To the Graduate Council:

I am submitting herewith a thesis written by Robin Jeanne Ramsey entitled "Paradoxical Counseling Strategies with Middle School Students." I recommend that it be accepted in partial fulfillment of the requirements for the degree of Master of Science, with a major in Guidance.

Charles L. Thompson

Charles L. Thompson, Major Professor

We have read this thesis
and recommend its acceptance:

William A. Poppen

Siegfried C. Dietz

Accepted for the Council:

L. Evans Beck

Vice Chancellor
Graduate Studies and Research

PARADOXICAL COUNSELING STRATEGIES WITH MIDDLE SCHOOL STUDENTS

A Thesis

Presented for the

Master of Science

Degree

The University of Tennessee, Knoxville

Robin Jeanne Ramsey

August 1980

3044831

ACKNOWLEDGMENTS

There are several people who have been of great assistance to me during the preparation of this study. Dr. Charles L. Thompson, my major professor, has been extremely helpful, encouraging, motivating, and understanding, throughout my graduate studies. I would also like to thank the other members of my committee, Dr. William A. Poppen, and Dr. Siegfried C. Dietz for their cooperation, suggestions, and assistance. Thanks also goes to Dawn Bowen, Debbie Dickison, Candice Evans, Bill Reynolds, Sheree Scruggs, and Lynn Turner, my student observers who were very dependable workers. Dr. Don Rhodes, the principal of Farragut Middle School, and the entire staff at Farragut Middle School are also to be thanked. I am very grateful to Mrs. Carolyn Brewer, guidance counselor at Farragut Middle School, for her time, help, support, and friendship.

I most want to thank my parents for their many years of love and support, and allowing me the opportunity to pursue my education.

ABSTRACT

The purpose of this study was to determine whether the treatment process of using a paradoxical intervention strategy when the counselor assumed a "one-down" position would be more effective than using a paradoxical intervention strategy when the counselor assumed a "one-up" position in increasing task relevant and socially appropriate behavior, while decreasing time-off-task behavior and disruptive behavior of students identified as behavior problems. The study was conducted at Farragut Middle School in Knoxville, Tennessee. Subjects were eleven students identified by their teachers as behavior problems. A Goal Attainment Scale was developed for each student and used to evaluate outcomes. A multiple baseline design was employed which provided baseline periods ranging from one to two weeks for different subjects; followed by two counseling interviews per week over a four week period. It was hypothesized that students who received counseling using a paradoxical intervention strategy when the experimenter assumed a "one-down" position would result in a greater increase in task relevant and socially appropriate behavior and a greater decrease in time-off-task and disruptive behaviors, than students in the groups using paradoxical intervention strategy when the experimenter assumed a "one-up" position or short-term problem-solving. The hypothesis was not supported by the data collected in this investigation.

TABLE OF CONTENTS

CHAPTER		PAGE
I.	STATEMENT OF THE PROBLEM	1
	Justification	1
	Hypothesis	3
	Assumptions	4
	Delimitations	5
	Definition of Terms	5
	Organization	7
II.	REVIEW OF THE LITERATURE	8
	The Need for Discipline	8
	Paradoxical Intervention Strategies	10
	Paradox and the double-bind	10
	Paradoxical Strategy Rationales	14
	Learning theory	14
	Redefinition	17
	Interpersonal power	20
	Interactional View: Theory and Practice	26
	Interactional view of the problem	26
	Main principles	27
	Interventions	29
	Paradoxical instructions	31
	The therapeutic double-bind	33
	Operational Classification of Paradoxical Interventions	34
	Chapter Summary	43

CHAPTER PAGE

III. METHODOLOGY 46

Selection Procedures. 46

Phase I: Baseline Conditions 48

Phase II: Treatment Conditions 49

Experimental Design 52

Goal Attainment Scale 53

Analysis of the Data. 55

IV. RESULTS 56

Goal Attainment Scale Data. 56

Unobtrusive Measures. 83

Summary of Results. 83

V. SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS 85

Summary 85

Conclusions 86

Suggestions for Further Research. 88

REFERENCES. 90

APPENDICES. 97

Appendix A. 98

Appendix B. 100

Appendix C. 101

Appendix D. 102

Appendix E. 104

VITA. 105

LIST OF TABLES

TABLE		PAGE
1.	Summary of Goal Attainment Scores for S_1	58
2.	Summary of Goal Attainment Scores for S_2	60
3.	Summary of Goal Attainment Scores for S_3	63
4.	Summary of Goal Attainment Scores for S_4	65
5.	Summary of Goal Attainment Scores for S_5	67
6.	Summary of Goal Attainment Scores for S_6	69
7.	Summary of Goal Attainment Scores for S_7	71
8.	Summary of Goal Attainment Scores for S_8	74
9.	Summary of Goal Attainment Scores for S_9	76
10.	Summary of Goal Attainment Scores for S_{10}	78
11.	Summary of Goal Attainment Scores for S_{11}	80
13.	Assessment Parameters for Using Compliance and Defiance-Based Paradoxical Strategies	104

LIST OF FIGURES

FIGURE		PAGE
1.	Pre (△) and Post (○) Goal Attainment Scale Scores for S_1	59
2.	Pre (△) and Post (○) Goal Attainment Scale Scores for S_2	61
3.	Pre (△) and Post (○) Goal Attainment Scale Scores for S_3	64
4.	Pre (△) and Post (○) Goal Attainment Scale Scores for S_4	66
5.	Pre (△) and Post (○) Goal Attainment Scale Scores for S_5	68
6.	Pre (△) and Post (○) Goal Attainment Scale Scores for S_6	70
7.	Pre (△) and Post (○) Goal Attainment Scale Scores for S_7	72
8.	Pre (△) and Post (○) Goal Attainment Scale Scores for S_8	75
9.	Pre (△) and Post (○) Goal Attainment Scale Scores for S_9	77
10.	Pre (△) and Post (○) Goal Attainment Scale Scores for S_{10}	79
11.	Pre (△) and Post (○) Goal Attainment Scale Scores for S_{11}	81
12.	Mean Values of Pre and Post Scores on the Goal Attainment Scale	82

CHAPTER I

STATEMENT OF THE PROBLEM

Numerous theories and techniques have been formulated to deal with the problem of disruptive student behaviors (Ayllon and Roberts, 1974; Glasser, 1972; O'Leary, 1972; Tanner, 1978; Winett and Winkler, 1972). However, while each model has its own particular appeal (Davis, 1974; Tanner, 1978) and success rate (Marlowe, Madsen, Bowen, Rearden, and Logue, 1978), discipline continues to be viewed as one of the major problems in public schools today (Brodbelt, 1978; Smith and Gallup, 1977). Therefore the purpose of this investigation was to examine the effectiveness of applying paradoxical counseling strategies for middle school students engaging in disruptive behavior.

I. JUSTIFICATION

Counseling is one of the common approaches to dealing with the problem of disruptive behavior. Marlowe, Madsen, Bowen, Rearden, and Logue (1978) cite evidence to support the likelihood that short-term behavioral counseling (by taking an active role to create client change), rather than short-term client-centered counseling, may reduce inappropriate classroom behavior. Many studies have used behavior modification principles in the classroom (Barrish, Saunders, and Wolf, 1969; Hall, Lund, and Jackson, 1968; Madsen, Becker, and Thomas, 1968; McLaughlin and Malaby, 1972, 1975, 1976; O'Leary and Becker, 1967;

O'Leary and O'Leary, 1976). However, relatively few behavioral researchers (McAllister, Stachowiak, Baer, and Conderman, 1969; McCullough, 1972; Meyer, Strowig, and Hosford, 1970) have conducted studies with junior high school students. Evidence indicates that the behavioral approach is a more efficient form of counseling and preferred more by the client in comparison to client-centered and psychoanalytic approaches (Holen and Kinsey, 1975).

One aspect shared by these different techniques is that successful implementation is dependent, in one way or another, upon the student's accepting and complying with the counselor's suggestions and directives. Unfortunately, students are not always cooperative. Many times they do not listen or follow directives, and sometimes they defy any attempt to influence by doing the opposite of what is suggested (White, 1977). One explanation for non-compliance or resistance is reactance phenomena (Brehm, 1976). One of Brehm's recommendations is for the counselor to assume a "one-down" position. Among the writings which are most sensitive to reactance phenomena are those often termed uncommon or paradoxical. They include Victor Frankl's logotherapy techniques of paradoxical intention and dereflection (1960, 1963, 1967, 1969, 1973, 1975, 1978); the strategic, family-oriented therapies of Milton E. Erickson and Jay Haley (1961, 1963, 1973, 1976); the theory of negative practice or symptom scheduling (Dunlap, 1928, 1932, 1942; Newton, 1968a, 1968b); and the "interactional view" initiated by Jackson, Watzlawick, Weakland, Fisch, and others at the Mental Research Institute in Palo Alto, California (Watzlawick, Weakland, and Fisch,

1974; Weakland, Fisch, Watzlawick, and Bodin, 1974). While none of these therapists claim that beneficial results are always obtained, nor that these paradoxical strategy interventions are a universal panecea or miracle method, they have reported successful use of these tactics in the treatment of a wide variety of disorders, including anxiety, child management, delinquency, depression, insomnia, marital problems, obsessions and compulsions, paranoia, schizophrenia, and sexual dysfunction. Most of these reports have been of the anecdotal, case-study variety; controlled investigations are rare (Newton, 1968b; Solyom, Garza-Perez, and Ledwidge, 1972).

This study is an attempt to empirically test paradoxical strategy interventions in dealing with the disruptive behavior of junior high school students. The importance of this study is based on the recognized need for efficient methods of dealing with disruptive student behaviors, as well as the need for research to validate the use of paradoxical intervention strategies in an educational setting. It would seem that these strategies would be of interest to the school setting since they are designed, and have been successful, as brief-term techniques involving one to twenty sessions of treatment (Adler, 1972; Frankl, 1960; Gerz, 1966; Haley, 1961; Newton, 1968b; Sevini-Palazzoli, Boscolo, Ceechin, and Prata, 1974; Weakland, Fisch, Watzlawick, and Bodin, 1974).

II. HYPOTHESIS

The research hypothesis for the present study is: During the treatment phase, students who receive paradoxical strategy interventions

when the counselor assumes a "one-down" position will exhibit an increase in the number of socially appropriate and on-task behaviors and a decrease in the number of disruptive and time-off-task behaviors when compared to those students in the short-term problem-solving group and those students who receive the paradoxical strategy interventions when the counselor assumes a "one-up" position, as indicated by observation data, student's rating of him/herself, and the teacher's rating on the Goal Attainment Scale.

III. ASSUMPTIONS

1. Based on the available literature, even though they have not been systematically applied in the school setting, paradoxical intervention strategies can be utilized to effect change in the disruptive behaviors of students.

2. The counselor/experimenter applied the technique correctly and consistently.

3. Teachers have accurately identified disruptive students in their classrooms according to the stated criteria found in the procedure section of this study.

4. Since students were not randomly selected, but identified by disruptive behavior criteria; it is necessary to assume that any differences between them are a function of chance, and that they are representative of the population.

5. The individual student and teacher Goal Attainment scale rating form, while not a norm-referenced instrument, is valid and completed with as little as possible.

IV. DELIMITATIONS

This study has been delimited to the following conditions:

1. The sample of disruptive students were selected from the population of sixth, seventh, and eighth graders at Farragut Middle School. Farragut Middle School serves a suburban area of Knox County, Tennessee.

2. Further, the subjects were selected based on teacher identification according to the stated criteria in Appendix A.

3. Based upon the brief-treatment model, paradoxical intervention strategy counseling sessions were offered two times per week over a four week period for each treatment group. Thus, the number of counseling sessions was limited to eight per subject.

V. DEFINITION OF TERMS

Paradoxical Intervention Strategy. In order to facilitate an operational definition of what a paradoxical strategy involves, the classification proposed by Tennen (1977) has been adapted.

Prescribing Strategies. This is the most commonly used paradoxical strategy. Typically, the counselor "encourages or instructs the student to engage in the specific behavior to be eliminated." This might incorporate encouraging the student to rebel, or instructing him/her to daydream. In some instances the counselor wants the student to comply with the prescription, while in others, the student is expected to rebel.

Restraining Strategies. Embracing this strategy, the counselor discourages or even denies the possibility of change. The counselor may emphasize the consequences or possible "danger" of change, or possibly just tell the student to "go slow" in implementing the proposed change.

Positioning. By accepting and exaggerating an assertion the student makes about him/herself, the counselor attempts to shift the problematic "position." Its use is thought to be maintained by either a complementary or opposite response by others.

One-Up Position. This refers to the counselor's place or role in the relationship. In a "one-up" position, the counselor is regarded as a superior figure who is all-wise and has overcome the everyday problems of the average person. Not only is he/she successful in handling his/her problems, the counselor is also superior in that he/she is in a position to help others solve their problems. This position is characterized as "I'm the expert, I know what I'm doing; I have no problems in my own life" (Tennen, 1977).

One-Down Position. Again, this encompasses the counselor's place in the relationship. Assuming a "one-down position" involves the counselor's manner and speech. The counselor conveys an informal relationship and comes on as a modest person who is willing to allow human frailities to show. For example, the counselor might ask to go on a first name basis. If the student exhibits difficulty in expressing him/herself, the counselor would seek to assist by saying something like: "Hang in here with me for a minute, I'm a little bit slow in

picking up on things so let me ask some nit-picking questions." At other times, when the counselor wants to offer an idea and have it accepted by the student, he/she may present the idea as originating from some other, perhaps higher authority: "I'm not sure what would be the best thing for you to do, but I'll tell you what my professor at U.T. would advise" (Tennen, 1977).

Short-Term Problem-Solving. In this strategy, the counselor attempts first to get the client to describe and define the problem. The client is then asked to make a value judgement on the behavior, i.e., How is it helping you? Once the client decides what he/she is doing is not helping, the counselor and client examine alternatives, and together they develop a plan for the alternative the client would like to try. The plan is written up and the client makes a commitment by signing a contract. If the plan is ineffective or the contract is broken, the contract is torn up and the client is asked to write a new one that has a better chance to be implemented.

VI. ORGANIZATION

The remainder of this study will be organized as follows: First a review of the current and historical literature in discipline and paradoxical intervention strategies will be pursued. This will be followed by the proposed methodology of the study. The methodology will be organized in terms of selection procedures, baseline phase, treatment phase, experimental design, rating scales, and analysis of the data.

CHAPTER II

REVIEW OF THE LITERATURE

This chapter begins with a brief survey of the literature which establishes the need for better discipline and current approaches to the problem. This will be followed by a review of the literature concerning the principles of this study's treatment strategy. The following concepts are included: negative practice or symptom scheduling, Adlerian uses of paradox, paradoxical intention and dereflection, Haley's strategic, brief therapy, the "interactional view" and use of paradox, the reactance theory, and "one-up/one-down" position.

I. THE NEED FOR DISCIPLINE

The 1977 Phi Delta Kappan research poll, conducted by Gallup, asserted that for the last six years the number one problem facing public schools was discipline. Consistently, parents, teachers, and administrators have perceived the increasing difficulty in promoting adequate discipline in the classroom, halls, and playgrounds (Smith and Gallup, 1977). A series of articles in the Baltimore Sun from April 25 to May 6, 1977, reported that discipline was the most consistent problem facing teachers in the Baltimore city junior highs (Brodbelt, 1978). A 1972 survey revealed that a full 54 percent of all teachers found student disruption in their classrooms to be

a problem of moderate to crucial proportions (Joda, 1975). These reports indicate that discipline continues to be a widespread problem.

While students sometimes misbehave simply to see if they can get away with it, real behavior problems stem from a complex blend of sources such as home environment, schools, and teachers. A consensus of opinion on methods of disciplining students is yet to come (Ainsworth and Stapleton, 1976). Historically, discipline most often meant corporal punishment. DeMause (1975) traces the disciplining of children through the following stages: the infacide mode during antiquity, the abandonment mode during medieval times, the ambivalent mode during the Renaissance, the intrusive mode during the nineteenth century, the socializing mode during the nineteenth and twentieth centuries, and the recently begun helping mode.

Tanner (1978) identifies the most commonly used models today as: the training model, behavior modification, psychodynamic, group dynamics, and personal-social growth model. The basic dichotomy appears to be whether to focus directly on the behavior or on developing personal insight and decision making. Holen and Kinsey (1975) designed a study to ascertain whether different types of counseling outside the classroom (behavioral and Rogerian client-centered) or teacher approval within the classroom, with the counselor serving as a consultant, would be more effective in changing student's inappropriate behavior. The results indicate that short term behavioral counseling, which actively seeks to create client change, was more effective than short-term client-centered counseling, which focuses on helping the client become

more responsible through facilitating self-insight. Additionally, they indicate that not only is the behavioral approach more efficient, it is also the form preferred by the client in comparison with psychoanalytic and client-centered approaches. Therefore, it seems that approaches which deal directly with behavior change are desired and efficient methods to deal with the disruptive student behaviors.

II. PARADOXICAL INTERVENTION STRATEGIES

Paradox and the Double-Bind

Since its Greek beginnings, paradox (paradoxom: contrary to expectation, incredible) has fascinated the human mind for the last two thousand years. Some of this century's most important achievements in the areas of logic, mathematics, and epistemology are directly linked with paradox. Noteable developments include mathematic's theory of proof, the theory of logical types, and problems of consistency and computability. Paradox also permeates our daily lives in the form of paradoxical communications between parents, children, wives, husbands, friends, employers, and employees.

The American College Dictionary defines paradox as "a statement or proposition semmingly self-contradictory or absurd, and yet explicable as expressing the truth."

According to Watzlawick, Beavin, and Jackson (1967), paradox may be defined as "a contradiction that follows correct deduction from consistent premises" (p. 188). This definition allows the exclusion of "false" paradoxes which are based on a concealed error in reasoning

or a deliberate fallicy built into the argument. These same authors identify three types of paradox--logicomathematical (antimonies), semantical (semantical antionomies), and pragmatic. The pragmatic is of main interest to this review because of its behavior implications. Pragmatic paradoxes are distinguished from simple contradictions since a choice may be a solution in the later, but not even possible in the former.

Perhaps the most frequent form of paradox in the pragmatics of human communication is through an injunction demanding specific behavior that by its very nature can only be spontaneous. For example, the command to "Be spontaneous" is an untenable position since anyone faced with this injunction would have to comply and be spontaneous within a frame of compliance, hence non-spontaneity. Other examples include: "You ought to love me"; "I want you to dominate me" (request of a wife to her passive husband); "You should enjoy playing with the children, just like other fathers"; and "You know that you are free to go, dear, don't worry if I start crying" (Andolfi, 1974; Watzlawick et al., 1967; pp. 199-200).

The effects of paradox in human interaction was first described by Bateson, Jackson, Haley, and Weakland (1956) in their theory of schizophrenic communication by seeking the sequences of inter-personal experience that would induce (rather than be caused by) behavior that could justify the diagnosis of schizophrenia. They hypothesized that, "The schizophrenic must live in a universe where the sequences of events are such that his/her unconventional communication habits will be in

some sense appropriate" (p. 253). They labeled this interaction by coining the term "double-bind."

Sluzki and Vernon (1971) modified and expanded this definition so as to make it applicable to neurotic clients as well. They enumerate three ingredients of a double-bind: (1) Two or more persons in an intense relationship that has a high degree of physical and/or psychological value for one or all of its members. Included, but not limited to this, are family life, love, friendship, loyalty to an idealogy, and the psychotherapeutic relationship.

(2) Within this context, a message is given that is so structured that (a) it asserts something, (b) it asserts something about its own assertion, and (c) these two assertions are mutually exclusive. There are two levels of injunctions. At the first or primary negative level, the meaning of the message cannot be decided, i.e., in a parent-child relationship this first message could be "Don't do so and so, or I'll punish you." This assumes that the punishment may be either the withdrawal of love or the expression of anger that results from the parent's expression of extreme helplessness. The second message (secondary injunction) conflicts the first at a more abstract level. It is commonly communicated by non-verbal means and may even impinge on any element of the primary prohibition. This could take the form of "Don't see me as a punishing parent."

