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LOYOLA UNIVERSITY OF CHICAGO

THE EFFECTS OF INFORMED CONSENT AND DECEPTION ON PSYCHOTHERAPISTS' RATINGS OF THE ACCEPTABILITY OF SYMPTOM PRESCRIPTION

A THESIS SUBMITTED TO
THE FACULTY OF THE GRADUATE SCHOOL
IN CANDIDACY FOR THE DEGREE OF
MASTER OF ARTS

DEPARTMENT OF COUNSELING AND EDUCATIONAL PSYCHOLOGY

BY

BRIAN A. MCELWAIN

CHICAGO, ILLINOIS

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INTRODUCTION

Over the last 15 to 20 years, paradoxical interventions --the most common and controversial of which is symptom prescription--have been popular treatment strategies in psychotherapy. A brief survey of the professional literature reveals that there is much disagreement among therapists regarding how these techniques work, when they are indicated, and even what constitutes a paradoxical intervention. It is not surprising, then, to find similar dissent regarding the relative importance of the ethical issues involved in the use of paradoxical interventions.

Some therapists employ paradoxical techniques frequently and tend to minimize the ethical questions associated with their use (e.g., Fisch, Weakland, & Segal, 1982; Haley, 1987). Others say that, in consideration of the ethical dilemmas that the use of paradoxical interventions raise, such methods should only be employed as a last resort (e.g., Fischer, Anderson, & Jones, 1981; Van Hoose & Kottler, 1985). Still others, such as Whan (1983), would contend that the use of paradoxical interventions is inherently unethical and their use can never be justified. Further, critics such as Henderson

(1987) and Schmidt (1986) warn that psychotherapists who use paradoxical interventions may be inviting claims of malpractice.

Two of the primary ethical issues regarding the use of paradoxical interventions relate to the use of deception and the violation of informed consent. The first objection--that paradoxical interventions involve deception--centers around the idea that dishonesty, or a lack of sincerity, is incompatible with the trust that is essential to the therapeutic relationship (Whan, 1983). For example, consider the use of symptom prescription in directing an insomniac to stay awake or instructing an impotent man to prevent himself from having an erection. Since one important purpose of therapy is to eliminate distress, are such methods "insincere," and, thus, unacceptable? The use of deception in employing paradoxical interventions is a significant ethical problem which has been commented upon by numerous writers (e.g., Deschenes & Shepperson, 1983; Haley, 1987; Johnson, 1986; Lindley, 1987; Tennen, Eron, & Rohrbaugh, 1985; Van Hoose & Kottler, 1985; Watzlawick, Weakland, & Fisch, 1974; Weeks & L'Abate, 1982).

The second objection--that the use of paradoxical interventions violates the client's right to informed consent--has also been addressed by a number of therapists

(e.g., Brown & Slee, 1986; Henderson, 1987; Hunsley, 1988; Kolko & Milan, 1986; Weeks & L'Abate, 1982). The Ethical Principles of Psychologists (American Psychological Association, 1990) require that psychologists provide their clients with adequate information regarding treatment procedures so that clients may make informed decisions about their participation in therapy. However, fully disclosing the nature of a paradoxical intervention to the client may rob the technique of its impact (Hills, Gruszkos, & Strong, 1985; Watzlawick, Beavin, & Jackson, 1967).

It is clear that the use of paradoxical interventions raises significant ethical questions, particularly in regard to deception and informed consent. However, almost no empirical research has been performed that examines psychotherapists' attitudes about these controversial techniques. The focus of this study was to identify which aspects of the context in which a symptom prescription is delivered (i.e., the degree of deception and of informed consent) affect its acceptability to psychotherapists.

REVIEW OF RELATED LITERATURE

Paradoxical Intervention Defined

The use of paradoxical interventions has not been limited to practitioners of any single theoretical orientation. These techniques have been espoused by therapists from a number of orientations, including psychodynamic (Greenberg, 1973), existential (Frankl, 1975), Gestalt (Beisser, 1970), and behavioral (Dunlap, 1928). However, paradoxical interventions seem to be most widely used by family systems therapists (e.g., Selvini-Palazzoli, Boscolo, Cecchin, & Prata, 1978; Watzlawick et al., 1974).

Because paradoxical interventions are described by therapists of such varying theoretical perspectives, there is no consensus as to exactly what constitutes a paradoxical intervention--not even among the acknowledged experts in the field (Watson, 1985). At the most simplistic level, paradoxical interventions seem to conflict with the goals of therapy (Hirschmann & Sprenkle, 1989); they clash with "common sense." In fact, the Greek word *paradoxos* means "conflicting with expectation" (*American Heritage Dictionary*, 1982). Paradoxical techniques, then, depart from conventional conceptions of how therapy should be

conducted.

The four most common types of paradoxical interventions have been identified by Dowd and Milne (1986) as reframing, restraining, positioning, and symptom prescription. In reframing the therapist provides an alternative meaning structure to shift the client's perspective about the problematic behavior--usually to a more positive one. A therapist may discourage or explicitly prohibit a client from changing for a period of time when using a paradoxical technique called restraining. With positioning a therapist might agree with (or exaggerate) a client's statements that reflect a negative view of a situation. Symptom prescription involves instructing a client to perform the problematic behavior or even to exaggerate its occurrence; sometimes the symptom may be "scheduled" to occur at a specific time. Symptom prescription is the most popular of the various paradoxical interventions (Hirschmann & Sprenkle, 1989), as well as the most controversial--presumably because of its directiveness. For these reasons, symptom prescription is the paradoxical intervention with which this study is most concerned.

Theories of Paradoxical Intervention

In light of the wide variety of theoretical frameworks within which the use of paradoxical interventions has been advocated, it is not surprising that a number of conflicting

rationales have been advanced for their use (Driscoll, 1985; Riebel, 1984). Among the common explanations are: utilizing resistance to energize change, interrupting the system of which the symptom is a part, changing the client's perspective on the problem, and counteracting the detrimental effects of excessive effort to solve the problem.

The classic rationale for the use of paradoxical interventions is that of the "therapeutic double-bind," as described by Watzlawick et al. (1967). A therapeutic double-bind is the opposite of the sort of "pathogenic double-bind" that has been described as a characteristic pattern of communication within the families of schizophrenics (Bateson, Jackson, Haley, & Weakland, 1956). It is worth noting that the notion of a double-bind assumes both an intense relationship between the parties involved and that the recipient cannot comment upon the double-bind or withdraw from the situation in which it occurs. Watzlawick et al. (1967) contend that a pathogenic double-bind can only be broken by a countering double-bind. A pathogenic double-bind places a person in a "no-win" situation; for example, consider the parent who complains that her child does not love her, but rejects the child's displays of affection. Now consider the bind that a client is placed in when the therapist employs a paradoxical

intervention. Psychotherapy is presumably intended to effect positive changes in the client's life, but the therapist tells him/her not to change. Watzlawick et al. (1967) contend that this places the client in a therapeutic double-bind, a "no-lose" situation. That is, when a therapist prescribes a client's symptom, the client can respond in one of two ways (each of which leads to gaining control over the problem). If the client disobeys the therapist's directive, then the symptom disappears; and if the client performs the symptom, then s/he gains volitional control over what was formerly perceived to be an involuntary action. This gives the locus of symptom control to the client and O'Connell (1983) asserts that this is the most important effect of symptom prescription.

Indications and Contraindications for the Use of Paradoxical Interventions

A survey of the literature on paradoxical interventions reveals that many therapists deem these techniques appropriate only after more straightforward approaches have proven ineffective (e.g., Fischer et al., 1981). They are typically regarded as last resort methods reserved for use against chronic patterns of resistance (Papp, 1979). Clients who fit the descriptions of "therapist-killers" (Weeks & L'Abate, 1982) and "help-rejecting complainers" (Greenberg, 1973) have been suggested as suitable candidates

for paradoxical interventions.

