

EFFICACY STUDY OF BRIEF MORITA THERAPY
INTERVENTION WITH SHY ADOLESCENTS

by

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ABSTRACT

The study examines the change effect of brief Morita counseling, based on Morita therapy, as an intervention with shy adolescent females ($n = 12$). The design used was a multiple-baseline across subjects with a time lag for treatment intervention. Subjects were selected from the mainstream student body at a Vancouver secondary school following screening with the Cheek and Buss (1981) Shyness Scale used in identifying shyness in individuals. Eligible students were randomly assigned to one of three groups each consisting of four subjects. The intervention consisted of 4 - 45 minute instructional-type group counseling sessions conducted over a 4-week period. Repeated measures were administered bi-weekly throughout the study period of 14 weeks. Clearly noticable changes in the positive direction occurred for the majority of subjects on almost all subscales. Subjects in the post-intervention phase reported greater coping effectiveness in their target situations, greater acceptance of their shy nature, less intensity of, and disturbance by anxious feelings and less difficulty in taking desired action despite anxiety. Behavioral counts taken pre- and post-intervention also support the positive change findings. Implications for further research are discussed.

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CHAPTER I

INTRODUCTION

This study aims to explore the experience of shyness for adolescent females and to assess the efficacy of Morita counseling, as an intervention, in addressing this problem.

I Background

Morita therapy, is a Japanese approach to treating self-focused, anxiety-ridden clients, and was developed in Japan by Dr. Shoma Morita in the early part of this century. The therapy's underlying foundation is an understanding and acceptance of anxiety as a normal and potentially useful human emotion. Instead of viewing anxiety as a personal weakness or as a drawback to social functioning, clients are encouraged to take a positive stance, accepting their anxious nature as an indication of their sensitivity to life and their desire for social participation. Another tenet of Morita therapy is that despite anxiety one still has choice of action taking, that is, the individual cannot control emotions willfully but can control behavior. Through appropriate action taking, the client of Morita therapy is empowered to constructively participate in life instead of withdrawing into non-productivity and isolation.

Morita counseling, firmly based on Morita therapy, has been promoted by Ishiyama (1986a, 1986b) in what he refers to as "the positive reinterpretation technique". This counseling intervention promotes clients' greater understanding and insight into the nature of emotion and simultaneously helps them appreciate their potential for productive living.

In applying Morita counseling as an intervention, the therapist is not aiming to rid the client of anxiety but rather to have them become constructive, self-valuing individuals despite their anxious nature. The Morita therapist uses a combination of empathic and didactic techniques and behavioral instruction in helping the client positively reinterpret their self-preoccupied and egocentric focus stemming from shyness and social anxiety symptoms. With increased self-focus, clients become mood-based and neglect attending to the tasks at hand leading to ever decreasing social participation.

Morita therapy has proved successful in treating anxiety-type emotional and behavioral problems including shyness both in Japan and in the West (Ishiyama, 1986; Kawai & Kondo, 1960; Miura & Usa, 1970; Morita, 1926/1974; Suzuki & Suzuki, 1977; Reynolds, 1976). Studies using brief, or single session Morita treatment have been successful in showing improvement in socially anxious Western clients (Ishiyama, 1983, 1986c, 1987b). In Ishiyama's (1983) study, where only one treatment session was used, a follow-up

observation one year later revealed no relapse in the client's former problem of test anxiety. Since Morita treatment the client continued on a positive trend. In other of Ishiyama's studies (1984b, as few as three counseling sessions resulted in clear therapeutic change, where qualitative changes, as reported by subjects, were consistent with objective findings. Longitudinal studies in Japan involving clients treated on either an in- or out-patient basis has shown definite positive change as observed 18 years following treatment (Suzuki & Suzuki, 1977; Suzuki, Kataoka & Karasawa, 1982). Many of these clients were originally severely handicapped by their nervous, self-focused conditions and were now able to lead productive lives despite their shy sensitive nature.

II Rationale

During adolescence the individual is exploring boundaries and is in the process of forming an individual identity. This developmental stage is a period of accentuated self-focus with heightened anxiety and self-consciousness. Exploration and introspection necessarily form part of this process. It can easily be understood how peer evaluative feedback and the adolescent's own self-evaluation could contribute to nervousness and performance anxiety leading to withdrawal and diminished social involvement. Zimbardo (1974) and other researchers have

reported the common occurrence of shyness amongst adolescents. He states that over 50% of North American adolescents claim to be shy as opposed to 40% of the adult population. It would appear that the adolescent group could greatly benefit from guidance and instruction pertaining to the emotional self and its nature and the knowledge that individual choice is always an option despite the presence of anxiety. Research on Morita therapy with Western clients is limited, and as to the involvement of adolescents in this particular type of research it is non-existent.

III Aim

The primary aim of the present study is to test if an instructional model of brief Morita counseling is effective in helping shy adolescent females to overcome their shyness-related emotional and behavioral difficulties. Possible implications of the study is in promoting an insightful and applied approach to adolescent shyness/social anxiety counseling and possibly bring about some needed changes in the practice of counseling shy persons. Professionals working with adolescents both in the school system and in community agencies may find within Morita counseling a new direction in dealing with this common problem area.

The present study is conducted by way of a multiple-baseline design across subjects. A time-lag of 1 week between 3 groups of subjects for treatment intervention is

in place. The intervention is 4-Morita counseling sessions conducted over a four week period. Self-report repeated measures were taken bi-weekly throughout the entire 14-week duration of the study. In addition, behavioral counts were recorded by subjects for 2, 5-day periods Pre- and Post- Intervention. Individual follow-up interviews were conducted by a research assistant approximately 3 weeks following the last observation point.

CHAPTER II

REVIEW OF RELATED LITERATURE

I INTRODUCTION

Shyness (Franco, Christoff, Crimmins, & Kelly, 1983; Zimbardo, 1977) and heterosocial anxiety (Arkowitz, Hinton, Perl & Himadi, 1978; Leary & Schlenker, 1981) have been identified as two specific problems for adolescents. Buss (1980) defines shyness in terms of one's reaction to being with strangers or casual acquaintances: tension, concern, feelings of awkwardness and discomfort and both gaze aversion and inhibition of normally expected social behavior. Shyness is also defined as , "... a tendency to avoid social interactions and to fail to participate appropriately in social situations", (Pilkonis, 1977b, p.596). Viewed in this manner, shyness can be seen as a form of social anxiety and social avoidance (Buss, 1980; Leary, 1983a). Another dimension of shyness is put forth by Buss (1980) who defines self-consciousness shyness as an acute awareness of oneself as a social object, involving a feeling of excessive exposure to the scrutiny of others.

In the period of adolescence with its generally increased levels of self-preoccupation and egocentric reasoning, one way in which shyness and heterosocial anxiety are translated is in cognitive self-focused negativity and

reluctance to take action (Csikszentmihalyi & Larson, 1984; Hansell et al, 1986; Kegan, 1982). Cognitive self-focused negativity that is, dwelling on one's negative thoughts and perceptions, is manifested in negative interpretation of anxiety, low degree of acceptance of the anxious self and diminished coping effectiveness in social situations (Ishiyama, 1984). According to Alden and Cappe (1986), shy individuals appear to be preoccupied with others' acceptability of their behavior leading to ongoing self-observation and evaluation which often results in negative assessment. Alden and Cappe (1986, p.343), wrote, "It is not surprising that this self-focused attention and negative self-evaluation increases anxiety and behavioral inhibition". In successfully accomplishing the developmental task of forming peer relationships (Kegan, 1982) the socially anxious adolescent must move through this cognitive and behavioral negativity in order to take the initial steps in initiating social interaction with others.

II SHYNESS/SOCIAL ANXIETY IN ADOLESCENTS

The adolescents' view of themselves and the world is in the process of on-going change. In the short five years from ages 13 to 17, one may observe significant maturation occurring (Kegan, 1982; Garbarino, 1985; Erikson, 1959) which, in turn, has an impact on personal character trait development and behavior. During this period, the individual

is in a state of developmental transition which necessarily involves a loss of one's organization (Kegan, 1982), and the stability and security it affords. A key stage for adolescents is identity formation (Erikson, 1959; Garbarino, 1985; Marcia, 1980). Success at this developmental stage is crucial if the adolescent is to move on to the developmental task of establishing intimacy in a mutually trusting life relationship (Grotevant, Thorbecke & Meyer, 1982). Erikson (1959) stated that affiliation with peers provides many of the essential experiences and opportunities for self-definition needed for the formation of identity. Further to this, Ornstein and Sobel (1988) proposed that the need for community is a key part of our evolutionary heritage and assists greatly in keeping us healthy. It is social interaction that brings about cognitive growth, particularly the ability to defocus and establish the self as separate from others (Piaget, 1952).

In this process of necessary interaction with others, a process usually diminished in shy adolescents, adaptation occurs. According to Garbarino (1985), adaptation takes place by way of two continually functioning complementary processes which are assimilation and accommodation. Hill (1980a, 1980b) proposes that successful adaptation involves the coordination of our changing selves and our changing contexts which is particularly critical in early adolescence. Thus the great need for the development of flexibility in social interaction by way of social

participation. According to Garbarino (1985), the interplay of organization and adaptation is what is responsible for intellectual development. Consequently, it can be readily seen how important is the establishment of social contact and inclusion in community. For the adolescent to allow the shy/anxious problem to inhibit the formation of these contacts results in critical and far-reaching effects. Cheek et al (1986) conclude that shyness is strongly associated with low self-esteem and that the experience of depression correlates with self-reports on loneliness in adolescents at a slightly higher level than found in college students. Cheek et al (1986) report that this affects dating in a negative way. According to Friedman (1980) and Ishiyama (1984, 1986b), shyness can sometimes interfere with success in academic achievement.

In addition to identity formation, social interaction and cognitive growth, the developing moral judgement of the child has the potential for creating a bias in measurement. If, as according to Piaget (1932), the maturing child takes rules literally and views good only in terms of obedience, he/she will evaluate acts not in accordance with the motive that has prompted these acts but in terms of how these acts conform with established rules. This is a recognized weakness of self-report measures as they rely solely on the individual's concept, understanding and observation/report skills in order to set forth a clear picture of internal

processes (Cheek & Buss, 1981; Clark & Bolton, 1984; Rapoport et al, 1981).

III SOCIAL ANXIETY STUDIES INVOLVING FEMALE SUBJECTS

It appears that relatively little research has been conducted on the topic of female social anxiety (Maccoby & Jacklin, 1975). Subjects involved in the following studies were college age females, none involved adolescents only. O'Banion and Arkowitz (1977) conducted a study involving 560 single college women on social anxiety and selective memory of others' evaluative information about self. They found that high socially anxious women selectively remember negative information about themselves better than low anxious ones. And, according to Clark and Arkowitz (1975), processing information about oneself in such a way as to selectively remember negative information is likely to be associated with negative self-evaluations.

Fenigstein (1979) measured 92 females involved in two studies on self-consciousness, self-attention and social interaction. He confirmed the hypothesis that persons high in self-consciousness would be more aware of how they are perceived by others, more sensitive and react more negatively to rejection than those low in self-consciousness.

A study on 45 females in relation to the modification of shyness-related social behavior through symptom

misattribution was conducted by Brodt and Zimbardo (1981). By misattributing social anxiety to an external source (high frequency noise), they found that shy females showed both verbal and behavioral responses comparable to the not-shy females in the study. Observer, self-report and psychological measurements indicated that misattributing arousal (social anxiety) to an external source can alter social behavior in a specific way, in this case, a positive way.

Here it can be seen that increased anxiety in females tends toward increased negative self-evaluation and thus the need of a therapeutic approach that addresses the positive acceptance of social anxiety. As is indicated, there is little research to draw upon involving the female population, especially adolescent females, which explores their anxiety experiences.

IV RELATED RESEARCH INVOLVING ADOLESCENTS AS SUBJECTS

Very few publications seem to be available on issues dealing with adolescents as research subjects such as in the interplay of developmental issues, reliability and stability of self-report and commitment and attrition in this age group. The following studies focus on group training, self-report and need for research of this population.

Christoff et al (1985) conducted a study on shy adolescents groups using a multiple baseline design where

the intervention sessions, within a school setting, were conducted sequentially across time. The intervention proved effective in producing socially significant behavioral change in peer relationships. The study revealed an increased frequency of daily interactions, more positive reports of social interaction skill and more positive patterns of self-evaluation. However, part of the results indicated less than clear change and it was suspected partly that fluctuation in lunch-time habits based on weather change could be accountable for this.

A survey study done by Ishiyama (1984) involved shy and non-shy groups of adolescents (based on shyness self-rating) of ages 14-16 years. Ishiyama's (1984) results pointed out how adolescents have different ways of processing the shyness experience. Using questionnaire and checklist, it was found that the shy group reported significantly more negative experiences than did the non-shy in loneliness, interference of shyness in academic success, and with developing friendships with peers and with the opposite sex. This population seems to be a prime one for the application of Morita therapy in helping them understand their shyness, sparing them the grief of painful isolation that this condition can bring and helping them nurture a more positive self-evaluation through appropriate action-taking. One of the most extended studies conducted on adolescents is that by Hansell, Mechanic and Brondolo (1986). The study compared introspectiveness and adolescent development to specifically

examining introspectiveness and health. Level of depression was one reflection of level of health. Subjects surveyed over three years included 1,236 adolescents of mixed cultural background in the 7th, 9th, and 11th grades. Age and introspectiveness were slightly but positively correlated. Females scored slightly higher on introspectiveness than males. Subjects with higher introspectiveness scores reported more depression, more anxiety and females reported greater depression than did males.

The results suggest that developmental discontinuities, other kinds of discontinuities such as family problems, difficulties with school or peers, accidents and illness and parents may be sources of adolescent introspectiveness leading to depression. This appears particularly true for female adolescents. Alden and Cappe (1986) state that from their clinical experience 40% of clients seeking treatment for shyness have significant levels of depression.

Despite the limited amount of published literature on adolescents, Lerner (1981) foresees an increased focus on research on the adolescent population due to, "...transitions in biology, cognition, personality, social relations and emotions that occur at this time of life" (p.259). He is optimistic that funding patterns will be affected by the need to study this group due to increases in teen pregnancy, incidences of venereal diseases, and unwed

motherhood. He concludes that this group will no longer be victimized by scientific neglect.

V RESEARCH STUDIES ON MORITA THERAPY

Studies carried out in Japan have already confirmed the efficacy of Morita therapy with shy/socially anxious adult clients (Suzuki, Kataoka & Karasawa, 1982; Suzuki & Suzuki, 1977). In outcome studies significantly high improvement rates have been shown (Suzuki & Suzuki, 1977; Suzuki, et al. 1982). These authors, in each of their studies, surveyed approximately eight hundred and fifty former inpatients who had been treated with Morita therapy for self-focused/neurotic conditions. In Suzuki & Suzuki's (1977) study ,of the 815 questionnaires sent out to patients discharged at least 6 months previous, those cured of neurosis and those not completely cured but still able to lead normal lives comprised 70.1%. In the same publication two case studies were presented and a follow-up of 18 years in one and 4 years in another showed similar sustained positive change. In the Suzuki et al. (1982) study, a follow-up 8 years after admission produced significant improvement in 90% of former inpatients treated with Morita therapy. The mean time required for improvement was 42.5 months. These results lend clear support not only to Morita therapy's efficacy in the short term but also to its sustained effect in treating clients with nervous/anxiety disorders.

An important contribution to the effective application of Morita therapy in the West was made by Ishiyama (1986b) in the introduction of the "positive reinterpretation technique" (see Appendix 5), whereby anxiety is shown to be a natural human experience and can be viewed as a signal reflection one's desire for social involvement. The idea that accepting anxiety and not fighting it, and thus opening up a possibility for choice of action taking, seems a concrete approach in helping socially anxious clients particularly shy adolescents. Would the adolescents in the present study reflect a higher acceptance of their feelings of shyness and gain a more positive attitude towards their shy nature? Several studies conducted by Ishiyama (1983, 1985, 1986c) have produced evidence of positive change in socially anxious clients incorporating the "positive reinterpretation technique" in the application of Morita therapy. Two were single case studies (1983, 1986c) one in which a client suffering from test anxiety showed ready and significant improvement, sitting for an examination without her former immobilizing stress one week after her single Morita intervention. The another involved a client experiencing anxiety when speaking in groups or to strangers. The results showed clear therapeutic changes (as reflected in repeated self-report measures and in qualitative reports) after the Morita intervention when the client became more accepting of her anxiety and viewed herself as better able to cope with her target problems.

Another study yielding definite therapeutic change involved two groups, $n=10$, a Morita therapy intervention group and an empathy-based control group (Ishiyama, in press). All subjects were adults. Not only were positive changes seen post-intervention, which consisted of 1 to 3 brief sessions, but were also shown to have lasting effects. In the single study case (Ishiyama, 1983) the change remained evident one year later thus showing this therapy's potential for carry-over positive effects.

Morita therapy has been applied to other than nervous/anxious clients as in the reports by Levine (1987) and Ogawa (1988). In a clinical report, Levine (1987) explores the use of Morita therapy in the treatment of bulimia with female clients. Positive outcomes are related as these clients were able to change focus from nervous self-preoccupation to making choices for productive living. The author states that one use of Morita therapy is to help create a position of calm centeredness from which clients can make responsible choice of focus. This could also apply to shy adolescents. It would be of interest to observe if the subjects in this study would establish a position akin to calm centeredness from which they could make constructive choices, for example, in coping more effectively in their shy situations. Similarly, Ogawa (1988) describes his application of Morita therapy to counseling victims of sexual assault. The focus is on helping the client accept feelings and in directing her in concrete ways to deal with

reality. Would the adolescents in the present study gain from the Morita intervention such that they would experience less difficulty in taking desirable action in their shy situations?

In addition to its application specifically to the above types of clients Morita therapy as proposed by Reynolds (1976, 1984, 1986), a leading proponent of Morita therapy in the West, describes how this approach can be employed as a life practice for increased constructive living for the average population. Reynolds (1984) has applied the principles of Morita therapy in the context of everyday life demonstrating, through case studies, Morita therapy's value for enhancing productive living in all individuals whether or not they suffered from shyness. Is it possible then that the Morita intervention would help adolescents in the study decrease the degree of their overall social anxiety and increase their confidence in their shy situations?

VI SUMMARY OF LITERATURE

Shyness has been defined as a form of social anxiety and social avoidance; an awareness of self as a social object exposed to the scrutiny of others and as failure to participate. Because adolescence is a period of marked self-preoccupation, shyness is commonly expressed in self-focused negativity and reluctance to take action (Csikszentmihalyi &

Larson, 1984; Hansell et al, 1986; Kegan, 1982). According to Ishiyama (1984), negative thoughts result in negative interpretation of anxiety, less acceptance of the anxious self and decreased ability to cope effectively in social situations.

In studies conducted with adolescents as subjects (Erikson, 1959; Ornstein & Sobel, 1988; Piaget, 1952) the process of adaptation takes place through social interaction with peers and adults. Social participation can thus be understood to play a crucial role in adolescent development. Garbarino (1985) goes so far as to state that intellectual development is closely related to success achieved in the establishment of social contact and inclusion in community. If shyness is permitted to inhibit these developments one can speculate on the critical and far-reaching effects on the growing individual.

Research (Clark & Arkowitz, 1975; Fenigstein, 1979; O'Banion & Arkowitz, 1977) has shown that socially anxious females appear to have accentuated sensitivity to evaluation by others and react more negatively to rejection than low anxious females. An extended study by Hansell, Mechanic and Brondolo (1986) showed females scoring slightly higher on introspectiveness than males and those higher in introspectiveness reporting more depression and anxiety. Female subjects were chosen for this present study partly in an attempt to observe more clearly Morita counseling's

effects on negative self-evaluation and reported levels of anxiety.

The participation of adolescents in research studies appear to be rather limited. Christoff et al's (1985) study produced socially significant positive behavioural change in peer relationships, that is, increased daily interactions, more positive reports on interaction skill and more positive patterns of self-evaluation. Ishiyama (1984) conducted a survey on shy and non-shy adolescents aged 14-16 years and found that the shy subjects reported more negative experiences in loneliness, interference in academic success and developing friendships with peers. Consequently, it can be recognized how an approach such as Morita counseling that encourages increased social participation would be of practical value in promoting more positive life experiences for adolescents.

Two longitudinal studies (Suzuki & Suzuki, 1977; Suzuki et al, 1982) have been conducted in Japan on the efficacy of Morita therapy and both report appreciable improvement for the subjects involved. In the West, studies by Ishiyama (1983, 1985, 1986c) have produced positive change results. The introduction of the "positive reinterpretation technique" (Ishiyama, 1986b) in the application of Morita therapy proved a successful endeavor in having subjects view their shyness/anxiety in a more positive light. Other authors (Levine, 1987; Ogawa, 1988) have applied Morita therapy with observable positive results in areas such as

eating disorders and sexual assault. Reynolds (1976, 1984, 1986) has applied the principles of Morita therapy to promote constructive living by encouraging greater social and purposeful participation in life. There is a gap however, in terms of applying Morita therapy to address the needs, specifically, of adolescents in dealing with social anxiety/shyness. Thus the underlying thrust of this present study attempts to demonstrate successful application of this unique therapy to this particular population with the aim of providing an alternate approach for counselors to use in helping this age group.

VII PURPOSE

The purpose of this study is to investigate how the use of brief Morita Counseling as an intervention, in the form of 4 group counseling sessions, would affect the reported levels of cognitive self-focused negativity and coping effectiveness of socially anxious adolescents. The specific objective is to determine the degree to which Morita Counseling, as a therapeutic intervention, changes the self-reported level of socially anxious cognition and behavior in a group of female adolescents.

VIII HYPOTHESIS

In this study, with the application of Morita therapy in the form of a brief Morita counseling intervention, it is hypothesized that socially anxious adolescent female subjects will show improvement on cognitive and behavioral measures after the treatment intervention. Specifically the subjects will:

(a) show higher acceptance of, and more positive attitudes towards their anxious nature as reflected in increased ratings on acceptability, usefulness, desirability and bearability, of their anxious nature as in Ishiyama's studies (1983, 1986c) - Self and Anxiety Questionnaire (Appendix 1).

(b) report higher coping effectiveness in their ways of dealing with anxiety provoking situations (target situations) as in Levine's report (1987) - Self and Anxiety Questionnaire.

(c) report a decrease in overall anxiety severity as in Reynolds' reported cases (1976, 1984, 1986) - Target Complaint Inventory (Appendix 1).

(d) show higher acceptance of own anxious nature in target situations as in Ishiyama's studies (1983, 1986c) - Self and Anxiety Questionnaire.

(e) show less difficulty in initiating desirable action in the target situations as in Ogawa's report (1988) - Target Complaint Inventory.

(f) report increased confidence in entering the target situations and carrying out desirable action as in Reynolds'

reported cases (1976, 1984, 1986) - Target Complaint Inventory.

(g) be less bothered by their anxiety problem as in Ishiyama's studies (1983, 1986c) and Reynolds' reported cases (1976, 1984, 1986) - Target Complaint Inventory.

CHAPTER III

METHODOLOGY

I Rationale and Brief Description

The experimental study was conducted by way of a multiple-baseline design across three groups of subjects time-lagged for treatment intervention (Hayes 1981, Hersen & Barlow, 1976). The treatment intervention for all three groups was Morita counseling sessions. Such a design involves serial observations over time to assess changes in trend and level for the subjects in each group as well as changes in trend and level for each group as a whole in response to intervention (Hersen & Barlow, 1976). Clinical researchers have used this method to observe individual change over time.

With time-lagged for treatment intervention some threats to internal validity that interfere with the drawing of valid inferences, (Cook & Campbell, 1979; Kazdin, 1981) can be controlled. Such threats as history in terms of external events, maturation (e.g., spontaneous improvements), testing, instrumentation, statistical regression, subject selection, attrition and interaction of selection and maturation were effectively taken into account in this way (Campbell & Stanley, 1966). The major question asked in this experiment is, "Does this treatment work?"

The three systematically staggered points of treatment intervention also enhanced external validity due to the treatment intervention being used with more than one population and in more than one setting (Cook & Campbell, 1979). Each phase of the study had a minimum of eight baseline data points as recommended by Tryon (1982) to encompass any stochastic effects. The last phase was extended to ensure permanence of the treatment effects and an attempt was made to address the role of attention placebo in the baseline phase (Hersen & Barlow, 1976). This element is a common threat in psychotherapy research whereby the therapist's presence and active listening alone, as discussed by Rogers (1951), can result in client improvement.

Due to the ethical concerns, sequential withdrawal or reversal of treatment effects (Hayes, 1981; Hersen & Barlow, 1976), were not used in the present study.

II Subjects

Females were chosen as subjects in this study in order to eliminate gender differences in terms of social interrelating. Doyle (1985, p.312) states that women learn assertiveness from other women and have difficulty standing up for their rights in settings involving men. Maccoby and Jacklin (1975) also report that girls, compared to boys, tend to form a coalition more readily with adults as a means

of coping with boy's aggressive dominance which they do not accept. Lastly, there seems to have been a neglect of female participants in social science research with preference traditionally being given to male subjects (Carlson & Carlson, 1960; Greenglass & Stewart, 1973; Pyke, et al, 1975).

The subjects were selected from Kitsilano Secondary School, one of Vancouver's large high schools rated, by the school counselors, in the high/lower to middle socio-economic class. The Cheek & Buss (1981) Shyness Scale (see Appendix 2) was voluntarily completed by a total of 65 female students as outlined in Appendix 11. From this pool of potential subjects, 12 students were finally screened to serve as subjects for the study. High scores on this scale indicates higher degree of shyness. An arbitrary cut-off score point of 20 was used to determine qualifying students. The resulting 35 qualified students were then seen in groups of approximately 9 students each for the purpose of soliciting volunteers. The result was 31 interested students. Of these, the highest scoring 15 consenting students were selected. Those not chosen were recommended either to various counseling resources or were given the option of participating in one Morita session. This number was reduced to 12 during the soliciting of parental consent. The final 12 subjects were then randomly assigned (Agnew & Pyke, 1987) to one of three groups using a random numbers table (Wilson & Bright, 1952). This number was sufficient to

allow for attrition. The subject's group and grade profile is as follows:

GROUP 1: Grade 8, n=1; Grade 10, n=3

Group 2: Grade 8, n=1; Grade 10, n=3

Group 3: Grade 8, n=1; Grade 10, n=1, Grade 11, n=2

A descriptive analysis of scores on the Shyness Scale is provided (see Table 1 on following page).

Subjects ages ranged from 13 to 17 years. They received a brief explanation that approximately four counseling sessions would be offered by a trained and experienced counselor (the researcher) after a waiting period during which period they would complete seven scales twice weekly.

Due to the nature of the research with its small number of sessions, subjects were told that there may be only limited effects of the treatment. Any subjects currently undergoing psychiatric treatment i.e., drug therapy were excluded from the study. A signed consent form (Appendix 3) was obtained from the subject's parent or guardian and from the student themselves approximately three weeks before initiating the study. The subjects were assured of confidentiality and anonymity.

Subjects in Group 3 deserve special note in that it appears that extraneous variables influenced their profile. It was brought to the attention of this author towards the end of the study (except for information on subject ten) that these subjects were experiencing some unusual events in

TABLE 1

SHYNESS SCALE (Note 1) SCORES of SURVEY STUDENTS
SCREENED for SUBJECT SELECTION

Overall
(all students
screened) : \underline{n} = 65, M= 19.9, S.D.= 5.9, Range= 11-34

Students not
eligible : \underline{n} =34, M= 16.6, S.D.= 6.2, Range= 11-34

Students qual-
ifying but not
included : \underline{n} =19, M= 23.4, S.D.= 4.8, Range= 19-28

Subjects : \underline{n} = 12, M= 24.0, S.D.= 6.6, Range= 20-30

Note 1 Cheek and Buss Shyness Scale (1981)

their lives. It was related by the school counselor and the subject herself that subject nine was recently separated from her father with whom she is close, he having moved away a great distance. Subject ten contracted mononucleosis during the third week of the study and was forced to remain at home for 3 weeks. She insisted on remaining in the study and so was permitted to complete her measures at home. These occurrences seemed to have left the subjects somewhat depressed which possibly influenced the shyness profile. Subject eleven had taken several trips for a week at a time during the study and also hostessed an intensive student exchange during this time. Both of which could have clearly detracted her from the requirements of the study. Subject 12, as related by her parent was demonstrating a marked rebelliousness. Verbally the subject was agreeable but often follow-through was not complete. In summary, all four subjects experienced pronounced interference in their lives during the period of the study and their data are included in the study for additional information rather than excluding the group from the study. It is difficult to state whether the time-lagged baselines of this group were affected by the history variable as there appears to be no consistent trend.

III Analysis of Results

Visual inspection of data was used as conventionally used in time-series research. Changes reflected primarily in the groups' graphs over time are inspected for this efficacy study. Kazdin (1978, p.138), states that, "...the use of statistics with single-case design is controversial". He continues to explain that statistically significant differences do not necessarily mean clinically appreciable improvement. The strength of the visual inspection demonstration derives from showing that performance during a given phase violates the predicted level of performance of the prior phase, (Kazdin, 1974; Tawney & Gast, 1984). Some of the acceptable criteria for relying on visual analysis, according to Ballard (1983), are: (1) that the baseline is stable; (2) the level of slope of data during the treatment phase is "obviously and substantially divergent from that pertaining during baseline" (p.71) and; (3) that the number of data points in each phase does not reach the range of 20 to 50 as needed for statistical analysis (Ballard, 1983).

Therapeutic change, i.e., whether the extent of behavior change during treatment enhances the client's functioning on a daily basis (Risley, 1970), is another way of examining treatment efficacy. According to Miller, (1985), this seems an appropriate method of analysis. Robinson and Foster (1979) state that the histogram is probably the simplest graphical way to present treatment results in a time-series data analysis. Miller (1985) cautions, however, that care must be taken in keeping the

width of each bar equal to avoid giving rise to a false impression of change.

IV Measures

1. Dependent variables measured

Scores on the shyness experience components constitute the dependent variable. These components are as follows: anxiety intensity, difficulty in action taking, level of confidence, degree of emotional disturbance, positive interpretation of the shyness experience, degree of self-acceptance, and effectiveness in coping in the shy situation. Scores were derived from answers checked off on a continuum which was provided with the presentation of each component by way of the following scales. In the graphs, acceptable trend stability is 85%, any percentage below this figure does not allow for generalizations to be made about positive change. Four scales were selected from Ishiyama's Target Complaint Inventory (1987), namely the Anxiety Intensity Scale, Level of Difficulty Scale, Degree of Confidence Scale, and Overall Disturbance Scale, and the remaining three scales derived from the Self and Anxiety Questionnaire (Ishiyama, 1987), namely the Positive Anxiety Interpretation Scale, Anxious Self-Acceptance Scale, and the Coping Effectiveness Scale. These scales were used in previous research studies on Morita therapy's efficacy on anxious clients (Ishiyama, 1985, 1986c, 1987b, 1987c).

Ishiyama's analyses of the scales were based on the data obtained from adult clients. Because a high positive correlation was found between the Positive Anxiety Interpretation Scale and the Anxious Self-Acceptance Scale, and conceptually these two scales overlap each other, they were collapsed into one scale and called the Anxiety Acceptance Scale in this study. Each scale is described here with additional information on the psychometric properties of each scale based on statistical analyses of the data from the adolescent subjects in the present study. The scales from the Target Complaint Inventory used 13 boxes vertically placed with, "not at all", "a little", "moderately", "very", and "extremely" at the first, fourth, seventh, tenth, and thirteenth box from the bottom respectively. The scales from the Self and Anxiety Questionnaire used nine spaces between bipolar adjectives in a semantic differential manner (Osgood, Suci, & Tannenbaum, 1957).

The order of presentation of the measures was varied, resulting in three different formats which were randomly rotated in the process of data collection.

The following 4 scales are from the Target Complaint 13-Box Scale. Battle et al. (1966) reported satisfactory clinical sensitivity and validity, and pre- and post-session reliability (a mean severity rating difference, pre- and post-interview, of .5 on a 13 point scale).

Anxiety Intensity Scale (AIS). This scale is intended to measure anxiety intensity by having the subject respond to

the following question: "How intense are your average anxiety reactions when you enter the shy situation?" by checking off the appropriate box on the continuum.

Level of Difficulty Scale (LDS). This scale is intended to measure the amount of difficulty the subject encounters in taking action in the target situation. The question preceeding the check-off scale is: "How much difficulty do you experience in carrying out a desirable action in the shy situation?"

Degree of Confidence Scale (DCS). In this scale the subject's level of confidence is measured as they anticipate entering the target situation and taking action. The question they must respond to is: "How confident do you feel about entering the shy situation and taking a desirable action?"

Overall Disturbance by Anxiety (ODA). This scale purports to measure how bothered the subject is by the shyness problem. The subject is to respond to the following question:

"Overall, how much does this shyness problem (i.e., emotional discomfort and behavioral difficulty) bother you?"

Positive Anxiety Interpretation Scale (PAIS). The PAIS and the CES described below are the improved versions of the previously used scales which showed high sensitivity to Morita intervention (Ishiyama, 1986c, 1987b). The PAIS is intended to measure the degree of positive attitude towards the anxious nature using semantic differential ratings on 4-adjective pairs (acceptable - unacceptable, useless -

useful, undesirable - desirable, bearable - unbearable). Each pair gives a score range from 1 to 9, and a total score range from 4 to 36. A higher score indicates a more positive interpretation of anxiety. The question accompanying this scale is: "How would you evaluate the anxious or nervous part of your personality that seems to surface in certain anxiety-arousing social situations?" Adequate construct validity with high internal consistency ($\alpha = .96$) has been reported of the scale (Ishiyama, 1987c).

Coping Effectiveness Scale (CES). This scale purports to measure the degree of effectiveness the subject experiences in coping with the anxiety-arousing target situation. The CES consists of six adjective pairs (competent - incompetent, impatient - patient, productive - unproductive, clear-minded - confused, unsuccessful - successful, relaxed - tense). Each bi-polar pair yields a score range from 1 to 9 and a total score range from 6 to 54. A higher score indicates higher effectiveness. The question accompanying the scale is: "How would you describe the way you deal with the anxiety-arousing social situations?" The scale has been found to have adequate construct validity and high internal consistency ($\alpha = .95$; Ishiyama, 1987c).

Anxious Self-Acceptance Scale (ASAS). This scale is intended to measure the degree of self-acceptance of the shy self by the subject when they anticipate becoming anxious in the target situation. Four bi-polar pairs (critical - appreciative, satisfied - dissatisfied, tolerant -

intolerant, pessimistic - optimistic) yield a score range of 1 to 9, and a total score range from 4 to 36. The question accompanying this scale is: "How would you feel toward yourself when you think of becoming anxious in the anxiety-arousing social situations?"

2. Ancillary measures

For screening purposes the Cheek & Buss (1981) Shyness Scale (Appendix 2) was administered once to the S during the initial 2 week screening phase. The scale involves 9 statements measuring the individual's affective state. They reflect the Ss emotional state in target situations. Statement 2, however, is a reverse item and therefore, requires recoding for analysis. Item score/remainder of scale score, analysis ($n=912$) revealed an alpha coefficient of .79, an acceptable level of internal consistency, that is, the test items are measuring the same trait. Ninety day test-retest ($n=96$) showed a reliability of .74, indicating that the traits the test is measuring remain stable over time. In addition, this scale correlated with Zimbardo's (1977) Shyness Self-Report ($r = .67$) and with Johnson's, (1980) 7-Point Scale ($r = .81$) showing that the test is measuring similar components to these shyness tests.

V Procedure

The Cheek & Buss Shyness Scale was administered to students as outlined in this chapter under Subjects section. The procedure for selection and orientation of subjects is found in that same section.

It was explained to the subjects that they would be partaking in four group counseling sessions, one per week, approximately mid-way through the study. They were informed that they would be asked to complete scales twice weekly for a period before the four counseling sessions, during the counseling sessions, and in the six week period following on a twice weekly basis. The repeated measures for each subject to complete were left, in individual envelopes with each subject's prearranged secret identification, in a pick-up and drop-off box at one of the counseling department's offices. Mid-week the researcher called each subject as a reminder inquiring if the scales had been completed and dropped off. The telephoning was kept consistent so that all ss received a uniform amount of attention.

Group 1 had eight observation points in its baseline while the time-lagged, (Hersen & Barlow, 1976), Groups 2 and 3 had nine and ten respectively. All groups had six and thirteen observation points in the intervention and post-intervention phases respectively. These points were equally distributed throughout except during the intervention phase where two were taken on the same day, before and after the counseling session.

VI Treatment

Session 1.

The counseling sessions for each group were held in an appointed quiet room in the school over lunch hour for a 45-minute duration. The first half of this session focused on establishing trust and rapport using empathic reflections with occasional probing into subjects behavioral, emotional, and cognitive reaction patterns when they are in anxiety-provoking social situations. The counselor focused primarily on exploring subjects' present ideas, behaviors, feelings, and beliefs in relation to their shy nature. This was followed by instructional-type discussion concerning the nature and mechanism of anxiety (Ishiyama, 1984a).

In the first session, one or two Morita counseling concepts, according to Ishiyama's (1984a) positive reinterpretation technique (Appendix 5), were introduced and the remainder of the session was spent discussing behavioral instructions 1 to 3 (Appendix 6). Short written summaries of Morita-based positive interpretation of social anxiety was given to each subject to carry as a reminder.

Sessions 2 to 4

Subsequent sessions began with reports on homework and any gains made. The counselor used empathic reflection and summarizing techniques to comment on the subjects' homework performance and facilitated discussion of the important

issues and problems that had arisen during the week. The following aims were given focus by way of instruction, confrontation and the positive reinterpretation technique: (1) increasing problem-related self-understanding, (2) modifying unproductive beliefs, attitudes and reaction patterns, and (3) developing effective behavioral strategies to cope with the target situation and to implement the target behavior. Behavioral instruction continued (Appendix 6) including a review at the end of each session. Subjects were encouraged to consult their written positive interpretation summaries daily to further increase familiarity with, and awareness of, the positive view of their shy nature. In general, the main message delivered to the subjects was self-awareness of experienced emotion and behavioral choices. It was expected by the researcher that once the subjects gained awareness that they can take action in spite of their emotions, they would be likely to take action.

Since this study's main concern is whether Morita counseling works or not, behavioral counts were taken daily over two 5-day periods and a frequency histogram (polygram) of cognitive and behavioral changes was plotted from repeated observations. This was done in order to determine the degree of subjects' application of material learned.

The author also served as the counselor in the present study. Advocates of single-case experimental designs, (Hayes, 1981; Hersen & Barlow, 1976; Kazdin, 1981) support the idea that the counselor conduct clinical research using his/her clients as these clients constitute readily available subjects.

The counselor was in her second year of a Master's level graduate program in counseling psychology. She had completed two Morita therapy training courses at introductory and intermediate levels and was presently under close supervision of an established Morita therapy trainer for further clinical and educational training. The counselor is a 41-year old caucasian female who has an adolescent daughter attending secondary school as well as two younger children. Her educational background is in preventive health care and psychiatric nursing where she has had many years of experience working with all age groups. She has had recent clinical and educational training in empathy-based counseling at the University of British Columbia.

CHAPTER IV

RESULTS

The results of this study are presented with the main focus on the visual analysis of results based on visual inspection as conventionally done in clinical studies using single case experimental designs. In addition, the results of statistical analysis and behavioral data are also provided. The visual analysis of the plotted data on each of the six scales (Anxiety Acceptance Scale, Intensity Coping Effectiveness Scale, Overall Disturbance By Anxiety Scale, Level of Difficulty Scale, Degree of Confidence Scale, Intensity of Anxiety Reactions Scale) is discussed in this chapter. Levels and trends are examined in the three phases (baseline, intervention, and post-intervention). In addition, results on behavioural counts taken pre- and post-intervention are analyzed. As well as examining the pre- and post-intervention phases for change, inter-group comparisons are made (see Appendices Part 2 for individual subject's performance in the repeated measures).

The strength of the visual inspection demonstration derives from showing that performance during a given phase violates the predicted level of performance of the prior phase (Kazdin, 1974). Treatment efficacy is sought by way of changes reflected in level of each phase, particularly pre-

and post-intervention, as well as changes in trend for these phases. The study's main concern is whether Morita counseling works or not and so these frequency polygrams of cognitive and behavioral changes, given that they were taken from repeated observations over approximately fourteen weeks, would be appropriate in addressing this concern, (Miller, 1985).

The objective of the study is to determine the degree to which Morita Counseling , as a therapeutic intervention, changes the self-reported level of socially anxious cognition and behavior in small groups of female adolescents. Results are presented to address the hypothesis that adolescent female Ss will show improvement on cognitive and behavioral measures following Morita counseling. The reader is reminded that the four counseling sessions, comprising the treatment intervention, were brief (a duration of forty minutes per session).

I Graphic Profiles of Self-Report Repeated Measures Scores

The results specifically will address the questions outlined in Chapter II. To arrive at answers to these questions, group graphs of results of repeated measurements are presented and described. Instruments used in gathering the data can be found in the Appendix 1, 1a, & 2. For ease

of discussion, the Baseline phase will be referred to as Phase A, the Intervention phase as Phase B, and the Post-Intervention as Phase C. On the 'Level Differences' graphs, the arrows indicate counseling sessions two and three. Counseling sessions one and four are adjacent to the intervention cut-off borders and therefore do not have indication arrows. Observations were taken bi-weekly at regular intervals except during the intervention phase where they were taken pre- and post- counseling session on the same day. Missing data is indicated by longer connecting lines between observation points.

Throughout the study it will be noticed that the performance of Group 3 is significantly lower than that of Groups 1 & 2. An examination of the individual Ss graphs (Appendix 8) from this group reveals Ss 9 & 10 generally reporting a somewhat flat profile with the odd exception and Ss 11 & 12 reporting a rather erratic profile, again with the odd exception. See Chapter 5 for discussion on Group 3.

Research Question #1: Will Ss show a higher acceptance of, and more positive attitude towards their anxious nature after the Morita intervention as reflected in increased self-report ratings on positive attitudinal and self-evaluative items?

On examination of group graphs for the 8-item Scale 8, "Anxiety Acceptance Scale", a clear positive change is seen in Groups 1 & 2 indicating a greater acceptance of anxious part of their nature. Despite Group 2's lesser increase in acceptance at the onset of the intervention, the increase continues very clearly into the post-intervention phase. Group 3 also shows a continuing less acceptance in the baseline and at the start of the intervention, shows an abrupt increase but this acceptance again decreases on entering the post-intervention phase.

In Figure 1, Group 1 shows a definite positive level difference of 7.96 increase, a difference of 11%, the second highest of the 3 groups, a clear indication of a higher acceptance and improved attitude toward their shy nature. As shown in Figure 2, Phase A reveals a down-angled trend line, i.e. a decrease in anxiety acceptance. However, this phase with its 89% trend stability (trend stability criterion envelope = 5.7) then took an abrupt upswing in trend direction (trend stability criterion envelope = 6.9) in Phase B where variability was low, trend stability of 83%, leveling off with a slight down angle in Phase C (trend stability criterion envelope = 7.1) and a 92% trend stability. The stability in this last phase suggests that improvement is being maintained.

Group 2 generates the highest level difference between Phases A & C, at 10.28, a 14% increase (see Figure 3); a distinct improvement in attitude and acceptance of their shy nature. Phase A trend shows a steep slope (trend stability criterion envelope = 7.5) with a 91% trend stability, drops (trend stability criterion envelope = 6.9) 5 points in Phase B with an 83% trend stability but continues on a up-slope (trend stability criterion envelope = 8.4) here and in Phase C which shows an 85% trend stability. As in Group 1, the improvement seems maintained.

Figure 5, Group 3's graph shows less change in that Phase A to C level difference is only 2.30, a 3% increase. The trend direction in Figure 6 in Phase A (trend stability criterion envelope = 6.3) with a 93% trend stability presents a down-slope, a decrease in anxiety acceptance. A sharp upswing (trend stability criterion envelope = 6.6) in Phase B with a trend stability of 83% indicating an increased acceptance and positive attitude after the counseling, drops somewhat (trend stability criterion envelope = 6.1) in Phase C but maintains a firm 100% stability.

Summary - There is a clear positive change in Groups 1 & 2 in anxiety acceptance and attitude towards their shy nature, whereas Group 3 presents a lesser change. In Group 2, although the pre-intervention phase already had an upward

Group 1, Scale 8

Level Differences on Scale 8 -
Anxiety Acceptance Scale

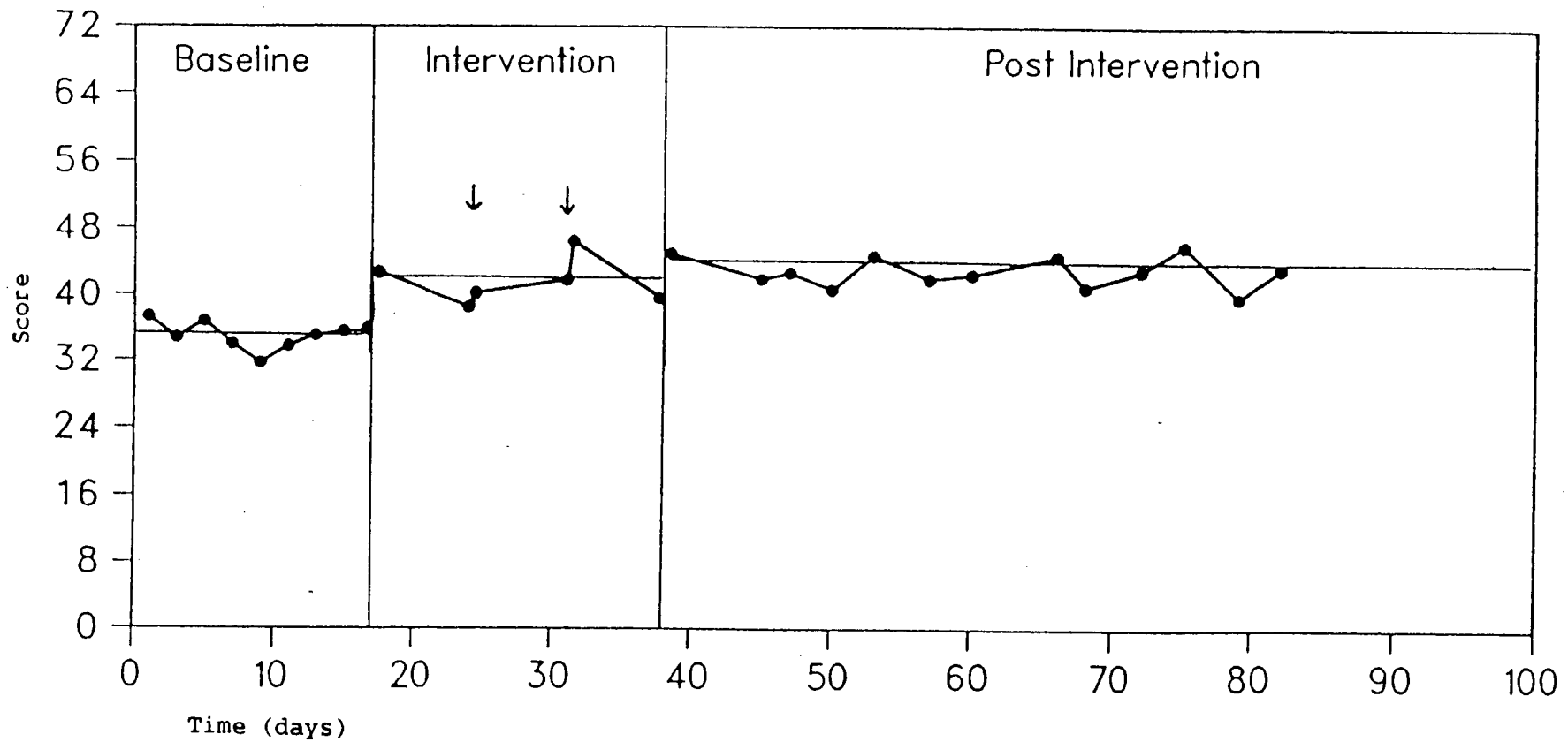


Figure 1

Group 1, Scale 8

Trends on Scale 8 - Anxiety Acceptance

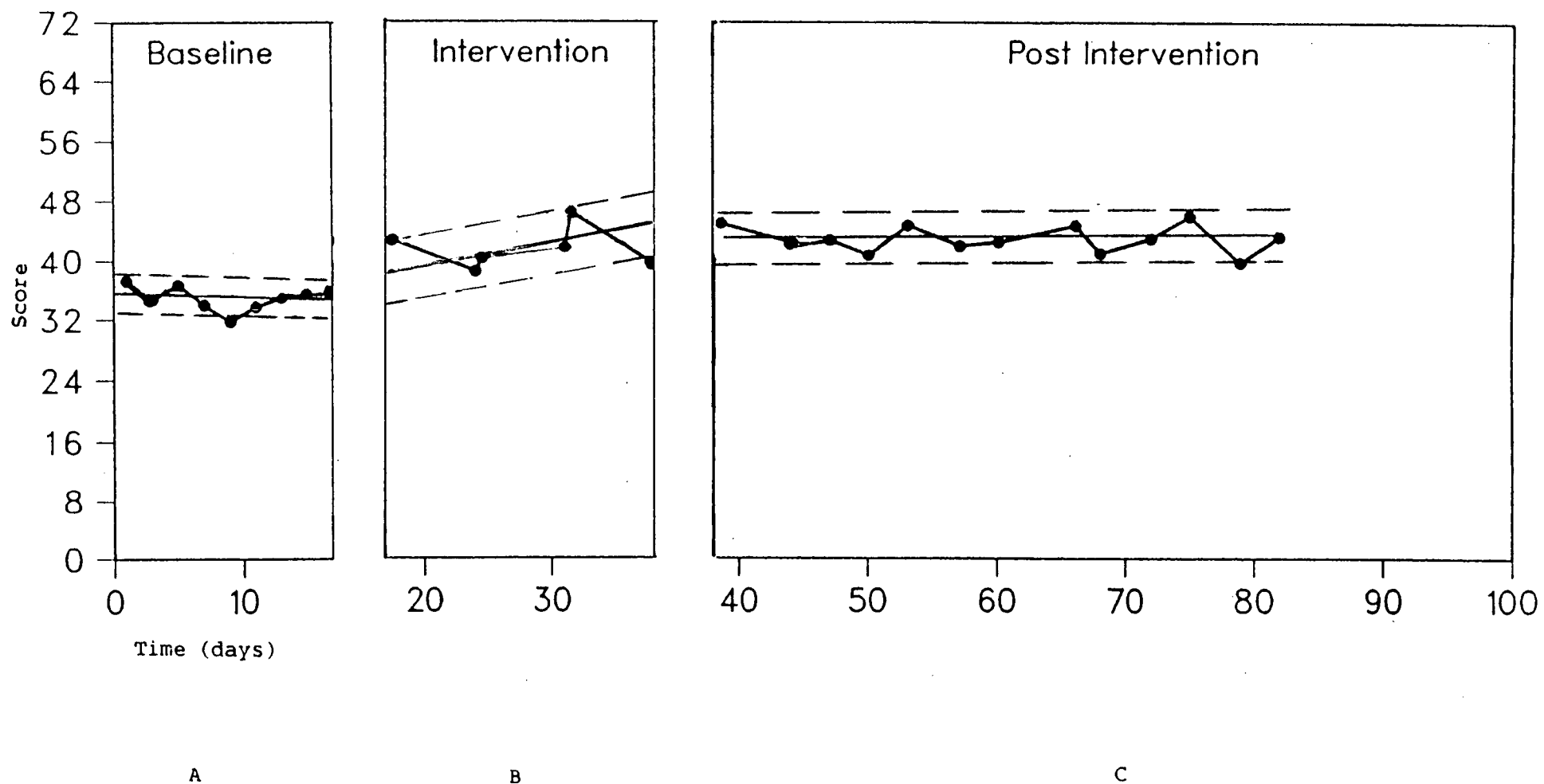


Figure 2

Group 2, Scale 8

Level Differences on Scale 8 -
Anxiety Acceptance Scale

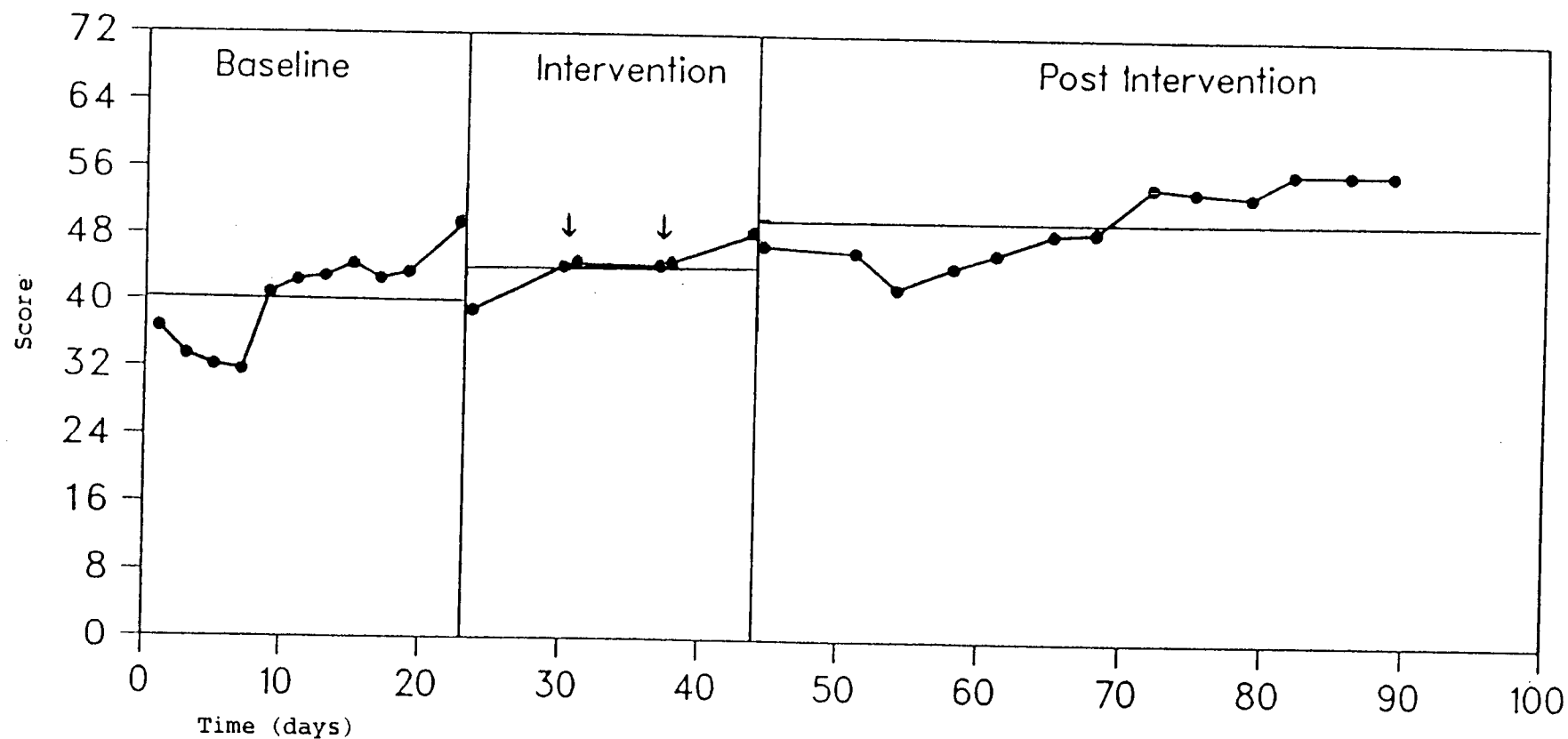


Figure 3

Group 2, Scale 8

Trends on Scale 8 - Anxiety Acceptance

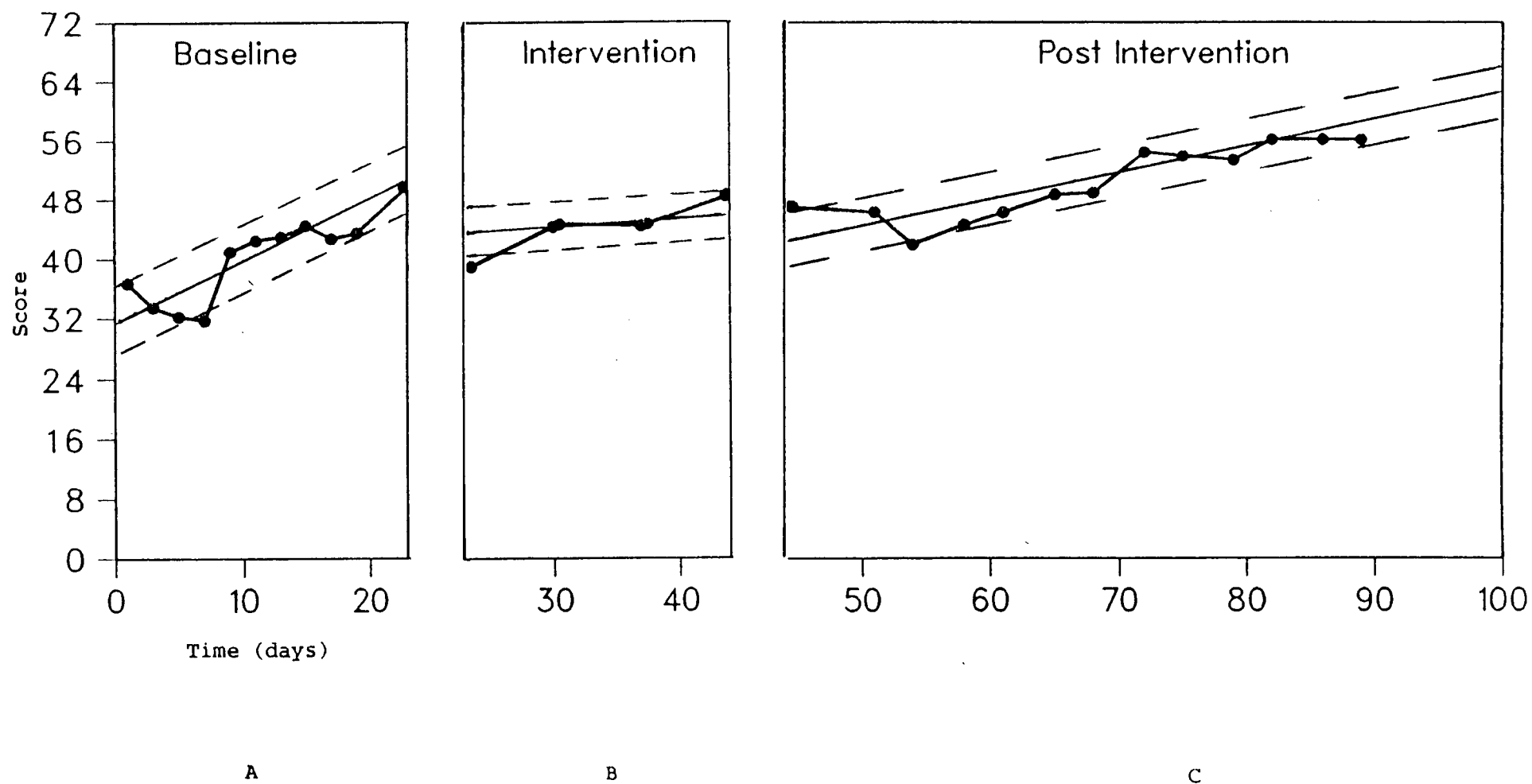


Figure 4

Group 3, Scale 8

Level Differences on Scale 8 -
Anxiety Acceptance Scale

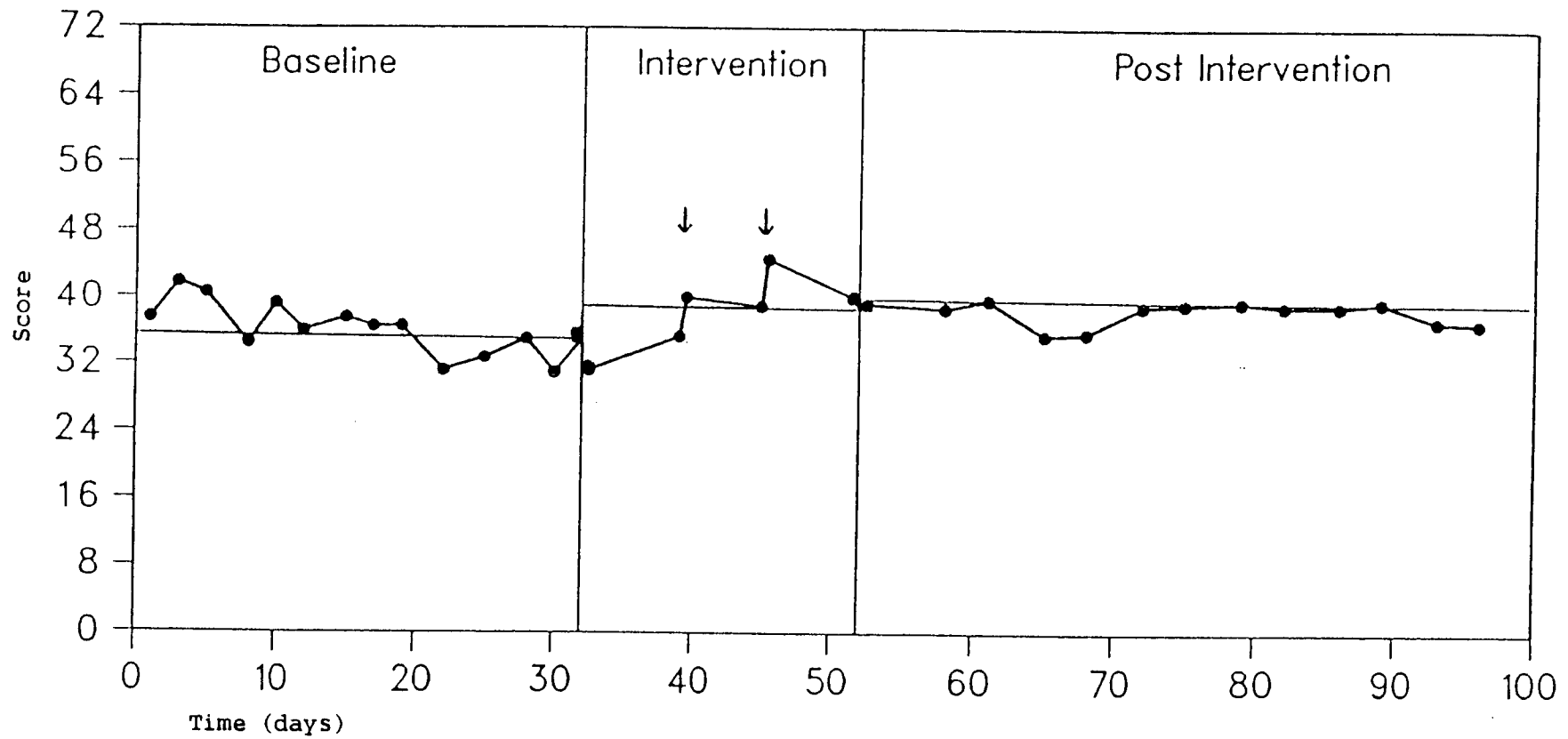


Figure 5

Group 3, Scale 8

Trends on Scale 8 - Anxiety Acceptance

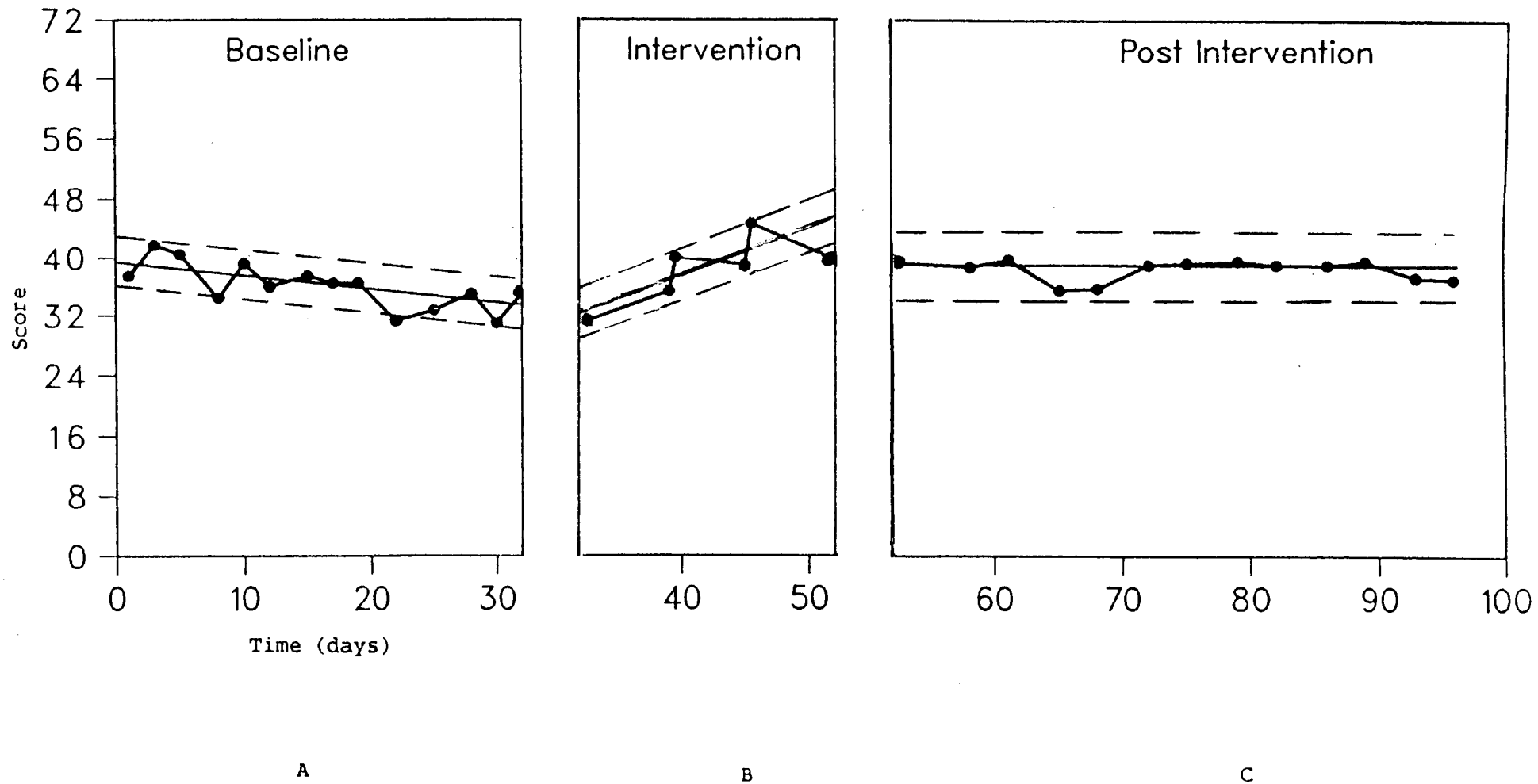


Figure 6

trend direction this levels-off before the post-intervention trend direction climbs. Group 1 & 2's post-intervention upswing trend direction and high trend stability suggests that improvement is definitely being maintained. Group 3 follows with a slight less upward trend direction but with a completely stable trend at 100%. Graphs, in figures one to six, are presented on the following pages.

Research Question #2: Will Ss report a higher coping effectiveness in their ways of dealing with the anxiety provoking situations, i.e., target situations, after receiving the Morita counseling intervention?

Results on the 6-item Scale 2, "Coping Effectiveness", the scale that taps a behavioral component produces the most obvious positive change for Groups 1 & 2. Subjects seemed to comprehend, and respond to this scale more readily as reflected in a consistently higher rating for most Ss. The result is that Ss report a decided increase in coping effectiveness in their shy/target situations after the Morita counseling.

Referring to Figure 7, Group 1's level difference between Phase A & C is a significant 7.98, i.e., a 14%

increase. In Figure 8 the trend direction (trend stability criterion envelope = 5) in Phase A shows a definite down slope with a trend stability of 78%. This abruptly changes in an up-slope (trend stability criterion envelope = 5.1) at the commencement of Phase B with trend stability of 100% and maintains this upper level (trend stability criterion envelope = 5.6) during a high 92% stable trend Phase C. The stability of this last phase points to a continuation of improvement.

