

Part Two

CONTROL THERAPY How to Teach It

Control and the Therapeutic Encounter

TRAINING MODULE FOUR



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Overview: This module adds the “client” to the self-learning of the first three modules, and contains four sections: 1) an introductory review and discussion; 2) an overview of the phases of Control Therapy; 3) a systems model of six components involved in the process of Control Therapy, including therapist, client, relationship, assessment, intervention selection; intervention “teaching”; evaluation; and 4) a session-by-session breakdown of a “typical” course of Control Therapy.

4. CONTROL AND THE THERAPEUTIC ENCOUNTER

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A clinical illustration

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"Bullying" and forcing are not positive options.

Control issues exist.

Clients may not be aware of these control issues.

The goal of Control Therapy.

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CONTROL AND THE THERAPEUTIC ENCOUNTER

In Part One, the three main aspects of Control Therapy were taught both didactically and experientially, through a self-management project, in which the trainee was both the therapist and the client:

1. Assessment: Developing a Control Profile (Module 1) - *Where are we?*
2. Self-observation, evaluation, goal setting (Module 2) - *Where do we want to go?*
3. Interventions (Training Module 3) - *How do we get there?*

In Part Two, Training Module Four, we are ready to add a client to the equation. In so doing, we are now shifting from self-learning (modules one through three) to teaching and working therapeutically with another person.

In this module we provide an overview of the phases of Control Therapy, then present a systems model of the components of CT; and finally, give a session-by-session breakdown of CT.

4.1 INTRODUCTORY SHARING TO BEGIN MODULE 4

CONTROL SPEECH: WHEN IS DOWN UP AND UP DOWN? Are there any examples of control speech that you noticed that you'd like to share?

Here's a seemingly paradoxical one, we'll call it when is up down and down up?

Story A. A bonsai expert takes wires and twists them over the limbs of a plant to stunt and shape its growth. He prunes and pares away certain branches. When asked if he sees that as controlling the plant, he says "No, not at all. I'm just *allowing* it to grow to its *natural* potential."

Story B. A person is asked whether they feel their drinking is "out of control" and they respond, "No, not at all. Not only can I stop whenever I want, but I never have a drink before 9:30 a.m. I'm in complete control of it."

Discussion: Would you agree with each of accuracy of these individuals' assessments of their behavior?

If you do not think it is accurate, why do you think, as in Story A, sometimes people exercise control, but don't want to call it that, or admit they are being "controlling"?* Do you think they are being "defensive", even self-deceptive? If so, what would motivate someone to act in a controlling manner, but not want to admit it? (Sometimes not even to themselves?)

If you look at Story B, do you think sometimes people believe they are exercising control, and say (and even believe) they are, when in fact they're not? For example, in Story B, the person is utilizing a cognitive rationalization to defend against realizing that his behavior is "out of control." Why would people be defensive, even self-deceptive, about believing they are exercising control when they are not?

* Politicians excel at masking their control desires: e.g., "I'm *only* running for office to serve the people. It's because of them that I do this."

When is an inaccurate control story health denial? When (if ever) is self-deception healthy (e.g., healthy illusions)? These are important issues to think about, and will be discussed further in this Module under assessment: when clients and therapists disagree.

QUIZ: MODES AND AGENCY

#We asked you to explore your views of the nature of the universe and your place in it in Module Two. Below are two “sayings” that have appeared on T-shirts that offer views of this issue! In terms of modes and agency, how would you categorize them?

A) Be patient. God isn’t finished with me yet.

B) Who we are is God’s gift to us. Who we become is our gift to God *

#Which modes might the following lines represent? Discuss.

Whatever happens happens?

Let it happen

Make it happen.**

#Using mode language, discuss how the following might be understood:

You can lead a horse to water, but you can’t make him drink.***

#What control related issues do you see involved in the following statement:

I’m tired of having people tell me what to do but I’m desperate for advice.****

SELF-MANAGEMENT PROJECT. Since the last session, how did your interventions go? What did you notice when you examined your expectations before you began an intervention? After? Have you noticed any change with practice? Any questions? Any issues of adherence? Are you able to follow your self-management contract? Would it be helpful to review and discuss the material in Module Three: Dealing with initial setbacks? You may also find it helpful, as you go through this Module, to further review any systems’ “feedback” components that may be worth evaluating: e.g., a) assessment of concern; b) selection of intervention, etc.

ADDITIONAL SHARING FROM MODULE 3.3 HOMEWORK: This is an opportunity to share learnings from the homework. Possible topics may include:

Building blocks: What did you learn about your building block preferences? Your ability to integrate different building blocks

Domains. What did you learn about your domain priorities; your ability to “juggle/weave” different domains? Your views of optimal mode control in each domain?

* A) This statement has the flavor of “I’m still changing”—i.e., a work in progress (positive assertive); and the agency is largely “Other control”: i.e., God as agent! B) This statement, as discussed in Module Two, begins with other agency (God) but has more the flavor of self-agency: once here on earth, it is up to us to grow and transform ourselves to fulfill our potential.

** Make it happen is obviously assertive (positive or negative depending upon situation?); let it happen is obviously yielding, accepting (positive or negative depending upon situation?) and whatever happens, happens...also yielding, again positive or negative depending upon the situation and the person’s attitude!

*** The first part is positive assertive, the second suggests positive yielding is needed.

**** Issues of self as agent, “other” as agent; freedom reflex; personal responsibility, decision making, and the modes!

Downward comparison. Are there any specific examples and learnings you had regarding your use and experience with “upward” and “downward comparison? Any “sympathetic joy?” 😊

We now turn to the heart of Training Module Four: an overview of the phases of Control Therapy; a systems model of the components of CT; and a session-by-session breakdown of CT.

4. 2. PHASES OF CONTROL THERAPY

There are two phases of Control Therapy: Assessment/Goal Setting; and Intervention. Each of these has an early, middle, and end phase.

PHASE ONE: ASSESSMENT AND GOAL SETTING involves where the client is and where the client wants to go. The early phase includes rapport building, exploring the client’s areas of concerns, and understanding the client’s control profile. The middle phase involves exploring control stories. The end phase is goal setting.

PHASE TWO: INTERVENTIONS. The early phase in selecting interventions is matching the client’s control profile and goals. The middle phase involves teaching the interventions in a way that maximizes adherence and compliance, making any mid course corrections as needed. The final phase involves ensuring that treatment goals have been met.

These phases should not be thought of as rigid and discretely bound. For example, it’s quite possible for there to be a deepening of clients’ understanding of their control story (a phase one task) during the middle of the intervention phase. However, as noted, there is a general flow and progression to the process of therapy, and the phases provide for and allow a useful teaching heuristic.

Figure 4.1 below outlines the different session groupings in Control Therapy and shows where Control Therapy is “in line” with various schools of psychotherapy that are familiar to most therapists.

FIGURE 4.1. CONTROL THERAPY: SESSION BREAKDOWN BY PHASES
Aspects in common with Other Therapeutic Approaches

CONTROL THERAPY	OTHER THERAPETUIC APPROACHES
THERAPEUTIC PROCESSES	
PHASE ONE	
<p><u>ASSESS CONTROL PROFILE</u> Engagement in relationship Problem exploration & selection Take SCI in or before session 1 Discuss answer sheet, Scale 4, Page 3 Share SCI test results / control profile Psycho-education on control concepts Control Stories, Control Dynamics</p>	<p>Client-centered (contextual/relational) Experiential (use of imagery) Psychodynamic (listen for developmental control stories) Gestalt (experiential, e.g., mode dialogue) Adlerian (social connectedness) Cognitive (irrational thoughts)</p>

<p><u>SELECT GOALS</u> Self-evaluation: options relative to what was found via SCI and self-observation Self-observation in session and as homework (Session 1 onward)</p>	Constructivist; narrative therapies (rewrite stories)
<p>PHASE TWO</p>	
<p><u>INTERVENTIONS</u></p> <p>Preparation for change (address belief in ability, right, responsibility, etc.) Homework to prepare for change (Session 2 onward) Client makes commitment to change Match techniques with Goals & Control Profile: Assertive Mode, Yielding Mode, Integration Teach relevant self-control skills Address any remaining obstacles to change Continue self-monitoring homework Homework using self-control techniques aimed at effecting the desired change.</p>	<p>Motivational Interviewing (The 5 Steps for Positive Assertive/Yielding Change) Behavioral assessment Skills assessment & training Dialectical Behavior Therapy A.C.T. Acceptance and Commitment Therapy Mindfulness-based Cognitive Therapy</p>
<p>Practice new skills Reinforce small successes Change process continues (Modulate goals) (Continue planning) (Continue/modify action) Evaluate (post-test) Terminate Follow-ups as needed</p>	Behavioral/cognitive/affective

Sometimes the process of therapy is simple. Sometimes it is not.

SIMPLE MODEL. (Up to Eight Sessions)

Based on what you have learned, you can see that the simplest, bare-bones model of Control Therapy involves:

1. ***Developing a personal Control Profile*** (through the SCI): overall and domain specific sense of control; modes of control; motivation for control, and agency of control. (Session One)
2. ***Self-observation, self-evaluation, and goal setting***: Exploring the items in Scale 4 (Domain-Specific Scale) to see which areas feel out of control;

which areas are of concern, and how the person wants to address those areas: through assertive/change, or yielding/acceptance. Self-observation occurs between session one and two; self-evaluation and goal setting in session two.

3. ***Clinical Interventions: Matching techniques to the goal and control profile.*** This begins in session two and is practiced for four to six weeks. (Note, research suggests that self-control practices can be effective within four to eight weeks, depending on client issue, practice, adherence and compliance.)

If therapy is successful, based on this simple model, there is no need to use all the additional techniques and strategies discussed in the first three modules (e.g., listening to control-related speech, exploring control stories, examining control dynamics, assessing self-efficacy beliefs). If everything goes smoothly, the goal is reached. Therapy ends and both client and therapist have a positive sense of control in their life. 😊

If therapy is not initially successful based on this simple model, then further exploration is necessary.

COMPLEX MODEL (Up to Twelve Sessions)

For some clients, the simple model will provide all the structure and guidance they need to reach their goals. For others, the therapist will need to spend some time with the client figuring out where important problems and challenges are. Remember our section on “start where you are”.

When things don’t go smoothly (and more often than not, they may not seem to!), the therapist needs to figure out where the problems/challenges are. In order to help do this, we provide in the next section a way of thinking systemically about the therapy process by utilizing a systems model consisting of six components: 1) therapist, 2) client, 3) relationship, 4) assessment, 5) techniques, 6) teaching of the techniques. In Section 3, we go through a session-by-session breakdown of a more complex model, and provide a table overviewing all the techniques that have been presented in the manual.

Goals and training/ behavioral objectives of control therapy: A Reminder. Before moving on to the systems model, it would be helpful at this point to re-look at the goals and training objectives detailed in the Introduction to the manual, pp. 5-7. Please take a few minutes to do so before proceeding.

