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The effectiveness of a short term, didactic, group psychotherapy in eliminating self defeating behavior, increasing internal locus of control and increasing self esteem.

John Alden Barbaro
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THE EFFECTIVENESS OF A SHORT TERM, DIDACTIC, GROUP PSYCHOTHERAPY IN ELIMINATING SELF DEFEATING BEHAVIOR, INCREASING INTERNAL LOCUS OF CONTROL AND INCREASING SELF ESTEEM

A Dissertation Presented
By
JOHN ALDEN BARBARO

Submitted to the Graduate School of the University of Massachusetts in partial fulfillment of the requirements for the degree of

DOCTOR OF EDUCATION
February 1982

Education
THE EFFECTIVENESS OF A SHORT TERM, DIDACTIC, GROUP PSYCHOTHERAPY IN ELIMINATING SELF DEFEATING BEHAVIOR, INCREASING INTERNAL LOCUS OF CONTROL AND INCREASING SELF ESTEEM

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By
JOHN ALDEN BARBARO

Approved as to style and content by:

Allen E. Ivey, Chairperson of Committee
Grace J. Craig, Member
Theodore Slovin, Member

Mario D. Fantini, Head
School of Education
DEDICATION

To all the children who grow into adults without being openly loved and warmly nurtured by those on whom they must depend.
ACKNOWLEDGEMENTS

To Susan, my love; for more than the dedicated and expert editing: While I gave birth to this she acted as midwife, at the same time giving birth to our daughter, and parenting her and our son.

To Gerry Weinstein; who gave me the opportunity to do graduate work.

To Pauline Ashby; who provided continuous support and good will throughout my graduate career.

To Ellis Olim and to Bonnie Strickland; for their initial sponsorship and direction in this study.

To Grace Craig and to Ted Slovin; who both lent extra support and advice when it was needed.

To Al Ivey; who provided required leadership at a crucial intersection in my research, and the opportunity to prove my self-direction.

To Jean Losco; who diligently organized my data into machine-analyzable form, while completing her own doctoral program, and gave the computer the appropriate commands.

To Marie Hartwell-Walker; for her gift of time, attention and advice, and for providing a focus in times of diffusion.
To Arne Welhaven; for the discussions and support which were instrumental in illuminating my desire to complete my life as a student and complete my professional credentials.

And to the others whose influence has been essential to this process.
ABSTRACT

The Effectiveness of a Short Term, Didactic, Group Psychotherapy in Eliminating Self Defeating Behavior, Increasing Internal Locus of Control, and Increasing Self Esteem

(February 1982)

John Barbaro, B.A., University of Massachusetts M.Ed., Ed.D., University of Massachusetts Directed by: Professor Allen E. Ivey

The purpose was to determine how effective the Elimination of Self Defeating Behavior group process was in decreasing the frequency and severity of self-selected self-defeating behaviors (SDB's) on the Participant SDB Questionnaire and on participant SDB's selected by associates on the Associate SDB Questionnaire, decreasing the score on the Internal Versus External Locus of Control Scale, and increasing the Global Self Esteem score on the Self Report Inventory.

Group I (treatment and follow-up group) had the ESDB treatment during five weeks, two nights weekly (equaling 30 hours); while Group II (control and treatment group) acted as a control. Group II then replicated Group I's treatment
period, while Group I waited for follow-up testing. Each group had 12 primarily college-educated, Caucasian, community participants with an average age of 31. The author, experienced in leading ESDB groups, facilitated both groups. Correlated and independent t-tests were used to determine significant differences (p<.05). Limitations included the narrowness of the population studied, the lack of a longer follow-up period, and the subjective nature of the instruments used.

Following treatment, significant SDB frequency and severity decreases were found for Groups I and II. One half of associates rated Group I SDB frequencies and Group II SDB severities as significantly decreased following treatment. Internal locus of both groups and self-esteem of Group I, significantly increased after treatment. Group II's increase in self-esteem following treatment was not significantly different from Group I's. Treatment procedure contamination may have led to significant frequency and severity decreases and self-esteem increases following the control period. There were no significant alterations in Group I gains two months after treatment. After determination of predicted significance in every measure (except one SDB frequency) from pre-control to post-treatment period for Group II, it was speculated that treatment enhancement...
follows from questionnaire completion and a five week pre-treatment waiting period.
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CHAPTER I
THE EFFECTIVENESS OF A SHORT TERM,
DIDACTIC, GROUP PSYCHOTHERAPY

The purpose of this study is to demonstrate that participation in a short-term, didactic, group process can:
(a) reduce the frequency of self-defeating behaviors; (b) increase internal locus of control; and (c) increase general self-esteem.

Self-sabotage is a good synonym for self-defeating behavior (SDB), which was defined by Warner (1966) and Cudney (1972) as meaning any behavior that one does repeatedly that impedes or interferes with the accomplishment of one's goals in living or prevents one from fulfilling one's potential. The SDB concept makes clear behavior which can be obscured in a multitude of reasons, descriptions, diagnostic labels, symptoms, and mystifying rationales for psychological disturbance. It is easy to see that if one feels defeated by one's own behaviors, self-esteem will be lowered and one's sense of personal power will be diminished. If this process is found to be an effective treatment for individuals seeking to change in the above ways, this group procedure holds promise to the increasing numbers of individuals seeking help with their
personal problems. Demonstrating that these kinds of individual positive changes can occur with this treatment process will add evidence challenging the assumption that only expensive, long-term, individual or group psychotherapy can provide the setting for personal growth.

The Need for an Effective Short Term Group Treatment

Faced in this country with ever-increasing numbers of people desiring and needing the assistance of trained mental health workers, and the continuing shortage of that same group of professionals, new treatment methods must continue to be explored and researched. Only in this way will psychological assistance be available to all who need it.

The Joint Commission on Mental Illness and Health Report in 1961 set a rough estimate of need for psychological services at 10 percent of the United States population (Finkel, 1976). Summarizing across four epidemiological surveys of mental illness and two early detection studies with young children, it was determined that thirty-three percent of the samples showed evidence of some degree of "psychiatric symptomatology or moderate to severe pathology" (Cowen & Zax, 1967, p. 14). Two of those four epidemiological surveys indicated an even higher percentage. In these two samples, from Manhattan and Stirling County, Nova
Scotia, fewer than 15-20 percent of the samples were without signs of emotional distress, indicating need to be as high as 80-85 percent of this population (Srole, Langer, Michael, Opler, and Rennie, 1962; Leighton, 1956). Stringer and Glidewell (1967) categorized the mental health status of a sample of school children in St. Louis County, Missouri. They found that 21 percent were "seriously disturbed" and 38 percent were "vulnerable", leaving 41 percent in the remaining categories of "minor problems" and "well-adjusted." In this population, then, 50 percent of the school children showed signs of needing psychotherapeutic services at that time or in the future. Schofield expressed the need in 1964 in this way:

Over one half of all the hospital beds in this country are occupied by mental patients. There are 600,000 psychiatric patients housed in public and private mental hospitals at any given time. There are approximately 125,000 new admissions annually to public institutions for custodial care of psychatically ill persons. Of the total number of patients admitted to state hospitals each year, nearly one third are patients who are entering such hospitals for at least the second time.

Such facts impress upon us the size of the problem in respect to the sheer number of persons who require hospitalization. They imply to us the tremendous economic costs that are involved—in terms of the expense of the custody and care of the patients, and in terms of the loss to our economy entailed in their incapacitation as productive citizens. These data state clearly the position of mental illness as our nation's paramount health problem. (p. 4)

In the last several years, there has been a decrease in the number of inpatient beds available to individuals.
In 1974 there were 132.4 beds per 100,000 people, as compared with 94.4 beds in 1977. This represents a loss of 28.7 percent bed-space in state and county mental hospitals in the time period 1974 to 1977 (U.S. Government Printing Office, Mental Health Statistics 153, 1979). And yet figures obtained from a different setting show an increased need for psychological services. The average number of people under care per Community Mental Health Center was 2,350 in 1971 and 3,066 in 1975. In that same time period, the number of Community Mental Health Centers increased from 295 to 528. In total these centers provided assistance for 693,260 people in 1971 and 1,618,746 people in 1975 (U.S. Government Printing Office, Community Mental Centers, 1978). Not including federally funded mental health centers, outpatient admissions to psychiatric centers in 1975 equaled nearly 1,600,000 or about 743 admissions per 100,000 people in the census of 1975 (U.S. Government Printing Office, Health Resources Statistics, 1977). From this, it appears that the trend, in the last several years at least, has been to seek assistance sooner, before hospitalization is necessary. In any case, the volume of outpatient service has dramatically increased.

The patients who can be counted fairly readily because their personal disturbances are severe enough to warrant hospitalization or intensive psychiatric treatment
are not of primary concern here. However, their numbers give a real feeling for the magnitude of personal disturbance and psychological need in the U.S., which can only be obtained through extrapolation. There are individuals who are emotionally disturbed and psychologically disordered but whose disturbances still allow them an unhappy existence apart from any psychological assistance. Schofield (1964) states that 50 to 70 percent of the general practitioner's caseload are these "chronic visitors to physicians' offices with complaints that are vague, anatomically and physiologically irrational, and unsupported by any actual organic defect" (p. 5).

It appears to be common knowledge that the need for psychological services goes far beyond that need which can be measured by those getting treatment (Cowen & Gardner, 1967). In fact, the statement was made in an epidemiological study of mental illness that nearly 90 percent of mental illness goes unrecognized and therefore untreated. This estimate was made in 1960. The actual number of people needing services was 17,500,000; of these, only 1,814,000 actually received treatment in hospitals or clinics or by psychiatrists (Plunkett & Gordon, 1960). This need estimate is on the conservative side, standing at about 10 percent of the general population of 179,323,175 listed on the U.S. Census in 1960 (Newspaper Enterprise Association, 1981). If we stay with this conservative percentage of need for
psychological services in the general U.S. population, we arrive at 22,000,000 people needing such services in 1981, out of an estimated population of 222,000,000 (World Almanac, 1981).

As the demand for services has increased, there has continued to be a limited number of mental health professionals. In 1959, Albee reported that in State and County hospitals nearly 21 to 23 percent of the professional jobs were vacant. Summarizing Albee's findings we find that the shortages of psychiatrists, social workers, and clinical psychologists ranged from 25 to 75 percent nationwide, and those figures were based on adequate rather than ideal circumstances. Relating that the country faced a mental health "manpower" crisis, he stated that it was not a temporary crisis and included estimates based on population growth for the next twenty years. Using the "best estimates of population growth and professional training potential" it seems unlikely that we will meet the demand for mental health services in the "near or distant future" (Cowen, Gardner & Zax, 1967).

Writing for Cowen et al. in 1967, Albee spoke pessimistically about the ability of the mental health system in this country to meet the demand for psychological services:

The time is not far off when the whole mental health bubble bursts! We have made irresponsible promises to the people, to Congress, to the state legislatures, and to the labor unions. We will not be able
to deliver adequate and meaningful services.  
(p. 63)

Finkel (1976), citing studies done in 1969, states that the professional humanpower needed to meet the present demand is "woefully inadequate and can hardly be expected to meet the demand requirements in the future." As of 1973, only 16.9 percent of the states in the U.S. had adequate mental health services according to Community Mental Health standards. That left 83.1 percent of the states with inadequate services, and indicates that in 1973 a tremendous portion of this country was handicapped by "structurally deficient mental health service systems" (U.S. Government Printing Office, Deficiencies, 1979, p. 57).

The problem of increased demand for service and limited professional mental health workers continues to plague us. In 1979 a published study for the U.S. Government found that establishing the appropriate staffing patterns was "difficult, if not technically impossible" (U.S. Government Printing Office, Deficiencies, 1979, p. 52). Schofield (1964) pointed out that, paradoxical as it seems, if one is an examiner of statistical trends, one can see that as more therapists appear to meet the demand, the demand for therapists increases. If that were not problematic enough, increasing the supply of mental health professionals (psychologists, psychiatrists, social workers, and others) appears impractical because of the massive
amount of money required to quickly educate enough workers to meet present demand levels (Finkel, 1976). Graduate schools would be hard-pressed to create enough new programs to create large increases in professional graduates.

The central problem of having insufficient resources to meet the increasing demand (not considering the need which is believed to be "many times greater") requires that we must explore new approaches to the mental health consumer (Cowen, Gardner & Zax, 1967). Albee writes that the manpower problem is unlikely to be solved any other way than by a conceptual breakthrough in terms of "causes and remedies to mental disorder" (Cowen et al., 1967).

The increasing demand for psychological services presses us to continue to research new methods that draw the least on the therapist's and client's time but deliver on the promise of a better quality of living. Alternatives such as cognitive, self-control, and crisis therapies are appearing (Garfield & Bergin, 1978), as well as new strategies of intervention and consultation, psycho-educational methods, the use of films, videotapes, computer terminals, biofeedback, and programmed manuals (Ivey & Simek-Downing, 1980). Of the two methods Finkel (1976) mentions as being possible ways of dealing with the mental health worker shortage, one is to use group rather than individual interventions and the second is to use shortened forms of therapy
(mentioning Reichian therapy, Primal therapy, direct analysis, and behavioral therapy as examples). Others have come to these same two conclusions as well. In the Community Mental Health Centers, for instance, because of the increased caseload (see above), more people were receiving care but for a shorter time. Short-term group procedures such as the one being studied here, when found to be effective, can extend our limited personnel and meet the burgeoning demand for psychological assistance.

**The Elimination of Self Defeating Behavior Model**

The group process used in this study is a short-term (25-40 hours of professional contact) group procedure that utilizes an educational approach. The object of this research is to determine the effectiveness of this model with people from the community who feel they could use some psychological assistance to help themselves alleviate personal problems. If it is found to be an effective change agent, this process could meet the demands of a significant portion of the psychologically needy.

Self-defeating behavior was defined by Warner (1966) and Cudney (1972) as any behavior that impedes or interferes with one's life and yet is done repeatedly. Behaviors such as chronic lateness, procrastination, non-completion of tasks, helplessness when under stress, powerlessness,
excessive worrying, perfectionism, stuttering, inhibition of creative skills, overeating, inability to "stick up for oneself" and so on. In 1972, Milton Cudney wrote a manuscript in which he described a short-term group process he designed to help people overcome these damaging but persistent behaviors. This short-term, didactic group psychotherapy, called the Elimination of Self-Defeating Behavior group process (ESDB), is the procedure being studied in this project. Prior to this study, the author, using the ESDB process, had facilitated about 16 groups of participants over a time-span of four years. The participants who attended all, or a majority, of the sessions reported moderate to very positive change in their lives. It was these informal findings that encouraged this research.

The ESDB group process utilizes both the teaching of concepts and group sharing of personal experience. The major concepts presented to the group are:

1. Personal creation of behavior and ownership of the consequences
2. Challenging the self-conclusions and tolerating the fear

These are presented in five subordinate categories: (a) behavior, (b) disownership, (c) personal cost, (d) inner choice, and (e) untested fears. Homework is assigned to
participants in the form of keeping a journal, relating personal experiences to the subcategory currently being taught in the group process. It is the homework, primarily, that is shared by members with the group. When all the concepts are understood in terms of each participant's own experience, then all group members participate in an imagery exercise where they encounter on a fantasy level the fears motivating the self-defeating behavior (SDB). The next two or three meetings are used for group discussion of the ease or difficulty in discarding the SDB's and for further internalizing of the concepts.

The Experimental Method

The ESDB group process will be tested via an analysis of scores obtained on three measures of change (the Barbaro Participant SDB Questionnaire, Rotter Internal-External Locus of Control Scale, and the O'Brien Self-Esteem Measure) as two groups undergo the treatment process. Group I will be compared to Group II as Group II acts as a control group by waiting to undergo the group process. All subjects in both groups will take the measures pre and post group, as well as a follow-up administration on Group I two months after completion of the experimental process. Personal statements from the participants regarding behavior or attitudinal change will also be reviewed. Friends of the par-
Participants will be asked to complete an Associate Questionnaire concerning the SDB's of their friend. The pre and post test results, as well as the follow-up scores, will undergo statistical analysis to determine significant differences indicating participant behavior change.

Summary

This study is an effort to establish the effectiveness of a short-term, didactic, group process. Participants are tested (a) to determine the frequency of behaviors they consider self-defeating, (b) to determine the internality or externality of their locus of control, and (c) to determine their level of self-esteem. These measures are expected to indicate that participants have changed in these three areas as a result of the group process.

In this country we are faced with an ever-increasing demand for psychological services. This is clearly shown by government statistics reporting the number of psychiatric admissions to mental hospitals, and requests for outpatient treatment. Early detection studies show even more emotional and mental disturbance in the general population than the epidemiological studies that continue to set the need for mental health assistance at ten percent of the population. The demand for services, always less than the reported need, continues to grow towards that ten percent figure.
Twelve years ago, reports clearly demonstrated the shortage of mental health workers. This shortage has continued to the present day. Government agencies, as well as researchers in the field, point out the limited availability of professionals to adequately meet the demand for their services. It even appears that, as personnel increases in availability, the demand increases to again outstrip the supply of professionals.

Increasing the mental health humanpower is believed to be unworkable because of the expense and time needed to train these workers; therefore, a conceptual breakthrough in treatment methods and delivery is seen as being the answer. Research is needed to examine group interventions and shortened forms of therapy. One of the ways being explored to reduce the time needed for treatment is using educational methods in a therapeutic setting.

This research is an attempt to test a method that may meet the need for more efficient psychological interventions. The treatment method being studied here is a psychological assistance intervention that uses an educational approach and, if demonstrated to be effective, works in a short period of time and reaches a group of individuals simultaneously.

The Elimination of Self-Defeating Behavior group process used in this study is a short-term method that
teaches participants psychological concepts in the midst of a group psychotherapeutic setting. Participants are encouraged to share personal information with the group and learn intrapsychic skills related to the behaviors they would like to change.

The group process will be tested by using two groups of participants, measuring their responses on three instruments, and then comparing these scores statistically to determine the amount of comparative change. One group will act as a control group initially, and then go through the treatment process in an attempt to replicate the results obtained by the first group.
CHAPTER II

REVIEW OF THE LITERATURE

In this chapter, a general historical summary of psychotherapeutic intervention will be followed by a closer look at how psychotherapy and neurosis can be defined (psychosis will not be examined due to obvious limits of the experimental group treatment process). A discussion of elements of short-term, cognitive, psychoeducational, and didactic group psychotherapy will follow. Included will be some advantages of these approaches, how they are appropriate to the task of meeting the massive demand for psychological services (presented in Chapter I), and how they serve to illustrate the experimental treatment.

Historical Outline of Psychotherapeutic Interventions

Many professionals and laymen alike credit the beginning of psychotherapeutic work to Freud and to Breuer, his collaborator. Many also consider Freud to be a proponent of genetic causes as the prime factor in human behavior because of his belief in human instincts. But the real advocates of genetic factors, such as Galton (1869), Dugdale (1877), Goddard (1912), Estabrooks (1916), and Lombroso (1891, 1899) were displaced from the ascendant theoretical
position by Freud's clear understanding of the power of experience in shaping human behavior. Psychoanalytic theory and practice moved in ever-broadening circles, in attempts to alleviate not only the originally studied problem of hysteria but also compulsive and obsessive behavior patterns as well, going "from neuroses to psychoses, from the socially constrained to the antisocial offender, from adults to children, and from medical-type problems to problems of living in general" (Bergin & Garfield, 1971, p. 4).

Unfortunately, psychoanalysis was unable to meet the demand to rectify so broad a range of problems. Freud himself originally advised that his procedure, psychoanalysis, was not recommended for those who "(1) lacked education, (2) did not have a reliable character, (3) were psychotic, (4) were in deep depression, (5) were near or above fifty years old, or (6) had dangerous symptoms" (Freud, 1904, pp. 70-71). Starting with Landis (1937), then Eysenck (1952), and Levitt (1957, 1963), a number of persons were claiming that psychoanalysis was generally no more effective than waiting for the same length of time as the treatment took. Such criticism marked the end of the ascendancy of psychoanalysis (Authier et al., 1975). Other psychotherapeutic methods did not escape the flood of doubts that was assailing psychoanalysis. Conventional wisdom tended to accept Eysenck's statement that 75 percent of neurotic con-
ditions improve with or without treatment. Testimony was given before the Colorado State Legislature that "about all we've [meaning psychologists] been able to prove is that a third of the people get better, a third of the people stay the same, and a third of the people get worse, irregardless of the treatment to which they are subjected" (Smith & Glass, 1977, p. 75). Professional clinicians were thrown into a struggle to demonstrate effectiveness.

This doubt of the true effectiveness of psychotherapy was gathering momentum just as the demand from the general public for the benefits promised by therapeutic treatment was outstripping the supply of professionals. The public, having desensitized itself to the stigma of psychotherapeutic treatment, was steadily increasing its demand for services even beyond the scope of psychoanalysis. Albee's writing in 1959 put into print what many professionals were thinking: without a change in forms of psychological service delivery, the demand for services would greatly outstrip the supply.

While psychologists argued whether psychotherapy worked, the public wanted what was promised by the method and the culture responded. Numerous varieties of psychotherapeutic processes sprouted and took root. The human potential movement with all its methods and aspects (Esalen, yoga, Erhard Seminar Training, Transcendental
Meditation, and consciousness-raising groups, to name a few) and the more exotic therapeutic modalities, such as dance therapy and art therapy, proliferated. Paraprofessionals became a viable body of helpers and were trained to meet the need (Authier et al., 1975; Gurman & Razin, 1977). Professionals also experimented with group approaches such as T-groups, sensitivity groups, and encounter groups (Bergin & Garfield, 1971; Pinkel, 1976). Even though these were never meant as procedures for deeply disturbed people, they did fill a demand by others to have more interpersonal and intrapersonal exploration.

Meanwhile, psychologists and psychoterapists gradually managed to extricate themselves from the statistical quagmire of studies of the effectiveness of psychotherapy. One group, faced with the difficulties of defining psychotherapy, neurosis, and effectiveness, found themselves asking a different question. This is succinctly stated in the preface of the Handbook of Psychotherapy and Behavior Change (Bergin & Garfield, 1971) as follows:

On a theoretical level, we appear to be beyond the stage of asking the overly general and unanswerable question, "Is psychotherapy effective?" Instead we are prepared to ask, "Under what conditions will this type of client, with these particular problems be changed in what ways by what specific types of therapists?"

The realization was, quite sensibly, that if one wanted to research the effectiveness of psychotherapy then one had to
be much more specific, rather than expect the same procedure and therapist to be equally effective for every client and problem.

Another group of professionals pursued the original question of overall effectiveness of psychotherapeutic treatment. Eysenck (1952) stated in his review of effectiveness studies that the data (drawn on 8,053 cases from 24 outcome studies) showed "that roughly two thirds of a group of neurotic patients will recover or improve to a marked extent within about two years of the onset of their illness, whether they are treated by means of psychotherapy or not" (p. 322). In an excellent review of Eysenck's data, Bergin and Lambert (1978) revealed that there were often errors in the computations used in original data, that Eysenck made errors copying the original data, and that Eysenck had to base his analysis on classifications that were used differently by different researchers (like "improved" vs. "slightly improved," and "neurotic"). They questioned his spontaneous remission rates of 65 percent by illustrating that spontaneous remission was a difficult label to apply, and after reviewing Eysenck's and more contemporary data, countered with a spontaneous remission rate of 43 percent.

It is clear that Eysenck imposed a set of criteria on the therapy data that yielded the lowest possible improvement rates while being more lenient with the spontaneous remission data. . . . However, the same standards should apply to both treated and untreated groups on order to eliminate bias. (Bergin & Lambert, 1978, p. 140)
They found even higher improvement rates in some studies, depending on the criteria used. However, even comparing 66 percent improvement with treatment to 43 percent improvement with no treatment, it is clear that psychotherapy is effective. More recently, Meltzoff and Kornreich (1970) reviewed outcome studies to determine effectiveness and found that of 57 studies judged "adequate," 84 percent of these showed positive results that were statistically significant.

As to the question of "which therapy for which problem," the two following reviewers are representative of the literature in their summaries of the research findings of the comparative studies of psychotherapies. Meltzoff and Kornreich (1970) reviewed 25 comparative studies and determined that very little evidence exists that demonstrates one school of psychotherapy to be superior to another in terms of outcome. Luborsky, Singer, and Luborsky (1975), using some studies that overlapped with Meltzoff and Kornreich, published a review of 105 comparative studies. The use of only adult outpatients as subjects in the chosen studies makes this review particularly relevant here because that is the primary focus of this dissertation as well. Luborsky, Singer, and Luborsky found that most studies obtained insignificant differences in amount of improvement based on method of psychotherapy. The Sloane, Staples, Cristol,
Yorkston and Whipple (1975) study is a good example of a recent comparative study that was mentioned again and again in the literature. Involving more than 90 outpatients seen at the Temple University Health Sciences Center, Bergin and Lambert (1978) refer to it as "probably the best comparative study of psychotherapy yet carried out" (p. 164). Of the no-treatment control group used, only 48 percent were rated improved, in comparison to 80 percent of those treated with either short-term analytically-oriented psychotherapy or behavior therapy. In their own review of the comparative studies, Bergin and Lambert concluded that psychoanalytic and insight therapies, humanistic and client-centered psychotherapy, many behavioral therapy techniques, and, to some extent, cognitive therapies, had empirically confirmed themselves as effective psychotherapies.

Generally, the debate over the effectiveness of psychotherapy has died down, with current reviewers of outcome studies finding what Eysenck (1952) stated was just the subjective feeling of most psychotherapists: that psychotherapy is effective. Bergin and Lambert (1978) put it this way: "They [psychotherapies] do achieve results that are superior to no-treatment and to various placebo treatment procedures." And as yet no researcher has been able to gather empirical evidence showing one psychotherapy to be more effective than another, even considering specific
treatment for specific problems (with the probable exception of behavior therapy for phobias). In summing up their review of comparative studies, Luborsky, Singer and Luborsky (1975) join the answers to the two questions together in this way: "As we mentioned, the nonsignificant differences between treatments do not relate to the question of their benefits—-a high percentage of patients appear to benefit by any of the psychotherapies or by the control [treatment] procedures" (p. 1006).

