# PART ONE

# EXAMINING CONTROL THEORIES

It is the theory which decides what we can observe.
EINSTEIN

CHAPTER 1

# A Historical and Contemporary Overview of Control Theories

HOW WOULD we interpret and respond to a client's statement *"All circumstances are beyond my control"*? Do we reflect with nonjudgmental warmth and accurate empathy? Do we seek the client's narrative story regarding control, the meaning it has for him? Perhaps we share authentically our own existential choices in a world seemingly out of control, noting the opportunity such crises of chaos provide.

From another perspective, we may seek to operationalize what he means by *control* and *all* so he can self-monitor *out of controlness*. Some will begin a search for childhood experiences—a domineering or too-passive mother or father—responsible for his loss of control. Others may reflect philosophically on the lessons of impermanence and the dangers of egoic striving. The central task, they will point out, beyond addressing the external circumstances, is to learn internal control—peace and equanimity. Finally, for those more biochemically oriented, there is the prescription pad and the latest (SSRI) generic for Prozac.

How we respond to and utilize issues of control in our therapeutic practice will be a function of our beliefs, values, assumptions—in short, our theories. A theory can be thought of as an effort to provide a map of a particular terrain, a story about events. The word *theory* comes from the Greek *theos*, which means divinity, and *reian*, which means a peak or promontory. From this perspective, the larger and more accurate our theory, the better we are able to take an encompassing view from the peak and guide ourselves and others through the terrain.

As health care professionals, each of us has an implicit or explicit theory that guides our work (Bandura, 1986; Kuhn, 1970). We should examine these theories closely, for they are the foundation that determines the scope

and nature of our investigations, our conception of the therapeutic process, and the ways in which clinical results are interpreted.

In this chapter we give a brief overview of research showing the importance of control in mental and physical health. We then examine the assumptions about control in several different schools of therapy. Each of these theories about human nature articulates how much control comes from the environment, from biology, and/or from the individual's cognition/volition. For each theory, the nature and scope of interventions is determined by beliefs about the relative amount of personal control humans can exert over their well-being. Finally, we review previous efforts to develop a unifying theory of control and a control-based approach to therapy. In Chapter 2, we detail our own efforts toward a unifying theory of control, showing how it emerges from and integrates previous ones.

## CONTROL AND SELF-CONTROL REEMERGE IN MIND–BODY STUDIES

It was only in the late 1950s and early 1960s that mainstream psychology began to seriously reexamine issues of human control. Before that time, when psychology disowned its parent, philosophy, issues of mental control, willpower, and voluntary control of consciousness had been relegated to the graveyard of epiphenomena (Skinner, 1953, 1971). There was not even a Cartesian mind–body split, but simply materialism. The elimination of these terms with their introspective (and sometimes teleological) philosophical connotations was seen as critical for psychology's empirical and scientific development.

Resurgence of interest in control came from multiple sources (Klausner, 1965), including neoanalytic perspectives on competence and dyscontrol (Menninger et al., 1963; White, 1959); early social learning theory (Rotter, 1954, 1966); and behaviorists' excursion into the lion's den of self-control and cognitive processes (Homme, 1965; Kanfer & Karoly, 1972; Meichenbaum, 1977; Thoresen & Mahoney, 1974).

In addition, anecdotal reports were appearing from India and Asia of extraordinary achievements of bodily control, as well as research on astonishing feats of mental control by long-term meditators (Anand, Chinna, & Singh, 1961; Kasamatsu & Hirai, 1966). With the development of increased technological sophistication (Green et al., 1970), Western scientists began looking at the possibility of increased human control over what heretofore had been considered involuntary and autonomic aspects of human functioning (DiCara, 1970; Miller, 1969).

During the past three decades, clinicians, researchers, and theorists have made a major contribution in addressing the question of how individuals gain and maintain a sense of control in their lives. Several control-related constructs have been explored and refined. Nonpharmacological self-regulation strategies were developed to provide individuals increased control over their affect, behavior, and cognition. Hundreds of studies and dozens of books were devoted to the theory, research, and application of a variety of personal control strategies to health care and psychotherapeutic concerns.