(3) Finally, the recipient of the message is prevented from stepping outside the frame set by this message, either by commenting about it or by withdrawing. Even though it is logically meaningless,

it is a pragmatic reality; the recipient cannot "not" react to it, but neither can he/she react to it appropriately (nonparadoxically); for the message is itself a paradox.

An excellent example of this double-bind situation is provided by Bateson et al. (1956, p. 254):

> In the Eastern religion, Zen Buddhism, the goal is to achieve Enlightenment. The Zen Master attempts to bring about enlightenment in his pupil in various ways. One of the things he does it to hold a stick over the pupil's head and say fiercely, "If you say this stick is real, I will strike you with it. If you say this stick is not real, I will strike you with it. If you don't say anything I will strike you with it."

Undoubtedly, the world we live in is far from logical and we all have been exposed to double-binds, yet somehow many of us manage to maintain a certain level of sanity. Based on its occurrence in interpersonal communication, it can be assumed that double-bind situations occur in psychotherapy. At times these are inadvertently imposed by the counselor as a double-bind situation which is similar to that used by the client, or the client can impose a double-bind situation on the therapist. At other times, the counselor seems to deliberately impose a double-bind to force the client to respond differently than he/she has in the past. Hence it is termed "therapeutic double-bind." The client must react to it, but the paradox prevents responding in his/her unusual symptomatic way. The most common therapeutic double-bind is the prescribing of the symptom for which the client sought counseling.

III. PARADOXICAL STRATEGY RATIONALES

Raskin and Klein (1976) review several approaches to psychiatric treatment which share the common demoninator of the counselor's overtly encouraging the client to keep the presenting symptom, practice it, or even embellish it; a technique which appears paradoxical. They delineate these approaches as the learning theory, redefinition, and interpersonal power rationales.

Learning Theory

The learning theory rationale is based on straining the problem behavior, extinguishing it, setting up aversive consequences, removing supports for its maintenance, or making its cessation rewarding to result in the removal of a symptom or problem behavior. The techniques of negative practice, symptom scheduling, and massed practice are based on this rationale.

Negative practice. Anedoctal examples of prescribing the symptom can be traced all through history. In the late 1920's Dunlap (1928, 1932) began applying a technique he labeled "negative practice." This term was employed to indicate that the response practiced is not the response learned, and that a response of one type can be practiced to convert it into a response of a different type (Newton, 1968). Dunlap had the client "practice" the symptom under prescribed conditions with the firm expectation of losing the habit. Hence, by practicing the symptom with a different feeling (affective component) and under instructional (ideational component) voluntary control and consequently

symptom remission were facilitated. He reported success in application to symptoms ranging from nailbiting and enuresis through stammering and sexual perversions (Dunlap, 1932).

Symptom scheduling. Newton (1968a) has dubbed this prescriptive strategy "symptom scheduling." He objected to the terms such as "negative" or "paradoxical" claiming they are pejorative and connotate mystery. He set forth some principles or generalizations for the use of this technique.

First, he identified four principles which are pertinent to the symptom of the client. (1) Expandable. Since symptoms with clear physiological limits and symptoms that are ubiguitous in nature are difficult for the client or counselor to control; the symptom chosen for scheduling should be changeable in its frequency or duration. (2) Current. Symptom scheduling is most effective with symptoms that are current rather than low-grade chronic symptoms. (3) Interpersonal. Those symptoms that involve and influence persons other than the client seem more amenable than intrapsychic symptoms. The rationale for this is that an interpersonal symptom usually requires the cooperation of a significant other in the treatment. By involving the significant other, often a disruption of the interpersonal patterns that maintain the symptom occurs. (4) Stress. The effectiveness of symptom scheduling is directly related to the level of subjective distress it incurs upon the patient.

Newton continued listing ten principles relevant to the schedule devised by the therapist. The first three, (1) Expandable, (2)

Interpersonal, and (3) Stressful, are direct counterparts to the symptom. Since they are identical, these principles will be picked up after that point. (4) Rationale. Giving the client a rationale relieves some of the enigmatic nature of the technique. (5) Humor. While not always appropriate, scheduling the symptom in a humorous context can be beneficial in changing the client's attitude toward the symptom. (6) Specific. Being specific in symptom scheduling can increase the client's initiative to practice. It also makes it easier to assess treatment effectiveness. (7) Within-sessions timing. The counselor should explain the schedule and allow plenty of time for the client to ask questions within that session. This reduces the client's anxiety concerning application. (8) Changing sessions. Since the effects of symptom scheduling are most evident immediately after practice, the counselor may want to see the client more frequently for shorter time periods. (9) Office exercises. It may be helpful to have the client practice the schedule in the office for the first time. This is especially helpful with reluctant clients. (10) A client associate. When a client has difficulty accepting the technique, it may be helpful to have a former client to give a testimonial.

Massed practice. Another technique based on learning theory principles is massed practice. Raskin and Klein (1976, p. 549) have defined this procedure operationally as requiring the client to ". . . practice the problematic behavior assiduously, rather than have it appear sporadically and without its being 'willed' into displaying itself." Among the explanations for its effectiveness in symptom

removal is that fatigue and boredom make the behavior aversive. Another is that the massed practice forced display of the symptom in a variety of settings and conditions which in turn changed the stimulus props. This decreases the likelihood of the response being spontaneously emitted in the original setting.

Redefinition

The redefinition rationale is best exemplified by Victor Frankl's logotherapeutic techniques of "paradoxical intention" and "dereflection" and by Raskin's (1976) symptom redefinition.

Logotherapeutic techniques. To enhance the understanding of these techniques, a brief review of Frankl's logotherapy is in order (Frankl, 1963, 1967, 1971, 1973). Developing out of his experiences in German concentration camps during World War I, Frankl's approach is existentially oriented. Rather than being retrospective or introspective like psychoanalysis, logotherapy focuses on the future; more specifically, on assignments and meaning to be fulfilled by the individual in the future. The logotherapy client is confronted with and reoriented toward the meaning of his/her life.

Logotherapy, sometimes hailed as "The Third Viennese School of Psychotherapy," derives its name from the Greek word logos, which denotes meaning. It focuses both on the search for and the meaning of human existence. This striving toward meaning in life is one's primary motivating force and is referred to as the will to meaning. As the primary motivating force in life, this meaning is specific and unique

for each individual. These ideals and values give the individual a reason to live. Frankl claims that these values do not drive the individual, rather they pull him/her. This implies that a freedom to choose is always involved, i.e., this meaning can be fulfilled to its potentiality or forfeited.

However, this will to meaning can be frustrated resulting in existential frustration. Existential, as used here, may refer to (1) existence itself; (2) the meaning of existence; or (3) the striving to find meaning in existence, i.e., the will to meaning. Existential frustration can result in neurosis for which Frankl coined the term "noogenic neurosis." These neuroses are not psychological in their origin, rather in the noological (from the Greek "noos" meaning mind) dimension of human existence. It refers to the "spiritual" core of the individual's existence. Thus the need for a therapy, logotherapy, to enter the spiritual dimension of human existence.

Logotherapy assumes its role as assisting the individual to find his/her unique meaning in life. This meaning in life is specific only for a given moment, but never ceases to exist. This meaning in life can be discovered in three ways: (1) doing a deed; (2) by experiencing a value; and (3) by suffering.

Paradoxical intention. Within the framework of logotherapy, two techniques are used, paradoxical intention and dereflection (Frankl, 1960, 1963, 1975, 1978). Frankl illustrates their use with anticipatory anxiety: a given symptom possessed by the individual evokes the fearful expectation that it might occur. Ironically, it is this fear which

tends to elicit the feared symptomatic response. To combat this fear, paradoxical intention, defined as "a process by which the client is encouraged to do, or wish to happen, the very thing he/she fears" (Frankl, 1978, p. 117) is used. Thus, the pathogenic fear is replaced by a paradoxical wish. Frankl (1978, p. 127) quotes this example:

> Vicki, a junior in high school, came into my counseling office. She cried and said she was flunking speech although she was a straight A student in all her other courses. I asked her why or whether she had any idea why she was flunking. She said that each time she stood up to make a speech she became more and more afraid to the point that she could not give any speeches, or stand up in class. She had many signs of anticipatory anxiety. I then suggested role-playing, she the speaker and I the audience. I used behavior modification techniques, with positive reinforcement, each time we role-played on three days. She set the goal that after her first successful speech in class she would receive an off-campus pass, something she wanted very much. The next day she could not make her speech in class and came into my office sobbing. Since behavior modification approaches had failed, I tried paradoxical intention. I firmly told Vicki that the next day she would show the whole class how fearful she was; she should cry, sob, shake, and prespire as much as possible, and I demonstrated. During her speech she attempted to demonstrate how fearful she was but could not. Instead she gave a speech that her teacher graded A.

De-reflection. Just as paradoxical intention was designed to counteract anticipatory anxiety, de-reflection was designed to deal with the compulsive inclination to self-observation (Frankl, 1960). It counter-compensates for self-observation by ignoring the problem behavior and thus de-reflecting from anticipatory anxiety to something else.

Frankl is careful to note that logotherapy is not a panacea (1978). The most common applications have involved obsessive-compulsive and phobic behaviors (Frankl, 1960, 1963, 1975, 1978; Gerz, 1966).

Redefinition. Raskin and Klein (1976) briefly report on an unpublished paper by Raskin in which he describes a technique he terms "symptom redefinition." This technique seeks to change the perception of the symptom, thereby changing the affect associated with it. "By redefining the symptom--by pursuing its meaning, value, and ultimate benefits--the counselor infuses the behavior with a totally different import" (p. 553). Thus, it involves a cognitive restructuring which results in an attitude change. The symptom is then viewed for its positive benefits.

This seems to be somewhat of a blend of Frankl's paradoxical intention and the soon to be discussed directive therapy of Erickson and Haley.

Interpersonal Power

This third and final rationale category of Raskin and Klein (1976) is the interpersonal power rationale. It involves viewing the symptom as an attempt to influence others. Although not mentioned by these authors, the individual psychology of Alfred Adler has been included because it fit the above description.

Adlerian perspective. Mozdzierz, Maccitelli, and Lisiecki (1976) attribute Alfred Adler as being the first person in Western civilization to write about a paradoxical strategy in terms of behavior change. Influenced by Hegel and Nietzsche, Adler accepted dialectical thinking as the modus operandi of his individual psychology. Succintly, it is the idea that things are not always what they seem, "Any statement

may contain its opposite" (Ansbacher, 1972, p. 23). Adler reconciled contradictory behavior from the viewpoint of an inferred goal of overcoming. For example, a speculator on the stock exchange may sometimes act as the bull and other times as the bear, but the object is always to gain money, and hence power (Adler, 1956, p. 232).

Adler regards neurotic behavior and the symptoms of which the client complains as a means of controlling people and thus exerting power over them, without taking the responsibility for doing so (1956, pp. 270-271). "Psychotherapy, in turn, also resorts to the paradox of dialectics by, e.g., prescribing or encouraging the symptom itself" (Ansbacher, 1972, p. 18). Paradoxical strategies are utilized as a means of transforming the client's symptomatic asocial behavior into a healthy cooperative venture shared by the client and counselor. With the Adlerian goal of increased social interest (cooperation) in mind, paradoxical strategies are employed and place the client in a therapeutic double-bind. If the client persists in the symptomatic behavior he/she does so while cooperating with the counselor. Contrarily, by rebeling against the counselor, the client abandons the symptomatic behavior which prevented cooperation. Either way the client exhibits cooperative behavior and wins (Mozdzierz et al., 1976).

Directive therapy. The directive therapies of Milton Erickson and Jay Haley also exemplify the interpersonal power perspective. Haley has assumed the responsibility for articulating a systematic formulation of this approach (Haley, 1961, 1963, 1973, 1976).

Haley would probably view the previously described techniques of symptom scheduling and negative practice as merely instances of the therapeutic use of the paradox. The emphasis in directive therapy is on accepting the client's views of him/herself, understanding the value of the symptom to the individual and the restructuring of the client's life so that the symptom is either more functional or unnecessary (Raskin and Klein, 1976).

Haley has described this directive therapy in terms of brief therapy (1961, 1963) since in order to change the symptomatic behavior the client is given specific directions. The emphasis is on giving the client something to do. His brief therapy, one to twenty sessions, differs from psychotherapy in that it is more active and directive in seeking to produce therapeutic change in a minimum amount of time.

Attempts to induce change begin with the initial interview. Information gathering and maneuvers to change are combined while little consideration is given to the past history. The focus is on the present circumstances and functions of the client's symptoms. The client is not always willing to offer the necessary information. One technique Erickson employs to solicit this information is to point out that the counselor wants the client to talk under therapeutic direction; however, since the client is resisting the counselor should take control by directly or indirectly suggesting that the client withhold the information. This circumvents the advantage retention of information gives the client since whether the client talks or withholds, he/she is conceding to the counselor's directions. Hence, the necessary information can be gathered.

The next step is to encourage the client to make a commitment to change as soon as possible. Once this is done, the client can use any change which occurs as evidence of continuing progressive change.

Several factors are crucial to initiating therapeutic change. Again the emphasis is on getting the client to do something. The client is placed in a therapeutic double-bind by being directed to spontaneously change his/her behavior. This paradoxical position calls for responding spontaneously to a directove, an untenable situation. There are two types of directives in this paradoxical procedure: (1) the client is directed to do something he/she can do; and (2) the client responds with involuntary, or spontaneous behavior.

Even though they have sought help, clients often resist following directives. Motivating them to cooperate in following directives often necessitates dealing with resistance. Erickson has formulated several techniques for persuading resistent clients to achieve their goals. Haley (1973) enumerates them as follows:

Encouraging resistance. The resistance is accepted and encouraged which places the client in the paradoxical situation of having his/her attempt to resist being defined as cooperative behavior. Thus no matter what the client does he/she is following the counselor's directions. Once cooperative is established, the client can be directed into new behaviors. Generally, Erickson utilizes a sequence approach of having the client or family deliberately do something they are already doing, and then implementing the paradoxical situation. To illustrate, Haley (1963, p. 53) provides the following:

> For example, a woman came to him (Erickson) for help in losing weight who had tried every form of diet and medical treatment. She could lose the weight, but she immediately gained it back again. In fact, the moment she dieted until she reached the chosen weight, she was compelled to rush for food and eat compulsively until she was overweight again. Erickson asked the woman if she was willing to lose weight in a way that met her personality needs, and she agreed. He then instructed her to go out and gain from 15 to 25 pounds. While she was gaining weight she could organize her thinking to be prepared to lose weight. The woman gained a few pounds and then became reluctant about gaining more. Yet, Erickson insisted she gain more. He finally compromised when she had gained 20 pounds and permitted her to stop gaining weight. She then went on a diet, lost the weight she wanted to lose, and has continued to maintain a low weight.

Providing a worse alternative. While it is preferable for the client to initiate new behavior and choose the direction of his/her life, the framework of change is also important. Thus, the problem is how to get the client to follow directives and achieve autonomy. One procedure to deal with this involves directing the client in one direction in such a way that he/she is provoked to go another. This can be accomplished by making it harder to keep the problem than relinquish it. One example of this is the benevolent ordeal, such as "exercising at two in the morning on any day that the symptom occurs more than the client wishes it to" (Haley, 1963, p. 26).

Causing change by communicating in metaphore. Another method for dealing with resistance to directives is to communicate with metaphore or analogies. When A is resisted, the counselor can talk about B, and when these are metaphorically related, the client will "spontaneously" connect the two and respond appropriately.

Encouraging a relapse. If a client is being too cooperative and improving too rapidly, Erickson will encourage him/her to have a relapse. The rationale for this is that if a client is following directives too promptly, it is difficult to determine who is in control. Such a client will suddenly stop being cooperative and express doubt in the process. This type of resistance is dealt with by issuing a challenge to resist, i.e., to try not to cooperate and fail. Another possibility is that the client who is too cooperative will experience a relapse and thus be disappointed with counseling. This problem is avoided by accepting the improvement but directing a relapse, thereby, the only way to resist is not to have a relapse and continue improving.

Encouraging a response by frustrating it. Haley explains this technique as directing the client to behave in a certain way, and just as he/she complies, cut this response off and shift to another area. Thus when this area is returned to, a response readiness has already been established.

Emphasize the positive. One of Erickson's key points, emphasizing the positive is based on his assumption that there is a natural desire for growth within the individual and that it will elicit greater cooperation.

Other methods listed include the use of space and position, seeding ideas, amplifying a deviation, amnesia and the control of information, awakening and disengagement, avoiding self-exploration. However, these methods relate more specifically to hypnosis and family interventions and thus are not relevant to this discussion.

IV. INTERACTIONAL VIEW: THEORY AND PRACTICE

The most succinct and parsimonious explanation of paradoxical intervention strategies has been developed from communications theory and articulated by Watzlawick, Beavin, and Jackson (1967); Watzlawick, Weakland, and Fisch (1974); and Weakland, Fisch, Watzlawick, and Bodin (1974). These authors assert that these intervention strategies are based on the previously discussed therapeutic double-bind. The therapeutic double-bind is a class of therapeutic communication based on the idiom similia similibus curantur--the cure is to be found in the pathogen (Watylawick et al., 1967, p. 240). Their theory actually encompasses all of the previously discussed explanations and techniques. Thus it serves as a summary and practical application of paradoxical intervention strategies.

Interactional View of the Problem

Weakland et al. (1974) present a general view of the nature of human problems and procedures for their effective resolution that have developed out of their work in family therapy at the Brief Therapy Center, Mental Research Institute, Palo Alto, California.

There are two central ideas in their family therapy: (1) focus on the present, observable behavioral interaction, and (2) deliberate intervention to alter the present functioning of the system.

They utilize a brief therapy schedule limited to a maximum of ten one hour sessions regardless of the nature or severity of the problem. This is based on the belief that setting time limits on

treatment exerts a positive influence on both the counselor and client. Their fundamental premis is that regardless of the origin or etiology, the problem presented presists only if "maintained by on-going current behavior of the client and others with whom he/she interacts" (p. 144). Thus, when the problem-maintaining behavior is changed, the problem will be resolved regardless of its etiology or duration. Accordingly, the problem behavior, a social phenomenon, reflects a dysfunction of the system and is best treated by modifying that system. This problem behavior, while incurring some disadvantages, is viewed as also attaining some recognizable advantages or "pay offs," for example, possibly exerting control of the relationship. However, these are not considered the cause of the problem nor an unsurmountable obstacle to change. The counselor's primary task is to directly intervene and attempt to alter the dysfunctional interaction pattern.

They attribute part of their theoretical base to the work of Milton Erickson (Haley, 1963, 1973). Two points are particularly important. First, Erickson's aim to directly alter and ameliorate the overt behavior by some redefinition. Second, his emphasis of working with the particular behavior the client offers counselor, even if it is resistent or pathological.

Main Principles

1. Symptom-oriented. Rather than seek insight or the roots of pathology, the brief therapy center views the presenting problem as offering that which the client is ready to deal with, a concentrated manifestation of the problem, and an index for progress.

2. Problems of interaction. Problems presented by the client are viewed as being situational difficulties between people.

3. Ordinary life difficulties. These situational interaction problems develop in everyday life and usually involve adaptation to some life change. When mishandled, they become an impasse or crisis in the relationship, and result in symptom formation.

4. Transitional steps. It is the transitional steps in family living that constitute the most common and important everyday difficulties which develop into problems.

5. Under/over emphasis of common problems. There are two main ways problems develop: (1) over-emphasis of a common problem, (2) under-emphasis of a common or more severe problem.

6. Feedback loop. It is assumed that once the difficulty is viewed as a problem, it is maintained and even intensified by the creation of a positive feedback loop which commonly attempts to resolve the difficulty, but, in reality, the attempted solution intensifies the problem.

> Consider, for instance, a common pattern between a depressed patient and his family. The more they try to cheer him up and make him see the positive sides of life, the more depressed the patient is likely to get: "They don't even understand me." The action meant to alleviate the behavior of the other party aggravates it; the "cure" becomes worse than the original "disease." Unfortunately, this usually remains unnoted by those involved and even is disbelieved if any one else tries to point it out (Weakland, Fisch, Watzlawick, Bodin, 1974, p. 150).

7. Repetition. Long standing problems are viewed as ones which are repetitively poorly handled, not chronic or "set" since the later implies a defect in the individual and/or family.