In order to reduce the apparent risks associated with discouraging positive client change, a number of client types and problems have been put forward as contraindicating the use of paradoxical interventions. Papp (1979), for example, says that paradoxical methods should not be employed in crisis situations, incest, child abuse, or with clients having suicidal or homicidal ideations. Others would add that paradoxical interventions are too risky with extremely suggestible clients (Rohrbaugh, Tennen, Press, & White, 1981), borderline personalities (Greenberg & Pies, 1983), antisocial personalities, and paranoid schizophrenics (Weeks & L'Abate, 1982). However, Fay (1976) reports three cases in which paradoxical interventions were used successfully with paranoid schizophrenics. This is but one example of the contradictions that can be found in the literature as to when paradoxical techniques are appropriate.

In contrast, Fraser (1984) contends that the use of paradoxical interventions should be determined much more idiographically. He argues that basing decisions regarding the use of paradoxical techniques upon diagnostic labels ignores the uniqueness of individual clients. Fraser maintains that paradoxical interventions should not be relegated to last ditch efforts to combat resistance;

instead, they should be among a therapist's initial alternatives in treatment planning. Further, O'Connell (1983) believes symptom prescription is best used in the initial therapy session in order to give the client something to do toward solving his/her problem immediately and to cast the therapist in his/her proper role as an expert who knows best how to help the client.

Research on the Efficacy of Paradoxical Interventions

Seltzer (1986) lists over 80 problems that have been treated paradoxically--from anorexia to marital problems to writers block. However, much of the literature on the efficacy of paradoxical interventions involves clinical anecdotes rather than empirical evidence. DeBord (1989) reviewed the 25 clinical outcome studies that appeared in the psychological literature from 1980 to 1987 and found that 23 (92%) reported some degree of positive outcome--none indicated any adverse effects. But the designs of only 12 (48%) of these studies included both a control group and an objective outcome measure; so half of these studies lacked two of the most basic features of empirical research.

In addition, two separate meta-analyses have been performed on the existing controlled outcome studies. Hill (1987) examined 15 such studies (with the presenting problems of insomnia, depression, agoraphobia, procrastination, and stress) which appeared in the

professional literature between 1979 and 1985. Hill concluded that paradoxical interventions were consistently and significantly more effective than were non-paradoxical interventions. However, Shoham-Salomon and Rosenthal's (1987) inspection of 12 of the same data sets led them to a more conservative conclusion--that paradoxical interventions were equally as effective as conventional treatments. Nevertheless, they also judged that paradoxical interventions produced greater therapeutic change than other types of treatment with more severe cases as well as one month after termination. These two meta-analyses lend support to the contention that, at least in some cases, paradoxical interventions are a viable treatment option. Even so, the use of these controversial methods raises difficult ethical problems.

Ethical Questions Regarding the Use of Paradoxical Interventions

Because there is not necessarily any relationship between what is therapeutically efficacious and what is ethical, the ethical dilemmas that paradoxical interventions raise will now be examined. Critics of these methods contend that no matter what the outcome research might indicate about the efficacy of such techniques, the ethical problems that they raise should take precedence in decisions about their use (Whan, 1983). These critics would say

that paradoxical techniques are inherently unethical and should not be used under any circumstances. On the other hand, it has been argued that the ethical considerations regarding their use do not differ significantly from those of other therapeutic modalities (Brown & Slee, 1986; Hunsley, 1988). Thus, Deschenes and Shepperson (1983) assert that whether or not a paradoxical intervention is unethical depends not on the nature of the technique itself, but on its particular application by a specific therapist. So the context in which a paradoxical intervention is delivered must be examined in order to make judgments regarding its ethicality. Certainly, a therapist's use of symptom prescription can be presented to a client using varying degrees of deception and informed consent. Since deception and a lack of informed consent have historically accompanied the use of paradoxical interventions (Haley, 1987), these two ethical problems will be given further consideration.

Paradoxical Interventions and Deception

Paradoxical interventions are often criticized as techniques that involve the deception of clients. For example, consider symptom prescription whereby clients are often instructed to continue the problematic behavior in order that they may learn more about the causes of the problem. Generally, the therapist is not concerned about

the problem's causes, this is just the most effective method of gaining the client's compliance with the directive. On a semantic level, Haley (1987) cautiously endorses the use of "benevolent lies" in therapy, and questions whether "deceit" is a meaningful concept in the context of psychotherapy. To Haley, if the use of deception seems important to facilitate progress in therapy, then that is sufficient justification for its use. But Whan (1983) wonders where the line can be drawn once any degree of deception becomes acceptable on the grounds that it may be therapeutically efficacious.

One problem with the use of deception in employing symptom prescription is that therapy becomes paternalistic. Lindley (1987) contends that "strategic communication" (such as that described in the preceding example) lacks a "truth-centered motive," so it is therefore disrespectful and wrong because it assaults the autonomy of clients. Moreover, in the case of symptom prescription, use of deception assumes a certain level of incompetence on the part of the client which justifies active intervention to serve what the therapist perceives to be the client's best interests. Consequently, such use of deception tips the balance of power even more toward the therapist. If it can be granted that the possession of accurate (versus inaccurate) knowledge translates into increased power in

a relationship, then deception adds to the power of the deceiver and diminishes that of the deceived (Bok, 1978).

In addition to problems related to paternalism and therapist power, there is the pragmatic concern of maintaining the client's trust. As Bok (1978) points out, the most fundamental concern of any person seeking the help of another is whether they can trust the person whose aid they seek. Ultimately, then, trust is the foundation of the therapeutic relationship and a therapist's use of deception would seem to violate that trust. In addition to the possible damage to a therapist's credibility that deception involves, the therapist may be forced into telling more lies in order to cover for earlier ones. This is a problem particularly in close relationships, such as therapy, where it is unlikely that one lie will suffice (Bok, 1978). To illustrate with the example of symptom prescription mentioned previously, some practitioners (e.g., Fisch et al., 1982; Haley, 1987) would urge this therapist to act surprised if the client "spontaneously" improved following this directive.

Three analogue studies have explored criticisms that paradoxical interventions may have detrimental effects on the therapeutic relationship. Conoley and Beard (1984) found that both symptom prescription and nondirective interventions can be delivered in ways that are either

high or low in perceived empathy, warmth, and genuineness. These researchers also found no differences between symptom prescription and nondirective interventions in terms of perceived attractiveness or trustworthiness, though symptom prescription was rated as higher in expertness. In another study, Perrin and Dowd (1986) found that symptom prescription was seen as more "tricky" and "confusing" than non-paradoxical techniques; however, this did not adversely affect subjects' perceptions of the therapist's willingness or ability to help. Finally, McMillan and Johnson (1990) found that a counselor who implemented cognitive-behavioral interventions was rated as more expert, attractive, and trustworthy than one who delivered paradoxical interventions (with or without an explanation of this strategy).

Certainly no final conclusions can be reached on the basis of the results of three studies whose results conflict as much as these do, but these findings do lead one to question whether paradoxical interventions have the negative effects on the therapeutic relationship that their critics expect. This issue is clouded by the fact that some therapists who use paradoxical interventions (e.g., Weeks & L'Abate, 1982) speak of the benefits of less than completely positive relationships in mobilizing resistance to paradoxical directives--thereby accomplishing the goals

of therapy. However, others such as O'Connell (1983) emphasize the importance of a strong, sincere therapeutic relationship in the use of paradoxical interventions. Further, there is the perennial question of how important the therapeutic relationship is in terms of accomplishing the goals of therapy--is it necessary or sufficient?

Paradoxical Interventions and Informed Consent

Use of deception in therapy is not consistent with the client's right to informed consent. The Ethical Principles of Psychologists (APA, 1990) require that therapists provide their clients with adequate information so that clients may make informed decisions regarding participation in therapy. At its core this means that clients must understand and agree to the treatment methods employed in their psychotherapy (Weeks & L'Abate, 1982).

The philosophical significance of informed consent, like deception, has to do with the relative power of the therapist in relation to the client. If it can be assumed that self-disclosure increases the power of the listener and decreases that of the speaker (Bok, 1983), then therapists have great power in their relationships with clients as self-revelation typically flows in only one direction. Additionally, if the therapist fails to disclose the nature and purpose of the methods used in therapy the client's power is diminished still further. Seeking to

balance the distribution of power both consumers and a number of therapists have come to stress the importance of more client participation in the decision-making of therapy (Coyne & Widiger, 1978). Corey, Corey, and Callanan (1984) contend that therapists have a responsibility to educate clients of their rights because therapy is a novel situation with which many clients are unfamiliar; it should be de-mystified as much as possible in order to facilitate individual autonomy.

