INFORMATION TO USERS

While the most advanced technology has been used to photograph and reproduce this manuscript, the quality of the reproduction is heavily dependent upon the quality of the material submitted. For example:

- Manuscript pages may have indistinct print. In such cases, the best available copy has been filmed.

- Manuscripts may not always be complete. In such cases, a note will indicate that it is not possible to obtain missing pages.

- Copyrighted material may have been removed from the manuscript. In such cases, a note will indicate the deletion.

Oversize materials (e.g., maps, drawings, and charts) are photographed by sectioning the original, beginning at the upper left-hand corner and continuing from left to right in equal sections with small overlaps. Each oversize page is also filmed as one exposure and is available, for an additional charge, as a standard 35mm slide or as a 17”x 23” black and white photographic print.

Most photographs reproduce acceptably on positive microfilm or microfiche but lack the clarity on xerographic copies made from the microfilm. For an additional charge, 35mm slides of 6”x 9” black and white photographic prints are available for any photographs or illustrations that cannot be reproduced satisfactorily by xerography.
Glendening, James Gilbert

THE PSYCHOTHERAPEUTIC EFFICACY OF HYPNOTHERAPY AND COGNITIVE EXPERIENTIAL HYPNOTHERAPY IN THE TREATMENT OF NON-INSTITUTIONALIZED ELDERLY

The Ohio State University

University Microfilms International
300 N. Zeeb Road, Ann Arbor, MI 48106

Copyright 1987 by Glendening, James Gilbert

All Rights Reserved
PLEASE NOTE:

In all cases this material has been filmed in the best possible way from the available copy. Problems encountered with this document have been identified here with a check mark ✓.

1. Glossy photographs or pages
2. Colored illustrations, paper or print
3. Photographs with dark background
4. Illustrations are poor copy
5. Pages with black marks, not original copy
6. Print shows through as there is text on both sides of page
7. Indistinct, broken or small print on several pages ✓
8. Print exceeds margin requirements
9. Tightly bound copy with print lost in spine
10. Computer printout pages with indistinct print
11. Page(s) lacking when material received, and not available from school or author.
12. Page(s) seem to be missing in numbering only as text follows.
13. Two pages numbered. Text follows.
14. Curling and wrinkled pages
15. Dissertation contains pages with print at a slant, filmed as received
16. Other

University Microfilms International
THE PSYCHOTHERAPEUTIC EFFICACY OF HYPNOTHERAPY AND COGNITIVE EXPERIENTIAL HYPNOTHERAPY IN THE TREATMENT OF NON-INSTITUTIONALIZED ELDERLY

DISSERTATION

Presented in Partial Fulfillment of the Requirements for the Degree Doctor of Philosophy in the Graduate School of the Ohio State University

By

James G. Glendening, B.S., M.A.

* * * * *

The Ohio State University

1987

Dissertation Committee: Approved by

James V. Wigtil
Peter H. Gwynne
Susan J. Sears
W. Bruce Walsh

James V. Wigtil
Adviser
Human Services Education
ACKNOWLEDGMENTS

It is with the deepest gratitude that I acknowledge the members of my dissertation committee. My thanks to Dr. Bruce Walsh for originally directing me to an outstanding doctoral program, as well as for his personal support and friendship; Dr. Peter Gwynne for my training in psychiatric hypnotherapy and his support in the conduct of this study; Dr. Susan Sears for both her friendship and her profound commitment in our legislative and professional organizational pursuits; and, particularly, Dr. James Wigtil who initiated and facilitated my academic and professional development, and who invested himself so extensively in the completion of this dissertation.

I further acknowledge Dr. Henry Leland for the exceptional training he provided me in psychodiagnostics and Dr. Jocelyn Fuller for her friendship and outstanding training in psychotherapy, both these individuals being among the very finest of clinicians. Though the names of my friends are too numerous to mention, I must acknowledge my deep appreciation for their love and support. Foremost among these friends is John Gentis, a dear friend and one of the world's most astute and successful financiers.
With profound and humble gratitude I also acknowledge my family. I make special mention of Ida Glendening who so fluently demonstrated a life of quiet dignity, commitment, and sublime spiritual vision. My love and gratitude to John, Jeanne, and Kelly Glendening; Richard and Louise Glendening; and Betty and Tom McNaught. And, finally, I especially acknowledge my parents Gilbert and Alice Glendening, whose love, commitment, and sacrifices I can only barely begin to fathom, and concerning which, words fail me utterly.
VITA

January 29, 1946 . . . . Born - Muncie, Indiana

1969 . . . . . . . . . . B.S., Ball State University, Muncie, Indiana

1977 . . . . . . . . . . M.A., Ball State University, Muncie, Indiana

1978 . . . . . . . . . . Graduate Research Associate, National Center for Research in Vocational Education, Columbus, Ohio

1979-1982 . . . . . . . Psychology Assistant, Ohio Department of Youth Services Columbus, Ohio

1983-1985 . . . . . . . Executive Director, Columbus Clinical Counseling Center Columbus, Ohio

1985-1986 . . . . . . . Executive Director, Midwest Neuropsychological Institute Columbus, Ohio

FIELDS OF STUDY

Major Field: Counseling, Professor James V. Wigtil

Related Fields:

Developmental Psychology, Professor Henry Leland
Counseling Psychology, Professor W. Bruce Walsh
Research, Professor James R. Warmbrod
Psychiatry, Professor Peter H. Gwynne
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>ACKNOWLEDGMENTS</th>
<th>ii</th>
</tr>
</thead>
<tbody>
<tr>
<td>VITA</td>
<td>iv</td>
</tr>
<tr>
<td>LIST OF TABLES</td>
<td>viii</td>
</tr>
<tr>
<td>LIST OF FIGURES</td>
<td>x</td>
</tr>
<tr>
<td>CHAPTER</td>
<td></td>
</tr>
<tr>
<td><strong>I. INTRODUCTION</strong></td>
<td>1</td>
</tr>
<tr>
<td>Background to the Problem</td>
<td>1</td>
</tr>
<tr>
<td>Need for the Study</td>
<td>6</td>
</tr>
<tr>
<td>Purpose of the Study</td>
<td>9</td>
</tr>
<tr>
<td>Hypotheses</td>
<td>9</td>
</tr>
<tr>
<td>Definition of Terms</td>
<td>10</td>
</tr>
<tr>
<td>Limitations of the Study</td>
<td>15</td>
</tr>
<tr>
<td><strong>II. REVIEW OF THE LITERATURE</strong></td>
<td>18</td>
</tr>
<tr>
<td>Aged Mental Health: Issues</td>
<td>18</td>
</tr>
<tr>
<td>Self-Concept</td>
<td>22</td>
</tr>
<tr>
<td>Self-Concept: Background and Concepts</td>
<td>22</td>
</tr>
<tr>
<td>Self-Concept: Description</td>
<td>24</td>
</tr>
<tr>
<td>Self-Concept: The Aged</td>
<td>26</td>
</tr>
<tr>
<td>Depression</td>
<td>32</td>
</tr>
<tr>
<td>Depression: Background and Concepts</td>
<td>32</td>
</tr>
<tr>
<td>Depression: Description</td>
<td>33</td>
</tr>
<tr>
<td>Depression: The Aged</td>
<td>34</td>
</tr>
<tr>
<td>Hypnotherapy</td>
<td>42</td>
</tr>
<tr>
<td>Hypnotherapy: Hypnosis Component</td>
<td>43</td>
</tr>
<tr>
<td>Hypnosis: Background and Concepts</td>
<td>43</td>
</tr>
<tr>
<td>Hypnosis: Relaxation</td>
<td>48</td>
</tr>
<tr>
<td>Hypnosis: Visual Imagery</td>
<td>51</td>
</tr>
<tr>
<td>Hypnosis: Suggestion</td>
<td>56</td>
</tr>
<tr>
<td>Hypnotherapy: Psychotherapeutic Component</td>
<td>59</td>
</tr>
<tr>
<td>Hypnotherapy: Implementation</td>
<td>60</td>
</tr>
</tbody>
</table>
TABLE OF CONTENTS CONTINUED

<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive Experiential Hypnotherapy</td>
<td>61</td>
</tr>
<tr>
<td>Cognitive Experiential Hypnotherapy:</td>
<td></td>
</tr>
<tr>
<td>Psychotherapeutic Component</td>
<td>62</td>
</tr>
<tr>
<td>Cognitive Therapy: Background and Concepts</td>
<td>62</td>
</tr>
<tr>
<td>Cognitive Therapy: Visual Imagery</td>
<td>68</td>
</tr>
<tr>
<td>Cognitive Therapy: Suggestion</td>
<td>70</td>
</tr>
<tr>
<td>Cognitive Therapy: Implementation</td>
<td>71</td>
</tr>
<tr>
<td>Cognitive Experiential Hypnotherapy: Implementation</td>
<td>75</td>
</tr>
<tr>
<td>Hypnotherapy and Cognitive Experiential Hypnotherapy-Related Research</td>
<td>83</td>
</tr>
<tr>
<td>Hypnotherapy and Cognitive Experiential Hypnotherapy: Conceptual Distinctions</td>
<td>83</td>
</tr>
<tr>
<td>Hypnotherapy and Cognitive Experiential Hypnotherapy: Related Studies</td>
<td>87</td>
</tr>
<tr>
<td>Summary</td>
<td>114</td>
</tr>
</tbody>
</table>

III. METHODOLOGY                                                     | 116  |
| Research Setting                                                     | 116  |
| Population                                                           | 118  |
| Sample                                                               | 119  |
| Therapist                                                            | 120  |
| Instrumentation                                                      | 121  |
| Tennessee Self Concept Scale                                         | 122  |
| Minnesota Multiphasic Personality Inventory                          | 132  |
| Data Collection                                                      | 140  |
| Research Design                                                      | 141  |
| Experimental Conditions                                              | 142  |
| Therapeutic Themes by Session                                        | 144  |
| Hypnotherapy Treatment Condition                                     | 147  |
| Cognitive Experiential Hypnotherapy Treatment Condition              | 148  |
| Control Condition                                                    | 150  |
| Administrative Procedures                                            | 150  |
| Statistical Analysis                                                 | 151  |

IV. ANALYSIS OF DATA                                                 | 152  |

V. SUMMARY, CONCLUSION AND RECOMMENDATIONS                             | 165  |
<p>| Summary                                                               | 165  |
| Discussion                                                           | 169  |
| Conclusion                                                           | 180  |
| Recommendations                                                      | 180  |</p>
<table>
<thead>
<tr>
<th>TABLE OF CONTENTS CONTINUED</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>LIST OF REFERENCES</td>
<td>183</td>
</tr>
<tr>
<td>APPENDICES</td>
<td>200</td>
</tr>
<tr>
<td>A. Hypnotic Induction and Trance Terminating Procedure</td>
<td>200</td>
</tr>
<tr>
<td>B. Hypnotherapy Treatment Protocol</td>
<td>209</td>
</tr>
<tr>
<td>C. Cognitive Experiential Hypnotherapy Treatment Protocol</td>
<td>213</td>
</tr>
<tr>
<td>TABLE</td>
<td>PAGE</td>
</tr>
<tr>
<td>-------</td>
<td>------</td>
</tr>
<tr>
<td>1. Illustrated Adaptation of RET A-B-C Model</td>
<td>67</td>
</tr>
<tr>
<td>2. Illustrated Adaptation of RSDH A-B-C-D-E Model</td>
<td>79</td>
</tr>
<tr>
<td>3. Hypnotherapy and Cognitive Experiential Hypnotherapy: A Conceptual Model</td>
<td>82</td>
</tr>
<tr>
<td>4. Summary Dimensions of the Study by Treatment Condition</td>
<td>117</td>
</tr>
<tr>
<td>5. Tennessee Self Concept Scale Test-Retest Reliability Coefficients</td>
<td>131</td>
</tr>
<tr>
<td>6. Minnesota Multiphasic Personality Inventory Test-Retest Reliability Coefficients</td>
<td>139</td>
</tr>
<tr>
<td>7. Analysis of Variance for Treatment Groups on Pretest Measures of Self-Concept Using the Tennessee Self Concept Scale</td>
<td>154</td>
</tr>
<tr>
<td>8. Analysis of Variance for Treatment Groups on Pretest Measures of Depression Using the Minnesota Multiphasic Personality Inventory</td>
<td>154</td>
</tr>
<tr>
<td>9. Cell Means and Standard Deviations for Treatment Groups on Repeated Measures of Self-Concept Using the Tennessee Self Concept Scale</td>
<td>155</td>
</tr>
<tr>
<td>10. Cell Means and Standard Deviations for Treatment Groups on Repeated Measures of Depression Using the Minnesota Multiphasic Personality Inventory</td>
<td>156</td>
</tr>
<tr>
<td>11. Analysis of Variance for Treatment Groups on Repeated Measures of Self-Concept Using the Tennessee Self Concept Scale</td>
<td>161</td>
</tr>
</tbody>
</table>
LIST OF TABLES CONTINUED

12. Analysis of Variance for Treatment Groups on Repeated Measures of Depression Using the Minnesota Multiphasic Personality Inventory . . 162
LIST OF FIGURES

<table>
<thead>
<tr>
<th>FIGURE</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Plotted Means for Treatment Groups on Repeated Measures of Self-Concept Using the Tennessee Self Concept Scale</td>
<td>158</td>
</tr>
<tr>
<td>2. Plotted Means for Treatment Groups on Repeated Measures of Depression Using the Minnesota Multiphasic Personality Inventory</td>
<td>159</td>
</tr>
</tbody>
</table>
CHAPTER I
INTRODUCTION

Background to the Problem

The mental health status of the elderly is rapidly becoming an area of major public and professional significance. An increasing number of articles and studies tend to bear witness to the magnitude of a steadily mounting concern over mental-health-related issues surrounding aging and the circumstances of the elderly. The nature of many elderly related mental health issues is graphically depicted with the following words:

The three saddest words in the English language are, I am old; the five saddest, I am old and poor; and the seven saddest, I am old and poor and sick; and the nine saddest, I am old and poor and sick and lonely (quoted by Shore, 1977, p. 11).

To a considerable extent, the prominence of difficulties reflected in such comments has been encouraged by pressures from the rapidly expanding size of the elderly population itself. That is, there has been an increase of elderly in the total population from about 4% in 1900 to 11.6% by the early 1980s (U.S. Bureau of the Census, 1982). By 2030, the U.S. Bureau of the Census (1983) predicts that
the elderly will have increased from a present one-tenth of the total United States population to one-fifth.

The ever increasing numbers of elderly persons pose social issues of considerable magnitude, particularly within the field of mental health research and service delivery. As a whole, over the period of a year, as much as 15% of the U.S. population is said to experience mental health difficulties which are in need of treatment (Regier, Goldberg, & Taube, 1978). The circumstances and issues surrounding aging may aggravate and/or accentuate mental health problems to such an extent, however, that an even higher incidence of these difficulties may be experienced among the elderly (Redick & Taube, 1980).

Due to the continually increasing number of elderly, and the many unique issues and circumstances of the aged that may especially impact mental health status, researchers are beginning to explore ways of responding most effectively by means of psychotherapeutic interventions. A preliminary attempt to identify viable psychotherapeutic interventions for use with the elderly might reasonably include an investigation of existing outcome studies, without regard to whether these studies were generated with an aged population. In this respect, Smith, Glass, and Miller (1980) conducted an especially comprehensive review and evaluation of all available and statistically analyzable outcome studies.
In addition to a large number of individual psychotherapies addressed within the research studies examined, Smith et al. (1980) were able to identify and assess 18 different psychotherapy types. Preliminary results permitted Smith et al. to cite a hierarchy of these psychotherapy types according to the degree of therapeutic benefit each was determined to have rendered. In the order of most benefits provided (among the 18 inspected), the two types initially shown to be most effective were Other Cognitive Therapies, first, and Hypnotherapy (HT), second.

One of the psychotherapies included under Other Cognitive Therapies was Rational Stage Directed Imagery (RSDI), RSDI being more appropriately entitled Rational Stage Directed Hypnotherapy (RSDH) given the specific treatment procedures employed. RSDH is one of various psychotherapies referred to in this study as Cognitive Experiential Hypnotherapy (CEH). RSDH may be viewed as a specialized form of hypnosis-based psychotherapy wherein rational/cognitive therapy (cognitive restructuring) is effected within the context of hypnosis, thus incorporating a cognitive feature not traditionally employed by HT alone.

In summary, it seems that two psychotherapeutic forms of hypnosis were initially determined by Smith et al. (1980) to be among those most effective—that is, RSDH, under Other Cognitive Therapies, and HT.
Subsequent to the preliminary analysis by Smith et al. (1980), which suggested superiority experienced by the two psychotherapeutic types, a final analysis was conducted. The final analysis disclosed that once varying characteristics among the different studies were controlled, there was no reliable difference in effectiveness between individual psychotherapies. Specifically, though all psychotherapies examined were generally deemed to produce benefits, benefits rendered by each were determined to be essentially equivalent in terms of magnitude.

Despite the seemingly conclusive finding for equivalent effectiveness (Smith et al., 1980), there are related studies with more equivocal outcomes, studies which incorporate a direct comparison of CEH (RSDH) and what is tacitly presented to be HT. Examples of these studies (a) conditionally support the Smith et al. conclusion as to significant and equivalent effectiveness of both HT and CEH (Marzella, 1975); (b) support the effectiveness of both, but with CEH being more so (Boutin, 1976); and (c) support the significant effectiveness of CEH alone (Howard, 1979). It should be noted, though, that by speaking of effectiveness in such global terms, a number of distinctions are lost such as severity/type of problem, therapist experience, or varying effectiveness with different dependent variables.

The equivocality of findings by the outcome studies just cited, in comparison to those of Smith et al. (1980),
tends to also be demonstrated with respect to the elderly alone. In the one HT-CEH-related study with the aged, Fuller (1982) reported significant benefits for institutionalized elderly experiencing HT or CEH (RSDH) type treatments, but with the CEH treatment being equivalent in effectiveness on one dependent variable (depression) and significantly more effective than HT on the other (selfconcept). While these differential results with the aged may merely reflect that HT-CEH-related outcomes are dependent-variable-specific, on whole, the results of HT-CEH studies seem to lack sufficient concordance to provide a sound basis for any firm conclusions.

As an alternative to the drawing of any firm conclusions, it might be posed that at least one possible consistency may be identified across the findings of HT-CEH type studies. That is, aside from both HT and CEH appearing to be generally effective, CEH has not been shown to be any less effective than other psychotherapeutic interventions such as HT. It seems questionable, however, as to whether CEH is any more effective; and should CEH actually be more effective, it appears equally unclear as to the type of populations or other conditions under which this might occur.

Such unknowns, surrounding HT-CEH efficacy in the literature at large, tend to be even more apparent in the case of pertaining research with the elderly. Among other
things, this is due to the existence of but one related study with the aged (i.e., Fuller, 1982) and the difficulty in generalizing its findings to elderly populations other than those that are institutionalized. Hence, any uncertainties as to the question of efficaciousness within the HT-CEH research as a whole, are consequently no less pronounced in the case of the aged in general and the non-institutionalized elderly in particular, the latter being a population with which no such research currently exists.

Need for the Study

The U.S. Bureau of the Census (1983) states that "the age groups which require special attention—and which will experience dramatic increases in numbers—are the aged and the very old" (p. 3). This observed need for special attention emphasizes a condition that exists and will continue to grow in magnitude as the size of the elderly population continues to expand. Further, a specific, already existing, and rapidly growing area of particular need involves the mental health circumstances of the elderly.

At the beginning of this decade, even though the elderly constituted only about 11% of the population, they included 18% of all those in need of mental health services (U.S. House of Representatives, 1980). Eisdorfer, Cohen, and Veith (1980) note that "85 percent of the mental health
needs of older persons are, and will continue to be, inadequately met by our current system" (p. 7). Zarit (1980) dramatizes this circumstance by stating: "Despite the extent of psychiatric impairment among the aged, older persons receive fewer mental health services than any other age group, except young children" (p. 14).

The traditional recipients of psychotherapy have been depicted as falling within the YAVIS category— that is, Youthful, Attractive, Verbal, Intelligent, and Successful (Schofield, 1964). It might be observed that mental health research has traditionally been of this nature as well. Such circumstances elicit the concern that "treatment modalities developed through experience with younger age groups have been borrowed for use with the elderly without sufficient attention to specific applications in the elderly" (Breslau, 1983, p. 136). This tends to emphasize a research need concerning the development and/or verification of effective psychotherapeutic interventions for use with the aged.

As mentioned, a survey of the literature for viable non-population-specific psychotherapeutic interventions might usefully consider Smith et al. (1980). Initial findings by Smith et al. facilitate an inference that HT and CEH (RSDH) are among the most effective psychotherapies, and with CEH being somewhat more so. After additional analysis, though, Smith et al. finally concluded that there was
essentially no difference in effectiveness among types of psychotherapy. Other studies (e.g., Boutin, 1976; Howard, 1979), however, appear to emphasize HT-CEH differences. Relative to just the elderly, insufficient evidence exists to provide much clarification concerning HT-CEH efficacy. Fuller (1982) emphasizes the need for such aged-related research, and with the non-institutionalized aged in particular—citing Grollman (1974) who indicates that only 5% of the elderly are institutionalized.

In summary, a variety of circumstances may be identified to indicate a need for aged-related HT and CEH research. These include (a) the increasing incidence of mental-health-related difficulties represented by a rapidly expanding population of aged; (b) a body of evidence that supports the general effectiveness of hypnosis-based psychotherapies such as HT and CEH, but with far more contradictory evidence as to the circumstances or conditions of such efficacy; (c) the relative dearth of research that addresses psychotherapeutic interventions with the elderly, and that employ HT-CEH-related therapies in particular; and (d) the complete absence of HT-CEH research with the non-institutionalized aged who constitute the greatest proportion of elderly.

More specifically, a need consequently exists for a study which would clarify uncertainties surrounding the
effectiveness of both HT and CEH in the treatment of non-institutionalized elderly. Such research might not only contribute to a generally increased scientific understanding, but disclose practical solutions which can facilitate an enhanced quality of life for a considerable proportion of society that includes the present and future elderly.

Purpose of the Study

The purpose of the study is to experimentally determine the efficacy of prominent hypnosis-based psychotherapies as interventions for use with non-institutionalized elderly. The problem to be investigated involves a determination of effectiveness for Hypnotherapy (HT) and Cognitive Experiential Hypnotherapy (CEH) in the enhancement of self-concept and reduction of depression among non-institutionalized elderly.

Hypotheses

The statistical (null) hypothesis is presented in three components as follows:

\[ H_0: \text{ (a) Hypnotherapy (HT), Cognitive Experiential Hypnotherapy (CEH), and Control (CO) do not differ significantly in effects on the dependent dimensions of self-concept and depression (main effects for group).} \]
(b) No significant difference exists between the times of measured effects across HT, CEH, and CO on the dependent dimensions of self-concept and depression (main effects for time).

(c) HT, CEH, and CO do not demonstrate differential significant effects depending upon time of measurement for the dependent dimensions self-concept and depression (interaction).

Definition of Terms

Various important terms employed herein are defined as follows:

Aging: "Aging refers to the regular changes that occur in mature genetically representative organisms living under representative environmental conditions as they advance in chronological age" (Birren & Renner, 1977, p. 4).

Aged: Aged, Elderly, Old, Older, and Old Age are similarly used herein to indicate those persons of considerably greater than average chronological age among the population as a whole. Some sources separately define each term relative to a specified number of chronological years. For example, the U.S. Bureau of the Census (1983) offers the following: older (age 55 and over); elderly (age 65 and over);
aged (age 75 and over); and very old (age 85 and over). Though the designation of a chronological age may be argued as quite arbitrary, and though some authors cited herein tend to view age 65 as a practical point of demarcation, for research purposes each of the terms shall interchangeably indicate the entire range of age 55 and over.

**Cognitive Experiential Hypnotherapy (CEH):** CEH is categorically defined herein to subsume hypnosis-based psychotherapeutic approaches embodying the integration of two primary components: (a) hypnosis, an induction or the hypnotic state alone (HO), and (b) Cognitive Therapy (CT), which is also frequently referred to as Cognitive Restructuring (CR). CEH includes the implementation of both induction contextual suggestions and post-induction therapeutic suggestions.

**Cognitive Restructuring (CR):** CR constitutes the generic process of effecting or implementing Cognitive Therapy (CT) within a therapeutic and/or research context. CR tends to be used interchangeably with the term CT within the literature.

**Cognitive Restructuring Treatment:** CR Treatment is used to indicate the specific use of CR as an independent research treatment condition.

**Cognitive Restructuring Component:** CR Component indicates the implementation of CR as one of the two
major components which constitute CEH or Rational Stage Directed Hypnotherapy (RSDH)—the other being a Hypnosis Only Component.

Cognitive Therapy (CT): CT shall indicate a rational/cognitive form of psychotherapy predicated upon Rational Emotive Therapy (RET) as presented by Ellis (1962). CT tends to be used interchangeably with the term CR within the literature.

Depression: Depression is defined as that construct or condition which is measured by the Minnesota Multiphasic Personality Inventory (MMPI) Depression Scale, and as designated by the Depression Scale Score. Elevations in scores are specified to indicate increased levels of depression. Decrements in such scores are deemed to indicate decreased levels of depression.

Hypnosis: Hypnosis is that condition or state following the administration of a hypnotic induction.

Hypnotic Induction: Hypnotic Induction, often shortened to Induction, is defined as Wolberg's (1964) four-step process for establishing a state of hypnosis: (a) deep breathing, (b) deep muscle relaxation, (c) imagining a relaxing scene, and (d) counting.

Hypnosis Only (HO): HO shall designate the use of hypnosis for research purposes and the existence of hypnosis or the hypnotic state alone—HO being
functionally delimited by the administration of a hypnotic induction. That is, the hypnotic state, once established by means of an induction, would not be subject to any procedures other than that of the trance terminating counting-out process. HO subsumes the implementation of induction contextual suggestions.

**Hypnosis Only Treatment:** HO Treatment is used to indicate the specific implementation of HO as an independent research treatment condition.

**Hypnosis Only Component:** HO Component indicates the implementation of HO as one of the two major components which constitute CEH or Rational Stage Directed Hypnotherapy (RSDH)—the other being a Cognitive Restructuring Component.

**Hypnotherapy (HT):** HT designates a hypnosis-based psychotherapy incorporating (a) hypnosis, an induction or the hypnotic state alone (HO), and (b) psychotherapy, primarily involving the direct use of issue-oriented, post-induction therapeutic suggestions. HT includes the implementation of both induction contextual suggestions and post-induction therapeutic suggestions.

**Rational Stage Directed Hypnotherapy (RSDH):** RSDH designates a hypnosis-based psychotherapy of the CEH variety incorporating two primary components: (a) hypnosis, an induction or the hypnotic state alone
Rational Stage Directed Hypnotherapy Treatment: RSDH treatment indicates the specific implementation of RSDH as an independent research treatment condition.

Relaxation: Relaxation is a process or state of reduced intensity, muscular loosening, and diminished effort or strain (Morris, 1982).

Self-Concept: Self-Concept is that construct or condition which is measured by the Tennessee Self Concept Scale (TSCS), and as designated by the Total P Score. Elevations in scores indicate enhanced self-concept. Decrements in such scores indicate decreased levels of self-concept.

Suggestion: Suggestion is the process of offering or proposing something for consideration or action (Morris, 1982). Induction contextual suggestions are those suggestions occurring during the hypnotic induction, usually for the purpose of facilitating same. Post-induction therapeutic suggestions are any psychotherapeutic suggestions rendered after the
conclusion of the hypnotic induction and hence within the context of hypnosis.