This body of work demonstrated that our ability to gain and maintain a sense of control is essential for our evolutionary survival (Averill, 1973; Bandura, 1989a; Shapiro, 1990; White, 1959); is a central element in psychotherapy and mental health (Bandura, 1989b; Beck, 1976; Beck & Weishaar, 1989; Frank, 1982; Shapiro, Schwartz, & Astin, 1996; Taylor & Brown, 1988, 1994); and is important for our physical health (Matthews, & Weiss, 1994; Peterson & Stunkard, 1989; Rodin, Schooler, & Schaie, 1990; Syme, 1989).

Further, having control has been shown to benefit both health and mood across the human life span, from childhood (Cohen, Evans, Stokols, & Krantz, 1986; Rothbaum & Weisz, 1989; White, 1959) through middle adulthood (Averill, 1973; Langer, 1983; Miller, 1979, 1980; Thompson, 1981) and for the elderly (Abeles, 1990; Baltes & Baltes, 1986; Riley, 1990; Rodin, 1986; Rodin & Langer, 1977; Shapiro, Sandman, & Grossman, 1995).

## Control, Mental Health, and Psychotherapy

There is increasing agreement among clinicians and researchers that control is a critical variable involved in individuals' psychological health and well-being (Bandura, 1989a; Beck, 1976, 1989; Seligman, 1991; Taylor & Brown, 1988, 1994). Mental well-being is associated with feeling in control of our internal psychological environment (e.g., cognitions, beliefs, thoughts, emotions) and our overt behavior. Regardless of diagnoses, patients entering therapy make significantly more statements about loss and lack of control, and fear of losing control than statements reflecting having control, or the belief that they can gain control (Shapiro, Bates, Greensang, & Carrere, 1991). A primary task, therefore, of schools of psychotherapy is to help individuals recognize what forces are shaping their lives, to learn which they can and cannot control, to teach them to have more control over those forces they can, and to accept those they cannot (Bandura 1989a; Frank, 1982; Menninger et al., 1963; Shapiro, 1998; Strupp, 1970).

## CONTROL AND PSYCHOPATHOLOGY

The *DSM-IV* (1994) cites *dyscontrol* as a major concept in clinical pathology. Impairment of control is a central feature in several clinical areas: stress- and anxiety-related disorders (Abramson, Garber, & Seligman, 1980; Bandura, 1988; Cloitre et al., 1992; Shapiro, 1990); depression (Burnette & Mui, 1994; Deutsch, 1978; Matthews, 1977; Seligman, 1975); drug and alcohol addictions (Marlatt, 1983; Nathan, 1986; Shapiro & Zifferblatt, 1976a); eating disorders (Jeffrey, 1987; King, 1989; Shapiro, Blinden et al., 1993; Williams et al., 1990); and the at-risk population of adult children of alcoholics (Black et al., 1986; Shapiro, Weatherford, & Kaufmann, 1994). Research has also shown that clinically specific control profiles can be developed for patients diagnosed with panic attacks, borderline personality, depression, and generalized anxiety (Shapiro, Potkin et al., 1993; Shapiro, 1994a).

## PSYCHOLOGICAL ADAPTATION TO PHYSICAL DISEASE

Sense of control is also related to positive psychological outcomes in individuals with physical illness (Affleck et al., 1987). In general, research shows that those who believe there is something they can do about their disease, or about the accompanying stresses, have a more positive psychological adaptation than those who do not. For example, the experience of personal control in late-stage cancer patients is positively correlated with scores on self-esteem, purpose in life (Lewis 1982), quality of life, and positive mood (Cunningham et al., 1990). Another study revealed that personal sense of control was the only psychosocial factor that predicted adaptation in cancer patients after 6 months of follow-up (Ell et al., 1989). Conversely, lack of control is related to the anxiety and depression experienced by many cancer patients (Derogatis et al., 1983; Freidenbergs et al., 1982; Greer & Silberfarb, 1982; Meyerowitz, 1983; Shapiro, Anton-Culver et al., 1998).

## CONTROL AND PHYSICAL HEALTH

Other research has shown that a person's sense of control has pronounced effects on morbidity and mortality. For example, in Alexander et al.'s (1989) study, nursing home residents who were taught internal self-control strategies (i.e., relaxation, mindfulness, meditation) tended to live longer than those in a control group. In Rodin and Langer's often-cited study (1977), nursing home residents given control over deciding about external variables (e.g., time and nature of meals, movies) lived longer than a matched comparison group.