Everstine, Everstine, Heymann, True, Frey, Johnson, and Seiden (1980) have outlined the information that they consider prerequisite to informed consent: (1) an explanation of the procedures of therapy and their purposes, (2) the role and qualifications of the therapist, (3) any risks and/or benefits to be expected from therapy, (4) alternatives to therapy, (5) a statement that questions about the procedures of therapy will be answered at any time, and (6) a statement that the client can terminate therapy at any time. However, Brown and Slee (1986) note that this outline is historically more closely associated with medical practice than psychotherapy and that such specific information is usually not available for any method of therapy. The risks and consequences of therapy and its alternatives are so wide-ranging and uncertain that they prohibit "full" presentation, thus fully informed

consent (Widiger & Rorer, 1984). To further complicate matters, there is widespread disagreement regarding what degree of disclosure--from a general orientation to psychotherapy, to the therapist's preferred theory, to descriptions of the specific interventions of therapy--is required in order to obtain an adequate degree of informed consent (Kolko & Milan, 1986).

In addition to the practical problems involved in implementing informed consent with any sort of psychotherapeutic method, there are theoretical problems specific to paradoxical interventions. For example, in classic double-bind theory if the bind is commented upon it can be escaped (Watzlawick et al., 1967), making the intervention impotent--and there is empirical evidence to support this contention. Hills et al. (1985) found that explaining the double-bind led to favorable evaluations of therapists, but diminished the efficacy of the intervention. In light of this problem, some (Kolko & Milan, 1986; Young, 1981-1982) have suggested that in the use of paradoxical interventions the client's consent not to be fully informed of the techniques to be used should be sought. Further, some who utilize paradoxical interventions point out that it would be impractical for any therapist to expose all the "machinery" of therapy to the client (Haley, 1987; Hunsley, 1988). Widiger and

Rorer (1984) conclude that it is not possible to have a single set of ethical principles that can be applied consistently across theoretical orientations; some ethical relativism is necessary.

But even if the mental health professions came to accept this sort of ethical relativism, the legal profession and the larger society may not be as willing to approve of such a complicated solution. In our increasingly litigious society, it is not surprising that Henderson (1987) has warned that a therapist could be held liable for malpractice where informed consent has not been obtained. Thus, in view of the theoretical difficulties involved in fully informing clients of the purposes of paradoxical interventions and the seemingly illogical nature of such methods, Schmidt (1986) expresses concern that a therapist who uses them may be open to claims of malpractice. However, suits alleging negligence in psychotherapy are very rare (Appelbaum & Gutheil, 1991). In regard to the use of innovative therapies such as symptom prescription, Simon (1987) notes that potential legal problems hinge on whether informed consent has been obtained and whether a specific therapy represents a substantial departure from standard and accepted practice (i.e., at least a respectable minority of the profession uses similar methods and the therapy has been employed responsibly).

Simon goes on to say that if a particular mode of therapy is found to be "customary," then liability is usually precluded. Stromberg, Haggarty, Leibenluft, McMillian, Mishkim, Rubin, and Trilling (1988) know of no reported cases in which a psychotherapist has been held liable for negligent verbal therapy, but they do not rule out that possibility. They also caution that related claims of failing to take precautions against the possibility of a client harming him/herself or others are more likely to succeed. In the case of a directive technique, such as symptom prescription, establishing the conditions for legal liability may be more easily accomplished. For example, if a client worsens after a symptom has been prescribed, a jury is likely to have difficulty understanding why the therapist employed such a directive. In a 1983 case in California, a therapist was found negligent because she told a rather large woman to sit on her disobedient son in order to assert parental control--the client took this directive literally and sat on the boy until he died of suffocation (Cormier & Cormier, 1985).

Assumptions Underlying Therapy

By now it seems clear that there are some fundamental differences between the conceptions of the therapeutic process that critics and proponents of these techniques

hold. Advocates of paradoxical interventions have an extremely pragmatic bent; they seem to be willing to use whatever approach works to produce change as quickly as possible. Not surprisingly, they do not hold to the traditional insight models of therapy that assume client self-understanding must precede significant change (Young, 1981-1982). Watzlawick et al. (1967) argue that people often change without knowing why--insight is not a necessary or even a usual antecedent of change. For the therapist who uses paradoxical interventions change is the goal; insight is irrelevant. On the other hand, critics such as Martin (1986) say that paradoxical interventions may work in the short-term, but they will not help clients to maintain their gains or deal with related problems in the future--because they presumably have not understood the process of change.

Henderson (1987) has noted that the increasing use of paradoxical interventions seems to be related to a shifting of responsibility for change in therapy from the client to the therapist. Incidentally, the label "symptom prescription" implies a doctor-patient relationship in which a professional provides a "cure" for the client's ailment. Further, Fisch et al. (1982) assert that the therapist is an "expert" whose responsibility it is to direct the course of treatment. They add that if the client

knew what s/he should do there would be no need for therapy. This represents another fundamental difference between the viewpoints of the critics and proponents of these techniques. Traditionally, with the responsibility for change resting with the client, therapy might continue for a long period of time without change in the client or the treatment approach in the hope that "resistance" or a "lack of motivation" might soon be overcome (Weeks & L'Abate, 1982). Haley (1987) contends that such an approach to therapy is more concerned with definitions of proper therapist behavior than it is with the task of helping clients solve their problems. Critics of paradoxical interventions would counter that directive methods promote dependency upon the therapist (Van Hoose & Kottler, 1985), which is diametrically opposed to their purpose of promoting the client's autonomy.

Acceptability of Paradoxical Interventions

As defined for the purposes of this study, acceptability referred to the subjective evaluation of a treatment procedure by an individual (Kazdin, 1980a, 1980b; Witt & Elliott, 1985). That is, how much does a person like the treatment in question? Is it appropriate, fair, and reasonable given the client's problem? If the client likes the interventions used in his/her therapy then they will be more motivated to be actively involved

and change than if they find them objectionable. But perhaps a more fundamental question is the acceptability of an intervention to those who may implement them. Two such groups are psychotherapists and classroom teachers.

Hirschmann and Sprenkle (1989) conducted a survey of the clinical members of the American Association for Marriage and Family Therapy. Seventy-six percent of the respondents were users of paradoxical interventions. (It should be noted that the field of marriage and family therapy is much more influenced by systemic theories than most other specializations within the broader field of psychotherapy. This may account for the high percentage of respondents who used paradoxical interventions.) They found users of these techniques to be more directive in their approach to therapy and less concerned with the ethical issues related to these interventions than their colleagues who did not employ paradoxical methods. However, they did not find non-users as a group to be averse to the use of paradoxical interventions by their colleagues. Hirschmann and Sprenkle concluded that paradoxical interventions were a part of the repertoire of the majority of marriage and family therapists, and that within that field they are viewed as effective and ethically acceptable techniques.

Cavell, Frentz, and Kelley (1986) have conducted the

only other empirical study to address the acceptability of paradoxical interventions. These researchers examined the acceptability of these techniques in the context of altering the problem behavior of delinquent youth. Middle and high school teachers rated the acceptability of a symptom prescription that had previously been demonstrated to be effective by Kolko and Milan (1983). The Cavell et al. (1986) study included five treatment conditions--four of which involved the paradoxical intervention with different rationales for its use and one of which involved continuing a program of positive reinforcement that was reported to be ineffectual. The teachers in all four paradoxical intervention conditions rated this treatment as significantly less acceptable than did the group which rated the continuation of the unsuccessful program of reinforcement. Additionally, there was a significant difference in acceptability ratings between the conditions employing a paradoxical intervention accompanied by a "paradoxical rationale" (an explanation in terms of the adolescents likelihood of defying the paradoxical directive leading to a reduction of the problem behavior) and the one involving "no rationale." The latter was rated as less acceptable. These results raise questions about the acceptability of paradoxical interventions among secondary school teachers.