**Visual Imagery:** Visual Imagery is a subjective mental process or state deemed to approximate objective visual-perceptual reality—also to be referred to as imagery or mental imagery.

**Limitations of the Study**

At least five limitations may mediate findings and/or conclusions of this study. These limitations are specified as follows:

1. Given that the study is primarily limited to the inclusion of non-institutionalized, lower-income, Caucasian, female elderly subjects from a moderately sized Midwestern community, generalizability of results is limited to a population that is representative of this sample. Two limitations are specifically emphasized in this respect:
   (a) Findings are limited to the relatively young mean age, of approximately 67 years, for the elderly subjects employed within this study. The perception of aging by these persons, the impact of age-related issues upon their mental health, and the results of any psychotherapeutic interventions that may be implemented on their behalf, might be markedly different with
elderly who are one or two decades older. The findings should therefore be interpreted with caution relative to their implications for the elderly as a whole.

(b) This study being a preliminary effort to address a population that had heretofore not been explored by HT-CEH-related research (non-institutionalized elderly), an attempt was made to acquire a representative sample of such aged persons without regard to mental health/treatment status. This resulted in a relatively non-clinical sample that was not under psychotherapeutic treatment. Therefore, the findings are not generalizable to specialized elderly populations such as those deemed to be clinically disturbed or classified as outpatients receiving psychotherapeutic services.

2. This study is limited by the relatively small number of research subjects employed, with the consequence of there being either 9 or 10 subjects per cell. Though such a limited number of research subjects does not necessarily invalidate the statistical results, the viability of such results may have been jeopardized.
3. The intended random assignment of subjects to the treatment conditions was not satisfactorily realized due to difficulties in scheduling, transportation, and/or various unanticipated personal issues of the elderly participants. This circumstance introduces a plausible threat to internal validity.

4. The participants were not screened for reading/comprehension level and there was a perceived reluctance of some elderly participants to ask questions concerning the self-administered assessments. This poses a possible limitation concerning the unknown effects of comprehension and response accuracy on the instrumentation.

5. Findings and conclusions drawn from the study are restricted to data generated by the limited number of self-administered instruments employed (one per dependent variable)—a constraint partially obligated by concerns with taxing the physical, mental, and emotional faculties of the elderly participants.
CHAPTER II
REVIEW OF THE LITERATURE

This chapter presents a survey of pertinent concepts, literature, and research concerning the efficacy of hypnosis-based psychotherapeutic interventions. This is accomplished with a view toward addressing various mental-health-related circumstances of the elderly. Specifically, seven sections will be presented, as follows: (a) aged-related mental health issues, (b) self-concept, (c) depression, (d) Hypnotherapy, (e) Cognitive Experiential Hypnotherapy, (f) Hypnotherapy and Cognitive Experiential Hypnotherapy-related research, and (g) Summary.

Aged Mental Health: Issues

Relative to the aged, older adults may encounter or experience various unique difficulties, issues, or events which sometimes substantially impact their emotional status and behavioral functioning. Such circumstances might be conceptualized in terms of classifications that concern the presumed source of influence or causation. In the literature, one model of considerable significance dichotomizes
such sources of influence or causation as either direct (internal) or indirect (external).

The direct sources often include internal, medically related difficulties surrounding such things as brain injury, electrolyte imbalances, or anemia. The indirect sources frequently involve environmentally related difficulties that may concern change or loss (examples below), and might even implicate conditions which include an older adult’s physical status, such as appearance or lameness. The central criterion concerning the indirect sources of causation is that they appear to be mediated by the individualized or idiosyncratic way in which a person mentally or emotionally reacts to any particular circumstance that might be perceived/encountered.

For purposes of diagnosis and the consequent formulation of an appropriate intervention strategy, much effort is often expended in trying to discern whether a presenting mental health problem is directly (internally) or indirectly (externally) precipitated. Some of the mental health problems encountered by the elderly may be either or both. For example, a head trauma might directly precipitate organically related mental or emotional difficulties, and/or the head trauma might indirectly facilitate similar types of problems, but through a person-mediated form of emotional reaction to the injury. Aging-related loss may pose a major source of direct and/or indirect influence or causation.
Pfeiffer (1977) states that losses can occur at any age, but that they are ubiquitous in old age. Often, the difficulties or circumstances of loss encountered by the elderly, which may constitute the direct sources of causation, are normal or natural, age-related decrements of ability. Areas of normal loss might encompass such things as vitality, health, ambulation and other motoric capabilities, sensory acuity, intellect, and memory. These changes or losses, though, are often not nearly so severe or pervasive as popularly thought, especially with respect to intellect (Botwinick, 1977).

In addition to these direct aging-related losses, there are circumstances that may be identified as having a more indirect (external) impact upon the mental health status of the elderly. Such circumstances include issues or events to which the aged may be particularly responsive or reactive. Johnson and Williamson (1980) identify and elaborate upon exploitation (often by employers); oppression due to loss of control or autonomy; discrimination (social and medical); crime/victimization; poverty/deprivation; and the fear or fact of institutionalization—these being aged-related influences that may be construed as indirect, external, or environmental in nature.

The mental health literature also tends to emphasize a variety of other indirect issues concerning the elderly.
These include such things as the loss of vehicular/geographical mobility; loss of income; loss of companionship through the children leaving home or the departure of important others as a consequence of their moving away or dying (migration and exiting); the difficulty or inability of meeting people and making new friends; and diminished levels of interests, activities, and pursuits—all these circumstances frequently resulting in difficulties such as isolation, boredom, and loneliness (Butler & Lewis, 1977; Zarit, 1980).

Concerning the influence of indirect sources of causation, Dohrenwend and Dohrenwend (1969) conducted a review which results in the conclusion that "virtually the entire gamut of psychological symptoms can be produced in previously normal persons by contemporary circumstances" (p. 172). These contemporary circumstances were emphasized to include a wide range of events. More specific to the aged, Breslau and Haug (1983) point out that "because of a variety of old peoples' frailties and sensitivity to traumas, situational reactions [italics added] become major clinical psychiatric problems for the elderly, whereas in other age groups situational reactions may be nonclinical and 'normal'" (p. 271).

The literature tends to reflect an almost endless variety of issues or events that could be interpreted as indirect precipitants of mental health difficulties. Given the prevalence and broad implications posed by just the
indirect precipitants of mental health difficulties, to which a large proportion of the elderly seem particularly exposed, the ensuing discussion concerning self-concept and depression consequently emphasizes an indirect perspective over the more direct one.

Self-Concept

In this section, the background pertaining to self-concept is first addressed and various related concepts are introduced. Next, a description of self-concept is presented. Finally, self-concept and its relevance to mental health and the aged is discussed.

Self-Concept: Background and Concepts

A history surrounding the construct known as self-concept is modestly rich. Religions throughout recorded history have intimated that the person we know as our self is somehow distinct from the body. Similarly, Plato portrays Socrates as emphasizing, just before drinking the fatal poison, that he is not his body (Plato, 1937). The ancient and historical pervasiveness of the concept known as self tends also to be illustrated by the saying, "know thyself," a statement with which no single author has been universally credited, but one which is specifically referenced by Plato (via Socrates) as an inscription at Delphi (Plato, 1952, p. 24).
Sigmund Freud and William James are some of the most notable contemporary developers in the area of self. Harms (1962) traces a recent history that begins in the 1820s with Friedrich E. Beneke, a professor of psychology in Berlin, advancing the critical concept of self relative to the process of self-observation, "the first real psychological perception of the self, or the ego" (p. 685). It is further noted by Harms that, taking the lead of Beneke, Wilhelm Griesinger subsequently espoused and elaborated a psychology of self. Finally, Harms observes that Griesinger, via his influential writings, "was the basic influence in Freud's ego psychiatry" (p. 685).

Among related concepts, James (1890) introduces the topic of self as a concept surrounding both what is me and what is mine, noting that it is often difficult to differentiate between the two. He elaborates that:

In its widest possible sense, however, a man's Self is the sum total of all that he CAN call his, not only his body and his psychic powers, but his clothes and his house, his wife and children, his ancestors and friends, his reputation and works, his lands and horses, and yacht and bank-account (p. 291).

Though similar constructs had been discussed from time to time (e.g., social self, self-regard, self-characterization, consciousness of self), it appears to have been Raimy (1943) who first formally introduced the term self-concept within the literature (see p. 450). Rogers (1951) states that Raimy "was the first to work in this area, supplying an
extensive theoretical framework of thinking about the self-concept" (p. 136). Raimy (1943) greatly expanded the then-prevailing conceptualization of self to one which embraced the organization and functioning of the human personality. That is, Raimy presented self-concept as a frame of reference regulating human behavior which is based on a learned perceptual system involving the relationship of approving versus disapproving attitudes that persons may hold concerning themselves.

Due, perhaps, to rich conceptual implications and a greater precision of meaning, the term self-concept has come to be widely utilized by the literature in lieu of other related terms. In this respect, Fitts et al. (1971) states: "The term self concept is much more commonly used than the simpler term self, because man is not always aware of his absolute, true, or actual self but only of his own concepts and perceptions of himself" (p. 3).

Self-Concept: Description

Despite the wide acceptance of the term self-concept, in addition to the popular use of other related terms that are sometimes employed interchangeably (e.g., self-acceptance, self-awareness, self-definition, self-esteem, self-identification, self-image, self-perception, and self-realization), no universally accepted definition of self-concept has yet emerged within the literature. In addition
to the operational definition of self-concept presented in the definitions section of this study, additional definitions are provided below.

Super (1963) cites self-concept as a person's "picture of himself, the perceived self with accrued meanings" (p. 18). Thomae (1980) states: "Self-concept is an organized, coherent, and integrated pattern of self-related perceptions" (p. 298). Similarly, Fitts, et al. (1971), one of the strongest proponents of self-concept theory and research, suggests the self to be one of the most important components perceived or experienced within one's own phenomenal world, and that this perception of self constitutes the self-concept.

However the construct self-concept may be conceived, it seems to be a widely accepted maxim that one's perceptions concerning one's self—which in some manner influence the way one perceives and then reacts to the world (internal or external)—are somehow related to one's mental health. Fitts (1972) summarizes this position, concerning the relationship of self-concept to mental health, as follows:

The theory is that the individual's image of himself influences the way he perceives and interacts with the world around him, that many aspects of behavior are highly correlated with self concept, that knowledge of self concept provides a basis for understanding behavior and that the self concept is a valid index of mental health (p. i).
Self-Concept: The Aged

Given the existence of a viable relationship between self-concept and mental health, it might be reasonable to examine the relationship between self-concept and the mental health of the aged. In exploring the nature of such a relationship, the literature tends to present conflicting or somewhat unclear positions. Repetitively discussed in the literature are three considerations pertaining to the dynamics of aged self-concept. One of the first underlying considerations involves issues surrounding societal attitudes. The second includes the pressure of societal attitudes upon the elderly, and the individual attitudes of the elderly concerning age and self. The third concerns the effects of aging-related crises, such as loss, upon elderly self-concept.

First, Chown (1977) notes that "the old are seen as having few advantages over younger people" (p. 674). Relatively few persons among the general public appear to identify older age as the more desirable time of life, with nearly 7 out of every 10 persons (69%) identifying the teens through the 30s as the best years (Harris & Associates, 1975). This same study discloses that the elderly are not seen by the public as particularly bright and alert, open-minded and adaptable, nor very good at getting things done. Harris and Associates note that "age appears to be the most
significant determinant of attitude" (p. 52), at least with respect to attitudes held by the public toward the elderly.

The nature of aged-related negative stereotypes and social bias seem to include such areas as physical illness; sexual, mental, economic, morale, and social decline; mental illness; and the inability to work (Palmore, 1976). Butler and Lewis (1977) emphasize that "medicine and the behavioral sciences have mirrored societal attitudes by presenting old age as a grim litany of physical and emotional ills" (p. 18). Similarly, Zarit (1980) and Salamon (1979) point to the pervasiveness of negative aging-related attitudes among both laypersons and many mental health professionals.

Second, in view of the impact that societal attitudes may have on individual attitudes and beliefs, prevailing negative attitudes concerning aging and the aged may have considerable influence upon the self-concepts of the elderly themselves. Crandall (1975) observes that "if an older individual has internalized the values of what is commonly referred to as the youth culture of America . . . then it would probably be difficult for the individual to validate the components of a positive self concept" (p. 35-36). Thus, the self-concept of the aged may well be at risk due to the pressure of societal views.

Third, it is also asserted that there are aging-related crises that impact aged self-concept or people's opinions about themselves (Chown, 1977). Rosow (1973), for example,
notes that the loss of roles involves crisis due to loss in status with a consequent depreciation in self-concept. Bengtson and Manuel (1976) emphasize, as a central tenet in social psychology, that "the groups to which we belong and identify play an intricate part in the manner by which we identify ourselves" (p. 44). They also indicate that as people age their view of themselves changes as their interpersonal relationships change. Relationships may involve loss-related crises due to relocations or deaths. Retirement alone involves the loss of both close relationships and social roles/status (Geist, 1968).

Given the seeming negative impact of such influences upon elderly self-concept, one might expect self-concept in the aged to suffer accordingly. Analyzing the data and findings of numerous studies that had employed the Tennessee Self Concept Scale (TSCS), Thompson (1972) provides one of the more comprehensive analyses concerning the question of relationship between self-concept and aging/old age. Thompson's analysis embodies the summarization of TSCS data for junior high school students (six studies); high school students (three studies); college students (four studies); adults (four studies); and elderly (two studies).

Thompson's (1972) preliminary analysis disclosed that, as the TSCS defines self-concept, junior high and high school students obtained below average self-concept scores, college students and adults received average scores, and the
elderly demonstrated above average self-concept scores. These findings seem to be somewhat congruent with findings of Harris and Associates (1975), where the aged self-reported seeing themselves in a relatively positive light—as opposed to the relatively negative attitudes concerning the elderly that were expressed by the rest of the same national sample. As such, self-concept does not necessarily seem to be negatively related to aging/old age. Indeed, it may even be positively related.

Upon further inspection of the TSCS results, however, Thompson (1972) tends to view these preliminary findings in a somewhat different light. The TSCS incorporates, along with the overall self-concept score, various specialized subscales which include a Self Criticism (SC) scale and a Defensive Positive (DP) scale. While the elderly received above average self-concept scores, they also received "consistently low Self Criticism Scores and high DP scores" (Thompson, 1972, p. 18). Low SC scores "indicate defensiveness, and suggest that the Positive Scores are artificially elevated by this defensiveness" (Fitts, 1965, p. 2). The high DP scores indicate "a positive self description stemming from defensive distortion" (Fitts, p. 5).

Interpreting the high self-concept scores among the elderly in the light of their SC and DP scores, Thompson (1972) states that these self-concept scores may be
artificially inflated due to defensiveness and a disinclination of the aged to make negative comments about themselves. Thompson further notes that such findings appear to be confirmed by Grant (1966). Grant indicates that "feelings which a person reports about himself tend to become more positive with age" (p. 65), but that there seems to be an increased reluctance to admit faults with age as well—that is, there is a tendency toward denial. Relatedly, Botwinick (1984); Salzman and Shader (1979); and Rosow (1974) discuss research indicating that the elderly appear to deny their old age, per se.

Interestingly, Thompson (1972) notes that an analysis of the TSCS high school group scores, as opposed to those of the elderly, discloses self-definition for these younger people as being more open, self-critical and lacking in defenses. Grant (1966) indicates that defensiveness and use of denial increase into old age. Relatedly, Trimakas and Nicolay (1974) found more defensiveness among the elderly as compared to the general population norms. They also report that aged "high self-concept scorers were found to be more defensive and better adjusted than those with low self-concept" (p. 438). In addition, Puglisi and Jackson (1978) present findings suggesting that "older individuals may use denial of old age to insulate themselves from societal devaluation" (p. 789).
Given the possibility of confounding self-concept versus denial, and in view of what Thompson (1972) refers to as unrealistic self-enhancement among the elderly, the use of aged self-concept scores alone may be unrepresentative and unrealistic. In this vein, it is noteworthy that Thompson's discussion tends to represent a configural interpretation of self-concept scale scores—that is, relative to TSCS denial sensitive scale scores (SC and DP). However, though such a procedure might be of utility, further research is necessitated to more clearly establish its validity. On the other hand, whether self-concept is impacted by denial and is unrealistically enhanced or not, the independent use of self-concept scores may still represent a viable estimation of aged adjustment, especially where within-subject or within-age-group comparisons are emphasized.

In summary, there does appear to be a relationship between self-concept and mental health, but the nature of a relationship between self-concept and age, or self-concept and the mental health of the aged, has not been adequately explicated in the literature. Some evidence does seem to suggest that elderly self-concept may well be at risk from pressures surrounding negative societal stereotypes, related attitudes the aged may hold concerning themselves, and/or from indirect influences involving crises such as those related to loss. Considering all these various aspects, self-concept seems to be a mental-health-related variable at
least as pertinent to the elderly as to any other age group. As such, self-concept might well serve as a viable index of mental health status among the elderly.

Depression

In this section, the background pertaining to depression is first addressed and various related concepts are introduced. Next, a description of depression is presented. Finally, depression and its relevance to mental health and the aged is discussed.

Depression: Background and Concepts

The earliest history surrounding the concept of depression is somewhat obscure. Blazer (1982) notes early Biblical descriptions of depressive symptoms that seem to occur in relation to major losses, involving anger both toward God and self. The condition of depression, formerly known as melancholia, was also depicted in ancient dramas prepared and enacted nearly 2,000 years ago. Aretaeus the Cappadocian, a physician of the second century A.D., may have been among the first to formally describe the symptoms of melancholia, though Hippocrates appears to have been the first to develop melancholia as a formal clinical syndrome (Beck, 1967).
The contemporary history of depression might be traced to Sigmund Freud. Freud essentially described symptoms similar to those observed by his predecessors such as Aretaeus and a considerable lineage of other critical observers. One of Freud's unique contributions was an attempt to explain the dynamics underlying depression—in this case, psychoanalytically. Specifically, Freud (1917/1949) cites depression as a condition wherein both sadistic tendencies and hate, generated toward a love object which has been lost, are turned around upon the self.

**Depression: Description**

Today, despite a formidable history of discussion and research, there appears to be no universally acceptable definition of depression. Aside from the operational definition of depression presented in the definitions section of this study, depression may most easily be described in terms of its somewhat consistent symptoms. Beck (1967) discusses depression by defining it with respect to (a) an alteration in mood (sadness, loneliness, apathy); (b) negative self-concept; (c) regressive and self-punitive wishes (to escape, hide, or die); (d) vegetative changes (anorexia, insomnia, loss of libido); and (e) changes in activity level (involving retardation or agitation).

Levy, Deragatis, Gallagher, and Gatz (1980) note that depressive symptoms among the aged may often be masked by an
atypical pattern that can include somatic complaints, apathy, withdrawal, and functional slowness, conditions which Stenback (1980) indicates might be wrongly taken as a part of the normal aging process. Salzman and Shader (1979) point out that aged depression may even manifest itself in the form of physical symptoms, often referred to as depressive equivalents, which can be difficult to accurately diagnose.

Depression: The Aged

Whatever the nature of depression, the relationship of depression to mental health is thus generally assumed, and this has certainly been so since the advent of Freud. Given the reasonableness of such a relationship, it seems appropriate to inquire about the nature of a specific relationship between depression and the mental health of the aged. As with the discussion of elderly self-concept, the literature tends to present somewhat unclear or conflicting positions.

Relative to the aging process, Zung (1967) cites "the fact that depression is a disease of older age" (p. 546). Butler and Lewis (1977) indicate that "depression in particular rises with age" (p. 13). These views are in concordance with what Renner and Birren (1980) refer to as the "classical teaching of psychiatry" (p. 330). There are other viewpoints, however. The DSM-III (American Psychiatric
Association, 1980) notes that "major depression may begin at any age, including infancy, and the age at onset is fairly evenly distributed throughout adult life" (p. 215). Lieberman (1983) specifically discusses longitudinal studies emphasizing that depression is not related to increasing age.

Aside from those who cite research indicating that depression does increase with age and those who cite research indicating that it does not, are yet others who more specifically emphasize an inverse relationship between depression and age. For example, the National Mental Health Association (1981) reports that depression is higher among those under age 29 than in those age 29 to 74. Gurland (1976), in a discussion concerning prevalence rates of depression as based upon an extensive review of the literature, concludes that "the majority of definite depressive disorders appear to occur before the age of 65" (p. 290).

Some confusion concerning the issue of a relationship between depression and aging/old age may thus be detected within the literature. Despite the existence of fundamental disagreement surrounding this issue, and though it has been pointed out that most elderly are not depressed (Cohen, 1980), much of the literature seems to agree on the significance of depression as the most prevalent complaint or disorder among the elderly (Butler & Lewis, 1977; Pfeiffer & Busse, 1973; Renner & Birren, 1980; Zarit, 1980).
In this sense, and speaking provocatively with respect to results from the Duke Longitudinal Study of Aging, Gianturco and Busse (1978) state that "depression is the price that has to be paid for the privilege of survival" (p. 6).

Gurland (1976) reports a 5% to 7% prevalence of depression among the elderly, both of the mild and a severe type. Grauer (1977) indicates a 5% to 11% prevalence of aged depression. In terms of actual hospitalizations, involving relatively severe cases, Zarit (1980) cites researchers who have estimated that between 21% and 54% of geriatric hospital admissions receive a diagnosis of depression. Given these prevalence rates, it would seem that a modest proportion of the elderly experience depression. This being so, an inspection of aged-related depression seems warranted.

Though there are many ways in which the dynamics of depression may be conceptualized theoretically, diagnostically, or therapeutically, one way which might be particularly pertinent to aging/old age is the classical endogenous versus exogenous (or reactive) dichotomy. Beck (1967) defines endogenous depression as being basically caused by internal factors and reactive depression, by external factors. Endogenous depression may be directly caused by some internal biochemical source, for example, while exogenous/reactive depression may be caused by some external (possibly environmental) event such as a reaction to retirement, divorce, or even to the loss of hearing.
For purposes of this discussion of depression and the aged, primary emphasis shall be placed upon the exogenous perspective of depression. Grauer (1977) cites literature indicating that mild or neurotic depression is quite common among the aged and that endogenous or psychotic depression is relatively rare. Numerous patients with endogenous symptoms actually report external precipitants according to DeBerry and Salamon (1983). Similarly, Stenback (1980) emphasizes that patients already diagnosed as having serious endogenous depression, when subsequently interviewed, can often link their depression to precipitating events.

Salzman and Shader (1979) cite data of Post (1965) and Busse (1975) as indicating that between "60 and 85% of elderly are able to identify the specific event or stimulus that precipitated feelings of depression" (p. 46). In this vein, a very large proportion of aging-related literature either incidentally or directly emphasizes the impact of external circumstances upon the well-being or mental health of the aged. Hence, though many paradigms may exist in explanation of depression, the exogenous perspective enjoys considerable support and seems quite useful in conceptualizing many dynamics of aged depression, particularly in terms of changes and losses so frequently experienced by the elderly.

From the exogenous perspective, Freud (1917/1949) is viewed as having specifically interpreted both mourning and
depression as relating to "the loss of a loved person, or to the loss of some abstraction" (p. 153). It is suggested that, even today, depression may still be considered as involving the loss of something to which a person has become particularly attached—for example, a person, object, belief, value (National Mental Health Association, 1981). Specifically, loss is cited as related to being separated from something of value with which a person has strongly identified or cathexed (Stenback, 1980). The loss might even be construed as a loss of one's own identity or a portion of one's anatomy.

Brink (1979) emphasizes that old age depression is usually reactive or exogenous in nature. Burnside (1976) states that "depressions in the aged are normally caused from loss" (p. 130). While it may be argued that depression has many sources, aged depression might thus be viewed as related in some way to a reaction, and particularly with respect to change or inevitable loss as Salzman and Shader (1979) phrase it. Post (1962) cites research findings with the elderly which indicate that relatively recent loss, or even the threat of a loss, might be seen to have a precipitating effect in nearly two-thirds of cases involving symptoms of depression or a more overt breakdown.

Stenback (1980) refers to three categories of significant life events: (1) the loss of relationships/things, (2) failures in personally significant pursuits, and (3)
physical illness. All three hold implications for aged depression. In terms of the loss of just things alone, be they possessions or activities, age often tends to diminish the ability to retain or maintain them. Due to increasing pressures on income or purchasing power, it may be difficult for the aged to perpetuate their standard of living. Consequently, the quantity and quality of housing and possessions may deteriorate over time, activities may decrease in concert with a decrease in disposable income and physical capabilities, and depression may precipitate.

As to the latter two categories of significant life events (failure in pursuits and illness), they too can be viewed in terms of losses, and with respect to depression in the elderly. Stenback (1980) indicates that failure in one's pursuits might be viewed as the destruction or loss of one's aspirations or goals, often a particularly intimate loss. As an example, Stenback cites the loss of goals due to retirement, though retirement also suggests additional losses in terms of social roles, status, activity, income, and peer relationships. Finally, Stenback mentions that the elderly person may be seen as having relatively little time left, and as feeling that it is not really worth the effort to find new goals.

Physical illness or disease may also be reinterpreted as loss—a loss of health. For example, Brink (1979) and Zarit (1980) observe that aged depression is more prevalent
among the physically ill than among the healthy. Similarly, the most severe depressive symptoms are often identified in relation to physical illness. Salzman and Shader (1979) also cite a close association between illness and aged depression, wherein depression is identified as an inevitable result from a diagnosis of cancer. Ostfeld (1983) emphasizes a somewhat different perspective—that is, "the greater the degree of psychological depression, the greater likelihood of dying of cancer" (p. 250).

Other change/loss health-related issues are considerably less threatening than cancer, but they may also be seen as major factors contextual to aged depression. For example, depression has been shown to be significantly correlated with age-related loss of sensory acuity. Butler and Lewis (1977) note that significant depression has been demonstrated in relation to the loss of vision, and that the loss of hearing—also related to badly articulated speech—causes greater social isolation than does the loss of vision. Depression and other changes in personality of a psychopathological nature have been shown in relation to even mild hearing loss (Granick, Kleban, & Weiss, 1975).

Lieberman (1983) emphasizes that aged depression is not merely the result of less desirable changes, but due to large decreases in the number of positive events, something which may also be viewed as a form of loss. Lieberman further points out that it is not any one particular loss
that elicits depression, but an accumulating chain of losses. Alternatively, Pfeiffer (1977) emphasizes the critical influence of difficulties that the elderly experience in learning to do with less. Finally, Pfeiffer (1977), Salzman and Shader (1979), and Stenback (1980) implicate problems concerning the replacement or restitution of losses as being critical to aged adjustment.

In summary, the relationship between depression and mental health appears to be reasonably well accepted, but the nature of a relationship between depression and aged mental health is considerably less clear. Elderly depression does seem to be quite prevalent. Much of it, however, appears related to circumstances surrounding an accumulation of changes or losses to which the elderly seem particularly susceptible. Also, difficulties in adapting to, or replacing, real or imagined losses, seem to be implicated in aged depression. Thus, depression appears to be a mental-health-related variable as pertinent to the elderly as to any other age grouping. As such, depression might well serve as a viable index of mental health status among the aged.

With respect to self-concept and depression, both may thus be seen as reasonably significant mental-health-related variables. Similarly, self-concept and depression appear to hold worthy implications relative to the mental health status of the aged. That is, both appear to be proximal to
many prominent aspects of aged existence, may constitute important indices of mental or emotional well-being among the elderly, and might credibly serve as dependent variables for purposes of aged-related psychotherapy research.