4.3 SYSTEMS MODEL OF CONTROL THERAPY: PUTTING IT ALL TOGETHER.

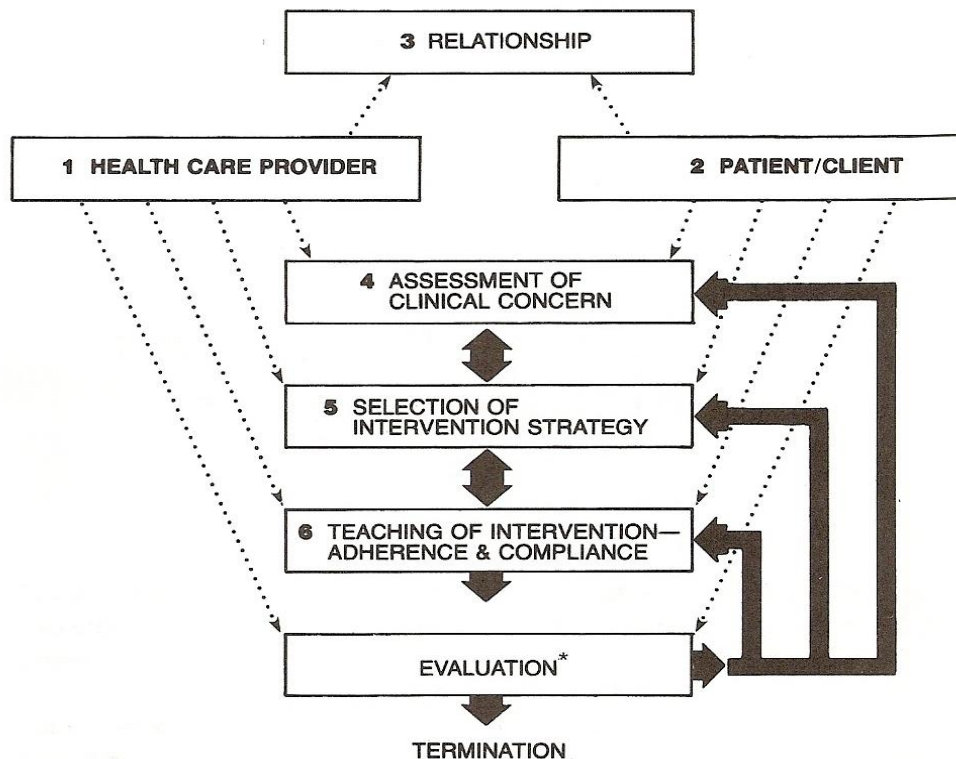
In the first three modules of the manual, we explored the control stories of the trainee. We also explored the theoretical orientation of the trainee, as it related to control, and specifically in terms of views of human nature, and vision of psychological health. In Figure 4.2 below, we illustrate a systems of the different components involved in Control Therapy (and, we believe, in any therapeutic approach). It can be helpful as part of training to have a group discussion of each person’s current theoretical/personal views of

each of the components, which can help further refine and extend the discussions from the previous modules. Specifically, what are

- 1 The qualities and role of an effective therapist (e.g., self-knowledge, listening skills)
- 2 The nature of personality (who the client is); the vision of psychological health (who the client can be); the reasons for the discrepancy between the two (e.g. disease etiology, poorly learned skills; childhood dynamics; desire to conform to societal expectations),
- 3 The role of relationship in therapeutic success, and the most effective type of relationship (e.g., detached, coach, authentic self-disclosing)
4. The most effective ways to assess the client’s personality, concerns and goals
- 5 The “best” interventions to help the client move from where they are to where they want to be
6. The best way to teach the intervention(s).

As can be seen from Figure 4.2, components 3-4-5 and 6 are connected by dotted lines signifying that both the client and therapist have views on these components, and these views need to be discussed and articulated to ensure there are no conflicts or misperceptions.

FIGURE 4.2. A SYSTEMS MODEL OF CONTROL THERAPY



In addition, the dark black lines represent feedback loops from EVALUATION. These loops are meant to show it is important that therapy involves a continual evaluation of each step of the process; and offer a way of determining if and when there are complications. Evaluation and Follow-Up are also important final components of the therapeutic process. Therefore, it is helpful to discuss how and on what dimensions evaluation is best conducted (e.g., in Control Therapy, the SCI can be used as a pre and post assessment instrument).

1. THE THERAPIST.

Differing orientation's views of the therapist's role. Each orientation, based on their view of the client, and their goal of psychological health (see Module 2, Figure 2.2 Comparison and Contrast of Five Schools of Therapy) has a view of the therapist, and a view of the most effective skillful relationship--discussed further below under relationship). For example, if you believe in a "humanistic" transpersonal orientation, you may feel that the person already has the answers within her, and your "job" is merely to remind her of that fact. "You know what to do. Trust yourself and look within. The wisdom is already within you. I'm just here to encourage and remind you."

If you believe in an existential, behavioral world view of human nature, then you may see yourself as a "coach." Existentially, it may not be your "job" to provide answers, as much as help them develop strategies so they can come up with their own answers, and take responsibility for their own choices. answers and choices in life (existential). Behaviorally, if you see patterns that don't serve the client well, or skills that they are lacking, then you may believe that part of your "job" is to bring these issue to your clients' attention, and help provide them the insights or skills that are needed. If you believe in a psychodynamic worldview, you may believe that there are amoral internal forces as well as other inner dynamics of which the client is unaware. Your task is to help them overcome their resistances to seeing what is going on within, and become more aware of their intrapsychic processes. How you see your role as therapist will depend upon your theoretical orientation, including your view of the client (personality theory), and the nature of the clinical concern. It is important to explore your view of the therapist's role as clearly and completely as you are able. (see Homework 4.2)

Beliefs about self-regulation strategies and their efficacy (Demand characteristics). In general, what is your theoretical orientation in terms of it's view of human nature and an individual's "natural" ability, personal responsibility and choice to self-regulate thoughts? Feelings? Behavior? To what extent do you as a therapist, believe there are techniques which can help an individual to learn skills to more effectively take responsibility for, make choices about, and regulate their thoughts, feelings, behavior? How much does that view vary across client? Across clinical concern?

If you, the therapist, are personally skilled at using self-control strategies, how do you feel about a client who isn't that effective? How do you deal with your own frustration and feelings of lack of competence at having someone not learn these skills as quickly as you believe they should? If you aren't able to use self-control that effectively in certain areas of their own life, how do you feel about your efficacy in teaching, and the client's efficacy in learning such strategies? What is your view of the use of medication in relation to self-control? Do you feel it can help a person gain increased control?

When might it be appropriate? When not? If there were research showing that either medication or personal control enhancing strategies (if practiced) would work equally well (e.g., in OCD, to address diabetes, heart disease), which would you recommend—for yourself? For your client?

General competencies. In the first three modules, during the self-management project, you served both as therapist and client. What were the qualities you found in yourself that were helpful to the therapeutic progress? When did you feel you were not being a good therapist to yourself? We assume some of the good qualities included self-awareness of thoughts and feelings, being able to listen to oneself, having compassion, awareness of bodily cues and feedback.

At this point, it can be helpful to have a general discussion of some basic skills, essential qualities, and competencies of a good therapist regardless of theoretical orientation, (listening to others, empathy and ability to form a therapeutic relationship, awareness of general transference and counter transference issues, knowledge of theories of personality and systems of psychotherapy, sensitivity to issues of culture, gender, and ethnicity).

Research tip: In doing research comparing Control Therapy to other approaches, basic therapist competencies are assumed. If they have not done so already, trainers who are using the manual as part of a research project should refer to the Research Appendix (6) for information on selection of therapists.

General control-based competencies

Personal awareness: Therapist self-knowledge and control stories.

One reason we like to begin our teaching with therapist self-exploration, is so that therapists know explicitly their own control stories (e.g., see the discussions in Module 2 about your orientation, views of optimal control; see also your control journal, and Appendix 7). For example, how comfortable are you as the therapist with the concept of control? What domains do you as the therapist personally struggle with related to issues of control? How high is your desire for control? Do you as the therapist prefer self or other agency as a way of gaining control? In areas where you have less control than you would like, how would you try to address those domains; do you have a bias toward or against either the accepting mode or the assertive change mode? How well are you yourself able to practice self-control strategies? Is it better, in general, to rely on self or others as agent?

These are topics that you have explored and addressed in your self-management project in the first three modules. In Module Three we also discussed the importance of “practicing what we preach (teach).” Here we would say that a therapist competency would also include knowing one’s own limitations. This may mean referring out a client for specific training that you feel might best be given by someone else (e.g., mindfulness meditation practice); as well as knowing if there are certain types of clients or clinical areas where you feel you may not be the best person to help the client.

Interactive Awareness: Communication skills, counter transference, modes. Are you as the therapist aware of potential control transference and counter transference issues (e.g. see cartoon at start of this section)? Do you have positive assertive skills to conceptualize the case, and executive skills for directing and structuring sessions? Do you as therapist know when to engage in positive yielding, and follow the client’s lead?

Now let's move from third person talking about "a therapist" to the second person "you." The following are questions to explore in your "Control Diary" in a section about "Control and the Therapeutic Encounter."

How high is your desire for control within the therapeutic encounter?

How "centered" (i.e., non-reactive, non-defensive) are you when you have a client who has a high desire for control? When a client becomes confrontive (negative assertive)? When a client is passive and helpless (negative yielding)?

Having a gradated range of skillful responses. Each orientation, as noted above, has a specific view of the role of the therapist. What is yours as it relates to how much and what type of control it is skillful for you as a therapist to utilize in therapy? How much active, "executive" control should a therapist exert during the course of therapy? How much is the role of the therapist to be a good empathic listener, whose job is to facilitate, but stay out of the way of the client's organic growth and unfolding? Your orientation and beliefs will influence the style and intensity of the feedback you believe is helpful for your client. With that understanding as context, we suggest that it can be useful for you as therapist to have a series of gradated therapeutic responses (dongjing) which balance yang and yin, so that you can utilize the appropriate response, from confrontive and challenging (maximum yang) to soft, compassionate, yielding (maximum yin), including nuanced options in between, depending on your orientation and beliefs. (Note that all these examples presume and are most effective within a therapist/client relationship of empathy, understanding, and trust).

If you feel and believe that there are some areas it might help the client to explore further (see, for example, client/therapist disagreement in topic 4 below), how might you raise the topic?

Soft therapeutic responses that also have an element of assertiveness.

(Again, we presume these responses are all employed within an empathic, understanding context, such as "That sounds rough. It doesn't seem as though s/he is responding very kindly to you. I can see how much that upsets you").

"Can you think of some different ways you could give this person feedback, while still being respectful...?"

"Would you be willing to consider...?"

"Let me invite you to look at..."

"A possibility that I believe may be worth exploring..."

"We all tell ourselves stories. I hear the story you are telling yourself, and if I told that story, I'd feel just the way you do, too." (This is both empathizing, at one level, but also subtly shifting the ground, suggesting that stories may have at least an element of choice—"if I told that story..."). Might there be other ways to look at this...?

More assertive responses might include:

"Do you feel you are doing anything that contributes to your concerns?"

"What might you do differently that could help address this issue?"

"I wonder what you were thinking (or trying not to think about) in the hours before your panic attack?"

"You blame her and want her to change, and essentially you feel helpless in the situation. Is there anything you personally might do to feel less like you're being victimized—what might be under your personal control?"

"I'd like to encourage you to consider what the other person might have been

feeling?” (to try to help the client step outside his/her story, and see it from another person’s point of view).

Still more assertive responses (if the client gives no response or says they notice “nothing” going on, or nothing for which they may be responsible):

“I hear how awful you feel he is. I’m wondering what you might learn about yourself in terms of how you respond to his words and behavior?”

“Do you realize that those are really not skillful behaviors (thoughts, stories). Can you see how they are bringing you and others a lot of unnecessary suffering?”

“This might be hard to hear, but what I see is...<e.g.,> micromanaging your teenage daughter’s life may actually be contributing to her rebelliousness. How would it feel for you to consider prioritizing the most important areas, and exploring whether you could let go of some active control in areas that are less essential?”

“I’d like us to focus a bit more on what may be your contribution to the problem?” (focus on self-agency, personal responsibility)

“It seems you want someone to rescue you ... let’s look at that wish and how well it serves you. What is your responsibility for your own self-care?”