To summarize, the literature on paradoxical interventions has been selectively reviewed with particular attention to the ethical problems of deception and informed consent and this treatment's acceptability. Few studies prior to this one have examined the acceptability of paradoxical interventions to psychotherapists. This study employed a format somewhat analogous to an ethics review board; that is, a group of professionals made judgments as to whether a hypothetical colleague acted "acceptably" in employing a symptom prescription. The primary hypotheses of this study were that in regard to the context in which a symptom prescription is delivered, psychotherapists would rate the intervention as less acceptable when: (1) deception was involved, and (2) informed consent was not obtained. Secondary hypotheses also investigated were that psychotherapists would rate a symptom prescription as less acceptable when s/he: (1) did not claim systems as his/her primary theoretical orientation, (2) was less directive in his/her approach to psychotherapy, (3) placed more emphasis on insight as a requisite for change, and (4) displayed greater sensitivity to ethical considerations.

METHOD

Procedure and Subjects

Four hundred potential participants were randomly selected from the Clinical section of the directory of the Illinois Psychological Association (1989-1990). Each of these individuals was mailed a packet which included: a cover letter, a demographic questionnaire, one of four variations of a treatment vignette, two treatment acceptability measures, a reply envelope, and a postcard on which to request a copy of the results of the study.

One hundred forty-four usable replies were obtained making the response rate 36%. A majority of the respondents indicated their primary theoretical orientation as eclectic (56%); other theories represented were psychodynamic (22%), cognitive (5%), humanistic (4%), behavioral (3%), systems (3%), other (3%), and 4% did not specify a theoretical orientation. The gender of the participants was fairly evenly distributed: 44% were female and 52% were male (4% did not indicate a gender). The mean age of the participants was 46.2 years (*SD*=10.4). Additionally, the participants had an average of 13.4 years of post-degree therapy experience (*SD*=9.4) and an average of 22.5

client-hours per week (*SD*=12.8). Based on these demographics, it seemed fair to assume that the participants were reasonably representative of the field and well-acquainted with the practice of psychotherapy.

Materials

Demographic questionnaire. In addition to the demographic information already reported, this questionnaire included five items relating to the participant's assumptions about psychotherapy (see Appendix A). Rated on a five-point Likert scale, these items addressed attitudes about directiveness (e.g., "The therapist--not the client--bears the primary responsibility for progress in therapy."), the importance of insight (e.g., "There can be no significant change in therapy without the client first gaining insight."), and ethical considerations (e.g., "The use of a deceptive intervention cannot be justified by any amount of constructive change.").

Treatment vignettes. The case descriptions used in this investigation (adapted from Dowd & Milne, 1986; see Appendix B) consisted of five paragraphs: (1) problem, (2) case conceptualization, (3) consent to treatment, (4) symptom prescription, and (5) the rationale given for the intervention. Paragraphs 1, 2, and 4 were the same for all four experimental conditions. The first paragraph described a young man who sought counseling because of

his compulsive vomiting and anxiety in dating situations. The second paragraph detailed the therapist's conceptualization of the client's problems and plan for intervention in terms of placing the client in a therapeutic double-bind by means of prescribing his vomiting. The fourth paragraph outlined the therapist's implementation of the symptom prescription. The third and fifth paragraphs varied according to the experimental group of the subject.

The subjects were randomly assigned to one of the four conditions of the study's 2 X 2 factorial design: low deception/low informed consent (n=33), high deception/low informed consent (n=31), low deception/high informed consent (n=42), and high deception/high informed consent (n=38). The manner in which the therapist described in the vignettes sought and obtained the client's consent to treatment, and the rationale that was given for the symptom prescription determined the four experimental conditions. The specific components of the vignettes relevant to the four conditions are described in the following paragraphs.

Low informed consent. In this condition the therapist told the client that he must agree to follow the therapist's instructions exactly--without asking any questions--before he will be told how to solve his problem. The client then gave his consent to proceed. (vignettes 1 and 2)

High informed consent. In this condition the therapist told the client that he will be asked to continue vomiting for awhile, though it might seem strange or be unpleasant. The therapist offered to answer any questions that the young man might have at any time during treatment. The client then gave his consent to proceed. (vignettes 3 and 4)

Low deception. In this condition the therapist disclosed to the client the rationale of the therapeutic double-bind that led to the formulation of the symptom prescription. (vignettes 1 and 3)

High deception. In this condition the rationale that the client was given for the symptom prescription was that it would increase his awareness of the causes of his vomiting so that a plan to eliminate it could be developed. (vignettes 2 and 4)

A counseling psychologist unfamiliar with this study evaluated the four treatment vignettes in terms of their levels of informed consent and deception and correctly identified all four treatment conditions.

Acceptability measures. Two different instruments were used in this study to measure treatment acceptability, the Treatment Evaluation Inventory--Short Form (TEI-SF; Kelley, Heffer, Gresham, & Elliott, 1989) and the Intervention Rating Profile-15 (IRP-15; Witt & Elliott,

1985).

The TEI-SF (see Appendix C) is a 9-item scale which asks respondents to rate various aspects of the acceptability of an intervention used to treat a child's problem on a 5-point Likert scale. This instrument is a revision of Kazdin's (1980a) original TEI. A coefficient alpha estimate of the internal consistency of the TEI-SF has been reported by Kelley et al. (1989) as .85. These authors also provide validity data in the form of the TEI-SF's ability to discriminate among treatments at the .01 level of significance.

The IRP-15 (see Appendix C) is a 15-item scale which also requires subjects to evaluate several aspects of the acceptability of a procedure used to treat a child's behavior problem using a 6-point Likert scale. The IRP-15 is a revision of the original 20-item IRP (Witt & Martens, 1983) with a simplified factor structure (the original scale had one primary factor and four secondary factors, while the IRP-15 has a single factor). Elliott, Turco, and Gresham (1987) report a .98 coefficient alpha estimate of the internal consistency of the IRP-15. Regarding validity, several studies (Elliott et al., 1987; Hall & Didier, 1987; Hall & Wahrman, 1988) have reported that the IRP-15 effectively discriminated among interventions in terms of acceptability.

Since both of these measures were designed specifically for the evaluation of behavioral interventions with children in school and institutional settings, the following minor changes in the wording of these measures were deemed appropriate for this investigation. "Child," "teacher," "classroom," and "problem behavior" or "behavior problem" were replaced by "client," "therapist," "therapy," and "problem," respectively.

RESULTS

Factor Analysis

Because the IRP-15 and the TEI-SF have not seen widespread use, it seemed important to verify their psychometric properties. However, the statistical package used in this study (SYSTAT-Version 4.1; Wilkinson, 1989) will not compute coefficient alpha estimates of reliability, so a decision was made to factor analyze the IRP-15 and the TEI-SF. This was done to develop more stable and homogeneous measures of treatment acceptability for the purposes of this study.

The 24 items composing the IRP-15 and the TEI-SF were subjected to a principal components analysis with varimax rotation. The criteria used in determining the number of factors were: the factors with eigenvalues greater than one, the scree test, the amount of variance accounted for by the factor solution, and the meaningfulness of the factor solution. Two factors emerged which combined to account for 71% of the total variance. These components approximated the factor structures reported for the unifactorial IRP-15 (Hall & Didier, 1987; Hall & Wahrman, 1988) and the duofactorial TEI-SF (Kelley et al., 1989).

Table 1 reports the items and their loadings on each factor.

Factor 1 was composed of 14 items from the IRP-15 and 6 items from the TEI-SF with item loadings ranging from .90 to .73. This factor accounted for 60% of the total variance. Factor 1 was named **General Acceptability** as it seemed to reflect a variety issues regarding the appropriateness of an intervention, including: willingness to use a treatment, willingness to recommend a treatment to colleagues, judgments of an intervention's sensibility, perceptions of a treatment's potential efficacy for a particular problem and additional ones, and perceptions of colleagial reactions to the type of intervention described.

Factor 2 was composed of 3 items from the TEI-SF and 1 item from the IRP-15 and accounted for 11% of the total variance. The item loadings on this factor ranged from .71 to .58. The items making up this factor focused on the acceptability of an intervention in light of the ethical considerations of consent to treatment and the possibility of negative side effects for the client. Factor 2 was named **Ethical Acceptability** as its items seemed to relate to an element of the broader **General Acceptability** factor. As might be expected, the two factors were found to be moderately correlated (r=.47; see Table 2).