Similarly, research on a variety of diseases indicates the importance of control in moderating outcomes. In cancer studies, low perceived control and a helpless attitude toward the disease is a powerful predictor of first recurrence and death from the disease (Andersen, Kiecolt-Glaser, & Glaser, 1994; Antoni & Goodkin, 1988; Di Clemente & Temoshok, 1985; Greer et al., 1979; Jensen, 1987; Pettingale et al., 1985; Schmale & Iker, 1961; Stavraky et al., 1968; Watson et al., 1991). Issues of control have also been implicated in cardiovascular disease where increased cardiovascular reactivity and risk have been associated with low perceived control, poor self-discipline, and external locus of control (Bugental et al., 1993; Karasek, 1982; Schnall, 1990; Wright et al., 1992).

## DIFFERENT THERAPEUTIC SCHOOLS AND THEORIES OF CONTROL

From this overview of the literature, we may conclude that there is virtually no system of therapy whose theoretical basis does not in some way touch on the issue of control. In this section we focus on the role of control in current schools of psychology. Textbooks generally divide the field of psychology into three (and sometimes four) major schools: psychoanalytic, behaviorist, humanistic/existential, and transpersonal (Peterson & Nisenholz, 1995). Although the divisions are somewhat imprecise, as noted in the following sections, we utilize them to illustrate different characterizations of control. Before doing so, we briefly overview some of the philosophical precursors to our current understanding of control.

### Philosophical Views of Control

Late nineteenth century psychology still had textbook chapters on will and self-control based on the image of a person as an initiator of action. American psychology after G. Stanley Hall, and German psychology after Ach and Lewin, moved away from those notions toward concepts of drive and motive, voluntary and involuntary muscles. Although psychology disavowed its parent, philosophy, there are numerous philosophical precursors (e.g., will, freedom, determinism) to concepts of personal control. These precursors examine questions such as Does personal control (i.e., will) actually exist? Do individuals have free choice, or is it an illusion of control? What is the relationship between will, personal control, and moral behavior? Table 1.1 summarizes these historical views. These philosophical discussions on control have found their way into contemporary psychological thinking.

TABLE 1.1
THE CONSTRUCT OF PERSONAL CONTROL (WILL, SELF-CONTROL)
HISTORICAL OVERVIEW

Greek Paradigm (Hadas, 1965)

Plato, in *The Republic*, noted that appetites needed to be guided and ruled by reason, but reason depends on spirit, for without its support, even wisdom must fail to influence conduct. The function of spirit was "what later writers call 'will.' " (Hamilton & Cairns, 1961).

Aristotle used the term *will* (along with wish, choice, purpose, impulse, appetite, and desire) to designate a motivating force—a factor that turns thought into action (Barnes, 1984).

Stoics made the will the sole repository of moral goodness. Epictetus said that "all good and evil lie in man's will and the morally neutral sphere is in the region outside the will's control" (Epictetus, 1956).

St. Augustine

Augustine first used will in a form similar to modern thinkers to point to the essence of the moral self (O'Meara, 1973).

Thomas Aquinas

Aquinas said will is just another name for the desire or appetite that is determined by reason. God is the ultimate cause of what a man freely chooses to do. Aquinas distinguishes between those acts of the will that are necessitated and those that are free (whereas Kant identifies will with free will: "natural necessity does not take away the liberty of the will") (Clark, 1972).

Immanuel Kant

Kant identified will in its pure state with reason. "A human act of choice . . . though in fact affected by impulses or stimuli, is not determined by them." For Kant the pure will is free will, "the active choice that is determined by pure reason is the act of free will." The freedom of the act of volitional choice is its independence of being determined by sensuous impulses or stimuli. Kant does believe in free will and doesn't believe, like James, that it needs to be an act of faith (Kant, 1956).

G. W. Hegel

Hegel believed that freedom and choice are the essence of will. "An animal, too, has impulses, desires, inclinations, but it has no will and must obey its impulses if nothing external deters it. Only man, the wholly undetermined, stands above his impulses and may make them his own, put them into himself as his own" (Weiss, 1974).

Thomas Hobbes

Hobbes argued that "imagination is the first internal beginning of all voluntary motion." Therefore, Hobbes' view is that willing is an act of desire (Molesworth, 1939/1651).

TABLE 1.1 (*Continued*)

John Locke

Locke believed that will is perfectly distinguished from desire and that desire may "have a quite contrary tendency from that which our will set us up upon." Will is "the power to direct the operative faculties to motion or rest" (Locke, 1965/1690).

