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THE EFFECTS OF RATIONAL STAGE DIRECTED THERAPY ON SELF CONCEPT AND REDUCTION OF PSYCHOLOGICAL STRESS IN ADOLESCENT DELINQUENT FEMALES

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 P. REARDON, B. S., M. ED.

The Ohio State University
1976

Reading Committee:

Donald J. Tosi
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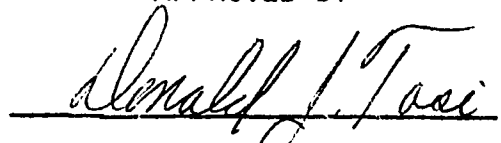

Advisor
Faculty of Special Services

To Molly

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CHAPTER I

INTRODUCTION

Numerous writers since the time of William James (1890) have referred to the self concept or similar self referring notions as crucial variables in psychological adjustment. Even prior to this in the eighteenth century according to Ansbacher (1965), Immanuel Kant proposed that mental illness occurs when a person fails to correct his "private sense". More than a century later Alfred Adler (1924) made similar references and used "private sense" as a synonym for "mistaken opinions", which he viewed as the source of neurosis. The hypnotists believed that "morbid ideas" implanted in the mind caused psychological disturbances. Pierre Janet (1907) believed that "fixed ideas" dissociated from awareness were responsible for psychological problems, while Paul DuBois (1909) referred to "incorrect ideas". A decade after Janet, Breuer (Breuer and Freud, 1957) referred to "unconscious pathogenic ideas" and Freud (Breuer and Freud, 1957) though he was most interested in unconscious emotions, agreed with Breuer that pathogenic ideas along with "strangulated affect" were responsible for hysteria. Near the middle of the century Sullivan (1953) emphasized the role that "parataxic distortions" of interpersonal relations has in mental illness.

Julian Rotter (1954) emphasized "erroneous expectations" and George Kelly (1955) posited "disordered constructs" as the sources of maladjustment. Around the same time Raimy (1943, 1948) was asserting that the self-concept (or Empirical Self) not only organizes and guides behavior, but also requires a significant modification for successful psychotherapy. Frank (1961) viewed therapy as an attempt to correct "erroneous assumptions" and according to Horney (1950), the "idealized self-image" must be modified to correlate more closely with the "real self". Ellis (1962) is perhaps the best single proponent of self-concept change since his system of psychotherapy is based on the nation of changing patients "irrational ideas" (or self-statements). Berne (1961) proposed that two of his personality conceptions, the "Child" composed of "prelogical perceptions" and the "Parent" made up of "imitative self-judgements" cause disturbance. In an early publication, Perls (1951) noted that behavior is neurotic when "the personality consists of a number of mistaken concepts of oneself" (Perls, Hefferline, and Goodman, 1965, p. 382).

More recently Bandura (1969, p. 187) infers two processes in the exposition of his "modeling" theory: "generalization of extinction effects" and "positive reinforcement of a sense of capability through success" (underlining mine). What might a "sense of capability" be, if not another synonym for self-concept. Finally, Tosi (1974), Lazarus (1971), Maultsby (1971), Beck (1967), Meichenbaum et. al. (1974) and numerous other cognitively oriented theorists and practitioners have referred fairly directly to the self-concept.

Although literally scores of writers representing more than a dozen individual "schools of therapy" affirm the crucial role of the self-concept in psychotherapy, and a common goal of therapy is for the client to "think, or feel differently about himself" there is a paucity of evidence to support the effect of any of the aforementioned therapies in bringing about modification of the self-concept. Truax (1966) and Truax and Carkuff (1967) have demonstrated that counseling and therapy to produce beneficial effects. Among the cognitive theorists Lazarus (1974), Tosi (1974), Tosi and Marzella (1975), Meichenbaum and Cameron (1974) and Moleski and Tosi (1975) have presented evidence that cognitive variables related to or comprising facets of the self-concept can be effectively modified. Studies too numerous to mention (see Fitts, 1969, 1970, 1972a, 1972b, 1972c among others) have examined and delineated the self-concept of every population from groups of subjects identified as "personality integration" to every diagnostic grouping, age grouping, and adjustment grouping, yet only a limited number of studies have specifically examined the effect of conditions termed "therapy" on the self-concept.

Raimy (19743, 1971) examined the effect of therapy on self-referencing statements through the PNAv method (Positive Negative Ambivalent verbalizations). He postulated that successful and unsuccessful cases could be differentiated on the basis of self-referencing verbalizations and he inferred that alterations in self-referencing statements reflected modification of self-concept. He concluded that the PNAv's may be a reliable measure of one of the essential structural relationships of the self-concept, the balance between

positive and negative self-evaluations. A number of recent studies, which will be discussed more thoroughly in Chapter Two, have examined the effects on self-concept of treatments ranging from discussion groups, experimental classrooms, encounter groups, chemotherapy, and systematic desensitization to survival training. One of the advantages of these studies is that most of them used a common instrument, the Tennessee Self-Concept Scale (Fitts, 1965). A shortcoming is the failure of many of the studies to use control groups and to control for other contaminating variables. Nevertheless, the main finding of most of the studies was that there was little change in the measured self-concept.

In a recent publication entitled "Misunderstanding of the Self Cognitive Psychotherapy and the Misconception Hypothesis, Raimy (1975, p. ix) asserts that "the approach to psychotherapy presented here specifies a particular cognitive variable-faulty beliefs or convictions... as responsible for psychological disturbances." He (1975, p. 9) goes on to state that: "Misconceptions about others and about the external world undoubtedly influence our adjustment, but misconceptions about the self probably play a major role in our enduring maladjustments. The self-concept (or self-image, or empirical self) not only organizes and guides behavior, but also requires significant modification for successful psychotherapy." This research is an attempt to examine the efficacy of a specific cognitive therapeutic technique which is an extension of rational-emotive therapy (RET), namely, Rational Stage Directed Therapy (RSDT) (Tosi and Marzella, 1975, and Marzella, 1975). The study will specifically

focus on the effect on self-concept as measured by the Tennessee Self-Concept Scale (Fitts, 1965).

RET developed by Albert Ellis (1962, 1971), is a cognitive-behavior therapy emphasizing cognitive control of affective-behavioral tendencies. Within this framework, the occurrance of negative emotions is considered to be evidence of irrational ideas or inaccurate cognitive appraisals of real or imagined stimuli (Arnold, 1968; Lazarus, 1971; Meichenbaum and Cameron, 1974; Beck, 1967; Maultsby, 1971; Moleski and Tosi, 1975; Marzella, 1975). RET focuses on a rational restructuring of irrational ideas or cognitions which are underlying maladaptive emotional/behavioral states.

RSDT has evolved from the theories of a variety of practitioners. It is an amalgamation and refinement of Ellis (1962) cognitive restructuring, Maultsby's (1971) Rational Emotive Imagery, Cautela's (1972) Covert Sensitization, Bandura's (1969) Modeling, and Jacobson's (1938) Progressive Relaxation. The contribution of each of these authors to RSDT will be briefly outlined.

RSDT follows many of the same theoretical tenets as Maultsby's (1971) Rational Emotive Imagery (REI). REI is a technique designed to accelerate the self-change process using imagery within a rational-emotive framework. Therapeutic imagery includes the client's basic understanding of his irrational behaviors and the processing of them via rational self-analysis. When the client has determined his self-talk and learned to challenge and confront his self-defeating ideas, he is asked to imagine himself in a situation in which he formerly experienced maladaptive thoughts, feelings, and behaviors.

While everyone else in the "scene" displays the same behavior, the subject imagines himself engaging in the rational sequence, and presumably experiencing more acceptable consequences. Maultsby (1971, p. 64) points out that "it is essential to remain calm while doing it. If you start to become upset, discontinue the imagery." Maultsby (1971, p. 65) states that the benefits of REI are: 1) deconditioning to environmental cues; 2) formation of more adaptive cognitive maps; and, 3) self-indoctrination in rational self-thinking.

Cautela's (1966a, b) covert sensitization has been successfully applied to a variety of behavior disorders including delinquent behavior (Cautela, 1967). In the application of covert sensitization the therapist generates a scene for the client which combines the problem behavior, relevant stimuli and aversive aspects into a coherent image. The behavior then becomes paired with noxious images, unpleasant emotions, and consequences and, therefore, is extinguished. In RSDT the behavior which we are focusing on an attempting to supplant is the subject's covert cognitive behavior or irrational thinking.

Bandura (1969, 1971) is the originator and principle exponent of modeling. The basic modeling procedure is quite simple: it involves exposing the client to one or more other individuals - present (live) or symbolic (filmed) - who demonstrate behaviors to be adopted by the client. Exposure to models also includes exposure to cues and situations surrounding the model's behavior, so that not only the behavior, but also its appropriateness to relevant stimuli is demonstrated. As will be shown, in RSDT the client serves as his own model through the cognitive-imagery process.

Jacobson (1938) propounded the psychological benefits of relaxation and formulated a systematic procedure to achieve it. Numerous other writers such as Lazarus (1971) Rimm and Masters (1974, p. 42) and Blake (1965) have stated the benefits of relaxation training procedures alone or in combination with other techniques. Unlike Jacobson, the muscle relaxation in RSDT is achieved cognitively and is used as an anciallary technique to facilitate the therapeutic process.

Rational Stage Directed Therapy (RSDT) (Tosi, 1974, Tosi and Marzella, 1975) attempts a synthesis of sensori-imagery, and relaxation techniques with rational or cognitive restructuring while simultaneously guiding or directing the client via imagery through various growth stages. The growth stages are: awareness, exploration, commitment to rational thinking and acting, implementation of rational thinking and acting, internalization, and change-redirection.

RSDT is a didactic-experiential, cognitive behavioral intervention designed to guide or direct the client through stages focusing on either one problematic area or a set of related problems. Being an extension of the more standard cognitive behavior therapies (ala Lazarus, 1971; Ellis, 1962; Maultsby, 1971) RSDT uses vivid cognitive-emotive imagery in conjunction with standard relaxation techniques (in Rational Stage Directed Imagery). Unlike systematic desensitization or aversive procedures that also employ relaxation and/or imagery, in RSDT the client is guided through clearly identified and discrete stages in the therapy process, with major emphasis placed on high level cognitive control over emotive, physiological, behavioral, and situational conditions. Through these stages, the client using a

cognitive restructuring paradigm, specifically Tosi's (1973) elaboration of Ellis ABC self-analysis, encounters directly (via imagery) external or internal events that serve to activate the irrational cognitions which underlie and perpetuate affective/physiological/behavioral disorders (Tosi and Marzella, 1975).

During the initial stages of RSDT, the client is exposed to the cognitive or rational restructuring technique, and begins to develop competence in its use. Cognitive restructuring skills, a logical critical thinking about disturbing internal and/or external events associated with emotional disturbance are developed, reinforced, and implemented while the client is in a deeply relaxed state. RSDT is then augmented with "in-vivo" behavioral tasks corresponding closely to the imagery content (Tosi and Marzella, 1975).

"Inherent to the concepts of RSDT is its potential for developing, reinforcing and maintaining a logical critical thinking relative to affective, physiological, behavioral and situational processes" (Marzella, 1975, p. 6). Specifically, RSDT is designed to enable the client to supplant maladaptive beliefs, emotions, and behaviors with more objective, self-fulfilling ones. By applying these new skills to past, present, and future events, both internal and external, these events taken on new meanings and maximize the client's control of his own destiny.

According to Tosi and Marzella (1975) RSDT may be considered as an inclusive rubric for rational stage directed hypnotherapy (RSDH), and rational stage directed imagery (RSDI). However, for the purpose of this study, RSDT will refer to a stage directed therapeutic approach

without the use of systematic relaxation or hypnosis. RSDH should only be practiced by therapists trained professionally in hypnosis. RSDI does not require hypnotic training, but does require the therapist be familiar with standard relaxation-imagery techniques (Tosi and Marzella, 1975). This research will only consider the effects of the latter two techniques (RSDI and RSDT).

PURPOSE

The purpose of this study is to examine the effects of two Rational Stage Directed Therapies on alteration of the Self-Concept and reduction of psychological stress. The major research question posed here is whether the application of Rational Stage Directed Imagery (RSDI) and Rational Stage Directed Therapy (RSDT) can significantly alter (improve) the self-concept as measured by the Tennessee Self-Concept Scale (TSCS) (Fitts, 1965), and significantly reduce emotional stress as measured by selected subscales of the Tennessee Self-Concept Scale and the Multiple Affect Adjective Checklist (MAACL) (Zuckerman and Lubin, 1965). A sub-question is the extent to which the therapists themselves contribute to the therapeutic process.

HYPOTHESES

The Hypotheses stated are:

Main Effects: Treatments

> Means representing the various aspects of self-concept and the total self-concept as measured by the Tennessee Self-Concept Scale and means representing psychological stress as measured by selected subscales of the Tennessee Self-Concept Scale and the Multiple Affect Adjective Check List, from groups of subjects defined in terms of various treatments Rational Stage Directed Imagery (RSDI), Rational Stage Directed Therapy (RSDT), Placebo,

and Control will not differ significantly across pre, post I, and post II conditions.

Main Effects: Therapists

Means representing the various aspects of self-concept and the total self-concept as measured by the TSCS and means representing psychological stress as measured by selected subscales of the TSCS and by the MAACL from groups of subjects within RSDI, RSDT, Placebo, and Control having assigned therapists will not differ significantly across pre, post I, and post II conditions.

Interaction Effects:

Observed means representing the various aspects of the self-concept and the total self-concept as measured by the TSCS and means representing psychological stress as measured by selected subscales of the TSCS and the MAACL from groups of subjects defined in terms of and in any combination of treatments and therapist will not differ significantly from the means expected from simple addition of the aforementioned main effects, across pre, post I, and post II conditions.

NEED FOR THE STUDY

The topic of the self or self-concept has been the subject of an enormous body of theory and research. Gordon and Gergen (1968, p. 1) noted that the disciplines of psychology and sociology alone had accounted for over 2,000 publications concerning the self. The systematic conceptualization of the self began with William James (1890), continued with Charles Horton Cooley's (1902) notion of the "Looking Glass Self" and was later described from a social interactionist perspective by George Herbert Mead (1934). Since that time, numerous writers such as Allport (1937), Adler (1924) and Raimy (1943, 1971, 1975) have alluded to similar conceptualizations.

In his doctoral dissertation Raimy (1943, p. 355-56) noted that one of the most important problems in the study of personality to which self-concept theory can be applied is the topic of "changes brought

about in personality by therapy where talking and social interaction are involved." In his preface to the published version of the dissertation Raimy (1971, xii) asserts, "The value of research lay in trying to find a relatively objective method which could trace changes in self-esteem during the course of psychotherapy... one might then hope to find those events in and out of psychotherapy which were of crucial importance in changing self-esteem." Fitts (1972c, p. 10) who is the originator of the Tennessee Self-Concept Scale and one of the most prolific writers on this topic, notes that one of the most crucial questions posed in this regard is, "how to change the self-concept". He goes on to say that "examination... reveals that a person's self-concept, his self-image developed over a lifetime, does not change very readily. Approaches, treatments, methods, and experiences which generate dramatic self-concept change are few and far between." Previous studies investigating the effectiveness of experimental treatment programs aimed specifically at obtaining self-concept improvement utilizing a variety of populations have demonstrated that the self-concept is not readily changed.

It appears that some important questions which were posed initially by Raimy (1943) and more recently by Raimy again (1971, 1975), by Fitts (1972c), and others still remain unanswered. Do changes in the self-concept occur in therapy? How can these changes be measured and accounted for? Can self-concept be effectively modified by psychotherapeutic intervention within a restricted period of time or is it such an enduring construct that only prolonged experiences and the passing of time will effect change?

In a recent book, Raimy (1975) has attempted to demonstrate that nearly all "schools of therapy" regardless of their theoretical focus of treatment (i.e. expression of affect, redistribution of psychic energy, behavioral change), in practice focus on altering and cognitive conceptions that the client has of himself. He further asserts that successful therapeutic intervention inevitably results in altered self-concept. The first contention is beyond the scope of this discussion, though it is an interesting notion. The evidence to support the second assertion is equivocal at best.

The purpose of this study is to examine whether two cognitively-oriented therapeutic approaches, Rational Stage Directed Imagery (RSDI) and Rational Stage Directed Therapy (RSDT) can effectively modify the self-concept as measured by the TSCS when employed over a brief (six sessions) period of time, while controlling for other significant variables. Hopefully the results will at least partially address the initial three questions posed and may respond to Raimy's assertions as well.

LIMITATIONS OF THE STUDY

This study is limited to a sample of thirty-two volunteers from the population of one adolescent delinquent female resident facility in Columbus, Ohio. The population of this school and sample although diverse in the variables of race, geographic commitment area and region does represent a limitation on random sampling in that no true sampling of the total population of female delinquents is represented. Also the reasons for commitment are primarily "status offenses", i.e.

incorrigability, truancy, runaway, and sexual delinquency, rather than criminal offenses.

A statistical limitation of the study lies in the number of people within each cell of the design, and the total N of thirty-two (32).

A final limitation was the relatively limited number (6) of therapy sessions that were conducted.

DEFINITIONS OF TERMS

The following definitions are presented for a more thorough understanding of terms used throughout the study:

Imagery:

> The ability to cognitively imagine, to mentally picture, and to vicariously experience oneself thinking, acting, and emoting in various real or hypothetical situations.

Self-Concept:

> Self-concept is operationalized as that which is measured by the nine (9) Positive self-concept scales reported by the Tennessee Self-Concept Scale. Elevated scores on any of these scales will be considered to reflect an improved self-concept, decreases will reflect a deterioration of self-concept.

Emotional Stress:

> Emotional Stress is operationalized as that which is measured by the Self-Criticism, Number of Deviant Signs and Empirical Scales of the Tennessee Self-Concept Scale and by the Multiple Affects Adjective Check List. Decremental changes in the MAACL scales and movement toward the mean on any of the TSCS scales will be considered a reduction of psychological stress.

Rational Stage Directed Therapy:

> A didactic-experiential cognitive behavioral intervention designed to guide or direct a client through various stages of awareness, exploration, commitment to rational thinking and acting, implementation of rational thinking and acting, internalization and change/redirection. Subsumed under RSDT for the purpose of this study are Rational Stage Direct Imagery (RSDI), an approach utilizing cognitive muscle relaxation and emotive-imagery, and

Rational Stage Directed Therapy (RSDT), a cognitive restructuring approach utilizing imagery and progression through the aforementioned growth stages.

Placebo:

The treatment conditions wherein Ss received direct suggestions that they should feel better about themselves and that any emotional stress they experienced would be alleviated. No specific method for dealing with stress was offered, and all questions were answered in a non-directive, reflective manner.

Juvenile Delinquent:

An individual between the ages of thirteen and seventeen, who by an authorized court of law has been adjudged delinquent. All subjects in this study meet these criteria.

Rational:

Rationality is a non-static concept based on logically correct thinking relative to a given set of data or facts. Sperry (1974) suggests that rationality is a method of dealing with subjective and objective reality as defined by a persons life goals. The following criteria may be employed in determining whether thinking and acting is rational or irrational (Maultsby, 1971). Thinking and acting are considered rational when:

a) These behavioral processes consider objective and subjective reality - the facts - be they environmental, cognitive, affective, physiological, or behavioral;

b) These behavioral processes contribute to the preservation and enhancement of life;

c) These behavioral processes contribute to the achievement of one's personally defined immediate and long-term life goals;

d) These behavioral processes minimize significant personal and environmental stress (Tosi and Marzella, 1975).

ORGANIZATION OF THE REMAINDER OF THE DISSERTATION

This chapter has included an introduction, statement of the problem, the hypotheses, the need for the study, limitations of the study, and

definitions of terms used throughout the study. Chapter II presents a review of the literature pertinent to the study. Chapter III contains the methodological considerations, the data analysis procedures, and the research design. Chapter IV is a report of the results and findings of the experiment, and Chapter V summarizes the results and conclusions as well as addressing future recommendations.

CHAPTER II

REVIEW OF RELATED LITERATURE

The major question which this study focuses upon is the effaciousness of two rational stage directed therapies in modifying self-concept and reducing psychological stress. A review of research pertinent to the variables contained in the research questions and their relationship to one another will be the concern of this chapter. The chapter will review related literature concerned with the: 1) self-concept in general and in delinquent populations; 2) self-concept measurement; 3) self-concept change; 4) cognitive behavior therapy; 5) Rational Stage Directed Therapy.

A systematic examination of the self-concept or self probably began with William James (1890, 1910). James (1910, p. 177) stated, "whatever I may be thinking of, I am always at the same time more or less aware of myself, of my personal existence." In his discussion of the self he refers to the "self that is known" or Empirical Self and its constituent parts: the material me (body); the social me; and, the spiritual me. Raimy, (1971, p. 97) notes the importance of James' conceptualizations in that even at such an early time, James' comments "imply the complexity involved in the self."

James also recognized most clearly the arbitrary nature of our self-concepts and the struggle between the real and ideal selves. He states,

> "So we have the paradox of a man shamed to death because he is only the second pugilist or second oarsman in the world. That he is able to beat the whole population of the globe minus one is nothing; he has pitted himself to beat that one; and as long as he doesn't do that nothing else counts. He is to his own regard as if he were not....Yonder puny fellow, however, whom everyone can beat, suffers no chagrin about it for he has long ago abandoned the attempt to carry that line... So our self-feeling in this world depends entirely on what we back ourselves to be and do." (1910, p. 184).

Charles Horton Cooley (1902, p. 156) formulated the notion of the "looking glass self: and again high-lighted the importance of the subjective judgement in the picture of self. He states (1902, p. 156), "...the imagined judgement is quite essential. The thing that moves us to pride or shame is not the mere mechanical reflection of ourselves, but an imputed sentiment..." George H. Mead (1934), viewing the self from a sociological perspective, concludes that in the course of social interaction the individual internalizes the ideas and attitudes expressed by the key figures in his life. By internalizing their posture toward him, he values himself as they regard and value him and he comes to demean himself to the extent that they reject, ignore or demean him.

Various neo-Freudians, Harry Stack Sullivan (1953), Karen Horney (1950), but particularly Alfred Adler, theorized on the self and the origins of self-esteem. Adler (1964, p. 67) stated, "The individual... does not relate himself to the outside world in a pre-determined manner, as is often assumed. He relates himself always according to his own interpretation of himself and of his present problem..."

Other writers, many of whom have already been mentioned, have referred to the importance of the self or self-concept, but Raimy (1943) was perhaps the first to deal exclusively and at length with the self-concept. His (1943) doctoral dissertation entitled The Self-Concept as a Factor in Counseling and Personality Organization has been described by Arthur Combs as "The original definitive statement of the self-concept in American psychology" (Raimy, 1971, p. vi). In both the original work (1943) and the published version (Raimy, 1971), the author asserts the primacy of cognition in both the development of self-concept and influencing of behavior. He (1971, p. 21) states, "The writer conceives of a self-reference as a psychological process in which intellectual content and emotional tone are usually inextricably mingled if there is emotional toning present. For it is possible to conceive of a purely intellectual referring or act of observing, but hard to imagine objectless emotional tone." He observes that the self-concept influences behavior and is itself altered and restructured by behavior (1971, p. 98), and that "a persons awareness of himself may have little relation to reality" (1971, p. 99).

In discussing the structure of the self-concept, Raimy recognizes that while it may be exceedingly sensitive and yield to rapid restructuring if conditions are sufficient, it has the ability to remain unaltered under conditions of violent stress (1971, p. 101). Regarding its functional characteristics, he states that "as an integrated or conflicted perceptual system, the self-concept forms the criterion against which choices as to direction and kind of behavior are made" (1971, p. 104).

There is no mistaking the centrality of the self-concept where Raimy is concerned. He states (1948, p. 154), "what we perceive in ourselves (self-concept) may have only partial correspondence with what other people perceive in us or the so-called objective personality. Yet, as always, we behave in accordance with our perceptions even though the opinions of others attempt to influence our perception of ourself."

A number of other writers have contributed to self-theory. Kinch (1963, p. 481) offered a general theory of self-concept in one sentence: "The individuals conception of himself emerges from social interaction and in turn, guides or influences the behavior of that individual." Hall and Lindzey (1970) make the distinction between "self-as-object" and "self-as-process". On the other hand, Combs and Snygg (1959, and Snygg and Combs, 1949) examine the total self as experienced by the individual and label it the "phenomenal self."

Fitts (1954, 1965a, 1965B, and others) who is probably the most prolific recent writer and researcher of the self-concept identifies eight principal parts or subselves of the self, namely: self-as-object (Identity Self); self-as-observer and judge (Judging Self); self-as-doer (Behavioral Self); Physical Self; Moral-Ethical Self; Personal Self; Family Self, Social Self. These eight subselves are all represented as scales on the instrument which he developed, the Tennessee Self-Concept Scale (1965a), and together they yield a total Positive Score. Fitts has examined numerous other factors related to self-concept but at this point it seems appropriate to examine the self-concept of delinquent populations, which is the topic of this study.

SELF-CONCEPT AND DELINQUENCY

A wide variety of variables have been related to delinquency rates (Tangri and Swartz, 1967), including demographic variables (Chilton, 1964), perception of social structure (Short, Rivera and Tennyson, 1965), personality variables. Westie and Turk (1965) found that it was possible to support findings "which indicate more delinquency in the lower class than in the middle class, more delinquency in the middle class than in the lower class, or no difference by class on the basis of current research and theory." Tangri and Swartz (1967) suggested that research in delinquency should be concerned primarily with personality variables rather than demographic or social variables.

The first major study in the area of delinquency which attempts to deal with variables of personality and self was that of Reckless and Dinitz. They have stated that the crucial variable in their research was self-concept or self-evaluation:

> "It is proposed that a socially appropriate or inappropriate concept of self and other is the basic component that steers the youthful person away from or toward delinquency and that those appropriate or inappropriate concepts represent differential response to various environments and confrontations of delinquent patterns (Reckless, Dinitz, and Murray, 1956)."

Reckless (et. al., 1956) viewed the self as playing the central role in behavior and regarded it as the independent variable in his research, while delinquency was regarded as the dependent variable. With this in mind, Reckless and his associates (Reckless et. al., 1956; Reckless et. al., 1957; Lively et. al., 1962) gave attention to the question of why one youngster became delinquent while another in the same neighborhood, the same block, or even the same family did not. Many of the sociological factors were the same, yet the outcome

was different. To account for this, Reckless and his researchers theorized that the non-delinquent was insulated against delinquency by a favorable self-concept. The unfavorable self-concept of the delinquent provides no insulation and may be viewed as a propulsion toward delinquent behavior. This theory has been supported by Epstein (1962) and Lefeber (1965). Motoori (1963) found that the "present self" of delinquents differed widely from that of a control group, but their ideal self was quite similar.

