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## Presence of Paradoxical Patterns of Response in Alcoholism Counseling

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PRESENCE OF PARADOXICAL PATTERNS OF  
RESPONSE IN ALCOHOLISM COUNSELING

by

Don Joseph Feeney, Jr.

A Dissertation Submitted to the Faculty of the Graduate School  
of Loyola University of Chicago in Partial Fulfillment  
of the Requirements for the Degree of  
Doctor of Philosophy

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1979

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To my closest friends: Larry, Mickey, and Kathy, my warmth and thanks for being genuine, and giving substance and meaning to the study of alcoholism.

To my daughter, Kelly, I express love and gratefulness. She teaches me what growth is all about.

## VITA

The author, Don Joseph Feeney, Jr., is the son of Don Joseph and Louise Feeney. He was born January 17, 1948, in Greenville, North Carolina.

His elementary education was obtained at Maternity of the Blessed Virgin Mary in Bourbonnais, Illinois. His secondary education was completed at Rich East High School in Park Forest, Illinois, where he graduated in 1967.

He attended Colgate University in Hamilton, New York, from September, 1967, to June, 1971. He graduated with a Bachelor of Arts degree in Psychology.

In September of 1972, he had returned to Park Forest and began his graduate work at Governor's State University. Simultaneously, he began attending courses at the Alfred Adler Institute in Chicago. He graduated from Governor's State University in December, 1973.

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The author is now Director of Treatment Services with both clinical and administrative responsibilities.

He was awarded a University Fellowship in order to complete his dissertation during the 1978-79 academic year.

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## CHAPTER I

### INTRODUCTION

Alcoholism is a severe health problem in this country. Terris<sup>1</sup> has conducted studies linking alcohol consumption with cancer, accidents, and cirrhosis of the liver. Gorski<sup>2</sup> reports from a National Council on Alcoholism Survey estimating that 20 to 30 percent of all persons hospitalized in this country are being treated for illnesses caused by, or coexisting with, alcoholism. Bruun Getal<sup>3</sup>, Eddy<sup>4</sup>, Schmidt and Popham<sup>5</sup>, and Schmidt and DeLint<sup>6</sup> have assembled evidence from mor-

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<sup>1</sup>Terris, M. "The epidemiologic revolution, national health insurance and the role of health departments." American Journal of Public Health vol. 66: pp. 1155-64; 1976.

<sup>2</sup>Gorski, T. "Treating the Alcoholic Patient: the physician and the alcoholism treatment center." (Alcoholism Treatment Center Ingalls Memorial Hospital, vol. 1) Harvey, Ill.: February, 1976.

<sup>3</sup>Bruun, K.; Edwards, G.; Lumio, M.; Makela, K.; Pan, L.; Popham, R. E.; Room, R.; Schmidt, W.; Skog, O. J.; Sulkuney, P.; and Osterberg, E. "Alcohol Control Policies in Public Health Perspective." (Finish Foundation for Alcohol Studies, vol. 25.) Helsinki: 1976.

<sup>4</sup>Eddy, J. The Teacher and the Drug Scene. Bloomington, Ind.: Phi Delta Kappa Educational Foundation, 1972.

<sup>5</sup>Schmidt, W. and Popham, R. E. "Heavy alcohol consumption and physical health problems; a review of the epidemiological evidence." Drug and Alcohol Dependency. Lausanne 1: pp. 27-50, 1975.

<sup>6</sup>Schmidt, W. and DeLint, J. "Causes of death of alcoholics." Quarterly Journal for the Study of Alcohol. vol. 33: pp. 171-185, 1972.

tality and morbidity studies to support the propositions that (I) there is a direct relationship between heavy drinking and premature death and (II) there is a direct relationship between heavy drinking and physical illness. Specifically, heavy users of alcohol have a high risk of premature death, tuberculosis, lung cancer, suicide, and cardiovascular diseases.

In addition to the health damage due to alcoholism, alcohol abuse takes its toll on the economy and in incidence of crime. The National Institute on Alcohol Abuse and Alcoholism<sup>7</sup> completed studies indicating the cost of alcohol problems in the United States at approximately \$25.3 billion per year, including \$9.3 billion in lost production of goods and services. Roffman and Froland<sup>8</sup> have also determined, through state surveys, that much law enforcement energy is being spent in arresting substance misusers. They have further found that significant numbers of these are being convicted (roughly 20 to 50% of prison inmates have major drug or alcohol problems). Current levels of treatment response are grossly inadequate for the size of the problem.

A review of the literature reveals little definitive information regarding effective helping relationships as specifically related to al-

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<sup>7</sup>National Institute of Alcohol Abuse and Alcoholism. "Can companies afford to help alcoholic employees?" Report on Alcoholism. vol. 34 (no. 2): pp. 26-34, 1976.

<sup>8</sup>Roffman, R. A. and Froland, C. "Drug and alcohol dependencies in prisons." Crime and Delinquency. vol. 22: pp. 359-366, 1976.

coholism. Rogers<sup>9</sup>, Truax and Carkhuff<sup>10</sup>, Bergin and Garfield<sup>11</sup> and others have been able to find the presence of regard, empathy, unconditionality, and congruence associated with positive changes in many types of clients. Yet, when Goby and Rossi<sup>12</sup> studied the relationships of these facilitative conditions with inpatient relationships, a willingness to continue therapy following treatment, and outcome measures of positive change with alcoholics, no significant relationships were found to be present. Also Melnick<sup>13</sup> found that there were effects of different methods of problem presentation and client problems based on the type of responses that counselors employed.

It is appropriate in light of these findings to investigate the relationship of these conditions as well as other patterns of counselor responses as they may relate to alcoholism counseling. Alcoholism may present a type of problem concern calling for an expansion of the

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<sup>9</sup>Rogers, C. R. "The necessary and sufficient conditions of therapeutic personality change." Journal of Consulting Psychology. 1970, 3, 6-16.

<sup>10</sup>Truax, C. B., and Carkhuff, R. R. Toward Effective Counseling and Psychotherapy: Training and Practice. Chicago: Aldine, 1967, pp. 34-69.

<sup>11</sup>Bergin, A. E. and Garfield, S. L. (Eds.). Handbook of Psychotherapy and Behavior Change: An Empirical Analysis. New York: Wiley, 1971.

<sup>12</sup>Gody, M. J. and Rossi, J. J. "Perceived dimensions of Therapeutic relationships and recovery from alcoholism." Presented at the National Conference on Evaluation in Alcohol, Drug Abuse, and Mental Health Programs, Washington, D.C., 1974.

<sup>13</sup>Melnick, R. R. "Counseling response as a function of method of problem presentation and type of response." Journal of Counseling Psychology. vol. 22, No. 2, 1975, pp. 108-112.

core conditions. This expansion may involve paradoxical responses that work within the framework of these facilitative conditions. It seems appropriate, therefore, to describe paradox both as it relates to the double-bind pathology of alcoholism as well as to the use of therapeutic paradoxes in the treatment and recovery from alcoholism. Chapter II further elaborates on these factors.

Paradoxical interventions appear to facilitate shifts in the client's frame of reference that result in new meanings and impact on the client's way of behaving. The concept of paradoxical interventions is a term that emerges from the work of Jay Haley<sup>14</sup> and Milton Erickson<sup>15</sup>. Their emphasis was to focus on the client in such a way as to accept the client's behavior while at the same time subtly shifting the meaning of where the client was in such a manner that the client was no longer there. Resistant clients were accepted and even encouraged to resist which redefined resistance as cooperation. Paradoxical interventions are utilized here to have clients focus upon their own fixed, rigid constructs, feelings, and so forth in differential ways. Paradoxical interventions facilitate a broader redefinition of their meaning thus illustrating the paradoxical nature of life dimensions. Paradoxical intervention aids emergence of a person's self-concept as a unique self interrelated to others (Erickson<sup>16</sup>).

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<sup>14</sup>Haley, J. "Paradoxes in play, fantasy, and psychotherapy." Psychiatric Res. Rep., vol. 2; 1955; pp. 52-58.

<sup>15</sup>Haley, J. Uncommon Therapy: The Psychiatric Techniques of Milton Erickson, M.D., (New York: Norton and Co., Inc. 1973); Chapter I.

<sup>16</sup>Erickson, M. A. "Naturalistic Techniques of Hypnosis." American Journal of Clinical Hypnosis, 1958, pp. 13-18.

Paradoxical interventions operate when the client's attention is intensified on problematic concerns. The basis is now laid for paradoxical shifting of the client's attention to unique and unexpected perspectives. This intensification involves direct or indirect focusing and concentration upon the experience phenomena. Tart<sup>17</sup> has proposed that intense concentration has the effect of fading out the background reality or irrelevant stimulation that room and space are created for increased suggestibility. Intensification of a counselor upon himself while the interaction is ongoing facilitates a letting go of a subjective involvement with the client enough so that the room for "new" self perceptions and redefinitions are available. Carkhuff and Truax<sup>18</sup>, Egan<sup>19</sup> and Gendlin<sup>20</sup> are among many who value focusing of attention in counseling.

Two case study examples will be presented to illustrate how paradoxical patterns of response can impact the counseling process.

#### Case Study Examples:

A client came into my office and expressed his need to be on guard against alcohol and women. He tended to be cautious and watchful

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<sup>17</sup>Tart, C. T. Altered States of Consciousness: A Book of Readings. (New York: John Wiley & Sons, Inc., 1969); Section 5.

<sup>18</sup>Carkhuff, R. R. and Truax, C. B. "Lay Mental Health Counseling." Journal of Consulting Psychology, 1965, vol. 29, pp. 426-431.

<sup>19</sup>Egan, G. The Skilled Helper: A Model for Systematic Helping and Interpersonal Relating. (Monterey, CA, Brooks/Cole Publishing Co., 1975) pp. 67-75.

<sup>20</sup>Gendlin, E. T. "The experimental response," Use of Interpretation in Treatment. (Grune and Stratton, Inc., 1968); pp. 208-227.

of how women can dominate him and tell him what to do.

Case #1.

Counselor: "I'm glad to see you're alert to the real danger of alcohol and especially women."

Client: "Well you can't be too careful. I've always got to guard against those women taking over and pushing the little guys around."

Counselor: "I can see why you leave home out of the fear and frustration which your wife has caused you. Be sure to stay on guard and on the defensive. We wouldn't want anyone to get to you. After all, look how weak and vulnerable you are. You really can't handle those big, powerful women."

Client: "It's not that I can't handle 'em. You just can't trust what they'll do to you. I really need a drink when I get near my wife."

Counselor: "That's right, be on guard, don't get near anyone, you never know what they might do to you. Defend yourself even if it costs you your wife, home, family, friends, and even your life. At least, you'll be safe."

Client: "You mean after a while I won't have anything left to guard against? That, maybe, I'll lose everything and be so alone that there won't be much of me left to protect."

Counselor: "You seem to feel the need to be protective. Could you guard against your own habits of withdrawing and avoiding contact with people you care for? It seems like you really may want to guard against guarding yourself."



Case #2.

A woman alcoholic is sitting stubbornly silent in a group therapy session. She has come to a number of sessions but refuses to communicate about herself, her alcoholism, and simply says I don't like the therapist. She has been told by her father that she must go into treatment. The woman is a 26 year old nurse.

Counselor: "How do you feel today?"

Client: Silence from the woman

Counselor: "Is there anything you'd like to discuss?"

Client: Silence

Various members in the group also try but receive similar responses. Counselor, then, proceeds to interact with others in the group obtaining feedback and give and take. However, the woman is still silent. As the time comes for group to end, one of the other clients asks "what is alcoholism?"

The counselor, upon seeing the impatience of the silent woman, asks the group to remain silent and proceeds upon a long, technical monologue of the etiology of alcoholism. The woman ultimately bursts to her feet, expresses her rage and storms out of the group. In the following day's group, the woman became involved with the other members. Whenever the woman engaged in passive aggressive silence, the counselor would call for extended periods of silence which precipitated the impatient reactions of the woman. Over time, the requests for silence by the counselor decreased as the woman slowly began to interact with other members on her own initiative.

The impact of intensification and paradoxical shifting is the differentiation of the client's perceptual and cognitive structuring. Bandler and Grinder<sup>21</sup> have formalized models by which both therapist and client construe, structure, and restructure their own reality. The essence of the differentiation process, as it is being utilized here, is that the basic assumptions and constructs that support an individual's frame of reference may be seen as being able to be defined and redefined in a number of different ways. Thus, personal responsibility could be viewed as a set of obligations owed to a higher, external authority, or it could be viewed as a response-ability; the ability to respond with one's own unique feelings and self. Differentiation may also refer to the process of being able to combine a variety of seemingly different aspects of feelings and concepts into a unique, creative whole.

The use of paradoxical interventions may be contrasted with what may be termed reality-oriented-confrontational interventions. This type of approach utilizes assumptions from William Glasser's Reality Therapy<sup>22</sup> including responsibility for one's own behavior, being realistic and dealing directly with the reality of the situation. It calls for the client to own the consequences of his behavior and realize that in order for his life to improve he needs to be willing to involve himself in a genuine relationship. This involvement is based upon making a com-

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<sup>21</sup>Bandler, R. and Grinder, J. The Structure of Magic I. (Palo Alto, CA, Science and Behavior Books,) 1974; Chapters 1-3.

<sup>22</sup>Glasser, W. Reality Therapy: A New Approach to Psychiatry. (Harper & Row Pub., New York: 1965); pp. 5-41.

mitment to invest one's self in a meaningful relationship and to realize that one is responsible for determining the quality of that relationship.

The client is asked to be realistic about what can or cannot be expected in any situation and suggests that reason be used in understanding the way he can affect the outcome of any relationship. The client is confronted in a supportive, caring, empathic relationship as to how his own actions, beliefs, and feelings were responsible for the consequences of any negative or positive consequence.

Essentially, this approach while defining all behavior as a responsibility of the client does not involve blame or guilt with regards to the past. It only stresses what the client can do in the present here-and-now situation. While confrontation regarding consequences of behavior is used, the purpose is to encourage the client in what he is doing successfully not in how he "is" a "failure." Additional focus is to aide the client in acquiring competence in interpersonal skills.

The essential difference between this approach and that of the therapeutic paradox is that while the former is concerned with assisting the client in focusing his attention upon what he is doing and thus implies that he needs to change his ways, the latter focuses the client's attention on his behavior with the implication that he should do more of it. In many ways both approaches use confrontation as a technique confronting the client with his behavior. The difference is that one (Reality) implies that there are requirements to do something (Therapy) about it, the other calls for change by exaggerating the detrimental way the client is behaving in such a way that the client himself feels the need for a shift in perspective and then calls for the change

on his own. The goals for both are similar but their methods differ.

### Purpose of the Study

The purpose of this study is to examine the presence of paradoxical qualities in appropriate helping responses. Interventions that are deemed growthful and of assistance to alcoholics in treatment seem to utilize significant themes, perceptions, experiences, and behaviors in various combinations that often appear paradoxical, atypical and unexpected (O'Neil)<sup>23</sup>. However, at this point, no significant evidence of long lasting effect for sobriety has been demonstrated by any approach. While multitherapeutic approaches are utilized in alcoholism rehabilitation programs (Forrest)<sup>24</sup> the level of positive outcome, in relation to the avoidance of a relapse into drinking, has been only 32% of those receiving treatment (Hore)<sup>25</sup>. Alcoholics Anonymous has been known to be the single most effective method of treatment, yet even here a great many alcoholics continue to relapse. Investigation into the effectiveness of paradoxical patterns in various approaches may prove fruitful as these patterns seem present in Alcoholics Anonymous. A view into the nature of alcoholism reveals significant disturbances based on the negative presence of paradox.

The goal for this study is to evaluate patterns of response that break through the double-binds of the alcoholic in order to allow

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<sup>23</sup>O'Neill, P. "Alcohol Confrontation." Australian Journal of Alcoholism and Drug Dependence, Vol. 3, No. (2), p. 43-45, May 1976.

<sup>24</sup>Forrest, G. G. The Diagnosis and Treatment of Alcoholism. (Springfield: Charles C. Thomas, 1975).

<sup>25</sup>Hore, B. "Factors in alcohol relapse." British Journal of Addiction, 1971, 66, 89-96.

meaningful treatment progress to occur. Alcoholics believe in their own intrinsic worthlessness and helplessness which contributes to their resistance of treatment (Jellinek)<sup>26</sup>. It is for these reasons that efforts need to be focused on ways of gaining access to the alcoholic in treatment.

While Alcoholics Anonymous has been effective, even here, resistance and relapse are quite high. Alcoholics may not have "hit bottom" yet (A.A.)<sup>27</sup> for the program to work. Alternately, they may have "hit bottom" repeatedly but not meaningfully attended to their own life style such that treatment was ignored. It appears that effective treatment even in Alcoholics Anonymous cannot begin without methods that meaningfully focus the alcoholic's attention upon the very process in which he is engaged. Alcoholics Anonymous seeks to achieve this to some extent by stressing the requirement of each person's individual effort and simultaneously emphasizing that the person cannot do it alone, thus needing to surrender to a high power. The need for commitment to a group is essential. Thus, control, power, responsibility and relationship are all redefined in a paradoxical manner. The client is being introduced to the meaning of interdependence by paradoxically being told that he needs to do it but cannot do it by himself. This condition unexpectedly redirects the client's way of perceiving, focusing attention

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<sup>26</sup>Jellinek, E. M. "Phases of alcohol addiction." Quarterly Journal of Studies on Alcohol, 1952, 13, 673-684.

<sup>27</sup>(Alcoholics Anonymous), Alcoholics Anonymous. (New York; Works Publishing, 1939); pp. 13.

on what was an assumed but unconfirmed definition of individual effort.

Additional critical issues also arise in the treatment that concerns severe negative self-image and fear of control by others (Getter<sup>28</sup>, Gore<sup>29</sup>, and Rotter et. al.<sup>30</sup>). Not only is there a need to attract the alcoholic's attention but to do so in a way that will not at the same time reinforce the alcoholic's fears and low self-esteem. Approaches utilizing self-diagnosis such as the paradoxical methods of Alcoholics Anonymous seem to provide significant ways of working through these issues.

Confrontational patterns of response can be used to focus attention but may also engender feelings of punishment, criticism, and control. Cognitive styles while avoiding the hypersensitivity of the alcoholic's sense of disapproval espouses a logical and rational lifestyle that may not be viewed as experientially connecting with the "irrational" aspects of the alcoholic. It may, thus, engender a sense of intellectualism at best and judgmentalism at worst. This possible double bind could be resolved by the use of anti-expectations or paradoxical techniques designed to focus and accept the irrational ways of life but in such a manner as to redefine them in a more positive, open and self-decision-making process. Thus, low esteem and fears of control could

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<sup>28</sup>Getter, H. "Variables affecting the value of the reinforcement in verbal conditioning." (Doctoral dissertation, Ohio State University, 1962). Dissertational Abstracts, 1963, 23 no. 63-1280.

<sup>29</sup>Gore, P. M. and Rotter, J. B. "A personality correlate of social action." Journal of Personality, 1963, 31, 58-64.

<sup>30</sup>Rotter, J. B.; Chance, J. E.; and Phares, E. J. Applications of a Social Learning Theory of Personality. (New York: Holt, Rinehart, and Winston, Inc., 1972); pp. 49-63.

be accepted and redefined as true perceptions on the alcoholic's part and thus no change should occur until he has reason to believe otherwise. This normally elicits a surprised response from the alcoholic client who is expecting the counselor to persuade or shift his point of view. Paradoxically, it could be seen that this kind of response is exactly what will change his perspective (Haley)<sup>31</sup>. The counselor need not feel caught in the dilemma of not wanting to support drinking related behavior but fearful of the consequences of confrontation. By supporting the pattern of the alcoholic's thinking, feeling, and behavior, attention is implicitly directed to the absurdity and irrational aspects involved. Paradoxes juxtapose alternative ways of defining the same (e.g., appears to be the same) form of behavior which leads to (e.g., multiple meanings) positive, surprising redefinitions and outcomes in behavior. Gerz<sup>32</sup> has found use of paradoxical intervention in the treatment of various forms of compulsion neuroses to be effective in the aforementioned manner. While there are models in a cognitive mode that are effective (Ellis)<sup>33</sup>, the transition process for the shift in perspective may not occur. Also, it would seem that approaches like Ellis' borders on the judgmental side in referring to labeling various forms of self-talk as rational or irrational without adequately providing an alternative for the client to creatively utilize his own irra-

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<sup>31</sup>Haley, J. Strategies of Psychotherapy, 7th ed. (New York: Grune and Stratton; 1972); pp. 41-68.

<sup>32</sup>Gerz, H. O. "The Treatment of the Phobic and the Obsessive-Compulsive Patient Using Paradoxical Intention." Journal of Neuropsychiatry. 1962-3, 375-387.

<sup>33</sup>Ellis, A. Reason and Emotion in Psychotherapy, (New York, Lyle Stuart, 1962).

tionality.

It would seem that in many ways this would not only deprive the alcoholic of a much needed internal resource (his own style used constructively) but also engender resistance. It is for this reason then that studying the effectiveness of paradoxical patterns of response that assist the person in utilizing their irrationality constructively is deemed worthwhile and essential.

Paradoxical patterns of response seek to redefine all forms of resistant, symptomatic and neurotic behaviors in relation to cooperative efforts and seek to focus and shift the clients expecting response from the counselor to one of anti-expectation (Haley)<sup>34</sup>. The client's attention would be concentrated at the focal point of what he was pursuing contrasted with what he experienced. The client would thus realize for what he was striving when his efforts were encouraged but left unfulfilled. It may be suggested that this action sets up a paradoxically conflicting situation that evokes change, growth and expanded interpersonal relationships.

It is being proposed that the use of paradoxical techniques which encourage the client to continue present behavior, but in such a way that unexpectedly alters its meaning, provides a "smoother" transition in shifting to more open perspectives. It can provide the essential component in treatment of perceiving one's own style of relating juxtaposed to alternative modes. Further, this juxtaposition of different

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<sup>34</sup>Haley, J. Strategies of Psychotherapy, 7th ed. (New York: Grune and Stratton, 1972); pp. 151-178.



ways or modes of perceiving the person's same form of behavior offers the person more freedom and choice in influencing and directing his own life style and major life constructs. It is proposed that the use of paradoxical patterns facilitates empathy and resource utilization to a much greater extent than do present confrontational-reality oriented approaches to alcoholism.

#### Definition of Terms

Prior sections of Chapter I have included some background material covering alcoholism, paradoxical interventions, and other terminology. The following specific definitions will be useful to the reader in analyzing and evaluating this investigation.

1. Alcoholism: For purposes of this study, Jellineck's definition and typology of alcoholism will be used. He defines alcoholism as "any use of alcoholic beverages that causes damage to the individual or society or both."<sup>35</sup> He perceives alcoholism as a progressively deteriorating disease consisting of four stages. These are 1) pre-alcoholic; 2) prodromal; 3) crucial; and 4) chronic.
2. Alcoholics Anonymous is a self-help group that provides steps and guidelines for the alcoholic's recovery process.
3. Paradoxical Intervention: The operational definition of this term is the rating form developed to measure presence or absence of the type of interventions described in the introduction section of Chapter I. The rating form may be found in the appendix. It may be defined as a

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<sup>35</sup>Jellineck, E. M. Disease Concept of Alcoholism (New Haven, Conn.: Hillhouse Press, 1960): 4-5.

type of intervention occurring in treatment that alters the meaning and impact of clients' behavior. Utilization of client's own styles of response to create antithetical effects is the nature of this intervention.

4. Facilitativeness: This is operationally defined as that measure obtained on the rating scales utilizing a Carkhuff<sup>36</sup> system of value. Also, Carkhuff skills are a major focus of this scale. It may be defined as that quality of therapeutic responses that serve to move the client constructively through the treatment process.

5. Positive progress in counseling: This is pre-post difference measure of the client's degree of problem expression and resolution. This rating form scale can be found in the appendix. It may be defined as the degree to which clients achieve active problem resolution in their problematic concerns.

6. Counselor Type of Response: This variable consists of a scale with twelve types of responses utilized by counselors. Ratings are for presence or absence of these types of responses. It may be defined as a wide range of counselor responses referring to reflection of feeling, reflection of content, summarization of feeling and content, immediacy, concreteness, support, confrontations, self-disclosure, advise, silence, questioning.

7. Short-term sobriety: This refers to a six to eleven week follow-up utilizing goal attainment scales. These are ratings for client at-

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<sup>36</sup>Carkhuff, R. R. Helping and Human Relations, Vol. I: Selection and Training. (New York: Holt, Rinehart, and Winston, 1969); pp. 54-69.

tained levels of expected performances. This scale is broken down into a number of specific categories. There are three divisions of these categories: 1) length of soberness; 2) sobriety; 3) drinking life style. Length of soberness simply involves how long the client is not physically ingesting alcoholic substances. Sobriety is a composite measure involving length of soberness, socialization behaviors, and Alcoholics Anonymous meeting attendance. Drinking life style refers to attitudes towards drinking regarding abstinence or controlled drinking.

#### Design of the Study

1. Setting: The study was conducted at the Champaign County Council on Alcoholism in Illinois. The council is community based with a wide range of community education, prevention, and treatment services available. The council is a non-profit, locally, and state funded agency.
2. Population: The study consisted of 40 persons classified as alcoholics. They represented various stages of disease progression. They were all out-patients of the council's treatment program. There were 25 male and 15 female clients, all white, averaging 37 years in age. They were predominantly lower-middle class and primarily from urban backgrounds. The majority of the S's were diagnosed as crucial or chronic alcoholics using Jellineck's chart for progressive deterioration.
3. Design: The approach was to audio-tape 152, individual out-patient counseling sessions of three or more sessions. The seven participating counselors used their own treatment styles. The focus was to sort out, through rating scales and follow-up measures, how paradoxical patterns of response were related to process and outcome variables. This was a

field study with no manipulation of the variables.

