The effectiveness on problem resolution of three different treatment modalities: client-centered, rational emotive therapy and paradoxical directives

Michael Wagner Gombatz
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THE EFFECTIVENESS ON PROBLEM RESOLUTION OF THREE DIFFERENT TREATMENT MODALITIES: CLIENT-CENTERED, RATIONAL EMOTIVE THERAPY AND PARADOXICAL DIRECTIVES

The College of William and Mary in Virginia

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THE EFFECTIVENESS ON PROBLEM RESOLUTION
OF THREE DIFFERENT TREATMENT MODALITIES:
CLIENT-CENTERED, RATIONAL EMOTIVE THERAPY
AND PARADOXICAL DIRECTIVES

A Dissertation
Presented to
The Faculty of the School of Education
The College of William and Mary in Virginia

In Partial Fulfillment
of the Requirements for the Degree
Doctor of Education

by
Michael Wagner Gombatz
April 1983
THE EFFECTIVENESS ON PROBLEM RESOLUTION
OF THREE DIFFERENT TREATMENT MODALITIES:
CLIENT-CENTERED, RATIONAL EMOTIVE THERAPY
AND PARADOXICAL DIRECTIVES

by

Michael Wagner Gombatz

Approved April 1983 by

Fred L. Adair, Ph. D.
Charles O. Matthews, Ph.D.
David Hopkinson, Ph.D.
Chairman of Doctoral Committee
Dedication

To Linda Doane
ACKNOWLEDGEMENTS

This work would never have been completed without the help and support of many valuable friends. I would like to thank all of you.

To my committee: Dave Hopkinson who introduced me to paradoxical techniques and spent long hours figuring out what I really meant; Fred Adair for his wisdom and guidance throughout my doctoral studies; Chuck Matthews who taught me how not to panic. To my consultants: Kevin Geoffroy who was always there, Chuck Matthews who taught gentleness and Pat Dorgan who taught the art of paradox so generously. To Armand Galfo and Ron Wheeler and Hugh Brooks who helped me with the design and told me what all those numbers called statistics meant. To my counselors: Jo-Ann Moore, Jeanette Wedding, Mike Grainer, Jean Craig, Marian Maloney, Bob Grant, Dave Hall, Yvonne Sidall and John Bistline who gave their time, their talent and themselves. To my associates: Dixie Shields, Bob George, Dennis Bourdeau, Debbie Boykin, Hella Strube, Ron Grote, Jerry Laferty, Priscilla Dooley, Marsha Davis, Karen Humphrey, Ron Clair, Cathy Leathy, Mark Johnson and Sherry Losito who all helped me with the interviewing. To Dorothy McGaffe who helped coordinate the rooms; to John Lavach, Roger Ries and George Bass who
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CHAPTER 1: INTRODUCTION

The Need for Study

Client-centered therapy was developed by Carl Rogers (1942) and rational emotive therapy was developed by Albert Ellis (1955, 1962). Both are well known and widely researched counseling approaches. The focus of this study is on a lesser known therapy: paradoxical directives. Paradoxical directives are defined as "therapist initiated messages that convey that a specific aspect of a client's problem may be expressed as much or more than it already is occurring" (Hopkinson, 1980, p. 20). Studies reviewed elsewhere in this paper suggest that giving paradoxical directives in the framework of brief therapy may be sufficient to change client behavior. Claims are made in the literature that a single message from the therapist can at times completely resolve a client's problem. Despite the enthusiasm of these therapists and the dramatic claims of success with the techniques of paradox and the numerous case studies offered as examples, there is little experimental evidence that paradox produces results better than client-centered therapy or rational emotive therapy. More generally, there is no evidence that paradox is superior to any other
counseling treatment. In fact, it has not been established empirically that paradox is an effective treatment in its own right. The purpose of this experiment was to determine if paradox is superior to client-centered, rational emotive therapy and/or no intervention as an approach to solving real life problems with college students.

The design of this study was such as to allow the experimenter to determine whether or not paradox is superior to rational emotive therapy, client-centered therapy and/or no intervention. If paradoxical directives are superior, then the design was such as to allow the experimenter to investigate under what conditions, with what kind of clients, and for which problems is this technique effective.

**Statement of the Problem**

The study compares the effectiveness of client-centered, rational emotive therapy and paradoxical directives treatment modalities on problem resolution with college students at the College of William and Mary.

**Theory**

The theoretical conceptualization of paradox is described by Hopkinson (1980). He stated that the underlying concept of paradox is that some problems can be improved by interventions which seemed to be directed to make them
worse. Fay (1978) also organized paradoxical directives this way in his humorous publication *Making Things Better By Making Them Worse*. Using this conceptualization, paradox can be examined from two viewpoints: one as the structure of psychotherapy and two as a specific technique.

In the first viewpoint, the structure of psychotherapy can be seen as "paradoxical." Haley (1963) first described psychotherapy this way. He asserted that the "procedure" of psychotherapy is itself paradoxical. The paradox is that the therapist (a) "sets up a benevolent framework defined as one where change is to take place," (b) "he permits or encourages the patient to continue with unchanged behavior," and (c) "provides an ordeal that will continue as long as the client remains unchanged" (p. 181).

In the second viewpoint, paradoxical directives can be viewed as a specific technique or a kind of intervention used to bring about change. Haley (1963) believed that "one factor which is held in common by all types of psychotherapy is the way the psychotherapist poses paradoxes to the patient" (p. 180). He writes that some are obvious and some so subtle that the patient is unaware of what the therapist is doing. Hopkinson (1980) states that paradox operates as a technique when the therapist attempts to bring about change by verbally and actively encouraging the client to continue the problem he or she brings to the therapist to be
changed. He suggests to avoid confusion that paradox as a technique be kept separate from the level of analysis on which paradoxical directives are a structural element in all of psychotherapy. This research examines "paradoxical directives" as a technique. That is, the level of analysis is on the overt therapist-initiated verbal messages to encourage or exaggerate the client's presenting problem.

In examining paradoxical directives as a technique, Hopkinson (1980) cited several definitional problems with the use of the word "encourage." The major ones were: (a) the meaning of the word encourage, (b) the degree of therapist-client interaction necessary to label the intervention encouragement, (c) the question whether how much passive acceptance of the client's behavior can be labeled encouragement. Haley (1963) meant "encouragement" in the broadest possible way including silence, acceptance and permissiveness. Because this study focuses on paradoxical directives as a technique, a definition of paradox narrower than Haley's definition is used. For this investigation the operational definition of paradox used in Hopkinson's study has been adopted. Paradoxical directives are defined as "therapist initiated messages that convey that a specific aspect of a client's problem may be expressed as much or more than it already is occurring" (Hopkinson, 1980, p. 20).
The theoretical base for understanding how a paradoxical directive works is described by Weeks and L'Abate (1982). They say that a paradoxical directive gives a person no choice. According to Andolfi, "If the message is an injunction, it must be disobeyed to be obeyed; if it is a definition of self or other, the person thereby defined is the kind of person only if he is not, and is not if he is" (1974, p. 222). The principle is that the person is expected to change by following the injunction not to change. The therapist tries to put the client in a special situation by encouraging or permitting the problem so that control over the problem is realized no matter how the client responds. The classic example used by a number of writers (Haley, 1963; Watzlawick, Weakland, & Fisch, 1974; Weeks & L'Abate, 1982) is the injunction, "Be spontaneous." As soon as the client attempts to obey, he cannot. If he disobeys, he obeys. Only when the client gives up trying to behave spontaneously can he be spontaneous. A therapeutic paradoxical message operates in the same way. If the client obeys the therapist, he is behaving symptomatically (continuing his problem behavior) under the direction of the therapist. If he disobeys the therapist, he gives up his problem behavior. If the theory is correct, one effect of a paradoxical directive should be to help the client feel more in control of the problem and have some mastery over it. Two ways of
enabling the client to gain this kind of control are either
by symptom prescription (encouraging the client to become
more symptomatic) or by exaggerating in a humorous way the
client's view of reality. The characteristic underlying
paradox is to widen the distance between the client and his
or her problem so that humor and detachment can come more
easily, clearing the way for adaptive solutions.

In summary, a paradoxical directive puts a person in a
no-lose situation. Watzlawick, Beavin, and Jackson (1967)
state:

If he (the client) complies he no longer 'can't
help it,' he does "it" and this as we have tried
to show makes "it" impossible, which is the pur-
pose of therapy. If he resists the injunction, he
can do so only by not behaving symptomatically
which is the purpose of the therapy (p. 241).

Hypothesis

The major question addressed by this present study is:
will paradoxical directives increase the client's self-rated
problem relief more than no intervention at all? The study
is also designed to determine whether or not the method of
paradoxical directives is superior to the well known and
well established styles of therapy, client-centered and
rational emotive therapy. For the purpose of research the
following hypotheses are formulated:
1. Subjects in the paradoxical directives group will evaluate their self-rated problem relief as higher than subjects in the client-centered, rational emotive counseling and/or control groups.

2. Subjects in the paradoxical directives group will rate the quality of the relationship formed between counselor and subject, as measured by the Barrett-Lennard Relationship Inventory, higher than client-centered and/or rational emotive therapy.

3. Subjects in the paradoxical directives group will state a greater willingness to disclose themselves, as measured by the Willingness-to-Disclose Questionnaire, than client-centered, rational emotive and/or control groups.

4. Subjects in the paradoxical directives group at follow up will report less depression, anxiety, and/or hostility, as measured by the Derogatis Brief Symptom Inventory, than will subjects in the client-centered, rational emotive and/or control group.

For the purpose of research the secondary hypotheses are formulated:

1. The seven subjects in the paradoxical directives group who rate problem relief highest will have a higher mean score on the Barrett-Lennard Relationship Inventory than the seven subjects in the paradoxical directives group who rate problem relief lowest.
2. The seven subjects in the paradoxical directives group who rate problem relief highest will have a higher mean score on the Willingness-to-Disclose Questionnaire than the seven subjects in the paradoxical group who rate problem relief lowest.

**Definitions of Terms**

Following are key terms defined as they relate to this study:

**Client-centered therapy** - Client-centered therapy is based on the theory of Carl Rogers (1942) which postulates that when genuineness, empathy and unconditional positive regard are present, then positive change in the client will be observed. Gerard Egan (1982) has operationally described the skills necessary. Listed they are: physical attending, speaking concretely, primary level accurate empathy, use of probes for information, advanced accurate empathy, appropriate self-disclosure, confrontation, immediacy, goal setting. These are all specified in detail in Egan's *The Skilled Helper* (1982).

**Rational emotive therapy** - Rational emotive therapy is based on the work of Albert Ellis (1973). He writes that since warmth, genuineness and authenticity are neither sufficient nor even necessary to produce change in the
individual, the therapist should focus on the irrational thought process that presents problems on a feeling level for the client. The therapist functions as a teacher and tries to get the client to think differently. The major components of RET are: activating event, belief system, consequences, and counselor's dispute of irrational beliefs. The counselor directly confronts the client with his problem and how he thinks about it. The assumptions are that major irrational ideas cause the client's problem and that the therapist corrects the irrational ideas. The major irrational ideas are: (a) it is a necessity for an adult to be loved or approved of by every significant person in his community, (b) one should be competent in everything, (c) human happiness is externally caused and people have little or no ability to control their sorrows of disturbances, and (d) a person's history is the all important determinant of what he is. The major thrust of RET is to tell the client that the way he is thinking about his problem is causing his problem (Ellis, 1973).

**Paradoxical directives** - In using paradoxical directives, the therapist encourages the client to continue with the presenting problem behavior. The three main types of paradox are: (a) prescribing, (b) restraining, (c) positioning (Rohrbaugh, Tennen, Press, & White, 1981).
In using a prescribing strategy, the therapist instructs, encourages, "exhorts" the subject to actually do the specific piece of behavior to be eliminated. For example, in trying to control a distraction over study, the counselor would prescribe practice in being distracted when trying to study. When restraining, the therapist discourages change and even denies that change is possible in this situation. An example of this would be, "You probably can't change." Resistance is mobilized when the therapist suggests gently that change may not be good at this time. Such resistance can only be expressed by changing. Restraining has been described by Haley (1976). In positioning, the therapist attempts to shift the problematic "position" that the person is taking concerning himself or an important other by accepting and exaggerating that position. This is often done humorously. For example, when a depressed person expresses pessimism, the therapist attempts to "out do" the depressed person's pessimism by describing the situation as worse than it is.

Plan of Presentation

This chapter has introduced the topic of the present research. The problem has been addressed, the hypotheses stated and the relevant terms defined. The remainder of this volume is divided into four chapters as follows:
Chapter 2 - Review of Literature

This chapter reviews the part of literature relating directly to the variables defined and to the means of assessing those variables.

Chapter 3 - Methodology

Chapter 3 contains the methodology of the experiment, the population sampled and the instruments used. Statistical analyses are specified.

Chapter 4 - Analysis of Results

This chapter contains the results of the statistical data analysis by hypothesis.

Chapter 5 - Summary and Conclusion

In the final chapter a summary is presented of the present research with relevant conclusions and implications for counseling theory and practice. Limitations of the study are cited and recommendations for further research are made.
CHAPTER 2: REVIEW OF THE LITERATURE

This chapter will be restricted to a review of that part of the literature which relates to the theoretical rationale and pertinent research for the present study. The three modalities, client-centered, rational emotive and paradoxical directives will be treated separately. Since the focus of the study is on evaluating paradoxical directives, the major portion of the literature review is devoted to this modality. The primary purpose of reviewing client-centered and rational emotive therapy is to provide the empirical evidence that establishes both modalities as effective treatments with which paradoxical directives can be compared.

Client-Centered Therapy

The literature review of client-centered therapy is outlined as follows: theory, research, and summary.

Theory

Client-centered therapy was developed by Carl Rogers in the early 1940's. In 1942 Rogers first published his theory in Counseling and Psychotherapy. Initially Rogers was
trained in traditional Freudian views, but these conflicted with the objective and scientific ideas Rogers also had developed.

Rogers presents 19 propositions of his theory. Synthesized they are: (a) every individual exists in a changing world of experience of which he/she is the center, (b) behavior is basically the goal-directed attempt of the organism to satisfy its needs as experienced, (c) the best vantage point for understanding behavior is from the internal frame of reference of the individual, (d) most of the ways of behaving which are adopted by the organism are those which are consistent with the self (Shertzer & Stone, 1974).

Concepts of Rogers. Most schools of psychotherapy appear to be in accord with Rogers that a positive relationship between patient and therapist is a necessary precondition for any form of psychotherapy. Rogers went far beyond this agreement when he introduced the startling hypothesis that only six conditions in combination were necessary to produce "constructive personality change" (Rogers, 1957, p. 100). Three of these conditions refer to specific attitudinal characteristics of the therapist: (a) genuineness, (b) unconditional positive regard, and (c) empathy. A fourth is that the client is able to perceive the therapist's attitudinal characteristics. The remaining two conditions are apparently so self evident they are dropped out
of subsequent discussion of the necessary and sufficient hypothesis. These two conditions are (a) that the patient and therapist must be aware of the presence of the other and (b) the client must be in a state of incongruence, i.e., that the client must be vulnerable or anxious (Rogers, cited in Parloff, Waskow & Wolfe, 1978, p. 213).

The core conditions required of the therapist were stated as follows:

(a) Genuineness

The therapist should be, within the confines of this relationship, a congruent, genuine, integrated person . . . within this relationship he is freely and deeply himself, with his actual experience accurately represented by his awareness of himself (Rogers, 1957, p. 97).

(b) Unconditional positive regard

To the extent that the therapist finds himself experiencing a warm acceptance of each aspect of the client's experience as being a part of that client, he is experiencing unconditional positive regard (p. 97).

(c) Empathy

The therapist is experiencing an accurate, empathic understanding of the client's awareness of his own experience . . . To sense the client's private world as if it were your own, but without losing the 'as if' quality--this is empathy . . . (p. 98).

(d) The client's perception of the therapist's attitude

The client perceives, to a minimal degree, the acceptance and empathy which the therapist experiences for him. Unless some communication of these attitudes has been achieved, then such attitudes do not exist in the relationship as far as the client is concerned and the therapeutic process could not, by our hypothesis be initiated . . . (p. 99).
Rogers wrote that psychotherapy is a "special kind of relationship, different in kind from all others which occur in everyday life" (p. 101). Parloff et al. (1978) noted that Rogers dismissed any notion that techniques of various therapies were important other than as vehicles for achieving one or another of these conditions. Parloff et al. stated that Rogers abandoned his own view that reflective feelings had any unique or specific therapeutic impact. He proposed that all techniques, such as free association, analysis of resistance were simply mechanisms for communicating the therapist's positive regard. Finally, he stated if one or more of these conditions is not present constructive personality change will not occur (p. 244).

According to Parloff et al., Rogers set forth a remarkably specific set of hypotheses. Rogers attempted to provoke research in testing his hypotheses that would advance the field. He challenged some of the most treasured beliefs concerning the role of techniques, seeing techniques secondary to the quality of the person of the therapist.

Research

Proponents of client-centered therapy have published a number of research studies suggesting that high therapist conditions, genuineness, unconditional positive regard, empathy, perception of the client's attitude, are associated with constructive personality change. One common research
plan is to have minimally trained judges rate the level of therapist conditions as reflected in a two or three minute taped excerpts of each interview. Truax and Carkhuff (1967) and Bergin (1971) reported that low empathy is related to client deterioration. Anderson (1968) showed that the therapist functioning at high levels of therapeutic conditions could confront clients without decreasing the depth of self-exploration, although confrontation by a less empathic therapist had a detrimental effect on self-exploration. The high functioning therapist confronted clients with their resources; the lower functioning therapist confronted clients with their limitations.

Kratochvill, Aspy, and Carkhuff (1967) found no relationship between therapist "condition" and depth of client self-exploration. Bergin and Jasper (1969) found global supervisor rating of patient outcome unrelated to therapist empathy as rated on the Bergin Solomon Empathy Scale. Somewhat equivocal results were obtained with another group of non-client-centered therapists. Four psychiatric residents treated 40 psychiatric outpatients at the Phipps Psychiatric Clinic (Truax, Wago, Frank, Imber, Battle, Huehn-Saric, Nash & Stone, 1966). The most striking result was that the patients who received therapy given high ratings of therapeutic conditions were assigned the most favorable global improvement ratings by their therapist. The patient's global
rating of their own improvement had a considerably lower, although significant, correlation with the ratings of therapeutic conditions. Thus, therapists who offer high therapeutic conditions tended to see greater global improvement in their patients than their patients did, and there was some (relatively meager) evidence to confirm their perception.

A number of investigators have been concerned about the validity and reliability of empathy ratings and some recent research has suggested caution in accepting earlier results at face value.

Rogers' theory generated a sizable amount of research on variables that appeared to facilitate or inhibit the development of the necessary and sufficient therapeutic conditions for personality change. Based on a thorough review and analysis of the pertinent literature up to 1970, Truax and Mitchell (cited in Parloff et al., 1978) drew the following conclusion:

. . . therapists or counselors who are accurately empathic, nonpossessively warm in attitude, and genuine are indeed effective. Also, these findings seem to hold with a wide variety of therapists and counselors, regardless of their training or theoretic orientation, and with a wide variety of clients or patients, including college underachievers, juvenile delinquents, hospitalized schizophrenics, college counselors, mild to severe outpatient neurotics, and the mixed variety of hospitalized patients. Further, the evidence suggests that these findings hold in a variety of therapeutic contexts . . . (p. 245).

Their conclusion directly supports Rogers' hypotheses stated
above and points out that patients who receive low levels of these prerequisite conditions not only fail to improve but become clinically worse (Parloff et al., 1978, p. 245).

Rogers' hypotheses continue to be tested with numerous different kinds of populations, with professional and para-professional therapists and with different kinds of treatment modalities.

In one recent study to evaluate Rogers' hypotheses, Rudolph, Langer and Tausch (1980) compared client-centered therapy with untreated control groups. One hundred and forty-nine subjects had an average of 11 treatment sessions with 80 person-centered therapists. The untreated control group had 149 subjects also. In the pretest, both groups showed general insecurity, social differences, psychosomatic complaints and neurotic disturbances. The results indicated that 35% of the client-centered group and 14% of the control group showed constructive personality change. Both groups showed negative changes in 22% of the subjects. Rudolph et al. report that their findings lend support to Rogers' (1957) hypotheses of the necessary and sufficient conditions for constructive personality change.

In four other studies to evaluate the qualities of genuineness, congruence, and warmth, Tausch (1978) examined the relationship formed by 234 teachers with pupils. His results showed that while each dimension facilitated the pupil's intellectual contributions, spontaneity,
independence, initiative, and positive feelings during the lessons, only a small percentage of the subjects improved their grades under these conditions. In a second study reported in the same article, Tausch assessed 2,300 students using person-centered textbooks. These students were able to demonstrate significantly better learning and retention ability than 300 subjects using programmed instruction. In his third study, adults took personality tests and characterized their parents in terms of the four dimensions of Rogers, genuineness, congruence, empathy and warmth. His results showed that the more the parents were perceived as possessing these qualities, the greater the subjects' psychological health. In a fourth study, he evaluated the progress of 132 clients in 14 person-centered encounter groups. Again results seemed to support the contention that Rogers' necessary and sufficient conditions are facilitative for growth with neurotically disturbed clients.

Rogers' hypotheses have also been tested in a number of studies with school age children. Bernal, Klinnert, and Schultz (1980) investigated behavioral parent training and client-centered therapy for children with conduct problems. Thirty-six families of 36, 5 to 12-year old conduct-problem children were screened and assigned randomly to one of three groups, behavioral parent training, client-centered therapy, or wait-list control. The therapists were supervised
graduate students. They conducted 10 treatment sessions for each family. Parental reports showed a superior outcome for behavioral treatment over client-centered and wait-list control groups. At an 8 week follow up however the behavioral group did not maintain the superiority over the client-centered groups. When independent evaluators made home observations, they found no advantage of behavioral treatment over client-centered treatment or wait-list control groups. Bernal et al. described methodological problems in the design of the study which may have contributed to the inconclusive results.

Client-centered therapy has also been used with children who suffer from minimal brain dysfunction. Gobel (1976) warns that a non-directive, client-centered style of counseling may not be indicated for this kind of population. Such an unstructured situation like play therapy could result in a loss of self control and orientation for the child. She does note that client-centered therapy might be useful under special circumstances. Empathy, warmth, and genuineness can be helpful when the therapist supports the child in structuring and regulating the child's perceptions and actions.

In another study of client-centered play therapy with children, Schmidtchen and Hobrucker (1978) pre- and post-tested school-aged children from 9 to 13 years-old with
personality and achievement tests. These children were divided into three groups, client-centered and two types of controls. The subjects in the client-centered group underwent play therapy at a child guidance center. In comparison to the two control groups, the client-centered group showed significant improvement in social and intellectual flexibility as well as a decrease in anxiety and behavior disorders. Their social self-concept score approximated the self-concept score assigned to them by their mothers. Schmidtchen and Hobrucker's results showed improvement in 55% of the client-centered group and in 31% of the controls. There was a 27% deterioration in the client-centered group and 16% deterioration in the control group. They noted that more experienced therapists may further improve the results.

In a third study of school age children, O'Keefe (1973) compared the effectiveness of two treatment approaches using group counseling. The two treatment approaches were client-centered therapy and interventions based on Glasser's (1965) reality therapy. There was also a third no-treatment control group. Assessment focused on areas of self-concept, behavior, attitude and attendance in school. His results showed no significant differences among the groups with regard to behavior change but there were changes in the self-concepts of the students. The client-centered group showed the greatest increase followed by reality therapy group and
then by the control group. No differences were found in any of the attitudinal measures. All three groups showed improvement with attendance, with the reality therapy group making the greatest decrease in absenteeism, followed by client-centered and the control groups.

These two treatment modalities, reality and client-centered therapy, have also been compared using adolescent males as subjects. Crowley (1973) assessed adolescents on behavior ratings made by teachers, on grade point average, and on the California Psychological Inventory. Crowley divided the adolescents into three groups, reality therapy, client-centered, and no-contact control. The groups met twice a week for 10 weeks. At post-treatment assessment, independent raters were able to discriminate the styles of the groups. Results showed no significant main effects of any treatment under any criterion. Crowley pointed out that his subjects were not volunteers but were required to be in treatment. He raised questions as to the value of such treatment methods with non-volunteer subjects.

Client-centered treatment has also been used for sexual problems. Kelly (1976) described the course of treatment of a 20-year-old male college student who suffered from ejaculatory incompetence. He writes that full exploration of the problem was encouraged by the establishment of a warm and understanding therapeutic relationship. The client was
allowed to feel that he had permission to be sexual. Sensate focus was used and misconceptions were dispelled by factual information. Kelly attributed the success of the therapeutic process to the fact that the client received warm interaction from the counselor and the client's sexual partner.

Hylland (1978) investigated the effects of hypnosis, self-help therapy, and client-centered therapy on self-concept improvement in college students. The Tennessee self-concept scale was used as a pre and posttest. Subjects were assigned to the three different types of therapy or control groups. Hylland found no significant differences. He concluded that the three types of interventions have little effect on subject self-concept as measured by the Tennessee self-concept improvement inventory.

Client-centered therapy has also been evaluated using hospital patients. Cole, Klarreich and Fryatt (1980) compared client-centered treatment with a newly devised interpersonal coping skills program and a no-treatment control group. Their dependent variables were affective and behavior change. The strategy of the interpersonal coping skills approach was to present an explanation for learning coping skills, to have patients draw from their experience of stress for examples and, to have the patients vicariously experience those activities. Client-centered treatment involved
affective responding to the experience of stress. After the treatments, patients were assigned tasks to be carried out in actual social situations. Instruments used to measure the changes were the Minnesota Multiphasic Personality Inventory (MMPI) and the community adjustment profile. The results of Cole et al. showed that subjects in the coping skills treatment improved more than the client-centered and the control groups. A number of explanations were offered and the most promising one was that in short-term evaluations specific behavior training seemed to have an advantage. When evaluated later in follow up outside the hospital, no significant differences could be found among the treatments.

Client-centered therapy has also been used with the elderly. Ronnecke (1976) examined the relationship between client-centered psychologists and para-professional therapists with this population. Twenty-four elderly people had eight ½-hour conversations with a psychologist or para-professional therapist. There was also a wait-list control group. Before and after these talks, life satisfaction and attitude toward death and dying were evaluated. The rated life satisfaction of those talking to psychologists was greatly improved. There was also improvement of those who talked with para-professional therapists. Two-thirds of all the counselees were significantly helped. By contrast, in
the control group less than a third claimed improvement. Ronnecke concluded that if the elderly experienced a moderate degree of empathic understanding they found their own self-exploration most helpful during the consultations.

In another study that compared professional and para-professional help using client-centered therapy, Schwab and Matthiesen (1979) divided professional helpers and students of client-centered therapy into two groups of 16. Each group had one analogue therapy session with four different people. Dependent measures were expectations, motivation, personality traits of helpers and helpees. They were evaluated through tape recordings. These results showed significant positive correlation between helpers' self-exploration and helpees' empathic responding. They also found a negative correlation between helpers' self-exploration and helpees' self-disclosure. Professional helpers were only slightly more helpful. One weakness of this study was that there were no controls applied for fatigue felt by the four subjects who were sequentially interviewed by the therapists.

Client-centered therapy has also been evaluated as a treatment for family disorders. Klein, Alexander and Parsons (1977) investigated family systems interventions by focusing on primary, secondary and tertiary effects. Eighty-six families of delinquents were randomly assigned to
four treatment conditions: control, client-centered, an eclectic/dynamic approach, and a behaviorally oriented short-term family systems approach. The evaluation was on three levels: process changes at the end of treatment, recidivism rate of the identified delinquents 6 to 18 months after treatment, and rate of sibling contact with the court. The results of Klein et al. showed that the family systems approach was significantly better in the process measure and in reducing recidivism. Only 20% of the families in the treatment conditions had subsequent court contacts for siblings compared to 40% for no-treatment controls. Fifty-nine and 63% of the delinquents had subsequent court appearances in the client-centered and eclectic/dynamic conditions.

Client-centered therapy has also been attempted with incarcerated felons. Leak (1980) compared 80 felons in a new highly structured counseling method that used specific counseling exercises and with 80 felons in a more traditional non-directive client-centered group which was relatively low in structure. There was also a wait-list control group. Outcome measures of improvement were scores on the California Psychological Inventory, the MMPI and the Behavioral Measures of prison adjustment for one year following treatment. Leak's results showed no treatment produced differences in self-esteem, self-disclosure or reduction of
total rule violation using any of the above standard measures in any of the groups. Leak's results did show that the structural approach produced a significantly low reduction of serious rule violations compared to the client-centered group.

Another area where much research has been done with client-centered therapy has been in encounter groups. Bruhn, Schwab, and Tausch (1980) examined 127 clients with psychological complaints who participated in 2½ days of person-centered encounter groups. There were a total of 17 groups with 16 qualified person-centered therapists. After a pretest, all subjects were tested for changes in their complaints 4 weeks and 6 months later. Thirty-one clients served as a control group. Results showed positive changes in both individual complaints and personality tests after 4 weeks in 24% of the client-centered group as opposed to 7% in the wait-list control group. Slightly better improvements were shown by 47% of the client-centered group and 19% in the control. A worsening of complaints occurred in 8% of the client-centered group and 32% in the control. The changes the clients made were positively correlated with the perception that the therapists were empathic, respectful, warm and congruent, giving further evidence of the validity of Roger's hypotheses.
Summary

This section of the literature review presented the theoretical position of client-centered therapy as well as the pertinent literature evaluating Rogers' hypotheses of the necessary and sufficient conditions for personality change. Impressive evidence exists that the "therapeutic conditions" continue to be researched with a wide range of populations using various assessment instruments and outcome criteria. It has not been clearly established whether genuineness, empathy, warmth, and congruence are "necessary and sufficient conditions" for all personality change. It can be asserted with reasonable certainty however that client-centered treatment is a valid counseling modality with which to compare the use of paradoxical directives. Client-centered treatment provides clients with a common set of "non-specific" elements, an emotionally charged relationship with a helping person and an opportunity to use the personal qualities of the therapist as a vehicle for client change.

Rational Emotive Therapy

The literature review of rational emotive therapy is outlined as follows: theory, research, and summary.
Albert Ellis first published his theory in 1955. Using his life experience and clinical observations, Ellis developed rational emotive therapy (RET) as a method to treat the faulty belief systems which he said truly made people miserable and which psychoanalytic therapy seemed to ignore. Shertzer and Stone (1974) state Ellis came to believe that orthodox analytical procedures with their emphasis on insight were not sufficient to enable clients to overcome their deep-seated fears and hostilities. Drawing upon his experience as a private practitioner and his knowledge of behavioral learning theory, he formulated rational emotive therapy.

Corey (1977) described RET as a highly didactic action oriented model of therapy that stresses the role of thinking and belief systems as the root of personal problems. Humans adopt irrational beliefs and proceed to reindoctrinate themselves with self-defeating thoughts. Corey noted, "RET is cognitive/behavior/action oriented and stresses thinking, judging, analyzing, doing, and redeciding. This model is didactic-directive. Therapy is a process of re-education" (p. 186).

RET is known for a rather active or even forceful role of the counselor in disputing a counselee's irrational beliefs. Johnson (1980) addressed this point by commenting
that counselors who are more supportive and less confronta-
tive can effectively use rational emotive therapy princi-
pies. He stated, "Even Ellis indicates that RET can suc-
cessfully be used by non-RET therapists who wish to incor-
porate aspects of this theory into their own approaches to
dealing with clients" (p. 49). Ellis (1973) in *Humanistic*
Psychotherapy wrote of two solutions to a client's emotional
problems. One is an "elegant solution" and the other "inel-
egant." The former solution is "to show the individual that
he does not have to rate, assess, or value himself at all,
that he can merely accept the fact that he exists." Ellis
states that it is better for him to live and enjoy than for
him to die or be in pain. The latter solution is to have
him believe that he is "good" or "worthwhile" as a person,
not because he does anything well or is approved by others
but simply because he exists.

Dinkmeyer and Loscosy (1980) offered numerous tech-
niques for encouraging human behavior, especially in the
school setting, which is based in RET beliefs. Counseling
strategies offered are: (a) relationship building and ex-
ploring, (b) communication skills, (c) self-awareness and
(d) focus on strength. They placed emphasis on RET metho-
dology as they state: "Beliefs are important. When beliefs
become irrational, the results are feelings of anger, de-
pression or fear. When our beliefs are rational, we become
temporarily displeased or upset but soon are mobilized to action" (p. 254).

Research

The initial study attempting to validate the effectiveness of RET was published by Ellis in 1957. According to his own ratings of his clients at termination, Ellis claimed that of patients receiving his orthodox psychoanalysis, 50% showed little or no improvement, 37% showed some distinct improvement and only 13% showed considerable improvement. He claimed with analytically oriented therapy the respective figures were 37%, 45% and 18%. His patients treated with rational emotive therapy showed the greatest trend toward success, 10%, 46%, and 44% respectively.

Ellis himself stated that his results may be suspect due to his own bias in favor of rational emotive therapy and his disdain for other treatment modalities. Meltzoff and Kornreich (1971) also criticized Ellis' claimed success. They stated: "The data from a single therapist is not representative and lacks generality especially when he is the sole judge of his own case records and the founder of the approach that show up the best" (p. 185).

Much research has been done with rational emotive therapy on college students. Jacobs (cited in DiGuisepppe, Miller, & Trexler, 1977) studied the effectiveness of
rational emotive therapy with college students using reading assignments and homework sheets. After treatment, the rational emotive group differed significantly from the two control groups in the predicted direction on the following dependent measures: Rational Beliefs Inventory, State-trait Anxiety Inventory and the Mooney Problem Check List.

In order to help students with personal upsets and give them an effective method for coping with personal conflicts, Maultsby brought rational emotive therapy into secondary schools (Maultsby, 1971). He called his program "Rational Behavior Therapy." Maultsby, Knipping, and Carpenter (1974) evaluated the effectiveness of rational behavior therapy in a number of controlled studies. Their results empirically demonstrated the value of using rational emotive therapy as a mental health tool with a "normal" population of high school and college students.

In a study on anxiety, Barabasz (1979) tested the hypothesis that pretested subjects classified as "high anxious" would reduce their anxiety after exposure to rational emotive therapy more so than subjects exposed to a control group attention-placebo and no treatment. Fifty-four subjects were evaluated by changes in psychophysical measures of skin conductance responses to test anxiety visualization. Her results found rational emotive therapy significantly more effective than either placebo or no treatment control.
groups in reducing anxiety as measured in this way. In a second study on anxiety Smith (1979) examined the effectiveness of RET and client-centered therapy with interpersonally anxious junior high school students. He found no significant differences between groups. However, a trend favored the rational emotive group in the reduction of interpersonal anxiety. In a third study on anxiety Gardner (1981) compared the effectiveness of rational emotive therapy with behavioral assertiveness training in stress reduction for adults seeking treatment for moderate to severe anxiety at a mental health clinic. He hypothesized that subjects in each of the active treatment groups would do better than subjects in the wait-list control group. He found support for this in that both active treatments did reduce anxiety more than the control treatment. There was no evidence, however, that RET was superior to the other active treatment group. In a fourth study on anxiety, Babbitts (1981) examined the relative effectiveness of short term group cognitive therapy procedures in the reduction of cognitive and behavioral manifestations of speech anxiety in school age children. His subjects were 20 girls and 20 boys who were assigned to one of three treatment conditions: (a) an RET speech procedure, (b) an RET general anxiety procedure, (c) a progressive muscle relaxation training procedure. All the subjects were required to give a two-minute
speech prior to and after treatment. Just prior to each speech, subjects completed the children's audience sensitivity index and a measure of speech anxiety. Results indicated that a specific cognitive procedure is more effective than a general cognitive procedure or to relaxation training in reducing speech anxiety.

Carmody (1977) did a comparative analysis of rational emotive, self-instructional, and behavioral assertiveness training with outpatients at a community mental health clinic. He used self-report measures of social anxiety, assertive and unproductive self statements, and behavioral measures as outcome instruments. His results indicated that the two cognitive training groups were not different from the behavioral assertiveness group on self-report measures and on social anxiety at posttest. Behavioral assertiveness training did not lead to significantly more behavioral changes than either of the cognitively based treatment groups. In summary, representative studies seem to offer sufficient evidence that rational emotive therapy is a valid treatment to reduce anxiety in a number of different situations. Though it cannot be concluded that it is the treatment of choice or the only effective treatment, it can be regarded as effective as any other anxiety reducing method of treatment.

Rational emotive therapy has also been evaluated for its effectiveness in reducing stress. Jenni and Wollersheim
(1979) investigated the effectiveness of two treatments for reducing stress associated with type A behavior patterns. The first treatment was Suinn and Richardson's stress management training. The second was Ellis' rational emotive therapy. Subjects were 42, 29-58 years-old, high or moderate type A personality types. They were evaluated as type A by a structured interview. There was also a wait-list control group. Dependent measures were physiological and self-report, with the State-trait anxiety inventory. Jenni and Wollersheim's results showed that cognitive therapy was more effective than stress management of no treatment in reducing self-perceived levels of anxiety. Neither treatment however reduced the subject's cholesterol level or blood pressure.

