Control Therapy?" After a discussion of issues of group confidentiality, four means of assessing an individual's "Control Profile" (Sense of Control, Modes of Control, Desire for Control, Agency of Control) are explored: the SCI (Shapiro Control Inventory); self-observation; listening to control speech; and "control stories." Homework suggestions are offered.

MODULE 1: ASSESSMENT: WHERE ARE WE

DEVELOPING A CONTROL PROFILE 9-39

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ASSESSMENT: DEVELOPING A CONTROL PROFILE

ADDITIONAL MEANS OF ASSESSMENT

The first session/training module is intended to provide a brief overview of Control Therapy, and then to focus on how a control profile is assessed, through both didactic and experiential learning.

ACTIVITY #1.1*:* Here is a possible way to begin the class[*], and raise questions for discussion:

> *Welcome to our training class on Control Therapy. We are delighted you are here. In this first session, we will give you an overview of Control Therapy and spend some time exploring your Control Profile as reflected in the SCI. To facilitate our goals for this session, let's begin with a series of questions which you may have asked yourself at some time in your life.* <Each question can be asked and discussed before proceeding to the next one. To facilitate discussion, we begin with positive topics.>
>
> - *Think of times when you have had a positive sense of control in your life. Can you share a few examples? Let's make a list and note the types of situations that create this sense of control.*
> - *What does a positive sense of control feel like? How do you "know" You have a sense of control? In your body? Your thoughts? Your feelings?*
> - *What are ways you personally use to gain a positive sense of control in your life? (Self as agent)* <These too can be listed and commonalities, differences discussed).
> - *What are ways that others can help you to gain a sense of control in your life? (Other as agent, including, where appropriate, your beliefs about the nature of the universe).*
> - *Does a sense of control always involve making changes to meet your needs and desires (an assertive, change mode of control)? Can it sometimes involve learning to accept and be at peace and harmony with "what is" (a yielding, accepting mode of control)?*

DEFINITIONS. As you can see from the above discussion, control and sense of control are multifaceted constructs, and can involve self-efficacy, fear of loss of control and learned helplessness, need for control, predictability. We define ***control*** as the "ability to cause an influence in the intended direction"; and we define ***sense of control*** as beliefs and expectancies, as well as the attainment of that "intended direction" through self and/or others as agent, and through using either assertive/change and/or accepting/yielding modes. [4]

To know what the "intended direction" is we both need to know where we are (Training

[*] If you are not reading this manual as part of a class, workshop, practicum/internship, or group experience, then—as noted in the introduction—you the reader will need to become both the student/trainee AND the instructor/ teacher/trainer.

Module 1) and where we want to go (Training Module 2). Training Module 3, Interventions, offers ways to get from where we are to where we want to go.

WHAT IS CONTROL THERAPY? Therapist/Trainee FAQ #1

All of us would like to have a positive sense of control in our life. Each of us—client, student, teacher—also knows from first hand experience that we receive assaults to our sense of control as we go through life. Some of these are the result of inevitable existential suffering inherent in being alive. Others are what we might call "unnecessary suffering" brought about by poor choices, lack of skillful responses to events, and/or not having learned appropriate cognitive, emotional and behavioral self-regulation strategies. In addition, according to control theory, one of our greatest human fears is losing control, and one of our strongest motivations is to have a degree of control over our lives (from *Control Therapy*, p. 31).

Therefore, according to control theory, we seek to gain or regain a sense of control by our actions, thoughts, emotions, and awareness. Sometimes we try to accomplish this by changing and altering a situation (and ourselves); sometimes by learning to accept, yield, and develop a peace and harmony with "what is."

Each of these ways to gain a sense of control can be accomplished by the use of self efforts (self as agent) and/or by help from others (others as agent, including our beliefs about the nature of the universe). What is important is that we match and tailor techniques and interventions to clients' clinical concerns, their goals, and their individual control profiles.

Control Therapy has its roots in self-regulation strategies, both Western (e.g., behavior self-control, cognitive therapy) and Eastern (Zen Buddhism and Vipassana, mindfulness meditation). Although this panoply of techniques from different psychological and religious traditions held promise, what was needed was systematic analysis and integration at both the theoretical and clinical levels. Control Therapy attempted to do exactly this, refining and integrating the wisdom and techniques from Western and Eastern traditions, to develop a systemic and wholistic theory and therapy Specifically, over the past thirty years the following have been developed:

1) A theory of human control and three postulates (cf *Control Therapy*, Chapters One and Two):

- 1.1 Gaining and maintaining a sense of control is a major motivational force across the human life cycle.
- 1.2 There are both higher and lower levels of control-related goals, desires and strategies by which people seek to gain a sense of control.
- 1. 3. There are individual differences with respect to how and why control is sought.

2) A clinically useful means of assessing the theory, and developing a ***control profile*** for each individual, including desire for control, overall sense of control in the general and specific domains, agency of control, and modes of control.

Through assessment by a standardized test (the SCI), self-observation, listening to control speech, and examining control stories, clients are helped to recognize their control profiles, assaults to their sense of control, and what forces are shaping their lives, including personal (i.e., behavioral, cognitive, and emotional), interpersonal, and environmental). (Module 1)

3) A way of understanding human control that is not culturally limited, but involves delineating ***four*** different ***modes of control***: positive assertive, positive yielding, negative assertive, and negative yielding. Clients are helped to explore their goals—e.g., to alter and change a situation; to learn to accept and be at peace with a situation; or some combination. (Module 2)

4) A method of ***matching*** a person's control profile and goal to the clinical intervention. This can involve teaching clients to gain more positive assertive control over those areas which are amenable to some degree of change; and to learn skills helpful to accepting those aspects of life which they either cannot or should not try to change. This involves both wise and skillful matching of the client's control profile to agency of control as well as mode of control. (Module 3)

5) A systems model of feedback and evaluation of each of the components of Control Therapy. (Module 4).

Phase One of Control Therapy involves assessment of the client's control profile, helping the client become more aware of his/her area of concern and control dynamics; self-evaluation of the area of concern; and goal setting. The second phase of Control Therapy involves teaching the client skills-- intervention selection and implementation -- with particular attention and emphasis on *matching* the client's control profile, concern, and goal to mode of control techniques.

CT believes that although there is individual variation, each of us has an ability to

- learn to pause, reflect, consider and reconsider our thoughts, actions, and behavior
- learn to choose, if we wish, to interrupt and override reflexive cognitive, emotional, and behavioral impulses and sequences
- learn to create alternative ways of responding-—behaviorally, emotionally, and/or cognitively -- that we feel are more in our (and others') best interest, and which help us gain, or regain a positive sense of control.

By integrating theory, research and practice, Control Therapy addresses these issues through an eight to twelve week course of sessions in order to help individuals learn to gain or regain a psychological "sense of control" in the "intended direction"-- by the most skillful means possible. This short term approach provides a systematic way to determine when to use which types of control strategies with a specific client given that person's unique control profile and consistent with that person's particular counseling goals.

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Because assessment is such an integral part of Control Therapy, we now turn to a discussion of assessing a person's control profile, after a brief comment on self-disclosure, personal responsibility, and group confidentiality.

--SPECIAL ISSUE-- Self-Disclosure, Personal Responsibility, and Training Group Confidentiality.

Before we go further, it is important that trainees/students take a few minutes to reflect on their comfort level with sharing personal experiences. Many of the topics discussed in this module are facilitated by personal sharing, beginning with the initial group discussion in this module: "Think of times when you have had a positive sense of control in your life." First and foremost, we encourage you to share at the level that is comfortable for you. No one else can determine that--only you. Often times, we can productively share a feeling or experience (e.g., grief and loss, feelings of not belonging, anxiety about being judged) without necessarily going into details. At other times, the details ARE essential to relaying the gravity of the situation.

As we noted in the introduction, our belief is that experiential understanding can help facilitate both knowledge and wisdom in teaching and sharing Control Therapy with your clients. Therefore, this manual is going to suggest homework assignments, such as self-monitoring, as part of a self-management project, so you can practice on yourself the very processes you will be teaching to clients. You will also be asked to keep a journal of your insights and understandings. Further, there are going to be several times in the modules when we suggest trainees break into dyads, approximating the clinical situation, to discuss topics with each other. You have already taken the SCI for yourselves and will be able to review your scores and share as much or as little about them as you like.