Hypnotherapy

The term hypnotherapy is used both (a) to generically identify any psychotherapy using hypnosis and (b) to designate a distinct or unique type of psychotherapy. In view of the confusion as to what meaning is intended by the term hypnotherapy, and also because of the term's wide liberal usage, it is argued that the term has been rendered relatively worthless (Mott, 1982). For the research oriented purposes of this discussion, however, the term Hypnotherapy, rather than hypnotherapy, will be emphasized and shall be taken to mean a specific and unique psychotherapy. This view of Hypnotherapy (HT) being a distinct psychotherapy is prevalent within the literature and seems appropriate for conceptually elucidating a body of research yet to be discussed.

In elaborating the nature of HT, it is useful to do so via a model depicting the way in which HT, and other hypnosis-based psychotherapies, are very often implemented—that is, by use of a hypnosis plus psychotherapy paradigm. As viewed from this model, HT fundamentally embraces (a) a hypnosis component (HO) and (b) a psychotherapy component
(summary of HT provided in Table 3, p. 82, at the conclusion of the following HT and CEH discussions). Given the prominence of hypnosis as operationalized within the hypnosis component of this paradigm, and the considerable similarity of hypnosis as employed across many hypnosis-based psychotherapies, including HT, it seems useful to first discuss hypnosis.

The review of hypnosis includes a discussion concerning (a) its background and related concepts and (b) various psychoactive modalities often viewed as being contextually relevant to a consideration of hypnosis (relaxation, visual imagery, and suggestion). The discussion then proceeds to a consideration of the psychotherapy feature, a feature which frequently most distinguishes HT and the other forms of hypnosis-based psychotherapy from one another. This section then concludes with a discussion concerning the implementation of HT itself.

Hypnotherapy: Hypnosis Component

Hypnosis: Background and Concepts

Since its use by the ancient soothsayers of Egypt, as referenced in the Ebers Papyrus of 3,000 years ago (Kroger, 1977), hypnosis has been a topic of considerable literary interest. Though used in various ways, such as for entertainment, religious rituals, and memory enhancement, one of the most persistent uses has been with respect to the
healing arts. From the fourth century B.C., hypnosis is cited as having served a crucial role in effecting dream healings within the Asclepian temples of Greece (Gindes, 1951; LeCron & Bordeaux, 1947). Kroger notes other examples of a hypnotic healing tradition as including the Biblical laying on of hands, the royal touch of French kings, and the magnetic healing of Paracelsus.

Richard Mead conducted research during the early 1700s into the concept of healing forces and magnetism. Father Maximillian Hehl placed steel plates and magnets on the naked body to effect cures. The epitome of these early hypnotic approaches to healing, however, is embodied in the work of Franz Anton Mesmer (1734-1815). Mesmer induced healing seizures of crisis in patients by purported use of universal magnetic fluids (Gibson, 1977; Shor, 1979). Eventually, however, with the help of explanations by Abbot Faria of Goa, who hypnotically induced more than 5,000 persons in Paris between 1814 and 1815, hypnosis began to be viewed as more suggestive in nature.

Faria stated that the resulting cures were not due to magnetism, but to the expectancy and cooperation of the patient (Kroger, 1977). Shor (1979) notes that Faria used both soothing and commanding suggestions. Historically, commanding suggestions had been predominantly favored. The first recorded application of hypnosis (mesmeric coma) as an anesthetic was by Recamier during a surgical operation in
1821. Further medical applications and a greater understanding of hypnosis, as a suggestive process, were promoted during the 1840s by the Scottish physician James Braid who is now often thought of as the father of modern hypnosis. It was Braid who introduced the term hypnosis (neuro-hypnosis or nervous sleep).

According to Shor (1979), the use of the term hypnosis by Braid may be viewed as a considerable improvement over Mesmer's theory of universal magnetic fluids passing from hypnotist to subject. Braid is said to have developed the idea of sleep as a result of witnessing the induction of hypnosis by means of having persons stare at an object until the eyes fatigued and a type of stupor resulted (Hull, 1933/1968). The view of hypnosis being but a form of sleep is not necessarily appropriate either, a realization that Braid eventually made before redefining it as more suggestive in nature. Braid finally replaced the nervous sleep conceptualization with what he referred to as Monoideism.

Later, Charcot, a prominent neurologist, helped to popularize hypnosis with dramatic inductions/demonstrations and research findings more aligned with Mesmer's concepts of magnetic influences (Hull, 1933/1968). At about the same time, Liebeault and another physician, Bernheim, who championed Liebeault's views, dispensed with showmanship, elaborate or impressive trappings such as magnetizing apparatus, and lengthy hypnotic inductions. Instead, they
primarily emphasized providing patients with direct verbal suggestions. As a consequence of the contributions made, Kroger (1977) specifically identifies Liebeault as "the real founder of suggestive therapeutics" (p.3). Shor (1979) does note that Liebeault's suggestive procedures may be traced back to the earlier work of Faria.

It is also noteworthy that Sigmund Freud helped to popularize hypnosis. According to Kroger (1977), Freud originally studied with both Charcot and Liebeault. Freud's early endorsement of hypnosis is indicated to demarcate a point of divergence in the use of hypnosis—that is, from its largely medical (physiological) application to its use as a treatment for mental health difficulties as well. Freud eventually rejected hypnosis as a psychotherapeutic tool, an act which consequently resulted in its loss of general acceptability. With the successful use of hypnosis as a rapid treatment for battle neuroses during World War II and the Korean War, and the publication of Clark Hull's book, *Hypnosis and Suggestibility*, in 1933 (Hull, 1968), hypnosis subsequently regained wide professional acceptance (Kroger, 1977).

As for a definition of hypnosis, this discussion is compatible with the operational definition presented in the definitions section of this study. Specifically, hypnosis may be viewed as a condition or state following the administration of a hypnotic induction. This seemingly
unsophisticated and limited definition is appropriate in that, after more than 200 years of theorization and research, the nature and efficacy of hypnosis remain somewhat obscure (Wadden & Anderton, 1982). However, even this definition has its detractors who credibly argue the uncertainty as to whether hypnosis is actually a unique condition or state, or even whether there is such a thing as hypnosis in the first place.

Despite the various views, hypnosis has traditionally been interpreted as some sort of unique state. Also, the specific use to which the hypnotic state is applied, such as medicine, entertainment, sports, or psychotherapy, may qualify, modify, or extend the concept. For example, the use of hypnosis with any form of psychotherapeutic procedure tends to redefine hypnosis as Hypnotherapy (HT) or another named hypnosis-based psychotherapy. In this vein, hypnosis is viewed as a "facilitator of psychotherapy" (Mott, 1982, p. 247), by plausibly enhancing the psychotherapeutic component and thus precipitating more favorable psychotherapeutic outcomes. This essentially serves as the rationale for viewing hypnosis-based psychotherapies from a hypnosis plus psychotherapy paradigm.

Relatedly, in discussions of hypnosis and its use, various modalities are frequently referenced. Though there may be authoritative scepticism as to the credibility of casting such modalities in an explanatory role for hypnosis,
they are of some historical significance and have been descriptively or operationally incorporated into prior HT-CEH-related research. One of the most prominent of these modalities is that of suggestion (Erickson, Rossi, & Rossi, 1976). Somewhat similarly, relaxation and visual imagery (Kroger & Fezler, 1976) are frequently emphasized within the literature as important psychoactive features of hypnosis. Each of the three features (relaxation, imagery, and suggestion) is separately addressed below in order to facilitate a discussion of succeeding topics.

**Hypnosis: Relaxation**

Relaxation has tended to be associated with hypnosis from the earliest days when hypnosis was believed to be related to sleep. More recently, however, it has come to be identified as an important variable in itself. That is, relaxation alone has been cited as a mechanism of considerable psychophysiological effect with marked research significance and validity (see Benson, Beary, & Carol, 1974). Additionally, relaxation appears to hold implications for the facilitation of both physiological and mental-health-related therapeutic benefits.

At a fairly fundamental level, relaxation has been repeatedly found to induce lower levels of muscular tension (Miller, Murphy, & Miller, 1978; Sime & DeGood, 1977). One of the earliest extensive efforts in the area of relaxation
research discloses that a systematic program of muscular relaxation lowers blood pressure in patients diagnosed as hypertensive (Brady, Luborsky, & Korn, 1974). Taylor, Farquhar, Nelson, and Agras (1977) have also demonstrated the singular use of relaxation as a treatment to induce large decreases in blood pressure, and at significantly greater levels than other treatments which include (a) pharmacotherapy alone and (b) pharmacotherapy plus a form of psychotherapy.

The process viewed to facilitate these relaxation-related physiological outcomes has been termed the Trophotropic Response by Hess (1957) and the Relaxation Response (the more widely known term) by Benson (1975). Other evidence demonstrates that the relaxation response can not only precipitate possible psychophysiological benefits related to decreased muscle tension, and decreased blood pressure level in those with elevated blood pressure, but decreased heart rate, decreased respiratory rate, and decreased oxygen consumption (Benson).

Relative to mental health, the implementation of relaxation is well grounded in the literature and has taken many forms as it has been integrated into various psychotherapeutic systems—for example, Progressive Relaxation (Jacobson, 1938); Autogenic Training (Schultz & Luthe, 1959); Systematic Desensitization (Wolpe, 1958, 1961); Cue-Controlled Relaxation (Russell & Sipich, 1973); and Rational
Stage Directed Therapy (Tosi & Marzella, 1975, 1977). Due to its implementation as a part of other treatments, comparatively little research is dedicated solely to investigating the psychotherapeutic effectiveness of relaxation alone.

Research testing the psychotherapeutic effectiveness of relaxation is frequently found where relaxation serves as a comparison treatment to other popular interventions such as Systematic Desensitization. For example, in a study where relaxation is incorporated as a distinct treatment, Laxer, Quarter, Kooman, and Walker (1969) found that both Systematic Desensitization (a problem-specific treatment) and general relaxation training (a non-problem-specific treatment) were equally and significantly effective in the reduction of test-anxiety. Also, the general relaxation training proved to be more effective in simultaneously reducing other, non-test-related anxiety via the generalization of effects.

Snyder (1974) also found that Systematic Desensitization and relaxation were both significantly effective in reducing test anxiety, but with no significant difference between them. The relaxation training produced more positive perceptions as to personal ability, however, and reduced the unpleasantness associated with test-taking. Bedell, Archer, and Rosmann (1979) were unable to demonstrate a significant difference in effectiveness for Systematic Desensitization and regular relaxation training.
in the treatment of test anxiety or snake phobia. They do note that the effectiveness of both treatments seems dependent upon the problem. That is, test anxiety being a less focused problem, it is less amenable to change by both procedures than is snake phobia.

Thus, in addition to certain physiological advantages, relaxation, at yet another level, has been shown to facilitate significant benefits that are often of a mental-health-related nature. Alternatively, there may be more of a question as to the relevancy of relaxation in the conduct of either hypnosis or hypnosis-based psychotherapy (Ludwig & Lyle, 1964; Wadden & Anderton, 1982). Research concerning this issue is sorely lacking. Nevertheless, relaxation may be seen within the literature as a nearly universal feature of hypnosis, and is generally presented as a viable psychoactive modality when either employed alone or within the context of hypnosis.

**Hypnosis: Visual Imagery**

Visual imagery might be defined as "the ability of an individual to create images in the mind's eye" (Pulvino & Hossman, 1976). This faculty was known and used in ancient Greece by orators who thereby memorized and recalled vast quantities of information, a process discussed by Aristotle (1931b). Aristotle (1931a) also observed that "the soul never thinks without an image" (431.a.16). Despite this
early awareness, however, research concerning visual imagery is not recorded prior to its being investigated by Sir Francis Galton (1880, 1907). As to the underlying process or actual nature of visual imagery, which is often less precisely referred to as imagery, much research has been conducted since the time of Galton's studies, but no universally agreed upon understanding yet exists. Speculations, however, abound.

At a fundamental level, visual imagery has been presented as a process wherein images serve to activate instinctual responses (Gordon, 1972). More broadly, Gordon sees images serving "as a means of clothing and giving form to conscious and unconscious experiences" (p. 71). Richardson (1980) observes that research during the 1960s "appeared to implicate visual imagery not only as an empirical phenomenon of considerable predictive importance, but also at the theoretical level as a major representational system underlying human cognitive behavior" (p. 1).

Operationally, there appears to be little doubt that visual imagery implicates some sort of perceptual process, one which might, in some manner, be analogous to actually seeing with one's own eyes. Oswald (1962) emphasizes that "the neurophysiological response present when a real object is perceived by means of one's sense organs is similar to that present when an image, a pseudohallucination or an hallucination is perceived" (p. 76). From a physiological
perspective, a variety of research has demonstrated that arousing events, which are imaged, will elicit changes in such autonomic responses as heart rate, respiration, and GSR (Grossberg & Wilson, 1968; Marzillier, Carroll, & Newland, 1979; McGlynn, Puhr, Gaynor, & Perry, 1973).

Evidence tends to suggest that subjects who imagine recently observed events, evoke physiological responses similar to those that were experienced when the events were first perceived (Brown, 1968; Shaw, 1940). Jones and Johnson (1980) conclude that: "imagery elicits complex global responding in autonomic, somatic, and central systems" (p. 347). Relatedly, imaging has been experimentally shown to specifically elicit changes in mood (Richardson & Taylor, 1982).

Singer and Antrobus (1972) regard imagery and fantasy as "fundamental human capacities or cognitive skills that can reflect serious pathology or distress but that can also be employed as valuable tools for self-gratification, planning, or creative activity" (p. 201). Mental health implications for visual imagery can be seen to embrace both psychodiagnostics and psychotherapeutics, one area sometimes being inseparable from the other.

In terms of diagnostics, Sheikh and Jordan (1983) note that most of the traditional projective tests are grounded in visual imagery, wherein "the subject is expected to 'see' or 'imagine'" (p. 415). Aside from such formal and/or
traditional diagnostic procedures, there are also a wide
variety of other imagery-related diagnostic approaches.
These authors cite imagery-based diagnostic approaches sur­
rounding free-association (using images) and controlled or
uncontrolled imaging/daydreaming using words, concepts,
pictures, memories, or other clinically significant stimuli.
Sheikh and Jordan propose that such imagery-based diagnost­
tics elicit content, affect, and meaning which is far less
limited than that derived from lexical or language based
diagnostics alone.

With respect to psychotherapeutics, both Lazarus (1977)
and Shorr (1977) suggest that our visual images influence
and produce our emotions; that our images tend to act as
self-fulfilling prophecies; and that controlled imaging is
akin to rehearsal prior to encountering the actual circum­
stance. Thus, visual imagery may, at one level, serve as a
medium for the acquisition and implementation of self/life
management skills, wherein options are generated for the
purpose of reality-based problem solving (Bullock & Severe,
1981). At yet another level, imagery might well serve as an
effective vehicle for inducing fundamental change (Morrison
& Cometa, 1980).

Sheikh and Jordan (1983) discuss the demonstrated
effectiveness of imagery in the treatment of a wide variety
of mental health problems that include depression, insomnia,
obesity, sexual malfunctioning, chronic pain, phobias and
anxieties, and psychosomatic symptoms. Some examples of psychotherapies that employ imagery-related approaches include Autogenics (Schultz & Luthe, 1959); Psycho-Imagination Therapy (Shorr, 1972); Psychosynthesis (Assagioli, 1971); and Systematic Desensitization (Wolpe, 1958). For purposes herein, Rational Stage Directed Hypnotherapy (Tosi & Marzella, 1975, 1977) also serves as a prime example and is specifically examined below. Many such approaches incorporate relaxation as well as visual imagery.

Relative to the importance of imagery within the hypnotic/therapeutic process, the recent work of Wilson and Barber (1983) is of significance. It indicates that many subjects capable of responding most effectively to the hypnotic process are, in normal life, able to image with hallucinatory clarity. This capability often extends beyond merely evoking vivid visual imagery and includes the ability to hallucinate within each of the other senses as well. Though many mentally ill individuals purportedly experience hallucinations of a seemingly similar nature, Wilson and Barber's subjects are reported to have not experienced any mental or emotional disabilities in excess of what might otherwise be found in the general population.

Wadden and Anderton (1982) note, on the other hand, that vividness of visual imagery may not be the critical variable that is often cited as eliciting outcome effects in imagery-related research. Rather, it may be the capacity of
subjects "to respond emotionally and physiologically to their imaginings" (p. 219). This postulation is based on the work of Lang (1979) who notes that some subjects experience significant changes in physiological responses from fearful imaginings, despite equivalent levels of self-report image vividness among other subjects who experience no such changes. Aside from these issues, however, Qualls (1983) concludes: "A substantial body of evidence clearly indicates that different patterns of physiological responses accompany different types of affective images" (p. 42).

Consequently, and regardless of any underlying variables or mechanisms, visual imagery seems pertinent to the implementation of hypnosis. Similarly, visual imagery seems relevant to the implementation of psychotherapy for purpose of facilitating beneficial mental-health-related outcomes. That is, the capacity of visual imagery to subjectively approximate reality and elicit responses similar to those evoked by actual events would seem to pose broad creative possibilities for its systematic psychotherapeutic use, and certainly as a part of, or in conjunction with, hypnosis.

Hypnosis: Suggestion

Suggestion is one of the more elusive constructs to be address herein. Though the term has been widely used, especially with respect to hypnosis (often as an explanation for same), relatively little writing or research has been
devoted to it exclusively (Lozanov, 1978). Suggestion has tended to become one of those generally unchallenged, unexplicated concepts which are taken much for granted—not unlike gravity. It has certainly been implicated in research, been observed and described, but is still poorly understood.

Denotatively, "to suggest" may be taken to indicate a process of offering or proposing something for consideration or action (Morris, 1982). Suggestion, however, from a psychological perspective, indicates a circumstance where an idea is offered and is "accepted without argument, command, or coercion" (Morris, p. 1216). Similarly, Kroger (1977) states that "suggestion can be defined as the uncritical acceptance of an idea" (p. 7). Kroger goes on to indicate that suggestion may occur verbally; intraverbally (voice modulation); extraverbally (the way that a suggestion is actually stated); and nonverbally.

Given this view of suggestion, it would seem that suggestion may occur almost anywhere that there is human communication and, certainly, in the absence of hypnosis. Hypnosis, however, has for some time been viewed by theorists as a special state wherein an individual is especially receptive or responsive to suggestions. In this vein, Hull (1933/1968) indicates that "the only thing which seems to characterize hypnosis as such and which gives any justification for the practice of calling it a 'state' is its
generalized hypersuggestibility" (p. 391). More recently, Fromm (1979) similarly proposed that hypnosis involves a circumstance where the ego is particularly receptive to both internal and external stimuli, but in a less critical or judgmental manner.

The position of researchers such as Hull and Fromm is that hypnosis constitutes the special state or condition mentioned above—state theory. Thus, hypnosis might be seen as a state of especially heightened susceptibility to suggestion. Given the viability of this view, suggestion may be taken as a critical functional feature of state theory. Additionally, suggestions are not only important to initially establishing the hypnotic state (induction contextual suggestions), but are also implicated in the process of applying that hypnotic state, via post-induction suggestions, toward subsequent goals or objectives such as entertainment, pain control, or psychotherapy.

Historically, given that the largest proportion of existing research and theory has operationally embraced state theory, as well as the induction versus post-induction dichotomization of suggestions surrounding the facilitation/application of hypnosis, the following discussion shall follow within this rubric. There is, however, a viable counter conceptualization of hypnosis in terms of a non-state theory. This alternative view poses that no special or unique state need be postulated as an explanation for
hypnotic phenomena (consult Barber, 1969; Wagstaff, 1981; or the compliance studies of Milgram, 1974). Like state theory, non-state theory also appears to recognize the relevance of suggestion as a prominent operational feature.

Regardless of the nature or functioning of suggestion, it does seem to be an important construct, and especially so with respect to hypnosis. Suggestion also appears to be particularly useful as a therapeutic tool in relation to relaxation and visual imagery. First, relaxation, imagery, and suggestion are frequently implemented within traditional induction processes, such as the four-stage induction of Wolberg (1964). Second, these modalities may be further employed psychotherapeutically during the post-induction phase. A wealth of creative techniques have been evolved which purportedly implement these modalities for the purpose of promoting specific psychotherapeutic outcomes, both via hypnosis-based psychotherapies and by psychotherapies purportedly devoid of hypnosis.

Hypnotherapy: Psychotherapeutic Component

Given the hypnosis plus psychotherapy paradigm, where the hypnosis component tends to remain somewhat similar in purpose and process while the psychotherapy component tends to methodologically change across hypnosis-based psychotherapies, a key distinguishing feature between hypnosis-based
psychotherapies might reasonably be found in the psychotherapy component utilized. In turn, a major aspect of the psychotherapeutic component often tends to be the nature and style of the post-induction therapeutic suggestions employed, frequently involving additional and sometimes elaborate procedures. Specifically with respect to the use of HT herein, the major distinguishing feature is viewed to be based in its almost exclusive use of post-induction therapeutic suggestions.

**Hypnotherapy: Implementation**

HT is frequently reflected in the literature as being a relatively direct and parsimonious psychotherapeutic procedure. Relatedly, the implementation is conservatively viewed, especially for the research purposes of this present study, to emphasize (a) the establishment of a hypnotic state by means of an induction and (b) the direct verbal administration of relatively purposeful, issue-oriented, post-induction therapeutic suggestions. Excluded are exercises or other tools such as relaxation or imagery that would be systematically manipulated within the context of a therapeutic strategy. Following the induction, implementation would thus require those receiving HT to serve as relatively passive recipients of therapeutic suggestions strategically addressed to one or more issues of therapeutic concern.
Reflecting this perspective concerning post-induction procedures, Wadden and Anderton (1982) emphasize that "following the induction, any number of interventions may be employed, including direct suggestions for behavior change [direct as per HT] or the rehearsal of new behavior in imagination" (p. 216). Concerning more elaborate, non-HT interventions such as the latter mentioned use of rehearsal in the imagination, Mott (1982) points out that:

The hypnotic state provides an excellent ground for the patient to rehearse new adaptive techniques. Because of the ability of the patient to visualize and fantasize in the hypnotic state, the rehearsal of new ways of responding more adaptively can be made quite vivid and creative (p. 247).

Such an approach is exemplified by Cognitive Experiential Hypnotherapy.

Cognitive Experiential Hypnotherapy

In elaborating the nature of Cognitive Experiential Hypnotherapy (CEH), it is useful to again employ a model depicting the way in which CEH, and other hypnosis-based psychotherapies, are very often implemented—that is, by use of the hypnosis plus psychotherapy paradigm. As viewed from this model, CEH fundamentally embraces a hypnosis component (HO) and a psychotherapy component that, as summarized in Table 3, p. 82, primarily consists of Cognitive Therapy (CT). CT is sometimes also termed Cognitive Restructuring (CR) to indicate the process of its implementation, often
within a therapeutic/research context. Given that the topic of hypnosis was previously presented during the discussion of HT, the survey shall proceed to a consideration of CT, the psychotherapy component.

The consideration of CT includes (a) a discussion concerning its background and pertaining concepts; (b) related psychoactive modalities (visual imagery and suggestion); and (c) its implementation. The intent is to facilitate the evolutionary development of concepts useful to the succeeding discussion of CEH and the process surrounding its own implementation.

Cognitive Experiential Hypnotherapy: Psychotherapeutic Component

Cognitive Therapy: Background and Concepts

Cognitive therapists and theoreticians tend to argue that affective responses are determined by the special meaning which people attach to their experience (Beck, 1976). It is similarly posed that one's emotional destiny tends to be controlled by the values or beliefs that the individual possesses—that is, pertaining to how a person sees or interprets life's events and then acts in relation to their perceptions/evaluations (Ellis & Grieger, 1977). Thoughts are viewed to be the critical structuring or controlling influence. As such, the spirit of CT is often cited as being succinctly depicted by Epictetus (Circa A.D.
50-130) who said: "Things do not trouble men, but the opinions whiche they concevve of them" (1567/1977, cap.8); or, as Shakspeare wrote, "There is nothing either good or bad, but thinking makes it so" (1813, p. 125).

The emergence of CT as a major psychotherapeutic conceptualization has resulted from key contributions by persons such as Aaron T. Beck and Albert Ellis. Primarily trained as traditional (Freudian) psychoanalysts, Beck and Ellis apparently came upon CT as a result of their independent experiences in clinical practice, rather than as a consequence of philosophical or academic inquiry. Both therapists describe treatment sessions with key patients who served as the catalysts for their somewhat similar conceptualizations. With respect to Beck, the session involved the use of free association where the patient was sharing a stream of thoughts in the form of angry criticisms of Beck. The patient subsequently cited feelings of guilt.

In addition to the anger, Beck's patient also verbalized a second stream of thoughts involving self-critical statements concerning the original criticisms--that is, "'I said the wrong thing . . . I shouldn't have said that . . . I'm wrong to criticize him . . . I'm bad . . . He won't like me . . . I'm bad . . . I have no excuse for being so mean'" (Beck, 1976, p. 31). These self-critical statements presented to Beck a previously unnoticed level of underlying thought, tending to explain a linkage between the anger and
feelings of guilt. That is, the patient had not so much experienced guilt due to anger with Beck, but due to self-criticisms. Two levels of thought were thus identified—one involving anger and criticism of Beck and the other involving self-critical thoughts about the criticism of Beck.

In the case of Ellis, the session involved a patient who had experienced a feeling of worthlessness and was being coached by Ellis to see that the feeling resulted from a belief, and that the reasons being cited for this belief really had no absolute basis in reality. The client questioned Ellis: "'Would you say, then, that I literally tell myself certain unvalidated sentences, and that my disturbance stems directly from these, my own, sentences?'" (Ellis, 1962; p. 27). From this client session, Ellis proceeded to crystallize the idea that it is cognitions, the thoughts or sentences that individuals say to themselves, which function as the activating variable by which beliefs may become translated into feelings.

Beck (1976) identifies two levels of thought which involve: (a) analytical thought having to do with judgment and decision making and (b) a rapid, uncomplicated thought. This second level of thought is often found to be automatic, involuntary, and plausible, though highly improbable. It also tends to involve critiquing—that is, judgmental thoughts about what one thinks, says, does, or is. CT tends to call these uncomplicated thoughts by various names such
as automatic thoughts, internalized statements, self-statements, self-warnings, self-commands, or just self-talk. It is this self-talk, and the nature of such self-talk—which may occur incessantly without any control or conscious awareness—that underpins CT.

Arnold (1960b) presents the thesis that "emotion is a complex process which starts when something is perceived and appraised" (p. 3). In this vein, Ellis and Grieger (1977) note that:

People have very strong innate and acquired tendencies not only to rate their acts, behaviors, performances, and traits as "good" or "bad" but to rate their selves, their essences, their totalities in the same manner. Their self-ratings profoundly influence their emotions and behaviors and constitute one of the main sources of their emotional disturbances (p. 52)

Ellis (1962) emphasizes that "much of what we call emotion is nothing more nor less than a certain kind—a biased, prejudiced, or strongly evaluative kind—of thought" (p. 41). Ellis poses that the kind of emotional feelings that people experience actually depends upon whether their preceding thoughts are rational or irrational. It is also posed that human nature tends toward the more irrational variety of self-talk (Ellis & Grieger, 1977, p. 52). This irrational self-talk purportedly involves highly absolutistic thinking related to such universals as should, must, never, can't, or catastrophe-laden words such as awful, terrible, or horrible (Ellis & Grieger). Thus, irrational
self-talk often concerns self-statements that tend to denigrate one's abilities and self-worth.