Group 2 in Figure 9 again shows greatest change with a Phase A to C level difference of 8.07, a 15% increase. The trend direction as seen in Figure 10 in Phase A shows a steep upward direction (trend stability at 82%, & trend stability criterion envelope of 5.9) followed by a less steep upward trend (trend stability criterion envelope = 5.9) in a 100% stable Phase B. Phase C's trend continues on a definite upward slope (trend stability criterion envelope = 6.8) and is a firm stable trend at 100%, promising continued improvement.

Group 3 presents the smallest amount of change in that the Phase A-C level difference is 1.22, a 3% increase (see Figure 11). On examining Figure 12, there is a slight downward trend direction (trend stability criterion envelope = 5.6) in Phase A which is 72% trend stable. Note, however, that this phase is 91% trend stable after the first 3

Group 1, Scale 2 Level Differences on Scale 2 - Coping Effectiveness

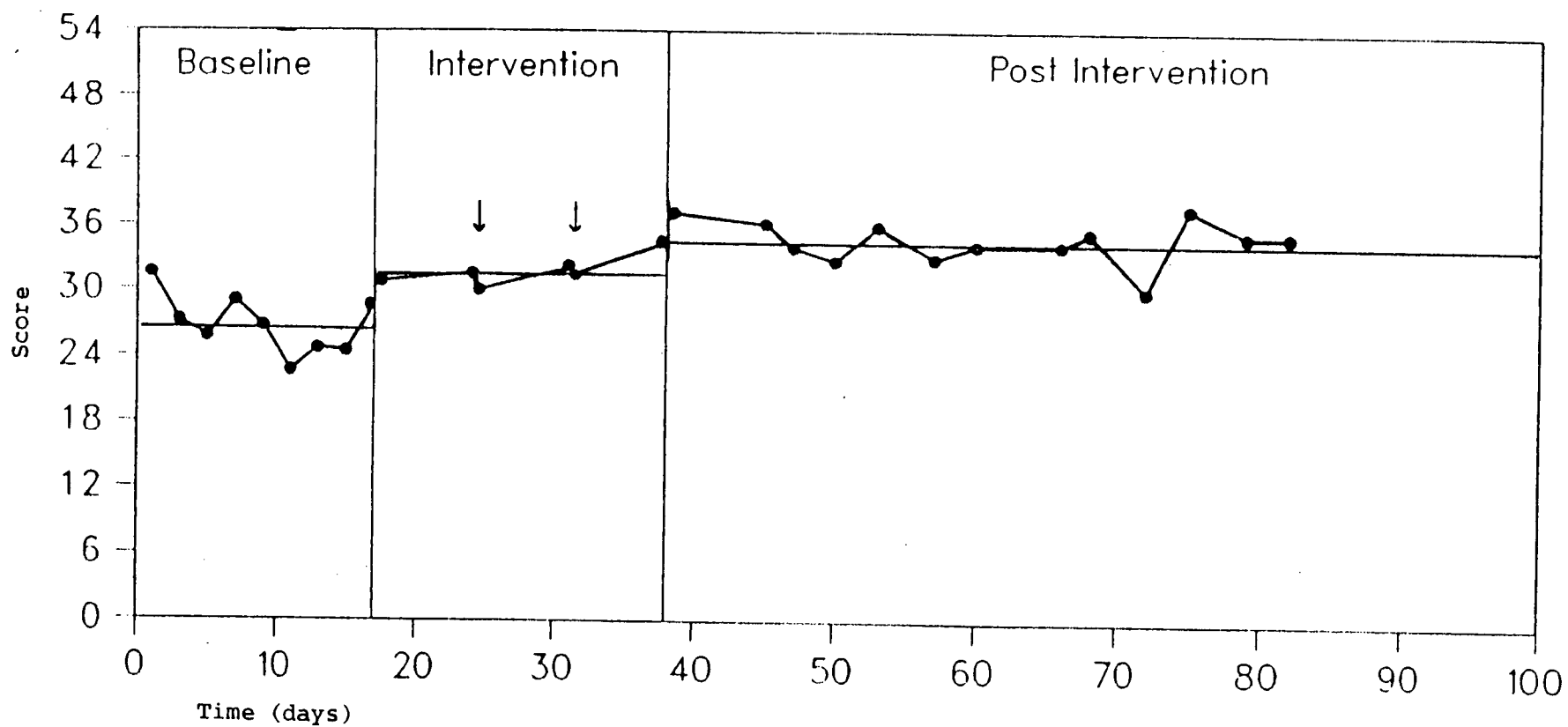


Figure 7

Group 1, Scale 2

Trends on Scale 2 - Coping Effectiveness
in the Shy Situation

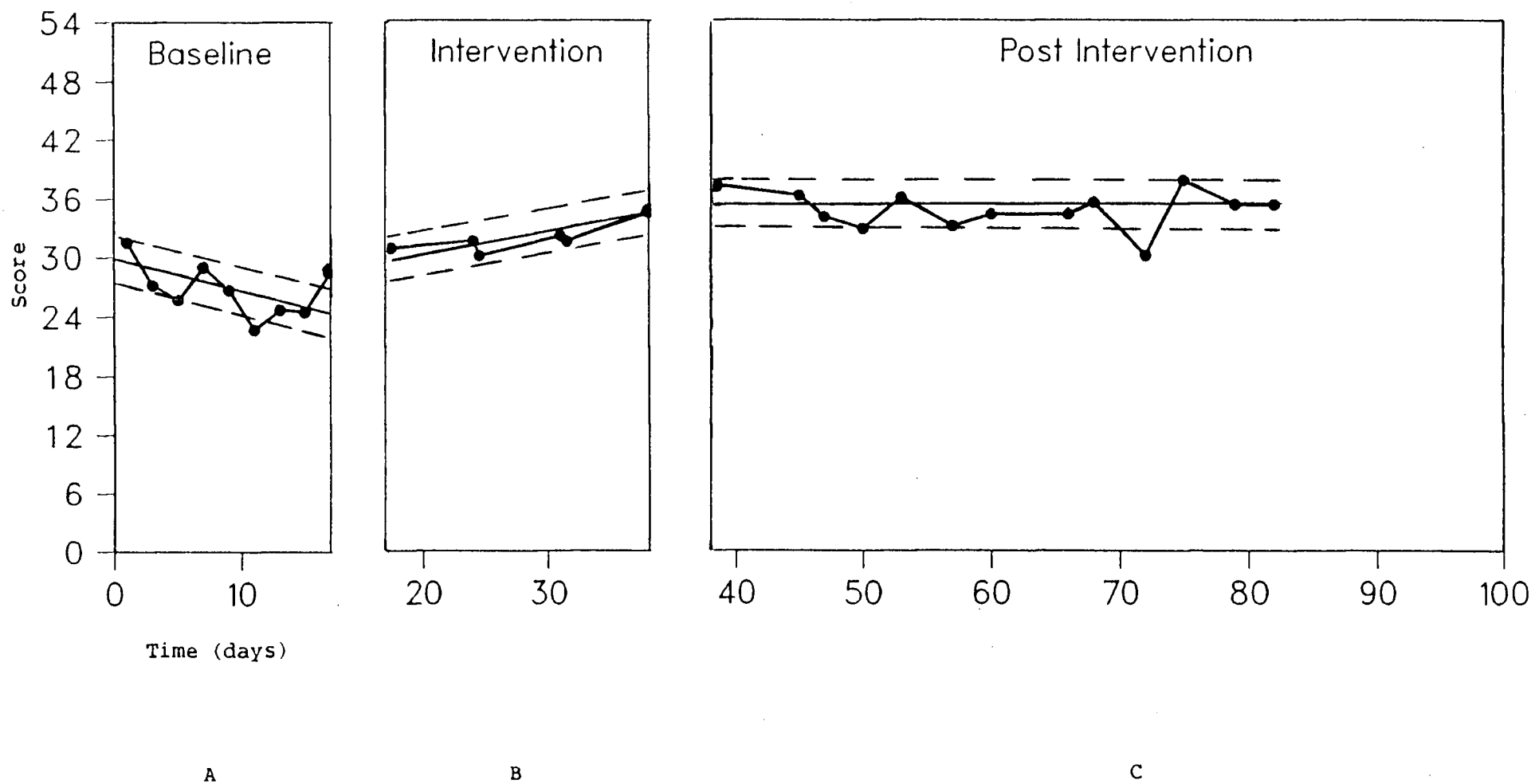


Figure 8

Group 2, Scale 2 Level Differences on Scale 2 - Coping Effectiveness

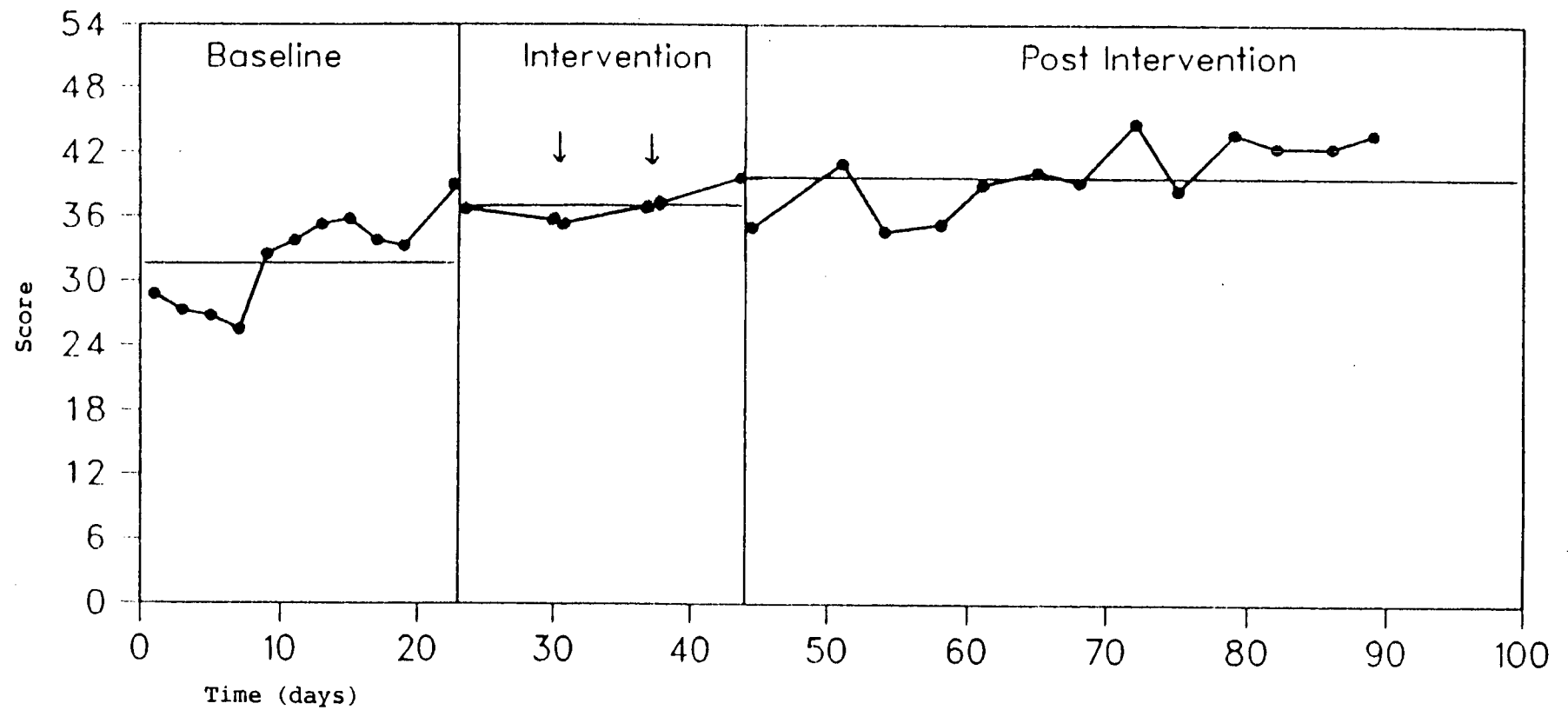


Figure 9

Group 2, Scale 2

Trends on Scale 2 - Coping Effectiveness
in the Shy Situation

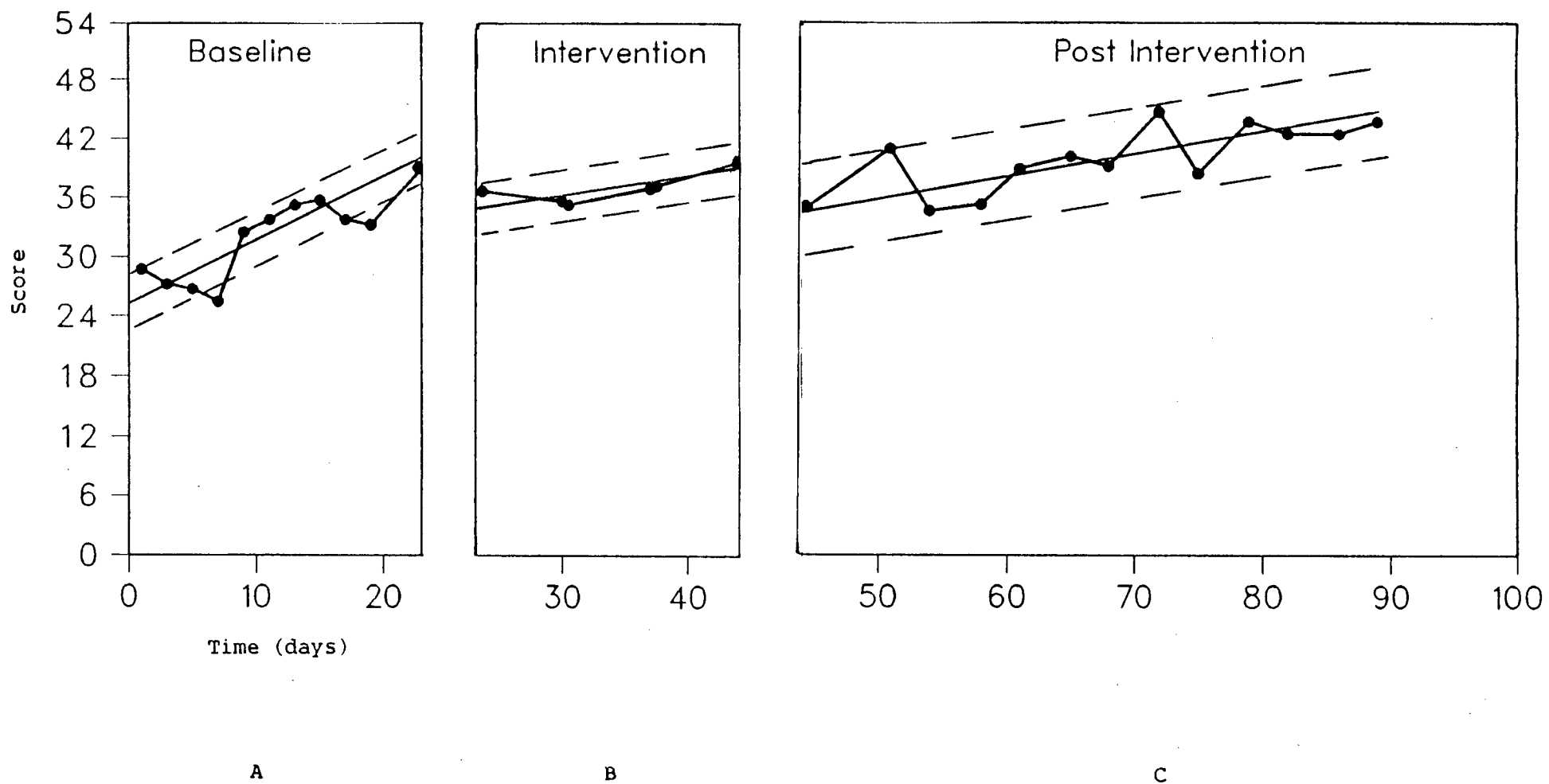


Figure 10

Group 3, Scale 2

Level Differences on Scale 2 -
Coping Effectiveness

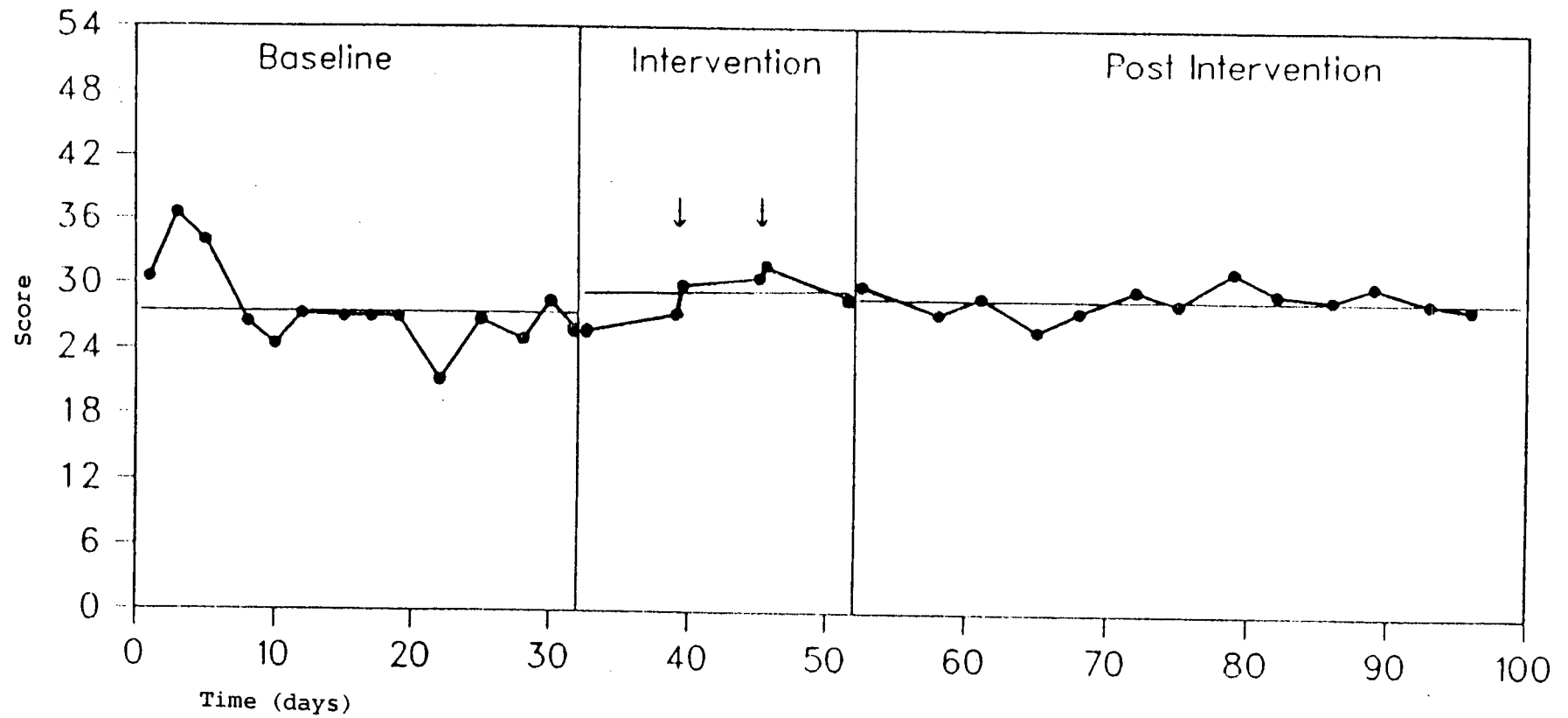


Figure 11

Group 3, Scale 2

Trends on Scale 2 - Coping Effectiveness
in the Shy Situation

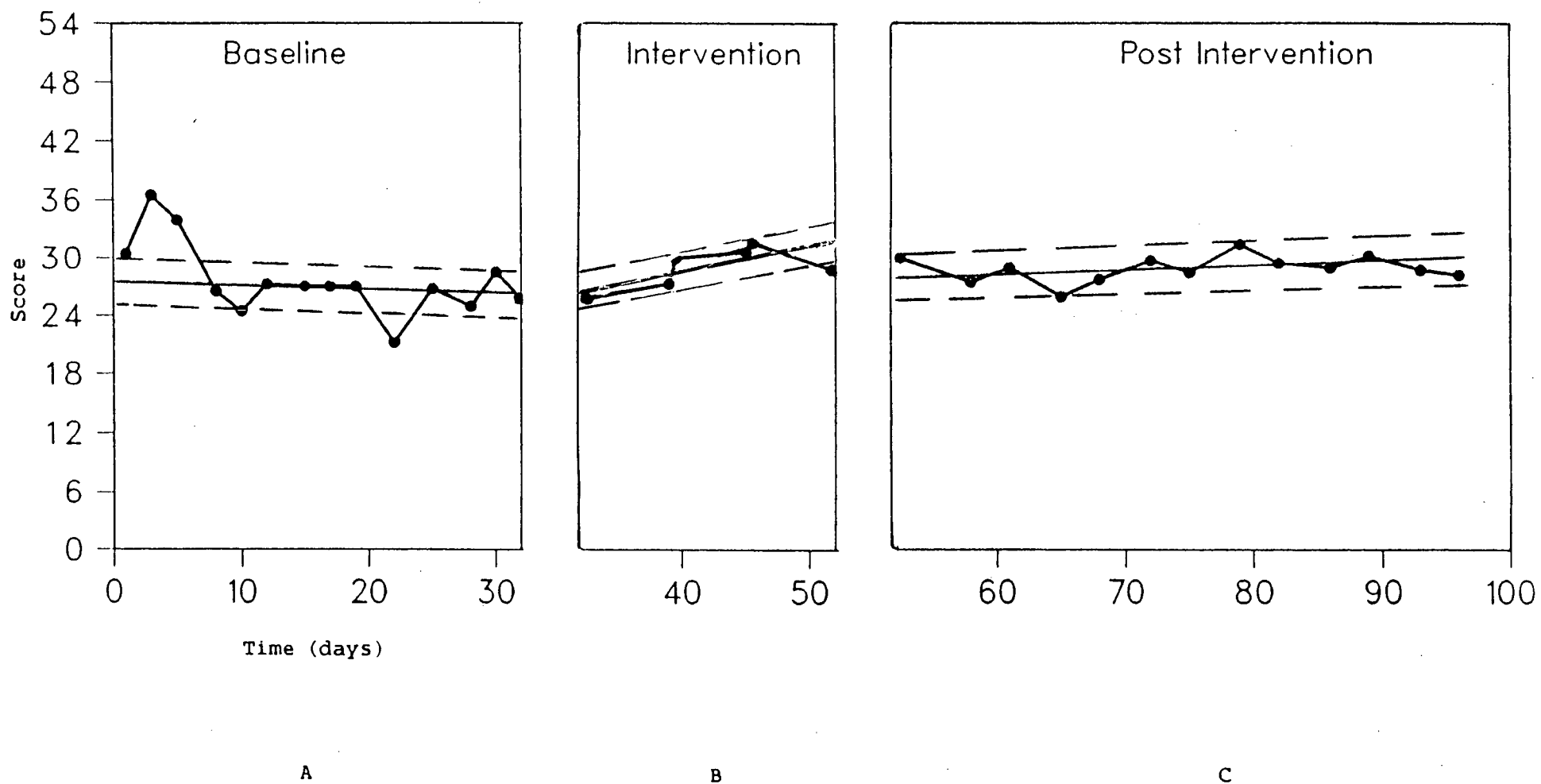


Figure 12

observation points. Phase B reverses to a steep upward slope (trend stability criterion envelope = 4.9) which is 83% trend stable, drops 1 point but continues on an upward trend direction (trend stability criterion envelope = 5) with 100% trend stability during Phase C.

Summary - All groups show improvement in their ability to cope more effectively with their shy situation, Groups 1 & 2 showing the greatest degree. It is noted that Group 1 commenced the study with a marked downward trend direction in coping effectively but this was clearly reversed during the intervention. This was also true to a lesser extent for Group 3. Post-intervention phases for all groups were highly trend stable promising a continued improvement. Graphs, in figures seven to twelve, are presented on the following pages.

Research Question 3: Will Ss report that they are less bothered by their anxiety problem after the Morita counseling intervention?

In Scale 7, "Overall, how much does this shyness problem bother you?", where a decrease in score indicates improvement, all 3 groups report improvement in a reported decrease in the disturbance or bother of the shyness

problem, particularly in Groups 2 & 3. These two groups show a definite and continuous decrease over all phases whereas Group 1 shows only slight positive change in the initial phases increasing to a more noticeable one in the last phase. If trend stability in the final phase was somewhat more firm then this measure would seem to offer a clear indication of the efficacy of Morita counseling.

Looking at Figure 13, Group 1's level difference is a drop of 1.45, which is 11%, from Phase A to Phase C. There is a slight downward trend slope (trend stability criterion envelope = 1.7) in Phase A but trend stability is an unacceptable low 44%. Phase B (Figure 14) trend line shows a very slight downward trend angle (trend stability criterion envelope = 1.6) indicating a minimal lower degree of disturbance with a less than acceptable trend stability of 67%. The downward trend direction (trend stability criterion envelope = 1.4) becomes clear in Phase C with an increased trend stability below acceptable at 77%.

Group 2's level of difference is a drop of 1.46 or 11% from Phase A to Phase C, (see Figure 15) indicating a clear improvement in anxiety severity. In Figure 16 there is only a slight down trend direction (trend stability criterion envelope = 1.2) in Phase A where trend stability is 73%. Phase B begins to show a pronounced downward trend direction (trend stability criterion envelope = 1.1) and is almost

acceptable with a trend stability of 84%. The final phase presents a clear downward trend slope (trend stability criterion envelope = 1.1) although variability is significant at the unacceptable level of 77%. As with Group 2, Scale 6, one can observe that the last half of the observation points has a trend stability of 100% suggesting that this group, given increased time, would possibly continue on a steady path of improvement.

Scores for Group 3 are comparable to the other two groups with a clear improvement. Referring to Figure 17, the group has a level difference from Phase A to Phase C of 1.29 or 10%. In Figure 18, Phase A shows a noticeable down trend direction (trend stability criterion envelope = 1.4) however, the trend stability is unacceptable at 72%. In Phase B, this trend direction disappears (trend stability criterion envelope = 1.3) however, trend stability is 100%. The noticeable positive change recurs in Phase C where a definite downward trend direction is observed. Trend stability remains steady at an acceptable 85% clearly indicating a positive change for these Ss.

Summary - According to these results, all groups show improvement in being less bothered or disturbed by their shyness problem. Group 1, during the intervention, begins to show less degree of disturbance and continues in this pattern into the final phase. Groups 2 & 3 show a similar

Group 1, Scale 7

Level Differences on Scale 7 -
Overall Disturbance Caused by
the Shyness Problem

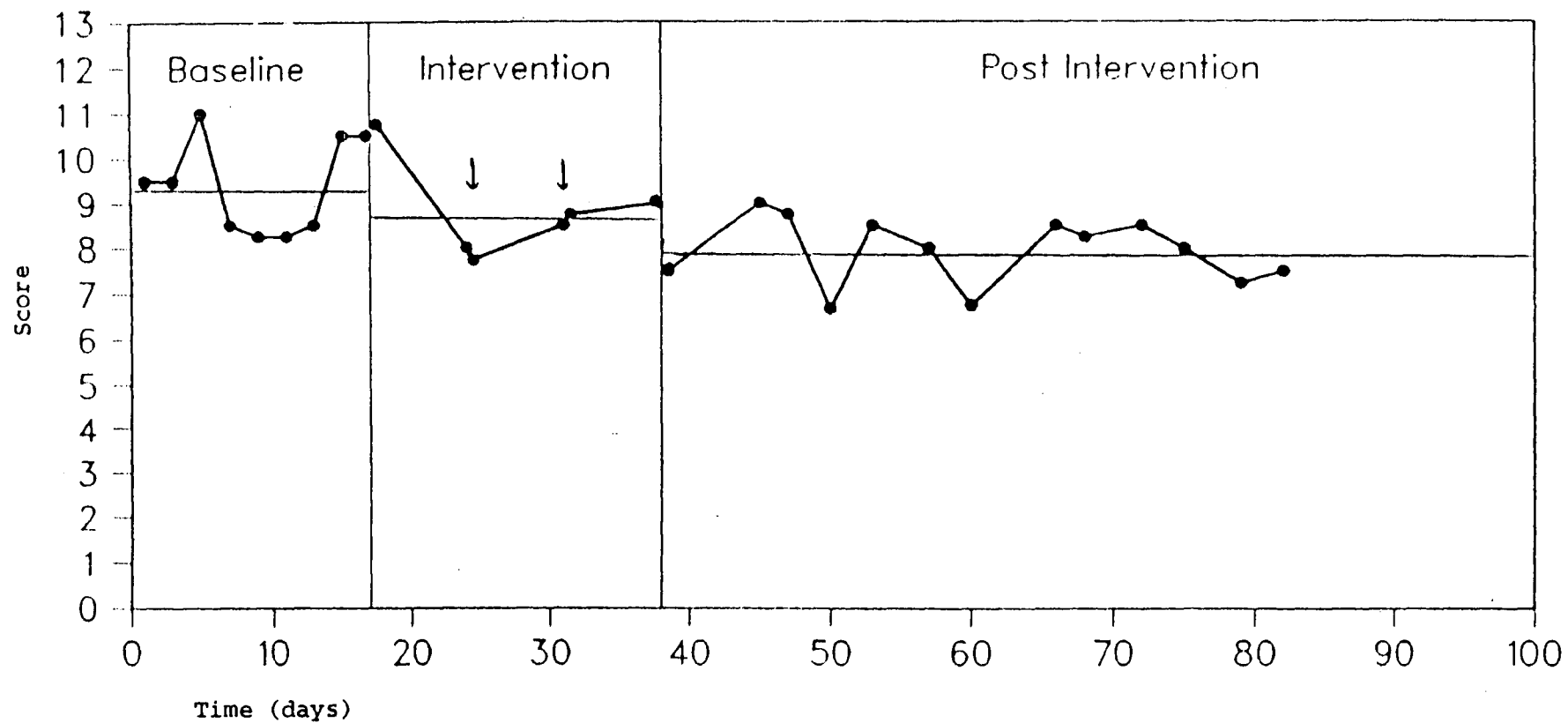


Figure 13

Group 1, Scale 7

Trends on Scale 7 - Overall Disturbance Caused by the Shyness Problem

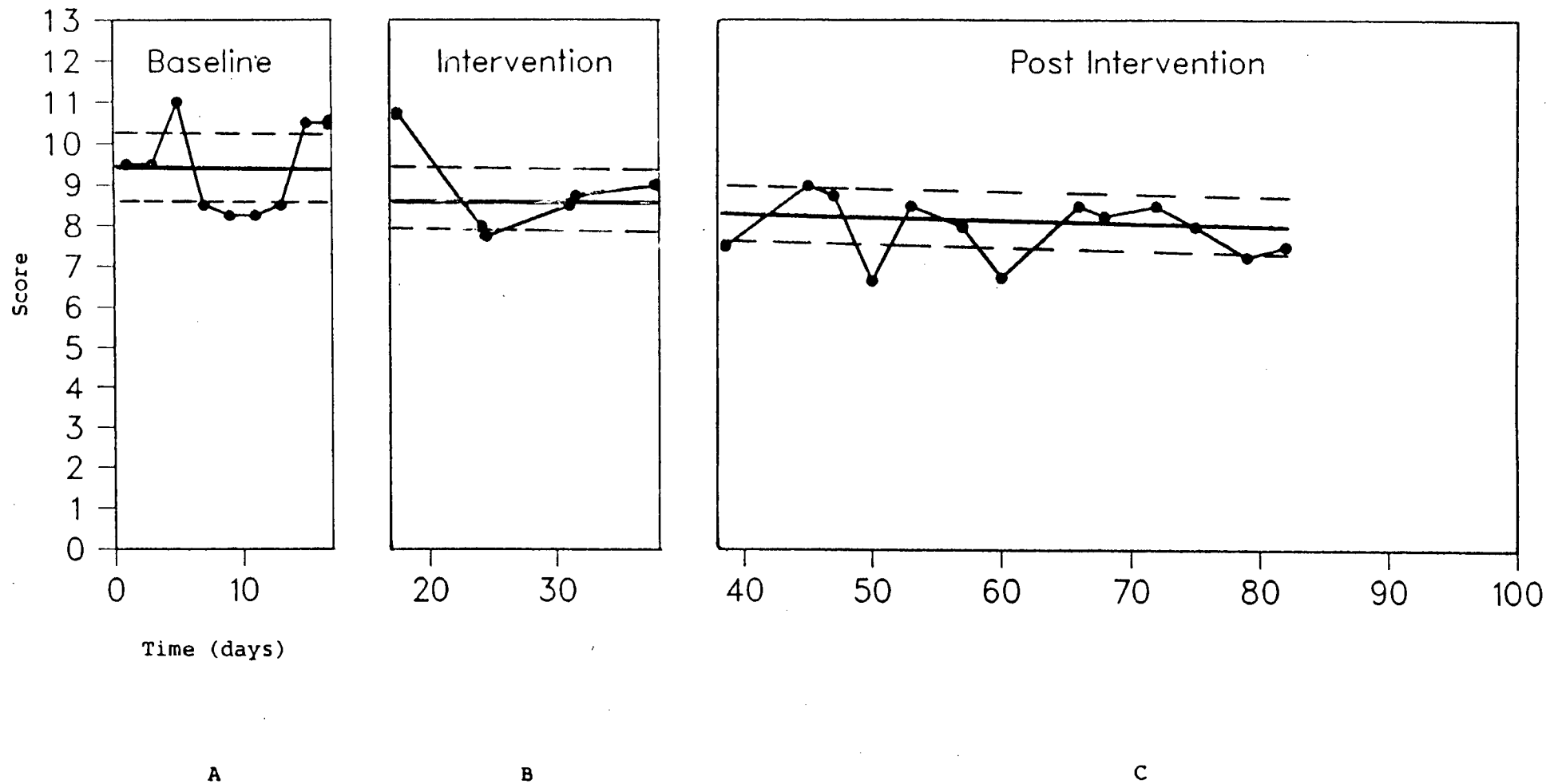


Figure 14

Group 2, Scale 7 Level Differences on Scale 7 - Overall Disturbance Caused by the Shyness Problem

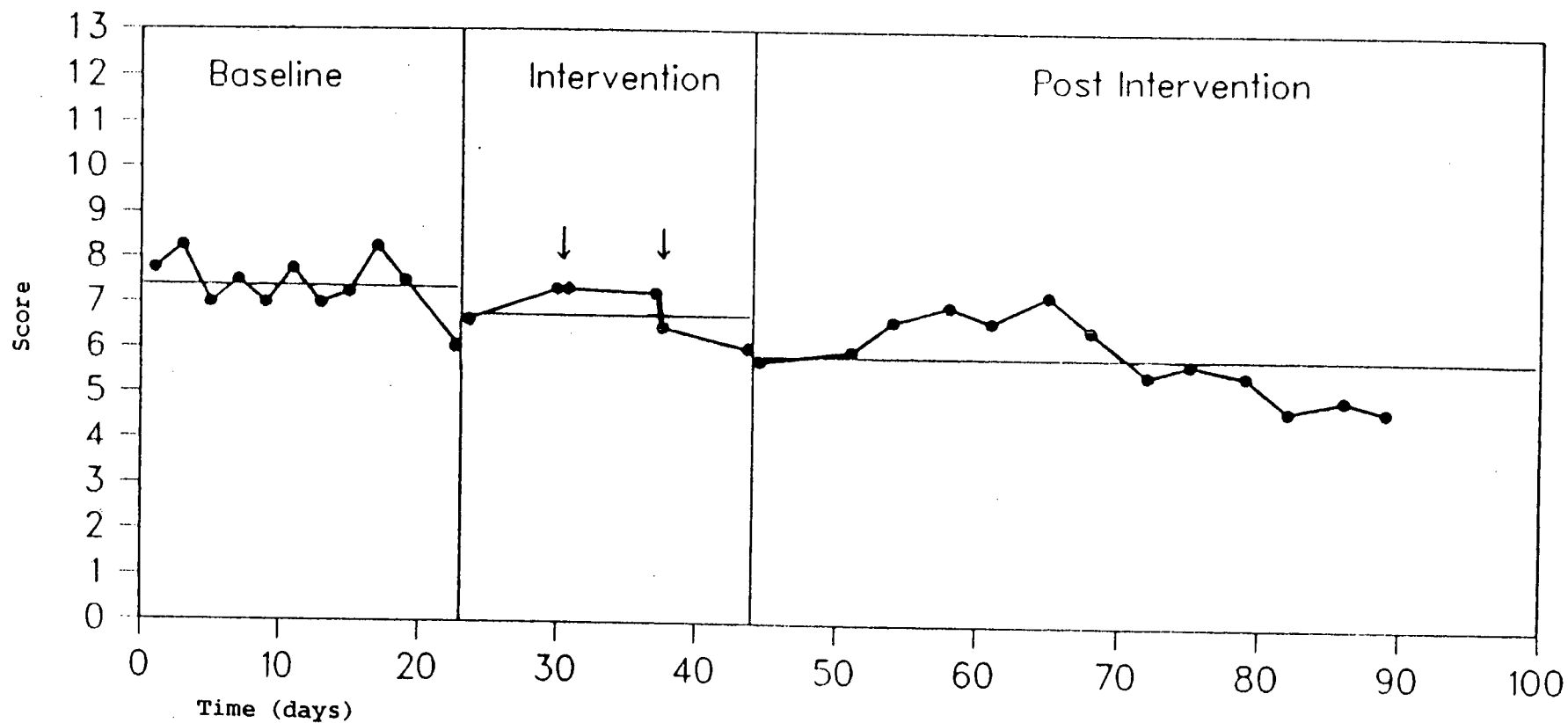


Figure 15

Group 2, Scale 7

Trends on Scale 7 - Overall Disturbance Caused by
the Shyness Problem

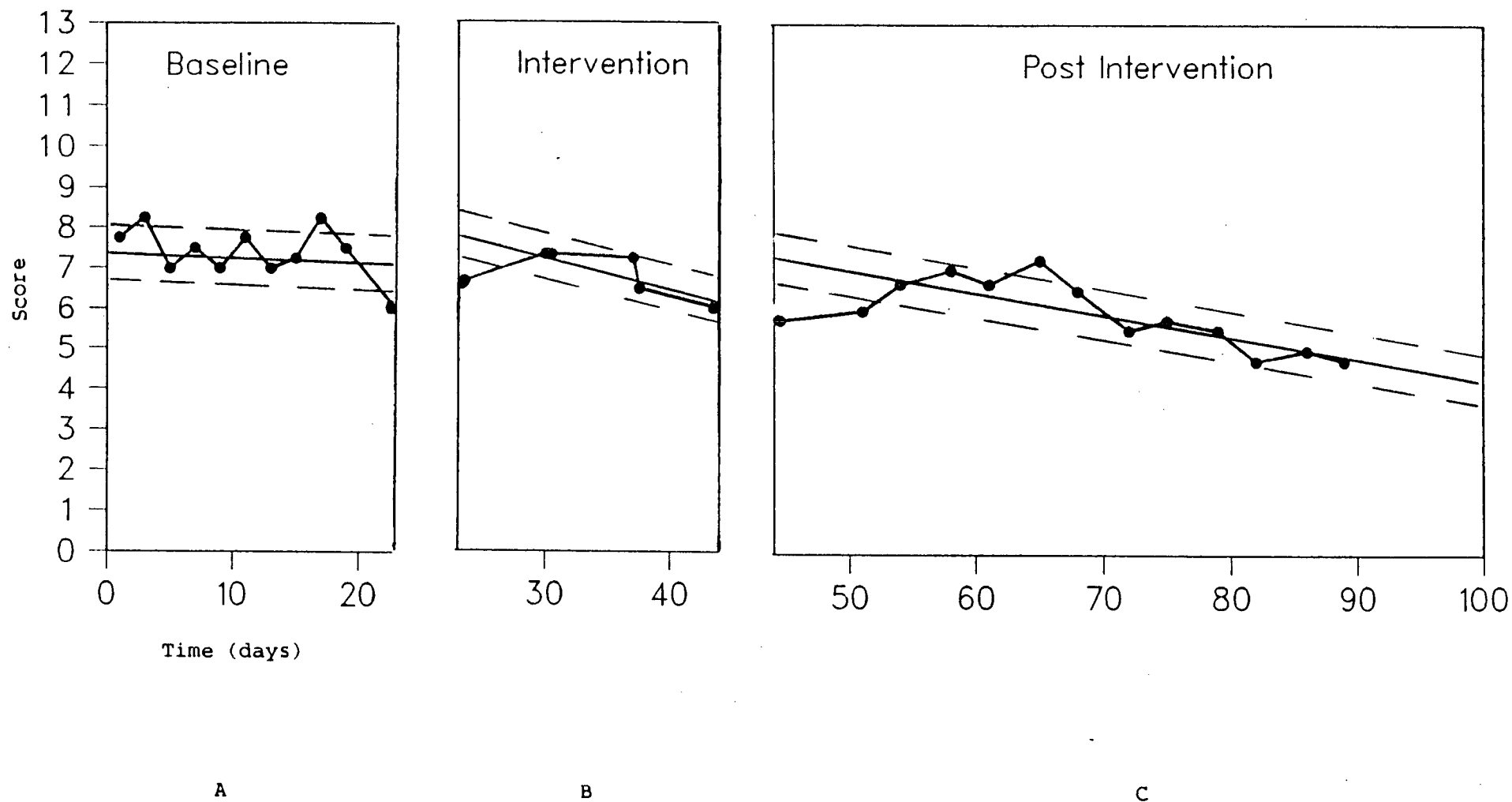


Figure 16

Group 3, Scale 7 Level Differences on Scale 7 - Overall Disturbance Caused by the Shyness Problem

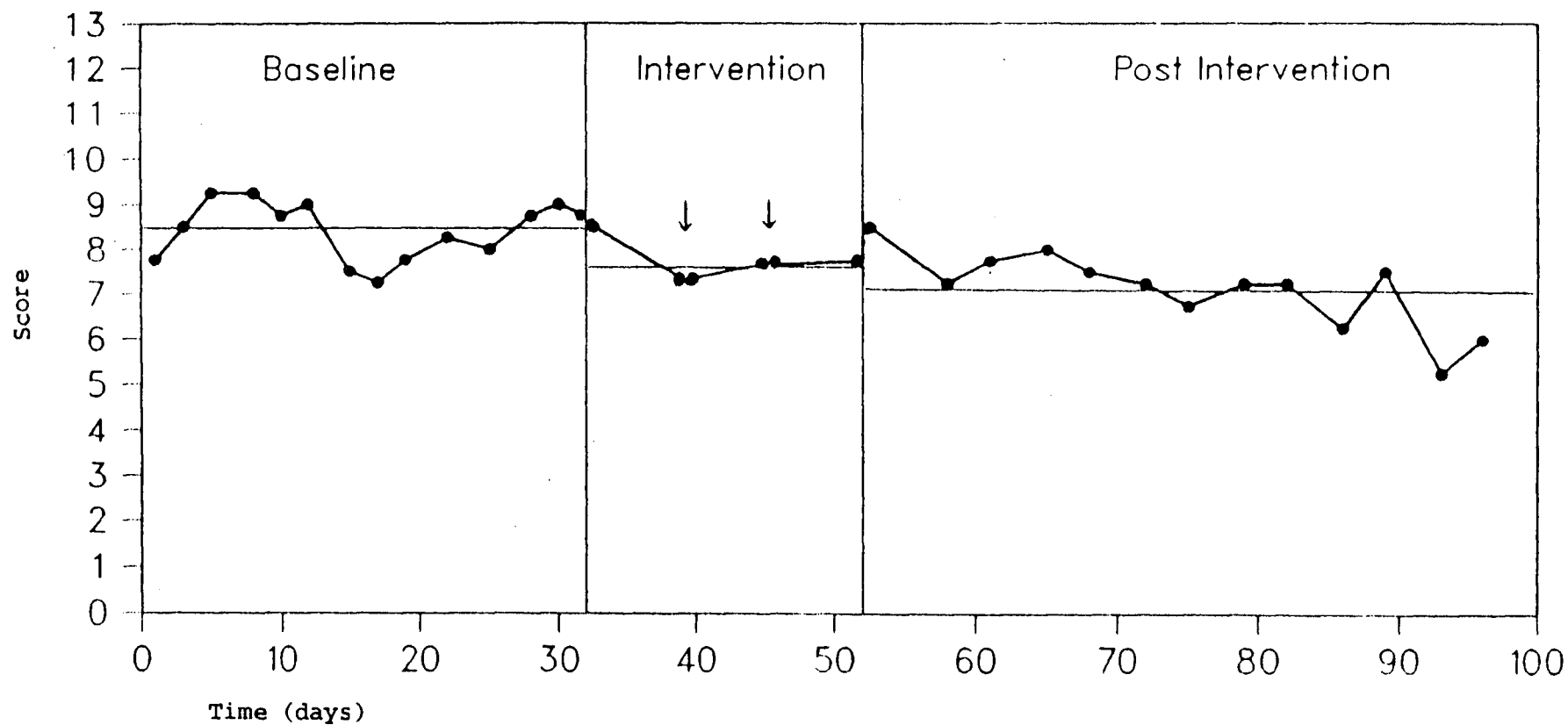


Figure 17

Group 3, Scale 7

Trends on Scale 7 - Overall Disturbance Caused by the Shyness Problem

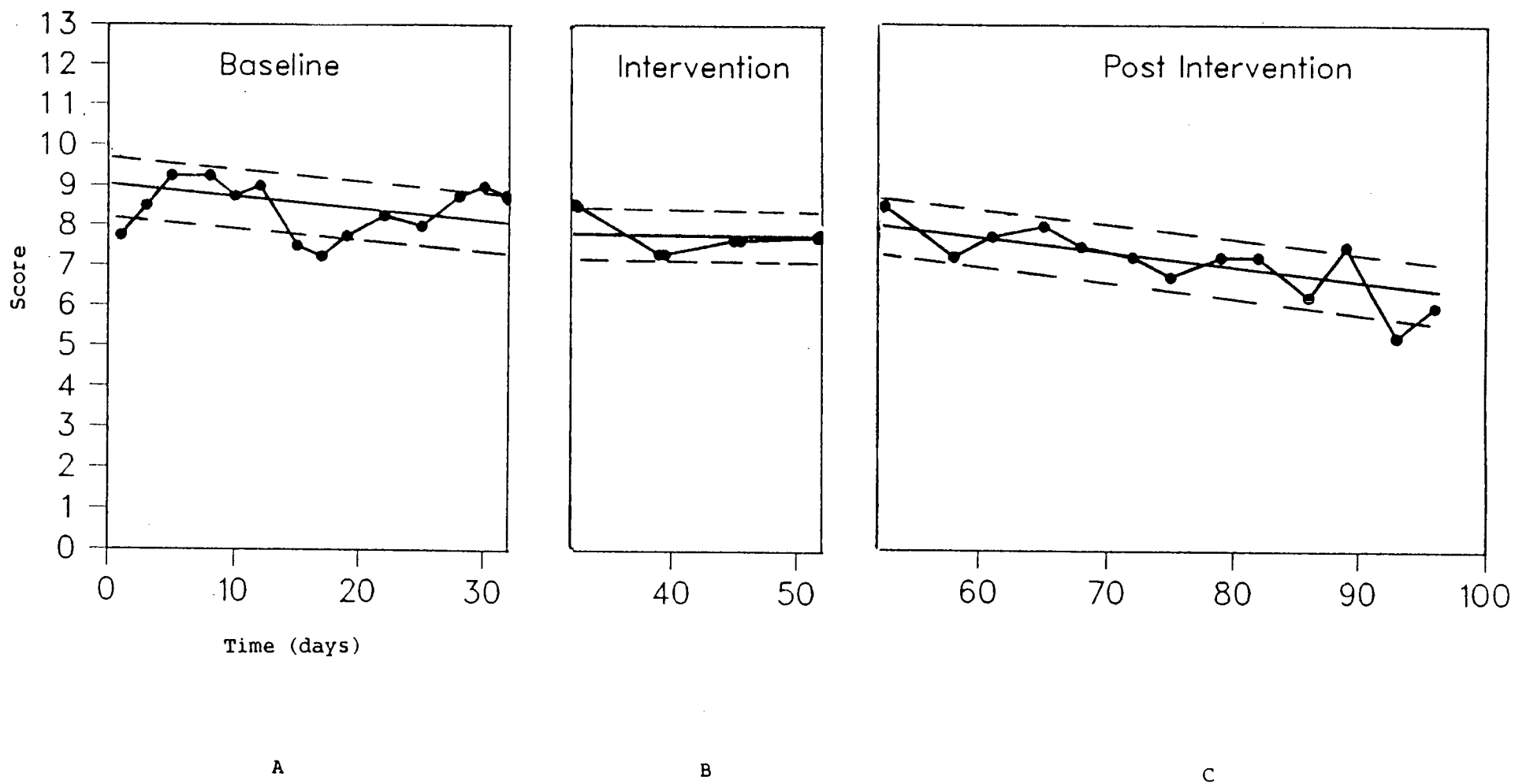


Figure 18

pattern in that there is already down trend directions in the pre-intervention phase but these continue to show even more improvement with a firm 100% trend stability criterion envelope in the post-intervention. It can be concluded, therefore, that all groups indicate being less bothered by their shy problem post-intervention. Graphs, in figures thirteen to eighteen, are presented on the following pages.

Research Question 4: Will Ss report less difficulty in initiating desirable action in their shy/target situations after the Morita counseling intervention?

Scores on Scale 5, "Degree of experienced difficulty in action taking in the shy situation", where a lower score indicates improvement, although no noticeable change occurs in the intervention phase, the Post-Intervention phase shows all groups with a definite downward trend direction. Trend stability is firm for two groups. This points out that while the Ss were learning no change effect occurred but, over time, the action taking difficulty clearly began to decrease.

The results shown in Figure 19 from Group 1 present a level difference decrease from Phase A to Phase C of 2.03 which is 16% lower, the greatest improvement of all groups

on this scale. In Figure 20, the trend direction (trend stability criterion envelope = 1.8) in Phase A is definitely a downward one and trend stability is high at 89%. In Phase B this trend direction (trend stability criterion envelope = 1.6) disappears and trend stability drops somewhat to 83%. However, in Phase C, a clear downward trend direction (trend stability criterion envelope = 1.5) can be observed, reflecting a reported decrease in experienced difficulty at this point in time for this group. The variability is significant though, at 77% trend stability.

Group 2's level difference shows a slight decrease from Group 1's at a value of 1.88 which is 14% lower (see Figure 21). Again, this follows closely to Group 1's level of improvement. On examining Figure 22, the pattern is similar to that of Group 1 with a definite downward trend direction in Phase A (trend stability criterion envelope = 1.4) and trend stability of 82%. Phase B (trend stability criterion envelope = 1.2) however, traces a sharp, but unstable (67%), upward trend direction, indicating that momentarily, Ss reported greater difficulty in their shy situations during the intervention. Phase C, on the contrary, shows a marked downward trend direction (trend stability criterion envelope = 1.1) as in Group 1 and variability is small at trend stability of 85%. During this phase, this group appears to be responding with at a consistently lower degree of difficulty in their shy situations.

Looking at Figure 23, Group 3 scores show a level difference from Phase A to C as a negligible drop of .14, only 1% lower. Phase A is stable at 93% trend stability with a downward trend direction (trend stability criterion envelope = 1.3). Phase B, like that of Group 2, reverts to an upward trend direction (trend stability criterion envelope = 1.2) which is very trend unstable at 50%. Phase C shows a clear downward trend direction (trend stability criterion envelope = 1.2) and has a solid trend stability of 92%. This group seems to have been positively affected by the intervention in this aspect of experienced difficulty.

Summary - In observing level differences, all groups show improvement by reporting less experienced difficulty in their shy situations, Groups 1 & 2 as much as 16% and 14% lower respectively. However, the three groups already reflect decreased difficulty in the pre-intervention phase with a downward trend direction. This levels-off for Group 1 but is reversed for Groups 2 & 3 during the intervention phase. The post-intervention reverts back to showing improvement and carry-over effect by a steady downward trend direction with firm trend stability for Groups 2 & 3 and a slightly less one for Group 1. Graphs, in figures nineteen to twenty-four, are presented on the following pages.

Group 1, Scale 5

Level Differences on Scale 5 -
Difficulty Experienced in
the Shy Situation

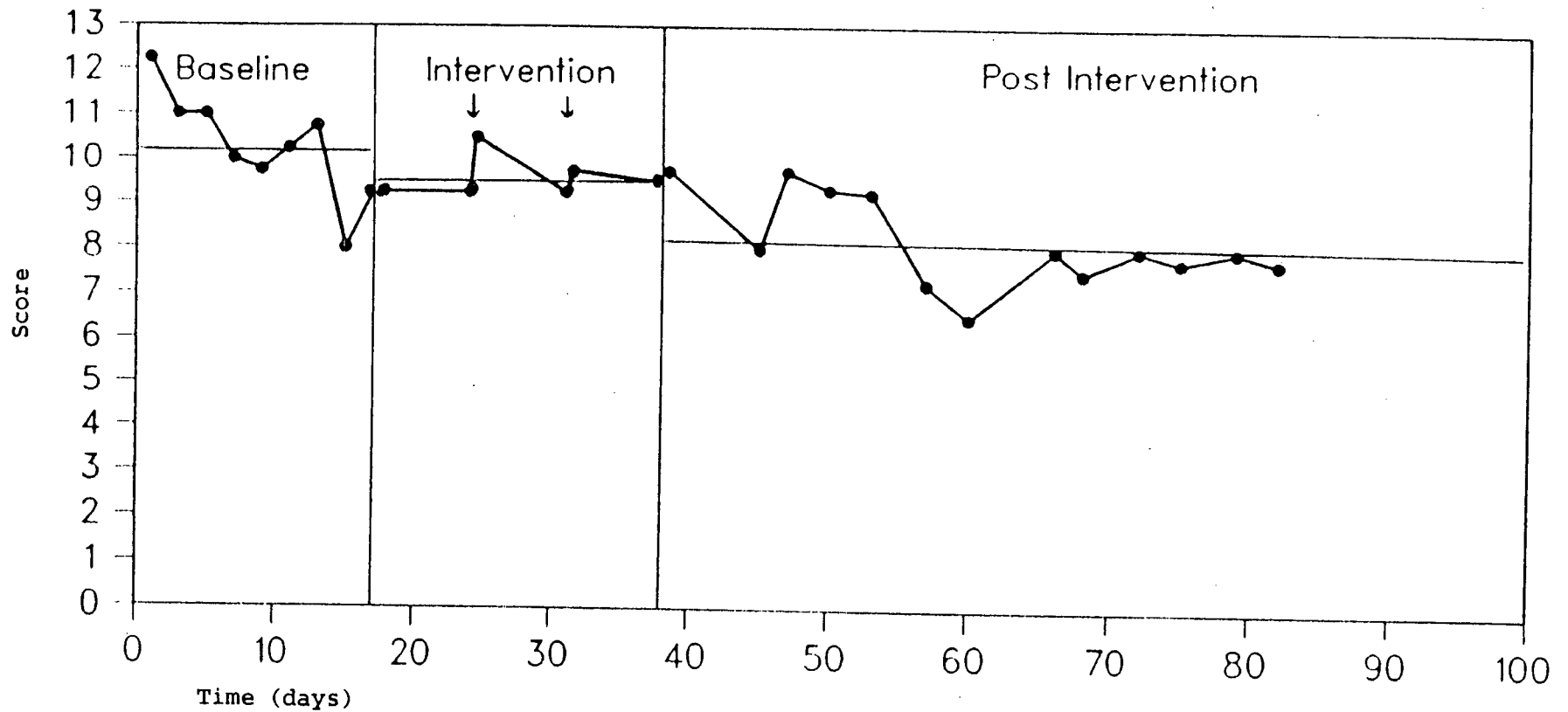


Figure 19

Group 1, Scale 5

Trends on Scale 5 - Difficulty Experienced in the Shy Situation

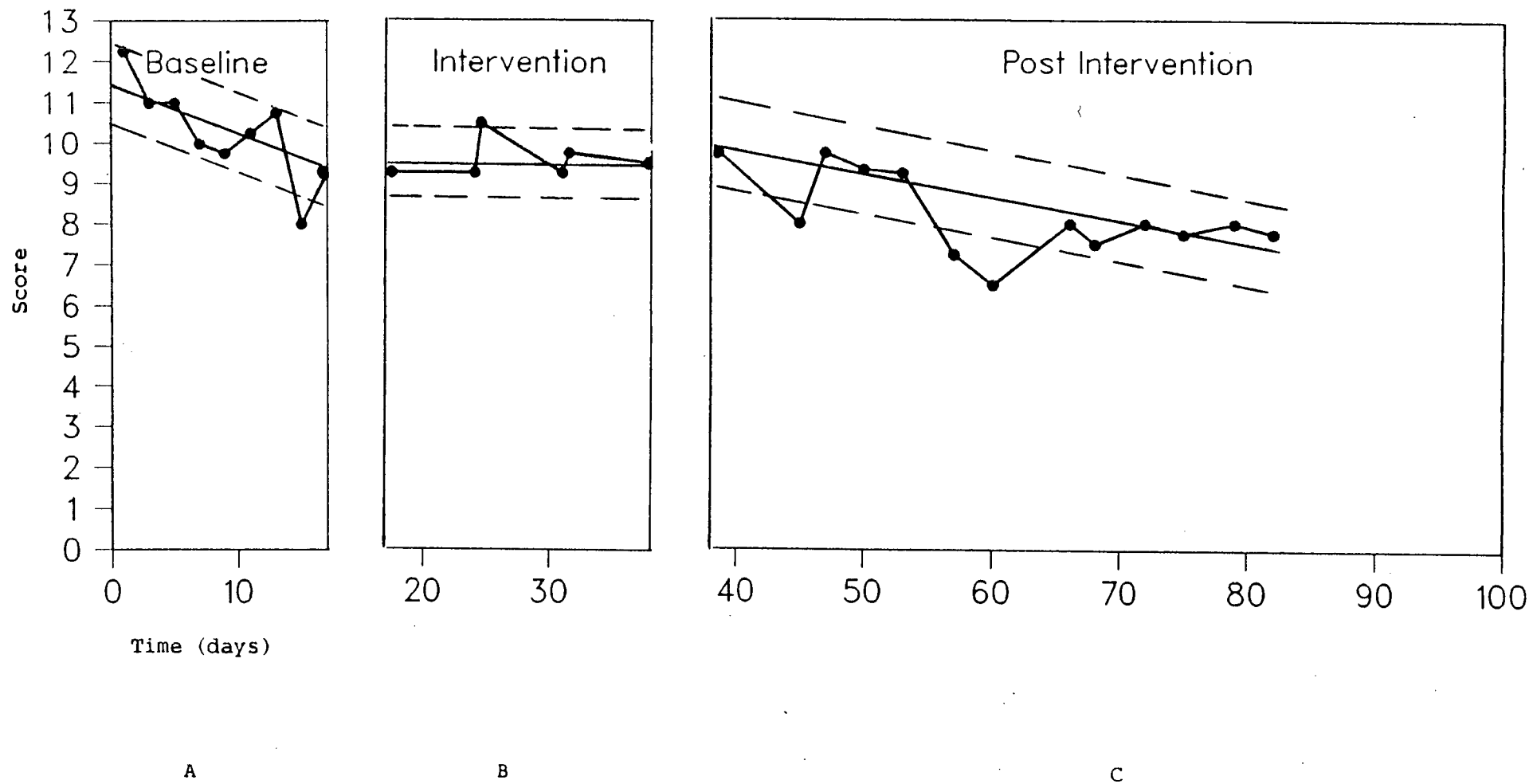


Figure 20

Group 2, Scale 5 Level Differences on Scale 5 - Difficulty Experienced in the Shy Situation

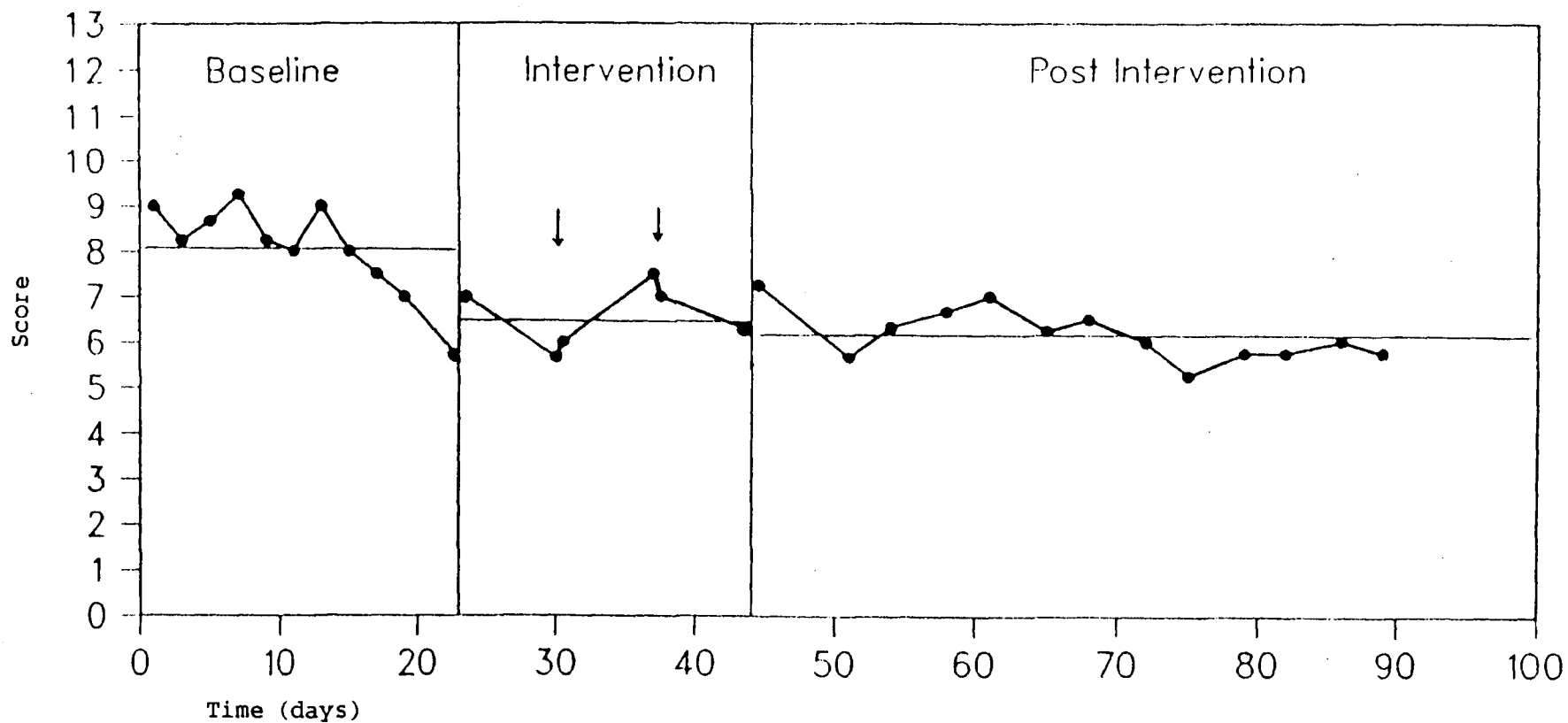


Figure 21

Group 2, Scale 5

Trends on Scale 5 - Difficulty Experienced in the Shy Situation

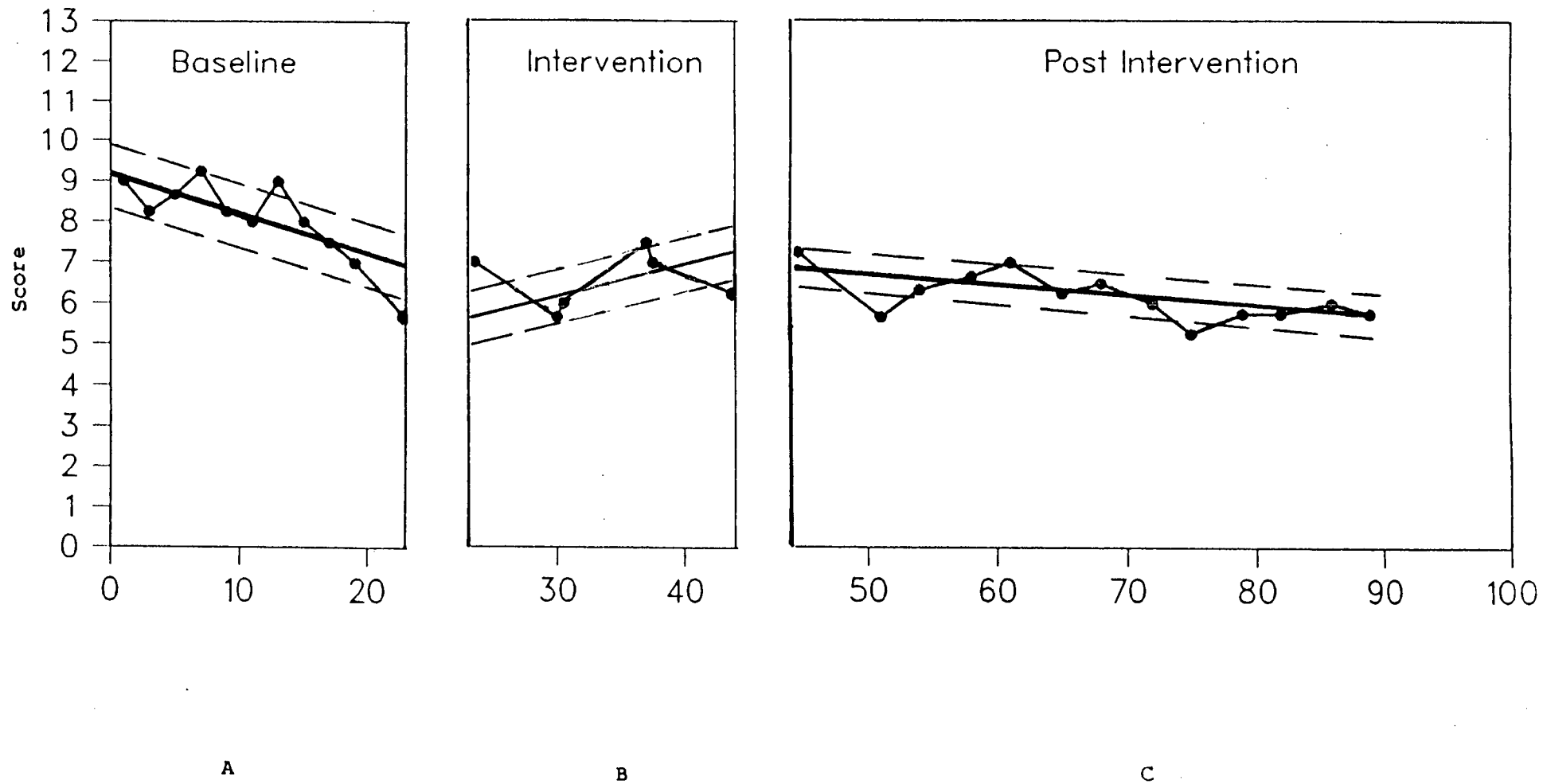


Figure 22

Group 3, Scale 5 Level Differences on Scale 5 - Difficulty Experienced in the Shy Situation

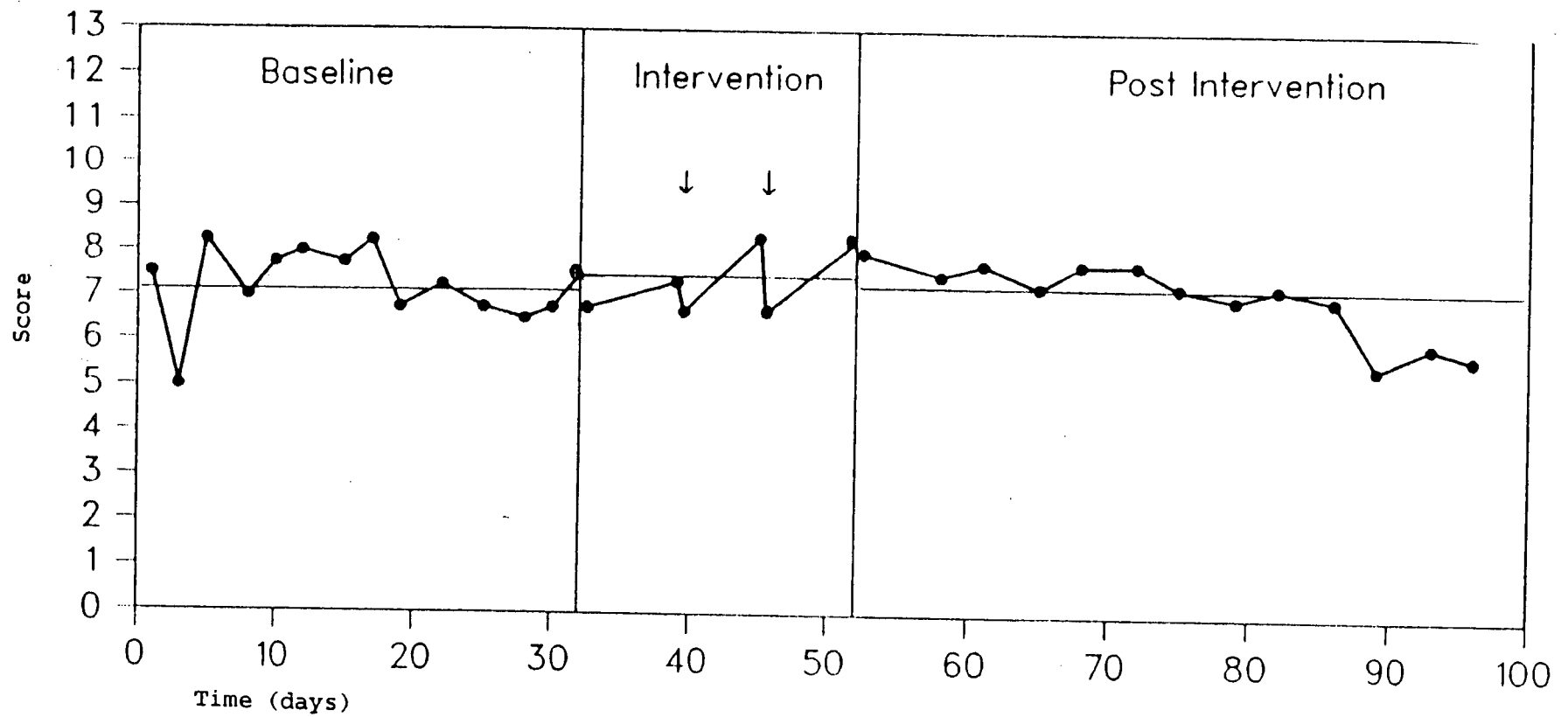


Figure 23

Group 3, Scale 5

Trends on Scale 5 - Difficulty Experienced in the Shy Situation

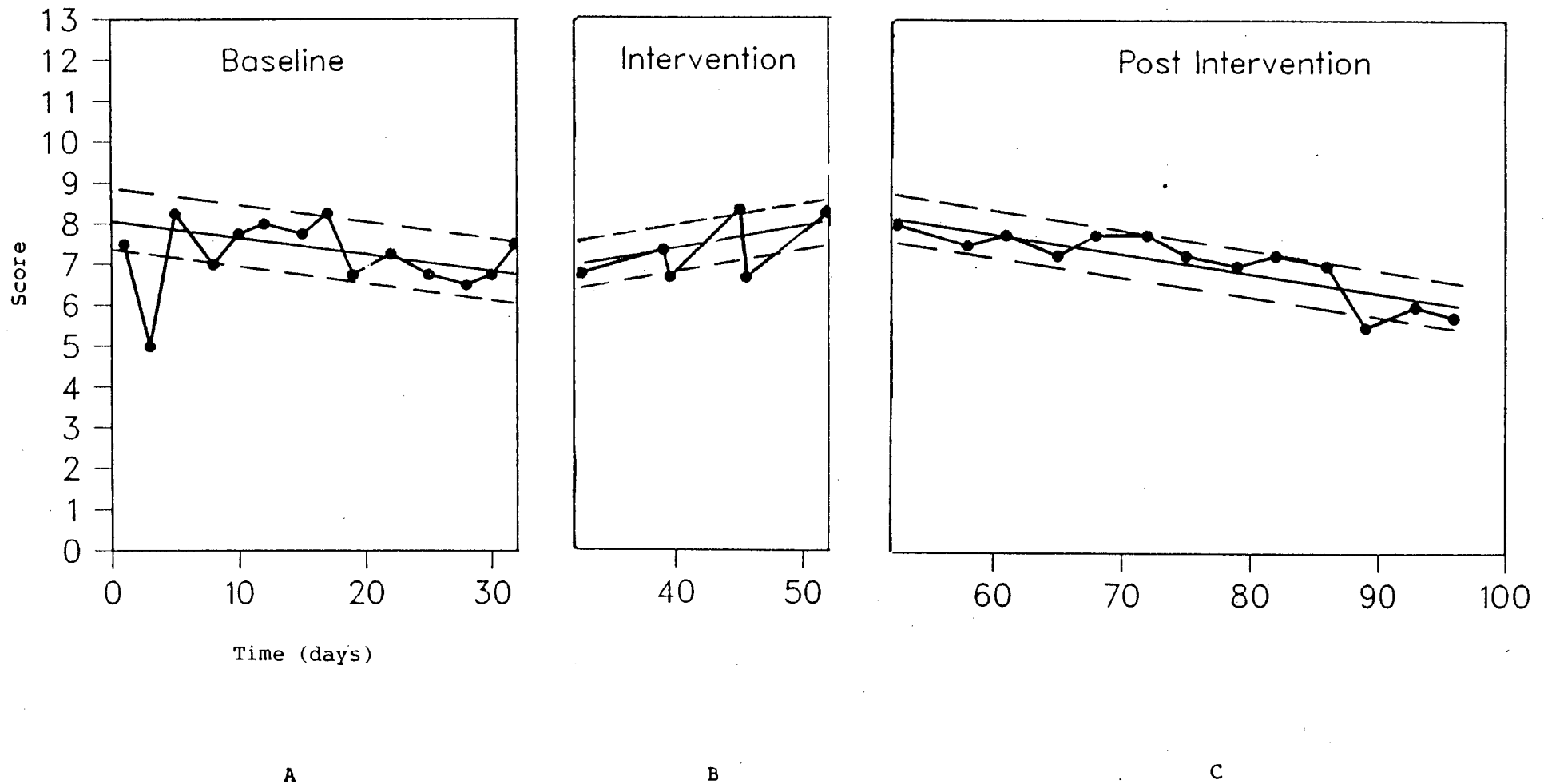


Figure 24

Research Question 5: Will Ss report increased confidence entering their shy/target situations a carrying out desirable action after the Morita counseling intervention?