> ***It is important at the start of a class or training session that the issue of group confidentiality be addressed directly and everyone agree that group confidentiality be strictly honored.***

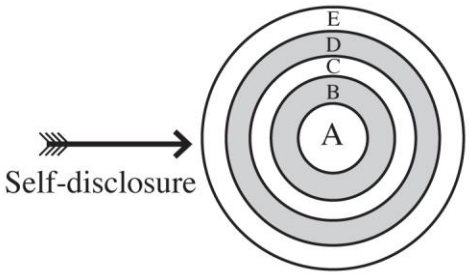
We are aware that different people have varying self-disclosure comfort levels, and feel it is important to be sensitive to each person's right to privacy. That is why, in discussing the **personal journal** later in this module, we specifically noted that it is **NOT to be handed in**, but is solely for the individual's own use. We believe that encourages personal, honest, authentic self-reflection.

We also believe that personal self-disclosure is important, and can be an asset in class discussions. We all know that in therapy, the more the client can be open and honest and authentic and self-disclosing, the more beneficial the process . But we also know in our own lives, that self-disclosure often takes time and the building of trust. Your training group may be at the beginning stage in Yalom's formulation, or it may be more advanced if all of you have worked as a group in the past. As you will see a little bit later on, the principle of "start where you are" is central to Control Therapy. Therefore, as part of any experiential exercise, like the self-management project, or breaking into dyads to discuss

personal Control profiles, we believe a discussion of personal responsibility and self-disclosure is necessary.

We address this topic below. <Much of this material is borrowed from a superb discussion about archery targets and self-disclosure by Arnold Lazarus heard at a conference decades ago. We give thanks to Dr. Lazarus for his creative and pioneering work, and take responsibility for any additions and alterations>.

Imagine an archery target, as a series of concentric circles, with the center as an A, and larger concentric circles out to E. (Figure 1.0) below:



The outer, E circle is what you would say to anyone: e.g. the weather is hot, cold, rainy. The D level you probably wouldn't be uncomfortable sharing, but you say to fewer people: e.g., I'm a psychology graduate student. The C level we share with fewer people still; the B level with only one or two closest friends, and the A level we share with no one, sometimes not even with ourselves!

We all know that in therapy, the more the client can be open, honest, authentic and self-disclosing, the more beneficial the process. But we also know in our own lives, that self-disclosure often takes time and the building of trust.

This schemata can be used in our interactions in general, and in this class in particular. We are going to be doing a self-management project, and would like each of you to be willing to share, as you are comfortable, as part of class discussion. With this in mind, please choose a project which is of a sufficient comfort level, so that you do not share more than is comfortable for you. *How much you share is your responsibility*. But we would also ask you to note, to yourself, in your personal journal, at what level (ABCDE) you are sharing, and why you do not wish to share deeper. This is only for you, but is information that may be important for you to explore about yourself.

There is no requirement that you participate in discussions beyond a level that works for you. But, at the same time, please be conscientious in your internal self-exploration, to learn about yourself.

We now turn to the issue of ASSESSMENT.

ASSESSMENT: DEVELOPING A CONTROL PROFILE

"In order to get to where you are going, you need to know where you are, and where you want to go." --Anonymous

ASSESSMENT: "WHERE THE CLIENT IS"

A basic premise of Control Therapy is that awareness is a necessary component of the therapeutic process--"knowing where you are". In order for a person to address a problem/concern, the issue has to be brought into awareness and explored. Thus, the first task of Control Therapy is to help individuals recognize what forces are shaping their lives including personal (i.e., behavioral, cognitive, and emotional), interpersonal, and environmental. This is achieved by having the client become familiar with their Control Profile--their overall sense of control, normal modes of control, agency of control, desire for control, domain-specific areas of concern, and assaults to their sense of control.

In this module, four ways which can be used in order to increase awareness of and assess a person's control profile are explored.[*] The first way is through the use of a standardized psychological assessment inventory, the SCI (the Shapiro Control Inventory), to which a majority of this module is devoted. In addition, at the end of this training module, other ways of complementing and deepening our understanding of the Control Profile are also examined, including 2) self-monitoring a control area, 3) listening to and for control speech, and 4) exploring "control stories."

1.1. THE SCI (SHAPIRO CONTROL INVENTORY)

The SCI is a quick and efficient way to assess a person's Control Profile: highlighting both strengths and possible problems related to control.

DESCRIPTION AND BACKGROUND STUDIES. The SCI is a clinically and theoretically derived, empirically validated inventory, which is used to assess "where a client is" and "where s/he wants to go". This 187-item standardized paper and pencil test provides nine scales and five additional "refinements", thereby generating a multi-faceted, yet "holistic" control profile, which has been shown to be both reliable and valid.

Studies include looking at neurobiological correlates of the Control Profile (with Positron Emission Tomography Scans), as well as discriminant and divergent, validity comparing the SCI to the Rotter Internal External Locus of Control Scale, and to theWallstons' Health Locus of Control scales. Incremental validity studies showed the SCI has more sensitivity (better predicting normals) and more specificity (more accurately predicting generalized anxiety disorder, depressed patients, panic attack, and borderline patients), when compared to Rotter's IE scale. (See SCI, Chapter 4, for a more complete discussion of the research on the Control Inventory).

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[*] CT acknowledges the importance of different types of awareness, and discusses other approaches in Module 2, as well as Modules 3.1 and 3.3.

The SCI is written at an 8th-grade reading level and takes approximately twenty minutes to complete online (www.controlresearch.net).

FOUR AREAS OF THE CONTROL PROFILE. Both clinical and cross-cultural research over the past twenty five years with several thousand individuals has shown that different people (and cultures) have different "Control Profiles." The SCI Control Profile covers four major content areas.

I. Sense of control. These scales (1-4) measure an individuals' current sense of control status, both positive (to what extent they believe they have the skills and competencies to gain and maintain a sense of control) and negative (losing control, feeling others have too much control). The scales cover sense of control both in the general domain, and in domain-specific areas (e.g., mind, body, relationships, work, self).

II. ***Modes of control.*** These four scales (5-8) reflect characteristic cognitive and/or behavioral styles of responding to control-related issues: positive assertive (change), positive yielding (acceptance), negative assertive (overcontrol), and negative yielding (too little control or helplessness).

III. ***Motivation for control***. This includes the desire for control scale, as well as domain-specific information showing how clients wishes to deal with areas of life that they experience as not in control. Additional items focus on the clients' level of motivation for addressing areas of concern as well as self-efficacy beliefs regarding control of thoughts, feelings, and behavior.

IV. ***Agency of control*** Provides information on the sources of a person's sense of control (i.e., from self efforts and/or the efforts of others).

HOW TO READ THE SCI

The SCI Control Profile consists of a twenty-five page Clinical Comprehensive Report.

The "voice" of the profile is speaking to the therapist and provides suggestions on how to interpret the findings, and what areas to explore with the client. The sample profile used here is the same as the one in Appendix A of the SCI Manual (reprinted in Appendix 2 of this training manual). On page three of the report, reprinted below, you will notice Figure 1.1, a summary overview in graph form.