TABLE 1

Factor Loadings for the Intervention Rating Profile-15 and the Treatment Evaluation Inventory-Short Form with Varimax Rotation

	Factor 1	Factor 2
Factor 1: Acceptability		
I4. I would suggest the use of this intervention to other therapists.	.90	.12
I12. This intervention is reasonable for the problem described.	.88	.21
I3. This intervention should prove effective in changing the client's problem.	.88	.06
I7. I would be willing to use this intervention in a therapy setting.	.88	.18
T1. I find this treatment to be an acceptable way of dealing with the client's problem.	.88	.20
T9. Overall, I have a positive reaction to this treatment.	.88	.21
I13. I liked the procedures used in this intervention.	.87	.18
T5. I believe this treatment is likely to be effective.	.87	.16
T2. I would be willing to use this procedure if I had to change the client's problem.	.87	.23
T4. I like the procedures used in this treatment.	.84	.25
I1. This would be an acceptable intervention for the client's problem.	.84	.20
I5. The client's problem is severe enough to warrant use of this intervention.	.84	.24
I10. This intervention is consistent with those I have used in therapy settings.	.83	.13
I14. This intervention was a good way to handle the client's problem.	.82	.35
I15. Overall, this intervention would be beneficial for the client.	.81	.35
I11. The intervention was a fair way to handle the client's problem.	.77	.41
I9. This intervention would be appropriate for a variety of clients.	.76	.25
I6. Most therapists would find this intervention suitable for the problem described.	.76	.07
I2. Most therapists would find this intervention appropriate for problems in addition to the one described.	.75	-.05
T7. I believe this treatment is likely to result in permanent improvement.	.73	.24
Factor 2: Ethical Issues		
T3. I believe that it would be acceptable to use this treatment without a client's consent.	.20	.71
I8. This intervention would **not** result in negative side effects for the client.	.37	.66
T6. I [do not] believe the client will experience discomfort during the treatment.	-.20	.59
T8. I believe it would be acceptable to use this treatment with individuals who cannot choose treatments for themselves.	.47	.58
Total Variance Explained	.60	.11

TABLE 2

Pearson Correlation Matrix

	1	2	3	4	5	6	7	8	9	10
1. Age	--									
2. Years experience	.78**	--								
3. Hours per week	.00	.03	--							
4. Attitude 1	.14	.13	-.07	--						
5. Attitude 2	.12	.04	.23	-.07	--					
6. Attitude 3	.16	.08	-.04	-.20	.19	--				
7. Attitude 4	.28	.28	-.12	.01	.01	-.10	--			
8. Attitude 5	-.02	-.14	-.24	.00	-.01	.37*	.02	--		
9. Factor 1	-.17	-.09	.06	.08	-.19	-.43**	.13	-.14	--	
10. Factor 2	-.13	-.06	.07	-.03	-.03	-.21	.18	-.24	.47**	--

n=107

Using Bonferroni correction method:

*$p<.05$

**$p<.001$

Descriptive Statistics

Means and standard deviations on the dependent variables of General Acceptability and Ethical Acceptability by the grouping variables of treatment condition, gender, and theoretical orientation are presented in Table 3. The full sample means on General Acceptability (2.70) and Ethical Acceptability (2.31) were slightly below the midpoints of 2.85 and 2.63, respectively. No significant differences among the dependent variables were found based on these independent variables, with one exception. When the psychodynamic and eclectic groups were compared across treatment conditions (the cell sizes of the other theoretical orientations were deemed too small for reliable comparisons), it was found that the psychodynamic therapists' ratings were significantly lower on General Acceptability than those of the eclectic therapists, $t(111) = 2.475$, $p < .05$.

Analysis of Variance and Analysis of Covariance

The primary purpose of this study was to examine the effects of using deception and informed consent on therapists' ratings of the acceptability of symptom prescription. This was accomplished using a 2 (low deception/high deception) X 2 (low informed consent/high informed consent) analysis of variance. However, no significant main or interaction effects were found on either

TABLE 3

Summary Statistics for Factor 1 and Factor 2 by Treatment, Gender, and Theoretical Orientation

	Factor 1		Factor 2	
	M	SD	M	SD
Treatment Group				
Low Deception/Low Consent (n=33)	2.47	.95	2.29	.78
High Deception/Low Consent (n=31)	2.66	1.14	2.33	.75
Low Deception/High Consent (n=42)	2.77	1.09	2.24	.79
High Deception/High Consent (n=38)	2.86	1.20	2.39	.77
Gender				
Female (n=63)	2.50	1.05	2.24	.80
Male (n=75)	2.87	1.14	2.37	.75
Unspecified (n=6)	2.75	.96	2.29	.80
Theoretical Orientation				
Behavioral (n=4)	3.19	1.26	3.06	.83
Cognitive (n=7)	2.28	1.11	1.96	.73
Humanistic (n=6)	2.87	1.02	2.79	.89
Psychodynamic (n=32)	2.28*	1.06	2.42	.81
Systems (n=4)	3.45	1.67	2.25	1.46
Eclectic (n=80)	2.85*	1.10	2.27	.70
Other (n=5)	2.78	.90	1.92	.41
Unspecified (n=6)	2.46	.69	1.96	.73
All Groups (N=144)	2.70	1.09	2.31	.77

*Theoretical differences were found to be statistically significant, $p < .05$.

Note: Factor 1 was composed of fourteen items ranked on a six point scale and six items ranked on a five point scale (range=1.00-5.70). Factor 2 was composed of three items ranked on a five point scale and one item ranked on a six point scale (range=1.00-5.25).

General Acceptability or Ethical Acceptability (see Table 4). In addition, a 2 X 2 analysis of covariance was performed using theoretical orientation as the covariate (psychodynamic or eclectic). Table 5 shows that this strategy also failed to yield any significant main or interaction effects on General Acceptability or Ethical Acceptability. Therefore, the context in which the symptom prescription was delivered was not found to effect psychotherapists' ratings of the intervention's acceptability.

Multiple Regression Analyses

A secondary focus of this study was examine whether therapists' attitudes would be related to their ratings of the acceptability of symptom prescription. To this end, separate stepwise multiple regressions were employed using the therapy attitude items on the demographics questionnaire (see Appendix A) to predict General and Ethical Acceptability ratings for each condition. Before the results of this procedure are described, it should be noted that the third attitude variable (use of deception cannot be justified) evidenced a significant correlation with both the fifth attitude variable (no intervention should be used without informed consent) and the General Acceptability factor (r=.37, p<.05, and r=-.43, p<.001, respectively; see Table 2).

TABLE 4

2 X 2 Analysis of Variance Effects of Deception and Informed Consent on Factor 1 and Factor 2

Factor 1

	SS	F	p
Deception	.68	.56	.46
Consent	2.22	1.82	.18
Deception X Consent	.11	.09	.76

Factor 2

	SS	F	p
Deception	.35	.58	.45
Consent	.00	.00	.98
Deception X Consent	.11	.19	.67

N=144

TABLE 5

2 X 2 Analysis of Covariance Effects of Deception and Informed Consent on Factor 1 and Factor 2 using Theoretical Orientation (Psychodynamic and Eclectic) as Covariate

Factor 1

	SS	F	p
Theory	6.66	5.49	.02
Deception	.10	.08	.78
Consent	.05	.04	.85
Deception X Consent	.24	.20	.66

Factor 2

	SS	F	p
Theory	.46	.84	.36
Deception	.06	.11	.74
Consent	.15	.27	.61
Deception X Consent	.04	.08	.78

n=112

Regression of the General Acceptability factor onto the five attitude variables, by treatment condition, revealed only the "deception cannot be justified" item as a significant predictor (see Table 6). This item was a predictor of General Acceptability in the low deception/low informed consent (R^2=.40; p<.001), low deception/high informed consent (R^2=.10; p<.05), and high deception/high informed consent (R^2=.15; p<.05) treatment groups. However, none of the attitude variables significantly predicted General Acceptability ratings in the high deception/low informed consent group. Finally, when all four treatment groups were combined this attitude variable accounted for 16% of the variance (p<.001) in General Acceptability ratings. In each case in which it was identified as a significant predictor, the "deception cannot be justified" item was negatively related to General Acceptability.