Within Ellis's Rational Emotive Therapy (RET) A-B-C paradigm of CT, A stands for Activating Experience (an object or circumstance which is perceived); B stands for Belief System (by which one articulates to oneself an interpretation of the circumstance at Point A); and C stands for Emotional Consequence (one's feelings or emotions about Point A). Unlike the assumption that an event causes one to feel either good or bad, Ellis indicates that it is not the experience or event that elicits the emotion, but one's interpretation of it; or, specifically, it is what one says to oneself (self-talk) about the event (Ellis & Grieger, 1977). A depiction of the RET A-B-C model or paradigm, demonstrating the interrelationship of thoughts and emotions, is provided (see Table 1).

From a mental health point of view, self-talk or self-instructions may actually become blatantly self-punishing. Beck (1976) states that: "If the person perceives a deficiency in his behavior or performance, he may barrage himself with regrets and reproaches. He may even make general evaluations of himself as bad, ineffective, or unworthy. The result of such self-reproaches is that he is likely to feel guilty or sad" (p. 40). From his experience, Beck also notes that as a patient becomes more disturbed,
### TABLE 1

Illustrated Adaptation of RET A-B-C Model*

<table>
<thead>
<tr>
<th>A. Activating Experience</th>
<th>-Mrs. Smith says &quot;hello&quot; to Mrs. Jones in the morning before breakfast at a retirement home. Mrs. Jones does not return the greeting.</th>
</tr>
</thead>
</table>
| B. Belief System (Cognitive Responses) | -Mrs. Smith summarizes the situation with the thought: "She ignored me!"
-Mrs. Smith affirms to herself: "I hate being ignored."
-Mrs. Smith observes to herself: "I must be a dislikable and worthless person because I was ignored."
-Mrs. Smith then states to herself: "I hate myself for being so worthless and disliked." Mrs. Smith finally concludes that: "It is horrible and terrible being such a disliked and worthless person, and I just cannot stand it!" |
| C. Emotional Consequences | -Anxiety, Self-doubt, and Anger. |

**Note.** As above, a person may choose to irrationally self-articulate an unfounded, unproven, or exaggerated judgment (at Point B) about one's worth as a result of another's actions (at Point A), and consequently feel miserable about it (Point C). However, that same person may alternatively choose to make more rational self-statements (at Point B about Point A).

For example, at Point B, Mrs. Smith may have said something more rational like: "Mrs. Jones seems not to have heard me greet her. I'll try to speak louder next time and see if that helps." At Point C, Mrs. Smith may experience friendly feelings toward Mrs. Jones; and, at worst, Mrs. Smith may experience feelings of concern for Mrs. Jones who might possibly have a hearing problem. Absent are the debilitating feelings of anxiety, anger, or self-doubt.

*Reference Fuller (1982)
such automatic thoughts become more apparent; and as a patient improves, such thoughts became less obvious.

Beck (1976) states that "overmonitoring can lead to self-consciousness and over-regulation to excessive inhibition. Cautionary signals tend to interfere with spontaneous self-expression" (p. 38). Within this monitoring process, such self-instructions may also drive a person, resulting in overachievement. Alternatively, Beck suggests that a lack of self-monitoring or self-instructions may result in disturbances where an individual ignores the consequences of certain behaviors or actions, as with excessive smoking or overeating. Relative to different types of disturbance, Beck sees automatic thought-related difficulties as often involving loss or the threat of loss; danger; self-deficiency, personal inadequacy or abnormality; and/or self-worthlessness.

**Cognitive Therapy: Visual Imagery**

Ellis notes that "emotion is caused and controlled in several major ways; and one of these ways is by thinking" (1962, p. 41). In contrast to the form of thinking that is often taken to be composed of self-verbalizations, visual imagery is also cited as a significant thinking-related variable that can be viewed to mediate the manifestation of emotions or behaviors. From personal experience, Beck
(1976) points to the importance of both verbal self-statements and imagery by recalling that: "It became apparent from my . . . work with patients that internal signals in a linguistic or visual form play a significant role in behavior" (pp. 37-38). Similarly, Ellis and Grieger (1977) state that:

People not only think about what happens to them in words, phrases, and sentences but also do so in nonverbal ways, including images, fantasies, dreams, and other kinds of pictorial representations. Such images contain the same kind of cognitive mediating messages as do verbal self-statements, and these cognitions contribute significantly to emotions and behaviors, to emotional disturbances, and to helping people change their emotions, behaviors, and disturbances (p. 40-41).

Some feel that imagery may actually have more potency than the verbal form of self-communication. Sheikh and Jordan (1983) present the belief that:

Images may have a greater capacity than the linguistic mode for the attraction and focusing of emotionally loaded associations in concentrated forms: Verbal logic is linear; whereas the image is a simultaneous representation. The quality of simultaneity gives imagery greater isomorphism with the qualities of perception, and therefore greater capacity for descriptive accuracy (p. 394).

Sheikh and Jordan similarly emphasize that images are less prone to being filtered, edited, or censored before reaching the conscious.

Further emphasizing the importance of imagery in relation to cognitive processes, Richardson (1980) cites the evidence as indicating that not only may imagery be of
considerable predictive importance, per se, but also a significant phenomenon underpinning human cognitive behavior. As such, imagery might well constitute an important medium for facilitating favorable psychotherapeutic outcomes when purposefully implemented within a cognitive approach to psychotherapy. Possibly for this reason, imagery has become an active part of various cognitive psychotherapies which shall be touched upon later. In conjunction with imagery, though, another consideration that may be of functional significance to a discussion of CT is that of suggestion.

Cognitive Therapy: Suggestion

As it is to hypnosis, suggestion may be considered integral to CT. Ellis (1962) notes "the exceptionally important influence of verbal self-indoctrinations in the maintenance of emotional disturbance" (p. 19). Put more vigorously, Ellis observes that: "As Bernheim (1887) [1887/1947], Coue and many other psychological practitioners have seen for at least the last 75 years, man is not only a highly suggestible but an unusually autosuggestible animal" (p. 19); and that man "... very actively and energetically keeps verbally reindoctrinating himself with his early-acquired hogwash" (p. 20) "... until it becomes an integral part of his presently held (and still continually self-reiterated) philosophy of life" (p. 22).
In a discussion of CT-related hypotheses, Ellis and Grieger (1977) emphasize that suggestion strongly influences behavior. In this respect, they further point out that:

Humans have a strong tendency to think, emote, and behave in accordance with the suggestions of others, even when these suggestions lead to poor individual or social results. They take such suggestions and make them into powerful autosuggestions, on the basis of which they significantly affect their own behavior. Their strong tendencies to act gullibly contribute to much of their emotional disturbance (p. 66).

Ellis and Grieger thus see suggestion as an important feature of CT and also note that people "can frequently ameliorate disturbance by acting on autosuggestion, on the suggestion of others, or on hypnotic suggestion. Almost all psychotherapy contains mighty elements of suggestion; an effective form of therapy consciously uses it to some extent" (p. 66).

Cognitive Therapy: Implementation

Beck (1976) summarizes CT by stating that "the special meaning of an event determines the emotional response [and] forms the core of the cognitive model of emotions and emotional disorders: The meaning is encased in a cognition --a thought or an image" (p. 52). Beck further states:

In the broadest sense, cognitive therapy consists of all the approaches that alleviate psychological distress through the medium of correcting faulty conceptions and self-signals. The emphasis on thinking, however, should not obscure the importance of the emotional reactions which are generally the immediate source of distress. It simply means that we get to the person's emotions through his cognitions.
By correcting erroneous beliefs, we can damp down or alter excessive, inappropriate emotional reactions (p. 214).

Ellis (1962) similarly addresses the implementation of CT by observing that:

If what has been hypothesized so far is true, and human emotions are largely a form of thinking or result from thinking, it would appear that one may appreciably control one's emotion by controlling one's thoughts. Or, more concretely, one may control one's emotions by changing the internalized sentences, or self-talk, with which one largely created these emotions in the first place (p. 52).

Beck (1976) identifies basic steps/procedures taken in the conduct of cognitive psychotherapy as follows (p. 217):

1. The need to first become aware of what one is thinking.
2. The need to recognize what thoughts are inappropriate.
3. The need to substitute accurate for inaccurate judgments.
4. The need to receive feedback so as to determine whether one's changes are correct.

Beck's (1976) four steps, to one extent or another, may be identified across many approaches to CT. A number of such approaches also specify the use of highly experiential features such as imagery or in vivo practice. Meichenbaum (1978), however, indicates that such experiential components tend to exist in psychotherapy whether overtly specified or not.
Based upon a comprehensive analysis of psychotherapies, Meichenbaum (1978) summarizes a sequence of cognitive mediating events which are indicated to account for behavioral change following psychotherapeutic interventions. These mediating events are viewed by Meichenbaum as impacting personal belief systems and to include (a) becoming an observer of one's own behavior (awareness); (b) experiencing the effects of maladaptive coping strategies so that the symptoms eventually become a cue for implementing more adaptive strategies; and (c) in vivo practice implicating dynamics surrounding internal dialogue and images relating to the behavioral change.

Three of the cognitive therapies significant to this discussion are Rational Emotive Therapy (RET), Rational Emotive Imagery (REI), and Cognitive Experiential Hypnotherapy (CEH). While RET and REI both tend to exhibit features identified in Beck's components or steps, both also represent points along a continuum that often reflect the degree to which experiential procedures may be overtly implemented. For example, whereas RET may sometimes incorporate experiential procedures, REI will almost always do so. CEH, however, with its reliance on hypnosis, often employs more elaborate cognitive and experiential features than REI. The implementation of the cognitive therapies RET, REI, and CEH is described below.
Briefly, the implementation of RET (see Ellis & Grieger, 1977) requires that one first identify or detect the irrational beliefs. This is accomplished by scanning and analyzing preceding thoughts which might have precipitated an inappropriate emotional or behavioral consequence. An evaluation instrument is sometimes used to facilitate the process. Second, one proceeds to actively dispute the irrational belief, often via an active dialogue/debate with a therapist and/or oneself. The intent is to minimize, destroy, or replace the irrational belief. Finally, a new philosophy is instilled that is more rational and less emotionally and behaviorally debilitating in nature. One is often asked to try out the newly resulting behaviors in daily life.

Emphasizing experiential imagery, Maultsby (1971) and Maultsby and Ellis (1974) present a form of cognitive psychotherapy known as Rational Emotive Imagery or REI. The positive version requires one to (a) vividly imagine an unpleasant (activating) experience, (b) experience the resulting thoughts and behaviors that present when imagining the event, and (c) notice the inappropriate or irrational nature of the thoughts themselves. These inappropriate thoughts are then to be (d) confronted or disputed by noticing/reciting their inaccuracies and (e) changed to ones that are more appropriate/rational. Finally, (f) one is to practice imagining the same situation, but with the more
appropriate/rational thoughts and behaviors, and (g) experience the improved affect.

REI tends to be somewhat representative of cognitive therapies that actively employ experiential features such as imagery. By not overtly utilizing hypnosis, REI might well be seen as the evolutionary link between RET and CEH due to its implementation of cognitive-based experiential procedures. An even closer association between REI and hypnosis or hypnosis-based psychotherapy, however, may be noted in a most recent version of REI that specifies a preliminary relaxation maneuver which can be taken as approximating a hypnotic induction (Maultsby, 1984).

Cognitive Experiential Hypnotherapy: Implementation

As previously indicated, Cognitive Experiential Hypnotherapy (CEH) is an approach to psychotherapy that may be seen to embody the functional integration of both hypnosis (HO) and Cognitive Therapy (CT). Also, both the hypnosis and CT features of CEH are essentially as were presented earlier during the independent discussions of each. First, hypnosis is established by means of a formal hypnotic induction. Then, as with Hypnotherapy (HT), the psychotherapeutic component is introduced within the context of this preestablished hypnotic medium. The psychotherapeutic component of CEH, however, specifically embraces the percepts
and methodology of CT, while also incorporating CT congruent post-induction therapeutic suggestions.

The functional integration of hypnosis and CT may be conceptually illustrated by briefly presenting several hypnosis-based psychotherapeutic approaches to CEH. Included are those of Petzold (1981); DeRoos and Johnson (1983); and Tosi and Marzella (1975, 1977). Herein, a discussion of the latter approach (Tosi & Marzella) is somewhat more extensive, due to its prominence within the literature and significance within the overall nature of this inquiry. First, however, Petzold describes a process involving the integration of both hypnosis and cognitive therapy of the RET variety, wherein subjects are initially hypnotized and imagery is subsequently introduced in lieu of merely disputing irrational statements.

Petzold (1981) poses that this integration of hypnosis and CT offers advantages otherwise absent in the use of either approach alone. That is, in consonance with the metaphor of left-right brain information processing, Petzold indicates that the cognitive therapy component tends to address the conscious, rational, linear thought processes generally missed by hypnosis and, alternatively, that the hypnotic component tends to address unconscious, subjective, or experiential processes missed by the rational or cognitive approach. For example, where there are difficulties in relinquishing inappropriate self-talk, hypnosis may be used
to "reinforce positive, self-enhancing statements, and to aid clients in 'forgetting' negative self-statements" (Petzold, p. 30).

Another integration of hypnosis and CT, of the RET variety, is Rational-Emotive Hypnosis, concerning which it is stated that: "Hypnosis does not alter the RET process, but rather strengthens, enhances and intensifies the RET process already being employed" (DeRoos & Johnson, 1983, p. 75). In conducting Rational-Emotive Hypnosis, DeRoos and Johnson indicate that hypnosis can be invoked during the initial phase so as to facilitate increased learning from RET. Next, REI, and/or any other procedure that might prove useful, is introduced. Hypnosis can then be subsequently utilized "as a means of reinforcing the newly acquired thoughts, feelings, and behaviors" (DeRoos & Johnson, p. 72). DeRoos and Johnson also discuss the Direct Method (not unlike the directness of HT), which entails the "systematic use of rational suggestions" (p. 72).

Rational Stage Directed Hypnotherapy or RSDH (Tosi & Marzella, 1975, 1977) is a treatment approach where "cognitive restructuring skills are developed, implemented and reinforced while the client is in a state of hypnosis" (Tosi, Howard, & Gwynne, 1982, p. 95). Tosi, Howard, and Gwynne also state that RSDH is "an extension and modification of Ellis's Rational Emotive Therapy (1962)" (p. 95). The influence of Arnold (1960a, pp. 172-178) might also be
considered. The contribution of REI (Maultsby, 1971; Maultsby & Ellis, 1974), relative to the procedures employed, is noteworthy as well. Finally, paradigms depicting the person-environmental processes and therapeutic stages underlying RSDH are often presented, they being cited by Tosi (1974) as influenced by, or adapted from, Mooney (1963) and Quaranta (1971).

The RSDH paradigm may be approached via these influences. For example, in developing RSDH, the A-B-C paradigm of RET—depicting the relationship of cognitions to emotions (see Table 1)—was adopted and partially elaborated beginning with Tosi (1974), and finally crystallized by Tosi and Marzella (1975, 1977), to include both D and E. D represents physiological reactions occurring after the emotional response C, whereas E represents a behavioral response such as approach or avoidance that follows D (Tosi, Reardon & Rudy, 1977). An illustrated adaptation of this RSDH paradigm is provided in Table 2. Effectively, both RET and RSDH emphasize that by changing the thoughts about an object or event, so too is the affect and behavior altered.

In this vein, the implementation of RSDH focuses upon procedures intended to facilitate changes in the cognitions, with a view to also precipitating appropriate changes in affect, physiology, and behavior. A substantial proportion of these RSDH therapeutic procedures are implemented and reinforced within the context of what is believed to be the
| Table 2: Illustrated Adaptation of RSDH A-B-C-D-E Model* |
|---|---|
| **A. Activating Experience** | -Mrs. Smith says "hello" to Mrs. Jones in the morning before breakfast at a retirement home. Mrs. Jones does not return the greeting. |
| **B. Belief System (Cognitive Responses)** | -Mrs. Smith summarizes the situation with the thought: "She ignored me!"  
-Mrs. Smith affirms to herself: "I hate being ignored."  
-Mrs. Smith observes to herself: "I must be a dislikable and worthless person because I was ignored."  
-Mrs. Smith then states to herself: "I hate myself for being so worthless and disliked."  
-Mrs. Smith finally concludes that: "It is horrible and terrible being such a disliked and worthless person, and I just cannot stand it!" |
| **C. Emotional Consequences** | -Anxiety, Self-doubt, and Anger. |
| **D. Physiological Responses** | -Increased blood pressure, heart rate, gastric secretion. |
| **E. Behavioral Responses** | -Avoid Mrs. Jones, act hostile toward Mrs. Jones in the future, and make no attempt to investigate the reasons for Mrs. Jones's behavior. |

*Note. Mrs. Smith might have alternatively chosen to make more rational self-statements (at Point B) such as: "Mrs. Jones may not have heard me greet her." Accordingly, it would be expected that Mrs. Smith may experience less feelings of distress (at Point C); greater physical calmness (at Point D); and different behaviors (at Point E) such as greeting Mrs. Jones in a louder voice a second time or merely dismissing the event.

*Reference Fuller (1982)
facilitative medium of hypnosis. In many respects, the modus operandi surrounding RSDH, apart from the hypnotic induction/HO component, involves the use of key REI psychotherapeutic procedures. Marzella (1975) effectively indicates that the CR component of RSDH basically follows the same theoretical process as REI. Essentially, Tosi, Reardon, and Rudy (1977) explicate the various steps or procedures in implementing RSDH as follows:

1. Globally identify self-defeating responses and conditions in categories B through E.
2. Describe hypnosis and teach the A-B-C-D-E model.
3. Implement a formal hypnotic induction.
4. Introduce a therapeutic sequence that functionally involves:
   (a) Recalling and imagining a difficult prior circumstance or event.
   (b) Analyzing the circumstance or event according to the A-B-C-D-E model.
   (c) Subjectively experiencing the negative consequences.
   (d) Noting that the negative consequences originate from the inappropriate cognitions (irrational).
   (e) Returning a second time to the same original circumstance or event, and again recalling and imagining it.
(f) Introducing more appropriate cognitions (rational) about the circumstance or event.

(g) Experiencing the more appropriate outcomes or results at Points C through E.

(h) Utilizing, experiencing, or receiving subjective rehearsal and other in vivo tasks, as well as appropriate post-hypnotic suggestions.

In addition to these procedural features, Tosi, Reardon, and Rudy (1977) indicate that, "differing from other cognitive/desensitization techniques that may employ hypnosis, RSDH progresses through specific developmental stages" (p. 2) which include awareness, exploration, commitment to rational/constructive action, implementation, change, and redirection. It is within the structure of these developmental growth stages that RSDH is said to be effected and change is deemed to occur (Fuller, 1982). For research purposes, however, many RSDH studies make either partial or no stated attempt to procedurally operationalize these developmental stages (e.g., Fuller, 1982; Howard, 1979).
### TABLE 3

**Hypnotherapy and Cognitive Experiential Hypnotherapy: A Conceptual Model**

<table>
<thead>
<tr>
<th>Treatment Condition</th>
<th>Hypnosis (Induction) Component</th>
<th>Psychotherapy Component</th>
</tr>
</thead>
<tbody>
<tr>
<td>HT(^a)</td>
<td>Hypnotic Induction(^c):</td>
<td>Post-Induction</td>
</tr>
<tr>
<td></td>
<td>subsuming Induction</td>
<td>Therapeutic Sugges-</td>
</tr>
<tr>
<td></td>
<td>Contextual Suggestions</td>
<td>tions</td>
</tr>
<tr>
<td>CEH(^b)</td>
<td>Hypnotic Induction(^c):</td>
<td>Cognitive Therapy(^d):</td>
</tr>
<tr>
<td></td>
<td>subsuming Induction</td>
<td>subsuming Post-</td>
</tr>
<tr>
<td></td>
<td>Contextual Suggestions</td>
<td>Induction Therapeutic</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Suggestions</td>
</tr>
</tbody>
</table>

\(^a\)Hypnotherapy (HT)
\(^b\)Cognitive Experiential Hypnotherapy (CEH)
\(^c\)As per Wolberg (1964)
\(^d\)As per Maultsby (1971) and/or Tosi and Marzella (1977)
Hypnotherapy and Cognitive Experiential Hypnotherapy-Related Research

Of particular significance to this discussion are controlled outcome studies that most directly address the question of efficacy for both Hypnotherapy (HT) and Cognitive Experiential Hypnotherapy (CEH). First, selected critical terminology utilized by these studies shall be reviewed. This discussion of terminology will also include an elaboration of related concepts/distinctions. The studies themselves shall then be individually inspected relative to their nature, purpose, results, and background circumstances. For each study, issues will be raised that may be viewed to impact the viability or interpretation of findings. Finally, four points shall be made concerning implications that this body of research may hold with respect to the current study.

Hypnotherapy and Cognitive Experiential Hypnotherapy: Conceptual Distinctions

Though explanations of terms deemed critical to the present study were offered within the definitions section of Chapter I, it seems important to emphasize, and to some extent elaborate upon, various terms and distinctions that might help clarify the nature and processes underlying the HT-CEH-related studies to be discussed. In so doing, important differences are emphasized between what is termed (a) HO and HT (or other hypnosis-based psychotherapies); (b) HO,
HO treatment, and HO component; (c) CR, CR treatment, and CR component; and (d) RSDH and RSDH treatment.

As to distinctions between HO and HT (or other hypnosis-based therapies), both HO and HT can be viewed as embracing similar modalities (such as relaxation, imagery, and suggestion). However, they most clearly differ in terms of suggestion. Suggestions provided with HO are induction contextual. That is, the suggestions are concentrated within the induction and are intended to induce a state of hypnosis only. HO thus consists of a hypnotic induction (a process) intended to establish hypnosis (the state), hypnosis having already been defined as that condition which follows a hypnotic induction. Though HO (the process) is not herein technically viewed as hypnosis (the state), convenience dictates that this distinction not be emphasized and that the term HO subsume both unless otherwise noted.

With HO being operationally viewed as only a hypnotic induction, once the induction process has been completed, nothing further is done to employ the hypnotic state which has presumably been established. That is, no subsequent therapeutic procedure is introduced, nor is mention made concerning benefits that might be derived. Should any therapeutic benefits incidentally manifest, then it might be argued that such results may have accrued by virtue of an unspecified generalization in effects from the hypnotic trance state itself.
On the other hand, once established, the state of hypnosis may be followed by additional suggestions which are of a psychotherapeutic nature, such being termed post-induction therapeutic suggestions. One of the most simplistic, limited, and direct of these suggestions is that the hypnotic state itself will be of personal benefit. It is at the point where these post-induction therapeutic suggestions are introduced, that HO may then be seen as definitionally transformed into Hypnotherapy (HT) or another named hypnosis-based psychotherapy. As such, the treatment then proceeds beyond the boundaries of a hypnotic induction (HO) alone, into the realm of a viable, fully functional hypnosis-based psychotherapy.

Concerning HO and HT, it shall be seen that some HT-CEH-related research studies tend to confuse the terms, and sometimes even employ one procedure where the other may have been intended. Though the term HO treatment is employed to signify a research treatment condition which only uses HO (hypnosis only/induction), in practice it may be discovered that an HO treatment may not implement hypnosis alone. Rather, some HO treatments employ brief post-induction therapeutic suggestions—indicating, for example, that the induction itself will be of benefit—which tend to manifest a weak, mild, or otherwise limited form of HT rather than the specified HO. Finally, the term HO component signifies HO where hypnosis (an induction) serves as one of the two
main components within CEH--Rational Stage Directed Hypnotherapy (RSDH) being one form of CEH.

As for the other terms, Cognitive Restructuring (CR) is sometimes employed as the term of choice to indicate the process surrounding the implementation of Cognitive Therapy (CT). CR treatment, as used within the literature, designates a research treatment condition utilizing CT. CR Component is interpreted as indicating the second of the two components which comprise CEH or RSDH. As employed herein, CR, CR treatment, and CR component may be taken as most closely based in the form of CT known as Rational Emotive Therapy or RET (Ellis, 1962). The term RSDH indicates a unique combination of HO and CR (or CT) components. RSDH treatment, as found in the literature, is intended to designate a research treatment condition that is taken to include RSDH (as per Tosi & Marzella, 1975, 1977).

These distinctions in terminology and related concepts form a necessary basis for the review of research studies to follow. They are also intended to help further clarify the nature of HT and CEH treatments as utilized by this current study with a non-institutionalized aged population. Finally, these distinctions may help to minimize the limitations and enhance the conceptual strengths of any future hypnosis-based psychotherapy research.
Hypnotherapy and Cognitive Experiential Hypnotherapy: Related Studies

In view of the just discussed terms and distinctions that have been identified with respect to the most directly pertaining HT-CEH-related research literature, a cursory presentation of this prior research could be easily misleading. Thus, these studies will be somewhat closely examined, in chronological order, and then will be followed by a review of the related meta-analysis by Smith, et al. (1980).

The first study to embody a combination of treatments bearing upon the discussion of efficacy for both HT and CEH was that of Marzella (1975). Marzella explored the effects of RSDH (a form of CEH); Rational Stage Directed Imagery (RSDI); Hypnosis-Only (or herein designated HO); Placebo; and Control in a study treating for the reduction of psychological stress in college students (N=60) over a series of six sessions. Dependent measures included the Barber Suggestibility Scale, State-Trait Anxiety Inventory, Minnesota Multiphasic Personality Inventory (MMPI), Multiple Affect Adjective Checklist, and Self Rating Depression Scale.

First, the RSDH treatment of Marzella (1975) included the specified two major components. That is, in addition to a hypnosis-only induction component (identical to the induction employed within the HO treatment), the RSDH treatment
also included a rational/cognitive restructuring component (CR)—as presented by Ellis (1962) and partially elaborated by Tosi (1974). This CR component of the RSDH treatment incorporated such things as information, directions, and therapeutic suggestions purportedly configured in accordance with the precepts of rational or cognitive therapy.

Additionally, Marzella (1975) incorporated a third component into the RSDH treatment in the form of a workbook entitled: Self Directed Behavior Change Instrument (Tosi, 1973). This document is also referred to herein as the SDBCI. The RSDI treatment implemented much the same rational therapeutic approach (CR) as did the RSDH treatment, but without the benefit of a hypnosis (HO) component. It also employed the SDBCI.

The hypnosis-only treatment, as Marzella (1975) first named it, included (a) a hypnotic induction intended to establish a hypnotic trance state and (b) therapeutic suggestions at the end of the induction stating that the "induction process alone would be enough to deal with emotional stress" (Marzella, p. 58). The Placebo treatment included suggestions to relax and become less anxious, but with no hypnosis (induction) or rational/cognitive therapy (CR). The Control received no treatment but included assessments of the dependent variables.

The results of the Marzella (1975) study disclosed conditional support for the therapies (i.e., Hypnosis, RSDH,
and RSDI) in reducing psychological stress among college students. Further, no marked difference was noted among the three treatments as to the degree of overall benefit each afforded the subjects.

Two issues of immediate interest arise concerning Marzella's (1975) study. First, subjects within the RSDH treatment were exposed to the SDBCI for the purpose of identifying therapeutic issues. The extensive information and exercises within this workbook might be viewed to embrace far more than the identification of therapeutic issues alone, plausibly constituting a therapeutic intervention in their own right. Given that the SDBCI represents an additional procedure that neither Marzella's review nor the literature as a whole establishes as integral or appropriate to RSDH or an RSDH treatment, it might possibly be seen as having contaminated the RSDH treatment. The RSDI treatment also benefited from the use of the same SDBCI, but the HO treatment received no such augmentation from any additional support material.