Recently a number of studies have examined this problem using a common instrument, the Tennessee Self-Concept Scale (Fitts, 1965a). The use of a single scale makes it possible to examine the self-concept in greater depth and scope and to compare the results of diverse studies. Self-concept profiles of delinquent populations on the TSCS based on group means have shown an amazingly consistent pattern in various studies. A comparison of profiles from Deitche (1959), Atchison (1958), Lefeber (1965), Joplin (1967), Kim (1968), Richard (1967), de Alverez (1969), Lamarche (1968), Zuriel and Shaked (1970), Scheurer (1971), Holland (1973), Anzivino (1972), Arnold (1971), Lee (1970), and Waters (1969), show striking profile similarities in characteristics of form and level. These studies provide self-concept data on over 800 adjudicated delinquents from samples in California, Indiana, Florida, North Carolina, Ohio, New Jersey, Georgia, as well as a number of foreign countries. Zuriel and Shaked (1972) in Israel, Lamarche (1968) in French-speaking Montreal, de Alvarez and Barrientos (1969) in Mexico, Kim (1967) in Korea have all reported cross-cultural data using translated versions of the TSCS. Each of these studies reports

TSCS differences between delinquent and non-delinquent populations that are similar to the studies already cited. Regardless of language, country, or culture persons characterized by antisocial and delinquent behavior tend to have poor self-concepts.

An examination of this typical delinquent profile reveals the following:

Positive Scores -- The mean Total P Score is typically in the range of 295 to 315. This range falls one to one and a half standard deviations below the mean of the TSCS normative group. The Row P Scores show significant deviation in the negative direction. Self Satisfaction (Row 2) is less deviant than are Identity (Row 1) and Behavior (Row 3), forming the inverted "V" common to delinquent populations. Thus, the delinquent seems to be saying that he is not much good and his behavior is proof of this, but that he is not really so dissatisfied with what he is. The Column P Scores reveal the same impoverished self-concept. In no area does the delinquent see himself positively, but he has a much less negative self-concept when using the Physical Self (Column A) as the frame of reference. The Moral-Ethical Self (Column B) and the Family Self (Column D) are quite negative and form the low points on the profile. The Social Self (Column E) is significantly higher than the Family Self and the Personal Self (Column C) is also moderately well defended.

Self-Criticism Score -- In all groups mean Self-Criticism Scores were indicative of a normal, healthy openness on the part of the delinquents.

Empirical Scales -- The pattern similarity of the groups reported is even stronger across the Empirical Scales than any other area of the overall profile. There were sharp peaks on the GM and PD Scales. All groups fall between one-half and one and a half SD above the mean on the PSY Scale and slightly higher on the N Scale. The scores on the DP Scale are uniformly below the mean and suggest poor psychological defenses. The degree of personality integration measured by the PI Scale is rather poor.

NDS Score -- Since NDS is a summary of all other deviant features, it discriminates maladjustment or pathology better than any other score. For those populations on which it was computed it indicates considerable deviance and tends to fall between one and one-half and two and one-half SD above the mean.

MEASUREMENT OF THE SELF-CONCEPT

Although the instruments used in the study will be fully described in Chapter Three it seems appropriate at this point to discuss the topic of measurement of the self-concept and why a particular instrument, the Tennessee Self-Concept Scale, was selected for use in this study.

One complication in self-concept measurement is the fact that there have been almost as many measuring devices as there have been self-concept studies. Wylie (1961) cited nearly 200 instruments that were employed up to 1960, and many others have been devised since then. Some have studied the self-concept only in terms of self-acceptance (Fey, 1957). Others have been concerned with the physical self-concept (Fisher and Abercrombie, 1959). Some have considered the question of whether it was positive or negative (Northway and Detweiler, 1956), or consistent and stable overtime (Brownfain, 1952), whether it featured positive or negative affect (Mason, 1954) or how realistic it was (Worchel, 1957). Numerous studies (Butler and Haigh, 1954; Fontana, 1966; Sheer, 1958; Smith, 1972) have employed the popular Q-sort technique which yields data about how the self-concept correlates with other variables. The most numerous studies have been those employing the popular "self" versus "ideal self" technique (Bailey, 1968; Friend, 1969).

A number of problems are involved in the measurement of the self-concept, which are common to most psychological tests. The vocabulary level of items, difficulty level of questions, mechanics of the answer sheet are all critical because they may seriously limit the testable population to persons of a particular level of intelligence and literacy.

Many Q-sort techniques, for example, have been found to be too difficult and time consuming for many persons. Individual items and scales must be constructed to reduce the influence of response set and social desirability to avoid cultural bias, and be resistant to faking. There is additional concern for the procedure used for standardization and for the reliability and validity of scores. In an effort to deal with many of these problems, Fitts (1965a) worked for many years to develop an instrument now known as the Tennessee Self-Concept Scale. Though it is subject to the limitations of any verbal, pencil and paper type scale, the TSCS is applicable to a broad range of people.

The TSCS Manual (Fitts, 1965a) describes the scale, and the computation and interpretation of its various scores, as well as a description of its development, reliability data, intercorrelations of scores, validity data and the like. The reliability estimate was based on test-retest data with 60 college students over a two week period. These reliability estimates range from .60 (Row Total V) to .92 (Total P, GM). Validity procedures reported were of four kinds: 1) content validity, 2) discrimination between groups, 3) correlation with other personality procedures, 4) personality changes under particular conditions. The remainder of the discussion will examine subsequent evaluations of the TSCS.

No additional studies of TSCS reliability overtime are reported in the literature. However, Nunnelly (1968) reported a reliability coefficient of .91 and a standard error of measurement of 3.30 for Total P Scores. These measures were obtained by using a Kuder-Richardson split-halves technique. The reported research contains much

indirect evidence attesting to the reliability of the test overtime, in that many studies have reported "no significant change" in various groups from pre-testing to post-testing on the TSCS. This finding suggests that persons tend to be consistent from one time to another in the reporting of their self-concepts with this instrument.

There are a number of studies which demonstrate the predictive validity of the TSCS. Smith (1969) found that involvement in a special preparatory course and the initial self-concepts of visually impaired college students was predictive of whether they would or would not persist in a rehabilitation program. Frankel (1970) using a Hebrew translation of the TSCS to evaluate paratroop trainees was able to reduce the drop out rate to one-eighth of the original level. Faunce (1967) and Flemister (1967) were able to identify potential and actual school dropouts by their TSCS profiles. Tiffany et. al. (1970), were able to predict the vocational rehabilitation potential of ex-psychiatric patients using the TSCS.

There is a great deal of evidence supporting the concurrent validity of the TSCS. Christian (1969) correlated five indices of physical fitness with nine TSCS measures of self-concept and found that three fitness measures (muscularendurance, cardiovascular index, and overall fitness) were significantly and positively correlated with the TSCS Physical Self Scale. Johnston (1967), Vacchiano et. al. (1968) and Bailey (1968) have all reported a significant negative correlation between dogmatism as measured by Rokeach's D scale (1960) and self-concept on the TSCS. Numerous studies have investigated the relationship between the self-concept and anxiety using the TSCS.

Fitts (1965a) administered the TSCS and the Taylor Manifest Anxiety Scale (Taylor, 1953) to 68 female nursing students and found negative correlations of -.43 to -.71 between the TMAS and the TSCS Positive Self-Concept Scales. All of these correlations were significant beyond the .05 level. Smith (1969) used the IPAT Anxiety Scale Questionnaire (Cattell and Scheirer, 1963) and TSCS in his study with blind students and found negative correlations of -.36 to -.71 with the TSCS Positive Scales, all of which were significant beyond the .05 level. Miller (1971) and Ornes (1970) reported correlations of -.65 and -.67 respectively between the TSCS Total P Score and scores on the State-Trait Anxiety Inventory (Spielberger, 1966).

A third type of validation, content validity, is met by the TSCS in that in construction of the Scale an item was retained only if there was unanimous agreement by a panel of seven clinical psychologist judges that it was assigned to the correct category.

A final type of validation procedure, the construct validity of the TSCS is addressed by a number of studies. George (1970) conducted a study in which he asked subjects to respond to test items in terms of how they would like to be, in contrast to their actual self-concept. As a result, the Self-Criticism score dropped markedly and the DP score increased, as did all the Positive scores. The GM, PD and N scores all dropped considerably. Crites (1965) in his review of the TSCS addressed the question of whether the TSCS provides a true phenomenological picture of the persons self-concept and concluded: "... the initial data on the Scale's psychometric attributes indicate that it measures up by traditional criteria rather well." (p. 331) A

study by Bealmer and his associates (1965) correlated responses on the "Who Am I" Test, an unstructured device allowing the subject to describe himself and the TSCS Total P Score. A strong positive relationship was found between the TSCS Total P Score and a clear positive sense of identity represented in the responses on the "Who Am I" Test.

A number of factor analytic studies of the TSCS have been reported. These studies (Vacchiano, Strauss, and Schiffman, 1968; Vacchiano and Strauss, 1968; Vincent, 1968; Rentz and White, 1967a, b; Grant, 1966) and their results are far too complex and lengthy to report in this paper, but as a group, they lend further understanding and considerable support for the content and construct validity of the factors represented by the column scores on the TSCS.

Several studies have been reported which have examined the possible effects of "response bias" on the TSCS. Fitts (1971, p. 54) suggests that TSCS results should be interpreted as the self-concept that the person is willing to publicize. However, the TSCS does have two scales (Self-Criticism and Defensive Positive) which may be interpreted as reflecting possible response bias. One cause of response distortion may be the purported reason for which the test is administered. A study investigating this effect on the TSCS has been reported by Jones (1966). He asked college students (N=94) to indicate for each TSCS item whether they would answer the item truthfully in each of four situations. The situations were: 1) research; 2) help - if they were seeking it; 3) judge - if it were being used in a court of law; 4) job - if a potential employer asked them to take it. Jones found that subjects would be almost completely truthful in the "help"

situation, only slightly, less truthful in the "research" situation, considerably less truthful in the "judge" situation, and that they would answer nearly half the items in a deceitful manner in the "job" situation. These differential levels of truthfulness were correlated with changes on the SC and DP scales. Cotriam (1970) found a similar self-favoring bias when the Scale was administered for "competitive selection" purposes rather than in a "helping" situation. Brassard (1964) and Tracy (1967) also reported "social desirability" response bias effects in test-retest situations where subjects were asked to respond in a personally desirable manner or according to what they thought American society would deem most desirable. However, they too reported the sensitivity of the SC and DP scales to social desirability affected profiles.

The variety of measurement studies which have been conducted with the TSCS gives ample evidence of the ease with which this Scale meets the criteria of reliability and validity suggested by Cronbach (1969) and Guilford (1965). After an extensive review of self-concept measures, Leake (1970) concluded that:

> "The advantages of the TSCS have been clearly demonstrated with respect to control and detection of irrelevant response determinants, the confirmation of research hypothesis, and relatively good standardization and cross validation procedures. While many crucial validity relevant issues remain unresolved with regard to the TSCS, its validity rests upon a broader base of positive findings than any other self-concept instrument presently available." (pp. 83-84)

Cronbach (1960) describes four principle purposes for which tests are generally constructed: 1) selection, 2) classification, 3) evaluation of treatments, and 4) verification of scientific hypotheses; a survey of self-concept literature indicates that the TSCS has been frequently

used in each of these ways. It is an objective test requiring no interpretation by an observer or scorer to arrive at a score. The testing procedure has been standardized and when it is followed the test yields results which may be interpreted with considerable confidence. In fact, the TSCS has been translated into several languages (Spanish, French, Hebrew, Korean), and has been used in numerous studies, the data from which indicates that the norms from groups in other cultures seem to be comparable to those reported from similar groups in the American literature.

SELF-CONCEPT CHANGE

A review of the studies which have employed self-concept change as the criteria for the efficacy of a wide variety of treatment procedures confirms Fitts (1965a) assertion of the relative stability of the self-concept. Numerous studies (Meese, 1961; Boyle, 1967; Kuntz, 1966; Faunce, 1967; Davis, 1969) have examined the effect of individual and group counseling approaches on delinquent and underachiever group self-concepts. All have found that no positive change was elicited and in two cases (Kuntz, 1966; Meese, 1961) the treatment groups showed deterioration of self-concept following the treatment.

Hamner (1968) conducted a well designed, tightly controlled study which examined the effect of a highly concentrated multi-variate treatment program on subjects (N=60) in a Tennessee juvenile delinquent treatment center. The experimental treatment tested the combined effects of group techniques, operant conditioning, peers as reinforcers, video tape feedback, and administration of d-amphetamine in a dosage of 20 mg. per day. Use of the drug was based on the work of

Eisenburg (et. al., 1963) who found that immates of the Maryland Training School improved behavior and reported diminished tension and anxiety while on d-amphetamine and without other treatment. In addition to the chemotherapy, experimental subjects received eight three-and-a-half group sessions covering a two week period. Following examination of the data by a 2x5x3 Analysis of Variance for Factorial Designs, Hamner concluded that the experimental treatment did not make any appreciable difference in measured self-concept.

A number of studies have examined the effect of "Sensitivity Training" and Encounter Marathon groups on self-concept as measured by the TSCS. Brook (1968) found that seven consecutive days of sensitivity training produced no changes in self-concept. Patterson (1974) concluded that none of the marathons in his study were effective in facilitating significant positive change in self-concept when compared with control groups. Link (1971) found similar results following a sixteen hour marathon T-group. Thomas (1974) reported similar results with a population of underachieving adolescent girls following sixteen one hour group sessions. In fact, in this study, experimental groups showed a slight deterioration. Livingston (1971) investigated the effects of a black awareness weekend encounter experience upon the self-concept of black college males and found that no appreciable changes occurred. Lunceford (1973), in a study which very closely replicated Livingston's study except that a black college female population was used, found that black college females who participated in the encounter did not show any more gains in reported self-concept than those who did not participate. An important additional feature

of both these studies is that subjectively treatment groups in both studies reported very positive reactions to the encounters, however, this may reflect emotional carryover, while on a more fundamental level, there was little impact.

Several studies have assessed the effect of more prolonged group approaches on the self-concept. Savarese (1974) employed "peer counseling" and "professional counseling" rap groups meeting two hours twice per week for four weeks using a college student sample and found no significant differences between either of these groups and control groups and no change by any of the groups.

Bailey (1968) evaluated the effect of group therapy in which self-confrontation via video tape was used. During a six week period, 30 sessions were conducted with 28 subjects in a federal womens prison. The result was no change in self-concept. Kuntz (1966) employed short term (10 weeks) group counseling using an unspecified modality and found no effects. Birmingham (1974) examined the differential effects of leaderless and counselor-led groups for 10 weeks and concluded that neither approach significantly affected self-concept. Smith (1971) found that neither short term individual counseling, nor short term group counseling or sensitivity training affected self-concept of male college students.

A number of studies have employed Modeling as a treatment for modification of self-concept. Spinks (1969) employed Vicarious Therapy Pre-Training (Modeling) tapes using same sex and different sex models and measured the effects on self-concept change in group counseling. All groups received eight hours of group each week for

four weeks and experimental S's were also exposed to the modeling tapes. The author reported no significant differences between groups and no significant changes for any group. Weinstein (1973) found that video tapes of 1) an ex-addict role model emphasizing the importance of self-concept change, 2) a "professional" counselor doing likewise, 3) factual information on drug effects were all equally ineffective in altering the self-concept of opiate dependent drug abusers. Palmerlee (1974) also found modeling to be unsuccessful in modifying self-concept with a prison population.

Despite the predominance of studies which demonstrate the difficulty in achieving measureable self-concept change as a result of therapeutic intervention, there are several studies which suggest that positive shifts in self-concept can be achieved. Kutner (1974) examined the impact of an intensive 60-day treatment program in a therapeutic community on the self-concept of drug dependent males. He found significant positive shifts in self-concept on 16 of the TSCS scores (.05 or beyond) from pre to post test. A fault in this study is that no control group was utilized and data was reported on 48 subjects who completed the program with no mention of whether these S's represented a selected sample who completed the program or the entire sample. Also no data on the dropout rate was reported.

Three studies in which treatments were successful in achieving self-concept have particular relevance for this study because of the modalities that they employed. Allen (1971) found that cognitive structuring combined with verbal reinforcement of positive self-reference statements was successful in enhancing the self-concept of

experimental subjects. Experimental S's (N=12) received fifteen hours of group counseling employing the above techniques, Placebo S's (N=12) received fifteen hours of group counseling employing an interactional approach emphasizing unconditional positive regard and reflection by the group leader, and Control S's (N=12) received only pre and post testing. The Semantic Differential was used as the self-concept measure and data revealed changes in the experimental group significant beyond the .05 level. Neither of the other two groups showed any appreciable change. The author concluded that cognitive structuring and verbal reinforcement of positive self-reference statements are effective in enhancing an individual's self-concept. This study is remarkably similar in findings to that of Raimy (1943) although Raimy did not systematically employ the treatment approaches used by Allen. Vaughn (1974) used a cognitive didactic approach with 206 S's drawn from psychology and guidance classes in four Los Angeles schools. Experimental and placebo groups received four 2 hour "class" sessions, with the experimental group receiving a film series dealing with cognitive variables in self-concept change and cognitively oriented counseling sessions, and the placebo groups receiving a film series dealing with psychology in general and non-directive counseling sessions. The control group received pre and post tests only. Results indicated significant gains by the experimental groups on four of the eleven TSCS scales used, while no appreciable gains were made by either the placebo or control groups.

A recent study by Sarkisian (1974) examined the relative impact on self-concept of a modeling approach and an imagery based covert

rehearsal approach. Ninety male and female eleventh grade volunteers were randomly assigned (30 each) to a covert rehearsal group utilizing ideal models which subjects created through imagery, to a verbalization group in which subjects discussed ideal models, or to a control discussion group focusing on school, home, and social problems. Length of treatment was not specified. Results demonstrated that covert rehearsal subjects displayed a significantly higher self-concept and greater congruence between real and ideal self. Subjects in the verbalization group showed a moderate though non-significant improvement and the control group showed no change. The author also noted that high imagery ability seemed to be related to change in self-concept and real-ideal self congruence.

An examination of these studies (all except one employing the TSCS) seem to indicate that short term or marathon type interventions are ineffective as are a variety of different longer term group approaches. Two studies (Joplin and Kutner) indicated that residential approaches may be effective, but that treatment is prolonged (3-9 months). Also, there are numerous studies of residential programs which elicited no positive change. Three studies employing relatively short term therapy approaches seemed to be successful in raising self-concept. Two of these approaches were described as cognitive and the third, a covert modeling through imagery approach, is similar to techniques employed by therapists of the cognitive behavioral persuasion. These three studies have particular relevance for this study because the primary approach which is being examined, Rational Stage Directed Imagery, is a blend of cognitive restructuring, covert modeling through imagery, covert sensitization and relaxation procedures.

After examining the reliability and validity of the TSCS and reviewing relevant studies on this topic Leake (1970) affirmed the relative impermiability of the TSCS to "incidential effects" and concluded that when this instrument is used as the criterion measure, "an experimental manipulation, or self related experience of any kind, would undoubtedly need to be extremely powerful in order to produce even minor changes in the self-concept, let along group changes large enough to be found significant" (p. 26). This discussion of the literature seems to provide ample support for that contention.

COGNITIVE BEHAVIOR THERAPY

Although cognitive behavior therapy (at least from a rational-emotive perspective) probably finds its origins in Adlerian theory, the centrality of cognition in a persons psychological adjustment is centuries old. As early as the fifth century B. C. Hippocrites discussed the function of the brain and the nature of consciousness and concluded:

> Some people say that the heart is the organ with which we think and that it feels pain and anxiety. But it is not so. Men ought to know that from the brain and from the brain only arise our pleasures, joys, laughter and tears. Through it, in particular, we think, see, hear, and distinguish the ugly from the beautiful, the bad from the good, the pleasant from the unpleasant..To consciousness the brain is messenger (In Jones & Withington, 1958).

Somewhat later in the first century B. C. the Roman Stoic philosopher Epictetus stated, "Men are disturbed not by things, but by views which they take of them." (Epictetus, 1899).

Alfred Adler's theories regarding behavior and psychopathology are one of the primary bases upon which cognitive therapy in general

and rational psychotherapy in particular are founded. Adler's theory reflects the notion that a person's emotional reactions, in fact his entire healthy or neurotic life style, are directly related to his basic ideas, beliefs, attitudes, and philosophies about the world and especially about himself. In other words, they are cognitively created. Adler realized that an individual's feelings of inadequacy or inferiority were cognitive in origin when he said, "In a word, I am convinced that a person's behavior springs from his idea." (Adler, 1964, p. 19). Adler (1927) viewed the experiencing of inordinate levels of negative emotions such as anger, depression, anxiety and hostility as attempts on the part of the person to control the environment, situations and other persons. He hypothesized that the major cause of these motivations lay in the person's striving for superiority in the face of feelings of personal inferiority (or poor self-concept). Although Adler was somewhat vague in identifying specific approaches to modify these self-defeating emotional reactions, one of the methods which he epoused was education. He (1958) pioneered the notion that therapy was educational and that education should be therapeutic.

Other early adherents to the idea that self-verbalizations mediate the production of emotions were Korzybski (1933), Johnson (1946), and Shaffer (1947, p. 463), who defined therapy as a "learning process through which a person acquires an ability to speak to himself in appropriate ways so as to control his own conduct." George Kelly's (1955) Fixed Role Therapy is an approach which involved a client's adopting the characteristics (behavior, thinking, feelings) of a fictional character "as if" he were that person. It involved cognitive-imaginal

control by the person over the problematic thoughts, feelings, and behaviors that he presented, and substitution of those characteristics adopted from the fictional idealized model.

Kelly's (1955) approach bears a similarity to Ellis (1957, 1962) Rational Emotive Therapy (RET), however, lack of specific therapeutic structure in Kelly's approach, for one reason, may account for the rise in popularity of RET and the relative decline of Fixed Role Therapy. Rational-Emotive Therapy assumes that psychological disorders arise from faulty or irrational patterns of thinking. Early in his professional career, Ellis subscribed to the prevailing dynamic point of view, but over the years, he evolved an approach (RET) that was increasingly more oriented away from the goal of "historical" insight and toward the here and now cognitive factors that directly mediate maladaptive behaviors and emotions.

The chief method which Ellis used in therapy was direct and nonsubtle activity by the therapists to persuade the client to modify his self-verbalizations. Since that time RET has incorporated many additional methods to clarify and restructure irrational thinking towards more rational ways of thinking, feeling, and behaving. Tosi (1974) cites several techniques which may be used within a rational framework: Rational emotive modeling based on Bandura (1969); utilization of the Premack principle (Tosi, Briggs, and Morley, 1971); assertive training, thought control (Lazarus, 1971); aversive imagery (Cautela, 1972); REI and systematic written homework (Maultsby, 1971). Others lending support to cognitive behavior theory include Meichenbaum and Cameron (1974, 1971), Schacter and Singer (1962), Aaron Beck (1967),

Magda Arnold (1960, 1968, 1970), Arnold Lazarus (1971) and Zimbardo et. al. (1972).

Meichenbaum and Cameron (1974) have demonstrated the clinical potential of modifying client's self verbalizations, and Meichenbaum, et. al. (1971) show that clients who suffered high anxiety could benefit more from RET than from standard desensitization procedures. Lazarus (1971), Jones (1969), Karst and Trexler (1970), Di Loreto (1971), Moleski and Tosi (1975), Trexler and Karst (1972), and Maes and Heimann (1970) have all shown RET to be effective in various situations. Beck (1967) has outlined specific cognitive interventions used in treating depressive disorders. Rimm and Masters (1974) have concluded, "The experimental findings we have reviewed, in concert with favorable outcomes obtained in the clinic, provide rather convincing evidence that Ellis' rational-emotive approach can be effective in modifying maladaptive behavior and emotions" (p. 429).

Schacter and Singer (1962) in their classic study concluded that "by manipulating the cognitions of an individual in such a state of physiological arousal, we can manipulate his feelings in diverse directions" (p. 395). Arnold (1970) underscores this notion when she says, "there is hardly a rival in sight for cognitive theory in the field of emotion" (p. 123). In line with this she regards emotion as a felt tendency toward anything appraised as good or away from anything appraised as bad or harmful. This attraction or aversion is accompanied by a pattern of physiological changes organized toward approach or withdrawal tendencies (Arnold, 1960, 1968). Leeper (1970, p. 156) contends, "Emotions are perceptual processes. I mean this, furthermore,

not in some odd and marginal sense, but in the full sense of processes that have definite cognitive content, or are rich in informational terms as well as in terms of their motivational properties." Numerous others have corroborated the notion of cognitive mediation in the induction of emotions both pleasant and unpleasant (Schachter, 1966; Zeisset, 1968; Raimy, 1975).

Zimbardo (1969, 1972) and his associates have suggested that hypnosis may have a great potential for use within a cognitive therapeutic framework. They stated that: "Hypnosis: a) is a state in which the effects of cognitive processes on bodily functioning are amplified; b) enables the subject to perceive the locus of causality for mind and body control as more internally centered and volitional; c) is often accompanied by a heightened sense of visual imagery; and d) can lead to intensive concentration and elimination of distractions (p. 543 - 544)". Lazarus (1971) has also advocated the potential of hypnosis for use with more standard cognitive behavior techniques.

According to Meichenbaum and Cameron (1974), "when standard behavior therapy procedures were augments with a self-instructional package, greater persistence of treatment efficacy, more generalization, and greater persistence of treatment effects were obtained." Other investigators have also suggested that a specific set of self-instructions significantly reduces anxiety (D'Zurilla, 1969; Zeisett, 1968; Goldfired, 1971; Suinn and Richardson, 1971). The same investigators substantiate the effacaciousness of a skills training program which is followed by an opportunity for in vivo application.

The implication of these studies is that the learning of a strategy to cope with problems is a crucial aspect of the treatment.

RSDT is an intervention which attempts to provide a strategic or structured approach designed to help people utilize their thinking more efficiently in dealing with self-defeating emotional, physiological and behavioral states. Both RSDT and RSDI offer a strategic approach to the restructuring of the cognitive appraisal of a variety of situations or events. In addition, RSDI offers the additional potential benefits of relaxation training, and heightened imageric processes.

RATIONAL STAGE DIRECTED THERAPY

A number of studies have suggested that one or more of the specific approaches subsumed under the title of RSDT may be effective in the treatment of disturbed persons in diverse situations. Marzella (1975) found conditional support for both RSDH and RSDI in an exceptionally well controlled study that was somewhat limited by statistical factors (the size of the N). Case studies by Reardon, Gwynne, and Tosi (1975) demonstrated that RSDH and RSDI respectively, have considerable potential for modifying behavior, ameliorating pathology as measured by the MMPI, TSCS, and MAACL and that positive variance in self-concept may be achieved. Boutin and Gwynne (1975) found RSDH to be an effective treatment for test anxiety.

RSDI is a refinement and synthesis of a number of proven treatment approaches. Numerous writers (Mowrer, 19740; White, 1941; Lazarus, 1971, Valins and Ray, 1967; and Jencks, 1973) have provided evidence that relaxation may be achieved cognitively, that relaxation heightens imagery, and that reduction of tension and anxiety significantly facilitates learning, and results in greater treatment generalization.

In addition to relaxation, RSDI combines cognitive restructuring with the techniques of covert sensitization in order to more effectively extinguish the maladaptive cognitive behaviors that the client may be presently engaged in. These self-defeating cognitive appraisals and the accompanying affective, physiological, and behavioral concomitants are replaced by a more adaptive sequence, through the imagery rehearsal process, in which the subject serves as his own model. The process is initiated (via imagery) in therapy and later carried out by the clinet "in vivo".

Lang (1968) has stated that "the absence of programs for shaping cognitive sets and attitudes may contribute to the not infrequent failure of transfer of treatment effects." RSDT seeks to maximize and generalize treatment effects through a multi-faceted therapeutic intervention in which clients engage in in vivo behavioral tasks corresponding closely to imagery content and which is integrated into clearly delineated stages in the therapy process.

