The effectiveness of cognitive restructuring and paradoxical directives counseling interventions of adolescent self-esteem: a comparative study

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THE EFFECTIVENESS OF COGNITIVE RESTRUCTURING AND PARADOXICAL
DIRECTIVES COUNSELING INTERVENTIONS ON ADOLESCENT SELF-
ESTEEM: A COMPARATIVE STUDY

The College of William and Mary in Virginia

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THE EFFECTIVENESS OF COGNITIVE RESTRUCTURING AND
PARADOXICAL DIRECTIVES COUNSELING INTERVENTIONS
ON ADOLESCENT SELF-ESTEEM:
A COMPARATIVE STUDY

A Dissertation
Presented to
The Faculty of the School of Education
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In Partial Fulfillment
of the Requirements for the Degree
Doctor of Education

by
David Alvin Hall
May, 1986
THE EFFECTIVENESS OF COGNITIVE RESTRUCTURING AND PARADOXICAL DIRECTIVES COUNSELING INTERVENTIONS ON ADOLESCENT SELF-ESTEEM: A COMPARATIVE STUDY

by

David Alvin Hall

Approved May, 1986, by

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Chairman of Doctoral Committee
DEDICATION

For their part in making my life rich, full, and exciting,
I dedicate this book to MERIEL, EMILY, and GRAEME HALL.
Acknowledgement

I would like to thank all those who participated in and helped with this research project: the school district and the participating middle schools and their principals, guidance personnel, teachers, secretarial staff members, and students for their enthusiastic assistance; counselors Melinda Myrom, Jane Reilly, Mary Strate, Rita Wagner, Carolyn Warrick, and Sherry Woodruff for their time and energy; Dwaine Harrell and Dan Avery, counselor trainers, for their kind, thorough efforts; Bob Abdo for his moral support and his monitoring of counselor techniques; Committee Members Fred Adair and Ruth Mulliken for their helpful suggestions and expertise; and especially Roger Ries, Dissertation Advisor, for his encouragement, advice, and wisdom.
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THE EFFECTIVENESS OF COGNITIVE RESTRUCTURING AND PARADOXICAL DIRECTIVES COUNSELING INTERVENTIONS ON ADOLESCENT SELF-ESTEEM:

A COMPARATIVE STUDY
CHAPTER 1: INTRODUCTION

Justification for the Study

While the feeling that we have little control over our life's situation occurs occasionally at most age levels, it is particularly persistent in adolescence. For these students, opportunities to differentiate and assume increased responsibility are met with conflicting expectations communicated by parents, teachers, and society in general. An important goal of counseling is to instill in our clients a degree of personal responsibility and a sense that they have the capacity to assert control over their lives so they can take credit for their accomplishments and feel good about themselves.

Clarizio (1984) notes that unlike adults with whom a negative correlation exists, there is a positive correlation between assertiveness and depression in children. He hypothesizes that since assertiveness is less acceptable with adolescents and therefore punished more frequently and severely, the child feels a sense of powerlessness and rejection. It is the fear of losing further control that Amanat (1979) sees as the cause of intense adolescent resistance to therapeutic intervention which may be perceived as submission. The psychoanalytic approach
assumes resistance and its subsequent analysis as integral to the therapeutic process. The cognitive therapists avoid the resistance issue, focusing instead on negative self-statements which accompany and perpetuate maladaptive behaviors (Meichenbaum, 1977). The Paradoxical Directives (PD) approach uses resistance as an ally.

Paradox has long been of interest to people and much has been written about it from a philosophical standpoint. An example of paradox is the statement: "This statement is a lie." To be true, the statement must be false. If it is false, however, it must be true; and so on. Paradoxes more germane to counseling, though no less stupefying, include: disobey me; be spontaneous; dominate me. If one actively attempts to follow such a directive, she will at the same time be doing the opposite. Haley (1963) suggests that the counselor's approach is to impose a therapeutic paradox, a no-lose double bind. The vehicle is the paradoxical directive which manipulates the client to gain control over his actions (a recognition that the symptomatic behavior is not "involuntary"), whether he obeys or disobeys the injunction. Because the client will strive to maintain interpersonal control (comfort) rather than risk confusion (discomfort), the degree of resistance to change is directly proportional to the success of the paradoxical intervention (Haley, 1978).
Pardoxical Directives (PD) counseling is a relatively new technique. Weeks and L'Abate (1982) note that as a specific therapeutic intervention, PD dates back only to 1967 and recently has incurred considerable interest. Very little attention was paid to paradoxical directives counseling by the cognitive behaviorists, although some research was done by them (Ascher, 1978; Hsu and Lieberman, 1982) under the behavioral label "paradoxical intention" (Frankl, 1975). In the 1984, volume 15 issue of the Journal of Behavior and Experimental Psychiatry, however, most of the issue was dedicated to paradoxical intervention. In that issue, Wilson and Bornstein (1984) write that currently there is very little empirical evidence to support the effectiveness of PD counseling. They note that most previous literature has been in the form of case studies or uncontrolled experiments. Nevertheless, in view of several recent investigations empirically demonstrating its effectiveness, they and others (Ascher, 1980; Wilson and Bornstein, 1984; Weeks and L'Abate, 1982) stress the need for further controlled research. Goldfried (1982), in fact, cites Parloff's (1978) mention of the need for outcome research in counseling in general. Strong (1984) in his review of recent research with PD discusses the future of the modality. "The experimental results reviewed above make a strong case for the viability of explicitly paradoxical interventions in psychological treatment, making them a valuable addition to therapeutic repertoires" (p.194).
PD has in several instances proved more effective than the Cognitive Restructuring (CR) approach (Beck and Strong, 1982; Feldman, Strong, and Danser, 1982). Again, Strong (1984) summarizes: "Overall, these studies suggest that paradoxical interventions have a therapeutic potency comparable to and, in some situations, superior to other behavioral interventions, but all were in each case more potent than treatment relying on attention, involvement, and expectations alone" (p. 193).

Further, although very little empirical research has been done with PD and adolescents, Amanat (1979) used PD to successfully treat resistant teenagers. It is just this resistance, in fact, to which he and Haley (1978) ascribe the success of PD treatment. It is felt, therefore, that this modality will be more effective with adolescents than CR.

Amanat (1979) notes that the greatest areas of his therapeutic work has been the resolution of conflicts with trust, integration, individuation, and self-esteem. Poor self-esteem in adolescents has been linked to numerous ills from anxiety (Saylor, et al, 1984) to irrational beliefs (Daly and Burton, 1983). Robinson and Shaver (1973) note the high, negative correlation between anxiety and self esteem. As a result of a plethora of studies about self-esteem, Byrne (1983) states the following: "Clearly,
self-concept is considered a critical variable in educational research" (p. 115). The critical relationship between self-esteem and depression has also been well researched (Clarizio, 1984; Pietromonaco and Markus, 1985; Noles, et al, 1985).

The purpose of this study was to examine the merits of the paradoxical directives counseling approach as a viable technique, comparing its efficacy with the cognitive restructuring modality on improving self-esteem in adolescents and measuring the relative effects of both interventions on anxiety, depression and locus of control. Therefore, this study may possibly add significantly to existing knowledge by providing further outcome research in counseling, by examining the effectiveness of a new and potentially very valuable therapeutic technique on a population which has not been empirically scrutinized, and by attempting to deal effectively with such critical adolescent issues as self-esteem, depression, anxiety, and locus of control.

Statement of the Problem

What is the comparative effectiveness of cognitive restructuring and paradoxical directives counseling interventions on adolescent self-esteem?
Theoretical Rationale

While early theories in psychology stressed the unconscious, more and more attention was soon given to social determinants of personality. For Adler (1956), purposeful and goal-directed (i.e., conscious) behavior was initiated by the individual to overcome interpersonal insecurity and interpersonal feelings of inferiority. Harry Stack Sullivan (1953), was another who broke with Freudian analysis in favor of the social framework. He saw the individual as motivated to overcome helplessness in relation to others. Personality itself was seen as the characteristic pattern which a particular person brings to recurrent interpersonal situations.

More recently, this focus on the interpersonal nature of behavior is seen in family systems theory (Haley, 1976; Minuchen, 1981; Bowen, 1978). Accordingly, the goal of therapy, whether individual or family, is to change the way one person is unsuccessfully interacting with another person or group.

In the psychoanalytical approach, people are often described in terms of their symptom. A person may be called anxious or phobic, fearful or depressed. These and other words such as unconscious and insight are all inferred, rather than observed, from behavior. The words also
describe behavior within a skin-encapsulated ego. Haley (1963) suggests that if you are to accept pathology in terms of an interpersonal paradigm, then you must reject skin-encapsulated intrapsychic descriptions of pathology. The description must be given in terms of patterns of communication, both verbal and non-verbal. Thus, if you think that a person becomes anxious as a reaction to repressed ideas quickly intruding on the conscious, then your vantage point is intrapsychic. Another way to look at anxiety, however, could be that it is a way of dealing with another in order to gain some semblance of interpersonal control.

At the heart of Haley’s theory is communication and how it affects and defines our relationship to others. He professes that people, in dealing with each other, establish a frame of reference for mutual interaction. Whenever we communicate, we are striving to define our relationship with someone else. Through clear definition, we gain control. There is nothing malevolent per se about attempting to gain control. It is a natural course. The individuals are merely attempting to define a relationship the way in which they are most comfortable (Haley, 1963). They do this through what Haley calls maneuvers. A maneuver is initiated, the other person counter-maneuvers by accepting or rejecting the maneuver, and so on until the relationship is clearly defined. Every exchange between two or more
people either reinforces or redefines the existing relationship. Maneuvers can be both verbal and non-verbal. As long as all parties accept the nature of the relationship, it does not matter whether the relationship is complementary (where one or more members are superior to others deemed subordinates) or supplementary (where all members share authority relatively equally).

When we interact, we communicate with each other but we also communicate about our communication. Communication at both levels may be congruent where verbal or non-verbal exchanges are clarified by the other. On the other hand, verbal and non-verbal messages may be incongruent. Such communication is called metacommunication (Haley, 1963). Rather than defining the relationship more clearly, Haley suggests that the relationship subsequently becomes more and more perverse. It is neither complementary nor supplementary but metacomplementary where one person is in charge and the other person is being controlled while both deny their positions. One person controls the maneuvers of the other thereby controlling how the other defines the relationship.

When a paradox (or metacomplementary communication) is posed, it does not necessarily lead to a metacomplementary relationship. The relationship can be terminated (option 1). The person may comment on his or her impossible
situation, if he or she is fortunate enough to realize it as such (option 2). It is only when the individual responds by indicating that he or she is not responding (option 3) that the situation becomes pathogenic and a symptom surfaces. The metacomplementary relationship revolves around a symptom which Haley describes: "A symptom can be seen not only as a way a patient deals with someone else, but also as part of an arrangement which is worked out in implicit collaboration with other people...the crucial aspect of a symptom is the advantage it gives the patient in gaining control of what is to happen in a relationship with someone else. A symptom may represent considerable distress to a patient subjectively, but such distress is preferred by some people to living in an unpredictable world of social relationships over which they have little control" (Haley, 1963, p. 15).