The Target Problem of This Review

And what of this patient population to which we keep referring? And how are their problems manifested? We began this dissertation in Chapter I with a clear presentation of how great the need is for psychological services and how rapidly these needs have grown in recent years. The problems requiring the services of a psychotherapist are generally grouped by professionals into two broad categories: 1) the psychoneurosis and (2) the psychoses. As used here, the psychoses refer to those mental and emotional disturbances that are so severe and overwhelming to the individual that (s)he cannot function in society on her/his own, and must be cared for by others, usually in a hospital setting. As sad and troubling as these types of difficulties are, our concern here is with individuals suf-
ferring from the first category of the problems, the neurosis. It is from this group—those individuals who can function on their own but with varying degrees of difficulty—that we find the rapidly growing demand for services. It is this population's needs we are addressing, as well as that group of individuals who want to improve their experiences in life but whose problems do not fit the neurotic category. We include this last group as well because sophistication of psychological services has reached the point that some of the demand for services is coming from this latter group, and because this "life improvement" group can fit in fairly easily with the group with problems categorized as neurotic.

Knopff, a former professor of medicine in Edinburgh, stated that the term neurosis dates back to William Cullen who used the term in 1769 to denote "a general affection of the nervous system" (Marks, 1978, p. 496). Toward the end of the 19th century, the term "neurosis" was used as a label for psychiatric difficulties not fitting under the psychotic, psychopathic, or organic disorder category. The World Health Organization, in its International Glossary, accepts the following meaning that can serve as the current use of the term "neurosis": "... any repetitive maladaptive behavior, especially in the interpersonal context, and characterized by conflict and pain" (Marks, 1978, p. 496).
This, then, is the targeted problem area on which our discussion rests. Most treatments mentioned in this review are designed with this population in mind, and anyone with "repetitive maladaptive behavior" primarily in interpersonal relationships resulting in "conflict and pain" probably would benefit from participating in these methods, as well as those who fit into any lesser subset of the above definition.

Psychotherapy Defined

Since the object of our review is psychotherapy in its various forms, how it works, and how we can streamline those workings to reach the largest number needing such services, it might be prudent to consider some general definitions of psychotherapy to guide us in our review. The three definitions following represent the literature on this subject well, and the fourth description of psychotherapy speaks for itself.

We can start with a definition of psychotherapy published by Nicholas Hobbs (1962) that looks from the experience of the client. Hobbs describes effective psychotherapy as providing:

An opportunity for the client to experience close-ness to another human being without getting hurt, to divest symbols associated with traumatic experiences of their anxiety producing potential, to use the transference situation to learn not to need neurotic distortions, to practice being responsible for
himself, and to clarify an old or learn a new cognitive system for ordering his world. (p. 486)

The definition by Meltzoff and Kornreich (1970) approaches the subject more from the professional's point of view:

Psychotherapy is taken to mean the informed and planful application of techniques derived from established psychological principles, by persons qualified through training and experience to understand these principles and to apply these techniques with the intention of assisting individuals to modify such personal characteristics as feelings, values, attitudes, and behaviors which are judged by the therapist to be maladaptive or maladjustive. (p. 3)

Strupp (1978) presents the most inclusive and yet tentative of the definitions to be found by this writer in the literature:

Without attempting a formal definition, it may be said that psychotherapy is an interpersonal process designed to bring about modifications of feelings, cognitions, attitudes, and behavior which have proven troublesome to the person seeking help from a trained professional. There is considerable controversy whether and to what extent psychotherapy differs from other human relationships in which one person helps another to solve a personal problem, however, as ordinarily understood, the psychotherapist is a trained professional person who has acquired special skills. (p. 3)

The above definitions help to give us the general picture of psychotherapy, but what of the details? What are the "special skills" of a "trained professional"? What exactly does the effective psychotherapist do during the psychotherapeutic relationship? Gottman and Markman (1978) generated a list of 15 therapist behaviors that they felt were the essential "active ingredients" of psychotherapy.
In attempting to predetermine the value of a potential therapeutic process, or to understand why one is not effective, perhaps this list will provide some answers:

1. The therapist conveys an expectation that change is possible and likely to occur.

2. The therapist conveys a faith that every problem has a solution.

3. The therapist helps the client elaborate and specify the problems presented.

4. The therapist provides a new language system for organizing behavior and events. This may include a relabeling of what is "pathological," and what is "healthy," (problems and goals), and perhaps etiology.

5. The therapist gives client normative data for client's experiences in therapy (e.g., "It is common to feel panicky at this point. We expect people to feel that way.")

6. The therapist provides ground rules (e.g., about fees, coming to sessions, number of sessions, calling if unable to come, homework, practice).

7. The therapist describes goals and methods for attaining goals.

8. The therapist structures situations that require approach instead of avoidance; therapist may also restructure situations so that it is more likely that approach behaviors will be rewarded naturally.

9. The therapist conveys the belief that positive consequences follow approach and negative consequences follow avoidance.

10. The therapist conveys and "experimental" norm:
  a. First try it
  b. Then evaluate it
  c. Then try it again.
11. The therapist conveys the message that he or she cares about the client (he or she is listening, empathetic, supportive).

12. The therapist teaches alternative ways of behaving and thinking with consideration of step size (small enough to maximize likelihood of success), pacing (mostly at client's own pace), and feedback (specific).

13. The therapist restructures norms of social interaction in behavior setting of importance (e.g., changes consequences of specific behavior exchanges, and changes eliciting stimuli).

14. The therapist reinforces client for trying new behaviors, for sticking to programmed interventions, and for personalizing change within client's own style.

15. The therapist fades self out and insures that the client attributes change to self not to therapist, and provides for transfer of training.

It should be noted here that no one definition of psychotherapy is accepted by all, or even the majority, of professionals (Strupp, 1978). For our purposes at present, it is enough to understand psychotherapy as an interpersonal process characterized by caring for, acceptance of, and faith in the client, during which the client learns new ways to understand the world and act in it, and which results in client changes in feelings, values, attitudes, and behaviors.

**Short Term Psychotherapy**

Strupp (1978), in his article on psychotherapy research, stressed the necessity of developing "psychothera-
pies that yield significant returns in the shortest possible time and with the least expense" (p. 18). He cites patient expectations, resources, motivation, and reality considerations as reasons for putting a time limit on psychotherapy. He felt psychotherapeutic methods should be designed to reach full effectiveness within 20 to 40 hours of treatment. Even before the mushrooming of demand for services made short-term approaches so necessary, the eventual development of briefer treatments was predictable. Freud is quoted by Strupp (1978) as foreseeing that psychoanalysis would one day be allied to other techniques to make it less time-consuming but equally effective.

Evidence is available and continues to accumulate that short-term approaches are effective (Wolberg, 1967; Strupp, 1978; Butcher and Koss, 1978; Lorion, 1978). Even more important is the finding that there is not convincing evidence that long-term (intensive) psychotherapy is more effective than time-limited therapy (Strupp, 1978). Bergin and Lambert (1978) reviewed outcome studies from 1953 through 1969, and concluded that "There did not seem to be a relationship between duration of therapy and outcome" (p. 145). Butcher and Koss (1978), surveying the body of outcome research that exists on brief and crisis-oriented psychotherapies, found that all available research studies excepting one showed short-term treatment to be at least as
effective as time-unlimited treatment. Returning again to the review of comparative studies of psychotherapies done by Luborsky, Singer, and Luborsky (1975), we find that they reviewed time-limited psychotherapy and time-unlimited psychotherapy outcome studies as well, and found that time-unlimited therapy demonstrated superior results only once. Five other comparative studies showed time-limited and time-unlimited treatments to have similar results, and in two of the comparative studies, time-limited psychotherapy demonstrated superior results. Because of these kinds of research findings, Butcher and Koss (1978) were able to conclude "Thus, in addition to being more efficient in terms of professional time required, brief therapy appears to be as effective with respect to measurable results" (p. 754).

In 1974, Frank published 20 year follow-up data on clients that supported the conclusion that patients continue to improve for years after brief therapy. Avnet (1965) also did a follow-up study of a large group of patients, and found that after short-term treatment, 81 percent of the patients and 76 percent of the therapists felt there had been some degree of improvement. In an unpublished report by Baxter and Beaulieu in 1976, 41 patients completing a short-term outpatient therapy contract were evaluated months after treatment (Butcher, 1978). Of the 23 patients who completed the follow-up material, 79.1 percent reported that
they felt "much better" than when they came in for treatment. All 23 had significantly lower scores on all of the Minnesota Multiphasic Personality Inventory (MMPI) clinical scales and reported significantly less anxiety and depression.

Findings such as those published above make the duration of treatment a more crucial variable than ever. If treatment methods are about equally effective, regardless of duration of therapy, then length of treatment becomes an important focus for researchers, practitioners, and consumers. Can we continue to ignore short-term psychotherapeutic methods because of their format, simplicity, or lack of sophistication, when it is so necessary to find short-term approaches that are effective, and when research indicates that it is no longer essential to have long-term methods for there to be therapeutic effectiveness? Recalling Eysenck's argument that 2/3 of untreated neurotics improve over a two year period, it may be appropriate to point out at this time that that argument no longer refutes the efficacy of psychotherapy, but supports it. "Treatment effects of this magnitude are frequently obtained in six months or less in formal psychotherapy, a considerable evidence of therapy's efficiency over no treatment" (Bergin & Lambert, 1978, p. 170).

Strupp (1978) referred to short-term methods as the
"practical treatment" (and, as such, saw much interest and research in these methods in future years). Butcher and Koss (1978) in their overview of brief therapies, stated that most practitioners gave 25 sessions as the upper limit of brief psychotherapy, with as many professionals using one to six sessions as there were using 10 to 25 sessions. If we take the typical psychotherapist's working week to be 30 hours, seeing one client for each hour, using long-term therapy (s)he would only be able to see 30 clients in one year (given that all clients continued in treatment). Since it is possible that this typical psychotherapist would work for 50 weeks per year, (s)he has available 1500 working hours per year. Using an effective short-term treatment of 25 hours for each client, (s)he could see as many as 60 clients in one year. Even if we do not consider the possibility that the long-term treatments most probably will continue for at least another year for those same 30 clients, an effective short-term treatment could double a professional's effectiveness in one year.

Apart from the crisis-oriented approaches that serve the anxious, suicidal, excited, panicky, delirious, psychotic and assaultive, short-term psychotherapy seems appropriate for those people who have a fair ability to relate to others, or whose mental-emotional health is better, or whose disturbance is less, than other mental health service con-
sumers (Butcher & Koss, 1978). This may be true because of the limited goals and focal nature of short-term approaches. Ursano and Dressler (1974) found those two elements to be the essential difference between brief and long-term psychotherapy.

Integrating the changed self-concepts resulting from a short-term approach into a patient's behaviors can be a lengthy process during which the patient would not typically have contact with the therapist (Wolberg, 1965) and so would need considerable self-confidence or "ego" strength. Wolberg sees short-term psychotherapy as guiding "patients in the right direction and helping them to begin the process of self study necessary to cope with the inevitable problems that arise after therapy has ended" (p. 731). A person who has constant experience of great personal disturbance and has difficulty in functioning day-to-day (differentiated from a relatively undisturbed person suddenly in crisis), would seem to need the on-going support and guidance found in most long-term processes. This individual strength to function in the world and utilize and integrate a short-term psychotherapy is illustrated by the observation that most clinicians suggest the patient have the major input in choosing goals for limited therapy since they usually come to therapy with a view of the symptoms they would most like to overcome (Butcher & Koss, 1978). This would seem to
indicate a relative lack of confusion in the population appropriate for short-term approaches.

Perhaps it comes as a bit of a surprise, but the level of demand from the seemingly more integrated, or better-functioning, individuals constitutes much of the overall need for psychological services. Scholfield (1964) and Finkel (1975) both make reference to the client sought after by most practitioners as the YAVIS client—-young, attractive, verbal, intelligent, and successful. Scholfield revealed that the typical patient seen by psychologists and psychiatrists in his survey fits this description. The patient able to achieve "professional-managerial" job status prior to seeking therapy (the typical patient cited in Schofield's findings) certainly would seem to have proven some measure of self-confidence or ability to function and relate to others. The HOUND patient (Finkel, 1975) "who is homely, old, unattractive, nonverbal, and dumb" (p. 73), is somewhat atypical of those seeking therapy. It would appear that the short-term approach is the appropriate one for the client typically seeking psychotherapy.

Garfield, in a 1977 paper, went so far as to recommend that short-term therapy be the treatment of choice for almost all patients. He based this conclusion on numerous findings he said indicated about 2/3 of all patients would respond positively to short-term treatment. Of the
remaining 1/3, their therapy could be continued if appropriate, or they could be referred elsewhere (Strupp, 1978).

In this same paper, titled "Short-term Psychotherapy For Whom?" (Strupp, 1978), Garfield summarized the contemporary view of short-term psychotherapy:

The goals of therapy should be the patient's—not the therapist's. (As noted earlier, such goals must of course be realistic and practicable.)

The therapist should take a much more active stance. In particular this means: The therapist must (a) set more modest goals in therapy; (b) take greater responsibility for becoming a "moving force" in the therapeutic encounter; (c) actively plan and implement interventions, as opposed to waiting for the gradual emergence of "problems" in the transference and their solution in that context; and (d) actively resist the temptation to broaden the therapeutic objectives once limited goals have been reached. (p. 18)

Therapeutic approaches that meet the above criteria can also be found in the literature under the heading of Cognitive Learning therapies. It is to our advantage, then, to review a few of these approaches since, in meeting the criteria of short-term treatments, they also can provide us with information as to how best we can fulfill the existing need for psychological services.

**Didactic Psychotherapy**

Cognitive Learning Therapies. This is the label used for methods that practitioners and theorists see as changing the cognitions in their clients that produce distress. There
are three possible divisions of approaches conceptualized in this way: (1) cognitive restructuring, (2) coping skills therapies, and (3) problem-solving therapies (Mohoney & Arnkoff, 1978).

In this literature review, we started by focusing on therapeutic process (i.e., short-term and long-term, an aspect of therapeutic process) as differentiated from aspects of client change (Behavior Therapy, Insight-Oriented therapies), or practitioner focus (Psychoanalysis, Gestalt Therapy, Transactional Analysis). Bandura (1969) offers the theoretical groundwork for Mahoney and Arnkoff's (1978) statement that:

We must guard against the tendency to confuse therapeutic procedures with therapeutic processes. The cognitive therapist may invoke cognitive processes as the primary mechanisms of human adaptation, but he or she should not overlook the fact that those processes are linked to specifiable intervention procedures. It is imperative that researchers and practitioners communicate what they did to produce therapeutic changes, not what they presumed to have occurred inside the client's head. (p. 713)

This researcher finds himself in agreement with Mahoney and Arnkoff's caution but would apply it to all outcome research. Stressing psychotherapeutic process can only help in efforts to determine the essential components of effective psychotherapy. Thus, we review cognitive learning therapies not only because many so-designated therapies have all the essential elements required to have psychotherapy that is short in duration, but also because
many cognitive learning therapies employ a didactic process as an integral component.

The American Heritage Dictionary defines didactic first as "intended to instruct: expository" (p. 366), which means "(1) a setting forth of meaning or intent and (2) a precise statement or definition; explication; elucidation" (p. 463). The meaning is faithful to the root word from which didactic evolved; from the "Greek didaktikoe, skillful in teaching, from didaktos, taught, from didaskein, to teach" (p. 366). The therapies we will be discussing all employ a didactic or educational approach to reach the client, teaching him or her new ways of thinking and new approaches to living. All cognitive therapies teach their clientel new cognitions of the world and new concepts of themselves, but not all methods use the didactic process.

Rainy (1975) recognized the education that clients get in cognitive therapy but concluded that a teaching or didactic method, as a primary procedure, would not be effective because of the "neurotic paradox." This term was created by Mowrer (1948, p. 571) to delineate failure by neurotics to integrate evidence that their disturbing behaviors have consistently produced negative consequences. Put into cognitive terms, the paradox prevents those with neurotic difficulties from using available experiences to correct their misconceptions about the world, or about
themselves. This partial difficulty in profiting from experience, or as Sullivan (Perry & Gawal, 1953) put it, selective inattention to experience, is probably the reason many therapists avoid direct teaching methods (or maintain that they do) as central to therapeutic process. This need not be the case. People suffering from neurosis can still be directly taught, if the subject matter is carefully chosen and presented.

Rainy (1975), in outlining the development of his cognitive therapy, determined that the cognitive approach can be found in use by many early theorists and non-Freudian analysts, the earliest mentioned being Janet (1907) and most notable being Adler (1929). Both of their approaches used a didactic method to re-educate the client. Murray and Jacobson (1978) assert that Adler should be viewed as the first of many modern cognitive therapists such as Rotter (1954), Kelly (1955), Berne (1961), Ellis (1962), and Beck (1970). All of these except Rotter and Beck, and including Adler, developed approaches to psychotherapy that use the didactic process as an integral part of the work with clients (and, as with any intervention, it is not intended to be used rigidly, without consideration for the specific needs of the client, but definitely as an initial preference in treatment).

Ellis's (1962, 1977) Rational Emotive Psychotherapy
is probably the most popular of the cognitive learning therapies. Professionally, it has an even larger following in the field of psychotherapy than the Client-Centered approach (Murray & Jacobson, 1978). There are other cognitive learning therapies, as well, that are appropriate to our discussion because they use the didactic process. Further categorized into three groupings by Mahoney and Arnkoff (1978), they are as follows:

**Cognitive Restructuring**
- Rational Emotive Therapy (Ellis, 1962, 1977)
- Self Instruction (Meichenbaum, 1974)

**Coping Skills Therapies**
- Covert Modeling (Cantela, 1971, 1973)
  (Kazdin, 1973, 1976)
- Coping Skills Training (Goldfried, 1971)
  (Goldfried & Thier, 1974)

**Problem Solving Therapies**
- Behavioral Problem Solving (D'Zurilla & Goldfried, 1971)
- Problem-Solving Therapy (Spivak & Shure, 1974)
  (Spivak, Platt, Shure, 1976)
- Personal Science (Mahoney, 1977)

These methods have been developed with thought given to further advancing procedures previously demonstrated to be effective, and themselves have been able to demonstrate
favorable results. The fact of so many methods being developed using the didactic process, plus the initial positive results, lends credence to the use of the didactic method in therapeutic processes. Of the methods listed above, the problem-solving therapies have the strongest empirical support going beyond the initial research phase.

Murray & Jacobson (1978) state: "Among the cognitive learning therapies, it is our opinion that the problem-solving perspective may ultimately yield the most encouraging clinical results" (p. 709). They feel this way because the problem-solving therapies appear to reflect the cognitive restructuring approach as well as the coping skills therapies, and even reach beyond the "cognitive" realm to encompass a "wide range" of other therapies. As with the other cognitive learning therapies mentioned, the problem-solving approaches directly teach clients specific procedures:

With the problem-solving approaches, clients are not only taught specific coping skills, but also the more general strategies of assessment, problem definition, and so on. In a sense, the therapist is sharing years of professional training by making the client an apprentice in therapy—a student of effective self-regulation (Murray & Jacobson, 1978, p. 709).

This treatment approach (by Spivak and associates) developed out of the finding that "emotionally disturbed" individuals were significantly inferior to "normal" peers, in a majority of instances, in creating possible solutions
to hypothetical problems. Moreover, the solutions suggested by the "disturbed" participants were often physically anti-social with unreal expectancies of the consequences (Spivak & Shure, 1974; Spivak, Platt, & Shure, 1976). Researchers were encouraged when systematic training in personal problem solving produced successful results with the deviant subjects in preliminary studies.

D'Zurilla and Goldfried (1971) reflect this point of view in their description of emotional disturbance or abnormal behavior:

Much of what we view clinically as "abnormal behavior" or "emotional disturbance" may be viewed as ineffective behavior and its consequences, in which the individual is unable to resolve certain situational problems in his life and his inadequate attempts to do so are having undesirable effects, such as anxiety, depression, and the creation of additional problems (p. 107).

The extent to which such an individual can be taught personal adjustment skills is the extent to which the problem-solving perspective, and all other therapies that utilize a didactic approach, will be found effective. So far, the extensive use of teaching methods in psychotherapy (starting prior to Adler's work in 1929) and the growing body of research on these methods indicate that many of the psychologically needy can profit from therapy approaches employing a didactic process teaching appropriate skills.

The didactic process used in the above methods (and in the treatment approaches following) has the advantage of
saving time over processes that must wait for the client to discover or develop the appropriate interacting, thinking, or problem-solving skills. Rotter (1954), in discussing how much interpretation (verbally clarifying client experiences and relationships) a therapist should use, indicates that sometimes there is a basis for the therapist to remain fairly passive, but "On the other hand, it is likely that such therapy would be highly inefficient (that is, at a minimum, overly long and drawn out" (p. 381). This prevents others from obtaining treatment, and costs each client more money and time than is really necessary.

Mahoney (1977) summarized some of the common indictments against psychotherapies by listing their lack of cost efficiency in monetary and phenomenological terms, as well as their ineffectiveness, especially from the client's point of view, poor generalization of benefits to situations and relationships outside of therapy, lack of maintenance of benefits over time, and substandard ethics where there is little respect for the client's responsibilities and rights. The problem-solving psychotherapies seem specifically designed to avoid the above indictments (Mahoney & Arnkoff, 1978) and, as such, epitomize the advantages of using a didactic process, as long as the material being taught provides useful tools for the client and results in more positive client experience.
The didactic process psychotherapy, direct teaching of concepts and ideas, has long been the essence of advanced and lower education. It is perhaps natural that some therapies in their search for methods of rapid cognitive, emotional, and behavioral change, would return to the ancient change process called education. The above approaches all rely on re-educating their clients, and to describe their procedures in any detail we would have to use terms formerly restricted to describe the classroom. There is another group of treatment methods also using primarily educational methods that can be found in the literature under the fairly new term of "psychoeducation."

Psychoeducational methods. There seems to have been some confusion in the literature over how to define psychoeducation. To some authors, psychoeducation means any intervention that is used within the school setting; to others, it refers to methods that employ a didactic process to create therapeutic impact; and to still others, psychoeducation is a broad new role of counseling psychologists encompassing both of these uses of the term. Yandell and Jose (1970), Tiedmans (1973), Aubrey (1973), Carroll (1973), Sprinthall (1973), and Cottingham (1973) use the term to mean school guidance, or personalization of school curricula in the classroom, with personal and social development of students as the goal. Mathison (1977) and
Guerney (1977) use the term to mean curricular interventions and programming innovations to treat depression resulting from illiteracy and math anxiety. Jackson (1970), Jackson and Bernauer (1975), and Cotugno (1980) talk about psychoeducation as a therapy occurring in the schools that is consistent with the educational goals of the school system. The above authors use the term psychoeducation differently but all mean psychological intervention that take place in the classroom or somehow reflects the needs of the school.

Ivey (1976), chairman of the American Psychological Association Professional Affairs Committee from 1974 to 1976, writes that psychoeducation is the comprehensive term to describe the work of the effective counseling psychologist of the future. He states that this work will now encompass "all important phases of helping-education, prevention, and remedial treatment" (p. 74). In this new role, counseling psychologists no longer have to be restricted to the traditional helping role but can view themselves as being able to help through educational endeavors and consultation services to paraprofessional and lay groups, "giving psychology away" in the manner hoped for by George Miller in 1969. The metagoal of psychoeducational work is to "increase individual intentionality" as well as increasing the "capacity to anticipate alternative
experiences" and "choose among them" to reach desired goals (Ivey & Alschuler, 1973, p. 592).

This new openness in terms of overall role has encouraged psychologists to reconceptualize their work in specific areas, like the remedial area, as well. The use of the didactic method in treatment, which is the meaning of psychoeducation in the writings of some professionals, is the focus of our literature review. Ivey and Alschuler (1973) describe psychoeducation as "deliberately teaching aspects of mental health," and as a "new curriculum" area for counseling psychologists. Haas (1973) follows the same train of thought when referring to teachers as the main implementers of psychoeducational change. In all likelihood, Ivey and Alschuler, and Haas were referring only to the educational and preventative function of psychologists as psychoeducators. However, some psychologists have conceptualized the educational thrust as integral to the remedial function. Authier, Gustafson, Guerney, and Kasdorf (1975) published an extensive review and historical perspective tracing the use of teaching in psychotherapeutic interventions. Karadimas (1977) published an article on Dr. Donald Pet's educational community which offers education and training in coping skills, and provides instruction about how one can face various issues in life. Masters and Johnson (1970) techniques for treating sexual dysfunction
rely on teaching the couple behaviors and mind sets that will result in pleasurable sexual responsiveness. Ivey (1973) used an educational approach employing videotape equipment to alter behaviors of hospitalized psychiatric patients. Wissot (1980) used Transactional Analysis as a curriculum to motivate the alienated student. These programs are just the recent manifestations (along with the cognitive learning therapies) of efforts to use an educational approach to achieve a psychotherapeutic result.

The didactic approach in psychotherapy has been employed as long as psychoanalysis. No less than Freud himself substantiates this claim:

Or, in other words under the doctor's guidance he ((the patient)) is asked to make the advance from the pleasure principle to the reality principle by which the mature human being is distinguished from the child. In this educative process, the doctor's clearer insight can hardly be said to play a decisive part; as a rule, he can only tell his patients what the latter's own reason can tell him. But it is not the same to know a thing in one's own mind and to hear it from someone outside. The doctor plays the part of this effective outsider; he makes use of the influence which one human being exercises over another. Or--recalling that it is the habit of psychoanalysis to replace what is derivative and etiolated by what is original and basic--let us say that the doctor, in his educative work, makes use of one of the components of love. In this work of after-education, he is probably doing no more than repeating the process which made education of any kind possible in the first instance. (Freud, 1968, p. 312)

Years before the advent of psychoanalysis, Dubois (1905) was describing and practicing psychotherapy as a spe-
cialized education for those suffering from neurasthenia (neuroses). Alfred Adler (1929, 1956, 1958), a colleague of Freud, developed "Individual Psychology" as psychotherapy that uses the didactic process with clients even more explicitly than does psychoanalysis. An Adlerian therapist first works to understand the unique "life-style" of the patient and the "mistakes" he or she is making. Then the therapist directly teaches the patient the errors inherent in his or her life-style, and offers other ways of behaving. The Adlerian psychologist teaches alternate ways for the patient to reach his or her goals in life.

The background for psychoeducational approaches to treatment was also laid down by other professionals in the field of behavior change. Researchers, such as Watson (1916), Jones (1924), and Pavlov (1927), explicitly discussed their research and findings in terms of learning. Max (1935) and Mowrer (1938, 1948) both described abnormal behavior and the processes of changing that behavior as learning processes.

Dollard and Miller, in the 1950's, brought further forward the point of view that human behaviors, including fears, guilt, and even social motivations, are learned by the individual early in life. Because of fears that keep these "learnings" unconscious, the typical "neurotic" has no language to describe the forces that are in conflict within
him or her. The labels for these feelings do not usually seem to exist for the client. "Successful psychotherapy provides new conditions under which neurosis is unlearned" (Dollard & Miller, 1950, p. 25) and other more adaptive habits are learned.

