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RATIONAL STAGE DIRECTED HYPNOTHERAPY IN TREATMENT OF SELF-CONCEPT AND DEPRESSION IN A GERIATRIC NURSING HOME POPULATION--A COGNITIVE EXPERIENTIAL APPROACH

The Ohio State University

Рн.Д. 1982

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RATIONAL STAGE DIRECTED HYPNOTHERAPY IN TREATMENT OF SELF-CONCEPT AND DEPRESSION IN A GERIATRIC NURSING HOME POPULATION--A COGNITIVE EXPERIENTIAL APPROACH

DISSERTATION

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

Вy

Jocelyn Kaye Fuller, B.S., M.A.

* * * * *

The Ohio State University

1982

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Department of Education Special Services

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CHAPTER I

INTRODUCTION

In recent years the problems of aging have become progressively more pressing in our culture. This may be seen as resulting from a variety of factors including improved medical care with consequent increases in life expectancy. History readily demonstrates that concurrent with improvements in living conditions, longevity increases. In a report by Lerner (1976) it is stated that longevity was about twenty years in ancient Greece, perhaps twenty-two in Rome, thirty-three years in England during the Middle Ages, about thirty-five in the Massauchetts Bay Colony of North America, forty-one in England and Wales during the nineteenth century, forty-seven in the United States in 1900, sixty-nine in the United States in 1954, and about seventy today. With the longer period of life expectancy, society finds that its population is composed of an ever increasing proportion of aged persons.

Today, there are twenty-two million people in the United States who are sixty-five years of age or older. Mental health problems of this elderly age group (particularly in the areas of self-esteem and depression) are more numerous than in the rest of the population (Zaret, 1980).

Increased incidence in psychopathology has been correlated with aging (as reported in the Group for Advancement of Psychiatry Report, 1970). Furthermore, Butler (1975) stated that 25% of all reported suicides are by the elderly. Such emerging conditions as these pose potentially significant problems to society in meeting the special needs of this growing population.

The lower levels of self-esteem and subsequent depression, as experienced by many of our elderly, may be partially attributed to cultural influences within our society that place such strong emphasis on youth and negative connotation on growing old. Zinberg (1975) found that cultural stereotypes of the aged person in our society have been quite negative and, hence, have provided a limiting influence on the personal growth of many aging persons in America. Consequently, it is not unreasonable that elderly persons should reject the fact that they are old, as was the finding in a ten year study by Boltena and Powers (1978) which employed 235 subjects of age seventy or older.

Major questions that may be addressed relevant to these ever growing problems might therefore include: (1) what is the nature of self-concept; (2) is there a link between self-concept and aging; (3) is there a possible link between self-concept and periods of depression in the aged; and, (4) how can such self-concept related problems be treated as to facilitate a higher quality of life for the elderly

in America.

William James (1890) was one of the first authors to discuss the importance of self-concept. Later, Alfred Adler (1924) was perhaps the first psychiatrist to address the subject. Adler developed a comprehensive theory concerning the construct of self-concept. Adler believed that people suffered from inferiority feelings. He was the first person to use the term "inferiority complex". He believed that individuals with severe inferiority feelings would display maladaptive behaviors such as aggression, avoidance, loss of social interest, and so forth. Adler believed that although all individuals experience feelings of inferiority, more healthy individuals overcome these feelings through engaging in productive activity, developing appropriate social interests and realizing their equality with other people.

Adler (1924, 1927) further stated that the manner in which a person interprets situations and events in their lives is critical in the determination of emotions and behaviors. Adler's position is pertinent to the nature and process of Rational Emotive Therapy (Ellis, 1962). Ellis (1977) cites two-hundred studies to support his position that cognitive thinking processes control emotions as well as other body processes--physiological and behavioral. From this perspective it can be seen that self-concept (ala Adler) may be viewed in Rational Emotive terms as statements or self-talk concerning one's views of self. Hence, it can further be postulated that such views of self can be modified positively when subjected to cognitive therapy.

Raimy (1975) discusses self-concept in a functional vein by stating: "The self-concept not only organizes and guides behavior, but also requires significant modification for successful psychotherapy." Raimy further emphasizes that misconceptions about self are primarily associated with pathology and must be changed in the direction of greater accuracy where reality is concerned. Raimy discusses the development of self-concept from a cognitive point of view and refers to Ellis as the leading current proponent.

In addition to self-concept, depression has been discussed as a major difficulty relevant to aging. The incidence of depression among the aged in our society is estimated to be between two and ten percent for aged individuals over 60 years (Gurland, 1976). When considering the prevalence of depressive symptoms, including somatic complaints, persons over 65 have been found to manifest greater amounts of depression than younger persons (Gurland, 1976). Perlin and Butler (1963) state that depression is, in fact, the most common complaint among otherwise healthy residents of communities for the elderly, with respondents indicating that they have more frequent and more disruptive episodes than earlier in life. The prevalence of depressive

symptoms is even greater among those elderly persons who have chronic health problems. For example, approximately 50% of cardiac patients manifest significant degrees of depressive symptoms (Dovenmuchle and Verwoerdt, 1962).

Periods of depression can lead to a high rate of successful suicide among the aging. There have been consistent reports of such high suicide rates among the elderly. For example, in 1970, the suicide rate for the population as a whole was 11.6 per 100,000, while the suicide rate for persons over 65 was 36.9 per 100,000 (Vital Statistics, 1974). A peak in the suicide rate occurs between ages 80-84 where the suicide rate is 51.4 per 100,000 (Pfeiffer, 1977).

About 5% of the people over sixty-five live in institutions at any one time; however, aging individuals have a 20 to 25 percent chance of being institutionalized at some point during their later years (Johnson and Williamson, 1980). With this consideration in mind, one can postulate the need for a comprehensive program in dealing with the mental health needs of aged persons.

A comprehensive technique for the facilitation of enhanced self-concept is Rational Stage Directed Hypnotherapy (Howard, 1979). In this modality both cognitive restructuring techniques and relaxation with imagery are used as psychotherapuetic change agents (Tosi and Marzella, 1975). This therapeutic package, sometimes referred to as cognitive experiential therapy, utilizes hypnosis and hypnotic

imagery and has already been shown to be an effective psychotherapeutic technique with both clinical and non-clinical disorders. In this study, the Rational Stage Directed Hypnotherapy approach will be modified for application to the treatment of self-concept and depression with aging nursing home residents. For purposes herein, the use of therapeutic stages (an important component of the RSDH Paradigm) has been de-emphasized. Awareness and exploration stages, however, have been utilized in this study (see the section on Rational Stage Directed Hypnotherapy in Chapter II).