### Hypotheses

The hypotheses to be tested in this investigation are as follows:

I. There is no significant linear relationship between the presence of paradoxical patterns of response and positive progress in counseling sessions with alcoholics.

II. There is no significant linear relationship between the presence of paradoxical patterns of response and types of counselor response in therapy with alcoholics.

III. There is no significant linear relationship between the presence of paradoxical patterns of response and facilitative level of counselor's responses in therapy with alcoholics.

IV. There is no significant linear relationship between the presence of paradoxical patterns of response and length of positive follow-up regarding sobriety of alcoholics.

### Limitations of the Study

The following are potential limitations of the study:

1. The population is composed of a relatively small number of 40 clients. This would make generalization to the broader population somewhat difficult.
2. As there could be effects from male and female clients differentially, the study lacks a large enough sample to adequately control for this.
3. The population draws from an out-patient program providing little or no control from other environmental influences (e.g., variations in in-

volvements with Alcoholics Anonymous, significant other therapy, medical treatment, etcetera). As there are many outside influences to which out-patient clients are open, some difficulty is presented in establishing cause-effect relationships. This is also a reality as a consequence of this being a correlational study.

4. The counselors involved in the study have differential levels of education and professional and personal experience with alcoholism.

While they may be seen as meeting a minimum standard of competence as an alcoholism counselor, their unique combinations for qualifying may have an effect on the response patterns used in the counseling session.

5. Rating scales are used extensively throughout the study. While efforts have been made to establish reliability and validity as required, the element of subjectivity cannot completely be removed. Thus, interpretations and conclusions must be made with this issue in mind.

#### Organization of the Study

Chapter I has presented an introduction, purpose of the study, definition of terms, design of the study, hypotheses, and limitations of the study. In Chapter II an in-depth review of the literature will occur exploring a wide range of related therapies touching upon the issues of therapeutic paradoxes in treatment. Also, the relationship of Alcoholics Anonymous to counseling and related principles is explored. Alcoholism and its concomitant problem areas are reviewed regarding etiology, psychodynamics, and severity of the problem. Finally, a presentation of measurements utilized in the study regarding relevant research is presented. Chapter III presents a detailed description of the design, procedure, profile of Ss, and statistical methods employed for

analysis. Chapter IV provides a thorough analysis of the data generated touching upon a variety of combinations of the variables involved. Numerous correlation measures are presented. Chapter V is the final section of the study and delves into the wide range of implications and interpretations of what the results suggest. Exploration and understanding of the possible meanings of hypotheses found to be significant or not significant will also occur.

## CHAPTER II

### REVIEW OF THE LITERATURE

#### Introduction

This chapter will present a review of paradoxical themes. Focus will be directed from the general to the specific. The sections that follow will deal with paradox regarding: 1) the nature of man; 2) the nature of alcoholism; 3) its therapeutic value; 4) studies and approaches advocating paradoxical interventions; and 5) the treatment of alcoholics. A final section reviews previous research using the instruments selected for this study.

#### Paradox: The Nature of Man

Numerous studies and articles have been written regarding paradoxical descriptions of man's nature. Alan Watts<sup>37</sup> mentions the illusion of man as inherently conflicting between reason and instinct, spirit and nature, and preserving his health and safety by "realizing" he "must" mistrust himself. Freud<sup>38</sup> perceived man to be battling with opposing forces of Eros and Thanatos. Jung<sup>39</sup> warned of man having to

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<sup>37</sup>Watts, A. W. Psychotherapy East and West. 5th ed., (New York: Ballantine, 1971) pp. 15-33.

<sup>38</sup>Freud, S. Civilization and Its Discontents, (Hogarth, London, 1930) p. 144.

<sup>39</sup>Jung, C. G. Modern Man in Search of a Soul, (Routledge, London, 1936) pp. 118-119.

maintain a precarious and unending balance between civilized and primordial destructive forces and urges. Ironically, it was Jung<sup>40</sup> who expressed the principle that change is possible only when a human being is first accepted as he is. The split or duality in man's character appears to be created by such mistaken logical conclusions that if there be consciousness or awareness there must be somebody within the person doing the conceiving. This is quite similar to Descarte's mind-body dualism.

There is distortion in this particular perspective of the mind or ego controlling and directing the body, possessing feelings, and combating alien forces of nature both from within and without the individual. This distortion grows from ignoring the holistic nature of man and his relationship to his environment. Watts<sup>41</sup> expresses the illusory nature of man "watching" or observing himself in a reflexive style as if he "were truly separate from himself." He suggests that there is only one total cortex of the human brain and that until the cortex develops another "fold" in the brain, it cannot be outside of itself. Indeed, to see the cortex thinking about itself as a whole implies that it is both itself yet apart and away standing back observing. This is a confusion of the reification of one of the cortex's functions (e.g.,

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<sup>40</sup>Jung, C. G. Psychology and Religion: West and East, Collected Works, vol. 11, Bollingen Series 20, (Pantheon, New York, 1958) p. 339

<sup>41</sup>Watts, A. W. Psychotherapy East and West. 5th ed., (New York: Ballantine, 1971) pp. 60-96.



the cortex of the brain is certainly capable of being able to remember some event) with the whole cortex-environment system itself. This is a paradox as defined by Bateson<sup>42</sup>, confusing members of a class with the class as a whole.

Indeed, the only way the human cortex can gain feedback regarding itself is from outside and this refers to the interpersonal relations areas of the social arena. Watts<sup>43</sup> thus refers to the illusion of an ego or mind-within-a-mind separate from the body of the person as part of a great "social lie" placing the individual in a double-bind position. In other words, the sense of an "ego" separate from the rest of the organism controlling it is really an internalized social control, Strauss<sup>44</sup> defines as a "generalized other." Thus, the individual is persuaded that he wants to do what society demands while making it appear that these "wants" or demands come from the individual's innermost self. This is similar to a mother saying to her child who is long-ing to slush around in the dirt, "Now, darling, you don't want to get into that mud!" This controlling form of paradox or bind thus generates the sense in the child that he has some agent or ego able to deny and not "want" what he wants. This mind-ego illusion is designed to give

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<sup>42</sup>Bateson, G. Steps to an Ecology of Mind. (New York: Ballantine Books, 1972), pp. 279-283.

<sup>43</sup>Watts, A. W. Psychotherapy East and West. 5th ed., (New York: Ballantine, 1971); pp. 97-104.

<sup>44</sup>Strauss, A. ed., The Social Psychology of George Herbert Mead. (Phoenix, Chicago: 1956): 37-62.

the impression of an inner controlling agent free of the physical bodily influences, restraints and limitations. The striving for detachment and control over the desires, feelings, and wants of the person occurs only to encounter unexpected, overwhelming experiential reactions from self and others. The universe may thus appear alien and formidable.

In dealing with this illusion and sense of dualism, psychotherapy may operate much in the manner of the Zen master seeking to provide therapeutic paradoxes or Koans. These essentially place the individual in a no-win situation. As long as he seeks to use his ego to solve the problem or deal with the intervention, he will be frustrated. Liberation is seen when the person gives up in a state of defeat that the ego cannot solve the problem, and, at that moment, he has won his freedom. Essentially, these Koans or therapeutic binds challenge the person to act as if his ego were real, such that the basic absurdity and nonsense of the situation may be revealed. There is no attempt to deny the individuality but rather to bring forth and expose the illusion and myth of a separate self-within-a-self capable of omnipotent control. Indeed, it is only through the ignorance of the whole person and interaction with the environment that anyone could abstract and reify a separate part of the total system as the source and cause of all effects (Watts)<sup>45</sup>. The sense of some part of the individual stepping outside his self stopping to think about what the "self" is going to do blocks action and is a form of hesitation. This interruption of the person

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<sup>45</sup> Watts, A. W. Psychotherapy East and West. 5th ed., (New York: Ballantine, 1971); pp. 34-59.

is the constrictive control, not of one part over another, but of the individual seeking to move in two conflicting directions at one time. This is the consequence of paradox. There indeed may be reflection of what one is doing but reflection emerges out of expanded awareness integrated with focused attention not as a consequence of some separate reified ego (Perls)<sup>46</sup>. Reflection thus becomes a part of the total person/environment system, not apart from it. When the "agent of cause making some effect is removed, the person is free to be what he is without, shame or fear."

In summary, it may be suggested that many problematic concerns arise from perspectives that ignore the total system of person/environment and seek to isolate causal components.

The process of defining the nature of man requires that a systems perspective be developed emphasizing the interaction of component parts of that system. Distortion and mistaken logic regarding the reality of man emerges when there is a desire to simplify the effect of many influences to an isolated set of causal agents.

#### Paradox: The Nature of Alcoholism

With the alcoholic, there is the concern that his life is externally directed such that he feels both the sources of control and evaluation are fixed in others (McClelland et. al.)<sup>47</sup>. It is paradoxical

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<sup>46</sup>Perls, F. S. Gestalt Therapy Verbatim. 7th ed., (California: Real People Press; 1971;) pp. 1-76.

<sup>47</sup>McClelland, D. C.; Davis, W. N.; Kalin, R.; Wanner, E. The Drinking Man, (New York: Free Press, 1972) pp. 240-288.

cal that the alcoholic has high goals and aspirations, is performance oriented, yet works very little for himself. He appears to be seeking approval, recognition, and support from significant others (parent, spouse, authority figure, etc.) such that he may live up to their expectations and in return he may receive a sense of power and worth from them.

Claude Steiner<sup>48</sup> has appropriately referred to games alcoholics play, suggesting is part of a life-style having very tragic, self-destructive consequences. It may be suggested that the non-alcoholic also strives for recognition and approval yet he is more internally motivated seeking constructive involvement and acknowledgement of himself as is, not of an idealized, other-directed self-image. The alcoholic has been described as a person fixated upon a maternal-like image where as a child he perceived his mother to be strong, domineering and smotheringly possessive. The father has been depicted as a passively perceived, emasculated male image (McClelland)<sup>49</sup>. This seemed to set the conditions for the alcoholic male and female to perceive the mother as the image to emulate, as this was where the source of power in the family was located. Bandura, Ross, and Ross<sup>50</sup> have found significant results to support this "social power" theory of identification. The

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<sup>48</sup> Steiner, C. M. Games Alcoholics Play, (New York: Grove Press, 1971);pp. 15-37.

<sup>49</sup> McClelland, D. C. et. al. Ibid, pp. 253-288.

<sup>50</sup> Bandura, A.; Ross, D.; and Ross, S. "A Comparative Test of the Stauts, Envy, Social Power, and Secondary Reinforcement Theories of Identificatory Learning," Journal of Abnormal Psychology, 67 (1976), pp. 527-534.

difficulty with this type of identification and fixation is that the alcoholic is placed in a virtual paradox of, on the one hand being verbally told to grow up and be a person of high achievement, and yet simultaneously on the other hand, non-verbally and/or subtly critiqued, ridiculed, discouraged, or otherwise led to believe in his own inadequacy. He thus, is placed in the double bind position of living up to another's high expectations for approval and support yet also taught to believe that he will probably fail or do something wrong in his efforts. This fear of failure becomes so intense that when responsibilities and life tasks become demanding, for example in adolescence, this fear may be transformed into a self-fulfilling prophecy. Thus, in not "being" permitted to be one's self, the alcoholic fears not being able to live up to another's idealized image of performance. Thus, his very tension and anxiety contribute to frustration and difficulties leading to failing experiences which shift his perspective to a framework of failure. There is further evidence that this fear of failure leading to self-fulfilling prophecies has incorporated within it resentments at "having" to "live up" to another's expectations. Many times the failed effort at meeting responsibilities, school dropouts, drugs, alcohol, etcetera, involve a form of rebellion. Chapman<sup>51</sup> has suggested that fathers with demanding expectations of their sons could find their sons becoming passive, failure-oriented, and even homosexual as a resistance and reaction to coercive controls and demands.

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<sup>51</sup> Chapman, A. H. Put-offs and Come-ons, 5th ed., (New York: Beckley Publishing Corp. 1972), Chapter 6.

If the alcoholic is perceived as someone who required the external support of others, yet fears and even angrily resents and rebels simultaneously against these demandings, then he must give the impression of living up to these external demands yet have a viable reason or strategy for not being able to do so. Haley<sup>52</sup> has suggested that persons placed in paradoxical relationships where they are sent conflicting messages of be a man on one level and but you can't do it on another, resolve the dilemma by giving the impression of trying but developing a symptom, headache, nerves, compulsions, etcetera that defines his efforts as not of his voluntary control (Lang et. al.)<sup>53</sup>.

Adler (Ansbacher)<sup>54</sup> refers to the person with the neurotic lifestyle as finding excuses for not meeting the responsible life tasks encountered as a result of the person striving to be superior and powerful over others. In many ways the alcoholic is encouraged to believe he should be superior over people, yet this very movement perpetuates feelings of inadequacy and the double bind. In short, then, the alcoholic may be viewed as using alcohol as his symptom of resisting demands to be perfect and live up to others' expectations while defining his behavior as "out of control." Thus, he seeks to manipulate others in sup-

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<sup>52</sup>Haley, J. Strategies of Psychotherapy, 7th ed., (New York: Crune and Stratton, Inc., 1972), Chapter 3.

<sup>53</sup>Lang, A. R.; Groeckner, D. J.; Adesso, V. J.; and Marlott, C. A. "Effects of Alcohol on Aggression in Male Social Drinkers," Journal of Abnormal Psychology 84, 1975, pp. 508-518.

<sup>54</sup>Ansbacher, H. L. and Ansbacher, R. R. The Individual Psychology of Alfred Adler. (New York: Harper and Row Torch Books, 1956); pp. 156-83.

porting him yet resisting their demands, but denying that he is doing so. Thus, we can see the "nice guy" who may be late or not even show up for work, and ultimately doing a poor job because of the pressure he placed on himself. It is as if he almost works himself out of demand.

Paradox in alcoholism also expresses itself on the intrapsychic level as well as the interpersonal. Alcoholics perceive the self or mind as opposed to the body. They have veiled the concepts of self and mind into an abstract mentalism vs. the body's physicalism. The life style of many alcoholics (obviously there are many types [Jellennick]<sup>55</sup>) is such that this mind-body split or dualism has led to fight with the pseudodynamic qualities of ego-alien temptations, forces, or urges beyond his self seeking to make him drink. He has structured this mind vs. body split such that he is constantly doing battle with some other outside force of which all responsibility for its presence is disclaimed.

Alcoholics Anonymous<sup>56</sup> has focused upon the futile, self-defeating nature of the alcoholic to use personal self-power to resist and control drinking. The alcoholic is perceived to place himself in the double bind situation of, on the one hand, negating any influential

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<sup>55</sup>Jellinek, E. M. Disease Concept of Alcoholism. (New Haven, Conn.: Hillhouse Press, 1960); pp. 1-63.

<sup>56</sup>[Alcoholics Anonymous], Alcoholics Anonymous. (New York; Works Publishing, 1939); pp. 45-69.

relationship to perceived threatening forces, temptations and urges to drink; and on the other hand, strive to control and have power over that which has already been acknowledged as out of his sphere or classification of influence.

The consequence is thus seeking to be the captain of his soul only to have the captain command sobriety and be disobeyed (Bateson)<sup>57</sup>. The alcoholic must always prove himself in response to a challenge that is risk laden with a high probability of failure and intoxication. The alcoholic sees sobriety as a challenge to be achieved and extremely difficult, it may be attained. However, as sobriety is achieved, there is a change in context and the challenge of risking failure is removed. The alcoholic now believes that he is no longer an alcoholic since he is presently not drinking.

Thune<sup>58</sup> has suggested that difficulty of the alcoholic in accepting and recovering from his disease lies in the way he defines alcoholism as a matter of temporality and not logical distinction. That is, the alcoholic tends to view himself as alcoholic when drinking and as a non-alcoholic when sober. This confusion of the life style of alcoholism with the physical substance of alcohol itself leads to paradox and thus continued drinking. This can also be viewed in relation to what was said earlier, that the dualistic thinking of the alcoholic creates paradox which perpetuates his "disease."

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<sup>57</sup>Bateson, G. Steps to an Ecology of Mind. (New York: Ballantine Books, 1972);pp. 312-314.

<sup>58</sup>Thune, C. E. "Alcoholism and the archetypal past: a phenomenological perspective on alcoholics anonymous." Journal of Studies on Alcohol. vol. 38, No. (1) 1977; pp. 82-83.



The alcoholic becomes cocky and overconfident (Alcoholics Anonymous, *ibid.*)<sup>59</sup> and is no longer satisfied with sobriety attained. Sobriety appears absolute with no risk of being lost and he now seeks to test out if he can control his drinking (Bateson)<sup>60</sup>. The risk factor is once again induced by the attempt at controlled drinking itself. Indeed the risk to the sobriety of the alcoholic is his need to take risks. This need for risk-taking expresses the alcoholic's intrinsic sense of self-dissatisfaction.

The paradox of self-control for the alcoholic is to always strive to do what he perceives to be a challenge of what he cannot do (Bateson)<sup>61</sup>. Thus, sobriety is rejected when achieved for the challenge of trying to drink and control it when he perceives challenged that he cannot. The nature of self-control for the alcoholic is then similar to a negative proposition (you cannot drink) of always striving to try and prove paradoxically that which is defined as never being possible to do. The alcoholic acts symmetrically seeking to "battle" on an equal basis with failure-ridden challenges. He thus not only takes on insurmountable challenges but actually accelerates his efforts to keep

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<sup>59</sup>[Alcoholics Anonymous], Alcoholics Anonymous. (New York; Works Publishing, 1939); "Bill's Story."

<sup>60</sup>Bateson, G. Steps to an Ecology of Mind. (New York: Ballantine Books, 1972); pp. 320-22.

<sup>61</sup>Bateson, G. Steps to an Ecology of Mind. (New York: Ballantine Books, 1972); pp. 324-26.

pace with the increasing imminence of defeat and suggestion that he can never meet the challenge.

He must have an opponent to resist yet this leads to the rather ironic situation of testing his self-control with his ultimate end of proving that "self-control" is absurd and ineffectual. By "testing" himself with continued drinking, he ultimately has achieved a reduction absurdum of the conventional epistemology. It has been suggested that this consequence may be purposive in that this is the alcoholic's way out of a constricted and stifling way of life (Adler)<sup>62</sup>. He has failed and thus, paradoxically, succeeded in extricating himself from demands and responsibilities felt to be imposed and not chosen. In this style, he is able to create the appearance of trying while the meaning of the behavior was to be free by failing and moving on to other goals. Ironically, when this works for the alcoholic, he feels guilty and seeks to engage in the same style of living that he resented primarily. The viciousness of this cycle is quite apparent.

While paradox may well play a role in the on-set of an alcoholic style of living through the instigation of double binds and serve a strategic purpose, there are many studies that suggest the drinking itself has paradoxical effects. That is, behaviorists like Conger<sup>63</sup>

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<sup>62</sup>Ansbacher, H. L. and Ansbacher, R. R. The Individual Psychology of Alfred Adler. (New York: Harper & Row Torch Books, 1956), Chapter 4.

<sup>63</sup>Conger, J. "Alcoholism: theory, problem, and challenge. II. Reinforcement theory and the dynamics of alcoholism." Quarterly Journal of Studies on Alcohol. 1956, 17: 296-305.

and psychodynamic theorists as in Sanford<sup>64</sup> and Blum<sup>65</sup> have persistently suggested relief, escape and avoidance to alcohol disruptions. However, studies by Cappell<sup>66</sup> and Marlatt<sup>67</sup> imply an inconsistency. While problem drinkers may expect alcohol to provide relief or the ability to forget environmental or intrapsychic stress, these studies point to the failure of research to provide consistent physiological, behavioral and experimental evidence of the relief of tension in drinkers.

The paradox then emerges as alcoholic drinking itself designed to provide relief appears to do nothing of the kind. Sadava et. al.<sup>68</sup> found that stress related misuse of alcohol appears to be impulsive and may reflect conflict, learned helplessness, or an attempt to reduce cognitive dissonance about drinking after its onset. He did not find, however, that escapism was achieved through the drinking process. Results leading to similar conclusions were found by Holroyd<sup>69</sup>. There

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<sup>64</sup>Sanford, N. Where Colleges Fail. (San Francisco: Jossey-Bass: 1967).

<sup>65</sup>Blum, E. Psychoanalytic views of alcoholism; a review. Quarterly Journal of Studies on Alcohol. vol. 27; 1966; pp. 259-299.

<sup>66</sup>Cappell, H. "An evaluation of tension models of alcohol consumption." pp. 117-209. In: Gibbins, R.; Israel, Y.; Kalant, J.; Popham, R.; Schmidt, W.; and Smart, R., eds. Research Advances in Drug and Alcohol Problems.

<sup>67</sup>Marlatt, G. "Alcohol, stress and cognitive control." In Sarason, I. and Spielberger, C., eds. Stress and Anxiety, vol. 3. (New York: Hemisphere; 1976).

<sup>68</sup>Sadava, S.; Thistle, R.; and Forsyth, R. "Stress, escapism and patterns of alcohol and drug use." Journal of Studies on Alcohol. vol. 39, No. (5);1978, pp. 725-736.

<sup>69</sup>Holroyd, K. "Effects of social anxiety and social evaluation on beer consumption and social interaction." Journal of Studies on Alcohol, vol. 39, No. (5);1978; pp. 737-743.

appears to be the experiential consequence that drinking not only does not relieve tension (though it may produce temporary states of euphoria which is quite different) but may actually increase tension and conflict through the triggering of withdrawal symptoms (Milan)<sup>70</sup>. The paradox of the addiction process in alcoholism is that problem drinking will begin to augment the pain (physiologically and psychosocially) it was designed to relieve.

The psychodynamics of alcoholics appear to contain many patterns suggestive of pathological paradoxes which are binding in nature. As the alcoholic seeks to respond to the double-bind experience, he utilizes a process of giving the appearance of trying to meet felt demands while developing symptoms that "prevent him from doing so. He is thus trying to be an adult but not able to really try as the involuntary symptom interrupts his "efforts." He is trying yet not trying and thus responds paradoxically to the double-bind situation. With patterns of paradox utilized by the alcoholic, it would seem to be most empathic that therapeutic paradoxes could utilize those paradoxes present reframing their meaning and perspective. Accepting the alcoholic where he is may mean the understanding and therapeutic manipulation of paradoxical patterns in the style of response within a framework that is therapeutic.

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<sup>70</sup>Milan, J. The Emergent Comprehensive Concept of Alcoholism, 7th ed.; (Kirkland, Washington; ACA Press; 1974); pp. 44-50.

Paradox: Therapeutic Value

Some clinicians view the function of the ego in the context of interpersonal relationships. Haley<sup>71</sup> refers to the ego-ridden neurotic seeking to gain control, being superior and unaffected by one's feelings and life using symptoms to control the definition of the relationship. Haley<sup>72</sup> views all forms of therapy as a type of personal communication where the therapist places the client in a therapeutic bind or paradox. In this position, the client, under the direction and request of the therapist, is encouraged to use his symptoms so that their meaning and purpose is changed. Essentially, the goal is to challenge and, at times, even provoke (Farrelly)<sup>73</sup> the client to try and continue his own neurotic ways until the underlying absurdity emerges that the client cannot win or be superior to the therapist since one cannot win over or be superior to one's self. It would seem that the client's contest with the therapist is fundamentally a contest with life or with the disowned qualities of one's feelings. In this defeat, one realizes that there really was no problem in the first place only difficulties that are part of living and dying. In this sense, Ellis<sup>74</sup>

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<sup>71</sup>Haley, J. "The art of psychoanalysis," ETC., vol. 15, 1958, pp. 190-200. Also, "Control in psychotherapy," in Progress in Psychotherapy, (Grune and Stratton, New York, 1959).

<sup>72</sup>Haley, J. Strategies of Psychotherapy, 7th ed., (New York: Grune and Stratton, 1972); pp. 151-178.

<sup>73</sup>Farrelly, F. Provocative Therapy. 2nd ed. (Shields Publishing Co., Ind., San Francisco, Calif. 1975); Chapter I.

<sup>74</sup>Ellis, A. Reason and Emotion in Psychotherapy. (New York: Lyle Stuart, 1962); pp. 79-83.

is accurate in referring to how man can irrationally think there is something wrong with him because he makes a mistake or behaves badly.

Greenberg<sup>75</sup> has identified the help-rejecting complainer as have other clinicians (Berger & Rosenbaum<sup>76</sup>; Brody<sup>77</sup>). Greenburg has suggested that the client often makes problems seem insoluble and appears to take special delight and pride in the insurmountability of difficulties. Lorand<sup>78</sup> claimed that neurotics come into treatment to learn how to become more neurotic. Berne<sup>79</sup> says something similar in that if the therapist or group will not play the rescue, persecutor or victim game then the alcoholic may withdraw from treatment. The alcoholic seems to want to be accountable or guilty of something so as to be challenged and then defeat others.

Greenberg suggests that the key to the client's control of this situation is the expectation that no matter what occurs the thera-

<sup>75</sup>Greenberg, R. Anti-Expectation Techniques in Psychotherapy: The Power of Negative Thinking Psychotherapy: Theory, Research, & Practice. vol. 10, (2) Summer, 1973.

<sup>76</sup>Berger, M. and Rosenbaum, M. "Notes on Help-Rejecting Complainers." International Journal of Group Psychotherapy, 1967-77, pp. 357-370.