8. Behavior substitution. Resolution of problems involves interrupting the feedback loop by substituting a more appropriate behavior pattern. "Everyone knows that people should do their best to encourage and cheer up a loved one who is sad and depressed. Such behavior is both 'right' and 'logical,' but often it just doesn't work" (Weakland et al., 1974, p. 150).

9. Illogical remedies. They advocate a pragmatic approach of using what works, even if the remedy appears illogical. For instance, instead of using the positive feedback loop and trying to cheer up the depressed client; they would be more likely to comment on how sad the depressed client appears. As paradoxical as it appears, they report greater success with this method as opposed to the traditional approach.

10. Small steps. While appearing insensitive to the "real" or "big" problem, the focus is on accepting the symptom presented, using a paradoxical treatment, and using small progressive steps to the goal of change.

11. Pragmatic. Avoiding the question of why due to its inferential nature, conceptions and interventions are based on direct observation of what is going on, how it is maintained, and how it can most efficiently be altered.

Interventions

In accordance with the above stated principles, once the problem is conceptualized and an estimate of what different behavior would lead to the specific goal selected is identified, an intervention

strategy is formulated. This is considered "the largest, most varied, and probably most unusual" aspect of their treatment approach (Weakland et al., 1974, p. 150).

The treatment approach (Weakland et al., 1974) consists of the following components:

1. Change and "insight." As previously stated, the aim is to produce behavior change. Insight is not a goal since it is often seen as being counter-productive. However, interpretations are enlisted in the aim of useful relabeling of the behavior. It is thought that redefining the meaning or implications attributed to the behavior itself, can have a powerfully positive effect on attitudes, responses, and relationships.

2. Use of idiosyncratic characteristics and motives. The treatments that are imposed seek to observe "where the client is at and meet him/her on his/her own terms, whether it is to believe in the magical, to defeat the expert, to be the caretaker of someone, to face a challenge, or whatever" (Weakland et al., 1974, p. 150). These characteristics are viewed as potential levers for change, not obstacles or deficiencies.

3. Directed behavior change. Reiterating, the main goal of their treatment is overt behavior change, i.e., stop doing things that maintain the behavior and start doing things that lead to remediation. Although they do not oppose giving authoritative directions, clients are seldom willing to comply. When made covertly, behavioral instructions have been found more effective in eliciting behavior

change. It is suggested that either the matter or the manner of the request is minimized. Changes are suggested, not ordered. If the client continues to be resistant, the counselor backs off further. Another approach would be to suggest that it is too early to do something; they should consider it but be sure not to take action yet. Homework assignments requesting the client to do a particular action once or twice before the next session, are assigned regularly to help promote change in the actual settings. For example, a client who avoids making any demands of others in his/her personal relationships may be assigned the task of asking for one gallon of gasoline at a service station, specifically requesting each of the usual free services, and offering a twenty dollar bill in payment (Weakland et al., 1974, p. 158).

Paradoxical Instructions

While appearing to be illogical, paradoxical instructions involve prescribing behaviors that appear to be in opposition to the goals of counseling. These instructions are considered the most important single class of interventions. This technique shares common elements with those used by Dunlap (1928, 1932), Frankl (1960, 1973), Haley (1963, 1973), Newton (1968b), and Watzlawick, Beavin, and Jackson (1967).

The most common form of paradoxical instruction used is "symptom prescription," the encouragement of an undesirable or problematic behavior in order to decrease it's frequency and bring it under control. Frankl (1975) cites an example of this being used in a classroom setting:

> Libby (11 years old) constantly stared at certain other children. These children complained to Libby, threatened her and all to no avail. Miss H., Libby's teacher, insisted that Libby must stop staring at the other children. The teacher had tried behavior modification techniques, isolation punishment, and one-to-one counseling. The situation became worse. Miss H. was most helpful when we formulated a plan of action. The next day before school she called Libby to the room and said, "Libby, today I want you to stare at Ann and Richard and Lois. First one and then the other for fifteen minutes each all day long. If you forget, I'll remind you. No classwork, only staring. Won't that be fun?" Libby eyed Miss H. quizzically, "B . . . b . . . but, Miss H., that sounds goffy." "Not at all, Libby, I am really serious," Miss H. replied. "It seems so silly," Libby replied, smiling slightly. Now Miss H. broke out in a wide grin, "It does seem ridiculous, doesn't it? Want to give it a try?" Libby blushed. Miss H. then explained that sometimes if we force ourselves to do something we don't want to do it breaks the habit. The class filed in and when all were seated Miss H. gave Libby the secret signal to begin. Libby looked at Miss H. for a moment and then came up to her and pleaded, "I just can't do it!" "O.K.," said Miss H., "we'll try again later." By the end of the day Miss H. and Libby were both delighted at Libby's inability to stare. For eight successive days Miss H. started each morning with this question to Libby privately, "Want to try staring today?" The answer was always "No!" Libby never fell back into her behavior pattern of staring. She was proud of her achievement and later in the term asked Miss H. if she noticed that the staring had stopped. Miss H. said she had and congratulated Libby. In our final consultation about Libby, Miss H. reported to me that Libby had gained stature with classmates and a much improved self-image (Frankl, 1975, p. 230; 1978, p. 132).

The success of this technique is explained in terms of motivation. By being able to make it worse, at least the client can feel he/she has some control of the problem behavior. Fortunately, this prescription technique usually results in decreasing the symptom. Nevertheless, the client can feel he/she has some control of the problem behavior. Fortunately, this prescription technique usually

results in decreasing the symptom. Nevertheless, if the client does make the symptom increase, it at least shows that the client has followed instructions and that the behavior is changeable.

The Therapeutic Double-Bind

Based on Bateson, Jackson, Haley, and Weakland (1956), the therapeutic double-bind (Watzlawick, Beavin, and Jackson, 1967, p. 241) is structured as follows:

1. An intense psychotherapeutic relationship possessing a high degree of survival value and expectation for the client is presupposed.

2. Within this context, the situation of the integration (a) reinforces the behavior expected to be changed, (b) implies that this reinforcement is the vehicle of change, thus (c) the paradoxical predicament is created, i.e., "the client is told to change by remaining unchanged" (Watzlawick et al., 1967, p. 241).

3. This situation forces the client to act by commenting on it. The pragmatic reality is that: "the patient cannot not react to it, but neither can he/she react to it with his/her usual symptomatic way" (Watzlawick et al., 1967, p. 241).

Three explanations are given for why clients accept these paradoxical prescriptions: (1) by definition, the counselor is seen as an advise giving expert, (2) prescriptions are given in a manner that facilitates acceptance, and (3) often nothing new is required of the client, the difference is the reason for doing it.

The Palo Alto group uses several techniques similar to Erickson and Haley (Haley, 1963, 1973). Some of these include: encouraging the

client to "go slow" and consider the consequences of changing their behavior; or prescribing a relapse to demonstrate control; adopting a "one-down" position. This position creates a paradox since by definition the counselor is an expert, but instead of acting like an expert, he/she suggests, or questions rather than ordering, and may appear ignorant or confused.

They believe that any time an individual changes his/her behavior, this change will be felt and influence others in their interpersonal relationships. Thus the consequences of their intervention must be considered.

One criticism of this type of psychotherapy and its intervention methods is that they require a great deal of influence by the counselor. Weakland, Fisch, Watzlawick, and Bodin (1974) do not try to justify their use of influence. There merely state their position as follows: (1) Influence exists in all human interactions. (2) The counselor is a specialist at influence. Since the client seeks counseling to change some undesired aspect of their life, the counselor is basically doing his/her job by influencing change. (3) Therefore, the counselor is obligated to seek and apply the proper means of influence.

V. OPERATIONAL CLASSIFICATION OF PARADOXICAL INTERVENTIONS

An operational classification of paradoxical interventions has been offered by Rohrbaugh, Tennen, Press, White, Raskin, and Pickering (1977) as prescribing, restraining, or positioning strategies.

Prescribing strategies are the most commonly utilized. Typically, "the counselor encourages or instructs the client to engage in the specific behavior to be eliminated. This might involve encouraging a rebellious adolescent to rebel, or a neurotic to practice an irrational thought. In some cases the counselor wants the client to comply in other instances to rebel.

Embracing a restraining strategy, the counselor discourages or even denies the possibility of change. The possible "dangers" of change may be emphasized; or the client is simply advised to "go slow" in implementing change. This technique is commonly used by Erickson and Haley (1963, 1973), and the Palo Alto group (Watzlawick, Weakland, and Fisch, 1974; Weakland, Fisch, Watzlawick, and Bodin, 1974).

By accepting and exaggerating an assertion the client makes about him/herself, the counselor attempts to shift the problematic "position" or attitude. Its use is indicated when the client position is thought to be maintained by either complementary or opposite response by others.

While they appear to be directly opposed to the goals of therapy, prescribing and restraining strategies appear to parallel a paradoxical message (Watzlawick, Beavin, and Jackson, 1967). It will be recalled that a paradoxical message is structured so that it: (a) makes an assertion, and (b) asserts something about that assertion, (c) this is done in such a way that the primary and secondary assertions are mutually exclusive (Watzlawick, Beavin, and Jackson, 1967). In a paradoxical prescription, the assertions are: (a) in order to lose

your symptom, (b) keep it or exaggerate it. Another example would be (a) your symptom is uncontrollable, (b) will that uncontrollable symptom to occur. In a restraining strategy, the assertions are: (a) in order to change, (b) remain the same. The positioning maneuvers do not fit neatly into this paradigm. When placed in the paradoxical message format, the assertions form a contradiction, rather than a paradox (Tennen, 1977, p. 6).

Rohrbaugh et al, (1977) claim close theoretical allignment with the Palo Alto group. Building in the therapeutic double-bind, they term their's a "compliance-defiance" model. The basis of their idea is that there are two different rationales for using paradoxical strategies. The compliance based strategies attribute the effectiveness of the paradoxical intervention to the client's attempts to comply with the counselor's directives. When the client attempts to resist or rebels against the counselor's influence, it is labeled a defiance based strategy.

The premise for compliance based strategies is that by attempting to comply with the paradoxical prescription to do his/her symptom, the client is forced to change. These compliance based strategies can work in one of two ways. First, "by attempting to comply the client won't be able to" (Tennen, 1977, p. 11). It is the very act of trying to comply that "short circuits" the problem preserving process. The most common and probably successful class of behaviors to be controlled with this strategy are symptoms such as obsessions, anxiety attacks, and somatic complaints which are maintained by the very action of trying

to stop them. The rationale is that the usual methods of trying to prevent it are stopped, and therefore the client gains control. This technique seems to share the same philosophical base as Frankl's paradoxical intention (1960, 1963, 1967, 1971, 1973, 1975, 1978).

A second way compliance can produce change is that "complying with the prescription creates an ordeal (Tennen, 1977, p. 12). In this strategy, the client is encouraged to engage in the behavior in a way that is frought with aversive consequences which decreases its appeal and makes it not worthwhile. It is still considered compliance because the client follows the counselor's request. Probably the best-known example is provided by Erickson (Haley, 1963, pp. 48-49).

> Erickson reports a case of a 65 year old man who was suffering from insomnia. The patient had been taking 45 grains of sodium amytal nightly and still could get only an hour or two of sleep. When he asked for an increase, his physician became frightened at the addiction and referred him to Erickson. Judging him to be both honest and determined, Erickson told him he could recover from his insomnia easily if he was willing to give up eight hours of sleep. The old gentleman was willing to make that sacrifice. Erickson had learned that the man lived alone with his son, and that he did not like to do housework. He particularly did not like to wax floors because he objected to the smell of floor wax. Erickson instructed the patient to go home and prepare for bed by putting on his pajamas at his usual time of 8 o'clock. However, instead of going to bed he was to get out a can of floor wax and polish the hardwood floors all night. At 7 in the morning he was to stop, have breakfast, and get ready for his usual day's work. The next night after working all day, he was to repeat this procedure and polish floors all night again. The third and fourth night he was to do the same, and at the end of that time he would only have given up 8 hours sleep since he was only sleeping 2 hours a night anyhow.
>
> The patient went home and dutifully polished the floors the first night, the second night, and the third night. The fourth night he said to himself, "I'm so weary following that

> crazy psychiatrist's orders, but I suppose I might as well polish again tonight since I still owe him two hours sleep." Then he decided that he would lie down and rest his eyes for just half an hour. He awakened at 7 the following morning. That night he was in a dilemma: Should he go to sleep or spend the night polishing the floors as he had promised. He decided to go to bed at 8 o'clock, and if he could read the clock at 8:15 he would get up and polish floors all night. He reports that he does not dare suffer from insomnia since if he does not fall immediately asleep he must spend the night polishing floors. As Erickson describes the case, "You know the old gentleman would do anything to get out of polishing the floors--even sleep."

Defiance based strategies are based on the client rebelling against prescribing and restraining maneuvers. Haley is known for his contributions to this strategy (1963, 1973). In using this strategy, the counselor wants the client to change by rebelling against and not following his/her directives. For example, in working with an over-protective mother who gives the child no freedom or responsibility, Haley (1976, pp. 70-71) suggested a defiance stragegy might be to

> . . . ask for more extreme behavior than the mother had been showing. For example, she should not only hover over the child, but she should also set aside a definite time to spend a whole hour warning the child about all the dangers in life (an hour is a long time). Or the counselor should take some other aspect of her behavior and make it more extreme. If this approach is done well, the mother will react by rebelling against the counselor and hovering over the child less. She will not like to do what she is doing because someone is telling her to do it

In addition to differing in intention and goal, compliance and defiance strategies also differ in domain. Compliance strategies tend to focus on the client's struggle with him/herself or symptom. Thus the emphasis is primarily intrapersonal. This is contrasted by the defiance strategies focusing on the client's struggle with the counselor and

thus emphasizes the interpersonal domain. In light of these differences, Rohrbaugh et al. (1977) suggest a model which seeks to maximize the benefits of each model, by setting up an either/or situation. In order to maximize the effectiveness of an intervention, the counselor must decide whether to use a compliance or definance strategy.

Tennen (1977) suggests that J. W. Brehm's (1966) social-psychology theory of reactance offers a framework to understand when it is appropriate to use compliance-defiance based paradoxical interventions.

It would seem helpful to first understand how reactance works. Reactance theory assumes that:

> . . . for a given person at a given time, there is a set of behaviors any one of which he could engage in either at the moment or at some time in the future. This set may be called the individual's "free behaviors" (J. W. Brehm, 1966, p. 3). (Note: This does not refer to freedom in general. Rather it is those behaviors or attitudes the patient perceives as free.)

The main premise of reactance theory is that ". . . a person will experience psychological reactance whenever any of his/her free behaviors is eliminated or threatened with elimination" (S. Brehm, 1976, p. 16). Consequently, ". . . reactance arousal is a motivational state that will be directed toward the restoration of the threatened or eliminated freedoms" (p. 19). J. W. Brehm's (1966) theory proposes three factors that determine the extent or magnitude of reactance arousal: the importance of the threatened freedom, the proportion of freedoms eliminated or threatened with elimination, and the magnitude of the threat. Thus, direct attempts by the counselor to change the client's behavior often triggers the arousal of reactance which is

manifested by non-compliance or rebellion. The defiance-based paradoxical interventions offer a means to use reactance to facilitate therapeutic change (Tennen, 1977; White, 1977).

S. Brehm (1976) suggests several ways the counselor can minimize reactance. The "most general recommendation is that the counselor avoid threatening his/her client's behavioral freedoms" (White, 1977, p. 22). Care should be given to not be over zealous in attempts to persuade. It may be helpful to "down-play" one's status as an expert since the status ascribed to the counselor is directly related to the pressure to conform, and hence reactance arousal.

Another suggestion Brehm makes is for the counselor to avoid one-sided messages and directives. The client should be encouraged to take the opposite side of an issue and oppose the counselor even when the counselor wants to support a position or belief the client already leans toward. Another possibility is to "isolate a persuasion or influence attempt from any implications it may have for future interaction." Statements such as "I'll only ask this kind of thing from you this one time." The rationale is that this type approach prohibits the client feeling that by complying with this request will require future compromises. Similarly, "doing favors" for the client should be avoided if the client places high priority on not being obligated. Finally, it should be pointed out that engaging in new behaviors does not automatically mean giving up old ones, i.e., particularly in paradoxical strategies where the client is encouraged to keep on with what he/she is doing (White, 1977, pp. 23-24).

White (1977) exemplifies how the clinical writings of the Palo Alto group use reactance phenomenon under a different label. The comparison is drawn between S. Brehm's "not coming on too strong with taking a 'one-down' position" (Watzlawick et al., 1974; Weakland, et al., 1974):

> . . . it is easier for a client to cooperate or relax if he does not regard the therapist as a powerful figure who is all wise and out of touch with the pains of human problems. After all, the client comes in to bare his unsuccessful living to a person whom he regards as not only successful in the handling of his life, but superior to the average person since he is in a position to help others solve their problems. In its simplest form, the patient comes in feeling significantly one-down to the therapist. For a therapist to take a one-up position intensifies this disparity and can make for considerable difficulty in the progress of treatment.
>
> By a one-down position, we mean that the therapist, in his manner and speech, comes on as a modest person whose frailities show, or at least are alluded to. For example, asking the client if it is all right to go on a first name basis, in itself, conveys an informality that removes the therapist from the "Herr Dokter" position. If the client is presenting difficulties in conveying information clearly, the therapist does not take him to task for it, but takes the one-down position of "Bear with me, Mr. X, but I'm a little slow on picking things up so let me ask some nit-picking questions." In other instances, the therapist may offer an idea he wishes the client to accept, but may attribute the idea to some other, perhaps higher, authority: "I'm not sure what would be best for you to do, but I'll tell you what my mother would advise in such a situation." As with other interventions, this stance may not require any special or brilliant ploy. Mostly, it only takes remembering that trouble may be caused by adopting a one-up position: "I'm the expert; I know what I'm doing; I have no problems in my own life, etc." (White, 1977, pp. 25-26).

Returning to the issue of prescribing, restraining, and positioning strategies as paradoxical interventions there are two rationales for using paradoxical interventions. One is based on the expectation

of compliance. Here the counselor presents the prescription in a manner that minimizes reactance and insures compliance. In the second, the expectation is that the client will experience reactance and thus attempt to defy the counselor, with this in mind, the counselor seeks to arouse reactance, hence increasing the probability the client will defy the prescription (White, 1977, p. 28).

The final consideration in this compliance-definance model is when to use compliance- or defiance-based paradoxical strategies. This decision is based on two factors. One consideration is the relationship between the counselor, and the client, specifically whether the client will experience psychological reactance in response to the counselor's planned influence attempts. The second consideration is the behavior to be influenced, specifically, whether it is defined by the client as "free" (something he/she could do or control voluntarily).

"In general, defiance based paradoxical interventions are not effective when potential for reactance is high and the target behavior is perceived as free" (Quadrant 1 of Table 13, Appendix E). Compliance based paradox, on the other hand, "tends to be most helpful with unfree or 'bound' target symptoms." They are most readily received when reactance potential is low (Quadrant 4 of Table 13, Appendix E). On occasion they can be successfully implemented when reactance potential is high, and behavior is viewed as "bound" (Quadrant 3 of Table 13, Appendix E). Those compliance-based prescriptions which operated by creation of an ordeal are most effective with free target behaviors

when reactance is low (Quadrant 2 of Table 13, Appendix E) (Tennen, 1977, p. 15; White, 1977, pp. 31-32).

VI. CHAPTER SUMMARY

Chapter II presented a survey of the literature related to the theoretical and applied base of proposed treatment and intervention. The chapter began with a statement concerning the need for discipline in the public school and some of the more popular approaches. An alternative approach to discipline is paradoxical intervention strategies.

Paradoxical intervention strategies are built upon communication theory and dialectics. These dialectics seem to be self-contradictory but are constructively rationalizable and join, rather than oppose behavior. Successful implementation of a paradoxical intervention requires a therapeutic double-bind. This is a class of therapeutic communication based on the idiom that the cure is to be found in the pathogen. Thus, the client must react to the counselor's communication, but the paradox prevents the client responding in his/her usual way.