NEED FOR THE STUDY

The study of viable and effective techniques for treatment of self-concept and depression in the aged can have long range effects on the quality of life experienced by our rapidly growing population of elderly persons. Zarit (1980) points to the need for psychotherapies and mental health delivery techniques to be used with the aging. Seligman (1975) discusses the importance of maintaining a positive self-concept in the elderly since drastically lowered self-concepts (due to loss of loved ones and loss of importance through work) may make a significant contribution to a form of depression he discusses as learned helplessness.

A question that might be posed is whether a treatment modality can be effective in changing self-concept over a

very limited number of sessions. Fitts (1972) has stated that changes in self-concept are difficult to effect. He states that a person's self-concept, which is developed over a lifetime, does not readily change.

Raimy (1975) states that if a therapeutic approach is successful, it creates its success through modification of the cognitions. He states that one of the most important problems in personality research is that of whether selfconcept change does occur during therapy. By means of a study wherein Rational Stage Directed Therapy was successfully applied to a population of adolescent delinquent females, Reardon (1976) positively answered the research question of whether short-term intervention can significantly and favorably alter self-concept. Later, Howard (1979) demonstrated that short-term intervention with Rational Stage Directed Hypnotherapy could significantly and favorably alter self-concept in athletes.

Given the success that appears to have been realized by use of a cognitive experiential approach in the treatment of self-concept with various youth oriented populations, the questions that arises with respect to this study concerns the effectiveness of a short-term therapeutic intervention (Rational Stage Directed Hypnotherapy) in the treatment of both self-concept and depression with the elderly. The RSDH approach seems particularly applicable for use with this aged population because it is designed to teach skills of thinking which can give the elderly more control over their environment. This technique appears to provide a positive alternative to other therapies used with the elderly, in that this technique utilizes the protection of a highly non-threatening state by which to examine past irrational behaviors and practice new ones.

PURPOSE

The purpose of this study is to examine the effects afforded by treatments with Rational Stage Directed Hypnotherapy (RSDH), hypnosis only (HO) and cognitive restructuring only (CR) on levels of self-concept and depression of a geriatric nursing home population. The major research question is whether the application of RSDH, HO and CR can significantly improve self-concept and lower levels of depression as measured by the Tennessee Self-Concept Scale Total P Score and the Depression Scale of the MMPI.

HYPOTHESES

The hypotheses for this study are as follows:

- H₀: Means across groups (RSDH, HO, CR and C) representing self-concept and depression, as measured by the Tennessee Self-Concept Scale Total P Score and the Minnesota Multiphasic Personality Inventory Depression Scale, will not differ significantly across the pre-test, post-test I and post-test II measurements.
- H1: Means representing self-concept and depression will be statistically superior for the RSDH group as compared to the HO, CR and Control groups across pre-test, post-test I and posttest II measurements. Furthermore, the effects

of CR and HO will be superior to the Control group across testing trials.

LIMITATIONS OF THE STUDY

This study contains the following limitations:

- (1) This study is limited to a sample of thirty-two geriatric residents of the Heritage House Nursing Home. The sample subjects were totally of Jewish ethnic origin and consisted of thirty females and two males. In no way is this sample considered representative of either a local, regional or national nursing home population.
- (2) Due to the fact that the study included only thirty-two subjects (four groups with eight subjects per group), there may be statistical limitations to the findings of this study.
- (3) Due to factors beyond control of the researchers (see Chapter 3), certain problems with the total randomization of treatment group assignments were encountered, further presenting possible problems to statistical analyses.
- (4) Due to the poor physical condition of some of the subjects, it was deemed necessary and appropriate to conservatively limit the extent of testing to be conducted. As a result of this constraint, measurements were limited to the Tennessee Self-Concept Scale and the Depression Scale of the

MMPI. A further limitation may have been posed by the fact that all items had to be read to subjects and the responses manually recorded by an examiner. This was necessary due to the fact that the majority of subjects had significant visual difficulties.

DEFINITION OF TERMS

The following definitions are provided as an aid to the reader to a more complete understanding of terms used throughout this dissertation:

Self-Concept:

Self-concept, as operationalized in this study, is that construct which is measured by the Tennessee Self-Concept Scale Total P Score. Scores which are more elevated over test-time measures are considered to be reflective of an enhancing self-concept, while a decrease in scores reflects a deterioration of self-concept.

Depression:

Depression is operationalized in this study as that construct which is measured by the Depression Scale of the MMPI. Scores which are more elevated over test-time periods are considered to be reflective of an increase in depressive symptoms, while a decrease in scores reflects a decrease in depressive behaviors.

Rational:

Rationality is a dynamic concept based on the idea that logical correct thinking behaviors, relative to a given set of data or facts, lead to more positive and appropriate emotions, physiological responses and behaviors. Multsby (1971) identified the following criteria of rational thinking:

- Rational thinking processes are based on objective reality.
- 2. Rational thinking processes tend to minimize personal stress.
- 3. Rational thinking processes tend to minimize environmental stress.
- 4. Rational thinking processes are engaged in the preservation of life.
- 5. Rational thinking processes tend to help one attain his/her goals.

Rational Stage Directed Hypnotherapy:

Rational Stage Directed Hypnotherapy is a stage oriented directive psychotherapeutic technique which utilizes hypnosis/relaxation and guided imagery to help the client re-condition negative or uncomfortable cognitive, affective, physiological or behavioral states. It is based on the premise that individuals have cognitive control over these aforementioned states. Cognitive restructuring skills are taught and reinforced via guided imagery during hypnotic/relaxation periods.

Cognitive Restructuring:

A therapeutic approach in which irrational thoughts and beliefs are identified, challenged and finally replaced with more rational beliefs and attitudes. This approach assumes high cognitive control over behaviors and points out that negative feelings and behaviors are associated with irrational thinking patterns (Ellis, 1962).