<sup>77</sup>Brody, S. "Syndrome of the Treatment-Rejecting Patient." Psychoanalytic Review, 1964-51, pp. 75-84.

<sup>78</sup>Lorand, S. Tech. of Psychoanalytic Therapy. (Intimatin Univ. Press, New York, 1947).

<sup>79</sup>Berne, E. What Do You Say After You Say Hello? (New York: Grove Press, 1972);pp. 186-88.

pist will try to be therapeutic. The client can be confident that therapeutic interventions will match the expressed negative self view. The therapist will seek to get the client to function therapeutically such as perceiving new alternatives for choice, gaining awareness of self-destructive dynamics, discovering positive assets, or even learning about the client's resistive nature of communication. Thus, clients anticipate the therapist's efforts to change him and can sabotage these efforts by matching the therapist's expected interventions with countering negative responses. The resulting statement, while giving the client some source of victory, can destroy the entire therapeutic process. Greenberg then advocates use of anti-expectation, paradoxical-type responses which reverse this situation "going with" the negative expressions of the client by agreeing with his efforts and even encouraging them to the absurd. The client, then not only has nothing to resist or counter but actually is confronted with the meaninglessness of the behavior. This ultimately provokes change.

Use of therapeutic paradoxes operate only when the therapist is perceived as benevolent in the ordeal he poses to the client (Haley)<sup>80</sup>. This seems to be an essential aspect for the effectiveness of these patterns of intervention to occur. Beier<sup>81</sup> also utilizes this combination of the helpful "problem." He calls it beneficial uncertainty. According to Beier, many patients in therapy attempt to engage the therapist either by their verbalizations or other communications; that is, they

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<sup>80</sup> See Reference 70.

<sup>81</sup> Beier, E. G. The Silent Language of Psychotherapy. Chicago: Aldine, 1966; Chapter I.

try to get the therapist to play their game. The client tries to hide this game under the guise of certain conventions, his real intent lying in subtle cues rather than in overt messages. The purpose is to keep the environment safe and controlled. To deal with this, Beier urges that the therapist disengage from the client by making what he terms the asocial response. Thus, if the client covertly attacks the therapist expecting negative counters, the therapist simply reflects the surface message allowing the client to "run into himself" thus not getting what is desired. It is striking then, that what appears to be the pure response of a reflection can be quite unexpected and even binding in nature. Haley<sup>82</sup> suggests that effective interventions employ such paradoxical and disengaging patterns.

In seeking to formulate treatment approaches, many others have also used the interpersonal dimension as a source of both problem formation and problem resolution. Watzlawick, Weakland, and Fisch<sup>83</sup> have suggested that the problem of many clients may be based in the paradoxically self-perpetuating solutions they employ. Their level of intervention seeks to effect a change not in the expressed problem area per se, but rather in the way various solutions are applied to alleviate the disturbance. They refer to this type of change as second-order change. Essentially, they seek to encourage the client to use their pre-

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<sup>82</sup>See Reference 71.

<sup>83</sup>Watzlawick, P.; Weakland, J.; and Fisch, R. Change: Principles of Problem Formation and Problem Resolution. (New York: Norton; 1974); pp. 31-39.



sent methods of solving their problems but in ways that alter the meaning and framework in which they initially are grounded. There is a shift to the next higher level of organization or second-order change. Thus, a teenager angry at a principal for being thrown out of school can be provoked into using his anger to get back at the principal described as hoping the boy will not return, not learn, and simply be a loser. Thus, the angry vengeance of the boy's resistant solution can be reframed and shifted towards engaging in what was previously perceived as cooperative behaviors towards that of working hard learning his school work to get back at the principal.

Problems may be perpetuated by not appreciating the issue that the problem is grounded in the way its solution is attempted. Many times the resolution of some problematic issue occurs not through applying more of the same type of solutions previously attempted but changing the way the solution is itself attempted. This may involve reframing the way old solutions are applied such that new solutions may be available utilizing themes already present. Essentially, a variance in the way change is attempted may be required when the problem lies in the present method of its solution. The design of the therapeutic paradox is to effect just this type of change.

#### Paradox: Studies and Approaches Advocating Paradoxical Interventions

Designing interventions focusing upon the solution of the client has been used by Alfred Adler<sup>84</sup>. Adler viewed behavior as emerging not from what the person really is but from how that individual construes

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<sup>84</sup>Adler, A. The Individual Psychology of Alfred Adler. Edited by H.L. and R. R. Ansbacher. (New York: Basic Books; 1956) pp. 385-394.

events and believes himself to be. Behavior then is based upon the expectations of the individual and may well take the form of self-fulfilling prophecies. The person who believes himself a helpless pawn will logically shrink from the world. This withdrawal not infrequently results in one having things done to him. The Adlerian therapeutic objective is to alter self-defeating and social beliefs, shifting from a vicious destructive cycle towards a growing spiral. Among the many techniques used by Adler is "spitting in the soup" of the client or "besmirching a clean conscience" (Adler)<sup>85</sup>.

The Adlerian perspective regards symptoms, hallucinations, delusions, etcetera not as disturbing eruptions but as tools the individual uses in dealing with life tasks (Mosak and Gushurst<sup>86</sup>; Shulman and Mosak<sup>87</sup>). The purpose is to spoil the self-defeating game of the client by undermining its utility. Thus, a client, seeking to claim specialness and demanding unique attention from others, might experience counselor responses on what its like to be a slave being tied to the movements and whims of others. The person flaunting independent behavior for special significance is now impaired as the behavior has now been reconstructed as probably having the antithetical meaning. Adler's

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<sup>85</sup>Adler, A. The Individual Psychology of Alfred Adler. Edited by H. L. and R. R. Ansbacher. New York: Basic Books; 1956; pp. 290-317.

<sup>86</sup>Mosak, H. and Gushurst, R. "What patients say and what they mean," American Journal of Psycho Therapy. vol. 25, No.(3); July, 1971; pp. 428-436.

<sup>87</sup>Shulman, B. and Mosak, H. "Various purposes of symptoms." Journal of Individual Psychology. vol. 23, May, 1967; pp. 79-87.

use of symptom encouragement or antisuggestion, reconstruing the meaning of behavior and avoiding engagement in client's self-defeating cycles all serve to interrupt this cycle and free the client towards more encouraging styles. The client with a severe sense of discouragement seeks to entrap the therapist by engaging him (e.g., through annoyance, hostility, repeated failures, etcetera) into behaving in ways that the client could use to confirm the private and mistaken logic (Adler)<sup>88</sup>. William Glasser<sup>89</sup> utilizes a here-and-now focus to avoid being entrapped in the client's self-fulfilling prophecy avoiding events of the past being used as justifications for present disturbances. Eric Berne<sup>90</sup> also expresses the need for the therapist to abort the client's self-defeating expectation-behavior-system by responding in ways contrary to expectations or life script.

Effecting a significant change in the style of problem solving clients employ first calls for interrupting the present style employed. This may be achieved in a variety of ways ranging from redefining the meaning of the client's behavior to a detached, disengaged position of the counselor permitting the client's efforts but not reinforcing them. This nullifying of the client's style of problem solving occurs in many approaches which interrupt the cyclic process at various points depending on the approach involved.

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<sup>88</sup>Adler, A. Superiority and Social Interest. Ed. by H. L. and R. R. Ansbacher, (Evanston, Illinois: Northwestern University Press; 1964); pp. 117-126.

<sup>89</sup>Glasser, W. Reality Therapy. (New York: Harper and Row, 1965); pp. 151-60.

<sup>90</sup>Berne, E. Games People Play. (New York: Grove Press, 1969); pp. 35-67.

Carl Whitaker<sup>91</sup> refers to the use of psychotherapy of the absurd. This approach seeks to augment or escalate the incongruity of a symptom or some behavior of the patient. In so doing, the basic absurdity becomes clearly apparent to the patient and he enjoys the implications. Whitaker parallels this to the occurrence of a slip of the tongue and all that "accidentally" is implied. He conceives of exaggerating the faulty belief system as building upon the leaning tower of Pisa. The more it is exaggerated or built higher the more unstable it becomes and eventually collapses.

Whitaker suggests that as life is somewhat absurd, that is, man's thinking is absurd to his senses, power is attained at the sacrifice of reason, and as we struggle to be who we are it is impossible to stop acting. Psychotherapy may be a microcosmic experience. Thus, both therapist and patient madness can interact inducing chaos and complexity assisting the patient towards more flexibility and freedom. Indeed, Whitaker claims that the very integrity of the therapist hinges on the therapeutic expression of his own madness. This type of madness can stimulate and encourage the client's madness to be growth accelerating and creatively rechanneled.

Ward<sup>92</sup> refers to the enteric-coated compliment where negativistic and depressed patients find it very difficult to accept compliments. Essentially, he gives the appearance of insulting the client while ac-

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<sup>91</sup>Ward, H. "The enteric-coated compliment," Psychotherapy: Theory, Research and Practice. vol. 8, no. (4), Winter, 1971; pp. 280-281.

<sup>92</sup>Whitaker, C. "Psychotherapy of the absurd: with a special emphasis on the psychotherapy of aggression." Family Process, vol. 14; no. 1; March, 1975; pp. 1-5.

tually being quite positive. Smith<sup>93</sup> reviewed the use of an indirect, circumventing approach to dealing with a highly negativistic, failure oriented, drinking client. He went with the client's resistance of making no progress and failing but shifted the focus to his own inadequacy as a therapist. This provoked a supportive and positive attempt by the client to assist the counselor in working out the process further. This provided a corrective emotional experience of affirming the client's worth as a valid helper and displacing the transference of authority away from the therapist.

The ability of the therapist to let go of the conventional frame of reference offers a model and opportunity to the client for release from his own style. As a consequence of the interaction with a therapist willing to engage in risking new, unique, and "crazy" behaviors, the client is freed to experiment with a wide range of behaviors. This can suggest to the client that losing one's mind (control) will not necessarily lead to insanity but rather a gaining of one's senses, emotions, and feelings.

Gendlin<sup>94</sup> refers to the use of the experiential response as an effective way for the therapist to assist the client's focus upon his felt meaning. This felt meaning or sense of the client is implied

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<sup>93</sup>Smith C. "An atypical session: resistance and the negativistic patient." Psychotherapy: Theory, Research and Practice. vol. 8 no. (4), Winter, 1971; pp. 276-279.

<sup>94</sup>Gendlin, E. T. "The experiential response," Use of Interpretation in Treatment. (Grune and Stratton, Inc., 1968); pp. 208-215.

and is more a complex of cognitive, affective and situations interactions. It would appear that approaches which facilitate client's focusing on this interactive complex of felt meaning would be effective. The use of therapeutic paradoxes in many ways gets at this felt sense of thought, perception, feeling and situational interaction. They actually encourage the presence of the felt meaning of the client's experience to such an absurd and unexpected sense that the entire complex can emerge as a whole gestalt. Many of the facets of the complex may then be clarified. Indeed, Rogers<sup>95</sup> discovered that resistance could be obviated if the therapist responded with, rather than against, the client's felt desires, perceptions and self-protecting urges. Even extremely negative and self-defeating material can emerge through this process in a positive life-maintaining style. This requires that the therapist respond to the client's actual felt intent, and not through an external evaluation.

It would appear that intensification of the client's felt meaning could serve as a focal point from which a shift in perspective and and life style may emerge. Indeed, to effect change in behavior, energizing where the client is at through intensification of experience may well provide one interruption of the present life style, restructuring the present framework, allowing new perspectives to emerge.

Behavior therapists have also used paradoxical ideas

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<sup>95</sup>Rogers, C. R. Client-Centered Therapy. (Boston: Houghton Mifflin, 1951); pp. 1-65.

advocating what is called "negative practice" (Dunlap)<sup>96</sup> which involves a patient repeating over and over undesirable habits which he is trying to break. Wolpe and Lazarus<sup>97</sup> report successful treatment of clients with this procedure. Malleeson<sup>98</sup> describes a technique called "emotional flooding," meaning the repeated presentation of intense anxiety-arousing stimuli until anxiety is extinguished.

Stumpfl and Levis<sup>99</sup> in reference to impulsive therapy report a similar behavioral approach based on psychoanalytic theorizing. The use of the patient's own imagery to expose him to the most intense anxiety-eliciting stimuli they can devise based upon their theoretical understanding of the case. Again, there is the expectation that continuous exposure to such a stimulus without harmful consequences (i.e., reinforcement) would cause it to lose all power to elicit anxiety.

Frankl<sup>100</sup> using an existential framework has employed a method called paradoxical intention. His approach assumes that anticipatory

<sup>96</sup>Dunlap, K. Habits, Their Making and Unmaking, (New York: Liveright, 1962), pp. 66-73.

<sup>97</sup>Wolpe, J. and Lazarus, A. Behavior Therapy Techniques. (New York: Pergamon Press, 1966); pp. 27-39.

<sup>98</sup>Malleeson, N. "Panic and Phobia. A Possible Method of Treatment." Lancet, 1959--1, pp. 225-227.

<sup>99</sup>Stumpfl, P. C. and Levis, D. J. "Essentials of Impulsive Therapy: A Learning-Theory-Based Psychodynamic Behavioral Therapy." Journal of Abnormal Psychology, 1967-72, pp. 496-503.

<sup>100</sup>Frankl, V. "Paradoxical Intention: A Logotherapeutic Technique." American Journal of Psychotherapy, 1960--14, pp. 520-535.

anxiety will frequently cause a symptom to occur. Working against this fearful expectation, the therapist encourages the patient to try and bring on his symptoms. It is anticipated that patients will have difficulty producing symptoms on demand and consequently will begin to change their attitudes.

Clients develop symptoms by trying to overcome fearful situation with anticipations of failure to do so. The failed attempt stimulates more of the same type of effort ultimately precipitating a feeling and belief of helplessness and hopelessness. Thus, symptoms may be inadvertently produced in this neurotic process. If, instead the client deliberately seeks to develop a symptom that developed inadvertently or spontaneously, his seeking to directly produce the symptom short-circuits this neurotic process. The goal is the same in both but the process is now one of direct, conscious choice as opposed to helpless avoidance of inevitable consequences. In addition, the try but failing process engendered by anticipation of failure has shifted focus from the anticipation to the failure itself. This breaks the connection between the two and gives room to a new process focused on non-distracted choice.

In short, to seek to directly and voluntarily produce that which is defined as occurring out of a process of failure and loss of control negates the initial meaning and definition of a symptom as an expression of helplessness. Indeed, the symptom has lost its symptomatic meaning of unresolved and uncontrolled underlying conflict and takes on a new meaning of being a deliberate goal of the client suggesting success and control. It may be said then that such use of paradoxical approaches ex-



tinguishes the neurotic meaning of symptoms and shifts it towards a more positive one.

Gerz<sup>101</sup> has found successful treatment of obsessive-compulsives and phobic complaints using paradoxical intention. He used exaggeration to evoke humor in clients. Humor, exaggeration, and the willingness to do the unexpected are suggested by Greenwald<sup>102</sup> in the approach "play therapy for children over twenty-one." The idea of using antiexpectation messages has been strongly advocated by Erickson<sup>103</sup> in describing hypnotherapy. The focus is upon naturalistic and utilization techniques. Instead of requiring initial acceptance and cooperation from the patient, the procedure is reversed so there is an initial acceptance and cooperation with the behavior presented by the patient no matter how adverse it may be in the clinical situation. The patient is frequently encouraged to have their symptoms while each time making some subtle addition or suggestion as to the way they are to be expressed. Erickson is able to gradually gain control over how, when and even if the symptom will appear. He perceives psychotherapy within the context of the relationship and communications theory. He describes techniques of direct therapy which rely heavily on anti-expectation messages to undermine the patients' defenses and enable the therapist to gain control of the psychotherapeutic encounter. The approach is re-

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<sup>101</sup>Gerz, H. O. "The treatment of the phobic and the obsessive-compulsive patient using paradoxical intention." Journal of Neuropsychiatry, vol. 3, 1962; pp. 380-87.

<sup>102</sup>Greenwald, H. "Play Therapy for Children Over Twenty-One." Psychotherapy: Theory, Research, and Practice, 1967-4 (1), 44-46.

<sup>103</sup>Erickson, M. S. "Further Clinical Techniques of Hypnosis: Utilization Techniques." American Journal of Clinical Hypnosis, 1959--1, pp. 3-21.

ferred to as therapeutic paradox which unexpectedly, from the client's point of view, gives him acceptance and even encouragement of resistant behaviors, symptoms, and other ways of relating. The patient is anticipating a struggle to change these from the therapist. There is also advocated the utilization of interventions that are unexpected and paradoxical in that it redefines the patient's behavior no matter what he does as occurring under the therapists' direction. There is a change in the effect, purpose, and meaning of the client's behavior in the relationship calling for a change in his own behaviors.

Goldfried<sup>104</sup> in conceptualizing systematic desensitization, has recently suggested the importance of cognitive factors and a learning system for self-control as mediational processes in anxiety reduction. The use of anti-expectation or paradoxical interventions (as those terms are synonymous for present purposes) serve the chief value of giving the client the clear feeling that he has the ability to exert some control over his behavior. These techniques could lead to the client's interpreting, controlling and placing his emotions within a cognitive framework. Interestingly, Ellis<sup>105</sup> suggests that disturbances can be eradicated by patients learning to tell themselves more rational and less self-defeating sentences. Anti-expectation or paradoxical approaches have highlighted the fact that certain patients can gain con-

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<sup>104</sup>Goldfried, M. R. "Systematic Desensitization as Training in Self-Control." Journal of Consulting and Clinical Psychology, 1971--37, pp. 228-234.

<sup>105</sup>See reference 73.

trol over their behavior by first trying to tell themselves more self-defeating sentences while being made very aware of what they are doing.

There are a wide range of approaches that suggest the use of paradoxical responses to disengage the therapist from the clients' neurotic transactions. Also, symptoms may be produced by clients through the fusion or association of seeking to overcome some fearful experience with anxious anticipation that failure will result. Thus the therapist needs to discern methods that will dissociate the clients' efforts from the pessimistic perspective of failure. The utilization of paradoxical interventions de-classifies the try-but-fail cycle by encouraging the client to forget trying to overcome tasks and difficulties, and rather seek to fail by producing the particular symptom in question, which could be severe anxiety, depression, drinking, etcetera. Thus symptoms are de-classified as symbols of failed efforts and redefined as efforts attained. Many techniques have been mentioned as means of effecting this type of shift in classification of the meaning of symptoms and behaviors.

#### Paradox: Treatment of Alcoholism

The goal of treatment is to provide the opportunity to the recovering alcoholic of freely involving himself in his own responsible endeavors. Hopefully, this will lead to and maintain meaningful sobriety. In providing this opportunity, a major area of focus is to facilitate a separation of the alcoholic's goals, values, and decisions from those of significant others.

If this separation and differentiation does not occur, he may spend the rest of his life ambivalent. He will seek to please and si-

multaneously resist confining expectations and definitions. Through undermining his own efforts, he can feel some freedom yet the price is his own self-destruction. To break the fusion with others and develop his own identity of internal value, worth, and power, he needs to find an alternative way of breaking the externalized fixations other than alcoholism. At times, this can only happen after he has proved to himself by "hitting the bottom" (e.g., Skid Row) that he will never be able to be some idealized self. It is then that he seems ready for therapeutic interventions.

The counselor then faces the challenge of designing and implementing approaches that adequately lay the groundwork in meeting with and adequately responding to these ongoing dynamics encountered in the therapeutic interaction. It would appear that the utilization of therapeutic paradoxes could assist the counselor in moving the client towards a more differentiated perspective no longer fused to others' expectations. He can thus, establish a more focused self, assertively relating to others.

Tiebout<sup>106, 107, 108, 109</sup> has quite extensively described the ego

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<sup>106</sup>Tiebout, H. M. "The act of surrender in the therapeutic process," Quarterly Journal for the Studies of Alcohol, vol. 10, No. (1), 1949; pp. 1-15.

<sup>107</sup> \_\_\_\_\_ "Surrender versus compliance in therapy, with special reference to alcoholism." Quarterly Journal for the Studies on Alcohol, 1953; pp. 1-6.

<sup>108</sup> \_\_\_\_\_ "Ego factors in surrender," Quarterly Journal for the Studies on Alcohol. vol. 15, No. (4), 1954; pp. 610-21.

<sup>109</sup> \_\_\_\_\_ "Intervention in psychotherapy," American Journal of Psychoanalysis, vol. 22, No. (1); 1976 pp. 1-6.

factors of the alcoholic and the need to surrender through "hitting the bottom." His entire perspective suggests that the alcoholic must experience the futility of his own egotistical control over drinking by paradoxically seeking to control drinking and fail. Before meaningful change can occur, the alcoholic requires some sense of a control beyond his own ego such that he may surrender his neurotic strivings.

When the alcoholic does hit bottom, he must surrender any sense of ego-control over himself and drinking. It is at this point, paradoxically, that while it appears that one has lost, only the illusion of egocentricity is lost and a new experience of selfness related to others is now possible. Wilson<sup>11</sup> refers specifically to this experience regarding conversion in the form of ego-reduction. This takes the form of humility in the face of the alcoholics compulsion to drink.

O'Neill<sup>110</sup> utilizes an approach similar to paradox coining in confrontation. This approach is designed to prompt a break in the denial system preventing effective therapy. Dramatic conversions from drug dependence to independence have resulted from this technique. The therapist increases the input of confrontation by exaggerating the client's feelings of worthlessness and helplessness. The resulting break in the denial system enables him to consciously decide to assume

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<sup>110</sup>Wilson, W. "Sobriety: Conversion and Beyond," Maryland State Medical Journal. vol. 24, No. 4, April, 1977; pp. 85-91.

<sup>111</sup>O'Neill, P. "Alcohol confrontation," Australian Journal of Alcoholism and Drug Dependence. vol. 3, No. 2, May, 1976; pp. 43-45.

responsibility for his own action. This decision has been found to be accompanied by a calm assurance of success. The underlying philosophy of the technique assumes that alcoholics are basically normal people who retain the right to decide whether or not to use alcohol. This decision can ultimately override the craving for the drug.

Kora<sup>112</sup> focuses upon an eastern approach known as Morita Therapy involving an implosive experience utilizing bedrest. Essentially, it intensifies the experience to such a degree that the client must either surrender one's neurotic strivings or face death. There would seem to be obvious parallels between this and the hitting bottom experience. The theme throughout suggests that paradoxically going with the client's style provides a corrective emotional experience allowing him freedom and integration of self.

There are studies that suggest that approaches using principles of redefining negative characteristics and behavior in positive ways are effective. Thus, the use of approaches assisting the client in sublimating, as it were, his energies and not seeking a radical restructuring of the personality are more effective. Approaches that effectively assist the alcoholic's utilization of what he already has in a positive mode appear to induce the more flexible, open-ended perspectives in the life style. In other words, there appears to be a shift not only from negative to positive channeling of behavior but also the quality of the definitions and meaning of the behavior becomes more open-

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<sup>112</sup>Kora, T. "Morita therapy," International Journal of Psychiatry, vol. 1, 1965; pp. 611-31.

ended and flexible. In a word, definitions in the alcoholic's life style of important constructs like control, power, and significance, shift from a rigid, absolute, all-or-nothing quality to one of flexibility, relativity, and differentiation.

Stewart<sup>113</sup> in referring to empathy with alcoholics supported this when he introduced the idea not of changing the alcoholic's tendencies but of giving them new names. These might be "childish," become "personable," "sensitive," becomes "alert," "fear of seeking and giving attention" is relearned as "being friendly is nothing to be ashamed of, nothing requiring a drunk," "grandoise" becomes "ambitious" and "wishful thinking" becomes "adventurous" or "imaginative." Thus a positive rechanneling and differentiation of narrow, negative impulses seems to be somewhat effective. Indeed, these are principles that Alcoholics Anonymous is based upon in part (Hayman)<sup>114</sup>. Thus, use of differentiation processes as facilitated by paradoxical interventions and their redefining impact would seem highly compatible with these trends.

Thune<sup>115</sup> refers to the use of Alcoholics Anonymous and how its

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<sup>113</sup> Stewart, D. A. "Empathy in the Group Therapy of Alcoholics." Quarterly Journal for the Studies on Alcohol, 15: pp. 74-110, 1954.

<sup>114</sup> Hayman, M. Alcoholism: Mechanism and Management. (Thomas Co., Springfield, 1966), Chapter IX.

<sup>115</sup> Thune, C. "Alcoholism and the archetypal past: a phenomenological perspective on alcoholics anonymous." Journal of Studies on Alcohol. vol. 38, No. (1), 1977; pp. 79-87.

effectiveness lies in the telling of the alcoholic's life story serving as a model for reanalyzing the past and recreating the future. The life story serves as a kind of meta-language to shift and manipulate symbols in the alcoholic's life so that a new perspective of both past and future behavior develops. Thus, redefinition and reconstruction of the alcoholic's life occurs through the life story first defining the problem of alcoholism as a "defective mode of life." Treatment needs to be aimed at reconstruction and redefinition of self and the world. Thus, using a model of alcoholism as that of a defective mode of being assists the alcoholic in accepting his being an alcoholic. The alcoholic's way of living then is the "disease."

Thus, while Alcoholics Anonymous recognizes that alcoholic abstinence is critical as a first concern, paradoxically it is not the most fundamental component. Rather, it is a necessary first step before altering other more basic aspects of the overall defective life style. In the Alcoholics Anonymous view, interpretation of one's life according to the model allows the alcoholic to begin to assert a kind of control over one's life not formerly possible.