STAGE DIRECTED THERAPY

The concept of employing stages in Rational Stage Directed Therapy has developed from the works of Mooney (1963) and Quaranta (1971). Quaranta (1971) identified six stages of development in career education. He maintains that a person is continually involved in either awareness, exploration, commitment, skill development, skill refinement, and redirection of change. Each stage is non-static, and the stages are successively contained in one another. Tosi (1974) adapted these stages to counseling and psychotherapy, and Tosi and Marzella

(1975) further adapted and modified these stages for Rational Stage Directed Therapy. The growth stages which they have identified in RSDT are self-awareness, exploration, commitment to rational action, implementation of rational action, internalization of rational action, and change-redirection. Rational action implies not only overt behavior, but the entire cognitive-affective-physiological-behavior process. The persons progress through these stages is monitored not only in therapy, but also (and more importantly) in real life situations. These stages are defined as follows:

> Awareness - The client sees in himself and his environment new possibilities for growth. He is introduced to new conditions that are contradictory to his self-defeating thoughts, feelings and actions. He sees that new thoughts, feelings and actions (skills) are needed to interact more effectively with his environment and with himself. He comes to consider himself both as subject and object. He realizes that he has consciousness of himself. Awareness implies witnessing, observing, as well as participating in ones innermost thinking, emotional experiences, physiological functioning, motoric functioning, and transactional functioning (Tosi and Marzella, 1975).

In the Awareness stage, the client begins to recognize the new possibilities that counseling may offer him. He is introduced to the based behavioral modifying process, and as he is guided through the awareness stage, he focuses on his current thoughts, feelings and behaviors. The maladaptive nature of these thoughts, and their association with unpleasant affective - physiological states and self-defeating behavioral consequences is impressed on the client through the application of covert sensitization techniques by the therapist. According to Tosi (1974), the awareness stage primarily emphasizes the cognitive functioning of the client, as the counselor facilitates the acquisition of information. As the client becomes more aware of these facts, he

is able to explore himself more deeply with respect to this newly acquired information.

> Exploration - The client tests out his new awareness of knowledge about himself in the therapeutic context and in real life situations. He submits his old as well as his new ideas, translated into hypothesis, to the empirical test. He is engaging in high level cognitive restructuring in an experimental way. He experiences or re-experiences situations he previously avoided, tries out new behaviors or roles, and evaluates the consequences of his acts. Awareness is expanded as a result of self-in-situation explorations. Resistance becomes increasingly apparent in this stage. He is exploring and developing skills in this stage (Tosi and Marzella, 1975).

The exploration stage is a time for the client to look at many different modes of thinking, feeling and behaving. Early in this stage, he may consider relinquishing some of his former behavior which is less appealing following the sensitization process. Maladaptive thoughts are supplanted by adaptive ideas and the client begins to serve as his own model through the therapeutic imagery process. After exploring many of these possibilities through the imagery rehearsal process, the client may begin to recognize the more pleasant consequences and he may consider a commitment to rational action.

> Commitment to rational/constructive action - Client poses his previous awareness and explorations against his tendency to resist or not to resist an authentic encountering of self-and-environment. He is more aware of the innermost thoughts that produce affective/physiological reactions associated with his tendencies to approach or to avoid significant life situations or to develop the skills necessary to overcome his cognitive/emotional/behavioral/social difficulties. The stage of commitment represents an act of faith, a risk. A last minute attempt to avoid subjective or objective reality. It is the juncture at which many terminate therapy - the point of choice or decision to act (Tosi and Marzella, 1975).

With greater awareness or exploration of self, and having "tried on" new behaviors and cognitions through imagery-rehearsal, the client,

if he chooses to pursue a more effective way of living, must commit himself to work toward change. The focus of this stage lies in having the client model for himself (through imagery) a commitment to more rational thinking, feeling, and acting. As he develops more effective living skills, the counselor encourages the client to trust himself and the therapist.. Through the imagery process he can confront circumstances that were formerly anxiety producing, process them more effectively while remaining calm and imagine himself being increasingly committed to more effective living. Because he is deeply relaxed, the client learns more readily, his resistances are bypassed and his commitment is more easily reflected in a transfer from imagery to in-vivo implementation.

> Implementation - The client, after privately and/or publically committing himself to constructive action, implements constructive action or the self and environmental management skills he is in the process of acquiring. His skills at this stage may involve cognitive control over emotional/physical, and behavioral states--via bio feedback, meditation, cognitive-behavioral restructuring, problem solving, decision making, self-hypnosis, progressive relaxation and the like (Tosi and Marzella, 1975).

The implementation stage is particularly important since it is here that the client actively tries out the new ways of living he has become committed to. His attempts to apply the behavioral modifying procedures to which he is committed are reinforced by the therapist, and he experiences more satisfying consequences from his environment additionally. As the client applies these new skills in real-life situations, they become more natural to him.

> Internalization - The client shows signs of making his new learnings and experiences a part of himself. He shows obvious signs of incorporating, more reasonable modes of thinking and acting into his behavioral repertoire. The use of behavioral

> modifying procedures becomes second nature - he implements them with greater ease and proficiency (Tosi and Marzella, 1975).

Internalization is a logical progression from preceding stages. As the client engages more frequently in the more self-enhancing thinking, feeling, and behaving patterns, he realizes that he can be more effective and he begins to perceive that the locus of control over his cognitive-affective-physiological-behavioral processes is internal rather than external or environmental.

> Change-redirection - The client observes himself. He notes significant changes in his thinking, he sees that he can control significantly negative emotions and self-defeating actions. He transacts more effectively with his environment. He may reaffirm his process at this point, or redirect himself through the stages once again - relative to some other set of problematic concerns. He realizes the need for further growth (Tosi and Marzella, 1975).

In each stage, the client is acquiring, developing and refining behavioral modifying skills. These stages provide the client with a logical strategy to use in approaching problematic internal or environmental situations or events. They also enable him to monitor his progress in therapy and to more clearly recognize his acquisition of greater skills in rational self-management.

CHAPTER III

METHOD

This chapter will describe the research methodology and statistical procedures using in the study. The chapter will also provide sections related to the selection of instruments, sample selection, therapists, design, treatments, statistical procedures, and a general chapter summary.

A 2x4x3 factorial design with two levels of therapists, four levels of treatment, and three repeated measures was used in the investigation of the effects of two Stage Directed Therapies on the modification of self-concept and the reduction of psychological stress. Specifically, this study was conducted to determine the effectiveness of RSDI and RSDT in producing positive variation in self-concept operationally defined by S's scores on the Positive Scales of the Tennessee Self-Concept Scale, (TSCS), and in reducing psychological stress operationally defined by Ss scores on the Self-Critcism, Empirical, and Number of Deviant Signs Scales of the TSCS and the clinical scales of the Multiple Affect Adjective Check List (MAACL).

The design included two treatment groups and two control groups each with equal number of Ss. The treatment groups were: 1) Rational Stage Directed Imagery; and, 2) Rational Stage Directed Therapy. The control groups were: 1) Placebo; and, 2) a no-treatment control group.

The dependent measures for this study were the pre and post measures on the 1) Tennessee Self-Concept Scale (TSCS), and 2) Multiple Affect Adjective Check List (MAACL). Pretreatment measures were obtained seven to ten days prior to the beginning of treatment. Post treatment I measures were obtained two days following the last session, and post II measures were taken two months after the completion of treatments.

SELECTION OF INSTRUMENTS

Tennessee Self-Concept Scale (TSCS): Clinical and Research Form

The TSCS Manual (Fitts, 1965a) describes the scale and the computation and interpretation of its various scores. A description of the development of the instrument is included and data are presented regarding the reliability of scores, intercorrelations of scores and validity data.

The TSCS consists of 100 self-descriptive statements to which the subject responds on a 5-point response scale ranging from "completely true" to "completely false". Ten of the items on the scale came from the MMPI L-Scale and constitute the Self-Criticism Score -- a measure of overt defensiveness. The other 90 items were drawn from a large pool of self-descriptive statements. The original criterion for selection was agreement by seven clinical psychologists as to the classification of the items on the basis of their content.

The overall self-concept is reflected in the Total Positive score which is indicative of a person's general level of esteem. The TSCS Total P score evolves from a 3x5 matrix of subscores which are explained as follows:

The rows are concerned with how the individual describes himself from an internal frame of reference. Row 1 represents his basic Identity or "what he is", as he perceives himself at the most basic level. Row 2 gives a measure of Self-Satisfaction or how the individual accepts himself. Row 3 deals with the subject's perception of his own behavior. The three rows then may be seen focusing on: 1) "What he is", 2) "How he feels about himself", 3) "What he does" (Hamner and Fitts, 1968).

The five columns deal with the external frame of reference the individual uses to describe himself:

Column A: Physical Self - The physical attributes or functioning, sexuality, stage of health or appearance.

Column B: Moral-Ethical Self - Moral, ethical, and religious aspects of the self.

Column C: Personal Self - Personal worth or adequacy, self-respect, and self-confidence.

Column D: Family Self - The individual's relationship with his primary group (family and close friends) and his sense of adequacy as a family member.

Column E: Social Self - The individual's sense of adequacy or worth in relationships with people or society in general. (Fitts, et. al., 1971).

This 3x5 grid results in 15 intersecting categories (e.g., Identity - Physical Self or Behavior - Family Self) within which there are an equal number of positive and negative items.

The Variability Scores of the TSCS reflect the consistency or inconsistency of self--perceptions. The variability is represented in three scores on the TSCS. The Total V score represents the total amount of variability for the entire record while variations within the rows and columns are summarized by the Row Total V and Column Total V Scores (Fitts and Hammer, 1969).

The Distribution Scores represent the number of times a subject uses each response category and these scores reflect the manner in

which he handles the tasks of self-description. The D Score is a summary score derived from the other five response scores. It is interpreted as a measure of certainty about the self-concept - whether the person has a clearly or vaguely differentiated self-concept. High D Scores indicate certainty and low D Score uncertainty.

The T/F Ratio is a ratio of the true versus false responses. It serves as a measure of response set and provides interesting data about the subject's tendency to agree or disagree, accept or reject items almost irrespective of content. Ratio Scores in the middle range of the distribution would probably be optimal, indicating that the person is able to differentiate between those statements which apply to him and those which do not.

The Net Conflict Score measures direction as well as amount of conflict in self-appraising statements which may be couched in positive or negative terms. These may be so variable as to cancel each other and reduce the Total Net Conflict Score. In order to give an absolute measure of the amount of such conflict without regard to direction, the positive-negative differences are also summed non-algebraically. This yields a Total Conflict Score. "High scores indicate confusion, contradiction, and general conflict in self-perception; whereas low scores have the opposite interpretation." (Fitts, 1965a, p.4)

Six of the scales of the TSCS were empirically derived from the 100 test items through item analysis. These scales are designed to differentiate among various groups often encountered in a clinical setting. In the development of these six scales, various "deviant" groups of subjects were identified, they are:

Norm	N = 626
Psychotic	N = 100
Neurotic	N = 100
Personality Disorder	N = 100
Defensive Positive	N = 100
Personality Integration	N = 75

Those items which differentiated one group of subjects from all other groups were used to compose a specific scale for that group. The six empirical scales derived by this method are as follows:

Defensive Positive Scale (DP) - This scale consists of 29 items which differentiated psychiatric patients having Total P Scores above the norm group mean from the other patient groups and from the norm group. It is thought to represent a more subtle measure of defensiveness than the Self-Criticism Score.

General Maladjustment Scale (GM) - This scale comprises 24 items which distinguish psychiatric patients from non-patients, but do not distinguish between psychiatric classifications.

Psychosis Scale (Psy) - Twenty-three items make up this scale -- items which best differentiate psychotic patients from the other groups.

Personality Disorder Scale (PO) - This scale is composed of 27 items, items which distinguish this psychiatric classification from the norm, psychotic, neurotic, personality integration, and defensive positive groups.

Neurosis Scale (N) - This scale is also composed of 27 items which distinguish neurotic patients from the other group. Like the GM and PD Scales, it is an inverse one. Low raw scores on these scales result in high T-scores.

Personality Integration (PI) - Twenty-five items are included in this scale, representing a group of subjects adjudged, by outside criteria, to have a better than average level of adjustment.

Number of Deviant Signs (NDS) - The NDS score is an empirically derived measure, being simply a count of the number of deviant features of other scores. It is the Scale's best index of psychological disturbance.

The norms for the TSCS were obtained from a broad sample of 626 people from various parts of the country, including males and females, in age ranges 12 to 68. They are representative of all social, economic,

intellectual levels and educational levels from 6th grade through the Ph.D. degree (Fitts, 1965a). However, the norms are over represented in the 12 to 30 year age bracket, in number of college students, and white subjects. Fitts (1965a) reported that the evidence gathered suggested that there was no need to establish separate norms by age, sex, race, or other variables.

The TSCS is applicable across the range of psychological adjustment from healthy, well-adjusted people to psychotic patients. The TSCS is self-administering for either individuals or groups and may be used with subjects age 12 or older and having at least a 6th grade reading level.

The test-retest reliability co-efficient of all major scores ranges from .60 to .92 with an average of .80 (Fitts, 1965a); they are reported below. The validation procedure (Manual, Fitts, 1965a) included: 1) content validity, 2) discrimination between groups, 3) correlation with other personality measures, and 4) personality changes under particular conditions. A more detailed discussion of the instruments validity and applicability was already presented in Chapter II.

MULTIPLE AFFECT ADJECTIVE CHECK LIST (MAACL):

The MAACL (Zuckerman and Lubin, 1965) is designed to fill the need for a self-administered scale to provide valid measures of three clinically relevant negative affects: anxiety, depression, and hostility. It is the reduction in the intensity of these three variables that is being observed over the course of this study. The MAACL consists of 132 adjectives each of which the subject reads and checks if he feels

TABLE 1

MEANS, STANDARD DEVIATIONS, AND RELIABILITY COEFFICIENTS

TENNESSEE SELF CONCEPT SCALE

SCORE	MEAN	STANDARD DEVIATION	RELIABILITY**
Self-Criticism	35.54	6.70	.75
T/F	1.03	.29	.82
Net Conflict	-4.91	13.01	.74
Total Conflict	30.10	8.21	.74
Total Positive	345.57	30.70	.92
Row 1	127.10	9.96	.91
Row 2	103.67	13.79	.88
Row 3	115.01	11.22	.88
Col. A.	71.78	7.67	.87
Col. B.	70.33	8.70	.80
Col. C.	64.55	7.41	.85
Col. D.	70.83	8.43	.89
Col. E.	68.14	7.86	.90
Total Variability	48.53	12.42	.67
Col. Total V	29.03	9.12	.73
Row Total V	19.60	5.76	.60
D	120.44	24.19	.89
5	18.11	9.24	.88
4	24.36	7.55	.79
3	18.03	8.89	.77
2	18.85	7.99	.71
1	20.63	9.01	.88
DP	54.40	12.38	.90
GM	98.80	9.15	.87
Psy	46.10	6.49	.92
PD	76.39	11.72	.89
N	84.31	11.10	.91
PI	10.42	3.88	.90
NDS* (Median)	4.37		.90

* This distribution so extremely skewed that conventional parametric statistics are meaningless, so the Median is used on Profile Sheet. Actual mean is 7.3 but about 68% of non-patients score below mean.

** Reliability data based on test-retest with 60 college students over a two-week period.

that it describes him generally. The checklist is brief and requires less than five minutes to administer. The general form of the MAACL was given because it is less sensitive to transient affective states.

Correlations among the three MAACL scales as administered to college students, both males and females, are reported to be: Anxiety vs. Depression = .75; Anxiety vs. Hostility = .72. Test-retest reliability over an eight day interval has been reported as: Anxiety - .77; Depression - .79; and Hostility - .84 (Zuckerman and Lubin, 1965).

SELECTION OF SAMPLE

During the Autumn Quarter, 1975 (September) the entire population of Rosemont School, a residential treatment facility and day-school for adolescent delinquent females, was given the TSCS and MAACL (N=80). Of this number, 41 subjects volunteered to participate in a study designed to help them cope more effectively with psychological stress. No mention of a specific treatment method was made at any time during the experiment.

From the 41 volunteers, 32 persons were randomly selected to participate in the study. Subjects consisted of 32 adolescent females, all of whom were residential students at Rosemont School. The mean age of the sample was 16 years. All subjects were enrolled in the 9th grade or above with a mean school grade of 10.4.

Each subject had previously completed the TSCS and MAACL when the entire population was tested. Ss were randomly assigned to a treatment process via a table of random numbers. Each S participated in six treatment sessions lasting approximately one hour each. All treatment was completed in a six week period. The content for the

treatment sessions was suggested by each subject's performance on the Self Directed Behavior Change Instrument (Tosi, 1973), and after an examination of their TSCS profiles (e.g. a low score on the Physical Self Scale or Family Self Scale suggested "irrational ideas" regarding their physical attractiveness, or worth as a family member respectively). All treatment took place in two Social Service lounges at Rosemont School.

THERAPISTS

The therapists providing the treatment were two doctoral students in Counselor Education at the Ohio State University. The ages of the therapists were 24 and 28. Both have completed considerable training in cognitive behavior therapy techniques and sensory-imagery approaches to counseling and psychotherapy; and, both therapists were in the final stages of completing internships in counseling and psychotherapy. In addition, both therapists have had previous training and experience working as counselors in a vision rehabilitation setting and in a state hospital.

Each therapist treated sixteen subjects, an equal number (4) across all treatments. Independent raters assessed randomly selected performances of each therapist to insure their adherence to each particular methodology. (See Rating Scale Therapists, Appendix C.) The judges, a Licensed Clinical Psychologist in private practice and an advanced doctoral student in the Faculty of Special Services, each rated 10 randomly selected sessions. The product moment correlations of inter-rater reliability as applied to therapists' performance are as follows:

TABLE 2

PRODUCT MOMENT CORRELATIONS OF INTER-RATE RELIABILITY FOR THERAPISTS' PERFORMANCE OF TREATMENT

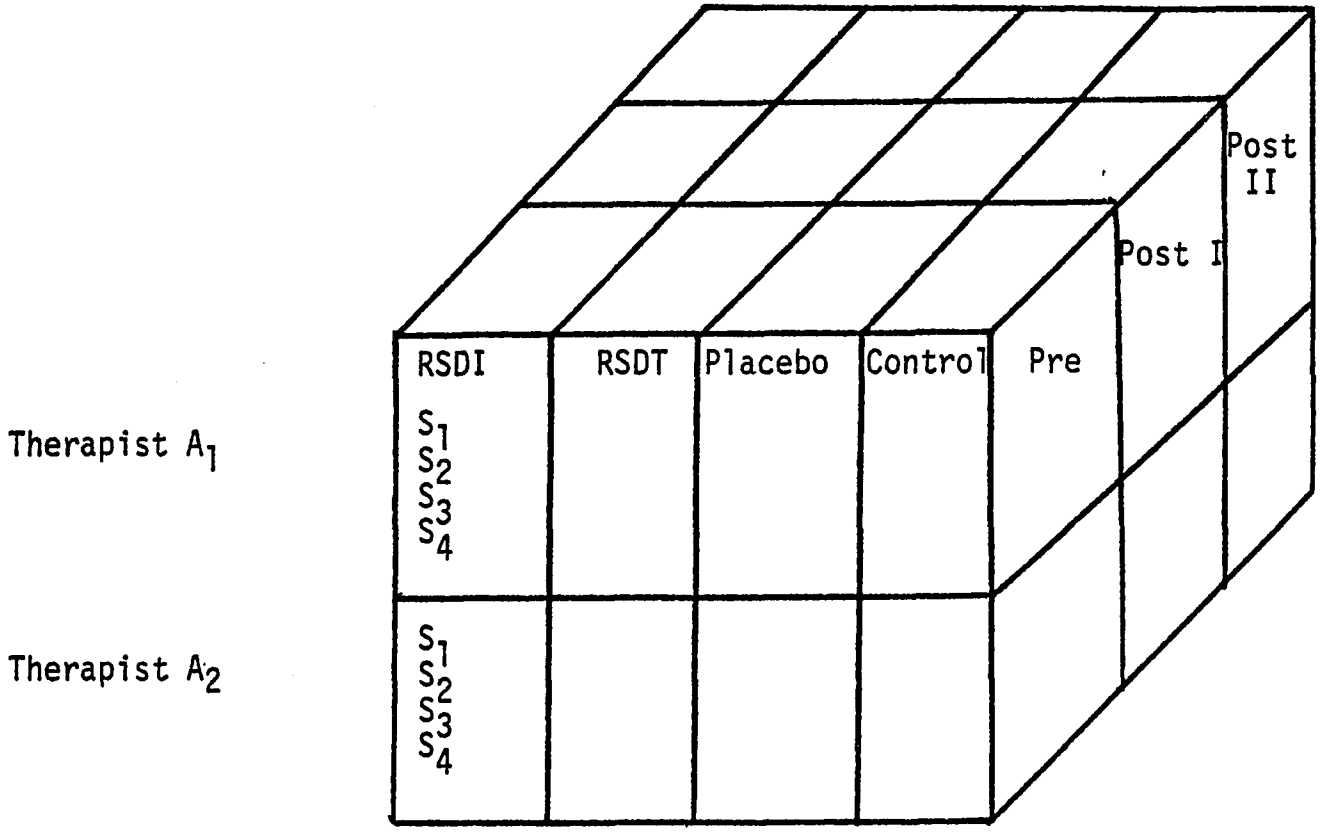
Therapist	Inter-rater Reliability
1	r = .88
2	r = .86

RESEARCH DESIGN

A 2x4x3 mixed model design with 2 between-subjects variables (therapists, treatments) and one within-subjects variable (3 levels of a repeated measure) was used in analyzing the data (See Figure 1). All Ss were assigned randomly to one of four treatment modes, with an equal number of Ss receiving each treatment. Each person received six treatment sessions, approximately one hour in length, over a six week period. All subjects received pre, post I, and post II tests. Variance due to therapists was accounted for in the statistical analysis. The therapist variable was random.

TREATMENTS RATIONAL STAGE DIRECTED IMAGERY (RSDI)

RSDI is an attempt to synthesize relaxation techniques, covert sensitization, covert rehearsal or modeling, and rational-emotive imagery with rational or cognitive restructuring while simultaneously guiding or directing the client through the growth stages of awareness, exploration, commitment to rational action, implementation, internalization and change-redirection. After the client was introduced to the basic concepts of rational emotive therapy, she was asked to identify



2x4x3 Anova

FIGURE 1

specific emotionally disturbing situations using the Self Directed Behavior Change Instrument (Tosi, 1973, see Appendix D).

After visualizing the situation and experiencing the emotional responses associated with that event, the client was then directed to challenge and confront her earlier identified irrational cognitions specific to that situation; to rationally challenge them and finally to supplant them with more rational self-talk.

The client was then assisted in achieving a deeply relaxed stage (see specific cognitive relaxation protocal in Appendix E) and was again directed to visualize specific pre-determined situations and to experience the concomitant emotions associated with these situations. This irrational sequence was then negatively reinforced by the therapist. The therapist then instructed the subject to refocus on relaxing thoughts and then visualize the same situations, imagine herself engaging in more rational self-talk and experiencing more positive affect, more pleasant physiological effects, and more adaptive behavioral consequences. In this way the subject served as her own model and desensitized herself to environmental cues associated with the situation. This rational sequence was then positively reinforced by the therapist.

The therapist guided the client through each stage at the client's own pace. Tosi (1974) suggested that the overall emotional effect of both real and imagined stimuli are often qualitatively the same; therefore, the client can learn to substitute personally desirable emotional tendencies for undesirable ones via imagery.

During homework assignments, subjects were instructed to only imagine the "rational sequence". It is hypothesized that by learning

relaxation skills and encountering situations initially via imagery that an individual can effectively learn to overcome self-defeating irrational cognitions and supplant them with more self-enhancing cognitive, affective, physiological, and behavioral response tendencies. (See Appendix F for RSDI treatment plan and Appendix G for an example session.)

RATIONAL STAGE DIRECTED THERAPY (RSDT)

RSDT is an intervention designed to help people develop and use their thinking more effectively in dealing with maladaptive emotional, physiological, and behavioral states. It is an attempt to restructure a persons method of appraising situations or events from one typified by catastrophizing and over-generalizing to a more logical, realistic and adaptive appraisal of situations. RSDT is much the same process as RSDI except there is no utilization of relaxation procedures present in RSDT.

RSDT is theoretically very similar to Maultsby's (1971) Rational Emotive Imagery (REI). Just as in REI clients are asked to imagine desirable behavior rather than self-defeating behavior. Subjects, under the guidance of the therapist, attempt to picture methods that may lead them away from disturbing behavior and toward more rational thoughts, feelings, and behaviors.

RSDT consisted of the following procedures: 1) The Ss were asked to identify situations or events to which they responded with a negative emotion. This content was derived primarily from the Self Directed Behavior Change Instrument (Tosi, 1973) and secondarily from Ss TSCS Profile; 2) The Ss were then instructed to imagine themselves thinking

only rational thoughts relative to the problematic situation. Ss were then guided by the therapist to experience positive emotions and behavioral consequences associated with their rational thoughts regarding the situation; 3) Ss were guided in this process through the aforementioned growth stages.

Ss are given homework assignments to practice this technique outside the therapy sessions. It is hypothesized that this will facilitate the process of overcoming self-defeating cognitions and replacing them with more adaptive self-statements. (See Appendix H for session by session treatment.)

PLACEBO

Ss receiving the placebo treatment met and were given direct suggestions to relax and that if they would "feel better" about themselves they would be less anxious. No formalized or patterned method of dealing with the situations producing emotional unrest was offered. Therapists in this treatment were instructed not to answer any questions directly but to be very reflective and non-directive.

CONTROL

The final treatment condition was the no treatment control group. Ss were assigned to the control group from the same population as the other Ss; however, no one in the control group received any form of treatment. They were administered all tests as were the other Ss.

STATISTICAL ANALYSIS

Data collected in this study were analyzed by a 2x4x3 factorial analysis of variance with repeated measures. This procedure is described by Kirk (1968) as a split-plot design -- factorial design with block treatment confounding. Winer (1962) uses the term, "multifactor experiments having repeated measures on some elements." Kirk (1968, p. 247) contends that split-plot designs are particularly well suited for research in the behavioral sciences, and are especially useful in assessing treatment effects such as learning, etc. The Newman Keuls test, a post hoc analysis, was used to compare all possible combinations of means following significant F ratios for main effects and interactions. Treatment trends emerging within groups across pre, post I, and post II trials were examined visually and graphically rather than statistically. The presence of a significant F ratio is indicative of a trend (Kirk, 1968), and therefore, legitamizes the examination.

SUMMARY

Chapter III has presented the procedures and methodology of the study. It contains descriptions of the sample, instrumentation, therapists, design, treatments, and the analysis of the data.

Chapter IV will discuss the findings of the experiment. Results of hypotheses testing will be presented by an examination of each variable and a summation of the findings.