There are four basic rationales for the success of paradoxical strategies. First, the learning rationale is based on straining the problem behavior, extinguishing it, setting up aversive consequences, and removing supports for its maintenance, or making its cessation rewarding to result in the removal of a symptom or problem behavior. Dunlap's negative practice (1928, 1932, 1942), Newton's symptom scheduling (1968a, 1968b), and massed practice used by Raskin and

Klein (1976) are based on this rationale. Second, the redefinition rationale is exemplified by Victor Frankl's logotherapeutic techniques of paradoxical intention and dereflection (1960, 1963, 1967, 1971, 1973, 1975, 1978), and by Raskin's symptom redefinition. The basic premis is that by changing the client's perception of the symptom or problem, a cognitive restructuring occurs, and the client then views it for it's positive benefits. As a result, the client is controlling the symptom or problem. The third rationale is the interpersonal power rationale. It involves viewing the symptom as an attempt to influence others. As used by Adler (1956), Haley (1961, 1963, 1974, 1976) and Erickson, the emphasis is on accepting the client's view of him/herself, understanding the value of the symptom to the individual, and restructuring of the client's life so that the symptom is either more functional or unnecessary. An elaboration of this view as practiced by the Palo Alto group was presented and discussed specific principles and components of the treatment approach. The fourth and final rationale is the compliance-defiance model proposed by Rohrbaugh, Tennen, Press, White, Raskin, and Pickering (1977). The compliance base strategies attribute the effectiveness of the paradoxical intervention to the client's attempts to comply with the counselor's directives. When the client attempts to resist or rebel against the counselor's influence, it is labeled a defiance based strategy. They also present an operational definition for these strategies. Prescribing strategies, used in both compliance and defiance, involves the counselor encouraging or instructing the client to engage in the specific behavior to be

eliminated. The restraining strategies embrace the counselor to discourage or deny the possibility of change by emphasizing the consequences or possible "danger" of change by telling the client to "go slow" in implementing change. In the positioning strategies the counselor accepts or exaggerates assertations made by the client.

The chapter concludes by discussing the theory of reactance to identify when it is appropriate to use a particular compliance-defiance based paradoxical intervention. The main premis of this theory is that the client experiences reactance when the counselor suggests anything that will eliminate or threaten his/her free behaviors. To deal with this the counselor can assume one of two roles in the relationship. In the "one-up" position the counselor is regarded as a superior figure who has overcome his/her everyday problems and is in a position to help others solve their problems. This is contrasted by the "one-down" position. In this role the counselor conveys a more informal relationship and comes on as a modest person who is willing to allow human frailities to show. The counselor considers the reactance potential and uses the most appropriate strategy.

CHAPTER III

METHODOLOGY

I. SELECTION PROCEDURES

Site. The site for this study was Farragut Middle School of the Knox County system in Tennessee. The student enrollment is approximately nine hundred and fifty students in grades six through eight. The physical plant of the school is that of the old Farragut High School, thus the building is several years old. Farragut Middle School serves predominately middle and upper-middle class residential neighborhoods. Only a small proportion of the students come from low income families or minority ethnic groups.

Farragut Middle School utilizes a team teaching program. Teams are formed to take advantage of the special competencies each team member possesses in the area of science, social studies, math, and English. Each team member teaches one section of reading in addition to his/her specialty area. The school also has a guidance counselor, resource, physical education, art, and music specialty as well as a librarian.

Each grade level is divided between two teams of teachers, creating seven teams. Students are assigned to a team in terms of grade level, not achievement standing. As a result, the teams are relatively equal in terms of student abilities and grade level functioning.

Teachers. The concepts involved in the treatment phase were presented to the entire staff during an after-school staff meeting. They were asked not to discuss with each other the students they thought would benefit from counseling, to guard against contamination of subject selection. The following day, the experimenter met with each teacher during their planning period.

Students/subjects. During this meeting with individual teachers, the teacher was given a list of descriptors describing disruptive students adopted from Williams and Anandam (1973). A copy of this list is in Appendix A. They were asked to identify five students in their classes who met the disruptive criteria. The individual lists of students were compiled by teaching team and agreement between individual lists was compared. The students consistently identified by at least three out of four teachers were selected. In cases where only two out of four teachers lists agreed, the experimenter met with the team as a whole to arrive at a consensus. Three students were identified by each team for a total of twenty-one.

The experimenter then met with each student. She explained that she was a student at the University and was studying to become a guidance counselor. Since one of the things a guidance counselor does is talk with students on a one to one basis, she wanted to improve her skills in this area. Many students were concerned that they were "in trouble." The experimenter assured them that they were not. The time spent with the experimenter was to help the experimenter and to work on

anything the student wanted to discuss. It was stressed that this was voluntary and was strictly their choice to participate. The student was then given a letter seeking parental consent (see Appendix B) and told that they must return this letter before the meetings could begin.

Attrition of subjects. Twenty-one students were identified by teachers and selected for this study. Three students chose not to participate in the study before treatment conditions began, one chose not to return after the first session. Scheduling conflicts resulted in three students being dropped from the study, since teachers thought that the students would suffer academically from classes missed for counseling sessions. Three students participated in the study through the final treatment session, but failed to give a post rating on the Goal Attainment Scale, thus the data of their progress could not be evaluated. As a result, there were two students (S_1 and S_2) in treatment group A which received paradoxical intervention strategies with the experimenter assuming a "one-down" position, two students (S_3 and S_4) in treatment group B where the experimenter assumed a "one-up" position in using paradoxical intervention strategies, and seven students (S_5, S_6, S_7, S_8, S_9, S_{10}, and S_{11}) in the short-term problem-solving group.

II. PHASE I: BASELINE CONDITIONS

Teachers were requested to continue their normal classroom procedures, interactions, and responses during the baseline period. For the first week of the study, all students were observed and no treatment conditions implemented, in order to establish a baseline of present behaviors.

III. PHASE II: TREATMENT CONDITIONS

During the initial interview with the student, time was spent getting to know the student and answering any questions he/she had about the meetings. The experimenter then introduced the Goal Attainment Scale (see Appendix C) by explaining that it would be used to help both the experimenter and student see how well they did in reaching the student's goals at the end of counseling. Each behavior category (Appendix D) and success level was explained in detail. The student was then assisted by the experimenter to begin filling out the scale.

In the second interview, the purpose, and explanation of the behavior categories and success levels on the Goal Attainment Scale were reviewed. The scale was then completed. Then, the student was asked to identify the present level of functioning for each behavior. Following the session with the student, the student's teachers, without knowing how the student rated him/herself, were individually asked to identify where they thought the student was presently functioning.

On the basis of these first two sessions, the experimenter assessed the reactance potential of each student. Students were accordingly assigned to one of the three experimental groups characterized as follows:

Treatment A. Five students were assigned to this group which received counseling utilizing one of the paradoxical intervention strategies (prescribing, restraining, positioning) with the experimenter assuming a "one-down" position. Due to their nature, the paradoxical

strategy implemented was unique for each student. The variable controlled in this group was the experimenter's "one-down" position.

For example, one student in this treatment group came reporting he had difficulty paying attention in class. In order to have more free time, he would rush through his assignments and therefore received poor grades. Moreover, when he finished his assignments, he liked to talk and sing with two or three of his classmates. This did not set well with his teachers. As a consequence for his behavior, he was often put in isolation. He believed there was nothing wrong with what he was doing. In his perception, it was the teacher's problem; they should give him more free time. Because of his resistance, it was decided that a "one-down" position would be most appropriate.

In session four, the student came in very upset. He had been put in isolation again. He felt that his teachers were picking on him and disciplining him unfairly. He thought if he could pay more attention to the teacher, he would get in trouble less. The problem was that he did not like listening to the teachers because in his mind, they were boring. The experimenter, assuming a "one-down" position, commented that he had a really tough problem and she had no solution to the problem. However, she had heard that some of her friends at the University had tried something with one of their professors that he might want to try. When they had a professor they did not like to listen to, they would play the following game. They would ovserve every move the professor made, nod their head when they understood what he was talking about, and ask questions when they did not understand something.

In doing this they paid constant attention to the professor and tried to see who could get most of the professor's attention. The experimenter asked the student what he would think of playing this attention game with his teachers. He liked the idea and decided to try it.

In the next session, the student reported that the game had gone well. He was paying more attention in class and getting in trouble less.

Treatment B. The counseling strategy implemented for the four students in this group was also a paradoxical intervention. In this treatment condition, the variable controlled was that the counselor assumed a "one-up" position.

One of the students in this group, reported during the second session that he had gotten in trouble for play-wrestling with his friends after lunch. He had been put in isolation. He was very upset because he did not see why his teachers disliked play-wrestling. The experimenter asked him if there was any way he could wrestle without getting caught. He was quite surprised at the suggestion, but said he thought it could be done. The experimenter was an expert, said the problem was not in play-wrestling, but in getting caught. Together they worked out a plan.

In the next session, he reported that the plan was working. The experimenter added to the paradox, by commenting that he should slow down and be more cautious. She explained by saying that the teachers would start expecting too much if he changed too fast. Following sessions revealed that the student was getting in trouble much less often.

Treatment C. This group of nine students did not receive a paradoxical intervention. Instead, a short-term problem solving model of counseling was used.

A sample of this technique is as follows: One of the girls reported her main difficulty was that she got in trouble for talking with her friends and flirting with boys, however she felt that the teachers were disciplining her more than other students. She spent more time emphasizing the teacher's behavior than her own. The experimenter asked the student to describe what she was doing. The student described situations of talking, whispering, and passing notes during class. The experimenter asked how this was helping her and the other students. She said it was getting them in trouble. The experimenter asked what she could do that would be better. She responded that it would be better to pay attention in class and talk later. Together, the experimenter and student developed a plan for how the student could avoid talking in class. The student decided that the alternative she would like to try was to tell her friends that she was not going to talk during class, but would talk afterwards. The plan was written up with a commitment. The student signed the commitment.

In the next session, the student reported the plan had been only partially successful. The student and experimenter drew up a revised plan. This procedure was continued until successful.

IV. EXPERIMENTAL DESIGN

A multiple baseline design (Baer, Wolf, Risley, 1970; Craighead, Kazdin , and Mahoney, 1976) was used in which the baseline period began

on the same day for all students, but varied in length from one to two weeks. Consequently, the four week, eight session treatment periods were not administered simultaneously to all individual students. The experimental design allowed for changes in the dependent variables to be attributed to the treatment conditions rather than other variables which might be operating during any one given time period.

V. GOAL ATTAINMENT SCALE

A Goal Attainment Scale was used to assess the effectiveness of the treatment. The scale was developed as an approach to measure client progress toward counseling goals (Kiresuk, 1973; Kiresuk and Sherman, 1968). There are three basic elements in developing a Goal Attainment Scale: (1) select the goals the client wishes to develop, (2) assign weight to each problem in the set to reflect the relative importance of each problem, and (3) develop a set of behavioral referents of expected change in the problem area (Seaberg and Gillespie, 1977; Shepperson, Mauger, and Zinober, 1975). For each goal set, a scale is constructed which specifies a continuum of five possible outcomes. These outcomes range from "most unfavorable treatment outcome thought likely" to "best anticipated treatment success" (Hegion, Fish, and Grace, 1974). The benefits of using the Goal Attainment Scale include: (1) increased client involvement through goal setting leading to increased treatment effectiveness (Galano, 1977); (2) increased specificity of goals (Weinstein and Ricks, 1975); (3) increased ability to measure treatment goal progress (Ricks and Weinstein, 1975); and

(4) increased involvement leading to increased client satisfaction (Willer, 1975).

A Goal Attainment Scale was adapted from Kiresuk and Sherman (1968) to fit the needs of this investigation. A copy of the scale used is in Appendix C. The design was chosen because of its ability to objectively identify and rate improvement, provide quantifiable data, and subsequently reduce rater bias.

The Goal Attainment levels were developed for each student immediately after the baseline period during the first two interviews. The same rating scale was rated independently by the teacher and student, at the beginning and conclusion of the treatment phase. Scoring procedure involved having the rater determine which attainment level most accurately reflects the student's behavior. Each behavior category (task relevant, time-off-task, socially appropriate, and disruptive) received a score.

In addition, an attempt was made to gather an on-the-count behavior observation for each of the four behavior categories (task-relevant, time-off-task, socially appropriate, and disruptive) for each student one-half hour once a week. However, due to special events within the school such as practice for field day, field day, plays, assemblies, etc., student schedules would be re-arranged and often the student to be observed would be in a class that prohibited behavior observation, i.e., gym, lunch, band.

VI. ANALYSIS OF THE DATA

Graphs and tables have been used to present the data obtained in this investigation.

Pre and post Goal Attainment Scale scores were recorded for each student. These scores were then placed in the following formula to permit intra- and inter-student comparison,

$$\frac{50 + 10\ \Sigma w_1 x_1}{\sqrt{(.7\Sigma w_1^{\,2}) + .3(\Sigma w_1)^2}}$$

where w = weight value,

x = scale value,

p = probability,

$\bar{x} = 50$,

$s_2 = 10$,

p = .3,

1 - p = .7.

CHAPTER IV

RESULTS

The results of this study are presented in Chapter IV. Included in the results are a discussion of the pre and post levels achieved by each student as perceived by the student and teachers, and the unobtrusive measures observed by the teachers, school counselor, and experimenter. In the presentation of the findings, students are designated as S_1, S_2, S_3, S_4, S_5, S_6, S_7, S_8, S_9, S_{10}, and S_{11}, while teachers are groups by teams A, B, C, D, E, and F and then identified as T_{A1}, T_{A2}, T_{A3}, T_{A4} through T_{F4}.

I. GOAL ATTAINMENT SCALE DATA

A Goal Attainment Scale was developed for each student during the first two interviews. The student and teachers independently rated each behavior category (task relevant, time-off-task, socially appropriate, and disruptive) at the beginning and conclusion of the treatment phase. Scoring procedures involved having the rater determine which attainment level most accurately reflects the student's behavior. To permit intra- and inter-subject comparison, the following formula was employed to calculate a pre and post Goal Attainment Score:

$$\frac{50 + 10 \ \Sigma w_1 x_1}{\sqrt{(.7\Sigma w_1^{\ 2}) + .3(\Sigma w_1)^2}}$$

where w = weight value,

x = scale value,

p = probability,

$\bar{x}$ = 50,

s_2 = 10,

p = .3,

1 - p = .7.

This formula yields a score of fifty if outcomes are at the "expected level" and a standard deviation of ten (Kiresuk and Lund, 1978). Previous studies using the Goal Attainment Scale view scores over fifty as successful (Galano, 1977; Hegion, Fish, and Grace, 1974; Kiresuk, 1973; Weinstein and Ricks, 1975).

Pre-treatment scores for S_1 on the Goal Attainment Scale ranged from 30.91 by T_{A1} to 55.21 by S_1 and T_{A4}, with a mean of 42.71. After counseling using a paradoxical intervention strategy with the experimenter assuming a "one-down" position, post-treatment Goal Attainment Scores ranged from 43.06 by T_{A1} and T_{A3} to 62.15 by T_{A2} and T_{A4} with a mean of 54.17 (see Table 1 and Figure 1).

For S_2, the pre-treatment Goal Attainment Scale scores ranged from 27.28 by T_{B2} to 55.68 by T_{B1} with 34.66 as the mean. S_2 received counseling using paradoxical intervention strategy with the experimenter assuming a "one-down" position. His post-treatment Goal Attainment scores ranged from 44.32 by T_{B4} to 77.72 by T_{B1} with 57.25 as the score's mean. These scores are displayed in Table 2 and Figure 2.

S_3 showed the largest change with the pre-treatment Goal Attainment scores ranging from 32.34 by T_{C3} to 50.93 by T_{C2}. The

TABLE 1

SUMMARY OF GOAL ATTAINMENT SCORES FOR S_1*

		Behavior				
		Task Relevant Weight: 30	Time-Off-Task Weight: 10	Appropriate Social Weight: 10	Disruptive Weight: 30	Goal Attainment Score:
Rater:						
S_1	Pre	0	+1	+2	0	55.21
	Post	0	+1	+2	+1	60.41
T_{A1}	Pre	-2	+1	0	-2	30.91
	Post	-1	+2	0	-1	43.06
T_{A2}	Pre	-1	-1	+1	-1	39.59
	Post	0	0	+1	+2	62.15
T_{A3}	Pre	-1	-2	+1	-2	32.64
	Post	+1	-2	+1	-2	43.06
T_{A4}	Pre	-1	-1	+1	+2	55.21
	Post	0	0	+1	+2	62.15
					Pre $\bar{x}$ =	42.71
					Post $\bar{x}$ =	54.17

*Paradoxical intervention strategy with experimenter assuming a "one-down" position.

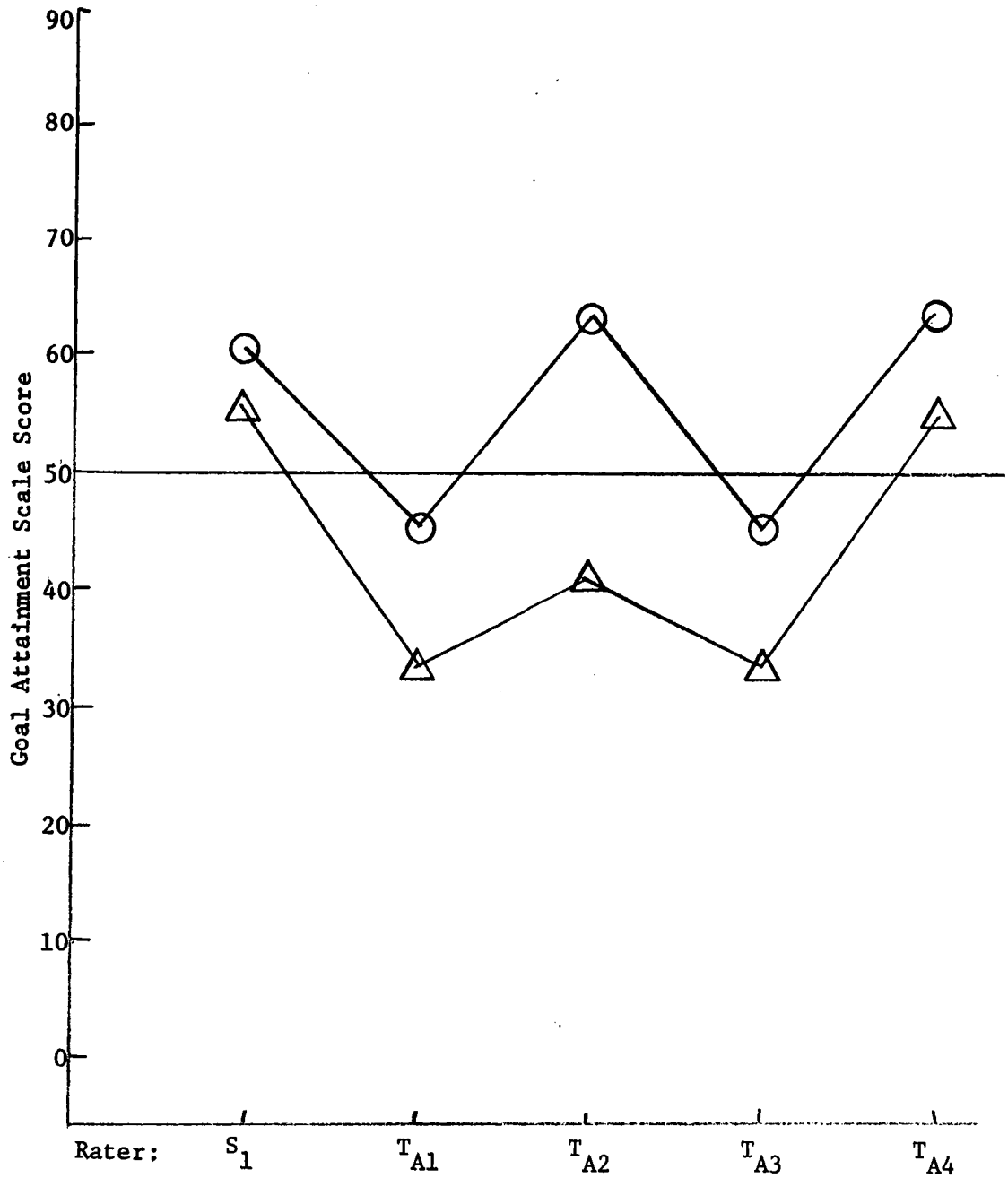


Figure 1. Pre (Δ) and post (○) Goal Attainment Scale scores for S_1. Paradoxical intervention strategy with experimenter assuming a "one-down" position.