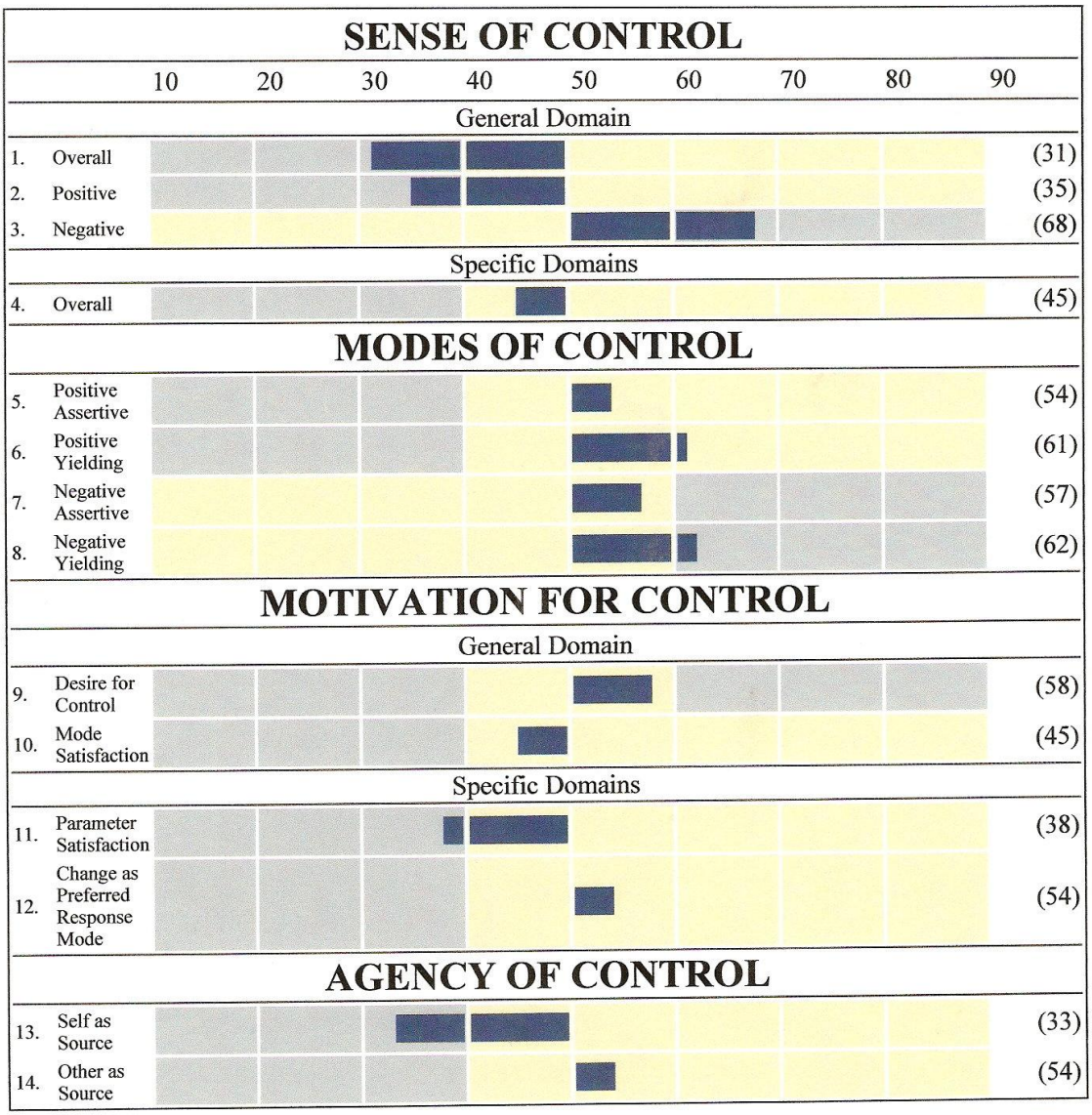
When the scored SCI control profiles are viewed and printed out after taking the SCI online, the trainees can be given their own personal profile sheets to review as they follow along in a discussion of an example profile.

Here is a simple way to read Figure 1.1 The numbers at the top (10-90) represent standardized scores, with a mean of 50 and a standard deviation of 10. A client's score is

compared to a healthy normal comparison group that was psychiatrically screened to provide an empirical reference standard against which to interpret the subject's scores.

Light gray shaded portions on the graph indicate score ranges that are considered to be of potential clinical concern. Thus, it is important to note when the dark bar (dark blue for those who have a color copy) enters those gray areas. (The light yellow area, for those who have a color copy is a "healthier" direction). For this client, a fifty four year old male, overall sense of control (general domain) is low (Scales 1-3). Negative yielding is high (scale 8), parameter satisfaction (number 11) is low; and self as source of control is low (number 13). Each of these is discussed in more detail below.

FIGURE 1.1 SCI CONTROL PROFILE



SENSE OF CONTROL (Scales 1-4)

General domain: Overall. As can be seen in the profile in Figure 1.1, the person has a low overall general sense of control (scale 1). This scale is composed of two subscales: positive sense of control (which for this person is also low), and negative sense of control (which is high).

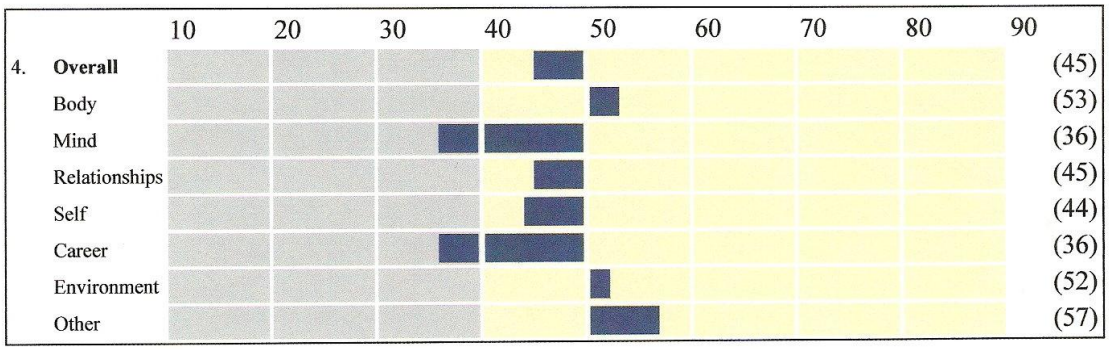
The **positive sense of control scale** consists of 11 items, including self-efficacy beliefs about one's ability to change what s/he wants; whether the person can calmly accept what cannot be changed; whether s/he is able to set goals; take appropriate responsibility for meeting those goals; has the self-control to achieve the goals. (See Appendix 2, see pp. 7-8, for a complete list).

The **negative sense of control scale** consists of five items, measuring whether the client feels s/he is losing or has lost control in spheres of life where s/he once had control; lacks control of his/her environment; feels s/he is controlled too much by others (for a complete list see Appendix 2 pp. 8-9,).

Domain specific overall (scale 4) is comprised of 25 areas of life, and the tabulation in Figure 1 is based on a composite score. As can be seen in the figure, the black line for this client is not in the gray area, but is 'inclining" in that direction.

Seven groupings of the domain-specific scale. In the SCI Comprehensive Clinical Report these areas are grouped into seven domains, in graph form, as follows: (See p. 10, Appendix 2.)*

Figure 1.2 Domain-Specific Sense of Control Scales



As can be seen from the above, the mind and career areas are in the gray area suggesting these are areas where the person feels less in control, and therefore worthy of further clinical investigation. In the following sections, we provide the building blocks for that investigation, including exploring the four modes of

* To avoid any possible confusion it should be noted that although the domain specific sense of control scale is Figure 1.2 in the manual, it is actually Figure 3 in the SCI Comprehensive Report.

control, agency of control, motivation for control, and then moving to the item level of each of these seven groupings.

Comparing general domain and domain specific scales. As part of the Sense of Control overview, it is interesting to compare Scale 1, General Domain, and Scale 4, Domain Specific Sense of Control. In the SCI printout for this client (p. 10), it notes, "The client's general domain is lower than healthy normals, but the client's specific domain score is in the normal range." This discrepancy should be kept in mind by the clinician to see whether there is a potential "disconnect" or lack of congruence between global attitudes and specific areas of the client's life.

THE FOUR MODES OF CONTROL (Scales 5-8)

Let us look now at the next four scales (5-8), Modes of Control. These are central to an understanding of Control Therapy. As a way of exploring your views and assumptions, and as a helpful introduction to the modes, the following experiential discussion may be helpful:

> ACTIVITY #1.2:
> Before discussing the modes, let us take a few minutes and everyone "free associate" to the term "control." Just say whatever comes to mind. (The trainer can take these comments, and list those that fit into each of the four quadrants. For example, terms like "empowerment" "taking charge" can go in Positive Assertive Quadrant One; terms like manipulation, control freak, coercion, power trip, can go in Negative Assertive, Quadrant Three.) What we often find in this exercise, is that all of us have both positive and negative associations with the term control, and these can be understood in a more nuanced way by distinguishing between positive assertive, and negative assertive.