There are other notables in the field of psychotherapy who can easily be grouped together as having encouraged the move toward the role of rehabilitative psychoeducation, if they cannot be called remedial psychoeducators themselves. Rogers and Skinner are two giants in the field of human behavior change who did much to encourage acceptance, in the last twenty years, of new models of helping. Rogers insisted on the helpee being termed a "client" and being treated as such. Client-centered therapy allowed clients to teach themselves about themselves. There is no doctor in the client-centered approach to cure the patient. The label "client" moves closer to the "student" label than the "patient" label. Therefore, if Rogers is not to be considered a "psychoeducator" himself, then he has at least brought professionals much closer to that role. Skinner, working so intensively with learning theory, has turned other professionals in the direction of learning concepts and turned still others towards applying learning theories directly to solve human problems. Without learning theory as a backup,
psychotherapist as teacher would be a difficult leap to make professionally.

Outlining the influence of professionals on psychoeducation as treatment would be incomplete without mentioning George Kelly's (1955) development of personal construct therapy. His is another good example of a therapy that works to provide a therapeutic education for the client. Sanford was ahead of his time, in 1955, when he called for a shift in role by psychologist, from one of doctor and priest to one of teacher. Thomas Szasz (1961) contributed to the explication and advancement of psychoeducational work by making therapists aware of the need for client independence of professional values. Albert Ellis (1962, 1977) and Rational Emotive Therapy, introduced with George Kelly's work in the cognitive learning therapies section of this review, need to be reintroduced in this section. Ellis has had an impact on both the professional level and the consumer level with his popular and clinical writings in the last twenty years. He has done much to encourage acceptance of the direct verbal intervention by the therapist in a clearly educative process of therapy.

There have been other popular writers in the last sixty years who offered the reading of their publications as therapy processes because these books were educational formats teaching the reader procedures which would result in
positive changes. We refer here to Coue (1922) who offered "self-mastery" by means of autosuggestion; Carnegie (1948) who taught "how to stop worrying and start living"; Peale (1956) who promoted the "power of positive thinking"; and Malty (1960) who felt by learning about "psycho-cybernetics" the reader would "get more living out of life." The availability of this type of psychological instruction has not gone unappreciated by the general public who seem to be using these materials. Wayne Dyer (1977) published yet another psychoeducational book titled Your Erroneous Zones and it soon became a best seller. Dyer's book was purposefully instructive and straightforward, using simple language and encouraging personal growth through behavior change. Professionally a psychotherapist, Dyer stated that each chapter was written as though it were a "counseling session" to teach readers how to change their behavior. Books by psychologists, such as I'm OK, You're OK by Thomas Harris (1969), Happiness by Harold Bloomfield (1976), and Self Creation by George Weinberg (1978), have been largely successful, as have credit-free courses on human relations skills and intrapsychic methods (Continuing Education, University of Massachusetts, 1974-1978).

It seems natural that psychotherapists would begin openly conceptualizing their work as psychoeducational. Education, after all, was the primary method to encourage
and achieve change throughout human history. The entire body of knowledge of the field of education can be tapped to improve and refine the process of psychotherapy. Murray and Jacobson (1971) assert that the process of transferring information from the therapist to the client occurs in all psychotherapeutic forms. They state, "It appears that the rule of informational learning has not been adequately emphasized, particularly with regard to the study of interpersonal behavior" (p. 751). They point out that information is essential to the process of effective psychotherapy, such as positive statements by the therapist that personal change can occur and is expected. Frank (1961) published a theory that one's assumptions are the core of a person's behavior (similar to Kelly's personal constructs) and that successful therapy would involve relearning one's assumptions about oneself and the world. Authier et al. (1975) list many new approaches to interpersonal difficulties that depend on the therapist teaching the client helpful procedures (like Wolpe; Maultsly; Collins; Rappaport; Ely, Guerney, and Stover; Weiss, Hops, and Patterson; Meichenbaum and Cameron, and others) and that conceptualize their approaches in learning or in training language.

In this sense, psychotherapy is a learning process and the role of the therapist is analogous to that of a teacher or mentor. Psychotherapy is based on the assumption that feelings, cognitions, atti-
Attitudes, and behavior are the product of a person's life experience—that is, they have been learned. If something has been learned, modification of the previous learning can occur. Where learning is impossible (for example, in conditions attributable to genetic or biochemical factors), psychotherapy has little to offer. (Strupp, 1978, p. 4)

The psychotherapist's role, therefore, becomes one of teacher-therapist, and the job more clearly is one of designing a program for establishing the changes requested by the client, teaching the client how to utilize the program, and providing evaluation and feedback at significant points in the therapy.

Some of the advantages of the didactic approach were briefly explained in the section on cognitive learning therapies. The following are some additional ways to understand the significance of an educational approach. Psychotherapists conceptualizing their work in this way can understand immediately that the responsibility for change lies with the client just as it does with the student. The client is in the best position to know that something is wrong, and it is the client who must determine if a therapeutic procedure is helpful. An educational view of therapy helps therapists be free of imposing values onto the client. And it helps psychotherapists to realize the necessity of the client learning the behavior change procedures since the client will have use of them after termination. Even though the burden of change lies always with the client, therapists
can more clearly understand their responsibility to alter approaches, processes, or procedures when the therapy is not working. When the client should be changing and does not, it is easier for the therapists to change approaches if they view themselves as teachers rather than as authorities who "know." The use of the psychoeducational approach helps therapists and their trainers to leave behind the authoritarian approach and the arbitrary distinction between those who are "sick" and those who are "well," attitudes left over from the period of ascendancy of the medical model in psychological treatment.

Authier (1975), in specifying the uniqueness and benefits of conceptualizing psychotherapists as teachers, wrote:

The willingness to respect and encourage clients to choose their own goals knowledgeably and a high degree of respect for the client's own ability to reach them, given the appropriate environmental circumstances, is a keystone of the "therapist-as-teacher" movement. (p. 35)

With the psychotherapist seen as a teacher and the client viewed as a learner, other techniques reminiscent of the classroom become conceivable, such as using: 1) written instructions; 2) behavioral models; 3) direct feedback on performance; and 4) conceptual or intrapsychic training. In a psychotherapeutic program designed and implemented by Stuart (1967), clients were given a textbook containing instructions on methods of how to take charge of their
eating habits. The therapist teaches the clients how to best use the book, how to observe and keep records on their behaviors, and so on. The educational approach encourages homework such as this, thereby taking the therapy actively out of the office and into other areas of the client's life. This also allows the therapist to teach the client another skill: the most useful way to evaluate any homework the client does. An advantage of programs such as these is that once a client has mastered the change procedure or procedures taught by the therapist, s(he) can carry out the program independently of the therapist just as students have been expected to do over the ages. Thus, therapy is purposefully training the client to be his or her own therapist.

The psychoeducational approach has not developed in isolation from the cultural forces in operation today. Authier (1975) postulates that the "demands for accountability and consumers rights", the educational experimentation in the schools, along with "greater student participation in goal setting and evaluation", and widespread adult classes that teach skills in all spheres of life, have made psychoeducation easy to accept and even necessary.

The psychotherapist must have answers for the explicit questions clients now ask concerning benefits to be
gained from therapy, and to the demands for clarity and a straightforward explanation of the method to be used. This also is part of the educational orientation where the recipient, be it student or client, has a right to choose what is to be learned, and has a right to understand. This means therapists can little afford now to hide behind the "mystery" of psychotherapy and must have a clear understanding of what they are about and how they do things. Perhaps it is clear at this point why the psychoeducational thrust is producing more efficient therapeutic procedures. Authier (1975) states that "the efficacy of an increasingly explicit teacher role for the therapist has ... been demonstrated" (p. 40). It is time now to briefly review another procedure in psychotherapy that also provides high return in terms of benefits, cuts costs in money and time for clients, and reduces professional time expenditure.

**Group Psychotherapy**

Group psychotherapy has gained wide acceptance in recent years (Harris and Levy, 1975) and has become a focus of therapeutic interest (Finkel, 1976) not only because research indicates its effectiveness, but because of its efficiency in utilizing professional resources. Luborsky, Singer, and Luborsky (1975) in their review of comparative outcome studies examined comparisons between individual and
group psychotherapy. They found that group work was as effective as individual therapy in nine studies out of thirteen, that group therapy was found to be better in two of the studies, and that individual therapy was more effective in the other two studies. Orlinsky and Howard (1978) examined the relation of process variables to outcome results in psychotherapeutic approaches. Their findings concur with Luborsky et al. when they summarize that the great majority of studies examining the relative efficacy of group versus individual therapy found no significant differences, and that a few studies found group processes significantly better. In their review of current perspectives on group research, Bednar and Kaul (1978) summarized 28 studies researching group methods that were meticulously selected because of the high caliber of their research methods. They state that these studies provide justification of the efficiency of group treatments. Further, they conclude that group treatments "work" and that they have been shown to be useful in "helping people achieve more positive and perhaps more healthy evaluations of themselves and others" (p. 792). Bednar and Lawlis (1971) state essentially the same conclusion. Group psychotherapy can be effective, achieving results that equal and, on occasion, surpass individual approaches.
The Didactic Process in Short Term Group Psychotherapy

It was our purpose in reviewing the literature on psychotherapeutic methods to become acquainted with approaches that work effectively and yet work efficiently, saving time spent with a professional and, thus, treatment cost. In this section, it is appropriate to examine the usefulness of combining these formats in an effort to maximize the benefits of therapeutic effectiveness and maximize the conservation of professional resources in order that all demands for psychological services can be met. We have concluded that it is possible to have effective psychotherapy that is didactic in process, and we have reviewed some recent findings by researchers that the group format can be as effective as individual psychotherapy. It makes sense, then, to determine what the effectiveness and appropriateness might be of combining the didactic process with the group format. Later, we can consider didactic group psychotherapies that are short in duration as a way to understand the usefulness of the experimental group treatment. For now, let us look more closely at didactic group approaches without consideration for the length of treatment.

Didactic group psychotherapy. Adorno (1950) indicated that emotionally disturbed individuals respond favorably to group
situations that are structured. Structuring a group event is a necessary element to using an effective didactic process. The point of Adorno's research in this context is that the psychoeducational model has a ready-made structure and can be quite relieving to clients because of that fact alone. In their study using students as participants, Levin and Kurtz (1974) found significantly more favorable perceptions of the structured group format versus the unstructured interactive group mode. Bednar, Melnick, and Kaul (1974) recommend a structured group model for treatment because it is easier for group members to practice risk-taking and encourages them to increase their personal responsibility as a final developmental stage. Along with the didactic instruction, the presence of a group allows individuals to see confirmation of their own issues in other group members, and allows feedback on their behaviors in the group. Many psychologists have worked with groups of clients following, in a loose fashion, the behavioral approach but even more closely following the didactism of the psychoeducational model—using instruction, perhaps assigning homework, leaving control of the treatment to the client, and facilitating feedback as well. Perhaps the most well-known of these essentially didactic models (albeit in a group of two clients and one or two therapists) is Masters' and Johnson's (1970) treatment model, designed to treat sexual
dysfunction.

Though the psychoeducational approach has been used individually (i.e., Adler, Kelly, Ellis, Dyer), its historic form has been in groups or classes, because of the inherent advantages of groups. Professional costs have long been decreased for students through the use of groups, without sacrificing the income of the one teaching, and the same is true for the costs of psychotherapy. Another advantage to using a group didactic model has been the power of the group in shaping behavior, power with which effective teachers have long been acquainted and have used successfully. Another is the opportunity for participants to relate to a number of different people, instead of interacting only with the educator or therapist. Sechrest and Barger (1961) confirmed that clients will perceive as helpful group sessions in which they participated the most.

It has been found that structured group processes are helpful even with individuals classed as disturbed enough to be placed in an institution. Singer and Goldman (1954) studied the use of structured group therapy with those clients labeled schizophrenics (roll call was taken, seats were assigned, and there was a fixed format of lecture and discussions) and concluded that, initially, schizophrenics found the structure useful in comparison to a democratic format. Anker and Walsh (1961) set up a treatment group for
those labeled schizophrenic. Their experimental group included structured activity, but the atmosphere of the group was permissive and designed to give the participants a sense of belonging. In comparison to standard group therapy, Anker & Walsh's group improved in patient mobility, cooperation, communication, affect and total adjustment. "Significant and consistent improvement" was made in their group, whereas the standard group therapy produced "relatively minor positive results" (p. 79). Pierce and Drasgow (1969) achieved positive results using a didactic format in training psychiatric inpatients in reflection of feeling skills. Goldstein (1973), Gutride, Goldstein and Hunter (1973), Gutride, Goldstein, Hunter, Carrol, Lower, Clark and Furia (1974) all found improvement of interactional skills in psychiatric inpatients when using the "microcounseling" curriculum in group format.

Research findings using didactic group psychotherapy with participants from the less disturbed "target population" isolated earlier in the chapter have produced as gratifying results as the above-mentioned studies. Truax, Shapiro, and Wargo (1968) reported that pretraining group members how to operate in group therapy had a beneficial effect on participants' ideal self-concept in comparison to regular group sessions with no vicarious therapy pretraining and in comparison to those groups
meeting alternate times without a group leader. Lewinson, Weinstein and Alper (1970) successfully developed a group-based training program that taught social skills to the depressed. Authier (1973) designed the "Step Group" psychotherapy by combining instruction in basic communication skills and a group interactive form of therapy.

The Step Group program not only occurs in a group setting but explicitly capitalizes on the advantages of a group as a practice ground for the interpersonal skills taught and as a source of multiple feedback agents. The group setting appears to maximize the training while the training contributes to much more effective interactions in the therapy group. (p. 43)

Clearly, the didactic group therapy model has far greater promise than is being tapped to date. Findings and developments such as these herald even more efficient and effective modes of delivery.

**Short term didactic group psychotherapy.** Combining the efficiency of the short-term approach with the efficacy of the didactic group method could be ideal in terms of providing effective psychotherapy to the target population. Professionals could then treat as many as 12 individuals at a time instead of one, and for an average of 30 hours total interaction time instead of 50 hours per individual (one year's sessions). If our average professional works 30 hours per week, and the average duration of individual therapy is one year, the professional could only treat 30
clients per year. With a 12-client, 30-hour psychotherapy, this same professional could treat 400 clients per year instead of 30. This amounts to a potential 1,333 percent increase in number of clients receiving treatment. It is increases of this magnitude that are needed to match the increasing demand for professional services.

Both group therapy and brief or short-term group therapy are accepted as reputable treatment processes in the mental-emotional health field, and didactic processes such as the psychoeducational approaches and cognitive learning therapies are gaining acceptance. Some research has already been done examining approaches that combine these processes creating short-term didactic group psychotherapies. Fairweather (1963) found that structured group therapy that included work assignments was the most economical of various formats, considering the time and effectiveness of the treatment. Vitalo (1971) used a 15-hour didactic group approach with inpatients of a psychiatric hospital and found improvement compared to a control group. In a study comparing the relative effectiveness of three short-term group approaches to control groups, DiLoreto (1971) found that the three forms of group therapy were all superior to the control groups in outcome. The study used as one of its experimental group therapies a well-known didactic psychotherapy—Rational Emotive Therapy. Adapted for use in
a brief-group format, it, along with the client-centered approach (also presented as a short-term process), did slightly better with introverts, while systematic desensitization, the third approach, did equally well with introverts and extroverts. Pertinent here is the brief duration of all three treatments, their effectiveness in comparison to the control groups, and the effective use of a short-term, didactic group therapy.

Didactic models of psychotherapy have the advantage of being short in duration. Inherent in the classroom, or didactic style, is the tendency to present the material in a specified length of time (normally courses last four months). This is made possible by the straightforward manner in which the material is presented, the simple, clear, nature of the teacher-student relationship, and the expectation that the student will continue any future study of the subject on his or her own using the methods and information gained during the course. Consciously adapting the didactic process to other forms of group therapy could provide a means to shorten their duration while still maintaining their effectiveness.

What is needed now is more research examining the efficacy of brief-group treatments of this type. The Elimination of Self Defeating Behavior (ESDB) is just such a treatment. Didactic in style, it can accommodate up to 12
participants at a time and requires 25 to 35 hours of professional contact time. Over four years, throughout 16 groups facilitated by the author, many participants reported benefits in their life and some related that these kinds of changes were sustained years after their groups met (Continuing Education, University of Massachusetts, Amherst, Mass., 1974-1978). Thus encouraged, this research was undertaken to determine, in a more rigorous manner, the effectiveness of the ESDB group model, hoping to provide another viable alternative to fulfill the promise of relief promoted by the profession of psychotherapy. The ESDB method appears to have all the advantages of brief-group therapy in terms of efficiency, and all the advantages of effectiveness in terms of the didactic processes. In the next chapter, we will take a detailed look at this ESDB method and determine how its effectiveness can be measured.

Summary

The goal of this chapter was to establish a framework to understand the Elimination of Self-Defeating Behavior group method, to justify the perception of it as a potential solution to the rising demand for psychological services, and to reveal the basis for the potential effectiveness of the ESDB method. Being in use only ten years, the ESDB method is not well-known. In addi-
tion, the use of the didactic process as part of its treatment method makes it imperative that the reader become acquainted with research on similar methods before reviewing the specifics of the ESDB process.

Since the ESDB experimental method is a form of psychotherapy, we began our review with a short history of theory illustrating how the geneticists like Galton (1869) and Estabrooks (1916) were displaced by the more environmental approach of Freud (1904). This led us to statements by reviewers like Eysenck (1952), Levitt (1957, 1963), Smith and Glass (1977), Meltzoff and Kornreich (1970), Bergin and Lambert (1978) about the effectiveness of psychotherapy in general. Determining that there is evidence that psychotherapy works, we defined the population that we were interested in helping. Using definitions by Knopff and the World Health Organization, we clarified the meaning of the psychoneuroses. Definitions of psychotherapy by Hobbs (1962), Meltzoff and Kornreich (1970), and others were quoted to provide a definitive background against which to understand the discussion to come of different aspects of psychotherapy.

Short-term psychotherapy was then established as a viable form of treatment referring to studies by Strupp (1978), Butcher and Koss (1978), and Wolberg (1967), among others. Elements of short term methods such as client goal
setting and an actively intervening therapist were found to be shared by the didactic psychotherapies.

In the next section, cognitive learning therapies developed by psychologists such as Bandura (1969), Raimy (1975), Kaydin (1973, 1976), Spivak and Shure (1974) were presented along with psychoeducational methods developed by professionals like Adler (1929), Kelly (1955), and Ellis (1962). Studies measuring effectiveness were favorable, and discussing the basis for the educational thrust into psychotherapy provided an historical summary of the use of didactic process in treatment. To many the father of psychotherapy, Freud (1968) is quoted as describing how psychoanalysis is really an educative process.

Some advantages of conceptualizing psychotherapy as the teaching of valuable living skills are presented from a practical, ethical, and philosophical point of view. Such an approach makes the therapist's role more flexible by placing the burden of change with the client, allowing the therapist more treatment options, and providing a format easily presented in groups.

Group psychotherapeutic research by Harris and Levy (1975), Singer and Luborsky (1975), and others showed group therapy to be a viable and effective form of presenting treatment. Moving in closer to the experimental method, separate treatment processes were combined and several
short-term didactic group psychotherapies were reviewed. Adorno (1950), Levin and Kurtz (1974), Masters and Johnson (1970) were some of those cited to illustrate the efficacy of using structured approaches in group treatment. Inpatient studies also provided a measure of the usefulness of the didactic group approach. Truax (1968), Authier (1975), Vitalo (1971), DiLoreto (1971) and the findings of others were used to provide support for determining the efficiency and effectiveness of short-term didactic group methods such as the Elimination of Self Defeating Behavior experimental procedure to be analyzed in this study.
CHAPTER III
THE ELIMINATION OF SELF DEFEATING BEHAVIOR MODEL AND RATIONALE FOR INSTRUMENTS

In this chapter, the theory, concepts and research on the Elimination of Self Defeating Behavior (ESDB) therapy model will be presented. In order to evaluate the treatment, this research measures self-defeating behavior, self-esteem, and the internal locus of control of reinforcement before and after treatment. A basis for hypothesizing changes in these three areas to measure psychotherapeutic effectiveness will be presented.

The Elimination of Self Defeating Behavior Theory

It is postulated that all self-defeating behaviors result from primarily subconscious and/or unconscious fears. These fears become unconscious because of constantly repeated failures in childhood to successfully resolve a fearsome situation. Over time, the individual unconsciously assumes that the only way to terminate the intolerable experience is to use the self-defeating behavior and thus sacrifices his/her goal. For example, an individual wants to achieve a grade of B or above on an examination. This
individual subconsciously fears (s)he does not have the intellectual capacity needed to do well in life. When (s)he starts to study for this examination, the fear is activated. Because the self-defeating individual is not able to distinguish the experience of the fear from what it is that (s)he is afraid will happen, if (s)he feels afraid, that means the exam will be failed. When this individual thinks about the exam, (s)he assumes the worst based on past experience and fears (s)he will not "make the grade" on the exam. Therefore, convinced the failure will inevitably happen, the solution for this individual is to put off studying in order to feel "okay." This results in a much lower grade on the exam, causing the person to believe his or her fears were well-founded. It is a vicious spiral form of reasoning with no way for reality to have an input. Thus, self-defeating people manage to neutralize the fear which threatens to overwhelm them, but in the process create the very situation of which they are afraid.

The birth of these fears is in the first decade or so of development. The different fears, such as fear of unattractiveness, stupidity, noncreativity, fear of success, happiness, and so on, can typically be found to lie in the fear of not being able to cope with situations in childhood. Basically, this is a fear of not surviving, born of situations repeated again and again in early life before one
had the maturity or ego development to deal with them successfully. The environment in those years—dependent on powerful others for survival needs, food, affection, and shelter—repeatedly put the individual in a fearful situation where just being who one was, at that stage of maturation, was not enough to resolve the problem in a satisfactory way. The individual was sure to fail, and knew it, so the fear was felt to be endless. In order to block out the fear and get out of the situation, the person adopted some behavior that removed her or him from the situation. Repeated over time, this behavior became habitual and the understanding of the fear became subconscious or unconscious.

The Elimination of Self Defeating Behavior (ESDB) method is defined by Chamberlain (1979, p. 73) as having the following conceptual core:

1. Individuals are created whole without self-defeating behaviors (SDB's).

2. SDB's are learned responses to cope with unusual life situations.

3. SDB's and accompanying erroneous self-concepts are learned in moments of pain, stress, anxiety, fear, or pleasure.

4. Fear is the major source of energy used to maintain SDB patterns in current moments of living and is assisted by the use of choices and disowning methods.

5. Inevitable prices; that is, adverse consequences, are paid by a doer of the SDB.
6. A SDB can be eliminated when the doer of it understands and applies basic principles by (a) exposing to greater self-awareness the choices, maintenance techniques, and disowning methods used; (b) recognizing and feeling the prices paid; (c) facing the fears of being without the SDB pattern; and (d) imagining coping in reality without the SDB pattern.

SDB's are defined as any recurring thoughts, feelings, or actions that create adverse consequences for the owner.

Examples of SDB's overcome in ESDB workshops include: procrastination, overeating, undereating, stuttering, obsessive thoughts, and memory loss.

The Elimination of Self Defeating Behavior

Group Therapy Procedure

The procedure used to deal with people with self-defeating behaviors is a process of teaching them theory, facilitating self-analysis, and encouraging and supporting new approaches to life situations. They are encouraged and assisted in putting their fear into words, so that they can then more successfully tolerate it. Being able to tolerate the fear experience for a longer period of time, they can establish that the fear that they feel is inaccurate, and they can teach themselves, finally, that the fear is anachronistic. This is the hoped-for result--that self-defeating people can realize that for years they have been avoiding testing the fear, and so have been unable to determine if the feared situation would really occur. It is as
if what was true in childhood is believed to be forever true. Using the self-defeating behavior not only avoids some of the feeling of fear, but also allows people to avoid testing the old "lessons" they learned as children. Once these fears are tested and the truth determined, it is no longer necessary for people to protect themselves from the "awful" truth, and the self-defeating behaviors can be discarded.

To achieve this end, participants are taught, in very individual terms, the two basic concepts: (A) personal creation of behavior and ownership of the consequences, and (B) challenging the self-conclusions and tolerating the fear. The subcategories of (a) behavior, (b) disownership, (c) personal cost, (d) inner choice, and (e) untested fears, help the group members to understand the two basic ideas. Each subcategory is presented by itself at the end of a group meeting and journal writing is assigned in relation to that subcategory. At the next meeting, members share and discuss this material and when the subcategory is thoroughly understood in terms of this personal material, they fill in the proper section of an ESDB facilitation form (see Appendix D). The next subcategory is presented in the last three quarters of an hour and more journal writing assigned and, so on, until all subcategories have been presented. The next meeting is used for summation and review and clari-
fication of any questions about the concepts or other material. Then the participants are taken through an imagery exercise to facilitate the realization of potential shifts in affect when they face their fears. Participants then conclude the process with two or three meetings where their attempts to face their fears in real life are discussed exclusively.

The entire process takes between 25 and 30 hours of leader/group contact time, plus some time for minimal journal writing each day while participating in the process. This journal writing is used in the self-analysis during the group meetings. Individual participants are encouraged to share journal assignments in turn during each of the group meetings. The didactic work is normally confined to the last half-hour to forty-five minutes of the meetings.

The five basic subcategories. In order for the group work to be successful, the participants must understand, in their own terms, the concepts and the subcategories. The first two subcategories (a) behavior and (b) disownership, aim at ending the tendency of participants to believe they are still so dependent on others. Participants describe the self-defeating behaviors in some detail and come to understand what they do that creates the situations in which they repeatedly find themselves. If change is to occur, responsibility for the behaviors must be accepted by the
participants. The opposite of this is termed disownship, and refers to the blaming of others for repeated predicaments. If participants want to achieve their goals in life, then they can only depend on themselves to make those achievements a reality. To disown is to continue unnecessary, and quite possibly unreal, dependency on others.

The third subcategory is the **personal cost** to the participants for using SDB's. This is one of the most important subcategories of the five taught. It is realization of the personal costs that gives individuals the motivation to try a different behavior. In order to continue behaving in self-defeating ways, individuals must ignore the actual detrimental results. By delineating in detail the disadvantages of the SDB's, most participants come to fully understand the consequences of their behaviors. The primary method of ignoring the cost is by putting personal upset on to others by blaming them. By blaming others, individuals place the origin of any negative effects away from themselves, and thus diffuse any sense of personal power or responsibility for the situation. This subcategory brings the pain "home" where self-defeating persons can take constructive steps, based on the negative information.