Hypnosis/relaxation:

A heightened level of attention, relaxation and awareness which is produced by leading the subject through an induction process composed of the following four parts (Wolberg, 1964):

- 1. Deep breathing
- 2. Cognitive muscle relaxation
- 3. Imagining a relaxing scene

4. A deepening procedure through counting

Guided Imagery:

A verbal description of a situation accompanied by a variety of suggestions leading the subject, via imagination and mental imagery, to subjectively experience/participate in a structured fantasy. Via such imaginative processes, the subject is often able to safely encounter imagery evoked feelings within the protective sphere afforded by a highly relaxed state.

CHAPTER II

REVIEW OF RELATED LITERATURE

The major issue addressed in this study focuses upon the effectiveness of Rational Stage Directed Hypnotherapy, Hypnosis Only and Cognitive Restructuring Only on the modification of self-concept and depression in a geriatric nursing home population. A review of the literature contained within this chapter will include the following sections: (1) self-concept and aging; (2) measurement of selfconcept; (3) depression and aging; (4) measurement of depression; (5) relaxation therapy and hypnosis; (6) cognitive therapy; and, (7) Rational Stage Directed Hypnotherapy.

SELF-CONCEPT AND AGING

Much of the recent literature in the area of aging addresses the problems connected with the self-concept of the aging individual and how that self-concept affects the lives of such persons. The following section will discuss the issues, results and findings relative to this literature.

There is evidence, that despite the negative emphasis on the aging process in our culture (see Chapter I), elderly persons may not always accept such a negative connotation

of their life period. In a study by Brubaker and Powers (1976), it is reported that whether the elderly would accept the culture's negative view of the aging process may be dependent upon their subjective definition of the self and their individual self-concepts. Therefore, self-concept would have a large bearing on the person's perception of their developmental life 1 ... d and their acceptance of it.

There is some further evidence in the literature to suggest that the elderly are more acceptant of their developmental period if they identify with their age group as a subculture of peers. Ward (1977) found that there was a positive relationship between aging "group conciousness" and self-esteem. According to these findings, the elderly might be helped to raise self-concept if they are sensitized to an awareness of their age group and are provided opportunities to identify with its members.

Negative self-conceptions in the aged appear to be due to a variety of reasons which are "almost too obvious to mention" (Schutz, 1980). According to Schultz, aging is characterized by losses in almost every domain important for an individual's view of themselves. These include such areas as: decline in physical and psychological functioning--need for stronger eyeglasses and hearing aids; possible loss of personal autonomy; loss of friends and relatives through death; and, loss of importance through work. Seligman (1975) reports that due to losses of such things as physical health, autonomy and important others through death, a state of "learned helplessness" may manifest wherein the aging individual begins to experience a lowered view of self and possible depressive tendencies. Such self-conceptions may culminate in increased physical illness, severe depression and early death.

With the recent emphasis on the importance of a healthy self-concept in the elderly--in order to help the aged experience fewer negative emotional effects and thus enhance their quality of life--it may be useful to examine the literature concerning self-concept in general. Discussions concerning self-concept (or images and thoughts about self) have existed in the literature for some time. Raimy (1975) suggests that current conceptions of the self-concept have evolved from a variety of cognitive approaches to human behavior. Homme (1965) also discussed the conflict between the "real self" and the "ideal self" and pointed out the disturbance caused by setting unrealistically high selfstandards. Historically, a discussion of self-concept begins with William James (1890, 1910), who discussed the complex nature of the self-concept by describing what he called the Empirical Self (the self that is known) and its parts: the material me (body); the social me; and, the spititual me. In his book entitled, Psychology: The Briefer Course, James (1910) writes of self-concept as follows:

"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 ...a puny fellow, however, whom everyone can beat ...so our self-feeling in this world depends entirely on what we back ourselves to be and do."

In more modern literature Horney (1950) discusses the concept of a clash between the "real" and the "idealized" self-image. However, perhaps Alfred Adler (1933, 1958) was the first writer to formally elaborate a cognitive perspective on self-concept. Adler states that perceptions and interpretations of events in an individual's world are critical determiners of emotion and behavior. Adler (1933) states, "In a word I am convinced that man's behavior springs from his ideas." He suggested that behavior could be understood if one determines how the individual "comes to know" and represent the surrounding world.

Adler's conceptions about self-esteem and human behavior are highlighted by his own statement: "An individual with a mistaken opinion of himself and the world, that is with mistaken goals and a mistaken style of life, will revert to various forms of abnormal behavior aimed at safeguarding his opinion of himself when confronted with situations which he feels he cannot meet successfully, due to his mistaken views and the resulting inadequate preparation (Ansbacher and Ansbacher, 1956)."

Perhaps the first writer to exclusively address

"self-concept" as an important psychological construct was Raimy (1943) in his doctoral dissertation entitled: The Self-Concept as a Factor in Counseling and Personality Or-In this original work, Raimy examined the reganization. lationship between negative and positive self-referring statements and pathology. His findings were that higher functioning individuals tend to have a larger number of positive self-referring statements in their behavioral repertoire than do lower functioning individuals. In a later work, Raimy makes a definitive statement on self-concept which he refers to as the "misconception hypothesis" as follows: "If these ideal conceptions of a client or patient which are relevant to their psychological problems can be changed in the direction of greater accuracy where his reality is concerned, his maladjustments are likely to be eliminated." The reality to which Raimy refers in the above statement is for Raimy the "individual's reality". and not objective reality. According to Raimy, the individual's reality consists of all the information of which the individual is aware. Raimy believes that individuals may "ignore certain aspects of their own knowledge," and, by twisting the information that they have placed in repression or suppression, they may distort their own reality. It is the "misconceptions of self" within the individual that Raimy discusses as being central to maladjustment. Raimy (1948) states that the self-concept (self-image or

empirical self) not only organizes and guides behavior, but also requires significant modification for successful psychotherapy.

The above literature points to the crucial importance of attending to self-concept relative to treating for positive mental health outcomes. With this in mind, the discussion now focuses on the population of concern for this study and examines factors relative to the facilitation of positive change in the self-concept of the elderly.

Among the literature, discussing hypotheses of factors that could aid elderly persons to increase self-concept and self-esteem, Harris (1975) poses that the physician may have a very important role in helping increase an elderly person's self-concept. He states that the physician can contribute to this process through: (1) interpersonal and professional relations with the patient; (2) interpersonal relationships with the family; and, (3) relationships with health care delivery systems. Harris states that through the above actions by the physician, the elderly patient's identity is enhanced by the physician's concern over such psychological factors as: the patient's adaptation, coping, responding mechanisms, goals, life styles, and behaviors. Harris further reports that negative physician factors include lack of skill and motivation in dealing with older people and negative attitudes towards aging.