Client and trainee FAQ #2. "Isn't control sometimes bad?" *To answer this question, it is helpful to ask what the person means by control. This question often assumes an "assertive/aggressive" view of the term control. Based on an explanation of quadrants one and three, as noted above, the answer is, "Sometimes, and that's why we need to take a careful, thoughtful, nuanced view, noting when control can be helpful, such as positive assertive, and when it can be counterproductive or harmful (e.g., negative assertive). <As we discuss in Training Module 4, issues of cultural and gender sensitivity are also important in how we assess whether control actions are viewed positively or negatively.>*

> **ACTIVITY #1.2 (CONT'D)** Now, let's take a few minutes to free associate about the opposite of control or lack of control. <Again, these terms can be listed in the appropriate quadrant. For example, terms like helpless, vulnerable, and powerless can go in Negative Yielding, Quadrant Four).

Interestingly**,** when we think of the **opposite** of control, in our culture, we generally think of more quadrant four, negative yielding terms., which is why the quadrant two box is often empty throughout both of these exercises.

Client and Trainee FAQ #3: Isn't positive yielding and acceptance, even though you call it positive, really passivity or fatalism, a kind of giving up*? To answer this question, it can be helpful to make a distinction between negative yielding (quadrant four) and positive yielding (quadrant two). For example, in the philosophy of Lao-Tzu, the highest form of control is symbolized by water, which, when confronted by an immovable rock, does not try to bulldoze through the rock, but accepts the rock's position, and yields and goes around. Lao-tzu points out that this "way of water" is actually very powerful—witness the way water eventually wears away rocks. Another example is the Chinese story of the origins of the philosophy of Judo, which is purported to have been discovered while watching snow fall on two different trees. A larger tree stood solid, strong, and unyielding while the snow piled upon its branches. After a while the snow became so heavy on each branch that they cracked under the weight. Meanwhile, the smaller tree also grew heavy with snow, but its branches were limber and merely bowed and yielded to the greater weight, gradually bending to the ground, casting off the snow, and returning to their original position. The smaller, more flexible branches survived the winter; the tree that yielded proved the stronger in the end. Sometimes, to yield in a situation can show great wisdom, and decrease our pain and suffering, and is not at all related to fatalism or giving up in a negative sense.*

Detailing the Four Modes. A thoughtful article by John Cloud (Time, February 13, 2006), describes how Beck's Cognitive Therapy—"change thoughts"--and Hayes' ACT (Acceptance Commitment Therapy)—"accept thoughts"-- seek to answer the question of how individuals gain a greater sense of control in their lives. However, as Cloud intimates, the issue may be less an "either/or" than at first appears. Specifically, research on Control Therapy has demonstrated over the past thirty years with several thousand individuals that an optimum sense of control frequently comes from having the flexibility to use either (or a combination of) positive assertive (change) as well as positive yielding (acceptance) strategies depending upon the particular situation and circumstances one is encountering.

In addition to bridging "change and acceptance," Control Therapy research also has shown that more refinement of these concepts is needed. An **assertive, change mode of control** can be positive (striving for excellence, self-improvement) or negative (overcontrol, perfectionism). Similarly, a **yielding, accepting mode of control** can be positive (at peace with self, gratefulness for what you have) or negative (passivity, helplessness). This gives us the following four-quadrant model—as shown in Figure 1.3 below.

The positive assertive scale (quadrant one) measures an individual's self-description in terms of ability to use an active, altering mode of control to change the environment,

others, and/or oneself. It includes descriptive words and phrases such as 'decisive,' 'communicating needs,' and 'leading.' The positive yielding mode (quadrant two) involves knowing when a sense of control can better come from letting go of active control. Its descriptive words include 'patient,' 'trusting,' 'accepting.' Negative assertive (quadrant three) is sometimes referred to as "overcontrolling." It involves efforts at active change, often in an aggressive or hypervigilant manner, based on inaccurate (sometimes even irrational) assumptions such as the notion that just trying harder (in certain uncontrollable situations) will eventually lead to the desired outcome even when so far such efforts have failed or only made things worse. Descriptive words include 'dogmatic,' 'aggressive,' 'manipulative.' The fourth mode of control, negative yielding (quadrant four), involves thoughts and behaviors that reflect a sense of helplessness and lack of control when in fact control might be realistically asserted. Descriptive words include 'indecisive,' 'manipulated,' 'timid.' (The items comprising the four modes and their interpretations are detailed more fully in the SCI Comprehensive Printout—Appendix 2, pp. 13-16).

FIGURE 1.3: A FOUR-QUADRANT MODEL OF MODES OF CONTROL

POSITIVE ASSERTIVE *Assertive, Change Mode of Control* (Quadrant One: Q1)	**POSITIVE YIELDING** *Yielding, Accepting Mode of Control* (Quadrant Two: Q2)
NEGATIVE ASSERTIVE *Overcontrol* (Quadrant Three:Q3)	**NEGATIVE YIELDING** *Too Little Control* (Quadrant Four: Q4)

For the individual in Figure 1.1, the black bars for positive assertive (Scale 5) and positive yielding (scale 6) are higher than the mean, and moving in a good direction. However, negative assertive is also high (though not in the gray area) and negative yielding (Scale 8) is high and in the gray area, a cause for clinical exploration.

This four-quadrant model can be applied at assessment (i.e., where the client is)—as noted in scales 5-8. It can also help with goal (where the client wants to go: e.g., be more assertive; be less negative assertive, not feel so helpless, etc); identifying ways to address areas of concern (through assertive/change or yielding/acceptance). It is to the topic of Motivation for Control that we now turn.

MOTIVATION FOR CONTROL

Information about Motivation for control comes from four places in the SCI: 1) the desire for control scale (Scale 9); 2) mode satisfaction (refinement 10); 3) parameter satisfaction (Refinement 11); and, 4) preferred response mode (Refinement 12). Together, these areas provide information about:

- how important active control and the appearance of being in control is to the person;
- where s/he would like to make changes in the four modes;
- what specific areas of his/her life are a concern; and
- how s/he would like to address those specific areas of concern.

FAQ #4: What does refinement mean, and how is that different from a scale? *In our usage, a "refinement" refers to a score on items 10-14 of the SCI (Figure 1.1). The nine scales are based on Likert response calculations, and have alpha internal consistency reliability and test-retest reliability. Refinements have different means of calculation, and provide additional clinically useful information. For example, the raw score for Refinement 12, Change as Preferred Response Mode, is the ratio of the number of "B" answers compared to the number of "C" answers in Step 2 on the Specific Domains Page. (for more, see the SCI manual, Chapters 2 and 4. The manual can be viewed and downloaded at no charge at the website controlresearch.net).*

Desire for control scale (Scale 9). The eleven items that make up the desire for control scale can be found on pp 17-18 of the SCI Comprehensive Clinical Report, App 2. As can be seen from Figure 1.1, this scale has gray shaded areas in two directions. This is because research has shown that a person can have too high or too low a desire for control. for the person in Figure 1.1, the desire for control is in the normal range.

Issue of overcontrol. In addition, although not comprising a scale, there are five items on the SCI that focus on issues of overcontrol and the desire to have less control (e.g., belief one is too aggressive and overcontrolling; feeling one exercises too much self-control). (See p. 18 of the SCI Report, Appendix 2, items 5,10,28,34,35). These items may be worth examining in more depth to determine the client's feelings about having too much control, either over oneself and/or others.

Mode satisfaction. (Refinement 10), comes from the last page of the SCI, where a test taker is asked regarding each word, do you want to a) be less like this; b) stay the same; or, c) be more like this. The overall score is a measure of acceptance of one's mode of control.

As can be seen from Figure 1.1, this client is relatively satisfied with his Mode Control Profile. (Additional details, including an item-by-item break down on each of the

four modes can be found on pp. 20- 21 of the Comprehensive Clinical Report, Appendix 2.) Further, as can be seen from those pages, when the client did want change, he wanted to increase positive assertive and positive yielding, and decrease negative assertive and negative yielding.