Another area where rational emotive treatment has been researched is in attempting to improve adolescents' self-concept and self-esteem. Dye (1980) investigated the influence of rational emotive education of the self-concept of adolescents residing in residential group homes. Twenty subjects were assigned to rational emotive therapy, nondirective attention or control groups. Dye used the Tennessee Self-Concept as a pre and posttest. Her results indicated that rational emotive therapy groups achieved a greater gain on scores of self-concept. She claimed this study demonstrated the effectiveness of rational emotive therapy in improving the self-concept of adolescents.
In another study of self-concept, Friedenberg (1977) attempted to increase levels of self-esteem in college students using an attitude change measure based on rational emotive therapy concepts. Subjects who heard an esteem enhancing message presented by an expert and attractive speaker measured significantly higher in self-esteem than control groups who did not receive an esteem enhancing message.

Behavioral problems have also been treated with rational emotive therapy. Bowman (1979) compared a cognitive behavioral program with client-centered therapy in the treatment of 10 impulsive male adolescents. The cognitive behavioral program included 10 weeks of didactic presentations, practice of formal problem solving, relaxation training, positive self-statements, and a variety of behavioral rehearsal strategies. The client-centered group received 10 sessions with an empathic relationship building counselor. Bowman found the rational emotive group differing significantly from the client-centered group. He reported superiority of the RET adolescents in the following measures: they earned fewer tickets for disallowed behaviors, and made significantly fewer errors, and showed increased latency scores on the matching familiar figures test. Bowman concluded that the treatment program is an effective and economical approach to modifying behavior of chronically impulsive adolescents.
In support of Bowman's study, Zelie, Stone, and Lehr (1980) assessed the utility of a pilot program in rational behavior therapy in the disciplinary process at a large urban junior high school. Sixty subjects who had been referred to the vice principal's office often for disciplinary action participated in the treatment program. They were divided into two groups of 30: one being treatment and the other being control. The dependent measures were behavioral ratings by teachers, and recidivism rate. Results indicated that the treatment group was significantly more improved than the control group on these measures.

The effectiveness of RET has also been explored with weight loss. Block (1980) compared rational emotive therapy with attention-placebo and no treatment control groups in an outcome study with overweight adults. The dependent measure was a decrease in the number of pounds that the subjects were overweight. The design was a 3 X 3 factorial one. The results showed differential effects among treatment groups with rational emotive therapy having the greatest reduction in weight over an extended period of time. Presby (1979) also described a method for identifying and disputing beliefs related to eating and weight problems. She used the framework of rational emotive theory in which dysfunctional behaviors and feelings are understood to be related to belief systems. She presented a case study to demonstrate how to change a "must loose" weight philosophy
to a more rational view of eating. Her method employed four steps. One, remove the "must" out of dieting. Two, list all reference words related to eating and weight. Three, relate eating patterns to behavior and other thoughts and feelings. Four, incorporate new thinking patterns into daily life. These steps were not followed by weight loss but did result in weight stabilization which was seen as healthier than swings between weight loss and gain.

RET has also claimed effectiveness in resolving sexual problems. In a preliminary study Forman (1980) used cognitive restructuring with a 22-year old rape victim. The woman presented multiple behavior problems as well as obsessive thinking. Forman trained her with a combination of group and rational emotive therapy emphasizing cognitive restructuring. She was trained in thought control to prevent thought patterns which had disrupted both her work and her marital relationship. The training in thought control also reduced her problems of anxiety and sexual dysfunctioning. Forman claimed the results were positive and illustrated the value of symptom-specific treatment of rape victims with rational emotive therapy. Shahar and Jaffe (1978) presented a case study which illustrates the use of rational emotive therapy in combination with behavioral desensitization in the treatment of vaginismus. Cognitive restructuring procedures along the lines of Ellis' therapy were introduced relatively early in her treatment in order to overcome
her underlying self-depreciating attitude and belief that interfered with the desensitization procedure. The authors concluded that in the psychological treatment of vaginismus and other sexual dysfunction, it is advisable to incorporate cognitive restructuring with behavioral procedures from the beginning.

Plachetta (1978) examined the effectiveness of rational emotive training techniques with behavioral practice in reducing dating fears and in increasing dating activity in minimal daters. There were two parts to the study. In the first part, a reliability check was made on the dating fear, the fear of negative evaluation, the social avoidance and the distress scales in a sample of 85 students. Reliability findings were satisfactory. In the second part, 70 minimal daters were assigned to experimental or wait-list control group. The experimental treatment received rational emotive training techniques to improve dating skills. Plachetta's results indicated that the experimental group experienced significant improvement on the dating fear and the distress scales. They showed non-significant improvement, however, on the negative evaluation scale and on increased dating activity. Changes were maintained through follow up. Positive changes were also made by controls who later participated in the dating skills program. Her results seemed to indicate that such a program and rational emotive training was effective in reducing social anxiety and possibly in
increasing dating activity in minimally dating males and females.

In the area of marital and family therapy, Ellis himself claims effectiveness of rational emotive therapy. Ellis (1978, 1979) proposed that most popular forms of family therapy, psychodynamic and systems oriented therapy fail to consider family members as individuals in their own right. He claims his phenomenological-humanistic view of families corrects this oversight. He states that client-centered family therapy is too passive and neglects some of the realities of human disturbance. His approach claims to be highly active and directive in order to help family members surrender their misconceptions of themselves and others and make profound philosophical changes in their interpersonal and intrapersonal attitudes. He claims this can be done best by using the principles of rational emotive therapy. Though Ellis seems to make claims in the area of marriage and family therapy, the research supporting these claims is sparse. Bigney (1979) investigated intrapsychic and interpersonal personality and temperament changes in married couples resulting from a marriage enrichment program based on rational emotive therapy. He used a posttest only control group design with six experimental couples and six control couples. The dependent measures used were the California Psychological Inventory and the Taylor-Johnson
Temperament Inventory. Couples also completed these measures for their spouses. Results showed no significant differences between the marriage enrichment and the control group with these measures.

Summary

This section of the review of the literature has described the conceptual foundations of rational emotive therapy and surveyed representative outcome studies of rational emotive therapy. The literature reviewed supports Smith and Glass' (1977) assertion that rational emotive therapy appears to have earned some form of scientific credibility as a relatively effective treatment modality.

The qualifications of Mahoney (1974) and Meichenbaum (1975) of seven and eight years ago still must be recognized. That is, while results now are generally positive with specific populations and specific problems, they are not conclusive. There does seem to be enough empirical evidence to conclude that, as a treatment approach with college students, rational emotive therapy is sound enough in theory and practice to use it in this study for comparison with the paradoxical directives approach.

A Comparison of Counseling Approaches

The following is a literature review of pertinent comparative studies attempting to evaluate client-centered and
rational emotive treatment as effective counseling modalities. The studies are presented chronologically.

In one of the first major comparative studies, DiLoreto (1971) compared systematic desensitization, Ellis' rational emotive therapy, and Rogers' client-centered therapy. He utilized inexperienced graduate students as therapists and provided treatment in groups. His results indicated that there were few significant differences between approaches. Any significant results favored behavioral therapy.

Garfield and Bergin (1978) consider the Temple study (Sloane, Staples, Cristol, Yorkston, & Whipple, 1975) the best comparative study published before 1978. Though it does not use the modalities studied in this dissertation, it is presented as a controlled study that demonstrates the effectiveness of therapy as well as provides evidence that no one treatment modality is significantly superior to another. The study involved more than 90 outpatients at the Temple University Health Science Center. Using diagnostic categories, two thirds were judged neurotic with the other one third having personality disorders. Patients were assigned to short term analytic therapy, behavior therapy, or a minimal treatment wait-list control group. Groups were matched according to sex and severity of symptoms but otherwise randomly assigned to the treatment groups. The therapists were six white males, five psychiatrists and a
clinical psychologist. Three were behaviorally oriented and three were psychoanalysts. All were considered good therapists, having an excellent reputation in the community. Assessment procedures were the MMPI, Eysenck Personality Inventory, the California Psychological Inventory, the Structured and Scaled Interview to Assess Maladjustment. There were also reports made by informants who had known the patients on an average of 12 years. There were also ratings by a therapist and an independent assessor. Outcome was assessed at 4 months and 1 year after beginning treatment. Results were consistent with DiLoreto's (1971) study. Behavioral therapy and psychotherapy groups improved significantly more than the wait-list control group. No differences were found between behavioral therapy and psychotherapy on any of the target symptoms. The three groups maintained this improvement at yearly follow up. Both of these studies support the notion that therapy accelerates change that is otherwise likely to occur more slowly without therapy.

Malan (1976) summarized the studies he and his colleagues did investigating the effectiveness of brief therapy (10 to 40 sessions). This study is presented here because the techniques of paradoxical directives are usually given in the framework of brief strategic therapy. In this study patients were treated with psychoanalytically oriented brief
therapy, however. The authors attempted to discover whether brief treatment which used the same kinds of intervention techniques as full scale analysis could be as effective as full scale traditional psychoanalytic treatment. Results showed that brief analytic treatment can be effective with some patients. Positive outcome was associated with the therapist interpreting and focusing on transference/parent links, and with the patient's motivation for change. This finding of the so-called Tavostock studies are similar to the findings reported in the Menninger study (Kernberg, Burnstein, Coyne, Applebaum, Horwitz, & Voth, 1972; Voth & Orth, 1973). Together, these studies support the importance of transference interpretation. It is still unclear when and with whom this is especially effective since other patients improve without going through this process. Garfield and Bergin (1978) conclude, however, that because of the time and expense required, and its failure to show success that exceeds other forms of brief therapy, psychoanalysis cannot be considered the treatment of choice over brief therapy. They do not, however, delineate either the types of psychological disturbance or the types of client for which brief therapy is the optimal choice.

In another brief therapy study, Moleski and Tosi (1976) compared the relative effectiveness of Ellis' rational therapy, systematic desensitization and no treatment in the
correction of stuttering. After eight treatment sessions, the patients in rational emotive therapy showed more improvement than patients in systematic desensitization. Both rational and systematic desensitization groups showed fewer speech deficiencies than an untreated control group.

Comparative research has also been done to examine client preferences for therapy. Helweg and Gaines (1977) examined selected personality variables such as sex, age, interpersonal values and educational level as antecedents to preferences for Rogers' non-directive or Ellis' RET therapy. Subjects were 77 hospitalized psychiatric patients and 77 normal undergraduates. A film of an individual patient being interviewed by the therapist was shown on separate days. The Barrett-Lennard Relationship Inventory and an expression of preference for the therapist were the dependent measures. Subjects high on the Rokeach dogmatism scale and high on the Rotter external locus of control preferred Ellis. There were no significant differences between groups on the Relationship Inventory.

In a study that examined the underlying commonalities of client-centered and rational emotive therapy, Koppe (1977) found that both approaches attempted to modify faulty evaluative standards. Only Ellis, however, focused on behavioral change. Client-centered therapy emphasized attitude rather than behavior. In rational emotive therapy,
Koppe stated that change occurs mainly from the patient's expectation of help from a socially sanctioned healer and from the persuasive and suggestive aspects of psychotherapy which are central to this modality. On the other hand, internalization of the counseling relationship occurs gradually in client-centered therapy which explains the behavioral change.

A major study that is considered by Garfield and Bergin (1978) to be representative of the research which has attempted to test Rogers' hypothesis of the necessary and sufficient conditions for client improvement is the Arkansas project. Mitchell, Bozarth, and Krauft (1977) examined therapist conditions of empathy, warmth, and genuineness and how they related to client change. The therapists were 75 experienced clinicians, one half in private practice. One third claimed an eclectic orientation, another third claimed a psychoanalytic orientation, and the remaining third claimed a variety of different orientations: behavioral, rational emotive, and client-centered among them. Subjects were 120 predominantly young, white, and lower middle class males and females. Thirty-seven percent were diagnosed schizophrenic, 29% were diagnosed neurotic, and 34% had other diagnoses. Forty-four percent had been in therapy for at least 6 months while 22% had been in therapy for 1 to 2 months and 34% were just beginning therapy.
The authors reported results which indicated that neither therapist empathy nor warmth were related to client change. High levels of therapist genuineness were found to have a modest relationship to client change, however. Using global measurements of Current Adjustment Scale, Social Ineffective Scale, Psychiatric Status Scale, MMPI, and Self-Ideal Q-sort, the results showed 43% to 70% of the clients improved, depending on the criterion. This study is often cited by critics of Rogers or by theorists who claim the quality of the relationship is not necessary for change (Ellis, 1978). Mitchell et al. (1977) attributed the study's results to a weak methodology which produced a lack of conclusive support for the presumed necessary and sufficient conditions for change.

In a study that attempted to evaluate the outcome of psychotherapy in general, Smith and Glass (1977) did a meta analysis of 375 controlled evaluations of psychotherapy. They coded and integrated them statistically. Their findings, like the Temple study, provide convincing evidence of the efficacy of psychotherapy. On the average, the typical client is better off than 75% of untreated individuals. Few important differences could be established among the many types of therapy. More generally there were no observed differences between the class of all behavioral
therapies and the non-behavioral therapies such as Rogerian, psychodynamic, rational emotive and transactional analysis.

Using a different kind of methodology, Whitney (1977) investigated client-centered therapy by examining the different demands made on the client. One aspect of the study attempted to evaluate whether various therapies could be arranged on an internal/external continuum. He hypothesized that the demands a client would make on a therapist would be congruent with the client's way of relating in the world. Clients at a university counseling center choose the type of therapy they thought appropriate for themselves. Though his results seemed to suggest support of the hypothesis, methodological problems prevented clear support for the hypothesis of congruence between client experience and preference for a therapy type.

Lang (1980) compared the verbal behavior of four therapists from each of four theoretical orientations. The orientations were client-centered, rational emotive, analytic communications, and object relations. Using a rating instrument of 31 verbal behaviors, the average ratings of the therapist verbalizations were subjected to factor analysis. Six factors were found which related to each of the therapeutic orientations differently. Differences existed which corresponded with the therapist's belief system. Lang
reported that to the degree the therapist's belief was strongly congruent with a particular modality there is a corresponding success in client change.

In some recent comparative studies, Lietaer (1979) compared psychoanalytic oriented therapy with client-centered therapy. He compared 52 client-centered and 40 psychoanalytically oriented therapists on the following dimensions: empathy, congruence, positive relationship, unconditionality, transparency, and directivity. Clients and therapists completed a revised form of the Barrett-Lennard Relationship Inventory after one session. Though therapists perceived many differences as a function of their orientation, clients perceived differences in directivity rather than in genuineness, warmth, or empathy. Analytically oriented therapists were much more directive and active than client-centered therapists. There were no significant differences, however, in the perceived quality of the relationship formed between the two groups.

In a recent study that demonstrated how therapies are more alike than different, Troemel (1980) analyzed three empathic person-centered responses from a linguistic perspective. He showed that although they seem simple and merely supportive on the surface, they actually operate in linguistically more complicated ways, carrying implicit messages on a deeper more indirective level of meaning.
Troemel concluded that client-centered responses have properties found in effective interpreting, restructuring and paradoxical interventions. He claimed this result supports the hypothesis that although psychotherapists may claim widely different forms of therapeutic orientations, they have many specific therapeutic interventions in common. When linguistic properties are analyzed, there is commonality in how they induce patients to modify what they are saying; that is how they get them to change.

In a very recent study that demonstrated a lack of superiority among different treatment approaches, Shapiro (1981) compared different treatment modalities to test the expectancy/arousal hypothesis which states that treatments differ to the extent they arouse differing degrees of expectation of benefits. He compared systematic desensitization with rational emotive and client-centered therapy. His results were consistent with DiLoreto's (1971) comparative outcome study stating that there were few significant differences between approaches. Shapiro's study also found that any significant results favored behavioral therapy.

**Summary of Comparative Studies**

The literature surveyed makes a convincing argument for the efficacy of psychotherapy, establishing the client-centered and rational emotive approaches as viable theoretical frameworks for therapeutic intervention. The literature
does not suggest conclusively, however, that any particular modality is superior to any other, even with any particular population. The purpose of this section of the review of the literature was to document the effectiveness of psychotherapy and establish client-centered and rational emotive treatments as modalities with which the use of paradoxical directives can be constructively compared.

**Paradoxical Directives**

The following is a literature review of paradoxical directives. The literature reviewed is outlined as follows: theoretical foundations; the psychodynamic-neo-Freudian perspective; the developmental perspective—children and adolescents; the behavioral perspective; paradoxical directives with substance abuse; paradoxical directives with obsessive-compulsive behaviors; the strategic perspective; the strategic perspective and its use with families; Hopkinson's research; summary of research and the relationship to the problem.

For the purpose of this dissertation, a paradoxical directive is defined as a "therapist initiated messages that convey that a specific aspect of a client's problem may be expressed as much or more than it already is occurring" (Hopkinson, 1980, p. 20).
Theoretical foundations

The therapeutic technique referred to as paradoxical directive is both old and new in the psychotherapeutic literature. It is old; historically therapists have been using this technique under other theoretical formulations. It is new to the extent that it is conceptualized within the framework of therapy as a specific technique. The theoretical framework on which paradox is based comes from many different disciplines, linguistics, philosophy, epistemology and mathematics. The application of these specific techniques depends on the theoretical persuasion of the clinician and the presenting symptoms of the patient. As a result, paradox has many meanings as well as a variety of formulations resulting in confusion for the reader. Some terms referring to paradoxical directive in the literature include: (a) siding with the resistance (Sherman, 1961), (b) joining techniques (Marshall, 1976), (c) symptom prescription (Mozdzierz, Macchitelli, & Lisiecki, 1976), (d) logotherapy (Frankl, 1975), (e) stimulus satiation (Ayllon, 1963), (f) utilization techniques (Erickson & Rossi, 1975), (g) double bind (Bateson, Jackson, Haley, & Weakland, 1956).

The rationale for paradoxical direction is best stated by Jay Haley (1963). He asserted that the structure of psychotherapy is in itself "paradoxical." He stated that psychotherapy would be meta analyzed in such a way that the...
nature of the therapeutic content poses one or more paradoxes for the client. Haley (1963) believed that the cause of psychotherapeutic change was based in the therapeutic paradox that almost all theoretical formulations of psychotherapy employed, either implicitly or explicitly. He stated that the basic paradox was that the therapist set up a benevolent framework defined as one where change was to take place. Secondly, he permitted or encouraged the client to continue with unchanged behavior and provided an "ordeal" to continue as long as the patient continued with the unchanged behavior.

Each of these conditions deserves some attention as they are present in almost all systems of psychotherapy. The first condition is virtually everywhere in psychotherapy. The therapeutic contract is established so that the therapist is considered "benevolent" by the patient. Whenever a troubled person seeks out a "professional" for help and the professional agrees to aid the person, the professional is seen as "benevolent." Thus the first criterion for a therapeutic paradox is met. The second condition is that the patient is permitted or encouraged to continue with unchanged behavior. This is referred to in the literature as encouraging the client's symptoms. Again this technique is used by most psychotherapists, at least in an implicit manner. At a risk of oversimplifying, it can be stated that
Rogers "accepts" the symptoms, psychodynamic psychologists "interpret" the symptoms, the behaviorist systematically "desensitizes" the symptoms and the strategic psychotherapist "encourages" the symptoms. Because of symptom acceptance, interpretations or encouragement, Haley suggests that therapies succeed regardless of their theoretical formulations because they impose these paradoxical messages which make it difficult for the patient to gain control of the relationship. The therapeutic context is paradoxical because it seems to contradict the explicit definition of the therapeutic relationship as one in which the patient's behavior is to change. This places the patient in a quandary: to "resist the therapist" in this context involves changing his behavior, while if he continues his behavior he does so at the direction of the therapist. This condition is similar to "negative practice" (Dunlap, 1949) as well as Frankl's paradoxical intention (Frankl, 1960). The third component of a therapeutic paradox is that the therapist provides an ordeal for the patient until behavioral change occurs. This is seldom mentioned in articles on psychotherapy, yet often employed by therapists. The ordeal of coming week after week and paying a sizable fee while talking about your problem is often seen as or becomes an ordeal for the client. The therapist's aim is to continue this ordeal as long as the patient keeps his or her symptoms.
The patient experiences greater subjective distress as the therapy sessions go on and increase in intensity. Haley states well that the ordeal cannot be considered as a "thing" itself but rather a part of the relationship between the patient and psychotherapist. In fact, the relationship formed between the patient and psychotherapist seemed to be at the core of Haley's theory of therapeutic paradoxes. The "cause" of change resides in what all methods of therapy appear to have in common—the therapeutic paradoxes which appear in the relationship between the psychotherapist and the client.

Haley's formulation is described in almost an identical way by Watzlawick, Weakland, and Fisch (1974). Other conceptualizations which use this similar formulation are reported by Andolfi (1980a), Mozdzierz et al. (1976) and Selvini-Palazzoli, Cecchin, Prata, and Boscolo (1978). The similar idea is that the context, the therapist's behavior and the commitment to stay with the client constitute a complex message that promotes change in a "paradoxical" way.

Though virtually all psychotherapies can be formulated or construed so as to fit into Haley's system, paradoxical intention can be more clearly defined as a specific technique. This specific technique is to be used within the over all "paradoxical" structure of the psychotherapeutic relationship. For the purpose of this dissertation
paradoxical directives are examined as a specific technique within the psychotherapeutic framework. From this perspective it can be said that even though most therapies provide a context for change, a commitment to stay with the client, and permission to the client to remain unchanged, most therapies make no specific statement about the nature or effects of a paradoxical directive as a technique. This study attempts to examine the effects of paradoxical intention as a technique within the context of psychotherapy. As recommended by Hopkinson (1980), this author suggests that paradox as a structural element in psychotherapy “be separated from that level of analysis on which the paradoxical directive is a technique” (p. 20).

**Psychodynamic Perspective**

The development of paradox has its foundation in Freud. He posited a dynamic model of mental functioning; there are forces in conflict within the individual. Thought, emotion and behavior, both adaptive and psychological, are resultants of these forces. The paradoxical approach is to move with these forces to produce their opposite.

Jung, Adler and other analytic clinicians have developed the concept of paradox more directly.

Jung's (1952) personality theory is structured also in such a way that it lays the groundwork for paradoxical
direction. He believed that a psychological theory of personality must be founded on the principle of opposition or conflict. He stated that the tensions created by conflicting elements are the very essence of life itself. Jung believed the more extreme a trait the more easily a therapist could produce a conversion of something into its opposite. Yet neither Jung nor Freud would ever have conceptualized psychoanalytic techniques as paradoxical directives.

While Jung and Freud used traditional techniques of therapist neutrality and non-directiveness, Ferenczi (1967) a neo-Freudian developed the use of paradox as a technique much more specifically. His methods, conceptualized in psychoanalytic language, seem to lead directly to the strategic communication perspective. Ferenczi directed his patients to act out their symptoms (symptom prescription) and to face the things they feared. He told them to give up the unconscious enjoyment they would receive if they followed his direction. Stated in psychoanalytic language, Ferenczi (1967) attempted to help his patients gain conscious control of their symptoms by stimulating repressed impulses.

Stanton (1981a) has developed a theory to explain how paradoxical directives work which seems to parallel the implicit assumptions of Freud, Jung, and Ferenczi. Stanton's theory is similar to the philosophical theory of Weeks and L'Abate (1982) in that Stanton stresses polarization or
dialectical forces operating in family systems. The key concept for Stanton is "compression." Dysfunctional families are overly close; enmeshed according to Minuchin and Fishman (1981); undifferentiated and fused according to Bowen (1978). A paradoxical directive compresses the nuclear family and extended families together which increases the intergenerational involvement. This produces an explosive counter reaction which enables the therapist to change the system. Along with the dialectical theory to explain paradox, Weeks and Wright (1979) have written that paradoxes can be useful in understanding development in family systems. Most of the time family members do not seek help when trying to make changes in their family. When and if they do, paradox helps to harmonize development. The major difference between Stanton and the neo-Freudians was that Stanton conceptualized the compression by analyzing the interaction of the family members, while the neo-Freudian conceptualized the compression by studying inferred hypothetical constructs existing within the individual.

Alfred Adler (Mosak & Driekurs, 1973) was a neo-Freudian whose ideas about personality and psychotherapy add a great deal to the understanding of the active technique of paradox also. For Adler, symptoms were weapons to gain socially useless or non-cooperative superiority over intimate others. His therapy was aimed at neutralizing these power
tactics. Using his own unique therapeutic style, he refused to fight them and adopted an attitude of acceptance. Once the patient's power tactics failed to work, Adler offered the patient socially acceptable goals. To reorient the patient to more socially acceptable behavior he would often prescribe the symptoms in an almost identical way such as paradoxical therapists do. Using Stanton's (1981a) theoretical formulation, Adlerian paradox would "compress" the conflict within the individual. Some examples of this are: insomniacs were told to keep worrying and to think of ways to help someone else during the night; depressed patients were told to stay depressed; obsessive-compulsive patients were encouraged to maintain their obsessions and compulsiveness.

Mozdzierz, Macchitelli, and Lisiecki (1976) went so far as to suggest Adlerian psychotherapy was functionally organized as "paradox as technique." They listed "12 P's" of paradoxical techniques that Adlerian psychotherapists used. Some examples are: (a) suggestions for clients to befriend the symptom, (b) prescription to do the symptom, (c) instructions on how to practice the symptom, and (d) restraint from the therapist which prohibited the client from giving up the symptom. The effect of these techniques as stated by Mozdzierz was that the therapist reframed how the client saw the problem so that he/she improved no matter how he/she
responded. When useless or uncooperative behavior was prescribed or restrained from stopping, he/she became socially cooperative with the therapist if he/she complied. If he/she disobeyed the therapist, he/she had stopped rebelling against society and others.

The Developmental Perspective (Children and Adolescents)

Paradoxical directive has been used extensively with resistant children and adolescents. The major contributor in this area has been Marshall (1972, 1974, 1976). He used "joining techniques" based on the double bind theory of Bateson et al. (1956) which stated parents are apt to communicate two contradictory messages--one on the overt level which is usually syntonic with reality and social values, the other on the covert level which demands contradictory and pathological behavior. This conflict produces confusion for the child. Marshall suggested that with his "joining techniques" he overtly sides with or "acts out" the covert message of the parents. He claimed that by joining with the parents' edict, he made their covert message overt in the present psychotherapy relationship and thus reduced the patient's confusion and anxiety. In addition to the individual therapy, Marshall recommended total milieu involvement based on the psychological understanding of a delinquent's problem in order to produce positive results.
Riton (1979) described the paradoxical directive treatment of a young woman for vomiting phobia by utilizing her needs to defeat the therapist and her orientation toward growth. Riton's basic strategy was to motivate her to perform the phobic action, i.e. to vomit. Riton noted that the powerfulness of this approach is also its greatest liability because by rapidly circumventing conscious resistance, the patient's ego is left out of the process of change. In other words, the patient may change without knowing why. Although Riton described this as a criticism, it does not seem to be a problem for other authors such as Haley (1963) who suggest knowing why is not at all important for the patient.

Jesse, Jurkovic, Wilkie, and Chiglinsky (1980) have written on the value of positive reframing for the treatment of children. The authors state that the standard nosological system focuses only on individual psychopathology and emphasizes the negative and pathological. Positive reframing shifts the emphasis to the positive, thereby shifting the symptom bearer's perception of himself and his perceptions of others. Secondly, a positive reframe also gives the child a greater sense of control and implies that his behavior has a good and useful function. The third reason the authors suggest for positive reframing is that it can break up power struggles between children and parents.
L'Abate and Jessie (1980) have also argued that paradoxical directives are effective with children in inpatient treatment settings. They state that paradoxical interventions can induce quick problem resolution, enable the child to assume the responsibility for change, allow the child to feel more normal. This is achieved by focusing on problems rather than on diagnosis and by allowing the child to lose his role as the identified patient in the family.

Baideme, Kern, and Taffel (1979) describe the application of Adlerian family therapy in a case of school phobia in a 9 year old child. Baideme et al. state that although the symptom was manifested in one member, the family system was instrumental in encouraging and maintaining the problem behavior. As the therapist engaged the entire family in therapy, the family learned new ways of relating to the patient. Baideme et al. discussed the importance of involving the entire family system, such as school personnel and siblings as part of the treatment process. The article described extended use of anti-suggestion and paradoxical direction as part of the treatment.

Amanat (1979) has described paradoxical treatment programs for resistant adolescents. In the treatment of 66 adolescents with various psychological difficulties, treatment was based on the technique of agreeing to disagree using paradoxical interventions such as "You probably
wouldn't be interested in our work" Amanat describes the population, members and staff. He notes that the program has a quasi-religious element making it difficult to assess the value of paradoxical directives in themselves.

Kraus (1980) has written about the common problems therapists encounter with adolescents. He says that adolescents are often resistant to treatment, and defensive and cynical. He states that this can be overcome by relationship building tactics which include advocacy positioning, the sharing of self, verbal encouragement, and support. Kraus writes that techniques that can be effective include psychodrama, future projection, role reversal and paradoxical directives.

The Behavioral Perspective

The major contributor to the conceptualization of the paradoxical direction in learning theory formulation is Dunlap (1942, 1949). He was one of the earliest to suggest practicing or scheduling symptoms as a specific method for behavioral change. Negative practice was used to indicate that the response practiced is not the response learned. The responses are practiced in order to be able to learn another one. The basic point of negative practice is to bring behavior which had been claimed as involuntary under voluntary control.
Behavioral therapy has also used symptom scheduling with treatments to reduce anxiety by arranging to increase it (flooding, implosion). Implosion is not difficult to conceptualize as paradoxical direction. Stampfl and Levis (1973) used this technique to eliminate anxiety by requesting the patient to engage in repeated intense and prolonged exposure to the feared stimulus either in imagination or in vivo.

Recently some behavioral therapists have begun to deliberately use paradoxical interventions with individuals. Ascher (1979) stated that rather than focusing on the family, the intervention can be made with a unit of two persons. Ascher describes the cure of a bedwetter through the use of paradoxical directives and behavior management.

Klein (1974) has reinterpreted behavior modification according to the communication analysis of Haley rather than the learning paradigm. He writes that the effectiveness of the behavior modification techniques depends on the establishment of a therapeutic paradox for the client. Client behavior is conceptualized as a change in choice patterns and personal responsibility rather as new learning. Klein notes that although this robs the techniques of their simplicity, important innovations emerge for the role of the therapist. The therapist must allow a client to choose and "win" while the therapist must be willing to "lose." This
may be difficult for some therapists who may resent or feel uneasy when clients fairly achieve control over them by proper performances of behavioral sequences. Those who are not willing to give up this type of control tend to wrestle back control from clients by their own tactics, thus negat­ing any treatment gain. His techniques are very similar to Marshall except that his formulations and conceptualizations use communication analysis to interpret techniques of behav­ior modification.

Perhaps the area in which behavioral treatment has been used most effectively as paradoxical directive is in the treatment of sexual dysfunctions. This is best demonstrated by Masters and Johnson (1970) with sexual problems of impotence or premature ejaculation. Clients are forbidden to have coitus. They are told to stop doing what they already are not doing or are not doing adequately. Marks (1976) confirmed the success rate for behavioral treatment of sexual dysfunctions. Before leaving the rationale of paradox­ical direction through behavioral techniques, the trend toward cognitive factors in behavioral treatment might be noted.

**Paradoxical Directives with Substance Abuse**

The uses of paradoxical directives have also been in­vestigated in the area of substance abuse. Morelli (1978) described the effectiveness of treating alcoholism and drug
abuse through paradoxical intention. In a case study offered as an example, an 18 year old female patient originally sought treatment for her obesity. She could not lose weight partly because of the high calorie intake in the volume of alcohol she consumed. The therapist adopted the paradoxical intention method suggesting large quantities of different types of drugs and alcohol she could take. When the patient described some of the behavioral consequences such as poor grades and missed classes, the therapist agreed but continued to tell her that he expected her to act excessively. When the patient reported more desirable behaviors, the therapist gave verbal reinforcement. As a result, appreciable behavior changes took place. Morelli concluded that the use of paradoxical intention shifted the patient's verbal statements and behavior away from irrational issues of rule breaking to the issues of aspirations and actual consequences of inappropriate behaviors. Following this shift in thinking, her behavior changed.

Cummings (1979) also reports a psychological model for treating drug and alcohol addiction. His model criticizes the medical approach as well as the traditional psychodynamic approach based on insight. The key elements in his approach include contracting, reality therapy, operant conditioning and communication techniques employing therapeutic double binds and paradoxical directives.
Feeney (1979) has also examined paradoxical patterns of counselor response while working with alcoholics. He studied seven counselors who worked with 25 male and 25 female alcoholics. He suggested that the presence of paradoxical patterns of counselor response can provide a valuable dimension in the treatment of alcoholism. Paradoxical patterns appear to assist the alcoholic in conflict resolution and self acceptance. Responding paradoxically unexpectedly focused the alcoholic's attention upon his own life style, challenged its meaning, and evolved new shifts in perspective. Paradoxical patterns of response were also found to be associated with a certain counselor style of being active, experiential, confrontative, and supportive.

**Paradoxical Directives with Obsessive-Compulsive Behaviors**

A number of studies treating insomnia by paradoxical directives have been done. Relinger, Bornstein, and Mungas (1978) treated a woman suffering from chronic insomnia for 20 years. Dependent measures were different dimensions of sleep. Treatment consisted of instructions to the client to stay awake as long as possible and to experience exact thoughts and feelings. The client was told no change would be expected till the end of treatment. The authors' results showed improvement on five of eight dimensions of sleep. Ascher and Efran (1978) treated five clients
suffering from insomnia for 3 to 12 years. Dependent measures were latency to sleep onset. Paradoxical directives were given in the context of a behavioral program. After 10 weeks of behavior modification, clients received 2 weeks of "stay awake" instructions. Results showed improvement during the behavioral treatment but they went to sleep faster when paradoxical directives were given. Turner and Ascher (1979) carried out a controlled study using paradoxical directives with patients suffering from insomnia also. Fifty subjects were randomly assigned to one of five treatments, progressive relaxation, stimulus control, paradoxical intention, placebo-control, and wait-list control. Outcome measures were daily scores on sleep questionnaires. Each client received 30 to 45 minutes of therapy one a week for 4 weeks. Results indicated that the three treatment groups improved yet there were no differences among treatments. The researchers explained the differences by stating randomization may have mismatched treatment difficulties. Ascher and Turner (1979) have replicated this study claiming the effectiveness of paradoxical therapy for insomnia in controlled experiments.

Solyom, Garza-Perez, Ledwidge and Solyom (1972) studied the use of paradoxical intentions with 10 obsessive compulsive men and women. The subjects' average age was 31 and all were chronically troubled by this symptom of an average of
9.2 years. Treatment lasted six weeks, each client being seen once each week. The subjects were instructed to pick two thoughts that were bothering them. One was treated by encouraging the patient to focus on the thought and the other thought served as the control by being ignored. Solymon et al. reported that of the ten target symptoms, five were eliminated, three were changed, and two clients failed to apply the technique as instructed.

Gerz (1966) applied paradoxical intentions to patients with various kinds of symptoms. Most of his work was done with phobics and obsessive-compulsives. He used no instruments to rate improvement, however, but decided on the basis of his clinical judgment whether clients improved. The paradoxical intentions given were analogous to symptom prescriptions. Phobics were told to do what they were afraid of, and obsessive-compulsives were given the instruction to obsess over their problem thoughts. Humor was an integral part of the prescriptions. Gerz claimed the following results: for phobics, a success rate of 75.8%; for obsessive-compulsives, a success rate of 66.7%, and for neurotic-schizophrenics a success rate of 68.8%. His study lacks specific information about his population. He does note that a few cases produced rapid results, but chronic cases required treatment for 2 years. Though his methodology may be criticized and the lack of standardized instruments
noted, he was one of the pioneers in researching the effectiveness of paradoxical directives.

Symptom prescription has been used treating individuals suffering from anxiety. Lamb (1980) described a case involving a college student who suffered severe test anxiety associated with grand mal seizures and fainting. He writes that she had been evaluated by specialists at two prestigious medical centers. They could find nothing medically wrong. The student consulted Lamb, her professor, about taking the exam in a private session. Lamb described the grand mal seizures of his own in great detail. He stated that if the seizures weren't so serious, they would be humorous. He claimed to throw strawberries all over the inside of his mother's car during a seizure, for example. Lamb said that he could pass out better than she, and instructed the student to go home and practice passing out. On the day of the exam, the student was rechallenged. During the exam, as the student's anxiety increased, he told her to pass out. Laughing, the student continued the exam and since then has not fainted in any situation.

The Strategic Perspective

Historically, perhaps the most influential person to develop paradoxical direction as a technique is the psychiatrist, Milton Erickson (Zeig, 1980a). He has been
Erickson is often referred to as the spiritual father of paradoxical direction. He has contributed to the concept of paradoxical direction in several ways. First, he introduced utilization techniques into the practice of hypnosis. Indirect suggestions are made to the client to continue what he is already doing. By doing this he forced compliance or redefined spontaneous behavior as occurring due to the therapist's request. Secondly, Erickson possessed an unique ability to gain rapport with his patients and this is essential to the utilization of paradoxical directives. Thirdly, he advocated naturalistic hypnotic techniques in which no trance was induced at all.