Another study by Trimakas and Nicolay (1974) examined the role of continued activity (in particular altruistic activity) as a factor in the restoration of a higher selfconcept in the aging. They found that high self-concept elderly were more altruistic than low self-concept elderly. Results of this investigation suggest that a program which could help the elderly give time and attention to others may also help increase self-concept. In this same vein, Payne (1977) proposed a model to be used with the elderly for the enhancement of self-concept which included role continuity, satisfaction and new social support systems.

The type of environment in which an individual lives appears to influence the self-concept. Gordon (1976) states that environments which seem to help the elderly enhance their self-concepts are those within which there is little discrepancy between the ideal-self and the perception of the environment. Schultz (1976) found in a study with institutionalized elderly that self-esteem is enhanced by an environment which is highly predictable, and over which individuals feel they have a high degree of personal control. In a similar study, Langer and Rodin (1976) found that feelings of control and predictability relative to the environment, not only enhanced the psychological wellbeing of institutionalized elderly, but also had a positive effect upon health.

Other areas which appear to affect self-concept of

the elderly concern life satisfaction and perceived meaning in life. In this area, Czaja (1975) found that those individuals who felt that they experienced meaningfulness and satisfaction in their lives also demonstrated a relatively small discrepancy between their "real" and "ideal" selfconcepts. Such meanings or "importances" seem to be related to different factors for elderly men, as opposed to elderly women. Women tend to shift their self-image from their "relationship toward others" to their own abilities and feelings. Back (1971) reported that since women are freed from family obligations, they feel they can be more easily accepted for what they are. However, he reports that men tend to be so heavily invested in their career roles over a lifetime, that they experience difficulties leaving such roles when forced to do so by the influences of aging. It can be concluded from such findings that it may be important to provide alternative activities and interests to the elderly in order to foster and maintain a positive selfimage throughout their developmental period.

Some literature discusses the special problems of selfesteem relative to those elderly who are confined to an institutional setting. Fielding (1979) states that when an elderly person enters a nursing home or hospital they have usually already suffered various substantial losses including: death of a marital partner; loss of personal health; loss of membership in formal or informal organizations; and, loss of income due to retirement. With entry into the particular institution, the elderly person must adjust to still another trauma--loss of independence. Kuypers and Bengston (1973) refer to a "social breakdown syndrome" in which elderly individuals, who are seen by the staff of the institution as being incapable of caring for themselves, gradually become molded into the dependent role of the senile old patient.

Zarit (1980) further discusses this problem by stating that staffs in nursing homes often provide care beyond what is needed by the patient (for example, dressing or feeding patients who could do these things for themselves). The result of excess care is that the patient is reinforced for being dependent, develops a lowered self-concept and begins to manifest an excess of disabilities which may not have appeared in a more independent situation. Therefore, one can see the need for a program of mental health which promotes control and independence in the individual (to the extent that the individual can physically handle such independence) and which fosters enhanced self-concept.

In light of the above findings, perhaps it would be useful to ask the question of whether self-concept, or the way in which individuals typically view themselves, can be changed. Kimmel (1974) states that ratings in self-concept appear to be relatively stable over time. Another study by Woodruff and Birren (1972) confirmed Kimmel's findings

and agreed that self-concept was a highly stable construct over time. However, whether this stability of self-concept is shown to persist among the aged is not known (Zarit, 1980). One study by Schwartz and Kleemeier (1965) suggests that illness may have a dramatic effect on self-descriptions. In this study both young and old subjects were asked to describe themselves on the Osgood Sematic Differential. Each age group of individuals included 25 persons in good health and 25 persons with significant health problems. Results disclose differences in self-description between healthy and ill subjects, but not between young and old subjects when controlled for by health. For the aged, these findings suggest changes in a personality variable(s) due to illness.

MEASUREMENT OF SELF-CONCEPT

With the growing importance in the notion of self-concept throughout the psychological literature, an ever increasing number of instruments have been developed to measure the self-concept. Wiley (1961) identified over twohundred such instruments which had been developed up to 1960 alone.

Such instruments have been constructed to measure various aspects and components of the self-concept. For example, Mason (1954) constructed an instrument which examined whether self-concept contained positive or negative affect.

Leforge and Scuzek (1955) originated the <u>Interpersonal</u> <u>Check List</u> which generated three scores: (A) a self-description score; (B) an ideal self score; and, (C) a measure of "self-acceptance" which is derived from discrepancies between the "self" and the "ideal self." Brownfain (1952) measured the consistency or stability of self-concept over time. Other studies have concerned self-acceptance (Fey, 1957) or satisfaction with body parts (Jenraed, 1953).

As with many psychological instruments, self-concept tests present a number of problems. Fitts (1971) states that the population to which these test can be applied are often limited by the difficulty of items, the vocabulary used, and the mechanics of the answer sheet. Fitts (1965) developed the <u>Tennessee Self-Concept Scale</u> (TSCS) in an effort to deal with some of the existent problems afforded by previously constructed instruments. A complete discription of this instrument is provided in Chapter III.

Fitts (1972) discusses the use of the Tennessee Self-Concept Scale in the measurement of self-concept with the elderly. He reports that previous studies utilizing this instrument with aging populations have disclosed numerous characteristics found in the typical profile of an aged individual. These characteristics appear to be rather consistent across represented aging samples. In regards to these research findings, Fitts reports that the groups show consistently low self-criticism scores and high DP Scores,

indicating defensiveness in self-report. He states that the P scores for this population are generally above average, except for the fact that Column A Scores are generally below the norm. In addition, most groups show elevated Row 2, Column B and Column E scores. These scores indicate that elderly people generally view themselves as less adequate in terms of physical self, but are above average in overall self-esteem. Many elderly persons in these samples show particular strenghts in self-satisfaction, in moralethical self and in social self. Fitts further reported that the Empirical Scale Scores for these elderly people are generally deviant, with frequent elevations in DP, Psy and NDS. In general, Fitts reported that the standard deviations for almost all TSCS scores for this elderly population are higher than those for the TSCS norm group. This finding indicates that among these elderly people, there is a great deal of variation in TSCS scores, with scores that are much more diverse and heterogeneous than those of the norm group. Refer to Chapter III for a complete description and explanation of the above TSCS scores.