The fourth subcategory encourages the participants to translate fleeting and transitory fears into words,
thereby stating their internal choices. The **inner choice** subcategory helps group members distinguish feeling choices from practical choices. Examples of outer choices are "New Year Resolutions" and any behavior choice that has to do with some external action (such as "Shall I study tonight or not?" or "Shall I eat between meals or not?") The inner choice is concerned with the fear that lies behind the SDB. Inner choices are best determined by the opening phrase "Do I dare find out if I'm . . ." finished with whatever fears participants have about themselves ("Do I dare really find out how intelligent I am?" or "Do I dare find out if I'm attractive?"). As long as individuals answer "no" to the inner choice, self-defeating behaviors will be chosen. A negative or positive answer to the inner choice automatically determines the outer choice for people, no matter what they consciously intend to do.

The fifth and final subcategory is that of **untested fears**. There are two aspects to untested fears: a) the experience, and b) the feared situation. The feeling is quite real. The feared situation refers to the event people fear will result from a choice made. For example, an individual may feel afraid that (s)he is unattractive to others. (S)he defeats her or himself by not accepting the invitation to a gathering of attractive others in order to avoid feeling afraid and to avoid certain confirmation of that
which is feared. This way, the person never disproves the fear (by finding that it is an illusion in his or her adult life) or confirms it. The fear hangs on, neither proven nor disproven, and the person must, therefore, act as if it were true while desperately hoping that it is not. This conception of the untested fear opens up the possibility to participants that the fear response is inaccurate in their present life. The process encourages them to put their fears to the test and discover if the old fears truly predict the outcome. Typically, self-defeating people discover that the fears are illusions based on the past. Usually participants are able to uncover situations they were repeatedly thrust into as children, when they were too young to cope with the situations successfully. Lacking information to the contrary, children learn early in life that they cannot succeed in one or another area. This message is then internalized and acted on for so many years that the resultant self-defeating behaviors become habitual.

More freedom to act is the benefit that usually replaces struggling to avoid confirmation of these early fears. Participants are consistently encouraged and supported in making choices that involve some risk to their concept of themselves, to attempt changes in behavior, and to then assess the results.
Research on the Elimination of Self Defeating Behavior

The Elimination of Self Defeating Behavior model outlined above was designed and implemented by Cudney (1972) at the counseling center on Western Michigan University campus in the late 1960's. The first research on the method was done in 1970, by Lowe, when Cudney ran his first workshop using his method (Chamberlain, 1979). Since then, the research on this method has grown considerably. Sixteen outcome studies were done (from 1972 to 1980) using the Cudney ESDB method (Hendricks, 1972; Fiester, 1973; Seelig, 1973; Coombs, 1974; Parks, Becker, Chamberlain, and Crandell, 1975; Chidester, 1975; Jacobs, 1975; Parks, 1976; Forsyth, 1976; Bohn, 1976; Turnbull, 1977; Jensen, 1978; Johnson and Chamberlain, 1978; Banks, Grimmer, Hardy, Hiatt, and Lowe, 1979; Hornak, 1979; and Younker, 1980). This method has been used in individual counseling, marriage counseling, in drug and alcohol groups, in prison, in systems and organizational consulting, in pupil personnel and teacher inservice training programs, and in the classroom from the 3rd grade through university levels. Most of the studies demonstrated positive statistically significant results. Positive changes were found in self-concept, state anxiety, behavior patterns, locus of control, and MMPI scale scores. The investigators of these
sixteen studies all concluded that the ESDB method is effective in modifying various aspects of internal and external behavior and that these changes could be maintained over time.

Lowe, in 1970, reported significant changes in pre-post MMPI scores over a five week time span during which the ESDB method was presented to the experimental group. The follow-up measures taken after four months also showed that significant positive change continued (Chamberlain, 1979).

Coombs, in 1974, reported significant change on the scores of the Tennessee Self-Concept Scale, indicating a movement toward more positive self-concept in the community college students who participated in the ESDB process compared to a non-participating control group. In the eight week follow-up testing, the ESDB group scores continued to show positive change.

Burke and Taylor in 1976 reported that five groups were exposed to the ESDB method along with other group methods and that 75 percent benefitted from the ESDB method. They stated that the ESDB method was much more effective than the other group methods used. Participants in this study were subjectively rated by the group leader, as well as reporting on a self-report survey pre-group and 30 days after the group process.

The results so far have indicated that the ESDB
model is effective, even compared to different methods (Hendricks, 1972; Seelig, 1974; and Bohn, 1976). In different settings—classroom, office, or hospital—and with different populations, it seems to be producing the positive changes expected from an effective psychotherapy. Banks, Grimmer, Hardy, Hiatt, and Lowe (1979) used this method with male and female veterans who had a history of being hard-to-serve. All of them were chosen because they typically dropped out of each treatment program in which they enlisted. For the ESDB program, 95 out of 128 completed, which was considered surprisingly successful. Jensen (1978) used high school students from five different high schools and found 80 percent of the participants in the ESDB groups effectively overcame their self-defeating behavior. Johnson and Chamberlain (1978) used male-female smokers responding to ads and notices at work and found significant (p < .10) decreases in smoking and externality on Rotter's Internal and External Locus of Control Scale. Subscales of the MMPI (Fiester, 1973), and the Personality Orientation Inventory (POI) (Turnbull, 1977), the Spielberger State-Trait Anxiety Inventory (Hornak, 1979), the Tennessee Self-Concept Scale (Coombs, 1974), and Rotter's Internal-External Locus of Control Scale (Fiester, 1973; Seelig, 1973; Coombs, 1974; Parks et al., 1975; Turnbull, 1977; Johnson and Chamberlain, 1978; Jensen, 1978; and Hornak, 1979) have all been used to
measure the effectiveness of the ESDB method. All the studies listed have had control or comparison groups and the ESDB method has consistently demonstrated benefits to those participating in the study.

However, the determination of this method as an effective psychotherapy or psychoeducational model is not yet fully complete. The studies above do tend to show that the method is not totally independent of the personality of the facilitator, but the research relies heavily on college students as subjects. These studies showed positive results with college students as participants. Students are often used as subjects because that population is most often available to researchers. Only Johnson and Chamberlain (1978), who studied smokers, and Banks et al. (1979), who studied hard-to-serve veterans, used non-students. In order for this method to be proven useful to meet the rising demand for psychological services, it needs to be determined effective with community participants—the cross section of people one might find utilizing a psychotherapy clinic or a psychoeducational center. This study, hopefully, will provide this type of information. This research replicates previous studies, providing multiple measures of the effectiveness of this method, using community members as participants.
Measuring the Effectiveness of a Psychotherapy

Testing the effectiveness of a psychotherapy is a difficult task primarily because of the difficulty in controlling for the multiplicity of variables that must be considered. In this case, the dependent variables chosen to demonstrate effectiveness are the ones believed to most reflect benefits of the ESDB treatment approach.

Self-defeating behavior. Since one of the main thrusts of the experimental treatment was to "eliminate" self-defeating behaviors, it seemed appropriate to determine how well this was accomplished. If this study demonstrated that participants used fewer self-defeating behaviors after participating in the ESDB process, then this would indicate that the method was effective in reducing these damaging behaviors.

Self-defeating behavior (SDB), a concept referring to the behavior to be eliminated, has had wide usage in the field of psychotherapy. Authors have used SDB as a clinical description since the time of Freud (Adler, 1929). In a recent computer literature search of Psychological Abstracts, there were 36 articles since 1967 that had self-defeating behavior (SDB) in the title or in the text, some of which are cited here: Rosenbaum, Jacobs, and Mann, 1968; Clarke, 1970; Rubin, 1970; Shulman, 1972; Vriend and Dyer,
In a similar search of the ERIC file, the SDB term was used in 12 studies since 1971, five of which are cited here (Moses, 1969; U.S. Government Printing Office, 1970; Timberlake, 1976; Dyer and Vriend, 1977; and Tobias, 1980). Of the 48 studies in the literature since 1967, only sixteen concerned studies of the ESDB method itself. All of the other 32 (and all of those cited in this paragraph) were studies reviewing or using another psychotherapeutic form.

Samuel Warner was a psychotherapist who wrote using SDB as a concept in 1966. His work, Self-Realization and Self-Defeat, is notable because it brought the term to the attention of the general public. It is a layperson's analysis of neurotic behavior by a professional and illustrates in depth the protective role of self-defeating behaviors and "defeatism" in general.

Self-defeating behavior as a term has had long and wide-spread use in the field of psychology and psychotherapy, but the ESDB group treatment appears to be the only approach specifically designed around the concept. In Milton Cudney's (1972, 1976) method of "eliminating self-defeating behavior," SDB's are illustrated, examined in general, analyzed in specific, and concentrated on as the primary manifestation of one's destructive fears. The effectiveness of such a method logically would rest on its
abilities to assist participants in divesting themselves of these behaviors.

**Self-esteem.** Self-esteem can be taken to mean a respect for one's self and a positive regard for one's activities. The Elimination of Self-defeating Behavior (ESDB) method teaches a description of, and encourages a personal clarification of, the inevitable connection between SDB and negative consequences. In fact, the negative consequences to people as a result of self-defeating behaviors are the reason people realize that they are behaving in self-defeating ways. Until they participate in the process, however, it may be difficult for them to understand the full extent of the negative consequences they must accept if they continue with their SDB. One of the most universally damaging consequences of any SDB is the loss of self-esteem. It is difficult to continue to defeat oneself and yet continue to regard one's self highly. Participants in the ESDB process are intentionally given instruction and experiences designed to empower them with the necessary information and confidence to act in more self-actualizing ways. An important measure of effectiveness thus would be an increase in self-esteem.

As was the case with defining self-defeating behaviors and reducing their occurrences, the increase in self-esteem as an indicator of therapeutic effectiveness has had
wide use in the field. It was one of the four major indicators of effectiveness of psychotherapy in the major review of all psychotherapy outcome studies by Smith and Glass (1977). A computer search of Psychological Abstracts revealed that between 1967 and 1981, 57 outcome studies had self-esteem as an important dependent variable (Goodstein, 1972; Teichman, 1974; Adesso, 1974; Caldwell, 1974; Attwell, 1974; Stevens, 1975; Ensey, 1975; Friday, 1975; Street, 1976; Cameron, 1976; Finando, 1977; LaFerriere, 1978; Fiedler, 1979; and Brown, 1980 are some of the references available). The ERIC computer search of materials from 1966 had nine references that prominently listed self-esteem as an important outcome variable: West, 1973; Beers, 1973; Boardman, 1974; Canfield and Wells, 1976; Novak, 1978; Martin, 1978; Blattstein, 1978; Helm, 1980; and Henker, 1980.

Internal versus external locus control. In 1966, Rotter defined the concept of internal versus external locus of control of reinforcement as a generalized expectancy individuals had for the control of reinforcement:

The effects of reward or reinforcement on preceding behavior depend in part on whether the person perceives the reward as contingent upon his own behavior or independent others. Acquisition and performance differ in situations perceived as skill versus chance. Persons may also differ in generalized expectancies for internal versus external control of reinforcement... The role of reinforcement, reward, or gratification, is univer-
sally recognized by students of human nature as a crucial one in the acquisition of skill and knowledge. However, an event regarded by some persons as a reward or reinforcement may be differentially perceived and reacted to by others. One of the determinants of this reaction is the degree to which the person perceives that the reward follows from, or is contingent upon, his own behavior or attributes versus the degree to which he feels the reward is controlled by forces outside of himself and may occur independently of his own actions. The effect of a reinforcement following some behavior on the part of a human subject, in other words, is not a simple stamping-in process but depends upon whether or not the person perceives a causal relationship between his own behavior and a reward. A perception of causal relationship need not be all or none but vary in degree. When a reinforcement is perceived by the subject as following some action of his own but not being entirely contingent upon his action, then in our culture, it is typically perceived as the result of luck, chance, fate, and under the control of powerful others, or as unpredictable because of the great complexity of the forces surrounding him. When the event is interpreted in this way by an individual, we have labeled this a belief in external control. If the person perceives that the event is based upon his own behavior or his own relatively permanent characteristics, we have termed this a belief in internal control. (p. 1)

Whether a person considers chance or a personal skill to be the deciding factor in events that shape his or her life can be crucial to the success of any behavior change process. The ESDB method teaches as an integral component of the process of behavior change the concept of personal responsibility for one's situations. Consequences are created by the individual. As such, it seems to fit very well with Rotter's idea of internality versus externality, which is demonstrated by the fact that seven of the sixteen studies of the ESDB method (Fiester, 1973; Parks, et al.,
1975, Parks, 1976; Bohn, 1976; Forsyth, 1976; Johnson and Chamberlain, 1978; and Jensen, 1978) use Rotter's scale to determine the effectiveness of the method. All these studies showed increases in internality as a consequence of participating in the ESDB process.

There were other psychotherapeutic researchers who used Rotter's scale as a measure to gauge the effectiveness of the psychotherapy that they were researching. Diamond and Shapiro (1973) examined the effects of encounter group experiences on participants' locus of control. Jerome Frank (1974) published a 25 year progress report of the therapeutic components of psychotherapy. Frank used Rotter's scale as a way of measuring the effectiveness of psychotherapy. Foulds and Hannigan (1976) studied the effects of group therapy on locus of control of participants. Watts, in 1977, studied the effects of reality therapy in individualized instruction on the locus of control expectancy of students. Christensen, in 1979, studied the differential effectiveness of two styles of Rational Emotive Therapy on internal locus of control and external locus of control alcoholics. A computer search in the psychological literature showed that between 1957 and 1981 the Internal Versus External Locus of Control Scale was used in 38 outcome studies of different forms of psychotherapy. Clearly, there has been considerable
interest in this variable since Rotter introduced it in 1966.

This interest can be partially explained by the findings. It is one of the better predictors for a wide range of competence and independent behaviors (Lefcourt, 1966; Joe, 1971) and, as such, the locus of control variable seems to have much relevance for use in therapeutic change programs. The results of investigations shows that a person who scores low on the internal of the Locus of Control Scale is more likely to take action to "better his life conditions" (Gore and Rotter, 1963). The more internal person (low scoring) has been found to be more prone to pay attention to, and to take in and remember, information that has relevance to his or her future goals (Seeman, 1963; Seeman and Evans, 1962). He or she tends to be more independent (Crowne and Liverant, 1963). Battle and Rotter (1963) found that these effects crossed ethnic, cultural, and social class boundaries. Furthermore, internals have been shown to be more interested in achievement (Rotter, 1966), less anxious (Feather, 1967), less insistent that they get their own way (Joe, 1971), less suspicious and more trusting of others (Hamsher, Geller, and Rotter, 1968), more insightful and self-confident, and less likely to use sensitizing defenses (Joe, 1971), and generally better adjusted (Hersch and Scheibe, 1967). Findings that inter-
nals have been demonstrated to be more likely to remedy personal problems and show a greater tendency to get information and adopt behaviors which would increase their personal control over their environment (Lefcourt, 1966; Rotter, 1966) are some of the reasons that Strickland (1978) stated the following:

Although results are not altogether as clear, convincing, and free of conflict as one might hope, the bulk of the research is consistent in implying that when faced with health problems, internal individuals do appear to engage in more generally adaptive responses than do externals. These range from engagement in preventive and precautionary health measures through appropriate remedial strategies when disease or disorder occurs. Findings suggest that the development of an internal orientation could lead to improved health practices for some individuals who have been inclined to believe that life events are beyond their responsibility and more a function of external control. (p. 1,205)

These findings suggest that increased perception of internal control over life's events is positively related to a wide range of competence and positive adjustment factors.

The internal locus of control has an apparent similarity to the concept of ownership that is taught in the ESDB group process. The concept of ownership is seemingly the same as the concept of responsibility for the consequences of one's actions, which is a primary focus in the elimination of self-defeating behavior. One would expect then to see a shift from externality to internality on Rotter's scale as a result of participating in this group process.
Summary

The Elimination of Self-defeating Behavior (ESDB) group psychotherapeutic model is a procedure that is short-term in length and didactic in process. Two basic concepts are presented to participants: (a) that one's personal behavior can create the consequences in one's life and (b) one can challenge the conclusions learned in one's lifetime about the limitations that one has. Ways of behaving, ownership, personal consequences, inner choice, and testing fears are taught as ways to help members integrate the above concepts. Research has been presented that shows that this method is effective in reducing self-defeating behavior, increasing internal locus of control and lowering anxiety. More research is needed replicating these findings using community members instead of college students as participants. Given the inherent difficulties of measuring the effectiveness of psychotherapeutic procedures, the level of change in participants' self-esteem, the amount of change in participants' locus of control, and measurement of the change in the frequency and severity of participants' self-defeating behaviors have been determined to be appropriate ways to determine the effectiveness of this psychotherapeutic method.
CHAPTER IV

RESEARCH METHOD

In this chapter, the research method used to determine the effectiveness of the Elimination of Self-Defeating Behavior group psychotherapy model will be reviewed. The following discussion will include the gathering of participants, the choice of instruments, the premises and hypotheses, the experimental design, the specific application of the ESDB group treatment, and the statistical analysis that was used.

The Research Problem

The problem was to test the effectiveness of the ESDB group treatment process. The overall premise, therefore, was that the ESDB group therapy procedure is an effective self-improvement therapy for people who behave in self-defeating ways, such as overeating, chronic lateness, procrastination, inability to state one's opinions, abuse of intoxicants, perfectionism, compulsive lying, and the like. It was determined that the effectiveness of the ESDB group psychotherapy could be determined by observing changes in subjects who participated in this group process. Of the
changes that are possible to observe, the following three were considered pertinent: (a) change in frequency and severity of self-defeating behavior, (b) change in the internal or external locus of control, and (c) change in self-esteem.

Participants

A pool of participants was drawn from the Pioneer Valley community through advertisements placed in local newspapers and notices sent to relevant agencies and placed on community walkways. These ads announced a course in "Overcoming Self-Defeating Behavior" at a nominal tuition rate of $25, $20 of which would be returned at the full completion of the course, and informed the reader that this same course had been offered through the Division of Continuing Education at the University of Massachusetts for four years at a higher rate. The ad defined self-defeating behavior, gave the length of the time commitment (25 hours over a period of 5 weeks), and stated where to register (see Appendix A). It also informed the reader that the course was to be used as part of a doctoral study and that was the basis of the reduced rate. Each applicant was interviewed over the phone and was again informed of the research and told of the number of participants, the materials presented, and that two separate groups would meet. In order to
enroll, the applicant had to find two associates who would be willing to fill out a questionnaire about him or her three times during the research. Community members thus identified themselves as self-defeating in the process of registering for the course.

In this manner, 32 potential participants were chosen. The participants were to be split into two equal groups of 12 which were matched for age, sex, educational level, and ethnicity. Because of dropouts prior to the first meeting of both groups, strict participant matching of the two groups became impossible. Of the 32 people who had agreed to attend the first meeting and participate in the project, only 21 attended this first group meeting. For statistical reasons, a minimum group membership had to be at least 12 members. To guard against future potential dropouts, 15 of those 21 were assigned to the first group that was to meet and the remaining participants, along with applicants who applied late, were assigned to the control group. This permitted the first group to proceed with the ESDB group treatment having a full complement of participants and no disruption in the schedule. The control group of 13 members was formed the first week after the project started. And, as it turned out, the two groups of participants were found to score in a very similar way (see Chapter V, Table 1).
Group I (the treatment and follow-up group) began with 15 members. Of those original members, three dropped out after one or two meetings which left 12 participants for the final analysis (see Appendix C). Of these 12, two were men and ten were women, ranging in age from 23 to 58 years old. The distribution curve of the age range was very flat, having a multi-modal shape with 23, 26, 29, and 31 years old each having a frequency of two participants each. The mean age was 30.5 with the median age being 29. The group was composed of Caucasian individuals except for one Black female. They all had backgrounds in college except for one female high school graduate. Two female participants had been to graduate school, with one of those achieving a status of full professor (this was the one who was 53 years old.) This group was composed of participants who applied early to the program, which may have been reflected later in the group when all participants were able to arrive at the last three or four meetings on time. This group took directions fairly well and was primarily interested in speaking with the therapist concerning the didactic portion of the material and responses to the material that they had shared.

Group II (the control and the treatment group) started with 13 members. There were no dropouts this time except for one female who was absent from one meeting which she made up by listening to tapes of that meeting. However,
it was decided to drop this participant for that reason when doing the analysis. This left 12 participants for analysis: five men and seven women (see Appendix C). Their ages ranged from 20 to 40 years old, having a mean age of 24.6 and a median age of 32. The frequency distribution again was flat but was bi-modal this time having the ages of 33 and 34 as the model points, again each with a frequency of two participants per age. This group was all Caucasian and was primarily composed of members who had college educations. There were three high school graduates (two of whom were male) and three female participants who had graduate school experience. This group was composed of participants one-half of whom responded late to the notices and ads which perhaps was reflected in their tardy behavior throughout the entire length of the treatment process. The members in this group were interested in speaking to each other concerning the didactic and personal material that was being presented. However, Group II's small differences in comparison to Group I do not appear to be reflected in the measures that were taken over the length of time of the study (see Chapter V, Table 1).

The Instruments

Four instruments were selected to measure the changes in self-defeating behaviors, internal locus of control, and self-esteem (the three dependent variables).
The Participant Self-Defeating Behavior Questionnaire was developed to record the frequency and severity of four self-defeating behaviors listed by the participant. The Associate Self-Defeating Behavior Questionnaire was developed to gain a more objective view of participant change by recording the associate's sense of the frequency and severity of a participant's self-defeating behaviors. The Internal versus External Locus of Control Scale (Rotter, 1966) was chosen to measure change in the locus of control of the participants. The Self-Report Inventory (O'Brien, 1980) was chosen to measure the change in the general self-esteem of the participants.

The Participant Self Defeating Behavior Questionnaire. This questionnaire was developed by the author in part from the curriculum of the Elimination of Self-Defeating Behavior process (see Appendices B and D). The questionnaire asks the informant to report four self-defeating behaviors, to estimate the frequencies of each of them, and to rate how severely each affects his or her life. (There is also a place to record the number and kind of relationships involved in the self-defeating behaviors, but this section was never used for any research findings).

A small pre-pilot and a pilot reliability test were done on the participant SDB questionnaire. The pilot test was accomplished using University of Massachusetts summer
session students, and there were 18 days between the first and second administrations of the questionnaire. Test-retest reliability coefficients (Pearson product-moment correlation) were computed for the four self-defeating behavior (SDB) frequency scores for each participant and the four SDB severity scores for each participant. There were 44 subjects who completed the frequency score of SDB #1; 41 who completed the frequency scores for SDB #2; 34 who completed frequency scores SDB #3, and 28 subjects who completed frequency scores SDB #4. For the pilot of the severity scale, there were 43 subjects completing severity scores for SDB #1, 40 completing severity scores for SDB #2, 30 completing severity scores for SDB #3, and 28 completing severity scores for SDB #4. The reliability correlation coefficients for frequency scores of SDB #1 was .64, SDB #2, .58, SDB #3, .67, and SDB #4, .66. These frequency correlations revealed that the questionnaire was measuring something fairly stable and the decision was made to proceed with the frequency questionnaire as it was constructed. The severity correlation for SDB #1 was .56, for SDB #2, .37, for SDB #3, .31, and for SDB #4, .47. The severity portion of the questionnaire was a Likert type scale with the five graded sections of the scale indicated by an increasing number of "plusses." It was felt accuracy would be improved by clearly labeling each of the five degrees of increasing
severity with appropriate adjectives. This change was made in the severity scale on the Participant Self-Defeating Behavior Questionnaire that was administered to the participants. During the first administration, participants filled out page one describing the self-defeating behaviors that were being graded for frequency and severity on page two. The completed page one descriptions were never changed. Page two, frequency and severity ratings, was redone on each administration.

In order to obtain a more objective view of the participant's self-defeating behaviors, associates of the participants were asked to fill out a similar questionnaire rating their participant friend's self-defeating behaviors. This Associate SDB Questionnaire was similar in form to the Participant's SDB Questionnaire except for a few words reflecting that the questionnaire was directed to the associate (see Appendix B). Because of ethical considerations revolving around the need to protect a participant's relationships with significant others, it was not possible to have the associates grade the same self-defeating behaviors that the participants had described. Associates, therefore, were asked to describe and grade for frequency and severity the self-defeating behaviors of the participants. As was the case with the participant questionnaire, the associates completed the description of the four self-defeating beha-
viors on page one only during the first administration. This description was returned to them on the following administrations in order for them to rate the frequency and severity of the same behaviors rated during administration one. Even though the behaviors that the associates were rating could have been very different from the behaviors that the participants were considering, it was felt that an independent measure of participant behavior was being obtained. It was expected that if the treatment changed behaviors of the participants, this change in behavior would be observed by the associates in their questionnaire.

The Internal versus External Locus of Control of Reinforcement Scale. This scale developed by Rotter (1966) to measure changes in a person's expectations about how reinforcement is controlled. The belief that one has control over the reinforcement contingencies available in life has been found to be an important variable in a person's psychological functioning. The ESDB group therapy promotes acceptance of personal control over the events in one's life, and so it was felt that this Internal versus External Locus of Control of Reinforcement Scale (IE Scale) would be able to evaluate the changes that participants might undergo as a result of participating in the ESDB group method.

It was reported by Rotter (1966) that with a one month test-retest, reliability was found to be .72 using 60
university psychology students. One month test-retest reliability measures using 28 prisoners at a Colorado reformatory yielded a reliability score of .78. With a two month follow-up, again using 117 Ohio State University psychology students, the test-retest reliability was found to be .55 when the first administration was done in a group, and the second administration was done individually (which may have confounded the results). In another study of the IE scale, 575 males were given the measure and a mean of 8.15 was obtained with a standard deviation of 3.88. Six hundred and five Ohio State psychology students were given the IE scale and a mean of 8.42 was developed with a standard deviation of 4.06.