It is within the strategic perspective of Ericksonian tactics that the use of paradoxical directive is most often discussed. The strategic perspective is primarily associated with the work of Erickson, 1977, Rabkin, 1977, Haley, 1976, Selvini-Palazzoli, 1975, and Watzlawick et al., 1974. The strategic approach is brief pragmatic, and applicable to a broad range of mental health problems. The therapist is active and directive, sees problems in terms of systems rather than an identified patient, and uses paradoxical interventions. A primary feature is that the responsibility is on the therapist to plan a strategy for solving the client's problems (Haley, 1963, 1976; Herr & Weakland, 1979;

In paradoxical psychotherapy, each therapy session is viewed as the beginning of a behavioral change. The emphasis is on doing rather than insight. Insight may help clients understand themselves in relationship to others but it does not necessarily produce a behavior change. Weeks and L'Abate (1979) have compiled a list of paradoxical directives. They discussed various dimensions of paradoxical psychotherapy: individual versus systemic, prescriptive versus descriptive, cryptic time bound versus time random, reframing versus relabeling, and specific versus general.

Stanton (1981b) has reviewed the literature on paradox. He concluded that paradoxical directives have been used a great deal and seem to be successful with different kinds of problems. Listed, they are: adolescents problems, aging, alcoholism, anorexic and eating disorders, anxiety, asthma, behavior problems and delinquency, childhood emotional problems, crying, depression, dizziness, drug abuse and addiction, eucopresis, enuresis, fire setting, homosexuality, hysterical blindness, identity crisis, leaving home, marital problems, sleep disturbances, stammering, suicidal gestures, excessive swearing, temper tantrums, thumb sucking, vomiting, and work problems.
Supporting Stanton's claims, Fisch, Weakland and Segal (1982) have claimed proven strategies for treatment of a multiple of clinical problems. Their work treats anxiety, depression, marital difficulties, family conflict, psychosomatic illness, and drug or alcohol dependence. The major thrust of their work is to demythologize psychotherapy by reducing the aura of obscurity, complexity and magic. The authors explain in detail how the therapist applies his craft paradoxically. It is a book that claims to explain how to do therapy effectively and efficiently. The authors describe the basic elements of paradoxical directives treatment: maintaining control, setting the stage for treatment, conducting the first interview, assessing the patient positioning or point of view, using specific interventions, and terminating treatment. The authors also describe problems that arise and offer examples of responses with therapist explanation.

Recently strategic therapists have described various types of paradoxical interventions. Fisher, Anderson, and Jones (1981) have identified three types of paradoxical interventions: (a) reframing, (b) escalation or crisis induction, (c) redirection.

Reframing according to Fisher et al. (1981) is similar to the Watzlawick et al. (1974) description. Fisher et al. elaborated somewhat by describing client characteristics for
whom reframing should be used. Such a client shows: (a) moderate resistance, (b) non-oppositional stance, (c) ability to reflect, (d) non-action oriented, (e) ability to handle frustration and uncertainty, (f) little, or no severe impulsive or acting out behavior, (g) no pressing external problems, (h) a rigid family structure, (i) repeated, but not severe crisis.

The second method of Fisher et al., crisis induction or escalation was defined in two ways, symptom prescription, and increasing the frequency or intensity of a crisis situation. Watzlawick et al. (1974) also described symptom prescription in the same way as prescribing more of the same. Minuchin and Fishman (1981) also described increasing the intensity or duration of a crisis situation as unbalancing. The Fisher et al. contribution is not so much a description of the method as a description of when the method should be used. They write that the method of escalation should be used when the family has the following characteristics: (a) vague style, (b) excessive verbal manipulation, (c) oppositional, (d) power struggle, (e) marked resistance, (f) need to move more slowly, (g) potential for acting out, (h) excessively rigid, (i) blocked with no area of compromise, and (j) adults who compete with the therapist to function as therapist.
For Fisher et al. the third type of intervention, redirection, is similar to a technique Milton Erickson (Zeig, 1980a) used. Though Erickson never called it redirection, both Fisher et al. and Erickson used it as a technique to change the circumstances under which the symptom occurs without changing the symptom itself. For example, as a directive strategy, Erickson (Zeig, 1980a) would prescribe to a couple that is continually fighting at home to have a fight while walking in a park on a Sunday afternoon. Here again, the Fisher et al. contribution is a description of when to use the technique. The authors recommend the use of redirection: (a) in an individual setting, (b) when the presenting problem is with a young child, (c) with specific symptoms, (d) with repetitive symptoms, (e) with educational and guidance setups, (f) when the family can respond to direction without sabotage, (g) when the person or family is non-oppositional and (h) when the family is overly compliant.

The Fisher et al. (1981) work is valuable in that for the first time in the literature, specific paradoxical methods are associated with family characteristics. Most of this work is applicable to families rather than individuals. Weeks and L'Abate (1982) write that these guidelines have been confirmed by clinical observations.
Papp (1980) also describes some of the interventions developed at the Ackerman project in the treating of families of symptomatic children. She classified the interventions as compliance-based, or defiance-based depending on the degree of the family's anxiety, motivation, and resistance. Defiance-based paradoxical interventions are based on the assumption that the family is in a power struggle with the therapist. As a result the therapist gives a prescription which if defied would make the family become less symptomatic. One example of this is called the Greek Chorus. In this intervention, the therapist and the family form a group which is observed by a group of therapists. The therapist debates with the observers about the family's ability to change. In this way the power struggle is defused.

Rohrbaugh, Tennen, Press, and White (1981) have also specified paradoxical interventions using Papp's categories: (a) use compliance-based paradox when the therapist intends the client to carry out the paradox or (b) use defiance-based paradox when the therapist intends the client to reject the paradox. The authors describe in detail how both of these strategies work. Compliance-based strategies may work in one of two ways. Either the client finds (a) it impossible to comply with the symptom prescription, or (b) that compliance will create an aversive or punishing situation for the client. For example, suppose a client is told
to enact symptomatic behavior such as anxiety, obsessive-compulsiveness or depression. A compliance-based paradox is prescribed (get anxious, be depressed, etc.) to bring under voluntary control behavior which has been claimed to be out of control. When the client enacts the symptom consciously, the symptom can no longer be called spontaneous or uncontrollable. A second way a compliance-based paradox works is by creating an ordeal. An example the authors offer is a woman who was afraid of harming her children with a knife. She stayed awake thinking about this problem and lost sleep trying to get rid of her obsessive homicidal thoughts. The client was given the paradox to set her alarm clock for 2:00 a.m., go outside when the alarm rang and lock herself out of the house. She was then to think about these thoughts on the front porch. It was mid-winter in the Northeast which meant she was confronted with the ordeal of the weather. The authors claimed that after two weeks she was sleeping soundly and her symptoms had disappeared.

Defiance-based paradox is based on the opposite expectation that the client will defy or oppose the therapist and not carry out the paradoxical directive. In giving the directive, the therapist actually wants the client to defy him or her by not obeying. This strategy is frequently used with couples that fight, in that they are encouraged to
fight more. Another defiance-based strategy is to encourage the client to go slow or not to try to change too fast.

Tennen (1977) distinguished between compliance and defiance-based interventions in that compliance-based paradoxes are intrapersonal or intrapsychic. Defiance-based paradoxes operate primarily in the interpersonal domain. They reflect the client's need to oppose or defeat or be one up on the therapist. Watzlawick et al. (1974) has done most of the work with compliance-based paradoxes. Haley (1976) has done most of the work with defiance-based paradoxes.

Again the question arises as to when is it most appropriate to use each of these two categories of paradox. Rohrbaugh et al. (1981) described a social psychological theory of reactance developed by J. Brehm (1976) to explain when to use these kinds of paradox. Rohrbaugh et al. (1981) wrote that the therapist must first assess the reactance potential of the individuals. Some individuals seem constantly to need to defy others. High reactant clients play the game of opposition with the therapist. They manage to do the opposite of what the therapist wants or suggests.

Rohrbaugh et al. (1981) writes that when the symptom is unfree (spontaneous), and the reactance potential is low (the client will do what the therapist requests), a compliance-based strategy is indicated. On the other hand, if the target behavior is free (occurring under the patient's
control, and the reactance potential is high (the client will resist the therapist), then a defiance-based strategy is recommended. The authors also state that when reactance potential is low (the client will obey the therapist), and the target behavior is perceived to be free (controllable), then a paradoxical directive should not be used, but rather a more direct or straight-forward approach to therapy is more effective. The authors claim the most difficult pattern to deal with is when the reactance is high and the target behavior is unfree. Rohrbaugh et al. (1981) offer a number of ways to deal with this pattern. They suggest to elicit compliance by saying something like, "I have only one suggestion, but I can't know whether it would work for you. This problem really has baffled me and I'm feeling helpless." A second approach could consist of providing a number of alternatives or an illusion of choice. Milton Erickson was very effective in using this approach. An example of this is, "You can do it today or tomorrow." A third option is based on the strategy of Watzlawick et al. (1974) called the devil's pact. The client must agree to doing it before he even hears what it is.

The Rohrbaugh et al. (1981) work is valuable because for the first time specific guidelines for a strategic use of paradoxical interventions have been specifically laid out in a clear format. The authors have done it in a way which
attempted to demystify the strategic use of paradoxical techniques by offering tangible guidelines for the practicing paradoxical therapist.

Not only have the types of paradoxes been increasingly specified but recently Madanes (1980, 1981) has attempted to outline the whole process of paradoxical psychotherapy. She described six steps to be followed when paradoxical intervention is to be used. She states that: (a) The problem should be defined and goals set. (b) The problem must be conceptualized in a way that the identified patient is seen as a protector of the parental system in some way. (c) Devise a direction that enables the parents to help the child using one of three types of prescriptions, prescribing or pretending to help the parent. (d) Get the family to enact the directive in the session. (e) Get a report in the next session. (f) Give the parents credit for the child's improvement.

These methods are similar to others using different names for the labels of these methods. Selvini-Palazzoli, Boscolo, Cecchin, and Prata (1980) called these principles hypothesizing, circularity, and neutrality. Hypothesizing refers to the formulations the therapist uses about how families function. Circularity involves gathering information from every member of the family. Neutrality refers to the therapist examining the systems through everyone's
perceptions of differences. The authors speculate that the use of these principles in a session may generate enough feedback to change a family.

Often times the difficulty after giving a prescription is in influencing the client sufficiently to carry out the task. Zeig (1980b) has described five techniques which increase the probability of a client's doing his homework i.e., carrying out the task. Listed they are: (a) provide a rationale for the paradox, (b) use indirection, (c) prescribe the symptom in such a way that the client can reject some of the directions, (d) utilize the client's curiosity, and (e) effect small changes in the symptoms.

The Strategic Perspective and Its Use with Families

The major area in which paradoxical directives are used extensively is in marriage and family therapy. Case studies abound. Madanes (1980) suggests that the psychopathology in children is result of incongruity in the generational hierarchy of the family. Parents are in a superior position to the child by the fact of being parents. And yet the problem child assumes a superior position by being symptomatic. She suggests three paradoxical strategies for helping parents solve the incongruity. They are: (a) dramatization (acting out the problem in role play), (b) pretending to have the symptom (behaving as if the
symptom exists which it does), (c) making believe the symptom exists—which it does.

Andolfi (1980a) suggests that it is helpful to prescribe the family's own rule as therapeutic strategy. Using paradoxical interventions, the therapist can remain detached and effective. He noted that while many families request help, they often times reject any offers of help. The use of paradox protects the therapist from being drawn into a game in which every effort is made by the family to nullify his/her work.

Minuchin and Fishman (1981) use family restructuring to create a crisis in the family such that the turmoil will be so intolerable that the family structure will change. In a sense he seems to make things better by making things worse. For example, he might plan a luncheon session with an anorexic patient. The theory behind Minuchin and Fishman and others with similar approaches is that rigid family systems can be fractured by stress that pushes the homeostasis mechanism beyond the ability to maintain the "sickness" in the system. Case studies offered as examples are typical of the research done on paradox in families.

In another article, Andolfi (1980b) has pointed out paradoxical change for families. He writes that there is often a "hidden" agenda of a family that asks for help. The family enters therapy implying that they want change while
at the same time giving the message as: (a) help us stay the same, (b) help us (me) get rid of the symptom without changing anything else, (c) help us with the problems with the identified patient but leave the rest of us alone. Often times the paradox the family presents is for the therapist to remove the symptom from the family without changing the family from which the symptom comes.

Protinsky, Quinn, and Elliot (1982) described paradoxical prescription with families as a way to move from the emphasis on the identified patient to a focus on the marital and family dynamics. Hoffman (1976) described in an analogous way the shift from child to marital focus by describing therapeutic interventions to break the homeostatic cycle. Once the cycle was broken, conflict between husband and wife would emerge. Protinsky et al. (1982) offer three clinical illustrations to present the procedure of breaking the homeostatic cycle. First there is a positive reframing of the child's symptoms. Selvini-Palazzoli et al. (1978) write that by qualifying the symptomatic behavior of the child as positive, the therapist is positively connoting the homeostatic tendency of the system. As it is positive, the therapist avoids being rejected out of the system. Secondly, a statement is often made that the child is "sacrificing" himself to protect the system and this helps to convince the child that the marital dyad can survive on its own
right, and that the child should not sacrifice himself for his parents' development. Thirdly, Protinsky et al. describe the value of having the prescription come from the team rather than the therapist so it will sound like a second opinion. On occasion a letter is mailed to the family. In this way, the child becomes detriangled and the parents can focus on themselves.

Dell (1982) criticized the entire conceptualization of the homeostatic notion with families. He says that family homeostasis is an attempt to come to terms with a perceived stability of the system. He describes the notion of self-regulation as epistemologically flawed. Dell argues that a system does not necessarily resist change. He says the system behaves in accordance with its own organized coherence. He argues that it appears to resist for three reasons: (a) the relationship between the system and the environment is misread, (b) there is a failure to see the wider system, and (c) there is an inability of the therapist to accept the facts that systems are mechanistic.

Dell (1982) asserts that a system functions the way it is, not the way it is organized to function. In other words, therapists often want things to be what they want them to be and become upset when their expectations are not fulfilled. Bowen's (1978) concept of differentiation makes sense here. The hallmark of an undifferentiated person is
that he or she can neither tolerate nor accept being different from what he or she thinks or expects they should be. First, therapists often expect a patient to act a certain way and can not accept that he or she acts other ways. To do so is an epistemological error which some then label resistance. The resistant patient is defined as unwilling to cooperate with treatment. Erickson (1964) long ago pointed out that the resistant patient is nothing more than a person in a situation where the therapist will allow him to have some symptoms and not others. Patients are not obnoxious, they are just who they are. Bandler and Grinder (1975) argue in the same way when they state the "resistance" is never in the client, only in the therapist. Dell (1982) says oftentimes therapists expect a patient to respond in a certain way to their interventions. Dell (1981) raises the question of whether an event can be paradoxical if it is expected. Sometimes the therapist is not surprised at the outcome of an intervention but the patient is. He argues that the occurrence of paradoxical events is entirely dependent on the expectation of what will happen.

For Dell (1982) in therapy, the organization of a system is the unalterable reality with which the therapist must contend. If that reality is denied, the system will be "resistant." He argues that strategic therapists change patients by going with the reality, not with the resistance.
In short there is no such thing as resistance, only a misunderstanding due to a refusal to accept the reality. He suggests the term coherence rather than homeostasis. Linguistically he claims this seems to make better sense. Coherence determines how families will behave and no amount of determined efforts will change that. The saying "You can lead a horse to water but not make him drink" capsulizes that principle. Dell urges that therapists reevaluate the notions of family rules, resistance, and therapeutic paradox in their practice to help them understand more precisely what they are doing. Though controversial, Dell's critical analysis points to the value of clearly articulating the premises that constitute a new logic for change.

Though conceptually paradox is criticized, its use as a technique permeates family therapy. Gaines (1978) described the technique of paradox for reducing parental obsessions in family therapy. The approach is to motivate the parent to confront his or her obsessive thoughts about the children by instructing him or her to write them down. Gaines offers a case study of a mother overinvolved with her son. He instructs her to focus on her overinvolvement by creating an "ordeal" in writing them down. The mother had expressed concern over her son's behavior and believed he had minimal brain damage. After the child was found to be normal, treatment focused on her overinvolvement with the
boy. Once the technique was successfully applied, she was helped to focus on the relationship with her husband.

Schwartz (1982) describes a class of paradoxical directives called parental reversals which is also aimed at the overinvolved parent. The technique involves inducing the parent to reverse the injunction or position regarding their problem with their child. In other words, the parents rather than the therapist deliver the paradoxical directive. There are a few examples of this type in family therapy (Papp, 1980) but they have never been seen as a separate class of interventions. Schwartz describes three types of parental reversals—defiance based parental reversal, parental position reversal, and ordeal reversal.

In a defiance-based parental reversal, the therapist encourages the parent to command the child to continue or increase the problem behavior. The symptom is prescribed with the intention that he rebel against the injunction. An example of this is the mother of an anorexic adolescent female telling her daughter to eat less. Schwartz outlines a specific rationale for this: when the parents are frustrated at attempted solutions, when they have faith in the therapist, and when the power struggle centered around eating. In the case reported, the daughter said she was sick of playing games and would gain weight if she wanted to.
In a parental position reversal, parents are asked to exaggerate the rebellious child's position. Instead of saying "We control you," parents are requested to give the message, "We are too weak and confused or disinterested to control you." Essentially this is to take a one down position in relationship to the child. Benevolent sabotage (Watalawick et al., 1974) is an example of this also. Parents are instructed to say their son is hopeless and that they can't control him, but to lock him out of the house "accidentally" at night.

A third type of parental reversal is the ordeal based parental reversal. Madanes (1980) reports an intervention of this type when an uninvolved father was asked to demand that his 12 year old son urinate purposely on his own bed and then sleep on it every evening for a week. The father tried but eventually gave up, deciding to talk to his son. This lead to the giving up of bed wetting. Schwartz (1982) concluded that parental reversals can be effective and cited Haley's (1981) guideline that paradoxical directives be used in the context of simple practical theories that help the clinician in their work.

Paradoxical directives have also been used extensively with couples. Wagner, Weeks, and L'Abate (1980) attempted to evaluate the effectiveness of written paradoxical directives with married couples. Fifty-six couples were divided
into four groups, a control, a marriage enrichment, an enrichment plus direct straight-forward linear letters, and a marriage enrichment plus a paradoxical directive letter. The treatment lasted six sessions. The results showed the three experimental groups made significant improvement in marital functioning. The paradoxical group did not differ significantly from the other two groups.

The researchers offered various explanations as to why the paradoxical group did not excel in improvement: (a) the paradoxical directives were specific while the instruments were global, (b) only one letter was given which may not have been enough to test its validity, (c) the couples were non-clinical. They did not present specific problems nor were they resistant. The use of paradoxical techniques with such couples may have been inappropriate to produce change.

L'Abate and L'Abate (1979) described the paradoxes of intimacy. They state that these three paradoxical conditions make the attainment of dyadic intimacy (showing hurts and fears) difficult. The paradoxes are: (a) one needs to be separate in order to be close, (b) the ones we love the most have the greatest power to hurt us, (c) we must seek to comfort and be comforted by those who hurt us. The authors offer intervention approaches which are necessary to bring about changes in marital intimacy. They are described as
indirect paradoxical approaches and linear step-by-step intervention. Paradoxical directives include prescribing the problem as a homework assignment in a concrete and ritualized fashion. Linear solutions involve an intrinsic overlap of caring and hurt, the separation of feelings and actions, of performance and personality. The authors note the shortest distance to intimacy is not a straight line.

Hopkinson's Research

Since the investigator's research is based on the design of Hopkinson's study evaluating the effectiveness of paradoxical directives with college students, a full description follows.

Hopkinson (1980) attempted to discover if a written paradoxical directive could effect more positive change in real life problems than no intervention at all with undergraduates in child development classes at a small midwestern college. Sixty-nine subjects filled out a premeasure packet that consisted of a cover sheet, the Rotter (1966) locus of control scale, a standardized symptom check list -- the SCL-90-R, and a series of questions asking the subject to identify the single most important problem in his or her life. This was followed by a set of 17-point attitude scales which asked the subject what he or she felt or believed about the focal problem identified. After filling out this packet,
subjects were interviewed by the experimenter to set outcome goals that described what the problem would look like if he or she achieved a major success, the minimal amount of change he or she would still regard as significant improvement, or a status of unchange. The subjects were randomly assigned into no-treatment control, attention-placebo, and paradoxical directives groups. Hopkinson then prepared a written letter for each subject in each group as a help with the focal problem presented. The no-treatment control group letter was addressed "Dear Student" with an envelope to the chairperson of the Psychology Department at St. Xavier College. The letter requested an evaluation of a textbook. The letters of the attention placebo and paradoxical directive manipulations were personalized, addressing the student by name and using the letterhead of the Psychology Department at DePaul University. The first paragraph was the same for both groups. The paragraph read

... we are a group of mental health professionals investigating ways to help people help themselves with their problems. Although we do not know your last name, we have examined the survey which you recently filled out as a part of Mr. Hopkinson's research. We picked your survey at random from all the surveys, before we had read any of them. Although some of our advice is likely to sound peculiar, a great deal of clinical experience has shown that following our advice can be quite helpful for problems such as yours (p. 92).

The second paragraph was drafted for all subjects in the attention placebo and paradoxical group. The paragraph
was structurally similar. It consisted of an empathic statement of the problem the student presented (eg. "We understand that you are bothered a great deal by . . . ")

The third paragraph was also structurally similar in both groups and was given to all subjects in both attention-placebo and paradoxical groups. It consisted of a statement claiming experience and familiarity with the focal problem by the experts who had "written the letter."

The first three paragraphs were the attention-placebo treatment. According to Hopkinson, the treatment was designed to convey respect for the person and give empathic feedback that let the reader know the content had been heard.

A fourth paragraph was written for subjects in the paradoxical directives group. This paragraph contained an individualized paradoxical directive with a rationale for its use. After all subjects received a letter, a follow up survey was done 4 and 8 weeks after the letter.

Hopkinson reported his results from two perspectives. One, by comparing the groups with one another statistically, and secondly, by examining the paradoxical directives group itself.

In the first perspective, Hopkinson's results showed that there was no significant differences in problem relief between any of the three groups, no-treatment control,
attention-placebo, and paradoxical directives. He found no evidence that the written paradoxical directives produced effects which were significantly superior to no-treatment or an attention-placebo treatment. No evidence was found that a paradoxical directive facilitates improvement with the less distressed college student.

In the second perspective, Hopkinson examined his results by looking at changes within the paradoxical group itself. On all the measures of symptom relief, the paradoxical directive group showed improvement. Of the 23 subjects in the paradoxical group 43% claimed a major success, 26% a minimal improvement, and 30% claimed no change. At the 8 week follow up the outcomes were 61%, 17% and 22%.

Hopkinson also evaluated outcomes on the basis of interpersonal problems and intrapersonal problems. Eighty-six percent of the 14 subjects who had interpersonal conflicts achieved the highest level of improvement on both categorical outcome measures in 8 weeks. Only 50% of the 16 subjects with a presenting problem categorized as intrapersonal achieved the same outcome. He concluded that his results support Newton's (1968) observation that paradoxical directives are more effective with interpersonal problems rather than intrapersonal problems. He also examined the paradoxical directive group by analyzing the distress level measured by the SCL-90-R. He reported suggestive evidence
that paradox may have a specific value for obsessive worry, relative to no-treatment and treatment of a non-paradoxical nature. A number of subjects had complaints similar to phobic anxiety, depression, and family problems. Hopkinson reported that his results suggest improvement with the use of paradoxical directives in each of these cases, whose numbers were too small to test statistically. From this second perspective Hopkinson concluded that his results seemed consistent with previous clinical observations and theories of paradox reported in the literature.

Hopkinson did offer a number of explanations why no null hypothesis was rejected. One explanation was that the message by itself had little or no effect on the dependent measure of symptom relief or attitude change. He also suggested that the demand characteristics might have a screening or selective effect on the focal problem cited. Subjects may have suppressed persistent or embarrassing problems as they may not be typical of college students. Many presented academic concerns. Another possibility was that the students presented transient problems in all of the groups and that the successful outcome may be explained by the nature of the problem rather than the intervention itself. This may have contributed to the paradoxical group's or any other treatment's failure to show superior results. A third possibility offered is the "Rosenthal" effect.
Subjects may have been trying to help the investigator confirm the hypothesis they guessed the experimenter to be testing. He notes how "self-help" was used throughout the study and subjects may have "self-helped" themselves better.

He listed numerous other explanations why the study did not generate significant results. It is the belief of this investigator however that paradoxical directives were not significantly different from attention-placebo and control groups because of one central characteristic -- the absence of an ongoing therapeutic relationship. Letters were given to all three groups and the only relationship the subject had with a "therapeutic person" was the experimenter during a goal setting session. According to Bateson et al. (1956) in his theory of the double bind, whether they be pathological or therapeutic paradoxes, one crucial ingredient must be present. That is, two or more persons must be closely connected in an intense relationship. There were no close connections of persons in Hopkinson's study. In fact, the paradoxical directive was given to the subject by the secretary of the Psychology Department. (Hopkinson, 1980)

This present study, though modeled on Hopkinson's research, attempts to evaluate the use of paradoxical directives in the context of a counselor-client relationship with non-seriously disturbed subjects. Though the intensity of the relationship may not be to the degree a counselor-
client would have in a clinical setting, this experiment was designed to parallel counselor-client relationship in an analogous way. The counselor was defined as a trained helper of people with problems and the subjects presented real life concerns that they wished to be changed.

Summary of Research in Relationship to the Problem

Ordinarily in summarizing research one considers the various findings and results in terms of their reflection on the theory. The findings of the stated studies on paradox are generally interpreted by reviewers in a sweeping fashion as indicating support for the theory of paradox as a technique. These findings are difficult to interpret as adding anything substantial to paradoxical theoretical literature because in most cases the paradigm used does not adequately reflect the phenomenon investigated. This is a common enough conclusion in the reviews. There is little relevant data about therapeutic paradox from controlled experimental studies.

Kisch and Kroll (1980) examined the notion of meaningfulness and effectiveness in evaluating psychotherapeutic research. Many research problems stem from the difficulty of defining criteria. While case histories and subjective reports point to the beneficial aspects of psychotherapy, more rigorous and controlled studies are unable to adequately provide descriptions of efficacy of treatment.
Kisch and Kroll make the distinction between meaningfulness (experienced worth) and effectiveness (demonstrated utility). This is a critical distinction with regard to the paradoxical literature. Paradox is often seen as meaningful through case studies and subjective reports but its effectiveness experimentally has not been thoroughly tested.

There remains a strong bias for the experimental method. If one prefers to work within its limitations in order to benefit from its advantages, one respects the concept's essential features. Conceptually valid operationalism of the therapeutic paradox should reflect paradox in the context of an important relationship. However difficult to specify, the flavor of the paradoxical technique must be preserved in experimental situations.

The three treatment approaches, client-centered, rational emotive therapy, and paradox all claim effectiveness. Each locates the locus of change in a different area which can be conceptualized as follows: rational emotive therapy is located in the intellectual, cognitive thinking process of the individual. The assumption is if that changes, improvement and problem resolution follows. Client-centered therapy focuses primarily on the affective emotional side of the individual. If the therapist begins to identify and empathically respond with the affective dimensions of the client, problem resolution follows. Paradoxical directives
locate the process of change by focusing on the use of the client's problem as a tactic to control the relationship in such a way that the client is able to define what sort of relationship he/she is to have with the other. When control is established by the therapist, the tactic ceases to be effective and problem resolution follows.

Given this rationale, Gottman and Markman (1978) point out three central questions of psychotherapy research: (a) Is psychotherapy effective? (b) What kind of therapy is most effective? And, (c) what therapeutic process leads to the most change? This research is designed to examine college undergraduates' problems in an attempt to discover which therapeutic process is most effective with this non-psychiatrically disturbed population.

The theme of Process study was expressed by Bordin (1962) in the first three volumes on research. He wrote:

The key to influence of psychotherapy on the patient is his relationship with the therapist... Virtually all efforts to theorize about psychotherapy are intended to describe and explain what attributes of the interaction between therapist and the patient will account for whatever behavior change (Bordin, 1962, p. 235).

As seen in this review of literature, there is impressive evidence that rational emotive therapy and client-centered therapy produce effective results as theoretical approaches to therapy. With regard to paradox, despite the enthusiasm and claims of dramatic success with the techniques referred to in many ways, there is little direct
experimental evidence that paradox produces results any better than client-centered, rational emotive therapy approaches or just spontaneous remission rates of untreated groups. There is no evidence to suggest that paradoxical direction as a technique is superior to any specific treatment modality. This present piece of research is designed to evaluate paradox as a technique in comparison to untreated control groups, client-centered, and rational emotive approaches.
CHAPTER 3: METHODOLOGY

The Sample

Subjects who were clients

Sixty subjects were drawn from a larger population of volunteers from undergraduate classes in Educational Psychology and Human Growth and Development, and from a graduate class in Human Growth and Development at the College of William and Mary to participate in the study. The 60 subjects were randomly assigned to one of four treatment groups: (a) client-centered, (b) rational emotive, (c) paradoxical directives and (d) control (no treatment) group. All subjects ranged in age from 19 to 31, the median age being 21; 16 subjects were male and 44 were female.

Exclusion criteria

Selection from the larger population to participate in the study depended on a number of factors. Volunteer students in the pool were excluded from selection in the study for one or more of the following reasons: (a) The student had been in treatment with a psychiatrist, psychologist, social worker, professional counselor or clergyman for more than five continuous weekly sessions. At the same time the
investigator did not want to exclude students who had sought help once or twice from a professional for a specific situational problem. (b) The student was currently in counseling. (c) The student scored higher than the 84th percentile on the psychoticism scale of the Derogatis Brief Symptom Inventory. (d) In the judgment of the investigator, a student reported a problem that indicated a need for prompt professional consultation. In such a case the student was given a proper referral. (e) Clinical errors in the pre-measure packet made statistical comparison impossible.

Description of Recruitment of Subjects

During the first week of class in the Fall semester of 1982, the investigator entered the following classes to solicit participation for the research study: two sections of undergraduate classes in Educational Psychology; Dr. George Bass' section (teaching majors in a required course); Dr. Roger Ries' section (non-teaching majors in an elective course); Dr. John Lavach's undergraduate course in Human Growth and Development (an elective); Dr. David Hopkinson's course in Human Growth and Development (a graduate required course).

The investigator was introduced by the professor of each class and the professor encouraged the students to participate in the research project as part of an educational
experience. All participation was voluntary. The investigator introduced the research as a request for participation in a five week "Wellness Clinic." He passed out a single page flyer explaining the clinic and asked the students to read it. After about five minutes he essentially repeated verbally what was in the flyer.

The investigator explained the clinic by stating that its purpose was to provide an opportunity for personal growth and development. Those who volunteered would have an opportunity to work with a trained experienced counselor on a focal problem of their choosing in order to become a more effective well-functioning person. The five week commitment of five hours (one hour a week) was explained. The investigator requested the students not to volunteer if they felt they could not follow through with the time commitment. Since, after the subjects who volunteered had met the inclusion criteria, selection would be done randomly, the randomization procedures were also explained. The investigator then made a statement concerning confidentiality of the study and his interest in group data. Those who were interested were requested to fill out the form attached to the flyer giving their name, address, and phone number, and an indication of when the student could most easily be contacted by phone. The investigator left the room and the papers were given to the professors after class.
A total of 98 students in the four classes volunteered. The student breakdown is as follows: 45 from Lavach's class, 33 from Ries' class, 17 from Bass' class, 3 from Hopkinson's class.

Of the 98 subjects who volunteered, 26 were excluded for the following reasons: 2 because they had been in counseling more than five sessions recently; 1 because she was presently in counseling being treated for anorexia nervosa; 2 because their focal problem was a dating relationship between them and the investigator judged that their involvement with each other might bias the treatment approaches; 8 for clerical errors in the pre-packet measures; and 13 either because they were unable to be contacted by phone or did not return phone calls.

Of the 72 remaining volunteer subjects, 60 were randomly selected and randomly assigned to one of the four groups: client-centered, rational emotive, paradoxical directives, and control. There were 15 subjects in each group.

A copy of the cover sheet distributed to the classes is in the Appendix (Appendix A). A description of the College of William and Mary and the copy of the contract are in the Appendix (Appendices B and C).

Subjects who were the counselors

Seven of the nine counselors for the study (three per each treatment approach) were volunteers drawn from the
Advanced Certificate and Doctoral Programs in Counseling at the College of William and Mary. Two of the nine were acquaintances of the investigator who were known to have training and experience as counselors. One was a doctoral level student in special education with a Master's degree in Counseling, and the other had a Master's of Divinity in Pastoral Counseling who had recently completed a year internship in counseling beyond her Master's degree. All who administered the treatment were roughly of the same level of experience and training. The following data were gathered in informal telephone conversations with the investigator using a structured questionnaire. The three counselors who administered the client-centered treatment had a total of 13 years of experience; two counselors were doctoral candidates in counseling, the third was a doctoral candidate in special education with a Master's degree in counseling. The three counselors in the rational emotive treatment approach had a total of 15 years experience in counseling; one was an advanced certificate student; one had completed a Master's of Divinity in Counseling plus a year internship in counseling; and a third was a doctoral candidate in counseling. The three counselors in the paradoxical directives group had a total of 11 years of experience; one had recently completed his doctorate in counseling; one was a doctoral level
candidate and the third was in the Advanced Certificate Program in Counseling.

The counselors were assigned to a particular treatment modality on the basis of a telephone interview with the investigator. They were asked to state the following using a Likert scale: (a) their familiarity with each modality, (b) their preference for a particular modality, (c) their choice, if forced to make a decision, of the modality they would select, and (d) their beliefs regarding the most and least effective modalities in the treatment of college students. The major factor in the assignment of counselors to a particular modality was the counselor's belief in the effectiveness of that method.

In the client-centered approach, all three counselors claimed a great deal of familiarity with that modality. In the rational emotive approach, two counselors claimed a great deal of familiarity and one claimed being somewhat familiar with that approach. In the paradoxical approach, one counselor claimed little familiarity with paradox, another claimed to be somewhat familiar, and a third to be a great deal familiar. In regard to preference, two of the three counselors selected for the client-centered approach, preferred that methodology. The third counselor had no strong preference but would have selected rational emotive therapy if forced to choose. Of the three counselors
selected for rational emotive therapy, one preferred rational emotive therapy first, the other two counselors had no strong preference but, if forced to choose, would have made rational emotive therapy their second choice. In the paradoxical directives approach, all three counselors preferred paradoxical directives. As stated above, the belief system of each counselor as to which modality was most effective with college students was the major factor in the selection of counselors to a particular modality. For the counselors assigned to the client-centered modality, two of the three believed more strongly that of the three methods, the client-centered method was the most effective approach with college students. The third counselor believed that client-centered therapy was the second most effective approach. All three of the counselors selected for rational emotive therapy believed it was the most effective. In the paradoxical directives approach, two counselors believed client-centered therapy was most effective, followed in their opinions by paradoxical directives. The third counselor believed rational emotive therapy was most effective, followed by paradoxical directives. No counselor was assigned to any modality that he believed to be the least effective of the three.
In summary, an effort was made to assign counselors to a particular modality such that they had roughly the same level of training, knowledge, preference and belief.

The form used to gather this information is in the Appendix (Appendix D). The letter sent to recruit counselors is also in the Appendix (Appendix E).

Pre-experiment training of counselors after selection

The nine counselors were divided into groups of three: client centered, rational emotive, and paradoxical directives. Before they administered treatment, each group of three met with a person defined as an expert in the modality they used. This was done to verify the competency of each counselor using a particular modality, and if necessary to improve the skills needed to administer the treatment adequately.

Within each treatment modality, each counselor was instructed to work on the focal problem of the client. Though it may have been tempting for the counselor to mix modalities, specific instructions were given to each therapist to stay with the modality assigned. It was assumed that rapport and relationship skills would be used by counselors in all modalities. As a check to evaluate whether the counselor had used the specified treatment modality assigned, the investigator spot checked the tapes of the
previous week, and the consultant was notified of any irregularities in the treatment plan. The tapes were reviewed periodically by the consultants. Also, the counselor was instructed that he or she would receive on-going consultation throughout the three weeks of treatment.

The Use of Consultants

Consultants were available to work with each set of three counselors in each of the treatment modalities. For the client-centered approach, Dr. Charles Matthews of the College of William and Mary reviewed the principles of client-centered therapy with the three counselors and made himself available to the counselors to help, instruct or assist them in implementing their treatment plan. Counselors were instructed that they could call Dr. Matthews or meet with him as needed. In the same way, Dr. Kevin Geoffroy of the College of William and Mary was available as a consultant to the rational emotive group. He also reviewed the principles of RET and was available to help with the treatment plan of counselors using the RET. Dr. Patrick Dorgan assisted the paradoxical group as a consultant. Since paradoxical directives are not so much a set of principles but a specific strategy for change, Dr. Dorgan worked with the three paradoxical counselors over the phone to develop specific strategies for change that were to be communicated to the clients in the sessions. Each counselor was instructed to contact
the consultant as needed to discuss problems with the interview. All three consultants were regarded in the community as having a high level of expertise in their respective modality.