CHAPTER IV

ANALYSIS OF DATA

The analysis of data will be presented in this chapter. This study was undertaken to test the hypotheses stated in Chapter I. Of primary interest were the effects of Rational Stage Directed Imagery (RSDI) and Rational Stage Directed Therapy (RSDT) on the elevation of the self concept as measured by the positive scales of the Tennessee Self Concept Scale and upon the reduction of psychological stress as measured by the Empirical Scales of the TSCS and by the MAACL. Also of concern was the extent to which the therapists contributed to the therapeutic process.

The hypotheses of this study were tested by a two between-subjects, one within-subjects factorial analysis of variance with repeated measures (Winer, 1962; ala split-plot, Kirk, 1968). The two between-subjects variables were: two levels of therapists, and four levels of treatments. The one within-subjects variable was the repeated measure (three trials). Individual F ratios were completed on each of the 20 dependent variables, and no significant differences were found between treatment group pre-test means. The analysis of variance with repeated measures program was used to compute F ratios for each main effect and interaction. Subsequent to significant F ratios, the Newman Keuls test was used in post hoc analysis (Winer, 1962; Kirk, 1968).

There were 20 dependent variables included in the study. Each dependent variable was discussed in light of the analysis of variance and post hoc results. A summary table of each analysis was included, and where statistical significance was observed a post hoc analysis was presented. Table 3 presents the mean scores for Ss performances on all 20 dependent variables, by treatments and trials. An examination of the individual variables follows it.

TSCS SCALES

The nine positive self concept scales of the TSCS were used in this study as measures of self concept in a number of dimensions. The eight additional TSCS scales were utilized as measures of psychological stress. Analysis of variance for the nine self concept scales revealed significant F ratios for the total positive self concept, identity, behavior, physical self, moral-ethical self, and social self (See Tables 4, 6, 9, 11, 13 and 15). The self criticism, acceptance, personal self, family self, defensive positive, general maladjustment, psychosis, personality disorder, neurosis, personality integration and number of deviant signs scales did not attain significance (See Tables 17 through 27).

Table 4 represents a complete analysis of variance with repeated measures for the Total Positive Self Concept of the TSCS. A significant interaction ($p < .01$) was found between treatment and trials. The significant interaction for treatments X trials suggests that the observed mean total positive self concept scores of Ss were different from those expected by the simple addition of appropriate main effects.

TABLE 3

Mean Scores for Ss Performance on the 20 Dependent Variables by Treatment and Trials

TSCS Self Criticism[a]	Pre	Post I	Post II
RSDI	36.50	36.38	35.88
RSDT	36.25	38.75	35.88
Placebo	35.13	36.38	35.13
Control	34.25	35.50	36.13

TSCS Total Self Concept[a]	Pre	Post I	Post II
RSDI	309.38	324.88	331.38
RSDT	303.88	310.00	298.00
Placebo	300.38	301.63	297.50
Control	308.13	281.25	300.13

TSCS Identity[a]	Pre	Post I	Post II
RSDI	117.75	125.25	124.00
RSDT	114.63	117.13	110.50
Placebo	107.88	109.88	106.13
Control	109.75	101.13	104.38

TSCS Acceptance[a]	Pre	Post I	Post II
RSDI	93.50	97.13	100.25
RSDT	90.50	95.88	93.75
Placebo	95.63	92.88	92.50
Control	96.75	91.75	97.88

TSCS Behavior[a]	Pre	Post I	Post II
RSDI	97.88	102.50	104.88
RSDT	98.75	97.00	93.75
Placebo	96.88	98.87	98.87
Control	101.62	88.38	97.87

TSCS [a] Physical Self

	Pre	Post I	Post II
RSDI	68.50	69.75	71.13
RSDT	67.63	66.38	64.88
Placebo	62.75	65.50	66.00
Control	67.50	62.25	62.50

TSCS [a] Moral-Ethical Self

	Pre	Post I	Post II
RSDI	56.63	63.75	64.63
RSDT	55.50	59.38	55.75
Placebo	58.50	59.50	62.13
Control	61.63	55.50	62.50

TSCS [a] Personal Self

	Pre	Post I	Post II
RSDI	60.37	63.25	65.38
RSDT	60.75	59.63	58.12
Placebo	57.13	59.00	57.50
Control	61.50	54.50	61.00

TSCS [a] Family Self

	Pre	Post I	Post II
RSDI	60.63	61.13	61.25
RSDT	59.88	61.13	58.88
Placebo	61.25	58.75	55.75
Control	55.88	50.38	53.88

TSCS [a] Social Self

	Pre	Post I	Post II
RSDI	63.13	67.00	67.88
RSDT	61.75	63.75	60.38
Placebo	60.38	58.75	57.38
Control	61.63	58.63	60.38

TSCS [a] Defensive Positive

	Pre	Post I	Post II
RSDI	44.38	51.88	51.63
RSDT	48.13	45.13	46.75
Placebo	47.38	43.00	45.13
Control	48.00	44.75	47.25

TSCS [a]
General Maladjustment

	Pre	Post I	Post II
RSDI	69.00	69.13	70.38
RSDT	73.13	70.25	70.88
Placebo	73.38	68.13	70.50
Control	70.50	75.88	69.75

TSCS [b]
Psychosis

	Pre	Post I	Post II
RSDI	69.25	68.38	67.25
RSDT	65.13	64.88	65.25
Placebo	66.00	66.63	66.88
Control	66.50	65.00	65.88

TSCS [a]
Personality Disorder

	Pre	Post I	Post II
RSDI	58.00	60.38	61.25
RSDT	61.75	58.50	56.63
Placebo	54.00	53.25	55.13
Control	55.50	55.75	52.75

TSCS [a]
Neurosis

	Pre	Post I	Post II
RSDI	61.38	64.50	67.25
RSDT	64.38	62.75	60.00
Placebo	61.63	58.50	58.50
Control	60.38	59.38	56.88

TSCS [a]
Personality Integration

	Pre	Post I	Post II
RSDI	6.00	8.00	8.38
RSDT	7.50	6.63	8.00
Placebo	8.00	8.00	7.88
Control	6.88	6.38	7.25

TSCS [b]
Number of Deviant Signs

	Pre	Post I	Post II
RSDI	34.75	32.88	28.38
RSDT	42.75	31.88	35.50
Placebo	35.25	36.63	35.25
Control	44.38	45.00	38.50

MAACL b Anxiety

	Pre	Post I	Post II
RSDI	10.13	6.13	4.63
RSDT	11.00	7.75	7.25
Placebo	11.63	9.75	8.38
Control	10.50	11.50	8.75

MAACL b Depression

	Pre	Post I	Post II
RSDI	17.63	11.13	6.63
RSDT	15.88	13.13	13.38
Placebo	18.63	17.13	15.00
Control	19.00	22.13	18.38

MAACL b Hostility

	Pre	Post I	Post II
RSDI	8.25	5.63	5.88
RSDT	10.88	9.38	9.50
Placebo	12.75	11.63	8.88
Control	9.63	10.88	9.75

NOTE: On scales with the super script a higher scores indicate health.

On scales with the super script b lower scores indicate health.

GM, PD, N scales are inverted, therefore, higher scores indicate health.

TABLE 4

Factor Analysis of Variance for Therapists, Treatments, and Trials for Adjusted Mean TSCS Total Positive Self Concept Scale Scores

Source	Ss	df	MS	F
Between Subjects	46,577.997	31		
Therapists (A)	38.760	1	38.760	0.025
Treatments (B)	8,534.414	3	2,844.806	1.865
Therapists X Treatments (AB)	1,395.928	3	465.309	0.305
Ss w/in groups (AB)	36,608.895	24	1,525.371	
Within Subjects	20,124.078	64		
Trials (C)	44.519	2	22.259	0.076
Therapists X Trials (AC)	183.377	2	91.689	0.314
Treatments X Trials (BC)	5,331.531	6	888.589	3.040**
Therapists X Treatments X Trials (ABC)	534.253	6	89.042	0.305
C X Ss w/in AB	14,030.398	48	292.300	
TOTAL	66,702.075	95		

** $p < .01$

The Newman Keuls tests presented on Table 5 reveal a number of significant pairwise comparisons between group means on the Total Positive Self Concept Scale. RSDI - post II is significantly different from the RSDT,Control,and Placebo groups at post II. RSDI - post I is significantly different from control at post I. The trends for all groups may be observed graphically on Figure 2.

These results suggest that RSDI was effective in elevating the Total Positive Self Concept Score and that the intervening time between cessation of therapy and post II testing not only did not produce a regression effect but, in fact, results in a further treatment effect. RSDT - post I showed a slight treatment effect immediately post treatment which was significantly different ($p < .05$) from the Control - post I mean. The significance was mostly attributable to a sizeable deterioration at post I by the Control group. This result was so unexpected that the investigator tested another sample of 10 subjects independent of the study to examine whether this deterioration could have been a sampling artifact. The additional sample showed a nearly identical deterioration effect of unknown origin. It is theorized that proximity to a holiday (Thanksgiving) may account for this effect in part. If so, it also suggests that the post I treatment effects may be even more notable. RSDT, Placebo and Control groups all tended to regress toward pre-test scores on post II.

The differences noted between groups and the favorable changes by the RSDI group on this variable are particularly significant because this scale is the best overall indicator of self esteem.

TABLE 5

Results of Newman Keuls Tests on all Ordered Pairs of Means for Treatments X Trials Interaction on TSCS Total Positive Self Concept

	i	e	f	a	d	b	g	c	l	j	k	h
i	---	6.50	21.38	21.50	23.25	27.50*	29.75*	31.00*	31.25*	33.38*	33.38*	50.13**
e		---	14.88	15.00	16.75	21.00	23.25	24.50	24.75	26.88	27.38	43.63**
f			---	0.12	1.87	6.12	8.37	9.62	9.87	12.00	12.50	28.75
a				---	1.75	6.00	8.25	9.50	9.75	11.88	12.38	28.63
d					---	4.25	6.50	7.75	8.00	10.13	10.63	26.88
b						---	2.25	3.50	3.75	5.88	6.38	22.63
g							---	1.25	1.50	3.63	4.13	20.38
c								---	.25	2.38	2.88	19.13
l									---	2.13	2.63	18.88
j										---	.50	16.75
k											---	16.25
h												---

** $p < .01$ *$p < .05$

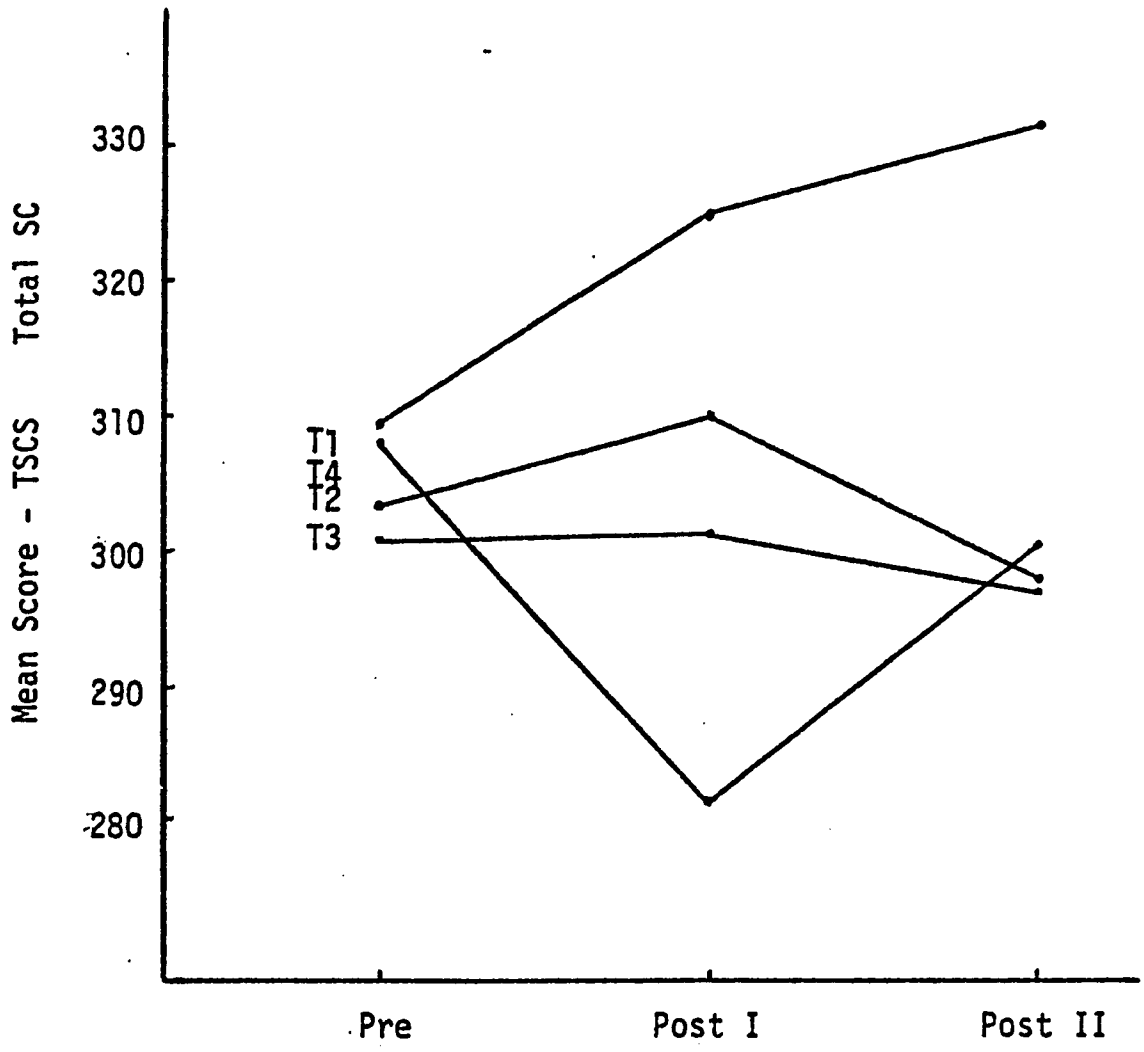


FIGURE 2

Treatments X Trials Interaction Effects on TSCS Total Positive Self Concept Scale Score

T1 = RSDI
T2 = RSDT
T3 = Placebo
T4 = Control

The ANOVA summary table for the TSCS Identity Scale appears in Table 6. It reveals a significant ($p < .01$) F ratio for the main effect of treatments. This suggests that the observed mean TSCS Identity scores for Ss were significantly different than might be expected.

The Newman Keuls comparisons of pre-group means revealed no significant differences. The post I group means yield some significant results, which are presented in Table 7.

TABLE 7

Results of Newman Keuls Tests on all Ordered Pairs of Means for TSCS Identity Scale for Treatment Effects - Post I

	e	f	g	h
e	---	8.12	15.37*	24.12**
f		---	7.25	16.00*
g			---	8.75
h				---

** $p < .01$ * $p < .05$

The RSDI treatment group mean is significantly different ($p < .01$) from the control group mean and the Placebo group mean ($p < .05$) at post I. The RSDT group mean differs significantly ($p < .05$) from the Control.

Inspection of Figure 3 reveals graphically the results at post I and post II testing. RSDI subjects report an improved sense of Identity at post I, which is maintained at post II. Table 8 examines group differences at post II.

TABLE 6

Factor Analysis of Variance for Therapists, Treatments, and Trials for Adjusted Mean TSCS Identity Scale Scores

Source	Ss	df	MS	F
Between Subjects	8,798.551	31		
Therapists (A)	551.036	1	551.036	3.404
Treatments (B)	4,134.656	3	1,378.219	8.514**
Therapists X Treatments (AB)	227.875	3	75.958	0.469
Ss w/in groups (AB)	3,884.984	24	161.874	
Within Subjects	5,094.516	64		
Trials (C)	77.897	2	38.948	
Therapists X Trials (AC)	273.258	2	136.629	0.495
Treatments X Trials (BC)	710.161	6	118.360	1.736
Therapists X Treatments X Trials (ABC)	256.302	6	42.717	1.504
C X Ss w/in AB	3,776.898	48	78.685	0.543
TOTAL	13,893.067	95		

** $p < .01$

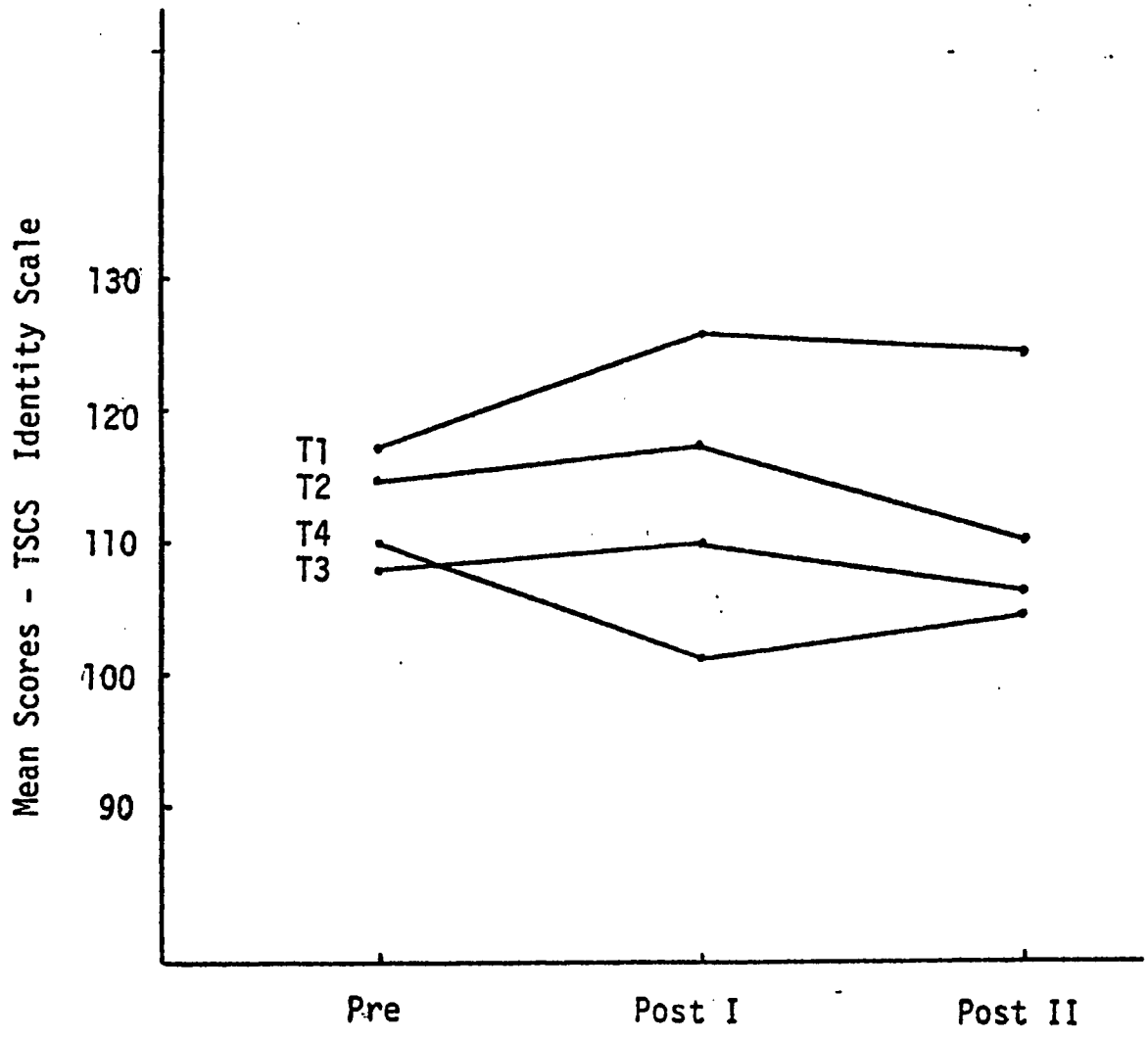


FIGURE 3

Treatment Effects across Pre, Post I, and Post II on TSCS Identity Scale Score

T1 = RSDI
T2 = RSDT
T3 = Placebo
T4 = Control

TABLE 8

Results of Newman Keuls Tests on all Ordered Pairs of Means for TSCS Identity Scale for Treatment Effects - Post II

	i	j	k	l
i	---	13.50*	17.87*	19.62*
j		---	4.37	6.12
k			---	1.75
l				---

* $p < .05$

RSDI is significantly different ($p < .05$) from Control, Placebo and RSDT at the post II testing. These results reveal that the RSDI treatment group experiences a significant treatment effect at both post I and II, and that the Control group evinced deterioraton once again. RSDT appeared to have a slight beneficial effect at post I but regressed at post II.

The ANOVA summary table for the TSCS Behavior scale appears in Table 9. The F ratio for the treatment X trials interaction is significant ($p < .01$).

The Newman Keuls tests presented by Table 10 reveal significant differences between RSDI at post I and post II and the Control group. These differences and the trend across trials can be observed graphically on Figure 4. Inspection of Figure 4 reveals that the RSDI Ss appraisal of their Behavior was significantly enhanced whereas the other groups showed no discernable effects or a slight tendency toward deterioration.

TABLE 9

Factor Analysis of Variance for Therapists, Treatments, and Trials for Adjusted Mean TSCS Behavior Scale Scores

Source	Ss	df	MS	F
Between Subjects	10,412.225	31		
Therapists (A)	53.999	1	53.999	0.144
Treatments (B)	491.536	3	163.845	0.438
Therapists X Treatments (AB)	893.585	3	297.862	0.797
Ss w/in groups (AB)	8,973.105	24	373.879	
Within Subjects	4,014.526	64		
Trials (C)	96.390	2	48.195	0.893
Therapists X Trials (AC)	218.681	2	109.341	2.027
Treatments X Trials (BC)	976.985	6	162.831	3.019**
Therapists X Treatments X Trials (ABC)	133.224	6	22.204	0.412
C X Ss w/in AB	2,589.246	48	53.943	
TOTAL	14,426.751	95		

** p <.01

TABLE 10

Results of Newman Keuls Tests on all Ordered Pairs of Means for Treatments X Trials Interaction on TSCS Behavior Scale

	i	e	d	k	g	b	a	l	f	c	j	h
i	---	2.38	3.26	6.01	6.01	6.13	7.00	7.01	7.88	8.00	11.13	16.50**
e		---	.88	3.63	3.63	3.75	4.62	4.63	5.50	5.62	8.75	14.12*
d			---	2.75	2.75	2.87	3.74	3.75	4.62	4.74	7.87	13.24*
k				---	0.00	0.12	.99	1.00	1.87	1.99	5.12	10.49
g					---	0.12	.99	1.00	1.87	1.99	5.12	10.49
b						---	.87	.88	1.75	1.87	5.00	10.37
a							---	.01	.88	1.00	3.13	9.50
l								---	.87	.99	3.12	9.49
f									---	.12	3.25	8.62
c										---	3.13	8.50
j											---	5.37
h												---

** p <.01 * p <.05

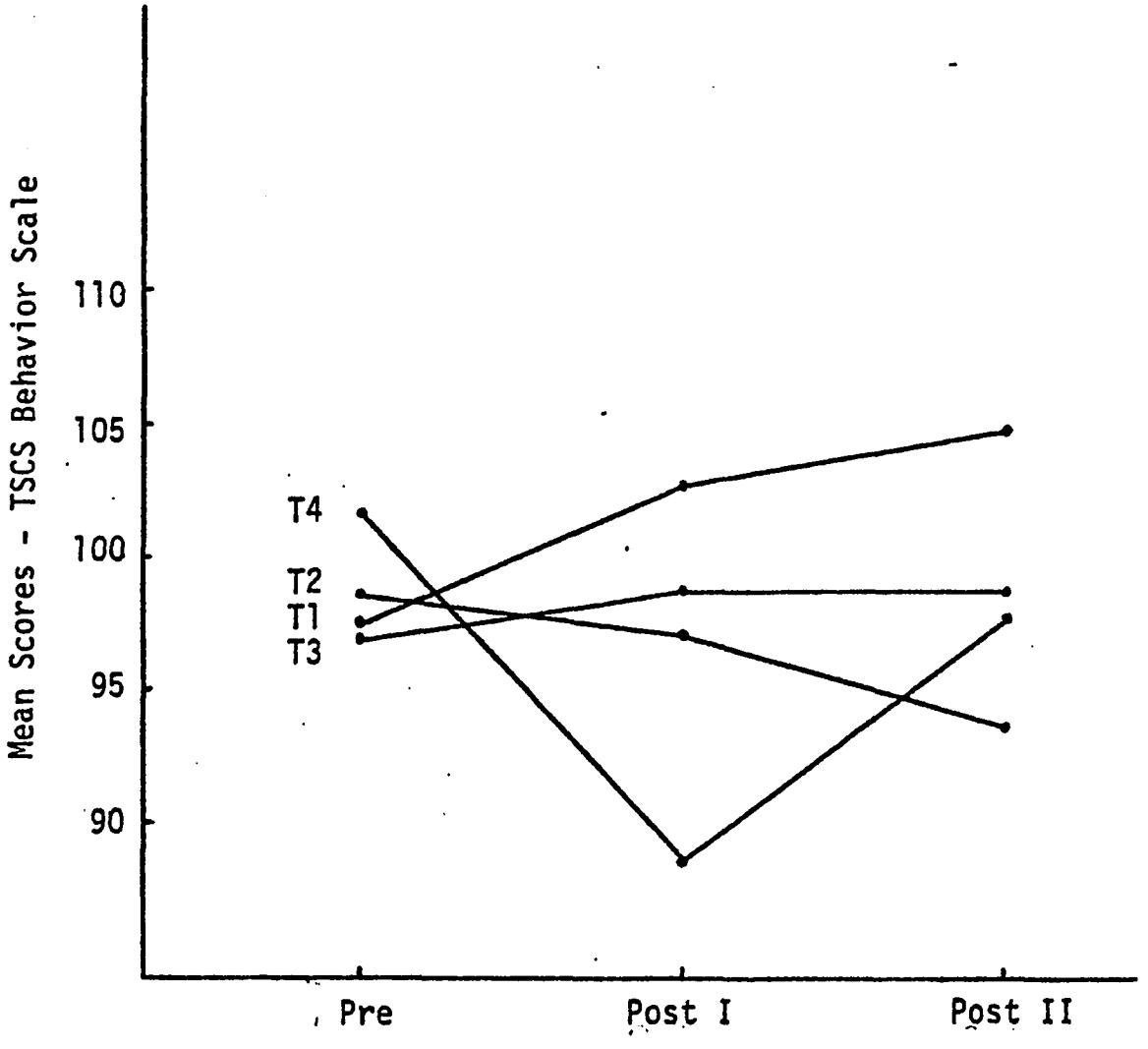


FIGURE 4

Treatment X Trials Interaction Effects on TSCS Behavior Scale Scores

Table 11 presents the ANOVA summary for the Physical Self Scale, and reveals once again a significant ($p < .05$) treatment X trials interaction. The Newman Keuls tests (Table 12) reveal that RSDI - Post II differs significantly ($p < .01$) from the Control group at post II. RSDI - post I also differs ($p < .05$) from Control at post I. These results are presented graphically by Figure 5. RSDI Ss show a steady improvement across post I and II and Control Ss experience a marked decline. Both of these trends contribute to the significant differences. RSDT decreases slightly and Placebo subjects show an increase.

In as much as adolescence is a time of major physical change and of deep concern with "body image", it seems that RSDI Ss learn to appraise themselves somewhat more positively and cope more effectively on this dimension. Conversely, Control Ss tend to become more negative in their physical appraisal of self.