The Self Report Inventory. This inventory was developed by O'Brien (1980) and is a multi-dimensional measure of self-concept or self-esteem. One of the primary ways a person knows he or she is behaving in self-defeating ways is by the negative consequences that are incurred from these kinds of behaviors. The loss of self-esteem is one of the more universal of these negative consequences. If treatment is to be proven effective, then it would seem that the negative consequences attributable to the self-defeating behaviors should decrease and self-esteem should increase. In order to test this, a self-esteem measure, the Self Report Inventory, was chosen because of its exceptionally high
level of reliability (over .80), its clear theoretical basis, and its contemporary development. Creation of the inventory had been guided by the theoretical writings of Epstein (1979) and other ego analytic writers (Rosenberg, 1965; Fitts, 1965; Coopersmith, 1967; Wylie, 1974) and a compilation of earlier self-concept research. The Self-Report Inventory represents the most up-to-date, holistically based, and statistically valid instrument available for measuring the changes in self-esteem.

The Self-Report Inventory that was administered to the participants contained 150 items that yielded scores on 12 sub-scales. One sub-scale, global self-esteem, was the sub-scale used for analysis; it also had the highest test-retest reliability. With the sample size of 50 students including 16 males and 34 females, the test-retest reliability was found to be .92. This reliability score included the scores of 5 erratic subjects and was over an interval of approximately 3 months. With a sample ranging in size from 189 to 193 male university students, global self-esteem scores ranged from 1.3 to 5.0 with approximately 50 percent of the students scoring between 3.4 and 3.5. With 444 to 451 female university students global self-esteem scores ranged from 1.1 to 5.0 with approximately 50 percent of the scores resting between 3.2 and 3.3 (O'Brien, 1980). O'Brien (1980) defined global self-esteem to mean:
Overall evaluations of self-worth and satisfaction with one's self versus dissatisfaction with oneself and feelings of worthlessness. Persons at the high self-esteem end of this dimension feel highly pleased and satisfied with themselves. They feel a solid sense of self-importance and significance as a person. These people feel and act in a manner which shows self-confidence and self-assurance. They expect to do well and be successful in the future, just as they feel quite positive about their past. Persons at the low self-esteem end of this dimension feel highly displeased and dissatisfied with themselves. They feel that as people they are insignificant and not important. They feel and act in an overly modest manner. These people are lacking in self-confidence and often experience pervasive self-doubt. They feel that they will do poorly and experience failure in many areas of their lives unless they can change some things about themselves. They feel self-critical and negative about their past. (p. 52)

Research Design

The research was organized so that there would be a treatment group (Group I) and a control group (Group II) with follow-up testing two months after treatment. This treatment period would be replicated by a second treatment group (Group II) with similar periods of time for the treatments (and for the control group). There had to be a fairly short period of time for the control to wait before becoming a treatment group because of the concern over dropouts during the control period. There needed to be a minimizing of practice effects on the measures, requiring administration of the measures a maximum of three times for each group. As Figure 1 shows, the design takes into account these needs. Group I and Group II (the control group) start with the
Group I
- Pre-treatment testing -
  ESDB TREATMENT PROCESS
  5 weeks
- Post-treatment testing -
  FOLLOW-UP PERIOD
  8 weeks
- Follow-up testing -

Group II
- Pre-control testing -
  CONTROL PERIOD
  5 weeks
- Post-control testing -
  ESDB TREATMENT PROCESS
  5 weeks
- Post-treatment testing -

Figure 1. Sequence of the time periods and testing administrations for Group I (the treatment and follow-up group) and Group II (the control and treatment group).
first administration of the measures and both proceed through either five weeks of treatment or five weeks of no treatment. Following that, there is a second administration of the measures, after which the control (Group II) goes through five weeks of treatment while the first group (Group I) goes through two months of no treatment as a follow-up. The control and treatment group (Group II) has a last administration of the measures after the ESDB treatment is completed (in five weeks), while the treatment and follow-up group (Group I) goes through another four weeks before follow-up and its third administration of the measures are completed.

The following are the specific premises and hypotheses that were developed to determine the effectiveness of the Eliminating Self-Defeating Behavior Group Method:

Premise one. The ESDB group treatment is effective in decreasing the self-defeating behavior of group members. The hypotheses developed to test this premise are:

1. There will be a significant decrease in the frequency and severity scores obtained on the Participant's Self-Defeating Behavior (SDB) Questionnaire between the pre and post-treatment administrations for Group I.

2. There will be a significant decrease in the frequency and severity scores obtained on the
Participant's SDB Questionnaire between the pre and post-treatment administrations to Group II.

3. There will be a significant decrease in the frequency and severity scores obtained on the Associate SDB Questionnaire between the pre and post-treatment administrations for Group I.

4. There will be a significant decrease in the frequency and severity scores obtained on the Associate SDB Questionnaire between the pre and post-treatment administrations for Group II.

Premise two. The ESDB group treatment is effective in increasing the internal locus of control of the group members. The hypotheses developed to test this premise are:

1. There will be a significant increase in the internal locus control as measured by the Internal versus External Locus of Control Scale between the pre and post-treatment administrations of Group I.

2. There will be a significant increase in the internal Locus of control as measured by the Internal versus External Locus Control Scale between the pre and post-treatment administrations of Group II.

Premise three. The ESDB group process will have a positive effect on participants' self-esteem. The hypotheses deve-
developed to test this premise are:

1. There will be a significant increase in the scores obtained on the Self-report Inventory between pre and post-administrations of Group I.

2. There will be a significant increase in the scores obtained on the Self-Report Inventory between the pre and post-treatment administrations for Group II.

Premise four. The people who participated in ESDB group treatment will have fewer self-defeating behaviors (SDB's), greater internal locus of control, and more of an increase in self-esteem than people who have not participated in the ESDB group treatment. The hypotheses developed to test this premise are:

1. There will be a significant decrease in the SDB frequency and severity as measured by a difference score of the Participant SDB Questionnaire for Treatment Group I in comparison to Control Group II.

2. There will be a significant decrease in the SDB frequency and severity as measured by a difference score of the Associate SDB Questionnaire for Treatment Group I in comparison to Control Group II.
3. There will be a significant increase in the internal locus of control as measured by a difference score of the Internal versus External Locus of Control Scale for Treatment Group I in comparison to Control Group II.

4. There will be a significant increase in self-esteem as measured by a difference score of the Self-report Inventory for Treatment Group I in comparison to Control Group II.

Premise five. The effects of the SDB group treatment process on participants will remain eight weeks after completion of the treatment process. The hypotheses developed to test this premise are:

1. There will be no significant difference in the frequency and severity scores obtained on the Participant SDB Questionnaire between the post-treatment and follow-up administrations for Group I.

2. There will be no significant difference in the frequency and severity scores obtained on the Associate SDB Questionnaire between the post-treatment and follow-up administrations for Group I.

3. There will be no significant difference in the scores obtained on the Internal versus External
Locus of Control Scale between the post-treatment and follow-up administrations for Group I.

4. There will be no significant difference in the scores obtained on the Self-Report Inventory between the post-treatment and follow-up administrations for Group I.

**Experimental Procedure**

In order to enroll in the Eliminating Self-Defeating Behavior study, the applicant had to a) find two friends or associates who would be willing to fill out a questionnaire about him or her three times during the course of the research, b) pay $25 at the first meeting, c) and attend all meetings and fill out all measures before the $20 would be returned (if a participant was absent, the deposit was forfeited and they were considered a dropout). The applicant had to sign an informed consent form that acknowledged these instructions. And the associates he or she chose also had to sign an informed consent form. These were to be mailed back to the researcher along with demographic and scheduling information prior to the first meeting of the two groups. A packet was sent to each applicant containing two Associate SDB Questionnaires with envelopes to be given to the appropriate associates, a map giving the location of the meeting room and the night and time, a demographic and sche-
duling questionnaire, and self-addressed stamped envelope with the participant consent form.

At the first meeting of participants from both groups, the $25 tuition deposit and the two completed Associate SDB Questionnaires were collected. All participants were asked to a) submit a written statement reporting reasons they were enlisting in the group process and what they hoped to gain, b) submit a completed Participant Self-Defeating Behavior Questionnaire concerning the nature, frequency, and severity of their SDBs, c) provide two completed associate consent forms and two completed Associate SDB Questionnaires concerning the nature of the participant's SDB's and their severity and frequency, d) complete an Internal versus External Locus of Control Scale, and e) submit a complete Self-Report Inventory. This, along with a short outline of the group treatment and the two group schedules, constituted the first meeting. This meeting took place in a classroom large enough to accommodate all 24 participants. All meetings for the ESDB group treatment for both groups took place in a more congenial atmosphere in a smaller, paneled room containing suitable chairs and a long seminar-like table. This first general meeting took place on November 9, 1980.

The treatment period and control period started on the above date. Both Group I (the treatment group) and
Group II (the control group) were to be given the second administration of the measures on the same night. The control group would then become the second treatment group and would be given the ESDB group treatment with the same schedule and over the same period of time as the first group, and then be administered the same set of measures for the third time. Three weeks later the first group (Group I), having gone through a period of approximately 8 weeks since the end of treatment, would be given its third administration of all the measures.

Each treatment phase (for Group I and Group II) continued for an average of 25 hours, spread over 9 meetings for Group I and 10 meetings for Group II. The difference in number of meeting times was necessitated by the difference in ease of concept assimilation and imagery manipulation for the participants. Though these group differences were minimal, an additional meeting was required by Group II in order to provide enough time for completion of the last administration of the measures. Each group was expected to require thirty hours to complete the treatment phase (counting the extra 1/2 hour provided at the end of each meeting for presentation overrun or special participant problems). Both groups completed the treatment phase in less than that time. These meetings included two testing administrations. One additional meeting was required for
each group in order for follow-up testing (for Group I) and precontrol testing (for Group II). Schedules for both treatment groups included a major holiday. Group I had to deal with Thanksgiving vacation and Group II had to deal with Christmas vacation.

During each meeting approximately 1/4 of the time was spent in instruction by the group leader and 3/4 of the time used for group sharing. The participant sharing was structured with each participant going in order, according to seating position. In this way each group member had an equal opportunity to speak. Group members were allowed limited verbal interaction with each other. The group leader introduced and taught two basic concepts:

1. Personal creation of behavior and ownership of the consequences

2. Challenging the self-conclusions and tolerating the fear.

The concepts were separated into five subgroupings—behaviors, disownership, personal cost, inner choice, and untested fears—and presented consecutively. Participants used forms in the group and homework (journal assignments) to analyze their behavior in terms of the concept subgroup currently being presented. After all the concepts had been presented and integrated to the satisfaction of the group leader, the group was led in an imagery exercise. The ima-
gery exercise allowed group members to experience the inner fear and struggle that usually occurs in choosing more actualizing behaviors. The remaining meeting times left for the group were used for the sharing of successes and/or failures at using more self-actualizing behaviors.

After twenty-four hours of ESDB treatment process, each participant in Group I (the treatment and follow-up group) completed the following: the Participant SDB Questionnaire, the Internal versus External Locus of Control Scale, and the Self-Report Inventory. Their associates completed page two (SDB frequency and severity) of the Associate SDB Questionnaire.

Group II (the control and the treatment group) members, having just completed a five week control period, filled out the same measures as Group I. These measures were also considered pre-treatment measures for Group II, for comparative purposes. The Group II post-control (pre-treatment measures) were to be compared to the post-treatment measures of Group II.

Group II then participated in the 25 hour ESDB group process. At the end of the treatment, they submitted the same data again. The final step in the data collection was an eight week follow-up scoring of group I on the same measures (see Figure 2).

Group I (the treatment follow-up group) started
<table>
<thead>
<tr>
<th>BEFORE ESDB GROUP PROCESS</th>
<th>AFTER FIVE WEEKS (AND 30 ESDB HOURS)</th>
<th>AFTER EIGHT WEEKS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pre-treatment</strong></td>
<td><strong>Post-treatment</strong></td>
<td><strong>Follow-up</strong></td>
</tr>
<tr>
<td>1. Participant SDB</td>
<td>1. Participant SDB</td>
<td>1. Participant SDB</td>
</tr>
<tr>
<td>Questionnaire</td>
<td>Questionnaire</td>
<td>Questionnaire</td>
</tr>
<tr>
<td>2. Associate SDB</td>
<td>2. Associate SDB</td>
<td>2. Associate SDB</td>
</tr>
<tr>
<td>Questionnaire</td>
<td>Questionnaire</td>
<td>Questionnaire</td>
</tr>
<tr>
<td>3. Internal Versus</td>
<td>3. Internal Versus</td>
<td>3. Internal Versus</td>
</tr>
<tr>
<td>External Locus of</td>
<td>External Locus of</td>
<td>External Locus</td>
</tr>
<tr>
<td>Control Scale</td>
<td>Control Scale</td>
<td>of Control Scale</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Inventory</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>BEFORE CONTROL PROCESS</th>
<th>AFTER FIVE WEEKS</th>
<th>AFTER FIVE WEEKS (AND 30 ESDB HOURS)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pre-control</strong></td>
<td><strong>Post-control</strong></td>
<td><strong>Post-treatment</strong></td>
</tr>
<tr>
<td>1. Participant SDB</td>
<td>1. Participant SDB</td>
<td>1. Participant SDB</td>
</tr>
<tr>
<td>Questionnaire</td>
<td>Questionnaire</td>
<td>Questionnaire</td>
</tr>
<tr>
<td>2. Associate SDB</td>
<td>2. Associate SDB</td>
<td>2. Associate SDB</td>
</tr>
<tr>
<td>Questionnaire</td>
<td>Questionnaire</td>
<td>Questionnaire</td>
</tr>
<tr>
<td>3. Internal Versus</td>
<td>3. Internal Versus</td>
<td>3. Internal Versus</td>
</tr>
<tr>
<td>External Locus of</td>
<td>External Locus of</td>
<td>External Locus of</td>
</tr>
<tr>
<td>Control Scale</td>
<td>Control Scale</td>
<td>Control Scale</td>
</tr>
</tbody>
</table>

Figure 2. A time sequence of the three administrations of the measures for Group I (treatment and follow-up group) and Group II (control and treatment group).
treatment with 15 participants and completed with 12. Group II (the control-treatment group) started and finished with 13 participants. One participant in Group II was eliminated on the basis of being absent for one group meeting. The participant total of both groups then equalled 24. The data for Group I (treatment and follow-up group) was collected on November 9, 1980, December 4, 1980, and January 29, 1981. The data for Group II (control and treatment group) was collected on November 9, 1980, December 4, 1980, and January 4, 1981. The measures were scored by paid volunteers prior to and following January 29, 1981 (the follow-up administration of Group I). The data analysis was accomplished using the SPSS computer analysis at the computing center at the University of Massachusetts.

Statistical Design

The research hypotheses were designed to obtain answers to three basic questions dealing with the type of changes expected to occur as a result of the ESDB treatment process. One analysis dealt with any within-group changes occurring in the treatment groups (Group I and Group II). The second analysis compared the changes across groups (Group I treatment phase in comparison to the control phase of Group II). The third analysis concerns the within-group (Group I) changes over time after the treatment. The sta-
Statistical procedure used for the within-group analysis was the correlated t-test. This compared the pre and post-treatment scores on four measures (the Participant SDB Questionnaire, the Associate SDB Questionnaire, the Internal versus External Locus of Control Scale, and the Self-Report Inventory) within Group I and within Group II, thus obtaining the difference score for each treatment group. The correlated t-test was used again in analyzing the difference in the post and follow-up scores on these four measures for Group I. The independent t-test was used when analyzing the differences on these same four measures, pre and post-treatment for Group I, and the differences pre and post-control for Group II. In addition, an independent t-test was run on the pre-group and pre-control data across groups (Group I treatment and Group II control) in order to compare the initial scores for each group in the four measures. In order to prove the hypotheses that predicts a difference in the direction only, a p of .05 was used with a one-tailed t-test.

Limitations

This study sampled a population composed of highly verbal, middle class, white Americans who identified themselves as having self-defeating behavior, and further, were motivated enough to respond to advertisements for a course
to eliminate those behaviors. They also were willing to be participants in a psychotherapeutic research project. Thus, the generalizability of any results may be confined to members of this narrowed population. In the context of a larger population, as the research on the ESDB method grows, even more accurate statements can be made concerning the effectiveness of this method. Another limitation is the lack of a longer time period before the follow-up data is collected. This limits statements concerning the lasting effects of treatment, preventing the discovery of any positive or negative results after the follow-up data is collected (some prior participants—prior to this study—have reported changes occurring after one year).

The data was obtained from self-report instruments. The one source of more "objective" data is from two associates of the participant. An intrinsic limitation of this type of this measure seems to be the subjectivity of the data. To really observe behavior, one must closely associate with the person being observed, and this intimacy increases one's subjectivity. So even the more "objective" data from the friends could be criticized on this basis.

**Summary**

The overall premise here is that the Elimination of Self-Defeating Behavior group psychotherapy process is an
effective self-improvement therapy for people who behave in self-defeating ways. It was determined that the effectiveness of this group procedure could be measured by observing changes in participant's frequencies and severity of self-defeating behaviors, self-esteem, and locus of control. A pool of participants was drawn from the community through advertisements and notices announcing a course in "Overcoming Self-Defeating Behavior." The research design was to create two groups from this pool of participants. Group I was to be a treatment group and then a follow-up group. Group II was to act as a control group and then as a treatment group. This design allows for a comparison group for a treatment procedure as well as a replication study using a similar group. Four instruments were used to measure changes in participants: the Participant Self-Defeating Behavior Questionnaire, the Associate Self-Defeating Behavior Questionnaire, the Internal versus External Locus of Control Scale, and the Self-Report Inventory. The experimental procedure consisted of didactic presentation by the group facilitator and group discussion, the process culminating in an imagery exercise during the final meetings. The length of time for the total procedure did not exceed 30 hours. The statistical design uses a correlated t-test for within-group analysis and an independent t-test for the analysis of differences between
groups. Limitations concerned the narrow population studied (highly verbal Caucasians), the lack of a longer follow-up period, and the subjective nature of the instruments.
CHAPTER V

RESULTS AND DISCUSSION

This chapter will present the results of the study, place those results in a meaningful context, and discuss some of the limitations and implications of the findings.

The central question this research was designed to answer is as follows: Can participation in a short-term, didactic group process (the Elimination of Self-Defeating Behavior group psychotherapy) (a) reduce the frequency and severity of self-defeating behavior, (b) increase internal locus of control, and (c) increase general self-esteem? This question was further subdivided into five premises and sixteen hypotheses. Affirmative results would provide evidence demonstrating that the Elimination of Self-Defeating Behavior (ESDB) group process is an effective self-improvement therapy for people who repeatedly behave in self-defeating ways. In fact, 11 of the 16 hypotheses are partially or fully supported by the data. This indicates that the ESDB method probably is effective in achieving its goals and ought to be more often considered in outcome research and the practice of short-term group methods.
Decreasing Self-Defeating Behavior

Premise 1. The ESDB Group Treatment is effective in decreasing the self-defeating behavior of group members.

Hypothesis 1. There will be a significant decrease in the frequency and severity scores obtained on the Participant Self-Defeating Behavior (SDB) Questionnaire between the pre and post-treatment administrations for Group I.

Hypothesis 2. There will be a significant decrease in the frequency and severity scores obtained on the Participant Self-Defeating Behavior (SDB) Questionnaire between the pre and post-treatment administrations for Group II.

A comparison of the initial means obtained by both groups on all measures is presented in Table 1. Inspection of this table shows no significant differences in either group, save for the means obtained for the first self-defeating behavior frequency. This indicates that, by and large, that Group I and Group II appear comparable at the beginning of the study. This allows us to be fairly certain of the significance of the comparisons taken at each juncture of this study.

Pre-treatment and post-treatment mean Participant SDB scores for Group I and Group II are presented in Table 2. The table reveals that in Group I (the treatment and follow-up group) participants significantly decreased three of four SDB's. Group II (the control and treatment group)
**TABLE 1**

Comparison of the Initial (Administration One) Means and Standard Deviations of All Measures and the t Values

<table>
<thead>
<tr>
<th>Four SDB's</th>
<th>Participant SDB Frequencies</th>
<th>Participant SDB Severities</th>
<th>The Two Associates SDB Frequencies</th>
<th>Associate SDB Severities</th>
<th>Internal Versus External Locus of Control Score</th>
<th>Global Self Esteem Score</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>( \bar{X} )</td>
<td>SD</td>
<td>( \bar{X} )</td>
<td>SD</td>
<td>( t ) Value</td>
<td>( \bar{X} )</td>
</tr>
<tr>
<td>Group I (Pretreatment)</td>
<td></td>
<td></td>
<td>Group II (Precontrol)</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>( f )</td>
<td>8.50</td>
<td>7.22</td>
<td>16.25</td>
<td>9.24</td>
<td>-2.29*</td>
<td>4.25</td>
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<td>( j )</td>
<td>9.25</td>
<td>7.73</td>
<td>10.08</td>
<td>8.21</td>
<td>- .26</td>
<td>3.92</td>
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<td>( i )</td>
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<td>7.70</td>
<td>7.27</td>
<td>.95</td>
<td>4.00</td>
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<td>( d )</td>
<td>9.36</td>
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<td>6.60</td>
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<td>3.00</td>
</tr>
<tr>
<td>Group II (Precontrol)</td>
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<td></td>
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<td></td>
<td></td>
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\( a_n=7 \)  \( b_n=9 \)  \( c_n=10 \)  \( d_n=11 \)  \( e_n=12 \)  \( f_n=12 \); \( df=22 \)  \( f_{df}=14 \)  \( g_{df}=17 \)  \( h_{df}=18 \)  \( i_{df}=19 \)  \( j_{df}=20 \)  \( k_{df}=22 \)  \( *p<.05 \)
<table>
<thead>
<tr>
<th>Group</th>
<th>Four SDB's</th>
<th>Pre Treatment</th>
<th>Post Treatment</th>
<th>t Value</th>
</tr>
</thead>
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<tr>
<td></td>
<td>X</td>
<td>SD</td>
<td>X</td>
<td>SD</td>
</tr>
<tr>
<td>Group I&lt;sup&gt;a&lt;/sup&gt;</td>
<td></td>
<td></td>
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</tr>
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<td>1st</td>
<td>8.50</td>
<td>7.22</td>
<td>5.08</td>
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<tr>
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<td>4.17</td>
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<tr>
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<td>9.10</td>
<td>5.50</td>
<td>5.84</td>
</tr>
<tr>
<td>4th</td>
<td>9.36</td>
<td>6.05</td>
<td>5.18</td>
<td>5.65</td>
</tr>
<tr>
<td>Group II&lt;sup&gt;b&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1st</td>
<td>7.50</td>
<td>4.58</td>
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<td>4.33</td>
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<tr>
<td>4th</td>
<td>4.70</td>
<td>2.98</td>
<td>3.30</td>
<td>3.09</td>
</tr>
</tbody>
</table>

**Frequencies of SDB**

**Severity of SDB**

| Group I<sup>a</sup> | | | | | |
| 1st | 4.25 | .87 | 3.50 | 1.00 | 1.75+++ |
| 2nd | 3.92 | .90 | 3.17 | .72 | 3.00 |
| 3rd | 4.00 | .85 | 3.58 | .90 | 1.33 |
| 4th | 3.00 | .78 | 3.18 | 1.40 | -.61 |

| Group II<sup>b</sup> | | | | | |
| 1st | 3.50 | .67 | 2.58 | .90 | 3.53++++ |
| 2nd | 3.25 | .97 | 3.08 | 1.00 | .56 |
| 3rd | 3.44 | .73 | 3.00 | 1.00 | 1.84 |
| 4th | 3.30 | .82 | 2.90 | .99 | .94 |

<sup>a</sup>_{n}=12 and df=11 for 1st through 3rd SDB; n=11 and df=10 for 4th SDB

<sup>b</sup>_{n}=12 and df=11 for 1st and 2nd SDB; n=9 and df=8 for 3rd SDB; n=10 and df=9 for 4th SDB

+ p=.0055  ++p=.0001  +++p=.0060  ++++p=.0025

* p<.05

** p<.01
significantly decreased the frequencies of one SDB out of four. It should be noted here that both groups show a decrease in the mean frequency of every SDB that was listed. The ratings by participants in Group I and II of the severity of each SDB decreased significantly in one of four SDB's listed. As was the case with the means of the frequencies of SDB's, the means of the severities decreased in every case.

These results appear to support the hypotheses as stated. The post-treatment scores for frequencies and severities of self-defeating behavior all show a decrease in which six of the possible decreases are significant or very significant. That this one-tailed matched t-test supports the prediction of change in one direction (downward) with high to very high significance so often is evidence that the SDB treatment is effective in decreasing self-selected self-defeating behaviors.

There were four studies that measured the frequencies of SDB's previous to this research (Fiester, 1973; Coombs, 1974; Parks, 1976; and Turnbull, 1977). As in this study, all appeared to find that the ESDB group therapy was effective in lowering the frequency of SDB's. In terms of our working definition of psychotherapy (see Chapter II) as "an interpersonal process . . . which results in client changes in feelings, values, attitudes, and behaviors," this
method seems to partially fulfill the requirements for what psychotherapy does.

All scores show a decrease; this is highly suggestive but statistically unsound as proof of effectiveness of the method. Perhaps even more significant results were not found because (a) the SDB method is only good for certain kinds of self-defeating behavior or (b) the questionnaire that measures the frequencies and severity is not yet reliable enough to ascertain the true degree of change in behaviors. Another problem that must be considered is the limitation of the method of data collection. Subjective impressions of one's own behavior are potentially both the most accurate or the least accurate way to measure change. This continues to be a problem for outcome research attempting to demonstrate change in complex human behaviors.

Some general implications of the findings are that more attention ought to be paid to this short-term didactic group process as an effective catalyst for behavior change. More research should be done on all aspects of this method in order to determine the full extent of its effectiveness. Types of behaviors that are best affected by this process and classes of participants who respond best to this method of behavior change have yet to be delineated.

Hypothesis 3. There will be a significant decrease in the frequency and severity scores obtained on the Asso-
Hypothesis 4. There will be a significant decrease in the frequency and severity scores obtained from the Associate SDB Questionnaire between the pre and post-treatment administrations for Group II.

Pre-treatment and post-treatment mean Associate SDB scores for Group I and Group II are found in Table 3. The table illustrates that the first associate for participants in Group I (treatment and follow-up group) rated the self-defeating behaviors of their participants as being significantly decreased following treatment. The first associates for participants in Group II (the control and treatment group) also found a significant decrease in the severity of self-defeating behaviors of their participants following treatment. It should be noted, as well, that all associates in both groups rated participants as decreasing both the frequency and the severity of their self-defeating behaviors.