There were five major reasons for using consultants: (a) Consultants insured that the same style of treatment assigned to the counselor was administered. (b) Consultants were informed of any problems with the interview and corrected them if necessary. (c) Consultants were used as an ethical safeguard. (d) Consultants were assigned in each treatment modality to ensure that treatment groups had the same amount of expertise. (e) Consultants were used for verification that the counselors had the basic skills necessary to operate in the specific modality.

In summary, the nine counselors were divided into three treatment approaches, with three counselors per group: client-centered, rational emotive, and paradoxical directive. The sixty subjects were divided into four groups of 15 each. They were client centered, rational emotive, paradoxical directive, and control. Each counselor, using his/her assigned modality, counseled five subjects each of whom was seen for three, 50 minute individual sessions.
Data Gathering Procedures

The researcher entered three undergraduate classes and one graduate class to request volunteers and made the presentation described above.

There were a total of five weekly sessions with each of the 45 treated subjects. All were individual sessions. The first session, referred to as the structured interview, was followed by three weekly treatment sessions which began one week to ten days later. The final session was held a week after the last treatment session.

The structured interview and the final session were done by the investigator and his associates. The treatment sessions were conducted by the nine counselors. Each counselor treated five students with the modality that he or she had been assigned.

The length of the sessions was as follows: structured interviews lasted 1 to 1½ hours, treatment sessions went for 50 minutes, and the final session took about 30 to 45 minutes.

The 15 subjects in the control group had two sessions: the structured interview and the final session. After the structured interview, they received a letter stating that more students had volunteered than expected. They were requested to wait until a counselor was available and told that when one was available, they would be contacted.
immediately. The letter also stated that the investigator might have to ask the student to retake some of the pre-packet measures in order to get the most recent data available to help the student benefit from counseling as fully as possible. After the data were collected for all subjects, paradoxical directives and client-centered treatments were made available to the control group.

The Structured Interview

At the structured interview, the researcher or his associate explained the contract, had the subject agree to the contract by signing it, and administered the following tests: the Derogatis Brief Symptom Inventory, the Mooney Problem Check List, and the Willingness-to-Disclose Questionnaire. A fourth instrument, the Relationship Inventory was used in the study but was given as a posttest only. All who volunteered and were able to be contacted received the initial structured interview. This was a total of 85 subjects.

The structured interview had three purposes. One was to review the materials for completeness and clarity. Any problem with regard to scheduling was corrected. A second purpose was to identify and screen out subjects who met the exclusion criteria described above. A third purpose of the interview was to develop a behavioral description of the
problem and criteria for outcome evaluation. The method of criteria setting was related to "goal-attainment scaling" (Kiresuk and Sherman, 1968; Hopkinson, 1980) but with major changes. In a joint effort with the researcher, his associates and the subject, four categories of possible outcome for the focal problem were developed. The focal problem was taken from the Mooney Problem Check List as a concern or problem the subject wished to work on with a counselor for the three weekly sessions. The four categories of outcome were: (a) what the problem would look like if it were greatly improved, (b) what the problem would look like if it were improved enough to call it changed for the better, (c) what the problem would look like if it remained the same, and (d) what the problem would look like if it got worse. As in Hopkinson's dissertation, the second category corresponded to the theory and research of the Mental Research Institute (Weakland, Fisch, Watzlawick, & Bodin, 1974). The unchanged category was explored with the subject in depth not only to set such a criteria but also to gather data so that a paradoxical directive could be given that would encourage with some precision a continuation or exaggeration of some aspect of the current problem.

Successful criteria setting resulted in four descriptions by the subject in dialogue with the researcher or his associate that corresponded to the descriptions: (a) greatly
improved, (b) minimally improved, (c) remained the same, or (d) worsened. The associate was instructed to frame the description in objective behavioral terms, with categories mutually exclusive, and individually tailored to be meaningful for the subject (Weakland et al., 1974). As stated by Hopkinson:

Defining global categories of outcome in different ways for different subjects meant sacrificing a certain amount of scientific "cleanliness" for the sake of creating a situation more closely analogous to psychotherapy. Goldstein, Heller and Sechrest (1966), Kiesler (1971), and Weakland et al (1974) have all pointed out that since psychotherapy deals with individuals, it makes little sense to measure outcome in some a priori way that applies to everyone with the same meaning (p. 87).

This investigator's scale of outcome criteria was designed to be in agreement with that view.

Format of the Opening Structured Interview

A copy of the structural interview is in the Appendix (Appendix F). A description follows. First, the interviewer asked if the subject was in counseling presently or if he/she had received psychological treatment more than five times from a professional within the past six months. If either was the case, it was explained that the study's design had to do with people who had not had that much exposure to counseling. If the subject's answer was "no" to both questions, the interviewer went on with the session.
Using the Mooney Problem Check List, the interviewer asked the subject to focus on a particular concern and then requested the subject to describe the concern behaviorally. The following information was also gathered: (a) a history of the problem, (b) the intensity of the problem, (c) previous ways of solving the problem, (d) outcome criteria (much improved, minimally improved, the same, or worsened), (e) an exploration of the subject's attitude toward the problem. The interviewer told the subject a counselor would be in contact with him or her. A copy of each subject's outcome criteria is in Appendix G.

Subjects Who Administered the Structured Interview

Subjects were recruited by asking acquaintances of the researcher to do the interview. They were Master's level and Advanced Certificate students in education. They met with the investigator one evening and practiced interviewing each other until they stated they felt comfortable and competent with the procedures.

Some of these associates also did the closing exit interview and administered the Brief Symptom Inventory, the Relationship Inventory and the Willingness-to-Disclose Questionnaire also. A copy of the closing evaluation interview is in Appendix H. A copy of the letter which was sent to these associates is found in Appendix I.
Format of the Exit Interview

The Willingness-to-Disclose Questionnaire and the Brief Symptom Inventory were administered again and the Relationship Inventory was given for the first time. Then the investigator or his associate conducted a 20-minute interview with each subject. The interviewer read back the subject's own description of the problem. The interviewer then asked the subject how the subject evaluated the conflict in terms of the descriptions maximally improved, minimally improved, the same or worsened. The self-report attitude survey was repeated again. The interviewer thanked the subject and informed the subject that he/she would be sent a letter of the results. A copy of the debriefing letter is in Appendix J.

Treatment (Independent Variables)

Client-centered therapy. The client-centered treatment mode is based on the theory of Carl Rogers (1957) and Gerard Egan (1982). Rogers holds that his modality is not a technique but an attitude. If genuineness, empathy and unconditional positive regard are communicated at least minimally, then positive change in the client will result. The primary ingredients for the therapist are Accurate Empathy I and II, unconditional positive regard, interpersonal skills such as confrontation, immediacy, transparency, and caring. These are sufficient factors to produce change
in the client. These concepts as internalized by the therapist are the primary skills used to treat this group of subjects. The skills used are basic relationship skills that are generally accepted as necessary in any helping relationship. In essence they are a behavioral description of the client-centered approach of Carl Rogers. A list of the skills follows.

1. **Physical attending**: Adopting a posture that indicates involvement that says, "I'm available to you." Paying attention to non-verbal behavior.

2. **Speaking concretely and expressing yourself concretely**: Getting the clients to talk about themselves in terms of specific behavior, specific feelings, in specific situations.

3. **Primary-level accurate empathy**: Reflecting the feeling the client states.

4. **Use of probes**: Gathering information.

5. **Advanced accurate empathy**: Reflecting accurately the feeling the client implies in his/her statement.

6. **Confrontation**: Dealing experientially with discrepancies.

7. **Immediacy**: Exploring what's going on in the here and now of the relationship.

8. **Goal setting**: Making goals more concrete; checking against established criteria.
Rational emotive therapy. The RET treatment mode is based on the work of Albert Ellis (1962) who believes that warmth, genuineness, and authenticity are neither sufficient nor even necessary to produce change in the client. Rather he believes the therapist should focus on the irrational thoughts that people take toward their problems and attempt to change their belief system. The assumption in doing so is that the upsetting emotional consequences will also be changed. The therapist's technique in this modality is designed to discover the thinking process of the client and to work to change it. Ellis' central philosophy comes from the stoical writings of Epictetus who wrote in The Enchiridon during the first century, "Men are disturbed not by things, but by the view which they take of them."

Rational emotive therapy follows three points referred to as A, B, and C. At point A, there is an activity, an action or agent (examples: job interview, fight with mate) that serves as the stimulus. Point B refers to the moment when the individual has a rational belief ($r_B$). An example of this is, "It is unfortunate that I am rejected." Sometimes an irrational belief is substituted for a rational one. Irrational beliefs cannot be supported by empirical evidence. Irrational beliefs can be recognized by implications of should, ought, must, absolute, and demand. There is no law in the universe that says one should do well.
Following point B is point $C_r$. This refers to rational consequences, such as "It is unfortunate if I get rejected." If the belief is irrational however, irrational consequences follow ($C_{ir}$). An example of this is, "I am a worthless person." The work of the counselor is to dispute the irrational belief system of the client. This approach stresses a no-nonsense direct confrontation to clients and their problems.

RET has a number of experimental techniques to get out emotions. They are as follows: (a) Get the client to express feelings, even if they are directed at the therapist. (b) Get the client to take emotional risks. (c) Have the therapist use role playing, story telling, humor, and strong language in an intense forceful manner. (d) Attack the client's defense system. (e) Have the therapist reveal his own authentic and personal feelings.

The practice of RET instructs the therapist to: (a) reinforce good and efficient changes during his time in therapy, (b) show that the client is not a bad person because of bad behavior, (c) role play with persons, (d) give activity homework, (e) show how emotional responses are connected with irrational belief systems, (f) show how and why the client's philosophical premises were illogical, inconsistent and contradictory, (g) teach the client how to question and challenge his self-defeating hypotheses about
himself. For example, "Why am I a worthless individual if I speak inadequately before a group of people?" "Who says that I should be perfectly successful in any overture I make toward women?" "Where is the evidence that if I haven't succeeded with a female during my first 30 years of my life, I am probably a homosexual?" "Why must I experience terrible trouble and pain if I try risk-taking experiences?" (h) Demonstrate why and how it is possible for the client to change significantly his thoughts, feelings and performances and thereby create a basic personality change.

Generally then, the therapist shows clients how their irrational ideas contribute to their problems. The following is a list of irrational ideas, according to Ellis:

1. That it is a dire necessity for an adult to be loved or approved by virtually every significant person in his community.

2. That one should be thoroughly competent, adequate and achieving in all possible respects if one is to consider oneself worthwhile.

3. That human unhappiness is externally caused and that people have little or no ability to control their sorrow and disturbances.

4. That one's past history is an all-important determinant of one's present behavior and that because something once strongly affected one's life, it should always have a similar effect.
5. That there is invariably a right, precise and perfect solution to human problems and that it is catastrophic if this perfect solution is not found.

6. That if something is or may be dangerous or fearsome, one should be terribly concerned about it and should keep dwelling on the possibility of it occurring.

7. That certain people are bad, wicked or villainous and they should be severely blamed and punished for their villainy.

8. That it is awful and catastrophic when things are not the way one would very much like them to be.

9. That it is easier to avoid than face certain life difficulties and self responsibilities.

10. That one should become quite upset over other people's problems and disturbances.

Ellis argues that these premises literally cause people to feel and behave badly. To change these premises, the therapist: (a) forces the client to look at anger and hostility, (b) is action oriented and gives homework, (c) is didactic rather than dealing with transference and countertransference and (d) is philosophical rather than psychological in approaching problems. The therapist is to teach emphatically: self-interaction, self-direction, self-tolerance (the right to be wrong), and acceptance of uncertainty.
Paradoxical directives. The paradoxical directives' modality is based on the work of Jay Haley (1963). In this modality the therapist, in the context of a caring relationship, attempts to gain control of the relationship by prescribing the problem behavior in such a way that the client cannot use it to his/her advantage. The three main kinds of paradox are positioning, restraining, and prescribing.

This modality is primarily focused in the present rather than the past, in action rather than interpretation, and on problem relief rather than growth.

Since paradox calls for a specific plan of action, each counselor in this study consulted with a person defined as an expert in paradoxical directives to come up with a plan of action for each client.

The paradox of action was an attempt to make change by encouraging the client to continue with the presenting problem behavior. The counselor's verbal and active encouragement of the student's presenting problem was the operational definition of paradox used in the study. The treatment plan of the subjects in the paradoxical group divided according to five problem categories is in Appendix K.

The control group. After the structured interview was given and random assignment was made to the three treatments and control group, the control group was contacted via letter. The letter stated, in sum, that due to the number of
subjects who volunteered, they were requested to wait until a counselor was available. A copy of the letter is in Appendix L. Subjects in the control group received counseling after the study if they wished. Twelve subjects did still want the counseling.

Ethical Safeguards and Considerations

A number of safeguards have been built into the study. The safeguards are as follows:

First, if any student experienced considerable emotional difficulty in the interview sessions, he/she was told that he/she could drop out of the study at any time. If one did drop out, an interview was held by the researcher to discover the cause of the drop-out. If it was because of the seriousness of the student's problem, the researcher referred the client to the counseling center for more intensive treatment. This situation arose once.

A second safeguard was the exclusion criteria described above for participation in the study by the students.

Third, if after the three sessions, any student wished to continue in counseling a referral was made to the college counseling center. This was done in four cases.

Fourth, after the three sessions and closing interview, the subjects were told that a debriefing letter would be
sent to all the participants fully explaining the study. Such a letter was sent. It stated that if anyone had questions, he/she could contact the experimenter for clarification.

Fifth, the selection of counselors was also specified. The criteria for inclusion were: years of experience and training, admittance into the Advanced Certificate Program in Counseling or Doctoral Program in Counseling, or employment in a counseling agency.

After the counselors were selected, the names were submitted to the researcher's committee for review. If any committee member felt that a particular student counselor was not competent, he/she was excluded from the study. An exclusion of this nature did arise once.

Sixth, consultants defined as experts in each modality were used to (a) ensure that the specified treatment was being followed and (b) supervise the counselors through personal interview or phone calls as they administered the treatment and (c) verify that the counselors had the basic skills necessary to administer the treatment in a modality.

Seventh, all interviews were taped and spot reviewed by the experimenter. This was to ensure that the counselors used the assigned modalities. If the experimenter had recognized serious problems in the interaction between counselor and student, he would first meet with the consultant
in that modality to discuss the issues involved. Should it be agreed upon that intervention with the counselor were necessary, the student counselor would have been contacted. The consultant, the researcher and the student counselor would review the tape and make appropriate changes. This situation, however, did not arise.

Eighth, the chairman of the dissertation committee, a licensed clinical psychologist, would review the tapes containing any intervention that the investigator, any of the three consultants or any of the clients considered having a potential for harm. The chairman would recommend appropriate changes. This situation did not arise.

Ninth, the chairman was prepared to review the tapes and interventions of (a) anybody who dropped out of treatment, and (b) anybody who complained about the treatment. This situation did not arise.

The researcher felt that this elaborate set of safeguards provided reasonable assurance that nothing detrimental would happen to the students who were subjects.

Instrumentation

The dependent variables were assessed using widely employed instruments which have demonstrated adequately degrees of validity and reliability.
Brief Symptom Inventory

The Brief Symptom Inventory (BSI) is essentially the brief form of the SCL-90-R. The SCL-90-R is designed primarily to reflect the psychological symptom pattern of psychiatric medical patients. The "90" has its historical antecedents in the Hopkins Symptom Check List (HSCL). It is a 90 item self-report symptom inventory which requires the patient to respond to each item in terms of a five point scale of distress ranging from "not at all" to "extremely."

The BSI is scored and interpreted like the SCL-90-R in terms of nine primary symptom dimensions and three global indices of distress. The primary symptom dimensions are: (a) somatization, (b) obsessive-compulsive, (c) interpersonal sensitivity, (d) depression, (e) anxiety, (f) hostility, (g) phobic anxiety, (h) paranoid ideation, and (i) psychoticism. Its appeal for use in this study was that it required only 10 minutes for completion.

There are three published norms used with the BSI: (a) a sample of 1,002 heterogeneous psychiatric outpatients, (b) a sample of 719 non-patient normal subjects and (c) a sample of 313 psychiatric inpatients. The sample of 719 non-patients was used as the normative group for comparison in this dissertation.

According to Derogatis and Melisaratos (Note 1), the non-patient norms used are based on the responses of "344
males and 341 females. It represents a stratified random sample from a single county in one of the large eastern states" (p. 7).

Reliability. Reliability is essentially of two types: internal consistency and test-retest reliability. Internal consistency measures the consistency by which "the items selected to represent each symptom construct actually reflect the underlying factor" (Derogatis & Melisaratos, Note 1, p. 8). Test-retest reliability measures the stability of measurement across time.

Table 1 provides the following internal consistency coefficients and test-retest reliability for the three affect measures as reported by Derogatis and Melisaratos in their introductory report.

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Number of items</th>
<th>Internal Consistency n = 719</th>
<th>Test-Retest</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>6</td>
<td>.85</td>
<td>.84</td>
</tr>
<tr>
<td>Anxiety</td>
<td>6</td>
<td>.81</td>
<td>.79</td>
</tr>
<tr>
<td>Hostility</td>
<td>5</td>
<td>.78</td>
<td>.81</td>
</tr>
</tbody>
</table>
The internal consistency reliability was established on a sample of 1,002 outpatients. The statistical procedure used was Cronbach's alpha ($\alpha$). Derogatis and Melisaratos claimed all were very good from a low of .71 on psychoticism (not used other than as a screening measure) to a high of .85 for depression.

Test-retest reliability reflecting stability across time as listed in Table 1 is from a sample of 60 non-patient subjects tested at a two-week intervals. They again claim it is very good with a low of .68 for somatization (not used) to a high of .91 for phobic anxiety.

Validity. According to Derogatis and Melisaratos (Note 1), major questions of validity for any psychological instrument are: what is the specificity of predictive validity, and what is pragmatic nature of the construct validity?

The first question is best focused as: "Is this test valid? For what purpose?" Tests are not valid in general but are valid for specific purposes. The second question focuses on the fact that psychometric experts emphasize construct validity as the major criterion for validating psychological tests and discovering what these instruments measure.

Convergent and Discriminant Validity. Convergent and discriminant validity refers to how highly scores from one
test (in this case the BSI) correlate with other measures of that same construct and show lower correlation with dissimilar constructs. Table 2 contains the correlation results of the BSI with the clinical scales of the MMPI (Dahlstrom, 1969), the Wiggins content scales of the MMPI (Wiggins, 1966 and the Tyrons cluster scores (Tyrons, 1966).

Table 2
Correlations of BSI and MMPI Clinical, Wiggins and Tyrons Scores

<table>
<thead>
<tr>
<th></th>
<th>BSI</th>
<th>MMPI</th>
<th>Wiggins</th>
<th>Tyrons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>*</td>
<td>.72</td>
<td>.67</td>
<td></td>
</tr>
<tr>
<td>Anxiety</td>
<td>.48</td>
<td>.40</td>
<td>.57</td>
<td></td>
</tr>
<tr>
<td>Hostility</td>
<td>.48</td>
<td>.35</td>
<td>.56</td>
<td></td>
</tr>
</tbody>
</table>

*This correlation was below .30 and omitted in the manual.

The analysis of the BSI with the other scales reveals excellent convergence. Depression, anxiety and hostility "all demonstrate maximum correlation with MMPI and are clearly convergent" (Derogatis & Melisaratos, Note 1, p.13). Derogatis and Melisaratos report that the finding of high convergence for the dimension of the BSI with the MMPI
scales is important confirmation of the validity of the scales.

**Construct Validity.** To assess the reproduceability of the internal structure of the BSI, scores of the psychiatric outpatient sample were subjected to principal components analysis with 1.00 in the diagonal correlation matrix. The correlation matrix was analyzed 49 X 49 omitting four items because they did not have any univocal loadings on any of the primary dimensions. Only the factors relating to the affects used in the study are reported here.

Factor III, the depression dimension was defined well with only one item, "Feelings of worthlessness" showing high loading on another factor. Also interpersonal sensitivity items were observed to load on the depression factor. Gorsuch (cited in Derogatis & Melisaratos, Note 1) reports no "obvious reason for this . . . except that the number of items may be too small to sustain the invariances across population parameters" (p. 14).

The general anxiety dimension seemed to split into two components, panic anxiety (Factor VII) and nervous tension which happened also in the confirmatory SCL-90-R study which established the construct validity of the longer test.

The hostility dimension (Factor IV) was consistent with previous confirmatory factor analysis of SCL-90-R (Derogatis & Cleary, 1977).
Derogatis and Melisaratos (Note 1) conclude that the results of the structure-comparing factor analysis lend additional support to the construct validation of the BSI.

Predictive validity. Derogatis and Melisaratos report that at the present time studies of predictive validity are lacking due to the "newness" of the instrument, but the high utilization of the BSI suggests that a number of criteria-oriented validity studies will soon be published.

Conclusion. Internal and temporal consistency forms of reliability prove to be satisfactory for the BSI. Convergent validation and internal structure studies seem to indicate the beginning of evidence for construct validity. Derogatis and Melisaratos conclude, "It appears that it has reached a point in its development where it is ready to be formally introduced" (Derogatis and Melisaratos, Note 1, p. 16).

A copy of the instrument is included in Appendix M.

Mooney Problem Check List

Mooney Problem Check List (MPCL) was developed in the early 40's to help clients "express their personal problems" by reading through the problem check list and underlining their concerns. Its intention was to help the counselor analyze the student's problems more quickly and to bring to light areas apt to be overlooked. The form used was appropriate for college students. In it there are 288 items
dealing with 24 items in each of the following categories: (a) health and physical development, (b) finance and employment, (c) social and recreational activities, (d) social-psychological relations, (e) courtship, (f) sex and marriage, (g) home and family, (h) morals and religion, (i) adjustment to college, (j) future, (k) vocation, (l) curriculum and teaching.

The check list is not built as a test. The manual contains a bibliography and relevant studies concerning the assumptions of the check list. The check list is designed to reflect problems at a given point in time. It is also designed to reflect changing situations and experiences in the individual.

The rationale for its use in this study is that it provides a means for assessing content problem areas to be treated within the frame of the three treatment modalities. These content areas are to be further specified by the outcome measure instrument used in the structured interview by the investigator's associate. The MPCL facilitates the articulation of the problem area for the subject.

**Reliability and Validity.** Since it is a check list, no norms for reliability or validity are reported.

A copy of the instrument is included in Appendix N.
The Relationship Inventory (RI) developed by G. T. Barrett-Lennard is designed to measure four dimensions of the interpersonal relationship adapted from Rogers' (1957, 1959) conception of the necessary conditions for personality change. Among published reviews, by far the most extensive was by Gurman (1977).

The Relationship Inventory samples the perceptions of the therapist by the client in a dyadic relationship which are relevant to the variables of empathic understanding, congruence, level of positive regard and unconditional regard. It is a 64 item questionnaire requesting that the client respond with a +3, "Yes, I strongly feel it is true," +2, "Yes, I feel it is true," +1, "It is probably true or more true than untrue," -1, "No, I feel that it is probably untrue or more untrue than true," -2, "No, I feel it is not true," -3, "No, I strongly feel that it is not true."

A brief description of the scales follows:

**Empathic understanding.** This scale refers to the extent one person is conscious of the immediate awareness of another. Qualitatively it is an active process of desiring to know the full present and changing awareness of another person, of reaching out to receive his communication and meaning.
Level of positive regard. This scale measures the overall tendency of one person's affective response to another. To use a factoral analogy, it is the composite "loading" of all the distinguishable feelings—reaction of one person toward another, both positive and negative on a single abstract dimension.

Unconditionality of regard. This scale is concerned with the aspect of constancy of variability of affective response, regardless of its general level. Specifically the less the therapist's response varies for the client the more unconditional the communication is.

Therapist congruence. This scale measures the degree to which the therapist is functionally integrated in the context of his relationship with another, such that there is an absence of conflict or inconsistency among his primary experience, his conscious awareness, his overt communication, and his congruence to this relationship.

Willingness to be known. This concept was developed to measure the degree to which the therapist is willing to be known as a person by his client. This was further defined primarily in terms of readiness to communicate self-experience.

Reliability. Reliability has been reported in several studies of the Relationship Inventory.
Snelbecker (1961, 1967) reports split-half reliability coefficients ranging from +.75 to +.94 for the four principle RI scales (excluding Willingness to Disclose) in separate assessments from two samples of data provided by observers viewing therapy films. Hollenbeck (1965) obtained split-half reliability ranging from +.83 to +.95 for the four RI scales in samples of parent-child relationships reported by college students. Test-retest correlation, over a 6 month interval, ranged from +.61 to +.81 for the four scales.

Validity. Evidence for or against construct validity derives from research in which the Inventory has been used, in particular, from carefully designed and conducted studies in which predicted associations between RI measures and other variables stem directly from the theoretical and logical scheme on which the instrument is based. The basic theory that the RI was designed to test (Rogers, 1957; Barrett-Lennard & Elliot, Note 2) is now also extensively supported by studies using the Truax and Carkhuff rating scales to assess levels of the relationship conditions (e.g. Truax and Carkhuff, 1967).

Barrett-Lennard and Elliot (Note 2) do not imply that the RI can be directly validated against the Truax and Carkhuff scales, or vice versa. Definitions of the variables are not identical in the two cases. More importantly,
the RI measures are based directly on phenomenological data from the participants in the relationship rather than from the behavioral form of the communication. The Truax and Carkhuff scale measures involve the perspective and judgments of an observer rating samples of communication data and so are necessarily more dependent on the behavioral aspects of the communication than the phenomenological experience of it.

The research, in addition to Barrett-Lennard's own work, which provides evidence relevant to validation of the RI includes studies by Thornton (1960), Clark and Culbert (1965), Gross and DeRidder (1966), and van der Veen (1965). Thornton's findings indicate, for example, that RI scores from the perceptions of either marriage partner are highly correlated with another kind of carefully developed measure (Burgess and Cottrell, 1939) of the adequacy of a marriage relationship. Emmerling (cited in Barrett-Lennard & Elliot, Note 2) employed a criterion of "openness," based on Q-sort data, which was designed to distinguish between relatively effective and ineffective teachers on the basis of the degree to which they saw themselves as responsible for difficulties and remedial action in their work situation. One would expect such persons to be more genuine, personally sensitive and accepting than persons who see problems as largely imposed on them and unconnected with their own
characteristics. The fact that the pupils of more open teachers did describe them more positively on each of the RI dimensions implies that the measures were sensitive to differences consistent with prediction and theory.

The studies by Clark and Culbert (1965), Gross and DeRidder (1966) and van der Veen (1965) involve investigation of associations between measures of functioning based on Rogers' psychotherapy process scale (e.g. Rogers, Gendlin, Kiesler, & Truax, 1967) and the RI relationship dimensions. The positive findings of association between these two theoretically related classes of measures are viewed as lending further support to the measuring procedures as well as the theory. Cahoon (cited in Barrett-Lennard & Elliot, Note 2) found that experiencing levels (Process Scale) and openmindedness (Dogmatism Scale) of practicum counselors were significantly related to the client-perceived quality of their counseling relationships as measured by the RI scales.

A copy of the instrument is included in Appendix 0.

Willingness to Disclose Questionnaire

The Willingness-to-Disclose Questionnaire is one of the earliest self-report questionnaires developed by Jourard and Lasakow (1958). There are a number of versions of the self-report questionnaire reported in the literature, a 60, 40,
and 25 item questionnaire. This study used the 40 item self-report.

This widely-used instrument (Dimond & Hellkemp, 1969; Dimond & Munz, 1967; Jourard, 1964; Melikan, 1962; Mulcahy, 1973; Pedersen & Breglio, 1973; Sousa-Poza, Shulman & Rohrberg, 1973; Truax & Whittmer, 1971; Doster & Strickland, Note 3) attempted to measure amounts of past or future willingness to disclose to a target person by asking subjects to rate each of the items using a 4 point scale:

-1 Would lie or misrepresent myself.
0 Would tell the person nothing about me.
1 Would talk in general terms about the item. The other person would have only a general idea about this aspect of me.
2 Would talk in full and complete detail about this item. He could know me fully in this respect and could describe me accurately.

The items are classified into groups of 10 within each of the more general categories of information. The categories of self-disclosure content are as follows: (a) attitudes and opinions, (b) tastes and interests, (c) work (or studies), (d) money, (e) personality, (f) body. The purpose of the questionnaire is to elicit the subject's estimates of future self-disclosure to a target person within a specified context. For the purpose of this research it is the
subject's willingness to disclose to a counselor within the context of a therapeutic relationship. Both a pretest and posttest were given.

Reliability. The general psychometric quality is considered quite good. Jourard and Lasakow reported (1958) an odd-even split-half reliability coefficients between +.78 and +.99 for six of the ten topic areas. Fiske (1966) compared the WTD favorably with widely used tests and questionnaires.

Validity. Campbell and Fiske (1959), using a multi-trait-multimethod matrix, found both convergent and discriminative validity for the WTD. Jourard (1961) found a significant correlation between scores on the WTD and Rorschach productivity ($\phi = .37, n = 270$) which suggests that there was some evidence for construct validity.

While reliability and construct validity appear sound, the predictive validity of the WTD as a measure of general disclosure has been seriously questioned. Himelstern and Kimbrough (1963) found a correlation of only +.10 with the number of items of information revealed during self introductions in a classroom setting. Berhenne and Mirels (1970), Pedersen and Breglio (1968) have reported non-significant correlations between the WTD and ratings of intimacy in self-descriptive essays. This is supported by Hurly and Hurly (1969), Lubin and Harrison (1964) who report
a failure to find significant correlations between ratings of disclosure in a group setting and scores on the WTD. Vondracek (1969a, 1969b) also failed to find a significant relationship between time spent talking and ratings of intimacy in structured interviews and scores on the WTD.

While reports of past disclosure did not predict interview behavior, Wilson and Rappaport (1974) did find that self-reported measures of generalized expectancy of the WTD (60 items) did predict actual interview disclosure to a stranger. Similarly, Simonson and Bahr (1974) reported a correlation of +.78 between self-reported willingness to disclose to the therapist.

These various studies suggest with somewhat discrepant findings that the WTD is a fairly valid measure of past disclosure to specific target persons, and with appropriate instruction, to a future person. The negative results probably can best be explained by the nature of the disclosure setting and the particular disclosure setting in which the WTD was filled out. In other words, given the importance of social situational variables, it is not surprising to find that self-report measures of past disclosure to specified individuals or targets are at variance with behavioral measures of on-going self-disclosure within specific new situations.

A copy of the instrument is in Appendix P.
The Structured Interview Questionnaire

The Structured Interview was developed from Hopkinson's (1980) research in paradoxical directives. Its aim was to formulate behavioral descriptions of the current problem and outcome criteria for the future. It was also designed to assist the counselor in a treatment plan for the sessions.

The four major questions are to be rated on a Likert scale and a subjective description is to be taken.

Reliability and validity. The outcome criteria formulated by the student in the first interview and the evaluation of that outcome criteria by each student was done by self-report.

According to Derogatis and Melisaratos (Note, 1), self-report dates back to World War I when Woodworth (1918) developed the personal data sheet. He lists several unique advantages to self-report which are applicable to this study. One, self-report measures information derived directly from the person experiencing the phenomenon; second, it is economical in time; and third, self-report inventories have been shown to be highly sensitive to a wide variety of therapeutic interventions (Keller, 1971; Lyerly & Abbott, 1964) and to have a high incidence of "increment validity" (Sechrest, 1963).
Derogatis and Melisaratos warn that self-report assumes the validity of the "inventory premise." That is, the individual being assessed can and will accurately describe his current symptoms and behavior (Wilde, 1972).

There is evidence to suggest that this does not always hold true, since a variety of factors can distort the validity of a self-report. Distortion can arise out of social desirability (Edwards, 1957) and from response styles such as acquiescence. Despite these weaknesses, Nunnally (cited in Derogatis & Melisaratos, Note 1) has clearly pointed out,

Even though self inventories definitely have their problems as approaches to the measurement of personality characteristics, attitudes, values and a variety of other non-cognitive traits, they represent by far the best approach available (p. 2).

Based on the above discussion, for the purposes of this dissertation the following operating assumption is used: if one is to assume a verbal or written report for the existence of a problem in the context of a confidential setting, it is appropriate to accept a verbal or written report for the improvement or lack of improvement of a problem.

Research Design

The research design used in this study is Campbell and Stanley's (1963) pre and posttest control group design. The design is as follows:
Experimental group 1:  \( R \ 0_1 \ X_1 \ 0_2 \)
Experimental group 2:  \( R \ 0_3 \ X_2 \ 0_4 \)
Experimental group 3:  \( R \ 0_5 \ X_3 \ 0_6 \)
Control group:  \( R \ 0_7 \ 0_8 \)

Key: An "R" indicates that subjects were randomly assigned to treatments. "X" represents exposure to an independent variable manipulated by the researcher, the effects of which are to be measured. "O" refers to the pre and post tests. "C" refers to the counselors. All symbols in a row apply to the same specific group.

Stated symbolically below is the treatment design organized according to the nine counselors.

\[
\begin{array}{cccccccc}
C_1 & C_2 & C_3 & C_4 & C_5 & C_6 & C_7 & C_8 & C_9 \\
X_1 & C_1X_1 & C_4X_1 & C_7X_1 \\
R & X_2 & C_2X_2 & C_5X_2 & C_8X_2 \\
X_3 & C_3X_3 & C_6X_3 & C_9X_3 \\
\end{array}
\]

Treatment Effects = 
\[
\frac{C_1X_1 + C_4X_1 + C_7X_1}{3} = \frac{C_2X_2 + C_5X_2 + C_8X_2}{3} = \frac{C_3X_3 + C_6X_3 + C_9X_3}{3}
\]

The pre-treatment interview was approximately 60-80 minutes. There were three weekly meetings where treatment was given. These sessions lasted 50 minutes. The post-treatment outcome meeting and debriefing lasted approximately 30 minutes.
Data Processing

In order to prepare for statistical analysis, the various protocols were scored by the researcher and his associates. All protocols were hand scored.

Statistical Analysis

Statistical methods were chosen to determine significant differences between treatments on the dependent variables. Major hypotheses 1 to 4 were analyzed by a one-way MANOVA with alpha set at the .05 level of significance. Secondary hypotheses 1 and 2 were analyzed by a t-test between groups with alpha set at the .05 level of significance.

The MANOVA SPSS program of statistical analysis was used on the IBM 370/145 computer at the College of William and Mary.

Hypotheses

Below the major and secondary hypotheses relevant to the problem examined by the present study are stated in their null form and as statistical alternatives.

Major Hypotheses

1. There is no significant difference in self-rated problem relief between subjects in paradoxical directives,
client centered, rational emotive counseling and/or control groups.

Symbolically: $H_0^1$: \[
\frac{\bar{X}_{1.1} + \bar{X}_{1.2} + \bar{X}_{1.3}}{3} =
\frac{\bar{X}_{2.1} + \bar{X}_{2.2} + \bar{X}_{2.3}}{3} = \frac{\bar{X}_{3.1} + \bar{X}_{3.2} + \bar{X}_{3.3}}{3} = \bar{X}_{4.0}
\]

Legend: $\bar{X}_{1.1} = \text{mean of group receiving client-centered treatment from client-centered counselor 1.}$

$\bar{X}_{1.2} = \text{mean of group receiving client-centered treatment from client-centered counselor 2.}$

$\bar{X}_{1.3} = \text{mean of group receiving client-centered treatment from client-centered counselor 3.}$

$\bar{X}_{2.1} = \text{mean of group receiving rational emotive treatment from rational emotive counselor 1.}$

$\bar{X}_{2.2} = \text{mean of group receiving rational emotive treatment from rational emotive counselor 2.}$

$\bar{X}_{2.3} = \text{mean of group receiving rational emotive treatment from rational emotive counselor 3.}$

$\bar{X}_{3.1} = \text{mean of group receiving paradoxical directives treatment from paradoxical directives counselor 1.}$

$\bar{X}_{3.2} = \text{mean of group receiving paradoxical directives treatment from paradoxical directives counselor 2.}$

$\bar{X}_{3.3} = \text{mean of group receiving paradoxical directives treatment from paradoxical directives counselor 3.}$

$\bar{X}_{4.0} = \text{mean of control group receiving no treatment.}$
Statistical alternative: Subjects in the paradoxical directives group will evaluate self-rated problem relief as more greatly improved than subjects in the client-centered, rational emotive, and/or control groups.

\[ H_{1a}: \frac{X_{3.1} + X_{3.2} + X_{3.3}}{3} > \frac{X_{1.1} + X_{1.2} + X_{1.3}}{3} = \frac{X_{2.1} + X_{2.2} + X_{2.3}}{3} = X_{40} \]

2. There is no significant difference in the quality of the relationship between therapist and client, as measured by the Barrett-Lennard Relationship Inventory, between paradoxical directives, client-centered, and/or rational emotive therapy.

\[ H_{02}: \frac{X_{1.1} + X_{1.2} + X_{1.3}}{3} = \frac{X_{2.1} + X_{2.2} + X_{2.3}}{3} = \frac{X_{3.1} + X_{3.2} + X_{3.3}}{3} \]

Statistical alternative: Subjects in the paradoxical directives group will rate the quality of the relationship between counselor and subject higher than the subjects in the client-centered and/or rational emotive group.
3. There is no significant difference in subject willingness to disclose as measured by the Willingness-to-Disclose Questionnaire between paradoxical directives, client-centered, rational emotive and/or control groups.

\[ H_{03} : \frac{\bar{X}_{1.1} + \bar{X}_{1.2} + \bar{X}_{1.3}}{3} = \frac{\bar{X}_{2.1} + \bar{X}_{2.2} + \bar{X}_{2.3}}{3} = \frac{\bar{X}_{3.1} + \bar{X}_{3.2} + \bar{X}_{3.3}}{3} = \bar{X}_{4.0} \]

Statistical alternative: Subjects in the paradoxical directives group will express a greater willingness to disclose as measured by the Willingness-to-Disclose Questionnaire than subjects in the client-centered, rational emotive and/or control groups.

\[ H_{3a} : \frac{\bar{X}_{3.1} + \bar{X}_{3.2} + \bar{X}_{3.3}}{3} > \frac{\bar{X}_{1.1} + \bar{X}_{1.2} + \bar{X}_{1.3}}{3} = \frac{\bar{X}_{2.1} + \bar{X}_{2.2} + \bar{X}_{2.3}}{3} = \bar{X}_{4.0} \]
4. There is no significant difference at follow-up in the affects of depression, hostility, and anxiety, as measured by the Derogatis BSI, between the paradoxical directives, rational emotive, client-centered, and/or the control groups.

\[ H_{04} : \frac{X_{1.1} + X_{1.2} + X_{1.3}}{3} = \frac{X_{2.1} + X_{2.2} + X_{2.3}}{3} = \]

\[ \frac{X_{3.1} + X_{3.2} + X_{3.3}}{3} = \bar{X}_{40} \]

Statistical alternative: Subjects at follow-up in the paradoxical directives group will show a lower symptom distress level in hostility, anxiety, and/or depression than subjects in the client-centered, rational emotive, and/or control groups.

\[ H_{4a} : \frac{X_{3.1} + X_{3.2} + X_{3.3}}{3} < \frac{X_{1.1} + X_{1.2} + X_{1.3}}{3} = \]

\[ \frac{X_{2.1} + X_{2.2} + X_{2.3}}{3} \bar{X}_{40} \]

**Secondary Hypotheses**

1. There is no significant difference within the paradoxical directives group between the highest seven self-rated problem improvement and the lowest seven self-rated
problem improvement with respect to the quality of the relationship, as measured by the Barrett-Lennard Relationship Inventory.