All Ss except those in Group 2 report similar ratings on Scale 6, "Degree of confidence in shy/target situation", where an increased score corresponds to an increase in degree of confidence. This measure stands out in the study in that it reflects the least positive change overall. Even though trend directions in Groups 1 & 3 show an increase in confidence during the intervention phase, one levels out and the other decreases. Only Group 2, in the final phase, shows a positive change but even this trend direction is very unstable. In other words, the Ss completed the study reporting feeling slightly less confident in their shy/target situations than when they commenced it.

In Figure 25, Group 1 reports a level difference of -.73, a 5% decrease from Phase A to Phase C. Examining Figure 26, Phase A shows a slight upward trend direction (trend stability criterion envelope = 1.5) but variability is unacceptable at a trend stability of 55%. Phase B, in contrast, presents a sharp upward trend direction (trend stability criterion envelope = 1.4) but has even less trend stability at 67% making this trend direction questionable. Phase C shows a clear leveling out of Phase B trend

direction (trend stability criterion envelope = 1.4) but with even greater variability, trend stability being only 54%.

In Figure 27, Group 2's level difference is a negligible $-.07$, only 1% from Phase A to Phase C. Figure 28 shows a slight down trend direction in results (trend stability criterion envelope = 1.2) in Phase A with a near, but not acceptable, trend stability of 73%. Phase B reflects a downward trend direction (trend stability criterion envelope = 1.3) with an even less trend stability of 67%. Although Phase C clearly shows an upward trend direction (trend stability criterion envelope = 1.3), indicating higher reported confidence, it again has high variability, trend stability being 54%. Note however, that the last 2/3s of the phase (the last 8 observations) has a trend stability of 88%, perhaps pointing to improvement over a long range for this group of Ss.

On examining Figure 29 Group 3, as with the other groups, a minimal level difference is revealed. Here it is $-.04$, which is 0%, from Phase A to Phase C, indicating no decrease in the reported degree of confidence. Figure 30 shows a slight down trend direction in Phase A (trend stability criterion envelope = 1.3) where trend stability is only near to acceptable at 79%. Phase B shows a definite upward trend direction (trend stability criterion envelope =

Group 1, Scale 6

Level Differences on Scale 6 -
Degree of Confidence Experienced
in the Shy Situation

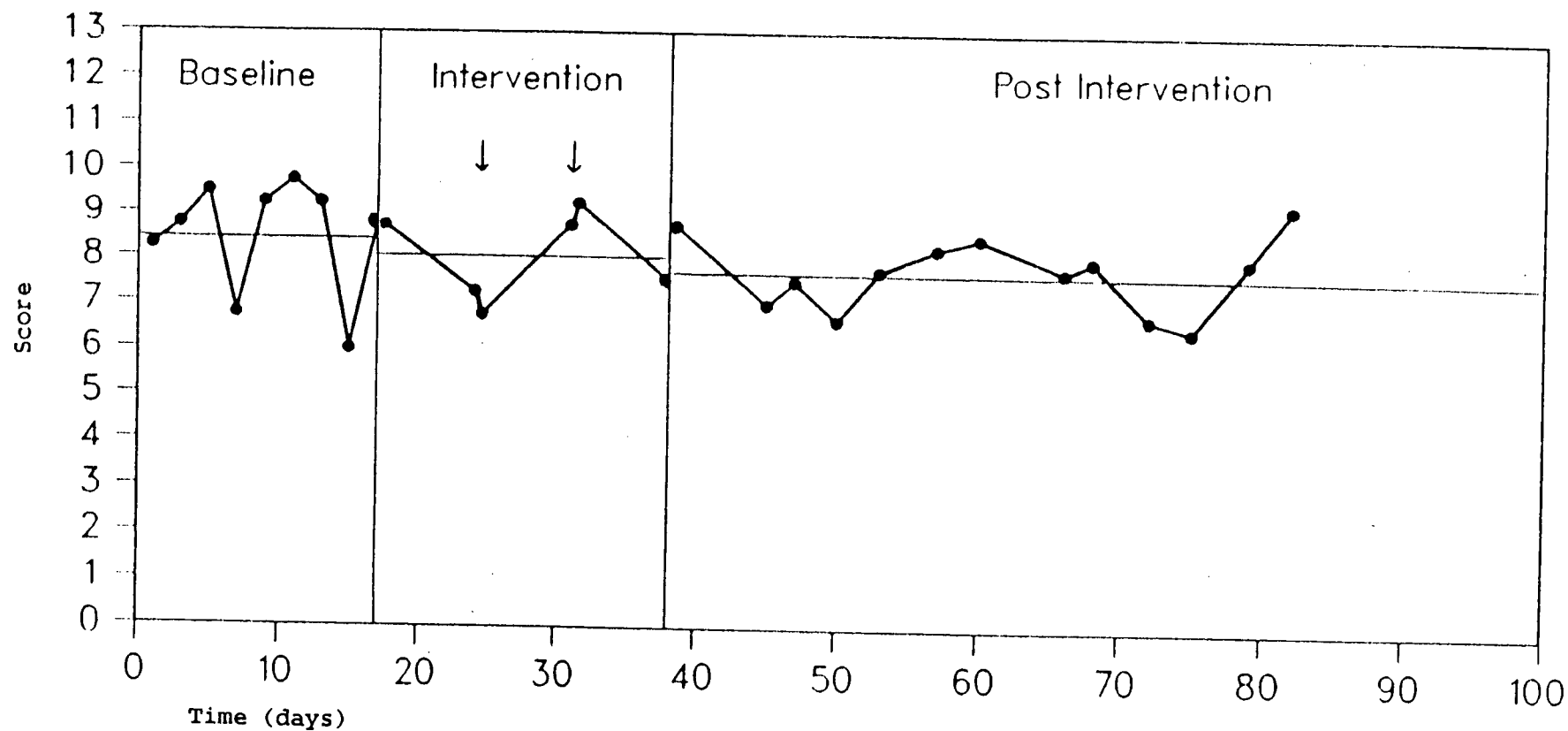


Figure 25

Group 1, Scale 6

Trends on Scale 6 - Degree of Confidence Experienced
in the Shy Situation

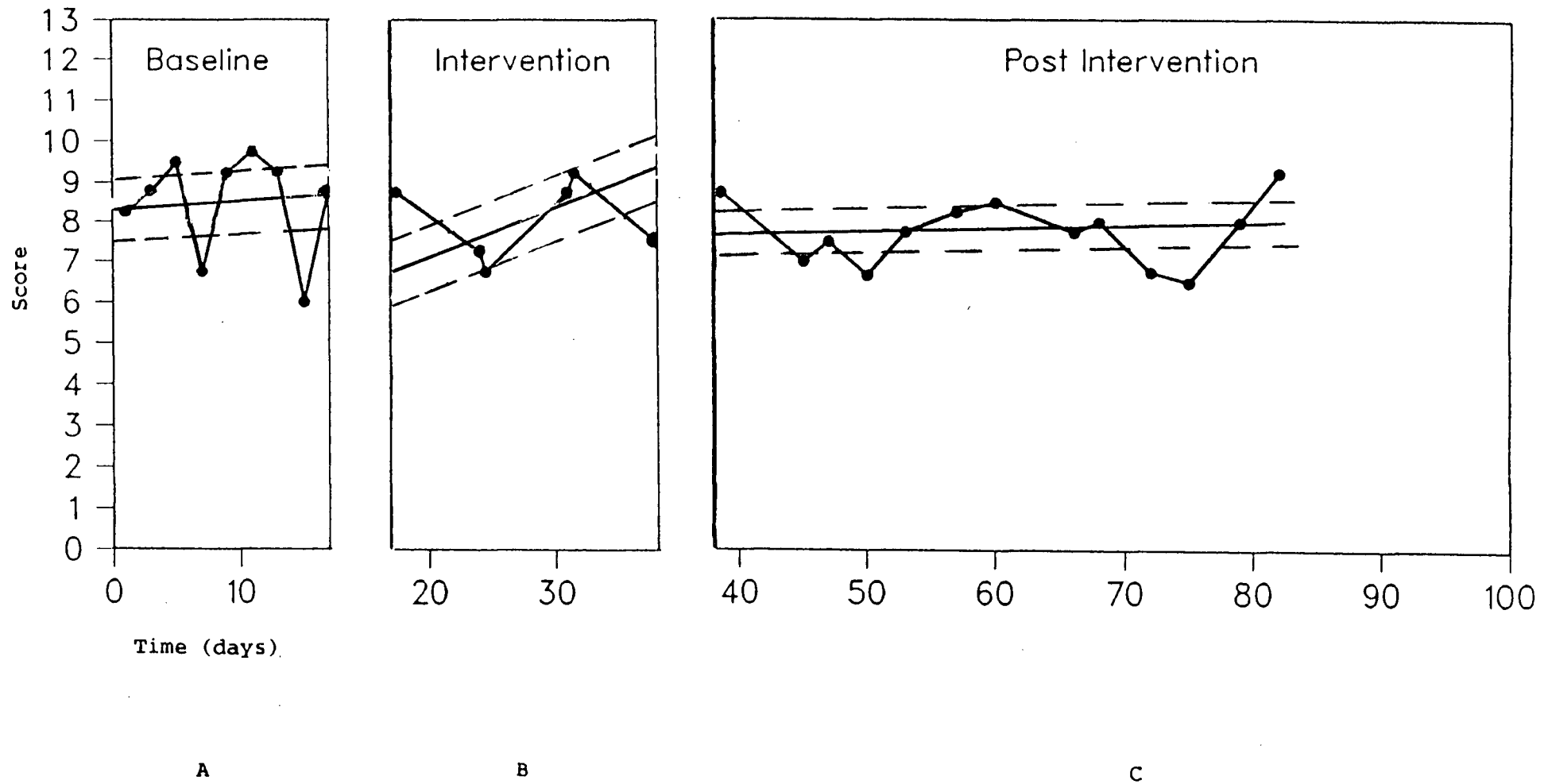


Figure 26

Group 2, Scale 6 Level Differences on Scale 6 - Degree of Confidence Experienced in the Shy Situation

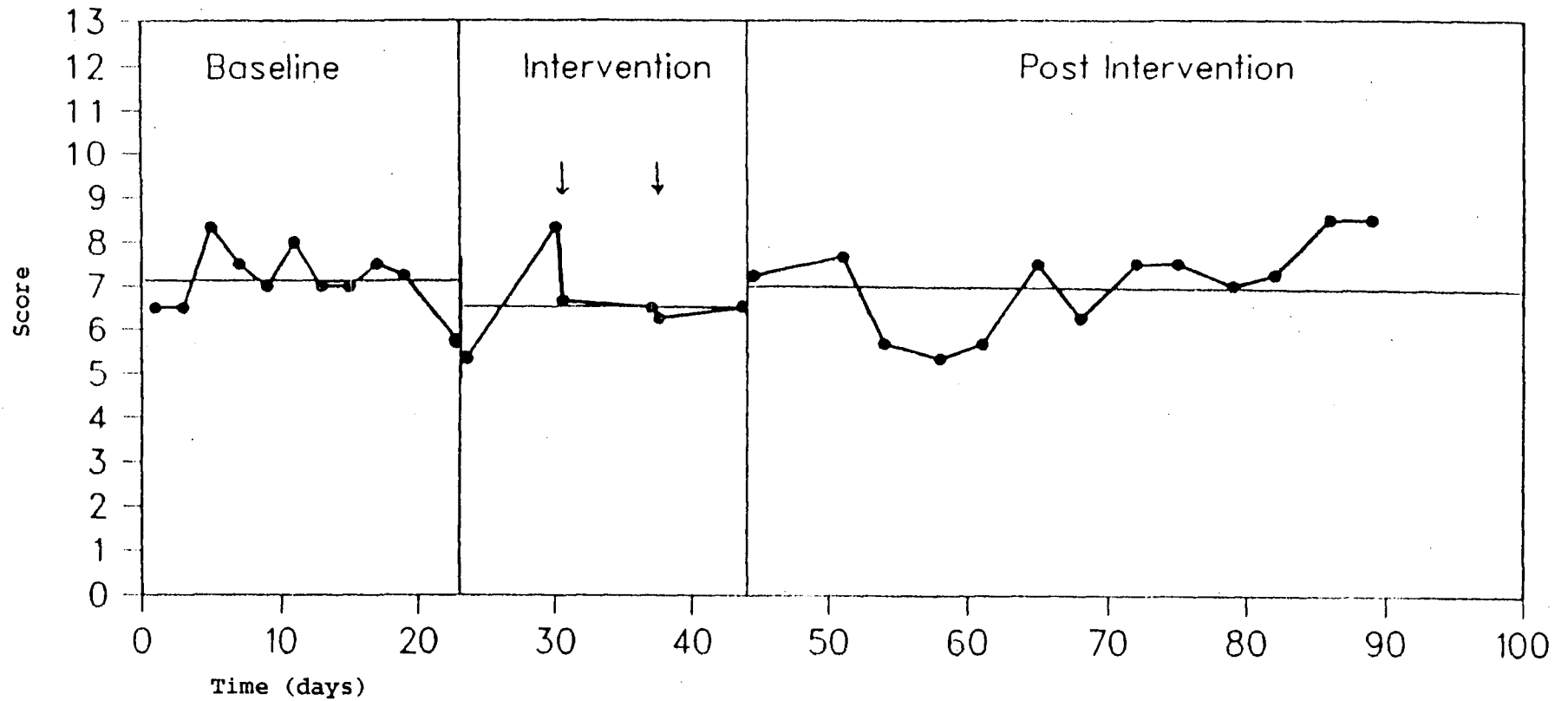


Figure 27

Group 2, Scale 6

Trends on Scale 6 - Degree of Confidence Experienced
in the Shy Situation

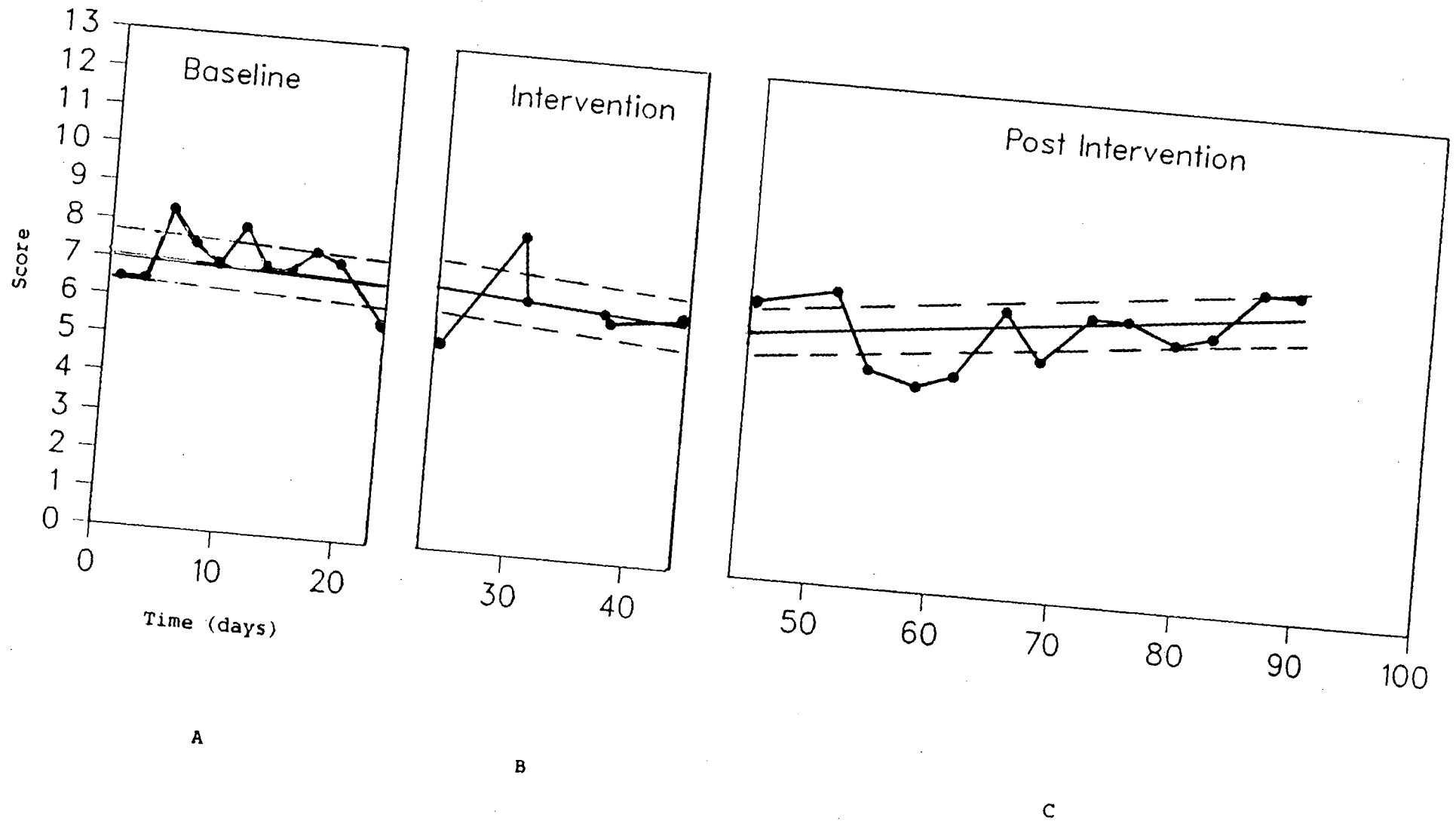


Figure 28

Group 3, Scale 6 Level Differences on Scale 6 - Degree of Confidence Experienced in the Shy Situation

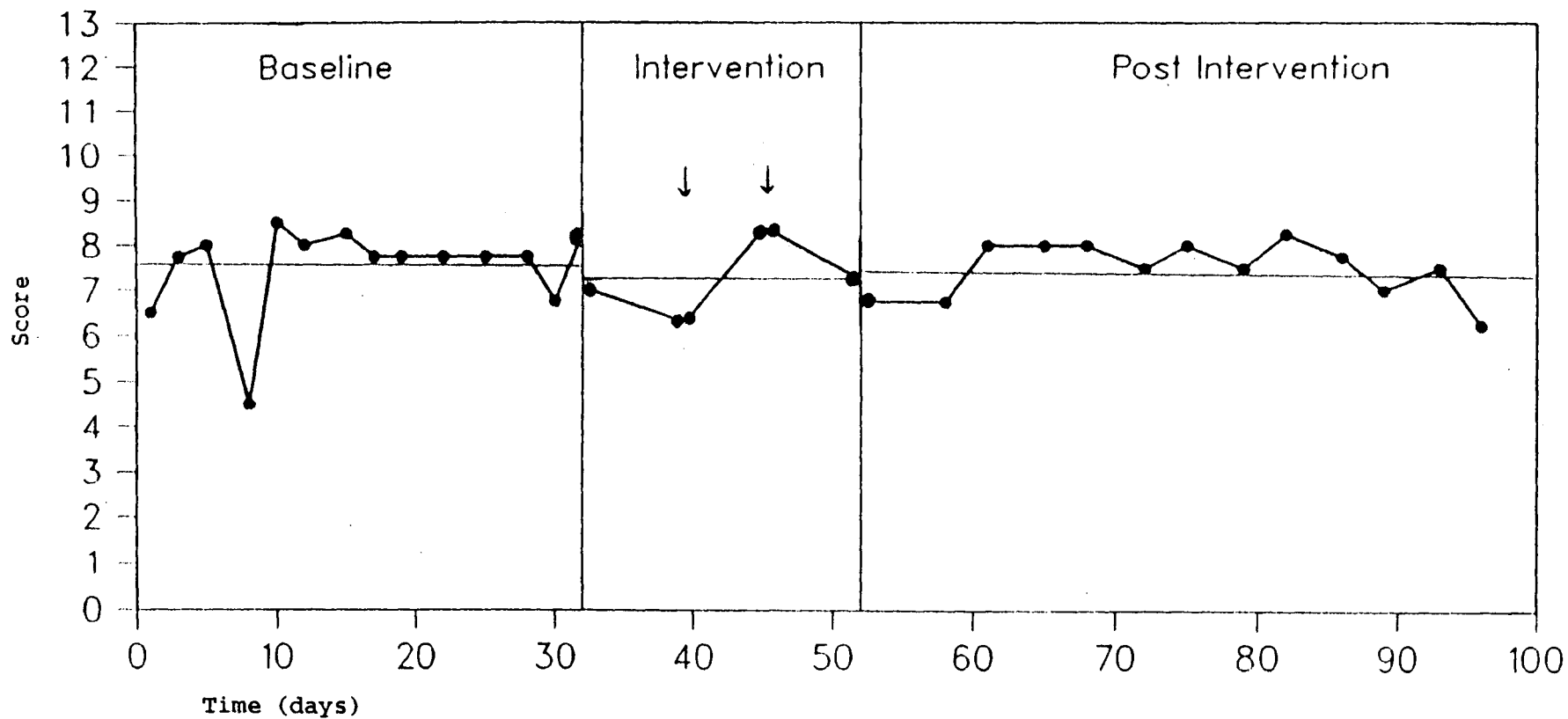


Figure 29

Group 3, Scale 6

Trends on Scale 6 - Degree of Confidence Experienced
in the Shy Situation

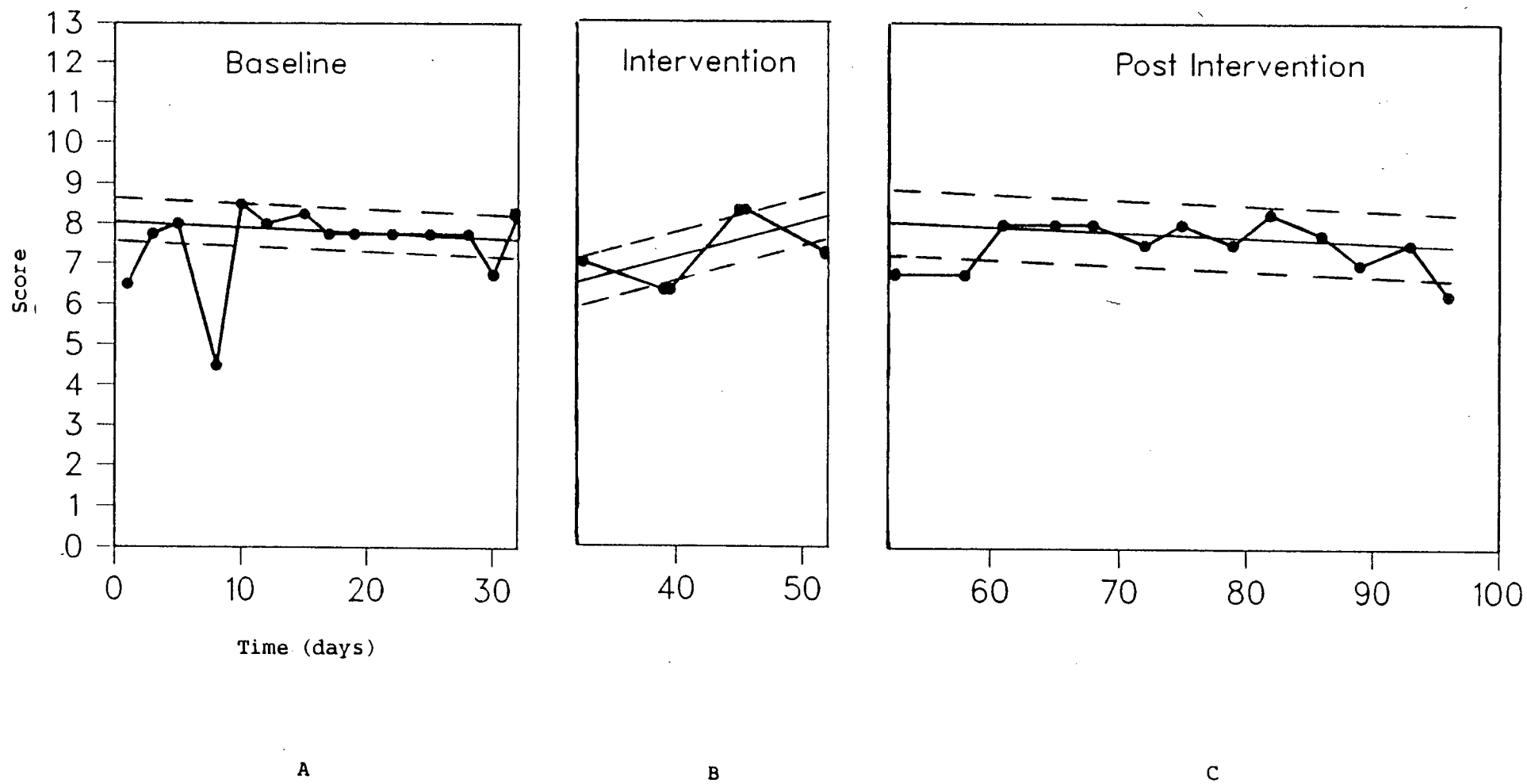


Figure 30

1.2) with great variability, trend stability being 34%. Phase C has a clear down trend direction (trend stability criterion envelope = 1.2) but with less than acceptable trend stability at 77%, indicating that confidence is declining but not at a stable rate.

Summary - According to these overall results, the groups completed the study reporting feeling slightly less confident than when they commenced. In the intervention phase Groups 1 & 3 show appreciable upward trend directions indicating increased confidence but these level-off or drop in the post-intervention. Only Group 2, although showing a downward trend direction in Phase A and B, indicates a clear improvement in that the stable trend direction, post-intervention continues on an obvious upward slope. Graphs, in figures twenty-five to thirty, are presented on the following pages.

Research Question 6: Will Ss report a decrease in anxiety severity in their shy/target situations after receiving Morita counseling as the intervention?

Examining the results on the 13 point continuum on Scale 4, "How intense are your average anxiety reactions in

the shy/target situations?", where a lower score indicates improvement, reveals again that Groups 1 & 2 present definite positive change, i.e., they report less anxiety intensity, while Group 3 lags behind with less reported positive change.

As seen in Figure 31, Group 1's level difference comparing Phase C to A is 2.49, a 19% decrease. This result reflects the greatest improvement for all groups on all scales. Looking at Figure 32, the Phase A trend direction (trend stability criterion envelope = 1.7) is a trend up - slope direction and very stable at 100%. At Phase B this trend direction levels out (trend stability criterion envelope = 1.6), and trend stability is only 67%. A barely perceptible downslope trend direction (trend stability criterion envelope = 1.47) is seen in Phase C but is quite stable at 92% stability.

In Figure 33, Group 2 shows a similar change to Group 1 in that the Phase C-A level difference is 2.22, which is 17% lower. This reflects the second greatest improvement for all groups on all scales. Examining Figure 34, the trend direction (trend stability criterion envelope = 1.4) in Phase A shows a sharp downslope trend direction with an almost acceptable trend stability of 82%. Phase B continues with this trend direction (trend stability criterion envelope = 1.1) but at a level 2 points lower than Phase A.

Here there is 83% trend stability. Phase C shows a definite continuation of downslope direction (trend stability criterion envelope = 1.1) however, trend stability is below acceptable at 77%. Again, almost the last half of this phase has a trend stability of 100%, pointing out that perhaps, if given an extension of time, this group's trend direction could stabilize.

Figure 35 shows Group 3 reporting being only slightly less bothered by the anxiety problem with a level difference of Phase C from A of .53, which is 4% lower. In Figure 36, the Phase A trend direction (trend stability criterion envelope = 1.4) slopes downward and has a trend stability of 79%, while Phase B (trend stability criterion envelope = 1.2) reverts to an upward trend direction again with a low trend stability at 67%. Phase C, however, shows a definite downward trend direction (trend stability criterion envelope = 1.3) indicating that anxiety intensity is diminishing. Variability is not at the acceptable level but comes near to it at 77%. It would appear that the intervention effect lagged somewhat and showed itself with further assimilation and/or practice of the Morita learning.

Summary - Improvement is indicated for all groups according to these results in that the anxiety severity caused by the shyness problem is decreased. The greatest improvement is shown by Groups 1 & 2 when level differences

Group 1, Scale 4

Level Differences on Scale 4 -
Intensity of Anxiety Reactions

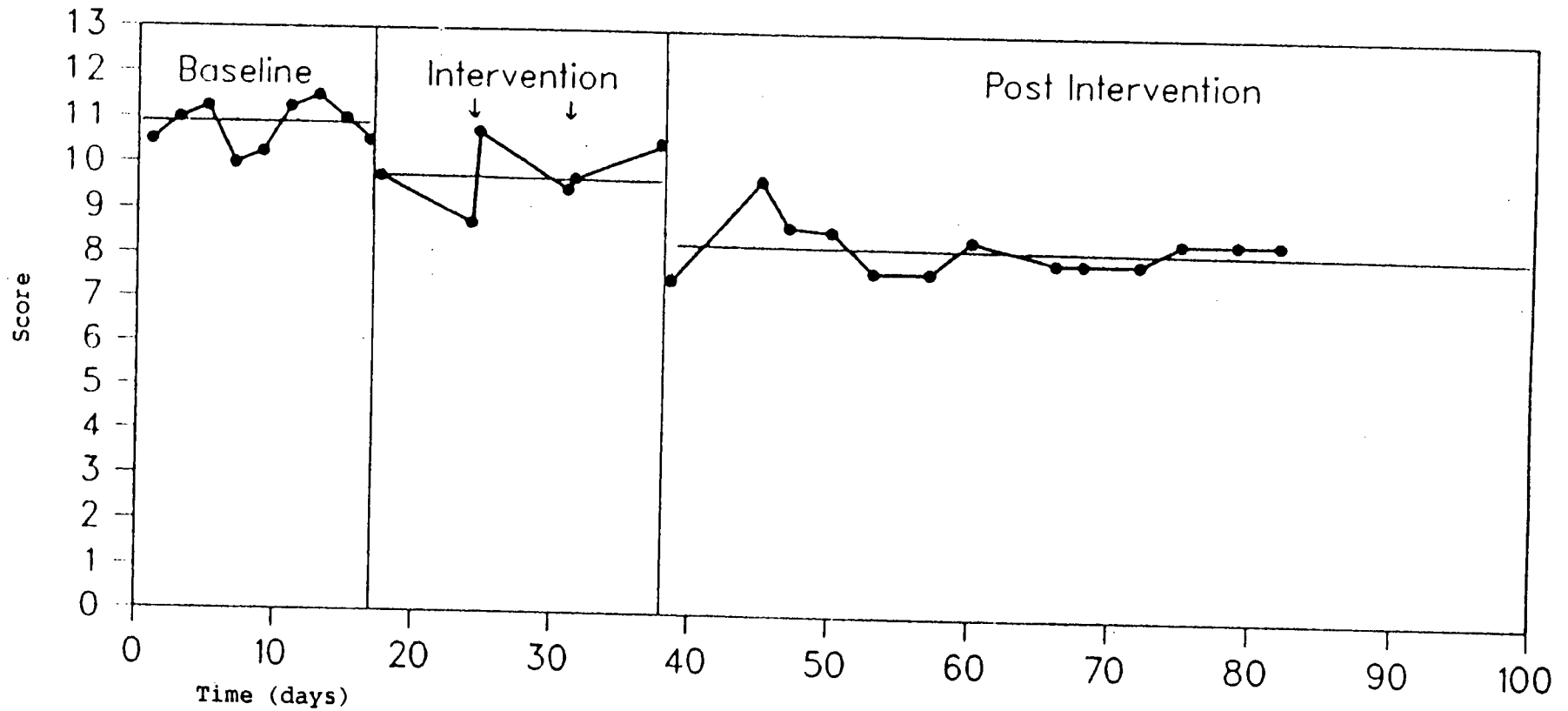


Figure 31

Group 1, Scale 4

Trends on Scale 4 - Intensity of Anxiety
Reactions

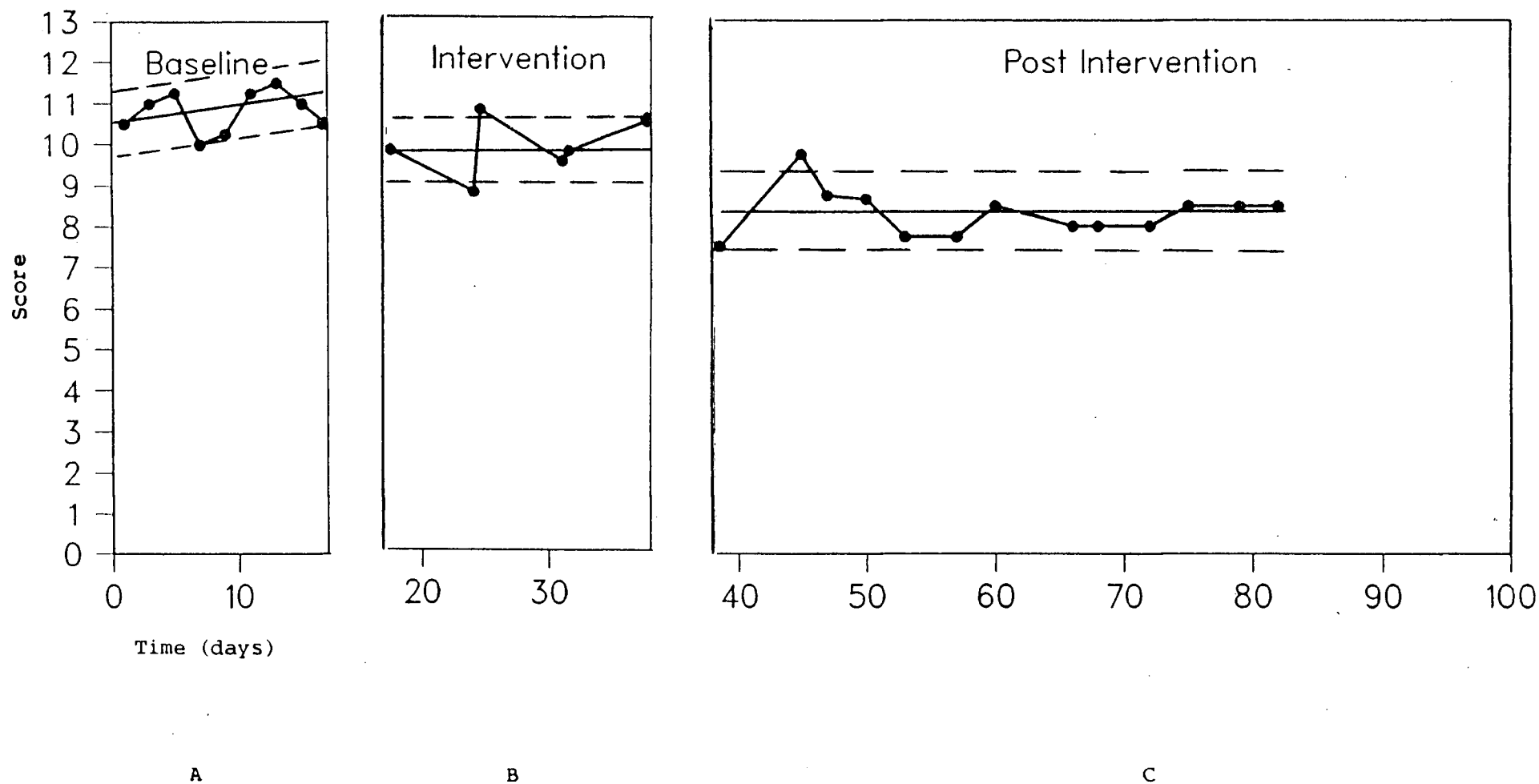


Figure 32

Group 2, Scale 4 Level Differences on Scale 4 - Intensity of Anxiety Reactions

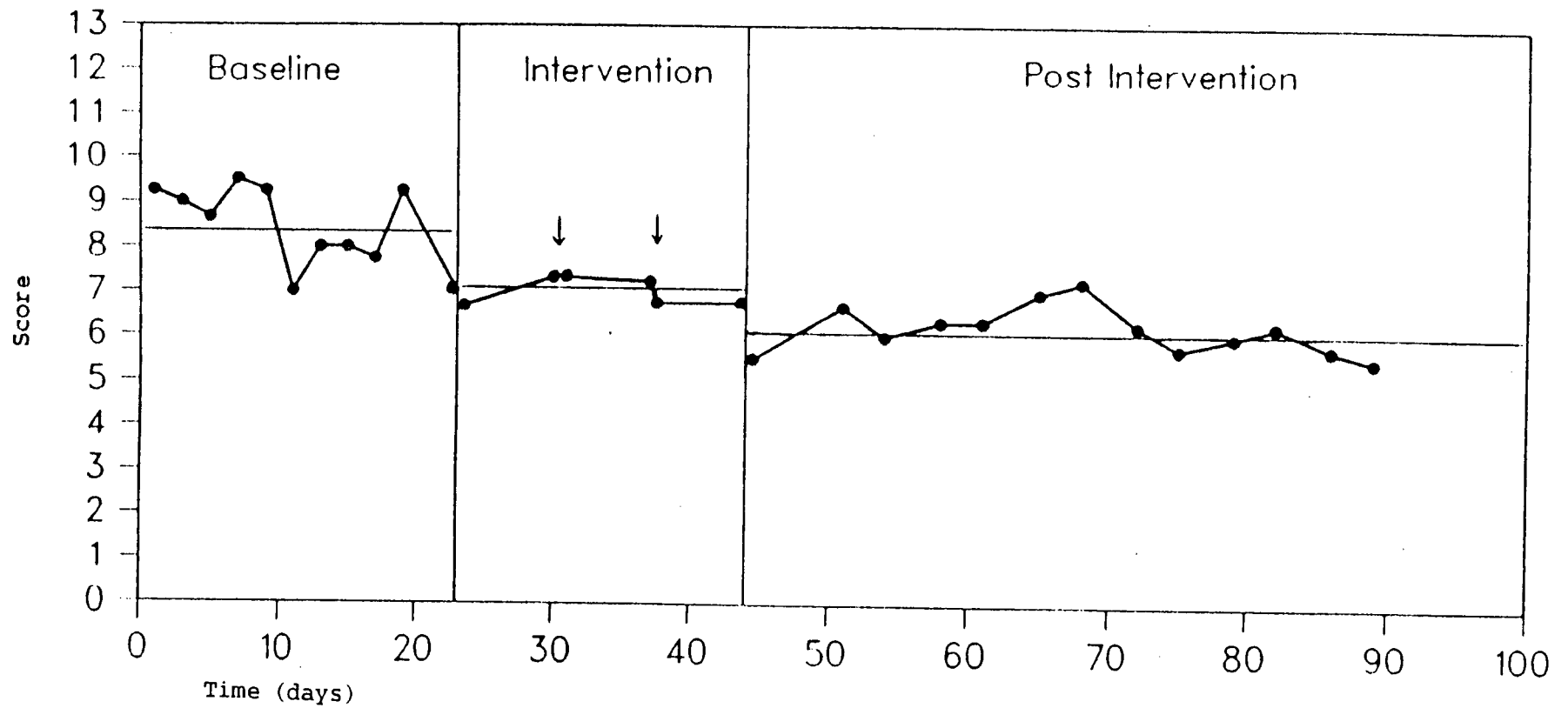


Figure 33

Group 2, Scale 4

Trends on Scale 4 - Intensity of Anxiety Reactions

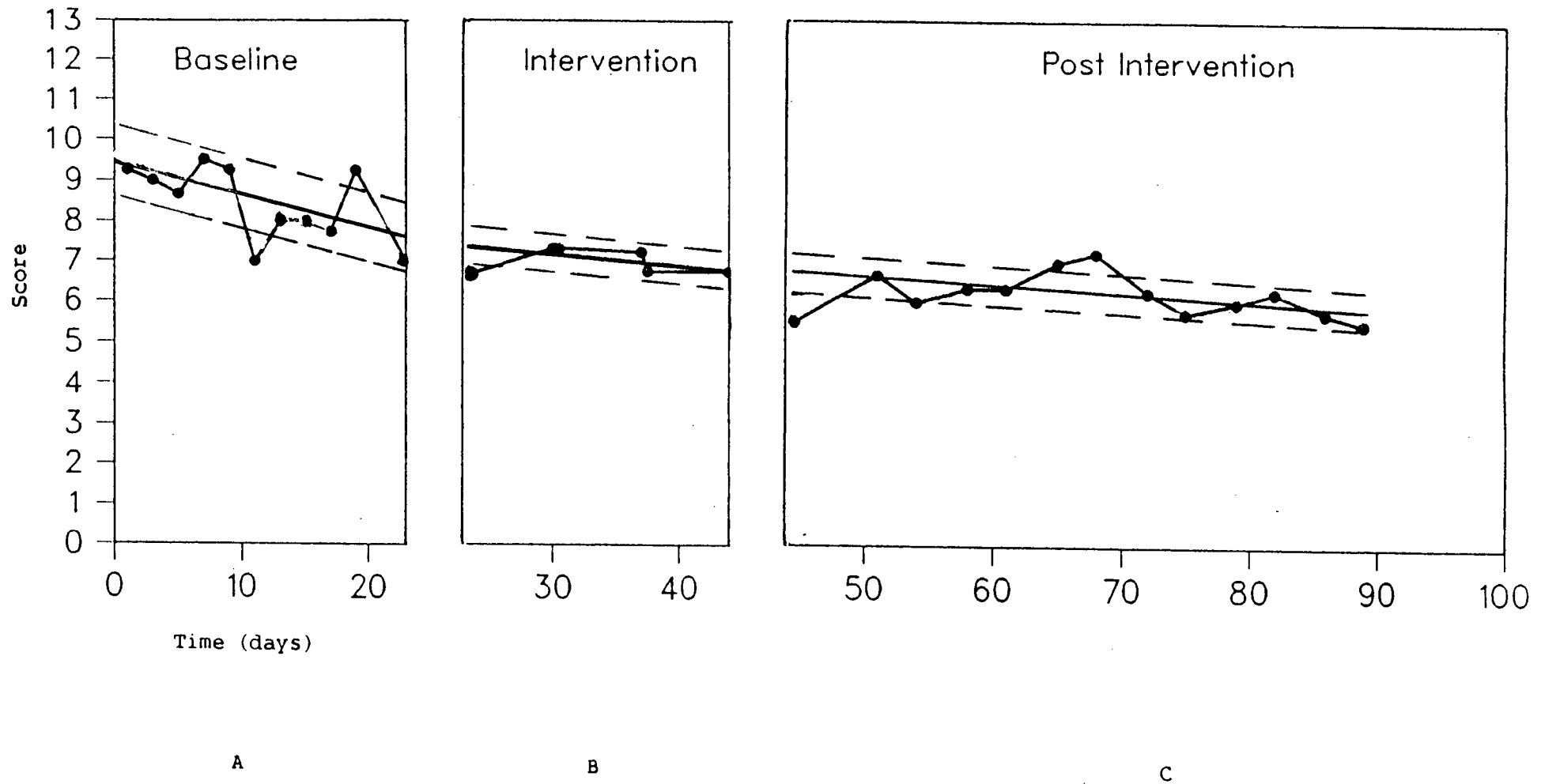


Figure 34

Group 3, Scale 4

Level Differences on Scale 4 -
Intensity of Anxiety Reactions

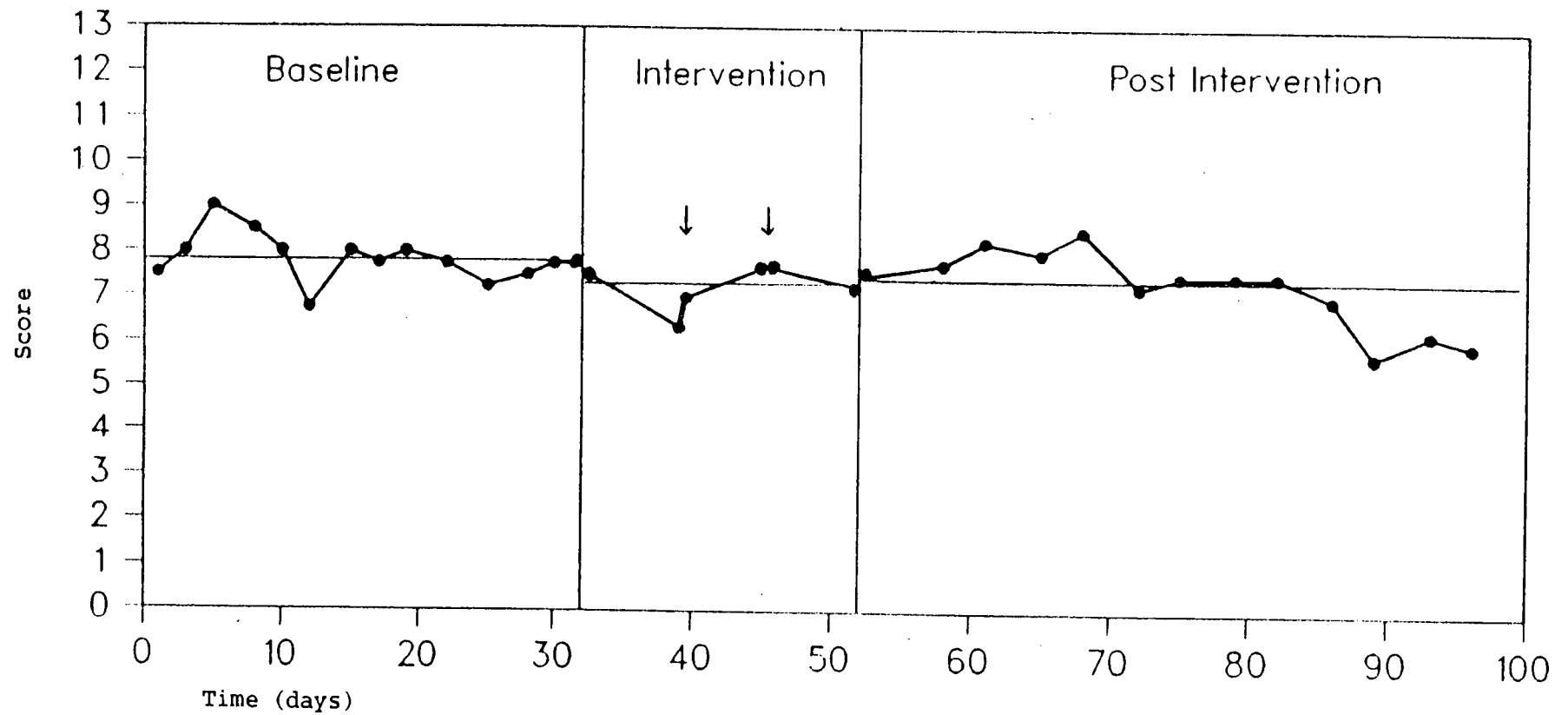


Figure 35

Group 3, Scale 4

Trends on Scale 4 - Intensity of Anxiety Reactions

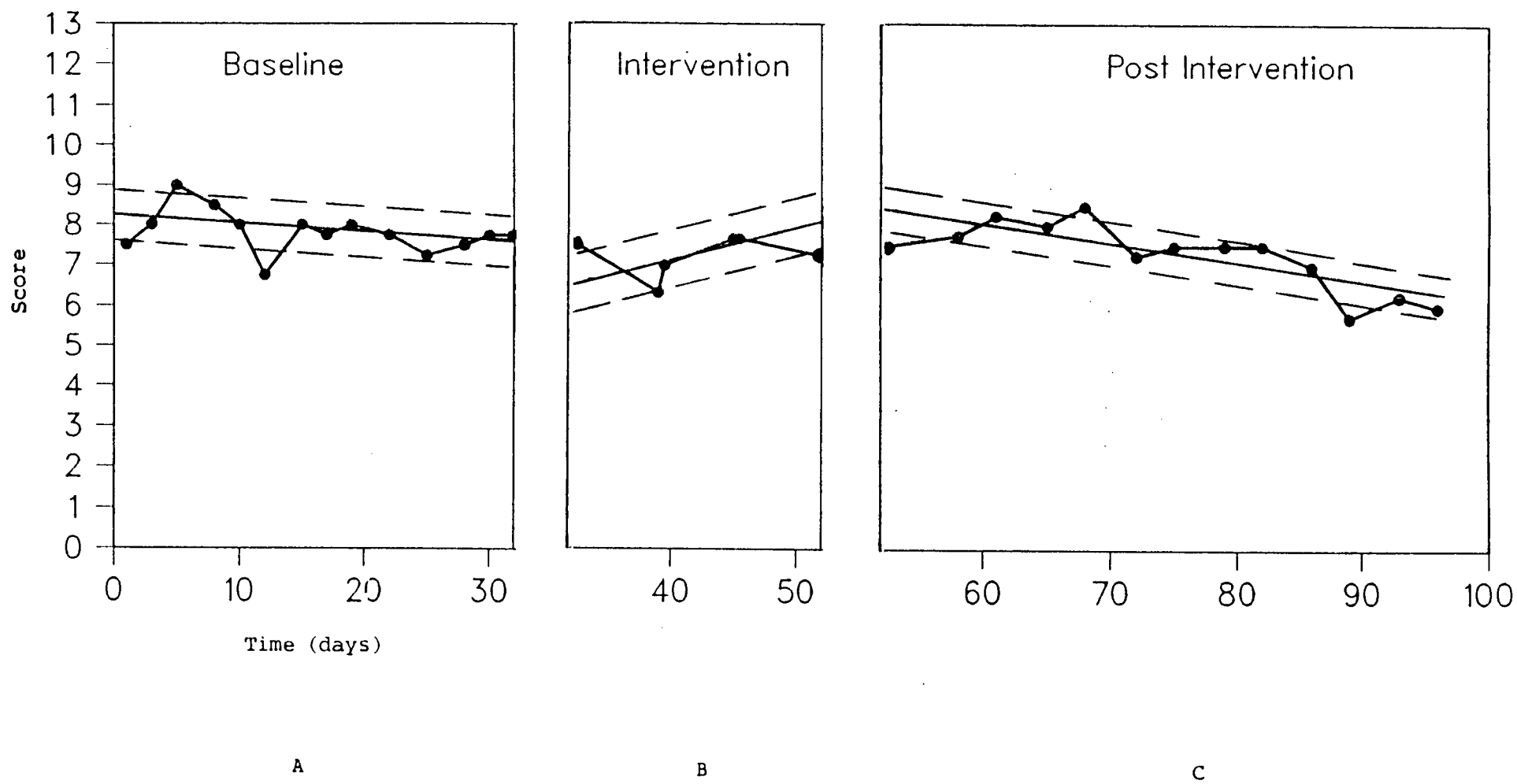


Figure 36

are observed. As to trend directions, Groups 1 & 3 show greater improvement in that anxiety showed an increase either in the pre-intervention or intervention phase but reverted to a downward trend direction in the post-intervention phase especially for Group 3. Graphs, in figures thirty-one to thirty-six, are presented on the following pages.

Considering scores from all three groups, the following Table 3 is a summary of the percentage of change that occurred, i.e., improvement reported by Ss over the 7-repeated measures when examining level differences. Due to the small n, no definite statement can be made as to whether changes are statistically significant.

II Statistical Analysis of Repeated Measures

In addition to item-analysis and internal consistencies reported under MEASURES in Chapter 3, the 7-Repeated Measures were examined for Mean differences during the Baseline and Post-Intervention phases. Table 4 on the following page lists these findings. It is possible that the use of T-tests could result in the findings not being generalizable due to the possibility of serial dependency.

TABLE 3

PERCENTAGES of IMPROVEMENT for all GROUPS
on the 7-REPEATED MEASURES (Note 1)

Scale	Group 1 (<u>n</u> =4)	Group 2 (<u>n</u> =4)	Group 3 (<u>n</u> =4)

Anxiety Severity Scale	19%	17%	4%
Degree of Difficulty Scale	16%	14%	1%
Coping Effectiv- ness Scale	14%	15%	3%
Anxiety Acceptance Scale	11%	14%	3%
Overall Bother- someness Scale	11%	11%	10%
Level of Confidence Scale	5%	1%	0%

Note 1: Taken by group, Mean score differences between
Pre-and Post-Intervention phases were calculated
for each scale and transformed into a percentage.

TABLE 4

STATISTICAL ANALYSIS of 7-REPEATED MEASURES -
a COMPARISON BETWEEN BASELINE and POST-INTERVENTION

	BASELINE		POST-INTERVENTION			
Scale	Mean (S.D.)		Mean (S.D.)		df	t (2-tailed)
Coping effect- iveness	28.70	(8.05)	34.73	(7.32)	11	-3.00*
Intensity of anxiety	9.05	(2.06)	7.30	(1.59)	11	3.99**
Difficulty experienced	8.54	(2.31)	7.17	(1.94)	11	3.31*
Level of confidence	7.71	(2.03)	7.54	(1.67)	11	0.39ns
Overall bother- some	8.45	(2.50)	7.01	(2.01)	11	2.82*
Anxiety acceptance	36.93	(6.90)	44.23	(8.06)	11	-2.79*

n=12

* $p < .02$

** $p < .01$

ns = non-significant

T-tests are normally applied in comparing random data samples.

With the exception of Scale 6, "Degree of confidence in the shy/target situation", T-tests show definite positive change with significance value $<.05$

III Shyness Screening Scale

An analysis of the Pre- and Post-Intervention score results are presented in Table 2.

This comparison of Pre- and Post-Intervention values indicates a positive change in Ss report on their level of shyness, with a Mean difference or $t = 2.27$ and $p < .05$. Values from the two remaining observation points were not statistically significant. The reader is reminded that the study was not attempting to change Ss shy nature but rather to help them accept it and be productive in spite of that characteristic. It is possible that the change referred to above resulted from Ss becoming more accepting of their shy nature.

In addition to its use in screening, the Cheek and Buss Shyness Scale (Appendix 2), which is not part of the time-series measures, was used as an ancillary scale at Pre- and Post-Treatment phase points as well as in the follow-up

TABLE 2

Statistical Analysis of the Pre- and Post-Intervention
Difference on Scores on the Cheek and Buss Shyness
Scale (1981)

<u>n</u>	Pre-Intervention Mean (<u>S.D.</u>)	Post-Intervention Mean (<u>S.D.</u>)	<u>df</u>	<u>t</u>
11	31.27 (4.50)	29.00 (4.27)	10	2.27*

* $p < .05$ (2-tailed)

phase to gather further documentation of cognitive and behavioral changes.

IV Behavioral Reports

The Ss were requested to document at the end of each day, over a 5 consecutive day period before and after the Morita counseling intervention, the number of times they had attempted to enter their shy/target situations and take appropriate action. These reports were intended to be used as a behavioral comparison of post- to pre-intervention shyness activity. Specifically, in the Post-Intervention phase they would indicate the extent of application the Ss were making of their Morita learning.

A. In the Behavioral Counts graph below of all Ss together where score represents the number of attempts made, a clear increase in counts has taken place with the Pre-Intervention phase $M = 2.5$ and the Post-Intervention phase $M = 4.6$. This latter score is close to a 100% increase from the Pre-Intervention total counts indicating that, overall, Ss made a significantly greater number of attempts to practice dealing directly with their shyness problem after the Morita counseling. The 'Behavioral Counts' graph, in figure thirty-seven, is presented on the following page.

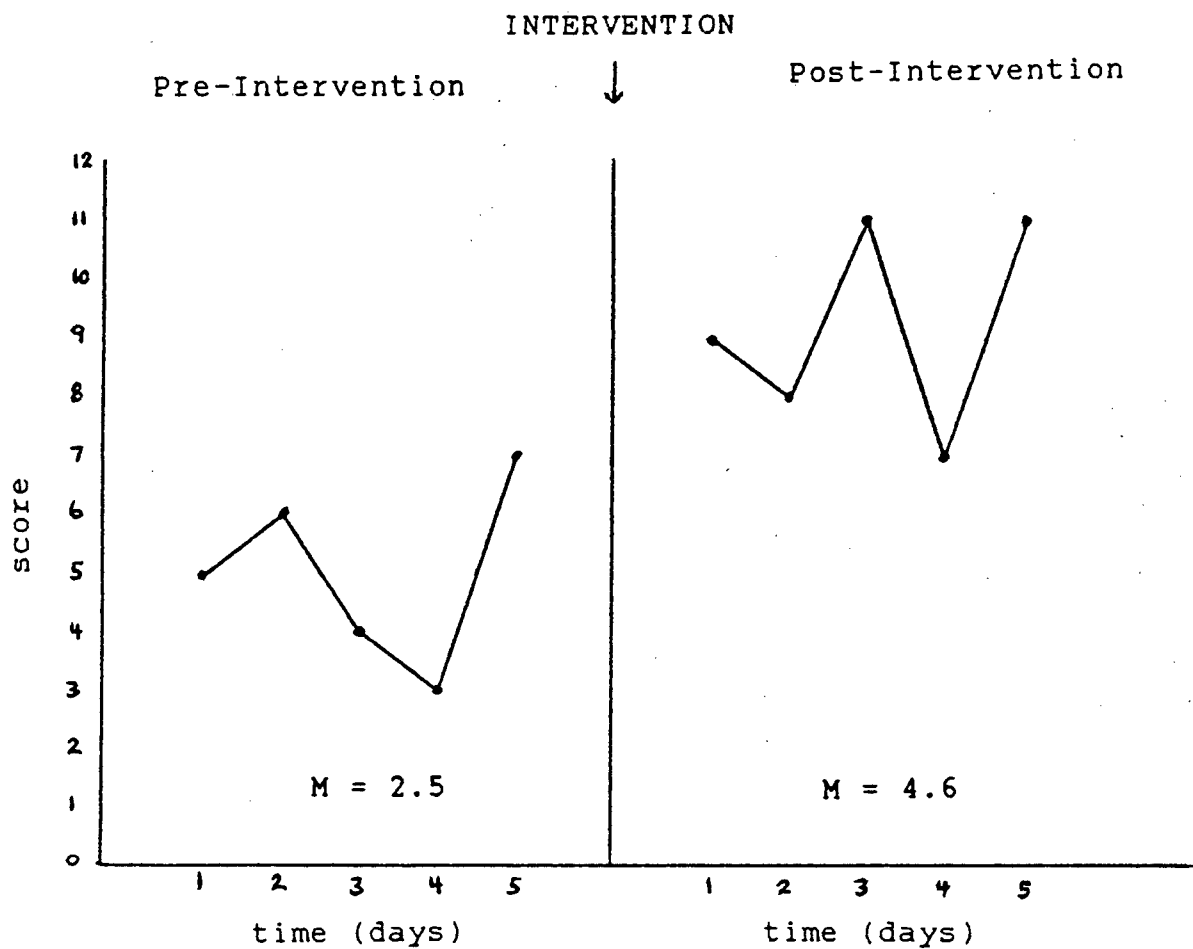
BEHAVIOURAL COUNTS - $N=10$ 

Figure 37

B. Statistical analysis of Behavioral Counts are also presented here (Table 5 on the following pages) where a comparison of Mean differences is included.

According to these results ($t = 2.02$), definite positive change has occurred for the Ss in total in terms of increased initiating of action taking in the shy/target situation. Table 6 provides a more detailed analysis.

V Summary

On examining the above results, it can be concluded that positive change occurred for all three groups as reflected by their scores on five out of the six scales administered. The exception is Scale 6, "Degree of Confidence in the Shy/Target Situation", where two groups revealed a slightly less degree of feeling confident. Only Group 2 showed improvement in the post-intervention phase. It is of interest to note however, that on Scale 5, "Degree of Experienced Difficulty in Action Taking in the Shy Situation", all subjects began by showing improvement in the pre-intervention phase. This positive change accentuated though, in the post-intervention for Groups 2 and 3, reflecting even less experienced difficulty for these subjects at the completion of the study. To a lesser degree, this same occurrence can be observed for these same groups on

TABLE 5

STATISTICAL ANALYSIS of DIFFERENCE in BEHAVIORAL COUNT
SCORES (Note 1) PRE- and POST-INTERVENTION PHASES

<u>n</u>	Pre-Intervention Mean (<u>S.D.</u>)	Post-Intervention Mean (<u>S.D.</u>)	<u>df</u>	<u>t</u>
10	2.50 (3.41)	4.60 (3.89)	9	-2.02*

* $p < .05$ (1-tailed)

Note 1: These values represent the aggregate number of attempts at entering their shy/target situations of all subjects as reported daily. Counts were recorded over two 5-day periods, one in the Pre- and the other in the Post-Intervention phase.

TABLE 6

STATISTICAL ANALYSIS of BEHAVIORAL COUNTS -
 a COMPARISON BETWEEN BASELINE and POST-INTERVENTION

GROUPS	BASELINE	POST-INTERVENTION
	Mean (S.D.)	Mean (S.D.)
Group 1 (<u>n</u> = 3)	1.0 (1.42)	3.0 (2.94)
Group 2 (<u>n</u> = 4)	3.5 (3.84)	6.5 (4.43)
Group 3 (<u>n</u> = 3)	2.7 (3.09)	3.7 (2.36)

Scale 7, "Overall Disturbance Caused by the Shyness Problem". Improvement in the pre-intervention is present but again a clear accentuation of positive change follows in the intervention and post-intervention phases. Based on these results, it is apparent that the intervention, Morita counseling sessions, effected an improvement for all groups on the components of the shyness experience measured except for level of confidence.

The Behavioral Counts recorded for the purpose of monitoring the subjects' application of the Morita concepts reveal a clear improvement overall for all subjects. The average number of attempts at constructive action taking post-intervention almost doubled that in the pre-intervention phase.

CHAPTER V

DISCUSSION, LIMITATIONS, RECOMMENDATIONS and CONCLUSIONS

I Discussion of Results

The discussion of results of this research study will focus on the central question, "Is Morita counseling, conducted in the form of 4 brief counseling sessions with small groups of adolescent females, effective in bringing about positive cognitive and behavioral change?". The sequential research questions from the previous chapter will not be repeated. Interpretation of results will be confined only to those findings that this researcher considers most interesting, important and significant.