These results seem to partially support the two hypotheses as they are stated. Both hypotheses predict a change in one direction only (decreasing). One significant difference out of four possible was found for each group following treatment. This lends support to the premise that the ESDB group treatment is effective in decreasing the
### TABLE 3


<table>
<thead>
<tr>
<th>Group</th>
<th>The Two Associates(^a)</th>
<th>Pre-Treatment</th>
<th>Post Treatment</th>
<th>t(^c)</th>
</tr>
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<tbody>
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<td></td>
<td></td>
<td>(\bar{X})</td>
<td>SD</td>
<td>(\bar{X})</td>
</tr>
<tr>
<td><strong>Frequencies of SDB(^b)</strong></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>Group I</td>
<td>A1(^d)</td>
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<td>2.85</td>
<td>2.61</td>
</tr>
<tr>
<td>(Treatment &amp; Follow-up Group)</td>
<td>A2(^e)</td>
<td>7.38</td>
<td>5.42</td>
<td>6.25</td>
</tr>
<tr>
<td>Group II</td>
<td>A1(^f)</td>
<td>3.13</td>
<td>2.23</td>
<td>2.19</td>
</tr>
<tr>
<td>(Control &amp; Treatment Group)</td>
<td>A2(^g)</td>
<td>4.07</td>
<td>3.87</td>
<td>1.79</td>
</tr>
<tr>
<td><strong>Severity of SDB(^b)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group I</td>
<td>A1(^h)</td>
<td>3.56</td>
<td>.62</td>
<td>3.25</td>
</tr>
<tr>
<td>(Treatment &amp; Follow-up Group)</td>
<td>A2(^i)</td>
<td>3.78</td>
<td>.80</td>
<td>3.61</td>
</tr>
<tr>
<td>Group II</td>
<td>A1(^j)</td>
<td>3.25</td>
<td>.83</td>
<td>2.55</td>
</tr>
<tr>
<td>(Control &amp; Treatment Group)</td>
<td>A2(^k)</td>
<td>3.86</td>
<td>.56</td>
<td>3.57</td>
</tr>
</tbody>
</table>

\(^a\)There are two possible associates for each participant in Group I and Group II.

\(^b\)Only the first two SDB were considered, and the mean was computed from the addition of these first two ratings by each associate.

\(^c\)In all cases df is equal to \(n-1\).

\(d_n=9\)  \(e_n=8\)  \(f_n=8\)  \(g_n=7\)  \(h_n=8\)  \(i_n=9\)  \(j_n=10\)

\(k_n=7\)  \(*p<.05\)
self-defeating behaviors of group members. Previously, no researcher investigating the effectiveness of ESDB group treatment has used associates of group participants as observers of change in group participants. Perhaps this is because of the ethical difficulties and complications presented by such use. The participants, attracted by the description in the ad, were interested and able to identify themselves as self-defeating. But would the associates be able to do likewise? The associates did not necessarily have this information. Unless the associates rated the participants using the associates' own sense of what the self-defeating behaviors were, the relationship between the participants and the associates might have been damaged by the associates gaining knowledge of the participants' self-selected SDB's. It was for this reason that the associates were not given the self-defeating behaviors that their friends were attempting to eliminate in the process of ESDB group method. This further complicated measurement because of the increased chance of lack of interest and information that would enable associates to successfully complete the questionnaire. It was even difficult to gather the same caliber of associate for each participant. Some participants had wives or relatives complete the questionnaire, while other participants used friends that they saw
infrequently. Even if the relationships had been uniform, it would still be difficult to accurately ascertain the level of knowledge an associate would have about the behaviors of a participant.

That the associates were able to find two significant decreases following treatment (one in each group), despite the difficulties, is important to notice. This adds confirmation to the reductions in frequency and severity of SDBs reported by the participants in the previous section on the first two hypotheses. This could mean that the participants were accurately assessing that their own behavior had changed following the ESDB group method. It would be important in the future to see more use of associate ratings of participants in order to improve the accuracy of the associates' observations. For instance, training sessions for associates could be included and, perhaps, a measure found that could verify the level of intimacy the associate had with a participant. Only then would we truly know what level of accuracy we have achieved here. For now, Premise 1 appears to be moderately well-supported. The ESDB group therapy process seems effective in decreasing the self-defeating behavior of group members.

**Internal Versus External Locus of Control**

Premise 2. The ESDB group treatment is effective in increasing the internal locus of control of group members.
Hypothesis 1. There will be a significant increase in the internal locus of control as measured by the Internal versus the External Locus of Control Scale between the pre and post-treatment administrations of Group I.

Hypothesis 2. There will be a significant increase in the internal locus of control as measured by the Internal versus External Locus of Control Scale between the pre and post-treatment administrations for Group II.

The comparison of the means obtained on the Internal versus External Locus of Control Scale (I.E.) pre-treatment and post-treatment are presented in Table 4. Inspection of the table shows that both Group I (treatment and follow-up group) and Group II (control and treatment group) achieved a significant average decrease in their scores on the Internal versus External Locus of Control Scale following the treatment phase in each group. Since the number recorded as the score for this scale equals the amount of externality of the subject, these results indicate a significant average increase in internality. Both increases in internality (decreases in externality) were found to be very significant (Group I, p = .004; Group II, p = .0005).

These highly significant results strongly suggest that the prediction of one directional change (increase) as stated by the previous two hypotheses is accurate. The premise, therefore, seems to be accurate as well: The ESDB
TABLE 4

COMPARISON OF THE PRE AND POST TREATMENT MEANS AND STANDARD DEVIATIONS OF THE INTERNAL VERSUS EXTERNAL LOCUS OF CONTROL SCORES AND THE t VALUES

<table>
<thead>
<tr>
<th>Groupa</th>
<th>Pre Treatment</th>
<th>Post Treatment</th>
<th>t Valueb</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>( \bar{X} )</td>
<td>( \bar{X} )</td>
<td></td>
</tr>
<tr>
<td></td>
<td>SD</td>
<td>SD</td>
<td></td>
</tr>
<tr>
<td>Group I</td>
<td>11.58</td>
<td>7.58</td>
<td>3.27+</td>
</tr>
<tr>
<td>(Treatment and Follow-up)</td>
<td>3.50</td>
<td>4.89</td>
<td></td>
</tr>
<tr>
<td>Group II</td>
<td>8.58</td>
<td>5.75</td>
<td>4.62++</td>
</tr>
<tr>
<td>(Control and Treatment)</td>
<td>3.34</td>
<td>3.62</td>
<td></td>
</tr>
</tbody>
</table>

\( n=12 \) for both groups.

\( df=11 \) in each case.

*\( p<.05 \)

+\( p=.004 \)

++\( p=.0005 \)
group treatment is effective in increasing the locus of control of group members.

These results appear to replicate previous research on the ESDB group method. All research projects (Fiester, 1973; Parks, et al., 1975; Bohn, 1976; Forsyth, 1976; Johnson, et al., 1978; and Jensen, 1976) studying the effectiveness of the ESDB process on locus of control reported significant change toward internality using Rotter's I.E. measure. There are many other outcome studies of other psychotherapeutic methods using the I.E. Scale as a measure of effectiveness of the psychotherapy under investigation (see Chapter III). It seems that the variable that the I.E. Scale isolates is amenable to psychotherapy. And, in our culture, an internal locus of control appears to be associated with health-related aspects of personality (see Chapter III).

The ESDB group psychotherapy appeared to bring both groups to a lower level of externality than the norm found by Rotter (1966) for his measure. This movement towards internality and away from externality has been associated with standard positive aspects of living in this culture (see Chapter III). Internality would then be a hoped-for result of psychotherapeutic treatment. Because the ESDB group treatment appears to be able to consistently achieve that result in participants, we could say, on the basis of
the increased internality, that the ESDB method is an effective group psychotherapy. Noting that the ESDB group treatment requires one group psychotherapist for every fifteen or so clients, and yet produces a desired psychotherapeutic result, we must consider that the ESDB treatment may provide an answer to the need for psychotherapeutic services that is outlined in Chapter I.

The same limitations exist for this measure that we have mentioned previously. Rotter's I.E. Scale is, after all, a self-report instrument. As such, it is subject to the criticism that it is not being an objective measure of change, that it is sensitive to factors that would obscure the results, such as trying to please (social desirability) and other mistakes that one can make in recognizing aspects of one's self. On the other hand one could argue that the only person able to truly know what changes occur to the individual, is the person who undergoes those experiences. For this particular measure, test re-test reliabilities were done by Rotter (1966) that found moderately successful re-testability correlations of .72 and .78. This would indicate that something fairly stable was being measured.

Given the above limitations, it would be prudent to temper any absolute statements of effectiveness of the ESDB method. However, with repeated successes such as these, more and more professionals can trust that the ESDB group
method does produce these kinds of changes in the populations that have been studied. Other populations and other conditions, of course, must be examined to determine the extent to which this method is truly effective in altering the locus of control.

**Self-Esteem**

**Premise 3.** The ESDB group process will have a positive effect on participants' self-esteem.

**Hypothesis 1.** There will be a significant increase in the scores obtained on the Self-Report Inventory between the pre and post-treatment administrations of Group I.

**Hypothesis 2.** There will be a significant increase in the scores obtained on the Self-Report Inventory between the pre and post-treatment administrations of Group II.

The comparison of the means obtained on the Self-Report Inventory pre-treatment and post-treatment for both Group I and Group II is presented in Table 5. The table reveals that only Group I (the treatment and follow-up group) achieved a significant increase in the global self-esteem score following treatment. Group II (the control and treatment group) did not achieve a significant increase in their global self-esteem score following treatment. Group II, however, did achieve an increase in that score.

These results are consistent with the first hypothe-
TABLE 5

COMPARISON OF THE PRE AND POST TREATMENT MEANS AND STANDARD DEVIATIONS OF THE GLOBAL SELF ESTEEM SCORE AND THE t VALUES

<table>
<thead>
<tr>
<th>Groupa</th>
<th>Pre Treatment</th>
<th>Post Treatment</th>
<th>t Valueb</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>X</td>
<td>SD</td>
<td>X</td>
</tr>
<tr>
<td>Group I</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Treatment and Follow-up Group)</td>
<td>2.16</td>
<td>.76</td>
<td>2.81</td>
</tr>
<tr>
<td>Group II</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Control and Treatment Group)</td>
<td>2.96</td>
<td>.85</td>
<td>3.22</td>
</tr>
</tbody>
</table>

a_n=12 for both groups.

b_df=11 in each case.

*p<.05

+p=.0015
sis of this premise and do not support the second hypothesis. Therefore, we can only state that possibly the ESDB group process does have a positive effect on participants' self-esteem. In Table 1 (see chapter introduction), it may be recalled that there were no significant differences in the means obtained by either group except for one frequency means obtained on the Participant Self-Defeating Behavior Questionnaire. This data from Table 1 indicates that both groups were fairly well-matched in terms of the means they obtained on the measures administered. Table 6 presents a comparison of the pre and post-control means obtained by Group II. (a full presentation of the data on Table 6 will be presented in the section following Premise 4.) At this time, it is important to note on Table 6 that Group II achieved a significant increase in global self-esteem following the control period. This raises a number of questions (such as, what occurred during the control period to affect Group II's self-esteem score?), but one must consider that if the group members achieved a significant increase in self-esteem prior to treatment, how much more of an increase could then be obtained during the treatment period? Referring back to Table 5, it should be noted that Group II, even after increasing the self-esteem score significantly during the control period, does show an increase in the global self-esteem mean following treatment, although
TABLE 6
COMPARISON OF THE PRE AND POST CONTROL MEANS AND STANDARD DEVIATIONS FOR GROUP II AND THE $t$ VALUES

<table>
<thead>
<tr>
<th></th>
<th>PreControl</th>
<th>Post Control</th>
</tr>
</thead>
</table>
|                      | $\bar{X}$  | SD           | $\bar{X}$  | SD           | $t$  
| Four SDB's           |            |              |            |              |     
| Participant SDB Frequencies |            |              |            |              |     
| 1$^a$                | 16.25      | 9.24         | 7.50       | 4.58         | 4.37$^+$  
| 2$^a$                | 10.08      | 8.21         | 5.75       | 7.14         | 3.06$^{++}$  
| 3$^b$                | 7.70       | 7.27         | 4.10       | 3.18         | 1.36$^+$  
| 4$^b$                | 10.40      | 6.60         | 4.70       | 2.98         | 2.97$^{+++}$  
| Participant SDB Severities |            |              |            |              |     
| 1$^a$                | 3.83       | .72          | 3.50       | .67          | 1.08  
| 2$^a$                | 3.83       | .84          | 3.25       | .97          | 1.74  
| 3$^b$                | 3.60       | .97          | 3.50       | .71          | .43   
| 4$^b$                | 3.50       | .97          | 3.30       | .82          | .69   
| The Two Associates SDB Frequencies |            |              |            |              |     
| A1$^c$               | 5.63       | 3.42         | 2.81       | 2.34         | 2.25$^*$  
| A2$^d$               | 7.50       | 6.34         | 4.17       | 4.23         | 1.04   
| Associate SDB Severities |            |              |            |              |     
| A1$^b$               | 3.35       | 1.00         | 3.45       | .55          | -.34  
| A2$^c$               | 4.06       | .86          | 3.88       | .74          | .41   
| Internal Versus External Locus of Control Score |            |              |            |              |     
| 9.00                 | 3.49       | 8.58         | 3.34       | .57          |     
| Global Self-Esteem Score |            |              |            |              |     
| 2.66                 | .76        | 2.96         | .85        | -2.53$^*$    |     

$^a$n=12; df=11  
$^b$n=10; df=9  
$^c$n=8; df=7  
$^d$n=6; df=5  
$^*p<.05$  
$^+p=.001$  
$^{++}p=.011$  
$^{+++}p=.008$
it is not statistically significant.

Table 7 shows a comparison of the pre and post-treatment differences of both groups on all the measures. Examination of this table reveals an interesting and important finding. The differences achieved by each group following ESDB treatment were not significantly different for any measure, including the global self-esteem measure. This tends to offer support for the hypothesis that the ESDB group process did have a positive effect on participants' self-esteem in Group II. Even though Group II did not show a significant positive difference in the global self-esteem score following treatments, as did Group I (illustrated in Table 5), since there was no significant difference in the gains following treatment for either group, perhaps this premise is adequately supported.

Three previous studies of the ESDB group treatment exist which look at its effects on self-concept (Hendricks, 1972; Coombs, 1974; and Jense, 1978). These studies can be useful here (as the underpinnings of the Self-Report Inventory do lie with different theories of self-concept and self-concept measures: see Chapter IV) because all three studies of the ESDB group progress contained other group methods to use in comparison. All studies conclude that the ESDB group process was effective in modifying self-concept. However, only Coombs (1974) was able to demonstrate a signi-
### TABLE 7

**COMPARISON OF THE PRE AND POST TREATMENT DIFFERENCE MEANS AND STANDARD DEVIATIONS OF BOTH GROUPS AND THE t VALUES**

<table>
<thead>
<tr>
<th>Four SDB's</th>
<th>Participant SDB Frequencies</th>
<th>Treatment Difference (Group I)</th>
<th>Treatment Difference (Group II)</th>
<th>t Values</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>$\bar{X}$</td>
<td>SD</td>
<td>$\bar{X}$</td>
</tr>
<tr>
<td>1g</td>
<td></td>
<td>-3.42</td>
<td>10.23</td>
<td>-5.17</td>
</tr>
<tr>
<td>2g</td>
<td></td>
<td>-5.08</td>
<td>7.09</td>
<td>-3.00</td>
</tr>
<tr>
<td>3k</td>
<td></td>
<td>-5.50</td>
<td>6.25</td>
<td>-1.33</td>
</tr>
<tr>
<td>4k</td>
<td></td>
<td>-4.18</td>
<td>7.60</td>
<td>-1.40</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Participant SDB Severities</th>
</tr>
</thead>
<tbody>
<tr>
<td>1g</td>
</tr>
<tr>
<td>2g</td>
</tr>
<tr>
<td>3k</td>
</tr>
<tr>
<td>4k</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>The Two Associates</th>
<th>Associate SDB Frequencies</th>
<th>Treatment Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>$\bar{X}$</td>
</tr>
<tr>
<td>A1^i</td>
<td>-2.56^c</td>
<td>2.76</td>
</tr>
<tr>
<td>A2^g</td>
<td>-1.13^d</td>
<td>3.29</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Associate SDB Severities</th>
</tr>
</thead>
<tbody>
<tr>
<td>A1^j</td>
</tr>
<tr>
<td>A2^h</td>
</tr>
</tbody>
</table>

**Internal Versus External Locus of Control Score**

-4.00^f | 4.24 | -2.83^f | 2.13 | -.85

**Global Self-Esteem Score**

- .65^f | .61 | -.26^f | .58 | 1.61

$a_n=7$ $b_n=8$ $c_n=9$ $d_n=10$ $e_n=11$ $f_n=12$ $g_n=12$ $d_f=22$ $g_d=13$ $h_d=14$ $i_d=15$ $j_d=16$ $k_d=19$ $l_d=22$

*p<.05
significant difference in comparison to a control group. Hendricks (1972) found that an effective study class was equally effective in modifying self-concept. Jensen (1978) found no difference in the modification of self-concept between each of four ESDB groups and one control group. These findings seem to replicate in part the results obtained in this study. The ESDB group method is effective in modifying self-concept or self-esteem, but in three research studies out of four, so does the control period.

When control groups produce as much change as the experimental process under investigation, it is important to examine the control group process to determine if it truly was a control group. In the discussion of Premise 4 following, we will examine more closely aspects of the control period in this study that might make the control period not truly representative of a no-treatment process. It is possible that the control processes in the previous studies of the ESDB method examining the self-esteem variable could share the same variability as this one.

The limitations of this data are primarily in the manner in which it was collected. The Self-Report Inventory is a self-report data instrument from which the global self-esteem sub-score was obtained. Criticism can always be leveled against the collection of data using this process. In this method, an individual is required to report infor-
information about him or herself. This makes the process a subjective one in which all the problems of human error can be compounded by one's feelings about oneself and one's perceptions about what one has to lose. Even if the person reporting data about himself or herself is accurate, influences that are barely conscious can affect one's score. Hopefully, the high test reliability over a three month period, obtained by O'Brien (1980) when testing the self-report inventory, can provide an answer to these criticisms.

The ESDB group treatment seemed to bring both groups closer to the norm for self-esteem found by O'Brien (1980). According to his norms and percentiles for females (Groups I and II were primarily composed of females; the norms for males were quite similar), Group I (treatment and follow-up group) started treatment at only 7 percent of the norm and finished treatment at about 26 percent of the norm. Group II (the control and treatment group) achieved a mean of about 34 percent of the norm at the pre-treatment administration, and achieved a mean that was about 45 percent of the norm following treatment. Though only Group I's increase in self-esteem has been found to be significant, support exists in the data (Table 7) indicating both groups did equally well in increasing self-esteem as measured by the Self-Report Inventory. Increases such as these are the desired consequences of psychotherapeutic processes, and
even if the norms quoted were not reached, one must consider the increase achieved to be beneficial. Global self-esteem norms have not been developed for people from the general population. The norms quoted above were developed from female college students. They are used here for comparison because both groups were primarily composed of females who were predominantly college educated. Aside from norms, self-esteem did significantly increase in the case of Group I and that is the desired result of psychotherapeutic treatment.

Though we cannot say conclusively that the ESDB group treatment does increase global self-esteem (or one's self-concept), that does appear to be the case. More research is needed using this measure in comparison with a no-treatment control group to determine if the ESDB group treatment can influence self-esteem in a way that no-treatment process cannot. In the meantime, it seems safe to assume that the ESDB group process at least does not damage self-esteem, and perhaps can improve it. In terms of increasing self-esteem, some support has been gained for the claim that the ESDB group method is an effective group psychotherapy.

**Treatment Versus Control**

Premise 4. The people who have participated in the ESDB group treatment will have fewer self-defeating behaviors
(SDB's), greater internal locus of control, and more of an increase of self-esteem than people who have not participated in the ESDB group treatment.

Hypothesis 1. There will be a significant decrease in SDB frequency and severity, as measured by a difference score of the Participant SDB Questionnaire, for treatment Group I in comparison to control Group II.

Hypothesis 2. There will be a significant decrease in SDB frequency and severity, as measured by a difference score of the Associate SDB Questionnaire, for treatment Group I in comparison to control Group II.

Hypothesis 3. There will be a significant increase in the internal locus of control, as measured by a difference score of the Internal versus External Locus of Control Scale, for treatment Group I in comparison to control Group II.

Hypothesis 4. There will be a significant increase in self-esteem, as measured by a difference score of the Self-Report Inventory, for treatment Group I in comparison with control Group II.

A comparison of the differences produced in the measures from pre-treatment to post-treatment in Group I, and pre-control to post-control in Group II, is presented in Table 8. In this table, the data collected was analyzed to determine if the treatment period for Group I produced more
TABLE 8
TREATMENT AND CONTROL PERIODS; A COMPARISON OF THE DIFFERENCE MEANS AND STANDARD DEVIATIONS WITH \( t \) VALUES

<table>
<thead>
<tr>
<th>Four SDB's</th>
<th>Participant SDB Frequencies</th>
<th>Treatment Difference (Group I)(^a)</th>
<th>Control Difference (Group II)(^b)</th>
<th>( t ) Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>1(^d)</td>
<td>-3.75</td>
<td>10.23</td>
<td>-8.75</td>
<td>6.94</td>
</tr>
<tr>
<td>2(^k)</td>
<td>-5.08</td>
<td>7.09</td>
<td>-4.33</td>
<td>4.91</td>
</tr>
<tr>
<td>3(^l)</td>
<td>-5.50(^e)</td>
<td>6.25</td>
<td>-3.60(^g)</td>
<td>8.34</td>
</tr>
<tr>
<td>4</td>
<td>-4.18(^f)</td>
<td>7.60</td>
<td>-5.70(^g)</td>
<td>6.08</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Participant SDB Frequencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>1(^d)</td>
</tr>
<tr>
<td>2(^k)</td>
</tr>
<tr>
<td>3(^l)</td>
</tr>
<tr>
<td>4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>The Two Associates</th>
<th>Associate SDB Frequencies(^c)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A(^1)^n</td>
<td>-2.56(^h) 2.76</td>
</tr>
<tr>
<td>A(^2)^o</td>
<td>-1.13(^i) 3.29</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Associate SDB Severities</th>
</tr>
</thead>
<tbody>
<tr>
<td>A(^1)^m</td>
</tr>
<tr>
<td>A(^2)^n</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Internal Versus External Locus of Control Score(^d)</th>
</tr>
</thead>
<tbody>
<tr>
<td>-4.00</td>
</tr>
<tr>
<td>- .42</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Global Self Esteen Score(^d)</th>
</tr>
</thead>
<tbody>
<tr>
<td>.65</td>
</tr>
<tr>
<td>.30</td>
</tr>
</tbody>
</table>

\(^a\) For Group I the mean is based on the post treatment score minus the pre treatment score.
**TABLE 8 - Continued**

bFor Group II the mean is based on the post control score minus the pre control score.

cThere are two possible associates for each participant in both groups. Only the first two SDB frequencies and severity ratios were used; adding the first two frequencies together to determine the mean, and adding the first two severities together to determine that mean.

\[
\begin{align*}
&d_n = 12; \quad df = 22 \quad e_n = 12 \quad f_n = 11 \quad g_n = 10 \quad h_n = 9 \quad i_n = 8 \quad j_n = 6 \\
&k_{df} = 20 \quad l_{df} = 19 \quad m_{df} = 16 \quad n_{df} = 15 \quad o_{df} = 12 \\
*p < .05
\end{align*}
\]
of a change than did the control period for Group II. The difference means for both groups obtained from each measure was analyzed for significant differences. The table reveals only one significant difference between the treatment period and the control period. There was found to be a significant increase in internality after the treatment period for Group I in comparison to a change in internality found after the control period for Group II. Of the measures used, only the Internal versus External Locus of Control Scale was able to isolate a significant difference in the treatment process versus the control period.

Based on this data, Premise 4 is poorly supported. People who have participated in the ESDB group treatment do not appear to have fewer self-defeating behaviors or more of an increase in self-esteem than people who have not participated in the ESDB group treatment. The data does seem to indicate, however, that people who have participated in the ESDB group treatment do have greater internal locus of control than people who have not participated in the ESDB group treatment. Thus, only Hypothesis 3 has been found to accurately predict the outcome for this premise.

Previous research on the ESDB method has used control groups in order to compare the effectiveness of the method against changes that might occur without the treatment. Nine of the 16 studies on the ESDB group treat-
ment have used "no treatment" control groups for comparison. Of these, all nine found significant differences in the ESDB treatment as compared to a control period (Fiester, 1973; Coombs, 1974; Parks, et al., 1975; Turnbull, 1977; Johnson, et al., 1978; Hornak, 1979; and Younker, 1980), and two studies found no significant differences between the treatment process and the control period (Forsyth, 1976; and Jensen, 1978). Our study appears to fall between these two groups of findings, since we have found one significant difference between the treatment group and the control group, but no others.

Forsyth (1976) found no significant difference between the ESDB group meetings and the control period using Rotter's Internal versus External Locus of Control Scale. Jensen (1978) also found no significant difference between the four ESDB groups and a control group, as measured by the Tennessee Self-Concept Scale and the Internal versus External Locus of Control Scale. However, like our study, Parks et al. (1975) and Johnson et al. (1978) found significant differences between the ESDB groups and the control periods based on the Internal versus External Locus of Control Scale. Coombs (1974) found that the ESDB group treatment produced a significant positive change in self-concept as compared to the control period as based on the Tennessee Self-Concept Scale. Turnbull (1977) found that
two ESDB groups showed significant positive change in correlates of mental health as compared to a control period based on the Personality Orientation Inventory (POI). Hornak (1979) and Younker (1980) both found the ESDB groups to be effective in significantly lowering the anxiety level of participants as compared to those participating in a control group. But, unlike our study, all of the previously mentioned studies of the ESDB group method found significant change in self-defeating behaviors when compared to self-defeating behaviors of those in control groups. It appears that the verdict is not in when comparing the ESDB group method against a control period, and our study replicates the indecision.