David Hume

Hume said there is no free will, even though it is "a matter of common experience." We suffer this illusion, he said, because we are motivated by "the fantastical desire of showing liberty." But the power and energy by which this is effected, like that in other natural events , is unknown and inconceivable (Selby-Bigge, 1967).

B. Spinoza

Spinoza similarly stated that there is no such thing as free will, even though he experienced it: "I am conscious of a will so extended as to be subject to no limits." Yet Spinoza said that the human mind "cannot be the free cause of its own actions." In each of its volitions as in each of its ideas, it is determined by a cause (Spinoza, 1927).

René Descartes

Descartes placed freedom in the will and identified it with the power of choice. "The faculty of will consists alone in our having the power of choosing to do a thing or choosing not to do it." "I make no assumption concerning freedom which is not a matter of universal experience." In responding to those who deny free will he said, "Refuse then to be free, if freedom does not please you; I at least shall rejoice in my liberty, since I experience it in myself" (Descartes, 1955).

William James

James saw will in terms of attention, effort, and responsibility: "The action which is performed voluntarily must before that, at least once, have been impulsive or reflex." "Effort of attention is thus the essential phenomenon of the will", an effort not determined by its object. The first act of free will should be to believe in free will. The grounds of his opinions are ethical rather than psychological. Belief in free will "should be voluntarily chosen from amongst other possible beliefs. Freedom's first deed should be to affirm itself" (James, 1979).

## Analytic Tradition

Psychoanalysis is generally considered the "first force" in psychology. Freud (1923) put forward a biologically based view in his early work, claiming that the individual is governed "by unknown and uncontrolled forces" a powerful, unconscious id. These forces involve instinctual desires to maxi-

mize pleasure and gratification, and contain a large share of innate aggression. As Freud (1961) noted, "Love thy neighbor as thyself is justified only by the fact that nothing else runs so strongly counter to the original nature of man" (p. 57–58).

Freud (1961) argued that the function of the ego was to learn to give individuals more control over (i.e., rein in) these powerful pleasure-seeking and aggressive id impulses: "Where id was, ego shall be" (p. 57–58). However, in his early work, Freud felt that we are relatively helpless to effect change, and was pessimistic about the possibility of personal control, noting that the ego was doomed "forever to be a horseback rider on the wild horse of the id." For example, when Freud (1959b) terminated Dora after only a few weeks, he said that one of the limits of psychotherapeutic influence was the patient's will and understanding (p. 131).

Psychoanalysis did not stop with classical id psychology (Greenson, 1968; Rosenblatt & Thickstein, 1977). Neo-Freudians continued to examine the role of control from several different perspectives (Haley, 1958, 1959). Hartman, Kris, & Lowenstine, (1949) discussed the idea of a conflict-free sphere of the ego, a precursor to several ego-based analytic approaches. Hartmann (1964) talked about the autonomous ego developing in a deterministic fashion but then becoming relatively independent of and able to regulate and thereby exercise greater independent control and mastery over the instincts from which it had arisen.

Rank (1950) attempted to develop a will psychology derived from Nietzsche, and Farber (1966) explored what he called the two types of will (conscious and unconscious) and taught a will training to individuals to help them gain greater control over their lives. Object relation theorists such as Klein (1932) and Mahler (1968) focused attention on how individuals differentiate from their environment and learn to gain control both over their own emotions and over the environment.

Adler (1964), attempting to move beyond Freud's psychosexual stages, posited a will to superiority as a primary drive, arguing that much of our behavior is motivated by a need to overcome our lack of control stemming from basic feelings of inferiority. To address these feelings of inferiority, he proposed that each of us create a lifestyle whose goals are to "understand, predict and control life and self".

Still within the psychoanalytic tradition, Hendrick (1943), referring to an innate desire to control, argued for an "instinct to master," and Angyal (1941) wrote of humans' "characteristic tendency toward self-determination . . . a tendency to resist external influences and to subordinate the [external] forces of the physical and social environment to their own sphere of influence." These theories can be seen as precursors to White's (1959) influential work on the concept of competence (i.e., personal control and mastery over the external environment) as a motivational force.