Because of the nature of the metacomplementary relationship, it is self-perpetuating. If one gives up the symptom, one risks giving up the interpersonal benefits derived from it. It is a no-win situation: continue to suffer with the symptom or give up the symptom and lose control of the relationship. The person is in a pathogenic double bind, unable to change for the better (Bateson, et al, 1956); change not only remains elusive under these conditions, it is undesirable and therefore is resisted strongly.
It is the job of the therapist to enter into the system and promote change, nevertheless. Haley (1963) states, "It will be argued here that a patient's symptoms are perpetuated by the way he himself behaves and by the influence of other people intimately involved with him. It follows that psychotherapeutic tactics should be designed to persuade the individual to change his behavior and/or persuade his intimates to change their behavior in relation to him. Insofar as the therapist is an intimate of the patient, both goals can be achieved simultaneously" (p. 6).

Haley (1963) hypothesizes that the counselor's approach is to impose a therapeutic paradox, a no-lose double bind. The vehicle is the paradoxical directive which manipulates the client to gain control over his symptom (a recognition that the symptomatic behavior is not "involuntary"), whether he obeys or disobeys the injunction. The paradoxical directive instructs the client simultaneously to do two or more mutually exclusive tasks or accept two or more mutually exclusive ideas: "(a) it asserts something, (b) it asserts something about its own assertion, and (c) these two assertions are mutually exclusive. Thus, if the message is an injunction, it must be disobeyed to be obeyed; if it is a definition of self or the other person, the person thereby defined is this kind of person only if he is not, and is not if he is" (Watzlawick, et al, 1967, p. 212). Resistance to the therapist encourages rather than discourages change.
The directive is delivered in such a way that symptomatic behavior becomes a detriment rather than an advantage to the interpersonal encounter between client and counselor. The client must give up his or her symptom in order to define (and therefore to gain control over) the relationship.
Definition of Terms

"Average Classes" -- a term used and defined by the school system in which the study was conducted. To ensure relatively homogeneous ability grouping of non-handicapped pupils, students are assigned to "basic," "average," or "advanced" classes based on results of SRA standardized tests administered annually.

Cognitive Restructuring -- a counseling technique which attempts to implement change by focusing on unrealistic thoughts and negative self-statements which accompany and perpetuate maladaptive behaviors. The intervention goal is to modify both cognitions and behaviors. Subjects review cognitive theory, identify, monitor, and challenge their negative self-statements, and reinforce appropriate, learned behaviors through modeling and role playing.

Internal/External Locus-of-Control -- the way an individual conceives of the relationship between his own behavior and the outcome of events. "Internal" connotes responsibility for one's behavior as it affects outcomes while "external" connotes outcome as reliant upon external, extra-individual forces.

Paradoxical Directives -- a series of therapeutic techniques
which enable the client to gain control over and thereby change symptomatic behaviors. There are three main types of PD interventions.

a. Reframing -- relabelling negative behaviors as positive.

b. Restraining -- where change or improvement is advocated to proceed slowly, is outwardly discouraged, or in some instances is forbidden (This technique includes "Predicting Failure" where the client is told that attempts to improve or change will probably fail).

c. Symptom Prescription -- encouraging the symptomatic behavior (This also includes "Giving Permission" where the client is "permitted" to have the unwanted behaviors; and "Scheduling" where the symptom is prescribed to occur at a specified time).

Research Hypotheses

1. Subjects receiving Paradoxical Directives will achieve higher post-treatment scores on the Coopersmith Self-Esteem Inventory than subjects receiving Cognitive Restructuring who will in turn achieve higher scores than subjects receiving no special treatment.

2. Post-treatment scores achieved on the Children's Depression Inventory will show subjects in the PD groups to be less depressed than those subjects in the CR groups who will in turn be less depressed than subjects in the control
3. Post-treatment scores achieved on the State-Trait Anxiety Inventory for Children (trait portion only) will show individuals in the PD groups to be less anxious than those in the CR groups who in turn will be less anxious than subjects in the control groups.

4. Post-treatment scores achieved on the Nowicki-Strickland Locus of Control Scale for Children will indicate that individuals in the PD groups conceive their locus of control as more internally oriented than the CR and the control groups.

Sample Description and General Data Gathering Procedures

The accessible population consisted of approximately 700 thirteen to fourteen year old eighth graders assigned to "average" classes in a Virginia public school system. Once school division permission was granted, a random sample of sixty students, two groups of ten from each of three (of four) middle schools, was chosen from the total number of volunteers. Students professionally counseled for at least five consecutive weekly sessions within the past year for emotional concerns, students prone to excessive absenteeism (more than 20 days the previous year), and students considered behaviorally disruptive by guidance personnel were excluded from the research sample.
After obtaining parental permission, (see Appendix A), randomization proceeded for group, treatment, and counselor assignment. Subjects were assigned to two groups of ten each for the PD modality and two groups of ten each for the CR intervention. The remaining twenty subjects constituted the control group. Dependent variables of self-esteem, depression, anxiety, and locus-of-control were measured in this pretest/posttest control group research design.

The Cognitive Restructuring treatment incorporated Meichenbaum's (1977) Self-Statement Training (SST). The first phase is educational and very didactic. Students are trained to identify and monitor maladaptive thoughts (negative self-statements). Phase two is action-oriented and includes modeling and rehearsing. Initially, the therapist models appropriate behavior while overtly verbalizing possible appropriate actions: the task is evaluated; and positive self-statements help present a positive attitude. The client then role plays effective behaviors while first overtly, then covertly, directing and reinforcing his/her competence through appropriate assessment of the situation and through positive self-statements (Meichenbaum, 1977).

The paradoxical directives approach used the following techniques defined earlier: restraining progress; positive reframing; predicting failure; giving permission;
prescribing; and scheduling.

Limitations of the Study

Threats to external and internal validity are listed below along with attempts that were made to minimize their detrimental effects on the study.

Subjects were chosen from an accessible population of volunteers. Participation was predicated upon both student and parent agreement. The question arises of just how representative a volunteer sample is of the population as a whole (the greater the number of volunteers from which to choose, the greater the possibility of the study's representativeness and its external validity). While results may be viewed as perhaps less generalizable as a result, effectiveness of technique is a major issue in this study and sample members were randomized by technique and counselor.

One possible threat to internal validity centers around the effectiveness of the counselor irrespective of technique. The importance of the relationship between counselor and client and therapeutic outcome is well documented (Lieberman, Yalom, Miles, 1973). An effort was made to compensate for this variable by assigning two different counselors for each intervention.
A major concern was whether or not the proposed technique was represented in the actual counseling session. Audio tapes were randomly scrutinized by an independent "blind" rater who listed counselor behaviors during counseling via a Counselor's Behavior Checklist (see Appendix B). It was then determined from these behaviors if the counselor was following appropriate modality-specific intervention strategies. Because all tapes were not reviewed, it is possible that effectiveness was not purely the result of the technique although reasonable certainty is ensured.

Ethical Considerations

To ensure that the rights of all subjects involved in the research were protected, ethical safeguards were in accordance with the National Association of School Psychologists and the American Psychological Association guidelines. Additionally, the project was approved by the School of Education and the College of William and Mary Human Subjects Research Committees. Only professionals trained in counseling (school psychologists, in this case) served as group leaders. Students were assured that they could drop out of the group at any time and that if they or the counselor deemed more intensive help necessary, provisions would be made with parental consent through appropriate mental health professionals. Parents and
student subjects were informed as to the nature of the research as fully as possible without posing a threat to internal and/or external validity.

All results remain anonymous in terms of individuals and school system and strict confidentiality has been maintained. Continued counseling was recommended (and with permission, provided) for any student whose circumstances indicated a need. Control groups received counseling after the experiment's completion.

Plan for the Presentation of the Study

This chapter has presented the problem to be studied, discussed the theoretical rationale, defined germane terminology, delineated possible limitations and ethical considerations, and stated the research hypotheses to be tested. In Chapter 2, related research will be reviewed. Chapter 3 describes the methodology used in the study. Chapter 4 reports and statistically analyzes the results of the investigation. Chapter 5 proposes relevant conclusions while examining implications and limitations of the study.
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Summary of the Rationale and Its Relationship to the Problem

The paradoxical directives paradigm is based on the theory that presupposes an interpersonal nature of personality where individuals, through verbal and non-verbal communication, continuously maneuver to clarify their relationships to others. It is clarity of definition that ensures a sense of control or comfort; a lack of clarity motivates additional attempts to define the relationship. A relationship may be defined as complementary or supplementary where members communicate their awareness and acceptance of their assigned roles. Metacommunication, where verbal/non-verbal or verbal/verbal messages are incongruent, may lead to a metacomplementary relationship: one person (in the superior role) is in charge of another (subordinate) while both claim the role of the other and deny their actual interpersonal positions. The symptomatic behavior that arises if such a relationship is maintained is syntonic; it can range from mild to extreme discomfort but because it affords a sense of control, however perverse, it is preferable to confusion and interpersonal helplessness (Haley, 1963).

Early adolescence is a transition period. It is for
many a time of great uncertainty and turmoil. Young children know what is expected of them. They follow the rules in a clearly defined complementary relationship status with adults, older children, and perhaps even some peers. Teenagers, on the other hand, are encouraged to "grow up;" unfortunately, their efforts to redefine interpersonal relationships with adults as more supplementary are frequently (sometimes fiercely) discouraged. Control rests with numerous adults who individually maneuver to control their relationships with teenagers by defining what behaviors are appropriate when, where, and to what extent. Thus, if the adolescent attempts to redefine relationships with adults under these terms, in order to gain control, he or she must relinquish it. The youngster, in essence, is told to be responsible and irresponsible simultaneously. This requirement may leave the adolescent feeling incompetent, confused, and helpless, and may even encourage resistance to change and growth.

This study examined some of the potentially debilitating aspects of adolescence (poor self-esteem, depression, anxiety, and an external locus of control orientation) and how PD and CR interventions compare in their effectiveness in dealing with them.

Theoretical Constructs and/or Historical Concepts for Paradoxical Directives
Historically, paradox has been used by behaviorists to treat symptoms. Dunlap (1932) used negative practice or repetition of the symptomatic behavior which he felt would inhibit rather than reinforce the behavior. This is sometimes used effectively with eliminating swearing in schools, for example. Hull, in 1943, gave a theoretical framework for negative practice. He postulated that repeating a behavior was aversive because it was fatiguing. The fatigue and the negative reinforcement of rest from the symptom following the behavior combined to eliminate the problem situation. He labeled the process "reactive inhibition."

Frankl (1975) directed his patients to "will" their symptom. He would require, for example, that his patients afraid of choking while eating precipitate a choking spell with the aid of an apple. Stimulus satiation (Ayllon, 1963), parallels this technique in that both not only give the client permission to have the symptom, but they also suggest that more of it is better.

Today, the counseling modality most heavily steeped in paradoxical directives is the strategic family approach which views symptomatic behavior as serving a protective function for members of the system; thus, only by changing the system itself can the symptom be relinquished (Haley, 1976). Andolfi (1980) discusses the hidden agenda that the
family brings to the counseling session: a) "Help us stay the same; b) help us (me) get rid of the symptom without changing anything else; c) help us with the identified patient but leave the rest of us alone. The paradox is to remove the symptom from the family without changing the family from which the symptom derives."