Our study seems to indicate that the ESDB group treatment did no better than no treatment during the same amount of time, except for the significant change toward an internal locus of control. Because of limitations in the methodology of this study, however, this finding may reflect some inaccuracy. In order for a control period to be truly a no-treatment period, there must be no psychotherapeutic intervention with the participants in the control group that reflects the thrust of the treatment process being investigated. Upon examination of the methods used to secure the participants of this study, it was found that, prior to the assignment to either the control period or
treatment period, significant statements may have been made about the treatment process in hopes of maintaining the interest of those participants who were to be assigned to the control group and had, therefore, to wait for five weeks prior to participating in the ESDB treatment. Experimental designs were considered that would hopefully obtain participants while offering no treatment process. These designs were passed over because of the unlikely nature of obtaining community members who would participate in a study that would have no intrinsic value for them. Therefore, it was decided to offer each participant an opportunity to obtain the treatment program and also enable a comparison to be made by having one group wait for five weeks prior to taking the treatment process. It was believed that for a control group to be truly representative of the population that might partake of psychotherapeutic services in a community, the control group would have to be composed of those people who were interested in such services. It was also believed unethical to offer a treatment process to a group of people and then refuse them the opportunity for taking the treatment. There was, as well, the real possibility that those assigned to the control group would tire of waiting and refuse to participate any further in the study. This possibility was highlighted by the number of dropouts discovered just prior to the first administration of the
measure. For all of the above reasons, statements may have been made about the treatment process in hopes of heightening the interest of those participants who would be assigned to the control period. These statements could have been contained in an outline of the SDB group treatment that was presented in that first meeting of the participants. Certainly, the definition of self-defeating behavior had to be given in order for participants to complete the Participant SDB Questionnaire.

Another possibility for the lack of significant difference between the control period and the treatment period of this study is the effects of reactivity on the participants in the control group. Campbell and Stanley (1963) discuss the importance of the reactivity to experimental designs in the social sciences. They stress that it has long been true in the social sciences that the process of measuring may change that which is being measured.

The reactive effect is to be expected whenever the testing process is in itself a stimulus to change rather than a passive record of behavior. Thus in an experiment on therapy for weight control, the initial weigh-in might in itself be a stimulus to weight reduction, even without the therapeutic treatment (p. 9).

This must not be misunderstood to mean that the changes measured are some kind of artifact produced by the situation and do not reflect real changes in the participant. The term "reactivity" simply refers to real changes in par-
ticipants, but highlights that these changes could be due to the instruments themselves and not to the treatment process being studied. In the case of reactive measures, the instruments being used simply become a part of the treatment process.

Table 9 is a comparison of the pre and post-control means found for Group II (the control and treatment group). This table reveals significant decreases in the frequencies of participants' self-defeating behaviors, the first associate SDB frequency rating, and a significant increase in the global self-esteem scores of group members. One might think, looking at Table 9 that Group II underwent a treatment process during this period of time (5 weeks). Quite possibly they did, based on the concepts presented in the above two paragraphs. It is possible that participants in the control group, knowing they were selected to participate in a University research group serious about overcoming self-defeating behaviors, and presented with what those self-defeating behaviors were, found themselves able to decrease the frequency of those behaviors during the control period with no further intervention. Knowing that they were participants in a study designed to be effective in overcoming self-defeating behaviors, they may indeed have felt a higher self-esteem for committing themselves to such a process. This could be what is reflected in the significant
TABLE 9
COMPARISON OF THE FIRST (ADMINISTRATION ONE) AND FINAL (ADMINISTRATION THREE) MEAN AND STANDARD DEVIATIONS FOR GROUP II (THE CONTROL AND TREATMENT GROUP) AND THE t-VALUES

<table>
<thead>
<tr>
<th>Administration One</th>
<th>Administration Three</th>
<th>Participant SDB Frequencies</th>
<th>Participant SDB Severities</th>
<th>The Two Associates</th>
<th>Associate SDB Frequencies</th>
<th>Associate SDB Severities</th>
<th>Internal Versus External Locus of Control Score(^a)</th>
<th>Global Self Esteem Score(^a)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(\bar{X})</td>
<td>SD</td>
<td>(\bar{X})</td>
<td>SD</td>
<td>t Values*</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1(^a)</td>
<td>16.25</td>
<td>2.33</td>
<td>1.37</td>
<td>5.54 .000</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2(^a)</td>
<td>10.08</td>
<td>2.75</td>
<td>1.36</td>
<td>3.25 .004</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3(^b)</td>
<td>8.00</td>
<td>3.00</td>
<td>1.50</td>
<td>1.96 .043</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>4(^b)</td>
<td>10.40</td>
<td>3.30</td>
<td>3.09</td>
<td>2.91 .009</td>
<td></td>
<td></td>
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<tr>
<td>Participant SDB Severities</td>
<td></td>
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<tr>
<td>1(^a)</td>
<td>3.83</td>
<td>2.58</td>
<td>.90</td>
<td>3.36 .003</td>
<td></td>
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<tr>
<td>2(^a)</td>
<td>3.83</td>
<td>3.08</td>
<td>1.00</td>
<td>2.14 .028</td>
<td></td>
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<tr>
<td>3(^c)</td>
<td>3.56</td>
<td>3.00</td>
<td>1.00</td>
<td>2.29 .026</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>4(^b)</td>
<td>3.50</td>
<td>2.90</td>
<td>.99</td>
<td>1.50</td>
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<td>The Two Associates</td>
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<td>Associate SDB Frequencies</td>
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<td></td>
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<tr>
<td>a1(^d)</td>
<td>5.44</td>
<td>2.19</td>
<td>1.28</td>
<td>3.33 .007</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>a2(^f)</td>
<td>7.50</td>
<td>1.92</td>
<td>1.59</td>
<td>2.05 .048</td>
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<td>Associate SDB Severities</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A1(^c)</td>
<td>3.44</td>
<td>2.56</td>
<td>.46</td>
<td>2.60 .016</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>A2(^e)</td>
<td>4.29</td>
<td>3.43</td>
<td>.67</td>
<td>2.83 .015</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Internal Versus External Locus of Control Score(^a)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>9.00 3.49</td>
<td>5.75 3.62</td>
</tr>
<tr>
<td>Global Self Esteem Score(^a)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2.66 .76</td>
<td>3.22 .69</td>
</tr>
</tbody>
</table>

\(^a\)n=12; df=11 \quad \(^b\)n=10; df=9 \quad \(^c\)n=9; df=8 \quad \(^d\)n=8; df=7 \quad \(^e\)n=7; df=6

*These superscripts represent the level of significance achieved.
increase in the global self-esteem score found following the control period.

To understand the significant change in the self-esteem mean for Group II, examination of entry to the group might be useful. The entrance requirements for being a participant were difficult. This was thought necessary to decrease the possibility of dropouts during the group process. The participant first had to respond to the advertisements by remembering the phone number and calling and then had to wait for a call from the researcher. Once the call was made, the participant needed to give his or her name and address to the researcher and then wait for an envelope containing materials to come to his or her address. At this point, if the participant was still interested, he or she had to a) sign the consent form, b) obtain two friends willing to participate in the study and sign their names and addresses to the associate consent form, c) mail the consent forms back to the researcher, d) at a later date arrive at the correct time and place to be administered the measures (which took approximately 1 1/2 hours) and e) give the researcher a $25 deposit and two completed associate questionnaires. After this process, members assigned to Group II (the control and treatment group) had to wait five weeks in order to take treatment process. It is possible that this complicated, and possibly
difficult, entrance procedure may have influenced in a positive way the self-esteem of the participants who may have felt all this as a demonstration of their commitment to changing aspects of themselves that they disliked. Each step required a conscious redecision to commit oneself to the change process. These decisions, plus hearing the introduction and the outline of the ESDB group treatment, as well as a pep talk (in order to insure continued commitment to the group process), and the taking of the measures all seem to have had a positive effect on the participants. The apparent effect was in the direction predicted for the treatment process.

These results can be seen as being very encouraging. These conditions prior to treatment could be highlighting the power of the ESDB group approach. Table 9 is a comparison between the first administration and the third administration of the measures for Group II (the control and treatment group). Because of the significant changes found in the control period and further significant changes found in the treatment period, analysis was undertaken to determine what the accumulative changes might be for the entire process that Group II underwent. Inspection of this table reveals that significant and highly significant changes were found for every measurement taken except for one (the fourth participant SDB severity). These are the kind of results
hoped for by those people seeking psychotherapeutic services. Looking at Table 9, one might consider the possibility that the control period in this study should be considered a portion of a treatment process, rather than a true control period.

In the light of the above discussion, it is interesting to note that the level of internality did not change during the control period. Apparently this variable was resistant to the influences on the participants during the control period and was only affected during the treatment process. This is not surprising considering the amount of difficulty most participants have, in accepting, during ESDB process, that they have responsibility for the situations in which they find themselves. Only after much discussion and facilitation do participants come to understand the manner in which they can be responsible for their own experiences.

Future research must be done examining both the effect of including a waiting period prior to the treatment process itself and construction of comparison control periods, in order to truly test the effectiveness of the SDB method against a no-treatment process. The findings imply that sought after changes in the frequency and severity of self-defeating behaviors, self-esteem, and locus of control can occur using the ESDB group method with a 5 week waiting
period prior to the treatment group. The influence of the knowledge that a prior group with whom one will be compared has undergone the treatment must be examined for its effects. The results found and depicted in Table 9 need to be replicated, but they seem to indicate that important changes can occur based on the intervention of the ESDB group treatment as presented to the participants in Group II.

Duration of Treatment Effect

Premise 5. The effects of ESDB group treatment process on participants will remain eight weeks after completion of the treatment process.

Hypothesis 1. There will be no significant difference in the frequency and severity scores obtained on the Participant SDB Questionnaire between the post-treatment and follow-up administrations for Group I.

Hypothesis 2. There will be no significant difference in the frequency and severity scores obtained on the Associate SDB Questionnaire between the post-treatment and follow-up administrations for Group I.

Hypothesis 3. There will be no significant difference in the scores obtained on the Internal versus External Locus of Control Scale between the post-treatment and follow-up administrations for Group I.
Hypothesis 4. There will be no significant difference in the scores obtained on the Self-Report Inventory between the post-treatment and follow-up administrations for Group I.

The comparison of the post-treatment and follow-up means for Group I (the treatment and follow-up group) can be found in Table 10. Examination of the data reveals no significant differences between the post-treatment administration of the measures and the follow-up administration of the measures 8 weeks later. These results provide positive support to the predictions as stated in the four hypotheses. We can say that the premise apparently is accurate: "The effects of the ESDB group treatment on participants will remain eight weeks after completion of the treatment process."

Previous research studying the effectiveness of the ESDB group procedure also looked at the duration of the change following treatment. Seven of the sixteen studies cited had follow-up measures taken (Parks et al., 1975; Bohn, 1976; Forsyth, 1976; Turnbull, 1977; Johnson et al., 1978; Hornak, 1979; and Younker, 1980). Two studies measuring the effectiveness of the ESDB group treatment on anxiety of the participants found significantly reduced anxiety continued until the follow-up administration five weeks after the treatment process ended (Hornak, 1979; and
**TABLE 10**

**COMPARISON OF THE POST TREATMENT AND FOLLOW UP MEANS AND STANDARD DEVIATIONS FOR GROUP I AND THE t VALUES**

<table>
<thead>
<tr>
<th>Four SDB's</th>
<th>Participant SDB Frequencies</th>
<th>Participant SDB Severities</th>
<th>The Two Associates</th>
<th>Associate SDB Frequencies</th>
<th>Associate SDB Severities</th>
<th>Internal Versus External Locus of Control Score</th>
<th>Global Self Esteem Score</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Post Treatment</td>
<td>Follow up</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>X</td>
<td>SD</td>
<td>X</td>
<td>SD</td>
<td>t Values</td>
<td>X</td>
<td>SD</td>
</tr>
<tr>
<td>1&lt;sup&gt;c&lt;/sup&gt;</td>
<td>5.08</td>
<td>6.93</td>
<td>4.17</td>
<td>4.30</td>
<td>.42</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2&lt;sup&gt;c&lt;/sup&gt;</td>
<td>4.17</td>
<td>3.90</td>
<td>2.67</td>
<td>2.27</td>
<td>1.26</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3&lt;sup&gt;d&lt;/sup&gt;</td>
<td>5.50</td>
<td>5.84</td>
<td>6.17</td>
<td>5.70</td>
<td>.37</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4&lt;sup&gt;d&lt;/sup&gt;</td>
<td>5.18</td>
<td>5.65</td>
<td>4.64</td>
<td>5.32</td>
<td>.54</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Participant SDB Severities

<table>
<thead>
<tr>
<th>The Two&lt;sup&gt;a&lt;/sup&gt; Associates</th>
<th>Associate SDB Frequencies&lt;sup&gt;b&lt;/sup&gt;</th>
<th>Associate SDB Severities</th>
<th>Internal Versus External Locus of Control Score&lt;sup&gt;c&lt;/sup&gt;</th>
<th>Global Self Esteem Score&lt;sup&gt;c&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A&lt;sub&gt;1&lt;/sub&gt;&lt;sup&gt;e&lt;/sup&gt;</td>
<td>2.45</td>
<td>3.13</td>
<td>7.58</td>
<td>2.81</td>
</tr>
<tr>
<td>A&lt;sub&gt;2&lt;/sub&gt;&lt;sup&gt;f&lt;/sup&gt;</td>
<td>6.25</td>
<td>4.81</td>
<td>7.33</td>
<td>3.02</td>
</tr>
</tbody>
</table>

<sup>a</sup>There are two possible associates for each participant. Only the first two SDB frequency and severity ratings by each associate were used to compute the means.
Because of the paired t-test, any absent scores required the deletion of its match. For this reason one frequency and one severity mean listed here is different from the ones listed in Table 2 under Post Treatment.

<table>
<thead>
<tr>
<th>Cn</th>
<th>df</th>
<th>Dn</th>
<th>df</th>
<th>En</th>
<th>df</th>
</tr>
</thead>
<tbody>
<tr>
<td>12</td>
<td>11</td>
<td>11</td>
<td>10</td>
<td>10</td>
<td>9</td>
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<tr>
<td>9</td>
<td>8</td>
<td>8</td>
<td>7</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*p < .05
Younker, 1980). Turnbull (1977) studied the effects of the treatment on correlates of mental health (the POI subscale) and found that the positive changes following treatment continued through the follow-up period. Of the four studies remaining to be discussed, all investigated the effects of ESDB treatment on the level of internality as measured by the Internal versus External Locus of Control Scale. Johnson et al. (1978) found some return to externality after a period of four weeks with smokers as participants. Forsyth (1976) and Bohn (1976) both found that the change toward internality continued through the follow-up period. Parks et al. (1975) had the longest follow-up period of the studies (four months) and found no significant change in the level of internality achieved following the treatment process. Bohn (1976), Turnbull (1977), and Johnson et al. (1978) also studied the effects of the ESDB group method on decreasing self-defeating behaviors (Johnson et al. studied smoking as the self-defeating behavior). All three found significant decreases in the frequencies of self-defeating behaviors and that these decreases continued through the follow-up period.

These results lend support to the hypothesis and premise as stated above. It seems safe to conclude that the changes occurring following treatment for Group I continued for two months. Previous research indicates that thera-
apeutic changes from the ESDB method can last for two months and beyond. Without this kind of long-term evidence that the desired changes persist, one could easily conclude that a psychotherapeutic process is ineffective. If changes do not persist over time, they are seen as being artificial, unreal, or at best temporary. To demonstrate real effectiveness, it was believed necessary to determine if the changes following the ESDB group treatment endured over time and it appears that they did.

The limitations of this data due to the self-report nature of the instruments has been mentioned. Another limitation is the lack of replicability of the follow-up results. Reviewing the experimental design, one can see that each group is administered all measures three times. Group I (the treatment and follow-up group) was administered the three measures over a time period of 13 weeks. Group II (the control and treatment group) was administered the measures three times over a period of 10 weeks. Because of the number of times that participants were exposed to the instruments and the relatively short period of time within which that took place, there was concern that the participants would exhibit a practice effect which would improve their scores artificially and obscure any true changes occurring as a result of the treatment (see Campbell and Stanley, 1963). On the other hand, administering the
measures three times seemed a justifiable risk in terms of this practice effect; however a fourth administration did not. Considering this, it was decided not to administer a follow-up administration to Group II. For these reasons, only Group I would have data available for a follow-up analysis. Another limitation was the lack of a longer period (such as 1 or 2 years) for the follow-up measurement. Good psychotherapy hopefully produces changes that have a duration of over eight weeks in length. In order to determine if ESDB group treatment was effective as a psychotherapy, then measurements should have been taken over a much longer span of time to determine the long-term effectiveness of the model. Unfortunately, however, the time was not available to accomplish this.

**Limitations**

This study samples a population composed primarily of highly verbal, middle-class white Americans who can identify themselves as self-defeating, and further, who are motivated enough to respond to advertisements for a course to eliminate those behaviors. They are also people willing to be participants in a psychotherapeutic research project. Thus, the generalizability of any results may only apply to members of this narrowed population. Research in the context of a broader population is necessary before much more
accurate statements can be made about the effectiveness of this method. Another limitation is the lack of a longer time period before the follow-up data is collected. This limits any statement concerning the lasting effects of any outcome (beyond 8 weeks) and prevents the discovery of any positive or negative results after the follow-up data is collected (some participants in ESDB courses given prior to this study have reported changes occurring after one year).

Much of the data is obtained from self-report instruments. The one source of more "objective" data is from two associates of the participant. An intrinsic limitation of this type of research seems to be the subjectivity of the data needed for this kind of investigation. To really observe behavior, one must closely associate with the person being observed and this intimacy increases one's subjectivity. So even the more "objective" data from the associates can be criticized on the basis of its subjectivity.

Summary

This research was designed to answer the question of the effectiveness of a short-term, didactic, group psychotherapy—The Elimination of Self-Defeating Behavior group method—in (a) reducing the frequency and severity of self-defeating behavior, (b) increasing the internal locus
of control, and (c) increasing self-esteem. It was found that 11 of the 16 hypotheses developed to address this question were partially or fully supported by the data.

A comparison of the initial means achieved by both Group I (the treatment and follow-up group) and Group II (the control and treatment group) indicated that the groups were not significantly different at the beginning of the study. This allowed us to be fairly certain of the similarity of the two groups and better able to interpret any differences that developed following treatment.

In the first analysis of the data concerning changes in Group I following the ESDB group method, it was found that three out of four self-defeating behaviors decreased in frequency and one self-defeating behavior decreased in severity. For the changes in Group II, one self-defeating behavior out of four decreased significantly in frequency following the treatment process and one self-defeating behavior out of four decreased in severity. This provides evidence that the ESDB group treatment process decreases the frequency and severity of self-defeating behavior in some cases. One should note that all scores for both groups decreased following the treatment process.

Added support for the premise that the ESDB Group Process decreases the frequency and severity of participants' self-defeating behaviors was obtained from
questionnaires administered to associates of the participants. One-half of the associates of participants in Group I found a significant decrease in the frequencies of self-defeating behaviors following treatment. One-half of the associates of participants in Group II found a decrease in the severity of self-defeating behaviors following treatment. These two significant findings add some external verification for the decreases found by participants in their own self-defeating behaviors following the ESDB Group Treatment. It is again worth noting that all associates found decreases in frequencies and severities of participants' self-defeating behaviors in all cases.

An analysis of the data obtained following treatment for both Group I and Group II revealed that both groups significantly increased their internal locus of control following treatment. This was the one variable that did not change during the control period and was only found to change toward internality following the group treatment for Group II. We can, therefore, be fairly certain that participating in the ESDB Group Treatment Process does significantly increase a participant's sense of internal locus of control.

A comparison of the self-esteem levels before and after treatment revealed that Group I significantly increased its level of self-esteem following treatment.
Group II, however, did not achieve a significant increase following treatment. Noting that there was some increase in self-esteem for Group II, an analysis was done comparing the pre and post-treatment differences for each group. This analysis of across-group differences following treatment revealed no significant differences in changes achieved during the treatment process. A significant increase in self-esteem was found for Group I after treatment. Although Group II did not significantly increase their level of self-esteem, the increase in self-esteem was not found to be significantly different from the increase found for Group I. These two findings allow one to say with some certainty that the Elimination of Self-Defeating Behavior group psychotherapy increases the self-esteem of participants.

When the differences obtained before and after treatment for Group I were compared to the differences obtained before and after the control period for Group II, no significant differences were found (except for the internal versus external locus of control score). This finding led to an analysis of the procedure used to enroll participants in the control group. It was discovered that the entrance procedures were sufficiently arduous, and the information provided at the initial administration of the measures sufficiently thought-provoking, that one could speculate that the control period encouraged changes in the
frequency and severity of self-defeating behaviors and increased self-esteem. It was also found that the instruments used may have had a reactive effect on the participants in the control group that itself affected behaviors. The result of the data analysis, however, give inconclusive support to the premise that participants in the ESDB Group Treatment will have fewer self-defeating behaviors, and more of an increase in self-esteem than people who have not participated in the ESDB Group Treatment. Conclusive support was obtained from the data analysis regarding the increase in internal locus of control by participants following the ESDB Group Treatment in comparison to participants who had not participated in the ESDB Group Treatment.

Analysis was also obtained regarding significant differences in means for Group II prior to the control period and following the treatment process. This comparison of the first administration of the instruments to the third administration of the instruments for Group II was very illuminating. Inspection of this analysis revealed that significant and highly significant changes were found for every measurement taken except one (the fourth participant SDB severity). These desired results allow one to speculate that the control period of five weeks prior to the treatment process may have enhanced the gains participants can achieve from the Elimination of Self-Defeating Behavior group
psychotherapy.

Analysis of the effects of the ESDB group treatment process on the participants in Group I (the treatment and follow-up group) were examined as well. The gains obtained by participants in Group I in decreasing the frequency of and severity of their self-defeating behaviors, increasing their internal locus of control, and increasing their self-esteem continued for two months following the treatment process. This finding firmly supports the proposition that changes in participants following the treatment process persist over time (at least for two months). Previous research indicates that these changes can persist up to four months.

The primary limitation of the research here is the subjective nature of the data collection process. Research into changes in internal and external human behaviors requires a level of intimacy with the subject such that the most accurate kind of statements obtainable are those from the subject or from those associated with the subject. This, of course, increases the risk of a distorted (subjective) account of the changes in the variables under investigation. Another limitation is the narrowed population that is used to examine the changes following participation in the ESDB Treatment. Although this is one of the first studies of the ESDB method done that uses people from the community as participants rather than college
students, it still represents a restricted population. These participants were white, highly verbal people from the middle classes of America. They were also interested in participating in a psychotherapeutic research project. Changes occurring in this population as a result of the ESDB are generalizable only to this restricted population. A further limitation of this study is the lack of a longer time-period (beyond two months) to determine the persistence of any changes following the group treatment process.

Bearing in mind the limitations of this study, it must be stated here that this study was moderately successful in answering the question of effectiveness and in predicting the changes in behaviors of the participants. Eleven out of the 16 hypotheses developed to investigate the five premises were found to be partially or completely accurate. The Elimination of Self-Defeating Behavior method, a short-term, didactic group psychotherapy, has been found to be effective in decreasing the frequency and severity of some self-defeating behaviors, in increasing the internal locus of control of participants, and in increasing their self-esteem. Questions continue to exist about the effectiveness of this method in comparison to a control period of the same length of time. However, duration of the changes occurring following the treatment process is well-established for a period of two months.
The purpose of this study was to determine if participation in a short-term, didactic, group process can: (a) reduce the frequency of self-defeating behaviors; (b) increase internal locus of control; and (c) increase general self-esteem. The Elimination of Self-Defeating Behavior (ESDB) group psychotherapy was the process investigated for effectiveness. Self-sabotage is a good synonym for self-defeating behavior (SDB) which was defined by Warner (1966) and Cudney (1972) as meaning any behavior that one does repeatedly that impedes or interferes with the accomplishments of one's goals in living, or prevents one from fulfilling one's potential.

In this country, we are faced with an ever-increasing demand for psychological services. This is revealed, in part, by government statistics reporting the number of psychiatric admissions to mental hospitals and the requests for out-patient treatment. Early detection studies show even more emotional and mental disturbance in the general population than the epidemiological studies that continue to set the need for mental health assistance at 10 percent of the population. The demand for services, always
less than the reported need, continues to grow toward that 10 percent figure. Twelve years ago, reports clearly demonstrated a shortage of mental health workers. This shortage has continued through the present time. Government agencies, as well as researchers in the field, point out the limited availability of professionals to even adequately meet the demand for services. It appears that even as personnel increases in availability, the demand for the services continue to outstrip the available supply of professionals.

Solutions to the above problem are varied. Two obvious solutions, however, are (a) to find a way to increase the mental health humanpower in order to keep up with the demand and (b) find methods of treatment that are effective and short-term. Increasing the numbers of mental health service workers is seen to be unworkable because of the expense and time needed to train these workers. Thus, research into effective short-term methods is seen as the primary way to adequately respond to the increase in demand for psychotherapeutic services. Educational and didactic methods, group processes, and short-term procedures of psychotherapy have, therefore, been developed and implemented.

This research was an attempt to test a recent method that combines the above innovations and thus may meet the need for a more efficient psychological intervention. The
treatment method that was studied here is a psychological intervention that used a didactic group process that is short-term. Being in use only ten years, the ESDB Group Method is not well-known. This research, therefore, holds a second purpose which is, if the method proves effective, to acquaint more professionals with the efficacy of this group process.

Research was presented which indicated that there is evidence that psychotherapy as a process "works." Since the preponderance of the demand arises from the population that can be described as "neurotic," it is the needs of this population that we are addressing in our research. Researchers have investigated short-term psychotherapeutic processes and found them to be effective. Educational processes such as the cognitive learning therapies and other methods grouped under the psychoeducational format have been shown to be effective in meeting the needs of psychological service consumers. Group psychotherapeutic research, as well, has demonstrated that group therapy is a viable and effective form of presenting treatment. Finally, research that combined some of these approaches and found them to be effective provides a background to the ESDB group method as one of the more potentially effective ways to meet the increased demand for services cited earlier.

The Elimination of Self-Defeating Behavior group psychotherapeutic model is a procedure that is short-term in
length and didactic in process. Two basic concepts are presented to participants: (a) that one's personal behaviors can create the negative consequences in one's life as well as the positive ones and (b) one can challenge the conclusions that were learned in one's earlier experience about the personal limitations that one has. The analysis of behaviors, ownership (and disownership), personal consequences, inner choice, and untested fears are taught to group members as sub-concepts to help them integrate the above concepts. Previous research has shown that the ESDB group method is effective in reducing self-defeating behavior, increasing internal locus of control and lowering anxiety, using college students as participants. More research is needed that replicates these findings using community members (who might typically desire psychotherapeutic services) as participants. Despite the difficulties of determining the effectiveness of a psychotherapeutic procedure, measuring the level of change in participants' self-esteem, the amount of change in a participants' locus of control and the change in the frequency and severity of participants' self-defeating behaviors were determined to be appropriate ways to test the effectiveness of this psychotherapeutic method.