Some aspects of the study, however, require special note as in the following:

a) Baselines - Ideally baselines should be extended in cases where high variability occurs. In this study, the time commitment already placed a great demand on the students resources and so extending this commitment would most probably have resulted in less participation and in attrition of Ss. To this researcher it seemed unrealistic, given the circumstances, to bring greater pressure to bear on the Ss, and to encompass further periods of examinations and holidays, in order to extend the study beyond the 14

week period. Additionally, for most Ss, high variability is seen in the initial part of this phase. This could have resulted from, a) a novelty effect, b) unclear comprehension of instruction, or c) lack of self-knowledge in reporting. Limitation is also observed for example in Group 2, the baseline was already starting to show improvement so it is difficult to state to what degree the intervention brought about positive change.

b) Intervention Phase - Frequent fluctuation is observed in this phase probably due to Ss being in the process of assimilation of new learning within a relatively short period of time and each with varying attempts at application. Therefore, high variability in this phase is understandable. In addition, there is suspicion that the mixture of different academic grade levels lends perplexity to the results.

c) Follow-up Interviews - Half-hour follow-up interviews were conducted by another graduate student, 3 weeks after the final observation point for Group 3. Most Ss gave permission for the audiotaping of these sessions. From the information given by subjects, no sign of disturbance was observed. The Ss appeared satisfied with the treatment and therefore, no further follow-up treatment was necessary.

d) Feedback - Pursuant to the follow-up interviews a final meeting was held for all Ss where the researcher provided feedback information on the study's results. Half of the Ss

attended and the others were reached by telephone. Lunch was provided in appreciation for their involvement.

The reader is reminded, when examining results for significance, that the intervention was relatively brief. The four Morita counseling sessions of 45 minutes each resulted in a total of 3 hours, over a duration of 4 weeks, within a 14 week research study period. Also Ss ages spanned five adolescent years encompassing a wide range of developmental fluctuation.

A. Acceptance and Positive Attitude Towards

Shy/Anxious Nature

At the conclusion of the study, the positive change in the acceptance of anxiety was significant suggesting that Ss gained an increased acceptance and more positive view of the shy/anxious part of their nature. This was particularly true for Group 2 and to a lesser degree, Group 1. Presumably, one could extend this to state that Ss learned that this dimension of self need not be viewed as an adversary but rather as a natural part of human nature. Group 2 reflected the greatest improvement with Group 3 showing the least when considering before and after intervention levels. The upward trend line in the Post-Intervention for Group 2 with its 83% near acceptable stability clearly indicates continued improvement for these Ss. However, the Baseline also shows a

similar improvement considering its similar upward trend line and this could be interpreted that Ss would have continued to improve simply by being measured as in the Hawthorne effect (Roethlisberger & Dickson, 1947). Groups 1 & 3, on the contrary, show a decided change in trend direction from downward in Baseline to a distinct upward in Intervention reflecting that the Morita counseling was having a positive effect. Both groups then level off with a stable maintenance of improvement. In summary, Groups 1 & 3's trend lines perhaps lean more to indicating improvement due to Morita counseling.

B. Coping Effectiveness in the Shy/Target Situations

Overall, Ss indicated improvement in the ways they reported coping with anxiety in their target situations. Groups 1 & 2 fell within the top 50% of overall percentage improvement in the study, (arrived at by phase level comparisons) with increases of 14% and 15% respectively. Group 3's improvement was relatively less at 3%. In the Baseline, Groups 1 & 3's trend lines show a decrease in coping effectiveness perhaps due to increased consciousness of the problem (Fenigstein, 1979). However, both groups reflect an upward swing during the counseling sessions and continue this trend in a stable post-sessions period,

indicating some permanence of effect. Group 2's trend line shows a clear increase in coping effectiveness in the Baseline, but this phase was not stable and so cannot be considered. These are Ss who could have benefited from an extension of this phase if circumstances could have permitted. This applies to Group 1 as well and to Group 3 to a lesser extent. The final phase for Group 2, in any case, clearly shows an improvement occurring on an upward stable trend. Morita counseling, which promotes appropriate action taking in shy/target situations appears to have made an impact on these adolescents.

Behavior counts, which are most closely related to this construct, produced results similar to that of Christoff et al (1985) in effecting more positive social interaction. Kazdin & Mascitelli (1982) conclude that assignments contribute more to behavior change than other approaches.

C. Degree of Being Bothered by the Shy/Anxiety Problem

It is not one of the aims of Morita Therapy to rid the client of shyness but rather to have this problem be less troublesome and interfering in their productive life to mention one aspect. In this study, it can be stated that clear improvement occurred for all groups on this measure. Groups 1, 2, & 3 reported, respectively, 11%, 11%, & 10%

reduction in degree of troublesomeness from the shy problem. Individually, Ss 2, 4, 5, & 10 show drastic reduction on this component (see Appendix - Individual Ss Graphs). Comparing Phases A and C, $t = 2.82$ with $p = 0.017$, reveals a significant difference. Taking into account the briefness of the intervention, this is a definite and significant positive change.

On examination of trends, although baselines are not stable, there is an improvement in this aspect throughout the Intervention phase. There are definite downward trends for all groups in the Post-Intervention phase with Group 3's being stable. Considered in their entirety, none are acceptably stable making it questionable from this assessment point whether this apparent improvement would continue. On closer inspection, none the less, it can be observed that in Groups 1 and 2 the last half of the phase enjoys an 100% stability and in Group 3 the first eleven out of 13 observation points are close to acceptable stability with 82%, the last 2 points continuing to be lower than the trend line envelope. It could be argued that an extension of this phase would unquestionably show continued positive change for Groups 1 and 2. It might prove useful to take measures on this component periodically over the coming year to observe for this possibility.

D. Degree of Difficulty in Initiating Desirable Action
in the Shy/Target Situation

Two-thirds of the Ss reported a significant positive change, an average of a 15% improvement, in this area when level differences between Phases A and C are considered. A comparison of these two phases reveal a significant $t = 3.055$ with $p = 0.007$. All Phase C trend lines reflect clear, positive change. As a unit Group 1's Post-Intervention phase is not stable but almost the entire last half of it is 100% stable. Group 2 & 3 enjoy a solid stability clearly showing that these Ss report experiencing significantly less difficulty in initiating action taking in their shy/target situations.

E. Level of Confidence in Entering the Shy/Target
Situations

Overall, this component yielded poor results. It appears that all Ss, except those in Group 2, uniformly showed little positive change. So although most seemed able to report improvement on all the other components, here they report no noticeable gain. One of Morita's tenets states that confidence is gained through repeated practice of

appropriate action taking. It is possible that time limitation was a factor in that Ss, while being measured, had insufficient practice opportunities to enable them to reach that point of increased confidence. Also, it is possible that because the measure is set up in such a way as to focus on the pre-action taking feeling, Ss were not attending to the confidence gained post-action taking and the carry-over effect from one attempt at action taking to another was not sufficiently developed. On the other hand, it may be that this aspect of gaining confidence is not one that adolescents respond to readily. It should be pointed out, however, that in addition to Groups 2 & 3 showing no positive change, Group 1 actually showed a 5% negative result indicating that these four Ss reported feeling that much less confident after the intervention. Although it may appear a drawback the reader must remember that all Ss, despite low confidence still were able to improve their coping effectiveness, lessen the anxiety intensity, the difficulty with, and overall bothersomeness with the shyness problem. This is consistent with the Morita principle that confidence does not have to be achieved in order for constructive action to be taken. Further, there is a fair probability that adolescent development is confounding these results in that adolescents are firmly in the process of developing a sense of self of which self-confidence is an integral part. If this is so, then it may be unrealistic to expect any significant positive change in this area.

F. Anxiety Severity in the Shy/Target Situation

This component revealed the highest percentage of improvement for two-thirds of the Ss. Group 1 showed a 19% positive change from Phase A to C and likewise Group 2 showed a 17% improvement when level differences are compared. Statistically comparing these phases results in a significant $t = 3.99$ and $p = 0.002$. It seems clear that these Ss report experiencing a significant drop in anxiety severity in their target situations. An aspect of Morita teaching proposes that the experienced severity of anxiety diminishes as one perseveres in appropriate action taking as opposed to focusing on the emotional symptoms of the shy/anxiety reaction. With the limited opportunities for practice, these Ss appeared to make a definite positive headway in reducing their situational anxiety severity. All three groups follow clear downward trends, especially Groups 2 & 3, in the Post-Intervention phase indicating a positive change direction. These phases are not acceptably stable though as whole units but Groups 2 & 3's last halves, respectively, are 100% and 88% stable which means that quite possibly complete stability is emerging with a further extension of this phase.

II Limitations and Recommendations for Future Research

A. Limitations

The most obvious limitation for this study is, of course, the measurement instruments themselves. They have been designed to address adults and accordingly, use adult terminology. This terminology required modification with periodic clarification as Ss academic comprehension ranged from Grades 8 to 11. The measures, aside from the Behavioral Counts, were self-report in nature and consequently, have questionable predictive validity as it is unknown to what extent results from them reflect cognitive process and behavior.

Because the study spanned a period of fourteen weeks, this period included examination times as well as holiday periods. Hersen & Barlow (1976) advise time-frame flexibility in conducting single-case type design experiments particularly in terms of sufficient time to establish a stable baseline. This latter was difficult to accommodate. These above external events posed a certain threat to internal validity such as history and attrition (Cook & Campbell, 1979; Kazdin, 1981). However, the time-lag

for treatment addressed these and there was no loss of Ss due to attrition.

There is a consideration, as well, about isolating the effects of the Morita-based treatment variables, i.e., positive reinterpretation of social anxiety techniques, (Ishiyama, 1984b) from other treatment variables such as attention, empathy, catharsis and treatment expectancy. The attempts at establishing a stable baseline (Hersen & Barlow, 1976) and time-lagged intervention points (Cook & Campbell, 1979) are directed at this confound, allowing the examination of the specific effects of the Morita counseling intervention.

In terms of sampling, one location is insufficient to enable broad generalizations even though that location, Kitsilano Secondary School, represented the socio-economic average. In addition, the constricted time allotted to the counseling sessions allowed for only minimal time for group discussion. Due to the small n in this study, generalization can only be made over these subjects.

In reference to Group 3's results and the suspected extraneous variables mentioned earlier, there was no provision, during the screening process, to enable the researcher to distinguish state (i.e. contextual) from trait (i.e. stable over time) (insert reference) anxiety or depression. If it were known that Ss were experiencing only state anxiety or depression then, by definition, these would fluxuate. However, as is suspected with Ss in Group 3, if

state anxiety or depression were present then little fluctuation could be expected in the results. If this researcher had not become aware of the other variables present in Group 3, the results from this group could have been more fully included.

B. Recommendations for Future Research

The following ideas would enhance and clarify the process of a similar research study:

1. A greater impact could be made by the treatment intervention if the counseling sessions were extended by approximately a half hour. This would allow time for greater exchange and group discussion and also remove some of the time pressure experienced by Ss which was cause for distraction.
2. A more thorough screening process whereby state and trait anxiety/depression can be distinguished. Perhaps seeking further background information on Ss from the school conselors would be useful.
3. Gathering Behavioral Counts over longer periods, perhaps extending the five day period to ten days if Ss would

co-operate. Not only would this longer period give the researcher a better picture of how Ss were applying Morita learning but it also serves as a reminder to Ss to continue their efforts between sessions.

III Implications and Conclusions

Of the results generated by this study it would appear that Morita counseling has a significant and most useful role to play in promoting, amongst developing adolescents, a greater sense of constructive living. Its impact on grooming a positive self-image through self-acceptance in the area of social anxiety is clear. Providing a concrete mechanism by which to approach and deal with shy/anxious situations is a pragmatic aide during a developmental stage renowned for indecisiveness and confusion. Having achieved positive results on most measures in the study following such brief counseling sessions, indicates that this Morita learning could time-wise be readily incorporated in the secondary schools' guidance studies. To teach adolescents early in this developmental stage that they need not be victims to the shy part of their nature and furthermore, that they can use this part to remind themselves of the importance to them of participating in community life seems a useful beginning

at promoting self-knowledge. Morita therapy directly addresses the issue of inner struggle and indecisiveness between emotion and action taking. Learning this approach as part of a regular component of a life skills program could conceivably reduce this common tension and struggle experienced by adolescents and assist them in moving forward constructively.

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APPENDIX

PART 1

THE 7-ITEM REPEATED MEASURE

Appendix 1

Self and Anxiety Questionnaire: please put an X for each adjective pair to best describe how you feel about yourself.

Ex: "I prefer to work .." fast :__:X:__:__:__:__:__:__:__: slowly
alone :__:__:__:__:__:__:__:__:X: in groups

1. How would you evaluate the anxious or nervous part of your personality that seems to surface in certain anxiety-arousing social situations?

"The anxious part of my personality is ..."

acceptable :__:__:__:__:__:__:__:__: unacceptable

useless :__:__:__:__:__:__:__:__: useful

undesirable :__:__:__:__:__:__:__:__: desirable

bearable :__:__:__:__:__:__:__:__: unbearable

2. How would you describe the way you deal with the anxiety-arousing social situations?

"I am ...in dealing with the anxiety-arousing social situations.

competent :__:__:__:__:__:__:__:__: incompetent

impatient :__:__:__:__:__:__:__:__: patient

productive :__:__:__:__:__:__:__:__: unproductive

clear-minded :__:__:__:__:__:__:__:__: confused

unsuccessful :__:__:__:__:__:__:__:__: successful

relaxed :__:__:__:__:__:__:__:__: tense

3. How would you feel toward yourself when you think of becoming anxious in the anxiety-arousing social situations?

I would feel (toward myself)."

critical :__:__:__:__:__:__:__:__: appreciative

satisfied :__:__:__:__:__:__:__:__: dissatisfied

tolerant :__:__:__:__:__:__:__:__: intolerant

pessimistic :__:__:__:__:__:__:__:__: optimistic

Appendix 1

The Target Complaint Inventory: please place an X to best describe your current view in response to each of the following questions.

1.How intense are your average anxiety reactions when you enter the shy situation.

2.How much difficulty do you experience in carrying out a desirable action in the shy situation?

3.How confident do you feel about entering the shy situation and taking a desirable action?

4.Overall, how much does this shyness problem (i.e., emotional discomfort & behavioral difficulty) bother you?

<input type="checkbox"/>	extremely
<input type="checkbox"/>	
<input type="checkbox"/>	
<input type="checkbox"/>	very
<input type="checkbox"/>	
<input type="checkbox"/>	
<input type="checkbox"/>	moderately
<input type="checkbox"/>	
<input type="checkbox"/>	
<input type="checkbox"/>	a little
<input type="checkbox"/>	
<input type="checkbox"/>	
<input type="checkbox"/>	not at all

<input type="checkbox"/>	extremely
<input type="checkbox"/>	
<input type="checkbox"/>	
<input type="checkbox"/>	very
<input type="checkbox"/>	
<input type="checkbox"/>	
<input type="checkbox"/>	moderately
<input type="checkbox"/>	
<input type="checkbox"/>	
<input type="checkbox"/>	a little
<input type="checkbox"/>	
<input type="checkbox"/>	
<input type="checkbox"/>	not at all

<input type="checkbox"/>	extremely
<input type="checkbox"/>	
<input type="checkbox"/>	
<input type="checkbox"/>	very
<input type="checkbox"/>	
<input type="checkbox"/>	
<input type="checkbox"/>	moderately
<input type="checkbox"/>	
<input type="checkbox"/>	
<input type="checkbox"/>	a little
<input type="checkbox"/>	
<input type="checkbox"/>	
<input type="checkbox"/>	not at all

<input type="checkbox"/>	extremely
<input type="checkbox"/>	
<input type="checkbox"/>	
<input type="checkbox"/>	very
<input type="checkbox"/>	
<input type="checkbox"/>	
<input type="checkbox"/>	moderately
<input type="checkbox"/>	
<input type="checkbox"/>	
<input type="checkbox"/>	a little
<input type="checkbox"/>	
<input type="checkbox"/>	
<input type="checkbox"/>	not a all

CHEEK AND BUSS (1981) SHYNESS SCALE

Please circle the number that best describes you at the
present time.

1. I am socially somewhat awkward.
not at all 1 - 2 - 3 - 4 extremely so
2. I don't find it hard to talk to strangers.
not at all 1 - 2 - 3 - 4 extremely so
3. I feel tense when I'm with people I don't know well.
not at all 1 - 2 - 3 - 4 extremely so
4. When conversing I worry about saying something dumb.
not at all 1 - 2 - 3 - 4 extremely so
5. I feel nervous when speaking to someone in authority.
not at all 1 - 2 - 3 - 4 extremely so
6. I am often uncomfortable at parties.
not at all 1 - 2 - 3 - 4 extremely so
7. I feel inhibited in social situations .
not at all 1 - 2 - 3 - 4 extremely so
8. I have trouble looking someone right in the eye.
not at all 1 - 2 - 3 - 4 extremely so
9. I am more shy with members of the opposite sex.
not at all 1 - 2 - 3 - 4 extremely so

Appendix 3

Jan./88.

Dear Parent or Guardian,

Your daughter _____ expressed interest and has been accepted as a participant, pending consent, in a social science research study to be conducted at Kitsilano High School, outside of school hours. The study is concerned with helping shy adolescent girls by use of an instructive-type counselling approach (Morita Counselling). The purpose is to examine whether the participants will benefit from this type of shyness counselling and show positive change in their social behaviour. The official title of the study is: Efficacy Study of Brief Morita Counselling Intervention with Shy Adolescents.

In summary what will occur is that measures of social anxiety, using an 11-item checklist (which requires about 4 mins. to complete), will be taken at regular intervals. The participant will complete this checklist twice per week over an approximate seven week period. There will be four group counselling sessions of about 45 minutes each conducted in

Appendix 3

the middle of the study. These will take place in a private room in the school. A 14-question Shyness Scale will also be administered at the end of the study. The total time commitment for the entire project will be 6 hrs., (about 2/3 hr. per week) over 7 weeks. The study will begin in Jan./88 and end in approx. mid-April/88.

The study is my thesis project for a Master's degree in Counselling Psychology at U.B.C. and I will be conducting the whole study including the counselling sessions under the supervision of my advisor, Dr. I. Ishiyama, of the Counselling Psychology Dept. at U.B.C.. Permission for this research has been granted by the principal of the school and the Vancouver School Board. In addition, a request for approval by the Ethics Committee on Research at U.B.C. is currently being processed..

I would like to inform you that confidentiality and anonymity of your daughter will be closely guarded (code identification will be used). All data collected will be promptly destroyed by burning, no later than 1 year from the completion date of the study. Those who will have access to data are, my advisor, Dr. Ishiyama, two thesis committee members at U.B.C. and myself. The principal, teachers, and counsellors of Kitsilano High School will not have access to the data.

Appendix 3

CONSENT FORM

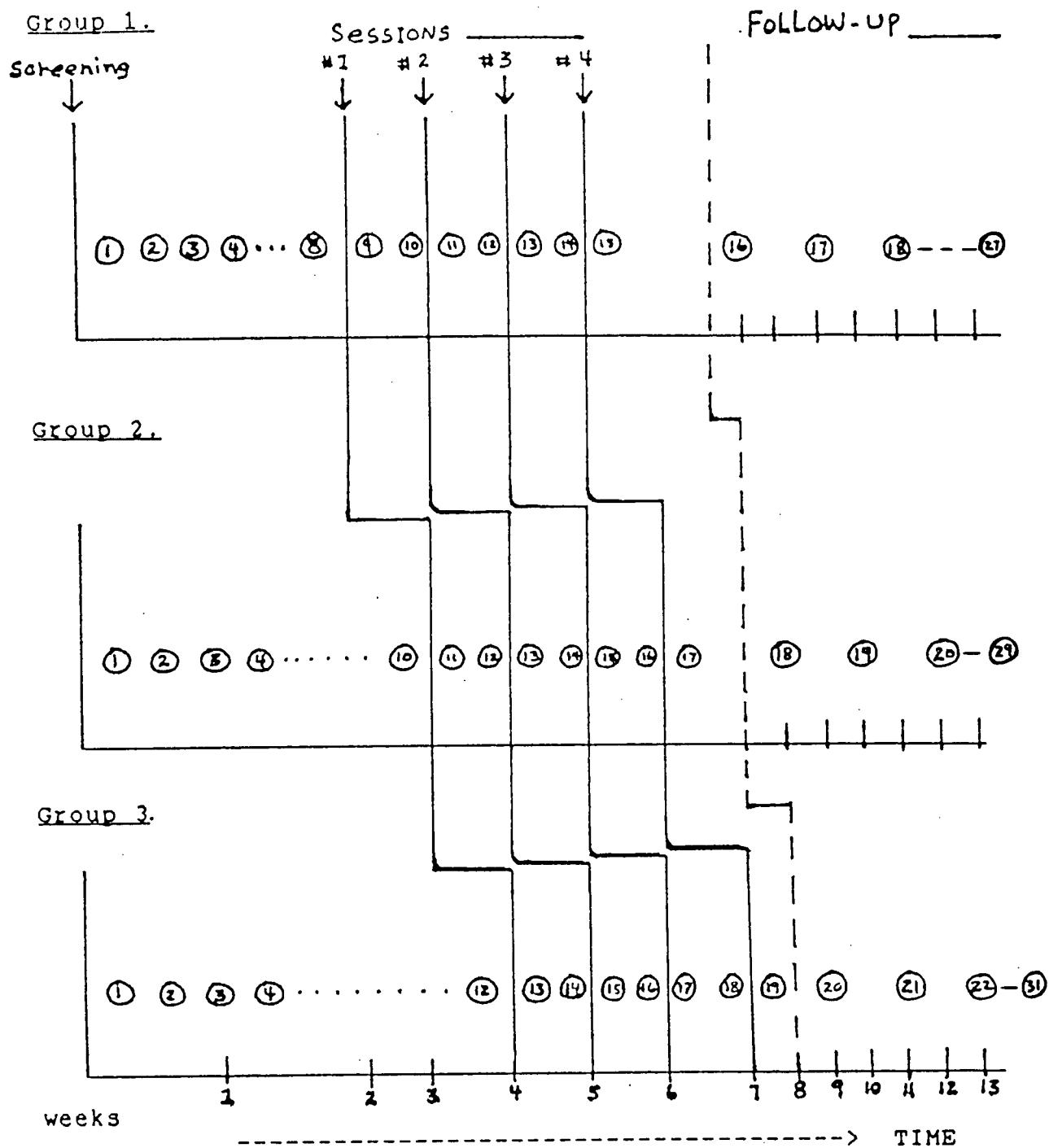
Jan. 1988.

I consent / I do not consent (circle one) to being a participant in the Efficacy Study of Brief Morita Counselling Intervention with Shy Adolescents to be conducted at Kitsilano High School (after school hours) by Patricia Donahue, a Counselling Psychology graduate student, beginning in January/88 and ending approx. in mid-April/88. I understand that confidentiality and anonymity will be assured and all the original data connected with my name will be destroyed one year from the completion date of this project. I hold the right to refuse to participate or to withdraw from the study at any time without jeopardizing my class standing at school. I also understand that this is a study of relatively short duration which cannot guarantee desired therapeutic results and distinguishes itself, therefore, from a regular counselling program. I have received a copy of this consent form, and it's attached letter of explanation, which I shall keep for my records.

Student's Signature: _____

NOTE: Please submit to: Mr.B.Kinghorn, Kitsilano Sec.School
*** Keep the attached copy of the Consent Form.

Appendix 4.

Graphical Outline of Research Study.

POSITIVE RE-INTERPRETATION TECHNIQUE

1. Anxiety is not an abnormal experience or personal disposition, but a common and normal human response to certain social situations.
2. Underneath social anxiety, there is a desire for being socially acceptable, effective, and constructive. Anxiety and desire are like two sides of the same coin. Thus, the denial of social anxiety means the denial of your desire to live constructively.
3. Anxiety can be accepted as it is, and you can still make constructive choice of action. The difference between socially effective people and ineffective people is not whether they feel anxiety or not, but rather whether they take action or not in spite of anxiety.
4. The more you try to fight or manipulate the symptoms of anxiety, the more self-preoccupied you tend to get. Also, by assuming that everyone around you is aware of your anxious and nervous reactions, you become extra self-conscious unnecessarily. This egocentric preoccupation interferes with your effective thinking and action. You end up neglecting what needs to be done in the given social context. By treating anxiety as your enemy, you feed attention and energy into the anxiety symptoms just to exaggerate them. If you accept anxiety and see the positive side of it, you can use your anxiety for constructive purposes.
5. Anxiety does not have to be a personal weakness. Social anxiety is a reflection of your social sensitivity. You care about, and feel sensitive to, how others might think, feel, and respond to you. As a result, you may end up feeling nervous and anxious. However, instead of getting preoccupied with anxiety symptoms and avoiding the situation, what needs to be done is to take advantage of your social sensitivity and redirect it to what is happening, and to what needs to be done in the given social environment.

Source: Ishiyama, F.I. (1986b). Brief Morita therapy for social anxiety: A single-case study of therapeutic changes. Canadian Journal of Counselling, 20:(1), 58-59.

Appendix 5.

POSITIVE/ENCOURAGING MESSAGES and INSTRUCTIONS

(given to Ss to carry with them as a reminder).

1. It is okay to feel shy. There is no need to fight shy feelings or to criticize shy personality.
2. Social anxiety is a transitory experience that may reach a peak but will subside eventually. Persevere without taking flight from the situation. Let anxiety take its own course of rising and falling without resisting it.
3. Your shyness and social anxiety reflect your desire for social involvement and social success. Because you do not want to fail socially, upset others, or be criticized by others, you become nervous and anxious. Therefore, anxiety is a "go" signal rather than a "stop" signal in your social interaction. Proceed with caution and nervousness in the given situation instead of running away from it.
4. You can take action in spite of anxiety and shy feelings. You need not control your inconvenient feelings to take necessary action.
5. You are not responsible for controlling spontaneous emotional reactions. Stop blaming yourself for the lack of ability to control shyness or to change your shy personality. What counts is your constructive action. An effective and constructive person does not have to be a fearless person.
6. You are responsible for your choice of action and its consequences. Pursue the action that will actualize your desire for meaningful social involvement and accomplishment of the practical tasks at hand.
7. There is a job to be done here and now, be it speaking up or approaching a stranger. It has to be done whether you happen to be in the "right" mood or not.
8. You have a lot to offer to people, such as your unique ideas and experiences. It is not fair to others or to yourself not to express yourself just because you feel shy and you don't feel like talking.

Appendix 5.

9. Because you are socially sensitive and cautious, you do not say offensive or hurtful things or act aggressively toward others, in contrast to the way fearless and insensitive people act. Try to use your social sensitivity in approaching and dealing with people to increase your personal effectiveness.

Source: Ishiyama, F.I. (1987a). Use of Morita therapy in shyness counselling in the west: Promoting client's self-acceptance and action-taking. Journal of Counseling and Development, 65, 547-551.

BEHAVIORAL INSTRUCTIONS

1. Do not resist anxiety. Accept anxiety as it is, and let it follow it's own natural course of rise and fall.
2. Stop blaming yourself for your anxiety and nervousness. Instead, consider the intensity of your anxiety as a reflection of how important the task is to you.
3. Persevere through the anxious moments, and do not lose sight of the task at hand.
4. Make choice of action, and not emotion.
5. Think and act in terms of how you can be productive and constructive instead of thinking how you can avoid or manipulate discomfort and anxiety.

Appendix 7

Item Analysis on Scales 1, 2, 3

Item/Scale Total Correlation

<u>Item</u>	<u>Scale 1</u>	<u>Item</u>	<u>Scale 2</u>	<u>Item</u>	<u>Scale 3</u>
1	.289	1	.622	1	.278
2	.277	2	.412	2	.361
3	.418	3	.612	3	.484
4	.180	4	.611	4	.172
		5	.507		
		6	.631		

Total Score/Total of 3 Scales Correlation

<u>Item</u>	<u>Scale</u>	<u>Item</u>	<u>Scale</u>	<u>Item</u>	<u>Scale</u>
1	.584	1	.731	1	.430
2	.482	2	.559	2	.722
3	.594	3	.706	3	.699
4	.528	4	.706	4	.313
		5	.642		
		6	.680		

n=12

Appendix 8

AVERAGES (LEVELS) of EACH PHASE by GROUP

GROUP_1					
Scale	(Phase A) Baseline	(Phase B) Inter- vention	(Phase C) Post- Inter- vention	Point Difference (Phase C- Phase A)	%
2	26.75	31.70	34.73	7.98	14%
6	8.47	8.04	7.74	-.73	5%
8	34.92	41.54	42.88	7.96	11%
				Point Difference (Phase A - Phase C)	%
4	10.81	9.83	8.32	2.49	19%
5	10.25	9.58	8.22	2.03	16%
7	9.39	8.79	7.94	1.45	11%

Appendix 9

AVERAGES (LEVELS) of EACH PHASE by GROUP

GROUP_2

Scale	(Phase A) Baseline	(Phase B) Inter- vention	(Phase C) Post- Inter- vention	Point Difference (Phase C- Phase A)	%
2	31.95	36.94	40.02	8.07	15%
6	7.11	6.60	7.04	-.07	1%
8	40.10	44.30	50.38	10.28	14%
				Point Difference (Phase A- Phase C)	%
4	8.42	7.01	6.20	2.22	17%
5	8.05	6.57	6.17	1.88	14%
7	7.39	6.85	5.93	1.46	11%

Appendix 10

AVERAGES (LEVELS) of EACH PHASE by GROUP

GROUP_3

Scale	(Phase A) Baseline	(Phase B) Inter- vention	(Phase C) Post- Inter- vention	Point Difference (Phase C- Phase A)	%
2	27.68	29.03	28.90	1.22	3%
6	7.52	7.26	7.48	-.04	0%
8	36.04	38.34	38.34	2.30	3%
				Point Difference (Phase A- Phase C)	%
4	7.82	7.24	7.29	.53	4%
5	7.20	7.33	7.06	.14	1%
7	8.41	7.71	7.12	1.29	10%

 n=12

Appendix 11

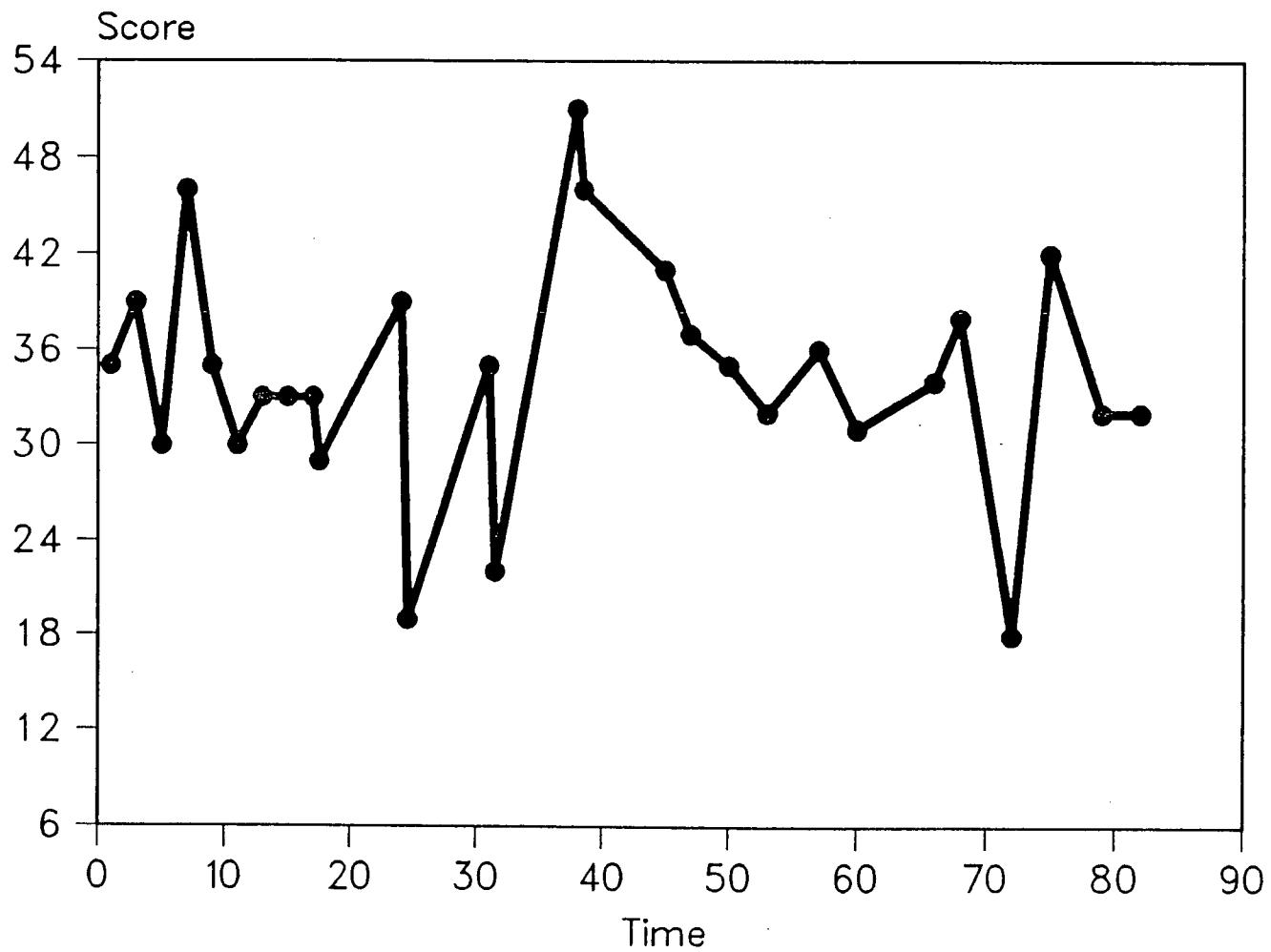
SUBJECT SELECTION - Screening Process

	Number of students responding to screening	Students with eligible scores	Number of students chosen as subjects
Gr.8 (during guidance class) ance class)	95	32	3
Gr.s 9,10,11, 12 (as recommend -ed by counsel- ors)	33	33	9