The reinterpretation involves a process of labeling and analysis (better, relabeling, and reanalysis) of segments of the past which give them a new meaning and defines new problems, thereby suggesting different strategies for living. Additionally, the result of revising the past to fit the model espoused in Alcoholics Anonymous is that the past acquires a formerly lacking pattern and coherence. There is no change in the alcoholic's behavior in Alcoholics Anonymous as in other forms of therapy as the change is that he learns a new definition for his illness while only altering his understanding



of his past and present. It follows that no one is cured in Alcoholics Anonymous as the problem remains while the assumptions and meanings have changed. Since any body of presuppositions may be problematic, a therapy based upon their alteration can never assume that it has lead to irreversible change.

While there is focus upon interventions by counselors utilizing paradoxical and redefining techniques, it is important to note that alcoholics may in their own way be "naturally" therapeutic. Drinking may be used in such a way as to make the act of drinking a form of therapeutic paradox in one's own presently dysfunctional life style.

It may appear that intensification of experience with the alcoholic occurs inadvertantly through hitting bottom or in some sort of therapy. Yet, this may be exactly what the alcoholic is pursuing (Cantor)<sup>116</sup> discusses case histories of alcoholics he has treated, who drink not to relieve tensions but rather to increase them. That is, alcohol ingestion temporarily served to intensify the felt sense of meaning regarding family, friends, everyday living, etcetera, while sobriety seemed boring and alienated. Even though the heightened tension increase involved closer contact with problematic areas, it still was a means to experience some meaning in an otherwise empty life. The effect is temporary and, this of course, cannot be generalized to all forms of alcoholism. However, the implications are interesting in that they suggest the alcoholic in part may be seeking some intensification

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<sup>116</sup>Cantor, F. M. "Alcoholism, tension-increase and existence," Psychotherapy: Theory, Research and Practice. vol. 7, No. (2), Summer, 1970; pp. 75-78.

of experience, and that approaches utilizing this theme may well be effective. The utilization of resistance by therapist (and client ironically) serves paradoxically to intensify the experience the resistance was designed to dissipate. Indeed, this positive use of resistance would follow from many statements among alcoholics who have requested of this author that they be "helped in spite of themselves." The Natural Mind by Weil<sup>117</sup> suggests that mental health needs are part of the reason many persons seek an altered state of consciousness. Drinking may well be the alcoholics' only means of seeking this alteration for experience even though in the long run the consequences are destructive and increasingly alienating. Herein lies an essential paradox of alcoholism that within a context of denial and escape through drinking, there still may lie the rudiments of the quest for intense meaning.

As there appear to be many paradoxical patterns of behavior in the alcoholic life style, any therapy seeking to work effectively with alcoholics would need to provide therapeutic paradoxes to offer a countering effect. The process of encouraging the pathological paradoxes of the alcoholic through challenging them to demonstrate their power (e.g., controlled drinking) can serve to negate their very existence (e.g., surrender). It is important to note that some paradoxes in the alcoholic may be of a positive nature. In many ways, therapeutic paradoxes can be used to amplify the meaning in the alcoholic's life that

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<sup>117</sup>Weil, A. The Natural Mind. (Houghton-Mifflin, Boston, Mass., 1972); pp. 14-39.

is being sought through an intensification of experience by drinking. The following section presents the instruments involved in the study with relevant reference material. Full descriptions are presented in Chapter III.

### Instruments

This study uses a variety of instruments for purposes of control and assessment of process and out-come variables. Those used for controlling or identifying the clients' individual differences are the Clinical Analysis Questionnaire (CAQ) and the Jellineck Chart. Measurement of process and out-come variables include: Presence of Paradoxical Patterns of Response Scale (PPPR); Facilitativeness Scale; Type of Response Scale; Problem Expression Scale; and Follow-up Sobriety Scale.

The Clinical Analysis Questionnaire (CAQ) is intended for use in general clinical diagnosis for evaluating therapeutic progress, and for basic clinical research, both with neurotics and psychotics. It is the outcome of the most comprehensive searches for structure by factor analyses that have yet been made in the domain of abnormal behavior, across several samples and types of clinical groups. These researchers have been published by Delhees and Cattell<sup>118</sup>, Cattell and Bolton<sup>119</sup>,

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<sup>118</sup> Delhees, K. H. and Cattell, R. B. Obtaining 16 PF scores from the MMPI, and MMPI scores from the 16 PF. Journal of Projective Techniques and Personality Assessment, 1970, 34, 251-255.

<sup>119</sup> Cattell, R. B. and Bolton, L. S. What pathological dimensions lie beyond the normal dimensions of the 16 PF? A comparison of MMPI and 16 PF factor domains. Journal of Consulting and Clinical Psychology, 1969, 33, 18-29.

Cattell and Bjerstedt<sup>1 20</sup>, Curran<sup>1 21</sup>, Weckowitz et. al.<sup>1 22</sup>, and several others.

Fuller<sup>1 2 3</sup> has done research, with alcoholics depicting their profile using the 16 PF. He found that they are guilt prone and unable to consistently express this in adjustive, constructive behavior. There appears to be high frustration and anxiety with an inability to release tensions adaptively or to control them. This latter situation may well create the cumulative stresses periodically seeking resolution in alcohol addiction. Also, high influence from feelings is present. Finally, autism, passive-dependency, and brooding depressive tendencies are all viewed as being present.

The Jellineck chart for identifying stages of alcoholism is also used. As there is no one type of alcoholic, the need to delineate just what form or stage of alcoholism is being dealt with appears to be essential. In 1960, Jellineck listed 33 formulations, including those from the American Medical Association's which allow for psychologi-

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<sup>1 20</sup>Cattell, R. B. and Bjerstedt, A. The structure of depression, by facotring Q-data, in relation to general personality source traits. Scandinavian Journal of Psychology, 1967, 8, 17-24.

<sup>1 21</sup>Curran, J. A P-technique experiment to determine the nature of depression and anxiety states. In press, 1971.

<sup>1 22</sup>Weckowicz, T. E.; Muir, W.; and Croypley, A. J. "A factor analysis of the Beck inventory of depression." Journal of Consulting Psychology, 1967, 31, 23-28.

<sup>1 23</sup>Fuller, G. B. "Research in Alcoholism with the 16 PF Test." Willmar State Hospital, Minnesota. IPAT Information Bulletin No. 12, 1966.

cal addiction, and 22 which imply a pharmacological process. This refers to criteria that were used to designate the degree to which the severity of alcoholism had progressed. Work by Jellineck<sup>124</sup> explored alcoholism as a process of increasingly serious symptoms leading to the destruction of personality and alcoholism psychosis. He divided this process into four stages of drinking. These are pre-alcoholic, prodromal, crucial, and chronic. The use of the staging chart employs the characteristics delineated by Jellineck and depict the stage of alcoholism in which the person lies. Mulford<sup>125</sup> utilized a similar four stage design capable of identifying different points of severity in the deterioration process of alcoholism. Comparisons with clinical records of 2,440 clients in 30 Midwestern community alcoholism centers were examined to develop the measure. The index measures the frequency of elements of alcohol-related behavior which have been shown by previous research to increase the individual's probability of being labeled and alcoholic. The Jellineck scale and the Alcoholic Stages Index both seem to delineate the progressive deterioration of alcoholic drinking in a similar manner.

The PPPR scale needed to be constructed prior to the study's implementation as no present instrument was suitable. The scale was developed by the author of this study in consultation with colleagues. Refinement of the instrument with feedback from the trained raters also

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<sup>124</sup>Jellinek, E. M. "Phases of alcohol addiction," Quarterly Journal of Studies on Alcohol, vol. 13, 1952; pp. 673-84.

<sup>125</sup>Mulford, H. "Stages in the alcoholic process: towards a cumulative, non-sequential index," Journal of Studies on Alcohol. vol. 83; No. 3; March, 1977; pp. 563-83.

occurred. The following depicts the field testing involved. In establishing validity of the paradoxical pattern of response scale, trained raters (to be described in Chapter III) involved in this study used the instrument rating taped sessions from individual counseling sessions. These sessions represented paradoxical patterns of response (e.g., Frank Farrelly's provocative therapy sessions) and non-paradoxical pattern of response (e.g., Carl Rogers conducting client-centered sessions). Five sessions from each type were rated. The segments played by the Rogers' tapes were such that conventional, expected, and non-paradoxical response patterns were present. Analysis of the ratings obtained on both types of taped sessions demonstrated that the scale could differentiate between the presence or absence of paradoxical responses. Use of a T-test comparing two independent means taken from the ratings utilizing the instrument on the two separate sets of tapes demonstrated significant difference at the 0.05 level. The mean was predictably higher for presence of paradox for the provocative therapy tapes.

Reliability was obtained using the test-retest method. Raters re-scored the same five sessions two weeks after their initial rating. Pearson r was used to measure the degree of correlation between the two sets of scored ratings. The correlation measured was  $r = .87$ .

The Facilitativeness Scale used relies heavily on Carkhuff dimensions of interpersonal functioning. These dimensions have been validated in extensive process and out-come research on counseling and

psychotherapy. Truax and Carkhuff<sup>126</sup>, Carkhuff<sup>127</sup>, and Carkhuff and Berenson<sup>128</sup> have summarized this research and its validity in the treatment process.

The Type of Response Scale derives its material from the Facilitativeness Scale. This scale uses practically the same response dimensions validated in the previous scale but uses them differently. Measurement here is only for identifying presence of these response dimensions or types. While research has already been cited noting their value, additional work by Carkhuff<sup>129</sup> and Egan<sup>130</sup> have suggested these response types are integral to the counseling process.

The Problem Expression Scale suggests the degree of problem resolution as a result of counseling sessions. It has been validated against such criteria as projective tests, MMPI changes, and evaluation by independent psychotherapists. These kinds of validations were com-

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<sup>126</sup>Truax, C. B. and Carkhuff, R. R. Toward Effective Counseling and Psychotherapy: Training and Practice. (Chicago: Aldine, 1967); pp. 11-67.

<sup>127</sup>Carkhuff, R. R. "Differential functioning of lay and professional helpers." Journal of Counseling Psychology, 1968, 15, pp. 117-126.

<sup>128</sup>Carkhuff, R. R. and Berenson, B. G. Beyond Counseling and Therapy. (Holt, Rinehart, and Winston, 1967); pp. 35-78.

<sup>129</sup>Carkhuff, R. R. Helping and Human Relations, Vol. I: Selection and Training. (New York: Holt, Rinehart, and Winston, 1969.)

<sup>130</sup>Egan, G. The Skilled Helper: A Model for Systematic Helping and Interpersonal Relating. (Brooks/Cole Publishing Co., Monterey, California, 1975); pp. 3-42.

pleted by the Rogers' group (Walker, Rablen, and Rogers)<sup>131</sup> who developed the scale to measure process changes occurring in psychotherapy. Tomlinson<sup>132</sup> found evidence that there is greater movement (process change) on the scale during the period of therapy in more successful cases.

Out-come measures are obtained using the follow-up sobriety scale. A variety of dimensions are reflected in this instrument including length of sobriety, social task functions and the like. Edwards, Bucky, Coben, Finchman, et. al.<sup>133</sup> and Crawford<sup>134</sup> have found these to be reliable and valid measures of treatment success.

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<sup>131</sup>Walker, A. M.; Rablen, R. A.; and Rogers, C. R. "Development of a Scale to Measure Process Changes in Psychotherapy." Journal Clinical Psychology, 1960--16, 79-85.

<sup>132</sup>Tomlinson, T. M. Three Approaches to the Study of Psychotherapy Process Outcome and Change. Unpublished doctoral dissertation, University of Wisconsin, 1962.

<sup>133</sup>Edwards, D.; Burchky, S.; Coben, P.; Finchman, S.; et. al. "Primary and secondary benefits from treatment for alcoholism." American Journal of Psychiatry. vol. 134; No. 6; June, 1977; pp. 682-83.

<sup>134</sup>Crawford, R. "Treatment success in alcoholism," New Zealand Medical Journal. vol. 84 (569): August 11, 1976; pp. 92-96.



## CHAPTER III

### METHODOLOGY

#### Introduction

Essentially, this study seeks to measure the relationship between paradoxical patterns of counselor responses and: 1) facilitative level of helpers' response; 2) progress in the counseling relationship; 3) type of counselor response; and 4) follow-up success involving length of sobriety incorporating positive socialization behaviors. Operational definitions for all variables are given via their respective rating scales found in the appendix of reference A (page 119).

All Ss originated from the Champaign County Council on Alcoholism's out-patient program which serves Champaign and Ford counties. The council is community based with ready availability of services to the community. Ss used in the study were those drawn from the out-patient counselors' case loads whom were willing to allow their sessions to be audio recorded and rated by trained raters.

#### Subjects

Since the study draws its data from measuring aspects of both client and counselor responses, the term subjects will apply to both.

##### 1. Clients:

The clients seen in counseling for the study were 40 white Ss, 25 males and 15 females. Their age range is from 23 to 57 years old.

The average income was \$8,000.00. Ss were all diagnosed as alcoholics according to the Jellineck chart which indicates the phase or stage of the disease's progressive deterioration.

Chart A on page 65 indicates the categorized distribution among Ss. The general description of the Ss is white, middle-aged, and separated or divorced, with about a high school education. The chart indicates that the majority of Ss, 25, were found to be in the crucial or 3rd stage of alcoholic deterioration. Nine Ss were in the last or 4th stage called chronic. There were three Ss each in the pre-alcoholic and prodromal stages. Also, 21 Ss were self-referred. Most of the Ss, 29, attended 3 sessions in individual, out-patient counseling, the remaining Ss were fairly evenly distributed over four, five, six, and ten sessions; that is, 2, 5, 2, 2 Ss, respectively.

## 2. Counselors:

The individual sessions were conducted by seven staff members who participated in the study. Chart B displays the qualifications of the counselors as well as the number of Ss counseled. Five counselors are working on advanced degrees in psychology or related fields with two or more years of experience in substance abuse counseling. Two counselors have two or more years of college with five years experience.

Chart A

Client Demographic Characteristics: Male and Female

	<u>Age</u>				<u>Stage of Alcoholism</u>				<u>Marital Status</u>				<u>Educational Level</u>			
	20-30	31-40	41-50	51-60	1	2	3	4	Mar.	Sing.	Sep./Div.	W	1-8 yrs.	9-12	13-16	17+
Males (25)	3	16	4	2	1	2	16	6	2	2	20	1	9	14	2	0
Females (15)	2	9	3	1	2	1	9	3	3	1	11	0	5	19	1	0

## CHART B

Counselor Background

Counselor	Highest Degree Earned	Years of Experience	Recovering Alcoholic	No. <u>Ss</u> Counseled
A	Ph.D. (cand.)	6	No	10
B	M.S.W. (cand.)	8	Yes	5
C	B.A.	5	No	10
D	Ph.D. (studies)	2	No	3
E	M.A. (studies)	7	Yes	7
F	A.A.	5	No	2
G	M.S.W. (studies)	2	No	3

Instruments

The instruments used in the study are: Clinical Analysis Questionnaire; Jellineck Chart; Presence of Paradoxical Patterns of Response Scale; Facilitative Scale; Type of Response Scale; Problem Expression Scale; and Follow-up Sobriety.

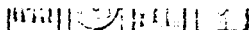
The Clinical Analysis Questionnaire was administered to the clients at the initial counseling session. The CAQ was used for the purpose of identifying and thus controlling for individual differences. The results displayed deviations from the norm. The profile showed clients to be emotionally less stable, with undisciplined self-conflict, and anxious. The pathological sub-scale indicated deviations regarding: hypochondriasis, suicidal disgust, depression, high guilt and resentment, high paranoia, high schizophrenia, suffering from insistent, repe-

titive ideas and compulsive habits and possessing feelings of inferiority and unworthiness. The profile is on page 68.

The Clinical Analysis Questionnaire is designed with scales for sixteen normal personality factors, plus scales and items for twelve further factors that lie in the pathological domain. The sixteen source traits in the 16 PF, as indicated above, constitute Part I of the test and belong to the domain of general personality theory. Part II of the test consists of twelve pathological dimensions. They take their meaning, in the case of five of the most important of them, from analysis of the domain of the MMPI (by items, not simply by scales) and several other sources of pathological behavior taxonomies. The descriptive titles for the list of factors are as given in Appendix B (page 129). This list includes both the twenty-eight first-order primary factors and the nine principal second orders or secondaries that are derived from them.

The Jellineck Chart depicts four stages of alcoholic deterioration. These are 1) pre-alcoholic; 2) prodromal; 3) crucial; 4) chronic. This chart depicts various physiological, psychological, and social behaviors characteristic of alcoholics at various stages of deterioration. Both the CAQ and the Jellineck Chart are used to control for individual differences through identification of client characteristics.

The Presence of Paradoxical Pattern of Response Scale consists of fourteen items referring to varying aspects of unexpected, unique, paradoxical interventions of the counselor. The rating scale for the degree of presence or absence of paradoxical qualities in counselor responses ranges from one through five. One indicates zero percent pre-



# CAQ PROFILE

Name: \_\_\_\_\_ Group-Score: N=40; Out-patient Alcoholic Clients.

FACTOR	Raw Score			STEN	LOW SCORE DESCRIPTION	STANDARD TEN SCORE (STEN)										HIGH SCORE DESCRIPTION			
	Form A	Form B	TOTAL			Average													
						1	2	3	4	5	6	7	8	9	10				
						4.7 - 6.3													
A				5.43	Reserved, detached, critical, aloof, stiff (Sizothymia)														
B				5.2	Less intelligent, concrete-thinking (Lower scholastic mental capacity)														
C				3.967	Affected by feelings, emotionally less stable, easily upset (Lower ego strength)														
E				4.667	Humble, mild, accommodating, conforming (Submissiveness)														
F				5.333	Sober, prudent, taciturn, serious (Desurgency)														
G				4.933	Expedient, disregards rules, feels few obligations (Weaker superego strength)														
H				5.467	Shy, timid, threat-sensitive, restrained, diffident (Threctial)														
I				5.567	Tough-minded, self-reliant, realistic (Marria)														
L				5.853	Trusting, adaptable, free of jealousy, easy to get on with (Alaxia)														
M				5.7	Practical, "down-to-earth" concerns, regulated by external realities (Praxernia)														
N				6.167	Forthright, unpretentious, genuine but socially clumsy (Artlossness)														
O				6.32	Self-assured, placid, secure, complacent, serene (Untroubled adequacy)														
Q1				5.63	Conservative, respecting traditional ideas (Conservatism of temperament)														
Q2				5.6	Group-dependent, a "joiner" and sound follower (Group adherence)														
Q3				3.9	Undisciplined self-conflict, lax, follows own urges, careless of social rules (Low integration)														
Q4				6.5	Relaxed, tranquil, unfrustrated, composed (Low ergic tension)														
						PART II													
D1				6.8	Is nappy, mind works well, does not find ill health frightening (Low hypochondriasis)														
D2				6.5	Is contented about life and surroundings, has no death wishes (Zestfulness)														
D3				5.699	Avoids dangerous and adventurous undertakings, has little need for excitement (Low brooding discontent)														
D4				6.3	Is calm in emergency, confident about surroundings, poised (Low anxious depression)														
D5				6.467	Shows enthusiasm for work, is energetic, sleeps soundly (High energy euphoria)														
D6				7.167	Is not troubled by guilt feelings, can sleep no matter what is left undone (Low guilt and resentment)														
D7				6.367	Is relaxed, considerate, cheerful with people (Low bored withdrawal)														
Pa				7.00	Is trusting, not bothered by jealousy or envy (Low paranoia)														
Pp				5.133	Avoids engagement in illegal acts or breaking rules, sensitive (Low psychopathic deviation)														
Sc				6.767	Realistically appraises himself and others, shows absence of regressive behavior (Low schizophrenial)														
As				6.667	Is not bothered by unwelcome thoughts and ideas or compulsive habits (Low psychasthenia)														
Ps				6.933	Considers himself as good, dependable, and smart as most others (Low general psychosis)														

sence and five indicates one hundred percent presence of paradoxical qualities in counselor responses.

The Facilitative Scale depicts Carkhuff dimensions of reflection of feeling, confrontation, immediacy, self-disclosure, etcetera (page 125). One to five rating scales are used indicating whether the response adds or detracts to the client's expressions. In addition, this scale includes interaction variables of movement, rapport, and understanding. Also measure of communication ability occurred involving the measured characteristics of: sensitive, empathetic, nonpossessive, warmth, genuine, deals with feelings and does not impose values.

The Type of Response Scale rated the presence or absence of twelve counselor response types on a one to five scale. This scale utilized similar types of response as in the previous scale. One indicated zero percent present and five indicated one hundred percent present.

The Problem Expression Scale has seven stages and judges rate individual responses on this range with one being most rigid with no problem expression and seven being least rigid in problem expression. Said another way, seven means the individual talks about and implements on actual resolution of the problem situation in regard to changes in his feelings, experiences, or attitudes. The PES involves pre and post measures occurring at the first and last counseling session of the client.

A Follow-up Sobriety Form is also utilized. The instrument assesses performance in the areas of socialization behaviors (involving work, family, and friends), Alcoholics Anonymous attendance, and drinking life style (attitudes towards drinking and actual length of soberness). Sobriety on the follow-up instrument is a composite score averaging the

the clients' function in the three areas of socialization behaviors, Alcoholics Anonymous attendance, and length of soberness. The form uses a one to five rating scale, one indicating excels expectations and five showing no progress.

### Hypotheses

The hypotheses are as follows:

- I. There is no significant linear relationship between the presence of paradoxical patterns of response and positive progress in counseling sessions with alcoholics.
- II. There is no significant linear relationship between the presence of paradoxical patterns of response and types of counselor response in therapy with alcoholics.
- III. There is no significant linear relationship between the presence of paradoxical patterns of response and facilitative level of counselors responses in therapy with alcoholics.
- IV. There is no significant linear relationship between the presence of paradoxical patterns of response and length of positive follow-up regarding sobriety of alcoholics.

### Design

The study attempts to address itself to the above four hypotheses. The methodology employed two procedures. In the first, preliminary procedure, trained raters were used to evaluate audio recordings of counseling sessions between counselor and client subjects. In the main procedure, the counselors evaluated their clients on dimensions of length of soberness, life style changes, and participation in Alcoholics Anonymous.



### Preliminary Procedures

Initially, there were three potential raters in the training group. All were female, Ph.D. candidates in the counseling psychology department at the University of Illinois. Training involved six, two-hour sessions of didactic group discussion, role playing, and the reviewing of audio cassette presentations of paradoxical and client-centered counseling. The cassettes of paradoxical sessions involved provocative therapy conducted by Frank Farrelly. The cassette of client-centered sessions were conducted by Carl Rogers. Also, various articles and text references were available as reading materials for trainers to study between sessions.

The opportunity to interact within the group provided for an intense learning environment. The potential raters were trained in four areas of discrimination: paradoxical patterns of response, types of counselor responses, Problem Expression Scale, and facilitative levels of response.

Each rater was to draw from her own experience and terminology in developing a working knowledge and skill in the use of the various instruments. The raters were encouraged to discover their own style or way of grasping the phenomena to be measured. This freedom seemed to assist the raters in developing their own framework for grasping the complex set of variables without losing consistency and, in fact, assisted in arriving at mutually accepted common denominators for what essential elements were involved in each variable of interest. While relatively high levels of consistency were achieved (e.g.,  $r=.65$ ), one trainee was less consistent.

At the end of the training period, only two of the three trainees were sufficiently consistent to be used as the official raters in this study. With the use of only two raters, a very high level of reliability (e.g.,  $r=.80$ ), was reached.

#### Statistical Procedures for Reliability of Raters

The use of intraclass correlation was the statistic involved to establish interrater reliability. The formula to determine the reliability of the raters is as follows:

$$r_k = \frac{Kr_1}{1 + (K-1) r_1}$$

Use of the intraclass correlation has been suggested by Winer<sup>135</sup> and Tinsley and Weiss<sup>136</sup>. The derivation of the component terms to be used in the intraclass correlation with this type of study was indicated by Guilford<sup>137</sup>.

The statistical computations were completed by having each rater listen and rate five taped individual counseling sessions conducted by one of the out-patient counselors at the Council on Alcoholism. Each rater performed a complete set of ratings on the tapes utilizing four instruments: 1) Paradoxical Pattern of Response Scale; 2) Type of Response Scale;

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<sup>135</sup>Winer, B. J. Statistical Principals in Experimental Design. (McGraw-Hill, Inc.,; 1962), Chapter IV.

<sup>136</sup>Tinsley, H. and Weiss, D. "Interrater reliability and agreement of subjective judgments," Journal of Counseling Psychology. vol. 22; no. (4); 1975; pp. 358-76.

<sup>137</sup>Guilford, J. P. Fundamental Statistics in Psychology and Education. 4th ed., (New York; McGraw-Hill, Inc., 1965); Chapter 12.

3) Facilitative Level of Response Scale; and 4) Problem Expression Scale.

Four correlations were obtained. Numbers 1, 2, and 3 above were correlated with instruments on five tapes. Twelve tapes were used for the Problem Expression Scale to obtain the fourth correlation. The procedure then was to drop the extreme correlation measures (highest and lowest) and average the middle three for each instrument. The overall correlation for each instrument averaged over the three remaining tapes was 0.798 for paradoxical. It was slightly higher with the Facilitative Level of Response Scale,  $r=.083$ . The  $r$  for the Type of Response Scale was 0.82. In establishing reliability for the Problem Expression Scale, use of twelve pre and post set of ratings were performed on twelve sets of first and last individual counseling sessions. Difference scores were compared using the intraclass statistic with  $r=0.84$ .