Menninger and his colleagues (1963) in the 1960s attempted a unifying theory of control. Focusing primarily on abnormal psychology, Menninger (1963) argued that mental illness is a function of disorganization and lack of control. This lack of control could come either from internal or external sources, and the less the control, the greater the mental illness. Menninger's theory was unified, if simplistic, in that it posited a single cause of mental illness. Thus, diagnoses ranging from mild anxiety to severe schizophrenia reflected varying degrees of a lack of control. Regaining normality would be achieved through psychoanalytic therapy designed to restore control to the patient.

### Behavioral Tradition

Radical behaviorists, somewhat in the vein of the philosopher John Locke, argue that people are neither good nor bad, and that the environment is the critical variable determining and controlling human behavior (Skinner, 1953, 1971; Watson, 1958/1925). Marxists, sociologists, and those anthropologists who emphasize political or cultural determinism also subscribe to this general orientation, that is, that external factors govern the course of human lives.

The behavioral approach has broadened considerably, based on the pioneering work of Wolpe (1969) and Lazarus (1971), the contributions of cognitive therapists (Ellis, 1962; Mahoney, 1977; Beck 1976, 1989; Meichenbaum, 1977) and the development of broad-spectrum social learning theorists (Bandura, 1986; Lazarus, R., 1981). Cognitive theorists argue that faulty thought patterns and belief systems play dominant roles in robbing individuals of their sense of control, and that people can regain control by reprogramming these patterns and belief systems. Thus, broad-spectrum behaviorists have modified the original position by allowing unobservable, internal factors as causes of behavior. They further point out that people need to have knowledge of the internal and external factors that control them as a prerequisite for self-directed change. As a result, behaviorists became vitally interested in topics of self-control (Goldfried, 1973; Thoresen & Mahoney, 1974) and self-regulation (Schwartz, 1982).

Within the general field of behavioral-oriented psychology, we find several control-related concepts:

- The *freedom reflex* of Pavlov (1960/1927), in which dogs in the lab conditioning experiments initially resisted being put in the harness.
- *Self-regulation and disregulation* (Schwartz, 1983), in which lack of awareness and repression inhibit optimal functioning, based on a cybernetic (self-regulatory) and general systems theory point of view.

- *Self-control,* variously defined as (a) response of an organism made to control the probability of another response (Cautela, 1969); (b) engaging in a low-probability behavior in the absence of immediate external constraints (Thoresen & Mahoney, 1974); and (c) a social label differentially applied to behavior patterns which involve some type of effort, are socially desirable and involve perceived sacrifice (Mahoney & Arnkoff 1979).
- *Delay of gratification* (Mischel et al., 1972, 1981), which occurs when the delay is not imposed by external situations (frustration), but is self-imposed, (will-power, ego strength), enabling individuals to "achieve mastery over many aspects of their being, including their psychological state."
- *Locus of control* (Rotter 1966, 1990; cf. Strickland, 1990), which represents the extent to which individuals believe that event outcomes are in their (internal) or other's (external) control.
- *Learned helplessness* (Seligman, 1975), which results from experiencing repeated instances of lack or loss of control over gratification and relief of suffering, in which the individual believes himself to be powerless and helpless, has a negative outlook on the future, and responding does not control important reinforcers.
- *Self-efficacy,* which is the subjective assessment that one has the internal or external resources to cope with a given or hypothetical situation (the "self-appraisal of competence and control" [Everly, 1989]), can occur over two non–mutually exclusive pathways: over the external environment and over the self (Bandura, 1977, 1989a).

## HUMANISTIC/EXISTENTIAL TRADITION

Textbooks summarize the first force, the psychodynamic position, as saying we are controlled by unconscious biological, instinctual forces. Behaviorism, the second force, ascribes control to environmental factors. Both theories argue that humans are influenced by powerful internal and external forces largely outside their conscious awareness and control. The third force, humanistic/existential, is seen in many ways as a rejoinder emphasizing the importance of personal choice, individual freedom, and the right and responsibility of individuals to be in control of their own lives.

There are also notable divisions within the third force. For humanistic, or client-centered therapists, humans are considered innately good. The goal of therapy, therefore, is to uncover that nature, to move away from the façades, oughts, and pleasing of others, and to move toward self-direction—being more autonomous and increasingly self-trusting (Angyal, 1965; Goldstein, 1559/1934; Maslow, 1968, 1971; Rogers, 1961). Psychological health

involves turning from external, other-directed control to internal self-control, personal autonomy, and self-responsibility.