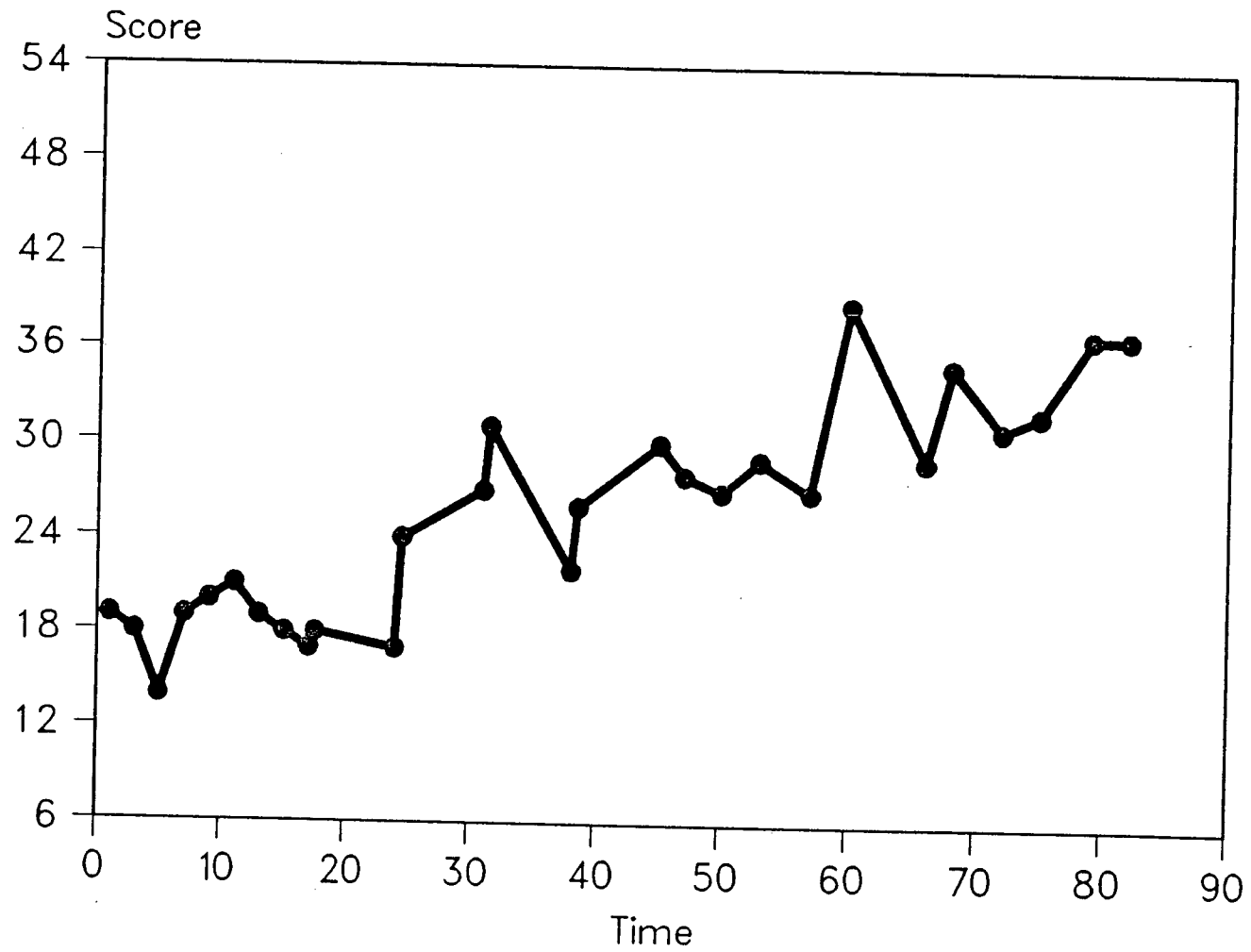
APPENDIX

PART 2

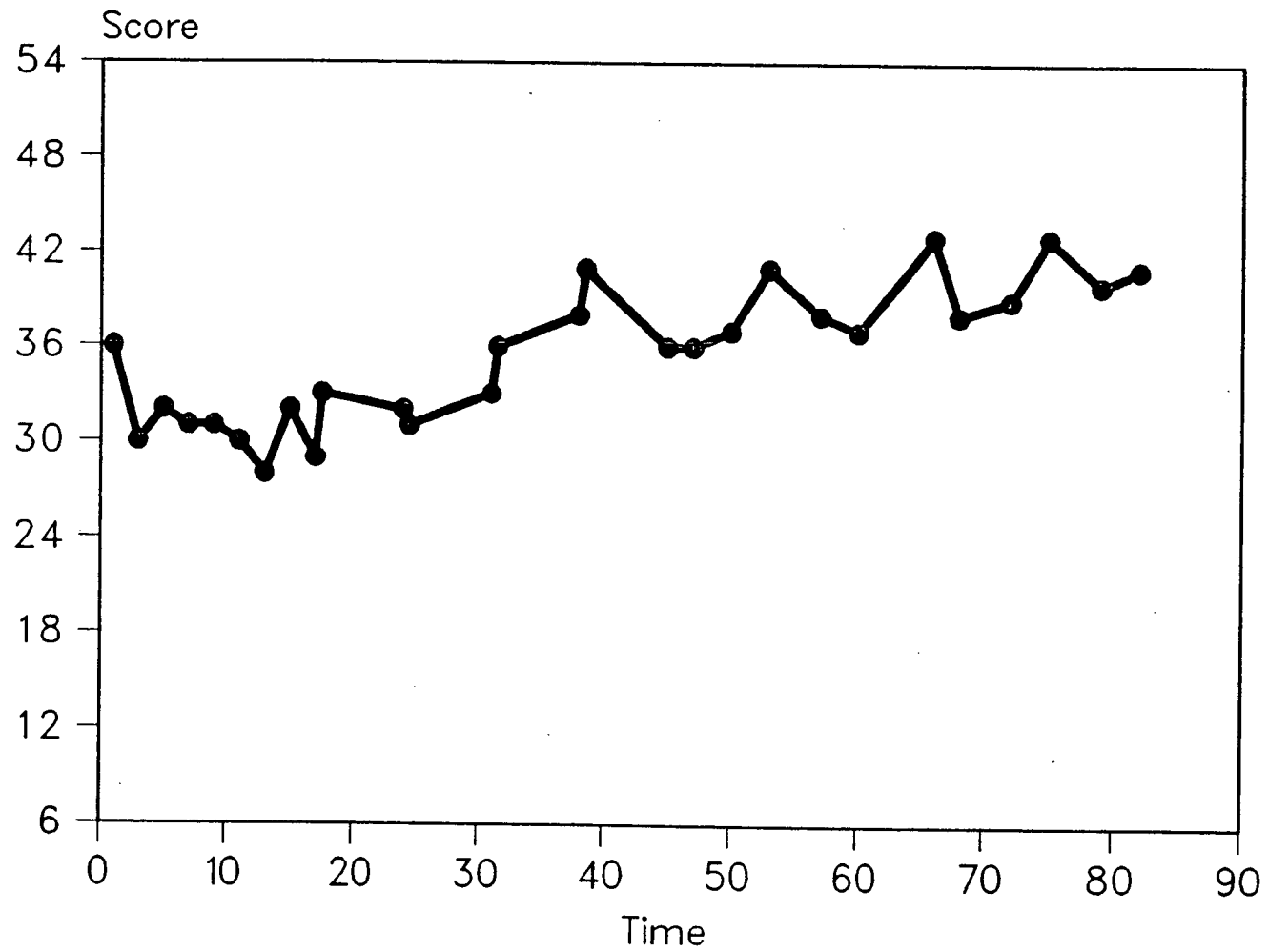
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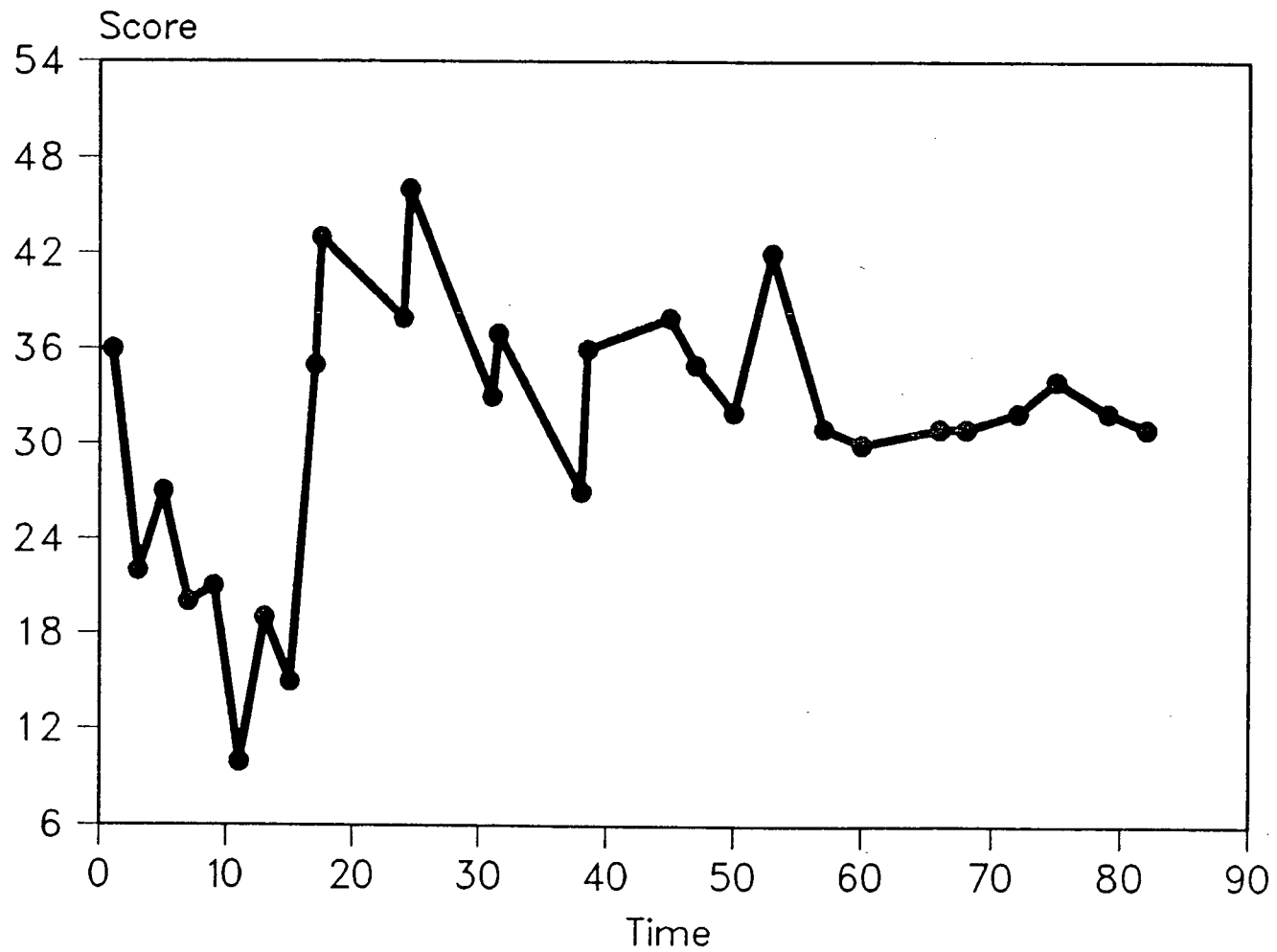
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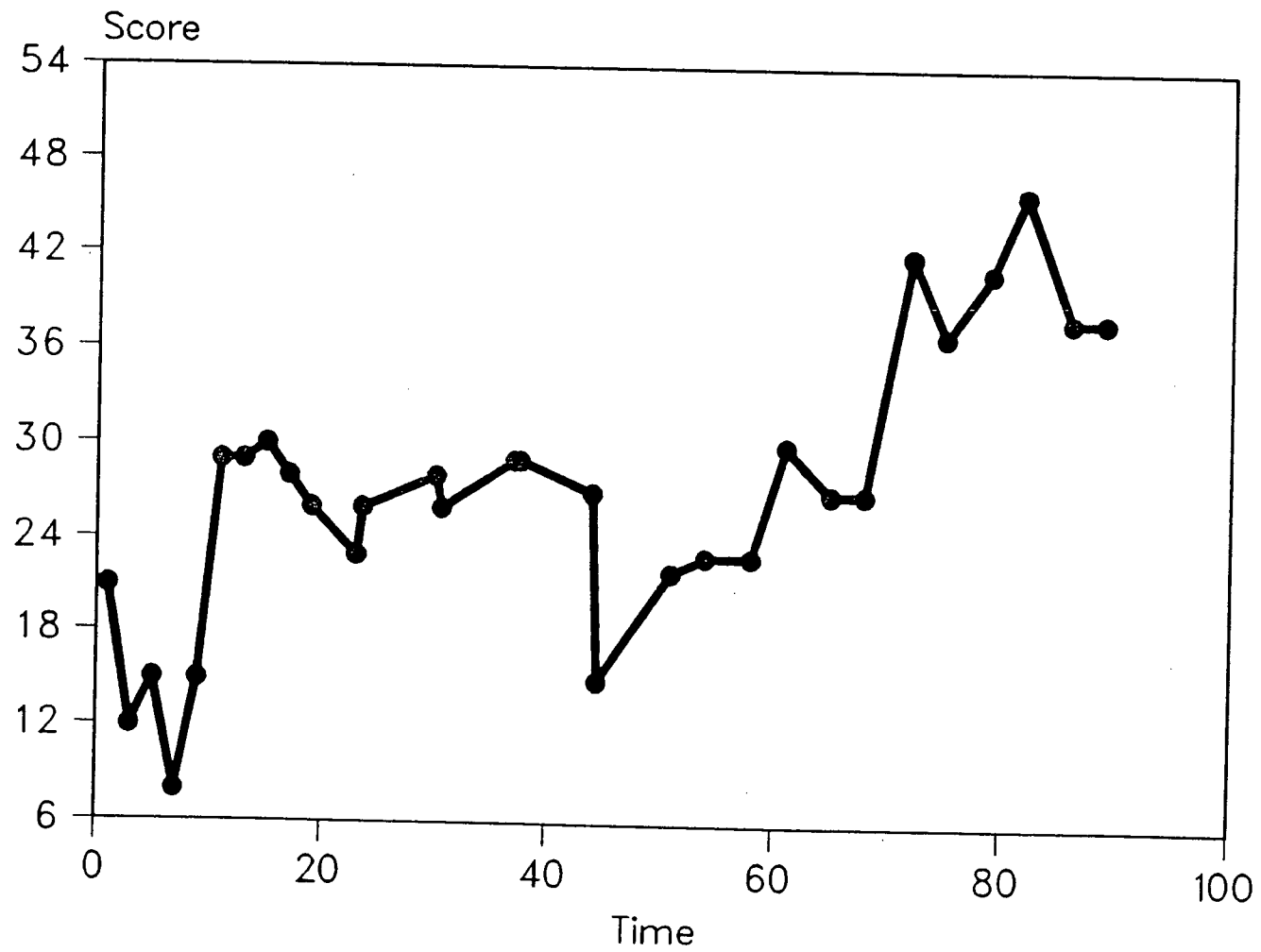
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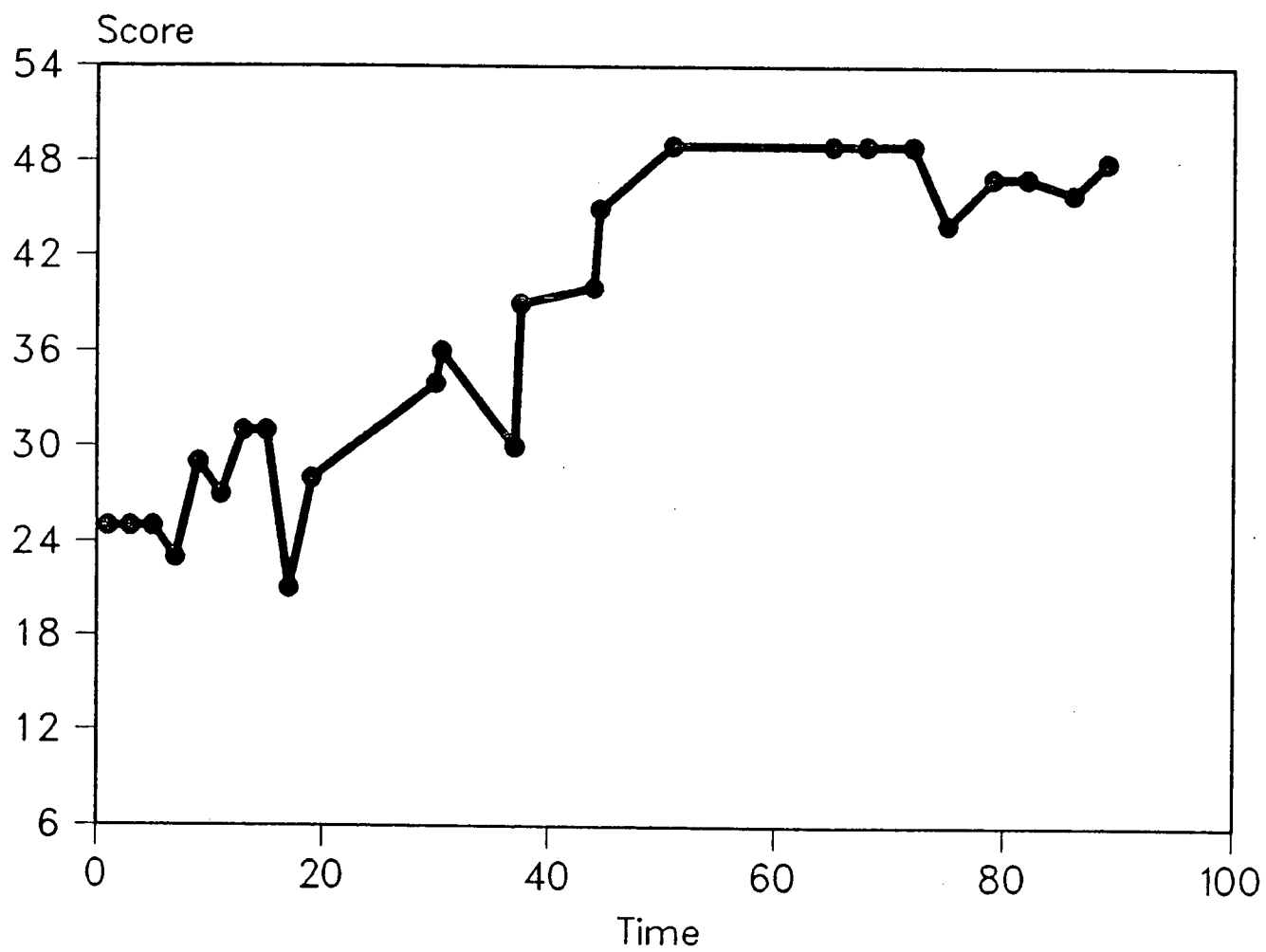
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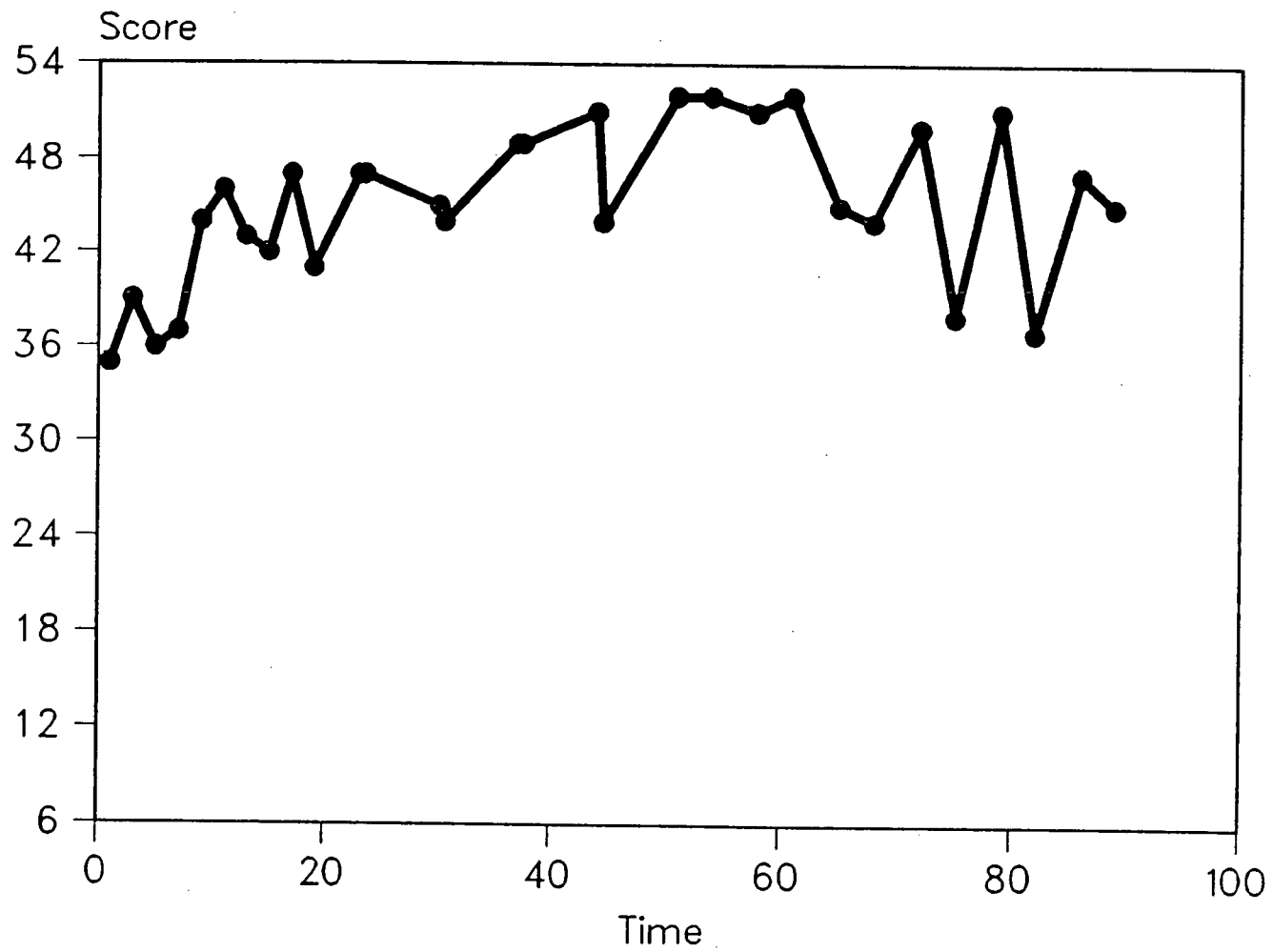
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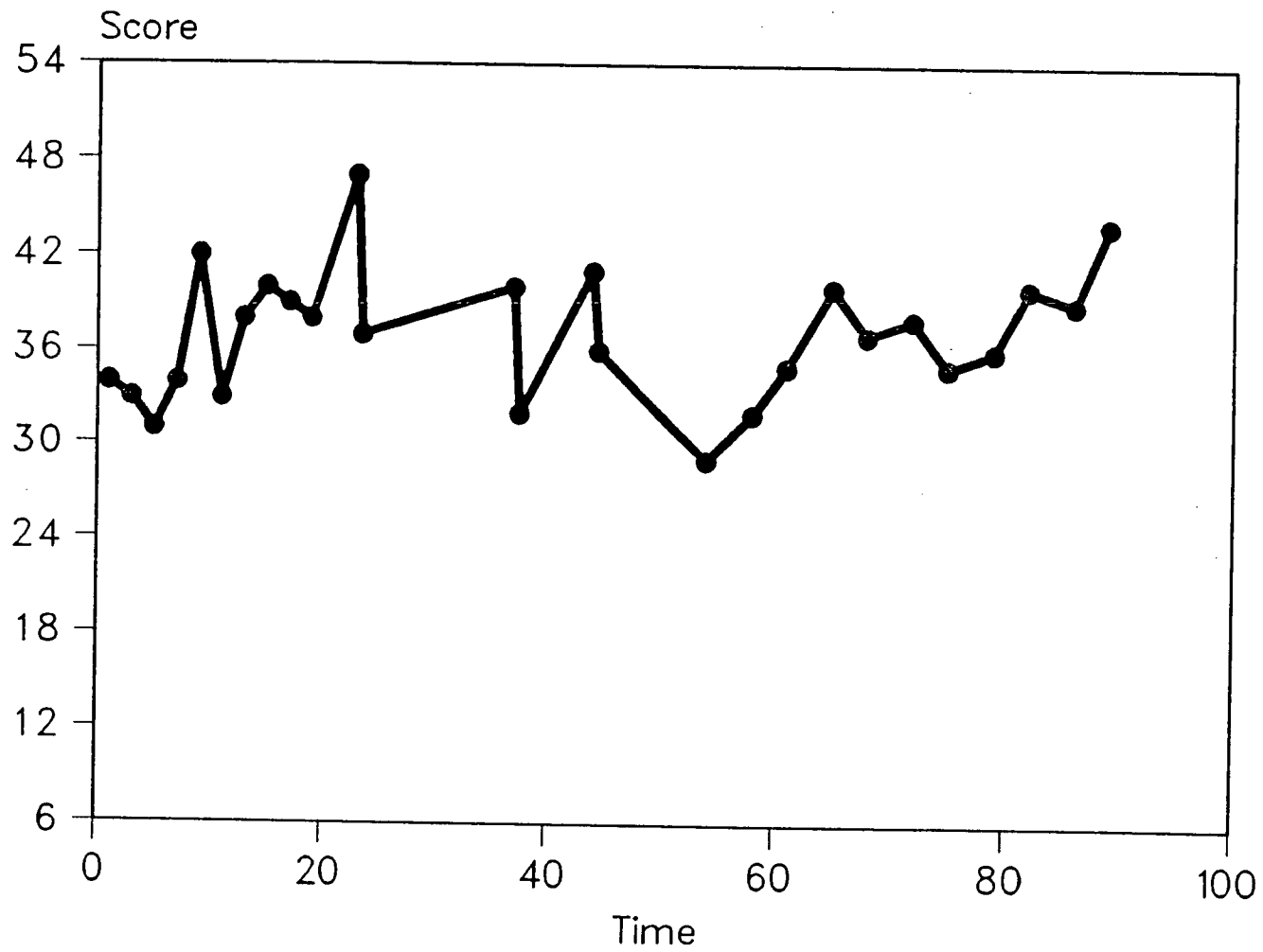
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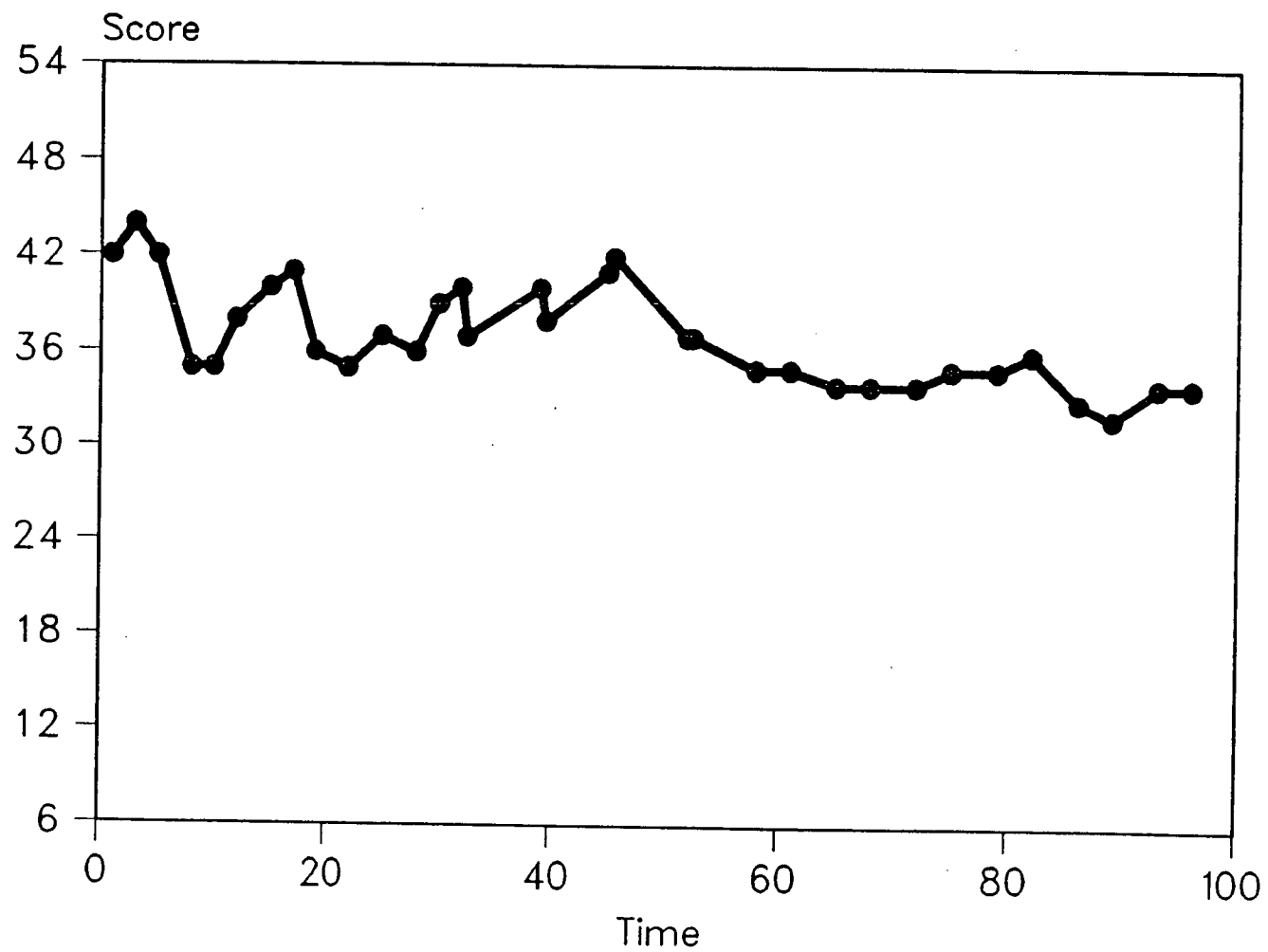
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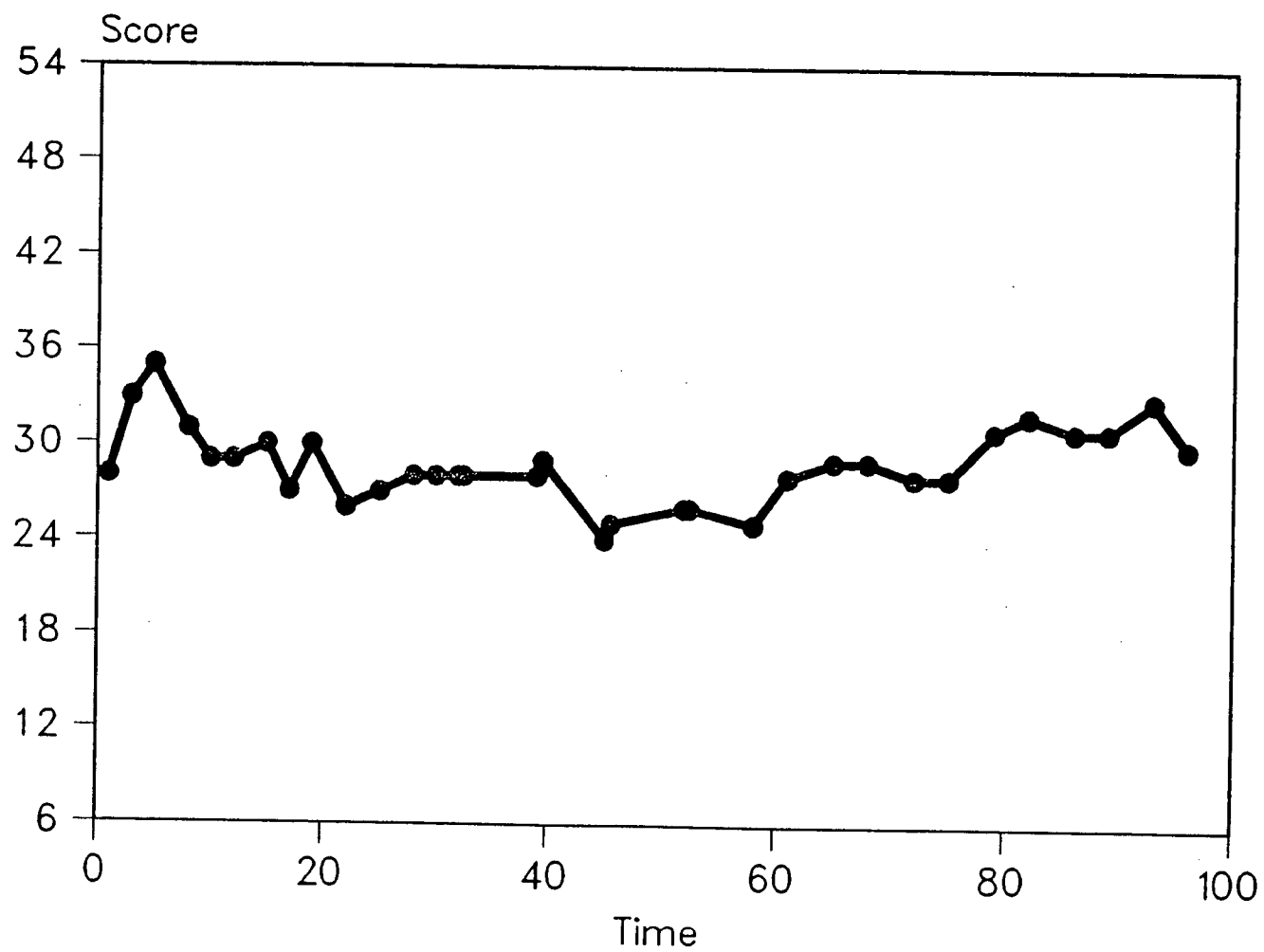
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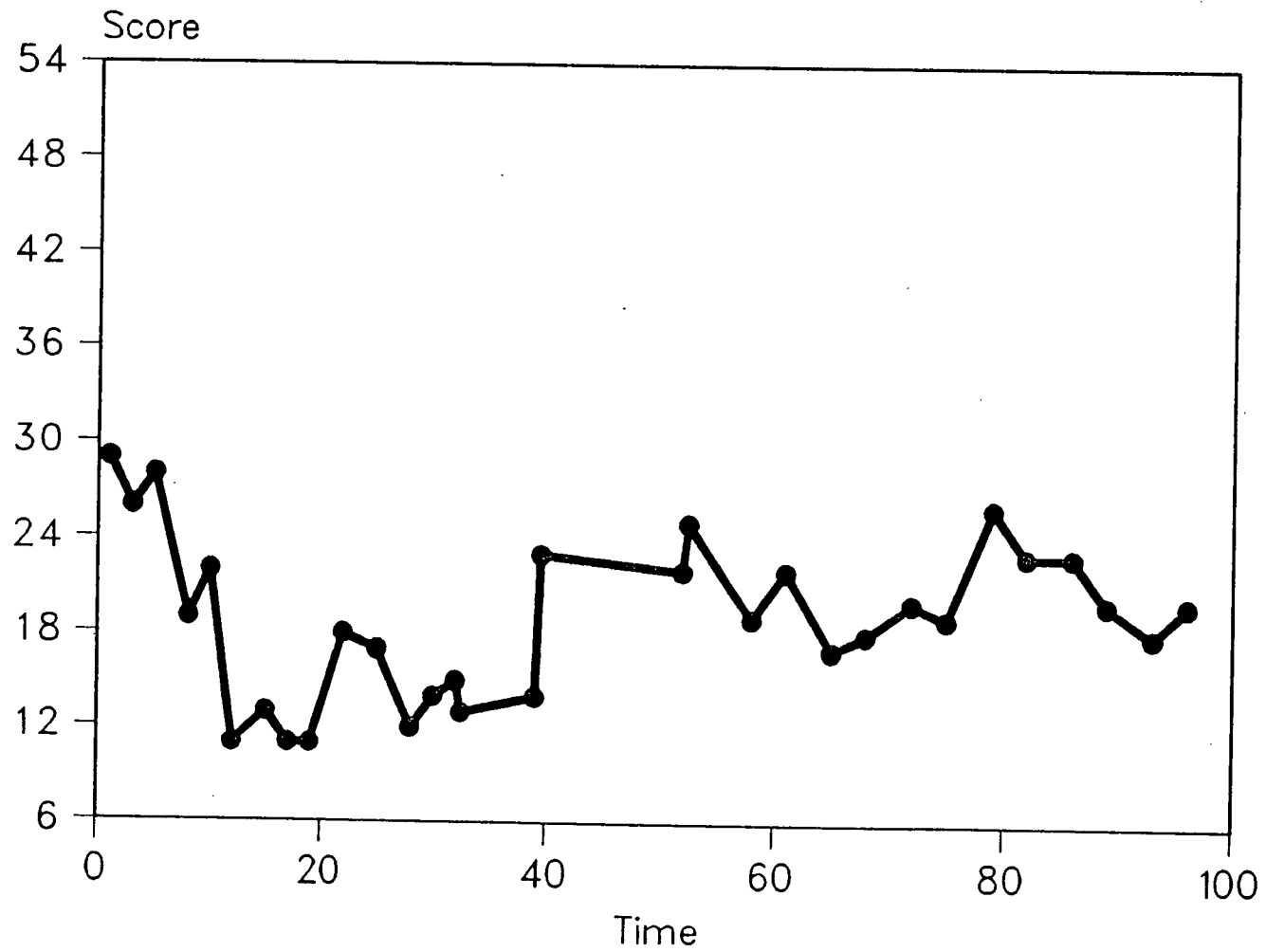
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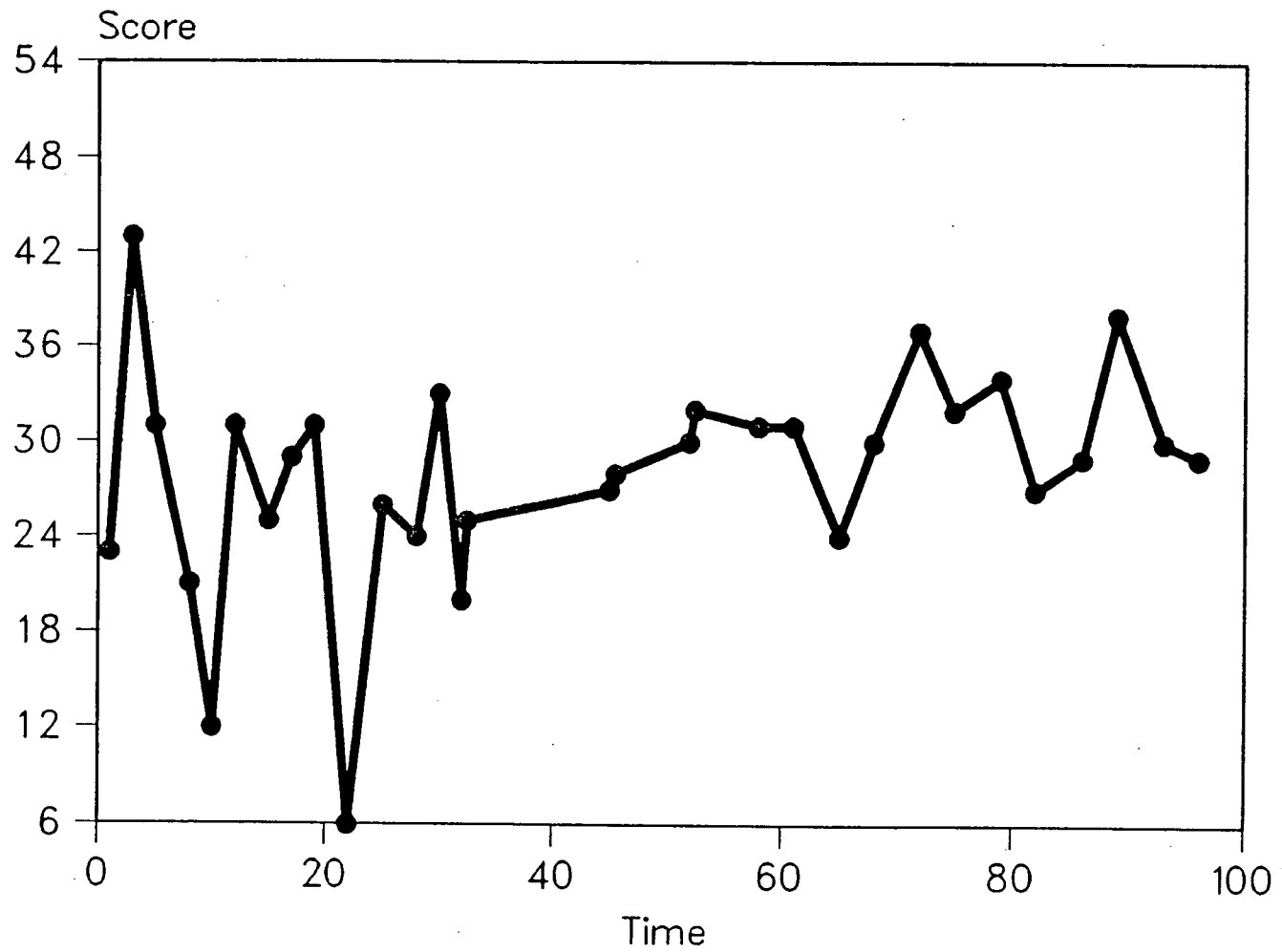
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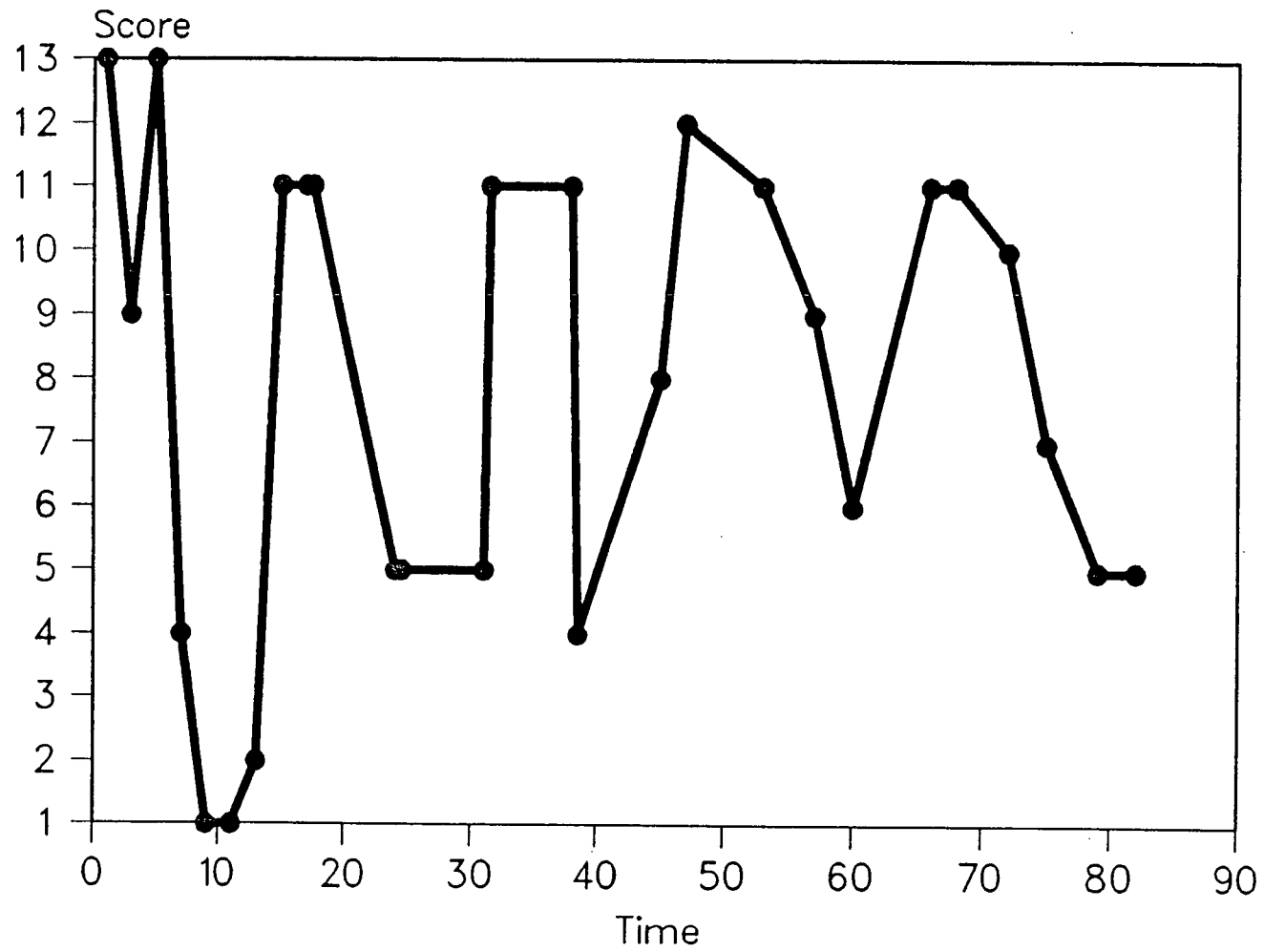
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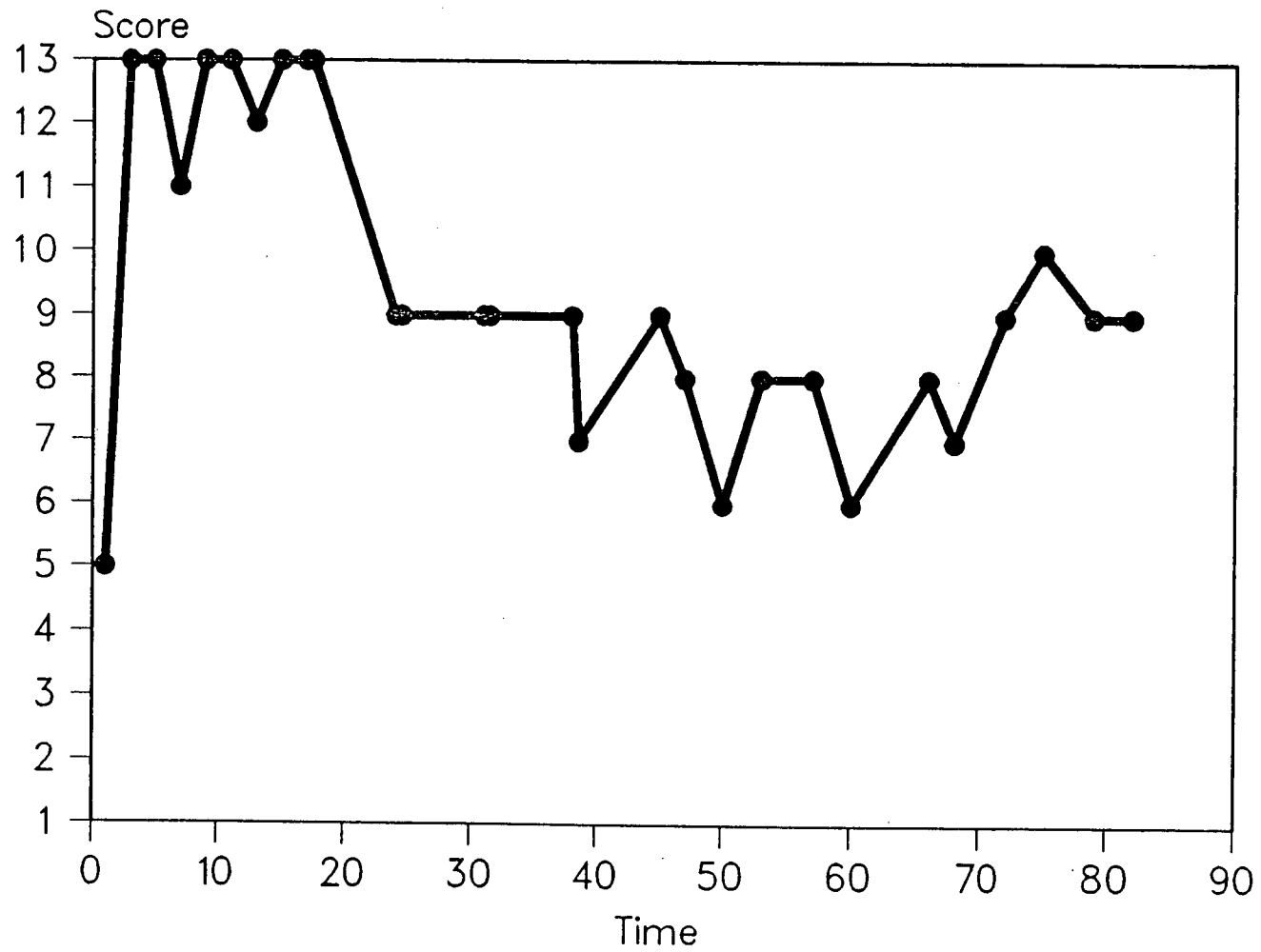
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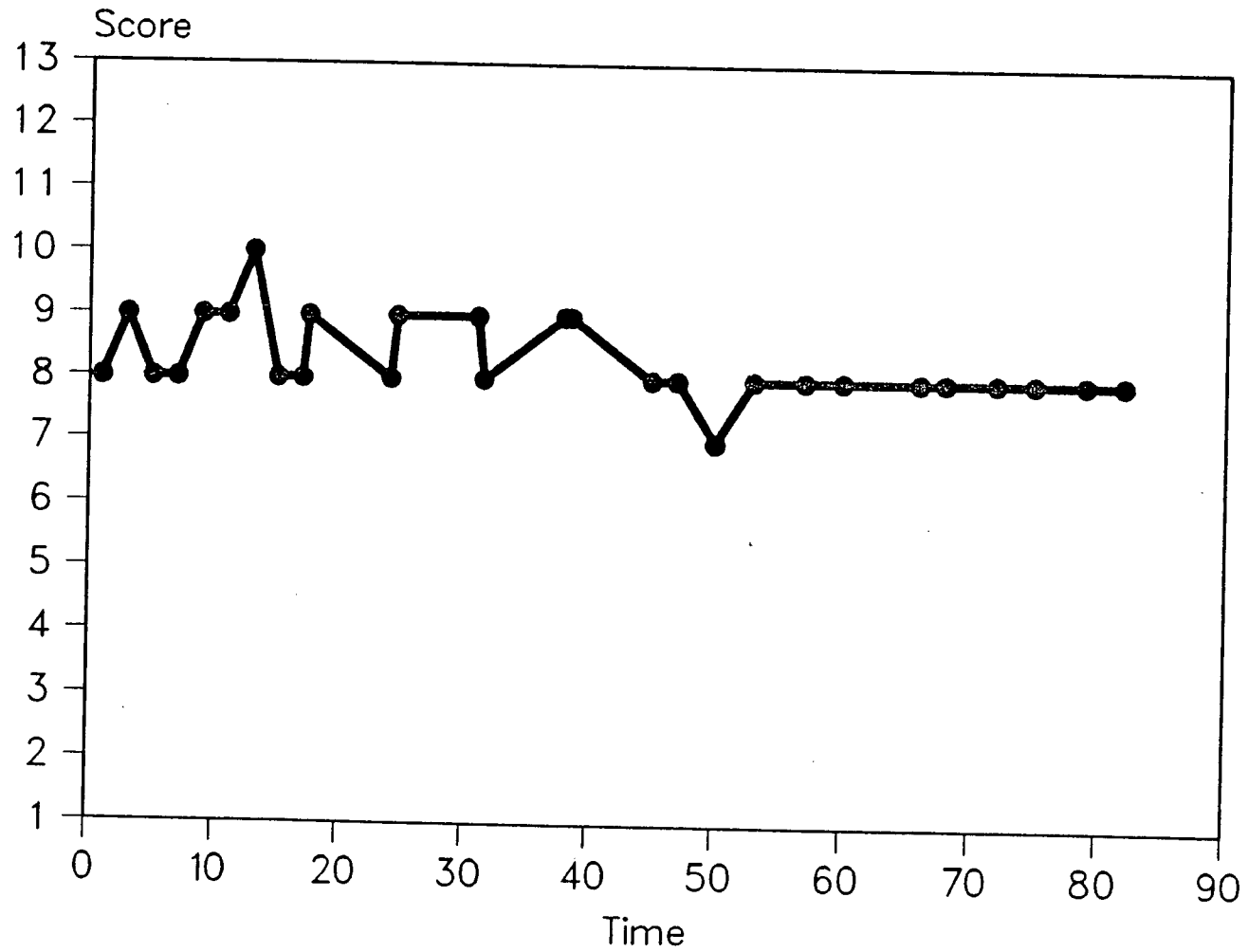
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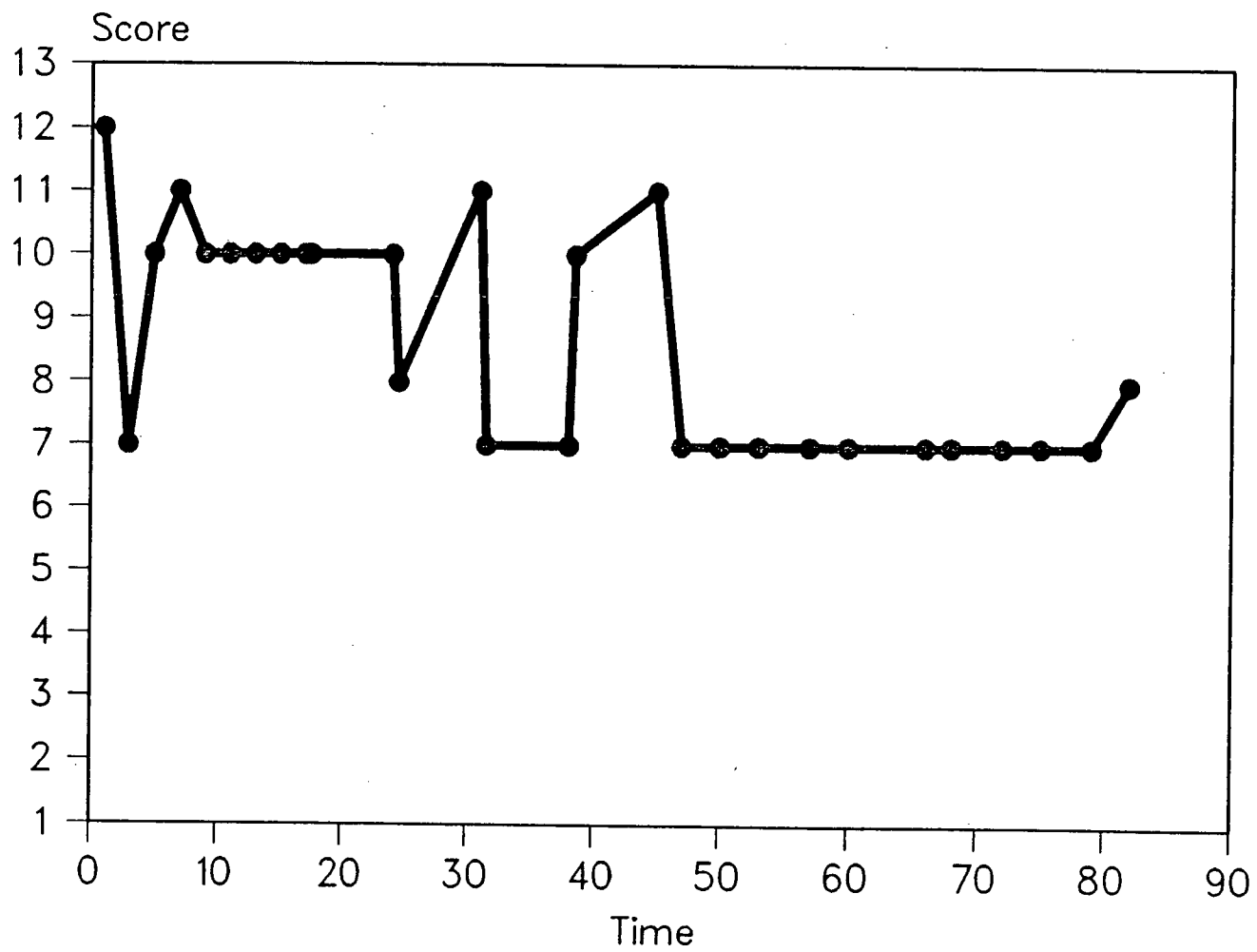
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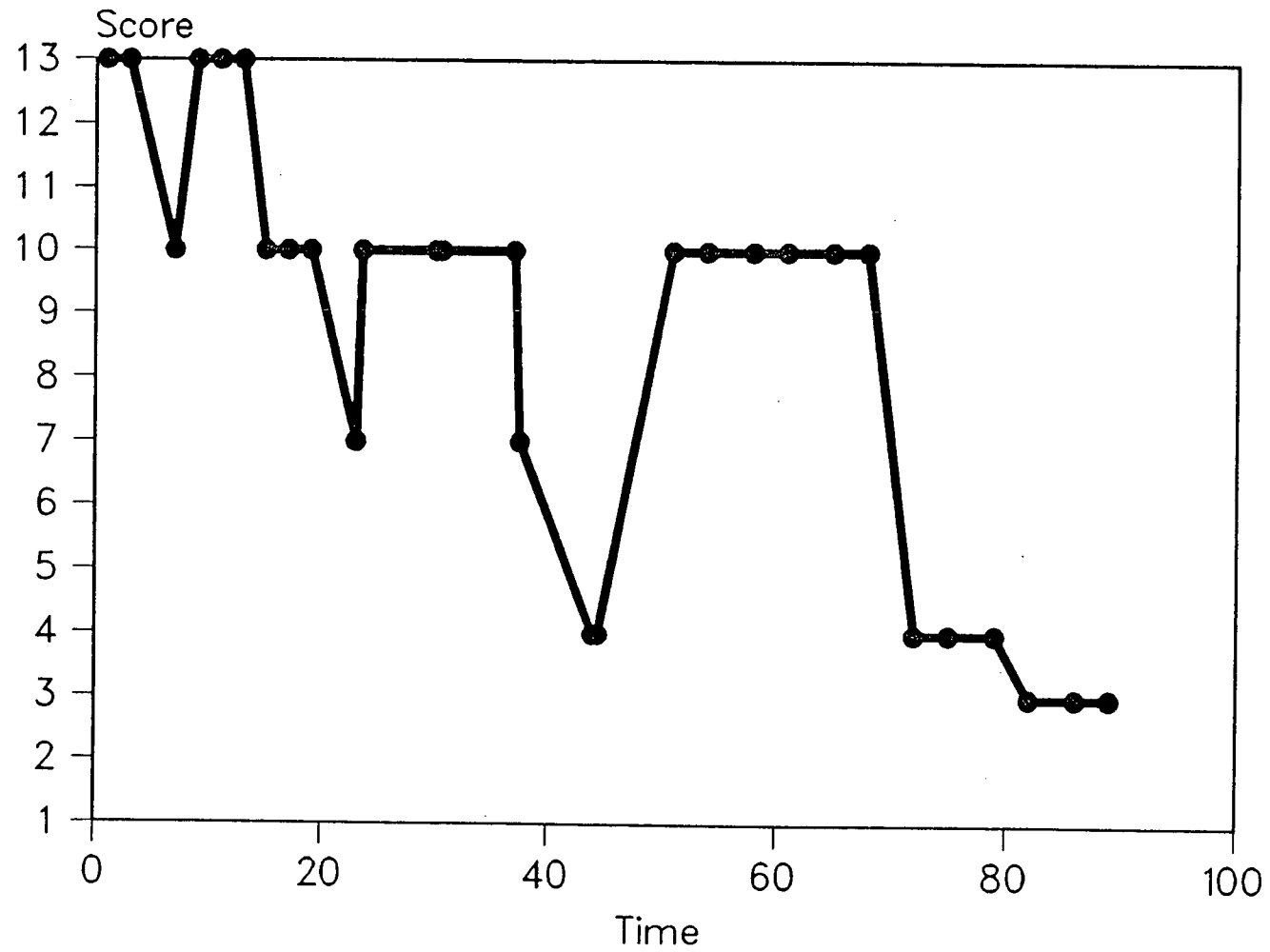
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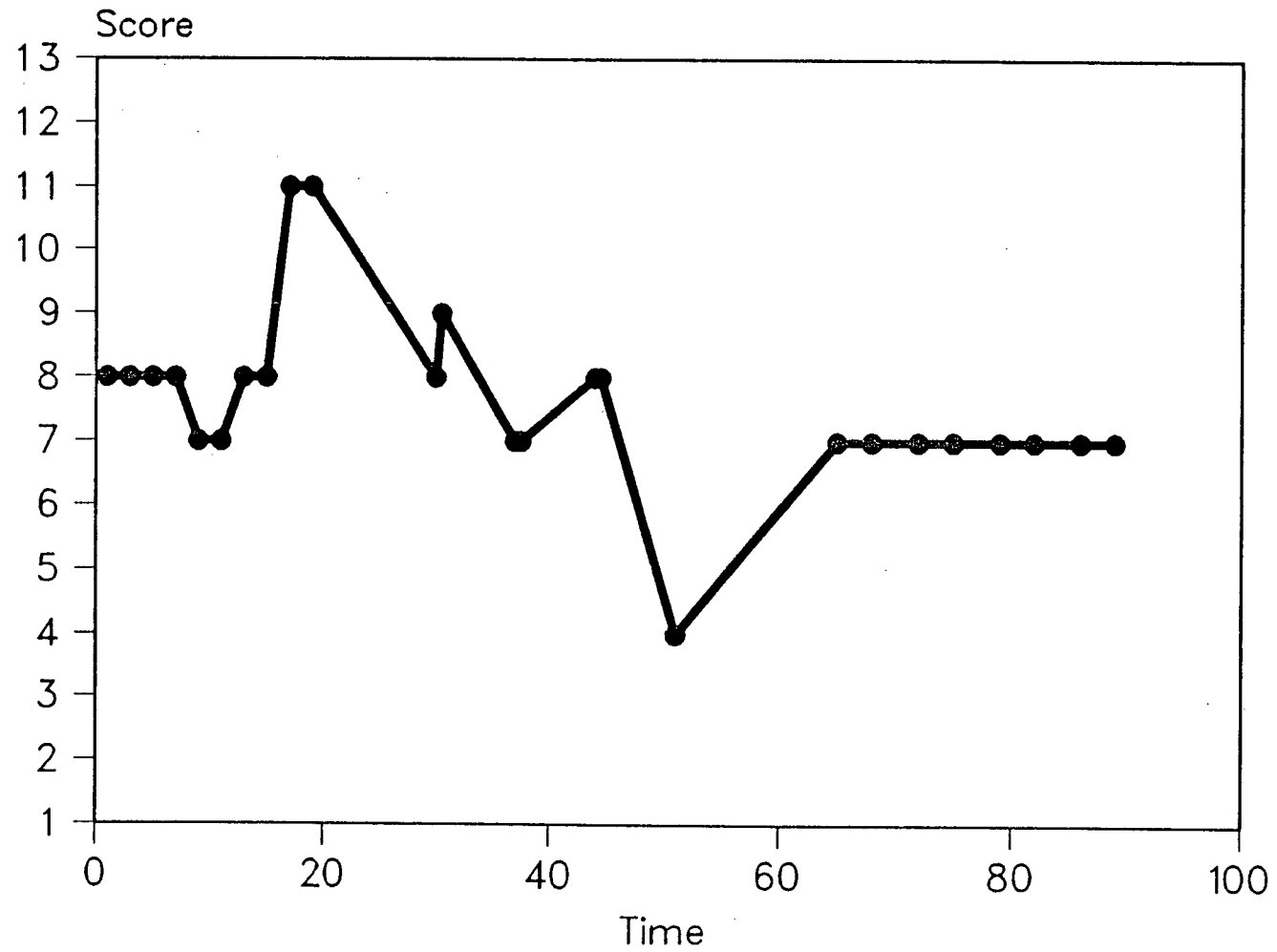
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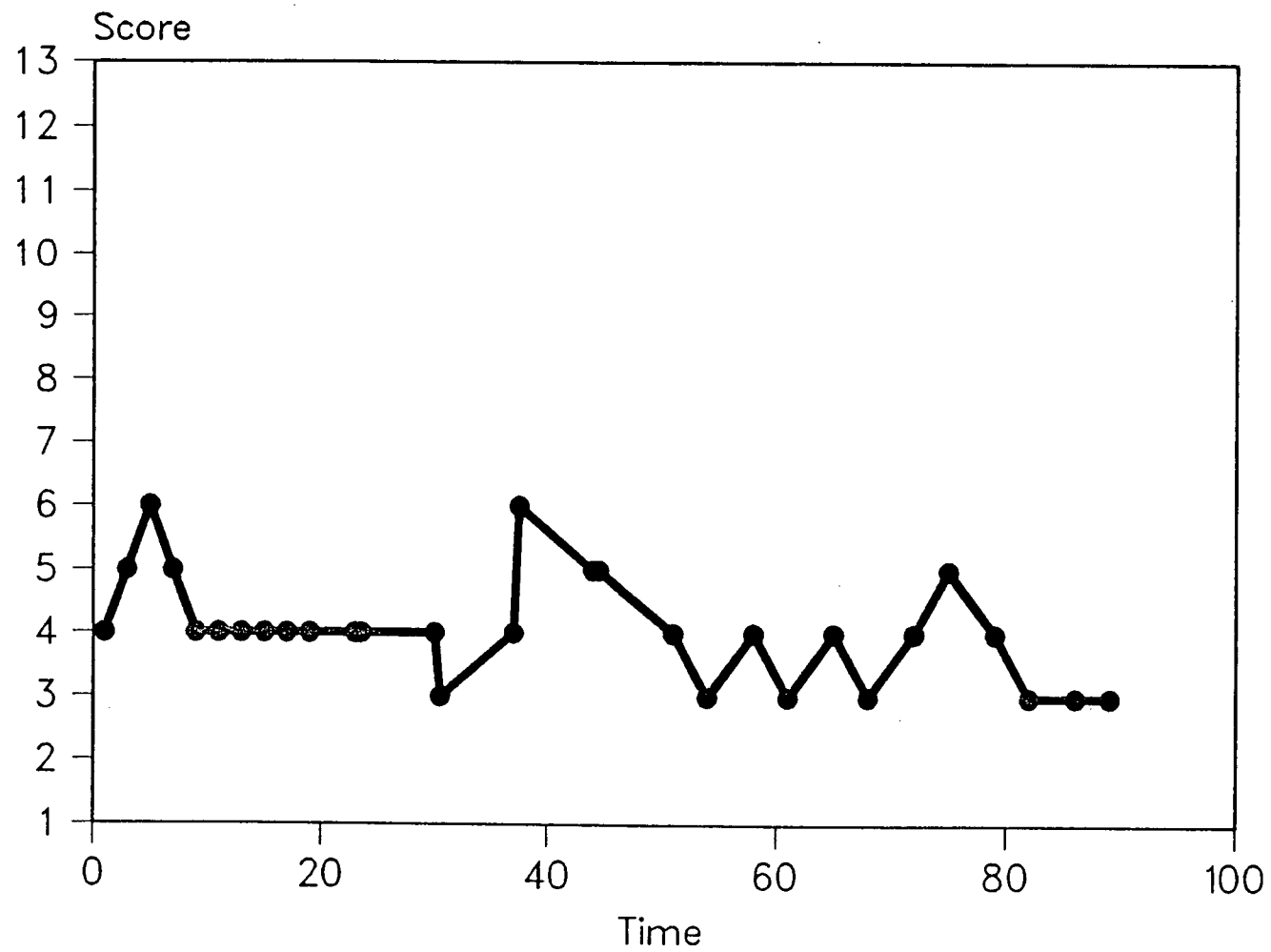
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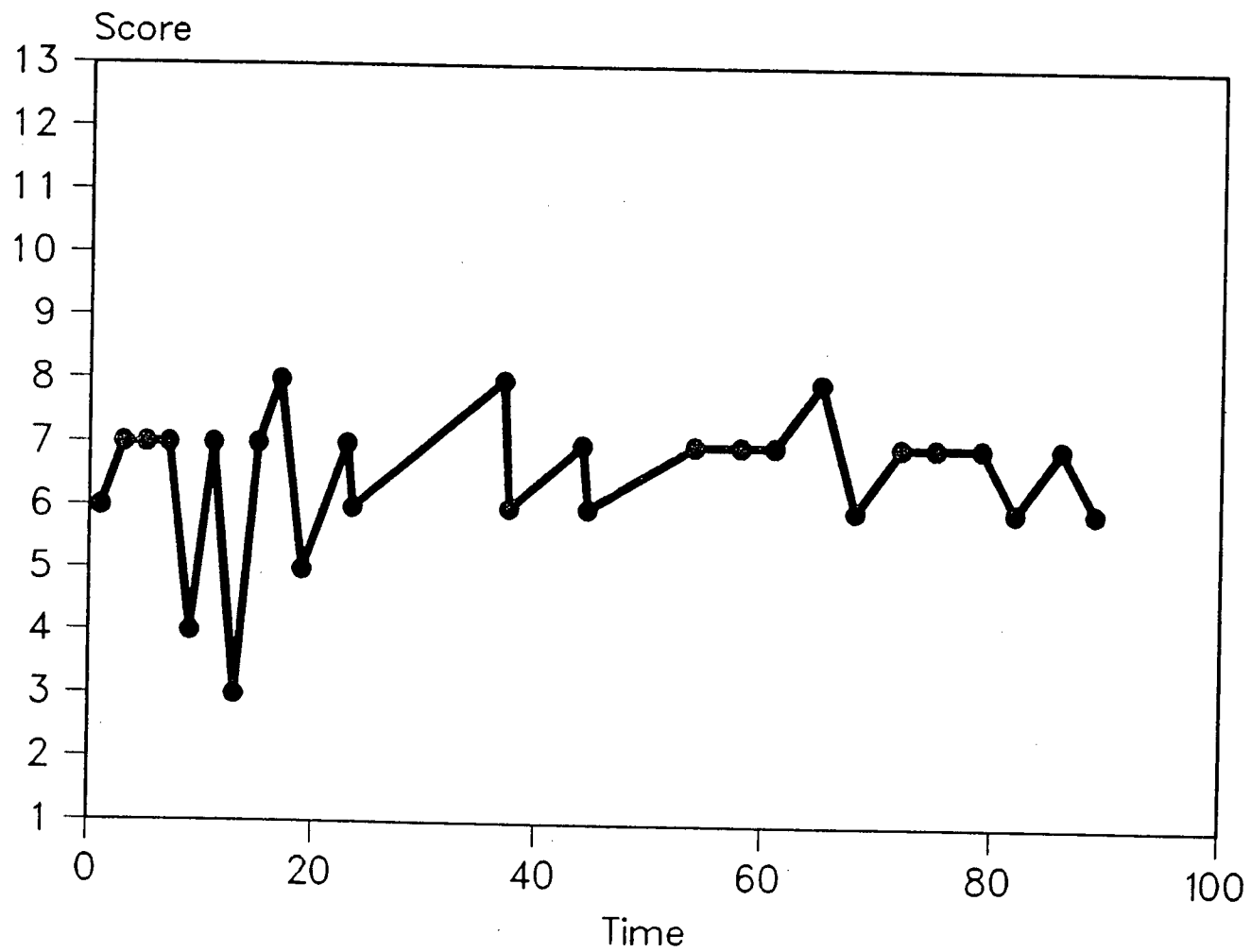
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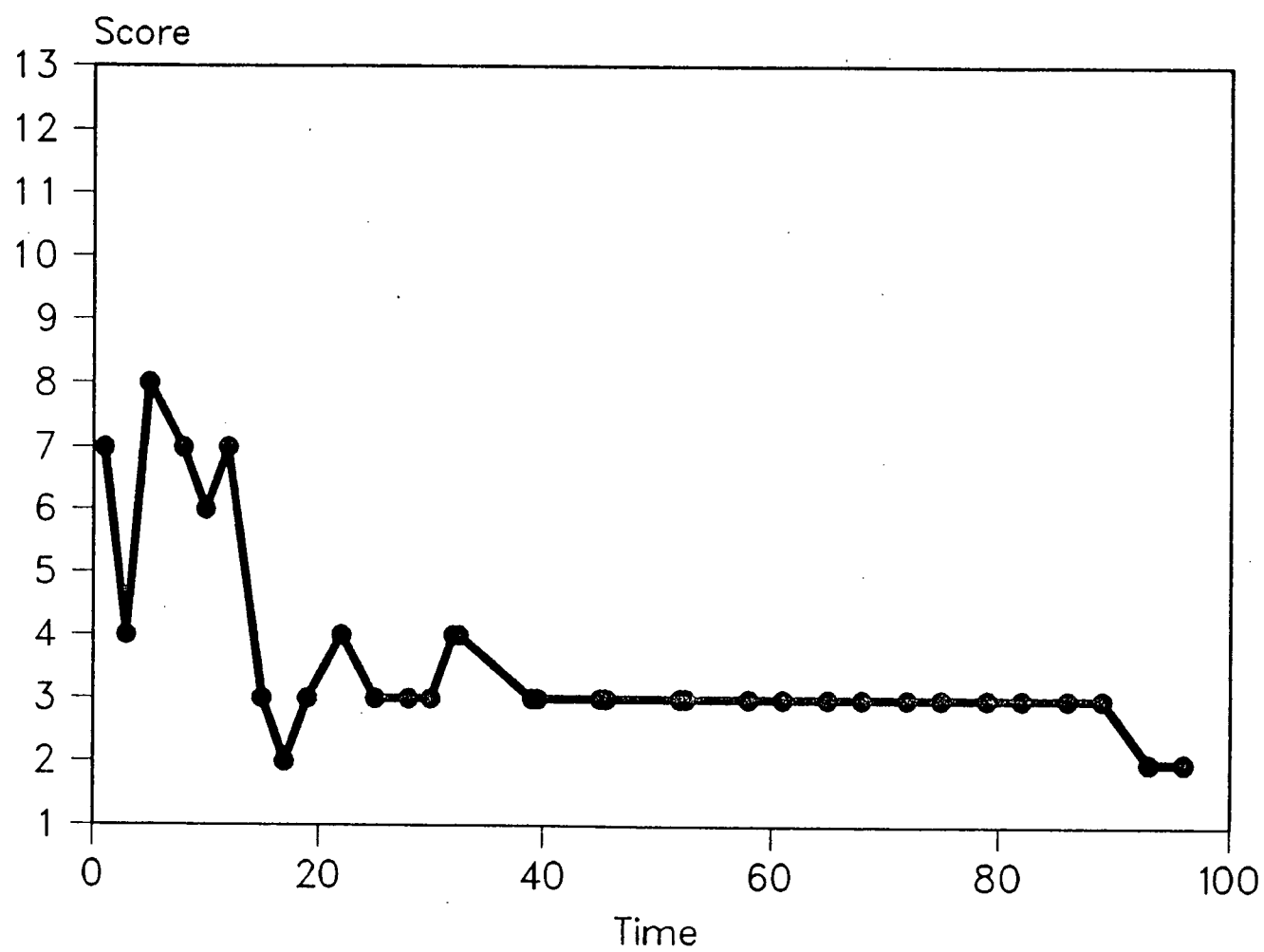
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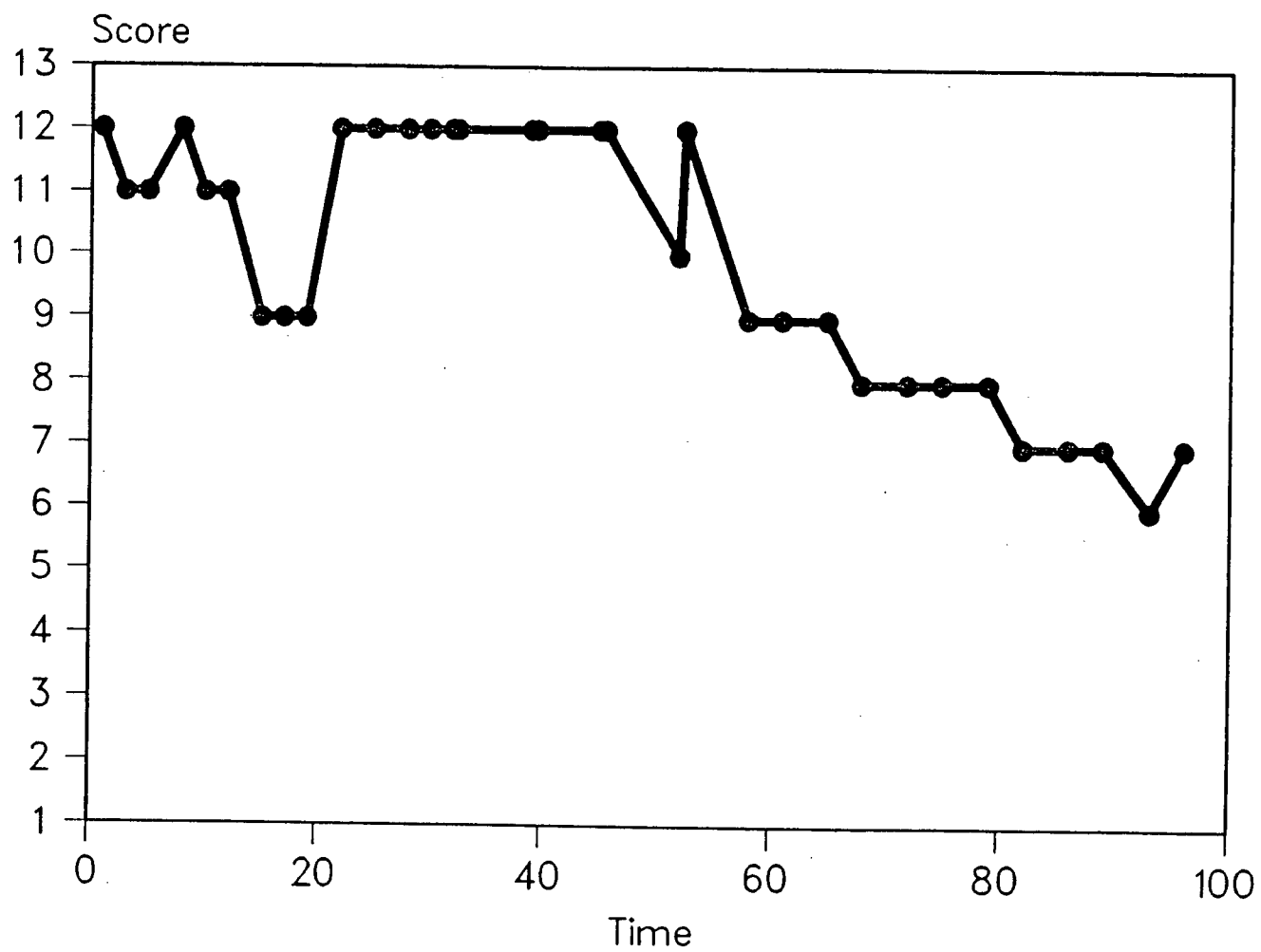