The ANOVA summary table for the TSCS Moral-Ethical Self Scale appears in Table 13. It can be observed that a significant treatment X trials interaction ($p < .01$) is present. This scale has particular relevance for the population of this study (delinquents), in that they typically have a very poor picture of themselves on this dimension. These feelings of "moral worthlessness" may serve as justification for behavior through reasoning such as "since I'm bad anyhow, I don't have any code to live up to." For this reason, the Moral-Ethical scale and Family Self scale (since poor family interaction and familial rejection are strong concerns) were of particular interest.

The Newman Keuls tests (Table 14) reveal significant differences between RSDI - post II and RSDT - post II ($p < .01$). RSDI - post I

TABLE 11

Factor Analysis of Variance for Therapists, Treatments, and Trials for Adjusted Mean TSCS Physical Self Scale Scores

Source	Ss	df	MS	F
Between Subjects	2,917.925	31		
Therapists (A)	121.498	1	121.498	1.509
Treatments (B)	480.031	3	160.011	1.987
Therapists X Treatments (AB)	384.079	3	128.027	1.590
Ss w/in groups (AB)	1,932.317	24	80.513	
Within Subjects	1,340.647	64		
Trials (C)	4.187	2	2.093	0.109
Therapists X Trials (AC)	19.313	2	9.656	0.503
Treatments X Trials (BC)	260.394	6	43.399	2.259*
Therapists X Treatments X Trials (ABC)	134.601	6	22.434	1.168
C X Ss w/in AB	922.152	48	19.211	
TOTAL	4,258.572	95		

* $p < .05$

TABLE 12

Results of Newman Keuls Tests on all Ordered Pairs of Means for Treatment X Trials Interaction on TSCS Physical Self Scale

	i	e	a	b	d	f	k	g	j	l	c	h
i	---	1.38	2.63	3.50	3.63	4.75	5.13	5.63	6.25	8.63**	8.88**	8.88**
e		---	1.25	2.12	2.25	3.37	3.75	4.25	4.87	7.25	7.50	7.50
a			---	.87	1.00	2.12	2.50	3.00	3.62	6.00	6.25	6.25
b				---	.13	1.25	1.63	2.13	2.75	5.13	5.38	5.38
d					---	1.12	1.50	2.00	2.62	5.00	5.25	5.25
f						---	.38	.88	1.50	3.88	4.13	4.13
k							---	.50	1.12	3.50	3.75	3.75
g								---	.62	3.00	3.25	3.25
j									---	2.38	2.63	2.63
l										---	.25	.25
c											---	0.00
h												---

** p <.01 * p <.05

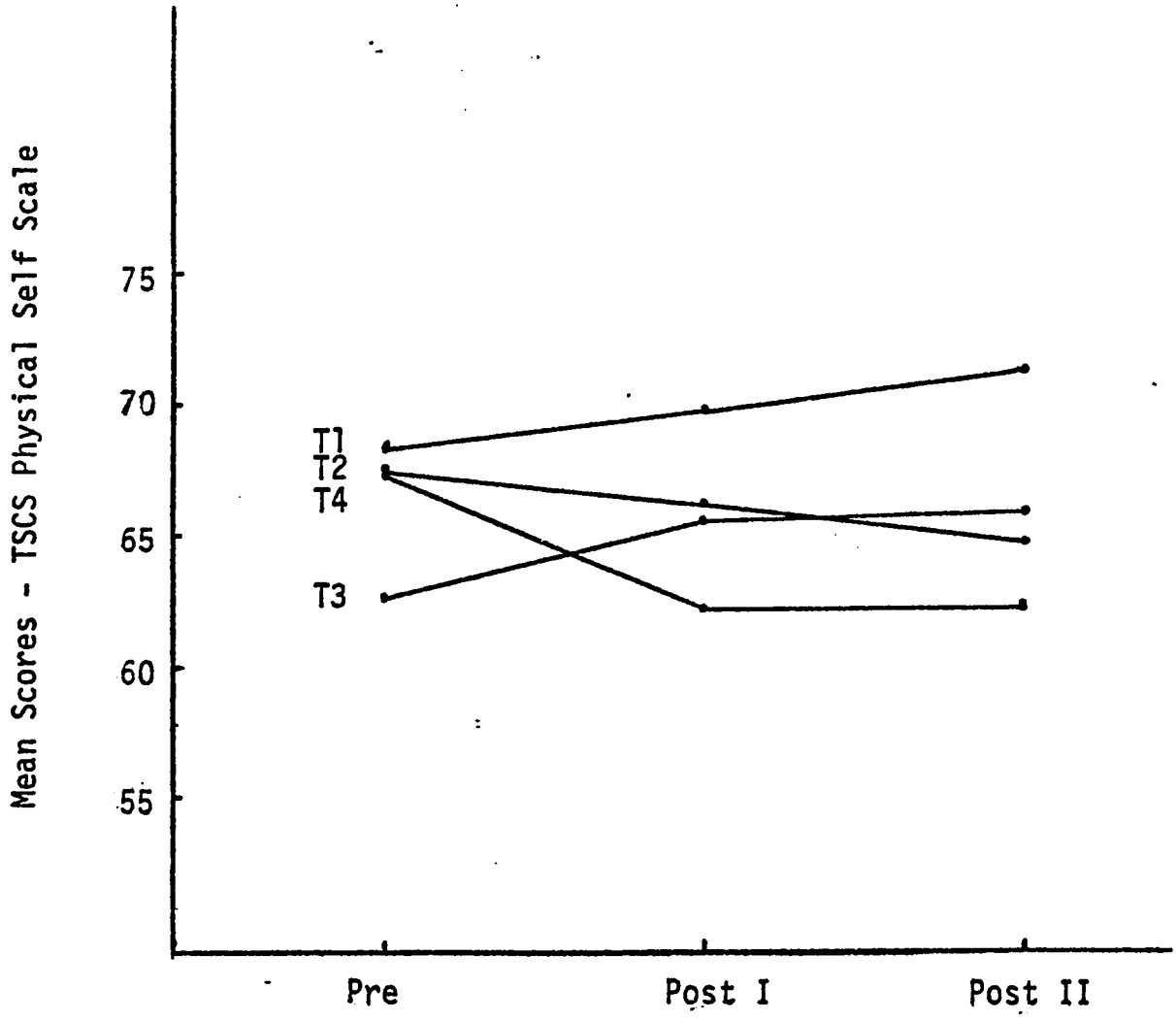


FIGURE 5

Treatment X Trials Interaction Effects on TSCS Physical Self Scale Score

T1 = RSDI
T2 = RSDT
T3 = Placebo
T4 = Control

TABLE 13

Factor Analysis of Variance for Therapists, Treatments, and Trials for Adjusted Mean TSCS Moral Self Scale Scores

Source	Ss	df	MS	F
Between Subjects	2,738.808	31		
Therapists (A)	11.344	1	11.344	0.114
Treatments (B)	309.609	3	103.203	1.042
Therapists X Treatments (AB)	40.114	3	13.371	0.135
Ss w/in groups (AB)	2,377.741	24	99.073	
Within Subjects	1,918.607	64		
Trials (C)	175.639	2	87.820	3.837
Therapists X Trials (AC)	13.563	2	6.782	0.296
Treatment X Trials (BC)	508.843	6	84.807	3.706*
Therapists X Treatments X Trials (ABC)	122.098	6	20.350	0.889
C X Ss w/in AB	1,098.464	48	22.885	
TOTAL	4,657.415	95		

* $p < .01$

TABLE 14

Results of Newman Keuls Tests on all Ordered Pairs of Means for Treatment X Trials Interaction on TSCS Moral-Ethical Self Scale

	i	e	l	k	d	g	f	c	a	j	h	b
i	---	.88	2.13	2.50	3.00	5.13	5.25	6.13	8.00*	8.88*	9.13*	9.63**
e		---	1.25	1.62	2.12	4.25	4.37	5.25	7.12	8.00*	8.25*	8.75*
l			---	.37	.87	3.00	3.12	4.00	5.87	6.75	7.00	7.50
k				---	.50	2.63	2.75	3.63	5.50	6.38	6.63	7.13
d					---	2.13	2.25	3.13	5.00	5.88	6.13	6.63
g						---	.12	1.00	2.87	3.75	4.00	4.50
f							---	.88	2.75	3.63	3.88	4.38
c								---	1.87	2.75	3.00	3.50
a									---	.88	1.13	1.63
j										---	.25	.75
h											---	.50
b												---

** $p < .01$ * $p < .05$

differs significantly ($p < .05$) from Control post I as well. These results suggest that while deterioration or regression and lack of treatment effect in the RSDT and Control groups accounted for some of the variance, it was due mainly to significant positive treatment effects in the RSDI group which were sustained and increased over time.

Inspection of Figure 6 reveals these trends even more clearly. RSDI Ss improve significantly in their moral appraisal of self. RSDT Ss improve somewhat at post I but regress at post II. Control Ss deteriorate at post I but recover at post II and Placebo Ss show little change across trials.

The final TSCS scale on which significant differences were noted was the Social Self Scale. Table 15 presents a complete summary for the ANOVA of Ss performance on this scale. A significant ($p < .05$) F ratio for the treatments X trials interaction is noted.

Results of the Newman Keuls tests (Table 16) reveal that the differences are primarily due to improvement by the RSDI group at post I and II. RSDI - post II differs significantly ($p < .01$) from Placebo, and Control (post II), and from RSDT - post II ($p < .05$). RSDI - post I differs significantly ($p < .01$) from Placebo at post I, and Control - post I ($p < .05$). While some of the difference is because of decreases among Placebo and Control groups, it is primarily accounted for by increases in the RSDI groups at both post I and II. Once again, following the time lapse between post I and post II, further treatment effects were noted in the RSDI group.

Figure 7 graphically reveals the short range and longer range trends for all the groups, RSDI Ss report consistent improvement in

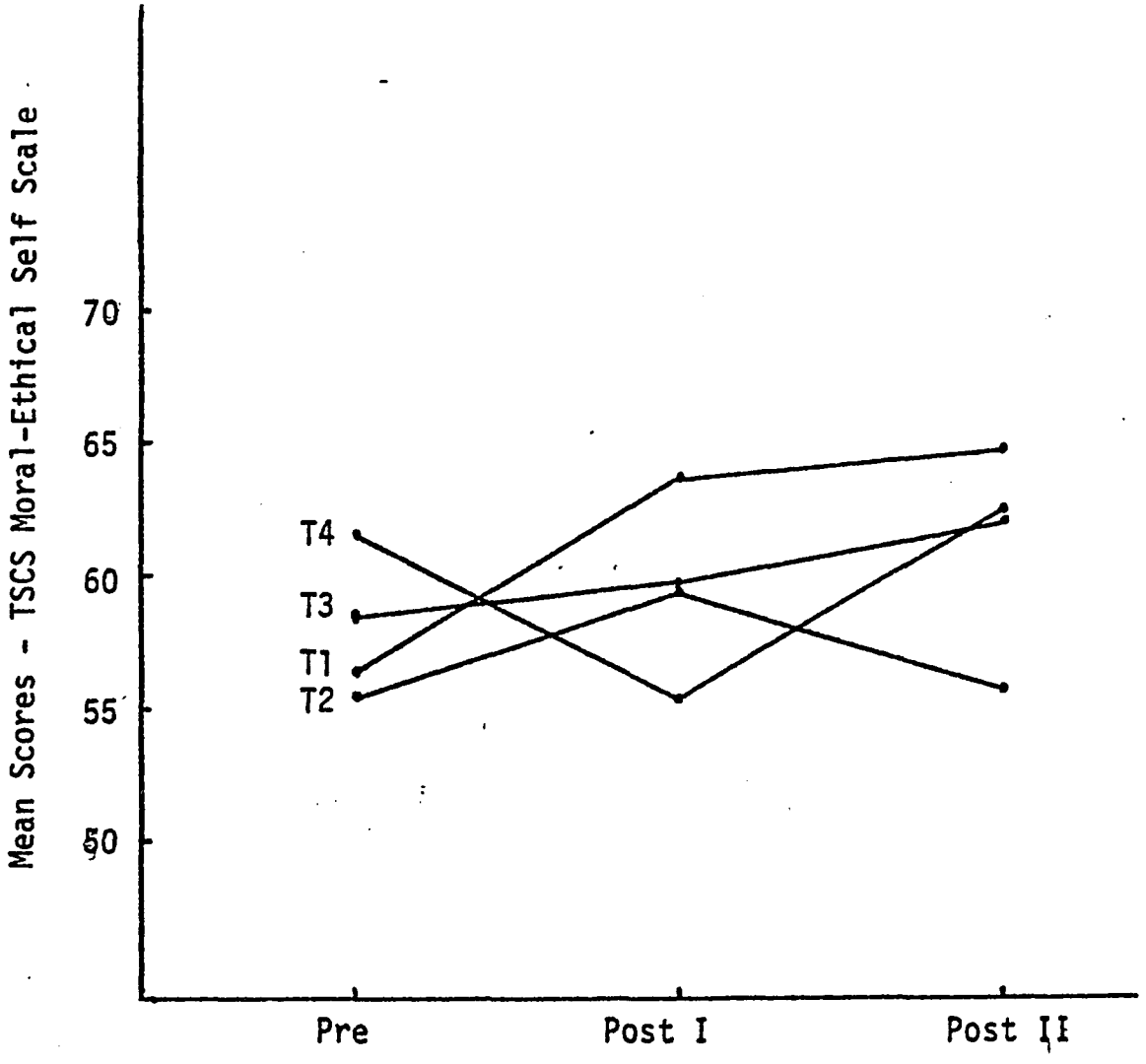


FIGURE 6

Treatment X Trials Interaction Effects on TSCS Moral-Ethical Scale Scores

T1 = RSDI
T2 = RSDT
T3 = Placebo
T4 = Control

TABLE 15

Factor Analysis of Variance for Therapists, Treatments, and Trials for Adjusted Mean TSCS Social Self Scale

Source	Ss	df	MS	F
Between Subjects	5,096.648	31		
Therapists (A)	88.166	1	88.166	0.537
Treatments (B)	695.751	3	231.917	1.412
Therapists X Treatments (AB)	369.580	3	123.194	0.750
Ss w/in groups (AB)	3,943.151	24	164.298	
Within Subjects	1,131.298	64		
Trials (C)	4.563	2	2.093	0.109
Therapists X Trials (AC)	1.271	2	0.635	0.039
Treatments X Trials (BC)	216.182	6	36.030	2.212*
Therapists X Treatments X Trials (ABC)	127.476	6	21.246	1.304
C X Ss w/in AB	781.806	48	16.288	
TOTAL	6.227.946	95		

* $p < .05$

TABLE 16

Results of Newman Keuls Tests on all Ordered Pairs of Means for Treatment X Trials Interaction on TSCS Social Self Scale

	i	e	f	a	b	d	l	c	j	g	h	k
i	---	.88	4.13	4.75	6.13*	6.25*	7.50**	7.50*	7.50*	9.13**	9.25**	10.50**
e		---	3.25	3.87	5.25	5.37	6.62*	6.62*	6.62*	8.25**	8.37**	9.62**
f			---	.62	2.00	2.15	3.37	3.37	3.37	5.00	5.12	6.37
a				---	1.38	1.50	2.75	2.75	2.75	4.38	4.50	5.75
b					---	.12	1.37	1.37	1.37	3.00	3.12	4.37
d						---	1.25	1.25	1.25	2.88	3.00	4.25
l							---	0.00	0.00	1.63	1.75	3.00
c								---	0.00	1.63	1.75	3.00
j									---	1.63	1.75	3.00
g										---	.12	1.37
h											---	1.25
k												---

** p <.01 * p <.05

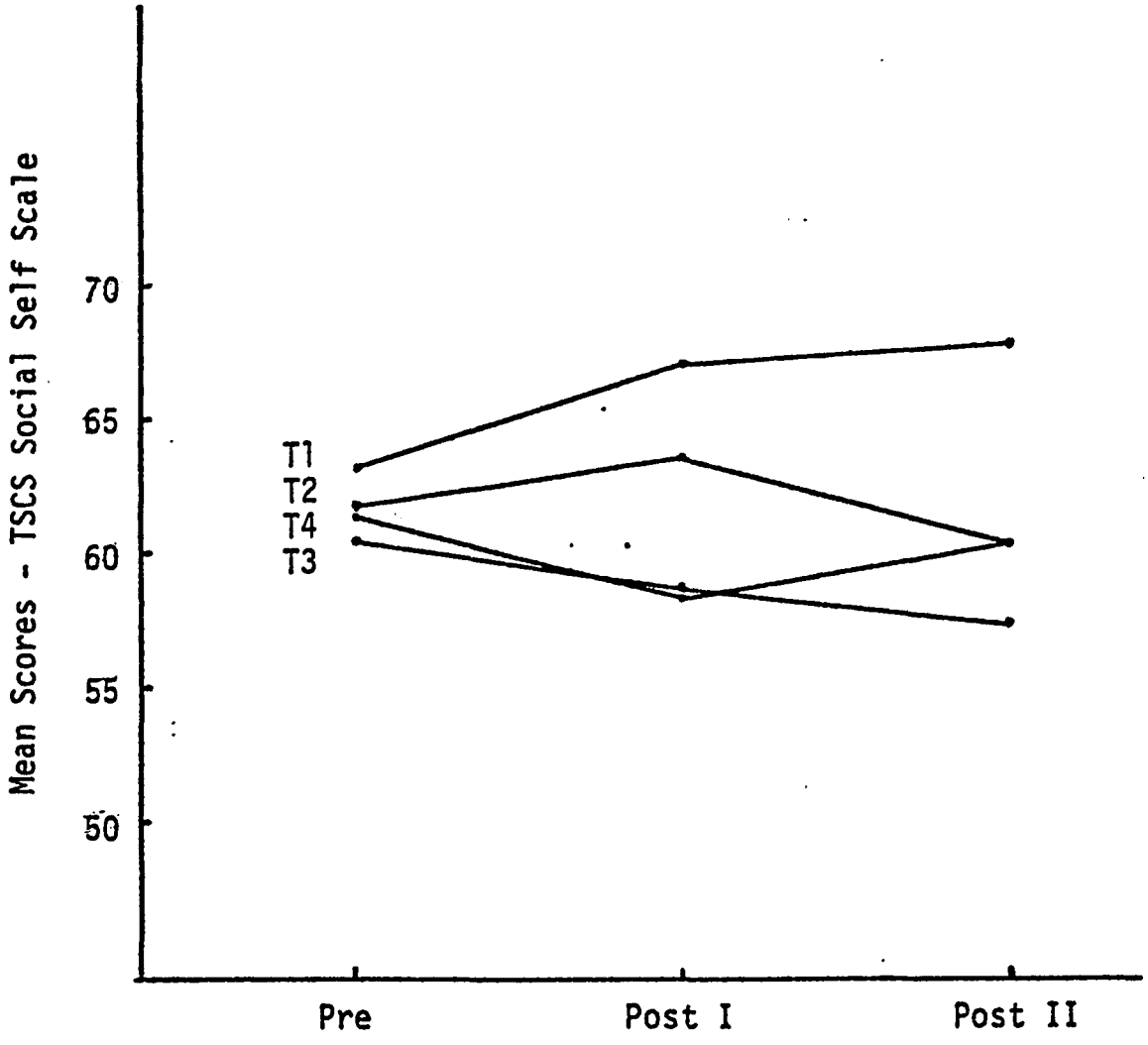


FIGURE 7

Treatments X Trials Interaction Effects on TSCS Social Self Scale Scores

T1 = RSDI
T2 = RSDT
T3 = Placebo
T4 = Control

the appraisal of their relations with society at large. RSDT Ss improve somewhat immediately post treatment, but show a slight overall decrease. Placebo and Control groups exhibit a slight overall decrease.

Examination of treatment effects on the nine positive self concept scales revealed significant F ratios on six on nine scales. Post hoc analysis using the Newman-Keuls method and graphic examination of group means show that the RSDI Ss tended to report significantly enhanced self esteem on the overall basis, as well as identity-wise, behaviorally, physically, morally, and socially. The RSDI group mean at both post I and post II frequently differed (to a statistically significant extent) from the means of Placebo and Control groups at post I and II and also (though somewhat less often) from the RSDT group mean at post II. These results suggest that the RSDI group experienced significantly enhanced self esteem immediately following treatment and that these beneficial gains were relatively enduring and fostered further increases over time, even without additional treatment. The Control and Placebo groups experienced a slight overall decrease in self esteem. The RSDT group improved somewhat immediately post treatment but these gains were not maintained and the group showed a slight decrease at post II from their pre-test level. This suggests that the RSDT treatment effects though discernable at post I were of a transitory nature and were not sufficient to endure without being continually reinforced through therapy.

Tables 17 through 27 present complete analysis of variance summary tables for those TSCS scales where statistical significance was not observed. These scales were self criticism, acceptance,

TABLE 17

Factor Analysis of Variance for Therapists, Treatments, and Trials for Adjusted Mean TSCS Self Criticism Scale Scores

Source	Ss	df	MS	F
Between Subjects	1,786.309	31		
Therapists (A)	33.842	1	33.842	0.509
Treatments (B)	40.615	3	13.538	0.204
Therapists X Treatments (AB)	115.279	3	38.426	0.578
Ss w/in groups (AB)	1,596.573	24	66.524	
Within Subjects	872.646	64		
Trials (C)	27.021	2	13.510	0.852
Therapists X Trials (AC)	1.313	2	0.656	0.041
Treatments X Trials (BC)	36.727	6	6.121	0.386
Therapists X Treatments X Trials (ABC)	46.436	6	7.739	0.488
C X Ss w/in AB	761.149	48	15.857	
TOTAL	2,658.955	95		

TABLE 18

Factor Analysis of Variance for Therapists, Treatments, and Trials for Adjusted Mean TSCS Acceptance Scale Scores

Source	Ss	df	MS	F
Between Subjects	10,622.506	31		
Therapists (A)	615.083	1	615.083	1.557
Treatments (B)	201.363	3	67.121	0.170
Therapists X Treatments (AB)	326.197	3	108.732	
Ss w/in groups (AB)	9,479.863	24	394.994	0.275
Within Subjects	3,118.592	64		
Trials (C)	74.081	2	37.040	0.720
Therapists X Trials (AC)	34.748	2	17.374	0.338
Treatments X Trials (BC)	442.408	6	73.735	1.433
Therapists X Treatments X Trials (ABC)	98.081	6	16.347	0.318
C X Ss w/in AB	2,469.274	48	51.443	
TOTAL	13,741.098	95		

TABLE 19

Factor Analysis of Variance for Therapists, Treatments, and Trials for Adjusted Mean TSCS Personal Self Scale Scores

Source	Ss	df	MS	F
Between Subjects	2,672.642	31		
Therapists (A)	0.010	1	0.010	0.000
Treatments (B)	352.027	3	117.342	1.273
Therapists X Treatments (AB)	108.866	3	36.289	0.394
Ss w/in groups (AB)	2,211.739	24	92.156	
Within Subjects	2,119.936	64		
Trials (C)	32.061	2	16.030	0.471
Therapists X Trials (AC)	57.642	2	28.821	0.846
Treatments X Trials (BC)	356.178	6	59.363	1.743
Therapists X Treatments X Trials (ABC)	39.603	6	6.600	0.194
C X Ss w/in AB	1,634.452	48	34.051	
TOTAL	4,792.578	95		

TABLE 20

Factor Analysis of Variance for Therapists, Treatments, and Trials for Adjusted Mean TSCS Family Self Scale Scores

Source	Ss	df	MS	F
Between Subjects	5,813.962	31		
Therapists (A)	121.501	1	121.501	1.509
Treatments (B)	834.745	3	278.248	1.470
Therapists X Treatments (AB)	314.579	3	104.860	0.554
Ss w/in groups (AB)	4,543.137	24	189.297	
Within Subjects	2,731.274	64		
Trials (C)	94.768	2	47.384	1.033
Therapists X Trials (AC)	80.059	2	40.030	0.873
Treatments X Trials (BC)	234.307	6	39.051	0.852
Therapists X Treatments X Trials (ABC)	121.349	6	20.225	0.441
C X Ss w/in AB	2,200.791	48	45.850	
TOTAL	8,545.236	95		

TABLE 21

Factor Analysis of Variance for Therapists, Treatments and Trials for Adjusted Mean TSCS Defensive Positive Scale Scores

Source	Ss	df	MS	F
Between Subjects	5,173.387	31		
Therapists (A)	2.344	1	2.344	0.012
Treatments (B)	211.782	3	70.594	0.348
Therapists X Treatments (AB)	83.866	3	27.955	0.138
Ss w/in group (AB)	4,875.395	24	203.141	
Within Subjects	2,389.252	64		
Trials (C)	36.020	2	18.010	0.508
Therapists X Trials (AC)	9.436	2	4.718	0.133
Treatments X Trials (BC)	413.295	6	68.882	1.941
Therapists X Treatments X Trials (ABC)	227.222	6	37.870	1.067
C X Ss w/in AB	1,703.279	48	35.485	
TOTAL	7,562.639	95		

TABLE 22

Factor Analysis of Variance for Therapists, Treatments, and Trials for Adjusted Mean TSCS General Maladjustment Scale Scores

Source	Ss	df	MS	F
Between Subjects	1,962.060	31		
Therapists (A)	128.342	1	128.342	2.035
Treatments (B)	75.282	3	25.094	0.398
Therapists X Treatments (AB)	244.530	3	81.510	1.292
Ss w/in groups (AB)	1,513.906	24	63.079	
Within Subjects	1,684.629	64		
Trials (C)	20.270	2	10.135	0.396
Therapists X Trials (AC)	22.938	2	11.469	0.448
Treatments X Trials (BC)	313.053	6	52.176	2.039
Therapists X Treatments X Trials (ABC)	100.061	6	16.677	0.652
C X Ss w/in AB	1,228.307	48	25.590	
TOTAL	3,646.689	95		

TABLE 23

Factor Analysis of Variance for Therapists, Treatments, and Trials for Adjusted Mean TSCS Psychosis Scale Score

Source	Ss	df	MS	F
Between Subjects	1,875.987	31		
Therapists (A)	26.042	1	26.042	0.424
Treatments (B)	136.582	3	45.527	0.741
Therapists X Treatments (AB)	238.709	3	79.570	1.295
Ss s/in groups (AB)	1,474.654	24	61.444	
Within Subjects	1,193.307	64		
Trials (C)	4.520	2	2.260	0.105
Therapists X Trials (AC)	7.145	2	3.573	0.166
Treatment X Trials (BC)	24.477	6	4.079	0.189
Therapists X Treatment X Trials (ABC)	122.851	48	20.475	0.950
C X Ss w/in AB	1,034.314		21.548	
TOTAL	3,069.294	95		

TABLE 24

Factor Analysis of Variance for Therapists, Treatments, and Trials for Adjusted Mean TSCS Personality Disorder Scale Scores

Source	Ss	df	MS	F
Between Subjects	3,546.922	31		
Therapists (A)	416.663	1	416.663	4.063
Treatments (B)	612.708	3	204.236	1.991
Therapists X Treatments (AB)	56.250	3	18.750	0.183
Ss w/in groups (AB)	2,461.301	24	102.554	
Within Subjects	2,009.952	64		
Trials (C)	13.396	2	6.698	0.198
Therapists X Trials (AC)	35.394	2	17.697	0.523
Treatment X Trials (BC)	195.348	6	32.558	0.962
Therapists X Treatment X Trials (ABC)	141.184	6	23.531	0.695
C X Ss w/in AB	1,624.630	48	33.846	
TOTAL	5,556.874	95		

TABLE 25

Factor Analysis of Variance for Therapists, Treatments, and Trials for Adjusted Mean TSCS Neurosis Scale Scores

Source	Ss	df	MS	F
Between Subjects	2,861.155	31		
Therapists (A)	5.042	1	5.042	0.057
Treatments (B)	470.001	3	156.667	1.771
Therapists X Treatments (AB)	263.454	3	87.818	0.993
Ss w/in groups (AB)	2,122.658	24	88.444	
Within Subjects	2,536.609	64		
Trials (C)	26.270	2	13.135	0.324
Therapists X Trials (AC)	26.271	2	13.135	0.324
Treatments X Trials (BC)	294.304	6	49.051	1.211
Therapists X Treatments X Trials (ABC)	245.972	6	40.995	1.012
C X Ss w/in AB	1,943.792	48	40.496	
TOTAL	5,397.764	95		

TABLE 26

Factor Analysis of Variance for Therapists, Treatments, and Trials for Adjusted Mean TSCS Personality Integration Scale Score

Source	Ss	df	MS	F
Between Subjects	441.623	31		
Therapists (A)	2.042	1	2.042	0.126
Treatments (B)	15.875	3	5.292	0.327
Therapists X Treatments (AB)	34.874	3	11.625	0.718
Ss w/in groups (AB)	388.832	24	16.201	
Within Subjects	295.994	64		
Trials (C)	13.937	2	6.969	1.797
Therapists X Trials (AC)	1.896	2	0.948	0.244
Treatments X Trials (BC)	29.311	6	4.885	1.260
Therapists X Treatments X Trials (ABC)	64.686	6	10.781	1.780
C X Ss w/in AB	186.164	48	3.878	
TOTAL	737.617	95		

TABLE 27

Factor Analysis of Variance for Therapists, Treatments, and Trials for Adjusted Mean TSCS Number of Deviant Signs Scale Score

Source	Ss	df	MS	F
Between Subjects	8,329.434	31		
Therapists (A)	508.757	1	508.757	2.537
Treatments (B)	1,395.944	3	465.315	2.321
Therapists X Treatments (AB)	1,612.526	3	537.509	2.681
Ss w/in groups (AB)	4,812.207	24	200.509	
Within Subjects	6,859.783	64		
Trials (C)	381.566	2	190.783	1.667
Therapists X Trials (AC)	178.579	2	89.290	0.780
Treatments X Trials (BC)	496.565	6	82.761	0.723
Therapists X Treatments X Trials (ABC)	310.737	6	51.789	0.453
C X Ss w/in AB	5,492.336	48	114.424	
TOTAL	15,189.217	95		

personal self, family self, defensive positive, general maladjustment, psychosis, personality disorder, neurosis, personality integration, and number of deviant signs. These scales were utilized as measures of psychological disturbance.