“Do you feel you’re over reacting?”

“Here’s a different perspective; although this is only my opinion, to be as honest as I can, I disagree with how you are seeing it. I think you’re making a mountain out of molehill. Let me try to share why, and see if this view might make any sense to you.”

“I’d like to urge you to go a bit deeper here. What else do you think might be going on to cause such a strong reaction in you?”

Notice how there can be a gradation of responses from “let me invite (ask) you; to “let me encourage you” to “let me urge” you to consider. This can all be done within a context of offering advice, suggestions, and without dictating. It can also be done, as we discussed in the Tai Chi dance, in a way that negotiates and dialogue about different points of view while staying connected, and having anchor points through which trust can be built (e.g., I hear your perspective;, here’s my perspective; I see it somewhat differently----versus “you’re wrong!)

Awareness of your own style and comfort level. Can you, the therapist be both yielding/accepting (not from fear of confrontation or passivity) as well as challenging without becoming angry and impatient? How comfortable are you as a therapist acting in a “controlling” forceful way in order to teach a client? Can you do this without feeling you are too pushy or overcontrolling?

Are you comfortable appearing to be doing nothing while the client “demands” help? Or do you start to feel too passive and helpless in the session?

These are all “general” control related competencies that are an important part of therapist self-awareness and self-exploration. Each of us needs to learn the range in which we are comfortable, and then, as we are able, stretch our limits a few degrees, so we have more options to use in helping those with whom we work.

Our goal through the use of this range of competencies is to be able to have the skills to allow clients to feel safe and trusting through our ability to listen, be empathic, and compassionately reflect their point of view; and to have the skills, within that context, to challenge our clients, when appropriate, to help them decrease their suffering and grow in understanding and wisdom.

2. THE CLIENT

Upon first meeting, the client is an unknown. What we do know from psychological research, however, is that therapists tend to form quick first impressions, based on little information, and these impressions can become long-lasting, affecting how the client is seen throughout the entire therapy process. (Often even information which seems to contradict this first impression is reinterpreted to fit the initial belief).

Further, as noted, the therapist brings a certain “control story” to the encounter, based on research and/or general beliefs, about how much control an individual can or should have over his or her life. For example, how do you feel about others who seem to have more self-control than you? What about those who have less than you? What is your bias regarding research showing that a person can achieve the same results clinically through medication or a clinical self-regulation strategy? Which would you prefer? Do you have a bias regarding which your clients “should” prefer? We need to be honest about the biases we have, and recognize them as such. This is true, not only about control issues, but in general. Then, we can be more able to use sensitivity and care, in allowing the client’s “person” to emerge throughout the course of therapy. This is true for all clients, including those of various ethnic/racial backgrounds, as well as persons with other differences, such as gender, sexual orientation and identity, social class, religious affiliation, physical dis/ability, and so forth.

Culture differences and the modes. As one example, what is considered desirable in one culture may be viewed quite differently in another. In America, the expression “The squeaky wheel gets the grease” suggests that acting assertively is positive. In Japan, one finds the phrase: “The nail that sticks up gets hammered,” implying that acting assertively is viewed more negatively. In a general sense, U.S. culture tends to stress the importance and value of individual achievement, while Japanese culture tends to emphasize acting for the good of the collective.

Gender differences and modes. Interestingly, traditional gender roles are similar in both countries. While times have changed somewhat (especially in the U.S.), traditional sex role stereotypes have tended to see yielding/acceptance on the part of a man, not as positive yielding, but as negative yielding (i.e., weakness or passivity). Similarly, traditional sex role stereotypes have tended to characterize what would be seen as positive assertive control in a man, as negative assertive if the same control efforts were engaged in by a woman. Though these views are changing, these are still dynamics about which therapists should be aware.

African Americans: An example. There is a great deal of stigma for African Americans to even attend therapy in the first place, so therapists should be aware that clients often come in hesitantly and worried they’ll be labeled “crazy.” African-Americans may arrive in therapy showing what is termed “healthy cultural paranoia,” that is, an adaptive suspiciousness of Whites and White institutions.* This shows up as challenging comments and behaviors, wherein the client may prompt the therapist to

* For more on multi-cultural counseling in general, and Control Therapy with African-Americans in particular, see Soucar, references 3,15. Ethnic minority groups may be especially sensitive to notions of control and the idea of Control Therapy since they have historically been excluded from the political and social groups “in control” in this country. They ask, “Who’s controlling whom and for what purpose?” (cf. FAQ 2,3 Module 1). This sensitivity can involve skepticism, which needs to be addressed, but also can involve curiosity and interest in issues of positive ways to gain control and empowerment, which can be built upon.

“show what s/he is made of.”¹⁵ Some studies suggest that, as a group, African Americans tend to be more vocal, to confront issues head on, and to express strong emotion. From the client’s perspective this may seem like positive assertive, while the same behavior may be disturbing to Whites, who tend to be more emotionally subdued, and therefore therapists from other cultural backgrounds not familiar with the African American perspective may perceive such behavior as negative assertive (quadrant three).

Second, African Americans tend to come to therapy with the same expectations one would have going to a physician—that is, expecting a diagnosis and prescription targeting the problem in one step. They expect a clear structure in the session (wanting positive assertive guidance) and tend to drop out if the therapist is highly nondirective, as in a purely Rogerian style (which they would see as negative yielding, not positive yielding as therapists or clients from other backgrounds might.) This positive assertive guidance, of course, needs to be within a context of giving the client an experience of being deeply listened to and validated.

Therapist sensitivity to the control implications of these potential viewpoints and styles - gender, cultural, ethnic, racial - are important in “encountering the client” both with openness to and with understanding of potentially different control-related belief systems and contextual meanings.

The multicultural counseling literature advises paying attention to both unique features common to a particular culture (emic) and broad dynamics present among all human beings (etic). In control related terms this means paying attention to how gender and culture can influence control related responses in individual clients. We invite you to explore, either in class discussion, or in your journal, issues of control as it relates to your understanding of different cultures, gender, and ethnicity.*

Developmental phase, modes, and agency. What importance does the client’s age (chronologically and developmentally) have on your view of the client? What are your feelings, beliefs, and understanding of control-related developmental tasks, issues and challenges that may occur: e.g., of a 3-year-old, a “tween”, an 18-year-old high school senior, a mother in her 40’s, a widowed man in his 80’s. How and to what extent would your understanding of what would be appropriate “mode” and “agency” be effected by where the client is developmentally? Chronologically?***

3. RELATIONSHIP.

Different orientation’s views of relationship. As noted above under “role of the therapist”, each school has a different view of the role of the therapist. This view is

* For you, personally, how would you handle a situation in which a client expresses views that you find racially insensitive, gender insensitive, religiously insensitive? Research has shown that individuals often get a sense of control from finding their—class, biology, religion, and/or ethnicity—better than someone else’s: ie., downward comparison. We would argue that in these areas, this is not a positive way to gain a sense of control. What role and responsibility do you feel you would have to comment? When would you? Would you feel positive assertive or negative assertive in so doing? How might the client respond (in quadrant terms)? Note where your “xujing” (center) is; then note what you feel would be the wisest (dongjing) response. How do you feel it is wisest to respond when you hear such remarks by others in daily social interaction?

*** Specific thoughts on the content of this topic have already been addressed in Module 2, FAQ 6 and 6a, on the “Developmental dance.”

based on what constitutes a beneficial therapeutic relationship, on their view of the person, their vision of psychological health (see Module 2 and above), and the barriers that keep individuals from reaching their potential. Classical Freudian id psychology felt the therapist needed to be a detached observer, who would, when appropriate, confront the patient in order to overcome resistances. Client centered approaches, believing the person is innately good, offer non-judgmental warmth and accurate empathy, so the clients can uncover who they already are. As noted, cognitive-behaviorists often see themselves as coaches, teaching new skills. Existentialists highlight the importance of authentic, mutual relationships, viewing clients as fellow travelers on a journey. As discussed above, in Control Therapy, there may be a place for all of these relational views and skills, at different points in therapy, and depending upon the client. Sometimes we may need to reinforce and honor a client's innate self-worth (Rogerian warmth, empathy, validation); sometimes, teach new skills (cognitive/behavioral coach); at other times, share authentically about the mutual journey (existential); and at still other times, be willing to work skillfully, even assertively, with denial and avoidance. Control Therapy would suggest that none of these positions need be mutually exclusive.

Which view of the therapist are you most comfortable with? How much is that view based on the research literature regarding what makes the best therapist? How much is that view based on what is most congruent with your personality style? For example, if you want to be perceived as a nice person (i.e., authentic, a friend) how willing would you be to challenge and confront your client, even if it meant the client might become angry with you? Conversely, if you are “naturally” by temperament more detached and analytical, how comfortable would you be becoming more involved in a caring way with the client?

The question for each of us is how much of our own style “draws” us to certain therapeutic approaches and orientations, where we feel more comfortable and have more of a “sense of control”? (See Homework 4.2 below). It is useful to explore when our own personal preference and style are helpful to a client, and when these might not necessarily best serve a client's needs and goals. In the latter case, as noted above, we can then decide to learn to stretch our limits and develop additional skills.

Two specific additional comments are warranted:

As context for self-regulation strategies. Developing trust and openness through careful listening skills, cultural and ethnic sensitivity, and showing empathy is often a critical context for teaching a self-regulation mode of control technique. Although teaching a simple relaxation technique may seem benign to the therapist, to some clients, the idea of closing their eyes in front of a relative stranger may feel threatening.

As process. Additionally, the therapist should be aware of relationship as part of the process of therapy; this includes both sensitivity to transference and counter transference issues, including specific control issues (e.g., power struggles) that can occur in the therapeutic encounter (*CT, Chapter 8*); as well as awareness that the therapist is constantly modeling for the client examples of (hopefully good) self-regulation and control of behavior, speech, and affect.

4. ASSESSMENT.

As can be seen from Figure 4.1, both client and therapist have a view of what the “problem” is. The therapist will also have a view of what the goal can or “ought” (Gordon Allport’s word) to be for this client. This goal will be both a product of the therapist’s view of this particular client, and of the therapist’s view of what constitutes psychological health (based on their orientation).

Relevant treatment populations. As noted, each therapeutic/ theoretical orientation has a view of the client, even before the client arrives. What does your theory state about what causes clinical pathology? How much is under the person’s voluntary control? Do you have different views of the relative percentage that is genetic/biological, cultural, psychological, depending upon the clinical diagnosis: e.g., depression, generalized anxiety, panic attack, borderline personality. *<Though beyond the scope of this manual, there are SCI Control Profiles for each of those groups, as well as adult children of alcoholics, those with restricted eating disorders,¹⁶ women with breast cancer ,and those at risk for heart disease: See SCI, Chapter 5).*

Therapists need to assess their own (and their clients’) view of how much of each diagnostic area they believe is outside of voluntary control (i.e., genes and biology), and what areas are potentially within human control and self-agency. CT would argue, based on the research, that each diagnosis can be best understood from an omni-deterministic perspective (see Module 2), and the task is to find out what is outside the person’s voluntary control; and what are areas that can be addressed within their control. These will vary across diagnoses.

Further research on CT can help refine the optimal extent, across diagnostic category and person, for utilizing different modes. As we have discussed, from a positive assertive perspective, the client and therapist can determine what is within the client’s active control; from a positive yielding perspective, they can determine where the problem is either outside the client’s personal control and/or it is in the client’s best interest to learn the positive/yielding accepting mode of control.