Watzlawick, et al (1974) believes the problem persists because the solution lies outside the system's present set of rules. Change is discussed in terms of first- and second-order change. First order change is linear within the system, and correlates with quantity not quality, ie. more of the same using the existing set of rules. Second-order change is structural and/or communicative change of the system itself. According to Bandler and Grinder (1975), "Second-order change refers to a change in the frame of reference or system itself, such as a change from dreaming to waking. Second-order change is actually the process which allows the client to escape from the pathogenic double-bind. The solution is the new frame created by the client's escape from the bind. The therapeutic double-bind implicitly challenges the client's model of the world by forcing him/her into an experience which contradicts the self-destructive limitations of the present model. This experience serves as a reference structure by which the client expands his model of the world" (p. 169). Weeks and Wright (1979) refer to second
order change as paradoxical change.

To counter the tenacity of symptomatic behavior and precipitate second order change, the strategic therapist uses paradoxical directives. Haley (1973) recommends predicting failure in order to gain a no-lose control over a situation: if the clients fail, you were right, and the symptom does not afford them the desired control in the relationship. If they do not fail, you have achieved your goal of eliminating the symptom. In another of his techniques, he asks the client to "pretend" to have the symptom in order to gain control over it, displaying it as voluntary, not involuntary.

Several other techniques used by Haley were labelled by Tennen (1977). They were positioning (where the therapist exaggerates the circumstances surrounding the seriousness of the behavior to the point where the client finds herself in the awkward position of saying: "Well, it isn't THAT bad." When you declare the situation hopeless and continue with therapy in an effort to improve the situation, you pose a paradox); restraining (in order to change, the client is forced to give up the symptom; this is particularly effective with defiant clients), and prescribing (the situation is, again, no lose: if the client complies, she gains control over an "involuntary" behavior; if she defies you and does not carry out the directive, she must give up
her symptom which is the contracted goal of therapy).

Related to restraining is the Milan group's positive connotation (Selvini Palazzoli, et al., 1978): when you define all behavior as positive, but continue therapy, you prohibit maneuvers of control by the clients since they cannot even be sure why they are being counseled.

Selvini Palazzoli, et al. (1978), also suggest ritualized prescription where one parent is put in charge of the identified patient on odd days and the other on even days of the week; one day is left open for "spontaneity."

Papp (1980) uses a Greek Chorus approach where several colleagues observe through a one-way mirror. They report their views to the counselor who debates with them in front of the client about the person's ability to change. This technique diffuses any power struggle between the therapist and client.

Hsu (1982), as a result of his work with anorectics, describes paradox as interpersonal jujitsu:

Paradoxically, this coalition reduces the anorectic patient's feverish need to maintain such rigid and dangerous control... Anorectic patients cannot do battle with someone who agrees with them -- to continue the battle he or she must argue for weight gain and health rather than for the emaciated state (p. 652).
Jacob and Moore (1984) group the paradoxical techniques into two main types: intraindividual and interpersonal. The main difference between these types is that intraindividual directives are compliance based and interpersonal directives are defiance based. Consider the three main paradoxical directives of reframing, restraining, and symptom prescription.

Dowd and Swoboda (1984) consider "reframing" a compliance based strategy because once the shift in meaning has been made overt, it is impossible for the client to perceive the symptom from just one perspective. "Restraining," on the other hand, is defiance based and is particularly effective in dealing with resistance. "Symptom prescription" can be either defiance or compliance based. "Since the prescription is a double-bind, a compliant client will attempt the behavior only to find that he can control it, therefore rendering it less unfree. On the other hand, a defiant client will disobey the injunction, only to find that in fact he or she is less anxious. Therapeutic benefits occur in either case" (Dowd and Swoboda, 1984, pp. 230-231).

Theoretical Constructs and/or Historical Concepts for Cognitive Restructuring

Early behavioral psychology organized all action in
terms of stimulus-response. As human activity became more and more closely scrutinized, the theory was criticized as unable to explain certain higher level behavior. To counter, behaviorists began stringing S-R variables together in an increasingly more complicated explanation of complex thought and creativity (for example, Skinner, 1948, 1971).

In 1966, Cautela, using a technique called covert sensitization, based his therapeutic intervention upon an imagery-based aversion procedure. Mahoney (1974) felt this paved the way for a major breakthrough in behaviorism: "For the first time in decades, behaviorists were openly and actively scrutinizing their subjects' self reported thoughts, feelings, and images...Besides some very serious conceptual problems, the conditioning model of cognition soon faced empirical embarrassments, and the time was ripe for yet another theoretical leap" (p. 38). That leap was to what is now referred to as cognitive behavior modification.

Cognitive therapists frequently refer to the quote by Epictetus, 1st century A.D., to summarize the essence of their theory: "Men are disturbed not by things, but by the views they take of them;" it is the intervening cognitions, not the event itself, that cause emotional trauma.

Perhaps as much as anyone, Ellis (1962) must receive
credit for popularizing the idea of a belief system intervening between the stimulus and the response. He attempted to change maladjusted behavior by altering irrational thought processes leading to destructive internal "self-talk" and precipitating inappropriate, destructive behavior. RET was later applied to the school setting by Maultsby (1971) in the form of REI, Rational Emotive Imagery.

Lazarus (1972) is credited with the term cognitive restructuring. His work dealt with the role of cognitive variables in stress and emotional reactions. He saw humans as cognitive appraisers, constantly evaluating environmental input in terms of relevance and significance, always searching for cues to more appropriately appraise the situation. Thus, to understand the kind of appraisal is to understand the emotional response precipitated by that appraisal.

Beck (1976) concerned himself with the stylistic qualities of the client's cognitions. He believed that inappropriate behavior resulted from selective attention to and inaccurate anticipation of consequences. Therapy focused on negative self-statements induced by thought distortions. His therapeutic approach is to help the client see the problem as solvable, and not catastrophic. Unlike Ellis, he sees the dysfunctional thought processes as less
irrational than too all encompassing.

Meichenbaum (1976) echoes this break with RET when he states that it is not the incidence of irrational beliefs that separates the abnormal from the normal, but the intervening management techniques used to cope with these thoughts and feelings. The goal of therapy is to modify the client's thoughts, premises, assumptions, and attitudes. "The cognitive therapist helps the patient to identify specific misconceptions, distortions, and maladaptive attributions and to test their validity and reasonableness" (Meichenbaum, 1977, p. 184).

The cognitive restructuring intervention strategy is three-fold (Meichenbaum, 1977). The first phase is educational and very didactic. The client is given an overview of the problem generally and idiosyncratically. The role of cognitions is explained. The client is also trained to monitor maladaptive behavior and to list accompanying negative self-statements (cognitions) which perpetuate the the behavior. Client and counselor then evaluate the situation.

Phase two is action-oriented and includes modeling and rehearsing; new coping strategies are discussed and developed; alternative behaviors are explored; and positive self-statements replace negative ones.
The last stage is the application of the knowledge and tactics learned within the counseling setting.

Current Research

Paradoxical Directives Intervention Strategies

Ascher and Efran are two behaviorists successfully using paradoxical intention. Their initial work in 1978 with insomniacs was particularly effective with resistant cases. Ascher (1979) further tested the efficacy of the treatment with five males experiencing involuntary urinary retention; the men were unable to void in a public bathroom. The treatment of choice in such instances is systematic desensitization, but this proved ineffective after eight weeks. At that time, the men were posed with the directive of entering a public facility, going through all the usual manipulations in front of the urinal, but not actually urinating. The therapist paradoxically "prescribed" the symptom and simultaneously asked the client to "restrain" from improving.

After six weeks, all clients reported little or no problems urinating in public bathrooms. Follow-up data indicated complete satisfaction in eighty percent of the cases with the last client experiencing only occasional discomfort which he learned to eliminate by re-imposing the paradox upon himself.
Hsu and Lieberman (1982) used paradox with eight chronic anorectics: all had been sick and under treatment for five years without remission; they experienced weight phobia; behavior to lose weight (laxative abuse, vomiting, purging, excessive running) was evident in each case; all suffered sexual impotency or amenorrhea; and weight loss was at least twenty-five percent (below the seventy-fifth percentile of average).

The clients were instructed to keep their anorexia because previous attempts provided only temporary success at best with negative side effects. "Benefits" of the anorexia were explained, although clients were encouraged to disagree with any of these. Sessions continued to meet to explore other possible benefits of continuing with the symptom.

After at least six one hour sessions, none of the patients remained under psychiatric care. Follow-up showed fifty percent to be normal weight and only one was considered very low weight after two to four years. The illness was framed as ego-syntonic, revolving around control issues.

In the Ascher (1979), and the Hsu/Lieberman (1982) studies, Frankl's paradoxical intention was cited as the basis for treatment. Interestingly, no research in support of the approach was offered. In fact, Ascher's study listed
a current literature review only about the "treatment of choice," systematic desensitization, which had failed with this population. While this in itself is not a drawback, this oversight becomes noticeable in relation to conclusions. In the urinary retention group, the researchers claim success resulted from anxiety reduction. In view of the fact that the anxiety reducing technique of systematic desensitization failed so completely, it is unlikely that this is the only curative factor involved. Similarly, Hsu and Lieberman caution against using the technique in that it succeeded only with regard to the anorexia, not sexual and social dysfunction. If a complete review of current research had been done, they may have used the paradoxical directives within the context of interpersonal control affording an opportunity for the clients to grow interpersonally as the paradoxical directive approach suggests.

Lopez and Wambach (1982) did an experiment comparing the effects of paradoxical directives and self-control directives using thirty-two college students who identified themselves as serious procrastinators.

There were three groups: a control, no treatment group of twelve students; a paradoxical directive group of ten; and a self-control directive group of ten students. The S-C-D group developed new behaviors incompatible with
procrastination. The P-D group was asked to observe the procrastination while it occurred, resisting studying for up to one-half hour while concentrating on the procrastination (practice and scheduling paradoxical techniques). Cheaters who did not procrastinate were admonished!

Both treatment groups showed significant change as opposed to no treatment with paradoxical directives slightly higher. The S-C-D group proved superior over the long term, however. One interesting result was that the P-D group members had a sharper rate of change in procrastination while continuing to view their problem as no more controlable.

In this study, two major deficiencies exist. First, subjects were self-identified and evaluated by a self-report. Validity may be jeopardized by such an approach. Secondly, there was no way to determine whether or not the subjects actually followed through on their directives.

Lopez (1983) used the paradoxical approach in vocational indecision with two college students. Since he believed the problem to be related to parental control issues in each case, he prescribed continued unproductive and dissatisfying father-son interactions about career matters and restrained vocational decisions. He imposed
Watzlawick's (1967) "devil's pact" compliance-based paradox which requires the client's agreement to follow through with given directives before the directives are presented to the client. Both clients made satisfying decisions about their career choice, and experienced better relations with their fathers.