TABLE 2

SUMMARY OF GOAL ATTAINMENT SCORES FOR S_2*

		Behavior				
		Task Relevant Weight: 30	Time-Off-Task Weight: 30	Appropriate Social Weight: 10	Disruptive Weight: 30	Goal Attainment Score:
Rater:						
S_2	Pre	-1	-2	-2	-1	30.12
	Post	+1	0	-1	+1	57.10
T_{B1}	Pre	+1	+1	+1	-1	55.68
	Post	+1	+2	+1	+1	77.72
T_{B2}	Pre	-1	-2	-1	-2	27.28
	Post	+2	-2	0	0	50.00
T_{B3}	Pre	-1	-2	+1	-2	30.12
	Post	+1	-1	+2	+1	57.10
T_{B4}	Pre	-1	-2	-2	-1	30.12
	Post	0	-2	-1	+1	44.32
					Pre $\bar{x}$ =	34.66
					Post $\bar{x}$ =	57.25

*Paradoxical intervention strategy with experimenter assuming a "one-down" position.

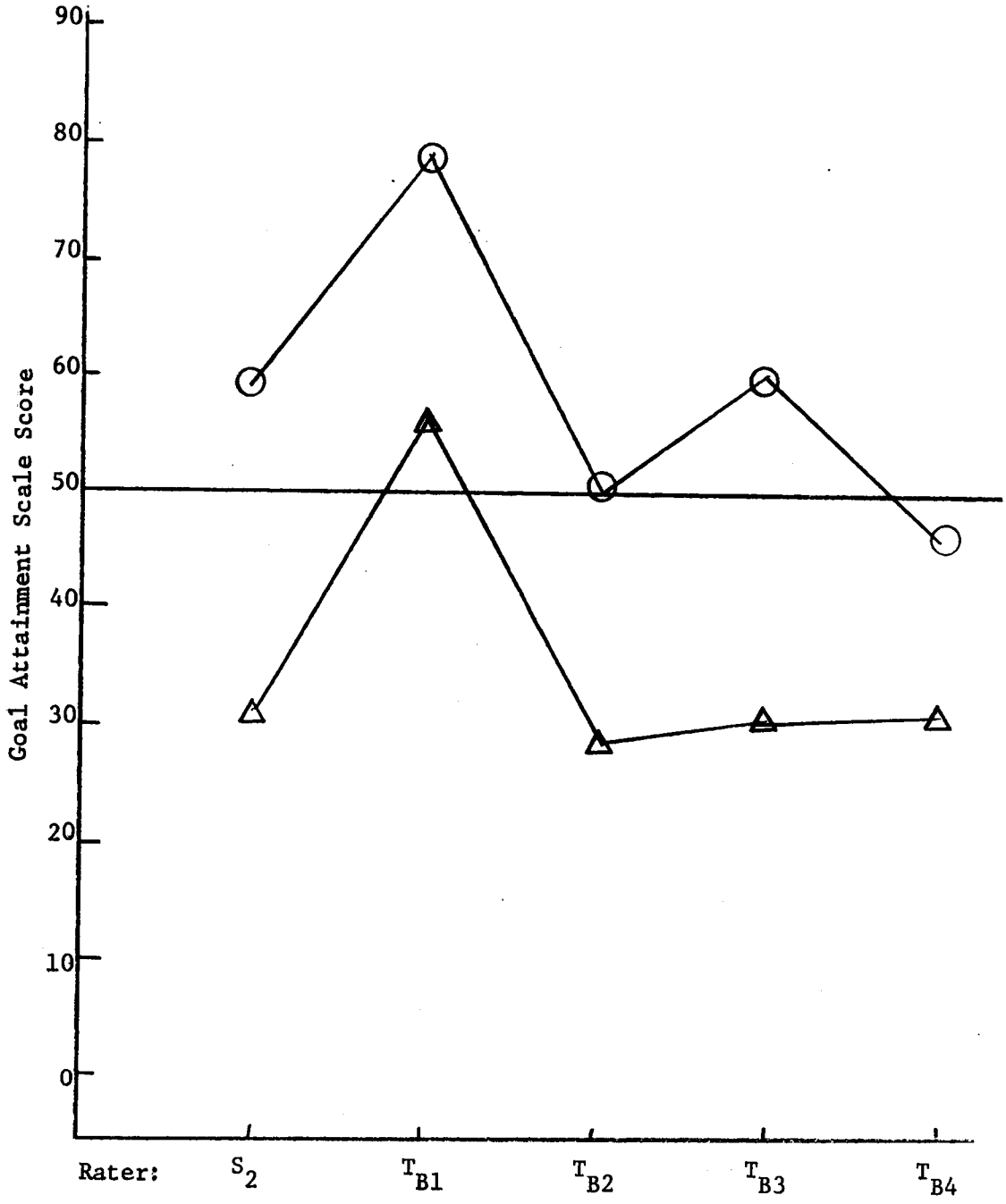


Figure 2. Pre (△) and post (○) Goal Attainment Scale scores for S_2. Paradoxical intervention strategy with experimenter assuming a "one-down" position.

experimenter assumed a "one-up" position in the relationship during counseling using paradoxical intervention strategy. Post-treatment Goal Attainment scores ranged from 55.58 by T_{C3} to 74.16 by T_{C4} with a mean of 65.43, as shown in Table 3 and Figure 3.

Table 4 and Figure 4 show that pre-treatment Goal Attainment scores ranged from 21.63 by T_{C2} to 37.59 by S_4 with a mean of 28.01 for S_4. Paradoxical intervention strategy with the counselor assuming a "one-up" position was the treatment received by S_4. Post-treatment scores ranged from 34.04 by T_{C3} to 58.86 by S_4 and 46.45 as the mean.

Goal Attainment pre-treatment scores for S_5 had a mean of 28.01 with a range from 21.63 by T_{D2} and T_{D3} to 35.81 by S_5. After short-term problem-solving counseling, post-treatment Goal Attainment scores ranged from 25.13 by T_{D2} to 48.32 by S_5, 38.64 was the mean (see Table 5 and Figure 5).

S_6 had pre-treatment Goal Attainment scores ranging from 32.46 by T_{B2} and T_{B3} to 50.80 by S_6, 32.72 was the mean. Treatment consisted of short-term problem solving counseling. Post-treatment Goal Attainment scores had a mean of 55.90 and ranged from 50.00 by T_{B4} to 69.93 by S_6 (see Table 6 and Figure 6).

S_7's pre-treatment Goal Attainment scores mean was 23.78 and ranged from 21.61 by S_7 to 27.45 by T_{E4}. Following short-term problem-solving, post-treatment scores ranged from 24.95 by T_{E1}, T_{E2}, and T_{E3} to 59.09 by S_7 with a mean of 36.14 as shown in Table 7 and Figure 7.

Pre-treatment scores on the Goal Attainment Scale for S_8 ranged from 31.31 by S_8 to 50.01 by T_{E3} and 40.88 the mean. Short-term

TABLE 3

SUMMARY OF GOAL ATTAINMENT SCORES FOR S_3*

		Behavior				
		Task Relevant Weight: 10	Time-Off-Task Weight: 10	Appropriate Social Weight: 25	Disruptive Weight: 30	Goal Attainment Score:
Rater:						
S_2	Pre	-1	+1	-2	-1	35.13
	Post	+1	+2	+1	0	60.22
T_{C1}	Pre	-1	-2	+1	-1	41.64
	Post	0	+1	+2	+1	66.73
T_{C2}	Pre	0	0	+1	-1	50.93
	Post	+2	+1	+2	+1	70.44
T_{C3}	Pre	-2	-2	-1	-1	32.34
	Post	+1	-1	0	+1	55.58
T_{C4}	Pre	+1	-1	+2	-1	46.28
	Post	+2	0	+2	+2	74.16
					Pre $\bar{x}$ =	41.26
					Post $\bar{x}$ =	65.43

*Paradoxical intervention strategy with experimenter assuming a "one-up" position.

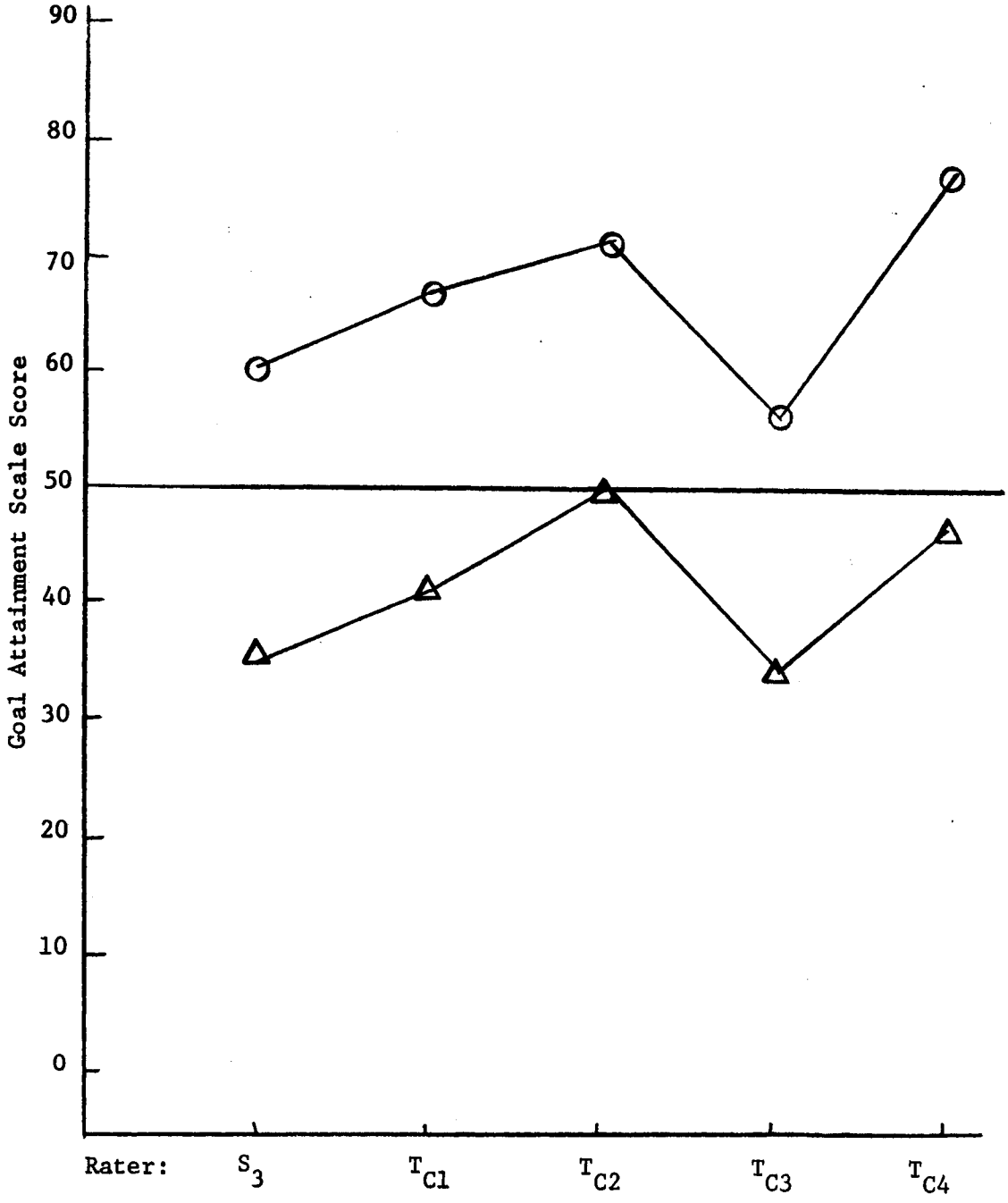


Figure 3. Pre (△) and post (○) Goal Attainment Scale scores for S_3. Paradoxical intervention strategy with experimenter assuming a "one-up" position.

TABLE 4

SUMMARY OF GOAL ATTAINMENT SCORES FOR S_4*

		Behavior				
		Task Relevant Weight: 20	Time-Off-Task Weight: 10	Appropriate Social Weight: 20	Disruptive Weight: 30	Goal Attainment Score:
Rater:						
S_4	Pre	-1	0	-1	-1	37.59
	Post	0	+2	0	+1	58.86
T_{C1}	Pre	-2	-2	-1	-2	25.17
	Post	-1	-1	+1	0	48.23
T_{C2}	Pre	-2	-2	-2	-2	21.63
	Post	-2	-1	-1	0	37.59
T_{C3}	Pre	-2	-2	-1	-2	25.17
	Post	-2	-2	0	-1	34.04
T_{C4}	Pre	-2	-2	-1	-1	30.49
	Post	-2	-2	+1	+2	53.55
					Pre $\bar{x}$ =	28.01
					Post $\bar{x}$ =	46.45

*Paradoxical intervention strategy with experimenter assuming a "one-up" position.

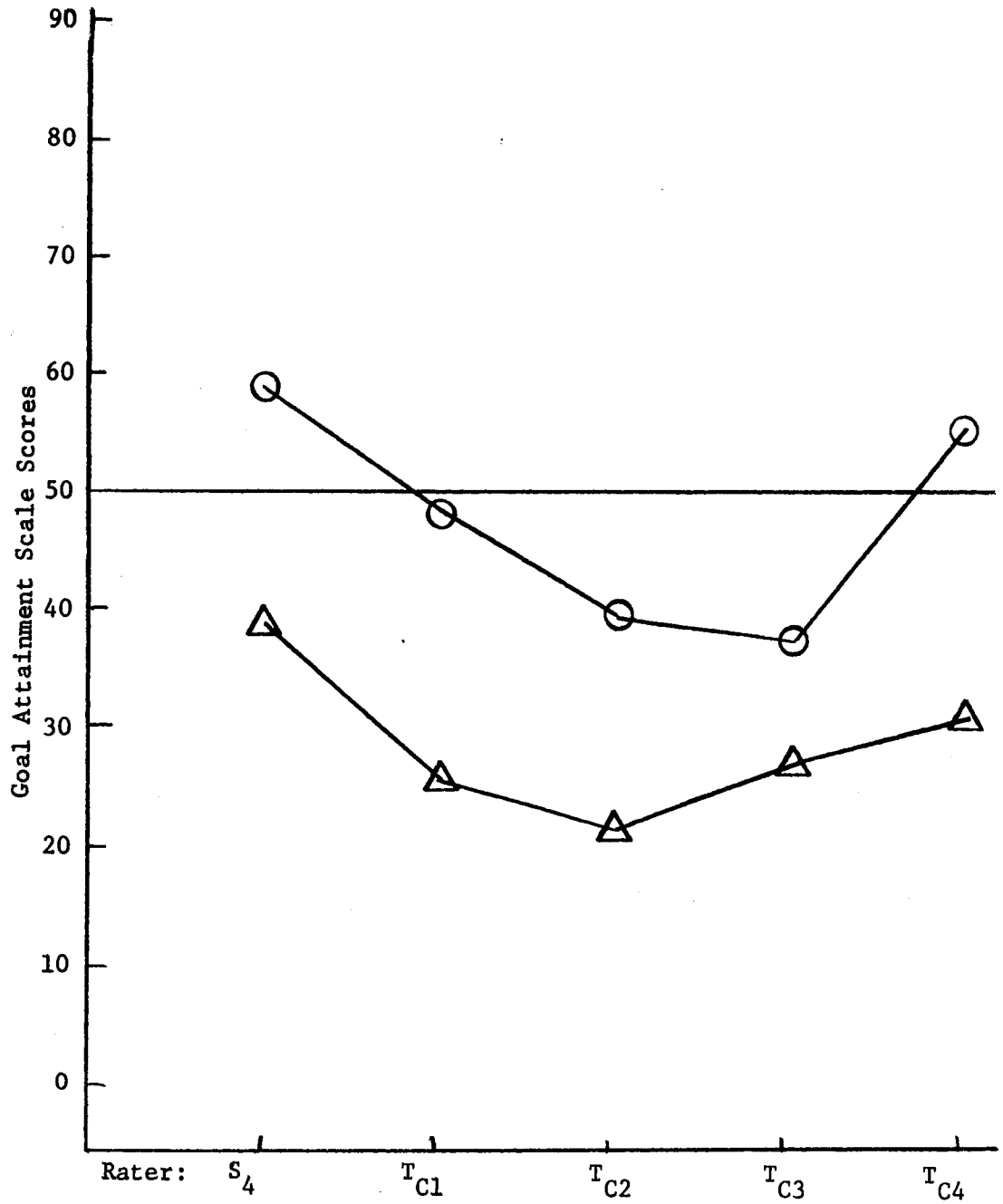


Figure 4. Pre (Δ) and post (○) Goal Attainment Scale scores for S_4. Paradoxical intervention strategy with experimenter assuming a "one-up" position.

TABLE 5

SUMMARY OF GOAL ATTAINMENT SCORES FOR S_5*

		Behavior				
		Task Relevant Weight: 20	Time-Off-Task Weight: 10	Appropriate Social Weight: 30	Disruptive Weight: 20	Goal Attainment Score:
Rater:						
S_5	Pre	-1	0	-2	0	35.81
	Post	0	+1	-2	+2	48.23
T_{D1}	Pre	-2	-2	N/A	-2	32.27
	Post	-1	-2	N/A	0	42.91
T_{D2}	Pre	-2	-2	-2	-2	21.63
	Post	-1	-2	-2	-2	25.13
T_{D3}	Pre	-2	-2	-2	-2	21.63
	Post	-1	-1	-1	-2	32.27
T_{D4}	Pre	-2	-2	-2	0	28.71
	Post	-1	-2	-1	+2	44.68
					Pre $\bar{x}$ =	28.01
					Post $\bar{x}$ =	38.64

*Short-term problem-solving.

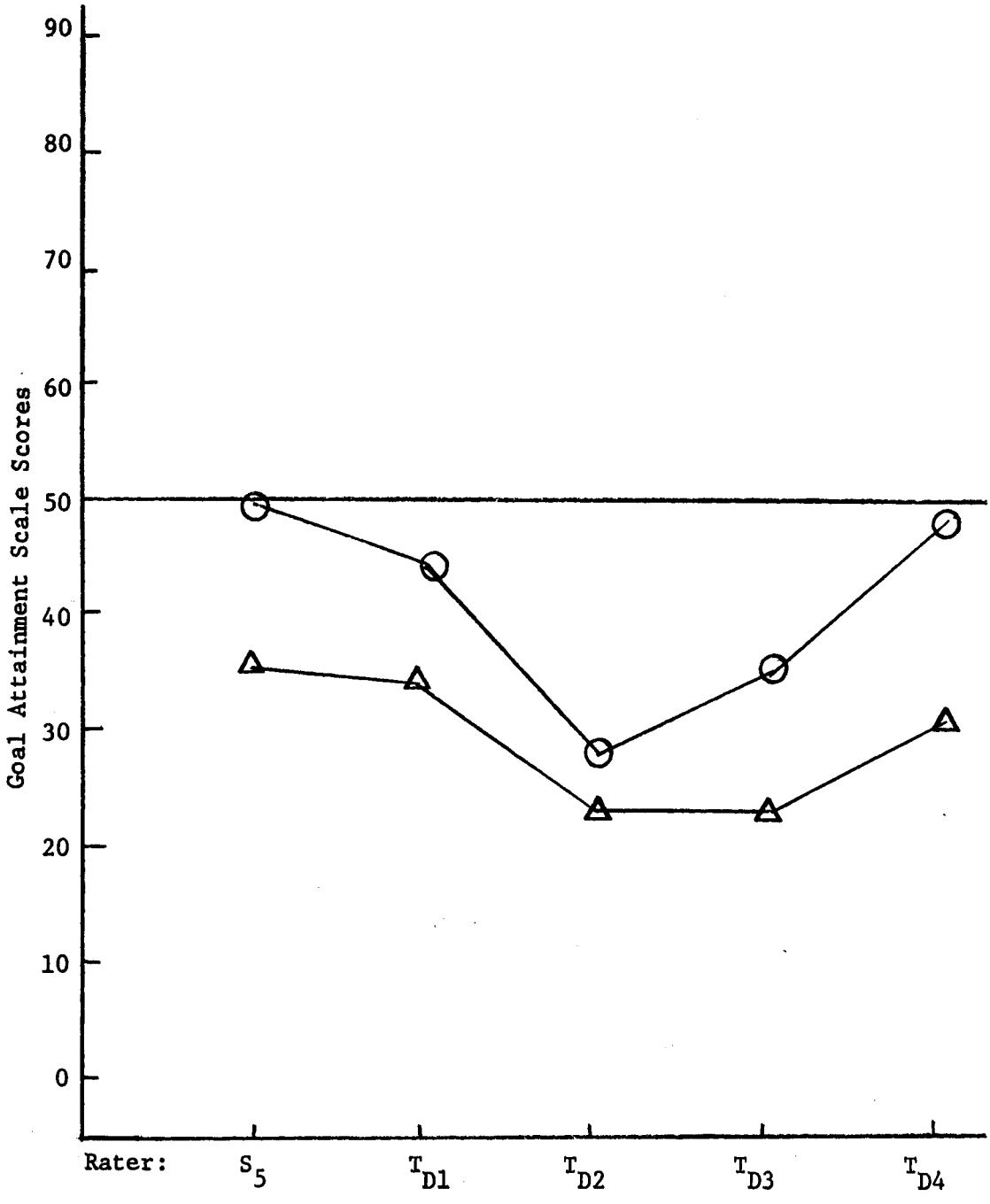


Figure 5. Pre (Δ) and post (○) Goal Attainment Scale scores for S_5. Short-term problem-solving.