MULTIPLE AFFECT ADJECTIVE CHECKLIST

Table 28 presents the complete summary for the analysis of variance on Ss performance on the MAACL Anxiety Scale. An F ratio was significant for trials ($p < .01$) on this scale. This result suggests that all groups tended to report diminished anxiety irrespective of treatment, an observation which is suggestive of an overall "placebo" type effect. This may indicate that relatively transitory anxiety states may be improved through a cathartic type experience by merely allowing individuals to discuss their concerns openly. Figure 8 graphically illustrates that all groups demonstrated a trend toward diminished anxiety, with no significant differences noted between groups.

Table 29 presents the complete ANOVA summary table for the MAACL Depression scale. A significant F ratio is observed for the treatment X trials interaction ($p < .01$).

Inspection of Table 30 reveals the significant pairwise comparisons of group means on the Depression scale. A highly significant decrease in reported depression for the RSDI group can be observed especially at the post II testing, which results in significant differences between RSDI - post II and RSDT, Placebo, and Control post II means ($p < .01$) RSDI - post I also differed significantly from the Control post I mean ($p < .01$).

Figure 9 reveals the trends for each of the groups across time. It can be observed that RSDI Ss showed markedly decreased self reported

TABLE 28

Factor Analysis of Variance for Therapists, Treatments, and Trials for Adjusted Mean MAACL Anxiety Scale Scores

Source	Ss	df	MS	F
Between Subjects	1,061.569	31		
Therapists (A)	3.760	1	3.760	0.143
Treatments (B)	218.113	3	72.704	2.769
Therapists X Treatments (AB)	209.448	3	69.816	2.659
Ss w/in groups (AB)	630.248	24	26.260	
Within Subjects	829.310	64		
Trials (C)	197.681	2	98.841	9.376**
Therapists X Trials (AC)	9.145	2	4.573	0.434
Treatment X Trials (BC)	91.726	6	15.288	1.450
Therapists X Treatment X Trials (ABC)	24.770	6	4.128	0.392
C X Ss w/in AB	505.988	48	10.541	
TOTAL	1,890.879	95		

** $p < .01$

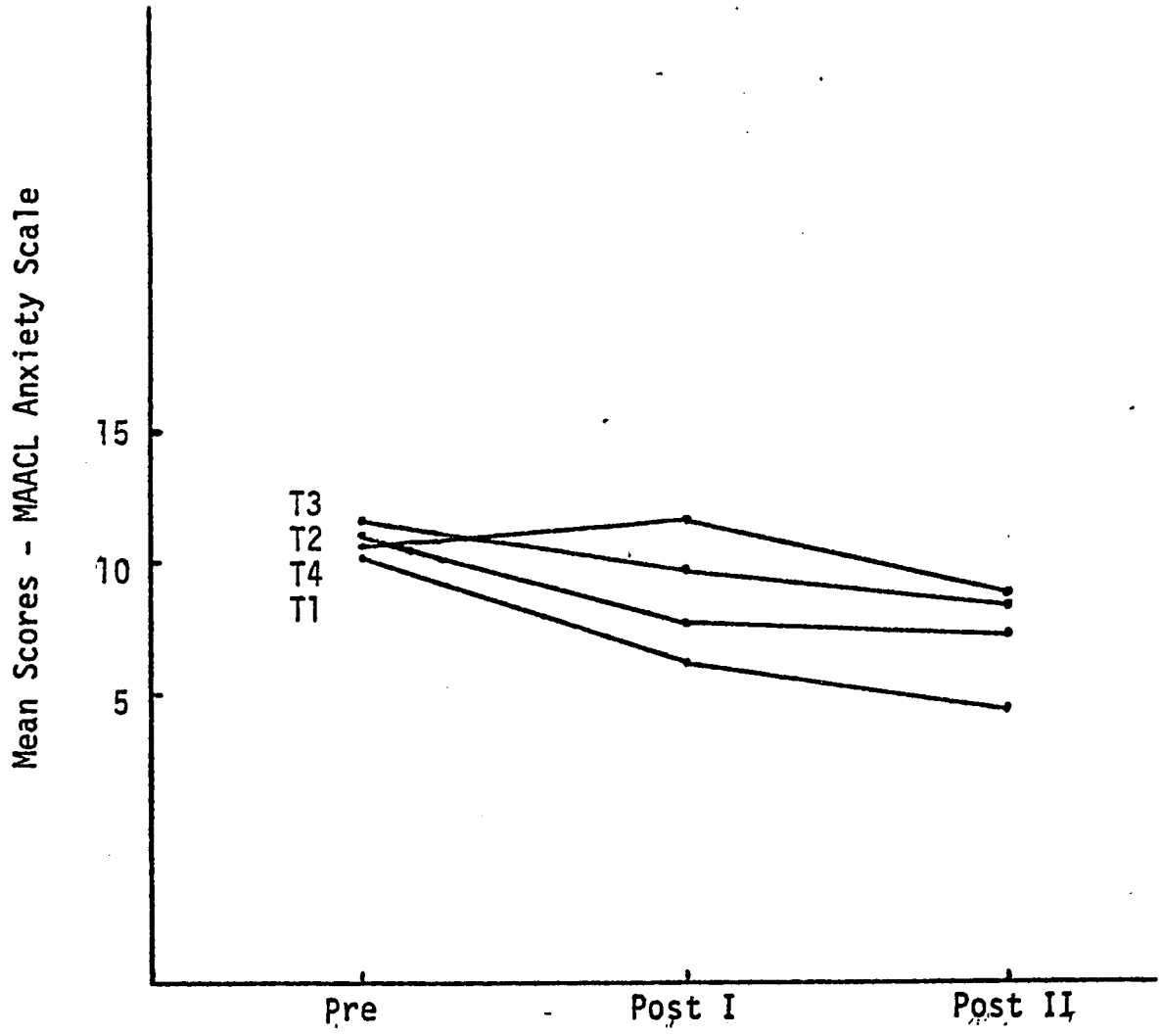


FIGURE 8

Treatment Effects across Pre, Post I, and Post II on MAACL Anxiety Scale Scores

T1 = RSDI
T2 = RSDT
T3 = Placebo
T4 = Control

TABLE 29

Factor Analysis of Variance for Therapists, Treatments, and Trials for Adjusted Mean MAACL Depression Scale Scores

Source	Ss	df	MS	F
Between Subjects	4,098.266	31		
Therapists (A)	10.011	1	10.011	0.081
Treatments (B)	846.864	3	282.288	2.276
Therapists X Treatments (AB)	264.117	3	88.039	0.710
Ss w/in groups (AB)	2,977.234	24	124.051	
Within Subjects	1,667.956	64		
Trials (C)	287.508	2	143.754	7.667
Therapists X Trials (AC)	8.896	2	4.448	0.237
Treatment X Trials (BC)	362.213	6	60.369	3.220**
Therapists X Treatments X Trials (ABC)	109.349	6	18.225	0.972
C X Ss w/in AB	899.990	48	18.750	
TOTAL	5,766.222	95		

** $p < .01$

TABLE 30

Results of Newman Keuls Tests on all Ordered Pairs of Means for Treatment X Trials Interaction on MAACL Depression Scale Scores

	h	d	c	l	a	g	b	k	j	f	e	i
h	---	3.13	3.50	3.75	4.50	5.00	6.25	7.13*	8.75**	9.00**	11.00**	15.50**
d		---	.37	.62	1.37	1.87	3.12	4.00	5.62	5.87	7.87*	12.37**
c			---	.25	1.00	2.50	2.75	3.63	5.25	5.50	7.50*	12.00**
l				---	.75	1.25	2.50	3.38	5.00	5.25	7.25*	11.75**
a					---	.50	1.75	2.63	4.25	4.50	6.50	11.00**
g						---	1.25	2.13	3.75	4.00	6.00	10.50**
b							---	.88	2.50	2.75	4.75	9.25**
k								---	1.62	1.87	3.87	8.37**
j									---	.25	2.25	6.75*
f										---	2.00	6.50*
e											---	4.50*
i												---

** p .01 * p <.05

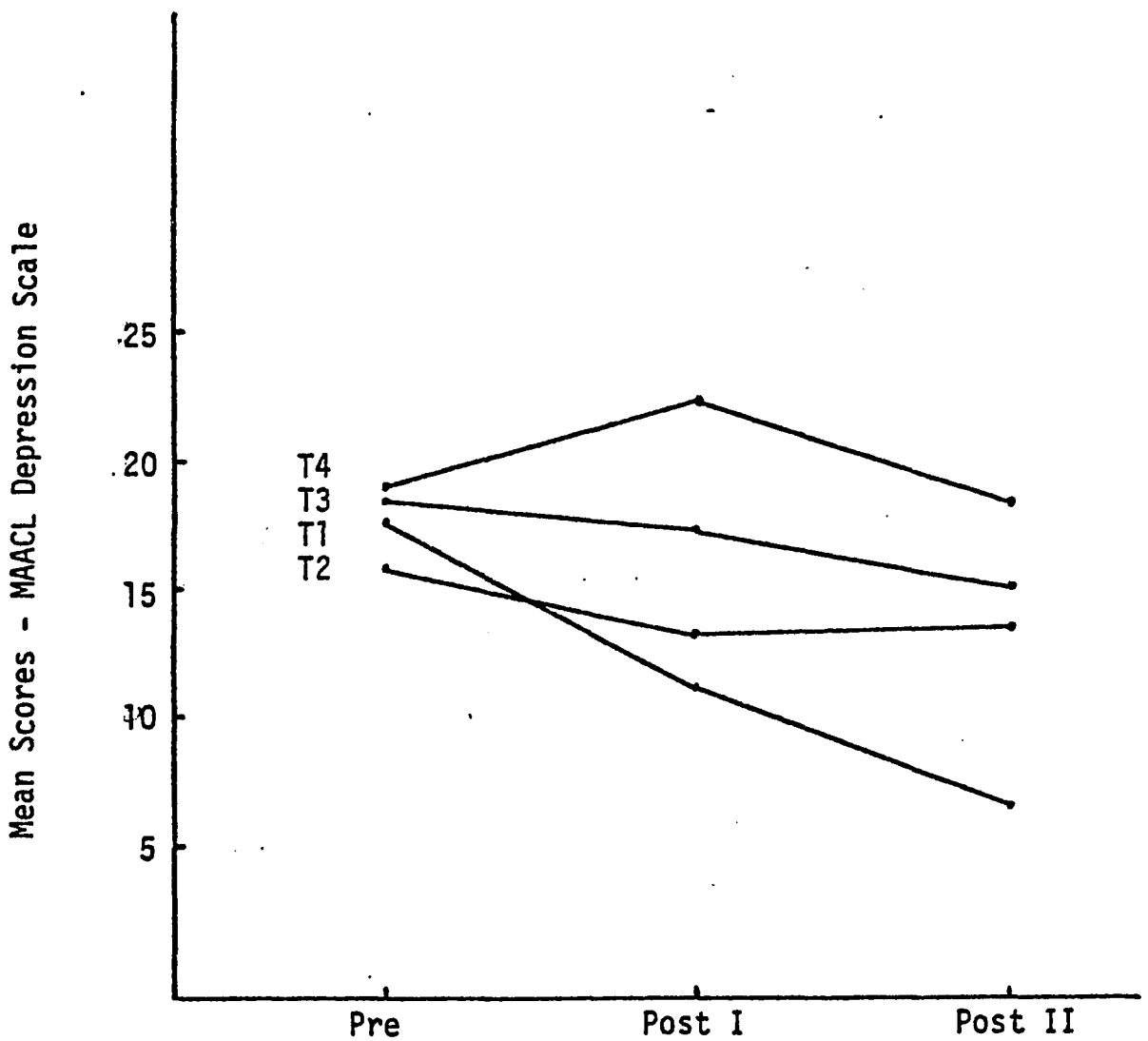


FIGURE 9

Treatment X Trials Interaction Effects on MAACL Depression Scale Scores

T1 = RSDI
T2 = RSDT
T3 = Placebo
T4 = Control

depression. This diminished depression was particularly notable at RSDI - post II. Whereas at post II the other groups tended to level off or regress toward pre-test scores, the RSDI group decreased considerably between post I and post II with no further treatment.

This phenomenon of further improvement by the RSDI group at post II while the other groups regressed toward pre-test means was a consistent trend throughout the data, both on variables where statistical significance was observed and on those where clear, though not statistically significant, differences were present. It suggests that perhaps some type of assimilative or integrative effect takes place during and/or following the RSDI therapy which is not present in the other approaches, and that this effect is associated with the relaxation-imagery elements of the approach working in conjunction with rational and stage directed techniques.

Table 31 presents the complete ANOVA summary table for the MAACL Hostility scale. No significant $\underline{F}$ ratio were observed on this variable.

TABLE 31

Factor Analysis of Variance for Therapists, Treatments, and Trials for Adjusted Mean MAACL Hostility Scale Score

Source	Ss	df	MS	F
Between Subjects	1,437.620	31		
Therapists (A)	63.375	1	63.375	1.531
Treatments (B)	264.789	3	88.263	2.276
Therapists X Treatments (AB)	116.126	3	38.709	0.935
Ss w/in groups (AB)	993.330	24	41.389	
Within Subjects	625.983	64		
Trials (C)	52.748	2	26.374	2.844
Therapists X Trials (AC)	19.000	2	9.500	1.024
Treatment X Trials (BC)	60.583	6	10.097	1.089
Therapists X Treatments X Trials (ABC)	48.498	6	8.083	0.872
C X Ss w/in AB	445.154	48	9.274	
TOTAL	2,063.603	95		

CHAPTER V

SUMMARY AND CONCLUSIONS

This investigation studied the effects of Rational Stage Directed Imagery (RSDI) and Rational Stage Directed Therapy (RSDT) on modification of the self concept and upon reduction of psychological stress. The self concept was operationalized as Ss mean scores on the Tennessee Self Concept Scale positive scales. Psychological stress was operationalized as Ss mean scores on the self criticism, and empirical scales of the TSCS and the clinical scales on the Multiple Affect Adjective Checklist.

Thirty-two adolescent delinquent females from the population at Rosemont School served as subjects for this experiment. The TSCS and MAACL were administered to the entire population at Rosemont School (N=80) and Ss were then randomly assigned from a pool of volunteers to one of four treatment groups.

A 2x4x3 factorial analysis of variance (or split-plot design) with three repeated measures was used to test the hypotheses of this study. Pre-test group means were examined by ANOVA and no significance was observed.

The hypotheses of this study consisted of two main effects hypotheses and one interaction effects hypotheses. The main effects hypotheses were concenred with the effects of therapists and treatments upon the elevation of nine positive self concept scale means and

reduction or regression toward the mean of mean scores on eleven other scales from two instruments used to measure psychological stress. The interaction hypotheses predicted that Ss observed means representing positive self concept and psychological stress as measured by the TSCS and MAACL from groups of Ss defined in terms of and in any combination of treatments, therapists, and trials would not differ significantly from the means expected from simple addition of the appropriate main effects.

The Null hypothesis for main effects for treatments was rejected inasmuch as a significant F ratio was found on the TSCS Identity scale. The Null hypotheses for interaction was rejected supporting the differential effects of treatments interacting with trials (time variable).

DISCUSSION

The data showed significant findings for six of nine TSCS positive self concept scales and two of three MAACL scales. All of these significant findings involved either treatment, or treatment X trials interaction effects. The therapist variable was effectively controlled for, both experimentally and statistically. No therapist effects were noted.

The total positive self concept scale of the TSCS, a measure of the persons overall self esteem, showed a significant interaction between treatments and trials. A Newman Keuls post hoc analysis revealed statistically significant differences between the RSDI (post II) mean and those of the Placebo, Control, and RSDT groups at post II, and between RSDI and Control at post I. A deterioration effect of

unspecified origin was noted for the Control group at post I. These results suggest that RSDI had the immediate effect of increasing Ss self esteem, and this effect was further heightened over time even with no additional therapy. RSDT showed a mild effect immediately post-treatment, however, this effect was not sustained over time. Since this scale is the single best indicator of overall self esteem it is particularly notable that RSDI Ss report a level of self esteem that is significantly higher than either the RSDT, Placebo, and Control Ss. These differences are present immediately post-treatment and they have become even greater at a two month follow-up.

A significant main effect for treatments was noted on the TSCS Identity scale. Post hoc analysis revealed significant differences between the RSDI pre-test mean and the RSDI post I and post II means. RSDT, Placebo, and Control groups showed no significant changes across trials, although a slight deterioration effect was noted. Differences are also apparent between RSDI and the other groups at both post I and post II. This data suggests that RSDI subjects have acquired a more adaptive or satisfactory notion of "who or what I am" as a result of the therapy process and that these effects were sustained for a period of time (2 months) following the cessation of therapy.

A significant treatments X trials interaction was noted on the TSCS Behavior scale. This scale purports to measure the Ss appraisal of their behavior. Post hoc analysis revealed a significant difference between the RSDI mean for post I and the mean for the control group (post I). While increases were noted for the RSDI group at both post I

and II, the substantial decrease by the Control group at post I contributed heavily to the overall significance.

Examination of results on the TSCS Physical Self scale, which measures a Ss picture of physical attractiveness, body image, etc., reveals a significant treatment X trials interaction. Post hoc analysis showed that RSDI (post I and II) was significantly different from the Control group (post I and II). This difference was due to improvement by the RSDI Ss and deterioration in the Control Ss. No significant changes were noted for the RSDT and Placebo groups, although the former decreased slightly and the latter showed a small increase.

The TSCS Moral-Ethical Self scale showed significant effects for the treatment X trials interaction. RSDI showed a significant improvement between pre and post I and this trend continued on post II. RSDI also differed significantly from the RSDT and Control groups at post II. As mentioned previously, this scale carried particular importance with the population of this study. In essense, the RSDI Ss seemed to have learned not to equate themselves with their acts. The improved moral appraisal of self opens the way for change and self-creative behavior and minimizes self labeling tendencies.

A significant treatment X trials interaction was noted on the TSCS Social Self scale. This scale examines the manner in which Ss relate to the world or society at large. The Ss of this study are in large part referred to facilities such as Rosemont because of poor relations with society and societal agents such as schools, and various "authority" figures (i.e., courts). This difficulty is reflected in the negative appraisal of ones relation to society or ones social self. Post hoc analysis revealed that RSDI Ss improved significantly in their

evaluation of their relations with society. RSDI group means (post I and II) differed significantly from RSDT, Control, and Placebo group means (post I and II). Each of these groups showed a slight tendency to decrease, though RSDT improved slightly at post I prior to the regression at post II. These results suggest that RSDI Ss may have learned to be more open to interaction with society at large, and to perceive it in a less hostile manner. Since a great deal of evidence indicates that cognitive perceptions are significantly associated with behavior, RSDI Ss may be more successful in their future interactions with society.

A significant effect across trials was noted on the MAACL Anxiety scale. This observation suggests that Ss tended to experience diminished anxiety irrespective of treatment and lends credence to the concepts of Placebo effects and catharsis which are reported to emerge from group experiences.

A significant treatment X trials interaction was observed on the MAACL Depression scale. Figure 9 reveals that RSDI Ss showed significant decreases at both post I and post II. This observation suggests that something more than mere "carry over" effects are operating. Newman Keuls analysis reveals that RSDI Ss (post I and II) show decreases in depression which are significant over those shown by RSDT, Control, and Placebo groups (post I and II). Each of these groups showed an overall slight decrease in reported depression. These results suggest that RSDI was not only effective in elevating mood immediately post treatment, but that Ss became increasingly less depressed as time passed even though therapy was not continued.

It is interesting to examine the pattern of changes within each treatment group. RSDI Ss showed significant positive changes immediately post-treatment. Moreover, even though therapy was discontinued, Ss continued to improve during the time between post I and post II. This finding suggests that a generalization or integration effect may be occurring. RSDT Ss showed mixed effects. There were slight increases at trial 2 on most scales, but a regression effect at trial 3 that left an overall slight decrease (in positive scales as well as pathological indicators). The Placebo group showed very little change across trials. The lack of a deterioration effect at trial 2 (as noted for the Control group), suggests that in fact a "placebo" effect may have been present. The Control group showed a marked decrease in positive self concept measures and an increase in pathological indicators at trial 2 which is still unaccounted for, however, Ss improved to slightly below pre-test means by trial 3. Though this result is unaccounted for, it is nearly identical with the profile of an independently (from the study) drawn sample result and suggests an effect that influenced the majority of the Rosemont population.

CONCLUSIONS AND RECOMMENDATIONS

Some tentative conclusions based on specific limitations of the study may be drawn from the data.

(1) RSDI Ss improved significantly in overall self concept and in the specific dimensions of identity, behavior, physical self, moral self, and social self, and these increases in self esteem were associated with a simultaneous decrease in self reported levels of anxiety and depression. On all of the above scales except Anxiety the

differences between RSDI and one or more of the other groups were large enough to attain statistical significance. These improvements may be attributed to the RSDI treatment effects, and were sustained and extended over time, even though treatment was discontinued. These results suggest that some assimilation, integration, or generalization effect is activated by or associated with the RSDI approach. In light of the RSDT results, this suggests that the relaxation or sensory-imagery aspects assimilated into a rational or cognitive framework heightened the effectiveness of the RSDI approach both in terms of immediate results and longer range integration, generalization effects. On many dependent variables the RSDI group improved to a statistically significant extent beyond a no-treatment control group, a group designed to measure placebo effects, and in some cases, even another rational therapy group. The imagery results confirm the findings of Sarkisian (1974) and others who have studied relaxation, imagery approaches.

(2) Contrary to Marzella's (1975) finding of differential therapist effects and only conditional support for RSDT approaches, in this investigation therapist effects were observed to be non-significant and considerable support for RSDI was noted. The differnce in findings may be due in part of the different populations used and also to the fact that this study examined modification of a primarily cognitive variable, the self concept, utilizing a cognitive approach. It may be noted that no significant effects in this study were observed on the TSCS Empirical scales, pathological indicators of a more global nature that correlates very highly with the MMPI scales (which were used in Marzella's study). A significant change (favoring the RSDI

group) was noted on the MAACL Depression Scale, which is perhaps a more specific and sensitive indicator of pathological clinical states such as depression and anxiety.

These conclusions must be regarded in light of the limitations of this study, and any generalization to other populations or settings must be offered very tentatively. There is a need for further research on the effects of RSDI on other populations and in other settings.

Nevertheless, it appears that Rational Stage Directed Imagery has considerable potential for use as a therapeutic approach in situations where a primary goal of therapy is to bring about a modification of self concept. Further, it seems the considerable elevation of self esteem might be accomplished over a relatively brief period of time, contrary to much of the reported research. Future studies will need to explore the nature of change or how RSDI impacts on the psychological processes to produce a therapeutic effect, and also the suitability of this approach for specific populations and types of disturbance. These findings do not suggest that RSDI is a panacea, but rather that it may be one more tool in a therapeutic armamentarium.

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APPENDIX A

TENNESSEE SELF CONCEPT SCALE

by

William H. Fitts, PhD.

Published by

Counselor Recordings and Tests

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FORM C AND R.