DEPRESSION AND AGING

The most prevalent emotional disturbance in the population of persons sixty-five and older is depression (Fassler, 1978). In fact, depression is such a frequent symptom in the aged that it can be considered "a character-

istic of senescence" (Epstein, 1976). The management of depression is seen to be of urgent concern to professionals in the mental health field due to the rising number of persons in the sixty-five and older age group (Zarit, 1980). These people find themselves in a transition period during which they begin to experience physical changes in their bodies and also in their environment. These changes, which aging persons may perceive as being beyond their control, may contribute to underlying factors in the development of depressions (Zarit, 1980).

It is for these reasons, that it is deemed important to examine related literature in the area of depression and aging for the purpose of attempting to determine appropriate intervention strategies or preventative measures.

Historically, definitions of depression in modern psychology begin with Freud and the school of psychoanalysis. Freud (1917) describes depression as hostility turned inward. He discusses the state of depression as "a painful degree of dejection" in which the individual displays certain patterns of behavior including somatic type symptoms such as insomnia, crying, psychomotor retardation or agitation, loss of appetite, disturbances in the gastro-intestinal tract, generalized aches, weakness and fatigue, poor posture, down cast expression and a slowing of speech. Abraham (1911) published what may be considered the first psychoanalytic investigation of depression. In that work
he describes depression as a regression to the first psychosexual or oral phase of development. He specifically states that the predisposing factors of depression include: (1) a constitutional factor in regard to an overaccentuation of oral-eroticism; (2) a special fixation of the libido at the oral level, manifested by disproportionate grievance when confronted with frustration, and an over-utilization of oral activities (sucking, eating, etc.) in everyday life; (3) a severe injury to infantile narcissism brought about by successive disappointments in love that lead to a childhood prototype of depression called "Primal Parathymia"; (4) the occurrence of the first important disappointment in love before the Oedipal wishes have been overcome; and, (5) the repetition of the primary disappointment in later life. Abraham (1924) presents his final position on depression in the following quote: "When melancholic persons suffer an unbearable disappointment from their loveobject they tend to expel that object and to distroy it. They thereupon accomplish the act of introjecting and devouring it--an act which is a specifically melancholic form of narcissistic identification. Their sadistic thirst for vengeance now finds its satisfaction in tormenting the ego-an activity which is in part pleasurable."

Kraepelin (1921) added the category of manic-depressive illness to the disorder of depression. He further distinguished four major subgroups: depressive states, manic

states, mixed states and fundamental states (disorders of mood experienced between, before or as replacing manic-dep-ressive attacks).

A revision of the psychoanalytic theory brought about by the effect of structural theory on psychodynamics was most thoroughly described by Rado (1927). In this paper Rado discusses depression and mania in terms of the interlocking relationships between the ego, the superego and the love object. He states that prior to the onset of an episode of depression, the individual displays a period of arrogant and embittered rebellion. Rado explained this period as typical (although an exaggeration) of the depressive manner of treating the love object during healthy intervals. He reported that as soon as the depressive is sure of the other's love, he treats his beloved with a "sublime nonchalance", gradually progressing to a domineering control of the love object. This behavior may ultimately push away the love object and when this occurs, the individual lapses into a depression.

Adler (1924) presents the culturalist view of depression. According to this view of depression, it is assumed that individuals have learned to utilize their weaknesses and complaints in such a manner as to force others into giving them their way. In this manner, they successfully avoid life's responsibilities. Therefore, by means of bemoaning type behaviors, depressive persons force others

to comply with their wishes, extorting sympathy and enticing others to sacrifice themselves to their welfare. The depressive may be willing to go to great expense and effort to prove how sick and disabled they are, and to escape from social obligations.

Seligman (1975) added a further dimension to the concept of depression in his discussion of learned helplessness. He reports documentation of many similarities between symptoms of depression in humans and learned helplessness in animals. Seligman's theory emphasizes that where there is an expectation that an outcome is independent of any possible response that might be made, there is a reduction in motivation to control the outcome. Seligman further states that if the outcome is traumatic (inescapable shock), it produces fear for as long as the subject is uncertain of the uncontrollable nature of the outcome. This fear is then followed by depression. Seligman concludes that there are six symptoms of learned helplessness and that each of these symptoms parallel depression. The six symptoms Seligman discusses are as follows: (1) reduced initiation of voluntary responses; (2) negative cognitive set (difficulty in learning that responses produce outcomes); (3) persistence over time; (4) reduced aggressive and competitive reponses; (5) loss of appetite, weight and libido; and, (6) physiological changes (including biochemical changes).

A more cognitive-behavioral approach to the definition

of depression is put forth by Beck (1967). He argues that depression may be due to accompanying disturbances in thinking. He believes that representing depression as a purely affective disorder is as misleading as it would be to designate scarlet fever as a disorder of the skin. Beck (1967) recognizes five components of depression as follows: (1) a specific alteration in mood (sadness, loneliness, apathy); (2) a negative self-concept (with self-reproach and selfblame); (3) regressive and self-punative wishes (desires to hide, escape or die); (4) vegetative changes (anorexia and loss of libido); and, (5) change in activity level (retardation or agitation).

In view of the overall importance these writers have placed upon the construct of depression and its effects on the individual, the focus of this review now turns to the literature concerning depression and the aged.

Various writers have explored some of the possible reasons for depression in the elderly. Willner (1978) cites that loss of important others is a chief reason for the depressive syndrome found in the elderly who seek help. He states that they come to therapy trying to overcome their feelings of helplessness and hopelessness. He reported that although there may be some question as to which methods are best employed for the treatment of the elderly, there is no question as to whether they should be treated. He further states that the strenghts and abilities of the aged have been tested and are not found to be as fragile as is commonly believed.

McKenzie (1980) states that the aging period is the developmental phase during which most stress occurs in a person's life. This is due to the change in life-style and to the possibility (or reality) of finding it necessary to depend on others. Such stress might also be seen as related to factors such as the death of significant others who may constitute all or part of one's personal support system. A further, but similar, stress related factor may merely include the loneliness that stems from such losses.