A discussion of clients with whom Control Therapy might present special challenges, based on our experience, is addressed below under-- *First Session, Test taking note regarding the SCI).*

Quantitative and qualitative assessment. You have seen how Control Therapy assesses the Client’s Control Profile, quantitatively through the SCI, and self-monitoring, and qualitatively through careful listening to clients’ speech, and exploring client control stories. In viewing the client, therapists will be hypothesizing, based on their own theoretical orientation, what is causing the client’s concern, what goals are really in this client’s interest, how able is this client to learn and benefit from control-enhancing strategies. Based on the therapist’s and client’s views, it is important to work toward a goal that both can agree upon. Ways to do this are discussed further below.*

When therapist and client disagree. We believe in “staying open,” recognizing complexity, not forcing, and being culturally sensitive to a client’s concerns. Within that context, when is it appropriate for a therapist to be more assertive or challenging?

* (See also *Control Therapy, Chapter 8* for more on client control dynamics and stories; and *Chapter 11 Technique Refinements* for addressing client resistances and other difficulties in gaining control).

Mode goals. Abraham Maslow once said that if the only tool you have is a hammer, every problem begins to look like the head of an undriven nail. People generally (by temperament, socialization, culture) favor one mode over the other. One way to share the idea of learning an additional mode is that it allows us to have greater choice and increases our degrees of freedom. In this way, a person, rather than relying on habitual patterns of reacting, can learn additional skills thereby giving them a greater range of options to choose from.

Because the client is often not aware of his/her control stories it takes more skill on the clinician's part to ferret them out and help make them explicit for the client. Sometimes those views and stories are different than what the therapist feels is in the client's interest. For example, the therapist may realize that by temperament and/or upbringing, the client feels that control can only be effectively exercised through assertiveness and change, and therefore may want to address every area of concern through that mode, and what the therapist would see as "positive yielding" the client believes is "negative yielding." (cf FAQ 2, TMI, Appendix 5). If in some area the therapist feels the client is being too perfectionistic, and that a "yielding accepting mode" is more appropriate, some time will need to be devoted to exploring the client's beliefs before initially teaching the strategy.

Conversely, a the client may say about an issue "I don't care" or "I'm not bothered by it." The client may see that as positive yielding, but the therapist may see it as negative yielding: fear of taking action, or unwillingness to face deeper feelings of pain or loss. To take an extreme example, a client in an emotionally abusive relationship may want to learn more "acceptance": "This must be God's way; God will provide for me; I don't have to act to change my abuser, or to leave the situation." In such an extreme example-- when the client is in an abusive relationship but says they want to practice *only* acceptance and forgiveness-- the therapist may clearly feel that the assertive/change mode is important. But even here, as we discuss in teaching of interventions below, it is important to create a trusting context, in which the client feels that their control stories and beliefs are understood, as a context for teaching an intervention.

Root issues 'versus' content issues. As discussed in Module Three, Section Two, Control Therapy believes it is important to address the client's concerns as they are presented, without assuming there must be underlying "dynamic" or "existential" issues at the root of the concerns. However, as we also pointed out, sometimes you as a therapist may feel there are "underlying" root issues that the client is either hiding from or unaware of, and therefore you may feel the client is not working at the right level. For example, what if you feel your client is working "on the surface" and missing the "real" deeper issues. For example, a person may say they want assertiveness training to change the other person they are currently dating: e.g., "I don't like his table manners and want to learn to tell him that." But as you talk, you realize this person has a history of finding fault with the other person—and you feel maybe she's doing this as a way to avoid commitment. Or, a person with the same desire to learn assertiveness training, may have, you feel, a fear of abandonment which is what keeps them from being more assertive. Do you still follow the client's lead and teach them to be more assertive?

Our experience is that it need not be an either/or. Sometimes, by working at the content level of where the client is, and having some success there, clients can develop a comfort and willingness to explore deeper issues that may also be present. For example, a

woman who needs a mammogram, says she is extremely distressed about problems getting the appointment, the staff not being kind, and people not seeming helpful. She may define her therapeutic issue as needing assertiveness training, so that she can demand better treatment. Indeed, this content issue could be addressed in therapy with bare awareness, i.e., helping the client to make sure that the mammogram is performed as well and efficiently as possible. Such a success experience, based on not power-struggling with the client about the “real” issue, might open doors to addressing any root issues suspected by the therapist, such as vulnerability and mortality, fears of loss of control that cannot be addressed through assertiveness training. This root issue, in an existential sense, might be her fear of death which may need to be addressed through acknowledging and talking about that fear. This might include meditation, grief work, and acknowledging that our bodies break down and decay as part of life’s processes. But it would, we believe, have a higher chance of working because the therapist had respected the client’s need to start with content that the client would feel safe enough to turn to this deeper level.

On the other hand, as we have also suggested in Module Three, existential root issues (e.g., facing mortality, addressing loneliness, seeking to find meaning) are clearly control-related concerns that all humans face, and try to gain a sense of control about in their own ways. If a client enters therapy wishing to address such root issues, of course they can and should be the focus of the clinical work. Again, this does not need to be an either/or. For example, a client may come in who wishes to address the existential root issue of loneliness: we are born alone, we die alone, and you can never really ever know another person totally. You, as therapist, may seek to work with and understand, and address these issues at the root level. However, you may also feel that this person spends too much time in their head philosophizing, and actually is feeling lonely at one level because he’s cut himself from other people and doesn’t have good social skills. Therefore, you may decide it might also be helpful to suggest that you work on, where appropriate, developing interpersonal skills and looking for ways to seek deeper connections

Thus, we believe it is possible to address where the client is (either at a content level or a root level), and at the same time, during the course of therapy, also address, if appropriate, the other level in a both/and manner. In this way, the client is able to sort out root and content issues and learns efforts to gain and maintain a sense of control on both levels, addressing each as skillfully and wisely as possible.

Self and other responsibility. Where a client is constantly deflecting blame onto others (she made me angry; he made me drink; it’s my boss’s fault I’m so upset, it’s all because of the way my parents raised me), one task is to help them learn to move from other-responsibility to self-responsibility, taking more responsibility for their behaviors, thoughts, and feelings, and perhaps to look at how easily offended they are. On the other hand, if the client feels that everything is his/her fault (I’m such a horrible parent; my kids’ problems are all my fault; I’m the one that causes my spouse to drink), exploring the issue of taking too much responsibility may be necessary, as well as why they are not more upset at how they are being treated.

In both cases, it is again important to initially “meet” the client where she is, and to understand empathically her point of view. For example, in the first case (blaming others) the therapist might say, “It sounds like you feel a lot of pain about the way others

are treating you.” Once empathy has been established, there can then be a discussion of “stories,” “decisional control (choice)” and “attentional focus” and, as discussed above, both empathizing with the feelings created by their story, but also pointing out there is an element of choice in the type of stories we tell. This can then be followed by: “I hear how bad you feel the other person is. Let’s take that as a given for the moment. Sometimes it’s hard to control the other person. I’m wondering if we can spend some time exploring what you can learn from this in terms of how you react to the other person’s unskillful behavior?”

Defensiveness and self-deception. As we noted in Module Three, Section Two, and at the start of this module, at times all of us can be defensive and self-deceiving. We seek to protect our “competent and special self”—sometimes through positive assertive actions and beliefs; sometimes through positive yielding actions and beliefs. For example, we may believe that we have more control than we actually do; we may be more controlling than we acknowledge. We may not take enough responsibility for our actions, and seek to protect our “ego” too much. Further, as noted above under modes, we may try to protect our ego in “yielding” ways by distancing from situations and events: “I don’t care; that doesn’t bother me; they weren’t very important in my life.”

At times, we may want to work with our clients to be less defensive, less self-protective of their “ego” and take more responsibility for their actions. If you disagree with the client’s assessment of the situation, as in the example above about the person who consistently blames others, it may take a certain amount of time, patience, and effort to work toward switching the focus from “blaming others” to exploring her own reactions, feelings, and behavior.

On the other hand, some may take too much responsibility for their actions, and allow themselves to be crippled by too much self-blame, and too low a sense of self-esteem. We may want to work with these clients to be “emotionally tougher” and not be so non-defensive that they take blame even when they are not responsible, and to develop their feelings of self-esteem: their competent and special self. If you feel the client is taking too much responsibility and has too high self-blame, that too may take considerable patience to work with them, even challenge them within an empathic context, to see explore other ways of seeing what is going on in terms of how they see events, and how they view themselves.

We have suggested several ways to help facilitate this process above under 1. Therapist: Having a Graded Range of Skillful Responses.

Self-efficacy beliefs (Therapist “demand characteristics”, client expectations and beliefs). Other issues may involve views of the therapist and client regarding the efficacy of the intervention techniques themselves. The therapist, based on the research literature and prior experience, may have confidence in the techniques. The client, based on prior life experiences, may have less confidence and self-efficacy beliefs that they can learn to effect change in their thoughts, emotions, and behaviors. When the therapist and client disagree on these issues, (e.g., amount of self-efficacy a person can have in changing thoughts), both need to work together to reach a common understanding. The therapist may empathically hear the client’s belief: “It seems you feel you can’t control your thoughts at all. I agree that they are hard to control. Would you be willing to try an experiment to see if we can’t affect control of thoughts by one or two degrees. As a wise person once said, It’s very difficult to keep the birds of thought

from flying through our mind; we just want to try to ensure that they don't make a nest there." The therapist can also point out that there is a substantial literature that shows that with practice, individuals can learn to increase their skill in learning self-regulation techniques.

Other examples: e.g., building blocks--emotions "versus" intellect. What if you think the client is too much "in her head" and would be served by "feeling" more: e.g., she wants to *talk about* feelings, but not feel. Or conversely, if she seems too driven by "gut" reactions and feelings, without being willing to step back and evaluate the stories that are being driven by those feelings, you might want to encourage the client toward greater cognitive self-questioning. Suppose you have concerns about the client's default mode in terms of where she focuses her attention. Or about the control stories she typically tells herself. Perhaps you feel your client is overly concerned with her body; or too "cut off" from her body. There are a myriad of areas in which the therapist and client may disagree, and what is important in each is the process of

- empathically understanding and hearing how the client sees and feels the world and her experiences;
- recognizing how her worldview and building blocks give her a sense of control because of their familiarity and "knownness"
- helping the client understand that while there may be advantages to her current style, there also may be some disadvantages that don't serve her well
- understanding the importance of patience on the therapist's part in sharing this information—including the difficulty the client may have in hearing your perspective, understanding it, and working with it;
- ensuring that this sharing is done in as respectful and honoring a style as possible.

What if the client denies or doesn't acknowledge the role of control; his/her "controllingness?" The opening discussion point of this module gave two interesting examples, one where a person said he wasn't exercising control when, at least from one perspective, he was (the bonsai practitioner); and one where someone believed he was in control (not drinking before 9:30 a.m.) when, from a different perspective, he clearly was not.

All of us may have areas of illusory control, and the research suggests that sometimes such illusions serve us well. But sometimes they do not. In the case of the person who is drinking early and often, yet still feels "in control," the therapist will need to work with care and diligence to help the client see the negative aspects of a false sense of control.

Much has already been written in the literature about this topic, so here we focus here on a clinical example of a person who is being controlling, but is denying it.

A clinical illustration. For example, a mother complains that her soon to be daughter-in-law is telling her that the mother-in-law is being too controlling about the upcoming wedding plans. The mother says, "*It's not at all about control; I never think about control. I'm just trying to be helpful and offer her suggestions from a place of love. What's wrong with her?*"

Response: Some people don't want to acknowledge the role of control in their lives. There may be different reasons for this. Some may not want the responsibility that

comes with feeling something is in their control. Others, like the mom above, may feel that being called “controlling” is negative. Others may have such a high need for control, and a desire to present themselves as appearing in control, that to have that questioned or challenged is threatening.