The second issue concerns the purpose and structure of Marzella's (1975) HO treatment. Marzella proposed that the subjects receiving what he termed the hypnosis-only method, essentially serve as a "control for the effects of the trance state or hypnotic phenomenon" (p. 58). In order to serve as a control for hypnosis, as Marzella apparently
intended, this HO treatment would only involve inducing a state of hypnosis—hence the term, Hypnosis Only or HO.

Given that an HO treatment was earlier defined as a hypnotic induction, such a treatment would seem to be uniquely eligible to serve as a control. In this way, with the HO treatment controlling for the trance state and any consequent hypnotic phenomena within the RSDH treatment, the researcher would be able to legitimately verify any independent contributions afforded by the remaining rational/cognitive restructuring (CR) component of RSDH.

A perceived difficulty is that Marzella (1975) was seemingly unable to accomplish the stated purpose of having an HO treatment serve as a control for hypnosis. That is, given the inclusion of post-induction therapeutic suggestions, the HO treatment becomes ineligible to serve as a viable control for itself (as replicated within the RSDH treatment) due to the HO treatment consequently embracing more than just hypnosis only (the induction alone). As such, it seems procedurally inappropriate for this HO treatment (induction plus therapeutic suggestions) to serve as a control against only one of its own two components (just the induction) within the RSDH treatment.

Given the actual composition of the Marzella (1975) HO treatment, with the added post-induction therapeutic suggestions, it is posed that the evidence which tends to disqualify the HO treatment from serving as a control for hypnosis
within the RSDH treatment, also serves to tentatively qualify it as a legitimate, though not necessarily adequate, Hypnotherapy (HT). Consequently, the process becomes, in effect, one of comparing a seemingly mild form of hypnotherapeutic psychotherapy or HT (the HO treatment) against an extensive hypnotherapeutic psychotherapy (RSDH).

Perhaps not surprisingly, and contrary to the stated purpose, Marzella's (1975) final analysis of the data and discussion of results opted to address the HO treatment as though it were a viable psychotherapeutic intervention, not as a control variable. Specifically, no emphasis was made as to any individual contributions (or lack thereof) that were afforded RSDH by its CR component once the hypnotic trance state was controlled for by the HO treatment.

Consequently, a broad issue with respect to findings/conclusions of Marzella (1975) is that possibly both the HO and RSDH treatments were contaminated by additional procedures. A mild or otherwise limited version of HT might consequently be interpreted as having been compared to an augmented, enhanced, or enriched RSDH. Despite an issue of appropriateness in making such a comparison, the findings indicated that no significant difference in effectiveness was realized between the various treatments employed. In view of the concerns expressed herein, however, the findings seem to be less than completely applicable in clarifying
uncertainties as to the effectiveness of both HT and CEH for purposes of this inquiry.

Chronologically, Boutin (1976) conducted the next study that bears upon the question of efficacy for both HT and CEH. This study was in many respects a replication of Marzella's (1975) study with a different population, different dependent variables, and the deletion of the RSDI treatment. Specifically, Boutin explored the effects of RSDH (CEH), HO, Placebo, and Control in a study treating for test anxiety with nursing students (N=48) over a series of six sessions. Dependent outcome measures included the Barber Suggestibility Scale, Multiple Affect Adjective Check List, State-Trait Anxiety Inventory, Test Anxiety Scale, S-R Inventory of Anxiousness (Test Anxiety), Anxiety Differential, Personal Beliefs Inventory, and Palmar Sweat Print.

The RSDH treatment was adapted from Marzella (1975) and employed essentially the same procedures. It included both the hypnotic (induction) component identical to the induction employed within the HO treatment and the rational/cognitive restructuring component (CR) as presented by Ellis (1962) and partially elaborated by Tosi (1974). It also included the SDBCI as employed by Marzella (1975).

The HO treatment included both a hypnotic induction and post-induction therapeutic suggestions similar to those utilized by Marzella (1975). The post-induction therapeutic suggestions were adapted to the new population and dependent
variables. Placebo subjects were merely given suggestions to relax, also similar to the procedure employed by Marzella. The Control condition received no treatment and subjects participated only in assessments via the dependent measures.

Results of the Boutin (1976) study showed both the RSDH (CEH) and the HO treatments to be significantly effective in reducing test anxiety as defined by the dependent measures. However, the RSDH treatment was declared by Boutin to provide the best results and to be significantly better than the HO treatment. Little change was noted relative to Placebo and Control conditions.

Because Boutin's (1976) study was a close replica of the Marzella (1975) study, it is subject to similar observations. Briefly, though no mention is made in Boutin's review of the SDBCI being integral or appropriate to RSDH or an RSDH treatment, subjects within the RSDH treatment were exposed to the SDBCI for the purpose of identifying therapeutic issues. Given that the extensive information and exercises within the workbook might be construed to embrace far more than just the identification of therapeutic issues, and plausibly constitute a psychotherapeutic intervention in their own right, the RSDH treatment may well have been contaminated as a consequence.

Similar to Marzella (1975), Boutin (1976) proposed that the HO experimental condition "was essentially a control
group for the effects of hypnotic phenomena" (p. 78). The HO treatment also included more than just hypnosis only (an induction alone), given the addition of post-induction therapeutic suggestions stating that the "induction would be enough to deal with test anxiety" (Boutin, p. 78). As such, the HO treatment might be viewed as more accurately approximating HT than HO. Given this circumstance, the HO treatment could conceivably be seen as an inappropriate control for hypnosis, even though the induction portion of the HO treatment was identically replicated within the RSDH treatment.

In the sense that Boutin's (1976) intended use of the HO treatment (as a control for hypnosis) might be viewed as methodologically inappropriate, it would not then be reasonable to expect an analysis or discussion concerning any independent contribution rendered to RSDH by its CR component once the effects of hypnosis have been removed by the HO control for same. Boutin, in fact, does not specifically address this issue, emphasizing results from a perspective that suggests HO to be a viable psychotherapy in its own right.

Hence, as in the case of Marzella (1975), a similar concern appears to impact the findings/conclusions of Boutin (1976). The concern is that both HO and RSDH treatments could be viewed as contaminated by additional procedures which render neither treatment a viable representative of HO
or RSDH, respectively. Consequently, a mild or otherwise limited version of HT might, at best, be interpreted as having again been compared to an augmented or enhanced RSDH. Any significance posed by the superior results of the RSDH treatment over the HO treatment might well be attenuated by an issue as to the propriety of making such a comparison. Consequently, findings would appear to be less than completely applicable in clarifying uncertainties as to the effectiveness of both HT and CEH for purposes of this present investigation.

Howard (1979) explored the effects of RSDH (CEH), HO, Cognitive Restructuring (CR), and Control in a study concerning the facilitation of enhanced athletic performance (N=32) over a series of four sessions. Dependent variables included self-concept; muscle growth (size of chest and dominant arm); neuro-muscular performance (amount of weight lifted in a bench press); and anxiety among weight-lifters. In addition to measures of size and weight, instrumentation included the Tennessee Self-Concept Scale and State-Trait Anxiety Inventory. The research strategy employed was similar to that used by Marzella (1975) and Boutin (1976), though neither RSDH nor Placebo was utilized and a new cognitive treatment (CR) was introduced.

The RSDH treatment loosely followed the format of previous studies, but was adapted to a considerable extent for use with athletes. It included both the hypnotic
induction component (identical to the HO treatment) and a rational/cognitive restructuring component (CR)--as presented by Ellis (1962); partially elaborated by Tosi (1974); and crystallized by Tosi and Marzella (1975, 1977). Possibly due to the necessity of effecting treatment adaptations for purposes of promoting enhanced athletic performance, the RSDH treatment included extensive hypnosis-based imaging procedures not utilized with prior RSDH research. As in the studies of Marzella (1975) and Boutin (1976), the SDBCI was again employed in the RSDH treatment.

The HO treatment employed by Howard (1979) included an induction very similar to that utilized by Marzella (1975) and Boutin (1976), one difference being that steps three and four were, for an unspecified reason, reversed—the nature and order of these four steps having been originally specified by Wolberg (1964). No therapeutic suggestions were employed at the close of the induction, constituting the first chronological instance in the reviewed literature where post-induction therapeutic suggestions were not utilized in what was referred to as an HO treatment.

The CR treatment, the first instance of its use in this literature, was based on Ellis's (1962) model of Rational Emotive Therapy (RET) and relied heavily on the use of the SDBCI. This CR treatment should not be construed as being equivalent to the CR component of the RSDH treatment, however, for they were formulated differently. Therefore,
the former might not appropriately serve as a control for the latter. The Control condition received no treatment and subjects participated only in the assessments. Howard (1979) found RSDH to be the only experimental condition that produced significant benefits.

A number of issues seem to merit consideration relative to the research of Howard (1979). First, Howard employed only four treatment sessions. This was by far the least of any study reviewed. Hence, the effectiveness of various treatments within the Howard study may have been compromised. At the least, findings from the Howard study are difficult to interpret in comparison to other related studies, all of which utilized between six and eight sessions.

As with Marzella (1975) and Boutin (1976), Howard employed an RSDH treatment augmented by the SDBCI. In this instance, however, the SDBCI appears to have been thoroughly implemented for the immediate purpose of realizing therapeutic benefits, rather than for the intermediate purpose of identifying only therapeutic issues. No evidence is presented in Howard's review indicating that the SDBCI is integral or appropriate to RSDH or an RSDH treatment. As such, the RSDH treatment may have been contaminated by the workbook's extensive exercises and might not necessarily be representative of RSDH alone.

Howard's (1979) HO treatment is unique in that it appears to be the first chronological instance where an HO
treatment might actually be considered to approximate HO (i.e., an induction or hypnosis only without additional suggestions indicating therapeutic benefit). As such, it seems to be especially qualified to serve as a control for hypnotic phenomena within the RSDH treatment, given that this same HO treatment is replicated as part of the RSDH treatment. However, Howard indicated that the intent or purpose of the HO treatment was other than having it serve as a control for hypnosis—that is, "the study was conducted to determine the effectiveness of RSDH, hypnosis only, and cognitive restructuring only" (p.71).

Given the apparent purpose of Howard (1979) to test the effectiveness of different psychotherapeutic interventions, the propriety of selecting a hypnotic induction (or HO) for comparison to an armamentarium of fully arrayed psychotherapy treatments might be queried. In summary, questions concerning the following four points tend to diminish the possible utility of findings from this study relative to the purposes herein: (a) the limited number of treatment sessions; (b) possible contamination of the RSDH treatment with the SDBCI; (c) a hypnotic induction serving in the capacity of other than a control without a cited rationale for so doing, and (d) the less immediate, mental-health-related relevance of the study's stated purpose in facilitating enhanced athletic performance.
Fuller (1982) explored the effects of RSDH (CEH), HO, CR, and Control in a study treating for depression and self-concept among institutionalized aged (N=32) over a series of eight sessions. In employing this mix of experimental conditions, Fuller tended to follow the lead of Howard (1979). The dependent measures which were utilized included the Tennessee Self Concept Scale and Minnesota Multiphasic Personality Inventory (Depression Scale).

The RSDH treatment followed the general paradigm employed by Marzella (1975) and Boutin (1976). It included both a hypnosis (induction) component identical to that within the HO treatment and a rational/cognitive restructuring component (CR)—as presented by Ellis (1962); partially elaborated by Tosi (1974); and crystallized by Tosi and Marzella (1975, 1977). For the first time, no use of the SDBCI was included in the RSDH treatment. This additional procedure was not employed, according to Fuller (1982), due to concern over taxing the faculties of the elderly research subjects.

As with the Howard (1979) study, the HO treatment employed only a hypnotic induction, without any post-induction suggestions indicating that subjects were to receive therapeutic benefits. The CR treatment followed the rational/cognitive model of Ellis (1962), but, despite the inclusion of similar examples, did not approximate the CR component within the RSDH treatment due to structural
differences. The Control condition did not include a treatment, but did include evaluations by means of the dependent measures.

Results disclosed both RSDH and HO treatments to be significantly effective in reducing depression and enhancing self-concept. However, where both proved to be of essentially equivalent efficacy in the reduction of depression, the RSDH treatment proved to be significantly more effective in enhancing self-concept than did the HO treatment. The CR treatment and Control condition demonstrated no significant effects.

The non-utilization of the SDBCI within the RSDH treatment by Fuller (1982) is the first instance in this discussion of pertaining research where an RSDH treatment may actually constitute RSDH as it is often described within the literature. Given the viability of such an assertion, this occurrence might also be seen as the first direct comparison of RSDH to any one of the other treatment conditions reviewed herein. As was the case with the previous studies, however, there are additional issues which merit consideration.

The HO treatment of Fuller (1982), just as in the Howard (1979) study, appears to be representative of HO. Given this circumstance, the HO treatment might then serve in the capacity of a legitimate control for hypnosis or the trance state within an RSDH treatment, as was the stated purpose of Marzella (1975) and Boutin (1976). Though the
statistical analysis did not make specific use of this capability, Fuller did note the added contribution apparently afforded the RSDH treatment by its CR component. Nevertheless, the HO treatment is not specifically stated to be a control variable and does tend to be functionally represented as a credible hypnosis-based psychotherapy, though without the presentation of a rationale for so doing.

Of the research thus far discussed, Fuller (1982) might be viewed as having one of the more structurally sound studies, despite concerns as to the HO treatment's purpose. The findings of Fuller are also interesting to the extent that though the RSDH treatment demonstrated significantly greater effectiveness on one dependent variable, an induction alone (HO) demonstrated relative equivalency to RSDH on the other. Despite the unique viability of the Fuller study however, given that HT was not operationalized within the HO treatment condition, the results are somewhat difficult to interpret for purposes herein of clarifying uncertainties surrounding the effectiveness of both HT and CEH.

As with Howard (1979) and Fuller (1982), Judah (1982) explored the effects of RSDH (CEH), HO, CR, and Control. The Judah study treated for cognitive, affective, physiological, and behavioral symptoms in ulcer patients (N=25) over a series of seven sessions. Dependent measures included the Harvard Group Scale of Hypnotic Susceptibility,
frequency of gastrointestinal disturbances, Millon Behavioral Health Inventory, and Common Beliefs Survey III.

Once again, the underpinnings of the RSDH treatment appeared to follow in the general format of many previous RSDH treatments (Boutin, 1976; Fuller, 1982; Marzella, 1975). It seemed to incorporate a hypnosis (induction) component (identical to much of the induction employed within the HO treatment) and a rational/cognitive component (CR)—as presented by Ellis (1962); partially elaborated by Tosi (1974); and crystallized by Tosi and Marzella (1975, 1977). Judah (1982) specifically identified this rational/cognitive component as cognitive restructuring or CR. The RSDH treatment also incorporated two additional components: (a) a considerably expanded version of the SDBCI over what had been previously employed and (b) bibliotherapy.

The HO treatment, unlike that in all previously reviewed studies, included an induction that had one of the traditional four parts deleted. Also, as with Marzella (1975) and Boutin (1976), the HO treatment used both induction contextual suggestions and those that were not (relative to the traditional RSDH induction of Wolberg, 1964). However, those suggestions that were not induction contextual might not be easily construed as constituting therapeutic suggestions which specifically address improvements pertaining to the dependent variables.
The CR treatment was essentially based upon Ellis (1962); as partially elaborated by Tosi (1974); and as crystallized by Tosi and Marzella (1975, 1977). In this configuration, Judah departed from the previous studies (Fuller, 1982; Howard, 1979) which employed a CR treatment based only upon the Rational Emotive Therapy (RET) of Ellis (1962)—not the elaborated version within RSDH. The Judah CR treatment also employed an enhanced version of the SDBCI and bibliotherapy, the same as were introduced to the RSDH treatment. For the first time in the research literature, it was indicated that the CR treatment was to be construed as approximating the CR component within the RSDH treatment. As such, it might thus have served as a control. The Control condition received no treatment, but did include evaluations by means of the dependent measures.

Judah (1982) indicated that results "conditionally validated" (p. 131) the "significant superiority" (p. 135) of RSDH (CEH) over both HO and CR on most criteria. The CR treatment was shown to be significantly effective, but to a less extent than the RSDH treatment. HO was reported by Judah to provide "the least overall positive response" (p. 133). The Control condition demonstrated no significance.

At least four issues arise relative to the Judah (1982) study. First, in that the review failed to establish the SDBCI as an integral or appropriate component of RSDH, the fully implemented SDBCI could be perceived as having
possibly contaminated the RSDH treatment. In addition, Judah's use of an expanded form of the SDBCI— it being enhanced to include considerably more information and exercises than the original version of this workbook— tends to accentuate any preexisting concern. Possibly confounding the treatment still further, Judah systematically and extensively introduced bibliotherapy to the RSDH treatment. This involved giving subjects reading assignments from various books on rational therapy. In addition to the RSDH treatment, Judah also included the bolstered SDBCI and bibliotherapy within the CR treatment.

Second, Judah (1982) effected an alteration in the HO treatment's hypnotic induction, a treatment which had otherwise been relatively stable across the previously discussed CEH studies (Boutin, 1976; Fuller, 1982; Howard, 1979; Marzella, 1975). The rationale offered by Judah was that this change constituted an adaptation of procedures to a duodenal ulcer population. Specifically, Judah deleted one of the four parts or stages traditionally utilized within the HO hypnotic induction process, a stage that involves the description of a pleasant scene to the subjects (Wolberg, 1964). The purpose of the scene is that of serving as an elaborate hypnotic trance-inducing technic. The RSDH induction was similarly altered.

Third, the alteration to the HO treatment included an extended, informational, and seemingly non-directional,
though permissive, discourse at the end of the abbreviated induction. Had the discourse included post-induction therapeutic suggestions (which were not readily apparent), indicating dependent-variable-related benefits, the HO treatment might reasonably qualify as HT. As it exists, however, the traditional HO treatment (induction) might well be viewed as having been compromised for research purposes by this non-directional, post-induction dialogue which consumed nearly one-third of the HO treatment. Given the viability of such concerns, and with respect to the purposes of this current inquiry, the HO treatment might qualify as neither HO or HT.

Finally, Judah (1982) employed only 25 subjects within a study incorporating four experimental conditions. This is the smallest sample size of any CEH study yet discussed, as the sample sizes of the other studies ranged from 32 to 60. Additionally, the 25 subjects were not evenly distributed among treatments. For example, only five subjects were included within the cell occupied by the HO treatment, the same treatment condition cited by Judah as providing the least benefits.

A number of concerns might thus be summarized relative to the findings of Judah (1982). These concerns include: (a) the plausible contamination of the RSDH treatment by both the SDBCJ and bibliotherapy, as well as by the altered induction procedure; (b) uncertainty concerning the
functional utility of the HO treatment due to an alteration of the induction, the treatment's conceivable contamination by post-induction dialogue, and the questioned propriety of the HO treatment serving as a practicable comparison psychotherapy (in view of the perceived absence of post-induction therapeutic suggestions); and (c) an especially small number of research subjects. The research findings would consequently seem to be of no utility in clarifying uncertainties as to the effectiveness of HT and CEH for purposes of this present investigation.

Smith, Glass, and Miller (1980) conducted one of the more comprehensive analyses of research literature (meta-analysis) bearing upon the effectiveness of psychotherapy. The study inspected 475 controlled outcome studies and involved the analysis of 1,766 effect-size measures. Among various objectives, this analysis was to provide not only an estimation of individual or relative strength for different psychotherapies, but also an overall determination of therapeutic effectiveness for psychotherapy.

Two psychotherapy types or classifications inspected by Smith et al. (1980) seem to be of particular significance to this discussion—that is, (a) Other Cognitive Therapies and (b) Hypnotherapy (HT). Other Cognitive Therapies is a classification including "cognitive therapies . . . other than, but similar to, Albert Ellis's rational-emotive psychotherapy" (Smith et al., p. 90). Grouped within this
category were four specific psychotherapies, one being Rational Stage Directed Imagery (RSDI).

In this instance, the RSDI treatment reviewed by Smith et al. (1980) is more appropriately identified as RSDH (CEH). Marzella (1975) indicates that "RSDI is much the same process as RSDH except that there is no hypnotic induction present" (p. 56). The RSDI treatment of Reardon (1976), however, employed an intensive relaxation procedure which Smith et al. classifies with hypnosis. Additionally, this relaxation procedure is highly similar to the hypnotic induction of Wolberg (1964) which has typically been used by RSDH studies. The first three stages of the Wolberg induction, which establish the hypnotic state, were employed, though the fourth trance-deepening stage was deleted.

Initial uncontrolled results demonstrated that, of all the psychotherapy types inspected, the greatest degree of benefit was provided by treatments included under the category of Other Cognitive Therapies. As such, the average subject was found to be better off than 99% of those who do not receive psychotherapy. The type of psychotherapy found to be second best was HT, wherein the average subject was found to be better off than 97% of those who do not receive psychotherapy. As a consequence, it might then be indirectly argued that RSDI/RSDH, as part of the Other Cognitive Therapies category, would seem to be a little more effective than HT.
In order to effect a more equitable comparison of the many studies taken under consideration, however, Smith et al. (1980) subsequently adjusted the raw results of each study so as to compensate for inequities such as blinding, selection/assignment of subjects, mortality, reactivity of measurement, and allegiance of experimenter. Though it might be argued that many of the adjustments were highly subjective in nature, it was emphasized by Smith et al. that adjustments were made via distinct criteria which were uniformly applied across all studies taken under consideration. This process of effecting adjustments was also underpinned by independent judgments of different evaluators with a sampled level of agreement at 92%.

Despite the initial analysis which established the superiority of both Other Cognitive Therapies and HT, and of the former over the latter, this subsequent and final analysis disclosed considerably altered findings. That is, after the adjustments, it was found that "different types of psychotherapy . . . do not produce different types or degrees of benefit" (Smith et al., 1980, p. 184).

Given the eventual finding by Smith et al. (1980) for equivalency among all psychotherapies (at least those inspected), it might be concluded that CEH (RSDH) is essentially equivalent to HT in the degree of benefit afforded. However, the evidence reviewed by Smith et al.,
relative to RSDH, may have been limited. Two issues might be mentioned in this respect.

First, many HT-CEH-related studies were conducted subsequent to the Smith et al. (1980) meta-analysis. Second, the one study which was emphasized as having been analyzed by Smith et al., that of Reardon (1976), was an RSDH outcome study that (a) employed an RSDH treatment plausibly confounded by use of the SDBCI and (b) did not include either an HO or HT comparison treatment. Though these circumstances may in no way compromise the findings of Smith et al. with respect to HT and/or CEH, this cannot be said with absolute certainty. Hence, for purposes herein, the findings of Smith et al. may be insufficient and of diminished utility in clarifying uncertainties as to the efficacy of both HT and CEH.

With respect to the foregoing discussion of Smith et al. (1980) and the other HT-CEH-related research, a number of points may be highlighted. First, aside from Fuller (1982), a viable assessment of CEH may have been compromised due to the use of the SDBCI within the RSDH treatments of these studies. The SDBCI is a procedure that can be viewed as a viable psychotherapeutic intervention in itself.

Though cognitive therapies will sometimes employ an added procedure to identify therapeutic issues, no supporting rationale has been presented in this HT-CEH-related research for the use of the SDBCI as an integral
aspect of RSDH. Alternatively, in addition to Fuller, many studies do embrace an RSDH treatment as generally described within the literature—devoid of additional procedures such as the SDBCI (e.g., Gwynne, Tosi, & Howard, 1978; Howard, Reardon, & Tosi, 1982; Reardon, Tosi, & Gwynne, 1977; Tosi, Howard, & Gwynne, 1982). A similar circumstance or concern exists with respect to the extensive implementation of bibliotherapy within an RSDH treatment (e.g., Judah, 1982).

A second issue is that, even where a version of HT might be said to exist within an HO treatment (e.g., Boutin, 1976; Marzella, 1975), the form of HT employed might not necessarily be considered appropriate for research comparison to RSDH, an RSDH treatment, or another psychotherapeutic intervention. For example, the therapeutic suggestions utilized by the HO treatments of Marzella and Boutin, herein viewed as approximating HT, only state that the induction itself will be of benefit. This appears to be a highly limited approach to HT. It is therefore not unreasonable to presume that, in comparison to other psychotherapy treatments, HT outcome effects might well be prejudiced from the outset.

Third, an issue of appropriateness might be raised concerning those studies that actually do employ HO in the HO treatment (without any benefit of post-induction therapeutic suggestions), but which tacitly suggest such treatments to be HT (i.e., Fuller, 1982; Howard, 1979). In these studies,
the induction is given, the hypnotic state established, and nothing further is done. Alternately, when that same point is reached within the RSDH treatments, the process has barely begun.

Given that HO is but an induction and constitutes a brief and identical portion of RSDH, the supplemental RSDH procedures might well be expected to often assure superior benefits for RSDH in comparison to HO. This expectation tends to be reinforced by a belief that "the hypnotic state [alone] cannot be considered any more therapeutic than the typical waking or sleeping state" (DeRoos & Johnson, 1983, p. 69). Consequently, HO psychotherapeutic effects, in research comparisons to those of viable hypnosis-based psychotherapies, might be viewed as plausibly prejudiced from the outset.

Specifically, if the intent is to compare psychotherapies, with the choice of one psychotherapy being either HO or HT, it might be more reasonable to select HT. HO is traditionally used to induce the hypnotic state, not as a therapy in itself. If HO is actually to be used as a psychotherapeutic treatment, sans any post-induction therapeutic suggestions, HO might be structured and labeled as relaxation (with or without purposefully evoked imagery). A rationale and limited literature base exists concerning the assessment of relaxation as a psychotherapeutic intervention. The term HO seems especially appropriate where it
signifies a treatment serving as a hypnosis-only control for just the hypnosis (induction) portion of any given hypnosis-based psychotherapy, as was originally proposed by Marzella (1975) and Boutin (1976).

A fourth and final issue of appropriateness underpins most of the research previously reviewed. Specifically, in each instance where a comparison of an HO and RSDH treatment was made, whether the HO treatment was considered to be HO or a limited form of HT, the HO treatment was apparently repeated in an identical fashion across all treatment sessions. The original intent for doing so was undoubtedly that of having the HO treatment serve as a control for the same induction within each RSDH treatment. The consequence, however, is that while the RSDH treatment sessions included new and different therapeutic protocols being introduced, often involving key shifts of therapeutic emphasis, the subjects receiving an HO treatment encountered the same procedures with perpetual regularity.

As a result, even if it were successfully argued that the HO treatments really did constitute very best (or even credible) examples of HT, a new treatment variable is introduced which might be argued to approximate repetition. From this perspective, even a purportedly potent therapeutic intervention might be found to produce unusual results were it to be scientifically replicated, with research-based precision, for the same subjects time after time. Once
again, it might be proposed that any psychotherapeutic outcomes realized by HO/HT treatments might well have been prejudiced in comparison to those of other, more fully represented treatments such as RSDH.

In view of the foregoing discussion, perhaps the simplest and most generous conclusion remains somewhat as was originally offered in Chapter I. That is, a general impression is received as to the seeming efficacy of HT- and CEH-related treatments, and that the latter appears to be no less effective than the former. Despite far more elaborate procedures, however, under some conditions CEH has been shown to be not any more effective than the use of a hypnotic induction alone. Hence, due to the various issues and somewhat differential outcome effects of the studies just reviewed, little is posed to be definitely concluded from the prior research for purposes herein.