Parameter satisfaction (#11) The overall parameter satisfaction score is based on how many of the twenty-five domain areas in Scale 4 the client says are "Not a Concern." As can be seen from Figure 1.1 the black line goes into the gray area for this client. Additional details regarding which areas are of concern are important, and are addressed when we discuss Scale 4 in more detail below.

Change as preferred response mode **(#**12) In Scale 4 when clients believe one of the domain areas IS a concern, they then state whether they want to address this area by a) active change; or b) acceptance. As can be seen from Figure 1.1, this client's score is slightly higher than normal, in a direction away from the gray area, so well within the "normal" range.

Self-control. Though self-control is addressed in specific questions in other scales, there are two items that specifically ask about self-control, 1) descriptive (#137, where we are); and 2) ideal (#187, where we want to be) (see p. 18, Appendix 2). It can be helpful to inquire what the test-taker was thinking when s/he answered the questions and in which specific areas s/he feels having greater self-control would help.

AGENCY OF CONTROL

The final refinements on the SCI Control Profile are "Self as Source of Control" (Refinement 13); and "Other as Source of Control" (Refinement 14). The original instrument assessing human control by Rotter in the 1960's provided a single output (internal or external locus of control). Second generation tests, such as Wallstons' Health Locus of Control Scale demonstrated that sources of control such as self and other are not mutually exclusive. For this reason, the SCI provides information on both self and other as possible sources of control.

As can be seen in Figure 1.1 (#13), self as source of control is low and goes into the gray area. Other as source of control (#14) falls within the normal range. Further comments about self and other are detailed in the SCI Comprehensive report. For illustrative purposes, we quote that material here (Appendix 2, p. 25):

> This individual reports experiencing sense of control coming from his own efforts to an extent less than a normal, screened group. However, he reports that control is coming from others to an extent comparable to or higher than that of healthy normals. It is suggested that the clinician investigate why the subject senses such a low degree of control from self. There may be too much of a feeling of a need for or reliance upon others, to the exclusion of one's own efforts. This profile is frequently seen in persons with depression or low self-esteem. On the other hand, this profile may reflect a healthy feeling of interconnectedness, control by a higher power, and/or a religious belief. This specific profile is not necessarily a concern, but should at least be investigated further by the clinician. <Note: Questions 21,22,23, are refinements of "other" as source of sense of control.>

DOMAIN SPECIFIC SENSE OF CONTROL, ITEM-LEVEL EXPLORATION

Having completed the overview of the SCI Control Profile, we now turn to a more detailed analysis of Scale 4, Specific Domains, at the item level. The raw data scoring sheet for our client is reprinted below in Figure 1.4.

FIGURE 1.4: DOMAIN SPECIFIC SCALE RAW DATA

Domains of Control

Step 1
1 = **Very Out** of Control
2 = **Moderately Out** of Control
3 = **Slightly Out** of Control
4 = **Slightly In** Control
5 = **Moderately In** Control
6 = **Very In** Control

Step 2
1 = Not a Concern
2 = Active Change/Alter
3 = Acceptance

#	Step 1						Statement	Step 2			#
	1	2	3	4	5	6		1	2	3	
38	○	○	○	○	◉	○	**Eating behavior**	○	◉	○	63
39	○	○	○	○	◉	○	**Physical exercise**	○	◉	○	64
40	○	○	○	○	◉	○	**The way my body functions**	○	○	◉	65
41	○	○	○	○	◉	○	**Physical appearance (general)**	○	○	◉	66
42	○	○	○	○	◉	○	**Body Weight**	○	○	◉	67
43	○	○	○	○	◉	○	**Sexuality**	○	○	◉	68
44	○	○	○	○	○	◉	**My thoughts**	○	◉	○	69
45	○	○	○	○	◉	○	**Attention/Concentration**	○	○	◉	70
46	◉	○	○	○	○	○	**Stress**	○	◉	○	71
47	○	○	◉	○	○	○	**Sadness**	○	◉	○	72
48	○	○	○	◉	○	○	**Relationships (friends)**	○	◉	○	73
49	○	○	○	○	◉	○	**Relationship with significant other (or none)**	○	◉	○	74
50	○	○	○	◉	○	○	**Relationship with my children (or no children)**	○	○	◉	75
51	○	○	○	○	◉	○	**Relationship with my family of origin**	◉	○	○	76
52	○	○	○	◉	○	○	**The way I feel about myself**	○	◉	○	77
53	○	◉	○	○	○	○	**Employment situation (or not employed)**	○	◉	○	78
54	○	○	○	◉	○	○	**Spending habits**	○	○	◉	79
55	○	○	○	○	○	◉	**Work habits**	○	◉	○	80
56	○	○	○	○	◉	○	**The place where I live**	○	○	◉	81
57	○	○	○	○	○	◉	**Drug usage**	◉	○	○	82
58	○	○	○	○	○	◉	**Alcohol consumption**	◉	○	○	83
59	○	○	○	○	○	◉	**Smoking**	◉	○	○	84
60	○	○	○	○	○	◉	**Violent behavior**	◉	○	○	85
61	○	○	○	○	○	◉	**Gambling**	◉	○	○	86
62	○	○	○	○	◉	○	**Management of time**	◉	○	○	87

Note how this item level material helps refine the global, generalized statement of our friend "Ziggy" at the start of the manual: "All circumstances are out of my control." Though a person may "feel" like everything is out of control, Scale 4 helps give a more precise and nuanced view of different areas and different degrees of "in" and "out" of control.

Step one: Looking at specific areas that are "in"--"out of control." The material on the left side (Step One) shows the amount of "in" or "out" of control a person feels on specific domains. It is helpful to briefly notice those areas that are marked "very", "moderately", and "slightly" out of control. These will likely be points of further clinical discussion.

For this client, there are three: stress, sadness, and employment. Also, refer back to Figure 1.3, in which the cluster areas of mind and career fall within the grey area (areas of concern). Can you see how the raw scores contribute to these area scores?

Step two: looking at areas not a concern. On the right side, step two, the client notes the relationship between the amount of control s/he has in a given area, and whether that area is *not a concern*. As can be seen from visual inspection of Figure 3, Step Two, Column 1, there were seven areas not a concern for this client.

Step two (a): areas of concern: change or accept? Visual inspection of Figure 1.4, Step Two, Column 2 **active change/alter** and (Step 2, Column 3) **acceptance** shows that for those areas listed as concerns, the client wants to change and alter the area in nine cases, and to accept where he is in seven areas.

Additional topics to explore in reviewing the data from Scale 4, include:

- Areas indicated as very out of control, but stated as not a concern**;** **(**flagged in the Comprehensive Clinical Report, Appendix 2, p 23);
- Areas that are in control but still felt to be a concern;
- If there is only **one** mode strategy selected for areas of concern (e.g., "assertive/change")
- Additional Information on Scale 4 at the item level is provided on pp. 21-22 in Appendix 2).

Activity # 1.3:Suggested dyad exercise*. Interview one another in pairs, asking your partner about how s/he answered the domains page. For example, you may notice your partner has listed sadness and eating habits as "slightly out of control". You may say, "These two are both slightly out of control. Are there any connections between them?" Or more broadly: "Tell me about the areas that catch your eye as you look at your page. Do you see any patterns across areas?"*

*Convey a spirit of exploration and emphasize that the page must be read **in the context** of your partner's life, not anyone else's. Help him/her explain the meanings of each item for him/herself. (As an alternative, trainees can sit around a table holding their own answer sheets and discussing their own control profiles at the level with which they are comfortable.)*

*When trainees break into dyads to discuss their answer sheets, they often find that they notice meaningful patterns in how they answered Specific Domains of Control. The layout of that page makes it easy for them to consider connections between different areas, such as eating behavior and stress, or feelings about self and spending habits. These initial "Aha!" experiences are exactly what the clinician will want to watch for as clients share their experiences with the instrument. Most of all, sharing this material is for the trainees an initial practice phase for learning how to use the SCI answer sheet to ground clients in specific life experiences that led to their self-ratings on the life areas. This grounding phase is a crucial part of the first few CT sessions. If clinicians can experience it for themselves, then they will start to appreciate the utility of using the SCI **in session** in structuring and guiding client self-exploration and understanding, somewhat akin to the metaphor of "holding up a mirror."*

We have now completed our introductory exploration of the SCI, a cornerstone of assessment and developing a client's control profile as part of the process of Control Therapy**.** Though it has been in large part, didactic, trainees have had the opportunity to follow along and see the results of their own inventories.