Symbolically: \[ H_{01}: \bar{x}_{3.1} = \bar{x}_{3.2} \]

Legend: \( \bar{x}_{3.1} \) = mean of the top seven subjects in paradoxical directives group who rated problem relief highest.

\( \bar{x}_{3.2} \) = mean of the bottom seven subjects in paradoxical directives group who rated problem relief lowest.

Statistical alternative: The seven subjects in the paradoxical directives group who rate problem relief highest will have a higher mean score in the Barrett-Lennard Relationship Inventory than the seven subjects in the paradoxical group who rate problem relief lowest.

\[ H_{a1}: \bar{x}_{3.1} > \bar{x}_{3.2} \]

2. There is no significant difference in the paradoxical directives group between the seven subjects who rate problem relief highest and the seven subjects who rate problem relief lowest with respect to the quality of the relationship as measured by the Willingness-to-Disclose Questionnaire.

\[ H_{02}: \bar{x}_{3.1} = \bar{x}_{3.2} \]
Statistical alternative: The seven subjects in the paradoxical directives group who rate problem relief highest will have a higher mean score on the Willingness-to-Disclose than the seven subjects in the paradoxical directives group who rate problem relief lowest.

\[ H_{2a}: \bar{x}_{3.1} > \bar{x}_{3.2} \]

Summary

Sixty volunteer subjects from a larger population of volunteers in undergraduate and graduate courses in education at the College of William and Mary were pretested with the Brief Symptom Inventory (Derogatis & Melisaratos, Note 1), the Mooney Problem Check List (Mooney, 1950), the 40 item Willingness-to-Disclose Questionnaire (Jourard & Lasakow, 1958) and interviewed by the researcher or his associates using a structured interview format to formulate a behavioral focal problem and to set outcome criteria. The sixty subjects were then randomly assigned into one of three treatment approaches (client-centered, rational emotive, and paradoxical directives) or a control (no-treatment) group.

Nine counselors at about the same level of training were assigned to one of the three treatment approaches. Assignment was made after an informal interview by the investigator in order to assess the counselor's familiarity,
preference and belief in each of the treatment approaches. Counselors were assigned according to belief system, preference and familiarity as closely as possible. Three counselors were in each treatment, client-centered, rational emotive, and paradoxical directives. Using the assigned treatment modality, they each met with five students individually for three weekly sessions of 50 minute duration. The control group received a preliminary interview (the structured interview) and a final session only.

After the three weekly sessions, the researcher and his associates administered the following dependent variable measures: the Brief Symptom Inventory, the Willingness-to-Disclose Questionnaire and the Relationship Inventory. The control group was administered the first two measures only. A 20 to 30 minute interview was done with all subjects after the instruments were completed in which the subjects were asked to evaluate their focal problem and their attitude toward that problem. The researcher or his associates stated a letter would be sent debriefing them and directing the students to the researcher for any questions they had.

The design of the study was a randomized pre and post-test control group design. All protocols were handscored and data analyzed on the IBM 370/145 computer at the College of William and Mary. Major hypotheses 1 to 4 were analyzed
by a one-way MANOVA. Secondary hypothesis 1 and 2 were analyzed by a t-test between groups.
CHAPTER 4: RESULTS

Statistical Analysis

All data used to evaluate the major hypotheses obtained on the posttests were analyzed using a one-way MANOVA. This statistical procedure analyzes differences among the treatments themselves and the differences between counselors administering the treatment in a particular modality. It was used in this study to determine if counselor personality differences were a confounding variable affecting the results of the treatment. When the F ratio indicated a rejection of the null hypothesis of equal means, a post-hoc comparison was made using the Scheffe method in order to determine which differences were significant.

The secondary hypotheses were evaluated using a t-test between groups.

Hayes (as cited by Wheeler, 1972) lists three assumptions underlying the analysis of variance: (a) the population from which the subgroups are drawn is assumed normal; (b) for each population the distribution has a variance which is assumed to be the same for each treatment population; and (c) the errors associated with any combination
of observations are assumed to be independent. In the present study the three assumptions were met as follows: (a) The population data from which the subgroups were drawn were considered to be normally distributed. (b) The assumption of homeogeneous variances can be violated without serious risk provided the number of cases in each sample is the same. In the present study the number of cases in each sample was the same. (c) Subjects were randomly assigned to treatments and were, therefore, independent.

The results of the statistical analysis are presented by hypothesis.

Hypothesis 1

There is no significant difference in self-rated problem relief between subjects in paradoxical directives, client-centered, rational emotive counseling and/or control groups.

\[
H_0: \frac{\bar{X}_{1.1} + \bar{X}_{1.2} + \bar{X}_{1.3}}{3} = \frac{\bar{X}_{2.1} + \bar{X}_{2.2} + \bar{X}_{2.3}}{3} = \frac{\bar{X}_{3.1} + \bar{X}_{3.2} + \bar{X}_{3.3}}{3} = \bar{X}_{4.0}
\]

Legend: \( \bar{X}_{1.1} \) = mean of group receiving client-centered treatment from client-centered counselor 1.

\( \bar{X}_{1.2} \) = mean of group receiving client-centered treatment from client-centered counselor 2.
\[ \bar{X}_{1.3} = \text{mean of group receiving client-centered treatment from client-centered counselor 3.} \]

\[ \bar{X}_{2.1} = \text{mean of group receiving rational emotive treatment from rational emotive counselor 1.} \]

\[ \bar{X}_{2.2} = \text{mean of group receiving rational emotive treatment from rational emotive counselor 2.} \]

\[ \bar{X}_{2.3} = \text{mean of group receiving rational emotive treatment from rational emotive counselor 3.} \]

\[ \bar{X}_{3.1} = \text{mean of group receiving paradoxical directives treatment from paradoxical directives counselor 1.} \]

\[ \bar{X}_{3.2} = \text{mean of group receiving paradoxical directives treatment from paradoxical directives counselor 2.} \]

\[ \bar{X}_{3.3} = \text{mean of group receiving paradoxical directives treatment from paradoxical directives counselor 3.} \]

\[ \bar{X}_{4.0} = \text{mean of control group receiving no treatment.} \]

This hypothesis was evaluated on the basis of a single dependent measure of outcome. The measure came from asking the subject during the interview in the final session to select one of the four descriptive phases representing change in the problem that the subject had described approximately four weeks earlier in the structured interview.

MANOVA analysis resulted in an \( F \) value of 11.71 for the effects of the treatment. With \( F \) significant at the .003 level of probability, the indication is that the groups differed significantly and the null hypothesis was rejected.

\[ H_1: \ (F = 11.7, \ df 3/48, \ p < .003). \]
In comparing the differences among the three counselors using the same treatment modality, MANOVA analysis resulted in an $F$ value of 1.45. With $F$ not significant at the .05 level of probability, the indication is that the subject's self-rated outcome improvement within each treatment approach did not differ significantly by counselor. These results suggest that counselor personality variables were not a confounding factor in the study. It appears that differences among groups can be explained on the basis of treatment effects. $H_1$: $(F = 1.45, df 8/48, p < .20)$.

Table 3 presents the means and standard deviations summarized according to treatment modalities and according to counselors within each treatment. Table 4 summarizes MANOVA analysis of treatment effects and differential effects of counselors within treatment.

A post-hoc comparison using the Scheffe method indicated that the three treatment group means, though not significantly different from each other ($\bar{X}_2 = 3.26$, $\bar{X}_1 = 3.40$, and $\bar{X}_3 = 3.40$), were each showing significantly greater improvement than the control group ($\bar{X}_4 = 2.133$). Table 3 presents the data for comparison. Based on the above analysis, the three treatments produced a more favorable outcome than the control (no treatment) group but the three treatments were not significantly different from each other.
Table 3

Hypothesis 1
Summary of Means and Standard Deviations
Grouped According to Treatment and
Counselors Within Treatment
On Scores of Outcome Improvement

<table>
<thead>
<tr>
<th>Treatment</th>
<th>n</th>
<th>Mean</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>$X_1$ (Client-centered)</td>
<td>15</td>
<td>3.40</td>
<td>.507</td>
</tr>
<tr>
<td>$X_2$ (Rational emotive)</td>
<td>15</td>
<td>3.26</td>
<td>.593</td>
</tr>
<tr>
<td>$X_3$ (Paradoxical directives)</td>
<td>15</td>
<td>3.40</td>
<td>.507</td>
</tr>
<tr>
<td>$X_4$ (Control)</td>
<td>15</td>
<td>2.13</td>
<td>.74</td>
</tr>
<tr>
<td>Total</td>
<td>60</td>
<td>3.05</td>
<td>.7903</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Treatment</th>
<th>n</th>
<th>Mean</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>$X_{1.1}$ C C</td>
<td>5</td>
<td>3.80</td>
<td>.447</td>
</tr>
<tr>
<td>$X_{1.2}$ C C</td>
<td>5</td>
<td>3.20</td>
<td>.447</td>
</tr>
<tr>
<td>$X_{1.3}$ C C</td>
<td>5</td>
<td>3.20</td>
<td>.447</td>
</tr>
<tr>
<td>$X_{2.1}$ R E</td>
<td>5</td>
<td>3.20</td>
<td>.447</td>
</tr>
<tr>
<td>$X_{2.2}$ R E</td>
<td>5</td>
<td>3.0</td>
<td>.70</td>
</tr>
<tr>
<td>$X_{2.3}$ R E</td>
<td>5</td>
<td>3.60</td>
<td>.54</td>
</tr>
<tr>
<td>$X_{3.1}$ P D</td>
<td>5</td>
<td>3.6</td>
<td>.547</td>
</tr>
<tr>
<td>$X_{3.2}$ P D</td>
<td>5</td>
<td>3.6</td>
<td>.547</td>
</tr>
<tr>
<td>$X_{3.3}$ P D</td>
<td>5</td>
<td>3.0</td>
<td>.0</td>
</tr>
<tr>
<td>$X_{4.1}$ C G</td>
<td>5</td>
<td>2.4</td>
<td>.894</td>
</tr>
<tr>
<td>$X_{4.2}$ C G</td>
<td>5</td>
<td>2.0</td>
<td>.70</td>
</tr>
<tr>
<td>$X_{4.3}$ C G</td>
<td>5</td>
<td>2.0</td>
<td>.70</td>
</tr>
<tr>
<td>Total</td>
<td>60</td>
<td>3.05</td>
<td>.79</td>
</tr>
</tbody>
</table>

4.00 means maximal improvement
3.00 means minimal improvement
2.00 means the same or no claimed improvement
1.00 means the problem got worse
Table 4

Hypothesis 1
Summary of MANOVA analysis
For Treatment Effects and Counselor Effects
On Scores of Outcome Improvement

<table>
<thead>
<tr>
<th>Source of Variance</th>
<th>Sum of Squares</th>
<th>Degrees of Freedom</th>
<th>Mean Square</th>
<th>F</th>
<th>Level of Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment</td>
<td>16.98333</td>
<td>3</td>
<td>5.66</td>
<td>11.71</td>
<td>.003</td>
</tr>
<tr>
<td>Counselor error</td>
<td>3.866</td>
<td>8</td>
<td>.483</td>
<td>1.45</td>
<td>.201</td>
</tr>
<tr>
<td>Within cells</td>
<td>16.00</td>
<td>48</td>
<td>.333</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
When inspecting treatment means, it appears that the client-centered and paradoxical directives approaches were both equally effective. Students in those groups claimed the most favorable improvements. This was followed closely by the rational emotive group. The mean score of all students receiving treatment signified a description of at least minimal improvement in self-rated outcome.

**Hypothesis 2**

There is no significant difference in the quality of the relationship between therapist and client as measured by the Barrett-Lennard Relationship Inventory between paradoxical directives, client-centered, and/or rational emotive therapy groups.

\[
H_0^2: \frac{X_{1.1} + X_{1.2} + X_{1.3}}{3} = \frac{X_{2.1} + X_{2.2} + X_{2.3}}{3} = \frac{X_{3.1} + X_{3.2} + X_{3.3}}{3}
\]

This hypothesis was evaluated on the basis of the summation of the test scores on the four scales of the Barrett-Lennard Relationship Inventory. The measure came from requesting the subjects in the treatment groups to complete the Barrett-Lennard Relationship Inventory a few minutes prior to the final interview.
MANOVA analysis resulted in an $F$ value of .9533 for the effects of treatment. With $F$ not significant at the .437 level of probability, the indication is that the three groups using one of the treatment approaches were not evaluated significantly different by the treated subjects on the quality of the relationship formed between counselor and client. $H_2$: ($F = .95$, df $2/36$, $p < .436$). Based on the analysis of this dependent variable, the null hypothesis was not rejected.

In comparing the differences among the three counselors using the same treatment modality, MANOVA analysis resulted in an $F$ value of 1.90. With $F$ not significant at the .108 level of probability, the indication is that the three counselors using the same modality in each of the three treatment groups were not evaluated significantly different by the treated subjects on the quality of the relationship formed between counselor and client. $H_2$: ($F = 1.90$, df $3/36$, $p < .108$).

These results suggest that neither the quality of the relationships formed by the nine counselors using the three different treatment approaches, nor the quality of the relationship formed by the three counselors using the same treatment approach are confounding variables in the study.

Table 5 presents the means and standard deviations summarized according to treatment modalities and according to
Table 5  
Hypothesis 2  
Summary of Means and Standard Deviations  
Grouped According to Treatment and  
Counselors Within Treatment  
For the Barrett-Lennard Relationship Inventory  

<table>
<thead>
<tr>
<th>Treatment</th>
<th>n</th>
<th>Mean</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>$X_1$ (Client-centered)</td>
<td>15</td>
<td>100.47</td>
<td>39.97</td>
</tr>
<tr>
<td>$X_2$ (Rational emotive)</td>
<td>15</td>
<td>88.33</td>
<td>31.77</td>
</tr>
<tr>
<td>$X_3$ (Paradoxical directives)</td>
<td>15</td>
<td>109.67</td>
<td>24.55</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>45</td>
<td>99.48</td>
<td>33.15</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Treatment</th>
<th>n</th>
<th>Mean</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>$X_{1.1}$ CC</td>
<td>5</td>
<td>123.80</td>
<td>43.28</td>
</tr>
<tr>
<td>$X_{1.2}$ CC</td>
<td>5</td>
<td>98.40</td>
<td>38.40</td>
</tr>
<tr>
<td>$X_{1.3}$ CC</td>
<td>5</td>
<td>79.20</td>
<td>31.49</td>
</tr>
<tr>
<td>$X_{2.1}$ RE</td>
<td>5</td>
<td>67.60</td>
<td>34.26</td>
</tr>
<tr>
<td>$X_{2.2}$ RE</td>
<td>5</td>
<td>114.20</td>
<td>22.39</td>
</tr>
<tr>
<td>$X_{2.3}$ RE</td>
<td>5</td>
<td>83.20</td>
<td>21.22</td>
</tr>
<tr>
<td>$X_{3.1}$ PD</td>
<td>5</td>
<td>110.80</td>
<td>25.21</td>
</tr>
<tr>
<td>$X_{3.2}$ PD</td>
<td>5</td>
<td>105.00</td>
<td>36.24</td>
</tr>
<tr>
<td>$X_{3.3}$ PD</td>
<td>5</td>
<td>113.20</td>
<td>10.75</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>45</td>
<td>99.48</td>
<td>33.15</td>
</tr>
</tbody>
</table>

The higher the score the more positive the relationship reported.
counselors using a particular treatment. Table 6 summarizes MANOVA analysis of the treatment effects and the differential effects of the counselor within treatment.

Though not significantly lower, the rational emotive group mean of this measure is 12 points lower than either client-centered or paradoxical directives. This may indicate that RET counselors may have been less concerned about the relationship than counselors in the other groups, and could possibly have been more confrontative. This is characteristic of the RET style.

**Hypothesis 3**

There is no significant difference in subject willingness to disclose as measured by the Willingness-to-Disclose Questionnaire between paradoxical directives, client-centered, rational emotive, and/or control groups.

\[
H_0^3: \frac{X_{1.1} + X_{1.2} + X_{1.3}}{3} = \frac{X_{2.1} + X_{2.2} + X_{2.3}}{3} = \frac{X_{3.1} + X_{3.2} + X_{3.3}}{3} = X_{4.0}
\]

The dependent measure used to evaluate hypothesis 3 was the score based on the Jourard-Lasakow 40-item Willingness-to-Disclose scale. The measure came from requesting
Table 6
Hypothesis 2
Summary of MANOVA Analysis
For Treatment Effects and Counselor Effects
For Relationship Inventory Scores

<table>
<thead>
<tr>
<th>Source of Variance</th>
<th>Sum of Squares</th>
<th>Degrees of Freedom</th>
<th>Mean Square</th>
<th>F</th>
<th>level of Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment</td>
<td>3434.84</td>
<td>2</td>
<td>1717.422</td>
<td>.95331</td>
<td>.437</td>
</tr>
<tr>
<td>Counselor error</td>
<td>10809.20</td>
<td>6</td>
<td>1801.533</td>
<td>1.90040</td>
<td>.108</td>
</tr>
<tr>
<td>Within cells</td>
<td>34127.200</td>
<td>36</td>
<td>947.9478</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
subjects in the treatment groups to complete the Willingness-to-Disclose Questionnaire a few minutes prior to the final evaluation.

MANOVA analysis resulted in an $F$ value of .21130 for the effects of treatment. With $F$ not significant at the .886 level, the indication is that the subjects in the three treatment approaches and/or the control group did not express a significant difference in their willingness to disclose themselves to a counselor during the three treatment sessions or in future treatment sessions (control group).

$H_3$: ($F = .21130$, $df 8/48$, $p < .886$). Based on the analysis of this dependent variable, the null hypothesis cannot be rejected.

In comparing the differences among the three counselors using the same treatment modality, MANOVA analysis resulted in an $F$ value of .71633. With $F$ not significant at the .676 level of probability, the indication is that the subjects having one of the three different counselors who used the same treatment approach did not express a greater willingness to disclose in any of the groups. $H_3$: ($F = .716$, $df 8/48$, $p < .676$). These results suggest that none of the treatment modalities as used by the counselors in the study has any differential effect on the subject's desire to disclose themselves in a counseling situation.
Table 7 presents the means and standard deviations summarized according to treatment modalities and according to counselors within treatment. Table 8 summarizes MANOVA analysis of the treatment effects and the differential effects of counselors with treatment.

In addition to posttest analysis, a pretest one-way analysis of variance was done comparing subject scores on the Willingness-to-Disclose Questionnaire. The rationale for this procedure was to evaluate whether differences existed in any of the groups prior to treatment. Results are summarized in Table 9. These results indicated an F of .388 for the differences among groups. This was not significant at the .76 level of probability. Because no statistical significance was found, these pretest data were not subjected to a pre-post test statistical comparison.

The mean scores of each group were compared before and after treatment. Table 9 presents a summary of the pretest data and Figure 1 provides depiction of the group mean scores. In general, the average student in the paradoxical directives and rational emotive group expressed an equal and slightly greater willingness to disclose after completing treatment than the client-centered group. The client-centered group initially stated a greater willingness to disclose than the other two treatment groups but this
Table 7

Hypothesis 3
Summary of Means and Standard Deviations
Grouped According to Treatment and Counselors Within Treatment on Posttest Scores on the Willingness-to-Disclose Questionnaire

<table>
<thead>
<tr>
<th>Treatment</th>
<th>n</th>
<th>Mean</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>X₁ (Client-centered)</td>
<td>15</td>
<td>74.07</td>
<td>7.42</td>
</tr>
<tr>
<td>X₂ (Rational emotive)</td>
<td>15</td>
<td>73.33</td>
<td>8.61</td>
</tr>
<tr>
<td>X₃ (Paradoxical directives)</td>
<td>15</td>
<td>74.27</td>
<td>7.04</td>
</tr>
<tr>
<td>X₄ (Control)</td>
<td>15</td>
<td>75.27</td>
<td>7.94</td>
</tr>
<tr>
<td>Total</td>
<td>60</td>
<td>74.23</td>
<td>7.60</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>n</th>
<th>Mean</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>X₁.₁ CC</td>
<td>5</td>
<td>73.40</td>
<td>8.35</td>
</tr>
<tr>
<td>X₁.₂ CC</td>
<td>5</td>
<td>73.40</td>
<td>10.47</td>
</tr>
<tr>
<td>X₁.₃ CC</td>
<td>5</td>
<td>75.40</td>
<td>3.13</td>
</tr>
<tr>
<td>X₂.₁ RE</td>
<td>5</td>
<td>72.70</td>
<td>3.70</td>
</tr>
<tr>
<td>X₂.₂ RE</td>
<td>5</td>
<td>78.64</td>
<td>2.04</td>
</tr>
<tr>
<td>X₂.₃ RE</td>
<td>5</td>
<td>69.60</td>
<td>13.88</td>
</tr>
<tr>
<td>X₃.₁ PD</td>
<td>5</td>
<td>72.60</td>
<td>8.32</td>
</tr>
<tr>
<td>X₃.₂ PD</td>
<td>5</td>
<td>72.20</td>
<td>8.61</td>
</tr>
<tr>
<td>X₃.₃ PD</td>
<td>5</td>
<td>78.00</td>
<td>1.87</td>
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<tr>
<td>X₄.₁ CG</td>
<td>5</td>
<td>76.80</td>
<td>2.82</td>
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<tr>
<td>X₄.₂ CG</td>
<td>5</td>
<td>77.80</td>
<td>2.34</td>
</tr>
<tr>
<td>X₄.₃ CG</td>
<td>5</td>
<td>72.80</td>
<td>13.97</td>
</tr>
<tr>
<td>Total</td>
<td>60</td>
<td>74.23</td>
<td>7.60</td>
</tr>
</tbody>
</table>

The higher the score the greater willingness-to-disclose reported.
### Table 8

**Hypothesis 3**  
Summary of MANOVA Analysis  
For Treatment Effects and Counselor Effects  
On Posttest Scores of the Willingness-to-Disclose Questionnaire

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>Degrees of Freedom</th>
<th>Mean Square</th>
<th>F</th>
<th>Level of Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment</td>
<td>28.60</td>
<td>3</td>
<td>9.53</td>
<td>.211</td>
<td>.886</td>
</tr>
<tr>
<td>Counselor error</td>
<td>360.93</td>
<td>8</td>
<td>45.116</td>
<td>.716</td>
<td>.676</td>
</tr>
<tr>
<td>Within cells</td>
<td>3023.20</td>
<td>48</td>
<td>62.98</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 9
Summary of Pretest Scores
On the Willingness-to-Disclose Questionnaire
Grouped According to Treatment

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Mean</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>$X_1$ (Client-centered)</td>
<td>76.0</td>
<td>6.24</td>
</tr>
<tr>
<td>$X_2$ (Rational emotive)</td>
<td>70.93</td>
<td>9.10</td>
</tr>
<tr>
<td>$X_3$ (Paradoxical directives)</td>
<td>72.20</td>
<td>8.78</td>
</tr>
<tr>
<td>$X_4$ (Control)</td>
<td>75.00</td>
<td>7.02</td>
</tr>
<tr>
<td>Total</td>
<td>73.53</td>
<td>7.95</td>
</tr>
</tbody>
</table>

Analysis of Variance

<table>
<thead>
<tr>
<th>Source</th>
<th>DF</th>
<th>Sum of Squares</th>
<th>Mean Square</th>
<th>F ratio</th>
<th>Level of Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between groups</td>
<td>3</td>
<td>251.6174</td>
<td>83.8725</td>
<td>1.351</td>
<td>0.2673</td>
</tr>
<tr>
<td>Within groups</td>
<td>56</td>
<td>3477.3298</td>
<td>62.0952</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>59</td>
<td>3728.9473</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Figure 1

Mean Scaled Score on Willingness-to-Disclose
As a Function of Group Measure

Client-centered
Rational emotive
Paradoxical directives
Control group

Pre-measure  Post-measure
decreased slightly after treatment. The control group mean did not change at all while waiting for treatment.

**Hypothesis 4a**

There is no significant difference in the affect of depression as measured by the Derogatis BSI between the paradoxical directives, rational emotive, and client-centered and/or control groups.

\[ H_{04a}: \frac{X_{1.1} + X_{1.2} + X_{1.3}}{3} = \frac{X_{2.1} + X_{2.2} + X_{2.3}}{3} = \frac{X_{3.1} + X_{3.2} + X_{3.3}}{3} = X_{4.0} \]

This hypothesis was evaluated on the basis of scores from the depression scale of the Brief Symptom Inventory. The measure came from requesting subjects in the four groups to complete the Brief Symptom Inventory a few minutes prior to the final interview.

MANOVA analysis resulted in an \( F \) value of .256 for the effects of treatment. With an \( F \) not significant at the .855 level of probability, the indication is that subjects in the four groups did not claim a significantly different reduction in depressed affect following any type of treatment or no treatment. \( H_{4a}: (F = .256, df 3/48, p < .855) \). Based
on the analysis of this dependent variable, the null hypothesis cannot be rejected.

In comparing the differences among the subjects receiving treatment, grouped according to counselors who used the same treatment modality, MANOVA analysis resulted in an $F$ value of 1.23. With an $F$ not significant at the .297 level, the indication is that the subjects receiving treatment from any one of the three counselors within a particular treatment modality did not differ significantly in claimed reduction of depressed affect. $H_{4a}$: ($F = 1.239$, df 8/48, $p < .297$). These results suggest that no one treatment or no treatment is any more effective in reducing self-reported depressed affect than any other. Results also seem to indicate that counselor personality was not a confounding factor on this measure.

Table 10 presents the means and standard deviations summarized according to treatment modalities and according to counselors with each treatment. Table 11 summarizes MANOVA analysis of the treatment effects and the differential effects of the counselor within treatment.

In addition to a posttest analysis, as a pretest a one-way analysis of variance was done comparing subject scores on the depression scale of the Brief Symptom Inventory. The rationale for this procedure was to evaluate whether differences existed in any of the groups prior to
Table 10
Hypothesis 4a
Summary of Means and Standard Deviations
Grouped According to Treatment and
Counselors Within Treatment
On the Depressive Scale of the Brief Symptom Inventory

<table>
<thead>
<tr>
<th>Treatment</th>
<th>n</th>
<th>Mean</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>$X_1$ (Client-centered)</td>
<td>15</td>
<td>.50</td>
<td>.65</td>
</tr>
<tr>
<td>$X_2$ (Rational emotive)</td>
<td>15</td>
<td>.48</td>
<td>.47</td>
</tr>
<tr>
<td>$X_3$ (Paradoxical directives)</td>
<td>15</td>
<td>.49</td>
<td>.61</td>
</tr>
<tr>
<td>$X_4$ (Control)</td>
<td>15</td>
<td>.66</td>
<td>.61</td>
</tr>
<tr>
<td>Total</td>
<td>60</td>
<td>.53</td>
<td>.57</td>
</tr>
</tbody>
</table>

| $X_{1.1}^{CC}$                                | 5  | .73  | .60                |
| $X_{1.2}^{CC}$                                | 5  | .50  | .93                |
| $X_{1.3}^{CC}$                                | 5  | .26  | .30                |
| $X_{2.1}^{RE}$                                | 5  | .26  | .22                |
| $X_{2.2}^{RE}$                                | 5  | .80  | .68                |
| $X_{2.3}^{RE}$                                | 5  | .36  | .21                |
| $X_{3.1}^{PD}$                                | 5  | .23  | .27                |
| $X_{3.2}^{PD}$                                | 5  | .86  | .93                |
| $X_{3.3}^{PD}$                                | 5  | .36  | .21                |
| $X_{4.1}^{CG}$                                | 5  | .40  | .34                |
| $X_{4.2}^{CG}$                                | 5  | .60  | .54                |
| $X_{4.3}^{CG}$                                | 5  | .96  | .81                |
| Total                                         | 60 | .53  | .57                |

The higher the score the more depression reported.
Table 11
Hypothesis 4a
Summary of Posttest MANOVA Analysis
Of Treatment Effects and Counselor Effects
On the Depression Scale of the Brief Symptom Inventory

<table>
<thead>
<tr>
<th>Source of Variance</th>
<th>Sum of Squares</th>
<th>Degrees of Freedom</th>
<th>Mean Square</th>
<th>F</th>
<th>Level of Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment</td>
<td>.31635</td>
<td>3</td>
<td>.10545</td>
<td>.256</td>
<td>.855</td>
</tr>
<tr>
<td>Counselor error</td>
<td>3.28</td>
<td>8</td>
<td>.41098</td>
<td>1.23943</td>
<td>.297</td>
</tr>
<tr>
<td>Within cells</td>
<td>15.91</td>
<td>48</td>
<td>.33158</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
treatment. Results are summarized in Table 12. The results indicated an F of .388 for the differences among the groups. This was not significant at the .7619 level of probability. Because no statistical significance was found on the pre-test, the data were not subjected to a pre-post test statistical comparison.

The means of each group were compared before and after treatment. Table 12 presents a summary of the data; the cell means are depicted in Figure 2. In general, the average treated subject reported a decrease in self-reported depressed affect in all of the treatment groups. Subjects in the client-centered group claimed the most decrease followed by rational emotive and paradoxical directives, which claimed a decrease in equal degree. The control group claimed a slight increase in depression over the four week waiting period.

**Hypothesis 4b**

There is no significant difference in the affect of anxiety among subjects as measured by the Derogatis BSI between paradoxical directives, rational emotive, client-centered and/or control groups.
Table 12
Summary of Pretest Scores
On the Depression Scale of the Brief Symptom Inventory
Grouped According to Treatment

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Mean</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>$X_1$ (Client-centered)</td>
<td>.8220</td>
<td>.5300</td>
</tr>
<tr>
<td>$X_2$ (Rational emotive)</td>
<td>.666</td>
<td>.4792</td>
</tr>
<tr>
<td>$X_3$ (Paradoxical directives)</td>
<td>.6330</td>
<td>.7114</td>
</tr>
<tr>
<td>$X_4$ (Control)</td>
<td>.6420</td>
<td>.4571</td>
</tr>
<tr>
<td>Total</td>
<td>.6903</td>
<td>.5448</td>
</tr>
</tbody>
</table>

Analysis of Variance

<table>
<thead>
<tr>
<th>Source</th>
<th>DF</th>
<th>Sum of Squares</th>
<th>Mean Square</th>
<th>F ratio</th>
<th>Level of Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between groups</td>
<td>3</td>
<td>.3569</td>
<td>.1190</td>
<td>.388</td>
<td>.7619</td>
</tr>
<tr>
<td>Within groups</td>
<td>56</td>
<td>17.1569</td>
<td>.3054</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>59</td>
<td>17.5138</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Figure 2
Mean Scaled Score on Self-Rated Change
In Affect-Depression Relief

Client-centered
Rational emotive
Paradoxical directives
Control group
This hypothesis was evaluated on the basis of scores from the anxiety scale of the Brief Symptom Inventory. The measure came from requesting subjects in the four groups to complete the Brief Symptom Inventory a few minutes prior to the final interview.

MANOVA analysis resulted in an $F$ value of 10.57 for the effects of the treatment. With an $F$ significant at the .004 level of probability, the indication is that the group differed significantly in the claimed reduction of anxiety. Based on the analysis of this dependent variable, the null hypothesis was rejected. $H_{04b}$: ($F = 10.57$, $df = 3/48$, $p < .004$).

In comparing the differences among subjects grouped according to counselors in the same treatment modality, MANOVA analysis resulted in an $F$ value of .26591. With $F$ not significant at the .297 level, the indication is that subjects receiving treatment from a particular counselor in any one modality did not differ significantly from the other two counselors in that same modality on self-reported reduction of anxiety. $H_{4b}$: ($F = .265$, $df = 8/48$, $p < .974$). Differences in treatment rather than counselor effects
suggest that the reduction of anxiety may be due to the treatment rather than the person of the counselor. The results suggest that one particular treatment modality may be more effective than the others in reducing self-reported anxiety as measured by the anxiety scale of the Brief Symptom Inventory.

Table 13 presents the means and standard deviations summarized according to treatment modalities and according to counselors within each treatment. Table 14 summarizes MANOVA analysis of treatment effects and differential effects of the counselor within the treatment.

A post-hoc comparison using the Scheffé method indicated that the paradoxical directives group mean ($X_3 = .3227$) was significantly lower than the control group mean ($X_4 = .7320$). The other group means, client-centered ($X_1 = .4860$) and rational emotive ($X_2 = .6213$) were not significantly lower than each other or the control group mean. Based on the above analysis, results suggest the paradoxical directives treatment approach seems to be more effective in reducing self-reported anxiety when compared to the control group. When client-centered and rational emotive are compared to the control group, the results indicate no significant difference. Table 13 presents the data for comparison. The data also suggest that the paradox group mean is also lower than the other treatment group means, but not statistically significant.
Table 13

Hypothesis 4b
Summary of Means and Standard Deviations
Grouped According to Treatment and Counselors Within Treatment
On the Anxiety Scale of the Brief Symptom Inventory

<table>
<thead>
<tr>
<th>Treatment</th>
<th>n</th>
<th>Mean</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>( X_1 ) (Client-centered)</td>
<td>15</td>
<td>.49</td>
<td>.41</td>
</tr>
<tr>
<td>( X_2 ) (Rational emotive)</td>
<td>15</td>
<td>.62</td>
<td>.33</td>
</tr>
<tr>
<td>( X_3 ) (Paradoxical directives)</td>
<td>15</td>
<td>.32</td>
<td>.27</td>
</tr>
<tr>
<td>( X_4 ) (Control)</td>
<td>15</td>
<td>.73</td>
<td>.49</td>
</tr>
<tr>
<td>Total</td>
<td>60</td>
<td>.54</td>
<td>.40</td>
</tr>
</tbody>
</table>

\( X_{1.1}^{CC} \)  
\( X_{1.2}^{CC} \)  
\( X_{1.3}^{CC} \)  
\( X_{2.1}^{RE} \)  
\( X_{2.2}^{RE} \)  
\( X_{2.3}^{RE} \)  
\( X_{3.1}^{PD} \)  
\( X_{3.2}^{PD} \)  
\( X_{3.3}^{PD} \)  
\( X_{4.1}^{CG} \)  
\( X_{4.2}^{CG} \)  
\( X_{4.3} \)  
Total

60  .54  .40

The higher the score the more anxiety reported.
Table 14
Hypothesis 4b
Summary of Posttest MANOVA Analysis
Of Treatment Effects and Counselor Effects
On the Anxiety Scale of the Brief Symptom Inventory

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>Degrees of Freedom</th>
<th>Mean Square</th>
<th>F</th>
<th>Level of Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment</td>
<td>1.40</td>
<td>3</td>
<td>1.40</td>
<td>10.57</td>
<td>.004</td>
</tr>
<tr>
<td>Counselor error</td>
<td>.35516</td>
<td>8</td>
<td>.044</td>
<td>.226591</td>
<td>.974</td>
</tr>
<tr>
<td>Within cell</td>
<td>8.01388</td>
<td>48</td>
<td>.16696</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
In addition to a posttest analysis, a pretest one-way analysis of variance was completed comparing subject's scores on the anxiety scale of the Brief Symptom Inventory. The rationale for this procedure was to evaluate whether differences existed in any of the groups prior to treatment. Results are summarized in Table 15. The results indicated an $F$ of .388 for the differences among groups. This was not significant at the .7619 level of probability. Because no statistical significance was found on the pretest, the data were not subjected to a pre-post test statistical comparison.