Here is a possible way to work with the mom.

First, paraphrase, and empathize.

“I can hear the frustration, even annoyance you’re feeling at what’s happening.”
you’re feeling, even some despair and worry.”

“Yes, I feel like I’m hitting my head against a wall, and all I’m trying to do is be loving and helpful. It makes me so sad. And I’m worried she’s going to drive a wedge between me and my son.”

“So there’s also some fear and sadness.”

“Yes, definitely, and I’m doing nothing wrong but being loving.”

“I hear that you are feeling you are acting in a very loving way toward your daughter-in-law to be, and you are just trying to be helpful to her. Yet she’s not appreciating your efforts, and in fact is criticizing them. Do I understand you?”

“Yes, exactly.”

<Note, as we have discussed, paraphrasing can show empathy and understanding without necessarily agreeing>.

Then, as one part* of the therapeutic process, we tried to get the mom to understand the daughter-in-law’s frame of reference (again, without necessarily agreeing with it). *“We’ve discussed the four different modes of control <Show four quadrant sheet> Without agreeing with your daughter-in-law, but just trying to understand her point of view, which mode does she think you are using?”*

“Well, quadrant three, negative assertive. But she’s wrong.”

“Ok, so she feels you’re using quadrant three, and you disagree with her. I understand that. Now, let me ask you a question, if you were to talk about your actions in control terms that she could understand, which mode do you think you’re using?”

“Well, mainly I’m being positive yielding—I’m staying out of almost everything; with maybe just a touch of positive assertive.”

“Excellent. So, from your point of view, mostly you’re being positive yielding, and allowing your son and daughter-in-law to handle almost all the arrangements themselves. But on a few issues, where you’re acting in a positive assertive way by making some kind, loving suggestions to be helpful, your daughter-in-law is misinterpreting these suggestions, correct?”

“Yes, exactly.”

* In the actual case, it took additional work to deal with the mother’s control issues, including power struggles with the daughter: *“Why should I have to phrase things in a way she can understand? It feels like I’m the one making all the concessions.”* We also explored her control story-- her fears regarding her son getting married, her anxiety about fear of losing control in having to “let go of her son.” She said that she was afraid that she was not only losing control of her son, but actually “losing her son.” The marriage also raised mortality issues for her—her son’s marriage meant that she had to face that she was getting older. It also raised role identity questions—what will be my role as a mother now when he has a wife?. These are the kinds of control stories and issues that may often need to be addressed as part of Control Therapy. We also worked with her to see that her fears of losing her son were exaggerated and to acknowledge that the daughter in law has made strides to connect with her and compromise at other times. This also helped her feel safe enough to explore a new way of approaching her daughter in law.

Now, there is a basis for dialogue with a common language, with which the mom can approach the daughter-in-law, as well as reflect on her own behavior more honestly. As an intervention, the mom can follow some of the principles (see Training Module 3, Section Four): breath, gratitude, intention, right speech. Taking a breath, she could say, “Daughter-in-law, I love you so much and am so happy you are going to be in our family. You really make my son happy (gratitude). I want you to know that I am here to help you both with your wedding plans (and your life). I really want to help only out of love. I see my efforts as positive; but I know that sometimes you see them as too intrusive. Can we work something out where I feel I have a role and can contribute in a way that feels comfortable to you? (intention and right speech: to create a feeling of harmony and peace and joy about the wedding).

FAQ 11: Does Control Therapy require that every client’s presenting problem must be fit into a box in which control is the most salient issue?

This is a critically important question, and the short answer has to be “Of course not!” Our first task as therapists is to hear the client’s concern in the client’s own words, and be sensitive and empathic to what the client is feeling. The very antithesis of that would be to force a client’s views into our preconceived constructs in order to validate our own perspective.

“Bullying” and forcing are not positive options. Clearly it would violate the basic integrity of the therapeutic relationship if the therapist tried to force every client’s concern into a predetermined schema. This would not be fair to the client, and would not involve the use of accurate listening or empathic understanding. Thus the therapist should not try to force a client into a control framework; nor should the therapist try to “bully” a client into seeing control issues even if the therapist believes such issues clearly exist. If a clinician feels s/he is engaged in a power struggle with a client, and is trying to force a method upon the client (whether it be how to frame an issue, or which technique to use), this can signify some counter transference issues that the clinician should address through self-exploration or with a supervisor. Why am I trying to exert my will over this person? Is it really only to help them (or is it Q3: overcontrolling, negative assertive)? Am I feeling powerless in some other areas (Q4: negative yielding) that cause me to feel the need to exercise excessive control with this client? Does the client remind me of someone with whom I have felt a victim in the past, or with whom I’m now in a power struggle?

Control issues exist. Having said that, we believe there are several lines of research that indicate that control is a factor in client concerns. For example, research has shown that asking clients to discuss “What brings you here today” and then conducting a subsequent content analysis of speech patterns by blind raters reveals that control-related issues are almost always present in the client’s response. Further, as noted, in our content analysis review of the DSM categories (*CT, Chapter 3*), there is a control-related component to all of them. Finally, even though individuals may use “control speech” in their daily language (as revealed by content analysis research), they may not *think* about their issues in control terms. This includes people with feelings of too little control (e.g., depression); fear of loss of control (e.g., anxiety disorders); and denial about their lack of control (e.g., drug and alcohol addictions).

Clients may not be aware of these control issues. Further, as noted above in the clinical illustration of working with someone who doesn't acknowledge her "controlling" behavior, sometimes clients aren't willing to see that control is at least part of the issue (*even when such issues exist*). This may be because they fear seeing themselves or having others see them as "controlling" (particularly in the quadrant three sense). They may also be afraid to openly show and share their high desire for control.

Some people don't want to own personal "control" because it may mean taking responsibility and being accountable. For example, someone might insist, "It's not my fault I'm upset. Other people are making me angry." More subtly, it may be easier to say to your child, "I have to go to work," (i.e., I have no control in that matter) rather than acknowledge the part of yourself that really feels "I want to go to work" (i.e., partly this *is* my choice, something I *want* to do).

The goal of Control Therapy. *Control Therapy attempts to highlight and clarify the themes of control that can be useful in helping clients understand and address their presenting problem. Its goal is to educate clients so that they can understand themselves, others, and the world at least partly in "control" terms and describe their situations in "control" language. As a basic premise, Control Therapy would argue that issues of control (and self-control) exist, whether or not we recognize them explicitly.* Control Therapy didn't create control issues; rather, it helps clients to recognize what is - the "control factor." The task, then, is to move from less healthy and maladaptive ways of seeking to gain and maintain control to healthier and more skillful ways.*

FAQ 12: Even if control issues exist, is it always necessary to discuss the issue in control terms with the client? There are three answers to this critical question.

1) Recognizing life's complexity! Even if control issues are present, they may not be the only motivating variables involved. There can be, and usually are, multiple motivating factors. For example, the parent mentioned above may have financial incentives to go to work, as well as desire for a life independent of the child. The politician may lust for control and power, yet also want to be of service and help others. The mother-in-law may be overcontrolling but see her behaviors as expressing caring. We feel it's only important to bring up the "control" aspect when not doing so is interfering with the person's quality of life. Raising the possibility of there being a control variable involved does not need to negate other possible motivations.

2) Finding the "best" therapeutic style for raising these issues. Just because control issues may exist, that does not mean that "bullying and forcing are positive options (see FAQ 7 above). However, there are positive ways to raise these issues with the client, and there are times when the therapist has not only the right, but also the responsibility to try to influence the client through the use of advice, guidance, suggestions, and "leading" questions. It is important for the therapist to have a range of responses, so that s/he can utilize the most appropriate, helpful response depending upon the situation, from soft, compassionate yielding (maximum yin) to confrontive and

* The context of the above discussion we hope makes clear that we are not stating that control issues exist as necessarily *the* sole variable and motivation. However, as the postulates state (See Module 1, What is Control Therapy, cf Appendix 10), even behavior which can be framed as "just trying to be helpful;" "only trying to be caring" contains an element of control as a variable: i.e., attempting to cause an effect in the intended direction

challenging (maximum yang) including nuanced options in between. (For specific examples, please refer back to Step One, Therapist, above: Therapist competencies and communication style: see *Having a Graded Range of Skillful Responses*).

In some ways the model of yoga is a helpful metaphor here. In yoga, as we discussed in TM3, there is a double movement, in which individuals begin by accepting where they are in terms of a particular asana (posture); then, from that calm, accepting place, they try to stretch in a slow, gentle way, challenging themselves to explore and test their limits, all the while keeping the context of self-acceptance. So too, the therapist wants to help clients to feel safe, understood, valued, and accepted as they are; and, when appropriate, to be able to challenge clients to help them grow and stretch their limits in ways that may be beneficial.

3) Finding positive ways to present and frame control issues, including alternative metaphors. The third answer is that we believe it is important to use words and metaphors that speak to the client where they are. As we have pointed out in Module One, there are some people who may find the term control problematic as noted in FAQs 2,3 (Isn't control sometimes bad? Isn't positive yielding really fatalism?).

In presenting Control Therapy to those who have difficulty with the world "control" it may be helpful to use metaphors that speak directly to the client, describing the therapist's role as helping clients "take charge" in new ways or to become more "empowered" to effect positive change and personal growth, to have more satisfying and fulfilling lives." Control Therapy can be described as way to help a client have more "influence", "guidance" and/or "self-direction" in their lives. Certainly metaphors like empowerment, taking charge, not being a victim, fighting spirit, resilience all make sense so the word control itself doesn't need to always be explicitly used.

The skillful therapist seeks a balance, so that the client doesn't feel s/he is being force-fed a predetermined schema; yet the therapist also doesn't avoid the topic of control just because it may be uncomfortable for the client to address. Listening to the client's speech, and speaking in the client's metaphors can help the therapist find the right finger with which to share with the client the direction leading toward the moon.

We address this issue further in the discussion below about interventions, particularly the "teaching" of interventions using words and metaphors congruent with the client's world view and cognitive/affective representational systems.

FAQ 13. You say that Control Therapy believes in "IN AND THROUGH." Is this necessarily the best approach for everyone?

We hope it's been clear throughout this manual that CT does not believe in a "one size fits all" approach. Therefore, we do not claim that "in and through" is necessarily always the best approach for everyone in all circumstances. Having said this, Control Therapy posits that, in general, concerns are most skillfully addressed through awareness awareness of one's control profile, control stories, control dynamics, areas of concern (i.e., "in") rather than through avoidance, distraction, or denial. Going "through" involves trying to address the concern through change, acceptance, or some combination (see the example of "in and through" using stress [Module 3.3, p. 231ff]). Control Therapy also recognizes that the therapist needs to be sensitive to the client's readiness to face issues. Further, we believe that "facing" an issue does not mean becoming inappropriately emotionally "caught" by, over analyzing, or perseverating on the issue.