ADDITIONAL MEANS OF ASSESSMENT

As noted at the start of this Module, there are four ways assessment of a person's control profile can be accomplished. As you have seen, the first, the SCI, gives a "quantitative snapshot" both of where a client is, and, some indication, through Scale Four (including the raw data) and Mode Satisfaction, of where the client would like to be.

As a way of bringing this first module to a close, we briefly discuss the other means of assessment of the control profile including 2) self-monitoring a control area, 3) listening to and for control speech, and 4) exploring "control stories".

1.2. SELF- MONITORING

Self-observation is an "awareness" strategy common to nearly all cognitive and behavioral approaches. Some methods look at the relationship between cognition and affect (based on cognitive theory regarding how beliefs create affect). Others, based on Skinner's functional analysis, look at the relationship between a) **a**ntecedent environmental events (e.g., who is present, where) and b) a person's **b**ehavior, and c) the **c**onsequences (e.g., reinforcement, punishment) of that behavior, sometimes referred to as the ABC model.

The self-observation model we use to explore control includes both. It is based on the simple A-B-C (antecedents, behavior, consequences) of Skinner but includes cognition and affect. A target area, such as an internal thought or feeling, or an external behavior, is selected for monitoring, and the individual records in systematic fashion not only the target behavior, but also: A) the antecedents: where you are, who is present, and events, actions, verbal statements, feelings that occur *before* and in some way may *trigger* the target behavior. C) how things change as a result (i.e., consequences).

A sample form is provided in Appendix 3.1. Alternatively, a person can devise his or her own means of recording, such as a free form journal. Again, like fingers and the moon, the goal here is what is important—i.e., some form of monitoring to gain greater self awareness—the means less so.

SELF-OBSERVATION HOMEWORK. Self-observation is best "learned by doing." Therefore, before the next session/module, please choose and begin to monitor some area of your life that seems interesting to gain additional information about you. This will not only teach you something about yourself (hopefully) but also familiarize you with the process that you will be asking your clients to do. Below is a list of topics related to a generic "Control Profile." What we would like you to do is pick one or two areas, based on your control profile, about which you would like to gather more systematic information, and bring a more refined awareness. We suggest several topics below. You may wish to use a standard self-observation form, such as the one provided in Appendix 3.1, or a form of your own creation. This self-observation will provide you with situation-specific variation and nuance about different aspects of the Control Profile. Try to be as specific and careful as possible about the area you monitor, as if you are turning up the "attentional" power of a microscope. As you bring this level of heightened observation and precise, careful attention to your experience, we want to invite you (and in turn your clients) to bring to the observing, the qualities of kindness, patience and compassion to whatever is being observed, whether in yourself or others.

In addition, please pay attention to your own particular way of experiencing the world. As you observe the topics discussed below, please pay close attention to the different sense modalities with which you experience the world. Different individuals may have one or more predominant senses. For example, are you more inclined to play back a video in your head (visual) , or hear a soundtrack (auditory)? Do you remember the movements of your body and the feel of tools in your hands (kinesthetic)? Everyone has access to all of these senses, but most of us are stronger in one sense than the other senses.

For example, if a professor said to you, please take out a piece of paper, we're going to have a pop quiz, how would you react? Perhaps the unexpectedness might cause you some stress. If so, how do you experience stress?

Some people feel stress primarily *cognitively:* they would notice lots of thoughts: "Oh my goodness, what's this about?" Or, "This is unfair, we weren't told there were going to be pop quizzes." Others may experience stress *kinesthetically*—in their body: e.g., sweaty palms, butterflies in the stomach, tightening in the neck. Some of us are

more internally *visually* oriented than others. For these people, a stressful image may appear (falling from a mountain, lost in a dark cave, splashing frantically in a body of water).

Think in your own life to what extent each of these styles is triggered in responding to a stressful input. How much are visual responses a part of your experience? Cognitions? Bodily sensation?

One additional variable that we would like you to consider is how much of your focus is on your "self" (internal) and how much on the "other" (external). In other words, in this example, do you "blame" yourself for not being more ready and prepared, or do you think judgmentally and negatively about the professor, and blame him/her for inappropriateness, arbitrariness? Or, do you do some of both?

As you monitor the topics below, please pay attention to ***how you know,*** recognize, and experience that area: e.g., a positive sense of control, a desire for control.

Topic #1. POSITIVE SENSE OF CONTROL GENERAL DOMAIN. For example, you may wish to note each time this week you feel a positive sense of control. Try to bring a refined awareness to your feeling and thoughts. What does a positive sense of control feel like? Where in your body do you notice different sensations? What are the thoughts you are having? Any images? What are you doing? Where, and with whom? Are you exerting high or low effort? You may also want to look at the different items that make up the positive sense of control scale Appendix 2, p. 8 and monitor any one of them that seems interesting to you.

Topic #2 NEGATIVE SENSE OF CONTROL. How do you know when you feel things are "not in control"? This may be an area you would like to explore in further detail this week. Again you may want to look at specific items from the scale, such as "when I feel others have too much control over me" and "when I feel too passive and helpless" (See Appendix 2, p. 9).

What are *antecedents* that seem to trigger these feelings of not being in control? Some may be small, such as a pen running out of ink, a person cutting in front of you on the freeway, your computer not functioning properly, or a busy signal when you make a phone call. Others may be more significant. Notice as carefully as you can, where are you; doing what; and with whom?

Now try to investigate in a very precise way your "target *behavior*"—negative sense of control in response to these antecedents. What are cognitive cues that you are feeling a negative sense of control? What are you saying to yourself? What are your bodily cues? What emotions do you notice? And what is the intensity of those feelings (e.g., one butterfly in your stomach, 10 butterflies)? Are there any images?

Finally, how do you react when you have this feeling of negative sense of control—the *consequences*? You may wish to note how you handle situations and events where you are feeling out of control in ways that are not helpful to yourself or others, as well as ways that you feel are helpful.

Topic #3. DOMAIN SPECIFIC AREAS. You may wish to explore one of the twenty-five areas in Scale 4, Specific Domains, that you marked as being out of control, or an area that you feel is "of concern" no matter where it falls on the control continuum.

Topic #4. MODES OF CONTROL.

Positive Assertive. You may choose to monitor one of the modes of control to learn about your use of different strategies. For example, this week you may note times where and when you act in a *positive assertive mode* to gain control; or when you feel you would like to, but don't, and act in a quadrant four *negative yielding mode*. What are the feelings each create in you? When you don't act, but feel you would have wanted to, you can explore the reasons for that (e.g., fear of being rejected, misunderstood, or drawing attention to yourself).

Negative Assertive. You may choose to monitor quadrant three, *overcontrol* examples this week. When you feel you are being too controlling, how do you know? What cues do you use to determine "overcontrol" – e.g., body cues, cognitions, feedback from others? You may also wish to note when you feel others are acting too controlling.

Can you begin to notice an "edge," a place where positive assertive seems to cross a line into Negative Assertive? An analogy might be when stretching. There is a place where a stretch is pushing ourselves in a good way, and a place where we push ourselves too much. When does your seeking of active control seem positive, and when does it start to feel like micromanaging and overcontrolling?

Positive Yielding. Finally, you may choose to notice when you act in a *positive yielding way*, and accept a situation over which you might be able to exert active control, but don't feel it's in your best interest. What does acceptance feel like to you? Cognitively? Emotionally? In the body? What would be an example (e.g., letting an extra car go in front of you even though it might be "your" turn)? You may also notice times when you don't have active control over a situation, but rather than feel passive and helpless, you frame it in a way which allows you to feel sense of control through positive acceptance (e.g., it's not that important; don't sweat the small stuff, etc).