The means of each group however were compared before and after treatment. Table 15 provides a summary of the data and Figure 3 depicts cell mean scores. In general, the average student in the three treatment groups claimed an equal decrease in anxiety. Of the treatment approaches rational emotive group claimed the greatest amount of anxiety prior to treatment followed by the client-centered and paradoxical directives groups. After treatment the order remained the same though anxiety in the paradoxical directives group decreased significantly enough to show statistically significant differences from the control in the posttest MANOVA analysis.
Table 15
Summary of Pretest Scores
On the Anxiety Scale of the Brief Symptom Inventory
Grouped According to Treatment

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Mean</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>$X_1$ (Client-centered)</td>
<td>.74</td>
<td>.47</td>
</tr>
<tr>
<td>$X_2$ (Rational emotive)</td>
<td>.88</td>
<td>.45</td>
</tr>
<tr>
<td>$X_3$ (Paradoxical directives)</td>
<td>.60</td>
<td>.51</td>
</tr>
<tr>
<td>$X_4$ (Control)</td>
<td>.70</td>
<td>.65</td>
</tr>
<tr>
<td>Total</td>
<td>.73</td>
<td>.53</td>
</tr>
</tbody>
</table>

Analysis of Variance

<table>
<thead>
<tr>
<th>Source</th>
<th>DF</th>
<th>Sum of Squares</th>
<th>Mean Square</th>
<th>F ratio</th>
<th>Level of Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between groups</td>
<td>3</td>
<td>.6384</td>
<td>.2128</td>
<td>.754</td>
<td>.5247</td>
</tr>
<tr>
<td>Within groups</td>
<td>56</td>
<td>15.1806</td>
<td>.2823</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>59</td>
<td>16.4445</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Figure 3
Mean Scaled Score on Self-Rated Change
In Affect-Anxiety Relief

Client-centered - - - - -
Rational emotive . . . .
Paradoxical directives - - -
Control group ____________
Hypothesis 4c

There is no significant difference in the affect of hostility among subjects as measured by the Derogatis BSI between paradoxical directives, rational emotive, client-centered, and/or control groups.

\[ H_{0c} : \frac{\bar{X}_{1.1} + \bar{X}_{1.2} + \bar{X}_{1.3}}{3} = \frac{\bar{X}_{2.1} + \bar{X}_{2.2} + \bar{X}_{2.3}}{3} = \frac{\bar{X}_{3.1} + \bar{X}_{3.2} + \bar{X}_{3.3}}{3} = \bar{X}_{4.0} \]

This hypothesis was evaluated on the basis of scores from the hostility scale of the Brief Symptom Inventory. The measure came from requesting subjects in the four groups to complete the Brief Symptom Inventory a few minutes prior to the final interview.

MANOVA analysis resulted in an $F$ value of 2.357 which is not significant at the .148 level of probability. The indication is that subjects in the four groups did not claim a significantly different reduction of hostile affect following any type of treatment or no treatment. $H_{4c} : (F = 2.35, df 8/48, p < .148)$. Based on the analysis of this dependent variable, the null hypothesis cannot be rejected.

In comparing the differences among subjects grouped according to counselors in the same treatment modality, the indication is that subjects receiving treatment from any one
of the counselors did not differ significantly in claimed reduction of hostile affect. $H_{4c}$: ($F = .68128, df 8/48, p < .706$). These results suggest that no one treatment approach or no treatment is any more effective in reducing self-reported hostility than any other. Results also suggest counselor personality variables did not effect reduction in self-reported hostile affect as measured by the hostility scale of the Brief Symptom Inventory.

Table 16 presents the means and standard deviations summarized according to treatment modality and according to counselors with each treatment. Table 17 summarizes MANOVA analysis of the treatment effects and the differential effects of the counselor within the treatment.

In addition to a posttest analysis, a pretest one-way analysis of variance was completed comparing subjects' scores on the hostility scale of the Brief Symptom Inventory. The rationale for this procedure was to evaluate whether differences existed in any of the groups prior to treatment. Results are summarized in Table 18. The results indicated an $F$ of .504 for the differences among groups. This was not significant at the .6809 level of probability. Because no statistical differences were found on the pretest, these data were not subjected to a pre-post test statistical comparison.

The means of each group however were compared before and after treatment. Table 18 presents a summary of the
Table 16
Hypothesis 4c
Summary of Means and Standard Deviations
Grouped According to Treatment and
Counselors Within Treatment
On the Hostility Scale of the Brief Symptom Inventory

<table>
<thead>
<tr>
<th>Treatment</th>
<th>n</th>
<th>Mean</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>$X_1$(Client-centered)</td>
<td>15</td>
<td>.30</td>
<td>.29</td>
</tr>
<tr>
<td>$X_2$(Rational emotive)</td>
<td>15</td>
<td>.28</td>
<td>.26</td>
</tr>
<tr>
<td>$X_3$(Paradoxical directives)</td>
<td>15</td>
<td>.41</td>
<td>.32</td>
</tr>
<tr>
<td>$X_4$(Control)</td>
<td>15</td>
<td>.55</td>
<td>.53</td>
</tr>
<tr>
<td>Total</td>
<td>60</td>
<td>.38</td>
<td>.37</td>
</tr>
</tbody>
</table>

| $X_{1.1}$CC                      | 5  | .24  | .16                |
| $X_{1.2}$CC                      | 5  | .38  | .38                |
| $X_{1.3}$CC                      | 5  | .28  | .30                |
| $X_{2.1}$RE                      | 5  | .36  | .29                |
| $X_{2.2}$RE                      | 5  | .20  | .34                |
| $X_{2.3}$RE                      | 5  | .28  | .10                |
| $X_{3.1}$PD                      | 5  | .28  | .17                |
| $X_{3.2}$PD                      | 5  | .48  | .36                |
| $X_{3.3}$PD                      | 5  | .48  | .41                |
| $X_{4.1}$CG                      | 5  | .36  | .43                |
| $X_{4.2}$CG                      | 5  | .80  | .67                |
| $X_{4.3}$CG                      | 5  | .48  | .46                |
| Total                            | 60 | .38  | .37                |

The higher the score the more hostility reported.
Table 17
Hypothesis 4c
Summary of Posttest MANOVA Analysis
Of Treatment Effects and Counselor Effects
On the Hostility Scale of the Brief Symptom Inventory

<table>
<thead>
<tr>
<th>Source of Variance</th>
<th>Sum of Squares</th>
<th>Degrees of Freedom</th>
<th>Mean Square</th>
<th>F</th>
<th>Level of Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment</td>
<td>.67783</td>
<td>3</td>
<td>.22594</td>
<td>2.257</td>
<td>.148</td>
</tr>
<tr>
<td>Counselor error</td>
<td>.76667</td>
<td>8</td>
<td>.09583</td>
<td>.68128</td>
<td>.706</td>
</tr>
<tr>
<td>Within cells</td>
<td>6.75199</td>
<td>48</td>
<td>.14067</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Table 18

**Summary of Pretest Scores**

*On the Hostility Scale of the Brief Symptom Inventory Grouped According to Treatment*

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Mean</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>$X_1$(Client-centered)</td>
<td>.64</td>
<td>.1073</td>
</tr>
<tr>
<td>$X_2$(Rational emotive)</td>
<td>.58</td>
<td>.0985</td>
</tr>
<tr>
<td>$X_3$(Paradoxical directives)</td>
<td>.45</td>
<td>.1287</td>
</tr>
<tr>
<td>$X_4$(Control)</td>
<td>.56</td>
<td>.1055</td>
</tr>
<tr>
<td>Total</td>
<td>.42</td>
<td>.0566</td>
</tr>
</tbody>
</table>

### Analysis of Variance

<table>
<thead>
<tr>
<th>Source</th>
<th>DF</th>
<th>Sum of Squares</th>
<th>Mean Square</th>
<th>F ratio</th>
<th>Level Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between groups</td>
<td>3</td>
<td>.2773</td>
<td>.0924</td>
<td>.504</td>
<td>.6809</td>
</tr>
<tr>
<td>Within groups</td>
<td>56</td>
<td>10.2666</td>
<td>.1833</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>59</td>
<td>10.5440</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
pretest data and Figure 4 depicts the group mean scores. In general, the average student in the client-centered and rational emotive group claimed an equal decrease in hostile affect.

Secondary Hypothesis 1

There is no significant difference within the paradoxical directives group between the highest seven self-rated problem improvement and the lowest seven self-rated problem improvement with respect to the quality of the relationship, as measured by the Barrett-Lennard Relationship Inventory after three weekly sessions.

Symbolically: $H_{01}: \bar{X}_{3.1} = \bar{X}_{3.2}$

Legend: $\bar{X}_{3.1} =$ mean of the top seven subjects in paradoxical directives group who rated problem relief highest.

$\bar{X}_{3.2} =$ mean of the bottom seven subjects in paradoxical directives group who rated problem relief lowest.

This hypothesis was evaluated by making a statistical comparison between the seven most and seven least improved subjects in the paradoxical directives group. The dependent variable was the score on the Barrett-Lennard Relationship Inventory.

$T$-test analysis resulted in a $t$ value of .23 for the effect of treatment. With a $t$ not significant at the .820
Figure 4

Mean Scaled Score on Self-Rated Change in Affect-Hostility Relief

Client-centered
Rational emotive
Paradoxical directives
Control group

Pre-measure  Post-measure
level of probability, the indication is that there were no differences between subgroups' (one which claimed most improvement and the other least improvement) evaluation of the perceived quality of the relationship. In the most improved group, the mean score on the Relationship Inventory was 111.28. In the least improved group the mean score was 108.0. These results suggest that the quality of the relationship formed by subjects claiming most or least improvement has no apparent effect on self-reported outcome. Table 19 provides a summary of the results.

Secondary Hypothesis 2

There is no significant difference in the paradoxical directives group between the seven subjects who rated problem relief highest and the seven subjects who rated problem relief lowest with respect to the quality of the relationship, as measured by the Willingness-to-Disclose Questionnaire.

\[ H_0^2: \bar{X}_{3.1} = \bar{X}_{3.2} \]

This hypothesis was evaluated by making a statistical comparison between the seven most improved and seven least improved subjects in the paradoxical groups. The dependent variable was scores on the Willingness-to-Disclose Questionnaire.
Table 19
Summary of t-test Analysis
For Treatment Effects on the Scores
On the Relationship Inventory
For the Paradoxical Directives Group

<table>
<thead>
<tr>
<th>Variable</th>
<th>n</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Standard error</th>
<th>t</th>
<th>df</th>
<th>Level of Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most improved</td>
<td>7</td>
<td>111.2857</td>
<td>23.42</td>
<td>8.853</td>
<td>.23</td>
<td>12</td>
<td>.820</td>
</tr>
<tr>
<td>Least improved</td>
<td>7</td>
<td>108.000</td>
<td>29.17</td>
<td>11.028</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
T-test analysis resulted in a $t$ value of 1.07 for the effects of treatment. With a $t$ not significant at the .304 level of probability, the indication is that there were no differences between the groups (one which claimed most improvement and the other which claimed least improvement) in stated willingness to disclose themselves. In the most improved group the mean score was 72.00. In the least improved group the mean score was 76.14. These results suggested that the stated willingness to disclose has no apparent effect on self-reported outcome. Table 20 provides a summary of the results.

Summary

The results of the statistical analysis of the hypotheses are reported in Table 21. Hypotheses 1 and 4b were rejected. When a post-hoc comparison using the Scheffé method to evaluate hypothesis 1 was done, the three treatment groups' results showed statistically significant improvement in claimed outcome improvement when compared to the control group which received no treatment. When hypothesis 4b was evaluated using the Scheffé method, results indicated that the paradoxical directives group claimed a significantly lower anxiety affect after treatment than the control group. Hypothesis 2 could not be rejected, indicating that the treatments did not result in significantly different
Table 20

Summary of t-test Analysis
For Treatment Effects on the Scores
On the Willingness-to-Disclose Questionnaire
For the Paradoxical Directives Group

<table>
<thead>
<tr>
<th>Variable</th>
<th>n</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Standard Error</th>
<th>t</th>
<th>df</th>
<th>Level of Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most improved</td>
<td>7</td>
<td>72.00</td>
<td>9.71</td>
<td>3.67</td>
<td>1.07</td>
<td>12</td>
<td>.304</td>
</tr>
<tr>
<td>Least improved</td>
<td>7</td>
<td>76.14</td>
<td>3.13</td>
<td>1.18</td>
<td></td>
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</table>
Table 21
Summary of Statistical Findings

<table>
<thead>
<tr>
<th>Hypothesis (null)</th>
<th>Statistic</th>
<th>Probability</th>
<th>Reject</th>
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</thead>
<tbody>
<tr>
<td>Major 1</td>
<td>$F = 11.71$</td>
<td>.003</td>
<td>yes</td>
</tr>
<tr>
<td>Major 2</td>
<td>$F = .95$</td>
<td>.437</td>
<td>no</td>
</tr>
<tr>
<td>Major 3</td>
<td>$F = .211$</td>
<td>.886</td>
<td>no</td>
</tr>
<tr>
<td>Major 4a</td>
<td>$F = .256$</td>
<td>.855</td>
<td>no</td>
</tr>
<tr>
<td>Major 4b</td>
<td>$F = 10.57$</td>
<td>.004</td>
<td>yes</td>
</tr>
<tr>
<td>Major 4c</td>
<td>$F = 2.35$</td>
<td>.148</td>
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</tr>
<tr>
<td>Secondary 1</td>
<td>$F = .23$</td>
<td>.820</td>
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</tr>
<tr>
<td>Secondary 2</td>
<td>$F = 1.07$</td>
<td>.304</td>
<td>no</td>
</tr>
</tbody>
</table>
Relationship Inventory scores. Hypothesis 3 also could not be rejected, indicating that the treatments did not result in significantly different willingness-to-disclose scores.

Hypotheses 4a and 4c evaluated differences in the affect of depression and hostility. Both hypotheses could not be rejected indicating that the treatments did not significantly differ in lowering claimed depressed or hostile affect. The secondary hypotheses 1 and 2 compared most and least improved subjects within the paradoxical directives group with respect to scores on the Relationship Inventory and the Willingness-to-Disclose Questionnaire. Both hypotheses could not be rejected indicating that the claimed outcome in the paradoxical directives group does not appear to have any relationship to the quality of the relationship formed between counselor and the subject, or the subjects' willingness-to-disclose themselves in an interview.
CHAPTER 5: SUMMARY, CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

This chapter will present a major summary and interpretations of results with relevant conclusions and implications. The limitations of the study will be noted and recommendations for further study of paradoxical directives will be made.

Summary

The technique of paradoxical directives has been reported in the literature as an effective treatment method in reducing and/or resolving a wide variety of problems in clinical and nonclinical settings (Stanton, 1981b). Despite the enthusiasm of many therapists, the dramatic claims of success with the techniques of paradox and numerous case studies offered as examples, there is no direct experimental evidence that paradox produces results better than client-centered therapy or rational emotive therapy. In fact, there is no evidence that paradox is superior to any other counseling treatment. Further, it has not been established empirically that paradox is an effective treatment at all. As Kisch and Kroll (1980) have noted, through case studies,
nonexperimental reports, and claims of success from distinguished authors in the field may demonstrate the value of paradoxical directives, what is important is an effective demonstration of its utility experimentally.

The present study attempted to define and investigate the experimental utility of paradoxical directives as a technique. For the purpose of this study paradoxical directives were defined as "therapist initiated messages that convey that a specific aspect of a client's problem may be expressed as much or more than it already is occurring" (Hopkinson, 1980, p. 20). The purpose of this experiment was to determine if paradox was superior to client-centered, rational emotive and/or no intervention as an approach to solving real life problems with college students. The design of the study allowed the experimenter to determine whether or not paradoxical directives were superior to client-centered, rational emotive therapy and/or no intervention. Also, if paradoxical directives were superior, then the experimenter could investigate under what conditions, with what kind of clients, and with which problems was this technique effective.

It was hypothesized that subjects who received the paradoxical directives treatment would (1) evaluate self-rated problem relief as greater than subjects in the client-centered, rational emotive and/or control groups; (2) rate
the quality of the relationship as measured by the Barrett-Lennard Relationship Inventory higher than subjects in the client-centered or rational emotive groups; (3) express a greater willingness to reveal themselves to a counselor as measured by the Willingness-to-Disclose Questionnaire than subjects in the client-centered, rational emotive and/or control groups; (4) show lower self-reported symptomatic distress levels in (a) depressed, (b) anxious, and/or (c) hostile affect than subjects in the client-centered, rational emotive and/or control groups. Secondary hypotheses were that subjects in the paradoxical directives group who had rated problem relief the highest would have a higher mean score on (1) the Relationship Inventory and/or (2) the Willingness-to-Disclose Questionnaire than subjects in the paradoxical directives group who had rated problem relief lowest.

The sample for the study consisted of 58 full time undergraduates and two part-time graduate students (n = 60) enrolled in education courses at the College of William and Mary. All subjects were pretested with the Brief Symptom Inventory (Derogatis & Melisaratos, Note 1), the Mooney Problem Check List (Mooney, 1950), the 40-item Willingness-to-Disclose Questionnaire (Jourard & Lasakow, 1958), and then interviewed by the researcher or his associate using a structured interview format to formulate a behavioral focal
problem and to set outcome criteria to be used for evaluation of the treatment in the final interview. The 60 subjects were then randomly assigned into one of three treatment approaches (client-centered, rational emotive and paradoxical directives) or a control (no-treatment) group. Nine counselors at about the same level of professional training were evenly assigned to each of the three treatment approaches. There were three counselors per treatment. Assignment was made after an informal interview by the investigator to assess the counselor's familiarity with, preference for, and belief in the effectiveness of the three treatment approaches. Counselors were matched to one of the three treatment approaches according to their belief in effectiveness, preference and familiarity as closely as possible. Using the assigned treatment modality, they met with five students individually for three weekly, 50 minute treatment sessions.

Seven to ten days after the third treatment session was completed, the researcher and his associates administered the following measures to assess each dependent variable: the Brief Symptom Inventory to assess subject's self-reported changes in the affects of depression, anxiety, and hostility; the Willingness-to-Disclose to assess subject's willingness to reveal himself/herself to the counselor following treatment in one of the three approaches and/or the control; the Relationship Inventory to assess the quality
of the relationship formed between counselor and client in each of the three treatment approaches. The control group was administered the first two measures only. A 20 to 30-minute interview was conducted with all the subjects after the instruments were completed during which subjects were asked to re-evaluate their focal problem and their attitude toward the problem. The researcher or his associates told them a letter would be sent debriefing them and directing the students to the researcher for any questions they still had.

The research design in this study was a randomized "pre and posttest control group design." All protocols were handscored. Hypotheses 1 to 4 were analyzed by a one-way MANOVA. Secondary hypotheses 1 and 2 were analyzed by a t-test between groups.

Statistical analysis resulted in significant F values for null hypotheses 1 and 4b which were consequently rejected. The Scheffé procedure was used to analyze differences among group means for both these hypotheses. Results indicated that all subjects receiving treatment from counseling using any of the three modalities claimed significantly greater improvement than the control group which received no treatment. Though the paradoxical directives method was not evaluated as superior to client-centered or rational emotive treatment, it was evaluated to be as
effective as either of the two more well established approaches. Results also indicated that subjects in the paradoxical directives group reported significantly less anxiety after treatment than subjects in the control, while subjects in the client-centered and rational emotive groups did not claim significantly lower anxiety after treatment when compared to the control group. None of the major null hypotheses 2, 3, 4a, and 4c could be rejected. This indicated that the subjects in the three treatment groups did not judge the quality of the relationship formed with their counselor to be significantly different, and that subjects in the four groups did not show significant differences in either their willingness to reveal themselves, or in their self-report of depressed or hostile affect. Also, the secondary null hypotheses 1 and 2 could not be rejected. This indicated that subjects in the paradoxical directives group who rated problem relief highest did not evaluate the quality of the relationship superior, nor did they express a greater willingness to reveal themselves to their counselor than subjects who rated their problem relief lowest.

Conclusions

Conclusions regarding the three modalities of client-centered, rational emotive, paradoxical directives
counseling, and their comparative effectiveness as a counseling approach will be presented by hypothesis.

Hypothesis 1

The null hypothesis that there is no significant difference in self-rated problem relief between subjects in paradoxical directives, client-centered, rational emotive and/or control groups was rejected at the .003 level of confidence. MANOVA analysis resulted in a significant F value for treatments. A post-hoc comparison using the Scheffé procedure indicated that the three treatment approaches were equally more effective than no-treatment control. Based on the above data, these findings seem to establish experimentally that the paradoxical directives approach, though not superior to client-centered or rational emotive approaches, is equally as effective and better than no treatment at all.

Hypothesis 2

The null hypothesis that there would be no significant difference in the quality of the relationship, as measured by the Barrett-Lennard Relationship Inventory, between paradoxical directives, client-centered and/or rational emotive approaches could not be rejected. MANOVA analysis resulted in a nonsignificant F value. This result indicated that the rating of the quality of the relationship was not associated with the level of self-reported outcome.
Hypothesis 3

The null hypothesis that there would be no difference in the subject's willingness to disclose as measured by the Willingness-to-Disclose Questionnaire between paradoxical directives, client-centered, rational emotive and/or control groups failed to be rejected at the .886 level of confidence. MANOVA analysis resulted in a nonsignificant F value. Based on the above data, it can be concluded that the subject's exposure to any of the treatment modalities or no treatment has an insignificant effect on the subject's willingness to disclose.

Hypothesis 4a

The null hypothesis that there are no significant differences in the affect of depression as measured by the depression scale of the Derogatis Brief Symptom Inventory between the paradoxical directives, rational emotive and client-centered and/or control groups could not be rejected. MANOVA analysis resulted in a nonsignificant F value. Based on the above data, it can be concluded that differences in self-reported depressed affect among the four treatments were insignificant.

Hypothesis 4b

The null hypothesis that there is no significant difference in the affect of anxiety as measured by the
The Derogatis Brief Symptom Inventory between paradoxical directives, rational emotive, client-centered and/or control groups was rejected at the .004 alpha level. MANOVA analysis resulted in a significant $F$ value for treatments. A post-hoc comparison using the Scheffe procedure indicated that the subjects in the paradoxical directives group claimed a statistically significant reduction in anxiety compared to the control group. Although statistically significant, this result must be interpreted cautiously. One possible interpretation is that the paradoxical directives group was lower than the other two approaches in pretest anxiety measures. Inspection of the four treatment means indicated a similar decrease in anxiety for the three treatment approaches while the control group claimed a slight increase in anxiety. Because the paradoxical group was lower than the other two approaches in pretest anxiety, similar decreases resulted in statistically significant differences at posttest between the paradoxical directives group and the control group. At any rate, the difference was not statistically significant from the other two treatment approaches.

**Hypothesis 4c**

The null hypothesis that there is no significant difference in the affect of hostility at posttest, as measured by the Derogatis Brief Symptom Inventory, among
paradoxical directives, rational emotive, client-centered and/or control groups could not be rejected. MANOVA analysis resulted in a nonsignificant $F$ value. Based on the above data, it can be concluded that differences in self-reported hostile affect at posttest among the four treatments were insignificant.

Secondary hypothesis 1

The null hypothesis that there is no significant difference within the paradoxical directives group between the highest seven self-rated problem improvement and the lowest seven self-rated problem improvement with respect to the quality of the relationship as measured by the Barrett-Lennard Relationship Inventory could not be rejected. The $t$-value for differences between the groups was not significant. Based on the above data, it can be concluded that the difference in the quality of the relationship as measured by the Barrett-Lennard Relationship Inventory between the highest self-rated problem improvement and the lowest self-rated problem improvement was insignificant. The quality of the relationship between counselor and client has no apparent relationship with the self-reported outcome improvement within the paradoxical directives group.
Secondary hypothesis 2

The null hypothesis that there is no significant difference in the paradoxical directives group between the seven subjects who rate problem relief highest and the seven subjects who rate problem relief lowest with respect to the quality of the relationship as measured by the Willingness-to-Disclose Questionnaire could not be rejected. The \( t \) value for differences between groups was not significant. Based on the above data, it can be concluded that the difference in the subject's willingness to disclose, as measured by the Willingness-to-Disclose Questionnaire, between the highest self-rated problem improvement and the lowest self-rated problem improvement was insignificant. Subject's willingness to disclose has no apparent relationship with self-reported outcome improvement within the paradoxical directives group.

Discussion

The data and analysis from this experiment are generally consistent with, and seem to support case studies, clinical observations and theoretical formulations claiming effectiveness of paradoxical directives in the literature (Fisch, Weakland, & Segal, 1982; Stanton, 1982b; Weeks & L'Abate, 1982). Though it seemed paradoxical directives
were as effective as client-centered or rational emotive, there is no evidence that paradoxical directives produced results which were significantly superior to the other two groups. Changes did occur in the paradoxical directives group which seem consistent with the theoretical claims in the literature but one is not able to conclude that the paradoxical directives treatment produced those changes.

Given the similar results of the paradoxical directives, client-centered and rational emotive groups, the experiment also corroborates previous research claiming that no one specific treatment modality is statistically superior to any other treatment method (DiLoreto, 1971; Lietaer, 1979; Moleski & Tosi, 1976; Shapiro, 1981; Smith & Glass, 1977; Sloane et al., 1975).

Though claimed outcome improvement of the paradox group seems consistent with the effectiveness of other treatments reported in the literature, there is a need to speculate why paradox was not superior to the other two groups. One area of speculation is the applicability of paradoxical techniques to the population of college students. Students in this study presented the following range of problems: career decisions, confusion over marriage possibilities, choice of major, handling stress, jealousy and possessiveness in relationships, lack of confidence, weight loss, resolving feelings over abortion, improving interpersonal
relationships, controlling temper, study problems, nervousness, understanding own sexuality, and family problems. Weeks and L'Abate (1982) describe two interrelated criteria on which to evaluate the applicability of paradoxical techniques. They are: "1) the dimension of resistance, ranging from very cooperative to difficult or impossible; 2) the dimension of pathology, ranging from mildly disturbed (e.g., transient and neurotic disorders) to severely disturbed (e.g., psychotic disorders" (Weeks & L'Abate, 1982, p. 57).

In the current study, no subjects cited problems with a serious degree of pathology. Furthermore, if subjects did present serious dysfunctional disturbances either by reporting them directly to the interviewer or by scoring above the 84th percentile on the psychoticism scale of the BSI, they would have been excluded from the study and referred for professional consultation. Of the 98 subjects who initially volunteered only one was excluded because of presenting a serious focal problem that needed professional consultation. The experiment was not designed to evaluate the effectiveness of paradoxical directives with seriously disturbed subjects. The study was designed to evaluate the effectiveness of paradoxical directives with quite ordinary problems as described in the work of Watzlawick et al. (1974).

Paradoxical directives have claimed effectiveness with less
seriously disturbed populations but up to now these claims have not been supported by direct experimental evidence.

The second criteria stated by Weeks and L'Abate is related to dimensions of resistence. For a paradoxical directive to work, Haley (1976) writes that there must be a degree of resistence. To test this, homework is often given in which the client is told direct ways to resolve the problem. If the client is compliant, then there is little need for paradoxical intervention. Consistent with Haley’s assertion is Weeks and L'Abate's (1982) statement that

The use of paradoxical techniques with an easy or cooperative case may be no more effective than the use of other techniques; however, paradoxical techniques may be more efficient in reducing the total amount of time required to solve a particular problem (p. 58).

In evaluating the sample used in the study by the above second criterion, some conclusions may be drawn. Subjects were volunteer subjects, not overtly seeking help. It was described as a wellness clinic. In participating the subjects were told they were helping the investigator complete his dissertation. In fact, when asked why one student volunteered to seek help, the reply was specifically "to help the investigator." It may be that some or all of the above issues contributed to the complaint behavior of the subjects. This is further supported by the fact that there were no drop outs throughout the five weeks of treatment. The compliant and nonresistant nature of the population is
perhaps the most plausible reason why paradoxical directives were not superior to the other two approaches.

A third question is how much of the positive treatment outcomes can be attributed to the paradoxical directives given in the three counseling sessions, rather than to personality assets of nine good counselors. What can be stated is that all counselors were on roughly the same level of training and each received at least an hour of training in the modality used. All counselors were supervised by recognized experts in the particular modality. In a post-treatment interview, all counselors reported to the investigator that they made every attempt to use the assigned modality. Counselors knew they were a part of an experiment. The interviews were taped and counselors were told they would be spot checked on whether they were using the modality assigned.

Hypothesis 2 could not be rejected since no differences were found among the three treatment approaches on ratings of the quality of the relationship. Since treatment effects are often explained on the basis of the quality of the relationship formed between counselor and client, one possible explanation is that the improved self-reported outcome was due to the equally good quality of the relationship formed between the nine counselors and the 45 subjects. If this theorizing is correct, then no treatment made any
difference, but the equal quality of the relationship explained the equally positive outcome. There is no evidence in the current data to rule out this possibility.

One way to tease out the differences is to examine the congruence scale of the relationship inventory. For the purpose of Hypothesis 2, all 4 of Barrett-Lennard's Inventory scales were summed to give a measure of the total quality of the relationship. As stated by Barrett-Lennard, the congruence scale can be used to evaluate whether each counselor in a particular modality "was functionally integrated in the context of his relationship with another such that there is an absence of conflict or inconsistency between his experience, his awareness and his overt communication" (Barrett-Lennard, 1962, p. 16; Barrett-Lennard, Note 4). In short, absence of inconsistency between awareness and communication is the theoretical criterion for congruence. For the purpose of this experiment, the congruence scale reveals how authentically and genuinely the counselors utilized the treatment modality assigned.

MANOVA analysis resulted in an $F$ value ($F = .900$) indicating no significant differences among the groups at the .455 level of confidence. When differences among counselors in each treatment were examined, statistical analysis resulted in an $F$ value ($F = 1.89$) which indicated no
significant differences among counselors at the .109 level of treatment. When comparing group means, the client-centered group mean was 23.6, the rational emotive group mean was 28.3, and the paradoxical group mean was 31.7. The nonsignificant differences in means seem to indicate that the counselors were evaluated as behaving in a congruent way, integrating the treatment modality used in the counselor client relationship. No empirical evidence exists in the current data to explain the positive outcomes on the basis of counselor personality variables.

Hypothesis 3 was not rejected, indicating that no differences were found among groups in subjects' willingness to disclose themselves. The small differences among groups can possibly be explained by describing the nature of the questionnaire and the population who used it. The 40-item Willingness-to-Disclose has been used primarily in comparing disclosure to male friends, a family member, mother, father, brother or sister (Jourard & Lasakow, 1958) as well as disclosure to nonprofessional people, intimate relationship in an essay (Himelstern & Kimbrough, 1963), and strangers (Wilson & Rappaport, 1974). The only comparison of treatment modalities was Brockman's (1980) study comparing matched representational systems with unmatched representational systems in relationship to empathic responses in an opening interview. Brockman's results found no differences
among groups using the Willingness-to-Disclose Questionnaire as a dependent measure.

This investigator suspects that the poor sensitivity of the instrument to distinguish fine levels of disclosure to a professional explains the lack of significant differences among groups in the current study. Inspection of the mean scores of each of the groups revealed: client-centered $X_1 = 76.0$, rational emotive $X_2 = 70.93$, paradoxical directives $X_3 = 72.20$ and control $X_4 = 75.00$. Since higher scores signify higher willingness to disclose, these means show a range of approximately 6 points with a standard deviation of 7.95. Given a maximum score of 80, all subjects expressed a high score. The population, educated college students volunteering for a wellness clinic to explore areas of their life, was one that favored disclosure. Subjects who volunteer for this kind of experiment seem disposed to revealing themselves to a trained professional in a confidential setting. In summary, the subjects' natural willingness to reveal themselves as well as the instrument's poor sensitivity to discriminate at high levels of self-disclosure may account for the lack of significant differences among treatment groups and control.

Hypotheses 4a and 4b were not rejected, indicating that there were no significant differences in the treatment or control groups in subjects' self-reported affects of depression or hostility at posttest.
In examining differences in depression, all four groups expressed greater depressed affect on the pretest than the norms published by Derogatis and Melisaratos (Note 1) who reported a mean of .28 with a standard deviation of .46 for the depression scale, standardized on 719 nonpatient normals. The three treatment groups and control group reported the following pretreatment means: client-centered, $\bar{X}_1 = .82$, sd = .53; rational emotive, $\bar{X}_2 = .66$, sd = .62; paradoxical directives, $\bar{X}_3 = .64$, sd = .77 and for control, $\bar{X}_4 = .64$, sd = .45. Table 12 presents a summary of the data. At posttest there was a large, though not statistically significant, decrease in claimed depressed affect for all of the treatment groups. This result seems consistent with the claimed outcome improvement of the treatment groups. As the focal problems moved toward resolution, the claimed depressed affect decreased. Subjects reported feeling more positive about themselves after receiving any one of the three treatments. The posttest means of claimed outcome were as follows: client-centered, $\bar{X}_1 = .50$, sd = .65; rational emotive, $\bar{X}_2 = .48$; paradoxical directives, $\bar{X}_3 = .49$, sd = .61; and control, $\bar{X}_4 = .66$, sd = .61. Figure 2 and Table 10 provide a summary of this data. Though lower at posttest than at pretest, all groups expressed greater depressed affect than the Derogatis and Melisaratos norm group at posttest. At posttest, all treatment scores clustered within
a minute range .02 of a point while the control group claimed an increase in depressed affect. This common decrease across all treatment modalities seems to support the equal effectiveness of all three treatment modalities.

The similar decrease, however, was not as consistent on the hostility scale. Derogatis and Melisaratos (Note 1) report a standardized norm of .35 on the hostility scale with a standard deviation of .42. The pretest mean scores were: client centered, $X_1 = .64$, sd = .10; rational emotive, $X_2 = .58$, sd = .09; paradoxical directives, $X_3 = .45$, sd = .12; control, $X_4 = .56$, sd = .11. Table 18 presents a summary of the data. At posttest there was a large, though not statistically significant, decrease in the client-centered ($X_1 = .30$, sd = .29) and rational emotive ($X_2 = .28$, sd = .26) group means. There was a slight decrease in the paradoxical directives group ($X_3 = .41$, sd = .32) mean while the control ($X_4 = .55$, sd = .53) group mean remained approximately the same. Table 16 and Figure 3 provide a summary of the data. Though it appears that the paradoxical directives did not decrease much, the pretest level of claimed hostile affect was lower in that group than in either of the other two treatment approaches. With their minute differences, any attempt to provide an explanation would be speculation. It does seem however that treatment did provide some reduction in expressed hostile affect.
The null hypothesis 4b was rejected, indicating that there was a statistically significant difference in the treatment groups with respect to the paradoxical directives and the control groups. A post-hoc comparison using the Scheffé method indicated that the paradoxical directives group claimed a lower anxiety than the control group, while the client-centered, rational emotive, and control groups indicated no difference among them. This result can be explained from two perspectives—conservative and liberal.

A conservative explanation is that there is no practical, as opposed to statistical, differences in anxiety among the three treatments. Inspection of the pre and post-treatment means support this conclusion. In the pretest, mean scores were the following: client-centered, $\bar{X}_1 = .74$, sd = .47; rational emotive, $\bar{X}_2 = .88$, sd = .45; paradoxical directives, $\bar{X}_3 = .60$, sd = .51; and control, $\bar{X}_4 = .70$, sd = .65. The standard mean score and standard deviation for nonpatient normals is $\bar{X} = .35$, sd = .45. All groups were above the mean and the rational emotive group mean was better than one standard deviation unit above. At posttest, the mean scores were the following: client-centered, $\bar{X}_1 = .49$, sd = .41; rational emotive, $\bar{X}_2 = .62$, sd = .33; paradoxical directives, $\bar{X}_3 = .32$, sd = .27; and control, $\bar{X}_4 = .73$, sd = .49. Table 13 and 15, and Figure 3 provide a summary of the above data. Figure 3 shows a clear and parallel
decrease in anxiety among all treatments. One could argue that if the three treatment means were equated at pretest there would be no differences among them at posttest. Therefore, though statistically significant, those results indicate no practical difference in anxiety among the treatment groups. Like the decrease in depression, it is consistent with the claimed outcome improvement among the three treatment approaches.

A more liberal explanation is that anxiety has long been considered a motivation for change (Byrne, 1974). The assumption is that a more anxious group will be more motivated than a less anxious group to do something different to reduce their anxiety level. If this theorizing is correct, the most highly motivated treatment group was rational emotive followed by client-centered and paradoxical directives. The group least motivated by anxiety was the paradoxical directives group. Yet at posttest, the group that showed the lowest level of anxiety was paradoxical directives. This possibly indicates that the use of paradoxical directives in itself was more effective in motivating a reduction in anxiety by prescribing the anxiety-producing problem than the client-centered group which focused on the relationship quality, or the rational emotive group which focused on the thought patterns which produced the anxiety. In short, prescribing the anxiety causing problem may have served as
its own motivation which reduced anxiety significantly lower than the control group. Though this latter explanation seems plausible, this investigator is inclined to select the former explanation as more sound empirically and also more consistent with the other results in the present study.