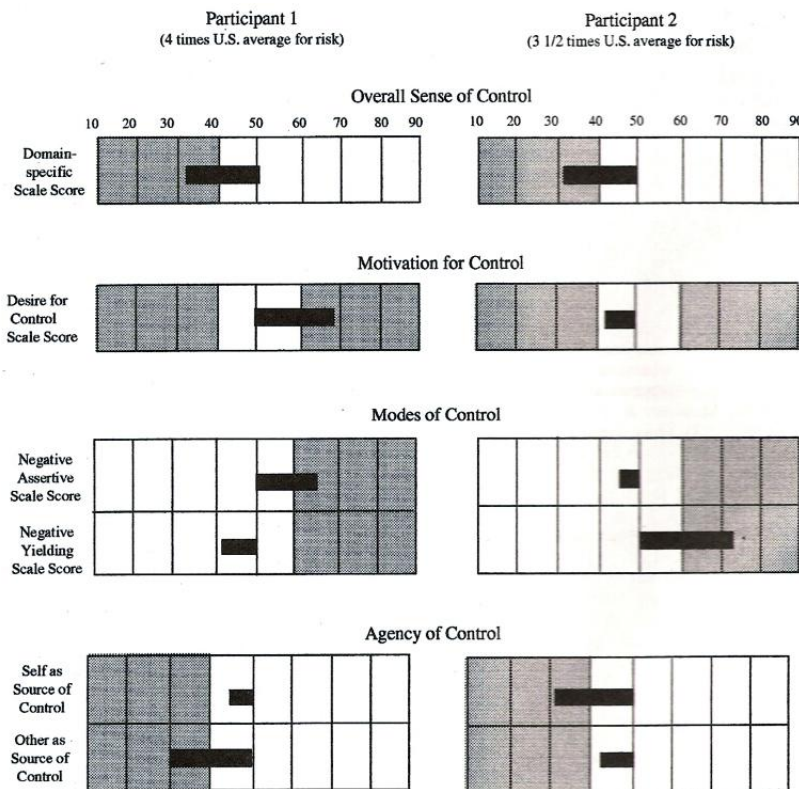
In and through can involve a conscious choice to face, let go, and move on. It can also involve a conscious choice to “change thoughts,” use cognitive refocusing strategies, and/or remove oneself from the situation. However, in most cases, as noted at the start of the manual, “In order to get to where you are going, you need to know where you are, and where you want to go.”

5. INTERVENTION: MATCHING GOAL AND CONTROL PROFILE.

A main task in Control Therapy, as we have discussed and illustrated throughout this manual, is matching the client’s clinical concern, goal(s), and control profile with the interventions. There have been several studies that have successfully matched control personality variables with particular control enhancing interventions. In matching, several factors need to be taken into consideration: the stage of treatment, person-situation interactions, development phases; assumptions about personal control and responsibility brought into the therapy session, the assault to person’s sense of control; and the individual’s preferred mode of control for addressing concerns.

Figure 4.2 below shows two control profiles of individuals at high cardiovascular risk. Note that each person’s domain specific score is in the gray area. However, the rest of their control profile is quite different. Participant one has the following gray areas: a high desire for control, high negative assertive, and low belief in others as a source of control. Participant two, on the other hand, is high in negative yielding; has a low self as a source of control.

FIGURE 4.2
CONTROL PROFILE OF TWO PATIENTS AT HIGH CARDIOVASCULAR RISK



Clearly a one-size fits all approach would not work. Each of these individuals would need to have their interventions tailored. Participant one needs to learn to have less desire for control, reduce his negative assertive mode style, develop positive yielding skills, and learning to trust others more. Participant two needs to learn to rely on him/herself more, and develop more positive assertive control skills. (See Training Modules 3.1 and 3.2 for step by step guidelines for each positive mode, as well as their integration).

6. TEACHING OF INTERVENTION; ADHERENCE AND COMPLIANCE.

Therapist teaching style, client mode of learning. In addition to matching intervention to assessment, it is also important to match, in so far as possible and comfortable for the therapist, teaching style to client profile, and to teach the intervention in a style which is most congruent with the client's preference. For example, someone with a high "other" agency as source of control does much better with hetero-hypnosis (Your eyes are feeling heavy. You now want to close them."). If a client has a high desire for control and a high "self-agency," then self-hypnosis is the preferred style of presenting the technique. ("You are in control of this technique, and can stop at any time. Notice if your eyes are feeling heavy, and if you want to, you may allow them to gently shut."). Similarly, those with a high freedom reflex (cf Appendix 3), no matter what the technique, will need to feel included in the process: e.g., "I think it may be helpful for you to consider... but it's got to be your choice." To someone with a low freedom reflex, the therapist might say, "I believe if you follow this plan regularly, it will really help you." "You're in control of this process at all times. I'm just here as a support, and, if you wish at times, a guide and facilitator."

Client's preferred mode of control; preferred agency. As noted, clients may have a preferred mode of control for addressing out of control areas, and a control story that justifies why one mode is better than another. Sometimes, as noted, the therapist may have to work with the client to explore how a particular strategy may not be appropriate. (e.g., acceptance of an abusive relationship; continuing to lose weight for an anorexic).

However, even if a client agrees to try a new mode, the initial use and experience of, for example, a yielding mode of control in someone who prefers an assertive mode, may be uncomfortable. Therefore, every time s/he starts to yield and accept a situation, s/he will immediately feel a discomfort in both body and mind. This may cause initial resistance to using that mode of control that will need to be addressed as part of adherence and compliance.

Part of the intervention may then be to work with the client to explore their control stories—to help them realize when these stories are helpful, and when they are less skillful. Less helpful control stories can then be "rewritten" in a collaborative process between therapist and client, as part of the clinical intervention.

Reframing and metaphors. The issue of how and when to frame issues in control terms is an interesting one. As noted above in FAQ 8, we believe it can be helpful to speak in terms and metaphors that are congruent with the client's cognitive/ affective representational system, and therefore not every control issue has to be described as a "control" issue. For example, if a therapist wanted to teach a person "meditation" to help relax them, and the client objected to anything of an Eastern derivation, what the therapist

could do is teach them “focused relaxation and breathing.” This would be a way to get to the moon (relaxation, stress management) by relabeling the finger.

We discussed above the use of words like “taking charge, empowering, resilience” as alternatives for “control.” Those terms all have a certain implication of “active, assertive control.” As important as that is, clearly not everything can be addressed successfully through active control, no matter what the metaphors. Part of the therapist’s task in Control Therapy is helping clients figure out what’s within their active control, what is not, and how to determine which is which.

In terms of integration of the positive assertive and yielding modes, again metaphors that speak to a client’s representational system can be helpful. For those whose belief system allows it, the serenity prayer, from a theistic perspective (God grant me...) is one way to frame an essence of Control Therapy: learning the courage to change what we can, to accept serenely what we cannot, and the wisdom to know the difference. From a non-theistic perspective, the Chinese philosophy of coming from a centered calm place --“xujing”—and then finding the best combination—“dongjing” of assertive (yin) and acceptance yang for a given situation may be helpful.

Further, as noted in Module 3.2, it is best to present the idea of dongjing to the client in a way most congruent with the client’s representational system. For those who are kinesthetic, the idea of blending hot and cold water; for those who are visual, the idea of blending colors (e.g., red and blue to get the right shade of purple), and for those who are more linear, verbal, going through the different yin (-- --) and yang (-----) combinations to find the best gradated response for a given situation.

***Control Therapy** attempts to provide the client an experience grounded in the client’s motivation, encouraging their self-exploration, honoring their unique cultural positions and world view, refining and addressing their self-stated goals, and tailoring interventions to help them meet those goals. In so doing, it helps clients learn how to focus on their own thoughts, behaviors, and feelings within the context of their lives and then learn how to positively influence the world and themselves in healthy and healing ways, whether through positive assertive, positive yielding, or an integration.*

EVALUATION. As can be seen from the above, the process of Control Therapy involves continuous feedback loops. These may involve a reassessment of the clinical concern, the therapist teaching style, and/or the strategy itself until both the client and the therapist agree that therapy has been successful. This can be determined by client verbal self-report, and more systematically by using the data from the self-monitoring (N=1 design); and the SCI as a (pre)- post test to determine changes in overall sense of control, and domain specific sense of control.

FOLLOW-UP. At the conclusion of successful therapy, some commitment to follow up: e.g., three months, six months—should be established, to ensure that treatment gains are being sustained.

4. 4. SESSION BREAKDOWN BY PHASES

We understand that therapy cannot be conducted in a paint by numbers approach. However, based on the above systems analysis, there are certain discrete tasks that are

needed for successful therapy, which we conceptualize as part of the control therapy therapeutic process. As noted at the start of this module, there is a general sequence to this material, but therapists should use their best clinical judgment in deciding the relative emphasis and pacing of sessions. For example, with some clients, assessing their control profile, discussing concerns, self-observation, and a goal can be achieved in two sessions. For others, it may take longer. Pacing of sessions is dictated by client needs, not by predetermined time periods.

Let us now look at these therapeutic stages in more detail. We have used a “typical” 12-session format for ease of reading, but please use your clinical judgment in pacing the therapy for each client. The breakdown into sessions described in this section is meant to illustrate just one possible time-frame, **NOT** to dictate a rigid format.

PHASE ONE: ASSESSMENT AND GOAL SETTING:

Where the client is, where the client would like to be

- gaining client trust,
- assessing the client’s control profile, giving feedback from the SCI
- listening to and understanding the control issues that are of concern to the client,
- exploring and discussing client control stories and dynamics
- helping the client formulate goals.

Before we turn to Session One--(Trust, Rapport, Exploring Areas of Concern), we need to make a few comments on the timing, presentation, and skill level needed for taking the SCI.

Note on timing of giving the SCI: Depending upon the therapist preference, agency structure, or research protocol, the SCI may be administered before Session 1 (and after some type of screening, orientation, and brief intake) or after Session 1. The timing of giving the instrument will influence how Session 1 is utilized, i.e., whether SCI results will be presented to the client as part of that session or presented in Session 2. (See pp 6-7 for information about on line scoring at www.controlresearch.net.)*

Presenting the SCI to the Client. We have found that a way to understand in a systematic fashion where you are now in your life, is to take a simple questionnaire. Since there are no right or wrong answers, please answer as best you can, and complete every item.

Test taking note regarding the SCI: As discussed in Training Module 1, the SCI is written at an 8th-grade reading level and takes an average of twenty minutes to complete. The SCI assumes some level of abstract and formal operational thinking (i.e., ability to handle abstract concepts, such as “sense of control”). It also requires an ability to tolerate feedback about one’s self, to follow logic, and to do basic reality testing. Anyone who cannot understand metaphors/abstractions, or is unable to comprehend “reality” sufficiently to take a written test, or anyone who is so perplexed by the concept of control that they cannot get through the first few questions on the control inventory

*If a computer is not available for a client to take the test, a hard copy of the test can be printed out at controlresearch.net (See SCI Manual: SCI test download; as well as at the end of Appendix 2 in this manual.)

and/or do not have the attentional focus and skills to self-reflect on his/her own behavior and actions would likely not do well with the test and the CT approach.

The test is probably not useful with chronic, low-functioning mentally ill individuals or those with moderate to severe cognitive disabilities. Persons with schizophrenia will not likely benefit from the instrument or the therapy, unless they are largely stable on medication. Clinicians should use their judgment in selecting clients who can benefit.*

Session 1. (Trust, rapport, exploring areas of concern, control profile)

The therapist starts by giving the client an opportunity to share why s/he has come for therapy. The therapist works to develop rapport and build therapeutic trust, and while listening empathically, seeks to gain information that helps the client identify areas of concern (i.e., where there may be assault's to the client's sense of control).** One way to present the results from the SCI is to start by saying, "In order to get to where we are going, it's important to know where we are. As we can see from the SCI sense of control scales (first three scales), you are, in general, feeling somewhat out of control in your life." If appropriate for the client (see discussion below about "Giving clients feedback about the SCI), the therapist can give more detail, explaining to them that scores falling within the gray area suggest some concern, e.g., that their positive sense of control may be low.