Further examination of psychological distress and its causes in the elderly was completed by Abrahams and Paterson (1978). They conducted a survey of 445 elderly persons living in predominately blue collar New England towns. Findings indicated that vulnerability to the stresses of aging would increase with the existance of habitual patterns of dependency, poor interpersonal skills and lack of social initiatives. It was further found that mental health services were not reaching many of the elderly in need and that there was minimal utilization of other types of helping services.

In a study by Wetzel (1978) it was indicated that the elderly appear to be more susceptable to depression if they are dependent on sustaining environments. In this study, Werzel hypothesized that the elderly would be more depressed

if they perceived their environment, upon which they were dependent, as not meeting their needs. The study found that the most depressed subjects were those who were dependent and in environments which did not meet their needs. This study further found that independent subjects in unsustaining environments also displayed depressive symptoms.

Zarit (1980) reported that another major cause of depression in the elderly was due to the gradual loss of physical health and the onset of chronic diseases.

Depression among institutionalized elderly may be particularly problemmatic since such institutionalization entails a change in living environment and life style (Zerit, 1980). Several studies in the literature discuss this phenomonon. Among this literature is the social psychological studies on control and depression.

Wolk and Telleen (1976) looked at the social correlates of life satisfaction as a function of residential constraint. They attempted to measure life satisfaction, developmental task resolution, self-acceptance, perceived autonomy, activity level, health, educational levels and levels of depression. Findings indicated that enhanced self-concept and perceived autonomy effected significantly lower levels of depression and higher levels of life satisfaction within less constrained environments.

In a study by Langer and Rodin (1976) it was found that the level of perceived personal control is an important factor relative to newly admitted nursing home patients. Those subjects who believed that they had higher levels of personal control over their environment displayed higher levels of self-concept, lower levels of depression, more participation in activities, greater expression of life satisfaction and fewer manifestations of physical illness.

In still another study investigating the topic of control and depression, Hanes and Wild (1977) administered a self-rating depression scale to forty-eight noninstitutionalized persons who were sixty to eighty years of age. Their results indicate that depression was associated with external locus of control orientation. Their overall findings support Seligman's (1975) hypothesis that depressives perceive themselves to lack personal control and they therefore feel helpless.

The treatment of depression with the elderly is becoming an increasingly important issue, what with the growing population of elderly persons in the United States. Many elderly who are admitted to nursing homes experience deep depressions due to their change in environment. Literature concerning the treatment of depression in the aged is therefore of considerable interest for determining optimal treatment modalities.

Power and McCarron (1975) investigated an interactivecontact method of alleviating depression with a residential geriatric population confined to a nursing home. A fifteen week treatment consisted of establishing physical contact, evoking communication and initiating the subject's interaction with their fellow residents. The findings indicated that the method significantly effected a reduction in selfreported and observed depression. They report that further research with these methods would be useful with other geriatric populations.

Ban (1978) suggests that depression in a geriatric group may be genetically different from depressive disorders in a younger group. Ban suggests that genetically based biological changes are more frequently associated with late-onset depressions. Therefore, Ban proposes that depression in the aged should be completely examined in order to determine whether chemical and/or psychological treatment should be employed.

Structured fantasy was used by Willis (1976) as an adjunctive technique for the treatment of depression with an aged population. With this technique the subject could explore the thoughts and beliefs that comprised their depressive fantasies. After exploring these systems the person could then replace their depressive systems with non-depressive systems.

Lewinsohn et al. (1976) describe a treatment approach for use with the elderly that follows a cognitive-behavioral paradigm. In their approach, the individual is first involved in activities which they find pleasurable, but in

which they have not been engaged for some time. Secondly, cognitive intervention is made so as to help the individual firmly associate the positive feelings with the activities.

Beck (1976) and Ellis (1962) emphasize treatment of depression in the aged by use of direct training to change the person's cognitions and behaviors. They describe the process of challenging and pointing out to the person ways in which their thoughts are incorrect or irrational. Through extensive repetition they attempt to modify such thoughts, with the result that an individual does not take commonplace events as suggesting one's lack of worth and ability.

Through examination of the above relevant literature, it can be seen that depression in the elderly is a major problem and that the identification of an effective treatment modality can be of considerable value for use with geriatric populations.

MEASUREMENT OF DEPRESSION

A number of instruments have been developed to measure depression. Gregory and Smeltzer (1977) discuss Beck's Depression Inventory and the Hamilton Depression Scale as being instruments which correlate .75 with the Depression Scale of the Minnesota Multiphasic Personality Inventory (MMPI). Gregory and Smeltzer believe that the above mensioned measures are among the best in the clinical assessment of depression, however, they emphasize that the Depres-

sion scale of the MMPI is by far the most utilized instrument in the measurement of depression.

However, studies restricted to the exclusive use of the MMPI Depression Scale (depression items presented alone) are not plentiful in the literature. Endicott and Endicott (1963) support the use of the MMPI Depression Scale relative to their finding that it provides an excellant index of momentary depressive levels. In another study, Zung (1967) reported that the Depression Scale correlates well with self-ratings of depression on a measure which Zung developed at Duke University.

Due to the widely reported application and acceptance of the MMPI in the measurement of clinical disorders (including depression), the Depression Scale of the MMPI was selected for use in this study. Further elaboration relevant to this instrument can be found in Chapter III of this text.

HYPNOSIS/RELAXATION THERAPY WITH THE AGED

Studies in the area of relaxation therapy/hypnosis with aged populations are not prevalent in the literature. However, there are some authors who address these issues and point toward its positive contribution in the treatment of mental health problems with the elderly. A review of these writings is presented in the following paragraphs.

Kroger (1977) reports that post hypnotic suggestions

in responsive elderly persons can effectively raise confidence and help direct thoughts from concerns of self to external events. By doing this, Kroger believes that depressive reactions and hypochondriasis can be significantly reduced. He further states that suggestions can help establish closer interpersonal relationships and help the elderly deal with their hostility over physical ailments and jealousy of younger and more agile persons.

Kroger (1977) states that: Definitive suggestions potentiated by hypnosis can be directed to: (1) taking an interest in the plans of younger persons (in this way the tragedy associated with the loss of friends or a mate is reduced); (2) developing avocational interests concerned with creativity, the acquisition of special motor skills, and cultural activities; (3) exercise such as walking as much as possible; (4) watching the diet and the weight; (5) correcting elimination; (6) overcoming insomnia; and, (7) physical involvements, such as cardiac congestion, arthritis, and neuromuscular involvements." From Kroger's statements it can clearly be seen that he believes that hypnosis can be effective in treatment of psychosomatic symptoms in the elderly, as well as in the treatment of purely psychological disorders.