Henning (1981) successfully treated writer's block through paradoxical intervention by prescribing the symptom. Lantz (1978) claims success with paradox in treating test anxiety, labeling her approach "provocative exaggeration." Essentially, the symptom is prescribed and exaggerated through humor. She encourages the client to have a good time with her anxiety, for example, and maybe even pass out and create a real commotion during an exam.

**Current Research**

**Cognitive Restructuring Intervention Strategies**

Some of the early cognitive behavioral interventions were based on Maultsby's RBT or Rational Behavioral Therapy, an offspring of Ellis' RET. RBT holds that rational behavior is based upon objective reality, is likely to preserve life, enables the person to achieve long- and short-term goals most quickly, helps avoid significant personal conflict, and helps avoid significant environmental conflict (Maultsby, 1971).
Steuer, et al (1984) compared the effects of cognitive behavioral and psychodynamic group interventions on depressed geriatric outpatients over a nine month period. No control group was used since it was deemed impractical and unethical to deny treatment for nine months to someone in need. Patients were solicited through local media and senior citizen organizations.

Client inclusion criteria were a DSM-III "Major Depressive Disorder" diagnosis, an obtained age of fifty-five or more, and a score of sixteen plus on the Hamilton Depression Scale. Alcoholics, suicidal, cognitively impaired, and schizophrenic clients were excluded as were those suffering depression as a symptom secondary to a physical illness. Initially, there were 35 people in the sample. Two groups of eight and nine received the cognitive behavioral treatment and two groups of eight and ten received the psychodynamic intervention. After nine months, only twenty subjects remained.

The results of the experiment showed no significant differences between the groups although there was linear improvement over time noted in both groups, particularly after twenty-six weeks. At the end of the nine months, however, only three members (two in the cognitive behavioral group and one in the psychodynamic group) rated themselves as "no longer depressed." Clients were chosen from
volunteers. Despite their willingness to become involved with the study and an inferred desire and commitment to change, the attrition rate was excessive. Neither group was able to satisfy certain needs of certain members, confounding attempts to draw legitimate conclusions about the study.

In addition to the physiological components of anger, Meichenbaum (1977) suggests that anger has a distinct cognitive component consisting of highly emotional self-statements. A recent experiment by Moon and Eisler (1983) attempted to study anger control through three behavioral treatment approaches (cognitive stress inoculation; problem-solving; social skills), and a minimal attention group. Ten college undergraduate males were assigned to each group.

All treatment groups differed significantly from the minimal attention group, showing improved anger control. On the Anger Inventory, the cognitive stress inoculation group rated itself significantly lower in anger-provoking thoughts and cognitive aggressive responses than the other groups. The social skills group differed significantly on behavioral measures such as assertiveness. However, in actual anger-arousing situations, the problem-solving subjects showed the greatest flexibility and competence. The researchers feel that a combination of behavioral and
cognitive solutions may best succeed in increasing actual control.

Kendrick, et al (1982) compared the efficacy of the cognitive behavioral approach with a behavior rehearsal group and a no-treatment control on musical performance anxiety. Since high anxious performers are believed to be more self-effacing than low anxious musicians, it was felt that the cognitive approach would be an effective intervention. Fifty-three pianists (aged 12-53 years) from the Metropolitan Vancouver area volunteered to receive treatment. To qualify for the experiment, each had to be judged as seriously affected by performance anxiety by their teacher, and self-report debilitating anxiety on at least five of fifteen items on the Report of Confidence as a Performer Scale during a performance. The group consisted of 48 females and five males. Using the above measures as well as a bio-feedback apparatus, pre- and post-test comparisons were made.

The cognitive behavioral subjects dealt with negative and task-irrelevant thoughts during piano performances. Negative thoughts were challenged and positive thoughts were substituted as the performance was observed on videotape. Positive self-statements were used as was a cognitive modeling tape-slide show. For homework, clients performed for family members, recorded negative and positive thoughts,
and rated anxiety and performance. The behavior rehearsal group consisted basically of performing for the group and receiving strong support and encouragement from members.

At the time of termination, there was no difference among the groups. A follow-up showed both the treatment groups differing significantly from the control group. Because the same therapist was used with both treatment groups, however, the question arises whether the individual had any personal biases regarding the modalities. Further, no measures were taken to insure that the one therapist was separating the two treatments.

In 1980, Zelie, et al, set up an experiment to discern whether RBT self-mastery skills could be taught as a tool to improve school discipline. Sixty racially mixed seventh, eighth, and ninth grade discipline problems were randomly assigned to treatment and no treatment groups. Success rate was based upon recidivism and a teacher disciplinary follow-up report. Alternatives to present behavior were stressed as was the idea that students have the power to choose and are responsible to do so in their best interest. The results indicated that the RBT group was rated significantly better than the control group. However, because no other treatment was used as a comparison, it becomes difficult to determine whether improvement resulted from RBT interventions or from mere attention versus no
attention. While it would be presumptuous to label all misbehavior the result of neglect, it seems reasonable to suspect that a group of miscreant teenagers might respond favorably to caring, well-intentioned graduate students.

In a similar study, Kendall and Braswell (1982), did an experiment with twenty-seven non-self controlled problem children aged 8-12 whose behavior was deemed by their teachers to be interfering with their learning. Groups received cognitive behavioral, just behavioral, or attention control treatments. Results support the usefulness of a cognitive component. Significant improvement occurred in teacher ratings of self-control and improved self-concept over both other groups. The cognitive and behavioral groups showed significant gains over the control in hyperactivity and achievement. Interestingly, no improvement of behavior in any group was noted by parents, the success apparently not generalizable to other than school situations. Except for parent rating scales, however, all other results were assessed mostly by college undergraduates (in fact only one of fifteen raters was a graduate level student). No inter-rater reliability was established while the amount of training provided may not have been sufficient, possibly affecting internal validity.

Babbitts (1980) studied the effectiveness of RET on speech anxiety in school children. Forty children were
assigned to one of three treatment approaches: RET speech procedures; RET general anxiety procedures; and muscle relaxation training. The specific RET modality was shown to be significantly more effective than either the general anxiety reduction or the relaxation treatment.

Schinke, et al (1981), used cognitive behavior techniques to test efficacy in adolescent pregnancy prevention. The cognitive groups received didactic attention to problem-solving, judgement, planning, and verbal and non-verbal communication skills through behavior rehearsal, role play, and modeling. A follow-up showed this group to have "better attitudes" and to be using more effective contraceptive devices over the no-treatment control group.

Results from Genshaft's (1982) experiment on math anxiety with adolescent girls suggest that self-instruction or SST (Meichenbaum, 1977), while not significantly more effective in increasing math achievement, had a significant effect on enhancing attitudes towards mathematics.
Comparative Studies between PD and CR

In a doctoral dissertation study, Gombatz (1983) compared the efficacy of client-centered, rational emotive therapy (RET), and paradoxical directives modalities on problem resolution with 60 college students. Each group (including a control, no treatment group) was comprised of fifteen students meeting individually with one of three counselors trained in the respective approach.

Results showed clear improvement at the .05 level between treatment and no treatment groups. As a result of this finding, credence was given to PD as an effective approach with college students, on a par with the more established therapies. No significant differences existed among the three modalities, however. Three individual counseling sessions may simply have been insufficient time to distinguish comparative efficacy.

Feldman, et al (1982), found PD to be superior in the treatment of depression, while Beck and Strong (1982) found both modalities equally effective. Although the CR group had a symptom relapse after one month, the PD group did not. An ANCOVA on measures of phobic severity, anxiety, and depression with 26 agoraphobics indicated a statistically significant improvement with both SST and PD interventions (Mavissakalian, et al, 1983). Immediate results suggest PD
as superior although marked improvement in the CR group occurred at a six month follow-up. Self-defeating statements were greatly reduced by the CR approach.

Summary of Previous Research and Its Relationship to the Problem

Cognitive restructuring as a behavior approach has been extensively empirically researched. Its effectiveness is well documented in the literature. On the other hand, until just a few years ago, very little research of any kind had been done using paradoxical directives. Much of what had been done was in the form of case studies or doctoral dissertations. Behavioral therapists engaged in some germane empirical research although they refered to their treatment as paradoxical intention, based upon Frankl's work (1955). The behaviorists tended to view the efficacy in terms of internal responses and ignored interpersonal theory. Regardless of terminology, however, the treatment was paradoxical in nature.

Recently, however, several empirically based studies noting the effectiveness of PD have encouraged behaviorists to examine the viability of this technique. In several instances, PD has been shown to have more potency than CR and other behavioral interventions and combinations thereof. Because PD is relatively new, research has generally dealt
with the ever accessible college population. Case studies with adolescents are impressive but not empirically so. The need for further controlled research is essential, particularly with the adolescent group which should respond well to the technique given PD's reliance on resistance. Both CR and PD have been effective in reducing anxiety and depression and in enhancing self-esteem. A controlled examination comparing the effectiveness of both PD and CR in the treatment of these crucial adolescent problems seems an important and logical step.
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CHAPTER 3: METHODOLOGY

The Sample

The sample consisted of sixty subjects (twenty students from each of three participating middle schools) randomly selected from a pool of eighth grade volunteers designated as having "average" ability by the public school system involved. Initial contact with individual schools was made through the respective principals who referred the researcher to guidance personnel. A series of meetings were held with teachers and team leaders of "average" classes in order to inform them of the study's purpose and to enlist their support and cooperation.

This researcher then canvassed all the applicable classrooms soliciting potential participants for the study, the purpose of which was framed as personal growth: to discuss and discern effective means of dealing with personal and interpersonal issues and concerns; and to get to know oneself and other group members better and from a different perspective. Logistics such as the number of meetings, group size, meeting times and basic group goals and guidelines were discussed at that time. Students were told that participants would be expected to make every effort to attend punctually each of eight counseling sessions scheduled twice a week for four consecutive weeks. Since
meeting times were staggered over seven periods, each class would be missed at least once while no class would be missed more than twice. Confidentiality issues and notification that sessions would be taped were discussed. Students were also assured that all teachers and guidance personnel were aware and supportive of the study and would assist them as much as they could in terms of making up missed coursework. Subjects were informed that a series of questionnaires would be administered just prior to and immediately following the counseling sessions to assess their personal feelings and attitudes and to assist in the evaluation process of the research.

Permission forms were given to students interested in participating. From the returned forms, sixty students were chosen and their names discussed with guidance and attendance officials at the school to determine eligibility for the study. Students who were receiving Special Education services, had been professionally counseled for emotional concerns for five consecutive weeks during the past calendar year, were absent more than twenty days the previous school year, or were considered behaviorally disruptive were ineligible. Further names were randomly chosen as needed from the volunteer population to complete group rosters.

Within each school, final subjects were randomly
assigned to one of two groups of ten students each which were in turn randomly assigned to one of three treatment groups: cognitive restructuring, paradoxical directives, or no-treatment control. With cell sizes of ten randomly selected students for each counselor and twenty for each modality, it is felt that the sample was representative in terms of therapeutic outcome and generalizable in that regard.

Fifty-nine students involved were between the ages of thirteen and fourteen; the sixtieth participant turned fifteen between the recruitment and the treatment phases of the study. Thirty-eight subjects were female and twenty-two male.