TABLE 6

SUMMARY OF GOAL ATTAINMENT SCORES FOR S_6*

		Behavior				
		Task Relevant Weight: 25	Time-Off-Task Weight: 15	Appropriate Social Weight: 20	Disruptive Weight: 30	Goal Attainment Score:
Rater:						
S_6	Pre	+1	0	-1	0	50.80
	Post	+1	+2	+2	+1	69.93
T_{B1}	Pre	-1	+1	-2	-1	37.25
	Post	0	+2	-1	+1	56.38
T_{B2}	Pre	-1	-1	-2	-1	32.46
	Post	0	0	-1	+1	51.59
T_{B3}	Pre	-1	+1	-2	-2	32.46
	Post	0	+2	-1	0	51.59
T_{B4}	Pre	-2	-2	+1	-1	35.65
	Post	-1	-1	+2	0	50.00
					Pre $\bar{x}$ =	37.72
					Post $\bar{x}$ =	55.90

*Short-term problem-solving.

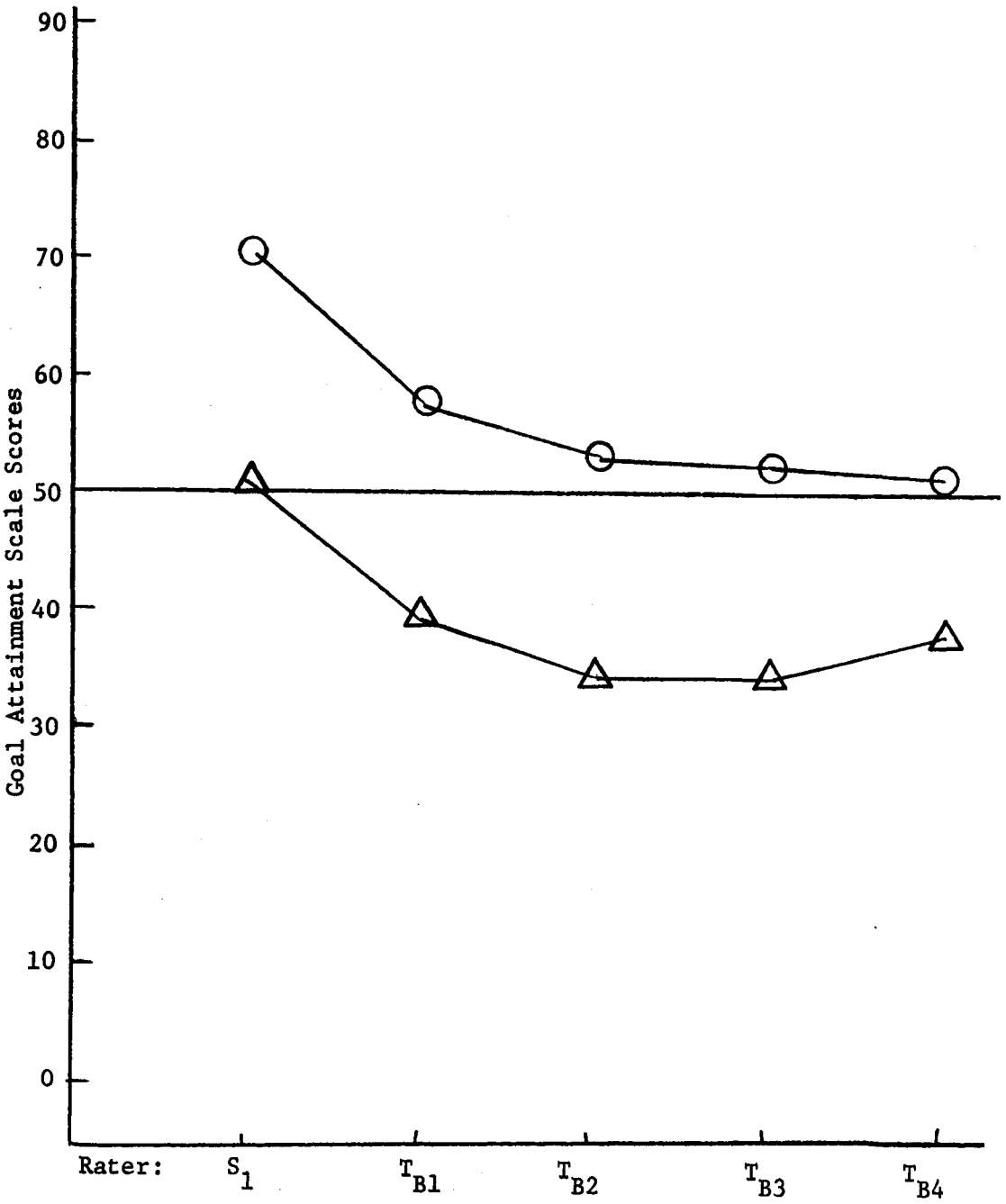


Figure 6. Pre (△) and post (○) Goal Attainment Scale scores for S_6. Short-term problem-solving.

TABLE 7

SUMMARY OF GOAL ATTAINMENT SCORES FOR S_7*

		Behavior				
		Task Relevant Weight: 25	Time-Off-Task Weight: 20	Appropriate Social Weight: 10	Disruptive Weight: 30	Goal Attainment Score:
Rater:						
S_7	Pre	-2	-2	-2	-2	21.61
	Post	+1	+1	-2	+1	59.19
T_{E1}	Pre	-2	-2	-1	-2	23.28
	Post	-2	-2	0	-2	24.95
T_{E2}	Pre	-2	-2	-1	-2	23.28
	Post	-2	-2	0	-2	24.95
T_{E3}	Pre	-2	-2	-1	-2	23.28
	Post	-2	-2	0	-2	24.95
T_{E4}	Pre	-1	-2	-1	-2	27.45
	Post	+2	-2	0	-1	46.66
					Pre $\bar{x}$ =	23.78
					Post $\bar{x}$ =	36.14

*Short-term problem-solving.

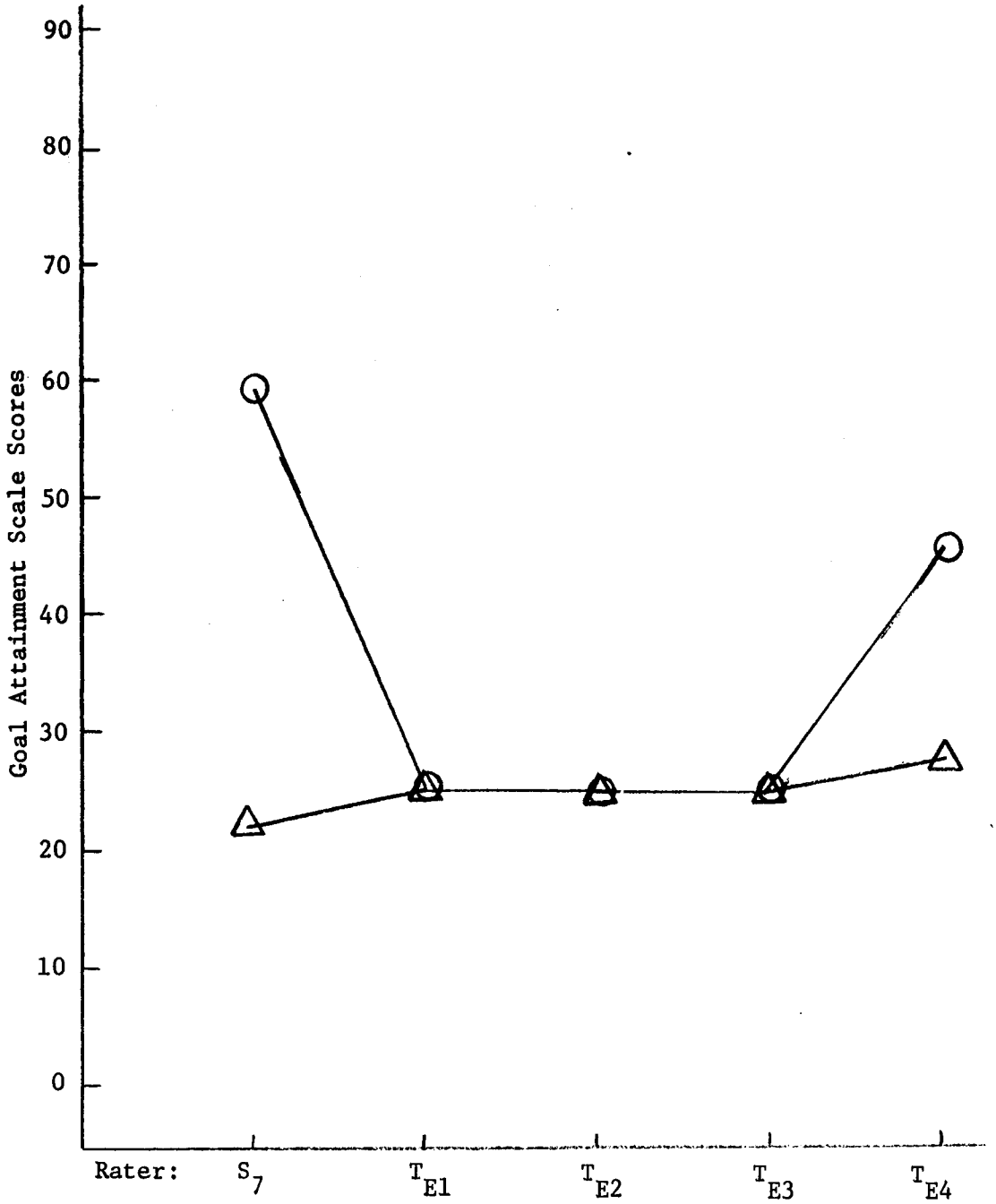


Figure 7. Pre (Δ) and post (O) Goal Attainment Scale scores for S_7. Short-term problem-solving.

problem-solving counseling with the treatment received by S_8. Post-treatment Goal Attainment scores ranged from 52.23 by T_{E1} and T_{E3} to 64.44 by T_{E4} with a mean of 57.68 (see Table 8 and Figure 8).

Goal Attainment pre-treatment scores ranged from 36.83 by T_{A1} to 55.64 by T_{A4} with a mean of 43.60 for S_9. The post-treatment scores, following short-term problem-solving counseling, ranging from 51.88 by T_{A1} to 72.58 by S_9 with a mean of 60.91, as depicted in Table 9 and Figure 9.

S_{10} had pre-treatment Goal Attainment scores with a mean of 25.04, ranging from 21.33 by T_{B3} and T_{B4} to 33.98 by S_{10}. Treatment involved short-term problem-solving. Post-treatment scores had a mean of 34.48 and ranged from 21.33 by T_{B3} and T_{B4} to 68.55 by S_{10} (see Table 10 and Figure 10). This was the least amount of change showed by any subject.

For S_{11}, pre-treatment Goal Attainment scores had a mean of 23.78 with individual rating scores ranging from 21.37 by S_{11} and T_{F3} to 26.65 by T_{F2}. Following short-term problem-solving counseling, post-treatment Goal Attainment scores had a mean of 47.74 and a range of 30.42 by T_{F3} to 58.29 by T_{F4} (see Table 11 and Figure 11).

In order to ease comparison of the pre- and post-treatment Goal Attainment scores between subjects, the mean scores for each subject have been graphed in Figure 12. All subjects showed some improvement, 16.83 being the average amount of change between pre- and post-treatment scores. The smallest increase, 9.44, was shown by S_5 in the short-term problem-solving treatment group. S_5 was the only subject in the study

TABLE 8

SUMMARY OF GOAL ATTAINMENT SCORES FOR S_8*

		Behavior				
		Task Relevant Weight: 25	Time-Off-Task Weight: 10	Appropriate Social Weight: 30	Disruptive Weight: 30	Goal Attainment Score:
Rater:						
S_8	Pre	-1	-1	-1	-2	31.31
	Post	+1	+1	+1	-1	55.32
T_{E1}	Pre	-1	0	+1	-2	41.78
	Post	+1	+1	+2	-2	52.23
T_{E2}	Pre	-1	0	+1	-2	41.78
	Post	+1	+1	+2	0	64.20
T_{E3}	Pre	-1	0	+1	-2	50.01
	Post	+1	+1	+2	-2	52.23
T_{E4}	Pre	0	-1	0	-2	39.54
	Post	+2	0	+2	0	64.44
					Pre $\bar{x}$ =	40.88
					Post $\bar{x}$ =	57.68

*Short-term problem-solving.

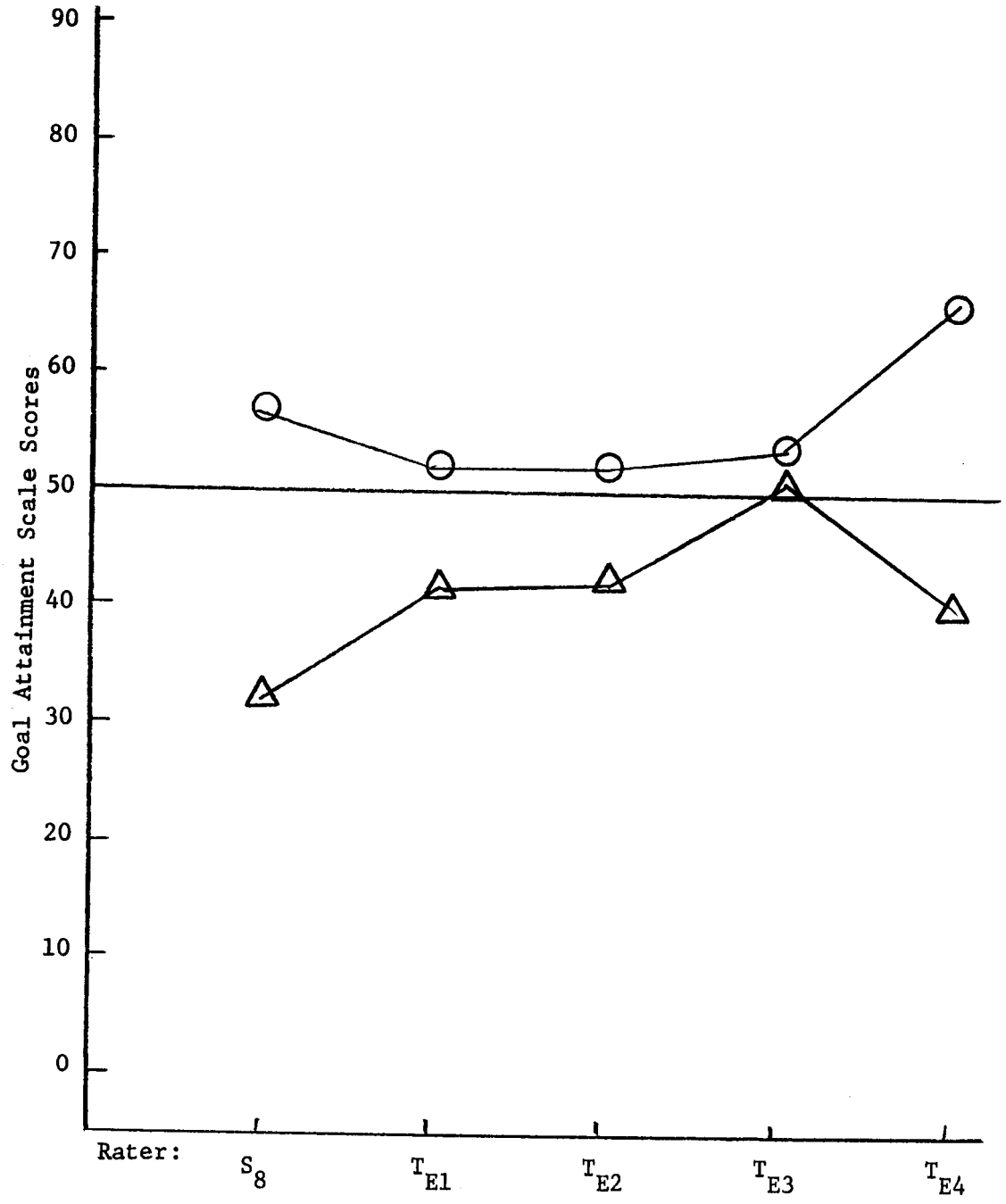


Figure 8. Pre (△) and post (○) Goal Attainment Scale scores for S_8. Short-term problem-solving.

TABLE 9

SUMMARY OF GOAL ATTAINMENT SCORES FOR S_9*

		Behavior				
		Task Relevant Weight: 20	Time-Off-Task Weight: 10	Appropriate Social Weight: 15	Disruptive Weight: 30	Goal Attainment Score:
Rater:						
S_9	Pre	0	0	0	-2	38.71
	Post	+1	+1	+2	+2	72.58
T_{A1}	Pre	-1	+1	0	-2	36.83
	Post	+1	+2	0	-1	51.88
T_{A2}	Pre	-1	0	0	0	46.24
	Post	0	0	0	+2	61.29
T_{A3}	Pre	-1	0	0	-1	40.59
	Post	+1	0	0	0	53.76
T_{A4}	Pre	0	0	N/A	+1	55.64
	Post	+1	0	N/A	+2	65.05
					Pre $\bar{x}$ =	43.60
					Post $\bar{x}$ =	60.91

*Short-term problem-solving.