The therapist can then examine with the client items of Scale 4 of the SCI, the domain-specific scale to "identify those areas where you feel most out of control and look at areas which you feel are of concern to you." From this material, the therapist can pose questions about the relationship between the client's rating in different life domains to generate clinically salient material. The therapist can then help the client be clear in what problem areas they want to seek active change, in which ones they would like to gain acceptance. Prioritizing areas of concern from most important to least can also be helpful.

* Administration of the SCI may need to be adapted for certain persons, such as those who need assistance with the instructions. In our experience, there are a few individuals who have reacted initially by feeling overwhelmed or confused by the directions. ~~Our experience has been that~~ such clients can be successful in terms of completing the SCI if someone sits with them and walks them through the directions, one section at a time. In these special cases, the SCI may take up to forty-five minutes to complete. Often it turns out that these clients, who are otherwise capable of benefiting from the SCI and Control Therapy, have had bad reactions to testing, often stemming from bad school experiences in childhood or job testing in which they felt discriminated against (feelings of lack of control!). Some were also so focused on answering the questions "correctly" that they were afraid to "put down the best answer possible" and needed to be reminded there are no "right" or "wrong" answers—just an opportunity for self-exploration, learning and growth. (See Appendix 4, References 3,10). An astute therapist can help clients acknowledge these reactions in order to then become open to the test-taking process and subsequent therapy.

** When working with couples, one interesting use of the SCI is to have each partner take the inventory twice, first describing themselves, and then describing how they see their significant other. In terms of self-description, the therapist can discuss with them where there are differences in control styles (e.g. one person may have a high self agency, the other a high "other" agency) and how those differences may both be understood and bridged. Differences in how they see each other, (e.g., seeing oneself as positive assertive while the significant other sees the person as negative assertive), can then be explored by the therapist in terms of how accurate each person's self-perception is, how much projection may be involved, and how the implications of these differences might be usefully addressed in therapy.

The therapist, with the aid of the client's SCI Control Profile, can help the client identify areas where there is a desire for greater control or a desire for less control, depending on the issues. The concept of the four modes of control (Positive Assertive, Positive Yielding, Negative Assertive, and Negative Yielding) is introduced (often with the use of a visual four-quadrant diagram: see Training Module 1; also Appendix 3). The client's current mode profile, and their "ideal" can be discussed: e.g., which modes do they want to increase or decrease. The client's preferred mode for dealing with areas of concern (i.e., number of "change/alter" vs accept) can also be discussed and explored.

The therapist listens for key words and phrases from the control content analysis scales, including control-related aspects of the client's personal history, and begins to get a feeling for the client's control stories and dynamics. This session is a time of exploration, identifying main themes and key issues, and starting to formulate general goals in terms of motivation for change/acceptance.

The therapist might summarize by saying something such as "I can see you are feeling (somewhat) out of control in your life in general, and in certain areas in particular. I can tell from what you've said that this is distressing to you, and I look forward to working with you to help address your concerns. This week it would be helpful if you could observe an area of concern (work this out with the client) which seems most important to you. This is an opportunity for us to gain more information from actual situations in your daily life where your concern shows up. Would you be willing to do that this week?"

Homework The homework stemming from Session One should be some type of self-observation task on an area of concern identified by the client, such as making a list of occasions during the week when a certain problem behavior, feeling, or experience occurs and listing the thoughts that happen at these times. Therapists may use the Self-Observation Form (Appendix 3.1). The client can also observe some aspect of his or her control profile that seems particularly relevant. One way to present the self-observation material is within the framework of developing greater awareness: "One way to learn more about yourself is to actually observe this week some of the areas we have been talking about. As a wise person once said, "it's hard to know how to address an area of concern, unless we first have some awareness of the area." Self-observation is one such tool for developing that greater, and more refined awareness of our behavior, thoughts and feelings."

A further note about giving clients feedback from the SCI. It is important to highlight in the Session One discussion above that therapists be thoughtful in how they share information from the SCI with clients, and how much they share at a time. Some clients can be shown the SCI overview page, and are interested in the bars, and understand easily the gray area is only a way to highlight areas for further investigation. However, others, if shown the SCI overview page, may be confused by the graphs, and may worry that if they have areas in the gray area, that might mean they are "crazy." Such individuals may need to be reassured that this is just a way of highlighting areas that may be of concern, and that it gives them a signal that something may want to be explored further.

For some clients, seeing their bars in the gray area, where they scored high or low, can serve as a wake up call, helping to push them out of denial, or at least stop minimizing the problem(s). Remember, we are using the SCI to, in a sense, hold up a mirror for clients to see themselves accurately.

For some clients, it's helpful to explain how the scales are constructed. For example, showing how Scale 2, Positive Sense of Control, and Scale 3, Negative Sense of Control create Scale 1, the Overall Sense of Control. Some find it helpful to go to the item level. This serves to demystify the scoring process and reduce any fears about being found "crazy". For example, the therapist can examine the items of the positive sense of control questions (p. 8 of the SCI Comprehensive Report), so the client can see which specific items are "areas of strength" upon which the therapist can build; and which items may be areas of vulnerability regarding their sense of control that deserve further investigation. It may be helpful to ask them what they were thinking when answering some of the items they rated lowest or highest. They can then do the same with Scale 3, Negative Sense of Control, again pointing out which items make up that scale, noting which items fall in the gray area. Such exploration can help the client consider the meaning of each item in the context of their life. The same applies to the items of the mode scales (five through eight) and the desire for control scale (nine).

How much and how to present the SCI material is left to the therapist's judgment, based on their assessment of each client.

Session 2. (Self-observation, evaluation, goal setting control stories, and dynamics) This session can begin with an exploration of what the client learned from the self-observation experience. If the client seems ready, then self-evaluation and goal setting can be addressed. For example, the therapist could say, "Based on your responses, it appears that you would like to address your area of concern by... (e.g., an assertive/ change mode; learning to better accept with serenity).

Let's work together now to refine how you can go about doing this. First, in order for us to reach our goal, we have to make sure we know what the goal is. Let's see if we can agree on the specifics of what you're hoping for. (Here goal setting as discussed in Training Module 2 is explored.) Once the goal is set, interventions matching the client's control profile and goal can be taught.

If the client is unsure whether this is the right goal, or if s/he needs more information about self-observation, that too can be discussed. The therapist can ask the client to engage in an "eyes closed" exercise, in which the therapist shares how to do diaphragmatic breathing for relaxation. After a few minutes, the client is asked to envision an incident that typifies the area of concern (e.g., anger at a family member), and identify feelings and meanings related to the matter. The therapist engages the client in a discussion of his or her "***control story***", dynamics, and assumptions. This would also be an opportune time (if not discussed earlier in Session 1) to mention the archery target (Lazarus' inner circle) and to ask the client about his/her "self-disclosure level as one measure of how trust and rapport building is evolving.

Depending upon client interest and goals, the practice of diaphragmatic breathing may be taught, as well as the mind scan (***mindfulness*** meditation) in which the person allows thoughts and emotions to come into awareness and simply notices them without judging, evaluating or doing anything about what is observed. The body scan, an

awareness and relaxation exercise in which one moves attention throughout the whole body can also be taught. These can be explained both as relaxation techniques in and of themselves, and also as ways to help observe more carefully one's own body and mind as part of the self-observation work.

Homework. The session can end with a summary regarding continued refinement of self-observation. Depending upon the progress, there may be additional observation of the same area of concern or a new area may be selected. The clients can also be invited to notice additional examples of where either positive assertive and positive yielding control have been utilized in their life, and any memories or associations they experienced with either mode. These can be written about in their control journal, as part of their exploration of their control story. Finally, depending upon client interest and motivation, the mind-body techniques described above may be practiced as often as twenty minutes a day, or as little as two or three conscious breaths, right before going to sleep.

Sessions 3-5 (The final aspects of Phase One). The third session contains a number of tasks, which for some clients need to be spread over several sessions. The therapist helps the client explore the self-monitoring information (homework) including the client's rights in a situation and/or responsibility for his/her own actions/choices. Any questions about the mind-body relaxation techniques can also be discussed.

The session can then further clarify goals and goal-setting. Several techniques are available, as noted in the previous Training Module, including (a) envisioning which mode to choose, (b) client handout for decision-making, (c) use of a written self-management contract.

If the therapist feels the client is choosing the wrong goal (e.g., yielding when s/he should be assertive; assertive when acceptance may be the healthier choice), there are several exercises that can be helpful. First it can be useful to review the client's mode satisfaction information for each of the four quadrants from the SCI (Appendix 2, pp.20-21) and see if there are any words in the "non-expected" direction. This can lead to a further in depth discussion of the meaning of each mode for the client, and the client's control stories regarding different modes.

Secondly, the Control Mode Dialogue discussed in Training Module 2.3 can be utilized in which the client comes up with a character or personification of each quadrant, and begins a dialogue to see if some kind of peaceful agreement on how to proceed might be reached. This, too can lead to a further in depth discussion of the client's control stories

Thirdly, the "*external Rorschach vignette*," discussed in Module 3.2.4 can be utilized as a means of identifying client control stories and client strategies for solving interpersonal problems. Utilizing the example, the therapist says, "You and your partner have agreed that your partner will water the plants. You notice that the plants are beginning to wilt. What would you normally do?" If the client gives negative assertive or negative yielding responses, this can be an opportunity to discuss control stories which lead to those responses. Listening to the control stories also offers an opportunity to communicate empathy.

This exercise also becomes an opportunity to share the practice of taking a breath before acting (developing xujing) and also a further opportunity to begin to explore and

generate alternative choices (i.e., dongjing). Donging, as discussed in Training Module 3.2, involves integrating yin (soft, yielding acceptance energy) and yang (assertive, change, strong energy) to achieve what feels like the best possible response for the situation.. The clinician may guide the client to envision the problem situation, and then envision steps to deal more effectively with it in ways that are either positive assertive, or yielding, or a combination.

Sessions 3-5 are also an appropriate time for the therapist to go over the Five Steps for Positive Assertive Change and Positive Yielding detailed in Module 3.1; (Appropriate handouts from Appendix 3 --e.g., 3.13-- can be given to the client, as appropriate). The therapist can also have the client work with the breath cycle as a way of grounding the four modes in the body, as discussed in Module 3 - i.e., voluntary in breath (positive assertive); continuing to take an in breath (negative assertive); letting go of breath for the out breath (positive yielding); continuing to let go of breath (leads to negative yielding).

The breath cycle can lead to two interesting discussions regarding the client's control stories. The first involves which mode they prefer; and how they now see that within the context of the breath cycle, where all modes are present. Secondly, it helps deal with exploration about issues of self and other agency. From one perspective, taking a breath voluntarily does seem like self is serving as the agent or source of control. And there is much truth in that. But it is also true that taking a breath depends on our lungs working, and the environment providing oxygen for us. So we are not entirely "in control" even when utilizing the positive assertive mode. As noted in Training Module 3, this can engender feelings of fear in some, but can also lead to a feeling of gratefulness for the ways in which we are supported and sustained by other forces and factors (outside of conscious control) even as we may be exercising such control.

Homework. Continued self-observation and daily practice of whatever mind-body techniques have been found relevant thus far in the therapy.

PHASE TWO: INTERVENTIONS

- matching techniques to clinical concern to control profile and goal.
- teaching techniques in a way that is congruent with the client's style
- evaluating the therapy process at each stage to ensure progress is being made.

The intervention phase, as we have discussed, involves matching techniques to the client's control profile and goals. Step-by-step instructions for interventions are detailed in Training Module 3.1 and 3.2 and Appendix 3. These interventions provide guidelines and principles for using the two positive modes of control, alone or in combination.