TENNESSEE SELF CONCEPT SCALE — ANSWER SHEET

ITEM NO.	PAGES 5 AND 6	ITEM NO.	PAGES 3 AND 4	ITEM NO.	PAGES 1 AND 2
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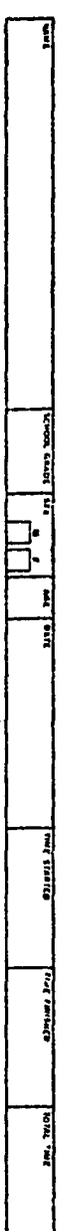

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SCORE SHEET

Clinical and Research Form
Tennessee Self Concept Scale

NAME	SCHOOL GRADE	SEX M F	AGE	DATE	TIME STARTED	TIME FINISHED	TOTAL TIME

HOW THE INDIVIDUAL PERCEIVES HIMSELF

IN TERMS OF:	COLUMN A PHYSICAL SELF	COLUMN B MORAL-ETHICAL SELF	COLUMN C PERSONAL SELF	COLUMN D FAMILY SELF	COLUMN E SOCIAL SELF	SELF CRITICISM	ROW TOTALS
ROW 1. IDENTITY WHAT HE IS	P-1 P-2 P-3 N-4 N-5 N-6	P-19 P-20 P-21 N-22 N-23 N-24	P-37 P-38 P-39 N-40 N-41 N-42	P-55 P-56 P-57 N-58 N-59 N-60	P-73 P-74 P-75 N-76 N-77 N-78	91 92 93 94	POSITIVE P + N; CONFLICT NET Algebraic Sum of P − N; CONFLICT TOTAL Non-Algebraic Sum of P − N; VARIABILITY Range of P − N Cell Scores
	5 5 5 1 1 1	5 5 5 1 1 1	5 5 5 1 1 1	5 5 5 1 1 1	5 5 5 1 1 1	5 5 5 5	
	4 4 4 2 2 2	4 4 4 2 2 2	4 4 4 2 2 2	4 4 4 2 2 2	4 4 4 2 2 2	4 4 4 4	
	3 3 3 3 3 3	3 3 3 3 3 3	3 3 3 3 3 3	3 3 3 3 3 3	3 3 3 3 3 3	3 3 3 3	
	2 2 2 4 4 4	2 2 2 4 4 4	2 2 2 4 4 4	2 2 2 4 4 4	2 2 2 4 4 4	2 2 2 2	
	1 1 1 5 5 5	1 1 1 5 5 5	1 1 1 5 5 5	1 1 1 5 5 5	1 1 1 5 5 5	1 1 1 1	
	P ____ N ____ P + N ____ P − N ____	P ____ N ____ P + N ____ P − N ____	P ____ N ____ P + N ____ P − N ____	P ____ N ____ P + N ____ P − N ____	P ____ N ____ P + N ____ P − N ____		
ROW 2. SELF SATISFACTION HOW HE ACCEPTS HIMSELF	P-7 P-8 P-9 N-10 N-11 N-12	P-25 P-26 P-27 N-28 N-29 N-30	P-43 P-44 P-45 N-46 N-47 N-48	P-61 P-62 P-63 N-64 N-65 N-66	P-79 P-80 P-81 N-82 N-83 N-84	95 96 97 98	
	5 5 5 1 1 1	5 5 5 1 1 1	5 5 5 1 1 1	5 5 5 1 1 1	5 5 5 1 1 1	5 5 5 5	
	4 4 4 2 2 2	4 4 4 2 2 2	4 4 4 2 2 2	4 4 4 2 2 2	4 4 4 2 2 2	4 4 4 4	
	3 3 3 3 3 3	3 3 3 3 3 3	3 3 3 3 3 3	3 3 3 3 3 3	3 3 3 3 3 3	3 3 3 3	
	2 2 2 4 4 4	2 2 2 4 4 4	2 2 2 4 4 4	2 2 2 4 4 4	2 2 2 4 4 4	2 2 2 2	
	1 1 1 5 5 5	1 1 1 5 5 5	1 1 1 5 5 5	1 1 1 5 5 5	1 1 1 5 5 5	1 1 1 1	
	P ____ N ____ P + N ____ P − N ____	P ____ N ____ P + N ____ P − N ____	P ____ N ____ P + N ____ P − N ____	P ____ N ____ P + N ____ P − N ____	P ____ N ____ P + N ____ P − N ____		
ROW 3. BEHAVIOR HOW HE ACTS	P-13 P-14 P-15 N-16 N-17 N-18	P-31 P-32 P-33 N-34 N-35 N-36	P-49 P-50 P-51 N-52 N-53 N-54	P-67 P-68 P-69 N-70 N-71 N-72	P-85 P-86 P-87 N-88 N-89 N-90	99 100	
	5 5 5 1 1 1	5 5 5 1 1 1	5 5 5 1 1 1	5 5 5 1 1 1	5 5 5 1 1 1	5 5	
	4 4 4 2 2 2	4 4 4 2 2 2	4 4 4 2 2 2	4 4 4 2 2 2	4 4 4 2 2 2	4 4	
	3 3 3 3 3 3	3 3 3 3 3 3	3 3 3 3 3 3	3 3 3 3 3 3	3 3 3 3 3 3	3 3	SC =
	2 2 2 4 4 4	2 2 2 4 4 4	2 2 2 4 4 4	2 2 2 4 4 4	2 2 2 4 4 4	2 2	
	1 1 1 5 5 5	1 1 1 5 5 5	1 1 1 5 5 5	1 1 1 5 5 5	1 1 1 5 5 5	1 1	
	P ____ N ____ P + N ____ P − N ____	P ____ N ____ P + N ____ P − N ____	P ____ N ____ P + N ____ P − N ____	P ____ N ____ P + N ____ P − N ____	P ____ N ____ P + N ____ P − N ____		
COLUMN TOTALS	TOTAL POSITIVE (ΣP + N) ____					Total Positive or P + N →	
	Σ (Algebraic) P − N ____					→ Total Net Conflict (P − N)	Row Tot. V.
	Non-(Algebraic) P − N ____					→ Total Conflict	
	V. (Range of P + N Cell Scores) ____					→ Col. Tot. V.	Tot. V.

DISTRIBUTION OF RESPONSES

NUMBER OF [ ] [ ] [ ] = 90 T/F = ___ = [ ]

SELF CRITICISM RESPONSES ___ ___ ___ ___ ___ = 10

TOTALS ___ ___ ___ ___ ___ = 100
X2 X1 — X1 X2

D = ___ + ___ + ___ + ___ = [ ]

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EMPIRICAL SCALES

DP = ___ − ___ = ___

GM = ___

PSY = (100 + ___) − (___) = ___

PD = ___ − ___ = ___

N = ___ − ___ = ___

PI = ___

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Tennessee Self Concept Scale

L. William H. Fitts 1964

PROFILE SHEET

Clinical and Research Form

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NASHVILLE, TENN. 37212

NAME | SCHOOL GRADE | SEX M F | AGE | DATE | TOTAL TIME

T SCORE	SELF CRITICISM	T/F	CONFLICT: NET	CONFLICT: TOTAL	TOTAL	POSITIVE SCORES: HOW 1	HOW 2	HOW 3	COLUMN A	COLUMN B	COLUMN C	COLUMN D	COLUMN E	PERCENTILE SCORES	VARIABILITY: TOTAL	VARIABILITY: COL TOT.	VARIABILITY: ROW TOT.	DISTRIBUTION: D	5	4	3	2	1	EMPIRICAL SCALES: DP	GM	PSY	PD	N	PI	NDS	T SCORE
PROFILE LIMITS	UP	16	7	29	44	14	11	24	13	17	16	24	11	17		8	14	39	6	34	19	34	34	14	29	14	22	9	-	19	
	DOWN	29	9	24	17	9	24	15	12	17	12	24	28	49		5	29	12	10	24	29	16	28	17	34	21	17	14	15	-	

INSTRUCTIONS

On the top line of the separate answer sheet, fill in your name and the other information except for the time information in the last three boxes. You will fill these boxes in later. Write only on the answer sheet. Do not put any marks in this booklet.

The statements in this booklet are to help you describe yourself as you see yourself. Please respond to them as if you were describing yourself to yourself. Do not omit any item! Read each statement carefully; then select one of the five responses listed below. On your answer sheet, put a circle around the response you chose. If you want to change an answer after you have circled it, do not erase it but put an X mark through the response and then circle the response you want.

When you are ready to start, find the box on your answer sheet marked time started and record the time. When you are finished, record the time finished in the box on your answer sheet marked time finished.

As you start, be sure that your answer sheet and this booklet are lined up evenly so that the item numbers match each other.

Remember, put a circle around the response number you have chosen for each statement.

Responses	Completely false	Mostly false	Partly false and partly true	Mostly true	Completely true
	1	2	3	4	5

You will find these response numbers repeated at the bottom of each page to help you remember them.

1. I have a healthy body

3. I am an attractive person

5. I consider myself a sloppy person

19. I am a decent sort of person

21. I am an honest person

23. I am a bad person

37. I am a cheerful person

39. I am a calm and easy going person

41. I am a nobody

55. I have a family that would always help me in any kind of trouble

57. I am a member of a happy family

59. My friends have no confidence in me

73. I am a friendly person

75. I am popular with men

77. I am not interested in what other people do

91. I do not always tell the truth

93. I get angry sometimes

Responses	Completely false	Mostly false	Partly false and partly true	Mostly true	Completely true
	1	2	3	4	5

2. I like to look nice and neat all the time

4. I am full of aches and pains

6. I am a sick person

20. I am a religious person

22. I am a moral failure

24. I am a morally weak person

38. I have a lot of self-control

40. I am a hateful person

42. I am losing my mind

56. I am an important person to my friends and family

58. I am not loved by my family

60. I feel that my family doesn't trust me

74. I am popular with women

76. I am mad at the whole world

78. I am hard to be friendly with

92. Once in a while I think of things too bad to talk about

94. Sometimes, when I am not feeling well, I am cross

Responses	Completely false	Mostly false	Partly false and partly true	Mostly true	Completely true
	1	2	3	4	5

7. I am neither too fat nor too thin

9. I like my looks just the way they are

11. I would like to change some parts of my body

25. I am satisfied with my moral behavior

27. I am satisfied with my relationship to God

29. I ought to go to church more

43. I am satisfied to be just what I am

45. I am just as nice as I should be

47. I despise myself

61. I am satisfied with my family relationships

63. I understand my family as well as I should

65. I should trust my family more

79. I am as sociable as I want to be

81. I try to please others, but I don't overdo it

83. I am no good at all from a social standpoint

95. I do not like everyone I know

97. Once in a while, I laugh at a dirty joke

Responses	Completely false	Mostly false	Partly false and partly true	Mostly true	Completely true
	1	2	3	4	5

8. I am neither too tall nor too short

10. I don't feel as well as I should

12. I should have more sex appeal

26. I am as religious as I want to be

28. I wish I could be more trustworthy

30. I shouldn't tell so many lies

44. I am as smart as I want to be

46. I am not the person I would like to be

48. I wish I didn't give up as easily as I do

62. I treat my parents as well as I should (Use past tense if parents are not living)

64. I am too sensitive to things my family say

66. I should love my family more

80. I am satisfied with the way I treat other people

82. I should be more polite to others

84. I ought to get along better with other people

96. I gossip a little at times

98. At times I feel like swearing

Responses	Completely false	Mostly false	Partly false and partly true	Mostly true	Completely true
	1	2	3	4	5

13. I take good care of myself physically

15. I try to be careful about my appearance

17. I often act like I am "all thumbs"

31. I am true to my religion in my everyday life

33. I try to change when I know I'm doing things that are wrong

35. I sometimes do very bad things

49. I can always take care of myself in any situation

51. I take the blame for things without getting mad

53. I do things without thinking about them first

67. I try to play fair with my friends and family

69. I take a real interest in my family

71. I give in to my parents. (Use past tense if parents are not living)

85. I try to understand the other fellow's point of view

87. I get along well with other people

89. I do not forgive others easily

99. I would rather win than lose in a game

Responses	Completely false	Mostly false	Partly false and partly true	Mostly true	Completely true
	1	2	3	4	5

14. I feel good most of the time

16. I do poorly in sports and games

18. I am a poor sleeper

32. I do what is right most of the time

34. I sometimes use unfair means to get ahead

36. I have trouble doing the things that are right

50. I solve my problems quite easily

52. I change my mind a lot

54. I try to run away from my problems

68. I do my share of work at home

70. I quarrel with my family

72. I do not act like my family thinks I should

86. I see good points in all the people I meet

88. I do not feel at ease with other people

90. I find it hard to talk with strangers

100. Once in a while I put off until tomorrow what I ought to do today

Responses	Completely false	Mostly false	Partly false and partly true	Mostly true	Completely true
	1	2	3	4	5

APPENDIX B

MULTIPLE AFFECT ADJECTIVE CHECK LIST

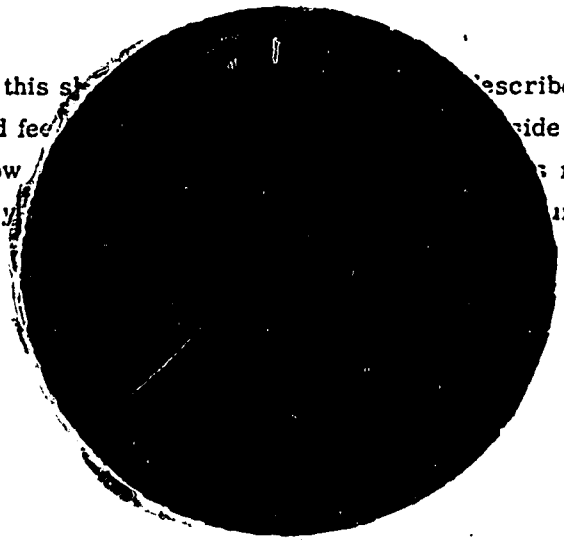
IN GENERAL FORM

By Marvin Zuckerman
and
Bernard Lubin

Name..... Age..... Sex.....

Date..... Highest grade completed in school.....

DIRECTIONS: On this sh[redacted]escribe different kinds of moods and fee[redacted]ide the words which describe how [redacted]; may sound alike, but we want y[redacted]ur feelings. Work rapidly.



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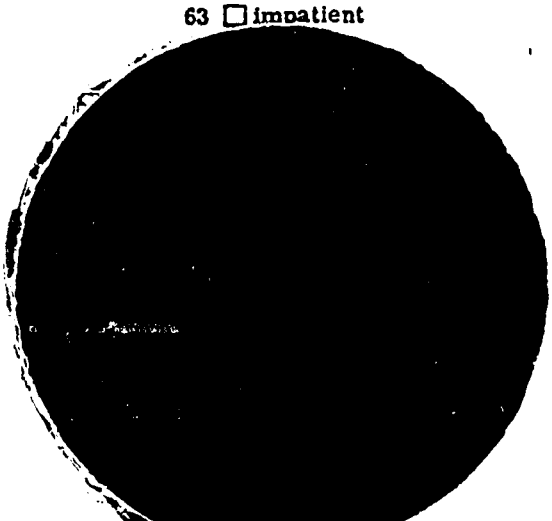
A D M

1 ☐ active
2 ☐ adventurous
3 ☐ affectionate
4 ☐ afraid
5 ☐ agitated
6 ☐ agreeable
7 ☐ aggressive
8 ☐ alive
9 ☐ alone
10 ☐ amiable
11 ☐ amused
12 ☐ angry
13 ☐ annoyed
14 ☐ awful
15 ☐ bashful
16 ☐ bitter
17 ☐ blue
18 ☐ bored
19 ☐ calm
20 ☐ cautious
21 ☐ cheerful
22 ☐ clean
23 ☐ complaining
24 ☐ contented
25 ☐ contrary
26 ☐ cool
27 ☐ cooperative
28 ☐ critical
29 ☐ cross
30 ☐ cruel
31 ☐ daring
32 ☐ desperate
33 ☐ destroyed
34 ☐ devoted
35 ☐ disagreeable
36 ☐ discontented
37 ☐ discouraged
38 ☐ disgusted
39 ☐ displeased
40 ☐ energetic
41 ☐ enraged
42 ☐ enthusiastic
43 ☐ fearful
44 ☐ fine
45 ☐ fit
46 ☐ forlorn
47 ☐ frank
48 ☐ free
49 ☐ friendly
50 ☐ frightened
51 ☐ furious
52 ☐ gay
53 ☐ gentle
54 ☐ glad
55 ☐ gloomy
56 ☐ good
57 ☐ good-natured
58 ☐ grim
59 ☐ happy
60 ☐ healthy
61 ☐ hopeless
62 ☐ hostile
63 ☐ impatient



77 ☐ mad
78 ☐ mean
79 ☐ meek
80 ☐ merry
81 ☐ mild
82 ☐ miserable
83 ☐ nervous
84 ☐ obliging
85 ☐ offended
86 ☐ outraged
87 ☐ panicky
88 ☐ patient
89 ☐ peaceful
90 ☐ pleased
91 ☐ pleasant
92 ☐ polite
93 ☐ powerful
94 ☐ quiet
95 ☐ reckless
96 ☐ rejected
97 ☐ rough
98 ☐ sad
99 ☐ safe
100 ☐ satisfied
101 ☐ secure
102 ☐ shaky
103 ☐ shy
104 ☐ soothed
105 ☐ steady
106 ☐ stubborn
107 ☐ stormy
108 ☐ strong
109 ☐ suffering
110 ☐ sullen
111 ☐ sunk
112 ☐ sympathetic
113 ☐ tame
114 ☐ tender
115 ☐ tense
116 ☐ terrible
117 ☐ terrified
118 ☐ thoughtful
119 ☐ timid
120 ☐ tormented
121 ☐ understanding
122 ☐ unhappy
123 ☐ unsociable
124 ☐ upset
125 ☐ vexed
126 ☐ warm
127 ☐ whole
128 ☐ wild
129 ☐ willful
130 ☐ wilted
131 ☐ worrying
132 ☐ young

APPENDIX C

THERAPIST RATING FORM

Rate the following dimensions of treatment in terms of the extent of agreement or disagreement of their presence. Rate the statements as follows: 1) Clearly Present; 2) Partially Present; 3) Unclear; 4) Not Present.

Rational Stage Directed Imagery

a)	Review of Self-Directed Behavior Change identified problems	1 2 3 4
b)	Explanation of stages	1 2 3 4
c)	Ss subjected to deep breathing, cognitive muscle relaxation, and imagination of relaxing scene	1 2 3 4
d)	Processing of Ss through cognitive restructuring	1 2 3 4
e)	Processing of Ss through stages	1 2 3 4

Rational Stage Directed Therapy

a)	Review of Self Directed Behavior Change identified problems	1 2 3 4
b)	Explanation of stages	1 2 3 4
c)	Processing of Ss through cognitive restructuring	1 2 3 4
d)	Processing of Ss through stages	1 2 3 4

Placebo

a)	Ss told to think positively about themselves and emotional stress will subside; no reason given	1 2 3 4
b)	All questions answered non-directly	1 2 3 4

APPENDIX D

Self-Directed Behavior Change in the Cognitive, Affective, and Behavioral Motoric Domains: A Rational-Emotive Approach

Donald J. Tosi, Ph.D.
The Ohio State University

TABLE OF CONTENTS

INTRODUCTION

This exercise is designed to facilitate self-directed behavioral change in the cognitive, the affective, and the behavioral motoric domains. The value of this exercise is that it can be performed in real life situations (in vivo) or in one's imagination (emotive-imagery). The exercise permits persons to develop a greater awareness of self through self-exploration. Moreover, it is intended to help persons acquire skills that they may use to excellent advantage in the control of their own behaviors.

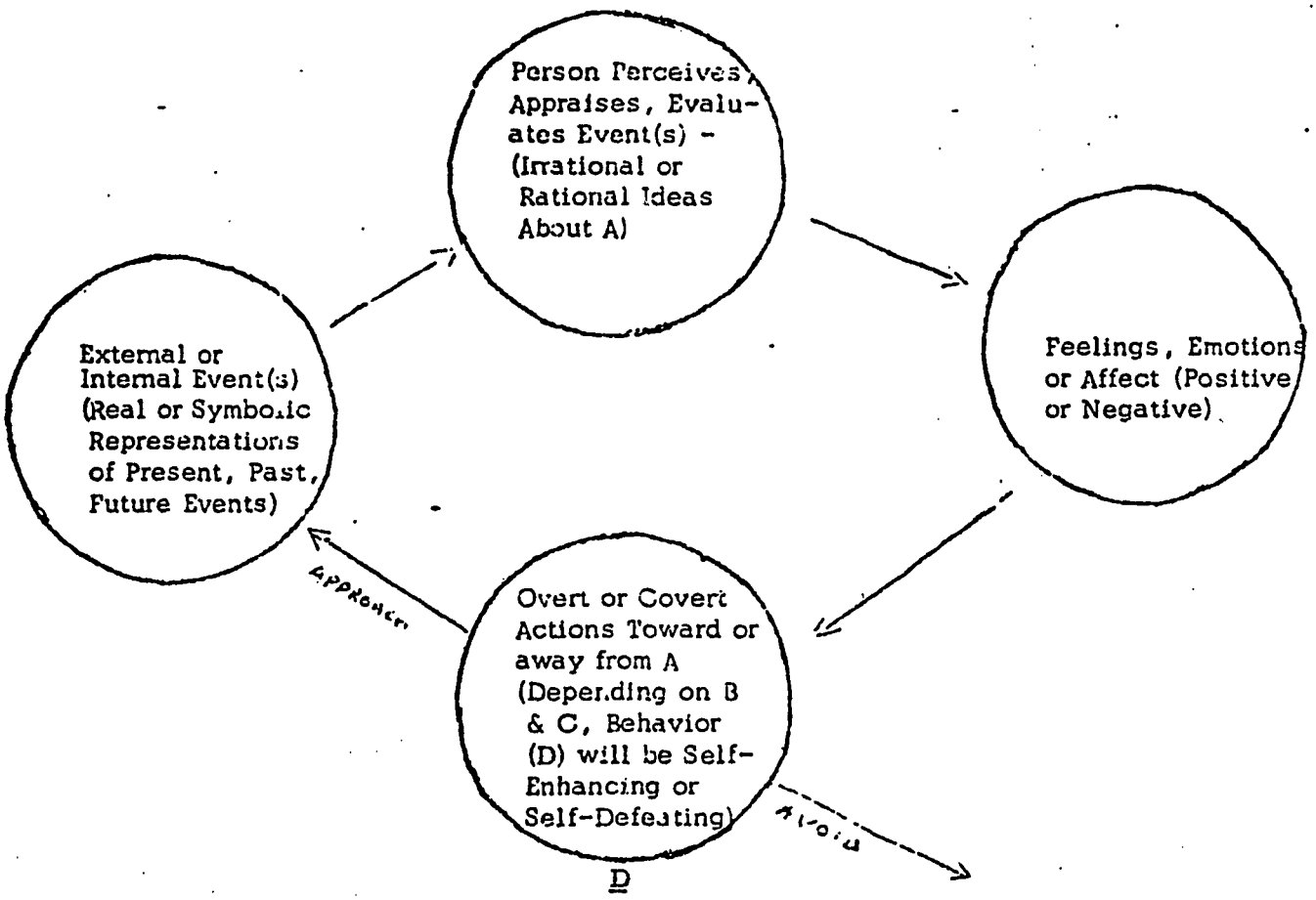
This self-directed intervention is based upon rational-emotive theory and thus emphasizes cognitive control over emotions and behavior. Rational-emotive theory holds that most sustained negative emotions which interfere with effective behavior (problem solving, self-assertiveness, decision-making, etc.) are the result of irrational ideas which take the form of biased, prejudiced, internalized sentences. Rarely do events external to us cause our discomfort. In reality, it is our own perceptions, attitudes, or internalized sentences about those events outside of us that affect us most.

Specifically, this exercise should (1) enable a person to explicate his thinking or ideas about significant events that are associated with areas of ineffective functioning, and (2) help that person to generate more reasonable thoughts or ideas that would be associated ultimately with more positive emotions and behavior.

In completing this exercise you will be assisted with any questions or difficulties you may have by your counselor, teacher, or workshop leader. If this exercise is being completed at home, you may write your questions or comments on the extra sheets provided.

2

ABCD
Model
of
Cognitive, Affective, and Behavioral Processes



(Note) Some persons report that their behavior (D) follows feelings (C) about events (A). They appear to be unaware of the thoughts that cause, support, and sustain the feelings. In other cases, some persons are not aware of their emotions (C) and attribute their behavior (D) to their thoughts (B). In actuality, both B and C interact to cause or to influence one's behavior (D). Thus, appropriate psychological interventions assist persons initially to become fully aware of the entire ABCD sequence.

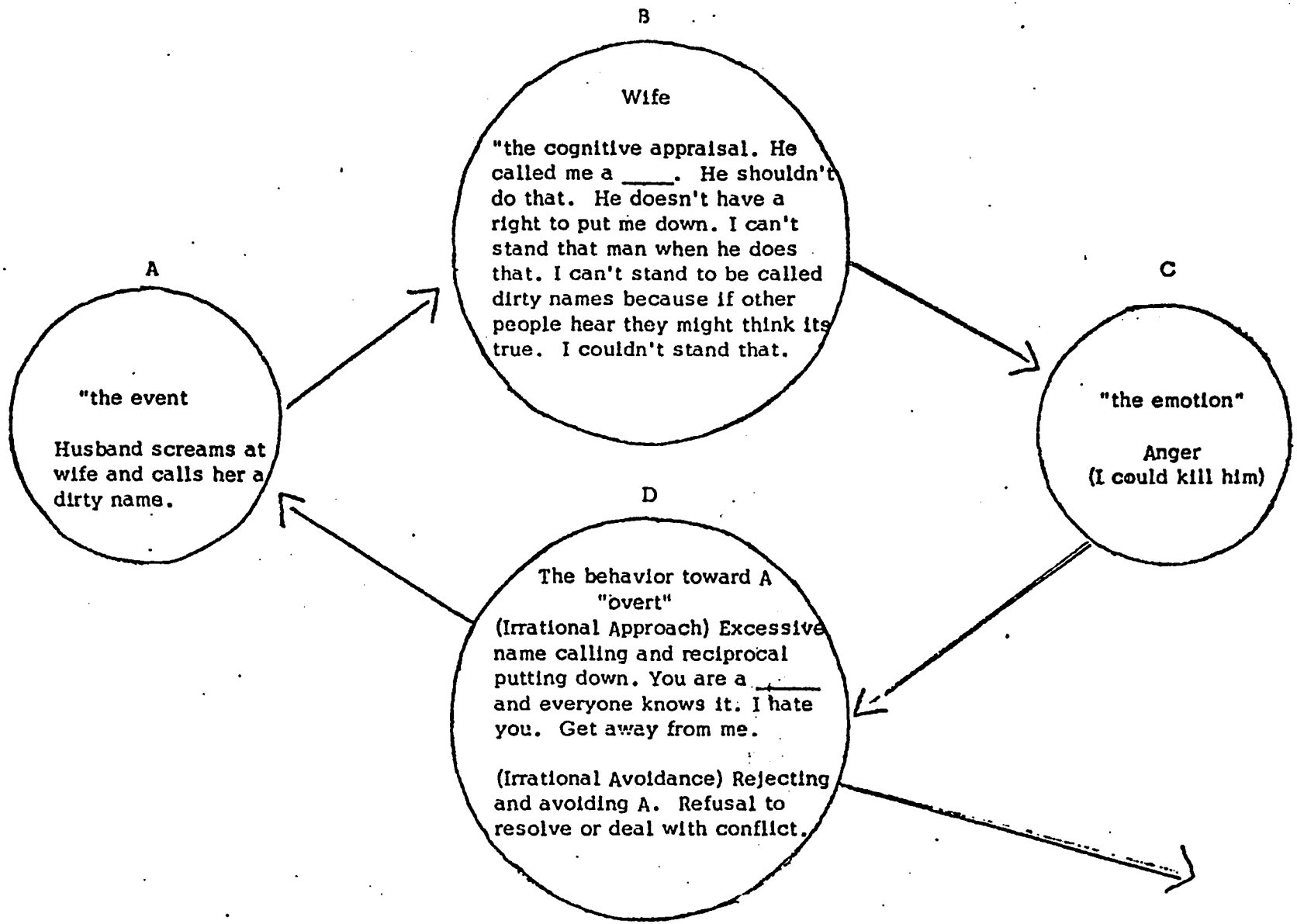
Since persons have the ability to observe themselves or consider themselves as objects, a B, a C, or a D may become an A. As can be observed, the ABCD process is cyclical in nature.