The stepwise multiple regression procedure yielded a much less consistent set of predictors when the Ethical Acceptability ratings were regressed onto the attitude variables by treatment condition (see Table 6). The attitude predictors which reached statistical significance fluctuated among treatment conditions. In the low deception/low informed consent condition, the "no intervention should be employed without informed consent"

TABLE 6

Summary of Stepwise Regression Analyses Using Attitude Variables to Predict Factor 1 and Factor 2

Factor 1

Group	Predictor	R^2	F	df	p
Low Deception/Low Consent	Attitude 3	.40	19.25	(1,29)	.00
High Deception/Low Consent	—	—	—	—	—
Low Deception/High Consent	Attitude 3	.10	4.15	(1,39)	.05
High Deception/High Consent	Attitude 3	.15	6.27	(1,35)	.02
All Conditions	Attitude 3	.16	26.30	(1,134)	.00
Psychodynamic	Attitudes 3+2	.55	16.83	(2,28)	.00
Eclectic	Attitude 3	.06	5.18	(1,76)	.03

Factor 2

Group	Predictor(s)	R^2	F	df	p
Low Deception/Low Consent	Attitude 5	.20	7.13	(1,29)	.01
High Deception/Low Consent	Attitude 3	.24	7.76	(1,25)	.01
Low Deception/High Consent	Attitude 4	.12	5.09	(1,39)	.03
High Deception/High Consent	Attitude 5	.13	4.87	(1,34)	.03
All Conditions	Attitudes 3+4	.11	7.89	(2,133)	.00
Psychodynamic	Attitude 3	.17	6.10	(1,29)	.02
Eclectic	Attitude 5	.08	6.23	(1,77)	.02

Note: alpha-to-enter and alpha-to-remove = .05

item accounted for 20% of the variance in Ethical Acceptability ratings ($p<.05$). In the high deception/low informed consent condition, the "deception cannot be justified" item accounted for 24% of the variance in the dependent variable ($p<.05$). For the low deception/high informed consent group, the "use the intervention which produces change" item accounted for 12% of the variance in the dependent measure ($p<.05$). Finally, in the high deception/high informed consent condition, the "no intervention should be employed without informed consent" item accounted for 13% of the variance in Ethical Acceptability ratings ($p<.05$). When all four treatment conditions were grouped together, the "deception cannot be justified" and "use the intervention which produces change most efficiently" items emerged as significant predictors combining to account for 11% of the variance in Ethical Acceptability ratings ($p<.01$). When the "deception cannot be justified" and "no intervention should be employed without informed consent" items were identified as significant predictors, they were negatively related to Ethical Acceptability. In contrast, the "use the intervention which produces change" item was positively related to Ethical Acceptability.

Because of the significant differences in the General Acceptability ratings of psychodynamic and eclectic

therapists and the inconsistent set of predictors identified for Ethical Acceptability, additional stepwise regression procedures were performed. The psychodynamic and eclectic groups were considered across treatment conditions using the attitude variables as predictors (see Table 6). For the psychodynamic group, General Acceptability ratings were negatively related to the "deception cannot be justified" and "no real change without insight" items (R^2=.55; p<.001). Only the "deception cannot be justified" item was related to Ethical Acceptability for the psychodynamic group (R^2=.17; p<.05). For the eclectic therapists, the "deception cannot be justified" item emerged as negatively related to General Acceptability (R^2=.06; p<.05), and the "no intervention should be employed without informed consent" item related negatively to Ethical Acceptability (R^2=.08; p<.05).

DISCUSSION

Use of Deception and Informed Consent and the Acceptability of Symptom Prescription

The primary question this study addressed was: Does the use of deception and/or informed consent in the delivery of a symptom prescription affect its acceptability to therapists? However, the results of this study did not support the conclusion that the presence (or absence) of deception and/or informed consent significantly impact the General or Ethical Acceptability of a symptom prescription. Further, when theoretical differences were taken into consideration, no differences were found in the acceptability of symptom prescription when the levels of deception and informed consent were manipulated.

Beyond the real possibility that the use of deception and informed consent do not significantly influence the acceptability of symptom prescription, there are at least two plausible reasons for this study's lack of conclusive findings. First, because no manipulation check was included in the study, it is not certain that the subjects perceived the treatment conditions as sufficiently distinct in regard to the independent variables. Second, the particular

symptom prescription involved (i.e., instructing the client to vomit) may have prevented any differences based on the treatment conditions from being detected; perhaps instructing the client to vomit was equally objectionable to the therapists across treatment conditions.

So the questions of whether and how the use of deception and informed consent affect the acceptability of symptom prescription remain unanswered. But on the basis of the foregoing, one might tentatively conclude (realizing the dangers of arguing from null results), that we should look elsewhere in trying to understand why paradoxical interventions are so controversial. Perhaps the key is whether paradoxical interventions can be accommodated by one's primary theoretical orientation--an idea for which this study provides preliminary support. However, this study also identified a relationship between therapists' attitudes about the use of deception and lack of informed consent and the acceptability of the symptom prescription.

Assumptions about Psychotherapy and Acceptability of Symptom Prescription

The secondary question this study addressed was: What are some of the attitudes that therapists hold which relate to their judgments of a symptom prescription's acceptability? The results of the study allow this question

to be answered more conclusively. General Acceptability was related to theoretical orientation and attitudes about the use of deception and of the role of insight in therapy. Ethical Acceptability was associated with attitudes about the use of deception and informed consent, as well as with an attitude which says essentially "the end justifies the means."

The relationship between theoretical orientation and General Acceptability was not surprising. Psychodynamic therapists found the symptom prescription to be significantly less acceptable than did the eclectic therapists. These theoretical differences could be anticipated as the traditional psychodynamic therapist who employs an insight-oriented approach to therapy would be expected to react negatively to the directive nature of symptom prescription. While those therapists who choose to call themselves "eclectic" could be expected to be more pragmatic and flexible in their modes of intervention.

Another attitude variable which emerged as related to General Acceptability of symptom prescription was the "deception cannot be justified by any amount of change" item. This item was negatively related to acceptability so that the more strongly a subject agreed with this statement, the less acceptable the intervention was to him/her, and vice versa. However, this attitude variable

did not relate to General Acceptability in the high deception/low informed consent condition. This condition should have been the most objectionable leading the deception item, and perhaps the consent item, to be predictive, but that was obviously not the case. Perhaps many of the subjects in this condition reasoned that a symptom prescription could only be effective in a high deception/low informed consent context--which is consistent with the classic double-bind theory. This could have led to their attitudes about the use of deception and informed consent being less predictive of acceptability than they would normally have been.

Finally, for the psychodynamic therapists, the attitude that insight is prerequisite to significant change combined with the deception variable to account for over half of the variance in General Acceptability. This finding was not surprising because the client's development of insight is seen as so very fundamental by psychodynamically-oriented therapists, but is usually ignored in the use of symptom prescription. However, the key attitude related to General Acceptability across groups was that regarding deception as it appeared once again--this time as the only signficant predictor for the eclectic therapists.

The attitude variables related to the secondary factor of Ethical Acceptability were less consistent and more

diverse making their interpretation more problematic. When all the treatment conditions were grouped together, the deception attitude was again the most significant predictor, but this time in tandem with the positively related therapeutic pragmatism item (use the intervention which produces change). That is, the more pragmatic the therapist indicated s/he was, the more Ethically Acceptable s/he rated the symptom prescription (and vice versa). In addition to its role in predicting Ethical Acceptability for the entire sample, the therapeutic pragmatism item was related to Ethical Acceptability in the low deception/high informed consent condition. However, it is worth noting that this treatment condition should be the least objectionable, and so the positive relationship between this attitude and acceptability ratings is not very surprising.

The deception item was the only one related to Ethical Acceptability in the high deception/low informed consent condition. Interesting to note, this is the only condition in which this attitude was not predictive of General Acceptability. These results show the "deception cannot be justified" item to be the one most consistently related to acceptability across treatment groups and dependent measures. It is also interesting to note that the therapists' attitudes about deception were related to

acceptability, while actual differences in the use of deception were not. Perhaps this is but another example of the discrepancies that are often found between persons' attitudes and their presumably related behaviors (Myers, 1987).