Negative Yielding. And when does "letting go" seem to cross the line into feelings of laziness, passivity, victimization? It may be helpful to think of a continuum of words in terms of how "yielding" is described (e.g., positive or negative). You may wish to relook at the words used for these scales. You may also wish to notice words you use to describe different situations along a positive and negative yielding continuum. For example, in an interpersonal situation, by "allowing another person's actions" are we being: *accepting, unconditional love, non-judgmental, tolerant, passive indulgence, enabling?* Note the different feelings that each word engenders.

Topic #5 DESIRE FOR CONTROL. You may choose to monitor times when you want to have control, or gain more control this week. How do you know you have a desire for control? Is there a bodily sensation, cognitions, images? Again, note the situation, circumstance, people involved. <You may also wish to monitor specific items from the desire for control scale Appendix 2, pp 17-18. For example, Is it important for me to give the appearance to others that my life is in control? Do I like things around me to be ordered and dislike ambiguity and the unknown? Do I want to control my anger better, etc.>

Do you notice that your "desire for control" increases or decreases when "antecedent" conditions seem to be more out of control? How do you respond (consequences): e.g., do you "micromanage" more when you have an increased desire for

control? Or do you become more passive and helpless when you have a decreased desire for control?

Topic #6. AGENCY OF CONTROL You may choose to notice times this week when you gain a positive sense of control from your own efforts; and/or when from "others." If from "others," what is the source: e.g., family, friends, a higher power? Or you may wish to note when you feel you are relying too much on others, when you feel you should be making the effort yourself. Or, conversely, when you feel you are relying too much on yourself, and not able or willing to ask for help from others (cf., quadrant four, negative yielding, above).

EXTRA CREDIT: GOING DEEPER: DESIRE, MODE, AGENCY.

It may be helpful to spend some time noticing the following four types of situations involving having and not having active control, and your different reactions and feelings:

1. **When you have active control and that feels good** (e.g., when you are in control of the channel changer).

2. **When you have active control, but that doesn't feel good** (e.g., when you feel you have too much responsibility for trying to keep all the parts of your life "in control").

3. **When you don't have active control and that bothers you** (e.g., someone else has the channel changer!). Or think of the weather. The weather is also not in our active control (unless we move!), and for some of us, some of the time, the weather is a concern (and we wish we had more active control over it).

4. **When you are not in active control, but that doesn't bother you.** For example, how do you feel about the earth revolving around the sun? We don't have control of that event, but most of us don't worry about this. Try to notice other examples in your daily life: e.g., you are willing to let someone else decide where to go to dinner because you have no strong preference.

Now, let's add the component of "desire for control" (more or less) to the above.

Try to notice those events and times ***when and where you would like to have more active control,*** and note why. Generally they will be ones that affect you personally, have meaning for you, where you have a desire for control to meet your own goals and preferences, and/or which cause in you a feeling of fear or loss of control.

Finally, you may want to think about ***ways you seek to escape what some have called the "burden" of active control (i.e., have less desire for active control).*** What are healthy ways or images that help you seek to let go of active control (e.g., listening to music: floating on water letting it hold you up: prayer)? What are unhealthy ways you seek to let go of active control (e.g., loss of impulse control, immoderate eating, drinking, etc.).

One more extra credit: Red lights. A daily occurrence for most of us is stopping at a red light. In general, how would you classify your response to red lights: Do you feel in control? Out of control? Positive yielding? Negative yielding? Positive assertive? Negative assertive?

For the next several times this happens, try to investigate with some curiosity your relationship and reaction to red lights. How does it feel to be told to "stop?" How do you deal with the time you have? Do you turn on the radio, roll down your window, look in the mirror, observe the people right and left, drum your fingers on the steering wheel? What are you saying to yourself? What are your bodily cues? What emotions do you notice?

Notice whether your reaction depends on such factors as the length of the light, where you are going, whether you feel you are late, how your day has been to that point.

It is interesting to discover how much we can learn about ourselves, our desire for control, our modes of control, our thoughts and feelings, the "control story" we tell just from ordinary events that occur during the day.

1.3. LISTENING TO "CONTROL" SPEECH

A third way to assess a control profile is through listening to speech. Let me invite you this week to put on control glasses (and hearing aids!) and listen to both your own and others' speech, noting when an issue of control is involved. You can do this informally.

There are also more formal ways to do this. A Control Content Analysis for coding speech related to the control profile has been developed: see CT, pp. 298-308. But this methodology is too formal for our educational purposes here. A good middle way is to look for certain key phrases relating to aspects of the control profile.

MODES OF CONTROL. You may also want to listen to speech related to the four modes of control. Examples are given in Figure 1.5 below.

FIGURE 1.5:
EXAMPLES OF CONTROL SPEECH FOR THE FOUR MODES OF CONTROL

QUADRANT 1—POSITIVE ASSERTIVE: ACTIVE, ALTERING, MODE

1. *Active Assertive Positive.*
   This refers to words that show instrumental activity in a positive way toward the accomplishment of something—goal oriented, self-starter, independent. They involve a concept of doing, of activity, of motion.
   EXAMPLES: I am going to go on a diet to try to lose weight.
   I'm working hard to influence my senator to vote to ban CFC.

QUADRANT 2—POSITIVE YIELDING: LETTING GO, ACCEPTING MODE

2. *Yielding, Letting Go Positive.*
   This refers to the positive aspects of acceptance, yielding, softness, gentleness, and nurturing. There is more a sense of stillness here, of quiet, of softness, of being.
   EXAMPLES: I am able to accept that I am never going to lose weight.
   I have learned to accept that I can never change her.

QUADRANT 3—NEGATIVE ASSERTIVE: OVERCONTROL

3. *Active (Overassertive) Negative (Overactive/Overcontrol).*
   This refers to too much activity, too high control, a sense of aggressiveness, a certain ruthlessness, a Machiavellian quality, a high agitation, an insensitivity, and a selfishness.
   EXAMPLES: I am unable to delegate responsibility and end up trying to control everything.
   She is an overprotective parent.

QUADRANT 4—NEGATIVE YIELDING

4. *Overyielding, Negative (Too Little Control).*
   This refers to too low activity, a mushiness, an overpassivity, a diffuseness, undifferentiatedness, helplessness, and hopelessness.
   EXAMPLES: I accepted his offer, but then felt like a victim.
   I let everybody boss me around.

SPECIES OF CONTROL: AGENT AND OBJECT OF CONTROL. For example, notice when one of the following terms come up: having or gaining control; efforts to gain control; desire for control; fear of losing control, losing control, lack of control, out of control (these are referred to as *Species of Control*).

Then you can look for the agent and object of control. That is, who is talking, about what or whom? For example, "the world is sure a mess, completely out of control." Or, "he always needs to be in control." Or, "I'm having trouble controlling my eating." Note, in the last sentence, "I" is the agent of control while "eating" is the object of control.

Figure 1.6 below provides the seven groupings possible with species, agent and object:

FIGURE 1.6: SEVEN GROUPINGS OF AGENT AND OBJECT OF CONTROL

	SELF AS AGENT			OTHER AS AGENT			
Self as Object	**Group 1: Self Control**			Other Controlling Self			**(Positive: Group 4) (Negative: Group 5)**
	Self as Agent	*Species*	*Self as Object*	*Other as Agent*	*Species*	*Self as Object*	
Examples:	I	cannot control	my eating.	Examples: God	gives strength	to me.	(Group 4)
	My thoughts	control	my feelings.	AA	helps	me stop drinking.	(Group 4)
				My spouse	dominates	my behavior.	(Group 5)
				The noise	makes	my mind crazy.	(Group 5)
Other as Object	**Group 2: Self Controlling Other**			**Group 6: Other Controlling Other**			
	Self as Agent	*Species*	*Other as Object*	*Other as Agent*	*Species*	*Other as Object*	
Examples:	I	cannot control	my spouse.	Examples: She	dominates	her spouse.	
	My	thoughts	control God.	The economy	controls	all human life.	
No Object	**Group 3: Self as Agent, No Object**			**Group Seven: Other as Agent, No Object**			
	Self as Agent	*Species*	*No Object*	*Self as Agent*	*Species*	*No Object*	
Examples:	My body	is out of control.		Examples: God	controls.		
	My thoughts	are running wild.		She	lacks control.		