Agras, et al. (1980) report significant effects of relocation training on the lowering of blood pressure. In this study hypertensive subjects, four males and one female

(with a mean age of sixty-two years) were monitored on a 24 hour basis for six experimental days. This included a notreatment baseline, three days of relaxation training and one day of recovery. Findings indicated that a lowering of both systolic and diastolic blood pressures persisted during the relaxation therapy and continued beyond the culmination of the therapy. Moreover, systolic blood pressure was significantly lower during relaxation training than during either baseline or recovery days. This difference was particularly noticeable at night when patients were sleeping. Since blood pressure has been found to be affected by the presence of psychological concerns (Brady, Luborsky and Kron, 1974), the results of this above study with the aged indicate that relaxation training may be a very effective therapy for use with the elderly.

COGNITIVE THERAPY

Cognitive therapy has a very rich historical background. This background, along with current trends, research and applications with the aged, will be discussed in this section.

The ancient stoic philosophers of Greece and Rome were probably the first on record to discuss the rational concepts of cognitive psychological theories. Among these figures were such names as Zero of Citium, Marcus Aurelius and Epictetus (Watson, 1978). The clearest representation of their ideas was represented by Epictitus (1899) in his remark: "Men are disturbed not by things, but by the views they take of them." Later, Shakespeare in <u>Hamlet</u> wrote: "Things are neither good nor bad but thinking makes it so." Still another powerful figure of the seventeenth century, Decartes (Watson, 1978), began his philosophical argument with the quote "cognito sum est" (I think, therefore I am). With this philosophy, Decartes is thought by many to be the father of existentialism. Cognitive philosophy can also be found in the words of Spinoza (Watson, 1978) who declared that things did not disturb him, save the effect they had on his mind.

In more modern psychological history, Freud (1900) discusses the concept that psychic structures are causal factors of human behavior. Later, Adler (1933) stated: "In a word I am convinced that man's behaivor springs from his ideas." This statement clearly demonstrates the influences of cognitive philosophy in Adler's beliefs.

Contemporary psychological theorists have incorporated cognitive philosophies into therapeutic approaches. Kelly (1955) developed what he called "Fixed Role Therapy". In this approach the clients adopt new cognitive, affective and behavioral roles.

An approach which is similar to Kelly's "Fixed Role Therapy" is Rational Emotive Therapy (RET) which is presently the most popular from of cognitive therapy (Ellis, 1977).

Ellis (1962, 1977) is the originator and founder of cognitive therapy (RET). His basic belief is that early learned, irrational, non-objective and magical beliefs account for a person's emotional and behavioral disturbances. In his model, he refers to the following three basic components which he believes are inherent in the development of an emotion: (A) the person becomes aware of an event or a situation in his/her environment; (B) the person thinks specific thoughts and has basic attitudes or beliefs about the situation at point (A); and, (C) the person experiences a resulting emotion or affective response. In this model the cognitions at point (B) are seen as directly responsible for the emotive responses at point (C).

In his theory, Ellis (1977) discusses the existence of learned irrational beliefs that are common to most human beings within our culture. Among these are included: (1) I must have sincere love and approval almost all of the time from those persons whom I find significant; (2) I must prove myself thoroughly competent, adequate and achieving, or at least have real competence or talent in something important; (3) my emotional misery comes almost completely from external pressures that I have little ability to change or control; and, unless these pressures change, I cannot help making myself feel anxious, depressed, self-downing or hostile; (4) my past life influenced me immensely and remains allimportant, because if something strongly affected me it has

to keep determining my feelings and behavior today; and, (5) I desperately need others to rely and depend upon, because I shall always remain so weak.

There are several studies in the literature which explore the concept of cognitive control over emotional states. These studies include an investigation by Velton (1968) in which he studied the effect of mood change of self-statements read to the clients which were positive ("This is great...I really feel good"), neutral ("Ohio is the Buckeye State"), or negative ("I have too many bad things in my life"). It was found that there was a direct linear relationship between the change in the content of self-statements and the alteration of mood states. Among other findings in this area, Newmark (1973) found that neurotics endorse more irrational beliefs than do normals, and Goldfried and Sobocinski (1975) found that individuals experiencing heightened anxiety also endorsed more irrational content than individuals not experiencing such anxiety.

Cognitive ideas appear to be very important when attempting to understand the mental world of the aged. Zarit (1980) states that the tendency to view one's self in an exaggerated, negative manner may increase with age. He believes that some persons may come to view themselves in terms of the stereotypes of old age, and may become overly pessimistic about their own abilities and self-worth. The findings of Kahn et al. (1975) tend to support the above

notion, in terms of aging stereotypes affecting the older individual's perception of their performance. They report that depressed older persons rated their memory as significantly worse than non-depressed persons, even though memory tests indicated that there was no perceptable differences in memory between the two groups. It was suggested that other negative expectations about aging may lead to similarly distorted perceptions of one's abilities, with these self-assessments related to poor morale.

In this same vain, Lewinsohn and Libet (1972) integrated the cognitive and behavioral perspectives on depression in their development of the Pleasant Events Schedule, an instrument used for the assessment and treatment of affective disorders. The schedule consisted of 320 events and activities selected from the universe of potential pleasant events. According to Lewinsohn, et al., events most often associated with mood include: (1) laughing; (2) being relaxed; (3) thinking about something good; (4) being told I am loved; (5) learning to do something new; (6) smiling at people; (7) sleeping soundly at night; (8) complementing or praising someone; (9) expressing my love to someone; and, (10) being with someone I love. Lewinsohn and Libet (1972) had their subjects make two ratings of the items presented on this schedule. These include: (1) a rating of how pleasantly they perceive each activity to be; and, (2) a rating of how often they have engaged in the activity during the past

month. They found that depressed persons differ from nondepressed persons in two ways: (1) depressed persons report having engaged in fewer pleasant activities; and, (2) depressed persons indicate that they find fewer activities potentially enjoyable. Lewinsohn and Libet report that depressed persons may not perceive these activities as pleasurable due to personal beliefs which cause them to see themselves as worthless and undeserving of pleasure. In these results, it can be seen that cognitions appear to have an affect on emotional states.