Finally, in both the low deception/low informed consent and high deception/high informed consent conditions the informed consent item (no intervention should be used without informed consent) emerged as a negatively related predictor. That is, those who agreed with this item tended to judge the symptom prescription as less Ethically Acceptable (and vice versa). Once again, the nature of the relationship between this attitude and acceptability is not surprising. However, offering reasons for why this attitude emerged as predictive in these treatment conditions involves mere speculation. One could surmise that in the low deception/low informed consent condition that since consent rather than deception was at issue, it makes sense that the consent attitude was related to Ethical Acceptability. However, such an interpretation does not leave room to explain with consistency why this attitude variable was predictive in the high deception/high informed consent condition. One might note the significance of the correlation between the deception and consent attitude variables, then proceed to say that it was merely chance

which led the consent item to be predictive rather than the deception item for this particular condition. But such an understanding leads to ever greater inconsistencies with the interpretations of the other treatment conditions.

Finally, Ethical Acceptability was related to the deception attitude variable for the psychodynamic therapists and the the informed consent attitude for the eclectic therapists. These findings serve to reinforce the large role that attitudes about deception and informed consent played in determining the Ethical Acceptability of symptom prescription.

Limitations of this Study

The weaknesses of this study can be divided into two groups, those bearing primarily on internal validity and those restricting external validity. Two limitations in regard to internal validity have been discussed earlier, but their importance bears repeating. First, because there was no manipulation check on the deception and informed consent independent variables included in the study proper, it is not certain whether the treatment conditions were perceived as being sufficiently distinct. Second, there are questions about the specific symptom prescription used in the treatment vignettes and how that may have led to null results in regard to the primary questions this study sought to address. Both of these limitations could have

been addressed more fully by the inclusion of a more substantial pilot study.

Regarding the external validity of this study, there were two more important limitations. First, because only 36% of those who were selected to participate in this study returned their packets, it is impossible to know if the other 64% differed from those who participated in this study in a meaningful way--perhaps some sort of self-selection bias was manifested. Second, only the psychodynamic and eclectic theoretical groups were represented by sufficient numbers to draw conclusions about their perceptions of the acceptability of symptom prescription--the evaluations of behavioral, cognitive, or family systems therapists may have been different.

Future Research

As mentioned earlier, only two other studies in the published literature have addressed the acceptability of symptom prescription to psychotherapists, and so this issue definitely warrants further empirical research. Certainly this study would bear systematic and conceptual replication. Such investigations might profitably use another example of symptom prescription (or other type of paradoxical intervention), a broader sample of theoretical orientations, and a broader sample of the therapeutic specialties (e.g., pastoral counseling, psychiatry, and social work). Further,

it could prove important to extend the examination of the acceptability of symptom prescription to clients--the ultimate consumers of psychotherapy. But perhaps the most interesting question this study raised has to do with the lack of congruence between therapists' attitudes about the use of deception and informed consent and their judgments of the acceptability of symptom prescription when the levels of deception and informed consent were manipulated.

Summary

Symptom prescription is the most directive and controversial of a group of unconventional techniques called paradoxical interventions. So it is not surprising to find--as this study did--that such a method is more acceptable to eclectic psychotherapists than to more traditional, insight-oriented psychodynamic therapists. A review of the literature revealed that the use of deception and a lack of informed consent are often part of the context in which paradoxical interventions are delivered. Accordingly, it seemed likely that these ethical problems could be important in contributing to the controversy surrounding paradoxical interventions. Nevertheless, manipulating these salient ethical aspects of the context of a symptom prescription did not evidence a statistically significant effect on therapists'

perceptions of the acceptability of the intervention in this study. However, the results of this study do suggest that psychotherapists' attitudes about deception and informed consent were related to their judgments of the acceptability of the symptom prescription.

APPENDIX A

Demographics Questionnaire

Please indicate your current status in regard to the following items.

Age: _______ Gender: ____ Female ____ Male

Years of post-degree therapy experience: _______

Primary theoretical orientation:
____ Behavioral
____ Cognitive
____ Humanistic
____ Psychodynamic
____ Systems
____ Eclectic
____ Other

Current number of client-hours per week: _______

Please circle the number that best represents your level of agreement with the following statements about psychotherapy (1=Strongly disagree, 2=Disagree, 3=Neutral, 4=Agree, 5=Strongly agree).

1. The therapist—not the client—bears the primary responsibility for progress in therapy.
   1 2 3 4 5
2. There can be no significant change in therapy without the client first gaining insight.
   1 2 3 4 5
3. The use of a deceptive intervention cannot be justified by any amount of constructive change.
   1 2 3 4 5
4. The most appropriate intervention is always the one that produces behavioral change most efficiently.
   1 2 3 4 5
5. No therapeutic intervention should be employed without first gaining the client's informed consent.
   1 2 3 4 5

APPENDIX B

Vignette #1

A young man sought therapy due to his compulsive vomiting (a physician determined that there were no physical causes of the vomiting). This client was so anxious about going on dates with eligible young women that he felt numerous urges to vomit during the course of the evening. His frequent absences to the bathroom understandably hindered his attempts at establishing intimate relationships, and he had developed a strong secondary anxiety (i.e., he had become very anxious about the prospect of becoming anxious, thus increasing his anxiety). He had begun avoiding dating situations entirely and had become extremely pessimistic about his ever being able to establish a permanent relationship with a woman.

Reasoning that the anxiety and the vomiting had become part of a self-perpetuating system that seemed to be out of the client's control, the therapist decided to intervene directly with the problem behavior. The therapist wanted to help the client gain control over an apparently spontaneous behavior—the vomiting. The intervention chosen was to instruct the client to vomit voluntarily. The therapist believed that this intervention would result in one of two outcomes: (1) the young man would be unable to vomit intentionally and the problem would be resolved, or (2) the vomiting might continue, but there would be less anxiety associated with it (making it more manageable) because the client was being directed to continue vomiting.

Before implementing the treatment, the therapist stated: "I know how to solve your problem, but I need you to trust me on this. Before I tell you, I need you to agree to follow my instructions exactly, without asking any questions. Will you do that?" The client agreed.

The primary therapeutic strategy consisted of instructing the client to go into the bathroom exactly forty-five minutes before an upcoming date--with toothbrush in hand and mouthwash at hand—and to vomit deliberately for as long as he could.

The rationale that was given to the client for following these instructions was as follows: "The reason that I want you to do this is that I think it will help you gain control over your vomiting—something that seems to be out of your control now. If you can vomit as I've directed you to, you will demonstrate that you really do have control over it, and you won't be anxious about it because I've given you permission to vomit. But I imagine that it will be difficult for you to vomit on purpose, and if that's the case, your problem will be solved."

Vignette #2

A young man sought therapy due to his compulsive vomiting (a physician determined that there were no physical causes of the vomiting). This client was so anxious about going on dates with eligible young women that he felt numerous urges to vomit during the course of the evening. His frequent absences to the bathroom understandably hindered his attempts at establishing intimate relationships, and he had developed a strong secondary anxiety (i.e., he had become very anxious about the prospect of becoming anxious, thus increasing his anxiety). He had begun avoiding dating situations entirely and had become extremely pessimistic about his ever being able to establish a permanent relationship with a woman.

Reasoning that the anxiety and the vomiting had become part of a self-perpetuating system that seemed to be out of the client's control, the therapist decided to intervene directly with the problem behavior. The therapist wanted to help the client gain control over an apparently spontaneous behavior—the vomiting. The intervention chosen was to instruct the client to vomit voluntarily. The therapist believed that this intervention would result in one of two outcomes: (1) the young man would be unable to vomit intentionally and the problem would be resolved, or (2) the vomiting might continue, but there would be less anxiety associated with it (making it more manageable) because the client was being directed to continue vomiting.

Before implementing the treatment, the therapist stated: "I know how to solve your problem, but I need you to trust me on this. Before I tell you, I need you to agree to follow my instructions exactly, without asking any questions. Will you do that?" The client agreed.

The primary therapeutic strategy consisted of instructing the client to go into the bathroom exactly forty-five minutes before an upcoming date—with toothbrush in hand and mouthwash at hand—and to vomit deliberately for as long as he could.