Neither secondary hypotheses 1 nor 2 were rejected, indicating that neither the quality of the relationship nor the subjects' willingness to disclose had any relationship to outcome. The conclusion seems consistent with the second and third hypotheses and lends support to the assertion that differences in outcome were a result of the three equally effective treatment modalities rather than the person of the counselor.

**Limitations and Implications for Future Study**

The limitations of the study are organized around issues of internal and external validity.

Internal validity refers to the extent the design controlled for extraneous variables that may have in some way affected the dependent variables. Failure to control for extraneous variables can make the results suspect or even meaningless so that causal inferences between the independent and dependent variables cannot be made. Threats to internal validity offer one kind of explanation for results
which blur attempts to explain the results based on independent variables.

The design of this experiment generally controlled for threats to internal validity. Subjects were randomly selected in a uniform way from a homeogenous population. It might have been better to use all undergraduates, however. Random assignment was made to the treatment groups. The investigator and his associates were kept blind to the assignment of treatments until after the initial structured interview. The investigator was also blind regarding which subjects received what treatment during the final evaluation.

Though it is impossible to determine the effects of extraneous factors, the study's design controlled for the factors this experimenter believed to be relevant to the study.

External validity refers to the degree the study's results are generalizable outside the target population. Several limitation concerns may be noted. One is the issue of whether the counselor-client dyad in this study was representative of a counselor-client relationship in a clinical setting. This investigator believes that the present study was a reasonably good analogue to a situation of three brief therapy sessions. Subjects presented real concerns in 50-minute interviews to a person defined as a professional
to help them with these concerns. It appeared subjects and counselors took the experiment seriously. Nevertheless, differences between the experimental setting and counseling/psychotherapy will be noted. First, subjects were drawn from a nonclinical population who were requested to describe a problem. Subjects did not initiate the help seeking but were solicited in order to be given unrequested help. Weeks and L'Abate (1982) have stated that paradoxical psychotherapy may not be the treatment of choice with this population. Other approaches seem to work equally as well with compliant subjects. Authors such as Rohrbaugh et al. (1981) note that paradox should be used primarily when traditional approaches are ineffective.

A third concern can be categorized as the translation process. The consultant in the paradoxical directives group gave specific instructions to each of the three counselors in that modality. There is no way to reliably assess how much of what was given was actually communicated to the subjects in the session. Though the counselors claimed to be doing paradoxical directives counseling, the question remains whether or not they really were. Given the fact that counselors were assigned to a preferred modality, this experimenter is inclined to believe that even though the directives were not as highly refined and artfully "given," the
treatment approximates the use of the modality as closely as the other two treatment groups and accounts for the claimed outcome improvement.

Recommendations

Future researchers using the same general design might proceed as follows: (a) Subjects may be selected presenting a more serious focal problem. (b) In order to more closely resemble a setting closer to therapy, subjects seeking help rather than those solicited for help might be used. (c) One modification of the design may be to include a placebo control in addition to a wait-list control. In the present study, if the control had been subjected to conversation, and the outcome evaluated, would differences still have existed? (d) Rather than study such a broad range of focal problem areas, subjects may be selected who present one type of problem, e.g. obesity, insomnia, adjustment to divorce. If the problem range were narrower the effects of paradox might be able to be more fully described. (e) With the use of one way mirrors, counselor-client sessions using a particular modality could take place while being evaluated by independent observers. This would ensure a method to evaluate how closely the actual treatment given matched the treatment claimed to be given. Finally though the variables
were operationally defined, future research on paradoxical directives needs to develop clearer paradigms in order to empirically evaluate the phenomenon studied. Though the experiment demonstrated claimed improved outcome of the paradoxical directives group comparable to client-centered or rational emotive therapy, more refined outcome criteria and more sensitive instrumentation need to be used to determine if what seemed to happen did in fact occur for reason of the treatment modalities used.
Appendix A

The Effectiveness of Certain Counseling Styles
On Problem Resolution
A Wellness Clinic
This is a request for your participation in a five week wellness clinic to help you know yourself and develop your potential. It is also a major research project conducted by Mr. Michael Gombatz in the School of Education at the College of William and Mary. Participation is voluntary so please be assured that you may decline without any penalty against you. Since research only has meaning to the extent you are willing to participate and complete the study, it would be preferable to the investigator that those not interested and able to make a commitment of approximately five hours of time would decline from participation in this study.

The major purpose of the clinic is to identify the problems typically experienced by college students, examine the ways in which they try to solve their problems and provide an opportunity for personal growth and development so you can become a more effective, well functioning person. In general then the investigator is finding out what problems you have and how you cope with them. In this as in most research, the emphasis is on group data.

A few of you will be chosen by chance (having no relationship to what you put on the pre packet measures) to work with a skilled experienced counselor who has been trained in specific techniques in helping people solve their problems and develop their potential. The commitment you will be asked to make is a total of four to five hours. One hour of pre packet measures and a pre measure interview, three 50 minute interviews a week apart designed to help you learn about yourself and teach you how to solve problems and cope more effectively and a closing interview lasting about one half hour.

Your confidentiality will be carefully guarded. It is necessary for the investigator to tape record your interview, but no one other than the investigator will listen to your tape. Your name will be coded on all pre packet and post packet reports. Only the investigator will ever have access to the connection between your responses and your name. The counselor who will work with you after the first interview will not.

If you are interested in your personal growth and a wellness experience, please fill out the form stapled to this sheet. Please indicate on the form the times you would most prefer to be interviewed and when it is convenient to reach you by phone. Detach and give it to the investigator.
If you sign up and are not contacted within two days please call Michael Gombatz at 229-3631. Thank you for your cooperation.

Yes, I am interested in participating in the Wellness Clinic and research study.

Name______________________________________________________________

Address__________________________________________________________

Phone number_____________________________________________________

The best time to reach me by phone is ________________________________
(day of week) (hour)

The best time for me to meet for the interviews is ______________________
(day of week) (hour)

My second preference for the time of the interviews is __________________
(day of week) (hour)

My third preference for the time of the interviews is ____________________
(day of week) (hour)
Appendix B

Description of the College of William and Mary
Description of the College of William and Mary

The College of William and Mary is a co-educational liberal arts college/university in Southeast Virginia. It is a state institution with approximately three thousand of its four thousand students coming from the Commonwealth of Virginia. The remaining one quarter of the student body comes from throughout the United States and many foreign countries.
Appendix C

Contract
CONTRACT

Subject_____________________________________ Code #

Investigator: Michael W. Gombatz

A Wellness Clinic: Problem Resolution

The investigator guarantees the confidentiality of your participation in the study. All data collected from you will be coded to preserve anonymity and the results will be anonymous. The paper and pencil instruments which you will complete before and after the three sessions are for research purposes only and under no circumstances will counselors have any information about you with the exception of the stated problem you decided to work on in the first interview, as a student at William and Mary you may use the services of the Center for Psychological Service of the College.

The subject will meet once with the investigator or his associate in an interview to identify the problem you wish to work on for the three sessions. Your description of the problem will be given to the counselor assigned to you. S/he will meet with you on a weekly basis for three weeks in Jones Hall at designated offices. Following the third interview, you will be asked to meet again with the investigator or his associate in an exit interview and evaluation session. While self exploration and self-relevant material involves some risk, you will be with a skilled trained counselor who is ethically bound to maintain your confidentiality and treat you with the utmost professional care. The subject hereby gives consent for the interviews to be audio tape recorded.

_________________________ subject's name Michael Gombatz (investigator)_________________________

_________________________ address ________________________________

_________________________ phone ________________________________

_________________________ date ________________________________
Appendix D

Evaluation and Selection Form for Counselors
Evaluation and Selection Form for Counselors

Date responded__________________________

Name_____________________________________

Address___________________________________

Phone number_____________________________ Work_____________________________________

How long have you worked as a counselor?_________________years

Are you licensed?______yes______no

What program are you in?________Doctoral_______Ad. Cert._________Masters

How familiar are you with client centered therapy?

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<tr>
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<th>4</th>
<th>3</th>
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<tbody>
<tr>
<td>thoroughly</td>
<td>a great deal</td>
<td>somewhat</td>
<td>a little</td>
<td>not at all</td>
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How familiar are you with rational emotive therapy?

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<tbody>
<tr>
<td>thoroughly</td>
<td>a great deal</td>
<td>somewhat</td>
<td>a little</td>
<td>not at all</td>
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</table>

How familiar are you with paradoxical directives?

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<tbody>
<tr>
<td>thoroughly</td>
<td>a great deal</td>
<td>somewhat</td>
<td>a little</td>
<td>not at all</td>
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</table>

Do you have a strong preference to be assigned to any treatment?

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<th>4</th>
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<th>2</th>
<th>1</th>
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<tbody>
<tr>
<td>yes very much</td>
<td>a great deal</td>
<td>somewhat</td>
<td>a little</td>
<td>not at all</td>
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</table>

Of the three, if you had to choose a preference which one would you select?

client centered____rational emotive____paradoxical directive______
Answer True or False

T or F  The client centered approach is effective with college students
T or F  Rational emotive therapy is effective with college students
T or F  Paradoxical directives is effective with college students

Of the three which do you think is the most effective?
client centered_____ rational emotive_____ paradoxical directive_____

Of the three which is the least effective?
client centered_____ rational emotive_____ paradoxical directive_____
Appendix E

Letter to Recruit Doctoral Level Counselors
Dear

For those of you who may not know me, I am in the process of doing my dissertation at William and Mary and we are in the same program together. I need your help with my research.

My research focuses on the effectiveness of three different treatment modalities, client centered, RET and strategic-paradoxical directives in problem resolution among undergraduates at William and Mary. I need your help to work within one of those modalities and counsel undergraduates in specific human growth/development behavior problems.

The big question is time. Now, what would this involve in time? Each counselor would contract and meet with five undergraduates a week for a period of three weeks. That is a total of fifteen hours. I will try to schedule you for time when you are going to be at William and Mary in the evenings or afternoons. The sessions would begin in September (Fall of 1982). In addition to the sessions, all the counselors would meet to review the design and for a training session where we would review client-centered and RET techniques. In addition, Pat Dorgan who trained under Jay Haley will present the strategic approach. At that time, it will be decided who will use what modality. Consultants will be available for supervision in all three modalities throughout the three weeks. If you volunteer, more information will be given.

I realize this is a commitment in the amount of time and energy and because of your skill you are also working elsewhere. I am prepared to reimburse you for transportation and pay you $75.00 to do the sessions with five students. That's the best I can do. I need your help because I want to go with quality counselors-doctoral level students like you.

If you are interested, please call me at 229-3631 (St. Bede's), 229-0227 (private number) or 723-6015 (Peninsula
July 7, 1982

Pastoral Counseling Center). I do need your help and I will
do everything I can to work out an interview schedule that
will be convenient for you. Most likely interviews will be
conducted in late afternoons and early evenings Monday
through Thursday. This five hours would probably take two
nights a week of your time. I'll work around your class
schedule.

Sincerely,

Mike Gombatz
Appendix F

Structured Interview Format
Structured Interview Format

Opening

Prior to the actual interview, the interviewer will ask the subject:

Are you presently in counseling or seeing someone professionally for help with your problems?

If yes: move to the explanation below immediately.
If no: ask the next question.

Have you ever sought out professional treatment by a psychiatrist, psychologist, social worker, counselor or clergyman for help with a problem?

If yes the interviewer asks:

Do you remember how many times you saw him/her professionally?

If more than five times, the interviewer responds in these or similar words:

Thank you for volunteering. This study is designed for people who have not had as much exposure to counseling as you have had. If you wish help with your problem, I'd be happy to refer you to (names of people at the counseling center) to talk over some of the concerns you have.

If no, go on with the interview.
Instructions to the interviewer:

Please state the following in these or similar words. Don't read it but make this presentation as natural as possible. (Before the interview, the interviewer is to be familiar with the MPCL that this person filled out.)

I noticed you have described several areas in the Mooney Problem Check List that you might like to work on. I'd like to go over them now. (Reads the Mooney Problem Check List in a clear concise way - as stated problem areas.)

Of all these areas that you listed can you pick the most important one that you might like to work on in each of these sessions. Explain, meet 5 times with a counselor for 50 minutes. Want a way to help you grow. (Student picks one.)

Interviewer: Can you tell me more about this concern. Spell out in behavior terms: what you are doing. Interviewer records.
O.K. I understand that the area you want to work on is this:

Can you describe the history of this problem. How long has it been going on?

When did it start?
The interviewer is instructed to get a complete description of what the problem would look like if the problem got better, got worse, or remained the same. Please help the client describe it in behavioral language as concretely as possible.

The conflict/problem would look like this if it improved a great deal or got resolved.

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

The conflict would look like this for you to say it changed for the better. (minimal improvement in order to claim change for the better)

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

The conflict would look like this if it remained the same.

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

The conflict would look like this if it got worse.

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
The interviewer is asked to request the subject think about these statements carefully and state whether they strongly agree, agree, are uncertain, disagree, strongly disagree.

1. During this past week, I thought about my problem most of the time.

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Uncertain</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
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<tbody>
<tr>
<td>5</td>
<td>4</td>
<td>3</td>
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</table>

Interviewer says: Tell me how often you thought about it.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

2. During this past week, I was very anxious over the existence of the problem.

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Uncertain</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
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<tbody>
<tr>
<td>5</td>
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</table>

Interviewer says: Tell me about how anxious you were.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

3. During this past week, I was highly motivated to resolve this problem very quickly.

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Uncertain</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>4</td>
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</tbody>
</table>
Interviewer says: Tell me how motivated you were to change.

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

4. This past week, I was able to laugh at myself on the existence of this problem in my life.

Strongly agree Agree Uncertain Disagree Strongly disagree

5  4  3  2  1

Interviewer says: Tell me how much were you able to laugh at it.

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
The interviewer is to thank the student/client for describing the conflict.

If there are more than one major issue that the student wishes to work on, the interviewer is to use another sheet of behavioral outcome, label it #2.

The interviewer is to tell the student that a counselor will be in touch with them and the best time to call them or reach them by phone is ________________

The best time to meet for the sessions is:

_________________________________________________________(1st preference).
_________________________________________________________(2nd preference).
_________________________________________________________(3rd preference).
Appendix G

Outcome Criteria
Outcome Criteria

The following is a description of the four category outcome criteria of each subject grouped according to treatment modality.

Client-centered

Student 1
Maximal Improvement

I would have a better feeling, be more relaxed and more at ease about my decision. I'd look at it more objectively. I'd see the issues more clearly and not have the decision always tugging on me.

Minimal improvement

I feel just talking about it and getting feedback would be helpful. I get laughed at when talking to students. It's difficult to talk to students that you see socially.

Same

I would only feel that it helped the investigator.

Worsened

I'd feel more confused about decision. I'd disregard it. I'd say it was just an experience.

Student 2
Maximal improvement

I'd feel a cloud lifted, a relief of tension. I'd enjoy the present more without worrying about the future.

Minimal improvement

I'd probably feel like I was at least headed in one direction
Same

I would remain concerned with my future plans in regard to a career and marriage.

Worsened

I'd breakup with my boyfriend. My grades might go down if I felt like there were no alternatives.

Student 3

Maximum improvement

I'd feel comfortable in the major that choose or I would know clearly that I should reject it. I'd feel more comfortable with decisions or be more comfortable going the other way.

Minimal improvement

I'd be more happy with my studies just a little bit. Things wouldn't feel as much work as something I wanted to do.

Same

I would still be uncomfortable, still contemplating another direction and still saying I could do it anyway.

Worsened

I'd hate my major but force myself to do it anyway.

Student 4

Maximal improvement

I'd be a lot happier. I'd do things without believing I'd know how it's going to turn out. I'd be able to stay in the present. I'd be more spontaneous. I'd not worry or question every request or wonder if I could respond in the "right way." I'd decide freely and immediately.
Minimal improvement

I'd expect it to help me accept myself a little bit. In that I'd worry a little less about myself. I'd do things a little bit easier.

Same

My lack of acceptance would block a fulfilling career. It would hinder me getting a family. I'd relate wondering if I was accepted and often doing things that indicate a search for acceptance.

Worsened

I would worry more and become self-centered and neurotic. I'd be totally wrapped up in myself.

Student 5

Maximal improvement

I would have some indication of the direction I want to take as my career, not necessarily a firm decision but a direction. I'd like to see why I seem more stable to myself than others at times perceive me to be. I'd like to come to grips with the fact of my sterility.

Minimal improvement

I'd feel comfortable talking about my problems with someone who is in a position to know.

Same

I'd leave with a lower self-sense of self-esteem and identity than I came with.

Worsened

If they made moral judgements about certain attitudes and activities that I participate in, I'd feel worse.
Student 6

Maximal improvement

I wouldn't be trying to impress people as much as I try. My social life would be different. I would do different things. I would probably study more.

Minimal improvement

I would have more confidence. I would have less insecurity. I would enjoy myself more and enjoy those people I am with instead of looking for more.

Same

I expect to improve and don't anticipate it to stay the same because I'm working on it.

Worsened

I'd feel more blue.

Student 7

Maximal improvement

A specific incident would occur. He would get excellent grades, excellent job and would go out without me and I wouldn't mind. I'd feel only happy. I wouldn't be jealous of him at all. I recognize this may be unrealistic.

Minimal improvement

I would be less extreme in my intensity of jealousy. I would not get carried away at all. I would feel less jealous at some incidents.

Same

I would not react well to the things that make me upset and him upset. I'd get jealous if he went out and made straight A's. If he achieved I would get upset at any and all of his achievements.
Worsened

I would have a really bad fight with him. We would both be upset. The relationship would be set back and we both would suffer.

Student 8

Maximal improvement

I'd be happier, not that I am sad. I'd feel more complete. I would be more expressive of my emotions. I'd stop having these feelings about them and be accepting of the way they are. I won't harbor those feelings of sadness.

Minimal improvement

If I could have new ways of figuring out my problems. I'd be helped to see how I could make it better, not do it for me, but help me come up with alternatives to my situation.

Same

I'd feel like I wasted my time. I'd still be feeling alone at school and unable to get any closer to anyone. I'd feel the same, almost cut off from everyone.

Worsened

I might not deal with them as much. I'd stay away, not letting myself get involved with them. I'd withdraw and stop trying to reach out.

Student 9

Maximal improvement

I'd be easier to get along with. I'd be happier, know more people and meet them easier. Academically, I'd feel I got what I deserved. Socially, I'd date more. My weight would change a lot. It's an obsession.
Minimal improvement

To start I'd be self satisfied. I'd feel more comfortable about myself around people.

Same

I'd always be self conscious about weight. I'd be constantly struggling academically. I'd be wondering what people think about me.

Worsened

I wouldn't be able to fit through the front door. I'd be in a rut, a cycle. I'd have a low opinion of myself. I'd be ashamed of myself.

Student 10

Maximal improvement

I would understand and accept the reality and why the pregnancy and abortion happened. I don't feel what I did was right and I need to accept my mistake and learn to deal with it. I'd feel like a regular person. I'd pick up the pieces and be able to go on. I'd free myself from the burdens of guilt.

Minimal improvement

I'd be able to live with it but not accept and understand what happened. I'd be able to carry the burden of guilt better but not be free from it.

Same

I'd still be highly distraught and continue to be really off the wall. I'm emotionally drained. Life is not worth living. I will be an unhappy person and not able to live.

Worsened

I would not resolve my feelings for the two men, and if I did choose I would be rejected. I'd get so nervous I would not be able to function in school or life.
Student 11

Maximal improvement

I'd react in proportion to the facts present in the situation. I would not take comments critically all the time. I'd evaluate the truth to a comment before I react emotionally to it. I'd take comments in the spirit that they were intended and no longer degrade myself.

Minimal improvement

I'd think more about it but I would not change my behavior. I'd have "insight" but no behavior change.

Same

I'd react emotionally to what people say and misunderstand people's comments toward me. I'd be overly sensitive.

Worsened

I'd go to psych services. I'd see the need for it. I'd be upset at the smallest critical comment about me. I'd tear up easily and go through most of the day hurt.

Student 12

Maximal improvement

My roommate and I would be able to sit and talk honestly about concerns. I would have no qualms about expressing myself in front of roomie. I would be treated as a competent adult by my coworkers, with respect and with personhood. I would like to be able to communicate better with friends. I'd ask them to do things (go to movies) and feel comfortable around them.

Minimal improvement

My roommate and I would be aware of the others feelings even if they could not agree. I'd be better able to express myself in front of roommate. I would be treated more as a coworker than as a wishy-washy adolescent. I would feel increased comfort around friends. My self confidence would be improved.
Same
My roommate and I would co-exist with little to no relationship. I would be a boarder in my own apartment. I would be treated as a baby, a wishy washy adolescent without respect. I would still feel uncomfortable, feel dumb and insecure, with no confidence interpersonally.

Worsened
My roommate, I, or another roommate would move out. I would quit my job. I would probably not speak to friends again. I'd become a recluse.

Student 13
Maximal improvement
I'd probably look for satisfaction inside myself rather than from others. I'd feel more self confident. Ninety percent of the jealousy would go away. I'd believe in myself more. I'd make more independent choices and I'd be more sensitive to myself.

Minimal improvement
I'd have a place to vent out feelings. I'd be able to vent feelings to someone I don't know so I would not feel stifled in sharing my feelings of jealousy.

Same
I'd still feel jealous and somewhat inferior. I'd still feel pressure to achieve like my husband. I'd feel torn and confused about being a mother at home or working. I'd be afraid of going crazy not working. I'd be afraid of dependence.

Worsened
I'd be very unhappy. I'd start withdrawing into self and be more defensive. I'd cry more and get more emotional and have more fights. I'd feel younger and immature.
Student 14

Maximal improvement

I would be able to control my temper (not blow up). I would be able to sit with my mother and not get angry. I would not be bothered by simple problems or little things. I would limit myself to one blow up per year.

Minimal improvement

I would be able to control my temper 75% of the time. I would be more tolerant of my mother's little things (which aggravate me a great deal). I would decrease the amount of blow ups per year to 2 or 3.

Same

I would still be able to control my temper only 50% of the time. I would still be relatively intolerant of my mother's little things and get angry at them. I'd still have blow ups. I would continue to be bothered by little things.

Worsened

I would not be able to tolerate even the smallest problems. I would possess a short fuse. I would control my temper 25% or less. Blow ups would increase.

Student 15

Maximal improvement

I'd key down a little bit. I'd slow down. I'd relax more. I'd lose a little weight. I'd see more clearly about my future. I'd decide for myself, not what other people want me to do. I'd be able to make strong decisions.

Minimal improvement

I'd be a little more at ease with people. I'd be able to confide a little bit more. I'd risk sharing what's bothering me. People would believe me more.
Same

I'd be non-assertive, ill at ease with people I don't know. I'd be just as nervous and unable to talk with people.

Worsened

I'd hide in my room and just stick to the dorm more. I'd start going out with friends less. I'd be more self conscious around anybody.

Rational Emotive

Student 1

Maximal improvement

I may not like him, but I'd respect him which is essential to play under him. There would be no friendship but I'd be able to tolerate the situation. I'd feel like I could make it through the next 3 semesters with little difficulty. His comments would not bother me that much. I'd understand it in a different way.

Minimal improvement

I'd be able to understand him slightly better not respect him but better understand his reasoning. I'd allow him to be the way he is and understand if not respect or accept.

Same

I'd continually be hassled. I might transfer out of college. I'd leave and get a job. It's not making me real happy. I'd decide to leave school. I'd not put up with all the hassles.

Worsened

I'd definitely leave school and get a job. I'd transfer to another school. I'd go to a University at home in Scotland.
Student 2

Maximal improvement

I'd be more happy with myself. I'd be more ambitious. I'd see more clearly with my studies rather than going on with no end. I'd be less annoyed at myself for not trying hard. I'd see the goal clearly and be able to attain it; right now, math teacher and ultimate Ph.D. in Education.

Minimal improvement

My understanding of subjects in school would improve. I'd make more connections between subjects and the real world and the subjects and its use with my goal. I'd feel less pressure at test time.

Same

I'd still be confused and lazy getting homework done. I'd not put in enough time studying. I'd search for definite goal.

Worsened

I'd start doing badly in courses. I'd be getting poorer grades than I've ever gotten before. I'd feel that I have to quit school and would not go on in school. I would not see any use in any of the courses at all.

Student 3

Maximal improvement

If he would accept me and participate and share in my activities. I'd be relieved of the pressure of our relationship and sure of marriage. Even if it would be resolved that we would go separate ways that would be O.K.

Minimal improvement

I'd have more direction in problem solutions or open up some other aspects for solution.

Same

We would use a trial separation
Worsened

I don't think it could be worse, but maybe it would and we would make the decision to breakup.

Student 4

Maximal improvement

What I said below but to a greater extent. I would not spend that much time analyzing, but spend more time on things I like to do. I'd save more energy and enjoy life more.

Minimal improvement

I'd be more relaxed and enjoy myself and other people more. I'd be more pleasant to be around and less irritated. Instead of analyzing compliments I'd enjoy them. I wouldn't put myself down so much. I would not ask for that much reassurance. I would fall asleep easier.

Same

It takes me ½ hour to 1 hour to fall asleep (once every two weeks). I pick fights with loved ones once every two weeks because I'm so nervous and tense.

Worsened

I'd be constantly tense and upset because I felt I wasn't good enough. I'd lose self-confidence in other areas. I'd be more irritated and angry around loved ones (several times a week). I'd have more trouble falling asleep instead of having trouble like once a week. It would happen more often.

Student 5

Maximal improvement

My grades would improve greatly. I'd volunteer freely in the class. I'd not be afraid to speak out. I'd be confident.
Minimal improvement

I'd feel better about the situation of school. I'd read slightly better and understand what the teacher says. I'd read it once and be able to understand what I've read.

Same

I'd be dissatisfied with school. I'd not volunteer answers at school. I'd be unable to retain things when I read them.

Worsened

It would be very dull. I'd lose interest in school and church and the whole thing. I'd be totally unmotivated to do anything.

Student 6

Maximal improvement

I'd participate in class and volunteer information. I wouldn't take anything personally. I'd be more relaxed. I'd think healthy thoughts and not spend my time worrying so much.

Minimal improvement

I would not feel so intimidated all the time. I'd have a quiet confidence in myself but not speak out much.

Same

I'd still see that I had the problem and I'd recognize that I didn't work at it. I'd lack self confidence and be worried about being accepted by others.

Worsened

I can just see me going inside myself and bowing out of all social situations. I'd withdraw to my room and study without any social companionship. Most everything I did would be by myself. I would like the situation less than I do now.
Student 7

Maximal improvement

I wouldn't have to stop and labor that after I said it I still wouldn't be wondering if it was right. I'd just be able to be more spontaneous in the speech that I have.

Minimal improvement

I'd be able to express myself clearly to two people. I wouldn't think too much about everything I wanted to say. I wouldn't say I don't know when someone asked me a question or stammer or stutter.

Same

I still wouldn't be able to express myself. My ideas would be there but I wouldn't be able to put them into words.

Worsened

I'd be mute. I'd never say anything. I'd be quiet for most of the day.

Student 8

Maximal improvement

I would be certain in my present relationship. I would not question my impulses to date others and would continue to go steady. I might become engaged. I would become comfortable in asking out and dating others. I'd have some successful dates and stop thinking about my current steady. I'd have another successful relationship. Ideally no one will get hurt.

Minimal improvement

I'd be more certain about my present relationship. I would question less my impulses to date others and would be more certain about going steady. I might be near considering engagement or I would become more comfortable in meeting others. I'd be considering dating more seriously. I'd be more confident in asking for dates.
Same

I would be confused about my future, where to go to look for a job. I probably would stay with my steady because it is secure. I would become self-centered in the relationship. I would suppress desires and impulses to explore other relationships. I might consider engagement. I would get depressed in the situation.

Worsened

Continuing in the present mode would make the situation worse. Engagement to my steady at this time might worsen the situation. It would confine me. I'd have frustrated impulses to see others. I would get even more depressed in the situation. I would possibly hurt others (i.e. his girlfriend).

Student 9

Maximal improvement

I'd have 2 hours free time for self a day. I'd be able to spend time with boyfriend at least twice a week (2 hours). I'd have regular meals; I'd make a schedule and not skip on a regular basis. I'd be able to say no to things I know I can't handle. I'd adhere to my already-made study schedules.

Minimal improvement

I'd have 1 hour of free time a day. I'd at least see my boyfriend once a week. I'd have regular meals; I'd make a schedule and not skip on a regular basis. I'd be able to say no to things I know I can't handle. I'd adhere to my already-made study schedules.

Same

I'd still feel overextended and anxious about doing everything. I'd still be unable to put priority on academics and say "no" to other things.

Worsened

I'd get more overextended on campus. Health problems would arise (mostly allergies) to interfere, also stomach disorders.
Student 10

Maximal improvement

I'd feel happy and confident, motivated, and handle things better with self and others. I'd go out with friends and celebrate. I'd drive around and think about past couple of years and feel resolved. I'd have a higher energy level. I'd do more specific things to achieve my goals.

Minimal improvement

I'd work harder at resolution, but I'd still be worried.

Same

I'd be worried, bored, sleeping a lot. I'd have low energy level.

Worsened

My fears would grow. I'd really feel aimless. I'd travel around. I'd work odd jobs. I'd waste time. I'd have routine social activities. I'd be tenser. My concentration would stay on the problem.

Student 11

Maximal improvement

I don't want to feel as though she is overwhelming me or I am too emotionally involved with her. I would be able to look at the relationship, the plus and minus of it objectively and evaluate it, which would free me to make some choices about it.

Minimal improvement

I'd have a better understanding of our relationship and see what I could do to feel more comfortable. (Nothing may be bothering her, it's more me.)

Same

I'd feel overconcerned and uncomfortable with my understanding of the relationship.
Worsened

I'd probably have increasing feelings of paranoia that she doesn't know what she wants and her feelings toward me might change.

Student 12

Maximal improvement

The counselor would listen and respond to my comments in such a way that what I saw as contradictory would be clarified and I'd see more clearly the options that I have about my future. The counselor would help me see it's my decision about my life and not live up to other expectations than my own.

Minimal improvement

I'd be more confused and this would motivate me to make a decision in the future about my career plans. Just the experience of talking to someone and meeting someone new.

Same

I'd still be completely in doubt about my major. I would not have done any more serious reflection on it.

Worsened

The person was not empathic and not listening to the points I brought up and would bring up other options that are very irrelevant. I would not be better off than when I came.

Student 13

Maximal improvement

I would feel comfortable spending time doing other things without pangs of guilt. I would not feel rushed. The list of things to be done running through my mind would cease. I could put down a book without guilt. I could feel comfortable with getting a B and even a C. I would feel more relaxed while taking tests and doing assignments.
Minimal improvement

I would feel semi-comfortable spending time doing other things, less guilty. The list of things running through my head would not be such a large concern. I'd only feel comfortable getting a B. I would feel a little more relaxed about taking tests but not as relaxed as the ideal situation. I'd feel less rushed.

Same

I'd feel pressed for time because I have so many things to do in addition to studying. I'd be uncomfortable doing other things than studying when they take up a lot of time. I'd feel anxiety about tests. I'd feel rushed.

Worsened

I would become frustrated and complain a lot. I'd feel more uncomfortable about taking tests and doing papers and getting them back.

Student 14

Maximal improvement

I'd know what to do with my life or at least I'd begin to have a much clearer perspective of what I want to do with my life. I'd have a purpose, some meaning, some goal.

Minimal improvement

Just talking about it would give me some insight. When I went to a psychiatrist he listened and it helped. I'd figure it would be the same.

Same

I'd still be confused and have no idea what I want to do with my life. I would think it was a waste of time.

Worsened

I'd be angry at the counselor. I'd be more confused about myself. It would be more waste of time. I'd feel used.
Student 15

Maximal improvement

My situation would look like this. I'd have a better pattern of behavior in life that could carry over in my professional life. I'd deal with things as they come, as they are, not procrastinate (e.g. write 10 checks and balance later, not do that anymore). Study and concentrated each day.

Minimal improvement

I would be able to realize something of what I am doing now is incorrect without being lectured to. The counselor would help me discern what is blocking my ability to achieve academically.

Same

I'd continue to find other things to do. I would have a block of study and procrastinate. I'd continue to constructively waste time on everything but study.

Worsened

I wouldn't study at all. I would not do reading assignments until just before finals or tests.

Paradoxical directives

Student 1

Maximal improvement

I would choose a major that I feel satisfied with. I would make at least a 3.5 average in my major. I would spend the same amount of time socializing (as presently). I would spend 5 hours a day studying efficiently (7 days a week).

Minimal improvement

I would spend 5 hours a day studying efficiently (7 days a week), but I still would not have chosen a major.
Student 2

Maximal improvement

I would have more time with my boyfriend and could concentrate on smaller things. Focus would shift to making it work. It would also affect relationship with others. I would be more confident about my own value system.

Minimal improvement

It would be wonderful, step by step. The process of relationship, but with a commitment to each other. The learning would continue in a positive way.

Same

I would do the same as I am doing now. I would enjoy life now. I'd make most of my time now. I would feel a need to go deeper in relationship to make it work while still enjoying other people, especially other guys as friends only. There would be no misconceptions on their part.

Worsened

My boyfriend would move to Denver. It would be worse if we stopped communicating.

Student 3

Maximal improvement

I'd have an inner peace that I'm doing the thing I'd know is the "right" way to cope with the situation. I'd be able to see the situation in a way that didn't cause me anxiety. I'd be able to face the situation and not being able to get out the house, go home and not having to leave again.

Minimal improvement

Being able to talk to someone who doesn't know about the situation would help me understand where my feelings are coming from. I'd identify what I am really feeling.
Same

I'd feel as anxious about the situation as I ever did. I'd wonder if any of my feelings were legitimate.

Worsened

I'd really question my ability to react to any kind of strenuous situation. I'd be extremely anxious. I'd question the way I'd react to any kind of situation. If another problem came up I'd wonder about my feelings.

Student 4

Maximal improvement

I'd discuss relationship with girlfriend by end of the semester. We'd have daily "mind to mind" conversations (about our feelings). I'd feel her trust by being free to change schools and her not doubting my love. My girlfriend would have other plans (besides with me) several times per month. Both of us would make a real effort to schedule in seeing others once a day.

Minimal improvement

I would have firmed up my own definitions of "commitment" and decided what things need to happen in relationship in order for me to pursue engagement plans.

Same

Nothing would be talked out with my girlfriend and I would not define "commitment" for self either.

Worsened

The relationship would drag on and on with nothing improving nor probably being resolved.
Student 5
Maximally improved

If the problem got improved. If it bothered me again
I'd seek help more easily. I'd also be immensely relieved.
If it got resolved, I'd be more open to talk about this
with others as a way to release the tension.

Minimally improved

I would be able to think about death and not get sharp
pains in my chest. I could think about it and not get
afraid and have my voice choke up.

Same

My voice would choke up if I thought about a person I
really loved. I would still feel upset about choking up. I
would continue to feel uncomfortable choking up in front of
others, especially if they didn't understand why.

Worsened

I'd probably consider psychiatric help. I'd need a
long period of counseling. I'd be overwhelmed and not be
able to cope at all. I'd be paralyzed and not be able to
function very well.

Student 6
Maximal improvement

I would get along with parents better. I would get
along with roommate better. I'd get along with sorority
sisters better. I wouldn't feel any anxiety about grades.
I'd feel more self confident. My study habits would im-
prove. I would be able to concentrate more.

Minimal improvement

I would be able to get along with my sorority sisters
better. Last year they thought I had dropped them when
really I was just dealing with a lot of problems they didn't
know about. I would improve my grades, B's and A's and no
more than two C's this semester.
Same

I would feel very very depressed. I'd feel like everything will fall apart again. I tend to get headaches when anxious, stomachaches too. My grades would go down again.

Worsened

I would take a year off from school. I would seek counseling. I would do no work, no job. I would be too upset to function effectively. I would be extremely sensitive towards myself and how others see me.

Student 7

Maximal improvement

If the sexual issue were resolved, I would have a sense of certainty. Anxiety would go down. I'd be more relaxed. I'd have more dates. I'd question myself less. I'd be more relaxed and be able to concentrate on lots of other things. My anxiety over sexuality would be reduced. I would know. I would spend less amount of time thinking about it.

Minimal improvement

I'd feel somewhat better. I'd feel I have pinpointed the problem and begin focusing on them. It may cause greater difficulty because I would not seek out professional help after it.

Same

I'd be very anxious over my sexuality. I still would not understand the specific problems. I'd still be confused.

Worsened

I'd probably block out the problem of sexuality and ignore it. I'd pretend it's not there. I'd deny the problem of my human sexuality.
Student 8

Maximal improvement

I'd feel more comfortable about talking to new people. I'd be able to see how to break the pattern of what I'm doing that hinders a full social life. I'd make some changes in how I choose to relate to others.

Minimal improvement

I'd be able to identify some problem areas that are hindering my social life. Though I identify them, I would not make any behavioral changes.