Once the training and selection of the raters were completed, the following design was employed.

#### Main Procedures

Individual out-patient counseling sessions were audio-taped. The counselors involved implemented their own approaches. No deliberate manipulation of treatment approaches occurred. The intent was to record the on-going therapeutic approaches used in counseling alcoholics and sort out from there variables that are positively correlated with process and outcome.

The number of such sessions ranged from three to ten with an average of about four. Follow-up occurred when a sufficient number of clients had been out of treatment a minimum of six weeks. The period of follow-up emerged to be six to eleven weeks by the time the total number

of required Ss met the six week minimum criteria. The breakdown is as follows: 7 S's at six weeks, 18 S's at nine weeks, and 15 S's at eleven weeks.

The "length of treatment" variable; while not formally contained in any hypothesis, was controlled. This was achieved through the removal of any "top" limit in the number of counseling sessions clients will attend. Analysis of the effects of this variable occurred as an adjunct to the other variables being measured. The delineation of what number of sessions constitutes various stages or lengths of treatment was dependent on the distribution of the Ss after the sessions had been completed. This is a natural consequence that seems unavoidable. In reviewing the distribution of the frequency of various lengths in treatment, three stages emerge. One is at 3 sessions. Another is at 4-6 sessions. The third stage is at 10 sessions. The highest frequency is at three sessions. There was no maximum limit of sessions set as whenever the client terminates or the study ends will be considered the "~~maximum~~" limit.

Data was gathered regarding presence of paradoxical patterns of response, type of response, facilitative level of response, progress in counseling, and follow-up length of sobriety. Raters' evaluation of all the previously mentioned variables were completed listening to the audio-recorded counseling sessions. Follow-up evaluation was made by counselors on their own clients regarding sobriety measures after the minimum six week period had passed or when the study was terminated.

The two raters with the highest sets of interrater reliability of the four instruments (e.g., .798 or above) listened to 152 audio-taped sessions. Each taped session had three segments rated using four instru-

ments. Segments were selected from the beginning, middle, and ending parts of the session averaging seven minutes in length.

The rating scales involved in these evaluations were the presence of Paradoxical Pattern of Response Scale, Type of Response Scale, Facilitative Level of Response Scale, and the Problem Expression Scale. All of these scales, except the Problem Expression Scale, were used to rate all segments of all sessions for each client. The Problem Expression Scale was used for only the first and last session of each client. In this situation, a pre and post score was obtained allowing a difference measure to be made regarding the client's progress in counseling. All the other instruments were used continuously throughout all sessions. The total number of segments rated for each of the other instruments when combined from all clients was 456. Therefore, after raters were finished, the 456 scores for each instrument used as segment ratings from all client sessions were placed together. It needs to be noted that each of the 456 scores obtained for each segment reflects an average score of the ratings made with that instrument for that segment. The exception is the Problem Expression Scale where there were only 40 scores as this instrument was used in the first and last sessions. The 40 scores are difference scores for each of the 40 clients. Counselors participated by completing the follow-up form regarding length of sobriety for each of the clients. This produced 40 ratings of follow-up.

The data was organized in different ways to allow appropriate statistical analysis regarding each of the hypotheses. For Hypothesis I, which compared presence of paradoxical patterns of response with progress in counseling, ordering of the data occurred in the following way. Mea-

asures for positive progress were obtained through the use of a difference score. This resulted from subtracting the raters' score on the problem expression scale for the first session taped from that of the last session taped. Measures for presence of paradoxical patterns of response were obtained first by taking the ratings on 14 items of the scale, averaging them and obtaining a score for that taped segment. Each tape has three scored segments. Final measures were obtained by averaging the raters' scores on the paradox rating scale for all sessions on each client. Thus, 40 Ss mean 40 difference scores and 40 averaged paradox scores paired together for analysis.

For Hypothesis II, which compared presence of paradoxical patterns of response with type of response, ordering of the data occurred in the following way. The measures for both variables are based on the 456 scores obtained from the raters on all taped sessions. Each variable has its own rating scale. The Paradox Rating Scale scores obtained by averaging the ratings on its 14 items were used without averaging these scores further into a composite client score as was done in Hypothesis I. The type of response variable had its own scale of 12 items depicting a wide range of different counselor responses. See appendix (page 124). Measurement on this instrument occurred in the identical style as in the Paradox Scale using the one to five continuum.

As there were 12 different types of responses described on the scale regarding their presence or absence, each response type was correlated separately with the Paradox Scale scores. As a result, there were 12 sets of 456 pairs of scores for analysis.

For Hypothesis III, which compared presence of paradoxical patterns of response with facilitative level of response, ordering of the data occurred in the following manner. Measurements for the paradoxical variable were obtained in the same manner as in Hypothesis II. Measurements for facilitative level were obtained from average ratings on a 24 item rating scale completed by the raters for all segments of sessions. The resulting 456 pairs of scores were then analyzed.

For Hypothesis IV, which compared presence of paradoxical patterns of response with follow-up measures of sobriety, ordering of the data occurred in the following manner. Follow-up measures of sobriety were obtained from scores gathered from follow-up ratings given clients by their counselors. Counselors followed up their clients when treatment terminated via a rating form.

This rating form utilized goal attainment scales which rate clients on a 1 through 5 scale as to whether they have reached or even surpassed their expected level of performance of attainment of the goal in question. One form was completed for each of the 40 clients. Measures were obtained for composite sobriety as well as for its component parts of socialization behaviors (involving work, family, and friends), Alcoholics Anonymous attendance and participation, and drinking life style (attitudes towards drinking and actual length of soberness). Also, a separate measure for length of soberness was made.

Each of the 40 composite paradox scores were paired with each of the above mentioned follow-up dimensions. These sets of pairs were then statistically analyzed. All of the paired scores were analyzed with the statistical procedure described in the following section.

### Statistical Procedures of the Study

The Pearson coefficient of correlation was used for all hypotheses. The Pearson r facilitated a more concise measurement. The formula is as follows:

$$r = \frac{ne (xy) - ex \cdot ey}{[ne (x^2) - (ex)^2] [ne (y^2) - (ey)^2]}$$

This statistic is appropriate as it will give an indication of the degree to which variables under study are related. The measure of the strength of the relationship would seem appropriate with the use of rating scales. The Pearson r will indicate the positive, negative, or neutral relations among the studied variables.

Chapters IV and V deal respectively with the results and discussion of the statistics denoted in this chapter and the conclusions and recommendations of the findings.



## CHAPTER IV

### RESULTS

#### Introduction

This chapter presents the results of the study. Each hypothesis will be stated, followed by a presentation of results, tables, and relevant discussion. The length of treatment variable will be dealt with as a separate discussion section.

Hypothesis I: There is no significant relationship between the presence of paradoxical patterns of response and positive progress in counseling sessions with alcoholics.

Results: The calculated  $r$  for the relationship of these two variables was .331 with 38 degrees of freedom. This  $r$  is significant at the .05 level. Therefore, Hypothesis I can be rejected. Table I shows the  $r$  for this relationship as well as  $r$ 's under short and long-term treatment.

Discussion: The significance of the  $r$  suggests a positive relationship between presence of paradoxical patterns of response and positive progress in counseling for alcoholics. This seems to mean that when counselors are communicating in ways that are deemed paradoxical, alcoholic clients will be found to make progress in counseling. Therefore, it is assumed that they will become more open to growth, problem resolution and responsible functioning. As correlation measures can demonstrate strengths of relationships but not cause and effect, it must

TABLE I

Pearson r-values for Paradoxical Patterns of Response by Progress in Counseling

	r-values	df	sign level	value needed
Total Sessions	.331*	38	.05	.3124
Short Term	.219	27	.05	.3809
Long Term	.502	9	.05	.6020

\* $p < .05$

be emphasized that these results suggest a strong, positive relationship. It can not be stated from these results that when counselors communicate in styles that are paradoxical that this will cause the alcoholic client to be free, flexible, responsible, and closer to problem resolution. What is being suggested is that presence of paradoxical communications on the counselor's part is in some way related to the client's progressive movement through treatment. The nature of this relationship is not clear.

Concerning the correlation measure itself, there are certain statistical issues. First, the restricted range of presence of paradoxical patterns of response could contribute to some inflation of the  $r$ . The same factor of restricted range is also involved in the problem expression scale used to measure progress in counseling.

However, collapsing the actual number of paradox ratings into an average rating for each client involved losing a larger N. That is, the actual number of ratings for presence of paradoxical response patterns was 3 scores per tape with 152 tapes in all. This meant going from 456 actual scores to only 40 (e.g., one per S). This was the consequence of averaging so as to be able to correlate both variables. The point here is that with a drastically reduced N and the concomitant reduction in degrees of freedom these results are still statistically significant.

Hypothesis II: There is no significant linear relationship between the presence of paradoxical patterns of response and type of counselor response.

Results: The Pearson r's for Hypothesis II showed significance at the .01 level with all types of counselor response and at both lengths of treatment with the exception of three incidences. The first of these occurred in the category of long-term sessions (4 to 10) where significance occurred at the  $p < .05$  level for reflection of verbal content as related to presence of paradoxical patterns. The degrees of freedom are 454. The other two incidences regard the responses of silence and questioning/information: probing seeking where no significance was demonstrated in any case. All the r's for paradox related to type of response are in Table II. The null hypothesis can be rejected concerning the lack of relationship between type of response and presence of paradoxical patterns for most of the response types.

The correlations are highest among confrontation and interpretation. The r's for these two are .56 and .54 respectively. The next

group of fairly high r's consists of summarization: content; self-disclosure; clarification and advising-directing. These respective r's are: .41; .40; .39; and .43. The rest of the response types are lower though significant except where indicated. Table II shows the r's for all twelve types for long and short-term treatment conditions.

Discussion: These results suggest that paradoxical patterns of response are significantly related to a wide range of treatment responses. This may be seen as suggesting that paradoxical patterns can be expressed in a wide range of counselor response types. There is thus little limitation in the modes of expression for paradoxical themes and patterns of communication. The results also suggest that paradoxical patterns of communication are more closely related to some types of response than to others.

Graph B depicts three profiles of the 12 r's for total sessions, long-term sessions, and short-term sessions. It can be seen that as the number of sessions increase so the r's increase. The exceptions are silences and questioning which seem to have an inverse relation to increase in sessions. Also, the pattern of all three profiles in terms of relative high and low r's is extremely similar in all three conditions. That is, confrontation and interpretation have the highest r's. Silences and questioning have the lowest r's. Clarification, advising-directing, and reflection-feeling all seem to be stable and in the middle areas.

Changes in positions of relative order to one another occurs for summarization: content, summarization; feeling, self-disclosure, and support. That is, as sessions increase the r's for these response

TABLE II

Pearson r-values for Paradoxical Patterns of Response by Counselor Type of Response

	Reflection: content	Reflection: feeling	Summarization: content	Summarization: feeling	Silences	Questioning/ info-seeking	Self- disclosure	Clarification	Interpretation high	Advising, directing, suggesting	Supportive	Confrontation highest
	1	2	3	4	5	6	7	8	9	10	11	12
Total Sessions	.20**	.36**	.41**	.36**	-.02	-.02	.40**	.39**	.54**	.43**	.36**	.56**
Short Sessions	.28**	.34**	.33**	.28**	.08	.14	.25**	.32**	.50**	.40**	.28**	.51**
Long Sessions	.18*	.41**	.50**	.51**	.01	.04	.46**	.46**	.58**	.44**	.46**	.64**

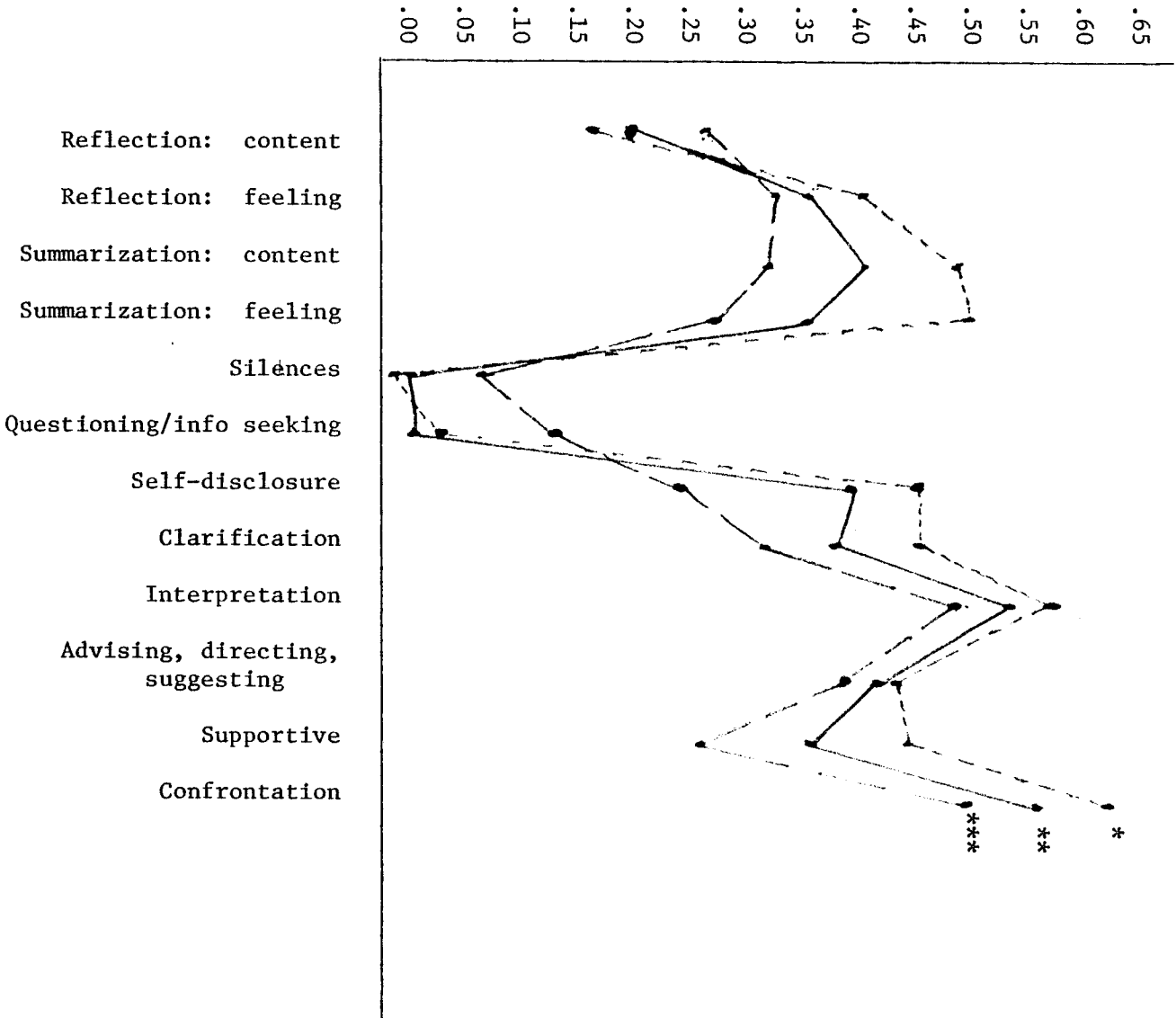
\*p &lt; .05

\*\*p &lt; .01

	N	df	.05	.01
Total Sessions	456	454	.098	.128
Short Sessions	261	259	.123	.168
Long Sessions	195	193	.138	.181

Table II A  
Degrees of Freedom and Levels of Significance

GRAPH B  
Three Profiles



\* Total sessions = straight line  
 \*\* Long-term sessions = dotted line  
 \*\*\* Short-term sessions = dashed line

types appear to increase to a greater extent than other responses with small increases. It may be that these responses are more influenced by length of sessions. Indeed, summarization responses would appear to logically occur after sessions had been in progress so that there would be material to summarize. Also, it may take time for paradoxical responses to be seen as supportive and appropriately integrated with self-disclosure.

The issues of limited range in the scales (1 through 5) and small degrees of presence of paradoxical patterns and types of response could inflate r's. While these are possibilities, anticipation of these occurrences is likely given the limited conditions of rating times and number of session involved.

Hypothesis III: There is no significant linear relationship between the presence of paradoxical patterns of response and facilitative level of counselors' responses in therapy with alcoholics.

Results: The r's for the relationship of paradoxical patterns of response with facilitative level are significant at  $p < .01$  level in all three cases: 1) overall sessions; 2) short-term (1-3) sessions; 3) long-term (4-10) sessions. The null hypothesis can be rejected on the basis of the obtained values. The data is shown in Table III. Table III depicts the r's for this relationship overall Ss and for short and long term treatment.

Discussion: The results suggest a significant positive relationship between the presence of paradoxical patterns of response and the facilitativeness of counselor responses. This relationship indicated that when there is presence of paradoxical themes and patterns there ap-

TABLE III

Pearson r-values for Paradoxical Patterns of Response by Facilitativeness of Response.

	r's	dfr	sign level	value needed
Total Sessions	.48**	454	.01	.128
Short Term	.44**	259	.01	.168
Long Term	.52**	193	.01	.181

\*\*p<.01

pears to be present a facilitative effect upon the alcoholic client. That is, the impact upon the client of paradoxical patterns is positively related to the movement of the client therapeutically in treatment. Whether at long or short term sessions, this relationship of the paradox's impact on the client with therapeutic movement is still maintained. The same statistical issues delineated previously can be ascribed to these results and dealt with in a similar fashion.

Hypothesis IV: There is no significant linear relationship between presence of paradoxical patterns of response and positive follow-up regarding sobriety.

Results: The Pearson r for sobriety related to presence of paradoxical patterns was .408 with 38 degrees of freedom. This is significant at the .01 level. The null hypothesis of no relationship between presence of paradoxical patterns of response and sobriety can be



rejected. The  $r$  for positive functioning in socialization behaviors (involving work, family, and friends) was .558. This was significant at the .01 level of probability. The  $r$ 's for Alcoholics Anonymous attendance and participation and for drinking lifestyle were not significant. Table IV represents the correlation matrix for paradoxical patterns of response and the follow-up measures. Regarding the presence of paradox variable, the mean was derived by averaging the ratings for all segments of all sessions. The average for 40 Ss was 1.634. This is given in Table IV A. This indicates that about 15 % of the counseling segments rated had paradoxical patterns of response. Also, the standard deviation was only .449. This was the smallest SD of all the variables.

Discussion: The results indicate that presence of paradoxical patterns of response is positively correlated with the composite measure of sobriety. While presence of paradox is related to composite sobriety, it is significantly related to only one of its component parts (e.g., socialization behaviors). Follow-up measures sought to distinguish between soberness (dryness or non-drinking) and sobriety (non-drinking) with a significant change in the alcoholics relating to self and to others in a constructive style of life. From the results, it appears that paradoxical responses are related more to life style changes rather than abstinence or attitudes related to this activity. This latter variable showed only a very slight relationship. The focus of the relationship of paradoxical responses to recovery is upon perspectives and themes in the alcoholic's way of living not directly upon his/her actual behavior of abstaining from alcohol itself.

Correlation Matrix for Paradoxical Patterns of Response by Follow-up Measures and Progress in Counseling. These r-values are for total Ss.

	Paradox	Progress in counseling	A.A.	Soc. Beh.	Drinking Lifestyle	Sober	Sobriety	Length of Treatment
	1	2	3	4	5	6	7	8
1	1.000	.331*	.161	.558**	.178	.284	.408**	.293
2	.331	1.000	.109	.047	.183	.201	.160	.154
3	.161	.109	1.000	.203	.517**	.418**	.674**	.266
4	.558	.047	.203	1.000	.436**	.546**	.713**	.198
5	.070	.157	.513	.427	.622**	.539**	.675**	.089
6	.178	.183	.517	.436	1.000	.787**	.846**	.466**
7	.284	.201	.418	.564	.787	1.000	.791**	.506**
8	.408	.160	.674	.713	.845	.791	1.000	.432**
9	.293	.154	.266	.198	.466	.506	.432	1.000

\*p < .05

\*\*p < .01

Reference Values for Table IV

df = 38

significance level	.05	.01
values needed	.3124	.403

TABLE IV A

Means and Standard Deviations for ALL Variables in Table IV

Variable	Mean	SD
1 Average paradox @ <u>s</u>	1.634	0.449
2 Pre-post difference score	0.786	1.171
3 A.A. participation and attendance	3.610	1.046
4 Socialization behaviors	3.120	0.693
5 Drinking life style	2.860	1.066
6 Length of being sober	3.150	1.528
7 Composite sobriety score	3.118	0.709
8 Length of treatment	1.275	0.452

Regarding the statistical issues of this relationship, the range of the paradox ratings was restrictive (as they were mostly one's and two's). This accounted for both the low mean of overall paradox rating and the small SD. This latter occurrence could be a contributing factor towards possibly inflating the correlation measures. However, the skewness of the ratings which were extremely low could be a negatively contributing factor in that the slight presence of paradoxical patterns of responses could tend to decrease  $r$ 's. The scarceness of the response could prevent extreme positive correlations even when such correlations do exist but are not able to be reflected by virtue of the response not largely present for the correlation to occur. It would appear there-

fore that the correlations are valid representations of the relationship between these variables. The mean and SD indicate that paradoxical patterns of response constitute a small percentage of the alcoholism counselor's set of response types. However, this kind of mean and SD might be expected with the small N of 40. Table IV A gives the means and SD for paradox and follow-up variables.

One particular variable appeared to have a mixed effect on the other factors. This was length of treatment. As length of treatment increased with more counseling sessions per client, the r's became greater. For example, with facilitativeness and paradox, the r went from .48 for short-term (3) sessions to .52 for long-term (4-10) sessions. A similar effect can be noted in correlations of presence of paradox and response types. In all but three response types (reflection of content, silence and questioning), the r's were higher and significant at .01 levels even though the N decreased when long-term sessions were analyzed. Length of treatment appears to have a positive increasing effect on the relationship of paradox to those variables mentioned.

When length of treatment was considered in progress in counseling and follow-up measures however, the effect was mixed. That is, significant relationships of presence of paradoxical patterns occurred for progress in counseling (.05), socialization behaviors (.01), and composite sobriety scores (.01). This significance did not remain when length of treatment was considered. In short-term treatment with an N of 29, the r for paradox as related to progress and length of sobriety was not significant. Table V shows r's under short-term treatment

TABLE V

Correlation Matrix for Paradox by Follow-up Variables and Progress in Counseling: Short-term.

	1	2	3	4	5	6	7
1	1.000	.219	.281	.469*	-.026	.027	.338
2	.219	1.000	.162	-.046	.122	.107	.102
3	.281	.162	1.000	.238	.460*	.324	.678**
4	.469	-.046	.238	1.000	.462*	.603**	.733**
5	.015	.196	.523	.423	.795**	.609**	.741**
6	-.026	.122	.460	.462	1.000	.718**	.821**
7	.027	.107	.324	.603	.718	1.000	.756**
8	.338	.102	.678	.733	.821	.756	1.000

\*p < .05

\*\*p < .01

Reference Values for Table V

df = 9

significance level

values needed

.05	.01
.3809	.4869

Means and Standard Deviations for ALL Variables in Table V.

Variables	Mean	SD
1 Avg. paradox	1.554	.359
2 Progress	.677	1.208
3 Alcoholics Anonymous	3.779	1.036
4 Socialization behavior	3.203	.725
5 Drinking lifestyle	3.162	.942
6 Sober	3.621	1.425
7 Composite sobriety	3.303	.678

conditions for progress and follow-up. The  $r$ 's for paradox as related to socialization behaviors and composite sobriety scores dropped to levels of .05 and .10, respectively. Both were significant at .01 level when all  $S_s$  were considered.

When long-term treatment was considered for its effect, there was only one significant correlation regarding paradox and that was with socialization behaviors at the .01 level. Table VI represents  $r$ 's under long-term treatment conditions for progress and follow-up. However, while it may appear that longer treatment has no relationship to positive follow-up or progress in counseling, it must be noted that with such a small  $N$  ( $df=7$ ), an extremely high  $r$  is needed to gain significance.

TABLE VI'

Correlation Matrix for Paradoxical Patterns of Response by Follow-up Variables and Progress in Counseling: Long-term.

	1	2	3	4	5	6	7
1	1.000	.502	-.237	.774**	.172	.520	.361
2	.502	1.000	-.232	.271	.144	.307	.120
3	.237	-.232	1.000	-.134	.462	.417	.522
4	.774	.271	-.134	1.000	.187	.285	.605*
5	.122	-.053	.555	.401	.229	.419	.571
6	.172	.144	.462	.187	1.000	.778**	.783**
7	.520	.307	.417	.285	.778	1.000	.645*
8	.361	.120	.522	.605	.783	.645	1.000

\*p < .05

\*\*p < .01

Reference Values for Table VI

df = 9

significance level

values needed

.05	.01
.602	.734

Means and Standard Deviations for all Variables in Table VI.

Variable	Mean	SD
1	1.845	.599
2	1.075	1.067
3	3.164	.180
4	2.900	.571
5	2.064	.992
6	1.909	1.044
7	2.627	.553

Thus, in this study longer treatment could have a positive effect but the small N prevented the relationships from showing. It is interesting that, even under these circumstances, there is a very strong relationship of paradox with socialization behaviors and at a higher significance level in long-term (.01) as opposed to short-term (.05) even when the N used was much smaller in long-term.