Clearly, it is impossible to consider in the short space of this manual the actual applications to the variety of specific clinical examples which clients may have. This is where the therapist's creative application comes into play based on the general guidelines and principles already enumerated. In this part of the manual, we focus on the process of ensuring that the techniques are selected, taught, and evaluated as clearly and wisely as possible.

Intervention Phase (Sessions 6/7) The Intervention Phase, which we will call Session Six but which can really occur as early as Session 3 (in the simple model), can begin with a review of the self-observation material, and, once the goal has been agreed upon, can move to an exploration of the Five Steps for Gaining Control. (detailed in Module 3.1). The therapist can focus on which pathway best matches the client’s goal and control profile. Specific building blocks -- cognitive, attentional, behavioral, and emotional – can be selected, tailored, and taught toward achieving a positive assertive mode, a positive yielding mode (Module 3.1) or toward an integration (Module 3.2).

A self-management contract can be drawn up, and the client’s homework for the coming week clarified. Any questions about techniques can be further explored. The therapist should ensure that s/he is teaching the techniques in a way most congruent with the client’s style (e.g., preference for self or other agency, learning style, etc).

Homework involves continued self-monitoring and practice of control-based techniques.

Session 7/8: Evaluating intervention progress. Again, we are following a “typical” progression, which will need adapting to each client’s pace and dynamics. This session can begin with a discussion of the client’s practice of control-based techniques during the past week.

As needed, the therapist helps the client enhance self-efficacy beliefs and commitment to change. This may be done through examining past successes, generating thoughts to enhance change, and/or reaffirming commitment to change. It also may mean reviewing control stories and beginning to “rewrite” them through exploring alternative scenarios, chapters, and outcomes. The homework involves continued self-observation and practice of control-based techniques.

Sessions 9-12. Depending upon when the intervention phase began, these sessions can be used to review progress from both the therapist’s and client’s perspectives, with a focus upon client self-observation data. Research shows that Control Therapy can be effective within four to eight sessions, but for some clients four additional sessions may be necessary to continue the work already outlined and to gain more practice with the various self-control techniques. When there are problems and issues, the feedback loop in Figure 4.1 can be used to evaluate Step 4: assessment of clinical concern; Step 5: selection of the intervention; and Step 6: teaching of the intervention, including issues of adherence and compliance.

Once the goals with which the client began therapy have been successfully met,* issues of termination can be discussed. The SCI can be re-administered to further evaluate progress. The final session is typically used to reflect on the process of self-change, validate progress, and consider ways that new behaviors may be generalized to address new problems as they arise. The final session can also be used as a way to “consciously” say good-bye as part of the ending of the therapeutic relationship. The therapist and client can also discuss any future booster sessions or follow-up as needed.

Figure 4.3 summarizes in an overview the technique material that we have covered in the manual, and where we have covered it.

* Even if initial goals are satisfactorily achieved, a client may raise additional concerns, as we have discussed at the start of Module 3.2. If so, these can be addressed in similar fashion by returning to the processes of assessment described in the early sessions.

Figure 4.3
**OVERVIEW OF TECHNIQUES WHICH CAN BE UTILIZED IN DIFFERENT
PHASES OF CONTROL THERAPY****

Note: references () are both to where the material is covered here in the Training Manual-- e.g., TM 1 , Appendix 1); and where it is found in the book *Control Therapy*: CT.)

ASSESSMENT AND GOAL SETTING: PHASE ONE

Identifying Areas of Concern: Assault to Sense of Control

Shapiro Control Inventory (SCI): Control profile: Desire, modes, agency (TM 1, App 2, CT Ch. 3)
Content analysis of language—control speech (TM 1, TM 2, CT Ch. 9, CT App C)
Self-observation (TM1)

Increasing Awareness: Insight and Oversight

Control stories: Sources of, exploring (TM 1.4; TM 2.2; TM3.1 CT Ch. 9& 11)
Control dynamics and assumptions (TM 2, CT Ch. 9)
Self-observation, self-evaluation (TM 2; Manual homework; CT Ch. 10, 11)^
Eyes closed mode dialogue: Awareness of preference (TM 2.4; CT Ch. 11) ^
Six dimensions of control and self-control: (TM2)
Right and responsibility (TM 3.1; CT Ch. 8, 10, & 11)
Diaphragmatic breathing (TM 3.1, Appendix 3.11; CT Ch. 10) ^
Body scan (TM 3, p. 64; Manual Appendix 3.12; CT Ch. 11)^
Mind scan [In TM3 “attentional control” including mindfulness and big mind game, TM4;
and “Appendix 3.10 (mindfulness): mind scan” ; CT Ch. 11)^
Exploring decision making process (TM 3.3)^

Clarifying Goals

Control Mode dialogue with resistances (TM 2.3; App 3.8; CT Ch. 11)^
Envisioning which mode to choose (TM 2.3; CT Ch. 11)
An external Rorschach vignette (TM 3.2; TM4, 116; CT Ch. 8)
Breath cycle and the four modes (TM3.1)
Decision making: prioritizing domains & modes. (App 3.9; CT Ch. 11)^
Client handout for short and long-term goals (Appendix 3.2; CT Ch. 12)^
Self-management contract (Manual Appendix 3.7; CT Ch. 11)^
Questions to Facilitate Discussion of Mode Control Stories (App 3.6.; CT Semi-structured
Interview, Appendix B),
Eyes closed: Clarifying issues, affect, meaning (TM3. TM4; CT Ch. 11)
Finding the root issue (TM 3.1; TM4, 4 ; Chapter 12, Case 1, p. 240)

INTERVENTIONS: PHASE TWO

Clarifying and Enhancing Motivation

Proactive exploration of barriers to control (TM 3.1; CT Ch. 11)
Enhancing motivation for positive assertive mode (TM 3.1; CT Ch. 11)
Recognizing limits of over control (TM 3; CT Ch. 11)
Enhancing motivation for positive yielding mode (TM 3.1; CT Ch. 11)

** The distinction between intervention phase, and baseline (assessment, goal setting phase) make sense at one level. However, the very act of going to a therapist, assessing oneself, self-monitoring, can also be considered techniques and an intervention of sorts. We realize this even as we sort techniques into two phases in Figure 4.3

Enhancing Self-Efficacy Beliefs and Commitment to Change/accept

- Self-efficacy beliefs (TM 3.1; App 3.3 Intention to change/accept CT,Chapter 11) ^
- Examining past successes (TM 3.1; CT Ch. 11)
- Thoughts to enhance change/acceptance (TM 3.1); CT Ch. 11)^
- Reaffirming-commitment to change/acceptance (TM3.1; CT Ch. 11)
- Visualizing success in each positive mode Control Mode Rehearsal) TM 3.1

Matching Techniques to Client

- Selecting techniques (TM 3.2; TM 4; CT Ch. 8)
- Five steps for assertive change mode of control (TM 3.1; CT Ch. 10)
- Five steps for the yielding mode of control (TM 3.1; CT Ch. 10)
- Dealing with negative thoughts (TM 3.1)
- Integrating and balancing two modes (TM 3.2; CT Ch. 10)
- Rewriting and editing control-stories (TM3.2.1); CT, Ch. 9)
- Control Mode Rehearsal (TM 3.1; App 3.14; CT Ch. 10)
- Positive Control Modes in Relationship (TM3.2) ; CT Ch. 13)
- Yoga dyad, Tai Chi Dance (TM 3.2)
- Xujing (centering) and donging (finding best response) TM 3.2
- Concentrative meditation objects of attention (TM 3.3)

Matching Teaching Style to Client

- Importance of relationship (TM 4,; CT Ch. 8)
- Addressing client's control needs in session (TM 4; CT Ch. 11)
- Meeting clients where they are (TM 4; CT Ch. 8 & 11)
- When therapist and client disagree: gradated responses (TM 4; CT Ch. 8)
- Teaching of techniques (TM 3.2, TM4; CT Ch. 8 & 11)

OVERVIEW: Figure 3.2.3

^= Client handouts and forms in Appendix 3

This concludes the didactic aspect of Part Two, Training Module 4. In many ways, this is just the beginning of clinical supervision and training. Role-plays among trainees, both live and videotaped, as well as “real” therapy sessions using one-way mirrors, closed circuit television, and/or videotaped sessions recorded and reviewed by the small group of supervisor(s) & trainees can all be helpful.

To help in the evaluation of skill development and competency in Control Therapy, we have created an Adherence Checklist (Appendix One). This can be used as a guideline and means of self-assessment for trainees as well as a systematic way for the trainer to give feedback at different points in the training process.

We leave the exact nature of that supervision to the creativity of the trainers.

HOMEWORK.

4.1. There were several questions raised on General control-related competencies for the therapist in the therapeutic encounter. Please go back through those questions and spend some time reflecting and writing as honestly as you can about how you would answer. Also please give some thought to the discussion question on your own views and values in terms of when a) therapist and client disagree; and b) your style and skills regarding nuanced ways, from assertive to yielding in addressing those disagreements.

4.2 Each therapist has to evolve his/her own view of the therapeutic relationship, based on personal style, theoretical orientation, view of the nature of the universe (and human nature), and the role of human control (Appendix 7). Please review from your journal the questions raise in Module 2: a) your views of the nature of the universe and

the role and importance of human control; b) your theoretical orientation's view of human nature (i.e., personality theory) and the limits and importance of human control. Further, as Jung observed, the personality theories we create and the systems of therapy we embrace are not unrelated to our own personalities. What have you learned, or what do you know about yourself and your own personal style, that might have influenced your choice of theoretical orientation and system of therapy? How might those views affect your ideas and expectations about the role of the therapist and the therapist-client relationship? (Discussed on pp.252, 257-258 above? E.g. Do you see individuals as innately self-actualizing and therefore see your role primarily as offering non-judgmental accurate empathy, and allow their true self to emerge in a safe environment? Do you feel it important to assess what skills a client may need to learn, or is not using skillfully, and therefore see yourself as an educator, a coach? Do you believe the client may use defensiveness, denial, rationalization, and other avoidant techniques that are not in the client's interest, and that you have a responsibility to help bring those to awareness?)

4.3. Please look at the *Adherence Checklist in Appendix One*, and evaluate at this point which areas you feel are your strengths, and which areas need further development and attention.

4.4. As you are willing, please continue to listen to your control speech. Actually, it's probably no longer necessary to remind you, is it? It's hard to unlearn a way of seeing the world once you've seen it! If we were to say, paradoxically, please don't listen to control speech anymore, what would happen? The issue of control is pretty tricky! Sorry! ☺ (It's like Dostoevsky's *Notes from the Underground* where the underground man is philosophizing about free will and how important it is to him. He says if it could be proved he didn't have free will, and someone could predict what he would do, he would do just the opposite just to prove he had free will. And, if that also could be predicted ahead of time, well, then life just might not be worth living. We've learned a lot since then about the nuances and complexity of free will and personal control, but it's still a bit of a conundrum, isn't it?)

4.5. Please continue *your self-management project*, and keep writing in your journal about what you are learning.

4.6. As a final point, we would like to remind you, as we end Training Module Four, and as you begin to see clients, to remember to *take care of yourself!* Working with clients, as rewarding as it is, also involves giving out a lot of energy. We like the medical metaphor of the heart. Where does the heart first pump blood? Although we might think intuitively the answer is the brain, or lungs, in fact the heart pumps blood to itself first, so it has energy to give to the rest of the body.

As you give and share your "heart" and intelligence and wisdom with others, we invite you to ensure that you are also paying attention to yourself on each of the domains we have discussed: Body (exercise, healthy eating, a good nights sleep); Mind (relaxing it, finding enjoyable ways to focus it); Interpersonal (time with friends); Spiritual (as you define it); and at least one fun thing a week!

We now turn to a few concluding remarks.