**Treatment and Control Group Counselors**

All of the counselors working with treatment subjects are members of the Psychological Services staff serving the participating school system. Each has an advanced degree in School Psychology. Three of the four counselors are currently in the Doctoral Program in Counseling/School Psychology at The College of William and Mary. The fourth individual has Masters of Education degrees in both counseling and school psychology. All counselors have previously run group counseling programs although some not specifically to improve self-esteem.
One of the control group counselors is also currently working towards her doctorate in Counseling/School Psychology at William and Mary. The remaining person is an intern with the school system working towards an Advanced Certificate Degree in School Psychology at James Madison University and was directly supervised by this researcher.

To ensure comparable skills, all counselors received approximately two hours of modality-specific training. Both trainers hold Doctoral Degrees in the mental health profession, and are knowledgable in the respective techniques. The CR trainer, a licensed psychologist and supervisor, is the Director of Psychological Services for the participating school system. The PD trainer is a licensed counselor currently working at a counseling agency in Gloucester, Virginia, where paradox as a therapeutic technique is used extensively. Trainers felt that counselor trainees would be able to use learned techniques adequately within the groups.

Following the training sessions, counselors felt competent and capable of performing as a counselor using the respective approaches (see Appendix C). In addition, all counselors reviewed specific lesson plans each week prior to the following week's sessions to ensure understanding of group meeting goals and implementation of techniques.
Interventions

Pretests were administered to chosen subjects two to four days prior to the initial counseling session. Group counselors met with subjects for eight 1-hour sessions. Previous research has indicated potency for both the PD and CR modalities in less time. However, four weeks (eight meetings) should have provided a thorough application of methods while not thoroughly discouraging the control subjects.

Within each group, the counselor focused on personal and interpersonal issues. Session One served to introduce participants to one another and to promote group cohesion through a variety of activities. Guidelines and goals were also reviewed; attendance, punctuality, and confidentiality issues were discussed. Just prior to dismissal, a final statement was made regarding group expectations. The CR group leaders indicated the potential for change while the PD leaders suggested the unlikelihood of change in just eight sessions. Individuals in this latter group were, in fact, asked not to make any significant changes in the way they thought, felt, or acted.

Session Two focused on the goal of getting to know group members and oneself better. Activities were processed in terms of feelings felt by the individual as compared to
those felt by others. Germane theory was introduced. The CR counselor discussed the intervening variable of self mediating between what occurs and what we feel about what occurs and the idea of self-statements which influence how we assess external stimuli in personal terms. The PD counselor discussed the importance of the status quo and the complexity of the mind which provides us with appropriate, personalized feelings which serve some beneficial purpose in the short run regardless of concurrent discomfort.

Sessions Three through Seven addressed issues of concern with respect to self, school, family, and peers, and then in terms of how all these affect the way we perceive ourselves. Information was presented through discussion and experiential activities.

Session Eight included a summary of theory and a review of group experiences.

Cohesion activities and/or "icebreakers" were used on a regular basis throughout the eight sessions. These were kept consistent regardless of therapeutic modality.

Interventions, on the other hand, were applied in accordance with modality-specific techniques. To certify that counselors did the prescribed treatment, audio tapes were made of all sessions. A "blind" rater qualified to
recognize a variety of counseling techniques randomly sampled tapes and reviewed them in terms of specific counselor directives and behaviors. A checklist (see Appendix B) was used to ascertain modality specific counselor behaviors. For example; "the counselor suggested that the students should not try to change at this time" (PD); "the counselor modeled appropriate behaviors" (CR). The rater reported that counselors appeared to carefully adhere to behaviors reflective of their assigned intervention strategies.

Two days after the final session, a posttest of the identical instruments was given treatment and control subjects. Control group counseling sessions began within one school week from the posttest.

**Ethical Safeguards and Considerations**

Counselors were all professional school psychologists. They are empathetic, concerned individuals proficient at building rapport and trust with students as a part of their daily working routine. They also received additional modality-specific training from a consultant knowledgeable of the respective intervention techniques. It is believed that counselors were both knowledgeable of technique and sensitive to the emotional needs of the participants involved.
Although students were asked to make a commitment for the entire four week period of counseling, they were explicitly told that they could drop out of the group or if they (or the counselor) felt that their emotional needs were greater than the group could provide for, after counselor consultation with and permission of parents, they would be referred to a staff psychologist (assigned according to school) or to a mental health facility if the problem was such that the city's Psychological Services Department felt it was outside its realm of competence. While audio tapes were reviewed randomly each week to assess counselor technique, attention was also given to potential problems in an effort to identify and deal with them before they became serious.

Confidentiality was maintained. All audio tapes were erased after the completion of the study. All reports are non-specific with regard to school and subjects.

Parents and subjects were told that the goal of the research project was to discuss personal and interpersonal student issues and perhaps discern effective means of dealing with those various matters. Following the completion of the experiment, students and parents were more specifically informed (see Appendix D). They were told that the research involved a comparative study of two different counseling techniques on improving self-esteem. A brief
statement was made as to the techniques involved. Cognitive restructuring was described as a means of didactically assisting students to re-think their personal concerns more realistically and their thoughts about their concerns as they affect self-esteem more positively. In the paradoxical directives groups, insecurities and unrealistic self-assessments were framed as somehow purposeful and at least temporarily beneficial and therefore, appropriate. PD was explained as providing an opportunity for positive change and fair, appropriate self-assessment in the absence of external demands. Results were reported in terms of intra- and inter-group change.

Control groups were counseled by similar professionals from within the school system. Treatment (PD or CR) was at the discretion of the counselors who received training similar to that of the treatment counselors.

**Instrumentation**

**Coopersmith Self Esteem Inventory** (Coopersmith, 1967)

The Coopersmith SEI is a 58 item questionnaire normed on over 40,000 children (age 9 and older) and adults from a cross-section of socioeconomic, ethnic, and subcultural groups (Byrne, 1983). The School Form or Long Form was originally normed on 86 fifth and sixth grade boys and girls
and later administered to a sample of 1748 public school children in Connecticut. This form is considered appropriate for students aged eight to fifteen. The scale may be given to individuals or groups. Twenty-six questions deal with general self image while three groups of eight items each investigate social self -- peers, home -- parents, and school -- academic relationships. Scores may be broken down into these subsections or a global score may be used. There is an eight question "Lie" scale as well. Queries are in the form of statements which the subject responds "like me" or "unlike me." Examples: "I spend a lot of time daydreaming;" "I'm pretty sure of myself;" "I'm easy to get along with."

Fullerton's research (1973) suggested substantial evidence of both convergent and discriminant validity for self-concept as measured by the SEI; this is to say that the instrument focuses on a specific construct (self-esteem) and excludes irrelevant variables. This form of validation is particularly germane with personality assessments since extraneous variables could confound and invalidate results (Anastasi, 1982). The SEI scale was found to be most reliable (test-retest) with the 12 to 15 year old group (Rubin, 1978).

Taylor and Reitz (1968, as reported in Robinson and Shaver, 1973) found a correlation of .45 between the CPI
self-acceptance scale and the Coopersmith inventory. In their research, correlations were higher (.66) with other unnamed scales. Robinson and Shaver (1973) note that while the measure appears to have good potential for self-esteem assessment, low inter-item correlations may require additions and/or changes in item selections. They also criticize the lack of data on validity.

Spatz and Johnson (1973), in a study consisting of 600 fifth, ninth, and twelfth grade students, determined the Kuder-Richardson reliability coefficient to be greater than .80 at each grade level. Adair (1984) describes the Coopersmith as "...well researched, well documented, and widely used" (p. 231). He notes the scale's appropriateness for establishing a baseline measure prior to self-esteem counseling intervention. He also describes the manual as thorough and understandable. "By using the CSEI judiciously one can achieve a measure of self-esteem that is as reasonable as possible with self-report instruments" (Adair, 1984, p. 231).

Children's Depression Inventory (Kovacs and Beck, 1977)

The Children's Depression Inventory, a downward extension of Beck's Depression Inventory, is a 27 item self-report inventory which assesses depression in children
from ten to seventeen years old. Saylor, et al (1984), cite the CDI as "...the best researched instrument available to measure depression from the child's viewpoint" (p. 955). They caution, however, that while the CDI may prove to be a valid measure of depression in children, the score produced may correspond to a broader range of symptoms. A good correspondence between the CDI and self-esteem was also noted.

Helsel and Matson (1984) examined the scale and found the split half reliability to be .89. An analysis established four factors across which content was consistent and approximated Kendell's (1976) Type A and Type B analysis of depression. The first factor (Type A related) was labelled Affective Behavior (example: "S(he) has trouble sleeping every night."). Other factors include Image/Ideation ("S(he) hates herself"); Interpersonal Relations ("Nothing is fun at all"); and Guilt/Irritability ("All things are his/her fault"). In a comparative study, a group of depressed children scored significantly higher on all 27 items than the non-depressed group although range of severity differed. CDI items appear to be consistently measuring the construct of depression.

Items are given in groups of three (scored 0, 1, or 2); example: "s(he) is sad once in a while" (0); "s(he) is sad many times" (1); "s(he) is sad all the time" (2).
State-Trait Anxiety Scale for Children (Spielberger, 1973)

The State-Trait Anxiety Inventory for Children (STAIC) is a self-report instrument assessing a person's transitional (state) and relatively enduring (trait) anxiety. The test, normed on 1554 elementary school children at six schools in two West Florida counties, is a downward extension of the State-Trait Anxiety Inventory for adults. This forty item measure can be administered on an individual or group basis.

Twenty state-anxiety questions ask how and to what degree the student feels about something in the present. For example, "I feel ...very upset--, upset--, not upset--; or "I feel ...very calm--, calm--, not calm." For purposes of this research, only the trait-anxiety portion of the protocol was used. Twenty trait-anxiety questions seek more general, long standing feelings and their frequency. For example, "My hands get sweaty;" or "I worry about school." Choices are listed: "hardly ever, sometimes, often."

Test-retest reliability ranged from .65 to .71 for trait anxiety (Spielberger, 1973). Because state anxiety is by definition subject to change, internal consistency coefficients were seen as a reasonable index of reliability.
and were found to range from .82 to .87 (Spielberger, 1973). Concurrent validity is based on correlations of .47 (state anxiety) and .52 (trait anxiety) with the Children's Manifest Anxiety Scale (Montgomery and Finch, 1974).

Walker and Kaufman (1984) praise the instrument's administrative and scoring properties. They recommend its use with junior high school students because of the required reading ability although they note the need for more normative data at this level. They also suggest sample investigations representative of a broader range of the population. Endler (1978) highly recommends the STAIC, describing it as the best scale available for assessing anxiety in children.

**Nowicki-Strickland Locus of Control Scale for Children**

*(Nowicki-Strickland, 1972)*

The Nowicki-Strickland Locus-of-Control Scale for Children is a forty item questionnaire normed on 1017 mostly white third through twelfth grade children from four different communities. Questions, answered yes or no, were drawn from a pool of 102 items, pared to fifty-nine items by a team of clinical psychologists, and finally reduced to the instrument's present length via item analysis. Examples are as follows: "Are some kids born lucky?" "Do you believe
that if somebody studies hard enough he or she can pass any subject?" "Do you believe that wishing can make good things happen?"