Concerned that telling the client the actual nature of the intervention would diminish its therapeutic effects, the following rationale was given to the client: "You should follow my instructions in order to increase your awareness of the causes of the vomiting. Pay close attention to your thoughts, feelings, and sensations before, during, and after you vomit. Write these things down and bring them to our next session. This will help us to more effectively plan how to eliminate your problem."

Vignette #3

A young man sought therapy due to his compulsive vomiting (a physician determined that there were no physical causes of the vomiting). This client was so anxious about going on dates with eligible young women that he felt numerous urges to vomit during the course of the evening. His frequent absences to the bathroom understandably hindered his attempts at establishing intimate relationships, and he had developed a strong secondary anxiety (i.e., he had become very anxious about the prospect of becoming anxious, thus increasing his anxiety). He had begun avoiding dating situations entirely and had become extremely pessimistic about his ever being able to establish a permanent relationship with a woman.

Reasoning that the anxiety and the vomiting had become part of a self-perpetuating system that seemed to be out of the client's control, the therapist decided to intervene directly with the problem behavior. The therapist wanted to help the client gain control over an apparently spontaneous behavior—the vomiting. The intervention chosen was to instruct the client to vomit voluntarily. The therapist believed that this intervention would result in one of two outcomes: (1) the young man would be unable to vomit intentionally and the problem would be resolved, or (2) the vomiting might continue, but there would be less anxiety associated with it (making it more manageable) because the client was being directed to continue vomiting.

Before implementing the treatment, the therapist stated: "There are many ways that we could address your problem, and I have an idea that I'd like to try with your permission. I know it will sound strange to you and it may even be unpleasant, but I'd like to ask you to continue vomiting for awhile. If you have any questions about this I will answer them now or as they come up later in treatment. Is that O.K. with you?" The client agreed.

The primary therapeutic strategy consisted of instructing the client to go into the bathroom exactly forty-five minutes before an upcoming date—with toothbrush in hand and mouthwash at hand—and to vomit deliberately for as long as he could.

The rationale that was given to the client for following these instructions was as follows: "The reason that I want you to do this is that I think it will help you gain control over your vomiting—something that seems to be out of your control now. If you can vomit as I've directed you to, you will demonstrate that you really do have control over it, and you won't be anxious about it because I've given you permission to vomit. But I imagine that it will be difficult for you to vomit on purpose, and if that's the case, your problem will be solved."

Vignette #4

A young man sought therapy due to his compulsive vomiting (a physician determined that there were no physical causes of the vomiting). This client was so anxious about going on dates with eligible young women that he felt numerous urges to vomit during the course of the evening. His frequent absences to the bathroom understandably hindered his attempts at establishing intimate relationships, and he had developed a strong secondary anxiety (i.e., he had become very anxious about the prospect of becoming anxious, thus increasing his anxiety). He had begun avoiding dating situations entirely and had become extremely pessimistic about his ever being able to establish a permanent relationship with a woman.

Reasoning that the anxiety and the vomiting had become part of a self-perpetuating system that seemed to be out of the client's control, the therapist decided to intervene directly with the problem behavior. The therapist wanted to help the client gain control over an apparently spontaneous behavior--the vomiting. The intervention chosen was to instruct the client to vomit voluntarily. The therapist believed that this intervention would result in one of two outcomes: (1) the young man would be unable to vomit intentionally and the problem would be resolved, or (2) the vomiting might continue, but there would be less anxiety associated with it (making it more manageable) because the client was being directed to continue vomiting.

Before implementing the treatment, the therapist stated: "There are many ways that we could address your problem, and I have an idea that I'd like to try with your permission. I know it will sound strange to you and it may even be unpleasant, but I'd like to ask you to continue vomiting for awhile. If you have any questions about this I will answer them now or as they come up later in treatment. Is that O.K. with you?" The client agreed.

The primary therapeutic strategy consisted of instructing the client to go into the bathroom exactly forty-five minutes before an upcoming date--with toothbrush in hand and mouthwash at hand--and to vomit deliberately for as long as he could.

Concerned that telling the client the actual nature of the intervention would diminish its therapeutic effects, the following rationale was given to the client: "You should follow my instructions in order to increase your awareness of the causes of the vomiting. Pay close attention to your thoughts, feelings, and sensations before, during, and after you vomit. Write these things down and bring them to our next session. This will help us to more effectively plan how to eliminate your problem."

APPENDIX C

Treatment Evaluation Inventory--Short Form

Instructions: Please respond to the items listed below by circling the number that best indicates how you feel about the treatment decribed in the preceding vignette (1=Strongly disagree, 2=Disagree, 3=Neutral, 4=Agree, 5=Strongly agree).

1. I find this treatment to be an acceptable way of dealing with the client's problem.
   1 2 3 4 5
2. I would be willing to use this procedure if I had to change the client's problem.
   1 2 3 4 5
3. I believe that it would be acceptable to use this treatment without a client's consent.
   1 2 3 4 5
4. I like the procedures used in this treatment.
   1 2 3 4 5
5. I believe this treatment is likely to be effective.
   1 2 3 4 5
6. I believe the client will experience discomfort during the treatment.
   1 2 3 4 5
7. I believe this treatment is likely to result in permanent improvement.
   1 2 3 4 5
8. I believe it would be acceptable to use this treatment with individuals who cannot choose treatments for themselves.
   1 2 3 4 5
9. Overall, I have a positive reaction to this treatment.
   1 2 3 4 5

Intervention Rating Profile-15

Instructions: The purpose of this questionnaire is to obtain information that will aid in the selection of therapeutic interventions. Please indicate the number which best describes your level of agreement or disagreement with each statement (1=Strongly disagree, 2=Disagree, 3=Slightly disagree, 4=Slightly agree, 5=Agree, 6=Strongly agree).

1. This would be an acceptable intervention for the client's problem.
   1 2 3 4 5 6
2. Most therapists would find this intervention appropriate for problems in addition to the one described.
   1 2 3 4 5 6
3. This intervention should prove effective in changing the client's problem.
   1 2 3 4 5 6
4. I would suggest the use of this intervention to other therapists.
   1 2 3 4 5 6
5. The client's problem is severe enough to warrant use of this intervention.
   1 2 3 4 5 6
6. Most therapists would find this intervention suitable for the problem described.
   1 2 3 4 5 6
7. I would be willing to use this intervention in a therapy setting.
   1 2 3 4 5 6
8. This intervention would **not** result in negative side effects for the client.
   1 2 3 4 5 6
9. This intervention would be appropriate for a variety of clients.
   1 2 3 4 5 6
10. This intervention is consistent with those I have used in therapy settings.
    1 2 3 4 5 6
11. The intervention was a fair way to handle the client's problem.
    1 2 3 4 5 6
12. This intervention is reasonable for the problem described.
    1 2 3 4 5 6
13. I liked the procedures used in this intervention.
    1 2 3 4 5 6
14. This intervention was a good way to handle the client's problem.
    1 2 3 4 5 6
15. Overall, this intervention would be beneficial for the client.
    1 2 3 4 5 6

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VITA

The author, Brian Alan McElwain, was born November 2, 1966, in Newark, Ohio.

In August, 1985, Mr. McElwain entered Kentucky Christian College. He received the Bachelor of Science degree with a major in psychology in May, 1989.

After entering Loyola University of Chicago in August, 1989, Mr. McElwain was granted an assistantship in the Department of Counseling and Educational Psychology. This enabled him to complete the Master of Arts degree in Community Counseling in 1992.

APPROVAL SHEET

The thesis submitted by Brian A. McElwain has been read and approved by the following committee:

Dr. Albert A. Agresti, S.J., Director
Assistant Professor, Counseling and Educational Psychology
Loyola University of Chicago

Dr. V. Scott Solberg
Assistant Professor, Counseling and Educational Psychology
Loyola University of Chicago

The final copies have been examined by the director of the thesis and the signature which appears below verifies the fact that any necessary changes have been incorporated and the the thesis is now given final approval by the Committee with reference to content and form.

The thesis is therefore accepted in partial fulfillment of the requirements for the degree of Master of Arts.

April 14, 1992
Date

Director's Signature