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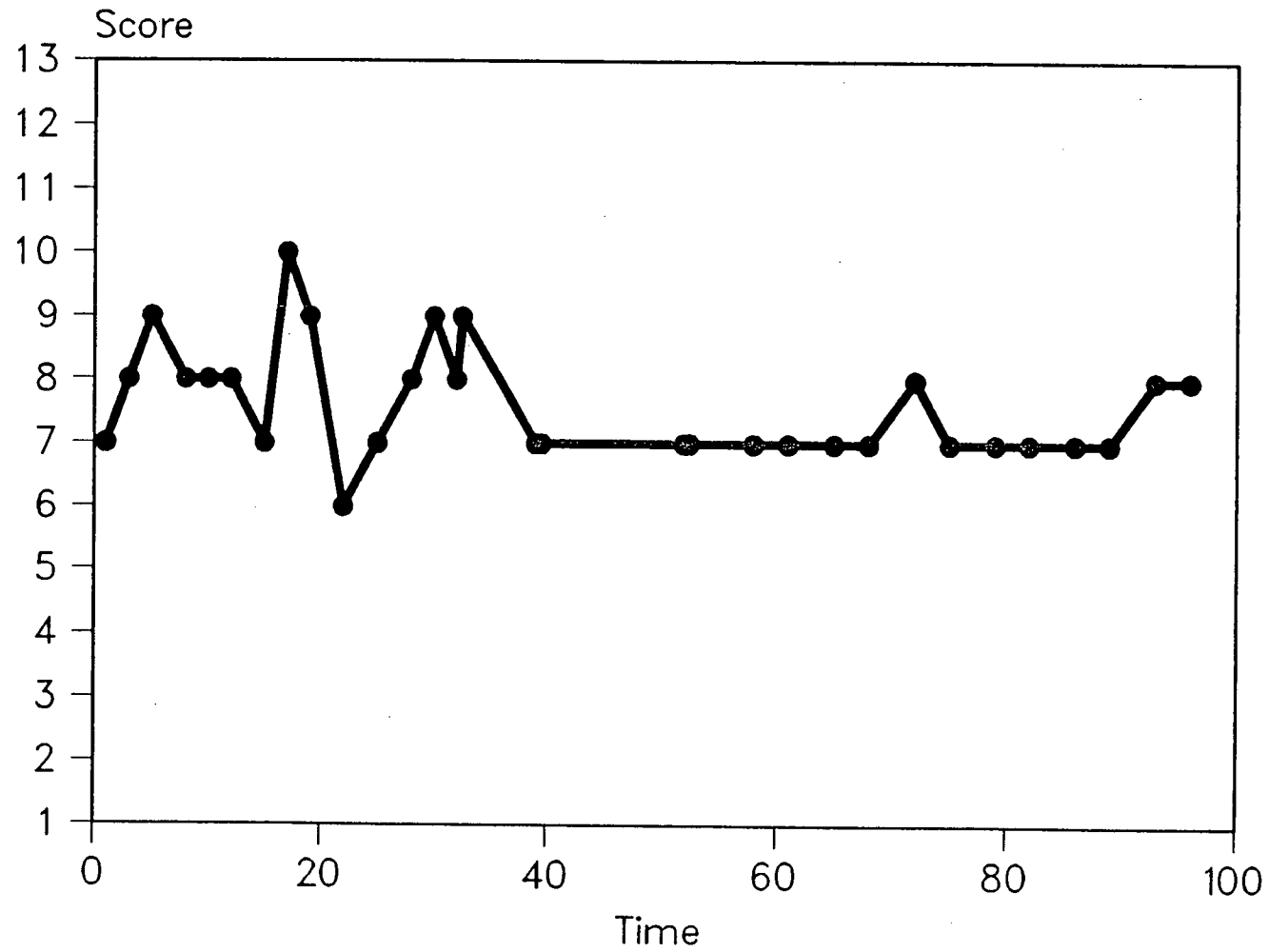
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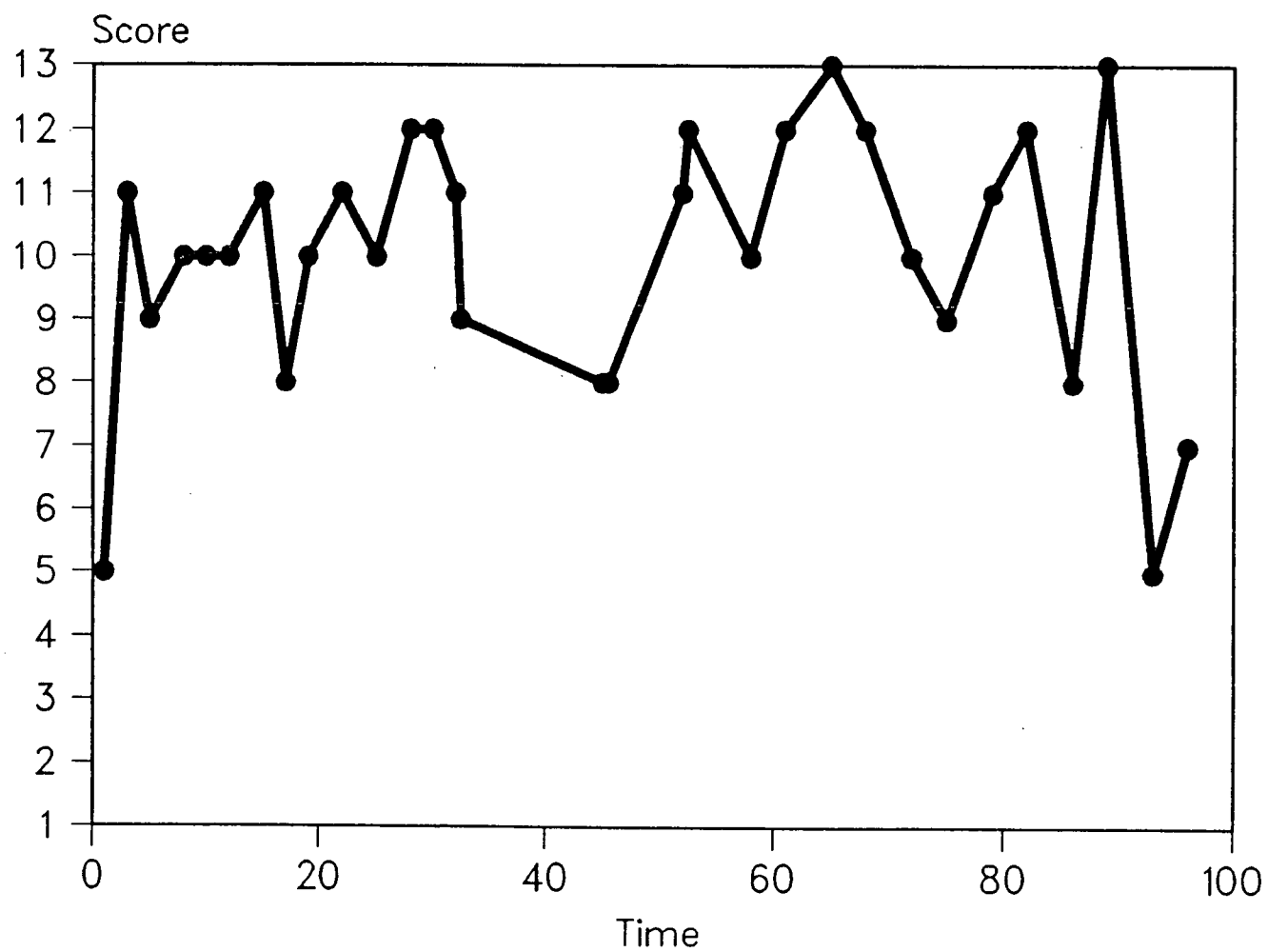
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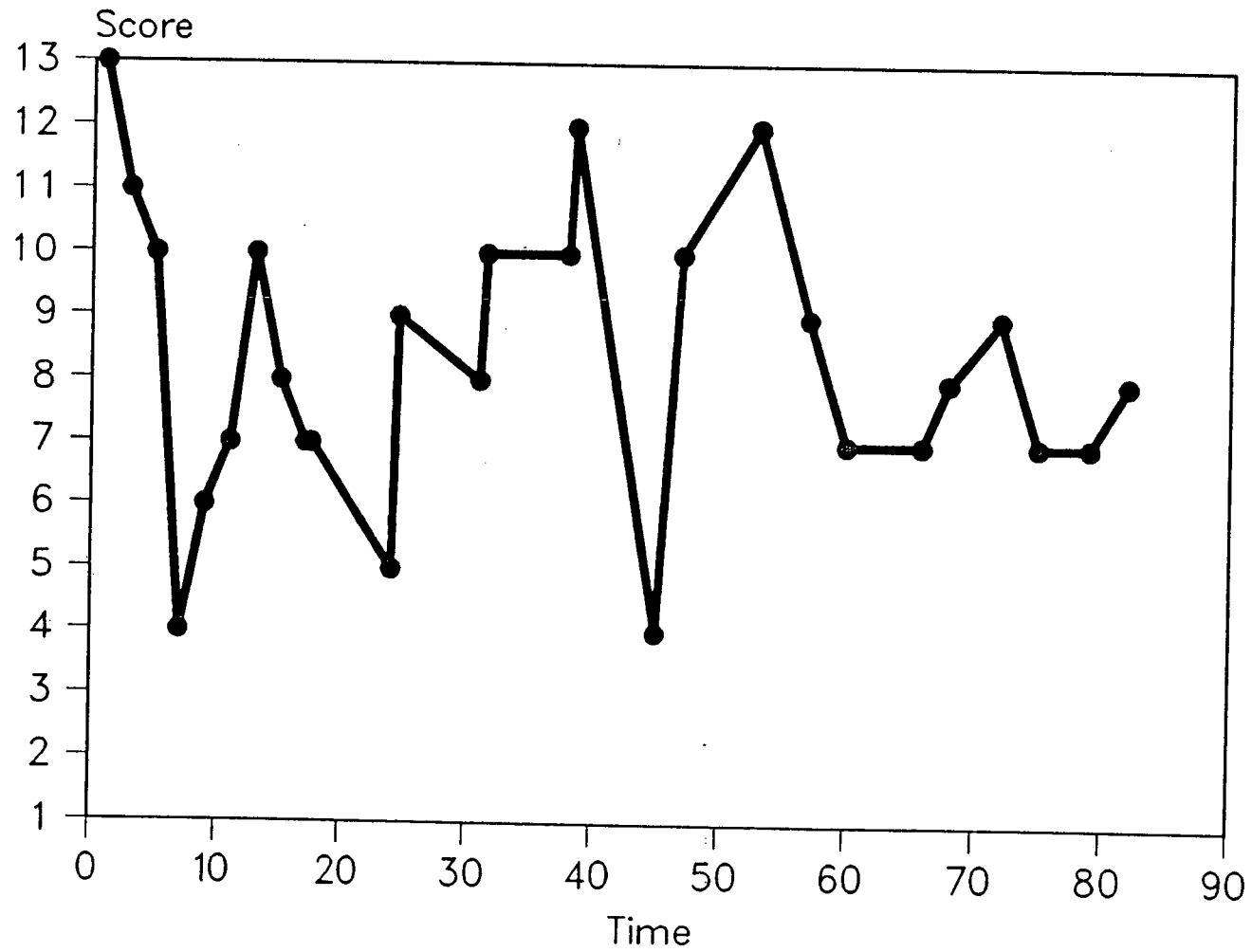
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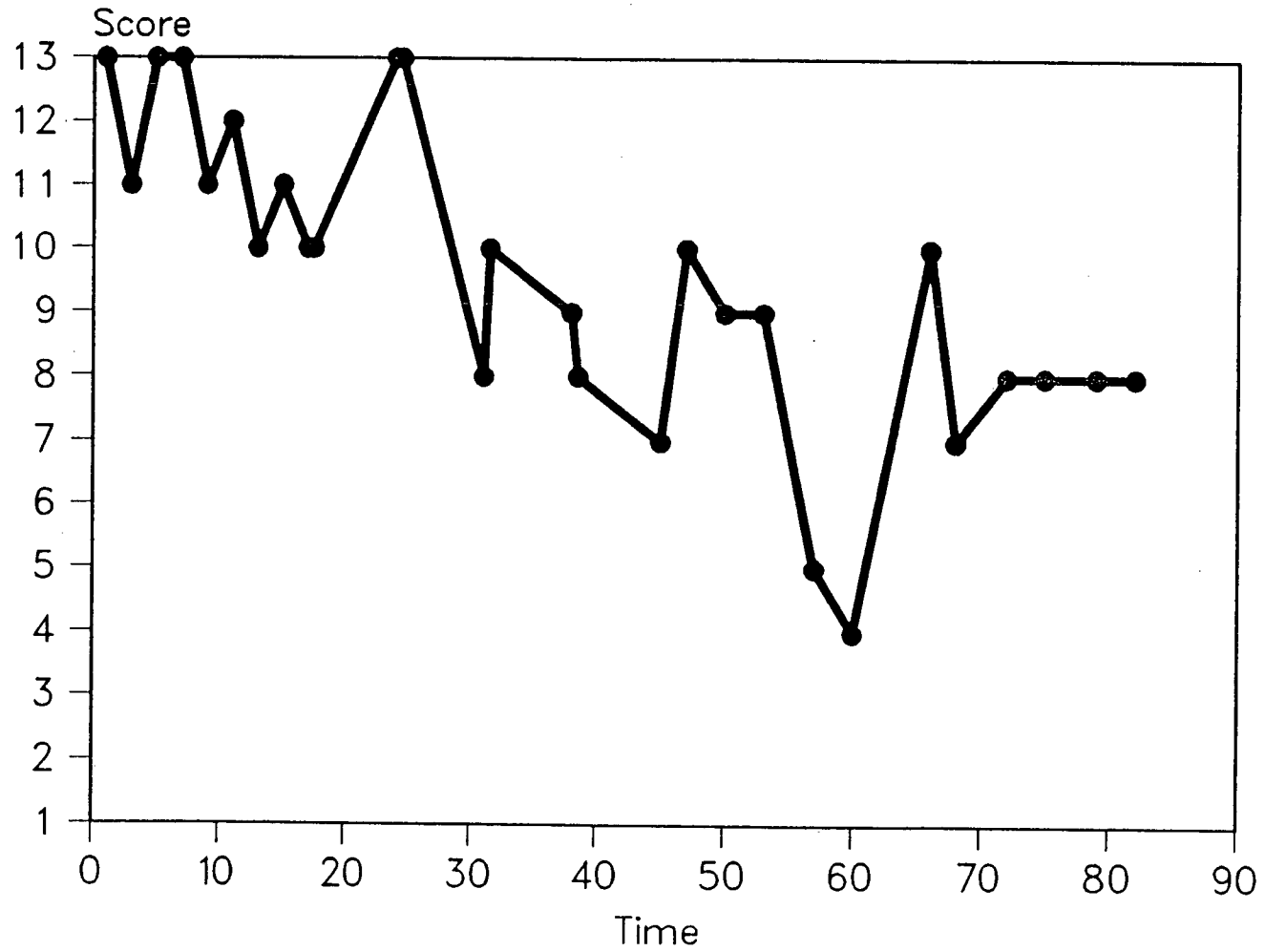
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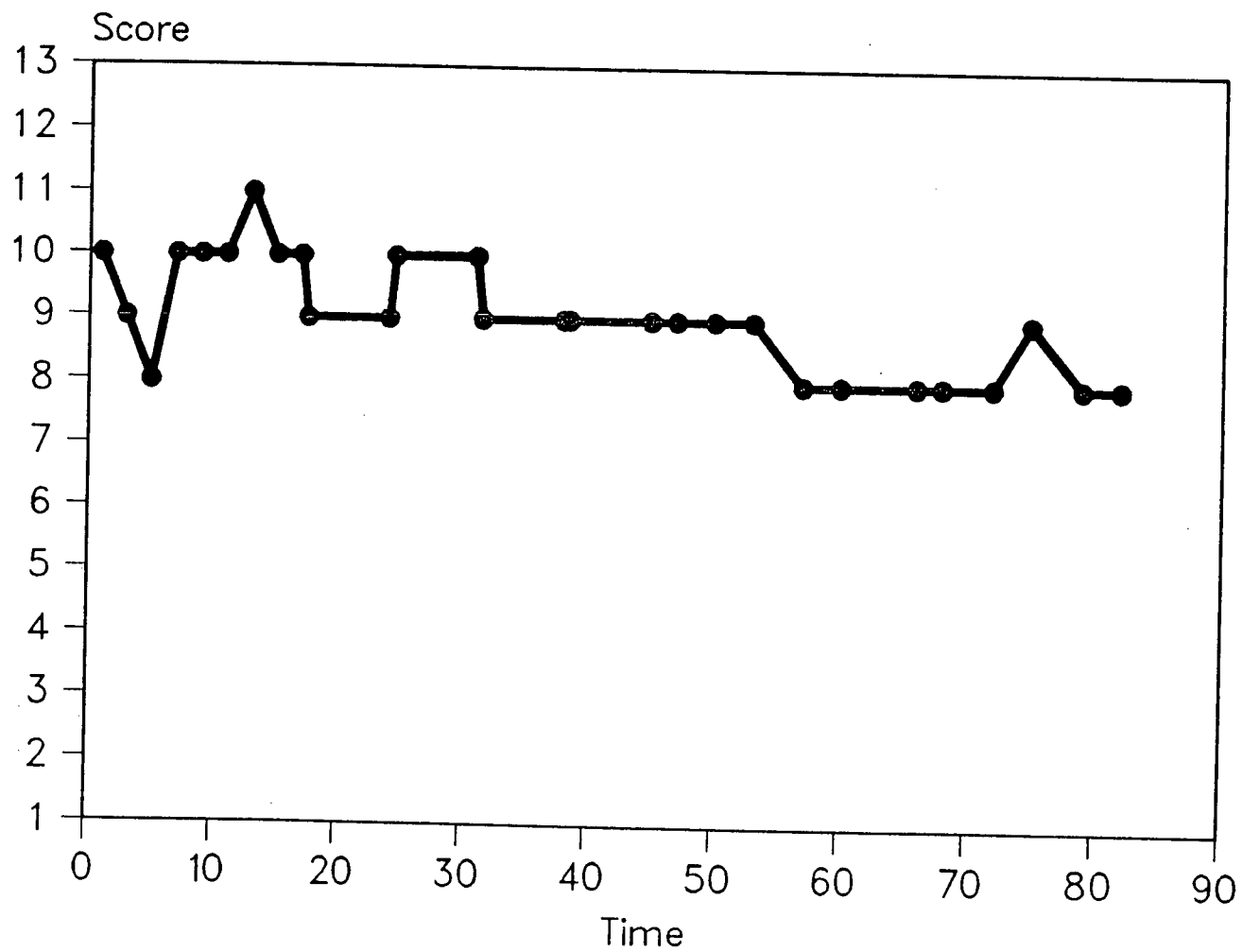
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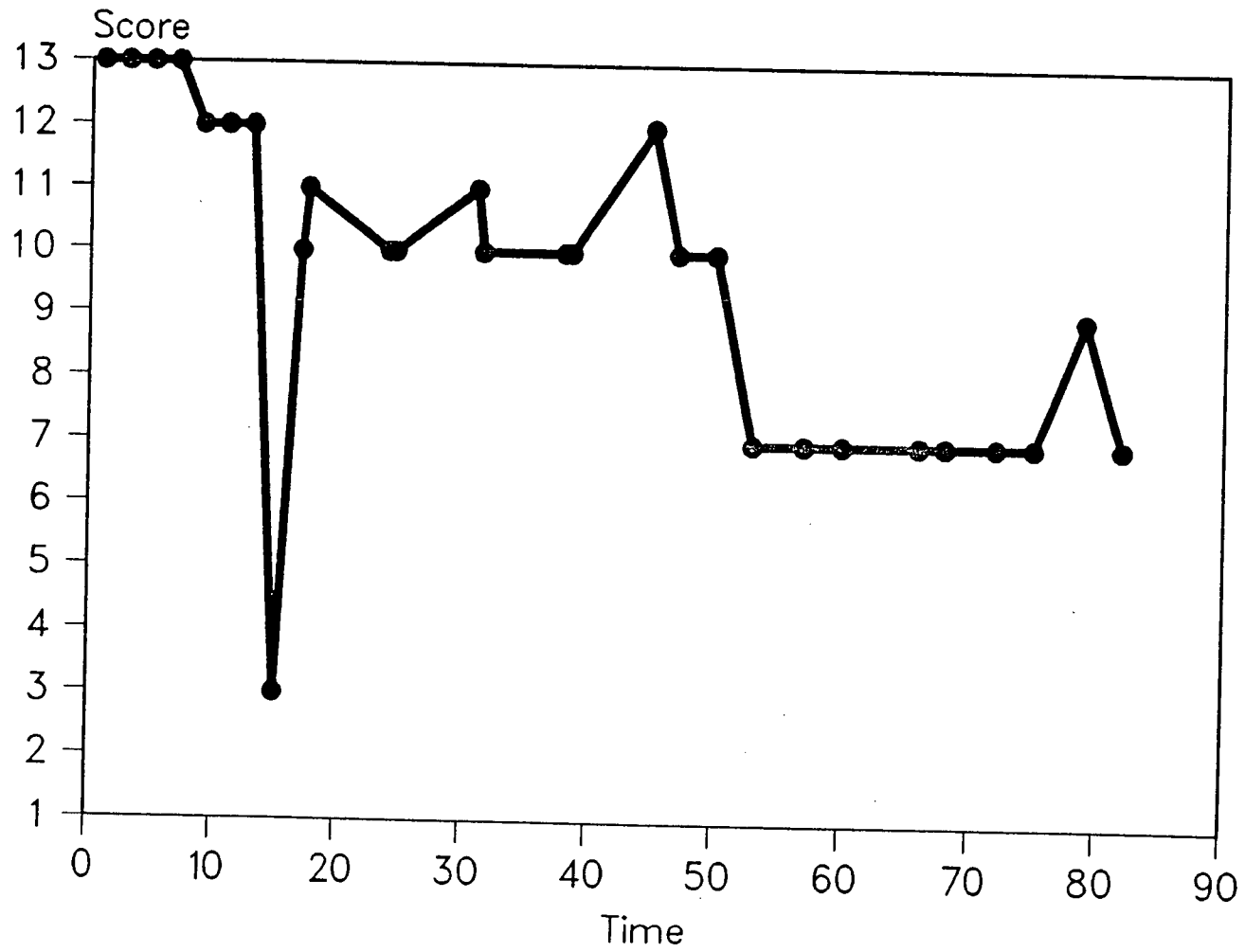
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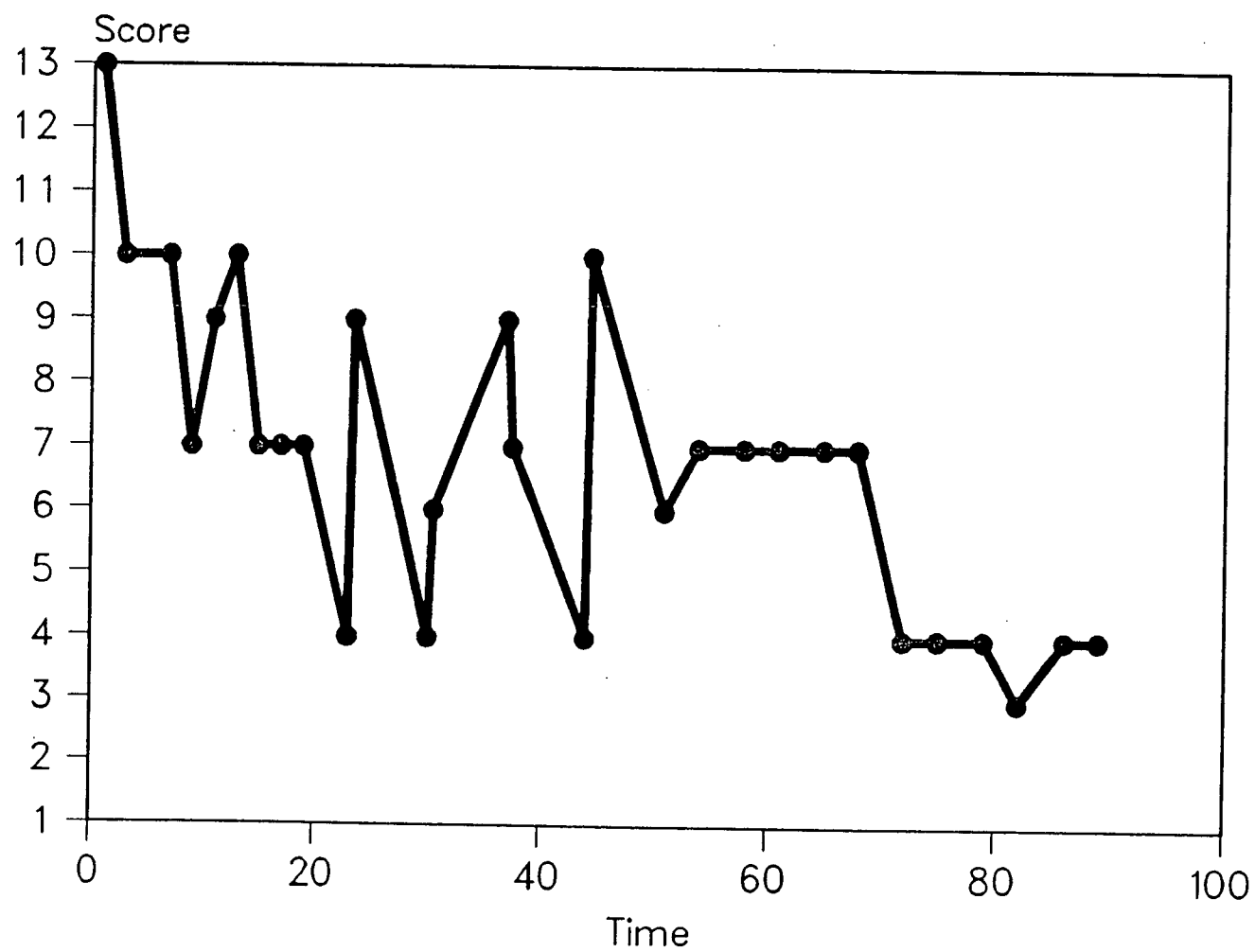
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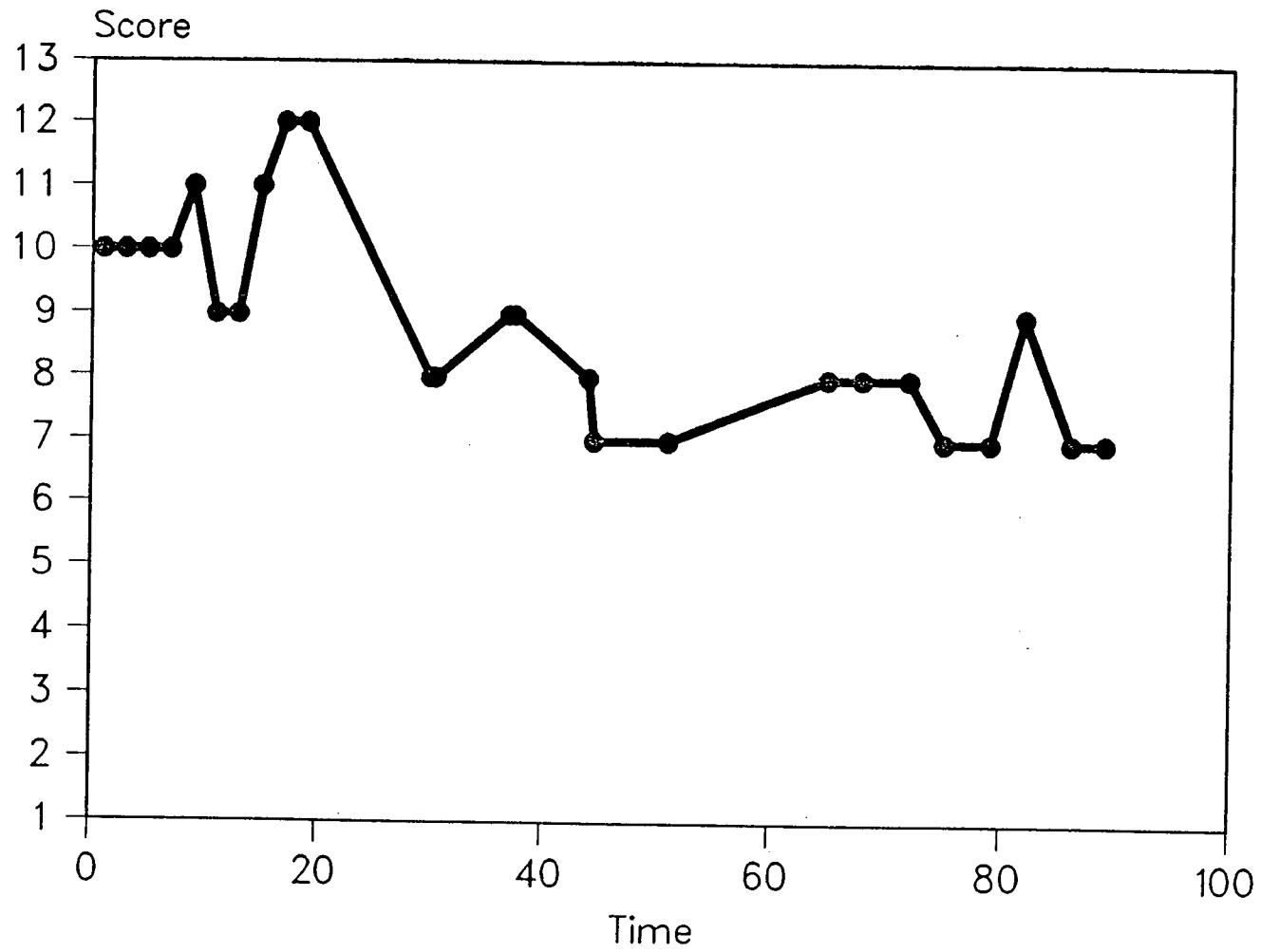
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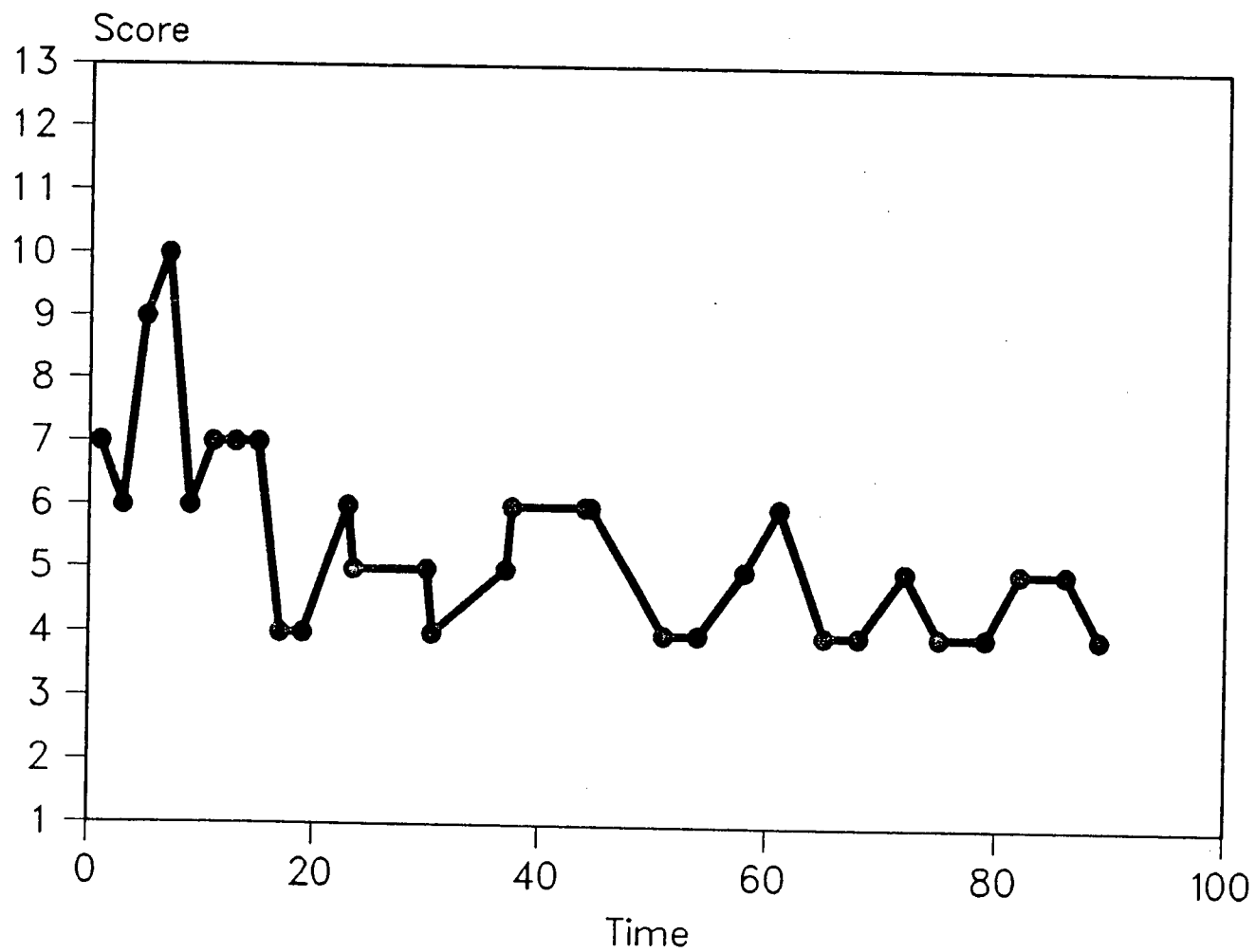
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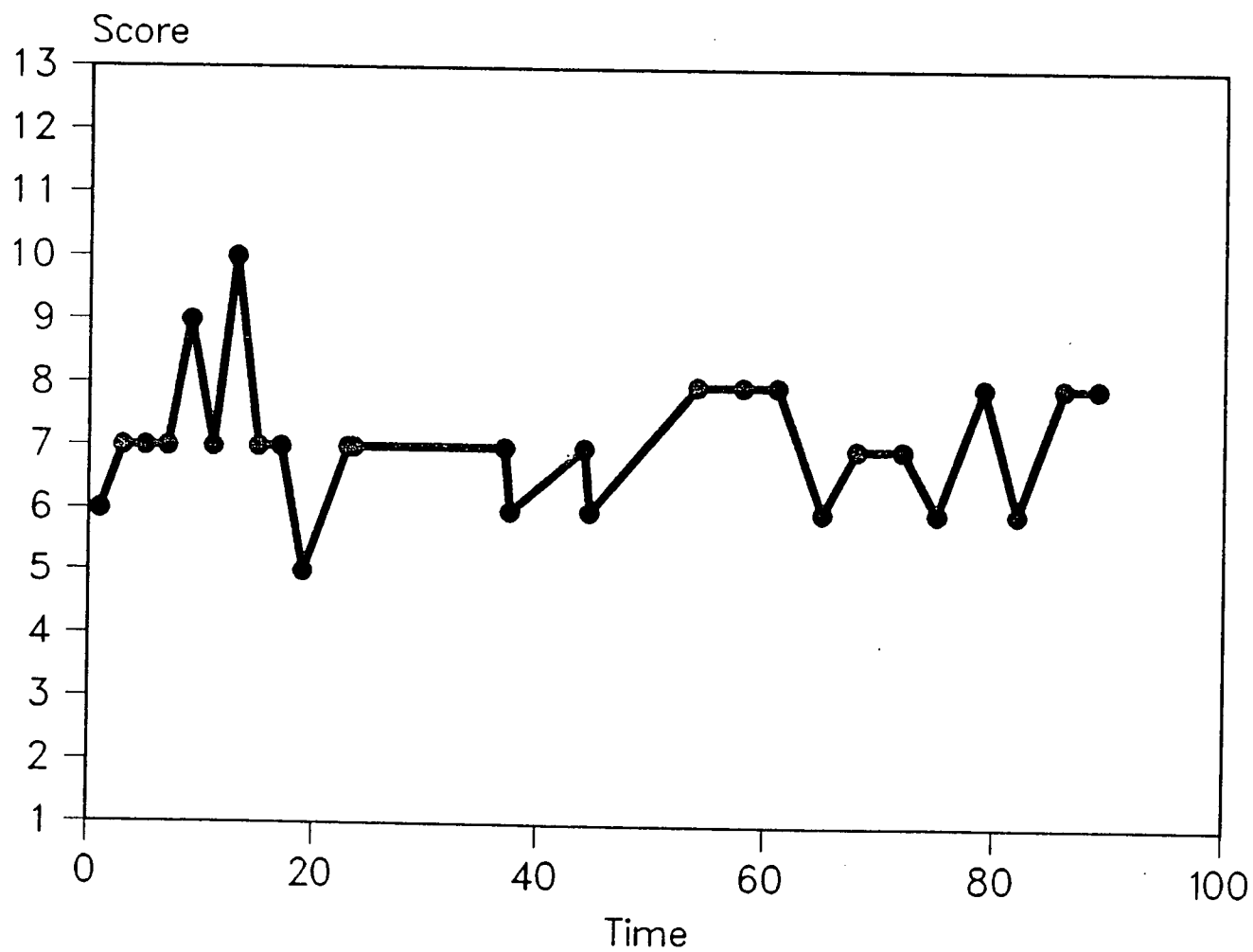
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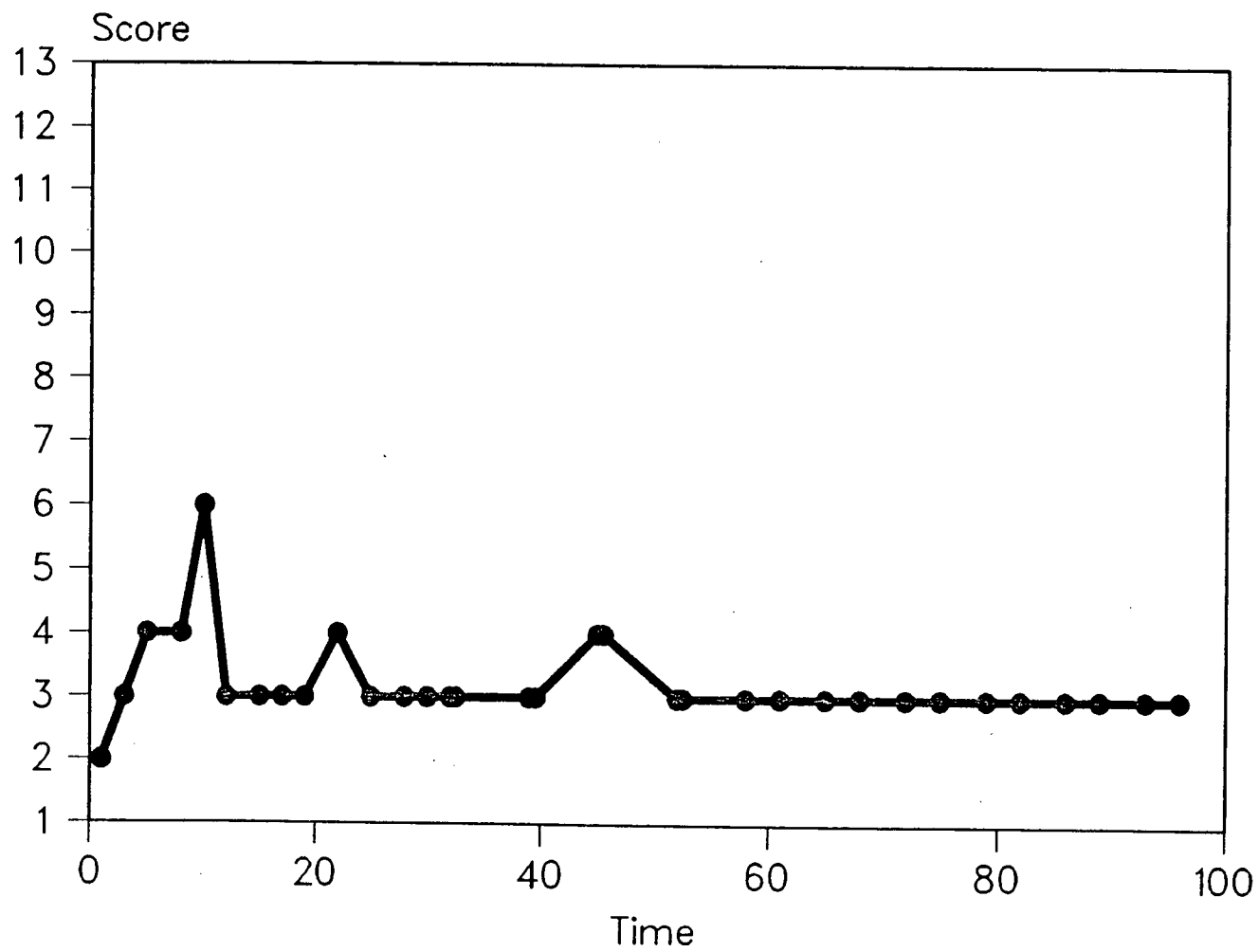
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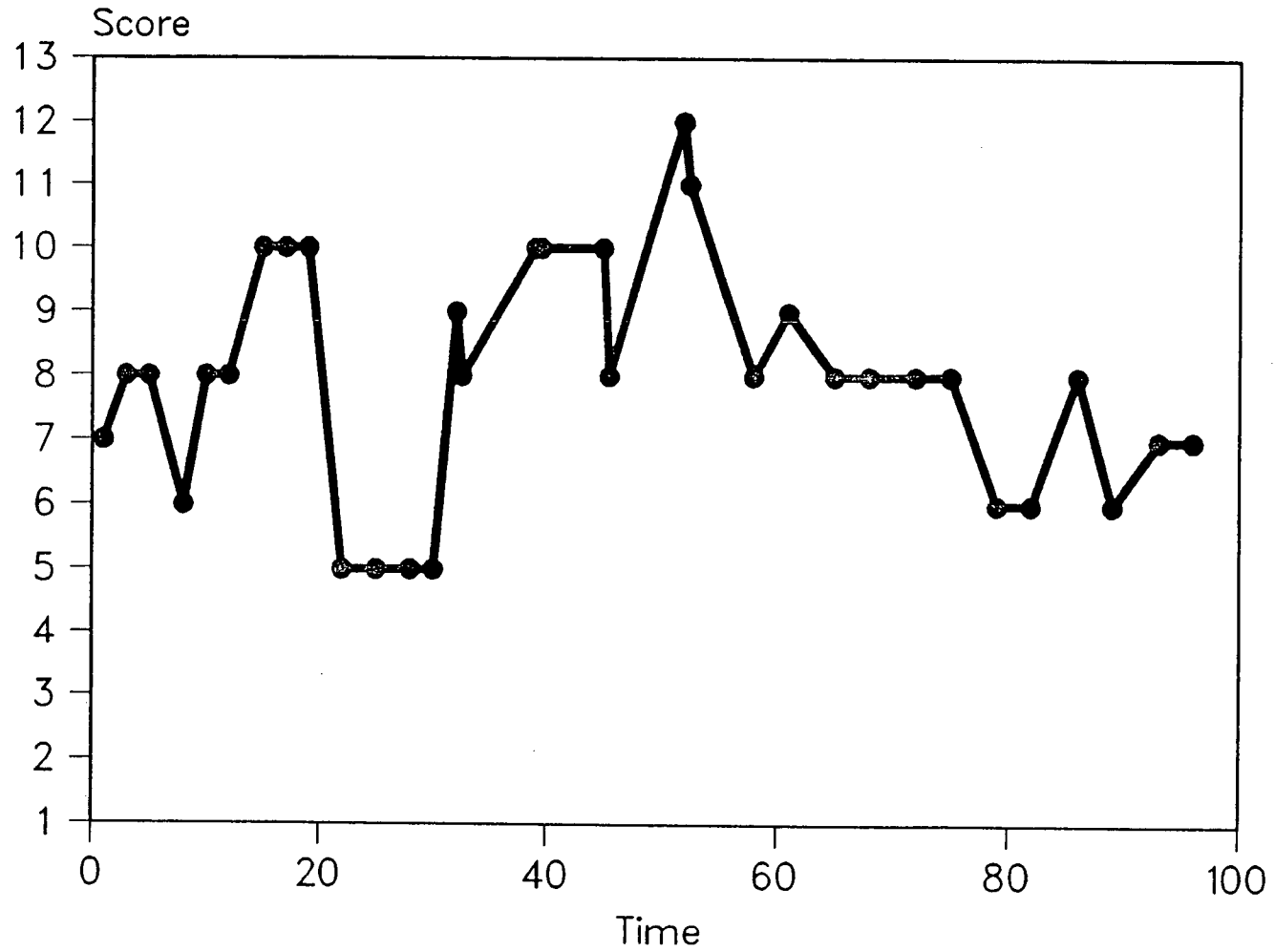
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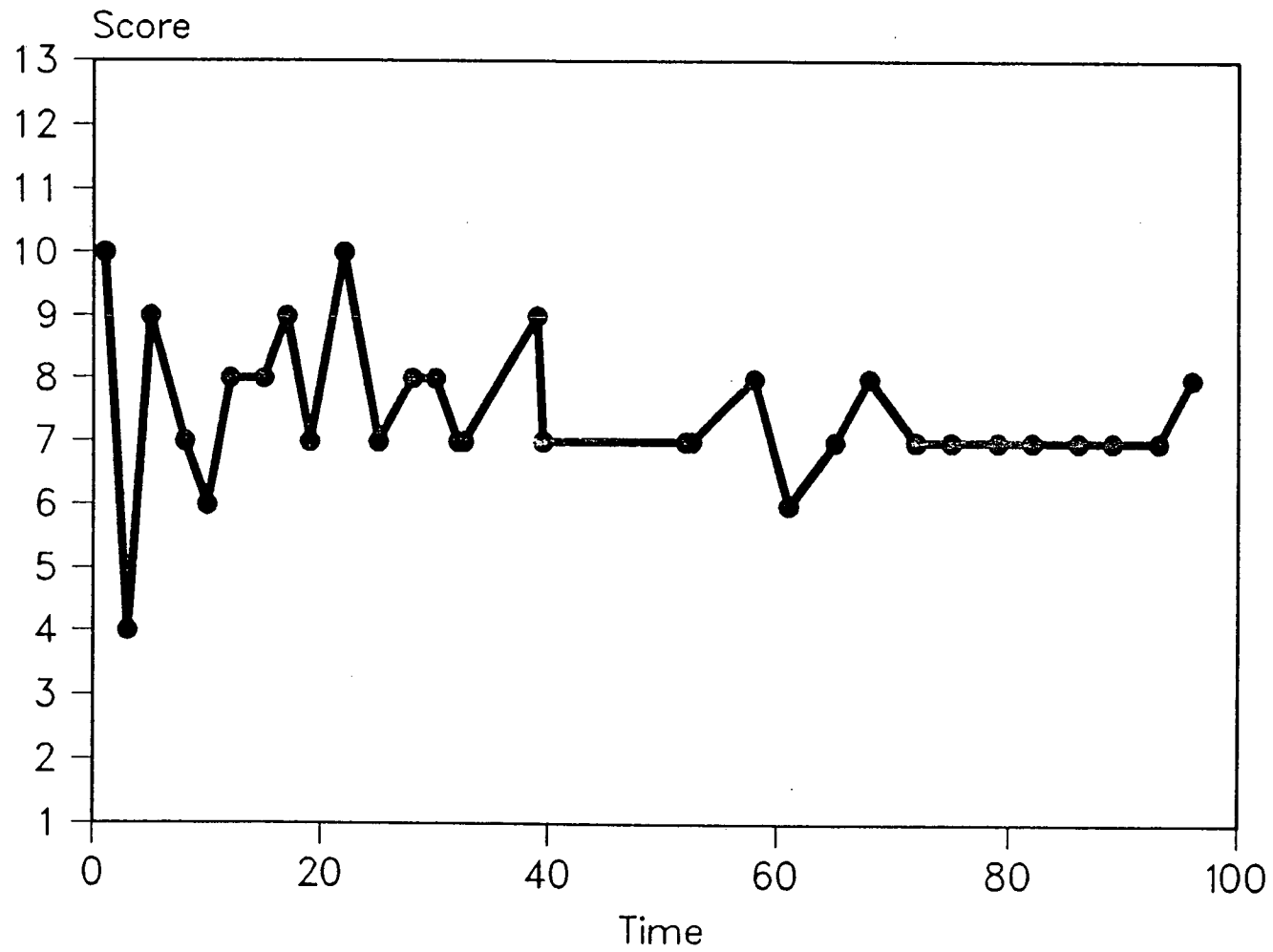
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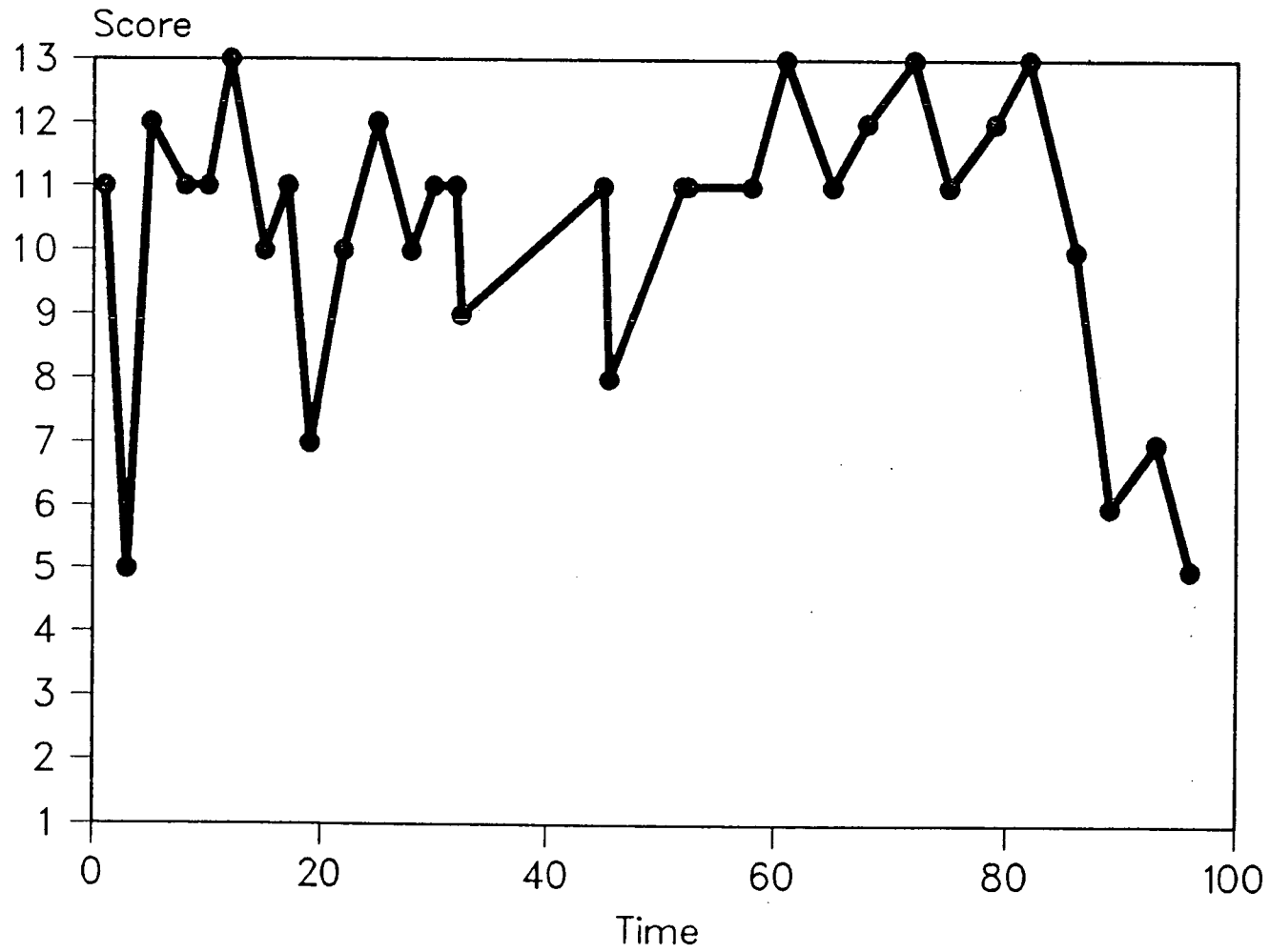
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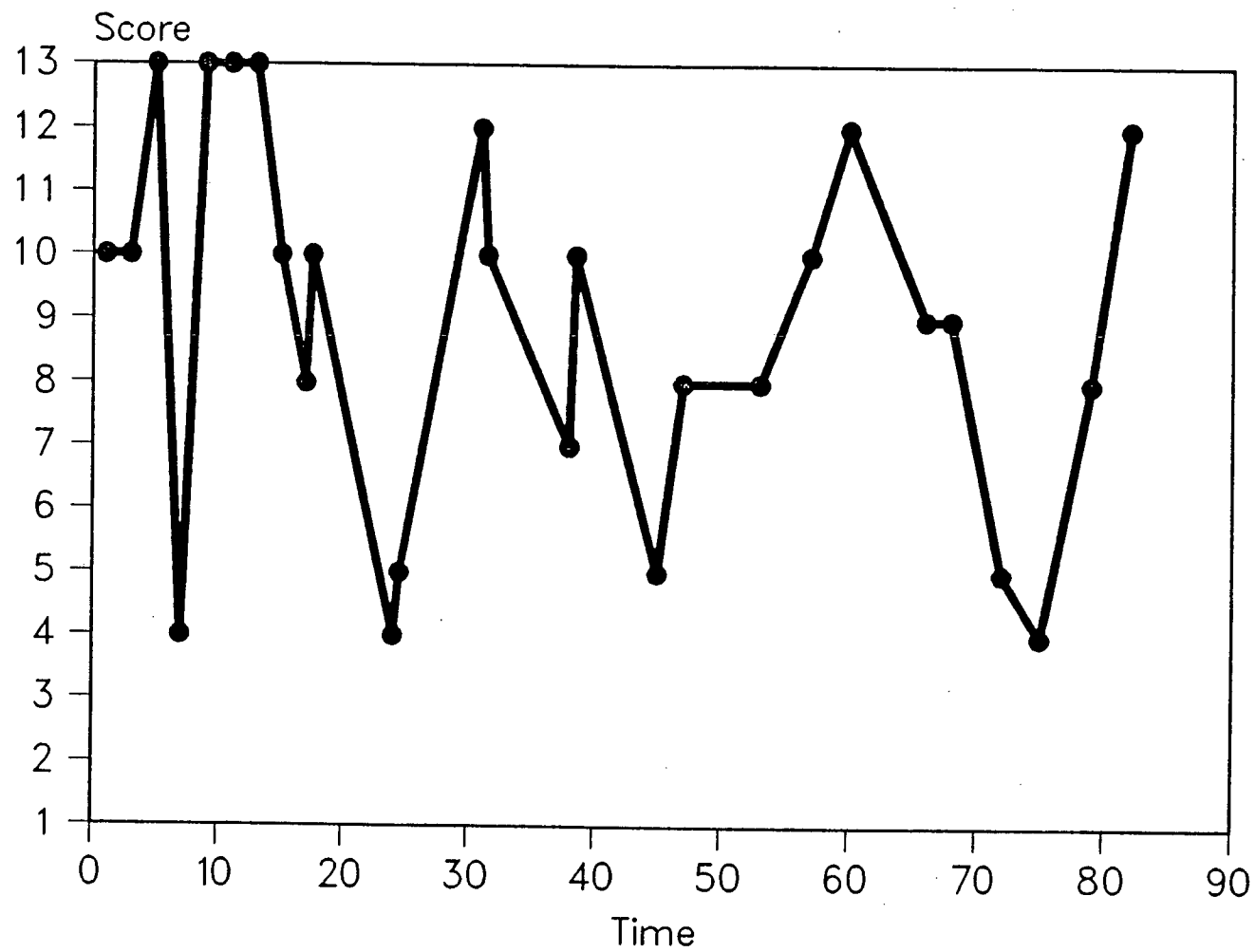
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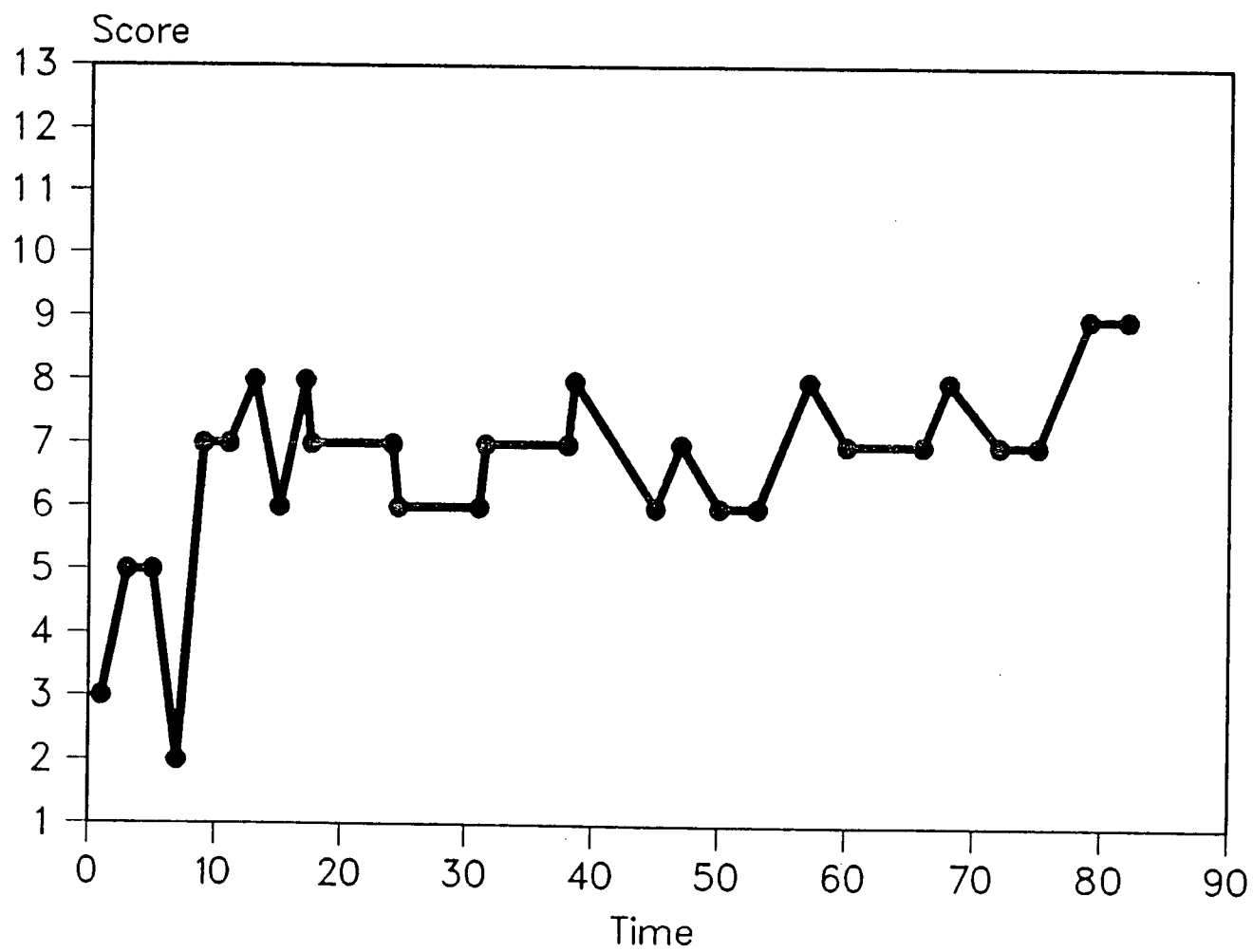
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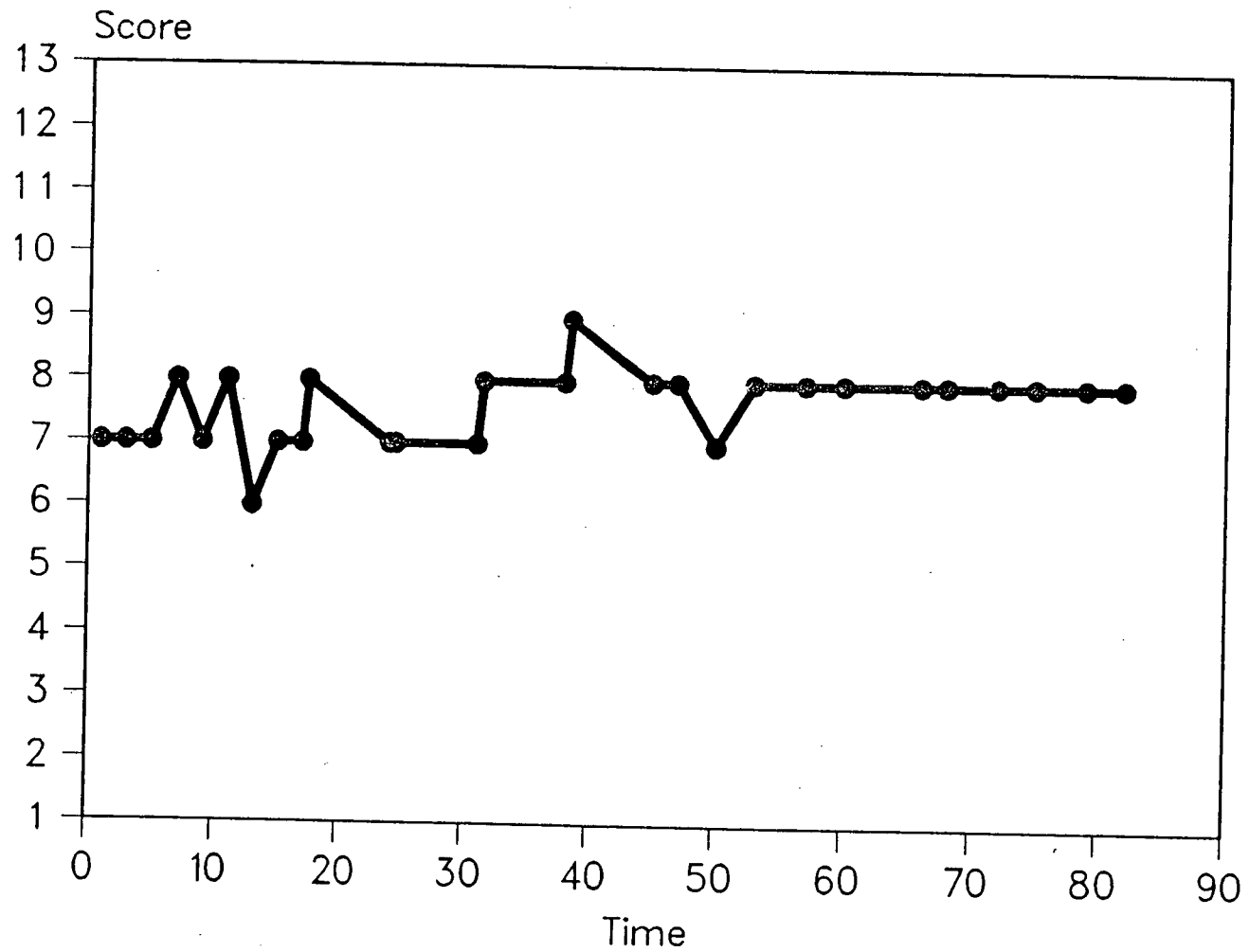
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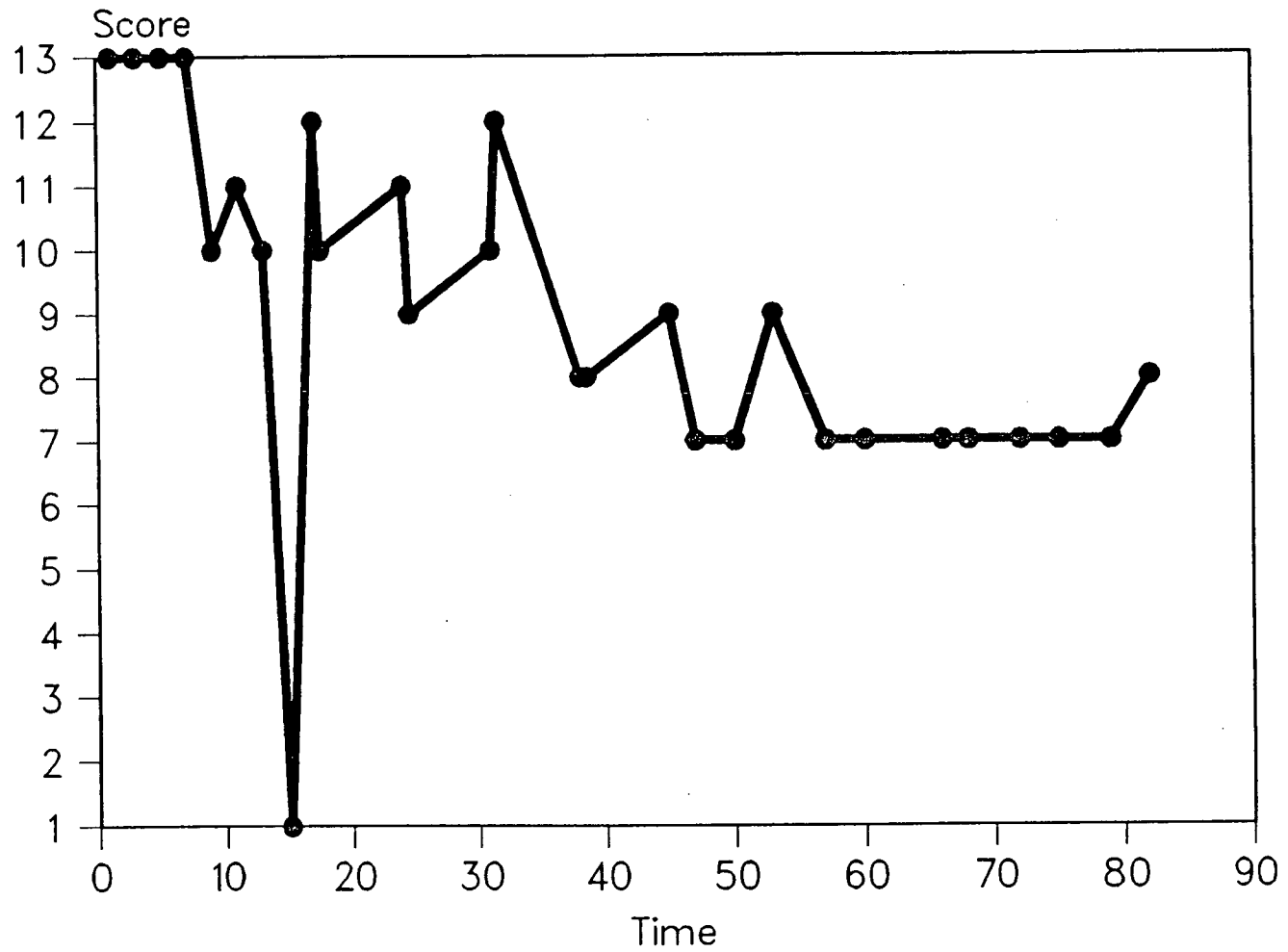
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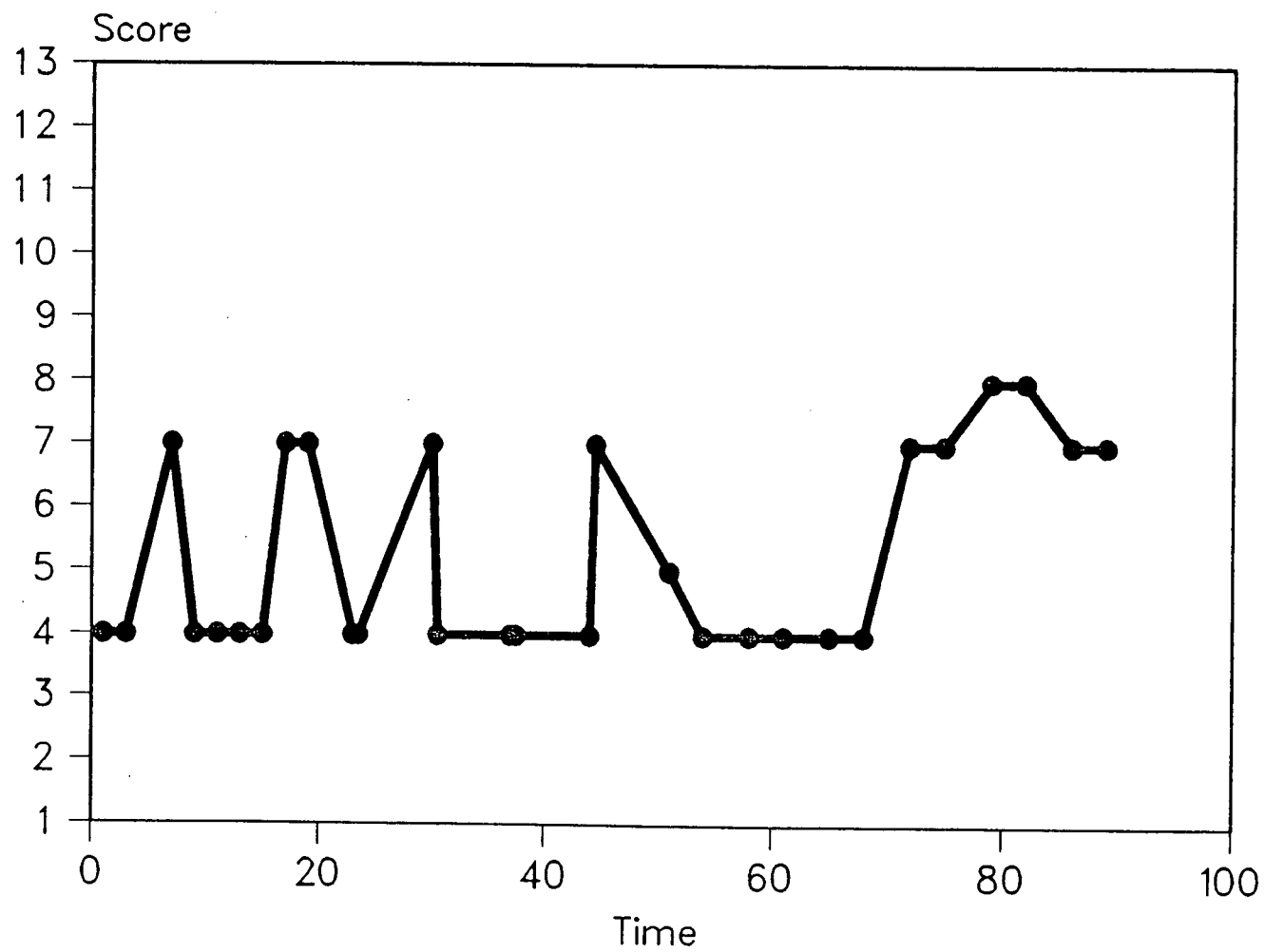
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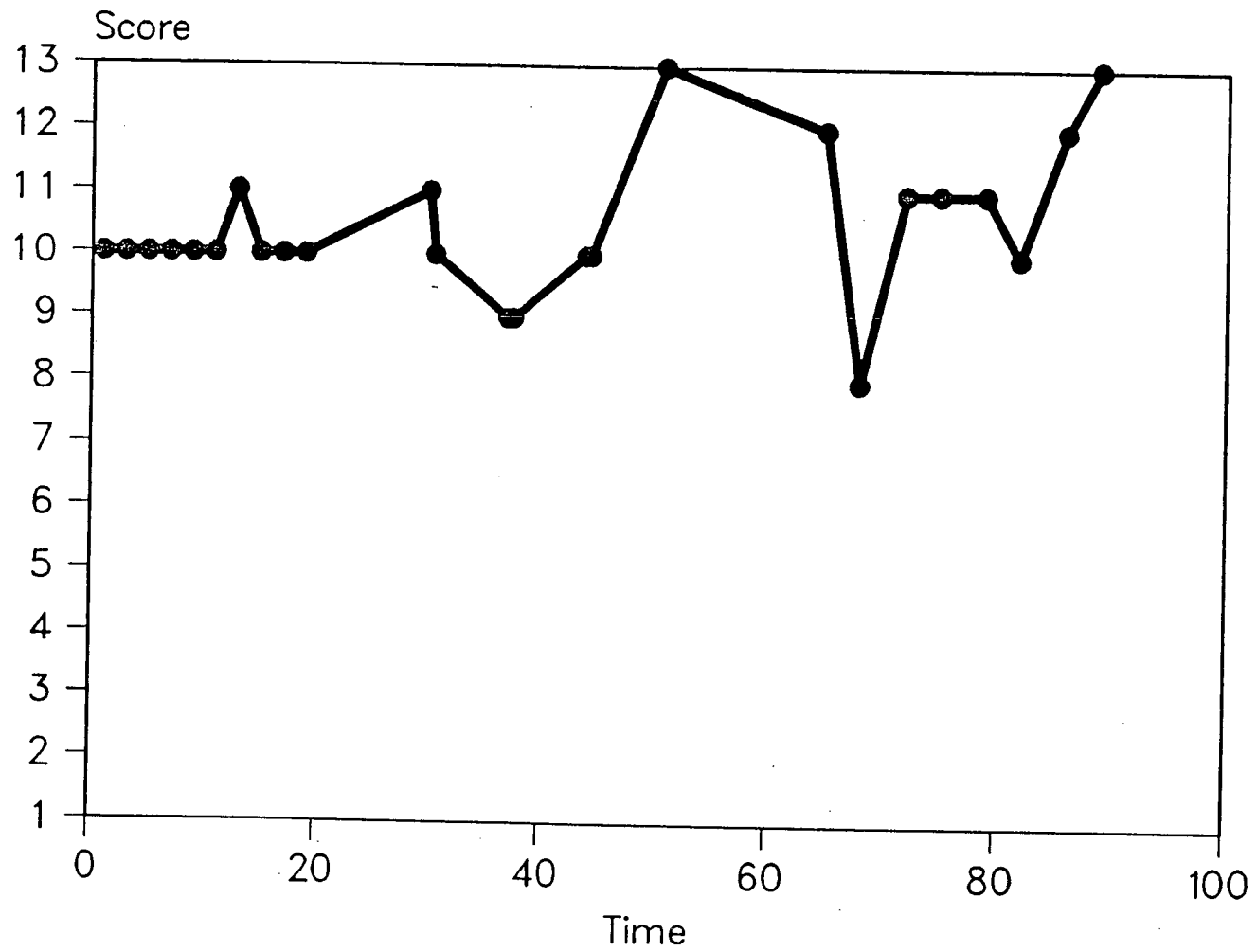