Existentialists such as Sartre, (1947, 1956), May (1989), and Yalom (1980) argued that personal control is realized through exercising our freedom to make choices. This position is captured in Sartre's phrase "existence precedes essence," the view that we are neither innately nor environmentally determined, but develop and evolve through our choices and actions. Existence (i.e., how people act and interact with the world) precedes essence (i.e., any biologically innate nature, such as an amoral id or self-actualizing essence). The existential theory of "existence precedes essence," is actually closer to the behaviorist's blank slate than it is to the humanistic view of an innate self-actualizing ego.

Historically, existentialism was a reaction to Kant and Hegel's systems of philosophy. Three existential tenets apply to control issues:

1. All of us must face decisions with partial knowledge and limited time in which to decide. There are no completely objective standards. Therefore, we are free and responsible.
2. To overcome the fear and anxiety accompanying responsibility, we try to escape our existential situation. Instead of escaping, we should be aware of and accept the human situation.
3. We best learn about ourselves by examining the most extreme trials of human existence: death and the shadow it casts on life; the difficulty, if not impossibility, of maintaining satisfactory relationships with others; the ultimate futility and absurdity of life; and the inescapable presence of anxiety and dread (Barrett, 1958; Bugental, 1976; Kaufmann, 1960; May, 1961, 1989; Wilde & Kimmel, 1962).

The goal for existentialists, in a relativistic world, is to use our power and control to make authentic choices, to create and forge meaning from a random universe, and to stand forth, to "deny our nothingness" (Malraux, 1953).

### Transpersonal Tradition

Finally, some textbooks (Peterson & Nisenholz, 1995) add a fourth force, a transpersonal approach. Peterson and Nisenholz (1995) note:

> The field of counseling and psychotherapy today is dominated by three major theoretical orientations: Psychoanalytic, behavioral, and humanistic–existential. A fourth force, a transpersonal approach, is also beginning to make its presence felt, and despite its lack of historical development, it's attracting a significant following.

Transpersonal psychology suggests that the traditional Western psychological goal and end state of a healthy, autonomous ego (even a self-actualized one) is limiting and insufficient. From a transpersonal psychological perspective, the goal of therapy is to go beyond the individual ego, or smaller self, through awakening, to a higher level of consciousness, an experience of interconnection with a larger self, others, and the universe (Wilber, Engler, Brown, 1986; Tart, 1975, 1986; Vaughan, 1986; Walsh & Vaughan, 1995; Wilber, 1993).

Although the transpersonal approach is not religious per se, it borrows heavily from esoteric spiritual/religious traditions and notes the importance of control in the world's great religious traditions (Astin & Shapiro, 1997). Transpersonal psychology holds two seemingly paradoxical views regarding control: (a) individual efforts are important to gain active control of our self, mind, and passions, and (b) surrendering active control is also essential (Astin & Shapiro, 1997). As Yogananda said, "Strengthen your will power so that you will not be controlled by circumstances, but will control them." Buddhism (1981) states that "A disturbed mind is forever active, jumping hither and thither, and is hard to control; but a tranquil mind is peaceful; therefore it is wise to keep the mind under control" (p. 364). Similarly, Judaism suggests "A master of his passions is better than the conqueror of a city" (R. Tarfon, Pirke Avot, 1985).

Some different traditions advise individuals to learn to let go, relinquish active control, and surrender themselves to the universe, the eternal present, the "isness" of life processes. For example Chuang-tzu stated, "No drives, no compulsions, no needs, no attractions. Then your affairs are under control. You are a free person." Some suggest an integration. Ramakrishna said that "Although the winds of God's grace are always blowing, you must raise your sail."

## SEEKING A UNIFIED THEORY OF CONTROL

In the previous section, we presented the control-related aspects of the four forces in psychology. All the mentioned schools of thought have theories that include aspects of control. Although there is some truth in the four force typology, it is clear that many of the positions overlap, that each school has accommodated insights of its rivals, and that concepts of causation and determinism have become elastic. However, this overview is an essential foundation for developing a more comprehensive theory and therapy of control.

In this section, we briefly present additional control-related psychological constructs, summarize different theories' views about the ultimate source of control, and highlight previous efforts to develop a unifying theory of control.

## Additional Control-Related Constructs

It has been suggested that control is a critical component underlying a number of related psychological constructs (Everly, 1989; Rodin, 1990; Rodin & Salovey, 1989; Skinner, 1996): coping, optimism, hardiness, sense of coherence, and reactance theory. We briefly note each of these in Table 1.2.