Johnson (1976) notes significant relationships reported between internality and grade point average while Nowicki and Strickland (1973) found a similar relationship between internality and age. Battle and Rotter's research in 1963 suggests that middle class whites tend to be the most internally oriented while lower class blacks had the most external orientation. Internal consistency (split half) ranged from .63 to .81 and test-retest reliabilities (over six week intervals) varied from .63 to .71, both measures apparently becoming more stable with age (Johnson, 1976). A correlation of .41 was found between this locus of control scale and the Bialer-Cromwell Children's Locus of Control Scale (Bialer, 1960).

The confounding effects of such extraneous variables as age, sex, race, and socioeconomic status are noted by Nowicki and Strickland (1973). Nevertheless, Robinson and Shaver (1973) commend both the authors and the instrument, noting their solid reputations as researchers and its adequate reliability and validity. "In short, it appears to be the best measure of locus of control as a generalized expectancy presently available for children" (p. 208).
Research Design

A pretest/posttest control group design was used which schematically is as follows with "G" representing different groups; "R," randomization of the accessible population; "0," pre/post testing; and "X," treatment.

G1: R 01 X(PD) 02
G2: R 03 X(CR) 04
G3: R 05 06

Specific Null Hypotheses

Among groups (PD, CR, control), at the .05 level of significance:

1. There will be no post-treatment difference in scores on the Coopersmith Self-Esteem Inventory.
2. There will be no post-treatment difference in scores on the Children's Depression Inventory.
3. There will be no post-treatment difference in scores on the State-Trait Anxiety Inventory for Children (trait-anxiety portion only).
4. There will be no post-treatment difference in scores on the Nowicki-Strickland Locus-of-Control Scale for Children.
Statistical Analysis Technique

Collected data was analyzed by analysis of covariance (ANCOVA) to discern statistically significant difference (.05 level) among groups. (ANCOVA was chosen to control for initial differences among groups).

Summary of Methodology

The sample was drawn from an accessible population of eighth grade students. A pretest/posttest control group research design was used. Dependent variables were self-esteem, depression, anxiety, and locus of control. Data was analyzed using an analysis of covariance (ANCOVA).
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CHAPTER 4: RESULTS

In this chapter, results of the experiment are reviewed and interpreted individually by hypothesis. Collected data consisted of the pre- and post-test scores for each of the four dependent variables measured. An analysis of covariance (ANCOVA) was used to discern statistical evidence of differences among groups after treatment (posttest) taking into account pre-treatment group differences (pretest).

Specific Research Hypotheses

Hypothesis 1

Subjects receiving Paradoxical Directives will achieve higher post-treatment scores on the Coopersmith Self-Esteem Inventory (SEI) than subjects receiving Cognitive Restructuring who will in turn achieve higher scores than subjects receiving no special treatment.

An ANCOVA analysis of post-total SEI scores by treatment with pre-total SEI scores resulted in an $F$ of 1.323 for treatment main effects (see Table 1). This was determined to be significant at only the 0.274 level. Therefore, the null hypothesis was accepted; Self-Esteem
Inventory posttest means among groups were not statistically different. Table 2 summarizes the means and standard deviations by treatment.
Table 1

Hypothesis 1
Summary of ANCOVA Analysis for Treatment Effects of Post- with Pre- Total Test Scores on the Coopersmith Self Esteem Inventory

<table>
<thead>
<tr>
<th>SOURCE OF VARIATION</th>
<th>SUM OF SQUARES</th>
<th>DF</th>
<th>MEAN SQUARE</th>
<th>F</th>
<th>SIGNIFIC OF F</th>
</tr>
</thead>
<tbody>
<tr>
<td>COVARIATES</td>
<td>11403.958</td>
<td>1</td>
<td>11403.958</td>
<td>153.134</td>
<td>0.000</td>
</tr>
<tr>
<td>PRETEST</td>
<td>11403.958</td>
<td>1</td>
<td>11403.958</td>
<td>153.134</td>
<td>0.000</td>
</tr>
<tr>
<td>MAIN EFFECTS</td>
<td>197.095</td>
<td>2</td>
<td>98.548</td>
<td>1.323</td>
<td>0.274</td>
</tr>
<tr>
<td>TRT</td>
<td>197.095</td>
<td>2</td>
<td>98.548</td>
<td>1.323</td>
<td>0.274</td>
</tr>
<tr>
<td>EXPLAINED</td>
<td>11601.053</td>
<td>3</td>
<td>3867.018</td>
<td>51.927</td>
<td>0.000</td>
</tr>
<tr>
<td>RESIDUAL</td>
<td>4170.347</td>
<td>56</td>
<td>74.470</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>15777.400</td>
<td>59</td>
<td>267.312</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 2

Hypothesis 1
Summary of Means and Standard Deviations Grouped According to Treatment on Posttest Scores on the Coopersmith Self Esteem Inventory

<table>
<thead>
<tr>
<th>TREATMENT</th>
<th>n</th>
<th>MEAN</th>
<th>STANDARD DEVIATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paradoxical Directives</td>
<td>20</td>
<td>74.100</td>
<td>13.8636</td>
</tr>
<tr>
<td>Cognitive Restructuring</td>
<td>20</td>
<td>76.200</td>
<td>15.8931</td>
</tr>
<tr>
<td>No-Treatment Control</td>
<td>20</td>
<td>65.400</td>
<td>17.7835</td>
</tr>
<tr>
<td>Total Population</td>
<td>60</td>
<td>71.900</td>
<td>16.3497</td>
</tr>
</tbody>
</table>
Post-treatment scores achieved on the Children's Depression Inventory will show subjects in the PD groups to be less depressed than those subjects in the CR groups who will in turn be less depressed than subjects in the control groups.

ANCOVA analysis resulted in an $F$ value of 3.058, approaching significance at the .05 level (0.055). Therefore, the null hypothesis was rejected at the .05 level of significance, suggesting that with a ninety-five percent level of confidence, Children's Depression Inventory posttest means among groups differed and that differences were not the result of sampling error. Further investigation using ANCOVA analysis indicated that while the CR group did not differ from either the PD or the C groups, the PD group significantly differed from the C group at the 0.014 level ($F=6.591$). Results are summarized in Table 3. A summary of means and standard deviations is found in Table 4.
Table 3

Hypothesis 2
Summary of ANCOVA Analysis for Treatment Effects of Post- with Pre-Test Scores on the Children's Depression Inventory

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>DF</th>
<th>Mean Square</th>
<th>F</th>
<th>Signif of F</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Groups</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Covariates</td>
<td>990.945</td>
<td>1</td>
<td>990.845</td>
<td>47.631</td>
<td>0.000</td>
</tr>
<tr>
<td>Pre-Test</td>
<td>990.845</td>
<td>1</td>
<td>990.845</td>
<td>47.631</td>
<td>0.000</td>
</tr>
<tr>
<td>Main Effects</td>
<td>127.214</td>
<td>2</td>
<td>63.607</td>
<td>3.058</td>
<td>0.055</td>
</tr>
<tr>
<td>TRT</td>
<td>127.214</td>
<td>2</td>
<td>63.607</td>
<td>3.058</td>
<td>0.055</td>
</tr>
<tr>
<td>Explained</td>
<td>1118.058</td>
<td>3</td>
<td>372.686</td>
<td>17.915</td>
<td>0.000</td>
</tr>
<tr>
<td>Residual</td>
<td>1164.942</td>
<td>56</td>
<td>20.803</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>2283.000</td>
<td>59</td>
<td>38.695</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

PD with CR Groups only

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>DF</th>
<th>Mean Square</th>
<th>F</th>
<th>Signif of F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covariates</td>
<td>507.516</td>
<td>1</td>
<td>507.516</td>
<td>21.169</td>
<td>0.000</td>
</tr>
<tr>
<td>Pre-Test</td>
<td>507.516</td>
<td>1</td>
<td>507.516</td>
<td>21.169</td>
<td>0.000</td>
</tr>
<tr>
<td>Main Effects</td>
<td>32.788</td>
<td>1</td>
<td>32.788</td>
<td>1.368</td>
<td>0.250</td>
</tr>
<tr>
<td>TRT</td>
<td>32.788</td>
<td>1</td>
<td>32.788</td>
<td>1.368</td>
<td>0.250</td>
</tr>
<tr>
<td>Explained</td>
<td>540.304</td>
<td>2</td>
<td>270.152</td>
<td>11.268</td>
<td>0.000</td>
</tr>
<tr>
<td>Residual</td>
<td>887.071</td>
<td>37</td>
<td>23.975</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>1427.375</td>
<td>39</td>
<td>36.599</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 3 (Continued)

CR with C Groups only

<table>
<thead>
<tr>
<th>SOURCE OF VARIATION</th>
<th>SUM OF SQUARES</th>
<th>DF</th>
<th>MEAN SQUARE</th>
<th>F</th>
<th>SIGNIFIC OF F</th>
</tr>
</thead>
<tbody>
<tr>
<td>COVARIATES</td>
<td>745.508</td>
<td>1</td>
<td>745.508</td>
<td>37.967</td>
<td>0.000</td>
</tr>
<tr>
<td>PRE-TEST</td>
<td>745.508</td>
<td>1</td>
<td>745.508</td>
<td>37.967</td>
<td>0.000</td>
</tr>
<tr>
<td>MAIN EFFECTS</td>
<td>23.950</td>
<td>1</td>
<td>23.950</td>
<td>1.220</td>
<td>0.277</td>
</tr>
<tr>
<td>TRT</td>
<td>23.950</td>
<td>1</td>
<td>23.950</td>
<td>1.220</td>
<td>0.277</td>
</tr>
<tr>
<td>EXPLAINED</td>
<td>769.458</td>
<td>2</td>
<td>384.729</td>
<td>19.593</td>
<td>0.000</td>
</tr>
<tr>
<td>RESIDUAL</td>
<td>726.517</td>
<td>37</td>
<td>19.636</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>1495.975</td>
<td>39</td>
<td>38.358</td>
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</tr>
</tbody>
</table>

PD with C Groups only

<table>
<thead>
<tr>
<th>SOURCE OF VARIATION</th>
<th>SUM OF SQUARES</th>
<th>DF</th>
<th>MEAN SQUARE</th>
<th>F</th>
<th>SIGNIFIC OF F</th>
</tr>
</thead>
<tbody>
<tr>
<td>COVARIATES</td>
<td>730.748</td>
<td>1</td>
<td>730.748</td>
<td>38.270</td>
<td>0.000</td>
</tr>
<tr>
<td>PRE-TEST</td>
<td>730.748</td>
<td>1</td>
<td>730.748</td>
<td>38.270</td>
<td>0.000</td>
</tr>
<tr>
<td>MAIN EFFECTS</td>
<td>125.858</td>
<td>1</td>
<td>125.858</td>
<td>6.591</td>
<td>0.014</td>
</tr>
<tr>
<td>TRT</td>
<td>125.858</td>
<td>1</td>
<td>125.858</td>
<td>6.591</td>
<td>0.014</td>
</tr>
<tr>
<td>EXPLAINED</td>
<td>856.606</td>
<td>2</td>
<td>428.303</td>
<td>22.431</td>
<td>0.000</td>
</tr>
<tr>
<td>RESIDUAL</td>
<td>706.494</td>
<td>37</td>
<td>19.094</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>1563.100</td>
<td>39</td>
<td>40.079</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TREATMENT</td>
<td>n</td>
<td>MEAN</td>
<td>STANDARD DEVIATION</td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------------</td>
<td>----</td>
<td>-------</td>
<td>--------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paradoxical Directives</td>
<td>20</td>
<td>5.9500</td>
<td>6.1342</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cognitive Restructuring</td>
<td>20</td>
<td>6.8000</td>
<td>6.0923</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No-Treatment Control</td>
<td>20</td>
<td>9.7500</td>
<td>6.0860</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Population</td>
<td>60</td>
<td>7.5000</td>
<td>6.2205</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Hypothesis 3

Post-treatment scores achieved on the State-Trait Anxiety Inventory for Children (trait portion only) will show individuals in the PD groups to be less anxious than those in the CR groups who in turn will be less anxious than subjects in the control groups.