In view of these circumstances, there is a significant and continuing uncertainty concerning the efficacy of both HT and CEH. Additionally, not only may this uncertainty be gleaned with respect to the pertaining research as a whole, but relative to the limited HT-CEH research with the elderly in particular. This uncertainty is, however, most apparent in the case of the non-institutionalized aged, a population with which no such prior research has been conducted.
Summary

The preceding review of the literature emphasized that aging-related issues tend to impact the mental and emotional well-being of the elderly. It was also emphasized that these issues are often of an external, indirect, or environmental nature; frequently involve circumstances of change or loss; and include such things as lower income, reduced social roles, and increasing isolation through the loss of friends and family members.

Two important constructs believed sensitive to the impact of aged-related issues, self-concept and depression, were then introduced. Based on a discussion of the background, salient concepts, and aging-related circumstances involving self-concept and depression, it was concluded that both may constitute viable indices of mental health status among the elderly. A further conclusion was that these two constructs can credibly serve as dependent variables for purposes of aged-related psychotherapy research.

Two hypnosis-based psychotherapies, Hypnotherapy (HT) and Cognitive Experiential Hypnotherapy (CEH), were presented as potentially viable interventions for use with the elderly. As developed from a discussion explicating these two interventions, and from an examination of critical terminology often utilized in discussions of each, a review was conducted of those studies deemed most directly related to assessing the efficaciousness of both HT and CEH. Based
upon the review of this literature, it is difficult to draw any firm conclusions concerning HT-CEH efficacy. This difficulty was indicated as being due to same-named treatments utilizing significantly different procedures, the use of procedures that are at times undocumented and/or employed inappropriately, and an inconsistency in findings from across these studies.

Despite any issues raised by the review of HT-CEH-related research, it was observed that this research does seem to provide a broad impression as to the efficacy of HT- and CEH-related treatments. However, the evidence appears to be insufficient for determining the degree or conditions of HT-CEH effectiveness. In view of these observations, it was concluded that a significant and continuing uncertainty exists within the literature concerning the efficacy of HT and CEH, and that this same uncertainty is no less prominent relative to the use of HT and CEH with the elderly as a whole or the non-institutionalized elderly in particular.
CHAPTER III
METHODOLOGY

This chapter describes the methodology utilized in conducting an experimental investigation to determine the efficacy for two forms of hypnosis-based psychotherapy. The areas addressed include research setting, population, sample, treatment therapist, instrumentation, data collection, research design, experimental conditions, administrative procedures, and statistical analysis. Many of these methodological dimensions are summarized in Table 4.

Research Setting

The site of the study was a community activity center for the aged located in the downtown area of a moderately sized city (population 24,093) situated within a Midwestern Metropolitan Statistical Area (U.S. Bureau of the Census, 1984). Membership in the Center is open to all elderly persons. Approximately 1,200 persons maintain active memberships, with several hundred members being served on-site per week. The staff includes four full-time management personnel for programs, transportation, food service, and outreach, respectively. As many as 20 additional full- and


TABLE 4

Summary Dimensions of the Study by Treatment Condition

<table>
<thead>
<tr>
<th>Dimensions</th>
<th>HT</th>
<th>CEH</th>
<th>CO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subjects</td>
<td>10 Subjects:</td>
<td>10 Subjects:</td>
<td>9 Subjects:</td>
</tr>
<tr>
<td></td>
<td>8 Female</td>
<td>9 Female</td>
<td>8 Female</td>
</tr>
<tr>
<td></td>
<td>2 Male</td>
<td>1 Male</td>
<td>1 Male</td>
</tr>
<tr>
<td>Treatment Sessions</td>
<td>7</td>
<td>7</td>
<td>X</td>
</tr>
<tr>
<td>Duration/Session</td>
<td>30 minutes</td>
<td>40 minutes</td>
<td>X</td>
</tr>
<tr>
<td>Length of Treatments</td>
<td>2 months</td>
<td>2 months</td>
<td>X</td>
</tr>
<tr>
<td>Dependent Variables</td>
<td>Self-Concept &amp; Depression</td>
<td>Self-Concept &amp; Depression</td>
<td>Self-Concept &amp; Depression</td>
</tr>
<tr>
<td>Instruments</td>
<td>TSCS &amp; MMPI</td>
<td>TSCS &amp; MMPI</td>
<td>TSCS &amp; MMPI</td>
</tr>
<tr>
<td>Times of Measurement</td>
<td>Pretest, Posttest I,</td>
<td>Pretest, Posttest I,</td>
<td>Pretest, Posttest I,</td>
</tr>
<tr>
<td></td>
<td>Posttest II</td>
<td>Posttest II</td>
<td>Posttest II</td>
</tr>
</tbody>
</table>

Note. Instrumentation consists of the Tennessee Self Concept Scale (TSCS) and the Minnesota Multiphasic Personality Inventory (MMPI). Experimental conditions include Hypnotherapy (HT), Cognitive Experiential Hypnotherapy (CEH), and a Control (CO). The times of measurement occurred as follows: The Pretest was given prior to the first treatment session, Posttest I was given just after the last treatment session, and Posttest II was given at a one-month follow-up.
part-time staff include program directors, food service workers, outreach workers, homemakers, drivers, and maintenance specialists. A cadre of as many as 65 volunteers provides additional service support.

A carpeted and well furnished room at the Center was selected as the location for all treatment sessions. This room was found to provide particularly effective insulation against both external sounds and visual distraction, and could comfortably accommodate up to 20 persons. Due to some deficits in hearing among a few of the participants, a small portable public address system was employed so that the treatments could be easily and comfortably heard at all times. Staff were available to facilitate necessities such as temperature control, seating, and the coordination of transportation.

Population

The population consisted of cognitively aware, ambulatory aged. All subjects possessed independent housing as their place of residence, such being located within a 20-mile radius of a moderate-sized Midwestern community. This population primarily encompassed middle to lower fixed-income-level Caucasian females who had acquired a high school education and who lead moderately active social lives outside their homes despite age and varying illnesses or other physical disabilities.
Sample

The selection of subjects initially involved an identification of candidates through numerous community sources such as membership in the community activity center for the aged; resident lists of various housing facilities that are restricted to the elderly; and county agencies for the aged that maintain statistics, coordinate housing, provide or oversee meal programs, and create or facilitate a variety of other special aged-related activities/events. Names of these candidates were compiled into a list and the researcher then attempted to individually contact each person and explain the project, describe possible benefits and hazards, answer questions, and identify volunteers. At no time were the candidates ever informed of either the hypotheses or differences between experimental groups.

During an individual meeting with the researcher, persons indicating a willingness to volunteer for the study were handed the necessary consent/release forms which they read and discussed. Once the forms were signed, and based upon each person's anticipated availability throughout the study, 30 volunteers out of more than 200 candidates were assigned to a subjects pool. Subjects were then assigned to the various experimental groups which included Hypnotherapy (HT), Cognitive Experiential Hypnotherapy (CEH), and Control (CO). One subject was subsequently eliminated from the Control condition for failure to properly complete an
assessment of the dependent variables. Average age of the remaining sample was 67 years 5 months (range 55-83 years), not including one subject who failed to self-report age. The sample included 25 females and 4 males.

Total random assignment of subjects to the experimental conditions was intended, but was thwarted due to various intervening circumstances. These circumstances included three married couples where the spouses were unwilling to be separated. Two couples were then placed in the HT group and one was placed in the CEH group. A fourth pair of participants also did not wish to be separated and was placed in the CEH treatment group. Transportation/scheduling appeared to be an influence in each case. That is, where pairs of such participants were originally split between treatments due to the assignments, and with each HT session being scheduled immediately prior to each CEH session, one person in each pair would at some point be left waiting for the other.

Therapist

The therapist was a 37-year-old, female, Caucasian, Ph.D.-level licensed psychologist possessing (a) more than 15 years of psychotherapeutic experience, (b) university level training in psychiatric hypnotherapy, and (c) training from the originators of specific cognitive and/or hypnosis-based psychotherapies especially pertinent to this inquiry.
(i.e., Dr. Albert Ellis for Rational Emotive Therapy, Dr. Maxie C. Maultsby, Jr. for Rational Behavior Therapy, and Dr. Donald J. Tosi for Rational Stage Directed Hypnotherapy). In addition, the project was under the clinical supervision of a 67-year-old, male, Caucasian, licensed psychologist with more than 30 years of academic and clinical experience. The supervising psychologist observed only and participated in the study in no other way.

Instrumentation

Two self-administered instruments were utilized to measure levels of self-concept and depression. Respectively, these instruments included the Tennessee Self Concept Scale (TSCS) and the Minnesota Multiphasic Personality Inventory (MMPI) Depression Scale (D). Due to the age of the subjects and some apparent visual difficulties with reading small print, each person was provided with a copy of TSCS and MMPI questions that had been retyped in large print with spaces for answers provided to the right of each question. A 10-item instrument, the Self-Rating Anxiety Scale (Zung, 1971), was piloted to assess its viability for use in a future project. No use of its data was made herein.
Tennessee Self Concept Scale

Due to increasing awareness as to the significance of self-concept, numerous instruments have been developed to measure it. Wylie (1974) specifically emphasizes an enormous proliferation of such instruments. Fitts (1965) notes that despite the early availability of these instruments, there was a continuing need for a self-concept scale which was "simple for the subject, widely applicable, well standardized, and multi-dimensional in its description of self concept," including the need for a scale that might "provide a common thread for tying together many research and clinical findings" (p. 1). The TSCS was developed to meet these perceived needs.

Among the myriad of self-concept-related instruments, the TSCS is recommended on the basis of its wide acceptance and usage, as well as its prior implementation with elderly populations (see Thompson, 1972). The TSCS is also cited as being "one of the finest self concept instruments available" (Crandall, 1975, p. 156). It consists of 100 self descriptive statements that an individual uses to portray "his own picture of himself" (Fitts, 1965, p. 1). Fitts also notes that this self-administered instrument is suitable for subjects "age 12 or higher having at least a sixth grade reading level," in addition to being appropriate for "the whole range of psychological adjustment from healthy, well adjusted people to psychotic patients" (p. 1).
The TSCS was developed from a large pool of items, many of the items having been adopted from other self-concept measures. New items were formulated from written self-descriptions of both patients and non-patients. The original pool of items was eventually reduced to 90. These items were then individually classified and equally divided as either positive or negative. The summary score for all 90 items was designated the Total P Score (for Total Positive). Added to these 90 items were 10 additional items taken from the MMPI L-Scale (Lie Scale) for use as the Self Criticism Scale (Fitts, 1965). The choice of responses to each item on the instrument includes the following: Completely False, Mostly False, Partly False and Partly True, Mostly True, Completely True.

In addition to being classified as either positive or negative, the 90 items which constitute the Total P Score were also classified according to a phenomenological system of eight categories based upon how people might represent themselves—the retention of each specific item in the instrument being dependent upon the perfect agreement of seven clinical psychologists who served as judges concerning its classification. This phenomenological system is operationalized as a 3 X 5 matrix or grid that is directly employed within the scoring system, each category effectively constituting a subscale of global self-concept or the Total P Score.
Descriptions for the Total P Scale, each of the eight major subscales, the Self Criticism Scale, and a variety of prominent additional scales are provided as follows (Fitts, 1965):

**Total P Score.** The Total P Score indicates the overall level of general self-concept.

**Identity.** Identity is descriptive of people as they see themselves. It describes an individual's basic identity.

**Self Satisfaction.** Self Satisfaction indicates the extent of self-satisfaction or self-acceptance. It is descriptive of how one feels about the self that is perceived.

**Behavior.** Behavior measures how individuals perceive their behavior, concerning the things that they do or the way they act.

**Physical Self.** Physical Self reflects how individuals view their body, health, physical appearance, skills, and sexuality.

**Moral-Ethical Self.** This indicates how persons describe themselves in terms of moral worth, relationship to God, feelings of being good or bad, and satisfaction with their religion.

**Personal Self.** Personal Self is indicative of one's sense of personal self-worth and encompasses an
evaluation of one's personality, but apart from one's physical body or interpersonal relationships.

**Family Self.** Family Self indicates an individual's perception of self-worth as a family member or in relation to others who are especially close or meaningful.

**Social Self.** Social Self is one's perception of self-adequacy in relation to others, but in a more general, less intimate sense than is reflected by Family Self.

In addition to these eight basic subscales, various other scales/scores are generated by the TSCS and are sometimes used to facilitate a more intricate clinical evaluation. These additional subscales/scores are as follows (Fitts, 1965):

**Self Criticism Score (SC).** The SC Score consists of mildly derogatory statements. Persons who deny most of these items (low scores) are often seen as defensive. Circumstances involving low SC scores would suggest that the Total P scores may be artificially increased by such defensiveness. High SC scores indicate normal or healthy openness and the capacity for self-criticism. Extremely high scorers may be pathologically undefended.

**Total Variability Score (Total V).** The Total V Score is a measure of inconsistency between different areas of self-perception. As opposed to a highly integrated
sense of self, those with elevated scores experience a tendency to compartmentalize and emphasize specific aspects of the self, apart from what is termed the remainder of self. This score is differentiated into subscores which highlight independent areas of compartmentalization.

**Distribution Score** (D). The D Score indicates (a) the distribution of responses across the five available answers for each item and (b) the certainty with which one views one's self (higher scores indicate more certainty, whereas low scores indicate less certainty and greater defensiveness). A Total D score and five individual D subscores are provided, each of these five subscores representing one of the five possible answers to each test item.

**Time.** The Time Score is the time taken to complete the instrument to the nearest minute. Fitts indicates that little is known of its significance.

**True-False Ratio** (T/F). The T/F Ratio is a measure of response set or response bias and is a ratio of Completely True and Mostly True responses to Completely False and Mostly False responses. Partly True and Partly False responses are not employed in the calculation.

**Net Conflict Scores.** The Net Conflict Scores (one for each of the eight major subscales) are said to be
highly correlated with the T/F Score, but more specifically measure the degree of conflict between one's tendency to endorse positive versus negative responses within various areas of self-perception. Two types of conflict are (a) Acquiescence Conflict where positive scores are greater than negative scores, indicating that subjects are over-affirming their positive attributes, and (b) Denial Conflict where negative scores are greater than positive scores, indicating that subjects are over-denying their negative attributes.

**Total Conflict Scores.** Total Conflict Scores (one for each of the eight subscales) measure the total magnitude of positive plus negative scores, rather than the net difference between positive and negative scores (as was the case with the Net Conflict Scores, above). High scores reflect confusion and general conflict relative to self-perception, with low scores indicating the reverse. Extremely low scores, however, reflect persons possessing a rigid description of self, suggesting what is referred to as an artificial, defensive stereotype versus a true self-image.

**Empirical Scales.** The Empirical Scales were derived on the basis of their capacity to differentiate various types of groups (via item analysis). Information relative to each of these scales follows:
Defense Positive Scale (DP). The DP Scale score is similar to the Self Criticism Score, though more subtly sensitive to defensiveness. That is, it may detect defensiveness even below the level of conscious awareness. High DP scores are indicative of a positive self-description deemed to result from defensive distortion, and low scores are said to indicate a deficiency in the usual defenses necessary for maintaining even minimal self-esteem.

General Maladjustment Scale (GM). The GM Scale discriminates psychiatric from non-patients without discriminating one patient group from another. Fitts refers to the GM Scale as a general index of adjustment-maladjustment.

Psychosis Scale (Psy). The Psy Scale differentiates psychotic patients from persons falling within other patient groups.

Personality Disorder Scale (PD). The PD Scale is said to differentiate persons with basic personality-related defects/weaknesses from those who experience psychotic states or neurotic reactions.

Neurosis Scale (N). The N Scale differentiates neurotic patients from other groups.

Personality Integration Scale (PI). The PI Scale identifies those persons possessing an at least
average level of adjustment or personality integration.

**Number of Deviant Signs Score (NDS).** The NDS Score is cited to be the TSCS's best index of psychological disturbance and involves the sum of all deviant scores from the other scales.

The group used by Fitts in the standardization and development of norms is cited to have included persons from across the United States with the following characteristics (Fitts, 1965): (a) an age range of 12 to 68; (b) an approximately equivalent number of males and females; (c) both Blacks and Caucasians; and (d) persons of all social, economic, intellectual, and education levels from grade 6 through Ph.D. Fitts notes that though it is possible to considerably expand the norm group or create separate norms, this has not been done because (a) "samples from other populations do not differ appreciably from the [existing] norms" and (b) "the effects of such demographic variables as sex, age, race, education, and intelligence on the scores of this Scale [TSCS] are quite negligible" (p. 13).

Fitts (1965) states that the TSCS addresses four kinds of validity, that is, content validity, discrimination between groups, correlation with other personality measures, and personality changes. The intended purpose of establishing content validity, according to Fitts, was to insure the dependability of the classification system which involves
the eight self-description categories. Content validity for the TSCS was deemed to have been established by the group of judges who reached unanimous agreement on the classification of each item with respect to these categories or subscales.

The concept of validity, as based on discrimination between groups, is grounded in the idea that "groups which differ on certain psychological dimensions should differ also in self concept" (Fitts, 1965, p. 17). The TSCS Total P Score, and most other TSCS scores, have been shown to discriminate between psychiatric and non-patients at a highly significant level, according to Fitts. Discrimination is also emphasized relative to within-patient groups and between groups with differing behavior. Relatedly, Fitts states that TSCS discrimination holds up quite well in cross-validation groups.

Fitts (1965) notes that "most of the scores of the Scale [TSCS] correlate with MMPI scores in ways one would expect" (p. 24). Concerning personality changes, Fitts observes that certain life experiences such as psychotherapy would be expected to affect the way people view themselves. Further, Fitts indicates that self-concept, as measured by the TSCS, does change in response to significant experiences and that this constitutes further evidence for the validity of the TSCS. Test-retest reliability is cited by Fitts as .92 for the Total P Score and between .60 and .92 for the other scales/scores (see Table 5).
### TABLE 5

**Tennessee Self Concept Scale**

**Test-Retest Reliability Coefficients**

<table>
<thead>
<tr>
<th>Scale</th>
<th>Coefficient</th>
<th>Scale</th>
<th>Coefficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total P</td>
<td>.92</td>
<td>Time</td>
<td>.89</td>
</tr>
<tr>
<td>Identity</td>
<td>.91</td>
<td>True-False</td>
<td>.82</td>
</tr>
<tr>
<td>Self Satisfaction</td>
<td>.88</td>
<td>Net Conflict</td>
<td>.65–.82⁴</td>
</tr>
<tr>
<td>Behavior</td>
<td>.88</td>
<td>Total Conflict</td>
<td>.61–.80⁵</td>
</tr>
<tr>
<td>Physical Self</td>
<td>.87</td>
<td>Defense Positive</td>
<td>.90</td>
</tr>
<tr>
<td>Moral-Ethical Self</td>
<td>.80</td>
<td>General Maladjustment</td>
<td>.87</td>
</tr>
<tr>
<td>Personal Self</td>
<td>.85</td>
<td>Psychosis</td>
<td>.92</td>
</tr>
<tr>
<td>Family Self</td>
<td>.89</td>
<td>Personality Disorder</td>
<td>.89</td>
</tr>
<tr>
<td>Social Self</td>
<td>.90</td>
<td>Neurosis</td>
<td>.91</td>
</tr>
<tr>
<td>Self Criticism</td>
<td>.75</td>
<td>Personality Integration</td>
<td>.90</td>
</tr>
<tr>
<td>Variability</td>
<td>.67</td>
<td>Number of Deviant Signs</td>
<td>.90</td>
</tr>
<tr>
<td>Distribution</td>
<td>.89</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Note.** Adapted from Fitts (1965, p. 14).

⁴Range for the NC Subscale.

⁵Range for the TC Subscale.
Minnesota Multiphasic Personality Inventory

The Minnesota Multiphasic Personality Inventory (MMPI) is perhaps the most prominent and established of all objective personality inventories, with more than 9,000 citations to its credit (Graham, 1977). The MMPI, originally called the Medical and Psychiatric Inventory, was created by Starke R. Hathaway (a psychologist) and J. Charnley McKinley (a psychiatrist) to provide an objective means of assessing "major personality characteristics that affect personal and social adjustment" (Hathaway & McKinley, 1967, p. 7). It was also developed as an objective tool for "routine psychiatric case work-up of adult patients and as a method for determining the severity of the conditions" (Dahlstrom, Welsh, & Dahlstrom, 1972, p. 4).

According to Hathaway (1972), most of the other personality instruments at the time the MMPI was developed incorporated scales derived from the rational development of items possessing face validity. An indicated consequence of this non-empirical approach to scale development was an inventory of personality assessment devices deficient relative to their theoretical bases and clinical usefulness. Hathaway further indicates that even if such other instruments were empirically derived, this was accomplished from clinically heterogeneous groups.

MMPI items were originally identified from a pool of more than 1,000 statements. These statements were drawn
from numerous sources including clinical reports, case studies, clinical experience, and other instruments. Utilizing an empirical approach, the statements were then refined and reduced in number to 504. That is, regardless of the nature or content, items were retained that tended to facilitate the discrimination of various abnormal conditions related to the nosological dimensions being assessed. Subsequently, items were added from other sources, as with the MMPI Lie Scale where items were adapted from outside research on character and deceit. All responses to MMPI items are limited to one of three choices—that is, True, False, or ? (Cannot Say).

Nine scales were initially developed, many of these scales sharing one or more of the original 504 items. Currently, there are 566 items which are said to be suitable for individuals with as low as a sixth-grade level of comprehension (Dahlstrom, Welsh, & Dahlstrom, 1972). Based upon these 566 items, there are now 14 primary scales and hundreds of additional special scales. The titles and descriptions of the 14 primary scales are presented as follows (Graham, 1977):

? Scale. The ? (Cannot Say) Scale is the sum of all responses marked ? as opposed to either True or False. The scale also includes those items left unmarked or ones where more than one response has been made to a particular statement. Dahlstrom, Welsh, and Dahlstrom
(1972) suggest that those with elevated scores on the ? Scale might be interviewed regarding possible causes, rather than attempting a blind interpretation.

L Scale. The L (Lie) Scale was intended to identify what is referred to as deliberate and rather unsophisticated attempts of individuals to make themselves look favorable.

F Scale. The F (Fake) Scale was intended to identify deviant ways of responding to the items on the inventory—that is, responses made by less than 10% of persons who are administered the MMPI. Graham notes that those who endorse items on this scale tend to exhibit paranoid thinking, antisocial attitudes/behavior, hostility, and difficulties concerning physical health problems. Valid F Scale scores may indicate the general level of overall psychopathology and serve as an index to test-taking attitude.

K Scale. As opposed to the insensitivity of the L Scale, the K Scale was developed as a more subtle vehicle for detecting test distortions made by persons completing the MMPI. Where the L Scale may detect intentional distortions, the K Scale was intended to detect distortions due to less conscious mechanisms such as denial. Higher scores are associated with a defensive orientation toward the test and lower scores to atypical frankness and self-criticality.
Hypochondriasis (Hs). The Hs Scale was intended to identify persons possessing a clinical preoccupation with their body, relative to fears of illness and disease. Graham states that factor analysis indicates this scale to be characterized by "the denial of good health and the admission of a variety of somatic symptoms" (p. 34).

Depression (D). The D Scale was developed to assess symptomatic depression. It addresses such things as broad dissatisfaction with one's life situation, withdrawal, lack of interest, and worry.

Hysteria (Hy). The Hy Scale is intended to identify persons who utilize hysterical behaviors in response to stressful circumstances.

Psychopathic Deviate (Pd). The Pd Scale is intended to identify persons who exhibit behaviors such as lying, stealing, sexual promiscuity, excessive drinking, and who might be diagnosed as asocial, amoral, or as a psychopathic type personality.

Masculinity-Femininity (Mf). The Mf Scale was originally developed to identify homosexual invert males. This scale has since been modified and is now interpreted to discriminate persons who deviate from their own sex. Extreme scores (either elevated or depressed) may be indicative of either masculine or
feminine appreciations and orientations, but not necessarily the actual presence of homosexuality.

**Paranoia** (Pa). The Pa Scale is intended to identify those with paranoid ideations and/or behaviors including such things as persecution, grandiosity, suspiciousness, or exaggerated sensitivity.

**Psychasthenia** (Pt). The Pt Scale might be interpreted as measuring something akin to obsessive-compulsive neurosis, and is deemed sensitive to such things as excessive doubts, compulsions, obsessions, and unreasonable fears.

**Schizophrenia** (Sc). The Sc Scale is intended to identify those who might be diagnosed as schizophrenic. This scale is deemed sensitive to disturbances in thinking, emotions, and behavior, as well as problems involving reality contact.

**Hypomania** (Ma). The Ma Scale is stated to identify those with elevated mood, accelerated speech and motor activity, irritability, flights of ideas, and brief periods of depression. Particularly elevated scores may be indicative of the manic phase of the manic-depressive syndrome.

**Social Introversion** (Si). The Si Scale is intended to identify the tendency to be socially active or withdrawn. Elevated scores suggest introversion and depressed scores suggest extroversion.
According to Hathaway and McKinley (1967), the original norm group consisted of approximately 700 normal persons who were friends and relatives of patients at the University of Minnesota Hospitals. This sample was considered a representative cross section of the Minnesota population, at least with respect to age, sex, and marital status (Dahlstrom, Welsh, & Dahlstrom, 1972). Also utilized in the norming process were data from 250 college entrance applicants. The actual development of the scales was based on more than 800 prediagnosed patients. The MMPI was subsequently renormed (Colligan, Osborne, Swenson, & Offord, 1983), but met with only limited professional acceptance.

Hathaway and McKinley (1967) emphasize that the major criterion of excellence for the MMPI was how well it predicted neuropsychiatric diagnosis. In this respect, a high scale score is cited to positively predict a comparable clinical diagnosis in more than 60% of new psychiatric admissions--the distinguishing between different clinical diagnoses being emphasized as far more difficult than distinguishing between normals and abnormals. It is further emphasized that even where the MMPI high scores do not match the final diagnosis, the presence of the MMPI designated trait will almost always be identified. While the authors admit their emphasis upon predictive power, rather than measures of reliability and validity, Hathaway (1972) states that the burden now rests upon construct validity.
Relative to reliability, Hathaway and McKinley (1967) point out that estimates of reliability for the MMPI heavily depend on the actual groups being tested, with scores for normals, as opposed to patients, being presumably more reliable due to the greater stability of these persons. Hathaway and McKinley present different sets of test-retest reliability data for the MMPI. Depending on the study and scale in question, test-retest reliability figures range from .46 to .93 (see Table 6). For the D Scale, which is of primary interest to this discussion, figures range from .66 to .80. The MMPI D Scale and the TSCS Total P Score have been cited as having a correlation of -.52 (Fitts, 1965).