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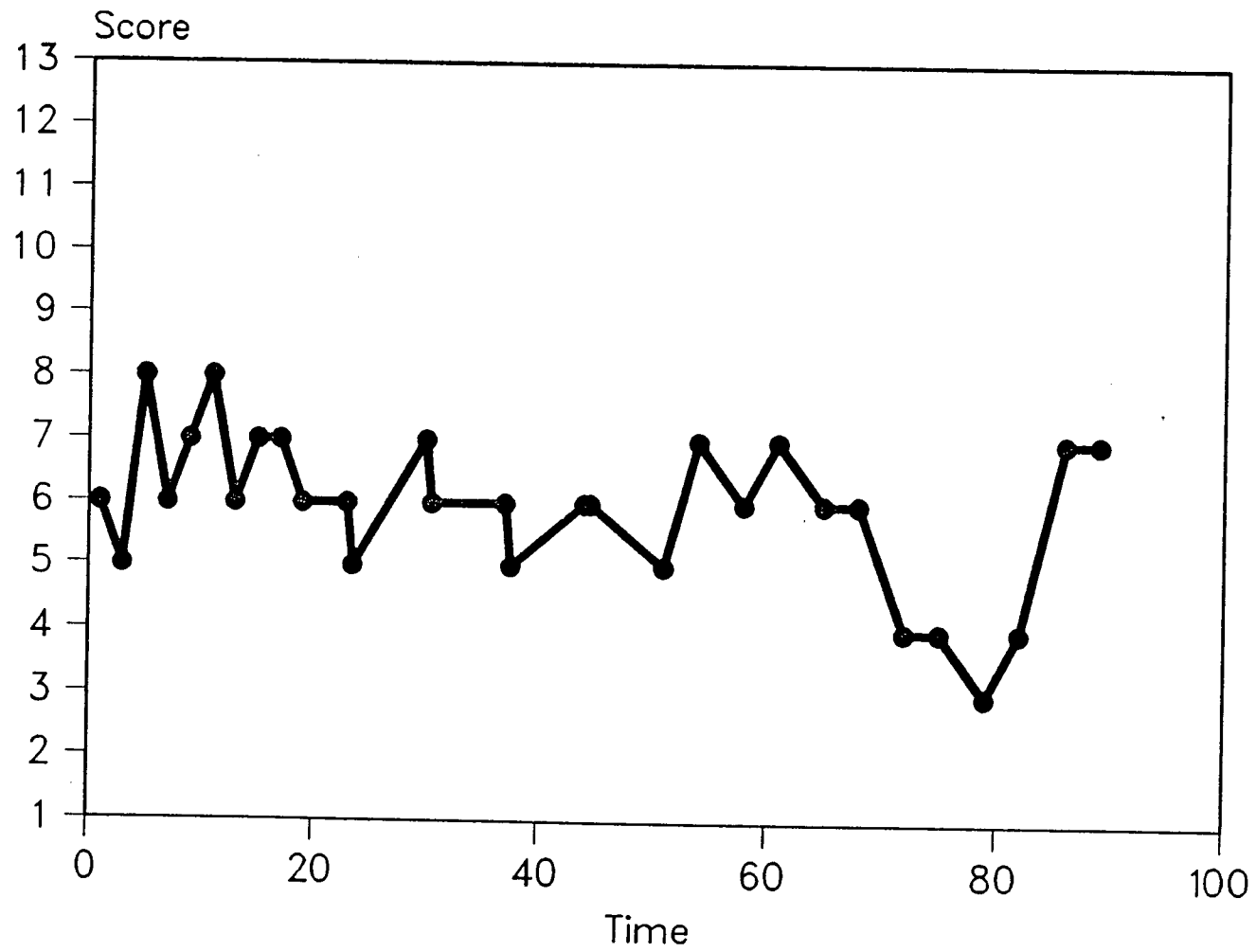
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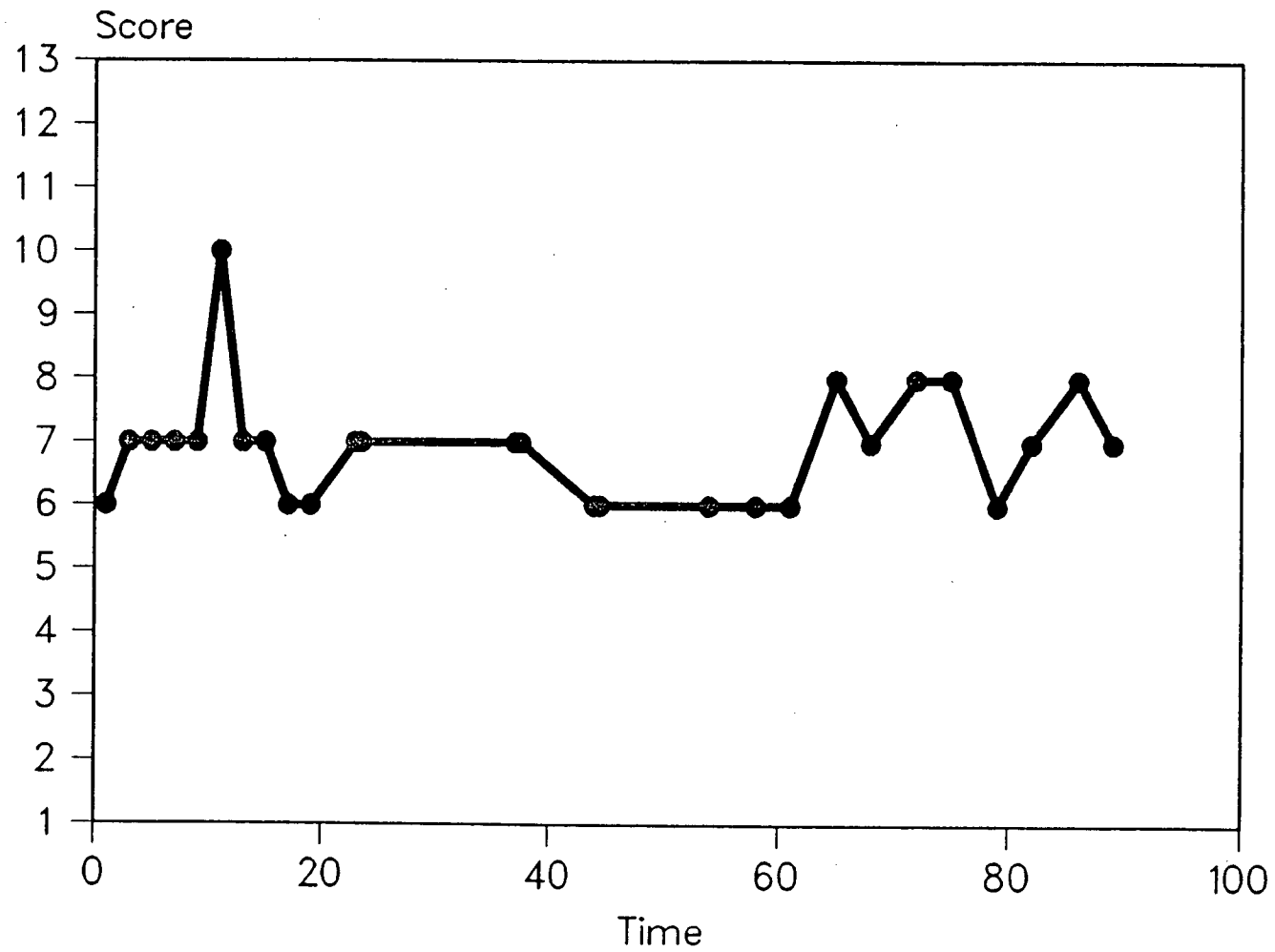
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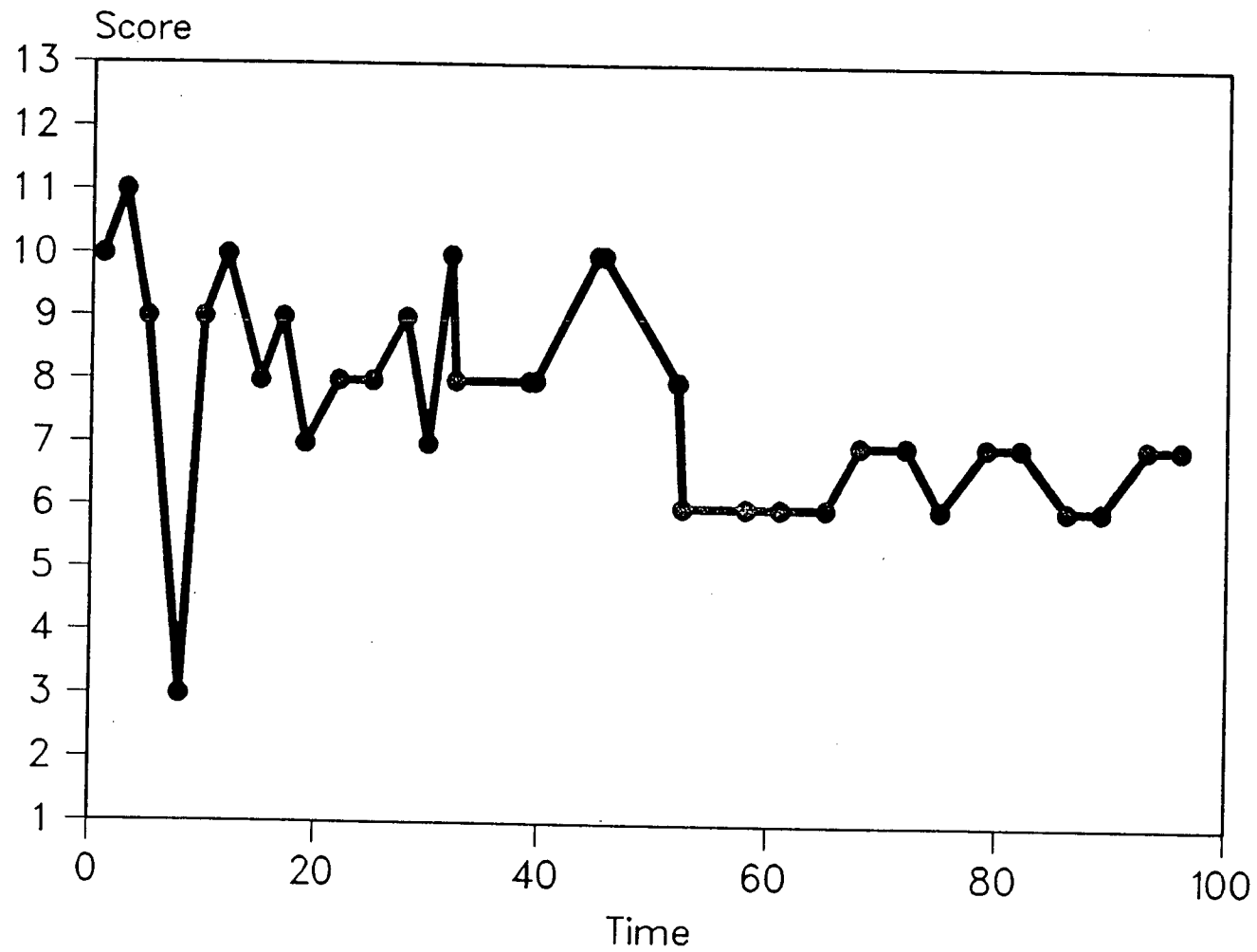
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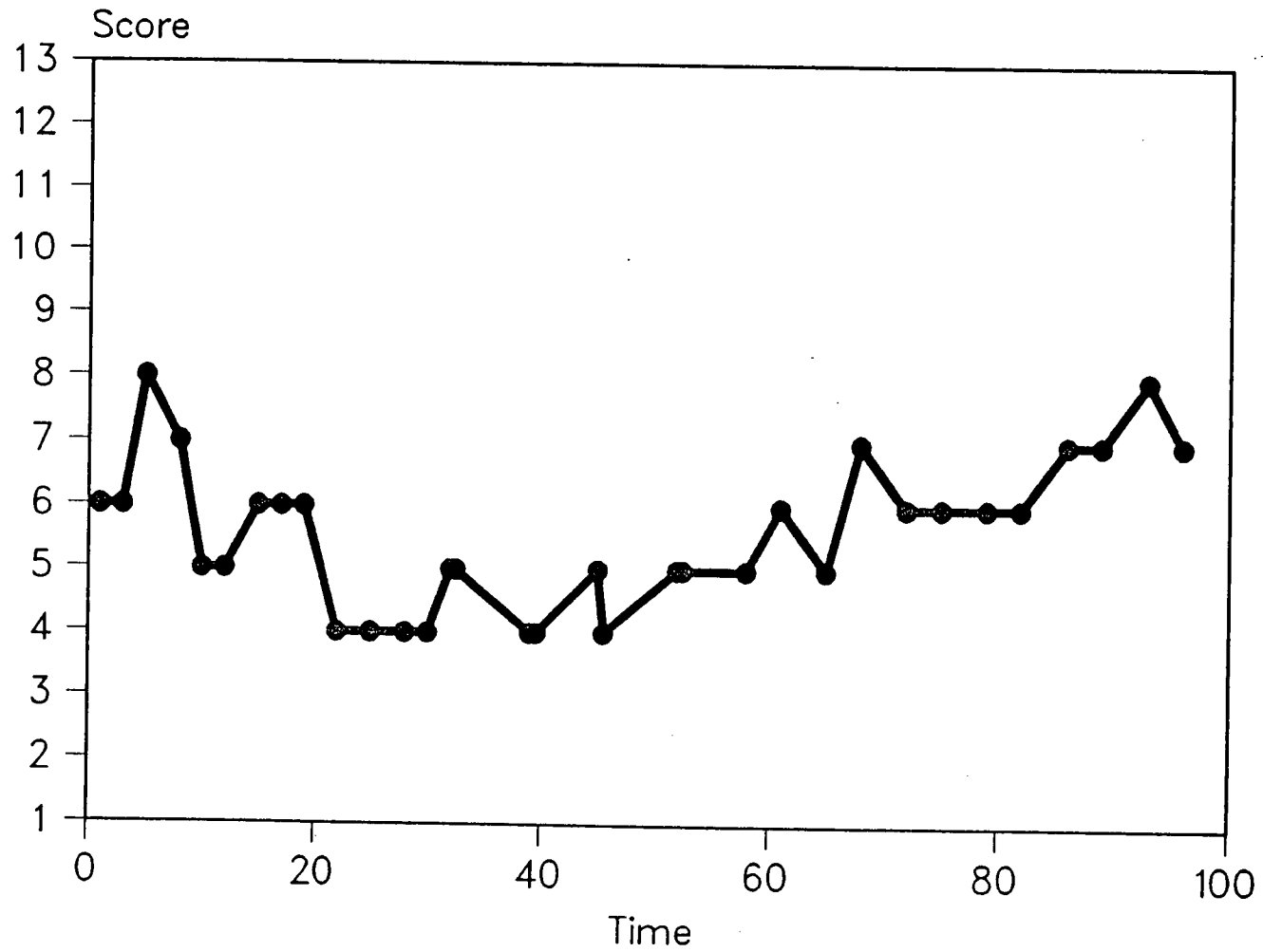
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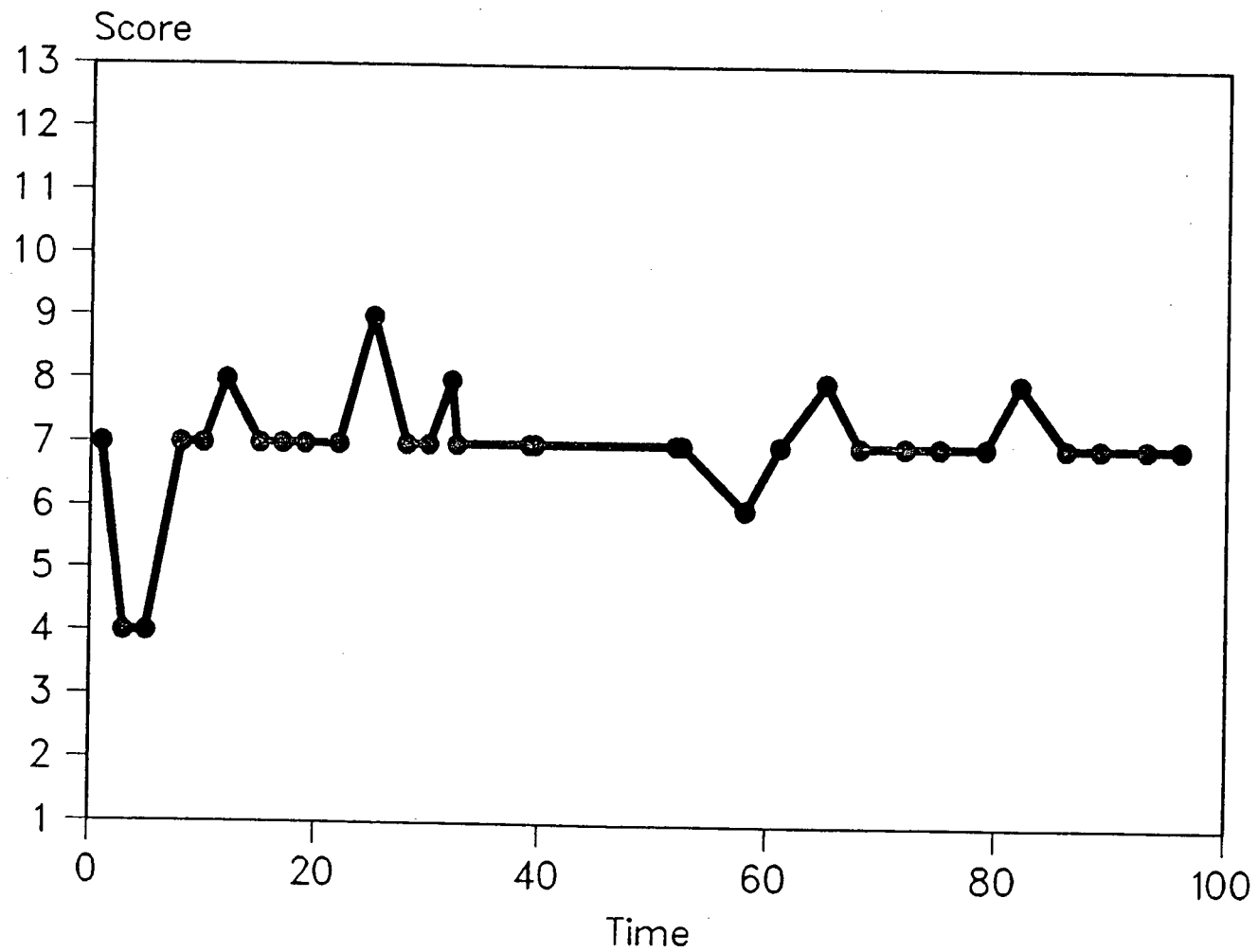
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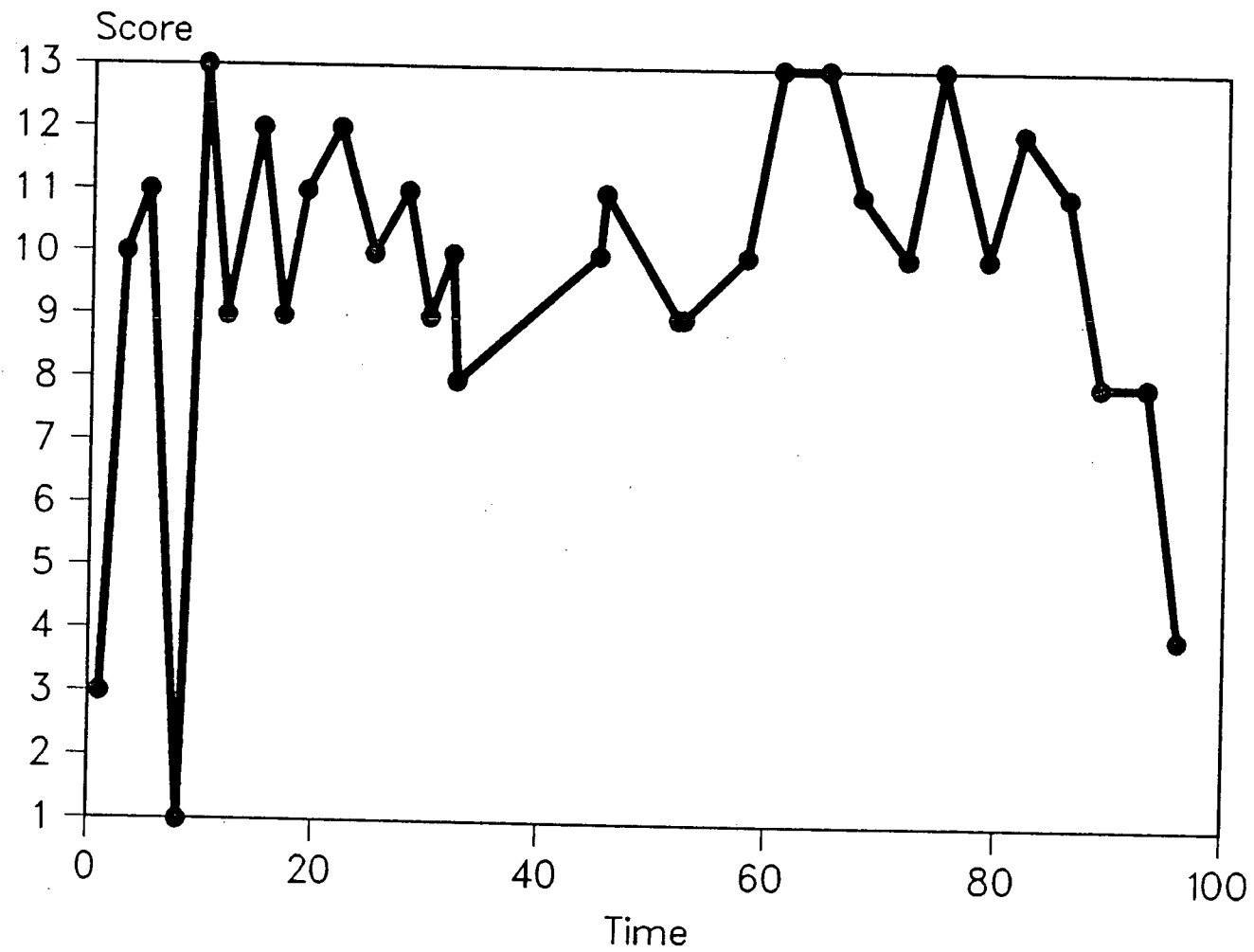
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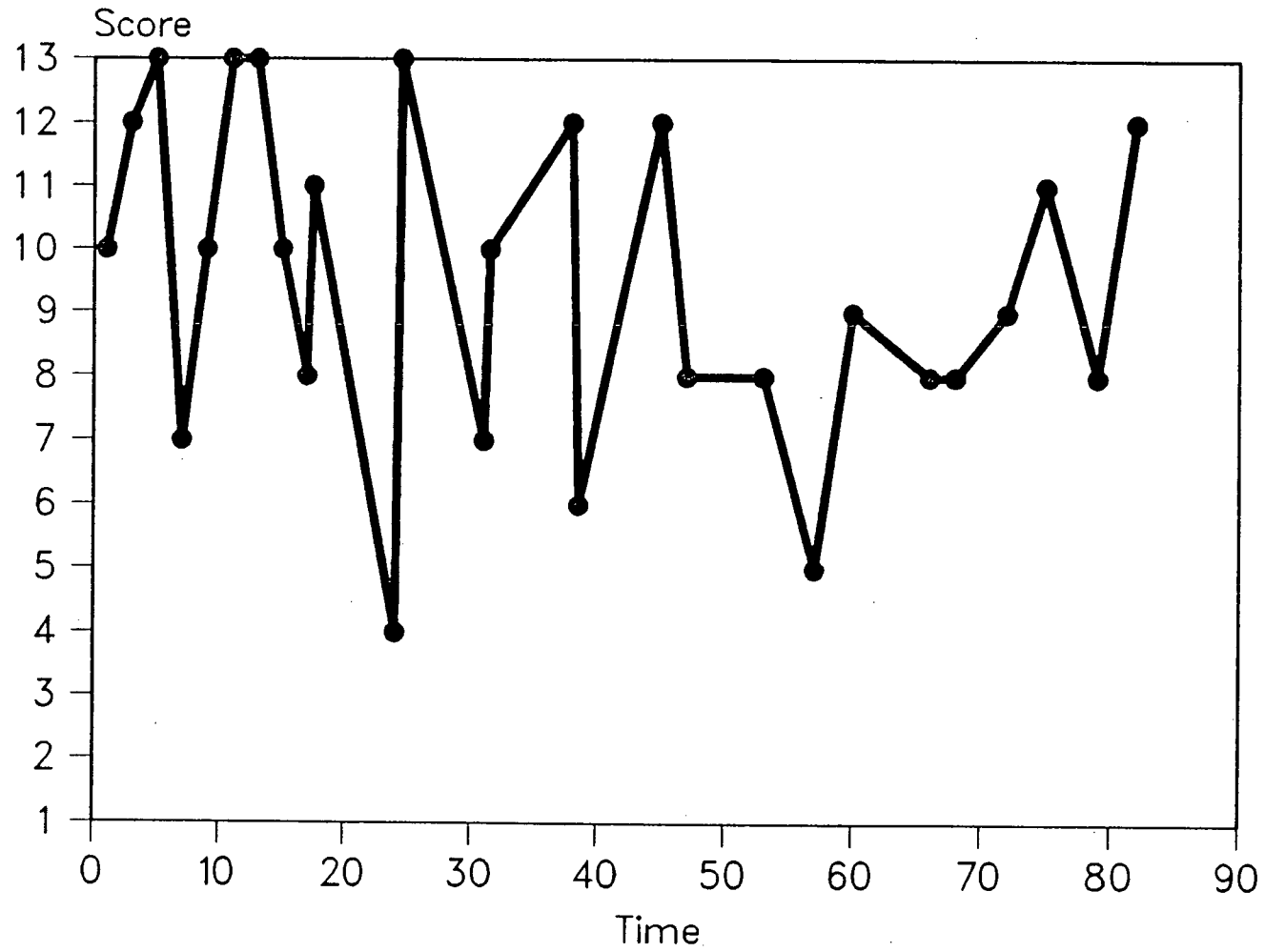
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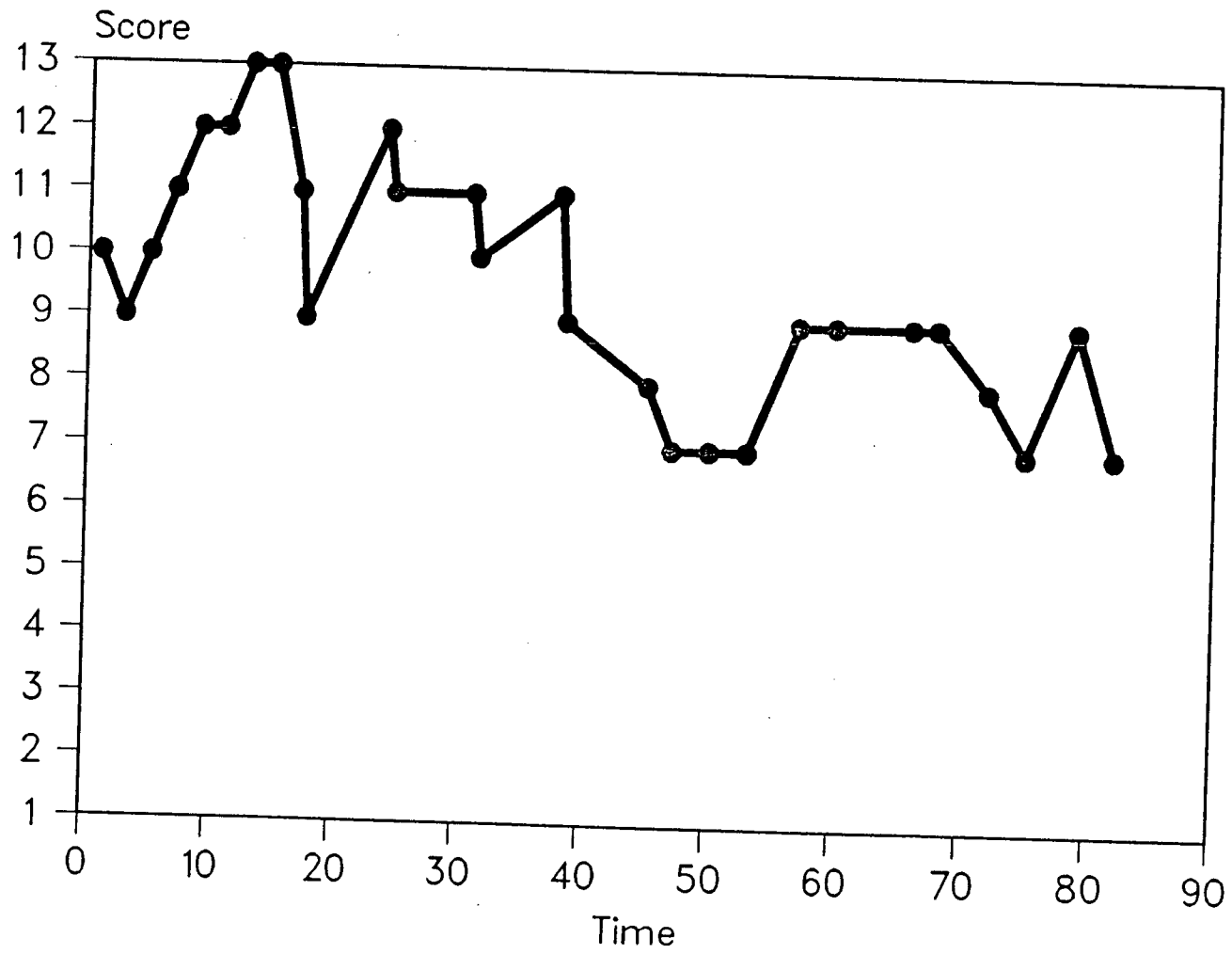
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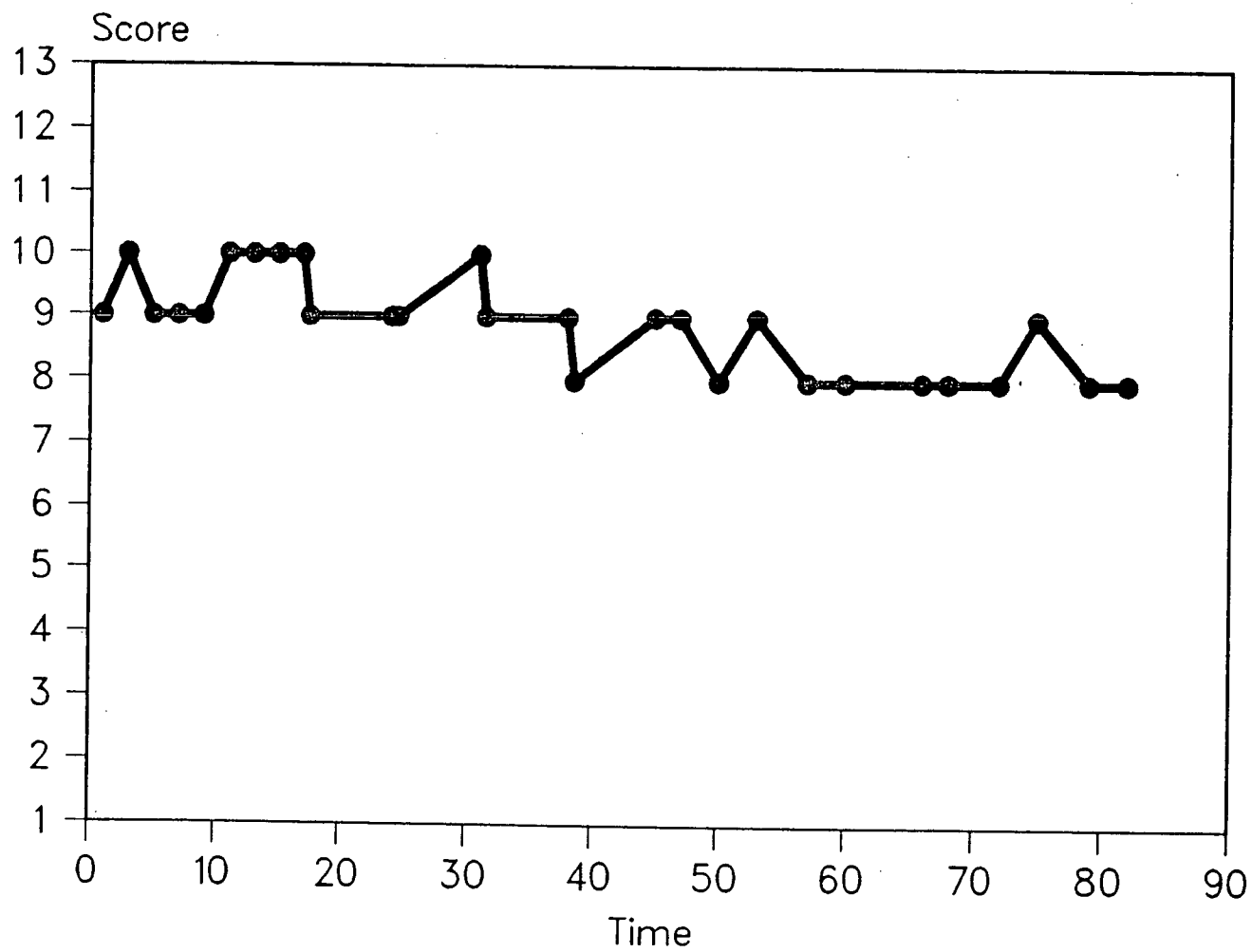
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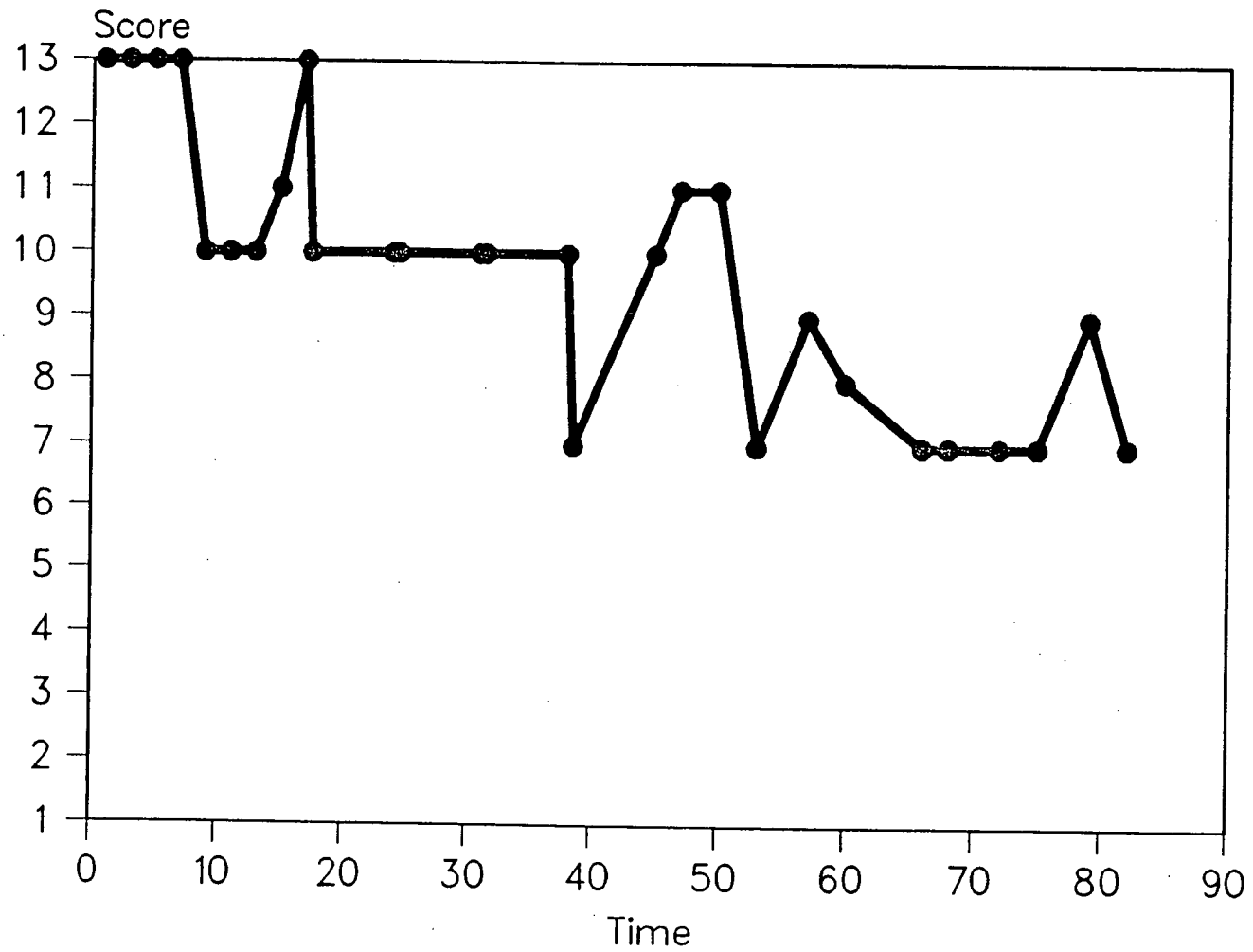
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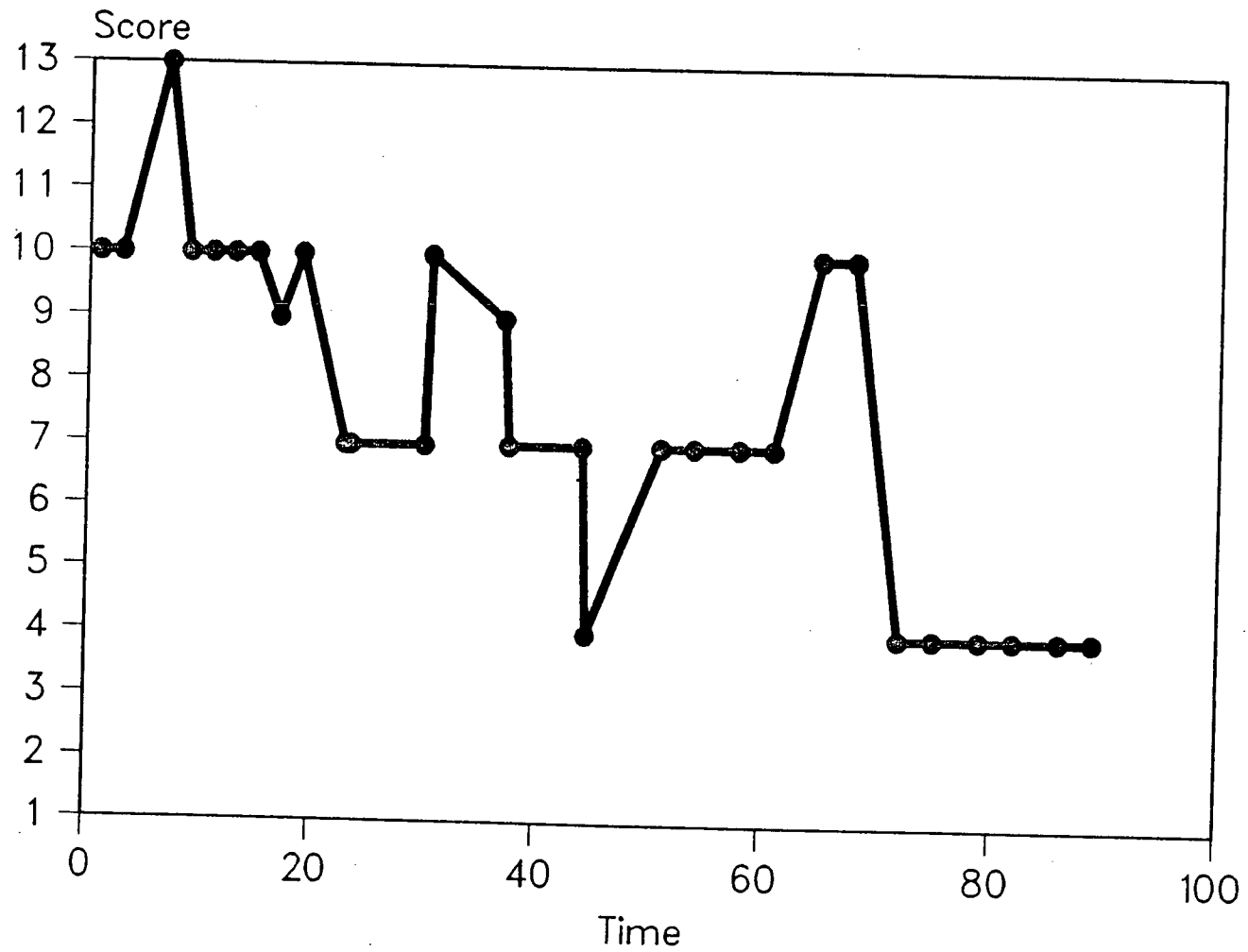
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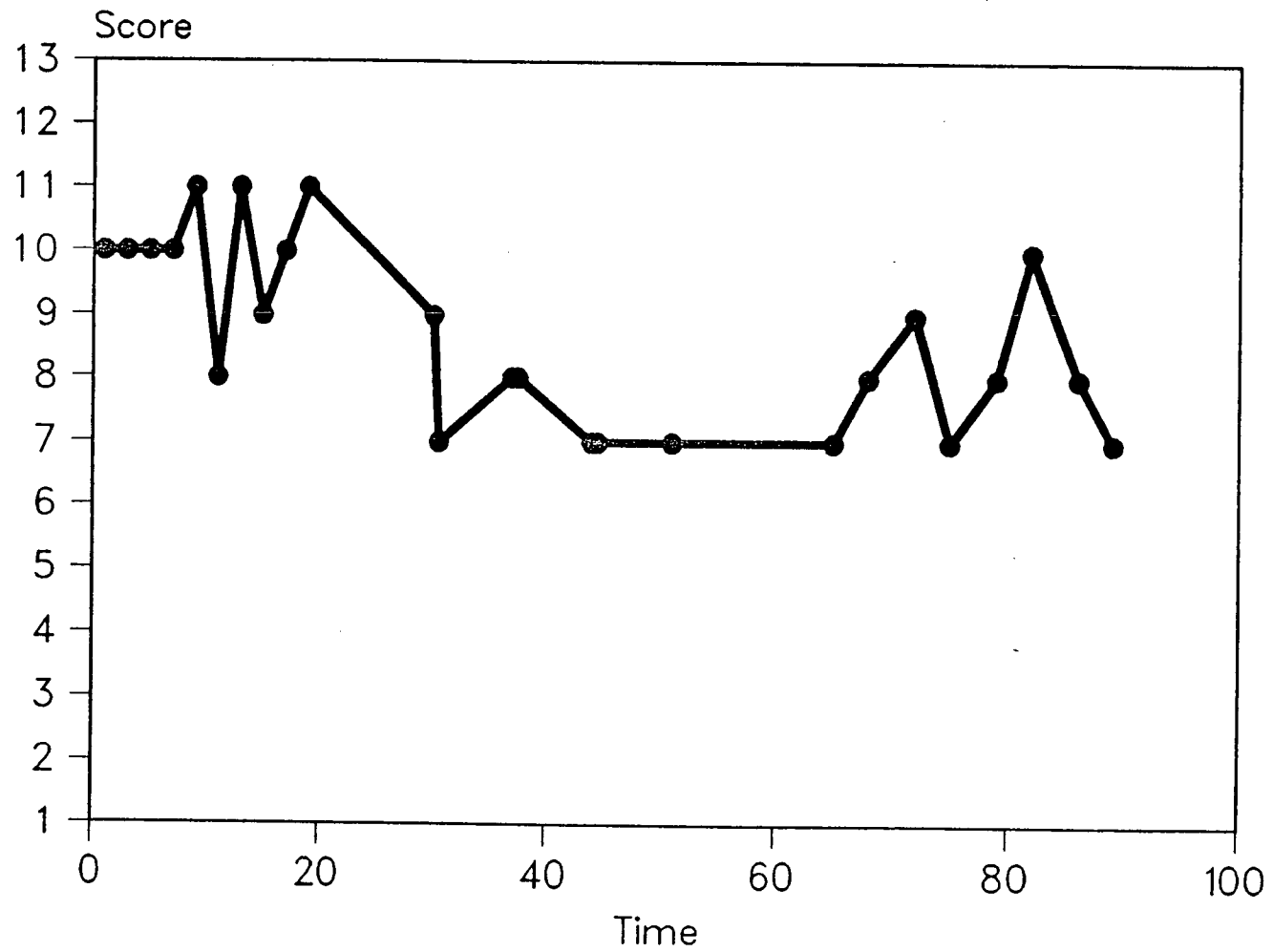
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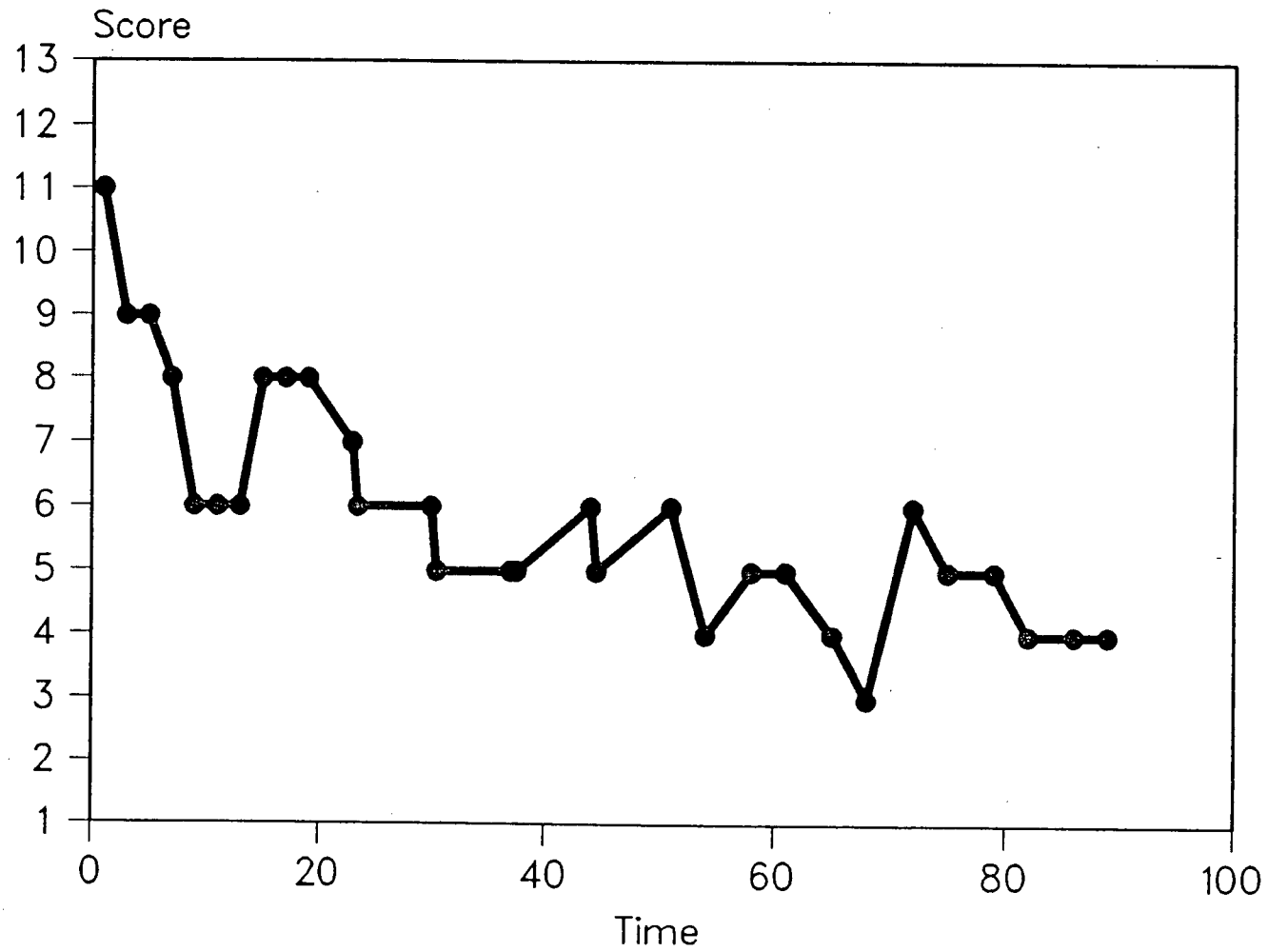
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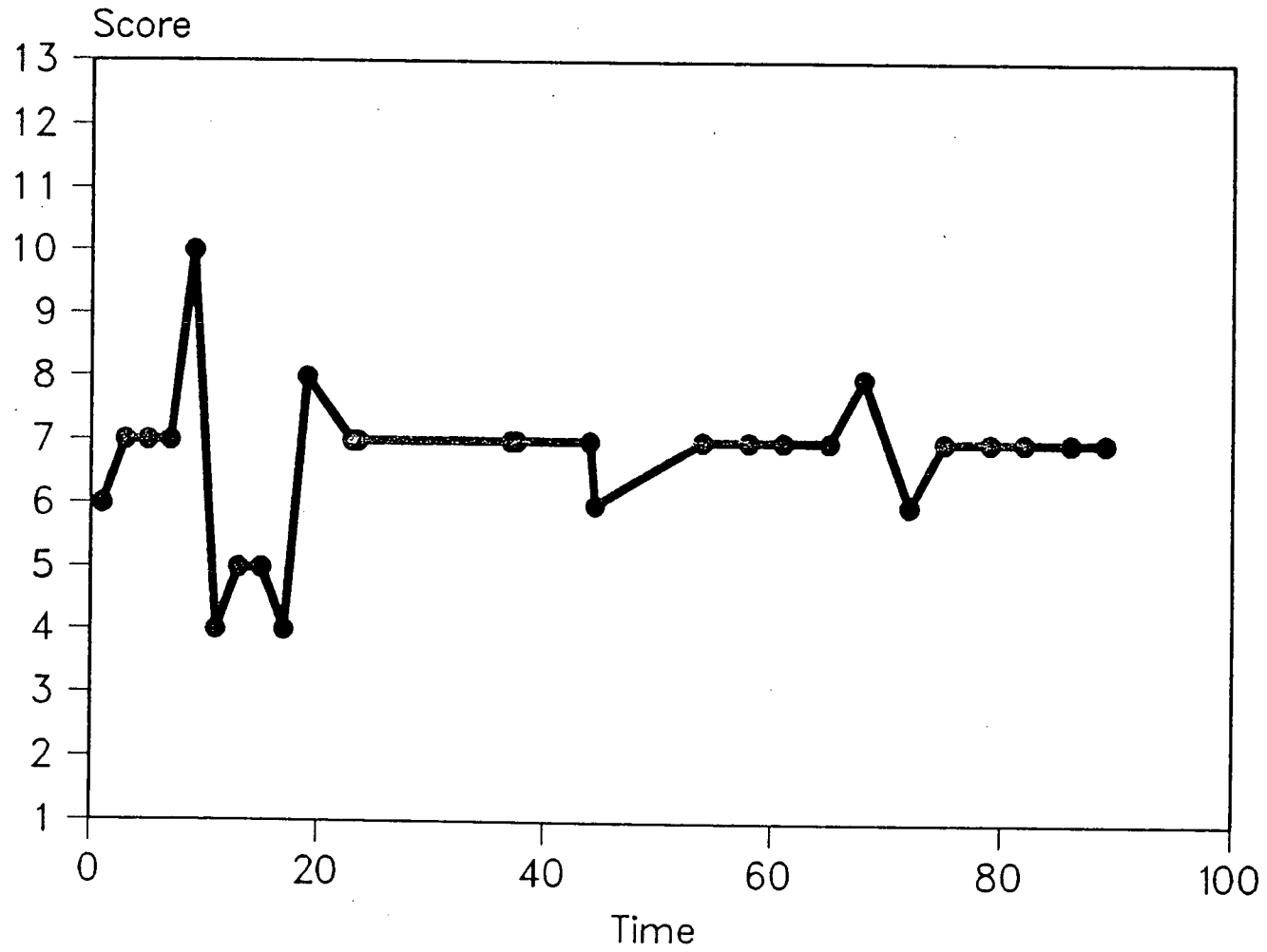
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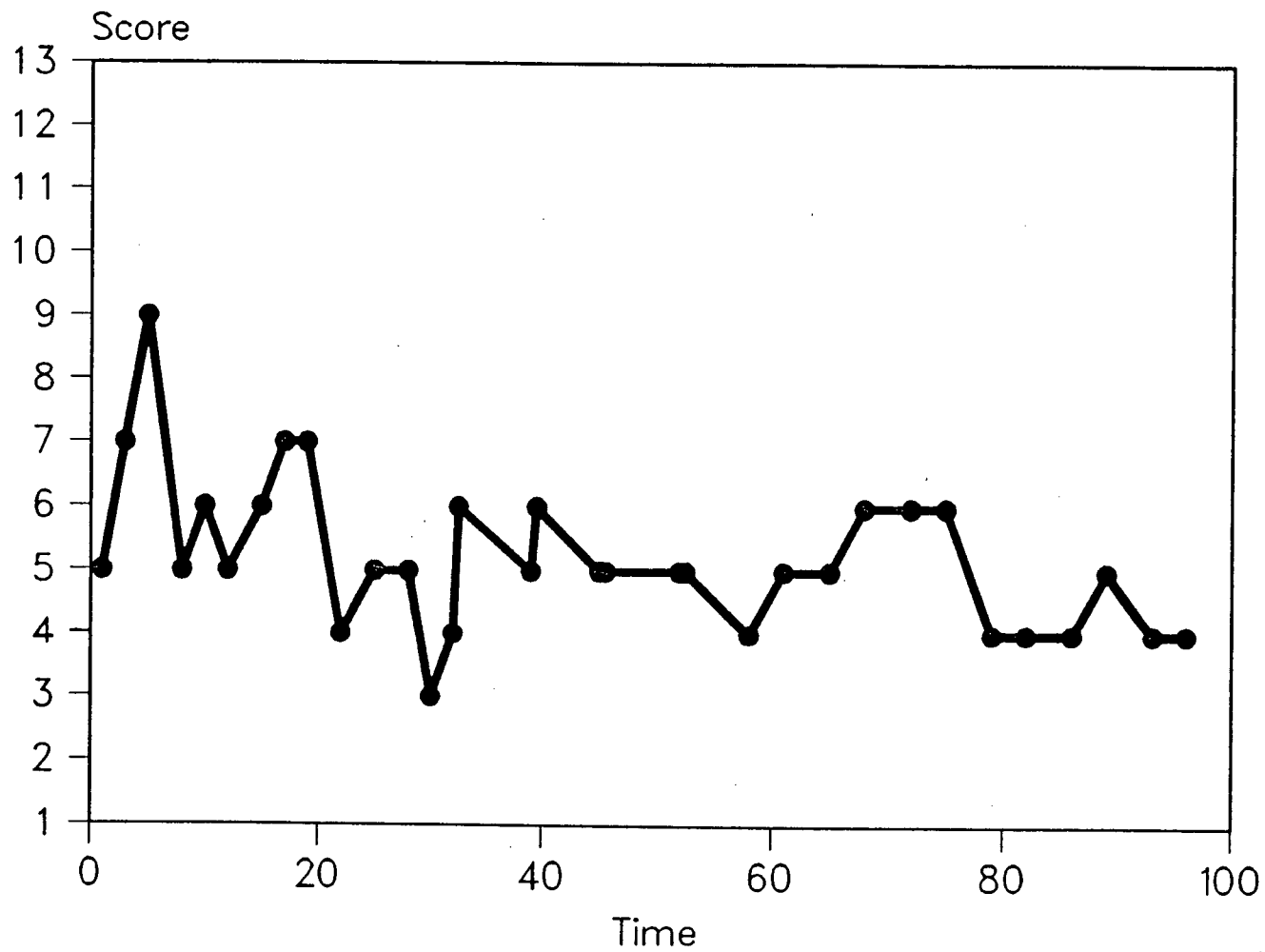
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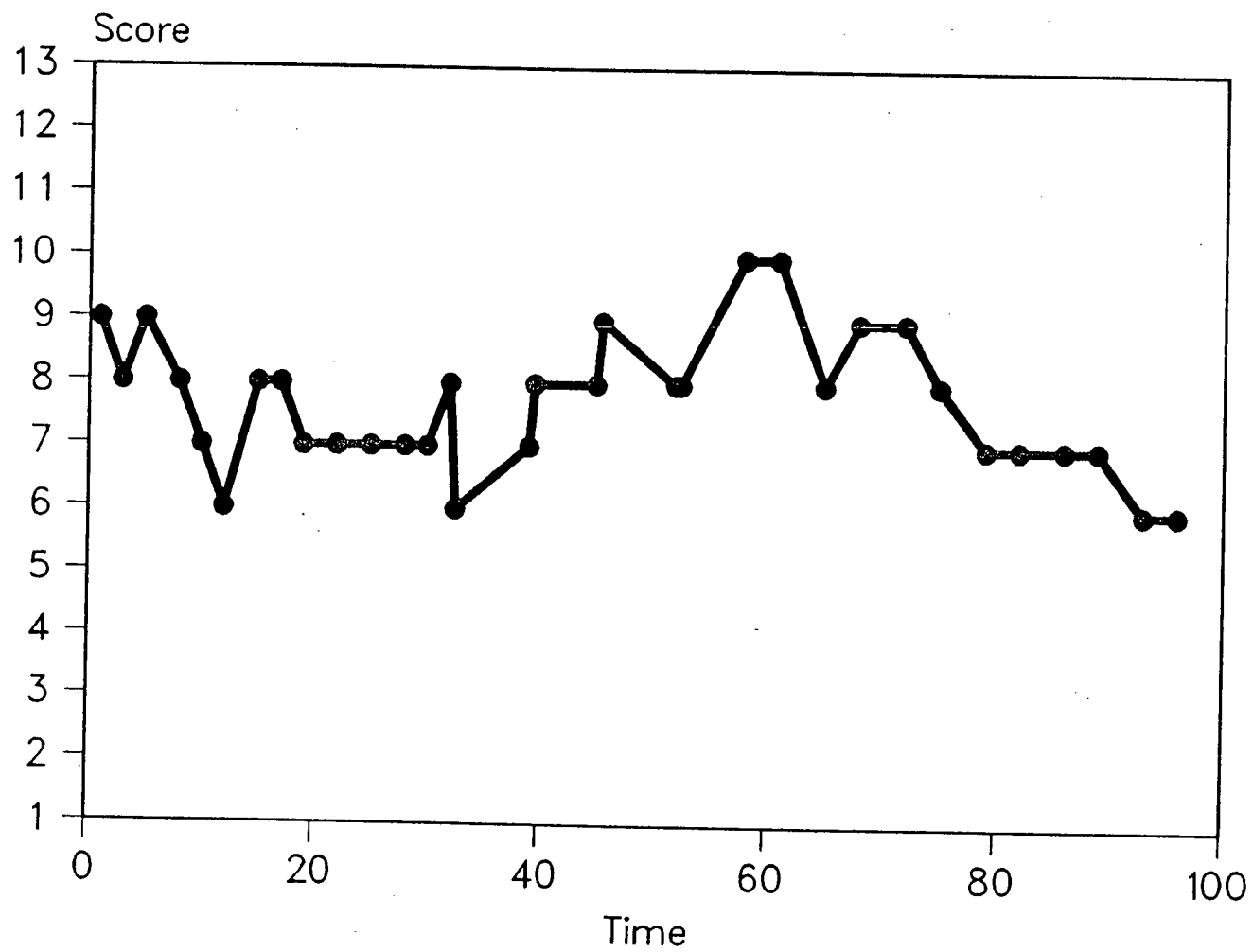
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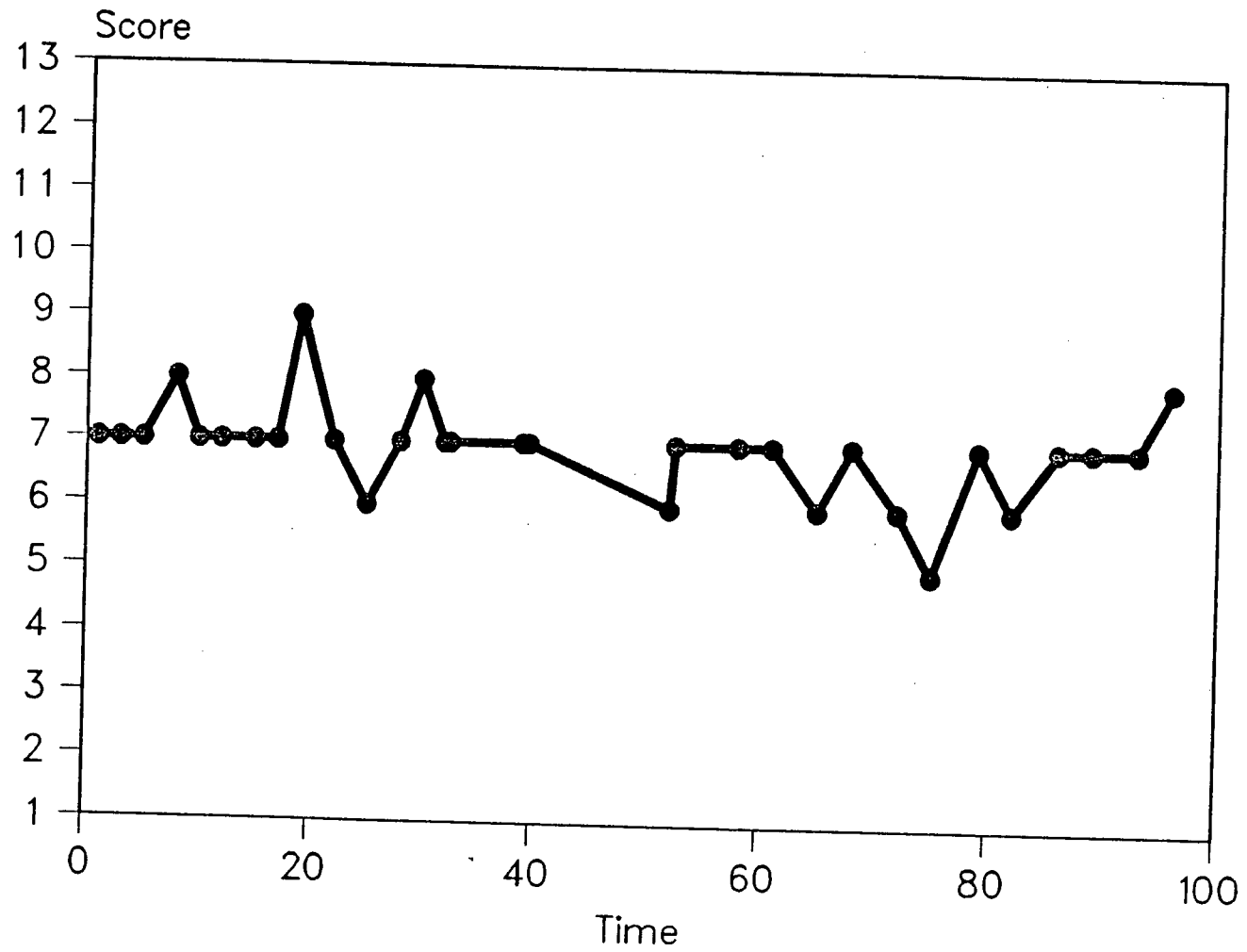
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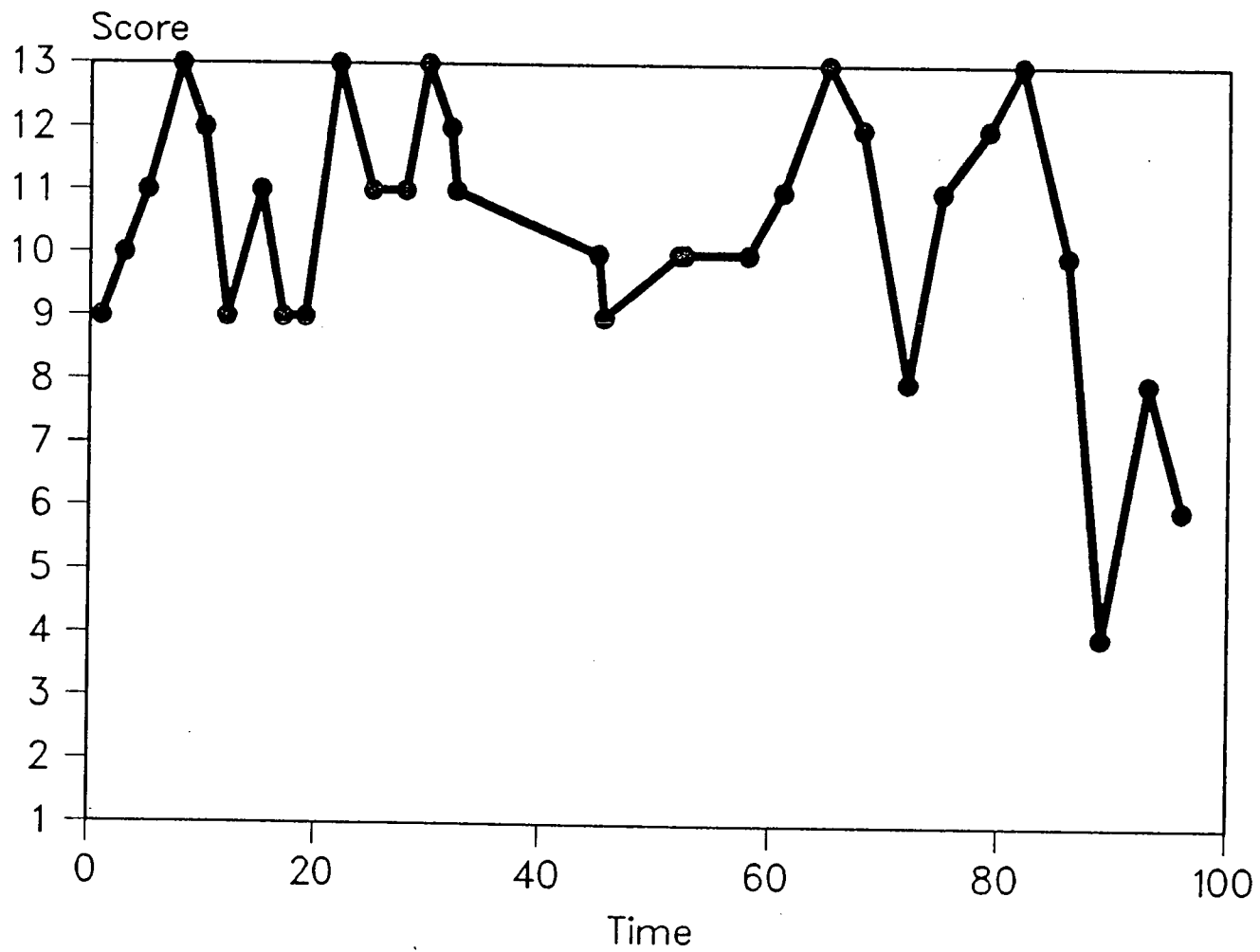
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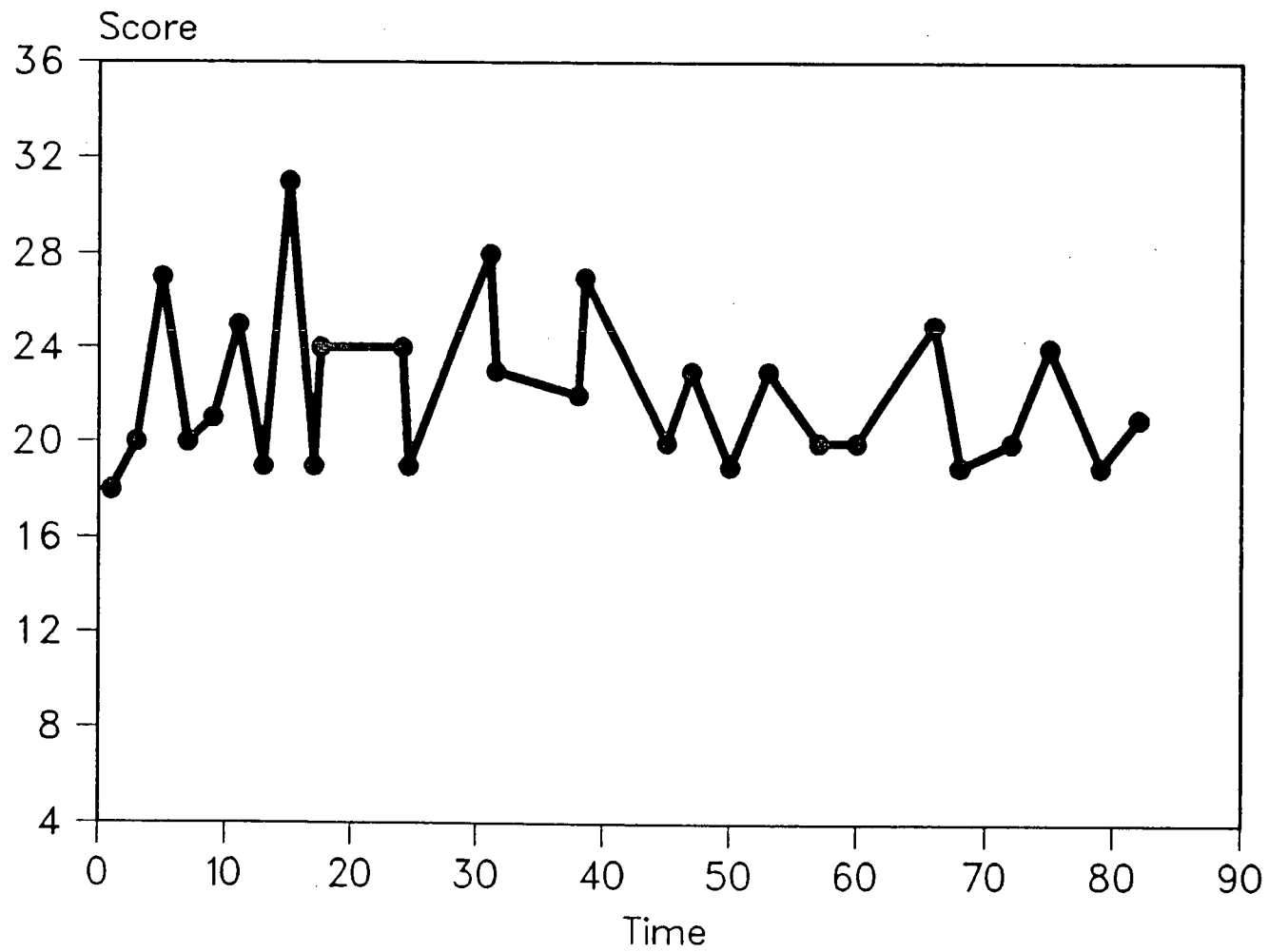
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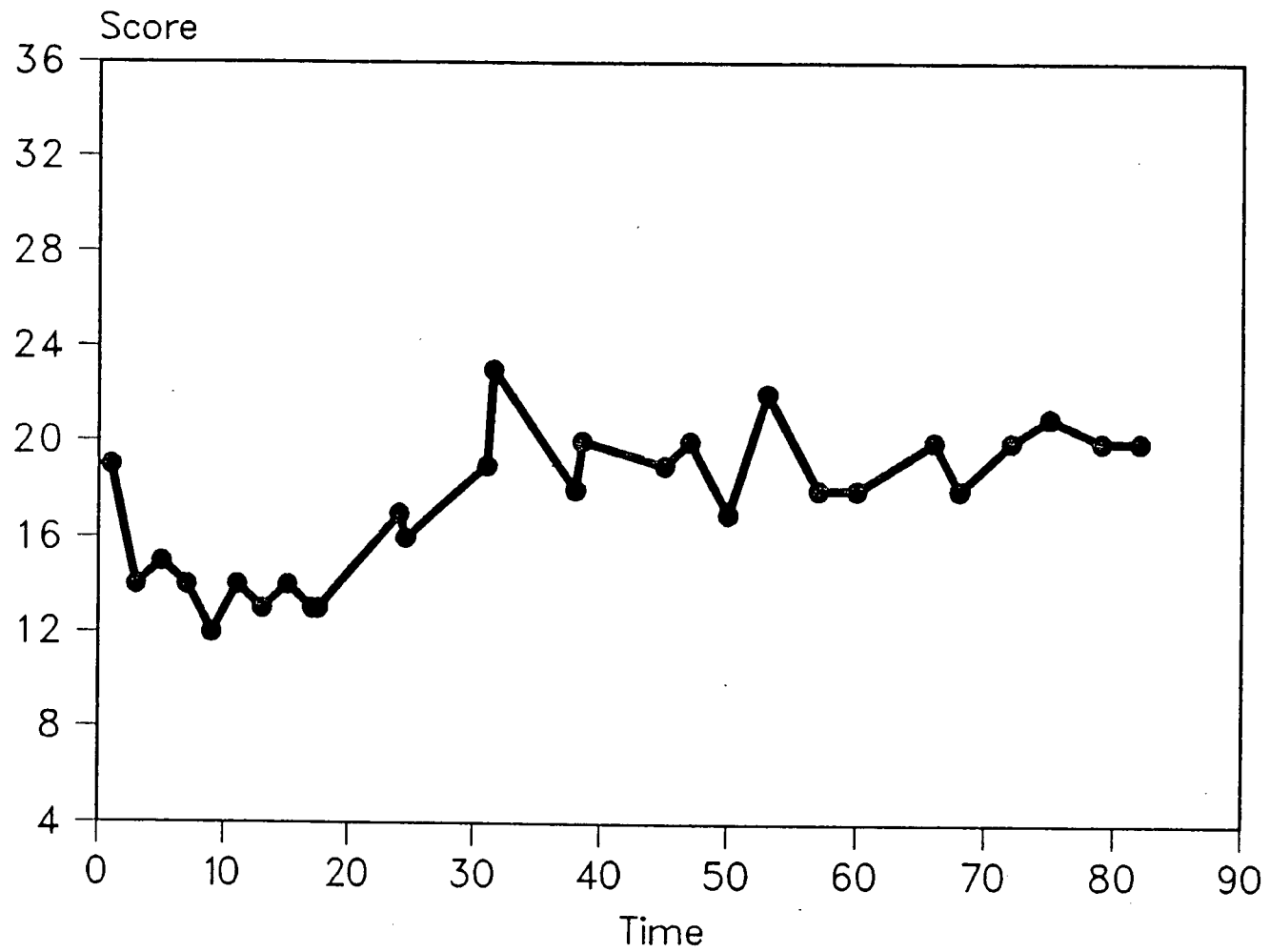
Subject 12, Scale 4