An ANCOVA $F$ of 0.484 for treatment main effects was determined not to be significant (0.619 level). The above analysis (see table 5) indicated that the interventions produced no significant differences among groups in trait anxiety reduction; consequently, the null hypothesis was accepted. Table 6 summarizes means and standard deviations by treatment.
Table 5

Hypothesis 3
Summary of ANCOVA Analysis for Treatment Effects of Post- with Pre-
Total Test Scores on the State-Trait Anxiety Inventory for Children (Trait Anxiety Portion Only)

<table>
<thead>
<tr>
<th>SOURCE OF VARIATION</th>
<th>SUM OF SQUARES</th>
<th>DF</th>
<th>MEAN SQUARE</th>
<th>F</th>
<th>SIGNIF OF F</th>
</tr>
</thead>
<tbody>
<tr>
<td>COVARIATES</td>
<td>775.247</td>
<td>1</td>
<td>775.247</td>
<td>27.735</td>
<td>0.000</td>
</tr>
<tr>
<td>PRE-TEST</td>
<td>775.247</td>
<td>1</td>
<td>775.247</td>
<td>27.735</td>
<td>0.000</td>
</tr>
<tr>
<td>MAIN EFFECTS</td>
<td>27.036</td>
<td>2</td>
<td>13.518</td>
<td>0.484</td>
<td>0.619</td>
</tr>
<tr>
<td>TRT</td>
<td>27.036</td>
<td>2</td>
<td>13.518</td>
<td>0.484</td>
<td>0.619</td>
</tr>
<tr>
<td>EXPLAINED</td>
<td>802.309</td>
<td>3</td>
<td>267.436</td>
<td>9.568</td>
<td>0.000</td>
</tr>
<tr>
<td>RESIDUAL</td>
<td>1565.341</td>
<td>56</td>
<td>27.953</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>2367.650</td>
<td>59</td>
<td>40.130</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 6

Hypothesis 3
Summary of Means and Standard Deviations Grouped According to Treatment on Posttest Scores on the State-Trait Anxiety Inventory for Children (Trait Anxiety Portion Only)

<table>
<thead>
<tr>
<th>TREATMENT</th>
<th>n</th>
<th>MEAN</th>
<th>STANDARD DEVIATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paradoxical Directives</td>
<td>20</td>
<td>34.150</td>
<td>6.0548</td>
</tr>
<tr>
<td>Cognitive Restructuring</td>
<td>20</td>
<td>33.400</td>
<td>5.0095</td>
</tr>
<tr>
<td>No-Treatment Control</td>
<td>20</td>
<td>32.500</td>
<td>7.8372</td>
</tr>
<tr>
<td>Total Population</td>
<td>60</td>
<td>33.350</td>
<td>6.3348</td>
</tr>
</tbody>
</table>
Hypothesis 4

Post-treatment scores achieved on the Nowicki-Strickland Locus-of-Control Scale for Children will indicate that individuals in the PD groups conceive their locus-of-control as more internally oriented than the CR and the control groups.

Analysis of co-variance by treatment on scores obtained from the locus-of-control scale resulted in no significant difference among groups ($F=2.387$). With significance determined to be only 0.101, the null hypothesis was accepted. Table 7 contains the statistical results for this measure. Table 8 contains the means and standard deviations by treatment.
Table 7

Hypothesis 4
Summary of ANCOVA Analysis for Treatment Effects of Post- with Pre-
Total Test Scores on the Nowicki-Strickland Locus-of-Control Scale for Children

<table>
<thead>
<tr>
<th>SOURCE OF VARIATION</th>
<th>SUM OF SQUARES</th>
<th>DF</th>
<th>MEAN SQUARE</th>
<th>F</th>
<th>SIGNIF OF F</th>
</tr>
</thead>
<tbody>
<tr>
<td>COVARIATES</td>
<td>1164.078</td>
<td>1</td>
<td>1164.078</td>
<td>120.344</td>
<td>0.000</td>
</tr>
<tr>
<td>PRE-TEST</td>
<td>1164.078</td>
<td>1</td>
<td>1164.078</td>
<td>120.344</td>
<td>0.000</td>
</tr>
<tr>
<td>MAIN EFFECTS</td>
<td>46.171</td>
<td>2</td>
<td>23.086</td>
<td>2.387</td>
<td>0.101</td>
</tr>
<tr>
<td>TRT</td>
<td>46.171</td>
<td>2</td>
<td>23.086</td>
<td>2.387</td>
<td>0.101</td>
</tr>
<tr>
<td>EXPLAINED</td>
<td>1210.249</td>
<td>3</td>
<td>403.416</td>
<td>41.706</td>
<td>0.000</td>
</tr>
<tr>
<td>RESIDUAL</td>
<td>541.684</td>
<td>56</td>
<td>9.673</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>1751.933</td>
<td>59</td>
<td>29.694</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 8

Hypothesis 4
Summary of Means and Standard Deviations Grouped According to Treatment on Posttest Scores on the Nowicki-Strickland Locus-of-Control Scale for Children

<table>
<thead>
<tr>
<th>TREATMENT</th>
<th>n</th>
<th>MEAN</th>
<th>STANDARD DEVIATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paradoxical Directives</td>
<td>20</td>
<td>13.100</td>
<td>4.7562</td>
</tr>
<tr>
<td>Cognitive Restructuring</td>
<td>20</td>
<td>11.250</td>
<td>5.9725</td>
</tr>
<tr>
<td>No-Treatment Control</td>
<td>20</td>
<td>13.550</td>
<td>5.5486</td>
</tr>
<tr>
<td>Total Population</td>
<td>60</td>
<td>12.633</td>
<td>5.4492</td>
</tr>
</tbody>
</table>
Summary

A pretest/posttest control group research design was used to determine relative efficacy of the paradoxical directives and cognitive restructuring counseling interventions on improving self-esteem, reducing depression and anxiety, and instilling a more internal locus-of-control. The sample was drawn from a volunteer population of eighth graders. Analyzed data using an analysis of covariance (ANCOVA) resulted in the acceptance of null for hypotheses 1, 3, and 4.

Among groups (PD, CR, control), at the 0.05 level of significance:

1. There will be no post-treatment difference in scores on the Coopersmith Self-Esteem Inventory.

3. There will be no post-treatment difference in scores on the State-Trait Anxiety Inventory for Children (trait anxiety portion only).

4. There will be no post-treatment difference in scores on the Nowicki-Strickland Locus-of-Control Scale for Children.

ANCOVA analysis for data collected on the Children's Depression Inventory resulted in an $F$ significant at the 0.055 level, suggesting that posttest means differed among groups. The null hypothesis was rejected at the 0.95 level
of confidence. Further ANCOVA analysis indicated that the PD group differed significantly from the no-treatment control group at the 0.014 level while no other differences among groups were noted.
CHAPTER 5: SUMMARY, CONCLUSIONS, DISCUSSION, RECOMMENDATIONS

This chapter will summarize the various aspects of the study and discuss findings by hypothesis. Recommendations and suggestions will be made to assist future research.

Summary

Until recently, successes attributed to the paradoxical directives therapeutic modality have lacked empirical evidence. Previous literature had been primarily in the form of case studies and uncontrolled experiments. In the 1984, volume 15 issue of the Journal of Behavior and Experimental Psychiatry, however, several researchers (Ascher, 1980; Wilson and Bornstein, 1984; Strong, 1984) cited the effectiveness of the PD approach under empirically sound experimental conditions and encouraged further investigation.

This study investigated the relative merits of PD as it compared to the more didactic cognitive restructuring intervention. It was hypothesized that subjects in the PD groups would show an improvement in self-esteem, a reduction in depression and anxiety, and a change reflective of a more internal locus-of-control orientation to a degree
significantly greater than the CR and the control groups.

The sample consisted of sixty eighth grade volunteers, twenty from each of three middle schools in a local area school district. Six groups were formed of ten subjects each, two groups for each treatment and two groups receiving no treatment. Participants were randomly assigned by treatment and counselor within each school. Eight group meetings were held, two a week for four consecutive weeks.

The research design used was the pretest/posttest control group design. Instruments used were the Coopersmith Self Esteem Inventory, the Children's Depression Inventory, the State-Trait Anxiety Inventory for Children (trait anxiety portion only), and the Nowicki-Strickland Locus-of-Control Scale for Children. An analysis of covariance was used to discern differences in posttest group means by treatment taking into consideration pre-treatment group differences. Statistical analysis resulted in the acceptance of null on hypotheses 1, 3, and 4 as reviewed in Chapter 4 and below. The null hypothesis was rejected at the .95 level of confidence for the second hypothesis. Posttest treatment means did not significantly differ with regard to self-esteem, anxiety, and locus-of-control. On the other hand, posttest treatment group means differed significantly at the 0.05 level on the measure of depression.
**Conclusions**

Findings and conclusions for this study are presented by hypothesis.

**Hypothesis 1**

Subjects receiving Paradoxical Directives will achieve higher post-treatment scores on the Coopersmith Self-Esteem Inventory (SEI) than subjects receiving Cognitive Restructuring who will in turn achieve higher scores than subjects receiving no special treatment.

An ANCOVA analysis of post-total SEI scores by treatment with pre-total SEI scores resulted in an insignificant $F$. As a result, the null hypothesis could not be rejected. No significant difference was found between post-treatment self-esteem scores of the treatment groups or the control groups.
Hypothesis 2

Post-treatment scores achieved on the Children's Depression Inventory will show subjects in the PD groups to be less depressed than those subjects in the CR groups who will in turn be less depressed than subjects in the control groups.

ANCOVA analysis results supported this hypothesis. Posttest treatment mean scores on the Children's Depression Inventory did differ at the 0.055 level of significance. Analysis of covariance between treatment groups indicates that the PD group posttest mean scores differed significantly from that of the no treatment control group scores. In this case, it appears that adolescents exposed to the PD intervention were significantly less depressed than those receiving no treatment. No other differences between treatments were found to be significant.