As mentioned, the D Scale was designed to serve as a symptom measure (Graham, 1977). In this respect, Dahlstrom, Welsh, and Dahlstrom (1972) note that D Scale scores "serve as sensitive reflectors of current mood" (p. 187). Based on the research evidence, these authors further cite that D Scale items reflect depressive mood states regardless of the underlying character structure or adjustment status. As to mental-health-related changes, Dahlstrom, Welsh, and Dahlstrom emphasize the viability of the D Scale in charting the course and evaluating the progress of different therapeutic regimes, as well as its utility with individuals dissimilar to the psychotic group of patients employed in the original development of the D Scale.
### TABLE 6

Minnesota Multiphasic Personality Inventory
Test-Retest Reliability Coefficients

<table>
<thead>
<tr>
<th>Scale</th>
<th>Hathaway and McKinley</th>
<th>Holzberg and Alessi</th>
<th>Cottle</th>
<th>Drake</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>?</td>
<td>.75</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>L</td>
<td>.85</td>
<td>.46</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>.93</td>
<td>.75</td>
<td></td>
<td></td>
</tr>
<tr>
<td>K</td>
<td></td>
<td>.76</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hs</td>
<td>.80</td>
<td>.67</td>
<td>.81</td>
<td></td>
</tr>
<tr>
<td>D</td>
<td>.77</td>
<td>.80</td>
<td>.66</td>
<td></td>
</tr>
<tr>
<td>Hy</td>
<td>.57</td>
<td>.87</td>
<td>.72</td>
<td></td>
</tr>
<tr>
<td>Pd</td>
<td>.71</td>
<td>.52</td>
<td>.80</td>
<td></td>
</tr>
<tr>
<td>Mf</td>
<td></td>
<td>.76</td>
<td>.91</td>
<td></td>
</tr>
<tr>
<td>Pa</td>
<td></td>
<td>.78</td>
<td>.56</td>
<td></td>
</tr>
<tr>
<td>Pt</td>
<td>.74</td>
<td>.72</td>
<td>.90</td>
<td></td>
</tr>
<tr>
<td>Sc</td>
<td></td>
<td>.89</td>
<td>.86</td>
<td></td>
</tr>
<tr>
<td>Ma</td>
<td>.83</td>
<td>.59</td>
<td>.76</td>
<td>.93</td>
</tr>
<tr>
<td>Si</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Note.** Adapted from Hathaway and McKinley (1967, p. 8). For scales listed under Hathaway and McKinley above, on Hs see McKinley and Hathaway (1940); on D see Hathaway and McKinley (1942); on Pt see McKinley and Hathaway (1942); and on Hy, Pd, and Ma see McKinley and Hathaway (1944).
Data Collection

Data collection for the study was initiated when the researcher met individually with each subject prior to the first treatment session. At that time, each subject was given a copy of the self-administered instruments. Instructions were read and explained by the researcher and administrative questions were then solicited and answered. The administration of the TSCS and MMPI Depression Scale was untimed, but typically requires between 15 and 30 minutes. These procedures were replicated during the week following the last treatment session (Posttest I) and again at a one-month follow-up (Posttest II). Code numbers rather than names were used on all instruments to protect the identity of each respondent. The same codes were also employed in the processing and storage of all data.

Responses on the self-concept scale were transferred by an independent party to a special TSCS form that permitted computerized scoring. Each transferred TSCS score was double-checked for accuracy. The experimenter subsequently rechecked a sample of transferred scores and discovered no errors. TSCS score sheets were then sent to the TSCS computer scoring service. A sample of the original unscored TSCS results was subsequently selected and hand-scored by the experimenter. Results were compared with the computer generated TSCS Total P Scores (global self-concept). No errors were identified.
Responses on the MMPI Depression Scale were hand-scored directly from the collection instrument by an independent party. Each response was then rescored to assure accuracy. Several scoring errors on the second trial were discovered and corrected. The scorer was instructed to again confirm the accuracy of all scores, with the result that no further errors were detected. The experimenter subsequently hand-scored a sample of the instruments and also discovered no further errors. All self-concept and depression scores were transferred to a tabulation sheet and subsequently encoded on IBM data cards for purposes of statistical analysis. Tabulating and encoding accuracy was double-checked with no errors being discovered.

Research Design

A pretest-posttest control group design was employed (Gay, 1981). This was configured as a 3 X 3 factorial with three levels of treatment (Hypnotherapy, Cognitive Experiential Hypnotherapy, and Control) and three levels of time-test measures (Pretest, Posttest I, and Posttest II). The design provides for random assignment of subjects to each treatment group. This design was implemented to control for as many sources of invalidity as possible and help ascertain the efficacy of treatment conditions over time-test measures. The design may be depicted as follows:
Where \( R \) indicates randomization, \( O \) represents time-test measures, and \( X_1 \) and \( X_2 \) designate HT and CEH, respectively.

Experimental Conditions

The experimental conditions employed with this study consisted of a control group (CO) and two hypnosis-based psychotherapy groups that are respectively identified as Hypnotherapy (HT) and Cognitive Experiential Hypnotherapy (CEH). HT and CEH treatments were structured to address various issues that plausibly impact the mental health of the elderly, with the mental health of the elderly being functionally viewed in terms of the dependent variables self-concept and depression. This constitutes a pre-specified, goal-direct treatment approach.

HT and CEH each possess integral and unique psychotherapeutic styles or approaches. The HT and CEH treatments were intended to reflect this uniqueness. Hence, other than in ways specified below, no attempt was made to control for inter-procedural inconsistencies that may occur between HT treatments and CEH treatments. Such inconsistencies might include the duration of individual treatment sessions (the equalization of which has been attempted in some previous
research) or specific wording employed during each phase of the parallel treatments. An attempt to manipulate treatments for high equivalency may not only be impossible, but might also arguably render one or both experimental conditions something other than viable examples of HT or CEH as herein introduced.

Balanced against this effort to maintain the functional integrity of the hypnosis-based psychotherapies employed, certain procedural parameters were implemented across both the HT and CEH treatment sessions to accommodate the experimental objectives of this study. These parameters are specified as follows:

1. That initial treatment sessions provide an explanation of the hypnosis process and an opportunity for subjects to ask questions.

2. That each treatment approximates a duration of 30 minutes (HT) or 40 minutes (CEH). HT sessions require less time to administer than the more elaborate CEH treatments.

3. That both HT and CEH treatments include identical hypnotic inductions, as grounded in Wolberg (1964).

4. That both HT and CEH treatments include identical trance terminating procedures.

5. That individual treatments for both the psychotherapies (HT and CEH) address identical therapeutic issues or themes within the same sequence.
6. That across all HT treatments and all CEH treatments, protocols for each of these two different forms of psychotherapy follow a general structure or process that is defined herein as characteristic of HT or CEH, respectively.

7. That both HT and CEH sessions are concluded by suggesting to the subjects that they practice/employ the procedure between meetings.

As per items 5 and 6 above, the therapeutic themes and the structure/process criteria for HT and CEH protocols are explicated by the discussions which follow.

**Therapeutic Themes by Session**

A review of the literature indicates that aging-related issues, themes, or events appear to be of psychotherapeutic significance relative to the mental health status of people in general, and the elderly in particular. Both the HT and CEH treatments employed by this study address many of these issues across the various treatment sessions. As therapeutically employed, these issues or themes may be summarized into three global areas: loneliness/boredom, health/helplessness, and income. Each treatment session was designed to address some aspect of these three areas and to introduce open-ended mental-health-related suggestions. The work of Tutaj (1975) reflects this issue/session oriented approach to the implementation of psychotherapeutic interventions for
purposes of researching the question of comparative treat-
ment efficacy with the aged.

Due to the integrated nature of psychotherapeutic
issues addressed by the treatment sessions, no attempt was
made to make any one issue completely independent of the
others. Often, one issue was referenced so as to augment
yet another related issue, or the same issue was addressed
from different perspectives. For example, loneliness was
addressed in terms of isolation and boredom. It was intend-
ed that both HT and CEH, each in its own unique way, be seen
to address the same psychotherapeutic issues. Therapeutic
issues or themes employed by both HT and CEH, during each of
the seven sessions, are itemized as follows:

Session 1: Loneliness--the loneliness that occurs from
the loss of family and friends as one grows older. Therapeutic emphasis was oriented
toward facilitating increased socialization behaviors.

Session 2: Isolation--the isolation of not feeling
acceptable to others, and loneliness resulting from people-avoiding behaviors.
Therapeutic emphasis was oriented toward
promoting a sense of acceptability, pleasure in others' company, and interests/
behaviors related to meeting other persons and the making of friends.
Session 3: Health—concerns surrounding one's physical health and taking care of oneself. Therapeutic emphasis was oriented toward facilitating greater confidence in one's health and the ability to actually cope with one's health-related circumstances.

Session 4: Boredom— the boredom of empty time and lost roles that may arise in later life through retirement and/or children leaving home. Therapeutic emphasis was oriented toward eliciting interests and behaviors related to activities that can be viewed as personally enjoyable pursuits.

Session 5: Income—personal concerns over financial issues ranging from basic survival needs to obtaining extras in life. Therapeutic emphasis was oriented toward evoking a sense of worth apart from money concerns and realizing one's ability to explore and implement ways of doing something about one's financial circumstances, such as budgeting or seeking outside help.

Session 6: Institutionalization—distress that health or vitality-related difficulties may result in either temporary or permanent institutionalization. Therapeutic emphasis was
oriented toward evoking greater self-confidence in one's health, a sense of personal coping over concerns relating to the possibility of institutionalization, and the realization that institutional care may in some ways be viewed to facilitate positive improvements in one's life circumstances.

Session 7: Future—difficulties posed by concerns of having nothing left to live for in the future. Therapeutic emphasis was oriented toward pulling together psychotherapeutic material presented in the previous six sessions, while also facilitating the possible application of such material through the medium of personal commitment to change and the development/realization of personally satisfying goals for the future.

**Hypnotherapy Treatment Condition**

The Hypnotherapy treatment condition (HT), as employed within this study, incorporates procedures across all seven sessions as governed by the following general guidelines:

1. Present four-part hypnotic induction (see Appendix A).
2. Introduce therapeutic issue for the session, such as isolation.

3. Elaborate issue via descriptive dialogue.

4. Introduce therapeutic suggestions relative to the issue or theme of the session.

5. Emphasize suggestions concerning positive views/feelings about oneself and behaving in a self-enhancing manner relative to the therapeutic issue, such as getting out and meeting people and finding satisfaction in doing so.

6. Introduce suggestions indicating positive future improvements/benefits.

7. Implement trance terminating procedure (see Appendix A).

For HT, an example demonstrating the operationalization of steps 2 through 6 is provided in Appendix B.

**Cognitive Experiential Hypnotherapy Treatment Condition**

The Cognitive Experiential Hypnotherapy treatment condition (CEH), as employed within this study, incorporates procedures across all seven sessions as governed by the following general guidelines:

1. Present four-part hypnotic induction (see Appendix A).

2. Introduce five-component Cognitive Restructuring paradigm (Tosi & Marzella, 1977).
3. Introduce therapeutic issue for the session, such as isolation.

4. Introduce irrational experiential sequence:
   (a) Elaborate issue via descriptions ending with subjects' selection of an issue- or theme-related activating event to be experientially analyzed/processed.
   (b) Elaborate irrational/negative self-talk.
   (c) Elaborate debilitating emotions following from the self-talk.
   (d) Elaborate uncomfortable physical sensations flowing from irrational/negative self-talk and debilitating emotions.
   (e) Elaborate less optimal behaviors occurring subsequent to the irrational/negative thoughts, emotions, and physical sensations.

5. Introduce rational experiential sequence:
   (a) Reintroduce original issue- or theme-related activating event to be experientially analyzed/processed.
   (b) Elaborate rational/positive self-talk.
   (c) Elaborate enhancing emotions following from the self-talk.
   (d) Elaborate comfortable physical sensations flowing from rational/positive self-talk and enhancing emotions.
(e) Elaborate more optimal behaviors that may occur subsequent to the rational/positive thoughts, emotions, and physical sensations.

6. Introduce suggestions indicating positive future improvements/benefits.

7. Implement trance terminating procedure (see Appendix A).

For CEH, an example demonstrating the operationalization of steps 2 through 6 is provided in Appendix C.

Control Condition

The Control (CO) was not subject to manipulation and was involved only in an assessment of the dependent variables. As with the other experimental conditions, data collection from the control was accomplished through a Pretest, Posttest I (at the conclusion of the final treatment session), and Posttest II (at a one-month follow-up) administration of the dependent measures.

Administrative Procedures

Just prior to each treatment session, the treatment facility was prepared by checking the temperature, arranging the chairs, and setting up the speaker system. Subjects unable to walk or drive to the treatment site, ranging between 8 and 17 persons for any particular session, were assembled by means of busses contracted for through the
activity center where the treatments were conducted. The treatments were scheduled in the evenings beginning at approximately 6:00 P.M. The HT treatment immediately preceded the CEH treatment. On three occasions, where one or more subjects could not attend one of the pre-scheduled sessions, all treatments for that day were cancelled and moved to the next treatment date. This was done so as to avoid providing individualized make-up sessions. HT and CEH treatments spanned a period of approximately two months.

Statistical Analysis

All analyses were conducted by means of the Statistical Analysis System (SAS), a comprehensive computer-based statistical analysis program. A one-way, or simple, Analysis of Variance (ANOVA) was preliminarily employed to verify the existence of equivalency between pretest scores, on measured dependent variables, for the various experimental conditions (Keppel, 1982). The subsequent analysis of data involved a 3 X 3 factorial Analysis of Variance with repeated measures (Myers, 1979). This included one between-subjects variable, group (three levels of treatment); one within-subjects variable, time (three levels of repeated measure); and a test for interaction effects. Group, time, and interaction respectively address each portion of the null hypothesis ($H_0: a, b, c$).
CHAPTER IV
ANALYSIS OF DATA

This chapter provides an analysis of the data, a presentation of the findings, and a summary of implications relative to the hypotheses. The statistical (null) hypothesis consisted of three components. It specified the realization of (a) no significant difference between experimental conditions that included Hypnotherapy (HT), Cognitive Experiential Hypnotherapy (CEH), and Control (CO); (b) no significant difference between the times of measurement across HT, CEH, and CO; and (c) no evidence of significant differential effectiveness between the treatment conditions depending upon the time of measurement.

A pretest-posttest control group research design was employed. This was configured as a 3 X 3 factorial with three levels of treatment (HT, CEH, and CO) and three levels of time-test measures (Pretest, Posttest I at approximately two months, and Posttest II at a one-month follow-up). The statistical analysis preliminarily involved a simple, one-way Analysis of Variance on pretest data to verify initial equivalency between the various experimental research conditions. A primary analysis was then conducted that
involved a Repeated Measures Analysis of Variance. This procedure tested for statistical significance of main effects on the variables group (between-subjects) and time (within-subjects), and for interaction effects at the various levels of each.

The preliminary one-way Analysis of Variance, on pre-test scores of self-concept across the experimental groups, generated the value $F(2, 26) = 2.26, p < .1249$ (see Table 7). A second one-way Analysis of Variance was conducted on pretest scores of depression and produced the value $F(2, 26) = 1.30, p < .2910$ (see Table 8). The related pretest cell means and standard deviations on self-concept and depression are provided (see Table 9 and Table 10, respectively).

These findings tend to indicate the absence of any initial significant difference between experimental research groups on the dependent variables self-concept and depression. That is, at the outset of the study, the treatment groups (HT and CEH), with their respective research subjects, may thus be presumed equivalent with a reasonable degree of certainty.

Subsequent to determining initial equivalency between research conditions on the dependent variables self-concept and depression, the means and standard deviations for the remaining cells at Posttest I and Posttest II were derived (see Table 9 and Table 10). All cell means, over each
### TABLE 7
Analysis of Variance for Treatment Groups on Pretest Measures of Self-Concept Using the Tennessee Self Concept Scale

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>SS</th>
<th>Mean Square</th>
<th>F</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group</td>
<td>2</td>
<td>4073.58</td>
<td>2036.79</td>
<td>2.26</td>
<td>.1249</td>
</tr>
<tr>
<td>Subjects(Groups)</td>
<td>26</td>
<td>23476.56</td>
<td>902.94</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>28</td>
<td>27550.14</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### TABLE 8
Analysis of Variance for Treatment Groups on Pretest Measures of Depression Using the Minnesota Multiphasic Personality Inventory

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>SS</th>
<th>Mean Square</th>
<th>F</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group</td>
<td>2</td>
<td>117.04</td>
<td>58.52</td>
<td>1.30</td>
<td>.2910</td>
</tr>
<tr>
<td>Subjects(Groups)</td>
<td>26</td>
<td>1174.82</td>
<td>45.19</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>28</td>
<td>1291.86</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### TABLE 9
Cell Means and Standard Deviations for Treatment Groups on Repeated Measures of Self-Concept Using the Tennessee Self Concept Scale

<table>
<thead>
<tr>
<th>Times of Measurement</th>
<th>Experimental Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>HT&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>Pretest</td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>359.10</td>
</tr>
<tr>
<td>Standard Deviation</td>
<td>26.84</td>
</tr>
<tr>
<td>Posttest I</td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>359.60</td>
</tr>
<tr>
<td>Standard Deviation</td>
<td>28.23</td>
</tr>
<tr>
<td>Posttest II</td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>358.80</td>
</tr>
<tr>
<td>Standard Deviation</td>
<td>27.92</td>
</tr>
</tbody>
</table>

<sup>a</sup>Hypnotherapy (HT):  n = 10  
<sup>b</sup>Cognitive Experiential Hypnotherapy (CEH):  n = 10  
<sup>c</sup>Control (CO):  n = 9
<table>
<thead>
<tr>
<th>TIMES OF MEASUREMENT</th>
<th>Experimental Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>HT&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>Pretest</td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>21.50</td>
</tr>
<tr>
<td>Standard Deviation</td>
<td>6.06</td>
</tr>
<tr>
<td>Posttest I</td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>22.60</td>
</tr>
<tr>
<td>Standard Deviation</td>
<td>6.67</td>
</tr>
<tr>
<td>Posttest II</td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>22.90</td>
</tr>
<tr>
<td>Standard Deviation</td>
<td>5.90</td>
</tr>
</tbody>
</table>

<sup>a</sup>Hypnotherapy (HT): \( n = 10 \)

<sup>b</sup>Cognitive Experiential Hypnotherapy (CEH): \( n = 10 \)

<sup>c</sup>Control (CO): \( n = 9 \)
repeated measure, were then plotted for both self-concept and depression. An inspection of the plot for self-concept (see Figure 1) tends to indicate that measured levels for HT and CO are fairly stable from Pretest through Posttest II. For the CEH treatment condition, a small increase is depicted in self-concept from Pretest to Posttest I, but is followed by a more substantial increase at the Posttest II follow-up. This increase introduces the possibility of a significant interaction at Posttest II between CEH and CO.

An inspection of the plot for depression (see Figure 2) tends to indicate that the various research conditions (HT, CEH, and CO) remained relatively stable across repeated measures. CEH may be seen to increase somewhat from Pretest I to Posttest II, and level off thereafter. HT increases slightly from Pretest to Posttest I, and again to Posttest II. The CO condition decreases somewhat from Pretest to Posttest I, but partially recovers by Posttest II. In summary, the overall outcome effects for the experimental research conditions do not appear to have been all that large or distinct from one another, with the possible exception of the noted increase in self-concept for CEH at Posttest II.

In order to statistically clarify these observations and test the null hypothesis, which specified no significant differences between groups, times of measurement, and no significant interaction between levels of each, a Factorial
FIGURE 1. Plotted Means for Treatment Groups on Repeated Measures of Self-Concept Using the Tennessee Self Concept Scale

Note. Experimental conditions include Hypnotherapy (HT), Cognitive Experiential Hypnotherapy (CEH), and a Control Condition (CO).
FIGURE 2. Plotted Means For Treatment Groups on Repeated Measures of Depression Using the Minnesota Multiphasic Personality Inventory

Note. Experimental conditions include Hypnotherapy (HT), Cognitive Experiential Hypnotherapy (CEH), and a Control Condition (CO).
Analysis of Variance for repeated measures was conducted. This analysis provides a test for group, time, and interaction effects on each of the dependent variables. Concerning a test of main effects for group, on self-concept the analysis produced an $F(2, 26) = 1.72, p < .1983$ (see Table 11). For depression, the analysis generated an $F(2, 26) = 2.69, p < .0864$ (see Table 12). These outcomes tend to indicate the existence of no significant difference. The experimental conditions (HT, CEH, CO) thus demonstrate essentially the same degree of effects on measures of self-concept and depression, respectively.

The Repeated Measures Analysis of Variance also provides, on the dependent variables self-concept and depression, a test of main effects for time across experimental conditions. For self-concept, the analysis produced a value $F(2, 52) = 2.63, p < .0813$ (see Table 11). For depression, the analysis produced a value $F(2, 52) = 14, p < .8663$ (see Table 12). As with the main effects for group, these outcomes indicate the existence of no significant difference. Consequently, no significant difference in effects was found between times of measurement on self-concept and depression across the experimental conditions (HT, CEH, CO).

Finally, the Repeated Measures Analysis of Variance for interaction effects, at the various levels of group and time, rendered an $F(4, 52) = 2.23, p < .0782$ for self-concept (see Table 11) and an $F(4, 52) = 1.74, p < .1545$
TABLE 11
Analysis of Variance for Treatment Groups on Repeated Measures of Self-Concept Using the Tennessee Self Concept Scale

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>Sums and Partial Sums of the Squares</th>
<th>Mean Square</th>
<th>F</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group</td>
<td>2</td>
<td>7857.12</td>
<td>3928.56</td>
<td>1.72</td>
<td>.1983</td>
</tr>
<tr>
<td>Subjects(Gp)</td>
<td>26</td>
<td>59283.13</td>
<td>2280.12</td>
<td>10.63</td>
<td>.0001</td>
</tr>
<tr>
<td>Time</td>
<td>2</td>
<td>1129.56</td>
<td>564.78</td>
<td>2.63</td>
<td>.0813</td>
</tr>
<tr>
<td>Time X Group</td>
<td>4</td>
<td>1913.91</td>
<td>478.48</td>
<td>2.23</td>
<td>.0782</td>
</tr>
<tr>
<td>T X S(Gp)</td>
<td>52</td>
<td>11149.08</td>
<td>214.41</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>86</td>
<td>81387.59</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

\(^a\)Subjects(Group)
\(^b\)Time X Subjects(Group)
TABLE 12
Analysis of Variance for Treatment Groups on Repeated Measures of Depression Using the Minnesota Multiphasic Personality Inventory

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>Sums and Partial Sums of the Squares</th>
<th>Mean Square</th>
<th>F</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group</td>
<td>2</td>
<td>639.37</td>
<td>319.68</td>
<td>2.69</td>
<td>.0864</td>
</tr>
<tr>
<td>Subjects(Gp)&lt;sup&gt;a&lt;/sup&gt;</td>
<td>26</td>
<td>3084.15</td>
<td>118.62</td>
<td>17.20</td>
<td>.0001</td>
</tr>
<tr>
<td>Time</td>
<td>2</td>
<td>1.99</td>
<td>.99</td>
<td>0.14</td>
<td>.8663</td>
</tr>
<tr>
<td>Time X Group</td>
<td>4</td>
<td>48.10</td>
<td>12.02</td>
<td>1.74</td>
<td>.1545</td>
</tr>
<tr>
<td>T X S(Gp)&lt;sup&gt;b&lt;/sup&gt;</td>
<td>52</td>
<td>358.66</td>
<td>6.90</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>86</td>
<td>4132.85</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<sup>a</sup>Subjects(Group)
<sup>b</sup>Time X Subjects(Grupo)
for depression (see Table 12). These values also suggest the existence of no significant effects.

As an ancillary procedure to the primary analysis, correlations were derived between self-concept and depression scores for each of the time-test measures. Results for Pretest, Posttest I, and Posttest II yielded a Pearson Product-Moment Correlation Coefficient $r$ (and level of significance $p$) = -.5340 (.0029), -.5202 (.0038), and -.4698 (.0101), respectively. These correlations indicate a moderate to substantial inverse relationship. Referencing assessments of 102 psychiatric patients reported by R. K. McGee (personal communication, 1960), Fitts (1965) cites a Pearson Product-Moment Correlation Coefficient $r$ (and confidence interval) = -.52 ($r +/-.25 = .01$) on these same variables using measures identical to those herein (p. 25).

The results from this analysis may be viewed to address the null hypothesis with a reasonable degree of certainty. First, the lack of a significant main effect for group tends to support the null contention that no difference exists in outcomes between HT, CEH, and CO. Second, the lack of a significant main effect for time may be viewed to support the null contention of no difference between times of measured outcomes across HT, CEH, and CO. And, third, the non-significant results for group-time interaction support the null contention that HT, CEH, and CO do not experience differential effects depending upon the time of measurement.
These findings result in a failure to reject the null hypothesis. No post-hoc analysis is necessitated.
CHAPTER V
SUMMARY, CONCLUSION, AND RECOMMENDATIONS

Summary

It has been observed that, "despite the widespread application of psychological treatment for a variety of emotional and human relationship problems, there are few case examples in the literature describing treatment with the aged, and virtually no systematic outcome studies of the impact of psychotherapy in an aged sample" (Zarit, 1980, p. 282). Similarly, it has been noted that "because of referral and treatment modality bias, few elderly are available for systematic, process and outcome outpatient studies, and most of the evidence of 'success' for individual treatment with community elderly is anecdotal" (Levy, Deragatis, Gallagher, & Gatz, 1980, p. 45). This study was designed to address such circumstances within the context of evaluating two hypnosis-based psychotherapies for use with non-institutional aged.

More specifically, the purpose of this study was to experimentally determine the efficacy of Hypnotherapy (HT) and Cognitive Experiential Hypnotherapy (CEH) in effecting mental-health-related benefits relative to self-concept.
and depression with a non-institutionalized elderly population. Dependent measures or indices of self-concept and depression included, respectively, the Tennessee Self Concept Scale (TSCS) Total P Score and the Minnesota Multiphasic Personality Inventory (MMPI) Depression Scale Score. Testing occurred just prior to the first treatment (Pretest), just after the last treatment (Posttest I), and at a one-month follow-up (Posttest II). The research setting consisted of a community activity center for the aged.

A sample of 30 volunteers was identified through calls and interviews from a population of non-institutionalized elderly living within a 20-mile radius of a moderately sized Midwestern community. Subsequently, each of these subjects was assigned to one of the three experimental conditions. The total randomization of assignments was intended, but was thwarted by unanticipated circumstances such as those relating to scheduling, transportation, and/or personal issues of the participants. Additionally, one subject was subsequently eliminated from the control group for failure to properly complete an assessment of the dependent variables.

The mean age for those completing the study was 67 years 5 months with an age range of approximately 55 through 83 years. One subject did not self-report age. The sample
included 25 females and 4 males generally possessing a high school education.

The HT and CEH experimental conditions received seven treatments over a period of nearly two months, with each of the sessions lasting approximately 30 minutes (HT) or 40 minutes (CEH). These treatments incorporated two parallel sequential presentations of seven therapeutic themes involving such issues as loneliness/boredom, health/helplessness, and income, which were adapted to the unique modus operandi of HT and CEH, respectively. All treatment sessions were provided from written transcripts by a psychotherapist previously trained and highly experienced with the specific psychotherapies employed. The Control condition (CO) involved only the collection of data by means of the dependent measures.

A 3 X 3 pretest-posttest control group design was employed with three levels of treatment (HT, CEH, and CO) and three levels of time-test measures (Pretest, Posttest I, and Posttest II). The statistical analysis included an initial one-way Analysis of Variance on pretest scores to test for preliminary equivalency between treatment groups. This produced an $F(2, 26) = 2.26, p < .1249$ on self-concept and an $F(2, 26) = 1.30, p < .2910$ on depression. No significant difference was demonstrated, indicating that the treatment groups were essentially similar on measured
levels of self-concept and depression at the outset of the study.

A primary statistical analysis was subsequently conducted by means of a 3 X 3 Repeated Measures Analysis of Variance. With each of the dependent variables, self-concept and depression, this provided a test of main effects for group and time, as well as a test for the existence of group-time interaction effects. For the variable group, the analysis produced an $F(2, 26) = 1.72, p < .1983$ on self-concept and an $F(2, 26) = 2.69, p < .0864$ on depression. For time, this analysis produced an $F(2, 52) = 2.63, p < .0813$ on self-concept and an $F(2, 52) = .14, p < .8663$ on depression. For interaction, the analysis produced an $F(4, 52) = 2.23, p < .0782$ on self-concept and an $F(4, 52) = 1.74, p < .1545$ on depression.