TABLE 1.2
Additional Control-Related Constructs

| | |
|---|---|
| Coping | Folkman (1984) noted that generalized beliefs about control influence primary cognitive appraisals (how much of a threat is a given circumstance), whereas situational appraisals of control are an important component of secondary appraisal (the evaluation of coping resources and options). |
| Optimism | Weinstein (1993) highlighted the close correlation between controllability and optimism, and Peterson (1990) discussed optimistic/pessimistic attribution theory and explanatory style (Petersen, Seligman, & Vaillant, 1988) as a "control cognate." |
| Power | Fiske (1993) defined "power" as "asymmetrical control over another person's outcomes" (p. 623). |
| Hardiness | Hardiness includes three components, one of which is control (Kobasa, 1979; and some have suggested that sense of personal control may be the critical component that mediates this construct's relationship to health outcomes (Cohen & Edwards, 1989). |
| Sense of Coherence | Coherence requires that one's coping activities occur within a personally meaningful context of community, tradition, or cosmos that both sets a limit to personal control and makes "affectively comprehensible" the many uncontrollable and tragic aspects of human life (Antonovsky, 1979) |
| Reactance Theory | Reactance grew out of the "balance theories" prevalent in social psychology in the 1950s and 1960s, and is defined as an unpleasant drive state and restoration of cognitive balance occasioned by the real or threatened removal of some perceived freedom or personal control (Brehm 1966, 1991). |

## BIOPSYCHOSOCIAL MODELS OF CONTROL

As noted, each theory, whether philosophical or psychological, has different assumptions and views about the amount of control that comes from (or is determined by) environmental, biological, or psychological variables. Some views are unideterministic and assert that there is one primary variable responsible. For radical behaviorists this variable is the environment, for existentialists it is personal choice, and for reductionistic biologists it is genetic/biological factors.

Other views involve reciprocal causality between two or more variables. These views form the basis for our biopsychosocial theory of control (Shapiro, Schwartz, & Astin, 1996), which we develop in Chapter 2. Our view says that there is no one single source of control, but rather there are multiple influences. For example, Bandura's (1978) reciprocal determinism notes that we influence the environment that influences us. Sperry (1985, 1988) argues that it is not just molecules and biochemical process that determine behavior (what he calls "control upward") but that "consciousness can be causal." Human values, beliefs, and goals help determine biochemical processes. Finally, some views involve multiple (omni) sources of causality

TABLE 1.3
UNI-, RECIPROCAL, AND OMNI-BIOPSYCHOSOCIAL MODELS OF CONTROL

| | |
|---|---|
| Radical Behaviorism | Behavior as function of environment; control determined by environment (Skinner, 1953, 1971; Goldiamond, 1965) within limits of nervous system. |
| Existential Will | Behavior as a function of the person; person chooses and is responsible for developing control (May & Yalom, 1989; Bugental, 1976) within existential limits and givens. |
| Biological Determinism | Control upward: Biology determines actions, thought, behavior (Sperry, 1988; Wender et al., 1982; Wilson, 1975; Dawkins, 1985; Crick, 1993; Churchland, 1995). |
| Reciprocal Determinism | Control as a function of mutual interaction between individual and environment (Bandura, 1978; Delgado, 1969); consciousness can influence biology (Pribram, 1988; Sperry 1985, 1988); control as emerging properties of brain function (Sperry, 1985, 1988). |
| Omni-determinism | Control as a function of multiple variables; analogous to a systems/cybernetic model (Minuchin, 1974; Schwartz, 1983) |

in which biological, psychological, and social/cultural processes all interact. These views have been compared to a systems or cybernetic model in which each part influences each other part. These views are summarized in Table 1.3.