Hypothesis 3

Post-treatment scores achieved on the State-Trait Anxiety Inventory for Children (trait portion only) will show individuals in the PD groups to be less anxious than those in the CR groups who in turn will be less anxious than subjects in the control groups.
No differences among treatments were found to be significant and the null hypothesis was accepted. It may be concluded that posttest scores on the anxiety portion of the State-Trait Anxiety Inventory for Children did not differ significantly among groups regardless of treatment.

**Hypothesis 4**

Post-treatment scores achieved on the Nowicki-Strickland Locus-of-Control Scale for Children will indicate that individuals in the PD groups conceive their locus-of-control as more internally oriented than the CR and the control groups.

Analysis of co-variance results do not support this hypothesis. $F$ was found to be nonsignificant and null was accepted. Based on the above data, it can be concluded that differences in treatment among groups at posttest were insignificant.

**Discussion**

While null was accepted in three of four cases, it was rejected with respect to posttest treatment mean scores on the Children's Depression Inventory. The PD treatment was statistically superior to no treatment. PD did not significantly differ from the CR intervention.
Nevertheless, in view of the fact that in four weeks no other significant differences were noted, it appears that depression may be somewhat responsive and sensitive to the PD technique. Pretest/posttest means for the CR group showed only a slight change for the better (7.1000 and 6.8000 respectively) while the control group worsened slightly (9.0500 and 9.750). On the other hand, the PD treatment changed from a pretest mean of 8.7000 to a posttest mean of 5.9500, an improvement of almost 3 points.

With the one exception noted above, results generally indicate that posttest outcomes did not statistically differ regardless of treatment (including no treatment). Several factors may have accounted for these findings. It may be that the dependent variables measured are more enduring than the investigator assumed; eight sessions over four weeks may simply not have been enough time to precipitate statistical change. In some cases, it appears that the treatment period may have served only to establish trust to the point where group members were willing to disclose serious concerns to peers and to counselors. Further, while ANCOVA results indicated no significant differences among groups, the instruments may tend to measure gross change and may not be sensitive enough to differentiate improvement in the short run despite the fact that chosen instruments were considered the best of their type. It may also be the case that participants in the study did not take the pre- and
post-test requirements as seriously as the researcher (and understandably so).

Counselor variables may have been a factor. Since counselors were relatively inexperienced with the modalities, despite adequate training and apparent appropriate use of technique, the intervention may not have been compatible with the individual's counseling style.

External threats must also be considered. During the course of the experiment, SRA testing occurred; the week immediately following posttesting, report cards were distributed just prior to a week's vacation. It is unlikely that these variables had no effect upon outcome; one counselor reported that a group member was informed that he was in danger of being retained while another was suspended for misconduct.
Recommendations

Results suggest the need for more research using the PD approach, particularly in conjunction with adolescent depression. Future research should proceed with the following cautions, however. Instrument insensitivity may require that more time is necessary to attain significant, measurable improvement. Longer counseling periods will also increase disclosure of concerns over denial. Counselor compatibility with the PD technique might be ascertained through a pilot study or previous experience.

While empirical studies on the paradoxical directives counseling technique are growing in number, the need for more research continues. In order to verify the modality's effectiveness, further investigation is required, especially with the adolescent group with which minimal research has been done to date.
PLEASE NOTE:

This page not included with original material. Filmed as received.

University Microfilms International
APPENDIX
APPENDIX A

Parent Permission Form
Appendix A - Parent Permission Form

February 13, 1986

Dear Parents:

Your son/daughter has expressed an interest in participating in a school approved research project focusing on means of dealing with adolescent issues. Students will meet in small groups with certified school personnel specially trained for this counseling experience. The goal of the program is personal growth: to provide the opportunity for members to discuss school and interpersonal concerns and to discern effective means of dealing with these various matters. Counselor directives and responses will be taped and monitored in order to provide supervision as necessary.

Groups will meet eight times over a four week span. Sessions will be rotated by period to minimize time lost from regular coursework. Because there are now seven periods in the middle schools, no class will be missed more than twice; most classes will be missed only once. Participants invariably view groups such as these as personally rewarding and enjoyable. Questionnaires will be administered to participants to assess personal feelings and attitudes about themselves. Results will be used without names for statistical research purposes only. All personal data will remain strictly confidential; tapes will be erased following the completion of the study.

Please sign the bottom of this letter if you give your permission for your child to participate in one of these groups. If you have any questions, please do not hesitate to call me.

Thank you,

Sincerely,

David A. Hall

Students Name ___________________________  Parent Signature ___________________________

Date ___________________________
APPENDIX B

Checklist of Counselor Behaviors
During Group Sessions
APPENDIX B

CHECKLIST OF COUNSELOR BEHAVIORS DURING GROUP SESSIONS

1. **Thoughts were tested as to their validity and reasonableness.

2. **The counselor modeled appropriate behaviors.

3. Negative self-thoughts and insecurities were framed positively as serving some purpose.

4. Change was defined as occurring only after long periods of counseling and was therefore not expected to occur in only eight sessions.

5. **The role of cognitions in attitude and/or behaviors was explained.

6. The counselor suggested that the student should not try to change for the duration of the counseling period.

7. **New coping strategies were developed.

8. Attempts to change negative thoughts or to improve attitudes about oneself were framed as probably (though not definitely) futile in the short run.

9. **Alternate behaviors were explored.

10. **The group members' thoughts, assumptions, and attitudes were challenged.

11. Change is defined as threatening (scary), and as such, is discouraged.

12. **Present coping strategies were discussed.

13. **Negative self-statements were discussed.

14. Group members were asked to temporarily not change any thoughts, feelings, or behaviors about themselves.

15. Inappropriate, negative attitudes were defined as serving a purpose.

16. **Appropriate behaviors and thoughts were rehearsed and evaluated.

17. Negative self-statements were deemed preferable to no statements at all.
18. **Group members were taught to identify negative self-statements which accompany inappropriate feelings or behaviors.

19. Counselor permission was granted for existing student self-doubts and insecurities.

20. **Positive self-statements were substituted for negative self-statements.

21. Possible benefits of self-doubts and insecurities were discussed.

22. **The counselor overtly verbalized appropriate assessment during a modeling or rehearsing situation.

23. **Appropriate covert assessment of a situation was discussed and/or rehearsed.

24. A short time during the sessions was set aside for students to worry about envisioned personal insecurities and inadequacies.

25. Insecurities, self-doubts, and negative feelings about self were discussed in terms of being under the control of others.

** Indicates Cognitive Restructuring
APPENDIX C

Counselor's Statement of Competence
I received approximately two hours of training in Cognitive Restructuring (CR) counseling with a trainer who is knowledgable in this field. I was made aware of germane theory and technique to a degree that I felt competent and was capable of performing as a counselor using this approach. In addition, specific CR lesson plans were reviewed each week prior to the following week's sessions to ensure my understanding of group meeting goals and implementation of technique.

Carolyn Warrick
Cognitive Restructuring Counselor
Experimental Group III
APPENDIX C: COUNSELOR’S STATEMENT OF COMPETENCE

I received approximately two hours of training in Cognitive Restructuring (CR) counseling with a trainer who is knowledgeable in this field. I was made aware of germane theory and technique to a degree that I felt competent and was capable of performing as a counselor using this approach. In addition, specific CR lesson plans were reviewed each week prior to the following week’s sessions to ensure my understanding of group meeting goals and implementation of technique.

Jane Reilly
Cognitive Restructuring Counselor
Experimental Group IV
APPENDIX C: COUNSELOR'S STATEMENT OF COMPETENCE

I received approximately two hours of training in Paradoxical Directives (PD) counseling with a trainer who is knowledgeable in this field. I was made aware of germane theory and technique to a degree that I felt competent and was capable of performing as a counselor using this approach. In addition, specific PD lesson plans were reviewed each week prior to the following week's sessions to ensure my understanding of group meeting goals and implementation of technique.

Melinda Myrom
Paradoxical Directives Counselor
Experimental Group I
APPENDIX C: COUNSELOR'S STATEMENT OF COMPETENCE

I received approximately two hours of training in Paradoxical Directives (PD) counseling with a trainer who is knowledgable in this field. I was made aware of germane theory and technique to a degree that I felt competent and was capable of performing as a counselor using this approach. In addition, specific PD lesson plans were reviewed each week prior to the following week's sessions to ensure my understanding of group meeting goals and implementation of technique.

Rita Wagner
Paradoxical Directives Counselor
Experimental Group II
APPENDIX D

Post-Treatment Informational Letter to Parents
Dear Parents,

Your eighth grade son or daughter was recently involved in a group counseling research project comparing two different counseling techniques on improving self-esteem. In one group, members were taught how to recognize unfair, unreasonable negative thoughts that they had about themselves, then encouraged through discussion and role playing to re-assess themselves more reasonably and more realistically.

In the second group, insecurities and unrealistic thoughts and emotions were not discouraged but described as temporarily appropriate and as serving a purpose and therefore, as personally beneficial. The theory behind this technique holds that without demands for change from others, students are freer to assess their own thoughts, emotions, and behaviors in relation to others more accurately and meaningfully and thus are better able to generate positive personal change on their own.

After the counseling experience, some improvement in self-esteem on an individual basis within each experimental group was noted. Statistically, no difference in the effectiveness of techniques was found. Participants perceived their group sessions as enjoyable and beneficial.

Similarly, all counselors felt that the experience was personally rewarding for them in that they enjoyed interacting with a group of bright, enthusiastic, sincere students in such a relaxed, positive atmosphere.

I appreciate your and your child's interest in the study. Thank you.

Yours truly,

David A. Hall
REFERENCES


Bandler, R., and Grindler, J. (1975). The structure of


Treatment and generalization effects of cognitive-behavior and goal-setting interventions with aggressive boys. *Journal of Consulting and Clinical Psychology*, 5, 915-916.


Vita

David Alvin Hall

Birthdate:  September 26, 1947
Birthplace:  Cranston, Rhode Island

Education:

1981-1986  The College of William and Mary
           Williamsburg, Virginia
           Doctor of Education

1975-1976  The University of New Hampshire
           at Plymouth State College
           Plymouth, New Hampshire
           Master of Education

1965-1969  The University of Pennsylvania
           Philadelphia, Pennsylvania
           Bachelor of Arts
This study investigated the relative merits of the paradoxical directives (PD) counseling techniques to the more didactic cognitive restructuring (CR) intervention. It was hypothesized that subjects in the PD groups would show an improvement in self-esteem, a reduction in depression and anxiety, and a change reflective of a more internal locus-of-control orientation to a degree significantly greater than the CR and the control groups.

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means by treatment taking into consideration pre-treatment group differences. Statistical analysis resulted in the acceptance of null on hypotheses 1, 3, and 4 as reviewed in Chapter 4 and below. The null hypothesis was rejected at the .95 level of confidence for the second hypothesis. Posttest treatment means did not significantly differ with regard to self-esteem, anxiety, and locus-of-control. On the other hand, posttest treatment group means differed significantly at the 0.05 level on the measure of depression.