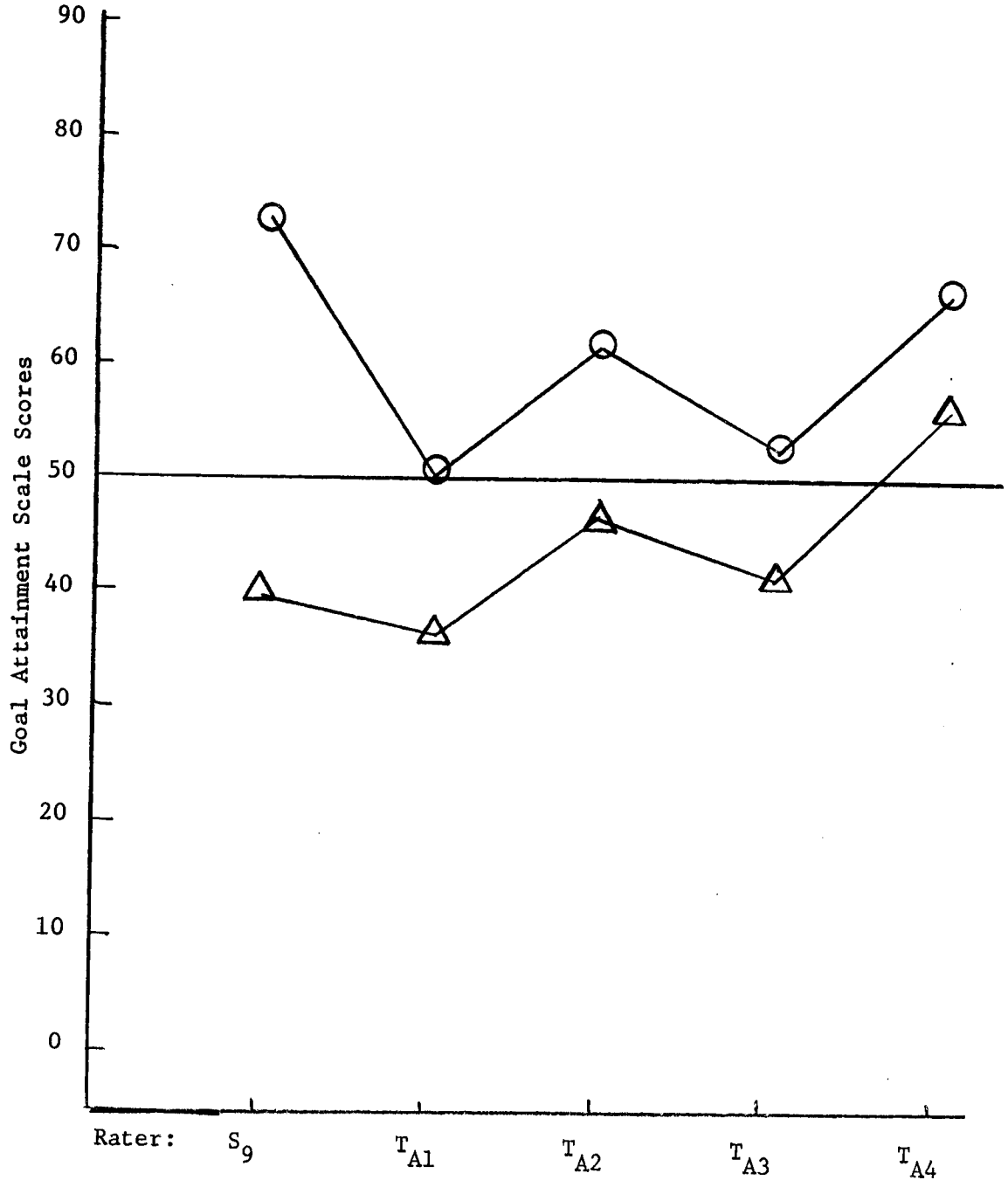


Figure 9. Pre (Δ) and post (O) Goal Attainment Scale scores for S_9. Short-term problem-solving.

TABLE 10

SUMMARY OF GOAL ATTAINMENT SCORES FOR S_{10}*

		Behavior				
		Task Relevant Weight: 20	Time-Off-Task Weight: 20	Appropriate Social Weight: 30	Disruptive Weight: 15	Goal Attainment Score:
Rater:						
S_{10}	Pre	-1	0	-2	-1	33.98
	Post	-1	+2	+2	+2	68.55
T_{B1}	Pre	-2	-2	-2	-1	23.86
	Post	-1	-2	-2	0	29.76
T_{B2}	Pre	-2	-1	-2	-2	24.70
	Post	-1	0	-2	-2	31.45
T_{B3}	Pre	-2	-2	-2	-2	21.33
	Post	-2	-2	-2	-2	21.33
T_{B4}	Pre	-2	-2	-2	-2	21.33
	Post	-2	-2	-2	-2	21.33
					Pre $\bar{x}$ =	25.04
					Post $\bar{x}$ =	32.48

*Short-term problem-solving.

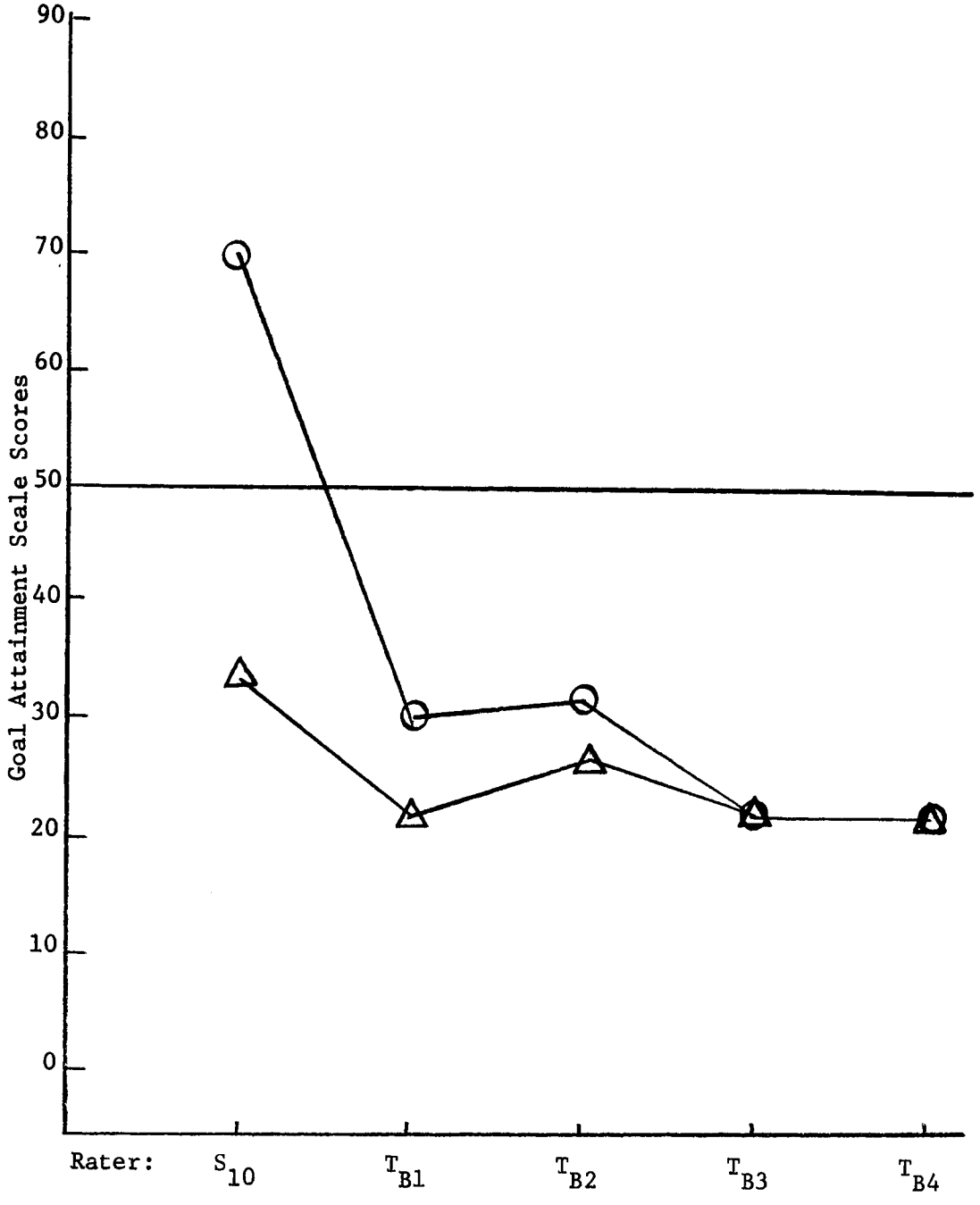


Figure 10. Pre (Δ) and post (O) Goal Attainment Scale scores for S_{10}. Short-term problem-solving.

TABLE 11

SUMMARY OF GOAL ATTAINMENT SCORES FOR S_{11}*

		Behavior				
		Task Relevant Weight: 20	Time-Off-Task Weight: 15	Appropriate Social Weight: 30	Disruptive Weight: 30	Goal Attainment Score:
Rater:						
S_{11}	Pre	-2	-2	-2	-2	21.37
	Post	0	+2	-1	+1	54.52
T_{F1}	Pre	-2	-1	-2	-2	23.63
	Post	-2	0	-1	0	39.45
T_{F2}	Pre	-1	-1	-2	-2	26.65
	Post	0	0	0	+1	54.52
T_{F3}	Pre	-2	-2	-2	-2	21.37
	Post	-2	-2	-1	-1	30.42
T_{F4}	Pre	-2	0	-2	-2	25.89
	Post	-1	+1	+2	0	58.29
					Pre $\bar{x}$ =	23.78
					Post $\bar{x}$ =	47.44

*Short-term problem-solving.

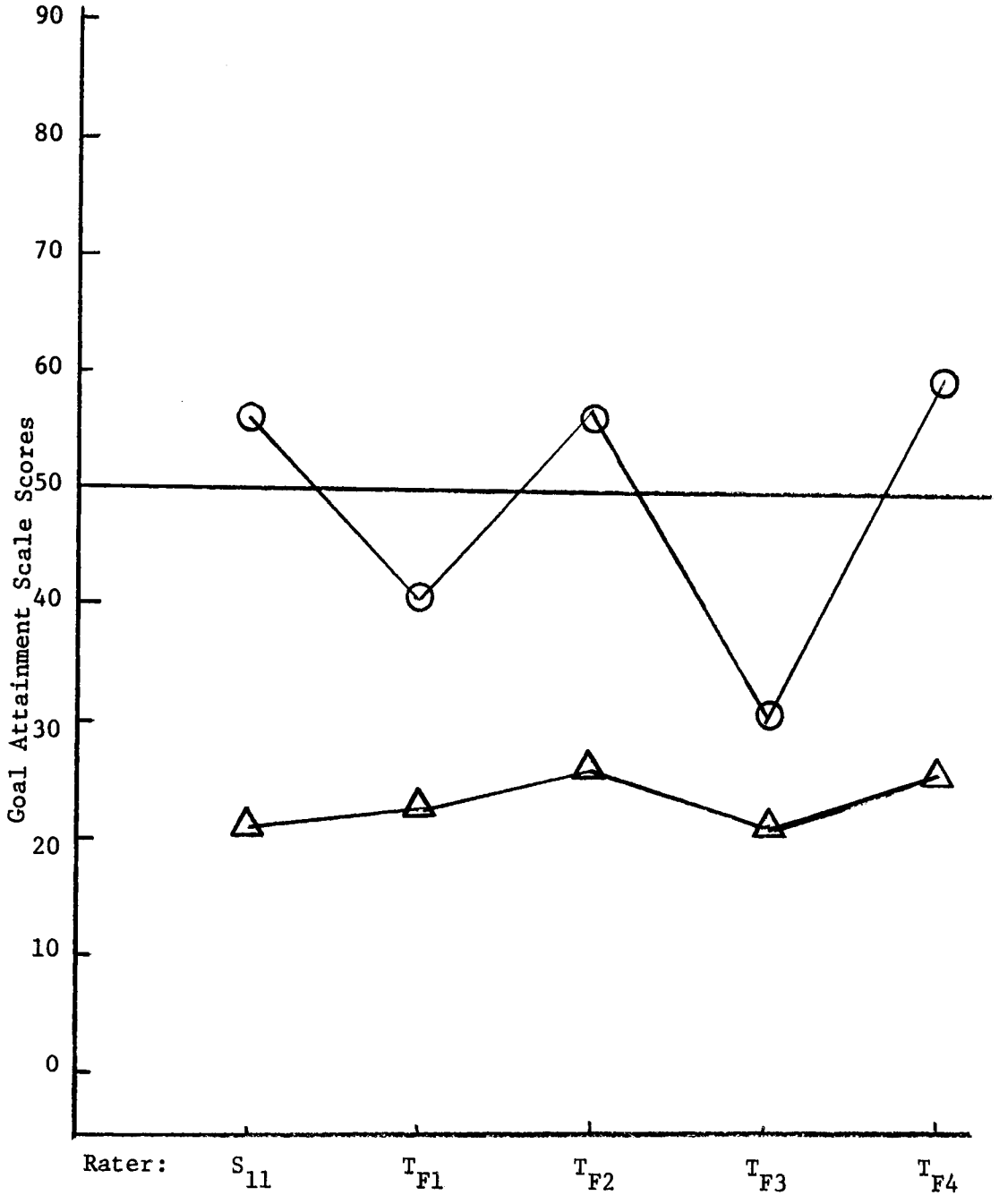


Figure 11. Pre (△) and post (○) Goal Attainment Scale scores for S_{11}. Short-term problem-solving.

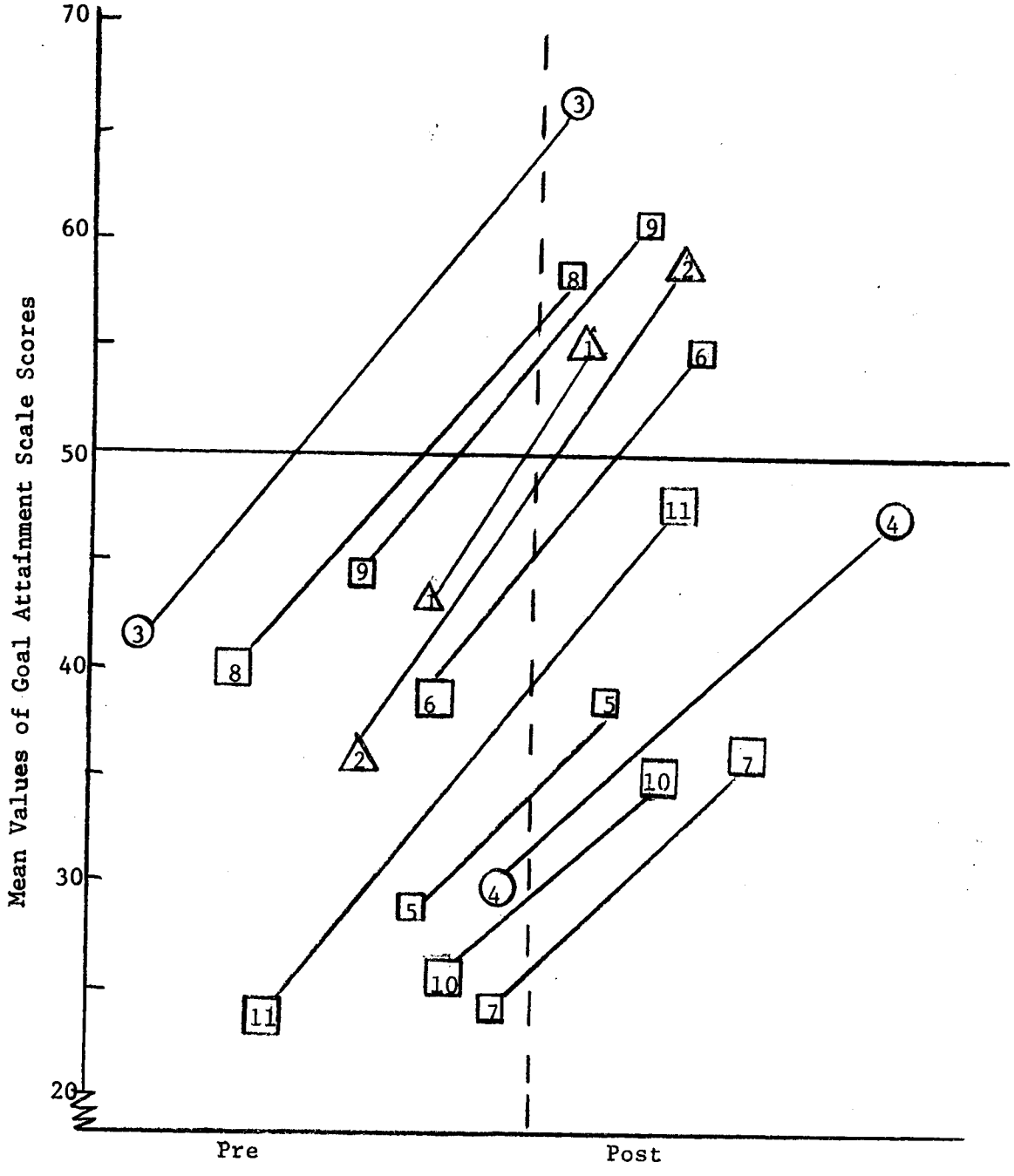


Figure 12. Mean values of pre and post scores on the Goal Attainment Scale. (△) = "Paradox-down," (○) = "Paradox-up," and (□) = Short-term problem-solving.

for whom all rater Goal Attainment scores were below the break-even point of fifty. S_2, S_3, S_6, and S_9 all had Goal Attainment scores by individual raters at or above fifty. The greatest increase, 24.17, was achieved by S_3 who received paradoxical intervention strategy where the experimenter assumed a "one-up" position.

II. UNOBTRUSIVE MEASURES

Some subjects showed a change in observed behaviors which were not a part of the problem statement. The school counselor and experimenter noticed that S_2, S_4, S_5, S_8, and S_9, all showed an increased willingness to come to the guidance office and talk with a counselor both for scheduled appointments and at other times. Teachers reported that S_2, S_5, S_8, S_{10}, and S_{11} were coming to them and attempting to work out problems more often than before treatment began. The school counselor and teachers on Team D noted an increased self-concept in S_5 at the end of the treatment phase. When asked to give post-treatment ratings on S_7 and T_{E4}, she reported that she had forgotten they were in the study. She noted additional changes of improved attitude toward school and increased cooperation in the classroom.

III. SUMMARY OF RESULTS

The research hypothesis for this study stated that students who receive paradoxical strategy interventions when the counselor assumes a "one-down" position would exhibit an increase in the Goal Attainment Scale scores on task relevant, socially appropriate, time-off-task and

disruptive behaviors when compared to those students in the short-term problem-solving group and those who receive the paradoxical strategy interventions when the counselor assumes a "one-up" position. To minimize the possible interference of extraneous variables, treatment was begun at different times such as used in a multiple baseline design. Differences between pre- and post-treatment scores on the Goal Attainment Scale showed that all students showed some improvement. The amount of improvement ranged from 9.44 for S_{10} to 24.17 by S_3 with 16.83 as the mean difference scores. These inter-subject comparisons indicate that no one treatment was more effective than another. Therefore, the results presented in this chapter do not support the research hypothesis.

CHAPTER V

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

I. SUMMARY

The purpose of this study was to determine whether the treatment process of using a paradoxical intervention strategy when the counselor assumed a "one-down" position would be more effective than using a paradoxical intervention strategy when the counselor assumed a "one-up" position in increasing Goal Attainment Scale scores on task relevant, socially appropriate, time-off-task, and disruptive behaviors of students identified as behavior problems. The study was conducted at Farragut Middle School in Knoxville, Tennessee. Subjects were eleven students identified by their teachers as behavior problems. A multiple baseline design was employed which provided baseline periods ranging from one to two weeks for different subjects, followed by two counseling interviews per week over a four week period. It was hypothesized that students who received counseling using a paradoxical intervention strategy when the experimenter assumed a "one-down" position would result in a greater increase in Goal Attainment Scale scores on task relevant, socially appropriate, time-off-task, and disruptive behavior, than students in the groups using paradoxical intervention strategy when the experimenter used a "one-up" position or short-term problem-solving. The hypothesis was not supported by the data collected in this investigation.

II. CONCLUSIONS

It has been concluded that the main findings show that student behaviors did not improve differentially according to their experimental group membership. Lietenberg (1974) has discussed the utility of the single case study method and concluded that it is especially valuable in verifying whether or not observed changes in behavior are really a function of particular therapeutic procedures. It is believed that taking this approach in analyzing the results has facilitated gleening the greatest amount of information possible from the available data.

Although every student experienced some success in achieving their goals, one treatment cannot be deemed as superior. It would seem that each technique proved to be more useful with some students than others. This is in agreement with Frankl's (1975, 1978) studies which indicate that paradoxical interventions are not a panacea. This appears to hold true also for the use of a "one-down" versus a "one-up" position in the counseling relationship. Even when the subjects in the two paradoxical intervention groups results were compared, there was no real significant difference in the Goal Attainment Scale score changes associated with the role assumed by the counselor in the relationship.

The amount of progress associated with having the student establish their own goals is unknown. Galano (1977) suggests that merely having clients develop their own Goal Attainment Scale results in greater success. In regard to changing the classroom behavior of

students, giving students the opportunity to establish their own goals is a paradox in itself. Most often (Hall, Lund, and Jackson, 1968; Madsen, Becker, and Thomas, 1968; O'Leary and Becker, 1967; Meyer, Strowig, and Hosford, 1970) students identified as disruptive are told what changes to make or the behaviors are unobtrusively conditioned. This returning of the decision making power to the student is viewed as a partial source of the success in this investigation.