B and C are states occurring within the person exclusively. A & D are often observable to others, but may also occur within the person.

PART I

THE ABCD IRRATIONAL SEQUENCE

EXAMPLE OF IRRATIONAL
ABCD SEQUENCE



- 5 -

(A's)

Activating Events

Each of us find that many situations or events in our environment are sources of joy or unhappiness. Significant situations for most of us are school, family, friends, church, etc. Examples of events typically associated with personal unhappiness are a mate screaming at you; a boisterous child; a pending divorce; politics; an undisciplined student; excessive demands made by bosses, friends, or relatives; and certain types of deviant behavior (homosexuality, criminality); examinations; social relationships, and, making career decisions. Events may also consist of your undesirable habits or behaviors such as eating and drinking too much, oversleeping and being late for appointments.

First, list three specific and significant events that are sources of psychological discomfort for you. Second, rank these events that activate negative emotional reactions from least emotionally upsetting to most emotionally upsetting.

Listing of Activating Events	Ranking of Activating Events from Least Emotionally Upsetting to Most Emotionally Upsetting
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____

(Cu's)

Undesirable Emotional or Affective States
Associated with Significant Situational Events

The follcwing is a list of negative emotional or affective reactions associated with certain events (internal or external). Identify those emotional reactions accompanying each of the activating events you have already listed. Record these under C (undesirable emotions) on Form A.

Undesirable Affects or Emotions

1. Anger or great irritability
2. Anxiety, severe worry, or fear
3. Boredom or dullness
4. Failure to achieve
5. Frustration
6. Guilt or self-condemnation
7. Hopelessness or depression
8. Great loneliness
9. Helplessness
10. Self-pity
11. Uncontrollability
12. Worthlessness or inferiority
13. Stubbornness
14. Resentful
15. Lazy
16. Sinful
17. Self-hate
18. Excessively shy
19. Hating others
20. Vulnerable
21. Dependent
22. Mistrust
23. Rigid
24. Foolish
25. Jealousy
26. Other (specify) _____

- 7 -

(Du's)

Undesirable Behaviors, Actions, or Habits

This is a list of behaviors generally considered to be self-defeating or undesirable, especially, when they are of a high frequency, intensity, and duration. From the list below, choose those behaviors that are most often associated with the activating event(s) you specified (A) and the undesirable emotional or affective states (C) you have already determined for yourself. Record these on form A. You may need to be more specific than suggested by the above behaviors.

1. Avoiding responsibility
2. Acting unfairly to others
3. Being late to appointments
4. Demanding attending
5. Physically, attacking others
6. Procrastinating
7. Telling people off harshly
8. Whining or crying
9. Withdrawing from activity
10. Excessive drinking of alcohol
11. Overeating
12. Undersleeping
13. Oversmoking
14. Excessively manipulating
15. Taking too many drugs or pills
16. Being sarcastic
17. Lying
18. Cheating
19. Overprotecting
20. Other (specify) _____

- 8 -

(IB's)

The Irrational Beliefs or Ideas

The following are commonly held irrational ideas or beliefs that are causes of emotional disturbance. From the list, choose those irrational ideas (IBs) that occur between the Activating Events (A) and the emotions (C) you generally experience. At first this may prove to be difficult because such thinking generally occurs in symbolic or shorthand form and may not be in one's awareness. The idea here is to slow down the thinking process enough so that those ideas associated with or cause emotional distress will come into sharp focus or awareness. It may be easier if you can translate the above ideas into words that are more familiar to you. Record those IBs you select under IB.

When you have finished this section you have completed the ABCD personal analysis of your specific thoughts, feelings, and actions associated with significant events.

(1) I must be loved or approved by everyone for virtually everything I do. Or, if not by everyone, by persons I deem significant to me.

(2) I believe that certain acts are sinful, wicked, or villianous, and that people who perform such acts should be severely punished and blamed.

(3) I can't stand it when things are not the way I would like them to be.

(4) When I am unhappy it is because something external to me such as persons or events causes me to be that way.

(5) I should be terribly concerned about things that may be dangerous or fearsome to me.

(6) Although I want to face difficult situations and self responsibilities it is easier for me to avoid them.

(7) I need someone stronger or greater than myself on whom to rely.

(8) In order to have a feeling of worth, I should and must be thoroughly competent, adequate, intelligent, and achieving in all possible respects.

(9) When something once strongly affected me, it will always or indefinitely affect me.

(10) I don't have much control over my emotions or thoughts.

(11) I should never be angry or express my anger because such expression is bad and a sign of personal weakness.

(12) I should rarely confront other people or assert my own thoughts or feelings about another person because people are fragile and are hurt easily. I don't want to hurt anyone.

(13) Most of the time I will please other people even if I have to forgo my own pleasure.

(14) I am happiest when I just remain inactive and passive.

(15) In order to be perfectly fulfilled as a human being I need (must have) a close personal, involved, and intimate relationship with another person especially a member of the opposite sex.

ABCD PERSONAL ANALYSIS

PART I
(Form A)

	LEAST EMOTIONALLY UPSETTING		MOST EMOTIONALLY UPSETTING
A) ACTIVATING EVENTS	1	2	3
IBs) IRRATIONAL IDEAS OR PHILOSOPHIES (THOUGHTS)			
C) UNDESIRABLE EMOTIONAL OR AFFECTIVE REACTIONS			
D) BEHAVIORAL CONSEQUENCES OR ACTIONS ASSOCIATED WITH C ++			

++ Try to be as specific as possible in describing IBs, Cs, and Ds.

PART II

THE RECONSTRUCTION PROCESS

- 12 -

Psychological Reconstruction

The purpose of this section "the reconstruction process" is to assist persons to move beyond a mere understanding or awareness of those socio-psychological processes that contribute to personal and/or environmental conflict. Moving beyond awareness and understanding implies intervention. That is, self-intervention or simply one's learning to do something about those feelings and behavior that contribute to his personal unhappiness.

The central theme of rational emotive theory is "cognitive control" over emotions and behavior. Thus, since it is man's thinking that is largely responsible for his emotional distress and ineffective behavior, it is of greatest import to man that he learn to challenge, contradict, and ultimately replace those thoughts, ideas, or beliefs that do not serve his best interest with more reasonable or self enhancing thoughts, ideas, or beliefs.

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(RB's)

The Rational Ideas or Beliefs
(Contrast to Irrational Ideas)

The following ideas (RB's) are contrasts to those irrational ideas presented in the last section. When a person substitutes these ideas for his previously held irrational ideas, he will eventually notice positive changes in his emotional states and resultant behavior.

This exercise is designed to (1) introduce persons to more rational ways of thinking about the Activating Events associated with emotional disturbance and to (2) assist persons in the contradicting and challenging of those self-defeating ideas that support negative emotions and self-defeating behavior. This exercise can be performed "in vivo" (real life situations) or through Imagery.

The numbering of the RB's correspond to the numbering of the IB's in the preceeding section. Record those RB's that contrast with those IB's you previously identified under RB in form B. While recording those RB's you select, try to imagine yourself using those ideas in those real settings (As) which are personal sources of disturbance.

(1) While it is desirable to be approved and accepted by others, it is not an absolute necessity. My life doesn't really depend upon such acceptance, nor can I really control the minds and behavior of other persons. And, furthermore, a lack of total acceptance is certainly not catastrophic or horrible and doesn't at all mean that I am worthless or a louse.

(2) Many persons do commit acts that are inappropriate, self-defeating, or antisocial. It is desirable to try to induce such persons to act more effectively than to spend needless time and energy blaming, accusing, and becoming upset over their acts. Moreover, needless blame and punishment rarely stops such persons who are usually ignorant, emotionally disturbed, or stupid from commiting such acts. Demanding that persons should not commit stupid acts often times is nothing more than a demand that reality be different - reality is reality. The crucial question is, what constructive actions can I initiate to modify reality?

(3) When things don't go the way I want them to go, it is too bad or inconvenient - but not catastrophic. And, it may be in my best interest to change them or arrange conditions so that they may become more satisfactory. But, if I can't change or modify situations to my liking, I would be better off accepting their existence rather than telling myself how awful they are.

(4) While most people are taught that external events are the direct cause of one's unhappiness, in virtually most cases, human unhappiness is caused by one's thoughts, appraisals, evaluations, or perceptions of those events. That is, I create my own disturbance. Since I am human, I can expect to disturb myself often. But, that doesn't mean I have to continually disturb myself forever.

(5) If something is or may be dangerous or fearsome, it is probably in my best interest to face it and try to render it less dangerous and, if that is impossible, I could stop dwelling on such fears - especially when little evidence exists that such horrible things will, in fact, occur.

(6) While it is humanly normal to want to take the easy way out such things as avoiding life's difficulties and self-responsibilities, in the long run, I would probably be better off confronting openly such difficulties, facing them squarely, and trying to solve them.

(7) Although the socio-cultural system teaches and reinforces one's tendencies to be dependent on others and things. I would be better off standing on my own two feet in facing life. Moreover,

if I fail to be independent in the short-run, that doesn't mean that I will fail in the future. After all, am I not a fallible person.

(8) Since I am a human being with biological, sociological, and psychological limitations, I cannot reasonably expect to be perfect in any endeavor. But, I certainly can strive to perform well in those tasks I deem as significantly contributing to my self-development. In those areas I am deficient, I certainly can strive to improve those areas. If, I fail, tough - too bad.

(9) Although I have been influenced greatly by my past experiences and that specific instances of the past greatly affect me today, I can profit by such experiences but not be overly prejudiced or biased by them. Nor do I need to be dominated by them in the future.

(10) Human beings, including myself, are happiest when they are actively involved in creative pursuits or when they devote themselves to people or projects outside of themselves. Long term withdrawal from the world or inaction rarely are associated with happiness. Therefore, it would be in my best interest to force myself into productive or creative activity.

(11) I could probably develop the skills necessary to control enormously my own emotions or feelings if I decide to commit myself to that process. And, it would be in my best interest if I would take the necessary risks in order to achieve a greater control over my own destiny. Of course, I don't really expect to develop these skills overnight.

(12) Anger is a normal human emotion and its expression is not a sign of personal worthlessness. Moreover, being aware of my anger and expressing it as a communication of current feelings without indiscriminantly attacking the personal worth of others may be in my best interest. Denying my anger is rarely in my best interest.

(13) If I share most of my thoughts and feelings (negative or positive) honestly and openly, it will probably help me communicate more effectively with others in the long run - even though in the short run, I might experience some temporary discomfort.

(14) Striving to know and to accept others for their humanness is a reasonable goal. Moreover, it is in my best interest to try to

act fairly with others so I may receive the full benefit of their humanness. However, trying to please others at the expense of my own well being is not personally growth enhancing. Therefore, I can only do my best in trying to please others. If I fail - tough!

(15) It is desirable for me to be able to develop meaningful and intimate relationships with persons especially those of the opposite sex. However, if I demand intimate and satisfying relationships with others, I will tend to focus on the outcome of such interpersonal relationships rather than the process of getting to know and accept another person. Therefore, I would be better off not demanding but trying to be spontaneous, responsive, and accepting towards significant persons.

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(Cp's)

Positive Emotions

This list is comprised of emotions that are generally positive or desirable. Although persons do not experience these always, these emotions are experienced or may be experienced under a variety of conditions with varying degrees of frequency, intensity, and duration. From this list, choose those emotional responses that would be more desirable associated with those Activating Events (As) and rational ideas (RBs) you have already listed. Also, it is important that you imagine these more positive feelings as emotional responses to those activating events (As) and rational beliefs (RBs). Record your choices under C or form B.

Desirable Affects or Emotions

1. Relaxed
2. Joy
3. Worthwhile
4. Loving
5. Hope
6. Warmth
7. Guiltless
8. Shameless
9. Elation
10. Gentle
11. Energetic
12. Merry
13. Cheerful
14. Confident
15. Self-Accepting
16. Dependable
17. Caring
18. Able
19. Lively
20. Happy
21. Patient
22. Trusting
23. Satisfied
24. Stable
25. Pleasant
26. Other (specify) _____

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(Dd's)

- Desirable Behaviors, Actions, or Habits

The following behaviors are generally considered desirable or self-enhancing. More often persons engaging in these are more effective than they are ineffective. Choose those behaviors (Dds) that are associated with more reasonable ways of thinking (RBs) and feeling (Cds). You may need to be more specific than suggested by the above behaviors. Again, try to imagine yourself utilizing these more self enhancing behaviors as a response to the As, Rbs, and Cds you have already determined:

1. taking responsibility
2. acting fairly
3. being punctual
4. self-assertiveness
5. spontaneity
6. moderate drinking of alcohol
7. being kind
8. honesty
9. considerate
10. helpful
11. reliable
12. tender
13. responsive
14. frank
15. eating normally
16. sleeping normaliy
17. patient
18. minimizing dependence on people, drugs, etc.
19. taking decisive actions
20. efficient

ABCD ANALYSIS
THE RESTRUCTURING PROCESS

PART II

(Form B)

	LEAST EMOTIONAL UPSETTING		MOST EMOTIONAL UPSETTING
A) ACTIVATING EVENTS			
Rbs RATIONAL IDEAS OR PHILOSOPHIES			
C) DESIRABLE EMOTIONAL OR AFFECTIVE REACTIONS **(Real or Imagined)			
D) DESIRABLE BEHAVIORAL CONSEQUENCES **(Real or Imagined)			

** In this exercise, the more preferred Cs and Ds may need to be imagined first before they may actually occur in behavior.

Thoughts, emotions, and behaviors you would like to change as a result of completing this exercise:

Strategies or solutions you might develop and use in achieving desirable cognitive (thinking), emotional and behavioral outcomes:

APPENDIX E

RELAXATION PROTOCOL

Part I: Deep Breathing

Start taking in deep breaths and feel the air circulating around your lungs to the very pit of your stomach. Breathe deeply and continue to inhale relaxation so that with each deep breath that you take, 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, 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 do, you find yourself becoming even more comfortably relaxed. You may notice outside noises and talking, but nothing will bother you...nothing will effect your becoming very deeply...comfortably...relaxed, so that with each deep breath that you take, you find yourself slipping deeper and deeper into relaxation. You find yourself becoming very relaxed...further relaxed...deeply relaxed....You find yourself in a very comfortable... a very warm...a very relaxed state...a very deeply relaxed state.... I want you to stop your deep breathing now and concentrate on the second part of our relaxation process...the muscle relaxation.

Part II: Cognitive Muscle Relaxation

I want you to concentrate on allowing all of the muscles in your body to become completely relaxed. You will find as you let your muscles relax, you can get even deeper into relaxation.

Concentrate now on all of the muscles in your forehead; feeling them losing tension...becoming very very soft and relaxed...absolutely relaxed and comfortable. With all the muscles in your forehead relaxed, I want you to allow the relaxation to spread through your 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...Allow them to become relaxed.... Allow every muscle to relax. There is no need for any tension... 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 comes over you...from your shoulders to your back...around your sides...to your chest. Your muscles automatically relax...As you concentrate on allowing them to become even more relaxed...they do so. Your chest wall moves effortlessly up and down...up and down...you can feel it floating as you become absolutely relaxed. You may be experiencing a very warm and a very comfortably floating sensation....a very safe feeling. Now, with each muscle in your chest absolutely relaxed...beautifully relaxed, concentrate on all the muscles in your arms.

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 through 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 the muscles in your hips and going to your knees, allow every muscle in your hips to become very relaxed...very comfortably relaxed. You can feel your strong thigh muscles becoming soft and comfortable...becoming very relaxed. The muscles feel like they are just hanging on your bones...they are completely relaxed. Now concentrate on the lower half of your legs becoming 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 will find that you can go very easily and automatically into the third stage of relaxation which is the scene we discussed earlier.

Part III: Description of Scene

The particular scene described to the subject is important in that it includes the following four essential elements:

(1) The scene should include a very serene setting which is loosely described by the therapist, e.g., a nature setting, or a peaceful seashore.

(2) A rhythm must be established using some facet of the scene, e.g., the waves are rolling, rolling, rolling, into the shore, in and out...in and out...

(3) Suggestions must be given that elicit peace, comfort, and serenity, as well as, the visualizing and hearing of sights and sounds within the scene, e.g., you find yourself at peace and extremely comfortable, so that you can actually see and possibly even hear the gulls gracefully floating overhead...

(4) Direct suggestion that it is easy for the S to experience the scene is important, e.g., you are more able to get into the scene...becoming more relaxed...as you get into it more, the details become clearer to you... there is no need for any tension...only relaxation.

The therapist must be careful not to describe the scene too rigidly, because his suggestions may conflict with the subject's projections, thereby lessening the relaxation rather than deepening it. After the scene has been described, the therapist says:

> I will let you savor and enjoy this relaxation for a moment, then I will count to five and you will awaken. You will feel inevitably much more refreshed and relaxed and able to carry on throughout the rest of the day (evening) in a very relaxed and very attentive state....
>
> I am now going to wake you by counting to five and you will feel very good...1..2..3..4..5...

APPENDIX F

RATIONAL STAGE DIRECTED IMAGERY (RSDI)

TREATMENT PLAN

Session #1:

A. Explain relationship between self-concept, one's thinking and how one feels, i.e., that self-concept is essentially composed of the thoughts that we have about ourself, which affects how we feel emotionally.

B. Self-Directed Behavior Change Instrument

1. pass out instruments
2. explain how to use it
3. identify specific problems, concerns, or erroneous ideas about self to work on for the rest of the treatment.

Session #2:

A. Explain Stage Directed Approach

1. Awareness
2. Exploration
3. Commitment to Rational Action
4. Implementation
5. Internalization
6. Redirection or Change

B. Specifically discuss their problems relative to the awareness and exploration stages.

C. Put Ss through RSDI using their examples

1. Introduce deep breathing and cognitive muscle relaxation technique.
2. Ask them to imagine themselves at each stage.
3. Concentrate on Awareness and Exploration

Session #3:

A. Review Self Directed Behavior Change Identified Problems

B. Outline problems and process through the six stages.

1. concentrate on Awareness and Exploration stages.
2. identify appropriate irrational and rational ideas.
3. using RSDI emphasize the more rational thoughts, emotions, and behaviors, and the resultant more pleasant consequences.

C. Ask Ss to practice RSDI at home three times per week for fifteen minute intervals.

Session #4:

A. Record the number of times each Ss practiced.

B. Review problems, processing them through all stages, concentrating on the Commitment to Rational Action and Implementation Stages.

C. Ask Ss to practice relaxation and RSDI at home three times per week for fifteen minute intervals.

Session #5:

A. Same as Session #4, only concentrate on Internalization and Redirection or Change Stages

Session #6:

A. Same as above sessions. Give equal weight to each stage.

APPENDIX G

RATIONAL STAGE DIRECTED IMAGERY:

AN EXAMPLE

An "ABCDE" model will be utilized in Rational Stage Directed Imagery while processing the client through stages of Awareness, Exploration, Commitment, Implementation, Internalization and Change. Prior to the relaxation procedure, the therapist will guide the client through each of the six stages, outlining rational cognitions concomitantly. During the initial sessions, the therapist will guide the client in focusing on the Awareness and Exploration of rational and irrational ideas. As the counseling progresses, the client is guided through the rest of the stages, focusing on each one and concentrating on the particular characteristics contained in that stage. Both the therapist and the client decide when to progress to the next stage.

After discussing, practicing, and understanding the RSDI process, the client is then assisted through the relaxation procedure and guided through the entire stage-directed approach. The following is an example of the process concentrating on the Awareness and Exploration stages:

T: I want you to focus on the specific events or situations that you have determined to be disturbing. (Describe a client-identified specific event) e.g. Imagine that you are in school and someone calls you a "bitch". If you can imagine this event, please use your right index finger. (If ideomotor response is elicited, proceed to the next phase; if it isn't, ask Ss to go deeper into relaxation, then repeat the suggestion.)

Allow yourself to feel the (specify emotion) e.g., anger and hostility in conjunction with this situation; notice how uncomfortable it is and realize how self-defeating this emotion is in this particular instance. Describe to yourself the ways in which these emotions are preventing you from experiencing or acting in ways that you would like.

What about the situation would you like to change? Now concentrate on the thoughts you are associating with this event. Concentrate on specific irrational thoughts. Imagine saying to yourself (state specific irrational idea) e.g. She has no right to call me a "bitch" and I can't stand it when she does; I haven't done anything to her. Besides, someone may believe her....Continue to concentrate on those irrational self-verbalizations and notice how you tend to become more anxious.

As you continue to see those thoughts in your mind, allow yourself to experience the emotional discomfort . . . . The more you continue to tell yourself irrational, self-defeating thoughts, the more you will tend to feel these negative emotions. Continue to concentrate on those irrational self-defeating thoughts and notice how you tend to become even more anxious, notice how your heart beats faster and you are so tense and nervous.

You can very clearly understand how those irrational thoughts are causing you to upset yourself. Now, I want you to tell yourself to stop thinking those irrational thoughts and we will begin to explore and become aware of more rational ways of thinking.

Let yourself imagine that you are thinking rational thoughts in conjunction with the same situation as before. Explore the rational thoughts. Become aware that you are thinking (state specific rational thoughts) e.g. Even if she does call me a "bitch", so what, that doesn't make one, and besides, she's rude and unfriendly to many people so I needn't have done something to cause her to act that way towards me.

Think those rational thoughts; explore them and become aware of your feelings when you tell yourself these rational thoughts. Notice how your negative emotions tend to subside. As the negative emotion, e.g., anxiety subsides, picture yourself in your mind engaging in rational actions and behaviors in conjunction with your rational thinking and feeling. Notice yourself becoming more effective when you think rationally. Explore new behaviors; think of new ways of acting in these situations, and continue to think rationally about them. (Allow the client a few moments to consider some of the more rational behaviors that you have previously outlined with him. You may wish to discuss rational exploration at length.)

> Now, I want you to allow yourself to relax very deeply.... clear your mind and return to a nice comfortable relaxing scene...go deeper and deeper into relaxation. Allow yourself to relax completely and concentrate on what I am saying to you. Between now and the next time we meet, allow yourself to practice this entire method of relaxation and rational thinking (the ABCDE method). Allow yourself to practice the relaxation and the ABCDE procedure at least three times a week for 15 minutes each time.
>
> Once more relax...I am going to count to five, and when I reach the number five, you will be wide awake, feeling very refreshed and very alert. When I reach the number "5" you will feel very refreshed and very alert. 1-2-3-4-5.

During later sessions the process is very much the same, only the focus is on higher level stages. After the therapist and the client feel they have sufficiently explored and have become aware of both irrational and rational ideas and behaviors, the client is guided into the third and fourth stages of Rational Stage Directed Imagery: Commitment to Rational Action and Implementation. The commitment stage involves the client imagining himself being publicly and privately commited to more rational ways of thinking and acting. A relaxed state often permits the lessening of resistance inhibiting commitment.

The Implementation Stage implies that the client is to actively engage in the newly acquired skills he has become committed to. He is asked to imagine his active participation in heretofore problematic situations in a more rational self-enhancing manner. The Implementation state is the testing ground for the client's new behaviors. He is encouraged and reinforced to apply what he has learned in the therapy session to situations outside of therapy.

T: I want you to concentrate only on the rational thoughts you have recently become aware of and have explored. Focus on these rational thoughts (identify specific thoughts) and images in your mind. You are committed toward acting, thinking, and feeling in more rational ways, e.g., imagine that someone calls you a name and you are able to handle the situation easily, with a minimum of stress and conflict.

Notice how you are becoming increasingly committed toward acting in a more self-enhancing way. As you become committed towards thinking more rationally you find yourself more in control of your emotions and your behaviors. As you act in more rational ways and are able to assess your life's situations more effectively, you become increasingly committed to rational action.

Now imagine that you are actually implementing the rational thoughts, feelings, and actions that you have committed yourself to. Notice how much more self-enhancing it is to act in a rational manner and how pleasant it is to control your own behavior and emotions.

Recall some of the different ways of acting rationally that we earlier explored. In your mind implement these ways of behaving; test them out; notice how much more adaptive and pleasant the consequences are; you will find them easier to transfer outside the sessions after you have practiced implementing them here.

Once the commitment to rational action and implementation of more self-enhancing thinking, feeling, and behaving is attempted, the client may then be ready to internalize the process and proceed to the internalization stage.

Internalization is a logical progression from the preceding stages. Once implementation of more self-enhancing thinking, feeling, and behaving is successfully attained, the client is more likely to internalize these.

T: Once you have committed youself to acting, feeling, and thinking more rationally and have actually implemented all of the processes (therapist may outline specific self-enhancing situations) you find it much easier to internalize the process. You can now imagine that you are in the act of internalizing a process of rational

> thinking and acting as well as desirable feelings. As you continue to think more rationally, you will further internalize a more self-enhancing way of perceiving, feeling, acting, and interacting.

Finally the client reaches the final stage of RSDI, the redirection/change stage. In this stage, the therapist observes the client engaging in self-directed activity and assuming responsibility for his behavior. The client is reinforced in his strivings to change. He is encouraged to generalize his newly acquired ideas for effective living to other problematic situations. If counseling was of a type requiring minimum change and was limited to one specific client concern, it may be terminated at this point. Should the client desire to continue working on his problems, he is redirected through the entire process once more, focusing on the particular stage wherein he may be having difficulty.

Note that all stages are reviewed in each session and all stages are contained within each other. While the client is exploring new rational thoughts he is also becoming more aware of them. As he becomes increasingly aware of rational thoughts he can more easily become committed to them and so on.

The stages present a specific, logical problem solving progression that the client be guided through by the therapist. As the therapist outlines the purpose of each stage the client can concretely focus on his problems and hopefully improve upon them.

APPENDIX H

RATIONAL STAGE DIRECTED THERAPY (RSDT)

TREATMENT PLAN

Session #1:

A. Explain relationship between self concept, one's thinking and how one feels, i.e., that self concept is essentially composed of the thoughts that we have about oneself, which affects how we feel emotionally.

B. Self-Directed Behavior Change Instrument

1. pass out instruments
2. explain how to use it
3. identify specific problems, concerns, or erroneous ideas about self to work on for the rest of the treatment.

Session #2:

A. Explain Stage Directed Approach

1. Awareness
2. Exploration
3. Commitment to Rational Action
4. Implementation
5. Internalization
6. Redirection or Change

B. Specifically discuss their problems relative to the Awareness and Exploration Stages.

Session #3:

A. Review Self Directed Behavior Change identified problems

B. Outline problems and process through the six stages.

1 1. Concentrate on Awareness and Exploration stages
2. Identify appropriate irrational and rational ideas
3. Using RSDT emphasize the more rational thoughts, emotions and behaviors and the resultant more pleasant consequences.

Session #4:

A. Review problems, processing them through all stages, concentrating on the Commitment to Rational Action and Implementation Stages.

Session #5:

A. Same as Session #4, only concentrate on Internalization and Redirection or Change stages.

Session #6:

A. Same as above sessions. Give equal weight to each stage.

PLACEBO

TREATMENT PLAN

Sessions #1 through #6:

A. Meet and discuss various problems of anxiousness, depression, hostility, and feelings about self.

B. Offer no methodology for dealing with these problems

1. suggest problems will dissipate by themselves
2. answer no questions directly
3. be extremely reflective and non-directive

NO TREATMENT CONTROL PLAN

Sessions #1 through #6:

A. This group will not meet

B. Will be given appropriate pre, post and follow-up tests.