Same

Social life would remain the way it is, pretty dead. I work too much, school work, too much study.

Worsened

I'd withdraw into myself. I'd become a hermit. I'd talk to fewer people. I wouldn't go out at all.

Student 9

Maximal improvement

I would be happy with myself as a prospective mate (my ways of dating boyfriend, should call, etc.). I would be more comfortable with myself and my behavior. There would continue to be a possible future in the relationship (may strengthen). I would be more sure of myself (confident) in general.

Minimal improvement

I would be more happy with myself as a prospective mate. I would be more comfortable with my dating practices. I would be more relaxed in the relationship. I would continue to consider the possibility of a future in the relationship. I would exude more confidence about the relationship.
I would continue to be unsure of myself as a prospective mate. I would continue to be uncomfortable because of my dating practices (insecure about them). I would doubt (self doubt) the future potential of the relationship I am currently in. I would continue to be frustrated by the tension in that relationship.

Worsened

The strain on the relationship would cause termination. I'd have bad feelings. If conflict were to worsen I would probably terminate it. My feelings are not strong enough that it would be worth continuing the relationship in its current mode.

Student 10

Maximal improvement

I would know exactly what I want to do for a living.

Minimal improvement

I'd feel sure about the field I want to go into but unsure about exactly what I want to do within that field. I've got to start narrowing things down. I've hardly started at all.

Same

I would be hopping from one occupation to another every 5 years which in itself may not be bad but it's hard to rise to the top of your field if you only stay for 5 years and then leave.

Worsened

If it were to get worse (but it won't because I'm already assured a job in the army), I would graduate with no job or I would narrow down the prospects, decide what field I want to go into, get a job and find out I really hate it. That would definitely be worse.
Student 11

Maximal improvement

I'd have more confidence in myself. I wouldn't be afraid of involvement because I'd have confidence in myself. I wouldn't be so easily manipulated any more. I'd be more in control of the situation and make choices about who to be with and how to be with them.

Minimal improvement

I guess I'd be able to talk about it and knowing I can talk about it and get some of it out in the open. I'd be able to talk about my sexuality with less apprehension.

Same

I'd go right on relying on Christianity to carry me through. Basic mistrust of men would remain and not be optimistic about satisfactory involvement with men.

Worsened

I'd recognize my need for intensive professional help as I would not be able to cope with any relationship with men. I would mistrust them all and withdraw into myself. It would affect my self-confidence. It would affect my school work and professional work.

Student 12

Maximally improved

I'd be a lot more outgoing, extroverted, verbally expressive, responsive for contributions in classroom and social situations.

Minimal improvement

I probably would be more comfortable, some increase in verbal expression like I'd feel I was contributing more.

Same

I would remain uncomfortable about my lack of assertiveness.
Worsened

I probably would become withdrawn and less likely to respond to a classroom situation.

Student 13

Maximal improvement

I would be much happier in the relationship. I would be able to concentrate on studies/duties. I would have no feelings of stress (tension) or anxiety. There would be improved communication with mate.

Minimal improvement

My boyfriend and I would be happier in the relationship. There would be improved communication with mate. I would have an increased ability to concentrate on studies/duties. I would have fewer feelings of stress (tension) and anxiety.

Same

I would continue to be unhappy in the relationship. I would be preoccupied with problems about him instead of with my studies. I would continue to be anxious and tense. My communication with mate would be poor.

Worsened

I would terminate the relationship. I would be depressed. I would be unable to concentrate on studies.

Student 14

Maximal improvement

I'd be a lot nicer person to be with. I'd be nicer to other people. I'd be nicer with people I deal with. I'd act on an even temperment and good disposition. I'd see myself in a more positive light. I'd see good points about 5 people. I would not think bad thoughts about people.
Minimal improvement

Any one of these things: better attitude toward people. See good points about 2 people. Not say anything bad about people. Control my tongue.

Same

I'd be impatient with people. I'd be in a bad mood, ridicule people. I'd have no patience with the average Joe. I'd run out of patience easily.

Worsened

My language would get worse. I'd be outright mean to people. I'd say cynical things. I'd act in a real angry mood. I'd explode at the least little thing that goes wrong.

Student 15

Maximal improvement

Thoughts of my family would not be nagging me. My attitude was helping the situation, not contributing. Sometimes in talking to Mom I give her more reason to be upset, than helping the situation. My response to the situation would help the rest of the family. I would have a clear perspective on my family situation and I would know how it was affecting me. I'd see clearly.

Minimal improvement

I'd get it off my chest and be able to talk about it freely. I'd have a little bit more insight into the problem. I'd be able to understand a little bit, but do nothing to change.

Same

I'd still be very concerned about my family and unable and not confident to be of valuable assistance to my mother. In responding to my mother, I would contribute to the problem rather than help it.
Worsened

I'd feel sorry for myself. I might feel it's all my fault. I would feel that I should be able to change the situation. I would feel that it's my problem and I should be able to change the entire situation. I'd feel it's my fault or all in my mind.

Control Group

Student 1

Maximal improvement

I could sleep six nights a week. I'd sleep soundly rather than have things go around in my head. If I find positive suggestions to change. I would be able to allow for mistakes in life and not be so hard on myself.

Minimal improvement

I'd feel a little bit more at ease. I'd sleep at least 4 of the seven nights a week. I'd be able to sit down and relax for \( \frac{1}{2} \) hour.

Same

I'd continually push myself and use every minute of time to do something productive. I'd be faithful to the Protestant work ethics.

Worsened

I would physically run myself in the ground. Sheer exhaustion would set in. I'd be so tired I couldn't move. I'd get no sleep. I'd try harder to be more perfect.

Student 2

Maximal improvement

I'd go into a large gathering of people feeling comfortable, excited about being there and not finding it difficult to talk to people, instead of be afraid. It's the initial stage that I want improved
Minimal improvement

I wouldn't feel quite so scared initially. I'd recognize that I will feel comfortable eventually and enjoy the evening. Sometimes I do that now but with prodding of friends. I would like to not have to rely on friends for prodding.

Same

I'd compare myself with others and/or groups and come up short, particular with women (appearance, the way I sound).

Worsened

I would feel everything more strongly. I would avoid those situations (any groups where I would feel uncomfortable). I would stop going to parties or occasions with large groups.

Students 3

Maximal improvement

I'd be able to come home and make myself work instead of watching T.V. I'd be able to say, no I have to study if somebody asked me to do something. I'd plan my day so the studying could get done. I'd have time for friends. My day would be balanced.

Minimal improvement

I'd be able to spend 3 to 4 hours studying with just 5 to 10 minutes breaks. I can't do that now.

Same

I would be able to study for 30 minutes to 1 hour and 1 hour of reading. I'd study for a while or watch T.V. or do something else.

Worsened

I wouldn't be able to study at all. I would call in sick at work in order to stay home and study.
Student 4

Maximum improvement

I would be able to make decisions without second guessing myself. I wouldn't feel I'd have to ask friends. I'd feel better about myself. I'd be more confident in day to day living (not ask at all). I'd raise my hand and volunteer information in class.

Minimal improvement

I would not have to ask someone all the time. I would know certain things to be right. I'd be more assertive. I wouldn't say, you should have been doing it (once a day). I wouldn't be nervous when they called on me.

Same

I'd be asking people if my decision was right all the time (3 times a day average). I'd lack confidence and feel nervous and afraid that they would call on me, even if I knew the answer.

Worsened

I'd ask for reassurance 5 to 6 times a day. I won't be able to make any decisions by myself. I'd withdraw into myself and become more nervous.

Student 5

Maximal improvement

I'd feel happy all the time. I'd be positive instead of negative. I'd smile a lot. I wouldn't have chest pains. I'd be "happy go lucky."

Minimal improvement

I'd be able to cope with pressure a little better. I'd handle things better. I'd be happier more of the time. The chest pains would be gone. I'd have a more rational thinking process.
Same

I'd be concerned about pressures. I would wish I was more easy going. I'd do a lot of introspection. I'd question my thinking process. I'd have chest pains relative to nervousness.

Worsened

I'd be out of William and Mary real quick. I'd be introverted, shy away from social events. I would become a study nerd. I'd be negative and not think twice. I'd be a jerk.

Student 6

Maximal improvement

I would orientate myself toward the present. I'd take things day by day and be confident in my worth as a person whether I'm worried or not. I'd accept the fact that I will be single in the future and still feel good about the future (not depressed).

Minimal improvement

I'd still be able to look toward the future without feeling defeated. I would still have some unresolved conflicts.

Same

I would still be depressed when I thought about the future.

Worsened

I would probably need long term counseling. I might not be able to concentrate on studying at all. I'd lose sleep and have a loss of appetite.
Student 7

Maximal improvement

I'd feel wonderful. I'd find a guy or go back to church. My guilt and self-centeredness would go away. I'd be more pleasant. I wouldn't be wild.

Minimal improvement

I'd achieve a balance between the desire to find someone and being outreaching. I wouldn't be obsessed with finding a guy and would be comfortable with myself as a religious being.

Same

I'd feel unsatisfied with myself and my relationship with guys and others. I'd feel drifted from the church. I don't like analyzing every male I go out with.

Worsened

It would become an obsessive thing. I'd be demented if it got worse. I would be totally away from church and further away from finding a male companion.

Student 8

Maximal improvement

I would not feel guilty in this relationship. I would come to accept and better able to deal with the differences that we both have. I'd know where the differences are and I'd be able to accept them as something to live with. Communication would improve 20%. Both of us would feel we could appreciate each other for what we are.

Minimal improvement

I'd be able to resolve conflicts in a constructive way.

Same

The situation would be liveable. I would not hesitate to go back there. It would not be a fulfilling relationship. It would be a contractual relationship. The friction would remain.
Worsened

To get worse, it would have to get to be not worth­­while to attempt to communicate. The problem areas would compound. We would go about our business and say only the minimal amount to each other.

Student 9

Maximal improvement

All testing, paperwork, applications would be com­­pleted. I would have made a choice of career fields and a course of study and have been accepted at a grad school.

Minimal improvement

I would have decided what I want to do but not been accepted.

Same

I would still be undecided. I would still be in the process of talking to professors and reading catalogues.

Worsened

I would have decided what direction to go in but wasn't accepted to any graduate schools. Then I would have to worry about what to do for a year.

Student 10

Maximal improvement

I'd be more enjoyable, more agreeable, a nicer person, argue less, be patient with people, and a better person. I would enjoy life more, look forward to the future, be optimi­­stic, and self confident. I wouldn't have any more stom­­ach problems. I'd do a lot less smoking (whole pack less a day). I wouldn't sleep as much. I wouldn't feel as tired. I'd get 6 to 7 hours of sleep.
Minimal improvement

I would just go ahead and do the task. I'd feel better. I'd take more time. My stomach problems would go away. I'd be less anxious, less tense, smoke less, like myself better, and sleep less and have more time.

Same

I'd be tense, anxious and have stomach problems. I'd be angry in general. I'd get myself worked up over nothing. This doesn't keep me from getting done what needs to be done. Once I get a project done, I realize that I do it to myself. I get angry, smoke a lot and sleep a lot.

Worsened

Minor things would appear like big problems. I'd be short tempered, talk with others (wife, friends). It would interfere with my relationship with my wife in the form of arguments. I'd take it out on my wife. My smoking would increase. I'd become quieter and sleep more.

Student 11

Maximal improvement

I would be a whole lot more relaxed. I could make a decision and keep and stay with the decision about sex. I would not feel like a kid any more. I would feel sure of myself. I would not be as anxious over the problem. I'd feel more secure in the stand I'm taking. The stand I'm taking with sex is no. I really don't know why. If it were resolved I'd know why and feel secure. I would expect to be able to resolve this problem in life.

Minimal improvement

It would not occupy as much time in my thoughts. There would not be a down fall in a relationship. If I did choose a boyfriend I'd have a reason behind it. I'd be confident with that reason.

Same

It would continue to get worse. I would get more and more emotionally involved with people. I wouldn't have an answer and I'd be torn even worse than I am now.
Worsened

I would not get involved in a relationship. I'd give up all relationships because I wouldn't want to deal with it all.

Student 12

Maximal improvement

I'd stop being suspicious. I'd start picking more appropriate things to worry about like school and would not have as many philosophical conversations with my friend.

Minimal improvement

I would spend less time pondering. I'd be more laid back, relaxed, less tense. I'd give people a chance. I would not analyze every little thing they say.

Same

As of right now, I worry a lot but it doesn't really interfere with my life.

Worsened

It would stop me from doing the things I wanted to do, studying, going out, sports. It would interfere with school life and leisure activities. I'd probably bite nails and would have trouble falling asleep.

Student 13

Maximal improvement

The major difference in my life would be that I could go and talk to people I've been uncomfortable around. I'd talk to more people. I'd tell my family and friends. I'd do more things with people. I'd flirt more and reveal interest in an attractive guy.

Minimal improvement

I'd talk more with anybody who came along. I'd continue to work on it.
Same

I would not flirt. I would keep interest in male friends expressed in a friendly basis not opening up to romantic possibilities.

Worsened

I'd withdraw more. I'd initiate less interaction with people.

Student 14

Maximal improvement

I'd find more things I'd like to do on my own, instead of brooding. I'd be happy on my own. I wouldn't need people as much. I'd have more academic pursuits, intellectual interests, self-improvement, not so hectic, not so many physical things, would be able to walk into party.

Minimal improvement

I'd be engaged. I wouldn't be upset when boyfriend doesn't call. I'd stop worrying about few extra pounds, enjoy food, and worry less about looks.

Same

I'd do the same things I do now.

Worsened

I would worry about social things (looks, etc.). I'd get very busy, too involved. I'd take on too much. I would worry a lot about my boyfriend, sitting by the phone. I would start brooding.

Student 15

Maximal improvement

I'd stop worrying, be optimistic, have definite plans to get a job or take a break from school or be in grad school. I'd make plans to visit my brother in England. If in grad school I could visit my parents.
Minimal improvement

I'd probably know where to start and how to work on it.

Same

I'd keep on trying to find out information, looking for advice from more people, exploring more kinds of jobs.

Worsened

I'd keep going to school. I'd go to grad school and then decide.
Appendix H

Final Interview
Prior to the outcome-final interview

Ask to take the Barrett-Lennard Relationship Inventory, Willingness to Disclose Questionnaire again, BSI again.
OUTCOME INTERVIEW AFTER THE THIRD SESSION

How do you describe your problem situation? In the initial interview you stated the following.

Improved greatly (4)

Minimal improvement (3)

Same (2)

Worsened (1)
Of those descriptions I just read, which of those descriptions comes closest to that which really happened?

Check which one the subject reports.

_____ Improved greatly (4)
_____ Minimal improvement (3)
_____ Same (2)
_____ Worsened (1)
SELFF REPORT

The interviewer is asked to request the subject think about these statements carefully and state whether they strongly agree, agree, are uncertain, disagree, strongly disagree.

1. During this past week, I thought about my problem most of the time.

   Strongly agree  Agree  Uncertain  Disagree  Strongly disagree
   5         4         3         2          1

   Interviewer says: Tell me how often you thought about it.

   __________________________________________________________
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________

2. During this past week, I was very anxious over the existence of the problem.

   Strongly agree  Agree  Uncertain  Disagree  Strongly disagree
   5         4         3         2          1

   Interviewer says: Tell me about how anxious you were.

   __________________________________________________________
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________

3. During this past week, I was highly motivated to resolve this problem very quickly.

   Strongly agree  Agree  Uncertain  Disagree  Strongly disagree
   5         4         3         2          1
Interviewer says: Tell me how motivated you were to change.

____________________________________

____________________________________

____________________________________

____________________________________

4. This past week, I was able to laugh at myself on the existence of this problem in my life.

Strongly agree  Agree  Uncertain  Disagree  Strongly disagree

5  4  3  2  1

Interviewer says: Tell me how much were you able to laugh at it.

____________________________________

____________________________________

____________________________________

____________________________________
Repeat Rating Scale

On a scale of one to five how would you rate the problem situation

<table>
<thead>
<tr>
<th>Got much worse</th>
<th>Worsened</th>
<th>No change</th>
<th>Improved slightly</th>
<th>Improved a great deal</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

Thank you, the researcher will send you a debriefing letter explaining the results of the study. If you have any questions, he'll be happy to explain the study to you.
Appendix I

Letter to Recruit Counselors to do the Structured Interview
Dear

Although this may seem like a form letter, it is addressed to you personally. I am writing this to you because you have some connection with the counseling program at the College of William and Mary. For those of you who do not know me, I am in the process of doing my dissertation at William and Mary and I need your help with my research.

Your name was given to me by one of the faculty members in the school of Education. This person felt that you might be interested in my research and have the skill necessary to help me with my study. Briefly my research focuses on the effectiveness of three different treatment modalities, client-centered, rational emotive and strategic-paradoxical directives in problem resolution among undergraduate students.

If you agree to help, your role would be doing structured interviews with the students' pre and post treatment. You would not be actually involved in the treatment as such. The structured interview is not difficult to do but does involve a critical component of the study. Your role is chiefly problem description and history gathering and not treatment intervention. It is similar to an intake interview.

I am writing to you because I believe you have the communication skills necessary to do a good job with the students.

A question you may have is how much time will this involve. At the most it will involve 5 hours, one or two evenings in early September. In October a final debriefing interview will take place and this will involve 3 or 4 more hours of your time. I am hoping to get a number of volunteers so that this amount of time can be decreased to about half.

For training you in your interviewer's role, we will have an evening of preparation in the late summer. At that time the design of the study will be explained fully.
Since your help demands of you time and transportation, I will reimburse you for gas. I need your help and want to use skilled communicators so the treatments can be as effective as possible. I also believe you'll have fun doing this as it is a well designed study.

If you are willing to help, please call me at St. Bede's 229-3631, my private number 229-0227 or the Peninsula Pastoral Counseling Center 723-6015. If I am not in please leave your name and number and I will return your call. I do need your help. I will do everything I can to make the time for the structured interviews convenient for you.

Sincerely,

Mike Gombatz

MG/1fd
Appendix J

Debriefing Letter
Dear Student,

I am writing this to explain my study and its results that you volunteered for in September of 1982. It was called the "Wellness Clinic."

My research involved evaluating three different kinds of treatments as approaches to helping college students with their problems. The three approaches were client centered therapy, rational emotive therapy and paradoxical directive therapy. Some of you did not receive any treatment. You were the control group. (You received a letter requesting that you wait for treatment.)

All of you were assigned by chance (randomly) to one of the approaches. The treatment approaches are somewhat complicated but I'll try to describe each method briefly. The client centered approach involves forming a close interpersonal relationship by responding empathetically, warmly and genuinely to what you talk about. Most responses to your statements were intended to be connected to your feelings. This approach was developed by Carl Rogers. You may have read about it. The second approach was rational emotive therapy. This approach focuses in not on the relationship formed but your thinking processes that lead you to describe what issue you wanted to work on. The counselor attempted to help you re-evaluate the way you thought about a problem in hopes that different thinking would enable you to change it.

The third method called paradoxical directives was the main approach I wished to test. The assumption of this method is that people use complaints, problems and symptoms as interpersonal tactics to get their way. A simplistic
example is "sad people get other people to try to cheer them up." In doing so they are able to control what kind of a relationship they are to have with another. To stop this, the paradoxical approach is for the helping person to prescribe exactly what the person wants to change. That was why the outcome criteria and description of the problem. If you are interested in this method any of the works by Jay Haley will be helpful.

My results showed all three treatment approaches, client-centered, rational emotive and paradoxical directives were equally effective in helping students with the concerns of their life. This was my expectation. The major value of my research is demonstrating the effectiveness of the paradoxical approach experimentally.

Enclosed also is a statement for your reference file that you participated in my research. You may like to have it as a reference to graduate school or some kind of employment opportunity. Once again, I thank you. Feel free to call me if you would like to talk about the study further; 229-3631.

Sincerely,

Mike Gombatz

MG/lf

Enclosure
Appendix K

Paradoxical Prescriptions
The following is a description of the directives given by the consultant to the three counselors.

The consultant explained the experiment as an opportunity to further refine their thinking and theoretical formulation of paradox, as well as being an opportunity to practice their skills. The consultant urged caution in the therapist expecting too much too soon. The rationale for the presentation style, though not stated explicitly, was that the consultant believed it was essential for the counselor to be given directives by the consultant in the same manner in which they were expected to give directives to their clients.

As a result, the counselors were told many of the same things they were instructed to tell their clients. This was done in order to help the counselor believe more strongly in the things he was saying. The consultant told the counselor: "Paradox is a complex phenomenon, not easily learned and one must go slow and be careful in learning and using it. It requires a lot of supervision and training. What could be hoped for at best will be a brief exposure and introduction to the technique."

The general format of the therapy session was as follows:

1. Social introduction: Get to know a little bit about each other. Conversation about issues not related to treatment.

2. The counselors were instructed to say: "I've read most of the material, tell me in your own words the nature of the problem" (joining strategy using relationship building skills.

3. Summarize the problem of the client by the therapist.

4. The counselors were then instructed to make a speech about change. This was essentially the rationale for the paradox. The consultant told the counselors: "Being intelligent people (or experienced therapists), you realize that little behavioral change could likely be expected after three hours of therapy. You can expect no behavioral change. After all, this is an experiment and you are doing this to help the investigator rather than produce change in yourself." The counselors were instructed to express his or her
belief that change is usually slow and gradual, and complete resolution of problems rarely happens in a short period of time. The counselors were instructed also to predict that if the subjects were asked later, that they would probably report no behavioral change at the end of the three sessions. What was hoped for was that clients could at least expect to clarify their thinking about the problem to better understand what they really wanted to change in their life, and to evaluate the pros and cons regarding changing vs. remaining the same. The counselors were told to discourage the clients from taking any action towards resolving the problem, but to defer change-producing measures until the thinking was sufficiently clarified. Once the clients were clear in their thinking, they would be able to decide how, when, where and why. (This essentially was more of the same prescription.) It was assumed that the students were cognitively orientated and their thinking most likely affected their academic problems, heterosexual problems or focal problems presented. They were then instructed that if for some reason they did make a change, to go slowly because small changes were better at first.

5. Then the complaint was associated with a positive connotation in order to help the subject view it differently. This was done by the Greek Chorus technique of Papp (1980). Counselors told subjects that their coded structured interview was reviewed by various mental health professionals in order to help formulate a way to best help you. All these experts were impressed with (description of the problem and what you have done to solve it).

6. Following is the presentation of the rationale, individually tailored paradoxes were given. Due to the confidential nature of the study, individual prescriptions have not been printed. The 15 focal problems have been organized around categorical problems and the type of paradox given is stated below along with the number of subjects who presented that focal problem.

In addition to the paradox, should the client have presented problem improvement or resolution, a relapse was predicted by the counselor warning the subject not to think that he or she would get better. Any credit for the improvement was disavowed by the counselor, claiming that he/she did not understand how the subject changed.

The paradoxical prescriptions were written to closely model the language used by the therapist.
Category 1: Assertiveness
Problem with boyfriend, lack of self-confidence
number - 6

Positive connotation

I am impressed with your devotion to your boyfriend such that you sacrifice your autonomy for him. You allow him to speak while you listen because it's probably very important for him that you allow him to get his needs met while keeping yours of secondary importance. Your sensitivity to his needs is truly exemplary.

Rationale

In order for you to become more self-confident, more assertive with your boyfriend you really need to be able to develop a conviction that this is what you really want. And if you do decide to do this, knowing full well of the risks involved in doing so, we think you should make changes gradually. If you suddenly become more open and express yourself directly this might cause too much tension/conflict in the relationship. Your boyfriend probably could not tolerate such an abrupt change in you. Also while you say you want to concentrate more on your studies and less on this relationship, you need to know that over the next three weeks you may find you are actually concentrating more on your relationship. We would be expecting this to happen because we think you need to consider very carefully the pro's and con's of changing your communication pattern with your boyfriend.

Behavioral prescription

I want you to make a conscious effort to focus your conversations with your boyfriend on him totally. Spend a great deal of time asking him about himself while deferring a discussion of your own thoughts and feelings. The idea is that you make a conscious decision not to open up to him because the relationship might be jeopardized should you do this right now. You need to think more about what you would like to say and to choose your words carefully first before speaking. For the next week practice listening to him in this way but after you separate from him go back to your room and write down in a log book all the things you wanted to say but did not because you chose not to. Write down your thoughts and feelings in great detail. Then you should
further analyze these things and write down your answer to these two questions: how would I have liked to have expressed myself and what do I fear might have happened if I had spoken up in this way? Spend at least 30 minutes daily doing this. Your log should reflect at least three statements daily.

Category 2: Disengagement
From family problem interfering with studies
number - 2

Positive connotation

All of the experts who read of your specific problem and I myself are quite impressed with the extraordinarily close ties you have to your family. It was truly remarkable to see such caring, affection, and concern on your part. The majority of people in the study all cited problems such as difficulties with their boyfriend or girlfriend, excessive concern over studies, inability to choose a major, lack of self-confidence, etc. as their primary concern. On the other hand you list your overinvolvement with your family as a problem. Your family obviously relies on your input to resolve problems and without you their difficulties would probably get worse. It is rare to find someone your age who cares so deeply about her family that she constantly thinks about them, worries about them, and keeps in close contact with them. We feel that more families today would do well to be closer like yours. At the same time it certainly is normal that you begin to question the degree of closeness you should have now.

Rationale

Given the extremely close relationship you have with your family we feel that to abruptly change the frequency of contact you have with them or in any way to tell them you wish for more autonomy would cause problems. They might possibly feel rejected and you would probably feel guilty and depressed. There are probably many very good reasons (both conscious and unconscious) why you have not become more independent of your family. The goal of these three sessions is to help you decide what you really want in this regard: you may find that the best decision is not to move farther away but to move closer. In any case we
strongly encourage you not to take any steps in either direction until you fully clarify and understand your thinking in this area. In the next three weeks we hope to help you do that. You may find that you are actually thinking about your family more often and there may be more contact needed. However, we think that the degree of contact should be decided more by you and it should happen in a more predictable fashion so that you begin to experience more control over it.

Behavioral prescription

Over the next weeks, we want you to call your family on even numbered days only and to do so at predesignated time of day (e.g. 7 p.m. - 8 p.m., etc.). Ask your mother/father about their well being and what problems they are having in any area. Express concern and interest as you always do, but defer offering any advice or solutions at that time. That evening, just before going to bed, write down in a log the specific problems cited by your family and begin to formulate a response to your family which you will give the next time you speak with them. In the diary or log write down your personal feelings about the problems, your worries and concerns, what you fear might happen to the family if the problem is not resolved, etc. Keep a record of all these thoughts/feelings you have during the day and put them in your diary. Thirdly, we want you to spend time each day (at least 30 minutes) writing in your diary the pros and cons of becoming more disengaged from your family. What would happen if you had less contact with them? Answer the question?

Category 3: Indecisiveness
Problem of choosing a major
Number - 2

Positive connotation

You say you have a problem making decisions and specifically this is seen in your inability to decide what major course of study to pursue. You would like to be able to decide by the end of these three weeks but we would encourage you not to do this. Decide only to refrain from reaching this decision in the three weeks. We feel that the most beneficial outcome of this brief experience of counseling will be that you may become clearer in your thinking and
perhaps know better what you want. We are very much impressed that you devote so much time and energy to this question. So often today we find college students not really taking the time to fully evaluate the question of what career they want to pursue. Consequently they end up becoming depressed and dissatisfied later in life but often are unable to say that they made a mistake. You are trying very hard to avoid this problem of later years and you are to be admired for having the maturity to introspective and think very carefully about how you can best use your potential in a career you would enjoy. It's such an important question that we doubt you can really spend "too much time" thinking about it.

Rationale

Rather than encourage you to think less about the problem and be "less preoccupied" with it, we actually think you need to give it more thought. This may sound crazy to you or may confuse you but we think it is important. You try very hard to keep yourself from attending to distracting thoughts about this question. The more you try to push them out of your conscious awareness, the more they will probably persist. Over the next three weeks, because we are going to encourage you to be even more devoted to analyzing your thoughts about this area of your life, expect that it may be more on your mind.

Behavioral prescription

This week, when you are bothered by concern and worry over choosing your major, rather than push the thought out of your mind immediately, allow yourself to entertain the thought for 2 or 3 minutes, even if it means interrupting other activities you were involved in at the moment. Keep a daily log of your thoughts, when you had them, what they were, what you concluded (if anything). At the end of each day, spend at least 30 minutes going over all these things you've written down, analyze them and then write a summary of the pros and cons of each field of study you've thought about that day. Try to allow yourself to consider all possibilities and do not feel compelled to decide on one course of action now. It would be beneficial if, while you do this, you worry considerably about whether or not you will be able to decide. But the goal is for you to defer this worrying process until that 30 minutes of the day rather than your allowing excessive worry to occur daily
and chronically. Worry is an expected reaction of the process and it only reflects your legitimate and appropriate concern. We would be worried if you demonstrated apathy over this question. Bring in the log for discussion next week.

Category 4: Problem of balancing social life with studies
Number - 4

Positive connotation

This is the most appropriate question one should be asking at your age in your situation as a college student. What is abundantly clear from your statements is that you see both areas of experience as of equal importance. So often we are amazed at how many, less mature college students devote all their energies into one or the other area. They behave as though it must be an "either-or" proposition and so when they graduate they have not had the opportunity to fully develop both their interpersonal and academic skills simultaneously. So we want you to know that we view the fact that you are asking this question as a decided strength in you. We are therefore reluctant to say or do anything which would change you significantly. We know that you are feeling a great deal of emotional distress and worry over this problem and you want very much to succeed in both areas. Your fear of failure only reflects the high standards of excellence you hold for yourself. Without such fear and concern you'd probably experience apathy, which is the greatest single reason why so many students lose interest in school, become depressed, or resort to drugs. You, on the other hand, are remarkably clear in your commitment to get the most out of your college experience. Learning how to juggle both interpersonal and academic needs is, of course, no easy matter for anyone and is the task of 4 years of college. Our goal here, for 3 sessions, might be to help you clarify your thinking about this problem and come to a better understanding of what you really want to change (if anything) and to learn what realistically can be done or should be done to change what you're doing.
Rationale

In order to accomplish our goal of increased clarity in your thinking, it will be necessary for you to actually begin spending more time reflecting on your interpersonal and academic experiences during the day. For me to be able to help you I will need a detailed record of your thoughts as they come into your mind with respect to this question. This will help guide me by helping me understand more fully your concerns. It is our belief that a complete and thorough analysis of your patterns of thinking may give you a new experience and a new perspective which you will probably find intriguing and hopefully useful.

Behavioral prescription

This week, when you are with other students, or with your boyfriend, or in any social situation you are enjoying, you will again be distracted by thoughts of whether you should be studying or not. Rather than put the thought out of your mind, take a few minutes to interrupt your conversation with your friends and write down exactly what subjects need your attention soon. Do not explain this to your friends other than to say you simply need to make a note about something. Likewise, when you are studying and you think you should or would like to be with friends, take a moment to write down "with whom and doing what" rather than studying. At the end of each day calculate the number of times you were distracted from the activity of the moment. Also calculate the total amount of time spent on interpersonal vs. academic activities. Bring this in for discussion next session.

Category 5: Problem of shyness and difficulty initiating a date

Positive connotation

All of the experts who reviewed the results of your interview, and I myself, are quite impressed with your high degree of sensitivity in relating to people. You obviously care very deeply about others and relationships are extremely important to you because you spend a great deal of time reflecting on how to make them better. You want to make a good impression so you are cautious and you should
be, rather than risk rejection early. You have learned, at such a young age, the value of going slow and not risking things in relationships. So many college students today tend to impulsively, and with little real forethought, rush into relationships. Little thought is given as to whether they really want to be involved with that person or the type of involvement they want. You are able to minimize the risk of rejection by going slow, being cautious, and discriminating highly. Your reluctance to initiate conversations with a stranger or to ask a boy/girl for a date only reflects your fear of failure. This is certainly a normal, appropriate and healthy fear. Of course, if you are to the point where you never ask a boy/girl out or become too withdrawn interpersonally that you're lonely, then it may be time to become a little more extroverted. Your coming in here suggests you do want such a change but we want you to go slow and not expect that such change will come over the next 3 weeks. We are, however, impressed that a person who labels himself "shy" should agree to participate in this study, which really reflects a fair degree of risk taking on your part.

Rationale

We think it's very important for you to spend more time thinking about what changes you really want and then to make a plan about how you'd like to begin making the changes. To begin making changes now (for example by becoming more outspoken and less inhibited interpersonally) would be premature and would risk a failure experience which will set you back farther. You spend a great deal of time thinking about the opposite sex and fantasizing about them. We consider such fantasy normal and appropriate, and in fact, encourage you to do more of it, but in a systematized way.

Behavioral prescription

Therefore, what I want you to do this week is to go to the library every day. Take a notebook with you that is to be used solely for this experiment. While at the library spend at least 30 - 45 minutes daily pretending to study but actually begin to observe the opposite sex there. Watch each person as closely as you can without staring or in any way letting them know you are watching. Assign each person a fictitious name and make a list of his/her assets and liabilities. What appeals to you and what does not. Ask yourself whether or not you would ask that person out, why
or why not. If you decide you might ask him/her for a date, write down all the things you might say at first meeting. How would you introduce yourself? What response you might anticipate? Do not ask anyone out at this time but we will begin to make a detailed plan which will probably help you. By the end of the week you should have observed quite a few people. Next week we will go over your log and decide which person you feel certain would decline to go out with you. I will ask that you ask that person for a date, knowing that he or she will say no. But once you prepare yourself for the inevitable rejection and once you get beyond this "failure" experience which you've planned and anticipated, you'll be able to endure it better, get it out of your system and move on from there to increased self-confidence.
Appendix L

Letter to Control Group
Dear

Thank you for volunteering for the Wellness Clinic. I appreciate your taking the test and meeting with the interviewer to clarify your concerns. As more people volunteered than was expected, unfortunately there is not a counselor available to work with you at this time. As soon as a counselor is available, I will be in contact with you personally. At that time, I am going to ask you to take the tests and meet with an interviewer again as it is important to me that we have fresh data and the latest description of your concerns so you are able to derive as much benefit from the meetings as possible.

I do realize that this is an inconvenience and appreciate your patience. It is frustrating for me also as I do want to deliver the service I promised as soon as possible. Once again, thank you for your patience.

Sincerely,

Michael Gombatz

MG/1fd
Appendix M

Brief Symptom Inventory
PLEASE NOTE:

Copyrighted materials in this document have not been filmed at the request of the author. They are available for consultation, however, in the author's university library.

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Appendix N

Mooney Problem Check List
Appendix 0

Relationship Inventory
Appendix P

Willingness-to-Disclose Questionnaire
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REFERENCE NOTES


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Abstract

The Effectiveness on Problem Resolution of Three Different Treatment Modalities: Client-Centered, Rational Emotive Therapy and Paradoxical Directives.

Michael Wagner Gombatz, Ed.D.

The College of William and Mary in Virginia, April 1983

Chairman: David Hopkinson, Ph.D.

This study investigated the effectiveness of paradoxical directives (PD) as a technique compared to client-centered (CC), rational emotive therapy (RET), and wait-list control. It was hypothesized that subjects who received PD treatment would (1) evaluate self-rated problem relief as more greatly improved than subjects in the CC, RET and/or control group (CG); (2) rate the quality of the relationship as measured by the Barrett-Lennard Relationship (RI) higher than subjects in the CC or RET groups; (3) express a greater willingness to reveal themselves to a counselor as measured by the Willingness-to-Disclose Questionnaire (WTD) than subjects in the CC, RET, and/or CG; (4) show self-reported lower symptom distress level in (a) depressed, (b) anxious and/or (c) hostile affect than subjects in the CC, RET and/or CG. Secondary hypotheses were that subjects who rate problem relief the highest will have a higher mean score on (1) the RI and/or (2) the WTD than subjects in the PD group who rate problem relief lowest.

Subjects were 60 college students who completed the Brief Symptom Inventory (BSI), WTD, and the Mooney Problem Check List (MPCL) and had an interview with the investigator to formulate a behavior focal problem and set outcome criteria to be used for evaluation in the final session. Subjects were randomly assigned into one of four groups, CC, RET, PD, and CG. Nine counselors on the same level ability matched according to counselor familiarity, preference and belief in effectiveness were assigned to the three treatments, three counselors per group. There were three weekly 50-minute treatment sessions. Seven to ten days after treatment the investigator administered the BSI, the WTD, and the RI to the 45 treated subjects. The 15 wait-list control received the BSI and WTD only. The design was a randomized pre and posttest control group. The major hypotheses were analyzed by a one-way MANOVA; secondary hypotheses were analyzed by a t-test between groups.
Results indicated a statistically significant difference of all three treatment groups when compared to the CG in self-rated problem relief. No significant differences were found among the treatments or control in the RI, WTD or the depression or hostility scale of the BSI. Statistically significant differences were found when the PD group was compared to the CG on the anxiety scale of the BSI. Though it may appear significant, inspection of the means reveals fairly consistent proportionate decrease of affect in all of the treatment groups. Results of the secondary hypotheses indicated no significant difference between groups on either dependent measures, the RI or the WTD.

It was concluded that PD are as equally effective as CC and RET as evaluated by self-report outcome criteria and proportionate decreased in negative affect after treatment.