Don't worry too much about these two tables now, unless you find them helpful reference points. The important thing is just to put on control eyes and ears, and notice what you see and hear.

1.4. CONTROL STORIES.

WHAT IS A CONTROL STORY? Control stories are the fourth way in which a person's Control Profile can be assessed. These stories are formed by the units of control speech, and coalesce and evolve into a narrative—consciously or unconsciously— by which individuals create stories to

- frame, explain, and understand events in our world—why things happen
- seek to explain chaos and disorder—internally and externally
- reflect attitudes and views about the amount of influence we believe we (and others) can and should have over events in our lives.
- explain our level of motivation and commitment, as well as our ability to develop self-regulation of our thoughts, emotions, and behavior.

Control stories further tell us whether, when, and how we are feeling in control, out of control, and the means by which we believe we can best gain and maintain a sense of control.

These stories are a chance to create explanations that make us feel more in control, and make events more understandable. Sometimes we do this by looking back and connecting the dots of our past into a meaningful whole. Sometimes we

do this by looking forward and creating and planning the dots of our future and how we would like to imagine things will be.

"Naïve" unexamined control stories are based on our early childhood experiences and parenting, personality, salient control-related life events in "love and work", and cultural and religious attitudes. In effect, our control story "not only creates beliefs about reality, but defines that reality." (CT, Chapter 9, p. 155).

Control stories can become fundamental, core belief systems and self-narratives we use to shape and define our lives--past, present, and into the future. Everyone has them. In addition to being conscious or unconscious, they also may be in varying degrees accurate or erroneous (or a mixture of both).

Control stories can help explain the world, creating meaning throughout the developmental life cycle, addressing the individual's need for a sense of cosmic perspective, and framing existential human concerns of identity (who am I?); direction (where am I going?), and meaning and purpose (why am I going there?). Control stories can also play a key role in determining a person's motivation, including his/her motivation for change. In fact, major thematic stories, once they take hold in a person's mind, then become like "perceptual filters" through which the person receives input from the environment, interprets it, rejects some of it, and accepts other parts of it.

PRACTICE: RAISING AWARENESS OF CONTROL STORIES

This is an exercise that can be done in class, breaking into dyads; or it can be done as part of a Control Diary. Recall that at the start of this module you were asked to reflect on *ways you personally use to gain a positive sense of control in your life.*

Now we'd like to have you explore the "control stories" that may be behind your preferred control style. At this point, all we want you to do is become aware of, make conscious, and learn about your control story as a way to gain a deeper understanding of yourself. In Module Two, we'll spend some time on how to "evaluate" our control stories to ensure that they serve our well-being; and in Module Three, we'll work on how to edit and rewrite our control stories if we think that is helpful.

Modes. Let's look first at modes. In terms of modes, one control story is whether a positive assertive mode is better or worse than a positive yielding mode. Which one do you feel and think is better? Why?

If you had to choose between being considered by others as a passive wimp (quadrant four) or an overcontrolling tyrant (quadrant three), which would seem better and which worse to you? Why? In answering this question, try to remember what you have learned in your past (e.g., from your parents—either directly or through modeling) involving these modes. What does your culture say about which mode is preferable? Your religious, spiritual beliefs?

Agency. We also have control stories about agency. For example, in general, how much do you feel you can rely on others for help and guidance; how much on yourself? Do you have some sense of the source from which these aspects of your control story were developed? Parents? Culture? Religion?

Desire. In this module, we have explored your desire for control. Where do you think that desire (high or low) comes from? Are there certain areas where you desire control more than others? If so, why might that be? What is the story that you tell about your desire for control?

In exploring these questions, you may want to reflect on your memories of early experiences, such as whether you feel your parents were overly strict, critical, unpredictable, absent, failed to protect you, laissez faire, and so forth. What connections, if any, do you see between their parenting style and your feelings of what it means to be in control, your desire for control, and the best ways (mode and agency) to achieve that sense of control? In what ways do you think your cultural background influences where you feel it is important to focus your control efforts , and how to achieve them? What influence might your religious and spiritual beliefs have on these questions?[*]

To explore these issues further, you might consider whether there was a defining moment that synthesized for you what the world is all about, and what your place is in it. This event may have something to do with fear of loss of control, actually losing control, or gaining a positive sense of control. Note the event, the feelings that it produced in you, any "generalizations" you may have made about "life" itself, and then how you felt it might be best for you to gain or maintain a sense of control as a result. Control stories can either create, explain, or exacerbate a feeling.

What happened was _____,

I remember feeling _____,

I concluded that life is/can be_____,

Therefore, to gain a sense of control , I _____.

For example, a major event for someone might have been the parents' divorce. A child might have several different feelings from that event: abandonment, loss of control, feelings of personal responsibility. These feelings may lead to a story: e.g., "The world is/can be a scary, overwhelming, fragile, chaotic, out of control place. I can trust only myself, because things can fall apart at any moment." Such a story can create a high desire for control and self-agency. It may also lead to an exclusive reliance on the assertive mode—seeking to always be alert and doing everything possible to manage and keep things in control. Thus,

[*] We discuss this topic in more depth in Module Two.

how an event is interpreted and the resultant control story that evolves may then influence future attitudes and behavior.

Let's look at another example: A child whose parents reinforce her only for performance may develop the belief that "I am not lovable as I am; I can be loved only for accomplishment." The person may remember feeling "I am not lovable as I am, and therefore cannot accept myself or be accepted and valued unless I am accomplishing. Life rewards those who succeed." With this story, time spent "being" instead of "doing" may feel uncomfortable. Therefore as an adult this person may develop a reliance on the assertive mode—-doing-—in order to gain a sense of control through competence and productivity, which are firmly associated in her mind with love and acceptance.

See if you can come up with a sentence or two that encapsulates your most central control story (core belief), and how that relates to your sense of control and views of modes, agency, and desire.

As noted, the topic of control stories is discussed in more detail in later modules. For now, it is sufficient that you become aware of and begin to explore your own stories.

CREATING A CONTROL DIARY

If you haven't already done so, please begin a "Control Diary," a personal journal. This journal is not to be handed in, but is solely for **your own** use, providing an opportunity for you to write down insights, reflections, thoughts, reactions, and explorations about you and control.

HOMEWORK SUMMARY

As part of your homework between training modules, please:

1.A. Go through and familiarize yourself with your own SCI Control Profile, including the Comprehensive Clinical Report. Note any questions or points you would like to discuss in the next class.

1.B. Select at least one area to self-monitor and begin to do so between now and the next session, again noting any thoughts or questions.

1.C. Listen to and write down examples of "control speech" that you hear yourself and others use (discussed in detail in Section 1.2 above).

1.D. Start exploring your own control stories in your journal. In addition to the questions raised so far in this module, here are two more bonus extra credit questions.

The first one is:

WHO (OR WHAT) CONTROLS YOUR LIFE?
Free associate to the question, and write down whatever comes to mind. Then, if you wish, you may refer back to the table on agent and objects of control, and refine your answer a bit more.

The second control story bonus question is:

IF ONLY I COULD GAIN MORE CONTROL…..
(fill in your greatest desire on one of the domains of your life: e.g., body, relationship, financial, etc),
THEN I WOULD BE…….
(fill in the emotional feeling).
This question can be helpful in exploring the aspect of your control story that connects a desire for control in some area, and the belief, whether conscious or unconscious, between gaining a sense of control in that area, and your emotional well-being and happiness

Finally, we are going to start the next training module (and all subsequent ones) with a *Show and Tell*. Therefore, please be alert to cartoons (such as the one starting this manual) or other pictures, things you see in a newspaper or magazine, that illustrate one or more points of what we have been discussing. Please bring in at least one thing for sharing at the start of our next module, with a brief explanation of how it illustrates some aspect of a Control Profile, or other topic we have discussed.

Note: for those using the manual in a self-learning format, we recommend you take a few days to explore the above issues before going onto Module Two.

ENJOY YOUR LEARNINGS!!