The primary statistical analysis failed to identify any significant effects for group, time, or interaction. These three findings respectively address each of the three components embodied within the null hypothesis which specify no significant differences between groups, between times of measurement, and no significant differential effects between groups depending upon the time of measurement (interaction). The outcomes thus result in a failure to reject the null hypothesis, indicating, with a reasonable degree of confidence, that no changes in self-concept or depression were realized as a consequence of the treatments employed.
Discussion

Research questions surrounding the efficacy of HT and CEH-related treatments have been answered with variable and inconsistent results by prior research. The variety of outcomes in the HT-CEH-related literature do, to some extent, suggest that these treatments are generally effective and that CEH is no less effective than other psychotherapeutic interventions. Such findings do not, however, provide a satisfactory basis of explanation for the unprecedented, uniformly non-significant outcomes realized by this study. The cause(s) of such consistently non-significant outcomes in the present study is not apparent and tends to be speculative at best. However, three prominent possibilities seem to merit consideration.

First, one possible explanation for the non-significant findings and the consequent failure to reject the null hypothesis concerns the treatments themselves. The treatments employed may be totally without psychotherapeutic efficacy. In view of the statistically significant results obtained across a considerable number of permutations to HT-CEH treatments in the related research, however, such a rationale does not seem to be sufficient.

Second, the emphasized limitations to the study, such as the number of research subjects employed, problems with random assignment of subjects, instrumentation, or possible reading/comprehension difficulties among the research
subjects, may have introduced sources of invalidity. Relatively, although designed and implemented according to the protocols presented and discussed, the treatments many have been executed by the therapist in such a manner as to render them ineffective. These explanations, however, also do not seem to provide a sufficient rationale considering the robust nature of outcome effects realized across related HT-CEH studies employing different research/treatment procedures and therapists as well.

The third explanation is one which was intended at the inception of the study to constitute a unique feature or strength. Specifically, given that the study was designed to investigate a distinct population that had not previously been explored, it seems reasonable that the non-institutionalized aged population employed may have contributed to the statistically non-significant results. In this respect, and for purposes of this inquiry, it might be questioned whether the circumstances and psychotherapeutic outcome effects pertaining to a non-institutionalized elderly population may be different from those of an institutionalized aged population. It seems appropriate to first discuss the institutionalized elderly in this regard, given that a population of this nature was previously investigated by Fuller (1982) in an HT-CEH-related study.

Brink (1979) addresses a possibly differentiating mental-health-related characteristic of institutionalization
by observing that "too many patients who go into LTCs [long-term care facilities] for purely physical reasons develop mental problems" (p. 288). Butler and Lewis (1977) refer to this circumstance as institutional neuroses. Pfeiffer (1977) cites figures which indicate the rate of psychiatric disorders among aged nursing home residents to be as high as 70% or 80%. In this sense, such institutions for the aged might be viewed as heavily embracing a clinically defined population of mentally and emotionally disturbed elderly. While institutionalization itself can be suspected as a primary cause of these disabilities, there are arguments to the contrary.

Gottesman (1977) argues against institutionalization as a major cause of mental health disabilities by emphasizing that many such mental-health-related difficulties already exist prior to institutionalization. In this vein, Levy, Deragatis, Gallagher, and Gatz (1980) observe that entry into an institution "normally follows increasing mental or physical incapacity or both in the absence of the social support that might otherwise have enabled the person to remain in the community" (p. 48). Brody (1981) concludes that "there is general agreement that negative effects cannot be attributed simplistically to the fact of living in an institution" (p. 315).

Regardless of whether institutionalization is the major influence upon the occurrence of mental health disabilities
in the aged, Brody (1981), in a particularly salient review, observes that "patients placed in cold, dehumanized, dependency-fostering environments show declines" (p. 316). Butler and Lewis (1977) graphically state that while some nursing homes are excellent, "the remainder of homes run the gamut from filthy and unsafe to clean but cheerless and depressing"; or, may be viewed as "stylized, motellike, antiseptically clean horrors" where "patients sit in numb silence with dejected faces or pace endlessly down hallways" (p. 244).

In this vein, Brody (1981) emphasizes a list of characteristics among the institutionalized that include "poor adjustment, depression, unhappiness, intellectual ineffectiveness, negative self-image, apathy, feelings of insignificance and impotency, docility, submissiveness, withdrawal, and unresponsiveness" (p. 314). Brody indicates that such circumstances may be related to "the lack of privacy, restricted mobility, separation from family and society, routinization, depersonalization, desexualization, loss of self-determination, lack of productive or enjoyable activity, and the transfer of power and surrender of control over one's own life to staff" (pp. 314-315).

As for the non-institutionalized aged, this population tends to be distinguished in terms of the contrasts that may be drawn between it and an institutionalized elderly population. For example, though the non-institutionalized elderly
may be suffering sufficient mental illness to warrant institutionalization, due to their ambulatory condition or social/family support (which may itself be therapeutic) they have escaped this outcome (Burnside, 1980). Alternatively, Lowy (1980) notes that "a respectable body of psychiatric opinion holds that no individual who manages to function in the community can be considered mentally ill" (p. 828). Such a controversial position tends to also differentiate institutionalized from non-institutionalized elderly populations and effectively holds that troubled community elderly merely experience social and legal problems.

It has also been emphasized that, with the aged, physical illness is profoundly related to a higher incidence of psychopathology (Butler & Lewis, 1977; Oberleder, 1977; Pfeiffer, 1977). As opposed to non-institutionalized elderly, institutionalized elderly tend to be heavily beset by seriously incapacitating physical disorders. Over three-quarters of institutionalizations are due to poor health (Brod, 1981). The impact of illness upon one's preferred lifestyle or activity level is of particular significance. Though some of the non-institutionalized subjects in this current study may have experienced acute and/or chronic illness, none were markedly incapacitated. Being ambulatory and reasonably active, the subjects may well have been less subject to mental-health-related difficulties.
Further, Brink (1979) observes that "the most deleterious effect of aging in general and institutionalization in particular is inactivity due to a loss of roles and the necessity for providing for oneself and others" (p. 278). Apart from an institutionalized elderly population, the subjects employed within this study demonstrated both a predilection and capacity for mobility and participatory activity merely by volunteering for the study. These subjects also demonstrated a reasonable level of independence merely by the fact that they were continuing to successfully provide for and maintain themselves independently within the community. This circumstance could also suggest a degree of insulation from influences to which the institutionalized aged may be somewhat more subject.

Brody (1981) summarizes such observations as these by succinctly stating that those who are institutionalized compare poorly to the non-institutionalized. Hence, in view of the high incidence of mental and emotional disability among institutionalized elderly, and the possibly debilitating influences posed by institutionalization (which may either initiate or aggravate such disabilities in the aged), the institutionalized elderly might reasonably constitute a population largely unique from a globally defined, non-institutional aged population. Such circumstances may well pose implications for any differential psychotherapeutic outcomes realized from treatments provided to samples
selected among institutionalized versus non-institutionalized elderly.

Motivation is one variable which possibly illustrates how such differential features, between institutionalized and non-institutionalized aged populations, may influence differential psychotherapeutic outcomes. That is, treatment results might be a function of the actual/perceived need for help, interest in acquiring help, and commitment to act on such help as may be offered or acquired. In view of the foregoing discussion, the non-institutionalized elderly may well experience less need, and hence, less motivation, to benefit from any such assistance. With regard to hypnosis-based psychotherapy, such factors may be of particularly crucial importance to benefits realized. The influence of motivation in effecting outcomes via hypnotic suggestion is demonstrated by Elkind (1981).

Elkind (1981) employed physiological measures in a controlled study testing the effects of hypnosis in reducing body age. Findings from this 1981 study tend to indicate that, as opposed to the induction alone, the interest and attention elicited by the content of suggestions was crucial in significantly reducing mean body age from 40 to 28 years. Wadden and Anderton (1982) note that an "individual is most likely to accept . . . suggestions [which] have an immediate positive consequence" (p. 237). Though stated somewhat simplistically, it is not unreasonable that those who can
benefit most from the psychotherapies employed herein are those (within limits) who are most interested in, or committed to, resolving their mental-health-related difficulties.

From a mental health perspective, the non-institutionalized elderly may thus constitute a unique population in two respects. They may be (a) largely non-clinical in nature and (b) experience little consequent motivation to improve circumstances that are not all that bad/intolerable in the first place. From such a perspective, the therapeutic issues introduced to the non-institutionalized elderly, during the treatment sessions within this study, could reasonably have been of less import to these subjects than the literature would otherwise intimate; and especially so in comparison to the institutionalized elderly who may be more disposed to respond to them due to a greater prevalence or intensity of mental-health-related difficulties or needs.

Such circumstances as these tend to offer some plausible explanations for any differential treatment outcomes between institutionalized and non-institutionalized elderly populations. Unfortunately, within the context of this particular study, these postulations cannot be verified and must remain speculative. However, the present study and the only other HT-CEH-related study with the aged (Fuller, 1982) do offer suggestive evidence that (a) institutionalized and non-institutionalized aged tend to be clinically distinct populations and (b) using HT-CEH-related treatments with the
two populations, as well as identical dependent measures, beget differential therapeutic outcome effects.

Specifically, the Fuller (1982) experimental groups produced mean pretest scores on self-concept that were sufficiently low as to straddle the cusp of clinical significance, scores that tend to be indicative of persons who might be "described as depressed, unhappy, and as possessing little self-confidence and maintaining undesirable views of self" (p. 112). On depression, the groups produced elevated mean pretest scores identified as clinically significant, also indicating mental-health-related difficulties. Fuller notes that "psychiatric patients often score within these ranges" and, referencing Lachar (1974), further states that "the discomfort that is reflected by this elevation may provide the necessary motivation to suggest favorable prognosis" (p. 112).

With respect to this current study, group mean pretest (raw) scores on the self-concept variable ranged between 331.70 and 359.10, falling solidly within the area of normalcy. On depression, for the study's predominately female participants, group mean pretest (raw) scores ranged between 21.44 and 25.70 and similarly fell within the normal range. In view of the differential pretest results obtained by Fuller (1982) and by this study, the Fuller sample seems to be representative of a clinical population while the subjects within this study seem relatively adjusted.
It should be mentioned, however, that chronological age might well have been a critical underlying factor between the clinical differences just noted in the institutional population employed by Fuller (1982) and the non-institutional population employed herein, as well as in the differential psychotherapeutic outcomes realized by each study. The mean ages for the two research samples were approximately 81 years and 67 years, respectively. This constitutes a difference of nearly one and one-half decades. Such earlier mentioned variables as physical condition and motivation might be impacted differently at these two mean ages, thus influencing clinical status and psychotherapeutic outcomes in different ways.

For example, advancing age is seen as being linked to a higher incidence of chronic physical disorders and institutionalization (U.S. Bureau of the Census, 1983). Physical illness has already been cited herein as strongly related to psychopathology. In view of the advanced age and institutionalized nature of the population employed by Fuller (1982), a finding for its clinical status might be deemed reasonable. From this same perspective, the younger non-institutionalized aged population employed herein might be expected to demonstrate a greater level of adjustment.

From such a perspective, for example, the younger elderly may perceive that their age holds little in the way
of the aging-related horrors that could have been anticipated during their earlier years, thus leaving them relatively free of marked mental-health-related difficulties, or at least somewhat able to ignore them. Under these circumstances, the motivation to address any mental health difficulties may be minimal, and efforts to do so relatively less productive. Over time, however, the aged might experience increased influences involving reality-base issues such as physical, economic, and social decline, as well as institutionalization itself. Coping skills may be taxed, mental health difficulties might escalate, increased commitment to the psychotherapeutic process may occur, and enhanced psychotherapeutic outcomes might result.

Given the uncertainties and seeming insufficiency of previously discussed explanations for the results realized by this study (i.e., concerning the viability of the treatments and possible limitations to the study), and the particular prominence of the non-institutional status possessed by the elderly subjects employed herein, the population itself is thus tentatively emphasized as a particularly viable explanation for the differential outcomes realized between this and previous HT-CEH-related studies. This explanation, however, remains unverified and cannot be posed as a formal conclusion. Consequently, the only formal conclusion to be drawn by this study is that which follows.
Conclusion

A failure to reject the null hypothesis results in the conclusion that: Both HT and CEH provide no significant therapeutic benefits relative to self-concept and depression in a non-institutionalized elderly population approximating the sample employed. No other conclusion is offered due to the procedural limitations of the study and a lack of HT-CEH-related research which has similarly addressed the non-institutionalized aged.

Recommendations

This study has focused on an area not previously addressed, involving the implementation of HT and CEH with a non-institutionalized elderly population. The findings and related discussion of this study tend to highlight five recommendations that are in need of future experimental investigation. These recommendations are as follows:

1. It is recommended that the findings generated by this inquiry be verified through future research, and that such research resolve many of the limitations experienced with the present investigation (e.g., random selection/assignment and sample size).

2. It is recommended that, aside from self-concept and depression, other dimensions of HT-CEH efficacy
with the elderly be inspected by addressing additional mental-health-related dependent variables (e.g., conditions listed among nosologies of mental and emotional disorders) and by utilizing multiple measures in the assessment of each. Specific nonmanipulated control variables such as clinical status, motivation to improve, and age (i.e., differences in age groupings, particularly among the elderly) should be emphasized as well.

3. In view of a tendency for some CEH-related treatments to generate progressive improvements in dependent variables after the termination of psychotherapeutic procedures, as demonstrated in this and other studies, it is recommended that CEH research center on three areas: (a) verifying the existence of any such phenomenon, (b) isolating any related precipitating variables, and (c) determining the full extent and duration of any such effects. This research should emphasize increased repeated measures over a greater span of time, a procedure from which all future HT-CEH-related studies might well benefit.

4. It is recommended that future HT-CEH studies specifically explore the existence of any preventative benefits afforded by the use of HT-CEH treatments with the non-institutionalized aged
(e.g., decreasing the prevalence/severity of mental illness and the incidence/duration of institutionalization that is due to mental-health-related difficulties).

5. It is recommended that HT-CEH studies be undertaken with clinically disturbed, non-institutionalized elderly subjects, and with specific emphasis on the use of subjects other than those represented among outpatient or waiting list samples. The intent is to identify and address a large and rapidly growing population of aged that has been overlooked by mental-health-related research and service delivery.
LIST OF REFERENCES
LIST OF REFERENCES


Clinical aspects of Alzheimer's disease and senile dementia (pp. 301-331). New York: Raven Press.


Raimy, V. C. (1943). The self-concept as a factor in counseling and personality organization. Unpublished doctoral dissertation, The Ohio State University, Columbus, OH.

Unpublished doctoral dissertation, The Ohio State University, Columbus, OH.


years of rational therapy (pp. 95-114). New York: Institute for Rational Living.


APPENDIX A

Hypnotic Induction and Trance Terminating Procedure
The following protocol consists of an example transcript for both the hypnotic induction and trance terminating procedure employed within this study. The punctuation used within the transcript was intended only to facilitate a verbal presentation of this material. No specific relationship was intended between the punctuation utilized and generally accepted rules of grammar.
Induction: Part I. Deep Breathing

Start taking in nice deep breaths and feel the air circulating around every part of your lungs, down to the very bottom of your stomach. Breathe deeply and continue to inhale relaxation, so that, with each deep breath that you take in, you find yourself becoming very relaxed and very comfortable. Concentrate on becoming relaxed; on inhaling relaxation, and exhaling tension. So that, with each deep breath that you take in, you find that you are becoming very . . . very . . . relaxed, and very . . . very . . . comfortable. Your eyes may feel heavy, and if they are not already closed, you might allow them to do so. And, as you let your eyes close, you find yourself becoming even more comfortably relaxed. You may notice outside noises and talking, but nothing will bother you . . . nothing will affect your becoming deeply . . . comfortably . . . relaxed . . . so that, with each deep breath that you take in, you find yourself slipping deeper and deeper into relaxation. You find yourself in a very comfortable . . . a very warm . . . a very relaxed state . . . a very deeply relaxed state. You can stop deep breathing now, if you have not already done so, and begin to concentrate on the second part of our relaxation process . . . the muscle relaxation.
Induction: Part II. Cognitive Muscle Relaxation

Begin to concentrate on allowing all of the muscles in your body to relax completely. You will find, as you let your muscles relax, that you can get even deeper into relaxation. Concentrate, now, on all of the muscles in your forehead . . . feeling them losing their tension . . . becoming very, very soft and relaxed . . . absolutely relaxed and comfortable. With all of the muscles in your forehead relaxed, just allow the relaxation to spread through your entire face . . . around your eyes and chin . . . around your mouth and nose . . . so that every muscle in your face is becoming very softly, beautifully and pleasantly relaxed. As each muscle relaxes, the relaxation very easily flows to the next set of muscles, and you find yourself becoming even more exquisitely relaxed. Now, with all the muscles in your face relaxed, concentrate on all of the muscles in your neck . . . allowing them to become relaxed . . . allow every muscle to relax. There is no need for any tension, whatsoever. Your neck muscles are very . . . very relaxed. Now, with all of the muscles in your neck relaxed, concentrate on allowing your shoulders and back to become very relaxed. You can feel these very powerful muscles relaxing . . . a feeling of comfort coming over them. This feeling of comfort is flowing down from your shoulders to your back . . . around your sides to your chest. Your muscles completely relax. And, as you
concentrate on allowing your muscles to become even more relaxed . . . they do so, automatically. As you breathe, your chest just moves effortlessly up and down . . . up and down . . . up and down. You may even feel as if it were floating, as you become absolutely relaxed. You may be experiencing a very warm and very comfortable floating sensation . . . a very safe feeling. Now, with each muscle in your chest absolutely relaxed . . . beautifully relaxed . . . concentrate on allowing all of the muscles in your arms to become relaxed. Allow your upper arms to become relaxed . . . to lose any tension that might be left. Your lower arms are becoming very relaxed, and the relaxation seems to flow right down to the very tips of your fingers . . . and you are finding yourself very comfortably . . . very beautifully, very softly, relaxed. Now, with every muscle in the entire upper half of your body very, very relaxed, concentrate on allowing every muscle in the lower half of your body to become completely and totally relaxed. Starting with all of the muscles in your hips and going to your knees, allow every muscle in your hips to become very relaxed . . . very comfortably relaxed . . . becoming very deeply relaxed. The muscles feel as if they are just melting into the relaxation . . . and they are now completely relaxed. From your knees to the tips of your toes, you find yourself in a very deep state of relaxation, a very deep and pleasant state . . . a very beautiful and
comfortable state. As you are in this very relaxed, comfortable, safe, state, you can go easily and automatically into the third stage of the relaxation process which involves the scene.

Induction: Part III. Relaxing Scene

Now, imagine yourself on a beach. It can be any beach you like . . . any that you are familiar with . . . even one that you may imagine. But, you are there all alone. There is no one there to disturb you. There is a beautiful blue sky overhead and a very calm, gentle sea in front of you. You can feel the warmth of the sun's rays as they touch your face. It is a perfectly glorious summer day. There is a very pleasant, soft, cool breeze coming off the water, cooling your sun warmed skin . . . helping you become even more deeply relaxed. You are feeling very relaxed and just enjoying the beauty of nature . . . the sea . . . the sky . . . and the soft cool breeze against your warm body. As you look out to sea, you notice that you can see that hazy blue line on the horizon where the sky meets the sea. And, as you look at the horizon, you can see, in the distance, that the water is . . . rolling . . . rolling . . . rolling, toward the shore. As you watch it . . . rolling . . . rolling . . . rolling toward the shore, you can see that the rolling mounds of water become waves. You can see the waves continue . . . rolling . . . rolling . . . rolling in, until they
finally come up onto the shore as white surf, and gently flow back to the ocean. You may even be able to hear the sounds of the waves as they come up to the shore. And, as you stand or lie on the beach, you may hear the sound of the seagulls as they glide and dart in over the beach and water. You may also be able to feel the dampness of the wet sand under your bare feet, or you may be able to feel the coolness of the water as the edge of the surf gently covers your sun warmed feet, and then flows back to the ocean. You may even feel the soft warm sand beneath your shoulders as you lie on this beach, and you feel so comfortable and relaxed that it is almost as if your were just . . . melting . . . melting . . . melting . . . into the sand. Overhead, you can see some beautiful white fluffy clouds, and you are so deeply relaxed that it is almost as if you are up there floating with them. And, you feel so completely safe and free . . . free from the worries and cares of the world . . . as you simply enjoy the deep comfort of a completely relaxed state. And, while you are in this beautifully relaxed state, we will count from one to twenty, and you will feel yourself becoming more and more deeply relaxed, until finally, at the count of twenty, you will find yourself in a total and complete state of relaxation, in which every part of your body and mind is completely free from tension.
Induction: Part IV. Deepening Technic

One, two, three, more and more relaxed; four, five six, deeper and deeper into relaxation; seven, eight, nine, you are becoming extremely well relaxed now, extremely well relaxed; ten, eleven, twelve, deeper and deeper; thirteen, fourteen, fifteen, very, very deeply relaxed now, deeper and deeper into the relaxation; sixteen, seventeen, eighteen, more and more deeply relaxed, very deeply relaxed; nineteen, you are almost there now, almost totally and completely relaxed; twenty. You are now completely and totally relaxed. And, while you are in this deep state of relaxation, just experience the comfort and pleasantness of this state, because it is a very beautiful state, indeed. Notice the sensations of comfort in your body and mind, and just enjoy them. Now, we shall pause to let you enjoy the state of relaxation for a few moments.

Trance Terminating Procedure

And, now, we will count from one to five, and on the count of five you will wake up feeling very, very refreshed indeed, and possibly with more energy than you had even in the very beginning of the day. And, with each moment after you open your eyes, you can find more and more comfortable sensations and energy flowing through you. This is because it is a physiological process as well as a psychological
one. When you relaxed your muscles, you relaxed yourself along with your muscles. One, Two, Three, Four, Five.
APPENDIX B

Hypnotherapy Treatment Protocol
The following Hypnotherapy (HT) protocol consists of an example transcript drawn from the initial treatment. It was similarly employed across all HT sessions in accordance with the guidelines explicated in Chapter III. The HT treatments are introduced between the hypnotic induction and the trance terminating procedure (see Appendix A). The punctuation used within the transcript was intended only to facilitate a verbal presentation of this material. No specific relationship was intended between the punctuation utilized and generally accepted rules of grammar.
Hypnotherapy Session: Loneliness

While you are in this highly pleasant, relaxed state, begin to experience what it is like to feel less anxious about the normal everyday problems, problems such as being lonely or alone as we grow older. As we know, there are many times in which we feel like we have fewer and fewer friends and family members. Those friends or family members often move away or pass on. But, notice that the comfort of deep relaxation feels so nice, helping us feel so much better. You may find that as each day passes, you experience and see yourself better able to cope with these sorts of concerns, and you see yourself feeling more and more relaxed and comfortable about making new friends. You may even find that making new friends is easier and easier for you to do and that you will very much enjoy making these new friends. You may also find that you will feel comforted and will want to reach out to others, experiencing the warmth of friendship. You may see that you are a very worthwhile person, and a very nice person to be with.

Indeed, with each passing day, you may find yourself with more and more energy as you feel better and better about yourself and realize that you are a very special person. You feel yourself surrounded with people who care about you. And, you seem to find that you can feel very good about others. It is such a nice, comfortable feeling. In the days and weeks ahead, you find yourself relaxing,
feeling more comfortable with your own company, and feeling warm and close to others even though you may not think about it.
APPENDIX C

Cognitive Experiential Hypnotherapy Treatment Protocol
The following Cognitive Experiential Hypnotherapy (CEH) protocol consists of an example transcript drawn from the initial treatment. It was similarly employed across all CEH sessions in accordance with the guidelines explicated in Chapter III. The CEH treatments are introduced between the hypnotic induction and the trance terminating procedure (see Appendix A). The punctuation used within the transcript was intended only to facilitate a verbal presentation of this material. No specific relationship was intended between the punctuation utilized and generally accepted rules of grammar.
Cognitive Experiential Hypnotherapy Session: Loneliness

While you are relaxed, it may occur to you that our thoughts affect our feelings. It seems that we can feel better simply by learning to change our thoughts about situations that happen to us. The process of using thoughts to feel good, has to do with the idea that certain irrational beliefs are associated with negative emotional, physiological and behavioral responses. By changing the irrational thoughts to more rational or positive thoughts, we can feel more positive emotions, often experience a decrease in some types of physical problems, and change our behaviors in ways that get us more of the things we want out of life. As you deeply relax, notice that many people believe that feelings are caused by what others do to us. If another person says something to us that we do not like, it is believed that the other person actually makes us angry or hurt by what they are saying. However, research has indicated that most of our emotional and physiological behaviors are actually caused by what we are thinking or by what we are telling ourselves. For example, following an incident, we have some thoughts and beliefs about it. These thoughts are the things that we constantly tell ourselves, and are also called self-talk. Following the self-talk, we will then experience an emotion. It is often directly connected with the type of self-talk that we used. It sounds as if the process would end there, but it does not.
If we are using irrational or negative self-talk, we may well develop some physical problems such as higher blood pressure, headaches, or nausea. If we are using rational self-talk, just the opposite may occur. These results also affect how we behave.

Now, while you are deeply relaxed and very comfortable, in your imagination you can experience how different thoughts may actually affect you. Consider the problem of losing a friend or loved one because they move away or pass on. Many times these situations upset us and we can even feel very bad or lonely. At times, we may wonder if we can live on. For an example of how thoughts affect our feelings, our physical condition, and our behavior, remember or imagine a time when you felt very lonely. Be careful to choose a time that is not too painful or upsetting.
Perhaps, there was a loss of a friend or loved one. This is the situation. When you think about this situation, perhaps you begin to feel the loneliness again. Notice your own thoughts, thoughts possibly concerning how there is no one left who cares for you, that you cannot live without this person, that you have nothing more to live for, that it is going to be impossible for you to develop new relationships with other people. As you may notice, these irrational or negative thoughts tend to develop very uncomfortable emotions. You may also feel a slight physical discomfort. This physical feeling is also directly related to one's
negative self-talk. Finally, our behavior may change. We might tend to withdraw from other people, not participate in any activities, become very irritable, and do other things that will only continue the less desirable thoughts and feelings.

Now, just forget this scene and begin to deeply relax. You are again very, very deeply relaxed. Feel the comfort, while remembering the beach and how really good those nice feelings are. Now, go back to the same situation. Only, this time, we are going to change the self-talk and experience a different feeling. Just go back and imagine the situation related to loneliness or the loss of a friend or loved one. Your thoughts this time are going to be somewhat different and more rational. Tell yourself that you very much cared for the person you lost, and feel good about the times you had with them; that you feel good about yourself and really do enjoy your own company; that you are a very worthwhile person and that you can adjust to the situation; that you can make new friends and that others can truly enjoy being with you; that you are a really special person. Now, notice the different feelings. By thinking these more rational and positive thoughts, you find that you have more neutral, or even positive, emotions about the same situation. You also notice that your body may feel better and more comfortable. These more positive thoughts and feelings may lead you to have more energy and comfort
concerning your own companionship, and lead you to develop new friends and goals that you could not have as easily developed with the former feelings. You also notice that you are not as lonely. In the days and weeks ahead, you find yourself relaxing, thinking more positive and rational thoughts, feeling more comfortable with your own company, and feeling warm and close to others even though you may not think about it.