Gerz (1966) suggests that paradoxical intention strategies should be used to supplement dynamic therapy, not replace it. By combining paradoxical intervention strategies with the Goal Attainment Scale, this was partially achieved; however, it is possible that even greater success could have been achieved if the paradoxical intervention strategies were used as a supplement and not the primary mode of counseling.

As in any research conducted in an applied setting, there were circumstances beyond the control of the experimenter. Spring in the public schools seems to be a time for field trips, plays, field days of sporting events, and assemblies. At times they made it difficult to maintain standardized procedures. It is possible the various treatments would have had more success if events within the school were on a less hectic schedule.

Some of the teachers noted that at times it was difficult for them to distinguish the difference between the various levels on the Goal Attainment Scale. Thus another improvement that might have enhanced the results of this investigation would have been to make the

behavioral referents on each of the different levels of the Goal Attainment Scale more distinct.

III. SUGGESTIONS FOR FURTHER RESEARCH

The utilization of a paradoxical intervention strategy when the counselor assumed a "one-down" position did not prove to be more effective than using a paradoxical intervention strategy with the counselor assuming a "one-up" position or using a short-term problem-solving model in increasing Goal Attainment Scale scores on task relevant, socially appropriate, time-off-task, and disruptive behavior in students identified by teachers as behavior problems. The investigation was conducted in a suburban, middle school composed largely of middle and upper-middle class white students. In conducting further research the setting of this study should be taken into consideration.

More research should be done in the following areas:

1. How specific do the discriminations between the various levels of the Goal Attainment Scale need to be to permit discrimination and determinination of success of counseling?

2. How effective would it be to teach teachers how to use paradoxical intervention strategies?

3. How effective would it be to teach teachers to use a "one-up" or "one-down" position with resistent students?

4. What would happen if teachers were involved in counselor iniated paradoxical intervention strategies?

5. What are the long range effects of these short-term paradoxical intervention strategies?

6. How will the increased appropriate behaviors and decreased inappropriate behaviors transfer to other settings?

7. What effect would increasing the number of sessions have on the success of the paradoxical intervention strategies?

8. Would paradoxical intervention strategies be more effective with students who sought counseling as opposed to those who were identified and consented?

9. Would paradoxical intervention strategies be more effective if used as a supplement to other counseling strategies and techniques?

10. How effective would the Goal Attainment Scale be with various counseling techniques?

11. How much effect does deciding goals and their level of attainment have on success in counseling?

12. What effect does assuming a "one-up" or "one-down" position have in other counseling techniques and strategies?

In spite of the plethora of literature concerning various techniques for dealing with the disruptive behavior of students, further research is needed in determining which techniques are most effective with certain types of students. This investigation has demonstrated relative success of paradoxical intervention strategies with a "one-down" and "one-up" position in one situation.

REFERENCES

REFERENCES

Adler, A. The individual psychology of Alfred Adler. Ed. by H. L. and Rowena R. Ansbacher. New York: Basic Books, 1956.

Adler, K. Techniques that shorten psychotherapy: Illustrated with five cases. Journal of Individual Psychology, 1972, 28, 155-168.

Ainsworth, L., and Stapleton, J. C. Discipline at the junior high school level. National Association of Secondary School Principals Bulletin, 1976, 60, 54-59.

Andolfi, J., Paradox in psychotherapy. American Journal of Psychoanalysis, 1967, 34, 221-228.

Ansbacher, H. L. Adler's "striving for power" in relation to Nietzsche. Journal of Individual Psychology, 1972, 28, 12-24.

Ayllon, T., and Roberts, M. D. Eliminating discipline problems by strengthening academic performance. Journal of Applied Behavior Analysis, 1974, 7, 71-76.

Baer, D. M., Wolf, M. M., and Risley, T. R. Some current dimensions of applied behavior analysis. Journal of Applied Behavior Analysis, 1968, 1, 247-255.

Barrish, H. H., Saunders, M., and Wolf, M. M. Good behavior game: Effects of individual contingencies and group consequences on disruptive behavior in a classroom. Journal of Applied Behavior Analysis, 1969, 2, 119-124.

Bateson, G., Jackson, D. D., Haley, J., and Weakland, J. Toward a theory of schizophrenia. Behavioral Science, 1956, 1, 251-264.

Brehm, J. W. A theory of psychological reactance. New York: Academic Press, 1966.

Brehm, S. The application of social psychology to clinical practice. New York: Grune and Stratton, 1976.

Brodbelt, S. The epidemic of school violence. Clearing House, 1978, 51, 383-387.

Cates, J. T. The effects of individualized lesson plans for teaching discipline to students. Unpublished doctoral dissertation. The University of Tennessee, Knoxville, 1975.

Craighead, W. E., Kazdin, A. E., and Mahoney, M. J. Behavior modification: Principles, issues, and applications. Boston: Houghton Mifflin Company, 1976.

Davis, J. E. Coping with disruptive behavior. Washington, D.C.: National Education Association, 1974.

DeMause, L. Our forebears made childhood a nightmare. Psychology Today, 1975, 8, 85-88.

Dunlap, K. A revision of the fundamental law of habit. Science, 1928, 67, 360-362.

Dunlap, K. Habits: Their making and unmaking. New York: Liverlight Publishing Corporation, 1932.

Dunlap, K. The technique of negative practice. American Journal of Psychology, 1942, 55, 270-274.

Frankl, V. E. Paradoxical intention: A logotherapeutic technique. American Journal of Psychotherapy, 1960, 14, 520-535.

Frankl, V. E. Man's search for meaning: An introduction to logotherapy. New York: Simon and Schuster, 1963.

Frankl, V. E. Psychotherapy and existentialism: Selected papers on logotherapy. New York: Simon and Schuster, 1967.

Frankl, V. E. The will to meaning: Foundations and applications to logotherapy. New York: New American Library, 1971.

Frankl, V. E. The doctor and the soul: From psychotherapy to logotherapy. New York: Alfred A. Knopf, Inc., 1973.

Frankl, V. E. Paradoxical intention and de-reflection. Psychotherapy: Theory, Research, and Practice, 1975, 12, 226-237.

Frankl, V. E. The unheard cry for meaning: Psychotherapy and humanism. New York: Simon and Schuster, 1978.

Galano, J. Treatment effectiveness as a function of client involvement in a goal-setting and goal planning. Goal Attainment Review, 1977, 3, 17-32.

Gerz, H. O. Experience with the logotherapeutic technique of paradoxical intention in the treatment of phobic and obsessive-compulsive patients. American Journal of Psychiatry, 1966, 123, 548-553.

Glasser, W. Schools without failure. New York: Harper and Row Publishers, 1972.

Haley, J. Control in brief therapy. Archives of General Psychiatry, 1961, 4, 139-153.

Haley, J. Strategies of psychotherapy. New York: Grune and Stratton, 1963.

Haley, J. Uncommon therapy: The psychiatric techniques of Milton H. Erickson, M.D. New York: W. W. Norton, 1974.

Haley, J. Problem solving therapy: New strategies for effective family therapy. San Francisco: Josey-Bass, 1976.

Hall, R. V., Lund, D., and Jackson, D. Effects of teacher attention on study behavior. Journal of Applied Behavior Analysis, 1968, 1, 1-12.

Hegion, A., Fish, E., and Grace, S. Goal attainment scaling: An alternative technique for measuring academic progress. Goal Attainment Review, 1974, 1, 20-34.

Holen, M. C., and Kinsey, W. M. Preference for the theoretically derived counseling approaches. Journal of Counseling Psychology, 1975, 22, 21-23.

Joda, M. A. Will you help stem violence in our schools? Social Education, 1975, 39, 349.

Kiresuk, T. Goal attainment scaling at a County Mental Health Service. Evaluation Special Monograph, 1973, 1 (No. 1), pp. 12-18.

Kiresuk, T. and Lund, S. Goal attainment scaling. In C. Attkisson, W. Hargreaves, M. Horowitz, and J. Sorenson (Eds.), Evaluation of Human Service Programs. New York: Academic Press, 1978.

Kiresuk, T., and Sherman, R. Goal attainment scaling: A general method for evaluating comprehensive community mental health programs. Community Mental Health Journal, 1968, 4, 443-453.

L'Abate, L. and Weeks, G. A bibliography of paradoxical methods in psychotherapy of family systems. Family Process, 1978, 17, 95-98.

Lietenberg, R. The use of single case methodology in psychotherapy and research. In C. M. Franks and G. T. Wilson (Eds.), Behavior Therapy and Practice. New York: Brunner-Mazil, 1974.

Madsen, C. H. Jr., Becker, W. C., and Thomas, D. R. Rules, praise, and ignoring: Elements of elementary classroom control. Journal of Applied Behavior Analysis, 1968, 1, 139-150.

Marlowe, R. H., Madsen, C. H., Bowen, C. E., Reardon, R. C., and Logue, P. E. Severe classroom behavior problems: Teachers or counselors. Journal of Applied Behavior Analysis, 1978, 11, 53-66.

McAllister, L. W., Stachowiak, J. G., Baer, D. M., and Conderman, L. The application of operant conditioning techniques in a secondary school classroom. Journal of Applied Behavior Analysis, 1969, 2, 277-285.

McCullough, J. P. An investigation of the effects of model group size upon response facilitation in the high school classroom. Behavior Therapy, 1972, 3, 561-566.

McLaughlin, T. F. and Malaby, J. E. Intrinsic reinforcers in a classroom token economy. Journal of Applied Behavior Analysis, 1972, 5, 263-270.

McLaughlin, T. F. and Malaby, J. E. Partial component analysis of an inexpensive token system across two classrooms. Psychological Reports, 1975, 37, 362.

McLaughlin, T. F. and Malaby, J. E. An analysis of assignment completion and accuracy across time under fixed, variable, and extended token exchange periods in a classroom token economy. Contemporary Educational Psychology, 1976, 1, 346-355.

Meyer, J. B., Strowig, W., and Hosford, R. E. Behavioral reinforcement counseling with rural high school youth. Journal of Counseling Psychology, 1970, 17, 127-132.

Mozdzierz, G., Maccitelli, F., and Lisiecki, J. The paradox of psychotherapy: An Adlerian perspective. Journal of Individual Psychology, 1976, 32, 169-184.

Newton, J. R. Considerations for the psychotherapeutic technique of symptom scheduling. Psychotherapy: Theory, Research, and Practice, 1968a, 5, 95-103.

Newton, J. R. Therapeutic paradoxes, paradoxical intentions, and negative practice. American Journal of Psychotherapy, 1968b, 22, 68-81.

O'Leary, D. K. Behavior modification in the classroom: A rejoinder to Winett and Winkler. Journal of Applied Behavior Analysis, 1972, 4, 505-511.

O'Leary, K. D. and Becker, W. C. Behavioral modification of an adjustment class: A token reinforcement program. Exceptional Children, 1967, 33, 637-642.

O'Leary, K. D. and O'Leary, S. G. (Eds.). Classroom management. New York: Pergamon Press, Inc. 1976.

Raskin, D. E. and Klein, Z. E. Losing a symptom through keeping it. Archives of General Psychiatry, 1976, 33, 548-555.

Ricks, F. and Weinstein, M. The influence of modified goal attainment scaling procedures on treatment outcomes. Goal Attainment Review, 1975, 2, 65-70.

Rohrbaugh, M., Tennen, H., Press, S., White, L., Raskin, P., and Pickering, M. R. Paradoxical strategies in psychotherapy. Symposium presented at the meeting of the American Psychological Association, San Francisco, August 1977.

Seaberg, J. and Gillespie, D. Goal attainment scaling: A critique. Social Work Research and Abstracts, 1977, 17, 4-8.

Selvini-Palazzoli, M., Boscolo, L., Cecchin, G. F., and Prata, G. The treatment of children through brief therapy of their parents. Family Process, 1974, 13, 429-442.

Shepperson, V., Mauger, P., and Zinober, J. Differences in client's and therapists' evaluations of goal content and success in psychotherapy. Goal Attainment Review, 1975, 2, 149-156.

Sluzki, C. E. and Vernon, E. Double bind as a universal pathogenic situation. Family Process, 1971, 10, 397-411.

Smith, V. and Gallup, G. H. What people think about their schools: Gallup's findings. Bloomington, Indiana: Phi Delta Kappa Educational Fundation, 1977.

Solyom, L., Garza-Perez, J., Ladwidge, B. L., and Solyom, C. Paradoxical intention in the treatment of obsessive compulsive thoughts; A pilot study. Comprehensive Psychiatry, 1972, 13, 291-297.

Tanner, L. N. Classroom discipline for effective training and learning. New York: Holt, Rinehart, and Winston, 1978.

Tennen, H. Perspectives on paradox: Applications and explanations. In. M. Rohrbaugh (chair), Paradoxical Strategies in Psychotherapy. Symposium presented at the American Psychological Association, San Francisco, August 1977.

Watzlawick, P., Beavin, J. H., and Jackson, D. D. Pragmatics of human communication: A study of interactional patterns, pathologies. New York: W. W. Norton and Company, Inc., 1967.

Watzlawick, P., Weakland, J. H., and Fisch, R. Change: Principles of problem formation and problem resolution. New York: W. W. Norton, 1974.

Weakland, J. H., Fisch, R., Watzlawick, P., and Bodin, A. Brief therapy: Focused problem resolution. Family Process, 1974, 13, 141-168.

Weinstein, M. and Ricks, F. The effects of goal attainment procedures on goal relevance and specificity. Goal Attainment Review, 1975, 2, 137-147.

White, L. Reactance theory and paradox: Compliance and defiance. In M. Rohrbaugh (chair) Paradoxical Strategies in Psychotherapy. Symposium presented at the meeting of the American Psychological Association, San Francisco, August 1977.

Willer, B. The relationship of goal attainment scores and client involvement in goal setting to inpatient therapeutic outcome. Goal Attainment Review, 1975, 2, 53-63.

Williams, R. L. and Anandam, K. Cooperative classroom management. Columbus, Ohio: Charles E. Merrill Publishing Company, 1973.

Winett, R. A. and Winkler, R. C. Current behavior modification in the classroom: Be still, be quiet, be docile. Journal Applied Behavior Analysis, 1972, 4, 499-504.

APPENDICES

APPENDIX A

LIST OF KEY DESCRIPTORS IDENTIFYING

DISRUPTIVE STUDENTS

List of key descriptors identifying disruptive students:

Please read over the following list of behaviors. Then identify students in your class for whom these descriptors are applicable. Finally, in order from most on down, list the five students in your class for whom these descriptors are most accurate.

Descriptors:

When a lesson activity has been assigned, the student . . .
just sits at his/her desk without appropriate materials and makes no effort to get these materials.
Looks at non-lesson material.
Gazes out the window or looks around the room.
. . . without distracting other students by his/her inattention.

The student exhibits one or more of the following behaviors that disrupts the academic performance of another student:

a. Motor behaviors: getting out of seat, walking around, gestures without talking, throws objects, looks at another student, turns toward another student, turns around when another student hits him/her.

b. Noise making: taps feet, claps hands, tears paper into pieces or crumbles paper, taps pencil on the desk, flips pages without looking at the book, drags chair or desk, exhibits other non-verbal noise producing behavior.

c. Verbalization: cries, screams, whistles, sings, laughs, coughs, talks to others, frequently seeks teacher permission to be excused from class or sharpen pencil.

d. Aggressive: hits, pushes, shoves, pinches, slaps, strikes, pokes others with objects, grabs objects from another student, destroys objects.

Students who frequently exhibit these behaviors:

1. (Most) _____
2. _____
3. _____
4. _____
5. _____

APPENDIX B

LETTER OF PARENTAL CONSENT

Informed Consent Letter

Dear Parents,

A new project will be beginning here at Farragut Middle School on April 21 and continuing to the end of the school year. Robin Ramsey, who is completing her Master's degree in Guidance at The University of Tennessee, will be offering thirty minutes of individual counseling two times per week to several students. This counseling will be aimed at improving academic performance and helping students get along better with their teacher. Sessions will be scheduled at a time that does not interfere with academic classes. Since they are a part of university course work, the sessions will be audio taped. The student's confidentiality will be protected at all times. Only Ms. Ramsey and her supervisor at the university will have access to these tapes. The tapes will be destroyed at the end of the school year. These counseling sessions are voluntary and the student may withdraw at any time without penalty.

If you are interested in your child participating in this project, please indicate by signing the attached form and having your child return it to school as soon as possible. If you have any questions or concerns, please contact Robin Ramsey, 974-6444, or Carolyn Brewer, counselor, 966-9756.

I would would not like my child_____
(PLEASE CIRCLE ONE)

to participate and receive this individual counseling.

_____
Parent's Signature

_____
Date

APPENDIX C

GOAL ATTAINMENT RATING SCALE

Level achieved:	Task Relevant Behavior	Time-Off-Task Behavior	Appropriate Social Behavior	Disruptive Behavior
I. Most unfavorable outcome thought likely (-2)				
II. Less than expected success with treatment. (-1)				
III. Expected level of treatment success. (0)				
IV. More than expected with treatment. (+1)				
V. Best anticipated success with treatment. (+2)				

A rating sheet such as this will be developed for each student immediately after baseline and the initial interview. It will be scored after the treatment phase.

Scoring Procedure: The rater will determine which attainment level most accurately reflects the student's behavior after the treatment phase.

APPENDIX D

DESCRIPTION OF BEHAVIOR CATEGORIES AND CODES*

Task Relevant (Tr): Includes answering or asking lesson-oriented questions, writing when directed to do so, looking at another student who is participating in lesson-oriented activity, raising hand to ask a relevant question, and any other behavior that is consistent with the ongoing lesson.

Appropriate Social Interaction (S): Includes talking, laughing, or just sitting at one's deak when students have not been instructed to engage in lesson activity and when these behaviors have not been forbidden by the teacher, like during free time.

Time-Off-Task (To): Includes just sitting at one's desk without appropriate materials or attempting to get appropriate materials, looking at non-lesson oriented material, gazing out the window or around the room when lesson activity has been assigned. The student, however, is not distracting another student by his/her inattention.

Disruptive Behavior (D): Includes any behavior that disrupts the academic performance of another student. Among these behaviors are such motor behaviors as getting out of his/her seat, walking around the room throwing things, and turning toward other students; noise making behaviors such as tapping feet or pencils, tearing papers, flipping pages and other non-verbal noise making behavior; verbalizations such as whistling, laughing, coughing, singing, talking, with other children, and asking the teacher's permission to be excused or to sharpen pencils; and aggressive behaviors such as hitting, pushing, pinching, grabbing objects from other students.

In rating disruptive behavior, distinctions should be made between three situations in the classroom.

Situation I: Includes lecturing, group discussion, showing a film, playing tapes, or any such activity involving the whole class. In this situation all D behavior is so rated.

Situation II: Includes seatwork, test-taking, or small group discussion. During situation II, the following behaviors are not rated disruptive unless the teacher calls attention to it or disapproves: asking permission to do something, looking at another student, getting out of one's seat for such tasks as sharpening pencils, etc.

Situation III: Includes preparing to use audiovisual aids, calling the role, collecting papers, or to other situations when the teacher has not specified what the students should be doing. In such situations D behaviors such as talking quietly to another student, being out of one's seat, noises from moving books and papers, etc., are only D when the teacher calls attention to them.

*Adapted from Cates (1975) and Williams and Ananadam (1973).

APPENDIX E

TABLE 13

ASSESSMENT PARAMETERS FOR USING COMPLIANCE AND DEFIANCE-BASED PARADOXICAL STRATEGIES

Reactance Potential	Perceived Freedom of Target Behavior: Free	Perceived Freedom of Target Behavior: Bound
HI	1	3
LO	2	4

VITA

Robin Jeanne Ramsey was born in Orlando, Florida, on July 11, 1957. She attended elementary schools in that city and was graduated from Colonial High School in June 1975. The following August she entered Carson-Newman College in Jefferson City, Tennessee, and in May 1978 she received a Bachelor of Arts degree in Psychology. From September 1978 to May 1979, she was employed by the Plateau Home School of the Morgan-Scott Project for Cooperative Christian Concerns in Deer Lodge, Tennessee to do family and individual counseling. In June 1979, she began study toward a Master's degree in Guidance. This degree was awarded in August 1980.