### Previous Efforts at Unifying Theories

As noted, efforts at a unifying theory of control can be seen in the work of Menninger (1963) from a psychoanalytic perspective, and Rotter (1966) and Bandura (1977) from a social learning perspective. There have been several attempts at a unified theory that combines different traditions. Becker (1973), in his Pulitzer Prize–winning book *The Denial of Death*, reinterpreted Freudian thought in terms of existential philosophy. He argued that the deepest human motive is the effort to gain control over death, the aspect of existence most out of our control: "We struggle, . . . for cosmic significance, . . . the desire to stand out, to be the one in creation, first in the universe [and hope that what we create is of lasting meaning that can] outlive or outshine death and decay" (p. 5)

The work of psychiatrist Victor Frankl (1980) provides another example of an attempt at a unified theory of control, utilizing both psychodynamic and existential foundations. Frankl developed logotherapy—his system of psychotherapy—during his experiences in a Nazi concentration camp. He claimed that what is most important to humans is the "will to meaning," the ability to use cognitive control to frame events in ways that order the turbulent flow of experience. Frankl believed it was essential for our well-being to find meaning in random or catastrophic events, to be able to create order out of chaos. He felt that the person who has a reason to live will be able to find a way to overcome adversity. Frankl's view puts considerably more emphasis on personal cognitive control than early Freud does. Frankl noted

> The experience of camp life shows that man does have a choice of action . . . of independence of mind, even in such terrible conditions of psychic stress. Everything can be taken from a man but one thing: the last of the human freedoms—to choose one's attitude in any given set of circumstances, to choose one's own way.

## SUMMARY

This chapter begins by citing research showing the importance of control in mental and physical health. Theory (which translates as "a divine view from a peak or promontory") is an important foundation for systems of psychotherapy, and there are control-related aspects of the four forces in psy-

TABLE 1.4
AN OVERVIEW OF CONTEMPORARY CONTROL-RELATED CONSTRUCTS

Analytical
- Freud (1923): Id governed by uncontrolled forces
- Hendrick (1943): Will to mastery
- Adler (1964): Will to superiority
- Rank (1950): Psychology of will and will therapy
- Farber (1966): Will training; theories of will
- White (1959): Concept of competence
- de Charms (1968): Pawn and originator
- Menninger (1963): Dyscontrol and mental health
- Mahler (1968) and Klein (1932): Control through differentiating from environment; Object relations

Cognitive/Behavioral
- Bandura (1977): Self-efficacy
- Rotter (1966): Internal/external locus of control
- Seligman (1975): Learned helplessness
- Mischel (1972): Control as delay of gratification
- Pavlov (1960/1927): Freedom reflex
- Kobasa (1979): Hardiness
- Kanfer (1979): Personal control
- Mahoney, Thoresen (1974), Cautela (1969): Self-control
- Beck (1976), Meichenbaum (1977), Lazarus (1981), Ellis (1962): Cognitive approaches
- Schwartz (1983): Disregulation

Humanistic/Existential
- Schutz (1958): Control in interpersonal behavior
- May (1961): Control as power, choice
- Rogers (1951): Self-determination
- Frankl (1980): Will to meaning
- Becker (1973): Death as loss of control

Transpersonal (Astin & Shapiro, 1997)
- Zen (Smith, 1983): Self-discipline
- Chuang-Tsu (Lao-tzu, 1936): Letting go of attachments and desire
- Judeo-Christian (Syme, 1986), (Bouwsma, 1976): Controlling passions
- Islam (Lapidus, 1976): Self-rule and surrender to Allah
- Yoga (Yogananda, 1946): Control of the mind and body

Social Psychology and Other
- Lefcourt (1973): Illusion of control
- Langer (1975): Mindfulness, illusion of control
- Averill (1973): Behavioral, cognitive, decisional control
- Rodin (1986): Control-enhancing options from environment

TABLE 1.4 (*Continued*)

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| Antonovsky (1979): Coherence |
| Taylor (1983, 1989): Cognitive adaptation, positive illusion |
| Burger (1979): Need for control |
| Lazarus (1981): Coping |
| McClelland (1961, 1975): Need for achievement; power motivation |
| Glass (1977): Too high desire for control |
| Brehm (1966, 1981): Reactance |
| Kamiya et al. (1971), Miller (1969), DiCara (1970), Schwartz (1979, 1983): Psychological self-regulation |

chology. Control is a critical component underlying several related psychological constructs, and there have been many efforts at unifying theories of control. Table 1.4 provides an overview of contemporary control-related constructs.

Theory, research, and practice during the past three decades has revealed that control is a multifaceted construct, much more complex than initially recognized. Therefore, none of the previous models of control—whether Menninger's dyscontrol, Rotter's internal/external locus of control, Bandura's self-efficacy, or Seligman's learned helplessness—is alone sufficient to understand such a multifaceted concept. In Chapter 2, we present our efforts at a unifying theory of control that attempts to build on and integrate the findings of this chapter.