The overall premise of this research was that the Elimination of Self-Defeating Behavior group psychotherapy
process is an effective self-improvement therapy for people who behave in self-defeating ways. A pool of participants was drawn from the community through advertisements and notices announcing a course in "Overcoming Self-Defeating Behavior." The research design was to create two groups from this pool of participants. Group I (the treatment and follow-up group) was a treatment group and then was tested for the duration of the effects found. Group II (the control and treatment group) was a comparison group for the first group treatment procedure as well as a replication of that group when it became a treatment group itself. Four instruments were used to measure the changes in participants: the Participant Self-Defeating Behavior Questionnaire, the Associate Self-Defeating Behavior Questionnaire, the Internal versus External Locus of Control Scale, and the Self-Report Inventory. The ESDB group procedure consisted of didactic presentation by the group facilitator and group discussion, with the process culminating in an imagery exercise during the final meetings. The length of time for the entire group treatment did not exceed thirty hours. The statistical design used a correlated t-test for within-group analysis and an independent t-test for the analysis of differences between groups. Limitations concerned the narrow (the highly verbal, Caucasian) population studied, the lack of a longer follow-up period (beyond two
months), and the subjective nature of the instruments used. Analysis revealed that the means achieved by both Group I (the treatment and follow-up group) and Group II (the control and treatment group) on the instruments, were not significantly different at the beginning of the study. This finding allows us to be fairly certain of the similarity of the two groups and certain of any differences that developed later following treatment. This was not surprising considering that both groups were similar in educational level, had a fairly similar range in ages, were from the same ethnic background, and were composed of a majority of females.

In the first analysis of the data concerning changes in Group I following the ESDB group method, it was found that three out of four self-defeating behaviors decreased in frequency and one self-defeating behavior decreased in severity. For the change in Group II, one self-defeating behavior out of four decreased significantly in frequency following the treatment process. This provides evidence that the ESDB group treatment process decreases the frequency and severity of self-defeating behavior in some cases. One should note that all scores for both groups decreased following the treatment process.

Added support for the premise that the ESDB Group Process decreases the frequency and severity of
participants' self-defeating behaviors was obtained from questionnaires administered to associates of the participants. One-half of the associates of participants in Group I found a significant decrease in the frequencies of self-defeating behaviors following treatment. One-half of the associates of participants in Group II found a decrease in the severity of self-defeating behaviors following the treatment. These two significant findings add some external verification for the decreases found by participants in their self-defeating behaviors following the ESDB Group Treatment. It is again noteworthy that all associates found decreases in frequencies and severities of participants' self-defeating behaviors in all cases.

An analysis of the data obtained following treatment for both Group I and Group II revealed that both groups significantly increased their internal locus of control following treatment. This was the one variable that did not change during the control period and was only found to change toward internality following the group treatment for Group II. We can be fairly certain that participating in the ESDB Group Treatment Process does significantly increase a participant's locus of control.

A comparison of the self-esteem levels before and after treatment revealed the Group I significantly increased its level of self-esteem following treatment. Group II,
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participation in the ESDB Treatment. Although this is one of the first studies of the ESDB method done that uses people from the community as participants rather than college students, this still represents a restricted population. These participants were white, and highly verbal people from the middle classes of America. They were also interested in participating in a psychotherapeutic research project.

Changes occurring in this population as a result of the ESDB are generalizable only to this restricted population. A further limitation of this study is the lack of a longer time period (beyond two months) to determine the persistence of any changes following the group treatment process.

Bearing in mind the limitations of this study, it must be stated here that this study was moderately successful in answering the question of effectiveness and in predicting the changes in behaviors of the participants. Eleven out of the 16 hypotheses developed to investigate the five premises were found to be partially or completely accurate. The Elimination of Self-Defeating Behavior method, a short-term, didactic group psychotherapy, has been found to be effective in decreasing the frequency and severity of some self-defeating behaviors, in increasing the internal locus of control of participants, and in increasing the self-esteem of participants. Questions continue to exist about the effectiveness of this method in comparison
to a control period of the same length of time. However, duration of the changes occurring following the treatment process is well-established for a period of two months.

Future research should take into account the need for a clarification of the inconclusive evidence in the research and in this study, of how this treatment process affects behaviors in comparison to a control process. As stated previously the control procedures must be examined in detail to determine that it is truly a no-treatment process. Research should also go forward to examine the finding that a five-week waiting period, beginning with an administration of instruments such as we have here, prior to the treatment process, seems to enhance the positive changes occurring as a result of the treatment process. It is, however, clear that the ESDB group treatment affects participants' behavior and does so in a positive fashion, as would be expected as a result of a psychotherapeutic procedure. For these changes to take place, only thirty hours of group contact time are required, using two evening meetings a week, over a length of five weeks. One can speculate that the changes found to hold for a period of two months following treatment will continue for some time. Before one can ascertain that these changes are permanent, however, more research on the duration of the treatment results must be done, though comparisons over a length of time of years are very difficult
due to the transient nature of the general population.

These findings are very encouraging. The need for psychotherapeutic services is pressing. This method could go far towards alleviating the demand for such services and do so in an efficient and productive fashion. Methods such as this, that can facilitate positive changes in participants in a group, and over a short period of time, are one of the primary answers to meeting the need that our greater community has demonstrated. It is hoped that this research will provide support for the increasing use of this method, and the alleviation of much needless suffering in the general population.
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APPENDIX A

Materials Used to Attract Participants
DEFEATING YOURSELF?

Self-defeating behavior is defined as any repeated behavior you do that interferes with your getting what you really want from life. A class in "Overcoming Self-Defeating Behavior" is now accepting participants. Because the class is part of a doctoral study, a reduced rate of $25 is possible, with $20 being refunded to each participant completing the course. The course takes 25 hours to complete over a period of five weeks. The meeting times will be determined at the introductory meeting.

The instructor is a psychotherapist in practice for six years in Amherst, and who has taught this course for several years through Continuing Education at the University.

For information call John A. Barbaro, M.Ed., 256-6940.

Limit of 15 students.
Offering 25 hour class in "Overcoming Self-Defeating Behavior" (A self-defeating behavior is any repeated behavior that you do that interferes with your getting what you really want from life). Now being taught for use in doctoral study at a special rate of $25; $20 of which is refunded upon course completion. Instructor, a psychotherapist in practice for six years, has taught this course several years through Continuing Education at the University. For information, call John A. Barbaro, M.Ed., 256-6940.
UM professor teaches ways to defeat self-defeating behavior, break habits

By RICHARD BARRELL
AMHERST — Constant daydreaming, procrastination, taking on work a person is not equipped to do, and excessive shyness are often examples of what Amherst-based psychotherapist John A. Barbaro calls, “self-defeating behavior.”

These patterns of behavior are habits, says the 34-year-old Barbaro, that often prevent people from getting what they want out of life and achieving real success and enjoyment.

To help people overcome their self-defeating behavior, Barbaro has developed a course which he has taught for six years through the Division of Continuing Education at the University of Massachusetts.

Now as a doctoral candidate at the UMass School of Education, Barbaro plans to teach a new edition of his course and has begun advertising for students.

The reason for the special effort is that he will be carefully monitoring and evaluating these classes and using the data for his thesis, which he hopes will convince other health professionals of the value of his work.

Students participating in the class will be guaranteed complete confidentiality.

Barbaro says. After completing the 25-hour course, students will be refunded all but $5 of the $25 course fee, he adds. This will give students added incentive to complete the course, because he says that’s essential to gathering the data for his study.

Barbaro says his methods are simple, easy to learn, and provide, “real tools,” for the instructor and the student.

The tools are a combination of his theories of behavior, homework, the student’s experiences, and students’ imagination, he says.

“Most people have an impression of themselves. My job is to make it objective,” Barbaro comments.

Barbaro begins with his theories, which he calls the four components of behavior, and uses the analogy of driving a car to explain them.

“You are in the driver’s seat,” he says, a belief he calls the “philosophy of personal responsibility.”

Selection of roads inspected
Each person is asked to look at not only how they are driving, but at their choice of roads as well, he says.

Just as some people habitually use roads which are full of potholes and tough on the car because the drivers are familiar with those roads, some people continue a behavior even though it is causing them problems, Barbaro maintains.

The problems, he says, are the cost or consequences of the behavior. People, he says, must decide if it is worth it to change.

For example, a person who tries to be an overnight expert at automobile repairs could end up lacking a day or two of transportation — plus incurring the added expense of having their auto towed to a garage.

Feeling that one must know everything can be at the bottom of this kind of self-defeating behavior. The emotional cost is that the person ends up feeling inadequate, as well as perhaps angering others if is their car he has promised to fix.

Barbaro calls his third theory, “the inner and outer choices.”

The person, he says, needs to determine what other ways of behaving are available to him. For example, the car repair expert may choose to bring the car to a garage, and instead take on another task which he is really capable of doing which will make him feel productive.

The fourth part of Barbaro’s theories is called, “illusive fear.”

He describes that as the element of subconscious fear or “uptightness” which at times causes people to reject doing things they would really like to do.

Through homework people get a chance to analyze their own behavior in terms of the concepts being taught, says Barbaro.

Each student is supplied with forms to fill out to provide material for class work, but it is up to the individual to decide if he or she wants to share the material with the class as a whole.

“It will work even if the person elects not to discuss it with the group,” says Barbaro, who adds “they will get more out of it if they do.”

Doing the exercises, he says, helps people achieve what he calls, “the wholistic effect,” that is, the bringing together of theory and a person’s experience, which allows one to see his or her behavior objectively.

Imagination a tool
As part of this process, Barbaro says he asks students to use their imaginations. Students might be asked to imagine what it would feel like to make a different choice, one which avoids any established self-defeating patterns.

The person who fears rejection and thus turns down party invitations, he asks to imagine what it would be like to accept an invitation.

By this method, in the safe setting of the classroom, the individual can determine what emotions — such as fear, anxiety, or excitement — they might feel if they behaved differently.

Barbaro, who is a member of the staff of High Street Therapy Associates of Amherst, says students from past classes have contacted him to tell him about benefits they derived from the course.

He said their encouragement and the fact that former students recommend the course to relatives and friends convinced him to engage in the project which has become his doctoral thesis.

In the thesis, he says, he will document how the theories he is working with make sense in terms of what happens in his classes.

The cost of providing therapy by this method will be low, he says, because a class consists of 15 people who meet with one teacher for a total 25 hours.

Barbaro says there is a need for low-cost methods, adding that he hopes his work will spread the idea.
APPENDIX B

Materials Sent to Applicants Prior to Selection for Each Group
FIRST MEETING FOR BOTH GROUPS
NOVEMBER 9, 1980 RM. 373 HILLS
CIDER AND COOKIES WILL BE SERVED.
BE SURE TO BRING QUESTIONNAIRES
FILLED OUT AND $25 DEPOSIT.
DEMOGRAPHIC INFORMATION

Check the correct categories....

SEX: female ___ male ___

AGE (fill in): ___

EMPLOYMENT: homemaker ___
employed ___
unemployed ___

YOUR YEARLY INCOME: $0-$2,500 ___
$2,500-$5,000 ___
$5,000-$7,500 ___
$7,500-$10,000 ___
$10,000-$15,000 ___
$15,000-$20,000 ___
$20,000-$25,000 ___
$25,000+$ ___

MARITAL STATUS: single ___
marrried ___
separated ___
divorced ___
living with ___

EDUCATIONAL BACKGROUND: gradeschool ___
highschool ___
college ___
degree and years of graduate school ___

ARE YOU: in crisis ___
resolving a crisis ___
not in crisis ___

STRESS LEVEL: high ___
typical for you ___
stress free ___

ETHNIC BACKGROUND: Asian ___
Hispanic ___
Black ___
White ___

* to be kept confidential and to be used by me to match up Group I and Group II. If you have any questions please call John at 256-6940 anytime.

SCHEDULES OF GROUP MEETINGS

Group times will be from 7pm to 9:30pm with ½ hour after class for special questions on weekday nights, and from 12:30pm to 6:30pm on the Sunday meeting.

Please circle any dates on which it will be impossible for you to attend:

SN M Th M Th SN W M Th Th
GROUP I: Nov. 9, 10, 13, 17, 20, 23, 26, Dec. 1, 4, Jan. 29.

SN Th M Th M Th SN T M F
GROUP II: Nov. 9, Dec. 4, 6, 11, 15, 18, 21, 23, 29, Jan. 2.

ATTENDANCE is as crucial to your growth as it is to my doctoral study. The $20 refund is contingent on complete attendance.

The FIRST meeting for both groups will be Sunday, November 9th, at 7pm to 9:30pm. Be sure to bring with you both Associate Questionnaires filled out, the rest of the material found in this packet, and the $25 deposit to rm. 1171 Hills South, UMass.

PLEASE COMPLETE THIS PAGE, PUT IT IN ENVELOPE PROVIDED, AND PUT IN THE MORNING MAIL. YOUR ENROLLMENT DEPENDS ON THE TIMELY RECEIPT OF THIS INFORMATION.
PARTICIPANT INFORMED CONSENT FORM

I understand that I am participating in a study of the effectiveness of a group process designed to help people overcome self-defeating behavior. The process involves learning material presented by the facilitator, analyzing my behavior according to that material at home and during meeting times, and attending 25 hours of group meetings. Similar results might be obtained from longer term individual work with a counselor or psychotherapist especially if one felt more comfortable in that setting.

I understand that my part in the study involves my taking various paper and pencil tests, and that there will be three of these that will be completed three times by me; once at the beginning of the group meetings, once at the end of the group meetings, and once again either following or preceding the group meeting series. I realize that the tests and test scores will be confidential because I will be using a code and because only the facilitator will have access to each participant's code. I understand that I may be assigned to either Group I or Group II (which meets five weeks after Group I begins). All potential members of both groups must meet November 6th at 7pm (until 9:30 approximately), room 373 Hill's South, UMass. I understand that membership in either group is not guaranteed until I've paid my deposit.

I understand that part of the requirement for participation in either group is to have two associates (friends, relatives, or people around me often) complete a consent form such as this one, and complete a questionnaire three times, over the length of this study. The questionnaire my associates are to complete deals with my self-defeating behavior as they perceive it and will be kept confidential even from me. I realize that I must take the completed consent forms and questionnaires (sealed in the envelopes provided) from my associates to the facilitator.

I understand that if I have any questions concerning the questionnaire or study I can ask the facilitator (John Barbaro, 256-69-40), and I understand the third administration of the measures for Group II my scores can be obtained from the facilitator.

I understand the facilitator's research and my own optimum growth depend on my complete attendance, and I agree to go to all meetings and to complete the three administrations of the measures. I realize that $25 is required as a deposit before I can be enrolled in either group, and that upon completion of all meetings and tests (including the completion of the three questionnaires by my associates) $20 will be returned to me. Excepting for the loss of the $20 rebate, I realize that there will be no penalty for my withdrawal at any point.

participant's signature ______________________ date ______________________
participant's name (please print) ______________________

PLEASE SIGN THIS AND RETURN IT WITH THE DEMOGRAPHIC FORM. THANKS.
Participant Self-Defeating Behavior Questionnaire

Instructions. A self-defeating behavior (SDB) is any REPEATED behavior that interferes with your attaining your goals, or impedes your getting what you really want from living. The SDB's can occur inside (such as thoughts, daydreams, feelings like boredom or sleepiness, etc.) or outside of you (such as failing to start, or to finish, projects, avoiding people you are interested in, being late, etc.).

Below are separately numbered sections where you are to describe, as precisely as you can, your SDB's. The number for each section will hereafter refer to the SDB listed under that number. So when you see number 3, on page two of this questionnaire, that is referring to SDB number 3, listed below.

A) LIST YOUR SDB's AT THIS POINT IN YOUR LIFE:

1. What is your SDB?
   How does it happen?
   When does it usually happen?
   Where does it usually occur?
   Who is usually involved?

2. What is your SDB?
   How does it happen?
   When does it usually happen?
   Where does it usually occur?
   Who is usually involved?

3. What is your SDB?
   How does it happen?
   When does it usually happen?
   Where does it usually occur?
   Who is usually involved?

4. What is your SDB?
   How does it happen?
   When does it usually happen?
   Where does it usually occur?
   Who is usually involved?
B) CHECK OFF THE RELATIONSHIPS IN WHICH THE LISTED SEX OCCURS:

<table>
<thead>
<tr>
<th>Intimate Relationships</th>
<th>Work Relationships</th>
<th>Social Relationships</th>
<th>When Alone</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

C) CHECK OFF HOW OFTEN THE LISTED SEX OCCURRED THIS PAST WEEK:

1. 0   | 1-3   | 4-6  | 7-9  | 10-12  | 13-15  | 16-18  | 19-21  | 22-24  | 25+     |
2. 0   | 1-3   | 4-6  | 7-9  | 10-12  | 13-15  | 16-18  | 19-21  | 22-24  | 25+     |
3. 0   | 1-3   | 4-6  | 7-9  | 10-12  | 13-15  | 16-18  | 19-21  | 22-24  | 25+     |
4. 0   | 1-3   | 4-6  | 7-9  | 10-12  | 13-15  | 16-18  | 19-21  | 22-24  | 25+     |

D) CHECK OFF HOW SERIOUSLY THE LISTED SEX AFFECTS YOUR LIFE:

<table>
<thead>
<tr>
<th>No Effect</th>
<th>Slight Effect</th>
<th>Moderate Effect</th>
<th>Serious Effect</th>
<th>Very Serious Effect</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

approximate time to complete ____
ASSOCIATE INFORMED CONSENT FORM

I understand that I am assisting my friend, relative, or colleague, to participate in a group process designed to help people overcome self-defeating behavior, and that this process is being studied for its effectiveness (as part of the facilitator's doctoral research). My part in the process is only to sign this form, and then to complete a questionnaire about my associate three times over the next ten weeks or so (previous estimates by associates state completion of the questionnaire takes from 10 to 20 minutes). I will put the questionnaire in the envelope provided, seal it and give it to my associate to return to the facilitator. I understand that these questionnaires are kept confidential even from my associate. I realize that I am free to relate the information I put on the questionnaire to my associate at any time if I wish.

The subject of the questionnaire is my associate's self-defeating behavior (any behavior that interferes with, or impedes living well), his or her relationships in which these occur, their frequency per week, and their seriousness.

I understand that if I have any questions concerning the questionnaire I can ask the facilitator (John Barbaro, High Street Therapy Associates, 46 High Street, Amherst, MA. 01002, 413-256-69-0) in person or by phone or mail.

I understand that the facilitator's research and my associate's continuing participation in the group process (and thus his or her $20 rebate) depend on my completing all three administrations of the questionnaire. I understand the last two administrations of the questionnaire will take half the time to complete as the first one. I realize that excepting the sacrifice of my associate's $20, there will be no penalty for my withdrawl from this study at any point.

signature_________________________ date________________________
name (please print)_____________________________
phone or address_____________________________
my associate's name_____________________________

PLEASE SIGN THIS, COMPLETE THE QUESTIONNAIRE, AND PLACE BOTH
IN THE ENVELOPE AND SEAL IT. THANKS.
Associate Self-Defeating Behavior Questionnaire

Instructions: A self-defeating behavior (SDB) is any REPEATED behavior that interferes with, or impedes your gaining what you really want from life. The SDB's can occur inside (thoughts, daydreams, feelings like boredom or sleepiness, etc.) or outside of you (failing to start, or to finish, projects, avoiding people you are interested in, being late, etc.).

Below are separately numbered sections where you describe, as precisely as you can, what you perceive as your associate's self-defeating behaviors. The number of each section below will (on page two) refer to the SDB you listed in that section. Thus: when you see number 3 on page two of this questionnaire, 3 refers to SDB number 3 listed below.

A) LIST YOUR ASSOCIATE'S SDB'S AT THIS POINT IN HIS OR HER LIFE:

1. What is the SDB?
   How do you notice it?
   How does your associate do it?
   When does the SDB usually happen?
   Where does the SDB usually happen?
   Who is usually involved?

2. What is the SDB?
   How do you notice it?
   How does your associate do it?
   When does the SDB usually happen?
   Where does the SDB usually happen?
   Who is usually involved?

3. What is the SDB?
   How do you notice it?
   How does your associate do it?
   When does the SDB usually happen?
   Where does the SDB usually happen?
   Who is usually involved?

4. What is the SDB?
   How do you notice it?
   How does your associate do it?
   When does the SDB usually happen?
   Where does the SDB usually happen?
   Who is usually involved?
B) CHECK OFF THE RELATIONSHIPS IN WHICH THE LISTED SIB OCCURS:

<table>
<thead>
<tr>
<th>Intimate Relationships</th>
<th>Work Relationships</th>
<th>Social Relationships</th>
<th>When Alone</th>
</tr>
</thead>
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<td></td>
<td></td>
<td></td>
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<td></td>
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<td></td>
</tr>
</tbody>
</table>

C) CHECK OFF HOW OFTEN THE LISTED SIB OCCURRED THIS PAST WEEK:

1. 0 _ 1-3 _ 4-6 _ 7-9 _ 10-12 _ 13-15 _ 16-18 _ 19-21 _ 22-24 _ 25+ _
2. 0 _ 1-3 _ 4-6 _ 7-9 _ 10-12 _ 13-15 _ 16-18 _ 19-21 _ 22-24 _ 25+ _
3. 0 _ 1-3 _ 4-6 _ 7-9 _ 10-12 _ 13-15 _ 16-18 _ 19-21 _ 22-24 _ 25+ _
4. 0 _ 1-3 _ 4-6 _ 7-9 _ 10-12 _ 13-15 _ 16-18 _ 19-21 _ 22-24 _ 25+ _

D) CHECK OFF HOW SERIOUSLY THE LISTED SIB AFFECTS YOUR FRIEND'S LIFE:

<table>
<thead>
<tr>
<th>No Effect</th>
<th>Light Effect</th>
<th>Moderate Effect</th>
<th>Serious Effect</th>
<th>Very Serious Effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
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<tr>
<td>2.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

approximate time to complete ___
APPENDIX C

Listing of Four Demographic Variables
by Participant Code for Group I
and Group II
<table>
<thead>
<tr>
<th>GROUP I</th>
<th>GROUP II</th>
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</thead>
<tbody>
<tr>
<td>1. XYZAB</td>
<td>1. THRAS</td>
</tr>
<tr>
<td>Education 3</td>
<td>Education 3</td>
</tr>
<tr>
<td>Age 36</td>
<td>Age 36</td>
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<tr>
<td>Ethnicity 3</td>
<td>Ethnicity 4</td>
</tr>
<tr>
<td>Sex 2</td>
<td>Sex 2</td>
</tr>
<tr>
<td>2. ZBYX</td>
<td>2. EBANO</td>
</tr>
<tr>
<td>Education 3</td>
<td>Education 2</td>
</tr>
<tr>
<td>Age 23</td>
<td>Age 20</td>
</tr>
<tr>
<td>Ethnicity 4</td>
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<td>Sex 2</td>
<td>Sex 1</td>
</tr>
<tr>
<td>3. PETRA</td>
<td>3. MITCH</td>
</tr>
<tr>
<td>Education 3</td>
<td>Education 3</td>
</tr>
<tr>
<td>Age 23</td>
<td>Age 24</td>
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<td>Ethnicity 4</td>
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<tr>
<td>Sex 2</td>
<td>Sex 1</td>
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<tr>
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<td>4. HOHOM</td>
</tr>
<tr>
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</tr>
<tr>
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<td>Age 29</td>
</tr>
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<td>Ethnicity 4</td>
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<td>Sex 2</td>
<td>Sex 2</td>
</tr>
<tr>
<td>5. CISUM</td>
<td>5. SHANE</td>
</tr>
<tr>
<td>Education 4</td>
<td>Education 4</td>
</tr>
<tr>
<td>Age 31</td>
<td>Age 33</td>
</tr>
<tr>
<td>Ethnicity 4</td>
<td>Ethnicity 4</td>
</tr>
<tr>
<td>Sex 2</td>
<td>Sex 2</td>
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<td>6. ALCDS</td>
<td>6. ILACE</td>
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<tr>
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<td>Sex 1</td>
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<td>7. JRKAW</td>
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<tr>
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<td>Sex 1</td>
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<tr>
<td>8. QJAGM</td>
<td>8. POPPY</td>
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<tr>
<td>Sex 2</td>
<td>Sex 2</td>
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<tr>
<td>9. JAIME</td>
<td>9. HOPSE</td>
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<tr>
<td>Age 29</td>
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<td>Sex 2</td>
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<td>Sex 1</td>
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</tbody>
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**KEY**

<table>
<thead>
<tr>
<th>EDUCATION</th>
<th>AGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 = Grade School</td>
<td>As printed</td>
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<tr>
<td>2 = High School</td>
<td></td>
</tr>
<tr>
<td>3 = College</td>
<td></td>
</tr>
<tr>
<td>4 = Graduate School</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ETHNICITY</th>
<th>SEX</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 = Asian</td>
<td>1 = Male</td>
</tr>
<tr>
<td>2 = Hispanic</td>
<td>2 = Female</td>
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<tr>
<td>3 = Black</td>
<td></td>
</tr>
<tr>
<td>4 = White</td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX D

Materials Used by Participants During the Treatment Procedure
Self-Defeating Behavior Change Facilitation Form

Concept 1
A. List your self-defeating behaviors (SDB's):
   1. 
   2. 
   3. 
   4. 

B. List the ways you disown responsibility for your SDB's:
   1. 
   2. 
   3. 
   4. 

C. List the personal cost to you when you do your SDB's:
   1. 
   2. 
   3. 
   4. 
   5. 

Concept 2
A. Write your internal choice that determines whether or not you will defeat yourself
   (It might help to start the sentence with "Do I dare find out..."):

B. Write the illusory fear you would face if you stopped doing your SDB's (this should
   be similar to what you wrote on the Internal Choice Facilitation Form, number 4.):

Internal Choice Facilitation Form

1. What are the external choices you make, carrying out the intent of the SIB internal choice (same as the SIB's you wrote on the SIB form only start each one with "I choose to...")?
   a. 
   b. 
   c. 
   d. 

2. Briefly list the negative things which happened to you early in your life (these laid the groundwork for your starting to use SIB's to cope):
   a. 
   b. 
   c. 
   d. 

3. What are the conclusions you made based on these negative events you experienced in your past?
   a. 
   b. 
   c. 
   d. 

4. What are the fears you have in letting go of all your SIB's?
   a. 
   b. 
   c. 
   d. 

5. State clearly and simply your inner choice or choices (the statement would start "Do I dare find out if I..." and would challenge statements made above).

name_________________________ date_________________________