Reviewing the means and SD's for the variables in both short and long-term treatment, the long-term means are higher in the direction of positive presence than in short-term. Thus, the average of presence of



paradox, extent of positive progress, change in counseling, attendance in Alcoholics Anonymous, etcetera all were greater in the direction of being more present and functioning. It needs to be clarified that the paradox scale is based on a 1 through 5 rating continuum with 1 meaning zero percent presence of paradox while 5 meant 100% presence of paradox with long-term having a higher average than short-term. The progress measure was a difference score with the long-term session showing a greater difference score than short-term. The rest of the follow-up measures were based on a 5 through 1 rating continuum with the reverse values of those in paradox scale. That is, 5 meant no progress and 1 meant exceeds expectations as contracted for between counselor and client. In all six follow-up means, they were smaller in long-term treatment than in short-term treatment indicating that the smaller they get the more the contracted levels of expected performance in areas delineated were attained. Goal attainment scales were utilized for the follow-up measures modified for the individual clients involved. The soberness scales ranged from a 5 of drinking since leaving treatment; a 4 of drinking three weeks after leaving treatment; a 3 of drinking five weeks after leaving treatment; a 2 of drinking seven weeks afterwards; to a 1 of no drinking since leaving treatment. This latter rating measured a period of up to 2 3/4 months after leaving treatment and was limited to this time frame by the controls of the study. Thus, a mean of 1.909 for long-term treatment means that the eleven clients on the average engaged in drinking from a period ranging from seven to eleven weeks after treatment terminated. The mean for short-term was 3.621 which implies that the 29 Ss in this category engaged in drinking on the aver-

age of three to five weeks after treatment terminated. While the time frame allowed for follow-up was of a short-term basis, the implications for increasing periods of soberness and increasing length of treatment seems apparent. It is important to note that the small N involved could prevent the real significance of length of treatment from showing itself and its effect on the variables mentioned. The review of the means of the variables involved is only to be perceived as suggestions and possible implications of what the relationships may be with larger N's with which to work.

When paradox, progress, and all follow-up variables were correlated directly with length of treatment, there was significance at the .01 level for drinking lifestyle, soberness, and sobriety. There was significance at .10 level for presence of paradox and Alcoholics Anonymous participation as both related to the length of treatment. Progress, socialization behavior, and attendance in counseling showed no significance at any level.

An additional note regarding the follow-up measures themselves, they were all significantly interrelated to the composite sobriety score at the .01 level in short-term. In long-term, though the N was small, significance still appeared at some level for all follow-up measures with composite sobriety save Alcoholics Anonymous attendance.

In reviewing progress in counseling as measured in a pre/post change score, no significance occurred with this in presence of paradox or any of the follow-up measures when broken down into short and long-term treatment categories. It appears possible that in short-term not

enough sessions were available to allow large difference scores and in long-term the problem with the small N is again encountered.

## CHAPTER V

### SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

This study assesses the presence of paradoxical qualities in appropriate helping responses and examines their relationship to therapeutic outcome. However, no significant evidence of long lasting effect for sobriety has been demonstrated by any approach or approaches. While multi-therapeutic approaches are utilized in alcoholism rehabilitation programs (Forrest)<sup>138</sup>, the level of positive outcome in terms of avoidance of a relapse into drinking has been only 32% of those receiving treatment (Hore)<sup>139</sup>. Alcoholics Anonymous has been known to be the single most effective method, yet even here a great many alcoholics continue to relapse.

The major contributors to resistance to treatment and relapse are the alcoholic's sense of intrinsic worthlessness and helplessness (Jellineck<sup>140</sup>; McLelland et. al.<sup>141</sup>). Reviewing patterns of treatment

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<sup>138</sup>Forrest, G. G. The Diagnosis and Treatment of Alcoholism. (Springfield: Charles C. Thomas, 1975.); 96-130.

<sup>139</sup>Hore, B. Factors in alcohol relapse. British Journal of Addiction, 1971, 66, 89-96.

<sup>140</sup>Jellineck, E. M. Phases of alcohol addiction. Quarterly Journal of Studies on Alcohol, 1952, 13, 673-684.

<sup>141</sup>McLelland, D. C.; Davis, W. N.; Kalin, R.; Wanner, E. The Drinking Man. (New York: Free Press), 1972, pp. 240-288.

in Alcoholics Anonymous indicates that many consist of paradoxical processes, situations, and procedures. Indeed, it appears that interventions which are growthful for alcoholics in treatment often utilize themes and behaviors that appear paradoxical--atypical. This study specifically examines such patterns of counselor response.

The setting for the study was the Champaign County Council on Alcoholism, a community based center. The council is a non-profit, locally and state funded agency.

The subjects consisted of two groups: counselors and clients. Clients were 40 alcoholics. They represented various stages of disease progression. They were all out-patients of the council's treatment program. There were 25 male and 15 female clients all white, averaging 37 years in age. They were predominantly lower-middle class and had mostly urban backgrounds. They were diagnosed as largely crucial or chronic alcoholics using Jellineck's chart for progressive deterioration. All clients were given the Clinical Analysis Questionnaire to control for individual differences.

The counselors were seven staff members conducting the individual sessions. Five counselors are working on advanced degrees in psychology or a related field and have at least two years experience in the field of substance abuse. Two counselors have two or more years in college with five years experience in the field.

Two specific procedures were involved. Preliminary procedures involved training of two raters to establish interrater reliability and insure the validity of the judges' ratings. Training involved six, two-hour sessions of didactic group discussion, role playing, and the

reviewing of audio cassette presentations of paradoxical and client-centered counseling.

Once raters had been trained, then, in the main procedures, they were asked to evaluate 152 audio-taped individual counseling sessions with alcoholics. They rated three segments of each taped segment on four scales. They were: presence of paradoxical patterns of response, type of response, facilitative level of response, and problem expression scale.

All clients had been administered the Clinical Analysis Questionnaire and Jellineck Chart to control for individual differences. Counselors worked with clients from their own caseloads using their own individual approaches. No efforts to manipulate variables were made as the design was essentially a field study.

After clients had been in three or more sessions and terminated treatment, counselors were asked to complete follow-up measures of sobriety. Follow-up did not occur until the clients had been out of treatment a minimum of six weeks. The maximum length clients were out of treatment before follow-up was eleven weeks.

Evaluation of variables occurred by comparing presence of paradoxical patterns of response with the other variables involved. This evaluation utilized correlation measures to discern strength and direction of the relationships involved.

The hypotheses tested in this investigation were:

I. There is no significant linear relationship between the presence of paradoxical patterns of response and positive progress in counseling sessions with alcoholics.

II. There is no significant difference between the presence of paradoxical patterns of response and types of counselor response in therapy with alcoholics.

III. There is no significant linear relationship between the presence of paradoxical patterns of response and facilitative level of counselors' responses in therapy with alcoholics.

IV. There is no significant linear relationship between the presence of paradoxical patterns of response and length of positive follow-up regarding sobriety of alcoholics.

The statistical procedure employed in the study was the correlation measure Pearson  $r$ . This was an appropriate statistic as direction and strength of relationships was the concern regarding presence of paradox and the other four variables: 1) progress in counseling; 2) type of counselor response; 3) level of facilitativeness; 4) sobriety.

The results of data analysis suggests that presence of paradoxical patterns of response are positively and significantly correlated with all four variables previously noted. Therefore, as paradoxical patterns increase in counselor responses there may also be an increase in therapeutic movement and progress in counseling. Also, when paradoxical patterns of response are more apparent, clients may be better able to maintain sobriety as defined in this study. Further, the data indicated that presence of paradoxical patterns of response is related to a wide range of types of response. The effects of length of treatment on these relationships was mixed.

### Conclusions

The data suggests that paradoxical patterns of response play an important role in process and out-come variables. Progress in counseling involves assisting the client in identifying, understanding, and resolving conflicts and problems. It appears that paradoxical patterns of response do assist the client in dealing constructively with problem resolution. It appears that the client is unexpectedly encouraged to focus his attention on his style of behavior, evoking new persepctives and problem resolution.

The impact of paradoxical responses destabilizes the client in that they intensify and confirm the client's most avoided but (hidden) most believed negative experience of himself. This intensification of experience occurs in a context that is supportive and permissive. It implies that it is okay to be unique and different. The shifting of the client's attention towards accepting a dreaded conclusion about himself in a way that appears exaggerated, unexpected and even humorously absurd is the process of paradoxical acceptance. This is a form of advanced empathy and creates a new context or perspective in which to view the meaning of failure, worthlessness, etcetera. From this, new dimensions of one's self and others are possible.

In studying the relationship of paradoxical responses to successful treatment and recovery from alcoholism, this study differentiated between soberness and sobriety. The former referred to simply length of period not drinking and the latter alluding to attitudinal life style changes in the recovering alcoholic. The results indicate that paradoxical counselor responses are related to issues of sobriety (life



style issues) rather than soberness (actual length of sobriety). This is not surprising since paradoxical interventions are designed to have their impact on the rules and meaning of interpersonal relating rather than direct focus of the drinking behavior itself.

The cessation of alcoholic drinking is a purpose of treatment. However, interventions dealing with the contextual life style aspects of interpersonal relating are effective in providing meaningful alternatives to alcoholic drinking. Indeed, the effectiveness of Alcoholics Anonymous is not simply whether a person has had a drink but whether they can learn to be honest and open with themselves, sharing responsibility with others in the group. The assumption is that developing the capacity for meaningful relationships with others obviates the need for aggressive, punitive self-destructive drinking. While drinking may still occur in many cases, the recovering alcoholic as experienced a re-modeling in his self-perception. He no longer will view himself as opposing others to the point of his or their destruction. The alcoholic, having accepted himself as valid in his own being can now be open, imperfect, share with others, and operate from his own set of values. His concern for approval and acceptance from others may be transformed to sensitivity and care when the center of his decision making and values come from within himself not from significant others.

Paradoxical interventions serve to facilitate the alcoholic in accepting himself, his alcoholism and his responsible relationships with others. The significant correlation of paradoxical patterns with socialization behaviors supports the contention that these patterns of response effect more the life style aspects that affect alcoholic

drinking than the drinking behavior itself. It may be contended further that interventions that seek to change the actual drinking pattern itself without dealing with life style issues could be less effective and even perpetuate the drinking. The experience of many significant others in trying to get their alcoholic spouse to stop drinking attests to this occurrence.

Focusing upon the counselor utilizing paradoxical interventions, the significant  $r$ 's indicate that a wide variety of response types can be construed to be paradoxical in effect on the client. Counselors responding with reflection of content and feeling, summarization, self-disclosure, clarification, interpretation, advising, supportiveness, and confrontation are all ways that paradoxical patterns may occur. Only two types of responses showed no significant relationship to paradoxical patterns: silences and questioning/information seeking. This is not surprising in that paradoxical interventions involve some commentary and activity on the counselor's part. Obviously when counselors are eliciting information or being quiet such operations are not overtly present. It would appear, however, that even these two could imply a comment on the client's behavior if defined as a covert comment. The raters had only a short time to rate sections of each tape (7-10 minutes). This period of available time would prevent the raters from perceiving the more subtle effects of these two responses. The way it was designed responses of a more active and direct nature would be more readily perceived as having paradoxical impacts on clients.

Reviewing the relative strengths of the  $r$ 's confirms this perception of paradoxical interventions. The  $r$ 's are lowest (though

significant) for reflection of content ( $r=20$ ). The  $r$ 's tend to increase as the response types become more active and experiential (e.g., self-disclosure,  $r=0.40$ ; interpretation,  $r=0.54$ ; confrontation,  $r=0.56$ ). From this set of data, it appears as if counselors with styles utilizing more active and experiential types of responses will tend to be perceived as more paradoxical in style of impact. Rossi and Filstead<sup>142</sup> have found a similar counselor style (e.g.: active, experimental, risk-taking, and open to complex experiences) to be effective in motivating alcoholics into treatment.

Regarding the statistical issues of the study, it is important to note that the use of correlation measures indicates the direction and strength of a relationship. While many inductive statements could be made regarding these relationships, cause and effect can not be established. Also, with the use of raters and scales, subjectivity and range restrictions are involved. These issues plus the relatively small  $N$  of 40 make it difficult to view the study as hard and fast proof of how paradoxical patterns are involved in treatment of alcoholics. Indeed, as this was a field study with no variable manipulation, the significant  $r$ 's and their implications must be viewed only as suggestive.

In reviewing length of treatment as an adjunct variable affecting correlations, increase in the number of sessions appears to increase the  $r$ 's for type of response. In practically every case, the  $r$ 's are

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<sup>142</sup>Rossi, J.; and Filstead, W. "Motivational issues in capturing alcoholism patients into a treatment program." In Perspectives on the Treatment of Alcoholism, ed. by Goby, M. and Keller, J. (Park Ridge, Illinois, Lutheran General Hospital, 1978): 66-77.

stronger for paradoxical patterns and types of response. They are especially stronger for interpretation and confrontation. This gives additional support for active and experiential counselor types being related to paradoxical impacts on clients. This effect of length of treatment on increasing  $r$ 's as number of sessions increased also occurred in other relationships. For example, in considering paradoxical interventions and facilitation an increase occurred. Increases were also seen in the relationship of socialization behaviors to paradoxical interventions. Increase in length of treatment negatively affected  $r$ 's for progress in counseling and composite sobriety. Since the  $N$  was very small where long term treatment is concerned, it is not clear whether the small number was the contributing factor to this negative affect or whether a curvilinear relationship exists. Further research will have to clarify this relationship.

In this study most of the clients had only three sessions. Only nine clients had 4 or more. It may therefore be suggested that most of the transactions rated were those occurring in the relatively early stages of treatment. It would appear that paradoxical interventions, which the results show are most highly correlated with confrontation and interpretation, could therapeutically work only after a relationship is established. In their appropriate time frame, they usually function to induce alternative perspectives. Thus, as most of the transactions are of an early phase in treatment where relationship building is a major focus, it would follow that there would not be a great deal of paradoxical interventions present.

Indeed this is the case where the average overall presence of paradoxical patterns occurred in only 15% of the transactions reviewed. As the number of sessions increased, the average overall percentage did increase to about 20%. An additional issue that could affect the degree to which counselors utilize these patterns of response is their knowledge and skill of paradoxical patterns of response themselves. This was a field study such that no deliberate effort to encourage counselors to use these responses occurred. Thus, the extent to which they were present may well reflect the low level of which counselors are aware and skilled in the use of these patterns of response.

This study suggests that paradoxical patterns of response may well play a role in treatment. It is not to be implied that use of these patterns are a total approach in themselves. Paradoxical patterns of response certainly seem to permeate a wide range of the counselor's repertoire. Yet, this indicates that treatment of alcoholism involves a wide range of approaches of which paradoxical patterns may be only a part, albeit an important one.

#### Recommendations

In light of the above conclusions of this study, a number of recommendations are warranted. The following recommendations will be divided into three general categories. The first applies to the field of alcoholism counseling, the second applies to counselor education, and the third applies to further research.

#### Alcoholism Counselors

The data and conclusions of this study suggest that paradoxical patterns of therapist-client communication play an integral role in

treating alcoholism. As a consequence, counselors working with alcoholics need to develop their capacity for utilizing paradoxical interventions. This can occur through increasing their knowledge and skills of these interventions. Accordingly, counselors need to develop awareness and perspective on when and how to use these intervention patterns appropriately. They are powerful and if not handled professionally, can be quite destructive. Finally, those working in the alcoholism field need to develop appreciation and awareness for the paradoxical nature of alcoholism and how paradoxical patterns of response are an effective response. Understanding the paradoxical nature of the alcoholic's communication is critical for effective responding on the counselor's part.

#### Counselor Educators

In order to meet these training needs of counselors, appropriate educational and training resources are required. These resources include the development and offering of courses that incorporate training for potential counselors in the knowledge and utilization of paradoxical patterns of response.

Experiential field work is an important training resource. Therefore, practicum experiences need to include supervision that augments and elucidates how counselors could best use paradoxical interventions in their counseling sessions. Such supervision would include issues of timing, appropriateness, and the individual style of the counselor.

The development of educational and training resources by counselor educators requires that they themselves possess the knowledge and understanding of these interventions. Thus, training of trainers ef-

forts need to be made.

### Research

The study demonstrates the need for further research. Such research might involve studies with larger number of sessions (e.g., 10-30), taped and evaluated. This would be helpful in discerning the process stages of occurrence and appropriateness in utilizing paradoxical responses. Larger N size could additionally be used. This would serve two purposes. It may provide a basis to generalize effects of paradoxical interventions on the treatment process. Also, it might allow break downs into sub-categories of male-female, age, stage of alcoholism, etcetera to identify type of clients most appropriate for paradoxical interventions. The inclusion of psychological tests designed to discern effects on personality regarding these interventions would add clarity to how clients may be affected. Experimental studies need to be conducted which provide more specific analysis of carefully controlled variables. Items such as counselor competencies, client support systems, and other client characteristics need to be subjected to more sophisticated statistical analyses.

Measures to gain data of the effectiveness of paradoxical interventions relative to long lasting periods of sobriety would also give clarity to the impact of these interventions in treatment.

It would be most important to investigate the actual training of counselors in paradoxical responses. This can add clarity to the assistance in this clarification process would be to compare paradoxical interventions with other techniques (e.g., systematic desensitization, reality-oriented responses, and client-centered responses). Use of

control groups and statistics capable of discerning significant differences between groups could be used. Studies in various treatment settings would also be valuable.

The field of alcoholism is limited in studies focusing on conceptual development and treatment intervention. Filstead and Rossi<sup>143</sup> suggest a critical attitude be assumed in studying the conceptualization of alcohol problems. They also apply this attitude to the study of treatment methods and interventions. It is recommended that future research focus on reconceptualization of basic concepts and assumptions of alcoholism. This will involve a re-examination of definitions, clarification of the role of alcoholism and viewing alcohol as but one of the many options open to an individual seeking to determine what leads to its preferential selection.

Research also needs to focus upon treatment interventions. This requires development of the ideologies of treatment, efficient utilization of existing knowledge permitting a wider range of treatment alternatives and developing experimental intervention programs with diverse groups of helpers in the field. In addition, what forms of intervention, for what purposes, with what benefit for whom at what expense are all areas for research and evaluation.

It is hoped that the interested reader will discern additional research areas. It is further anticipated that future research efforts will examine many of these relevant issues.

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<sup>143</sup>Filstead, W. and Rossi, J. "Some suggested priorities in the alcohol-problems field," In Perspectives on the Treatment of Alcoholism, ed. Goby, M. and Keller, J. (Park Ridge, Illinois; Lutheran General Hospital, 1978): 148-152.



## BIBLIOGRAPHY

- Alcoholics Anonymous, Alcoholics Anonymous. (New York; Works Publishing, 1939); pp. 13.
- Adler, A. The Individual Psychology of Alfred Adler. Edited by H. L. and R. R. Ansbacher. (New York: Basic Books; 1956); pp. 385-394.
- Adler, A. Superiority and Social Interest. Ed. by H. L. and R. R. Ansbacher, (Evanston, Illinois: Northwestern University Press; 1964); pp. 117-126.
- Ansbacher, H. L. and Ansbacher, R. R. The Individual Psychology of Alfred Adler. (New York: Harper and Row Torch Books, 1956); pp. 156-83.
- Beier, E. G. The Silent Language of Psychotherapy. Chicago: Aldine, 1966; Chapter I.
- Bandler, R. and Grinder, J. The Structure of Magic I. (Palo Alto, CA, Science and Behavior Books), 1974; Chapters 1-3.
- Bandura, A.; Ross, D.; and Ross, S. "A Comparative Test of the Stauts, Envy, Social Power, and Secondary Reinforcement Theories of Identificatory Learning," Journal of Abnormal Psychology, 67 (1976), pp. 527-534.
- Bateson, G. Steps to an Ecology of Mind. (New York: Ballantine Books, 1972), pp. 279-283.
- Berger, M. and Rosenbaum, M. "Notes on Help-Rejecting Complainers." International Journal of Group Psychotherapy, 1967-77, pp. 357-370.
- Bergin, A. E. and Garfield, S. L. (Eds.). Handbook of Psychotherapy and Behavior Change: An Empirical Analysis. New York: Wiley, 1971.
- Berne, E. Games People Play. (New York: Grove Press, 1969); pp. 35-67.
- Berne, E. What Do You Say After You Say Hello? (New York: Grove Press, 1972); pp. 186-88.
- Blum, E. Psychoanalytic views of alcoholism; a review. Quarterly Journal of Studies on Alcohol. vol. 27; 1966; pp. 259-299.
- Brody, S. "Syndrome of the Treatment-Rejecting Patient." Psychoanalytic Review, 1964-51, pp. 75-84.

- Bruun, K.; Edwards, G.; Lumio, M.; Makela, K.; Pan, L.; Popham, R. E.; Room, R.; Schmidt, W.; Skog, O. J.; Sulkuney, P.; and Osterberg, E. "Alcohol Control Policies in Public Health Perspective." (Finish Foundation for Alcohol Studies, vol. 25); Helsinki: 1976.
- Cantor, F. M. "Alcoholism, tension-increase and existence," Psychotherapy: Theory, Research and Practice. vol. 7, No. (2), Summer, 1970; pp. 75-78.
- Cappell, H. "An evaluation of tension models of alcohol consumption." pp. 117-209, in: Gibbins, R.; Israel, Y; Kalant, J.; Popham, R.; Schmidt, W.; and Smart, R., eds. Research Advances in Drug and Alcohol Problems.
- Carkhuff, R. R. "Differential functioning of lay and professional helpers." Journal of Counseling Psychology, 1968, 15, pp. 117-126.
- Carkhuff, R. R. Helping and Human Relations, Vol. I: Selection and Training. (New York: Holt, Rinehart, and Winston, 1969); pp. 54-69.
- Carkhuff, R. R. and Berenson, B. G. Beyond Counseling and Therapy. (Holt, Rinehart, and Winston, 1967), pp. 35-78.
- Carkhuff, R. R. and Truax, C. B. "Lay Mental Health Counseling." Journal of Consulting Psychology, 1965, vol. 29, pp. 426-431.
- Cattell, R. B. and Bjerstedt, A. The structure of depression, by factoring Q-data, in relation to general personality source traits. Scandinavian Journal of Psychology, 1967, 8, 17-24.
- Cattell, R. B. and Bolton, L. S. What pathological dimensions lie beyond the normal dimensions of the 16 PF? A comparison of MMPI and 16 PF factor domains. Journal of Consulting and Clinical Psychology, 1969, 33, 18-29.
- Chapman, A. H. Put-Offs and Come-ons, 5th ed., (New York: Beckley Publishing Corp. 1972), Chapter 6.
- Conger, J. "Alcoholism: theory, problem, and challenge. II. "Reinforcement theory and the dynamics of alcoholism." Quarterly Journal of Studies on Alcohol. 1956, 17: 296-305.
- Crawford, R. "Treatment success in alcoholism," New Zealand Medical Journal. vol. 84 (569): August 11, 1976; pp. 92-96.
- Curran, J. A P-technique experiment to determine the nature of depression and anxiety states. In press, 1971.

- Delhees, K. H. and Cattell, R. B. Obtaining 16 PF Scores from the MMPI and MMPI scores from the 16 PF. Journal of Projective Techniques and Personality Assessment, 1970, 34, 251-255.
- Dunlap, K. Habits, Their Making and Unmaking, (New York: Liveright, 1962), pp. 66-73.
- Eddy, J. The Teacher and the Drug Scene. Bloomington, Ind.: Phi Delta Kappa Educational Foundation, 1972.
- Edwards, D.; Burchky, S.; Coben, P.; Finchman, S.; et. a. "Primary and secondary benefits from treatment for alcoholism." American Journal of Psychiatry. vol. 134; No. 6; June, 1977; pp. 682-83.
- Egan, G. The Skilled Helper: A Model for Systematic Helping and Interpersonal Relating. (Monterey, CA, Brooks/Cole Publishing Co., 1975); pp. 67-75.
- Ellis, A. Reason and Emotion in Psychotherapy, (New York, Lyle Stuart, 1962).
- Erickson, M. A. "Naturalistic Techniques of Hypnosis." American Journal of Clinical Hypnosis, 1958, pp. 13-18.
- Erickson, M. S. "Further Clinical Techniques of Hypnosis: Utilization Techniques." American Journal of Clinical Hypnosis, 1959--1, pp. 3-21.
- Farrelly, F. Provocative Therapy. 2nd ed. (Shields Publishing Co., Ind., San Francisco, Cal. 1975); Chapter I.
- Filstead, W. and Rossi, J. "Some suggested priorities in the alcohol-problems field." In Perspectives on the Treatment of Alcoholism, ed. Goby, M. and Keller, J. (Park Ridge, Ill.; Lutheran General Hospital, 1978): 148-152.
- Forrest, G. G. The Diagnosis and Treatment of Alcoholism. (Springfield: Charles C. Thomas, 1975).
- Frankl, V. "Paradoxical Intention: A Logotherapeutic Technique." American Journal of Psychotherapy, 1960--14, pp. 520-535.
- Freud, S. Civilization and Its Discontents, (Hogarth, London, 1930) pp. 15-33.
- Fuller, G. B. "Research in Alcoholism, with the 16 PF Test." Willmar State Hospital, Minnesota. IPAT Information Bulletin No. 12, 1966.
- Gendlin, E. T. "The experimental response," Use of Interpretation in Treatment. (Grune and Stratton, Inc., 1968); pp. 208-227.
- Gerz, H. O. "The Treatment of the Phobic and the Obsessive-Compulsive Patient Using Paradoxical Intention." Journal of Neuropsychiatry. 1962-3, 375-387.