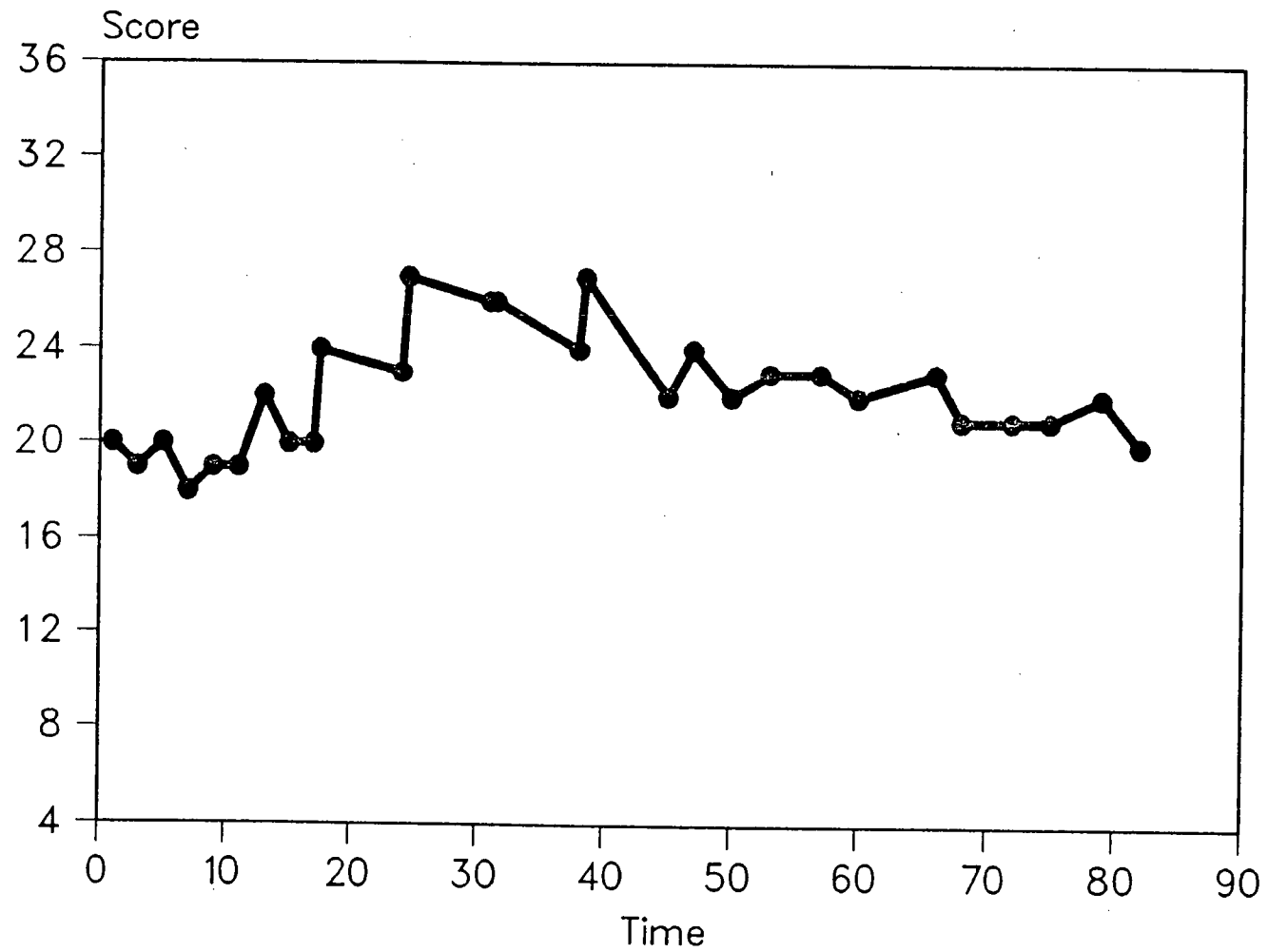
Subject 1, Scale 1



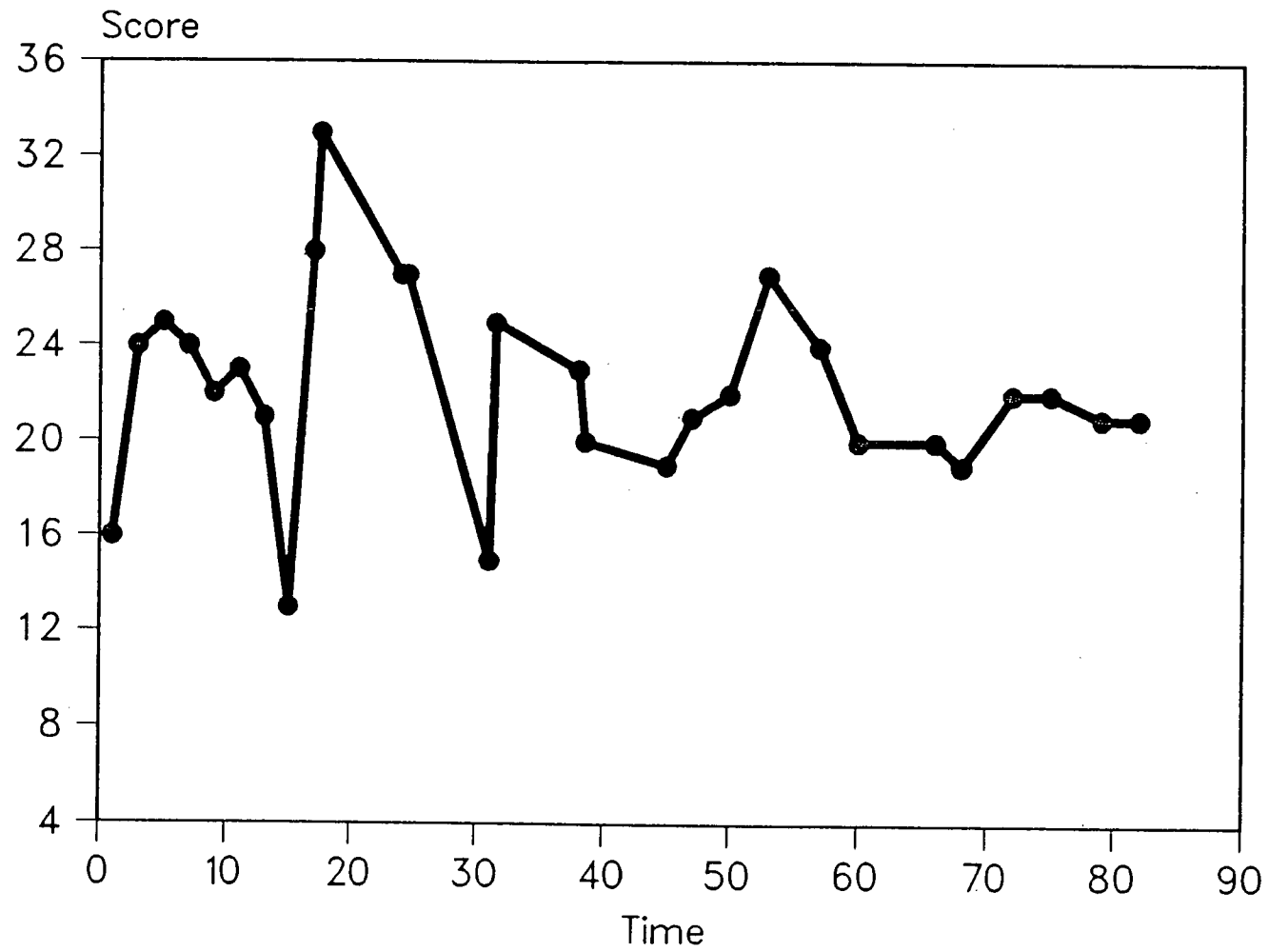
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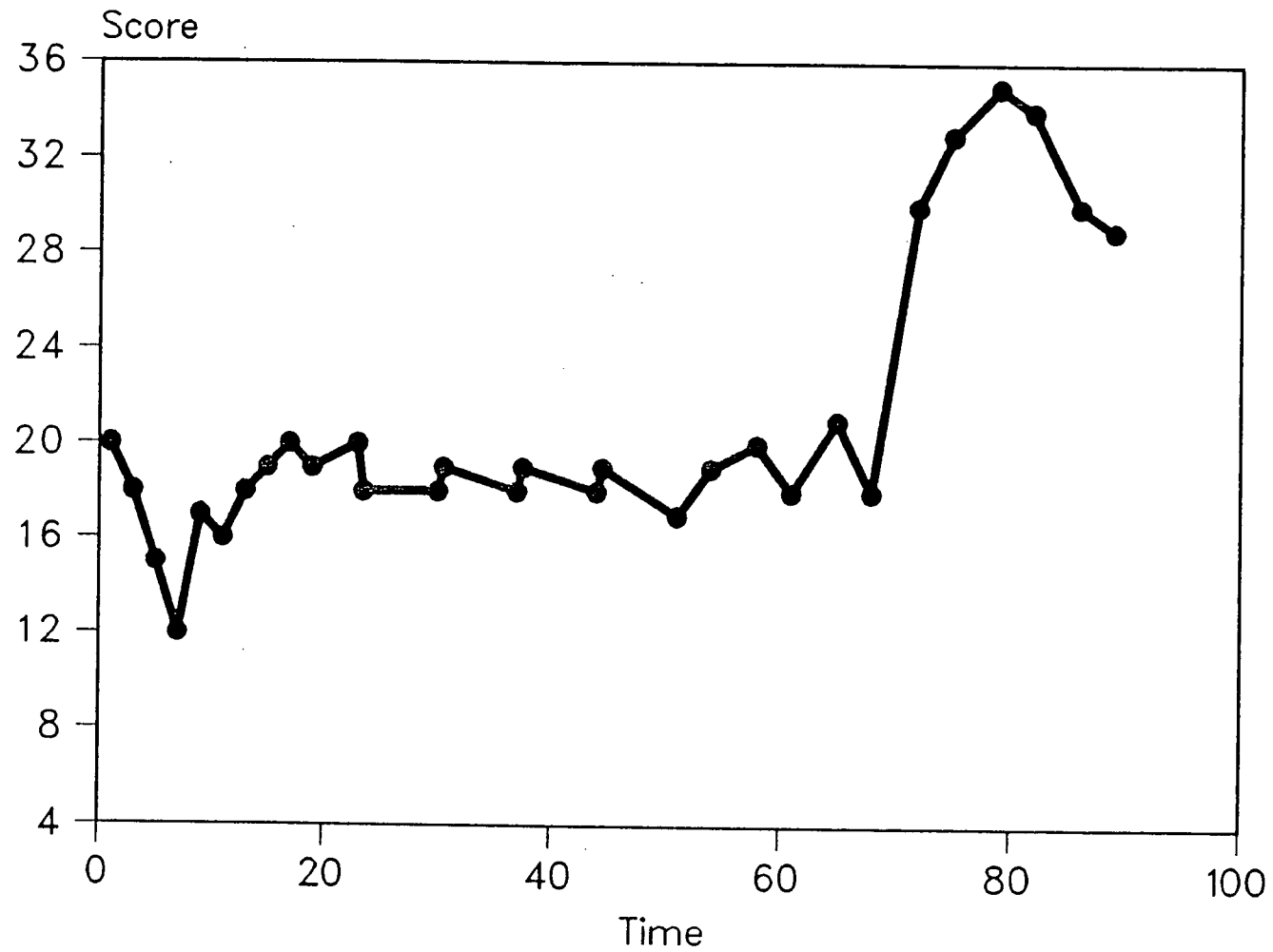
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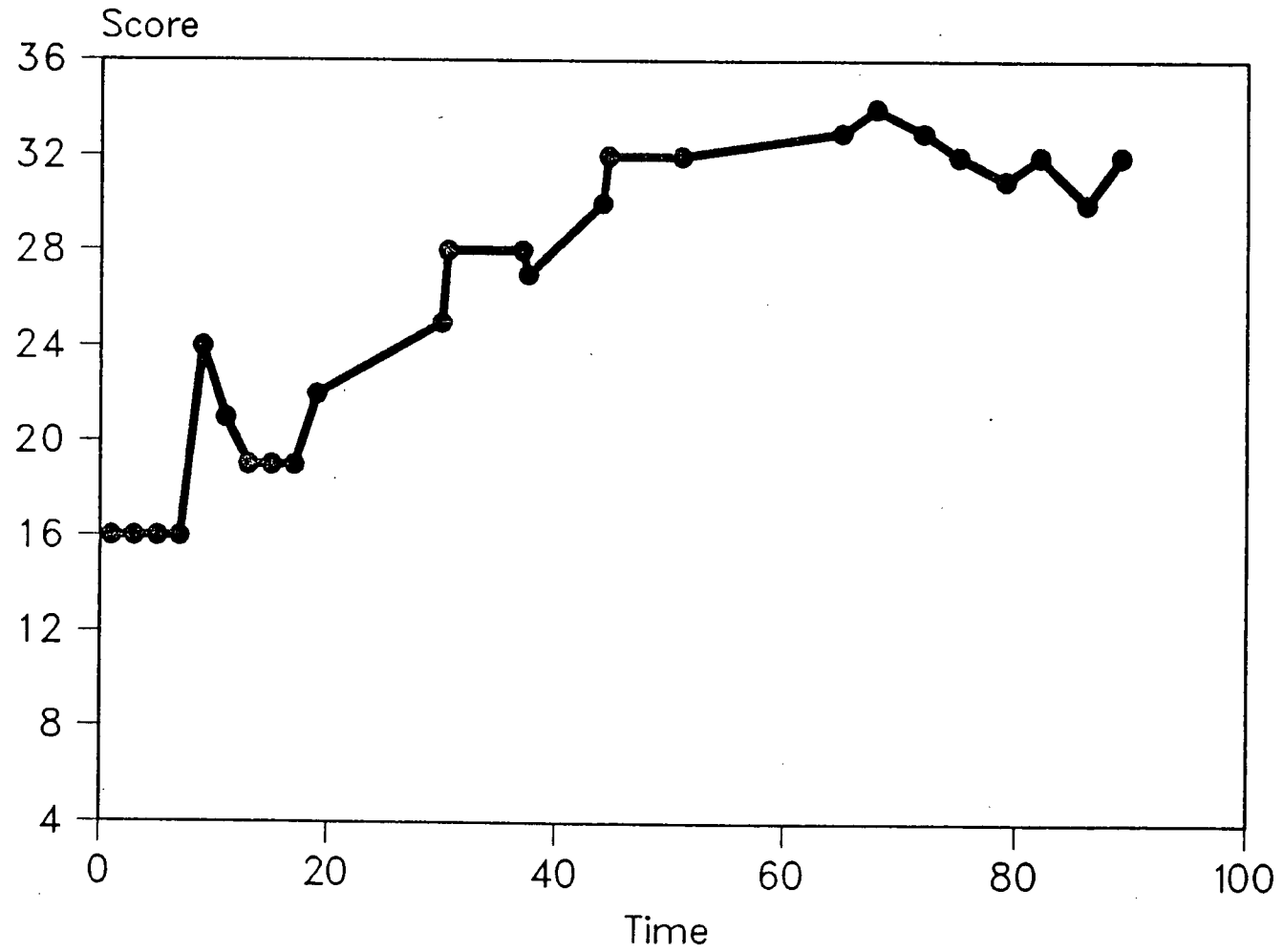
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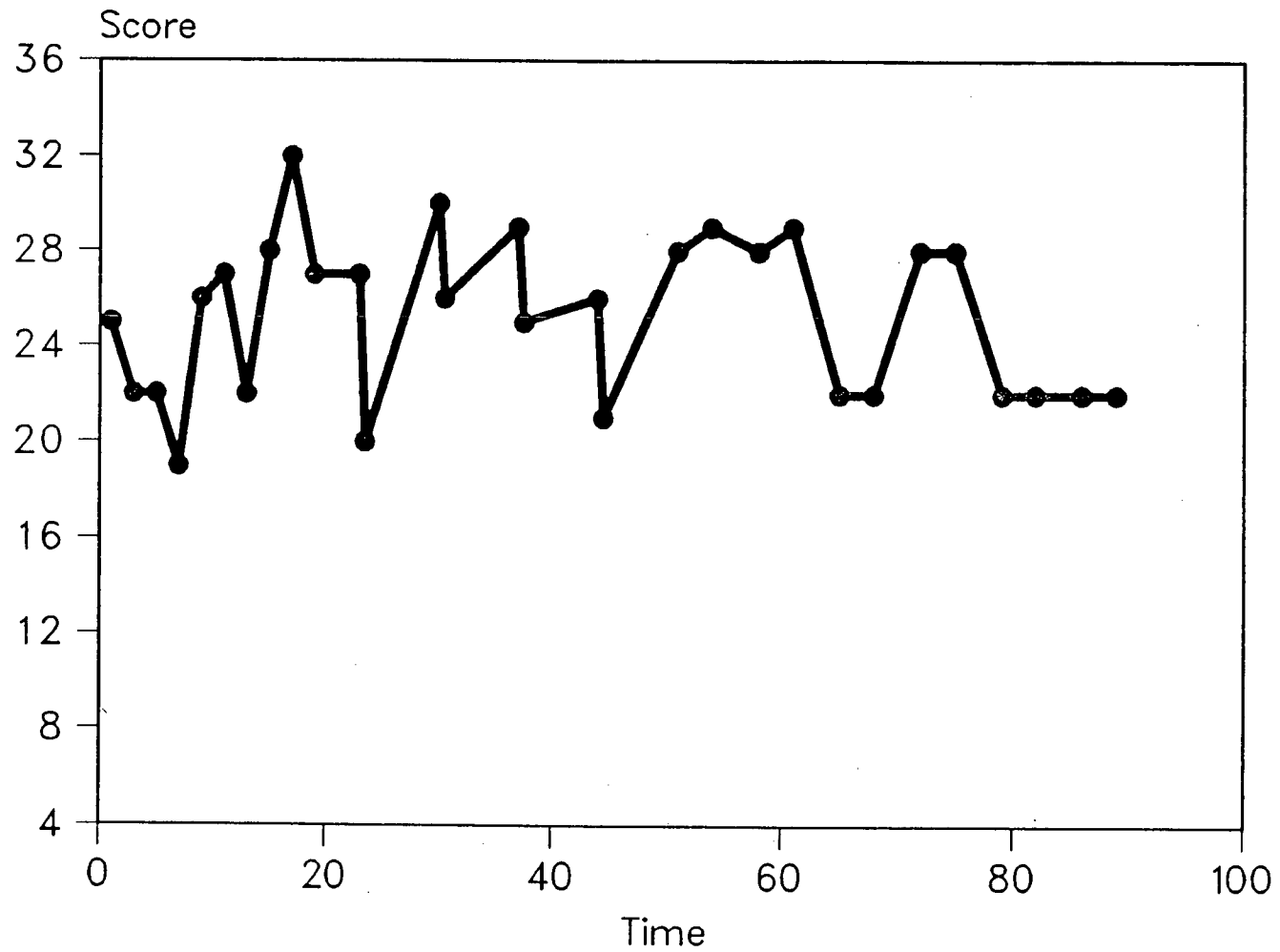
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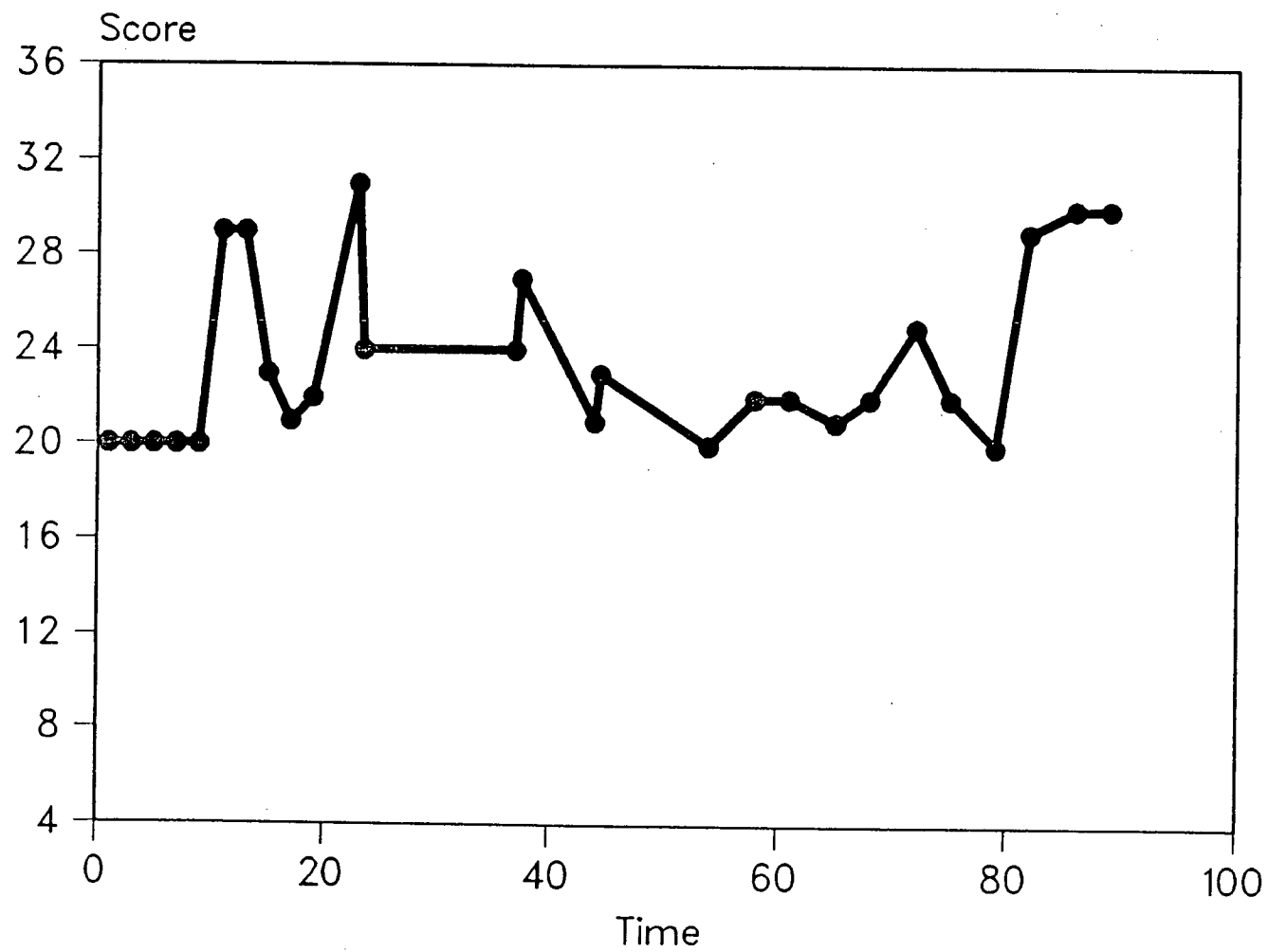
Subject 6, Scale 1



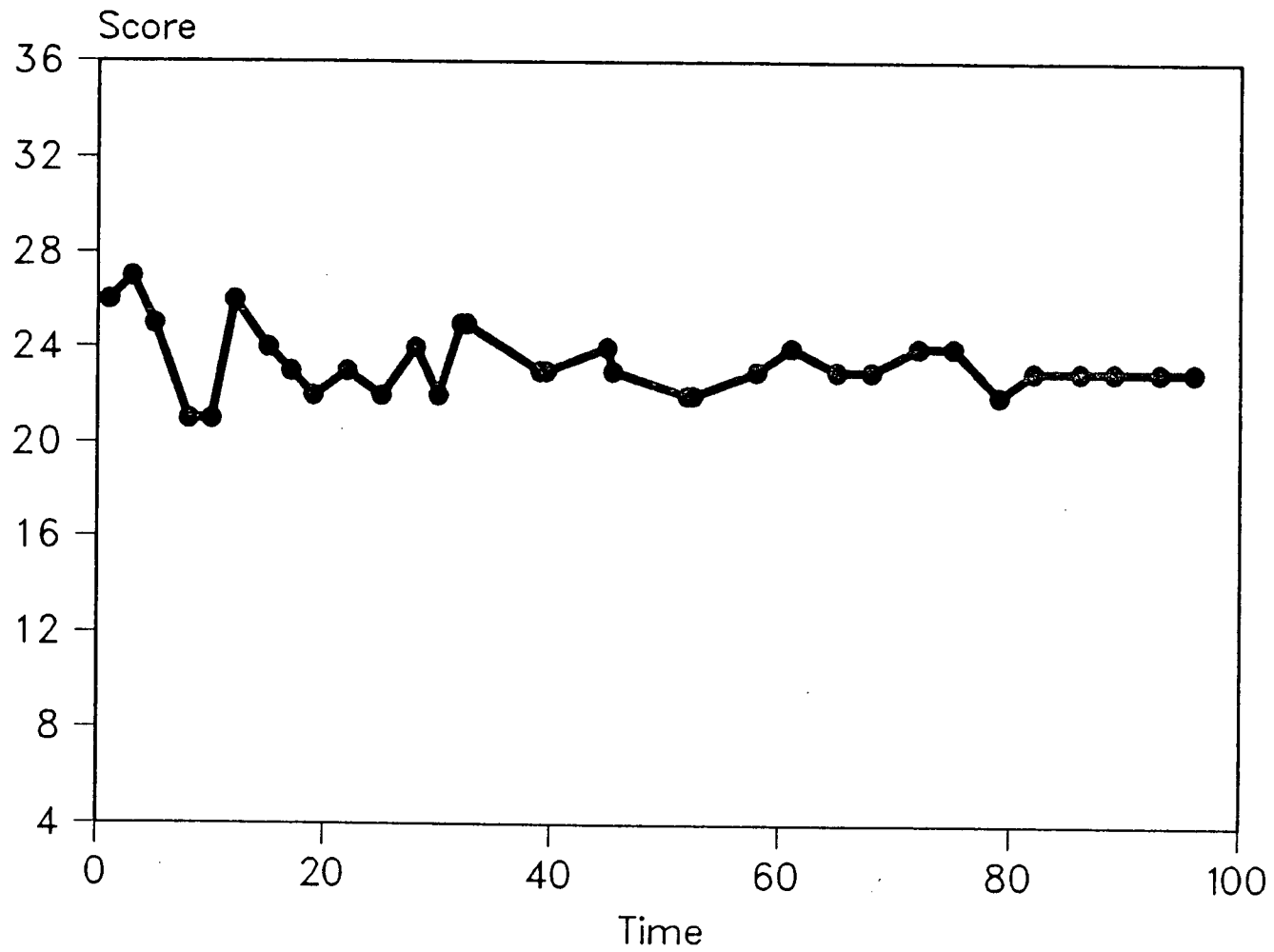
Subject 7, Scale 1



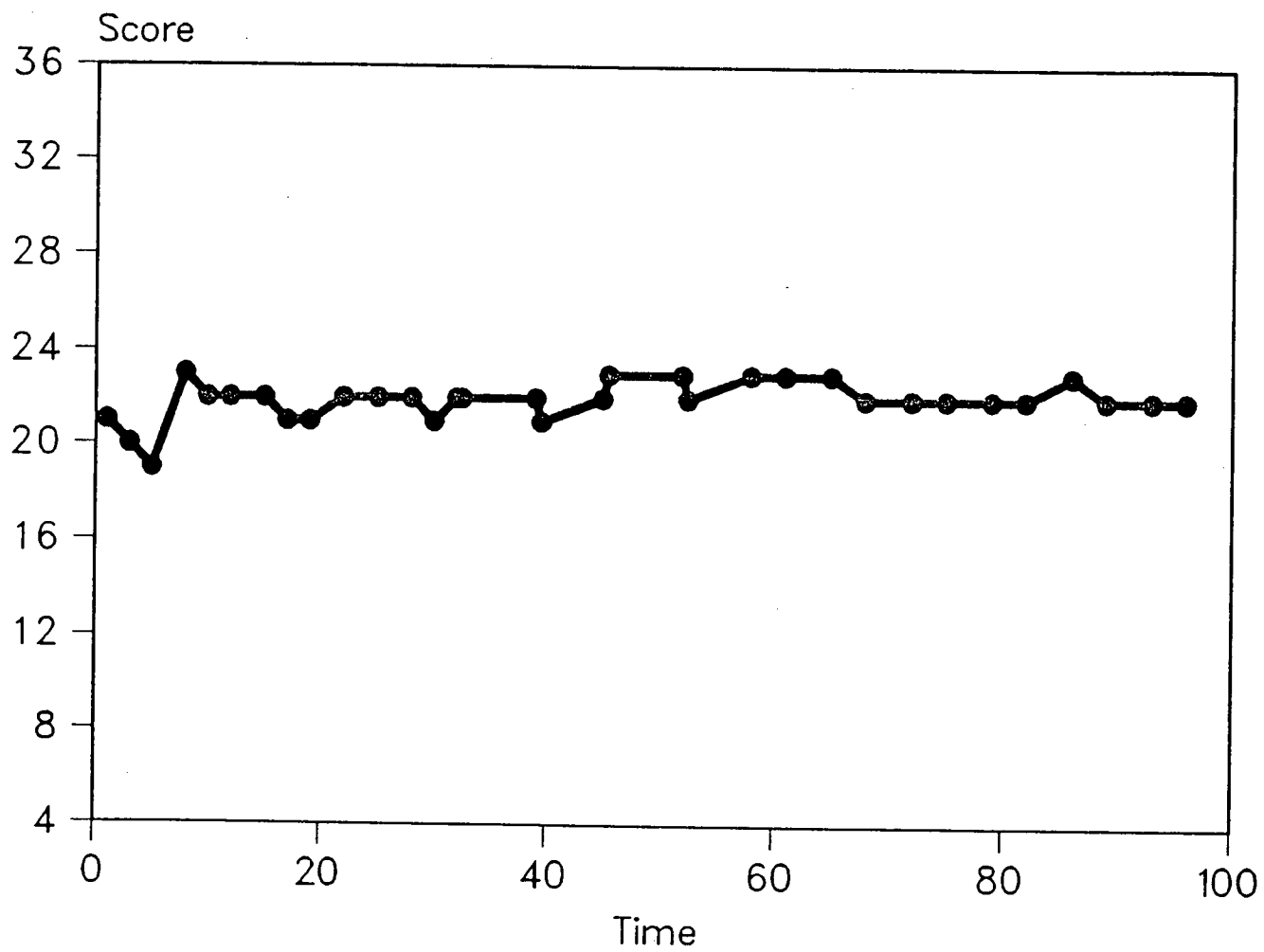
Subject 8, Scale 1



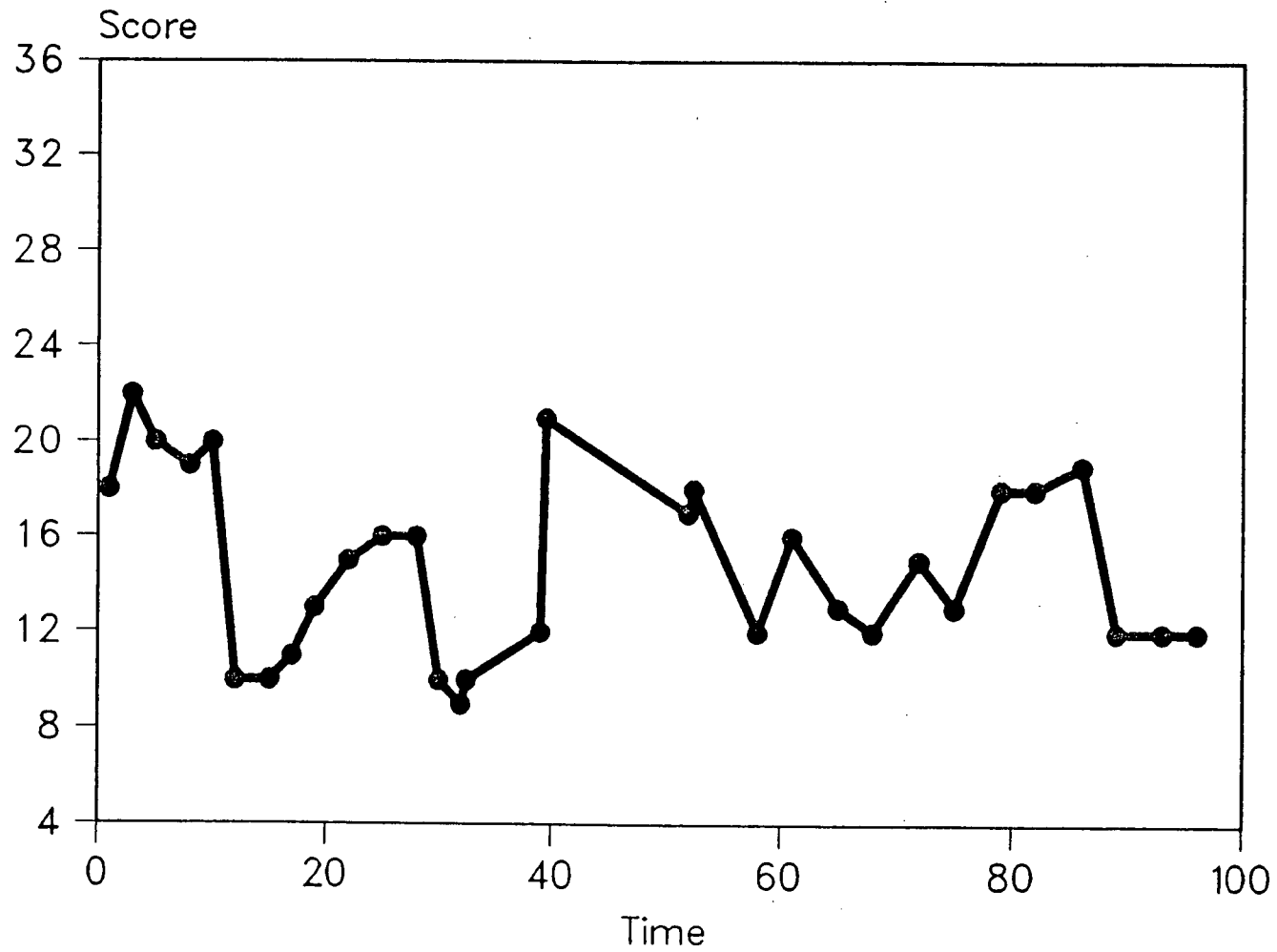
Subject 9, Scale 1



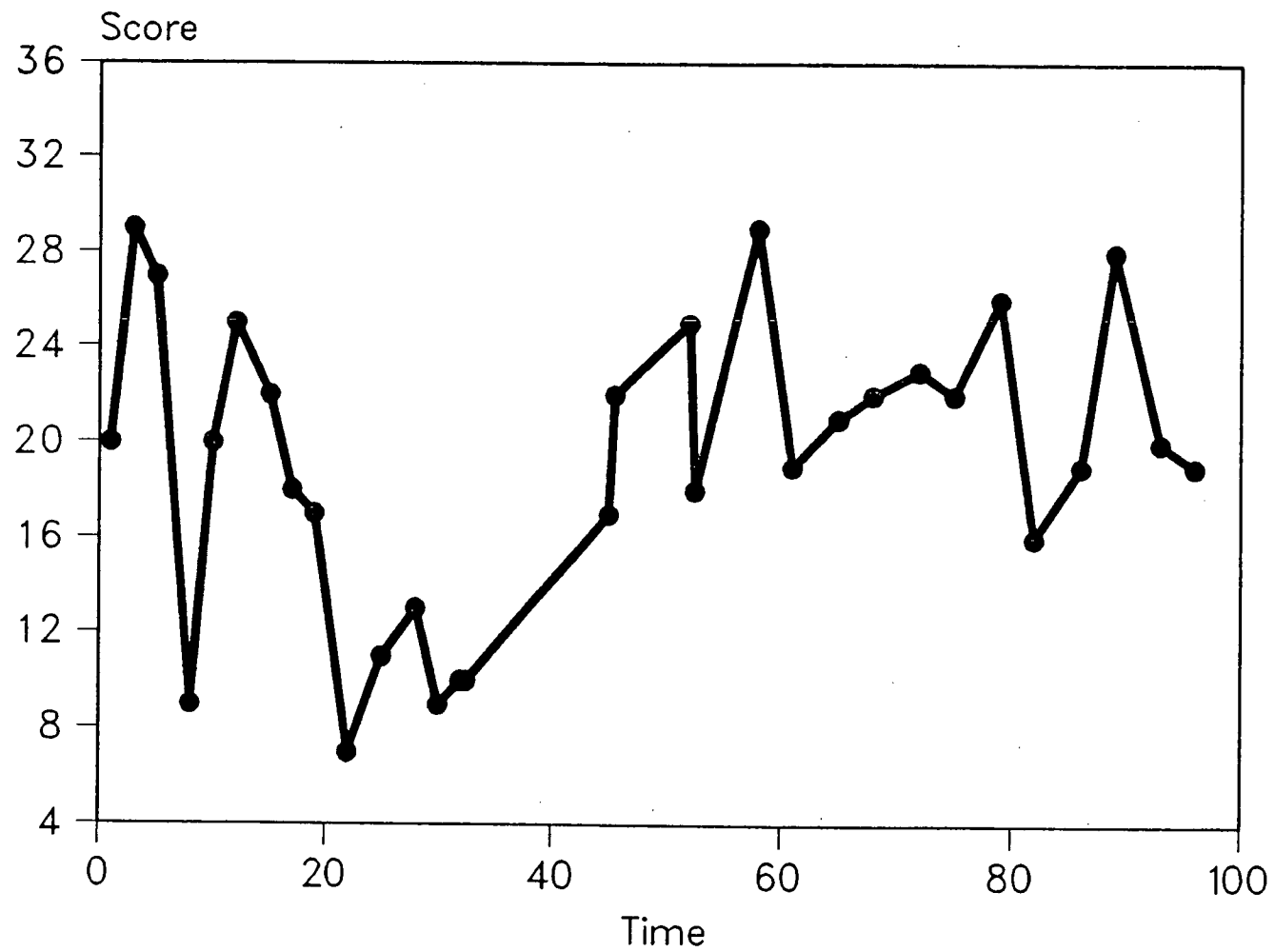
Subject 10, Scale 1



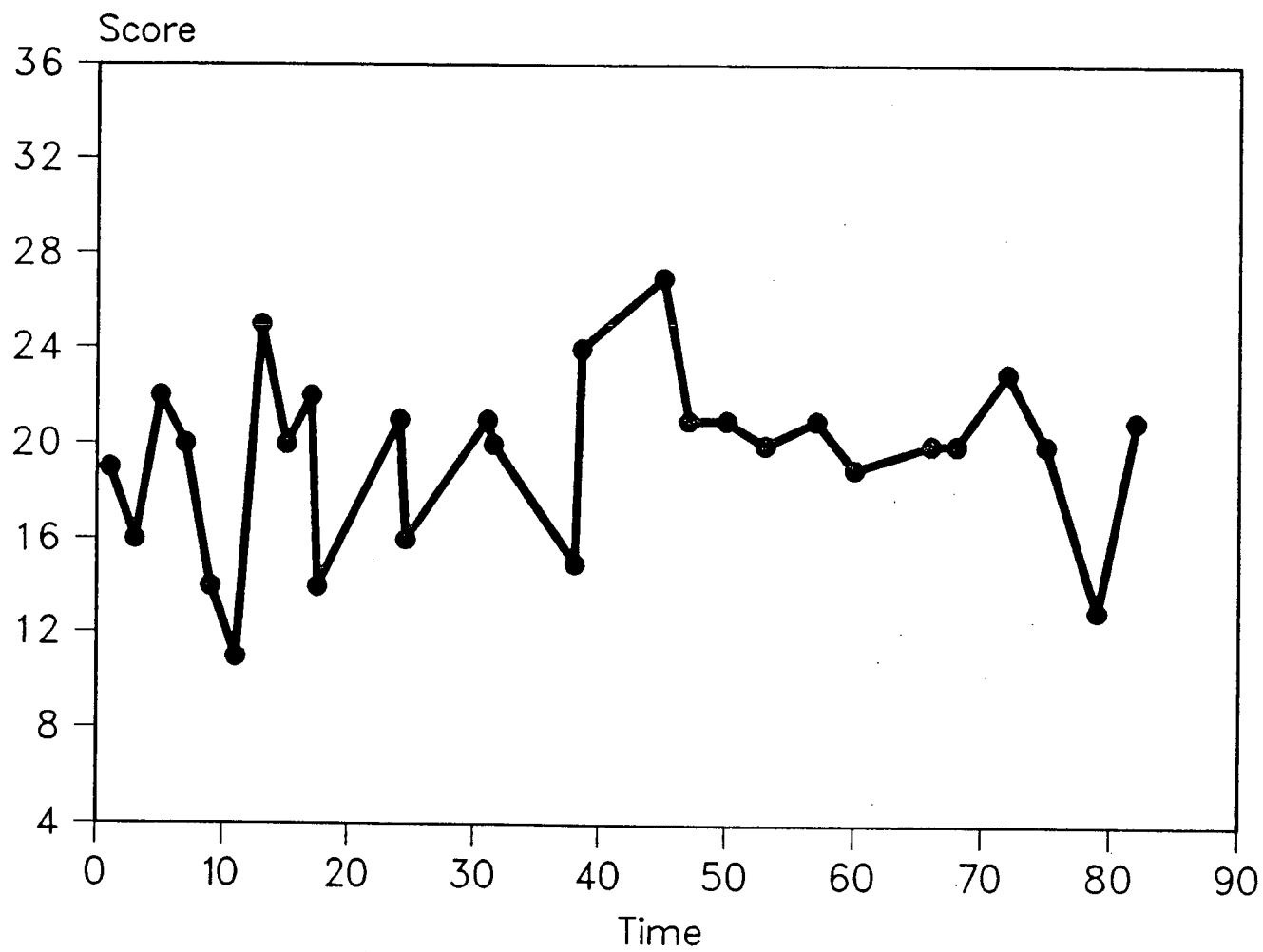
Subject 11, Scale 1



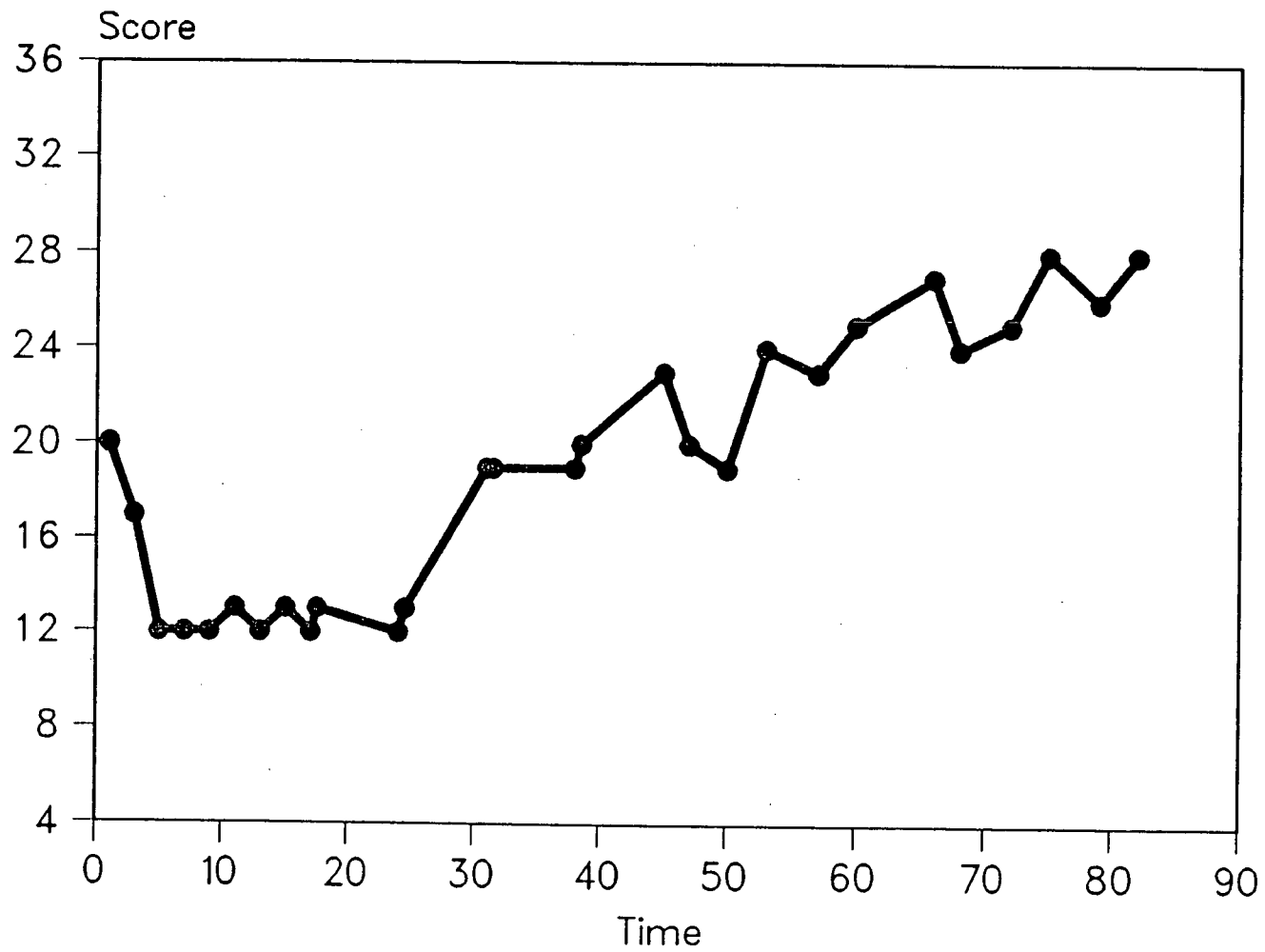
Subject 12, Scale 1



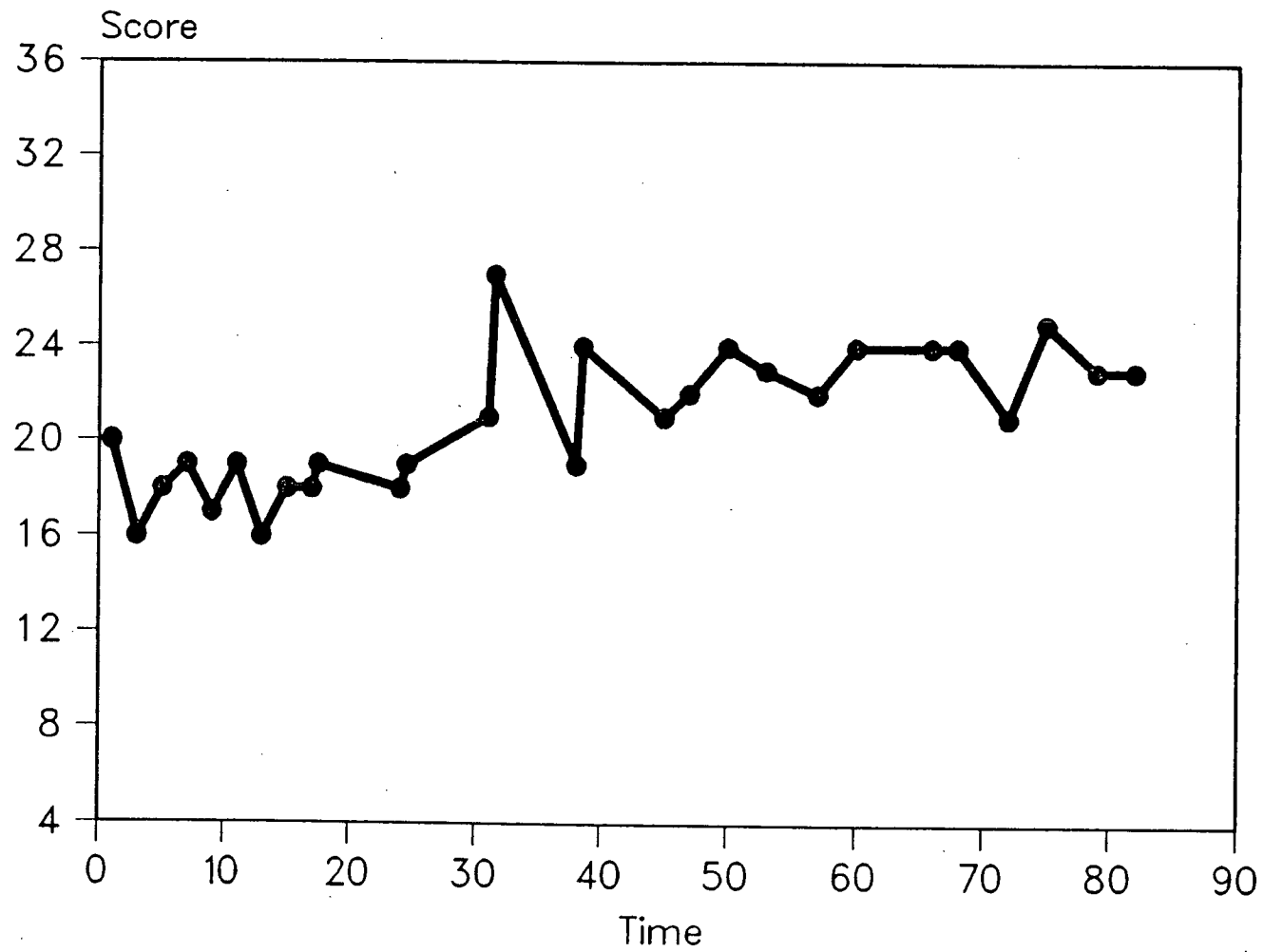
Subject 1, Scale 3



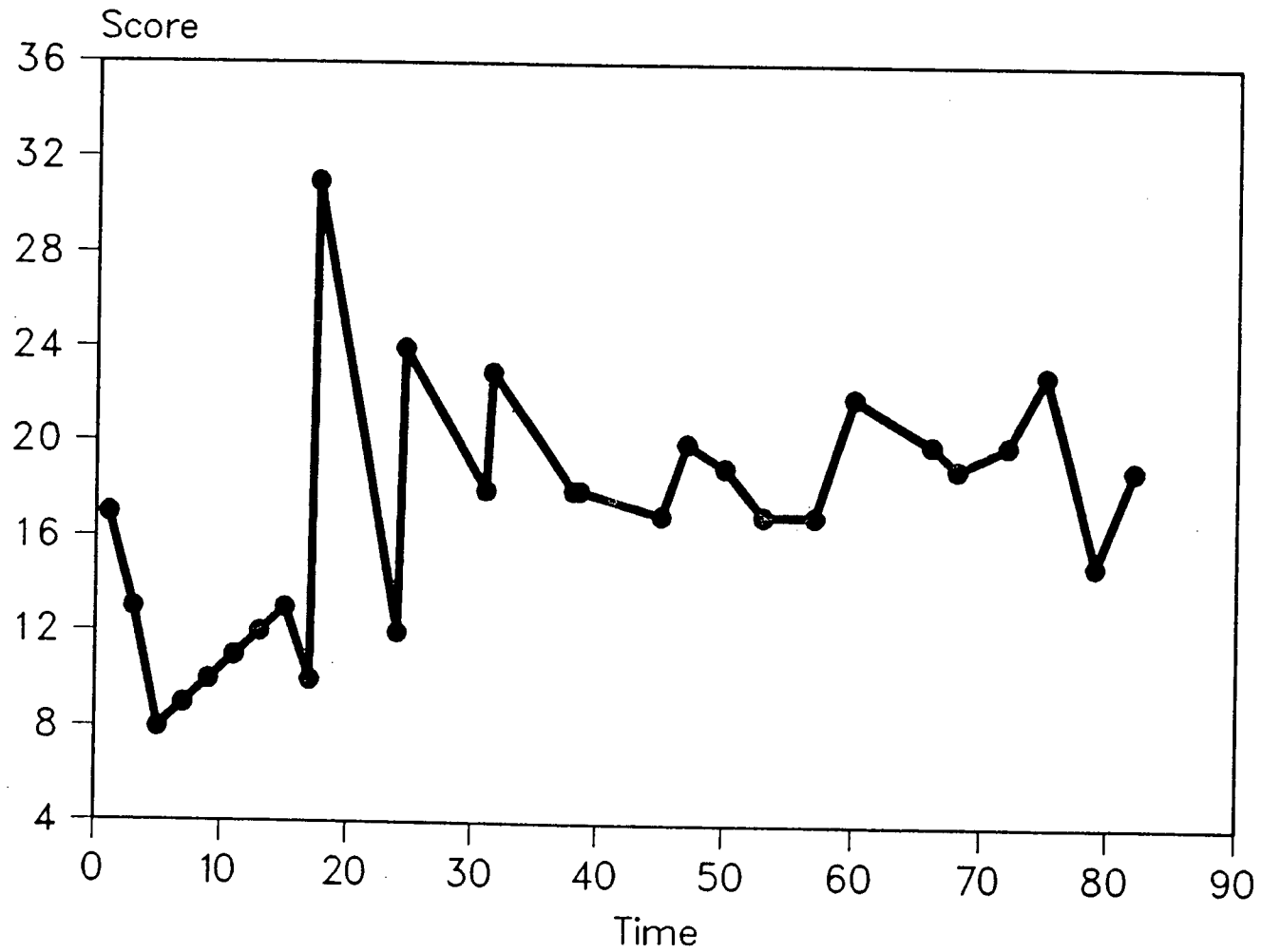
Subject 2, Scale 3



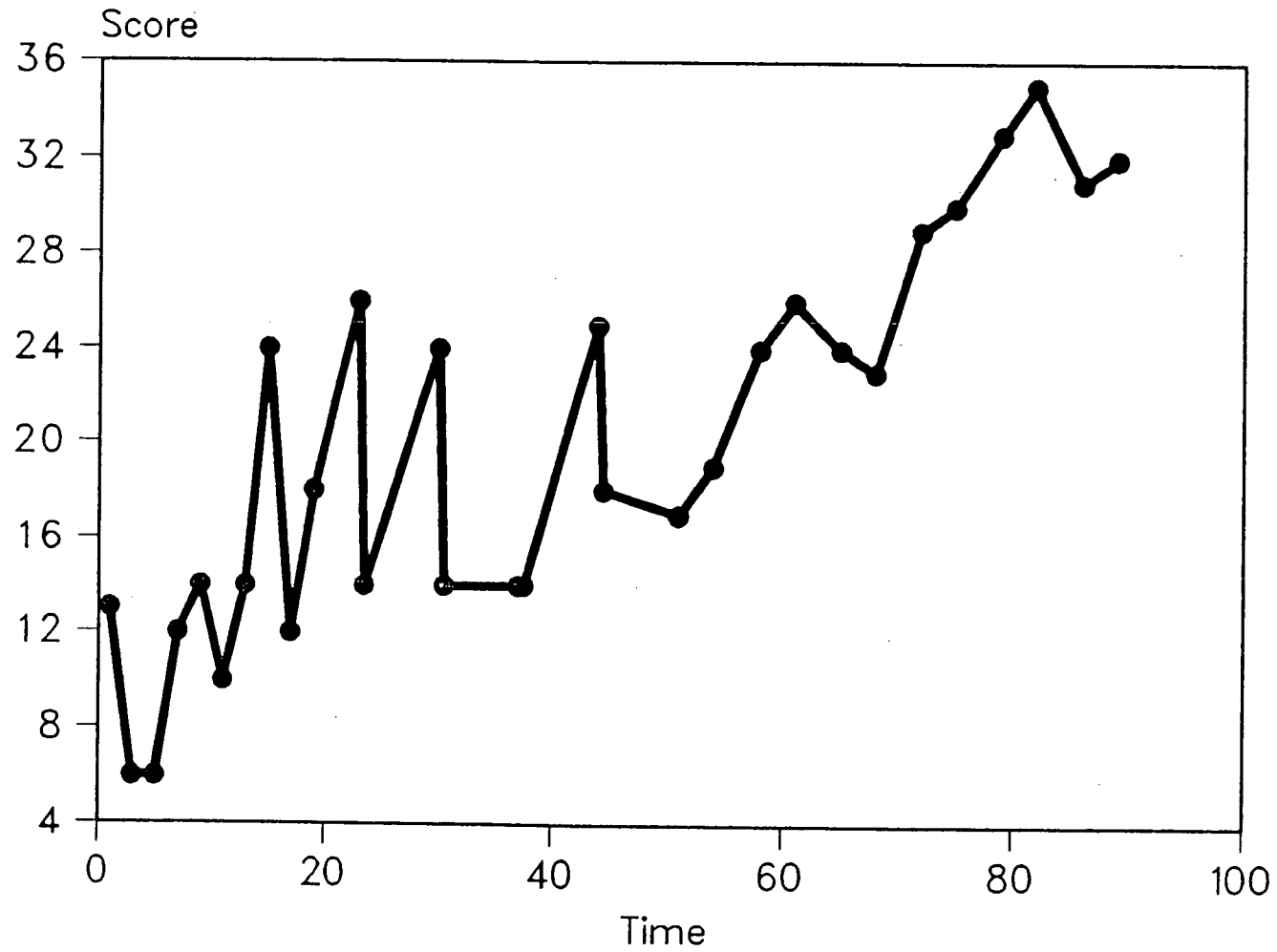
Subject 3, Scale 3



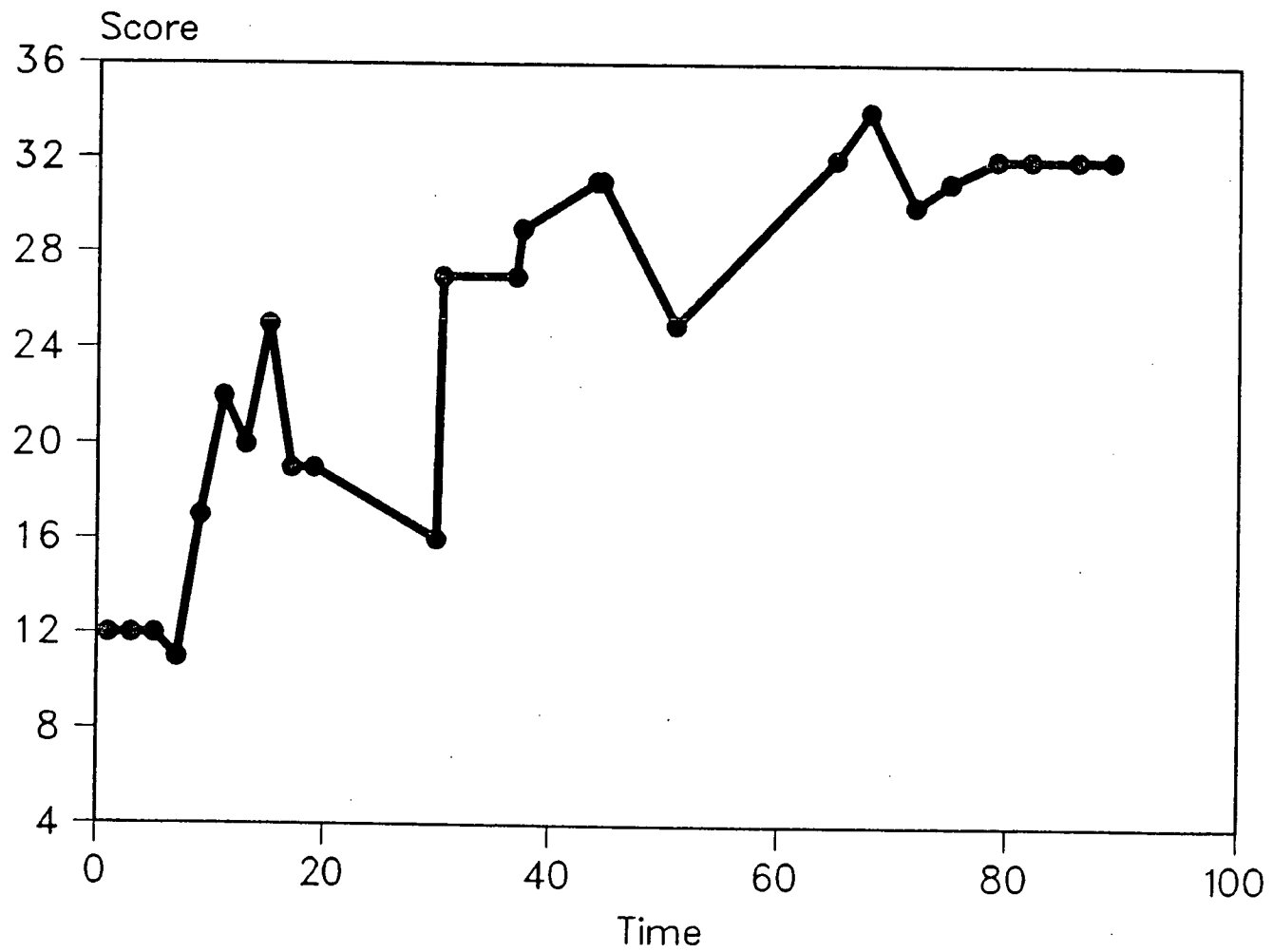
Subject 4, Scale 3



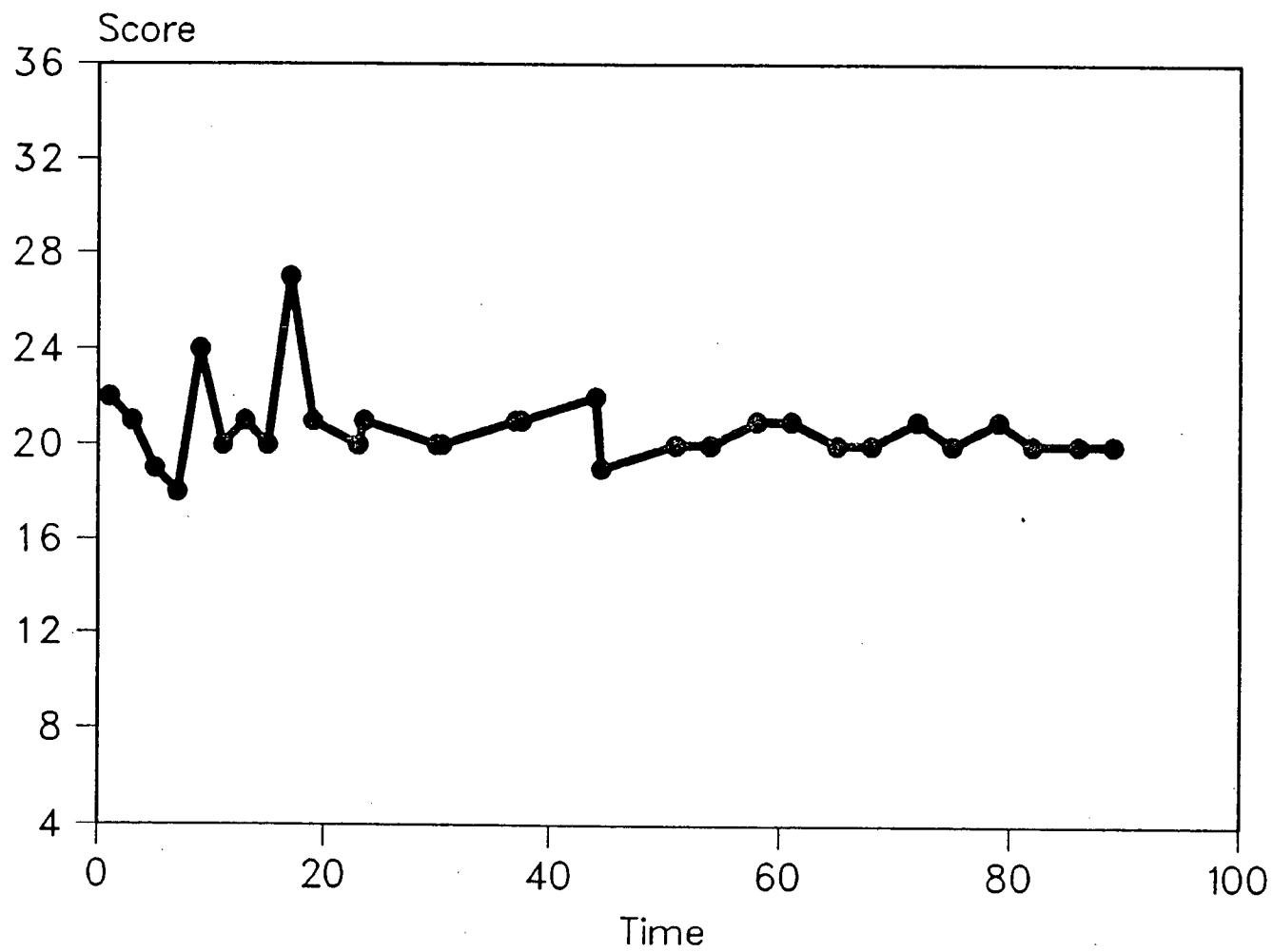
Subject 5, Scale 3



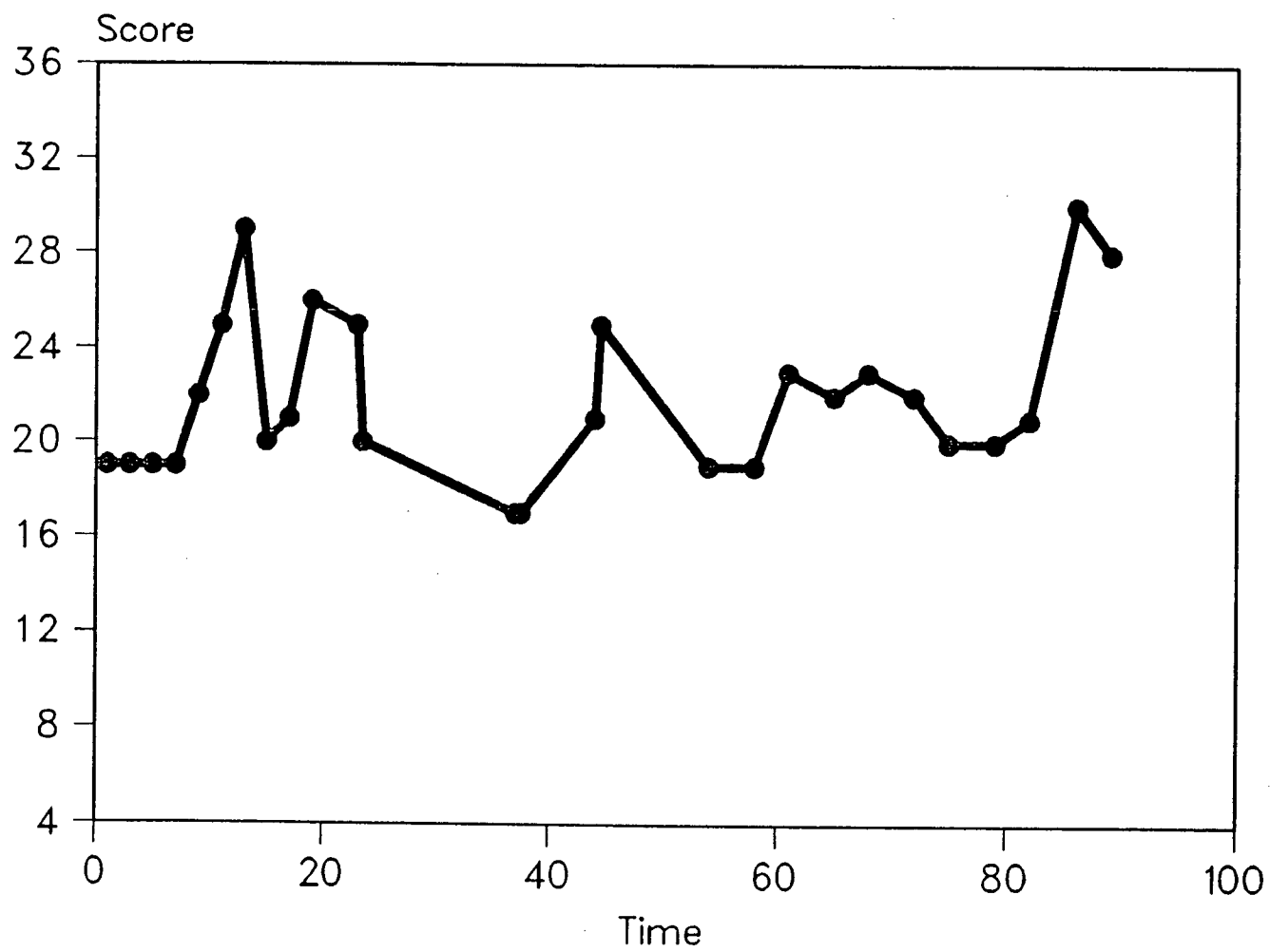
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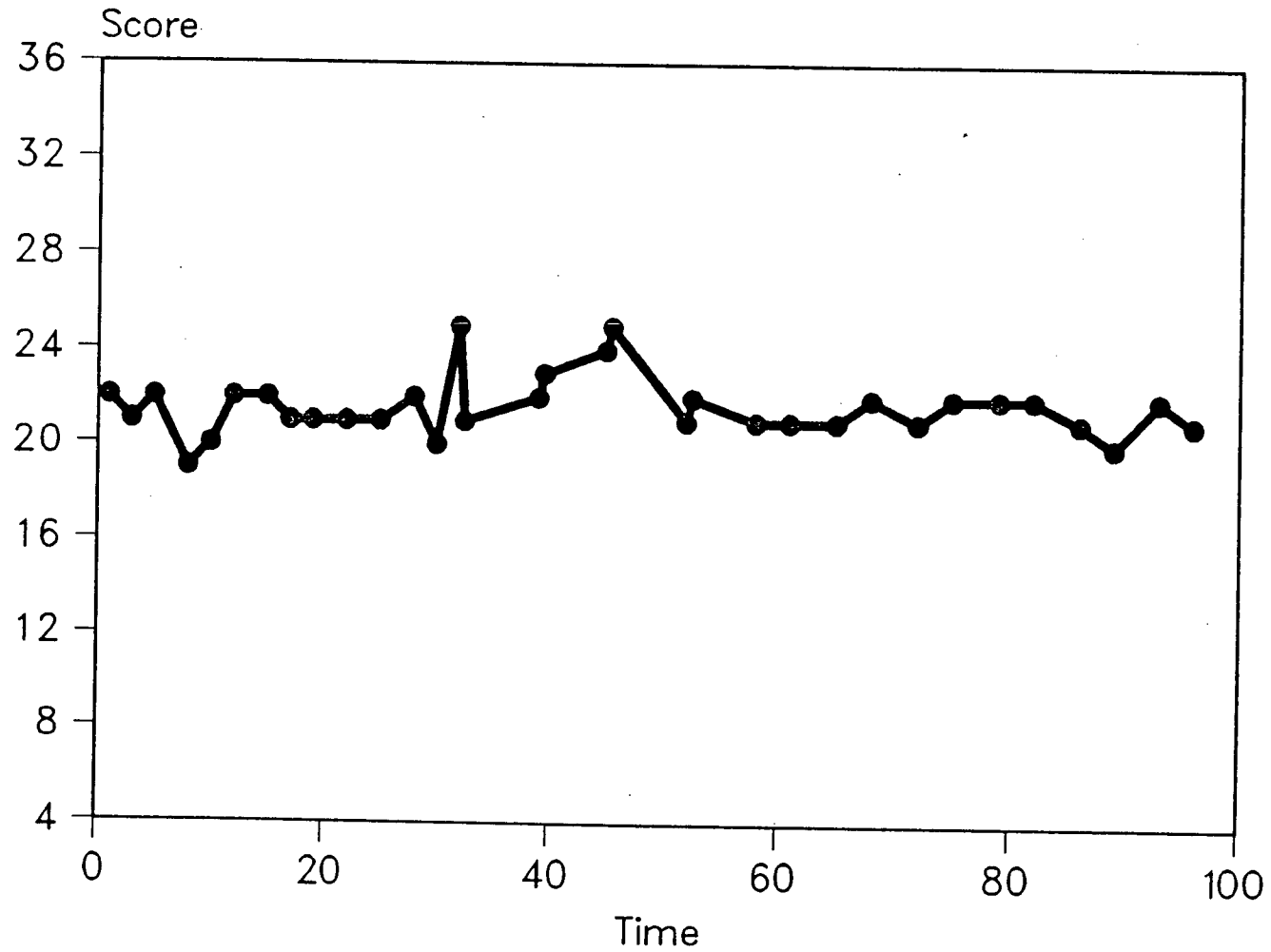
Subject 7, Scale 3



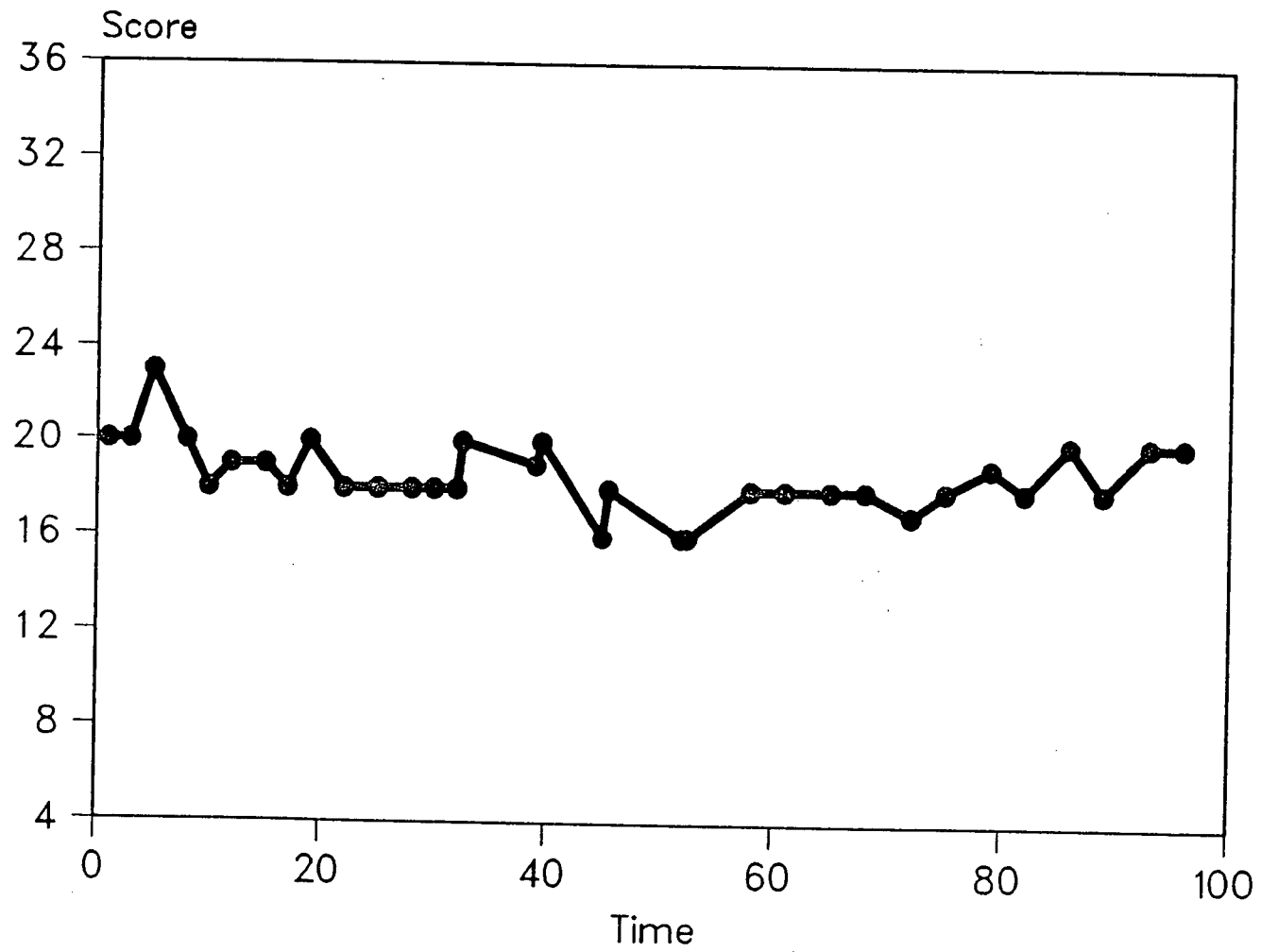
Subject 8, Scale 3



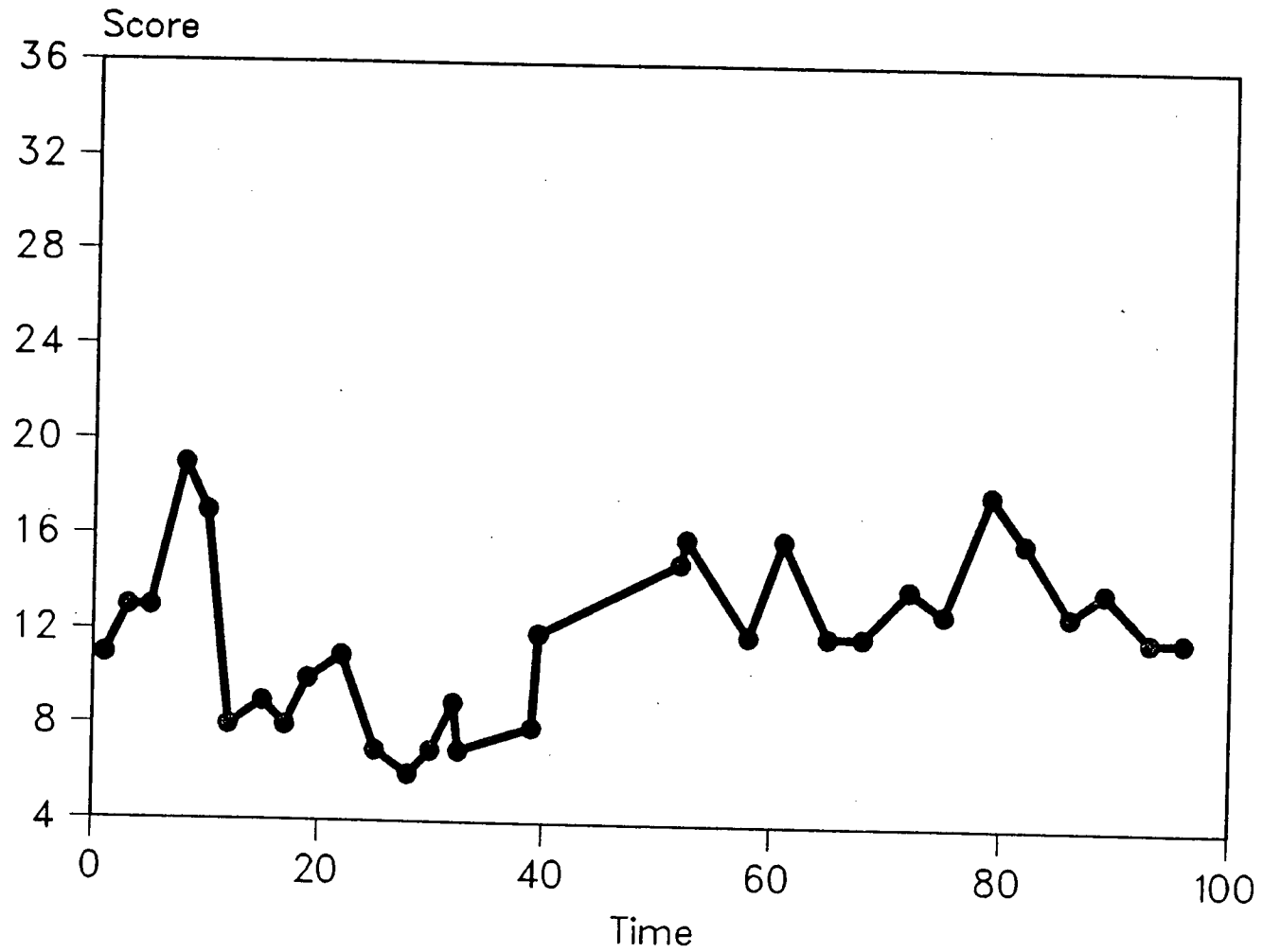
Subject 9, Scale 3



Subject 10, Scale 3



Subject 11, Scale 3



Subject 12, Scale 3