- Getter, H. "Variables affecting the value of the reinforcement in verbal conditioning." (Doctoral dissertation, Ohio State University, 1962). Dissertational Abstracts, 1963, 23 no. 63-1280.
- Glasser, W. Reality Therapy: A New Approach to Psychiatry. (Harper & Row Pub., New York: 1965); pp. 5-41.
- Gody, M. J. and Rossi, J. J. "Perceived dimensions of Therapeutic relationships and recovery from alcoholism." Presented at the National Conference on Evaluation in Alcohol, Drug Abuse, and Mental Health Programs, Washington, D. C., 1974.
- Goldfried, M. R. "Systematic Desensitization as Training in Self-Control." Journal of Consulting and Clinical Psychology, 1971--37, pp. 228-234.
- Gore, P. M. and Rotter, J. B. "A personality correlate of social action." Journal of Personality, 1963, 31, 58-64.
- Gorski, T. "Treating the Alcoholic Patient: the physician and the alcoholism treatment center." (Alcoholism Treatment Center Ingalls Memorial Hospital, vol. 1) Harvey, Ill.: February, 1976.
- Greenberg, R. "Anti-Expectation Techniques in Psychotherapy: The Power of Negative Thinking Psychotherapy: Theory, Research, & Practice. vol. 10 (2) Summer, 1973.
- Greenwald, H. "Play Therapy for Children Over Twenty-One." Psychotherapy: Theory, Research, and Paractice, 1967--4 (1), 44-46.
- Guilford, J. P. Fundamental Statistics in Psychology and Education. 4th ed., (New York: McGraw-Hill, Inc., 1965); Chapter 12.
- Haley, J. "The art of psychoanalysis," ETC., vol. 15, 1958 pp. 190-200. Also, "Control in psychotherapy," in Progress in Psychotherapy (Grune and Stratton, New York, 1959).
- Haley, J. "Paradoxes in play, fantasy, and psychotherapy." Psychiatric Res. Rep., vol. 2; 1955; pp. 52-58.
- Haley, J. Strategies of Psychotherapy, 7th ed. (New York: Grune and Stratton; 1972); pp. 41-68.
- Haley, J. Uncommon Therapy: The Psychiatric Techniques of Milton Erickson, M.D., (New York: Norton and Co., Inc. 1973): Chapter I.
- Hayman, M. Alcoholism: Mechanism and Management. (Thomas Co., Springfield, 1966), Chapter IX.
- Holroyd, K. "Effects of social anxiety and social evaluation on beer consumption and social interaction." Journal of Studies on Alcohol, vol. 39, No. (5); 1978; pp. 737-743.

- Hore, B. "Factors in alcohol relapse." British Journal of Addiction, 1971, 66, 89-96.
- Jellineck, E. M. Disease Concept of Alcoholism. (New Haven, Conn.: Hillhouse Press, 1960); pp. 1-63.
- Jellineck, E. M. "Phases of alcohol addiction." Quarterly Journal of Studies on Alcohol, 1952, 13, 673-684.
- Jung, C. G. Modern Man in Search of a Soul, (Routledge, London, 1936) pp. 118-119.
- Jung, C. G. Psychology and Religion: West and East, Collected works, vol. 11, Bollingen Series 20, (Pantheon, New York, 1958) p. 339.
- Kora, T. "Morita therapy," International Journal of Psychiatry, vol. 1, 1965; pp. 611-31.
- Lang, A. R.; Groeckner, D. J.; Adesso, V. J.; and Marlott, C. A. "Effects of Alcohol on Aggression in Male Social Drinkers," Journal of Abnormal Psychology 84, 1975, pp. 508-518.
- Lorand, S. Tech. of Psychoanalytic Therapy. (Intimatin Univ. Press, New York, 1947).
- Malleson, N. "Panic and Phobia. A Possible Method of Treatment." Lancet, 1959--1, pp. 225-227.
- Marlatt, G. "Alcohol, stress and cognitive control." In Sarason, I. and Speilberger, C., eds. Stress and Anxiety, vol. 3. (New York: Hemisphere; 1976).
- McLelland, D. C.; Davis, W. N.; Kalin, R.; Wanner, E. The Drinking Man, (New York: Free Press, 1972) pp. 240-288.
- Melnick, R. R. "Counseling response as a function of method of problem presentation and type of response." Journal of Counseling Psychology. vol. 22, No. 2, 1975, pp. 108-112.
- Milan, J. The Emergent Comprehensive Concept of Alcoholism, 7th ed.; (Kirkland, Washington; ACA Press; 1974); pp. 44-50.
- Mosak, H. and Gushurst, R. "What patients say and what they mean," American Journal of Psycho Therapy. vol. 25, No. (3); July, 1971; pp. 428-436.
- Mulford, H. "Stages in the alcoholic process: towards a cumulative, non-sequential index," Journal of Studies on Alcohol. vol. 83; No. 3; March, 1977; pp. 563-83.

- National Institute of Alcohol Abuse and Alcoholism. "Can companies afford to help alcoholic employees?" Report on Alcoholism. vol. 34 (no. 2): pp. 26-34, 1976.
- O'Neill, P. "Alcohol Confrontation." Australian Journal of Alcoholism and Drug Dependence, Vol. 3, No. (2), p. 43-45, May 1976.
- Perls, F. S. Gestalt Therapy Verbatim. 7th ed., (California: Real People Press; 1971); pp. 1-76.
- Roffman, R. A. and Froland, C. "Drug and alcohol dependencies in prisons." Crime and Delinquency. vol. 22: pp. 359-366, 1976.
- Rogers, C. R. Client-Centered Therapy. (Boston: Houghton Mifflin, 1951); pp. 1-65.
- Rogers, C. R. "The necessary and sufficient conditions of therapeutic personality change." Journal of Consulting Psychology. 1970, 3, 6-16.
- Rossi, J.; and Filstead, W. "Motivational issues in capturing alcoholism patients into a treatment program." In Perspectives on the Treatment of Alcoholism, ed. by Goby, M. and Keller, J. (Park Ridge, Ill., Lutheran General Hospital, 1978): 66-77.
- Rotter, J. B.; Chance, J. E.; and Phares, E. J. Applications of a Social Learning Theory of Personality. (New York: Holt, Rinehart, and Winston, Inc., 1972); pp. 49-63.
- Sadava, S.; Thistle, R.; and Forsyth, R. "Stress, escapism and patterns of alcohol and drug use." Journal of Studies on Alcohol. vol. 39, No. (5); 1978, pp. 725-736.
- Sanford, N. Where Colleges Fail. (San Francisco: Jossey-Bass, 1967).
- Schmidt, W. and DeLint, J. "Causes of death of alcoholics." Quarterly Journal for the Study of Alcohol. vol. 33: pp. 171-185, 1972.
- Schmidt, W. and Popham, R. E. "Heavy alcohol consumption and physical health problems; a review of the epidemiological evidence." Drug and Alcohol Dependency. Lausanne 1: pp. 27-50, 1975.
- Shulman, B. and Mosak, H. "Various purposes of symptoms." Journal of Individual Psychology. vol. 23, May, 1967; pp. 79-87.
- Smith, C. "An atypical session: resistance and the negativistic patient." Psychotherapy: Theory, Research and Practice. vol. 8 no. (4), Winter, 1971; pp. 276-279.
- Steiner, C. M. Games Alcoholics Play, (New York: Grove Press, 1971); pp. 15-37.

- Stewart, D. A. "Empathy in the Group Therapy of Alcoholics." Quarterly Journal for the Studies on Alcohol, 15: pp. 74-110, 1954.
- Strauss, A. ed., The Social Psychology of George Herbert Mead. (Phoenix, Chicago: 1956); 37-62.
- Stumpful, P. C. and Levis, D. J. "Essentials of Implosive Therapy: A Learning-Theory Based on Psychodynamic Behavioral Therapy." Journal of Abnormal Psychology, 1967-72, pp. 496-503.
- Tart, C. T. Altered States of Consciousness: A Book of Readings. (New York: John Wiley & Sons, Inc., 1969); Section 5.
- Terris, M. "The epidemiologic revolution, national health insurance and the role of health departments." American Journal of Public Health vol. 66; pp. 1155-64; 1976.
- Thune, C. E. "Alcoholism and the archetypal past: a phenomenological perspective on alcoholics anonymous." Journal of Studies on Alcohol. vol. 38, No. (1), 1977; pp. 82-83.
- Tiebout, H. M. "The act of surrender in the therapeutic process," Quarterly Journal for the Studies of Alcohol, vol. 10, No. (1), 1949; pp. 1-15.
- Tiebout, H. M. "Ego factors in surrender," Quarterly Journal for the Studies on Alcohol. vol. 15, No. (4), 1954; pp. 610-21.
- Tiebout, H. M. "Intervention in psychotherapy," American Journal of Psychoanalysis, vol. 22, No. (1); 1976 pp. 1-6.
- Tiebout, H. M. "Surrender versus compliance in therapy, with special reference to alcoholism." Quarterly Journal for the Studies on Alcohol, 1953; pp. 1-6.
- Tinsley, H. and Weiss, D. "Interrater reliability and agreement of subjective judgments," Journal of Counseling Psychology. vol. 22; no. (4); 1975; pp. 358-76.
- Tomlinson, T. M. Three Approaches to the Study of Psychotherapy Process Outcome and Change. Unpublished doctoral dissertation, University of Wisconsin, 1962.
- Truax, C. B., and Carkhuff, R. R. Toward Effective Counseling and Psychotherapy and Behavior Change: An Empirical Analysis. New York: Wiley, 1971.
- Walker, A. M.; Rablen, R. A.; and Rogers, C. R. "Development of a Scale to Measure Process Changes in Psychotherapy." Journal of Clinical Psychology, 1960--16, 79-85.

- Ward, H. "The enteric-coated compliment," Psychotherapy: Theory, Research and Practice. vol. 8, no. (4), Winter, 1971; pp. 280-281.
- Watts, A. W. Psychotherapy East and West. 5th ed., (New York: Balantine, 1971) pp. 15-33.
- Watzlawick, P.; Weakland, J.; and Fisch, R. Change: Principles of Problem Formation and Problem Resolution. (New York: Norton 1974); pp. 31-39.
- Weckowicz, T. E.; Muir, W.; and Cropley, A. J. "A factor analysis of the Beck inventory of depression." Journal of Consulting Psychology, 1967, 31, 23-28.
- Weil, A. The Natural Mind. (Houghton-Mifflin, Boston, Mass., 1972); pp. 14-39.
- Whitaker, C. "Psychotherapy of the absurd: with a special emphasis on the psychotherapy of aggression." Family Process, vol. 14; no. 1; March, 1975; pp. 1-5.
- Wilson, W. "Sobriety: Conversion and Beyond," Maryland State Medical Journal. vol. 24, No. 4, April, 1977; pp. 85-91.
- Winer, B. J. Statistical Principals in Experimental Design. (McGraw-Hill, Inc.; 1962), Chapter IV.
- Wolpe, J. and Lazarus, A. Behavior Therapy Techniques. (New York: Pergamon Press, 1966); pp. 27-39.



APPENDIX A

RATING SCALES

## RATING FOR PARADOXICAL PATTERNS OF RESPONSES

The following is a list of various dimensions designed to be used for rating counselor responses. After listening to the taped sessions, please rate the sessions along the continuum of each dimension as you perceive the extent to which the presence or absence of paradoxical patterns to occur in the counselor's responses. A rating will occur after the end of each of the three, 5-10 minute segments occurring at the beginning, middle, and end of the hour session taped.

The scale to be used is defined by the following:

Level 5.0) Focus upon client's responses including thoughts, feelings, behavior, etc., such behavioral occurrence, seemingly disturbing and of concern to the client, are paradoxically encouraged in an atypical, unexpected unique way. This may involve a provocative challenge to the client "playing off" his expressed themes and ideations such that potentially negativistic self-statements are "confirmed" in a way challenging the client to affirm himself. This may involve ascribing qualities to client expressions that challenge the very meaning and set of assumptions upon which the client's framework is based. There is a change from meaningful to meaningless or absurdity and vice versa. Essentially paradoxical responses appear to encourage more of the same in ways that at first seem to be doing what one is already doing yet the original meaning has been altered drastically. There is redefinition occurring in this process for the client is actually encouraged to be more of where he is even though he claims he seeks to change it and be rid of it.

<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>
(0%)	(25%)	(50%)	(75%)	(100%)

<u>None</u>	<u>Somewhat</u>	<u>Moderate</u>	<u>Greatly</u>	<u>Completely</u>
present	present	present	present	present

PARADOXICAL PATTERNS  
IN COUNSELING

	<u>1</u> 0%	<u>2</u> (25%)	<u>3</u> (50%)	<u>4</u> (75%)	<u>5</u> (100%)
	<u>None</u> present	<u>Somewhat</u> present	<u>Moderate</u> present	<u>Greatly</u> present	<u>Completely</u> present
I. <u>Congruence</u> between client's behavior and his goal as recognized by co., (As focused upon in content; counselor suggesting that the client is <u>already doing</u> what he wants to do). Behavior of client <u>as the goal</u> itself is attained. (e.g. What at first appeared to be the means to client's goals, focused upon by counselor as the <u>goal itself</u> ).	( )	( )	( )	( )	( )
II. <u>Congruence</u> of behavior as a goal calling for <u>no change</u> of the type present. This occurring in the context of the client stating he is not satisfied with his own behavior but counselor unexpectedly suggesting that maybe he really is satisfied.	( )	( )	( )	( )	( )
III. Exaggerating the behavior itself implying in the process <u>no change</u> to occur leaving the conclusions up to the client as to whether this is a behavior he really enjoys continuing.	( )	( )	( )	( )	( )
IV. Need for the client to accept the consequences of his behavior as what <u>his</u> "reality" should be. (e.g. if client feels guilty then that's what should be).	( )	( )	( )	( )	( )
V. Calling for client to <u>re-define</u> "old" set of beliefs and values in more consistent and therefore workable manner, (e.g. control as directing feelings not just as inhibition of them).	( )	( )	( )	( )	( )
VI. Emphasis on person gaining self-esteem through <u>experiencing that whatever he does, still o.k.</u> (e.g. persons value is <u>intrinsic</u> . Irrational to connect the two aspects). Thus behavior can be viewed as acting person really feels good about self. Okayness already present. Act as to bring it to awareness.	( )	( )	( )	( )	( )
VII. Emphasis on issue that the only real problem client has is that he <u>thinks he has a problem</u> . (e.g. "problem defined as something wrong with him as a human being.	( )	( )	( )	( )	( )

	<u>1</u> 0%	<u>2</u> (25%)	<u>3</u> (50%)	<u>4</u> (75%)	<u>5</u> (100%)
	<u>None</u> present	<u>Somewhat</u> present	<u>Moderate</u> present	<u>Greatly</u> present	<u>Completely</u> present
VIII. Counselors response seemed <u>unexpected</u> and atypical. (From client's point of view.)	( )	( )	( )	( )	( )
IX. Counselor's response focused upon more than one meaning for the " <u>same</u> " experience simultaneously.	( )	( )	( )	( )	( )
X. Counselor's responses seemed to be giving the client what he wanted such that he <u>didn't "want"</u> it.	( )	( )	( )	( )	( )
XI. Counselor's response focused upon the behavior in a <u>same</u> but <u>different</u> way that lead the client to experience a message about himself. (e.g. it must be nice to feel as free as you do regarding your "commitments".)	( )	( )	( )	( )	( )
XII. Counselor's response did not correspond (was either an <u>under</u> or <u>over-reaction</u> ) to the client's expectation.	( )	( )	( )	( )	( )
XIII. Counselor's response seemed to keep the client somewhat " <u>off-balance</u> " in that the client had to <u>stop and think</u> of what was happening.	( )	( )	( )	( )	( )
XIV. Counselor's response seemed to be encouraging the client to " <u>let go</u> " of negative behaviors in that the response <u>unexpectedly change the meaning</u> of the behavior.	( )	( )	( )	( )	( )

PROBLEM EXPRESSION SCALEThe Problem Expression Scale (PES)

Numerical rating to be given by judge	Identifying characteristic of rated speech sample
Stage 1	The individual does not talk about problems, i.e., wrongs, difficulties, confusions, conflicts, complaint, and so on.
Stage 2	The individual talks about problems or problem situations but not about his direct involvement in a problem situation or event.
Stage 3	The individual talks about his direct involvement in a problem situation or event but not about his own reactions in or to the problem situation.
Stage 4	The individual talks about his own reactions in or to the problem situation but not about the contribution of his own reactions to the problem.
Stage 5	The individual talks about the contribution of his own reactions to the problem but not about his own understanding of his feelings, experiences, or attitudes.
Stage 6	The individual talks about his own understanding of his feelings, experiences, or attitudes but not about an actual resolution in terms of change in his feelings, experiences, or attitudes.
Stage 7	The individual talks about an actual resolution of the problem situation in terms of changes in his feelings, experiences or attitudes.

\*Note: Samples which show mostly a given stage, but some of the next higher stage, receive a rating of higher than the given stage.

RATING SCALE FOR COUNSELOR TYPE OF RESPONSE:PRESENCE OR ABSENCE

(1) Not at all; (2) Little; (3) Moderate; (4) Majority; (5) Completely Present

	(1)	(2)	(3)	(4)	(5)
1. Reflection of verbal content	( )	( )	( )	( )	( )
2. Reflection of feeling content	( )	( )	( )	( )	( )
3. Summarization of content	( )	( )	( )	( )	( )
4. Summarization of feeling	( )	( )	( )	( )	( )
5. Silences	( )	( )	( )	( )	( )
6. Questions/Information probing seeking	( )	( )	( )	( )	( )
7. Self-disclosure	( )	( )	( )	( )	( )
8. Clarification	( )	( )	( )	( )	( )
9. Interpretation	( )	( )	( )	( )	( )
10. Advising, directing, suggesting	( )	( )	( )	( )	( )
11. Supportive statements	( )	( )	( )	( )	( )
12. Confrontation	( )	( )	( )	( )	( )

RATING SCALE FOR COUNSELOR LEVEL OF FACILITATIVE RESPONSES

(1) Not helpful at all; (2) Somewhat helpful, but subtracting from the process; (3) Minimally helpful, not subtracting from the process; (4) Adds positively to the process; (5) Deeply helpful, adding significantly to the process.

I. Counselor Attempting Behavior:

	(1)	(2)	(3)	(4)	(5)
Pleasing Voice Quality	( )	( )	( )	( )	( )
Appropriate Voice Speed	( )	( )	( )	( )	( )

II. Type of Response: (The following rating use Carkhuff scales)

Reflection of verbal content	( )	( )	( )	( )	( )
Reflection of feeling content	( )	( )	( )	( )	( )
Summarization of content	( )	( )	( )	( )	( )
Summarization of feeling	( )	( )	( )	( )	( )
Silences	( )	( )	( )	( )	( )
Questioning/Information Probing-seeking	( )	( )	( )	( )	( )
Clarification	( )	( )	( )	( )	( )
Interpretation	( )	( )	( )	( )	( )
Advising, directing, suggesting	( )	( )	( )	( )	( )
Supportive Statements	( )	( )	( )	( )	( )
Confrontation	( )	( )	( )	( )	( )
Immediacy	( )	( )	( )	( )	( )
Concreteness	( )	( )	( )	( )	( )

(1) None; (2) Little; (3) Some; (4) Great deal; (5) Completely Present

III. Overall Communication Ability:

	(1)	(2)	(3)	(4)	(5)
Sensitive	( )	( )	( )	( )	( )
Empathetic	( )	( )	( )	( )	( )
Non possessive warmth	( )	( )	( )	( )	( )
Genuine	( )	( )	( )	( )	( )
Deals with feelings	( )	( )	( )	( )	( )
Does not impose values	( )	( )	( )	( )	( )

IV. Overall Interaction Effect:

Rapport established	( )	( )	( )	( )	( )
Understanding	( )	( )	( )	( )	( )
Movement	( )	( )	( )	( )	( )



SERVICE PLAN GUIDLINES  
AND  
FOLLOW-UP EVALUATIONS  
OF OUT-PATIENT AND AFTERCARE

All ratings occur in relation to the contracted base line. Where appropriate, please rate each question according to the following scale:

- (1) Excels expectations, (2) Above expectations, (3) Meets expectations,  
(4) Below expectations, (5) No progress

I. Involvement with A.A. - Therapy.

- 1) Number of meetings attended each week as contracted. \_\_\_\_\_
- 2) Participating in a self-disclosing manner at meetings. \_\_\_\_\_
- 3) Number of contacts with sponsor. \_\_\_\_\_
- 4) Maintains A.A. telephone numbers and address book. \_\_\_\_\_
- 5) Makes regular contact with close A.A. friends. \_\_\_\_\_

II. Socialization Behaviors.

Social involvements (non-alcoholic)

- 1) Number of friendships established with persons whose lives are not alcohol centered. \_\_\_\_\_
- 2) Number of contacts with supportive agencies other than A.A. or CCCA. \_\_\_\_\_

Maintaining or developing mutually satisfying and acceptable working relationships with:

A. Spouse \_\_\_\_\_ B. Family \_\_\_\_\_ C. Employer \_\_\_\_\_

III. DRINKING HABITS AND LIFE STYLE SINCE LEAVING THE PROGRAM

(check one only)

A. Drinking Pattern and Drug Use (Prescription and Non-Prescription)

- 1) No drinking or drug use since leaving the program. \_\_\_\_\_
- 2) No drinking or drug use in seven (7) weeks. \_\_\_\_\_

Drinking pattern and drug use continued.

- 3) No drinking or drug use in five (5) weeks. \_\_\_\_\_
- 4) No drinking or drug use in three (3) weeks. \_\_\_\_\_
- 5) Drinking and/or drug use since leaving the program. \_\_\_\_\_

B. Client's attitude that complete abstinence is essential for recovery.

- 1) Client feels he must avoid drinking completely to aid recovery. \_\_\_\_\_
- 2) Client feels he should avoid drinking though he has considered that he may be able to drink later. \_\_\_\_\_
- 3) Client feels that he can handle some drinking and still recover from alcoholism. \_\_\_\_\_
- 4) Client feels that he can handle resumption of most of his drinking without risk to recovery. \_\_\_\_\_
- 5) Client feels that he can completely resume drinking without any risk to his recovery. \_\_\_\_\_

C. Intends to control or change drinking habits by:

- 1) Modification of life style and value system to provide satisfaction in social, family and work environments without resorting to mood altering materials. \_\_\_\_\_
- 2) Involve himself in supportive activities, (e.g.; A.A., outpatient groups, church or social organizations), and attempt to stay interested in life. \_\_\_\_\_
- 3) Staying too involved in everything to drink. \_\_\_\_\_
- 4) Stay busy with my job, overtime and work around my home so there is no time to drink. \_\_\_\_\_
- 5) Not change any habits or patterns but keep from drinking by using "will power". \_\_\_\_\_

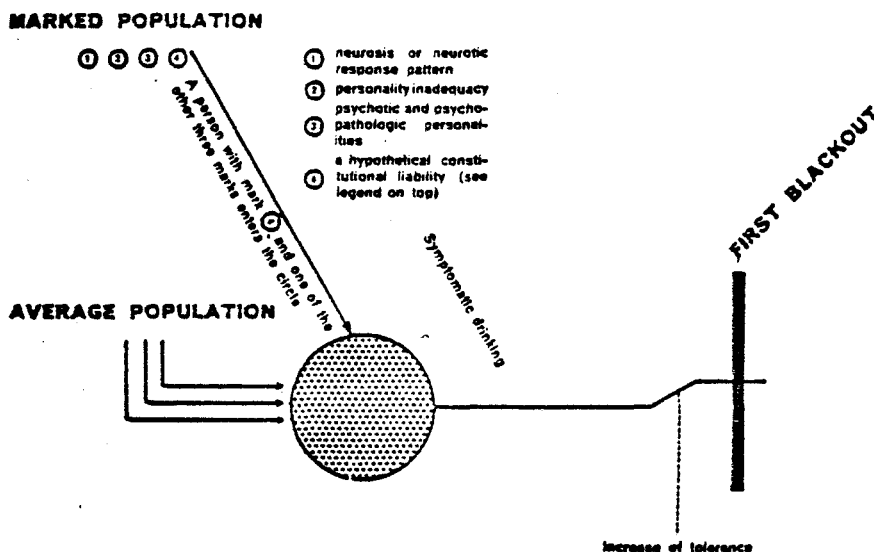
APPENDIX B

CONTROL INSTRUMENTS

DIAGNOSTIC INTERVIEW

## THE PHASES OF ALCOHOL ADDICTION

This chart depicts the course of alcohol addiction, which is only one form, the most extreme form of alcoholism. The criterion of alcohol addiction is the loss of control over alcohol intake. It is hypothesized that loss of control will appear in drinkers who have a constitutional liability factor of a physical nature which may be either hereditary or congenital. The hypothesis is based on the observation that many drinkers who drink as much as the addict, over periods of 25 years and more, never come to the stage of loss of control. While no satisfactory laboratory experiments exist on this matter, there are general indications that the constitutional liability factor may be some inital, slight deficiency of carbo-hydrate metabolism, or of the enzyme system or of certain endocrine relations or a constellation of these factors. The presence of such a physical liability factor may produce

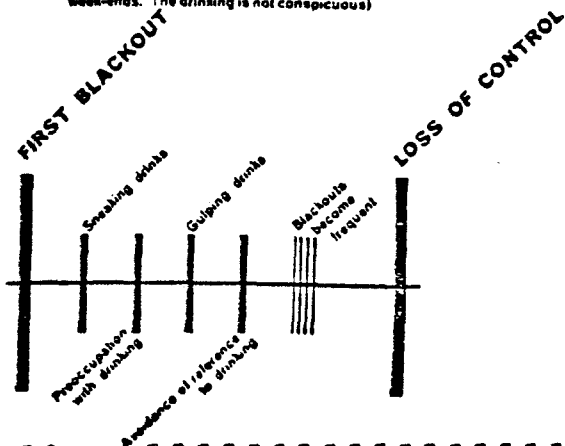


I. PRE-ALCOHOLIC PHASE (characterized by frequently reaching a "happy glow" condition, making rounds of parties, probably drinking at least as much as anyone else, maybe more)

	Yes	No	Maybe
A. <u>Drinks for relief</u>	_____	_____	_____
B. <u>Situational drinking</u> ("I can take it or leave it alone." Holidays, special occasions, weekends, etc.)	_____	_____	_____
C. <u>Shock</u> ("Who, me?", denial)	_____	_____	_____
D. <u>Increase in tolerance</u> (can drink more before intoxication)	_____	_____	_____

**PRODROMAL PHASE**

(In this phase intoxications are not severe and limited to evenings, except perhaps for week-ends. The drinking is not conspicuous)



alcohol addiction only if psychological tensions should lead to a prolonged heavy use of alcoholic beverages as a sedative. Such heavy use will come about only in the presence of certain social and economic factors. Thus alcohol addiction may be defined as an individual reaction to heavy prolonged alcohol consumption determined by psychological and physical characteristics of the individual under certain social and cultural conditions in his environment. In the absence of the physical constitutional liability factor, but presence of psychological tensions and certain social and cultural factors, other non-addictive forms of excessive drinking or alcoholism may occur. These latter forms may be regarded as symptoms of underlying psychological or social pathology while alcohol addiction may be viewed as a disease per se, which under the conditions described above is subsequent to symptomatic drinking.

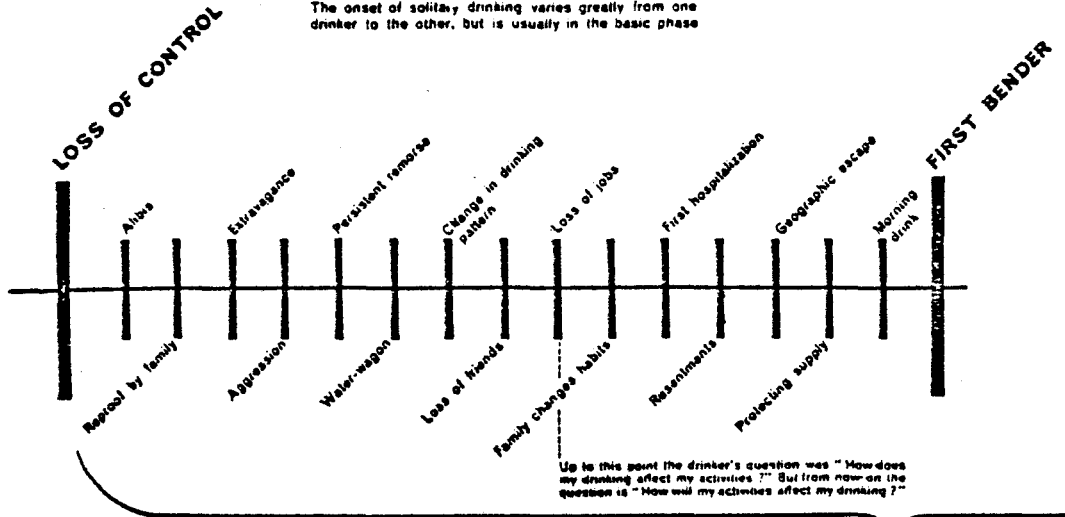
**II. PRODROMAL PHASE** (Intoxication not usually severe; may be limited to weekends, drinking is not a conspicuous part of day-to-day living)

	<u>Yes</u>	<u>No</u>	<u>Maybe</u>
A. <u>First blackout</u> (partial amnesia, without loss of consciousness. . . intoxication may not be apparent)	_____	_____	_____
B. <u>Sneaking drinks</u> (having drinks about which others do not know, tending bar at parties, etc.)	_____	_____	_____
C. <u>Preoccupation with drinking</u> (thinking of drinking ahead of time, RIF, a couple of drinks before the party, etc.)	_____	_____	_____
D. <u>Gulping drinks</u> (drinking out of the bottle, straight shots, shot & beer doubles)	_____	_____	_____
E. <u>Avoidance of reference to drinking</u> (refrain from entering discussion about drinking, prefer not to talk about it because people might find out I do not drink like others)	_____	_____	_____
F. <u>Blackouts become frequent</u> (the above symptoms alone may be common to simply excessive drinkers, but if accompanied by more frequent blackouts ---say, one of three times person drinks more than just a few. . .)	_____	_____	_____
G. <u>Goes only where alcohol is served</u> (avoids social gatherings where there will be on alcohol, or takes own supply)	_____	_____	_____
H. <u>Frequent absences or tardiness</u> (misses work or is late, especially on Monday, Friday, or days before and after holiday)	_____	_____	_____

**CRUCIAL OR BASIC PHASE**

(Intoxications are the rule but limited to evenings, with some "hangover" the next morning)

The onset of solitary drinking varies greatly from one drinker to the other, but is usually in the basic phase



**DISEASE OF ALCOHOL ADDICTION**

**III. CRUCIAL (OR BASIC) PHASE**

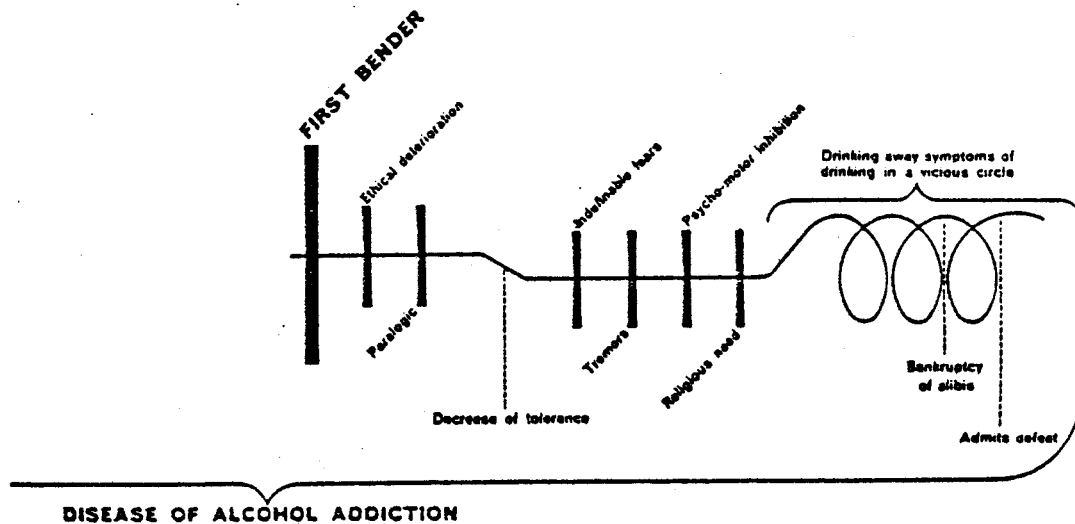
(intoxication now is "the rule", but is usually limited to evenings; some disabling hangovers; frequently prone to solitary drinking)

	<u>Yes</u>	<u>No</u>	<u>Maybe</u>
A. <u>Loss of control</u> (after one drink, a physical demand is created. Person seems unable to stop--often drinks to intoxication.)	_____	_____	_____
B. <u>Alibis, minimizing</u> (person says he/she drank "two"; less than they did; miss work but call in sick--or have spouse call)	_____	_____	_____
C. <u>Family reproof</u> (family criticizes amount drank, time spent drinking, money spent drinking, interpersonal difficulties)	_____	_____	_____
D. <u>Extravagance</u> (of time and money--not important whether drunk at time or not)	_____	_____	_____
E. <u>Aggression</u> (argue, fight, or life of the party--again, not important whether or not drunk at the time)	_____	_____	_____
F. <u>Persistent remorse</u> (feeling of guilt; "maybe I should quit/cut down on drinking")	_____	_____	_____
G. <u>"Water wagon"</u> (an attempt to control drinking--i.e., quit, or limit intake)	_____	_____	_____
H. <u>Change in drinking patterns</u> (drink a different brand, drink much more, switch to beer, wine, etc.)	_____	_____	_____
I. <u>Loss of friends</u> (loss or partial withdrawal of friendships)	_____	_____	_____

	<u>Yes</u>	<u>No</u>	<u>Maybe</u>
J. <u>Loss of Jobs</u> (whether quit, fired, or resigned in self-defense)	_____	_____	_____
K. <u>Family changes habits</u> (cannot count on drinker, so don't; dinner no longer kept waiting; children no longer bring friends home, etc.)	_____	_____	_____
L. <u>First treatment</u> (may alibi that treatment was for something other than alcoholism)	_____	_____	_____
M. <u>Resentments</u> (very general--against boss, fellow employees, wife, family, job; if feel sorry for self, is that generally a reason for the resentment?)	_____	_____	_____
N. <u>Geographic escape</u> (go to another town, state; change bars, liquor store--or think about changing)	_____	_____	_____
O. <u>Protecting supply</u> (buy ahead for weekend, holiday; hide bottles; drink before party; take own bottle)	_____	_____	_____
P. <u>Morning drink</u> (mors-or-less regularly drink before noon)	_____	_____	_____

This chart is based on a rigorous statistical analysis of the drinking histories of over 2000 male alcohol addicts. Neither does every symptom appear in every alcoholic, nor do the symptoms occur in every instance exactly in the same sequence. The chart depicts the sequence as it occurs in the majority of alcohol addicts and, in this sense, represents an average. According to various individual and environmental factors, the entire process may take 7 to 25 years. The average is 15 years. The different lengths of the lines showing the different phases do not indicate different lengths of duration, but are arbitrarily determined by the number of symptoms which fall into any given phase. While the phases and symptoms depicted here correspond to factual material, the interpretation reflects hypothesis and personal opinion.

**CHRONIC PHASE**



-----  
 VI. CHRONIC PHASE (drinking away symptoms of drinking in a vicious circle)

	<u>Yes</u>	<u>No</u>	<u>Maybe</u>
A. <u>First bender</u> (prolonged drinking--perhaps 12 hours or longer with little rest)	_____	_____	_____
B. <u>Ethical deterioration</u> (non-acceptable social behavior, morals--when sober, regrets action)	_____	_____	_____
C. <u>Paralogic</u> (faulty reasoning; poor decisions, changing subject when embarrassed, invalid reasoning, doesn't make sense; evasion of the real; sin in a chain of ideas; telling a story logically all the way, then suddenly illogical)	_____	_____	_____
D. <u>Decrease of tolerance</u> (now drinks less to reach intoxication)	_____	_____	_____
E. <u>Indefinable fears</u> (worries and doesn't know exactly what worrying about)	_____	_____	_____
F. <u>Tremors</u> (shakes--not always just when hung over)	_____	_____	_____
G. <u>Psychomotor inhibitions</u> (has trouble tying shoes, writing name, lighting cigarettes)	_____	_____	_____
H. <u>Religious need</u> (feel need for spiritual help; "God, just get me better this time")	_____	_____	_____
I. <u>Bankruptcy of alibis</u> (no longer can give any "legitimate" reason for drinking)	_____	_____	_____
J. <u>Admits defeat</u> (seems to be at the end of the road, bottom, surrender)	_____	_____	_____

-----  
 DIAGNOSTIC IMPRESSION:

Based on the above, recommended diagnostic impression is that of:



**WHAT TO DO:** Some tests are thinking tests. But this test is only to see ~~how you feel about~~ things. There is no right answer or wrong answer to these questions because people are different. All you have to do is just to answer what is true for you.

You have a separate ANSWER SHEET. On the answer sheet there is a number for each question and next to the number there are three little boxes, like this:    . Mark your answer for each question by filling in the left-hand box if your choice is the (a) answer, fill in the middle box if your choice is the (b) answer, and fill in the right-hand box if you choose the (c) answer. The (a) answer means yes, true, very much so, and so on. The opposite answer (c) means no, false, never, and so on. The (b) is the middle answer which you should not use very often.

Before you start the actual test, do the examples below for practice. Look at the right side of the answer sheet to where it says START HERE. Mark your choice of answers to each of the three questions now, by filling in the box for (a), (b), or (c).

#### EXAMPLES:

- |                                |                |                |
|--------------------------------|----------------|----------------|
| 1. I like to watch team games. |                |                |
| (a) yes (often)                | (b) sometimes  | (c) no (never) |
| 2. People say I'm impatient.   |                |                |
| (a) true                       | (b) uncertain  | (c) false      |
| 3. I prefer friends who are:   |                |                |
| (a) quiet                      | (b) in between | (c) lively     |

Inside, there are more questions like these. These examples were printed on the answer sheet to make it easy to see what to do. But only the *numbers* of the rest of the questions will be on the answer sheet. When you are marking your answer, make sure the number of the question matches the number of the answer.

When you are told to, start with number 1 and answer the questions. Keep these four things in mind:

1. Give only true answers about yourself. It is more helpful to say what you really think.
2. You may have as much time as you need, but try to go fairly fast. It's best to give the first answer that comes to you and not spend too much time on any one question.
3. Answer *every* question one way or the other. Don't skip any.
4. You should mark the (a) or (c) answer *most* of the time. Mark the (b) answer, uncertain or in between, *only* when you have to, because neither (a) nor (c) is right for you.

Table 14  
ALCOHOLICS

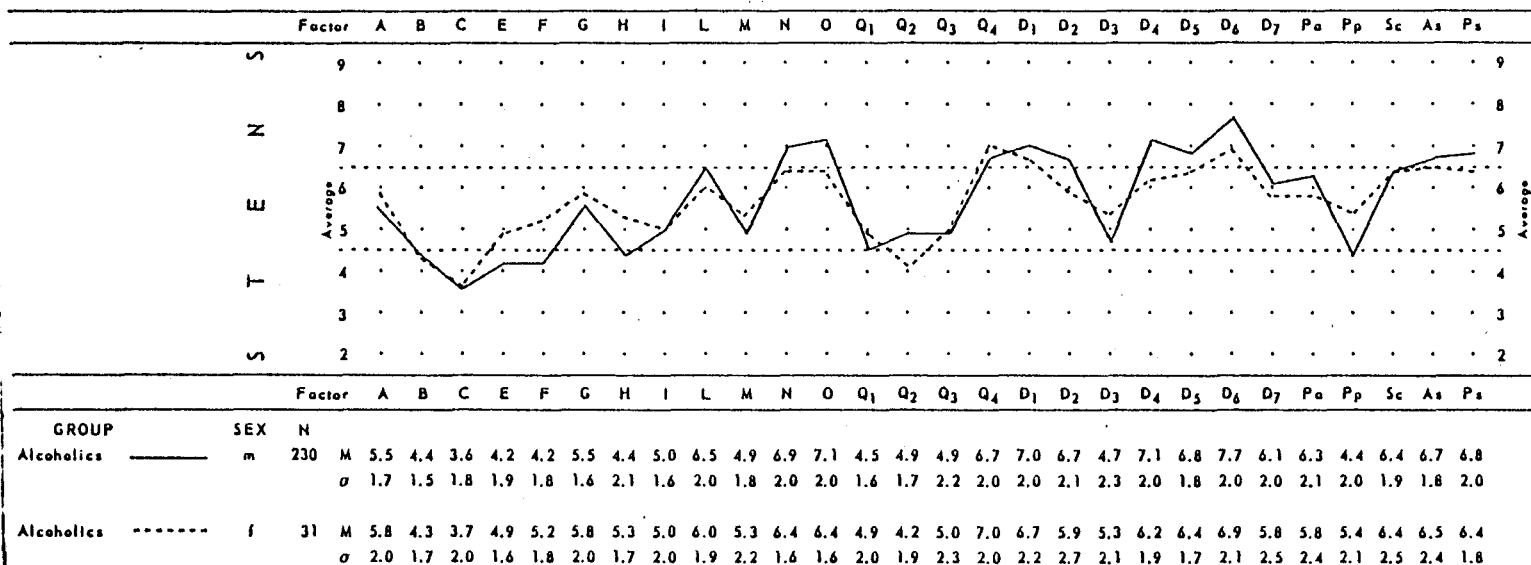


Table 1  
A. PRIMARY SOURCE TRAITS COVERED BY THE CAQ

## Part I. The Clinical 16 PF

Factor	Low Sten Score Description (1-3)	High Sten Score Description (8-10)
A	<i>Reserved, detached, critical, aloof, stiff</i> SIZOTHYMIA	<i>Warmhearted, outgoing, easygoing, participating</i> AFFECTOTHYMIA
B	<i>Dull</i> LOW INTELLIGENCE (CRYSTALLIZED, POWER MEASURE)	<i>Bright</i> HIGH INTELLIGENCE (CRYSTALLIZED, POWER MEASURE)
C	<i>Affected by feelings, emotionally less stable, easily upset, changeable</i> LOWER EGO STRENGTH	<i>Emotionally stable, mature, faces reality, calm</i> HIGHER EGO STRENGTH
E	<i>Humble, mild, easily led, docile, accommodating</i> SUBMISSIVENESS	<i>Assertive, aggressive, competitive, stubborn</i> DOMINANCE
F	<i>Saber, taciturn, serious</i> DESURGENCY	<i>Happy-go-lucky, lively, enthusiastic</i> SURGENCY
G	<i>Expedient, disregards rules</i> WEAKER SUPEREGO STRENGTH	<i>Conscientious, persistent, moralistic, staid</i> STRONGER SUPEREGO STRENGTH
H	<i>Shy, timid, threat-sensitive</i> THRECTIA	<i>Venturesome, uninhibited, socially bold</i> PARMIA
I	<i>Tough-minded, self-reliant, realistic</i> HARRIA	<i>Tender-minded, sensitive, clinging, overprotected</i> PREMIA
L	<i>Trusting, accepting conditions</i> ALAXIA	<i>Suspicious, hard to fool</i> PROTENSION
M	<i>Practical, "down-to-earth" concerns</i> PRAXERNIA	<i>Imaginative, bohemian, absent-minded</i> AUTIA
N	<i>Farthright, unpretentious, genuine, possibly socially too direct</i> ARTLESSNESS	<i>Astute, polished, socially alert</i> SHREWONNESS
O	<i>Self-assured, complacent, secure, placid, solid</i> UNTRIOUBLED ADEQUACY	<i>Apprehensive, self-reproaching, insecure, worrying, troubled</i> GUILT PRONENESS
Q <sub>1</sub>	<i>Conservative, respecting traditional ideas</i> CONSERVATIVISM OF TEMPERAMENT	<i>Experimenting, liberal, free-thinking</i> RADICALISM
Q <sub>2</sub>	<i>Group oriented, a "joiner" and sound follower</i> GROUP ADHERENCE	<i>Self-sufficient, resourceful, prefers own decisions</i> SELF-SUFFICIENCY
Q <sub>3</sub>	<i>Undisciplined self-conflict, lax, follows own urges, careless of social rules</i> LOW SELF-SENTIMENT INTEGRATION	<i>Controlled, exacting will power, socially correct, compulsive, following self-image</i> HIGH STRENGTH OF SELF-SENTIMENT
Q <sub>4</sub>	<i>Relaxed, tranquil, torpid, unfrustrated, composed</i> LOW ERGIC TENSION	<i>Tense, frustrated, driven, overwrought</i> HIGH ERGIC TENSION

Note: High score means the description on the right. For example, H+ is venturesome, H- is shy.

Table 1, *continued*

## Part II. The Pathology Supplement

Factor	Low Sten Score Description (1-3)	High Sten Score Description (8-10)
D <sub>1</sub>	Is happy, mind works well, does not find ill health frightening LOW HYPOCHONDRIASIS	Shows overconcern with bodily functions, health, or disabilities HIGH HYPOCHONDRIASIS
D <sub>2</sub>	Is contented about life and surroundings, has no death wishes ZESTFULNESS	Is disgusted with life, harbors thoughts or acts of self-destruction SUICIDAL DISGUST
D <sub>3</sub>	Avoids dangerous and adventurous undertakings, has little need for excitement LOW BROODING DISCONTENT	Seeks excitement, is restless, takes risks, tries new things HIGH BROODING DISCONTENT
D <sub>4</sub>	Is calm in emergency, confident about surroundings, poised LOW ANXIOUS DEPRESSION	Has disturbing dreams, is clumsy in handling things, tense, easily upset HIGH ANXIOUS DEPRESSION
D <sub>5</sub>	Shows enthusiasm for work, is energetic, sleeps soundly HIGH ENERGY EUPHORIA	Has feelings of weariness, worries, lacks energy to cope LOW ENERGY DEPRESSION
D <sub>6</sub>	Is not troubled by guilt feelings, can sleep no matter what is left undone LOW GUILT AND RESENTMENT	Has feelings of guilt, blames himself for everything that goes wrong, is critical of himself HIGH GUILT AND RESENTMENT
D <sub>7</sub>	Is relaxed, considerate, cheerful with people LOW BORED DEPRESSION	Avoids contact and involvement with people, seeks isolation, shows discomfort with people HIGH BORED DEPRESSION
Pa	Is trusting, not bothered by jealousy or envy LOW PARANOIA	Believes he is being persecuted, poisoned, controlled, spied on, mistreated HIGH PARANOIA
Pp	Avoids engagement in illegal acts or breaking rules, sensitive LOW PSYCHOPATHIC DEVIATION	Has complacent attitude towards own or others' anti-social behavior, is not hurt by criticism, likes crowds HIGH PSYCHOPATHIC DEVIATION
Sc	Makes realistic appraisals of himself and others, shows emotional harmony and absence of regressive behavior LOW SCHIZOPHRENIA	Hears voices or sounds without apparent source outside himself, retreats from reality, has uncontrolled and sudden impulses HIGH SCHIZOPHRENIA
As	Is not bothered by unwelcome thoughts and ideas or compulsive habits LOW PSYCHASTHENIA	Suffers insistent, repetitive ideas and impulses to perform certain acts HIGH PSYCHASTHENIA
Ps	Considers himself as good, dependable, and smart as most others LOW GENERAL PSYCHOSIS	Has feelings of inferiority and unworthiness, timid, loses his head easily HIGH GENERAL PSYCHOSIS

Note: High score means the description on the right.

Table 1, concluded  
 B. SECONDARY SOURCE TRAITS COVERED BY THE CAQ

I	Exvia-vs.-Invia	Extraverted, sociable, outgoing (Primaries A+, F+, H+, Q <sub>2-</sub> , P <sub>a-</sub> )
II	Anxiety	Standard definition (Cattell & Scheier, 1961) (Primaries C-, M-, Q <sub>1</sub> +, Q <sub>3-</sub> , Q <sub>4</sub> +, D <sub>1</sub> +, D <sub>6</sub> +) )
III	Cartertia-vs.-Pathemia	Alert, poised (Primaries A-, F+, L-, M-, Q <sub>2</sub> +, D <sub>3-</sub> , P <sub>a-</sub> )
IV	Independence-vs.-Subduedness	Independent, determined (Primaries E+, M+, Q <sub>1</sub> +, Q <sub>2</sub> +, D <sub>1-</sub> , D <sub>3-</sub> , P <sub>a-</sub> )
VIII	Broad Superego-vs.-Lack of Self-sentiment	Conscientious, social value oriented, shy, conservative (Primaries G+, Q <sub>3</sub> +, H-, Q <sub>1-</sub> )
IX	General Frustration Depression	Exhausted by conflict, depressed, hypochondriacal (Primaries D <sub>1</sub> +, D <sub>2</sub> +, D <sub>5</sub> +, D <sub>6</sub> +) )
X	Restless Depression	Bored and restless, with guilt, anxiety, and resentment (Primaries N-, D <sub>3</sub> +, D <sub>5</sub> +, D <sub>6</sub> +) )
XI	Suicidal Depression	Disgusted, suicidal, and hostile (Primaries D <sub>2</sub> +, D <sub>3</sub> +) )
XII	General Maladjustment Depression	Brooding discontent, expressed in psychopathic behavior, but with anxiety (Primaries D <sub>3</sub> +, D <sub>4</sub> +, P <sub>a</sub> +) )

#### 4. TEST DESIGN AND CONSTRUCTION

In order to keep the total test to a time limit entirely practicable for the clinical psychologist, it has been necessary to cut the number of items for each factor to the bare minimum—in order to cover twenty-eight factors. This cut has been made more severe in the case of the *normal* sixteen dimensions, since, first, they are not so vital to the whole diagnosis; and, secondly, it is quite possible that 16 PF trait measures will have been gathered already on many cases on the usual longer 16 PF Form A or Form B.

It is to aid this shortened use, i.e., of the pathology part only, when the full 16 PF has already been used, that the CAQ has been divided into two parts: Part I, *The Clinical 16 PF*; and Part II, *The Pathology Supplement* to the 16 PF. They can be given separately so that the latter can be used along with the ordinary 16 PF as an extension when an especially thorough testing on normal factors is required. However, it will be understood, when we come to look at the reliability and validity coefficients, that more exact scores for research purposes, for example, are attainable only if the clinical psychologist is prepared to give three to four hours, rather than one and a half to two hours to so comprehensive a testing. Actually, a parallel set of scales to the present CAQ, Parts I and II, is being developed for those who can give this longer (four-hour) time. Although the presently designed brevity of the scales limits reliability to the best figure obtainable for the two-hour length, yet, in terms of general information theory, it will be understood that it is much more profitable to measure twenty-eight factors with this degree of precision in one and a half to two hours than to measure, say, six factors with much higher sheer reliability. The prediction of all kinds of behavior or clinical outcome is better from the larger number of independent factors.