Lewinsohn and MacPhillamy (1974) have investigated the responses of older persons on the aforementioned Pleasant Events Schedule. Findings indicated that the non-depressed aged rated the events in a comparable manner to younger persons. However, in contrast to the young, these older people engaged in fewer activities that they perceived as potentially enjoyable. This lower rate of engaging in enjoyable activities does suggest reasons for the transient feelings of depression prevalent in the aged, and why older people may be vulnerable to depressive episodes.

Lewinsohn et al. (1978) conducted a study utilizing a treatment approach which involved both cognitive and behavioral procedures. The study was based on assessments made with the Pleasant Events Schedule along with other instruments. They found that engaging in activities that the subject views as enjoyable, but in which they have not participated for some time, results in an improvement of mood. Where the individual did not perceive activities as potentially enjoyable, the researchers intervened with cognitive based intervention techniques to help the person see potential gains from participation, and to help the person associate positive feelings with involvement in such activities. The cognitive procedures employed were those described by Beck (1976) in the treatment of depression by anlysis and restructuring of thoughts. Findings indicated that this treatment significantly helped reduce depression in these older persons.

Beck (1976) emphasizes the use of direct training to help the elderly person change cognitions and behaviors. Beck uses techniques related to Ellis's Rational Emotive Therapy (1962). In this, Beck describes a process of challanging a person's thoughts and pointing out to them ways in which their incorrect and irrational thoughts affect their emotions and behaviors. Through extensive repetition, Beck attempts to modify these thoughts so that the person learns to think more rationally and becomes less depressed.

Zarit (1980) also believes that the use of cognitivebehavioral approaches in the treatment of mental disorders with the elderly is very effective. He cites two cases in which cognitive techniques were successfully employed with aged individuals. Zarit (1980) writes concerning one of these cases as follows:

"Mrs. B. reported many examples of negative, self-defeating thoughts, and the treatment approach was largely cognitive. Mrs. B. was a 74 year-old widow who was moderately active, but often came away from activities feeling more depressed than when she started. As an example, if she did not get a response from someone at senior center when she initiated a conversation, she concluded that no one would ever be her While engaging in an activity she enfriend. joyed, she would be thinking of unpleasant things, including that she did not deserve to have any pleasant experiences, and she would come away from the activity feeling sad. Counseling involved helping her identify these negative thoughts and helping her to identify more positive self-statements. Mrs. B. responded immediately to the idea that her depression was the result of pessimistic thoughts, and she showed rapid improvement."

Zarit (1980) further advocated the use of cognitive-behavioral approaches for use with older persons in group therapy. He suggests that group treatment offers advantages for cognitive therapy in that the group setting can provide immediate reinforcement of clients by peers, opportunities for modeling appropriate behaviors of several persons and effective opportunities for the employment of role-playing. Rose (1977), in describing a behaviorally oriented group, stresses first helping clients to formulate specific goals and actively take greater responsibilities. Rose states that older persons may need additional assistance in establishing goals during initial stages of therapy, but that as clients learn to control thoughts, attitudes and behaviors, they will be able to gradually assume more responsibility in the area of goal setting. Rose (1977) recommends employing the

following types of therapeutic approaches for use with the elderly: cognitive, reinforcements, shaping, modeling, relaxation therapy and desensitization.

In addition to the use of cognitive therapies to help the aging individual deal with emotional and behavioral concerns, there is also evidence in the literature to indicate that cognitive paradigms may be effective in minimizing physiological illnesses.

Tosi (1974) expanded Ellis's "ABC model" to include points designating the existence of high cognitive control over physiological and psychological states, in addition to high cognitive control over emotions.

Another writer, Graham (1970), expanded Alexander's (1950) work discussing psychosomatic disorders. It was Grahams's belief that specific beliefs and attitudes are associated with specific psychosomatic disorders. For example, he related the following somatic symptoms as attitudinal derivatives from various cognitive states: (1) acne is seen as related to the attitude of believing one is picked on and wanting to be left alone; (2) low back pain is related to the desire of wanting to run away; (3) rheumatoid arthritis is related to the feeling of being tied down and wanting to get away; and, (4) migraine headaches are related to the feeling of needing to achieve.

Still another study that explores the cognitive effect on physiological behaviors is that of Zimbardo (1972). This

work was based on previous work of Luria (1938). In this study, Zimbardo (1972) used hypnosis to facilitate temperature changes between hands. Zimbardo suggested that individuals can learn to cognitively control what was previously considered involuntary.

In light of these studies concerning cognitive control over physiological states, cognitive therapy may be seen as a potentially powerful therapeutic intervention for use with aging populations who may be experiencing the gradual deterioration of overall physical health.

A number of studies comparing outcome results of cognitive therapy to other therapeutic approaches have shown that cognitive approaches are extremely effective and often superior to such alternative techniques.

The effectiveness of cognitive therapy was investigated by Ellis (1957). In this study he compared the therapeutic results of a group with 78 individuals who received psychoanalysis against a group of 78 individuals who received Rational Emotive Therapy (RET). Results indicated that the psychoanalytic group showed 63% improvement with a mean of 35 sessions, while the RET group showed 93% improvement with a mean of 26 sessions. Both groups were matched on significant variables. However, results may have been confounded by researcher bias.

In another study, Maes and Heimann (1970) compared the

effectiveness of RET, client-centered therapy and Systematic Desensitization in treatment of test anxiety in high school students. Results indicated that systematic desensitization and RET significantly lessened emotional reactivity (as measured by heart rate and galvanic skin response) in a testing situation. No such results were found for the client-centered therapy or the control situation.

Tosi and Moleski (1976) investigated the efficacy of RET and Systematic Desensitization. They found that RET was more effective than Systematic Desensitization in reducing stuttering, anxiety and negative attitudes towards stuttering. In turn, Systematic Desensitization was shown to be more effective in the reduction of stuttering than was demontrated with the control group.

Smith and Glass (1977) conducted a meta-analysis of psychotherapy outcome studies. Their results concerning therapy effectiveness are as follows:

- Systematic Desensitization--the typical client was "better off" than 82% of untreated individuals.
- 2. Rational-Emotive Therapy--the typical client was "better off" than 78% of untreated individuals.
- 3. Adlerian Therapy--the typical client was "better off" than 76% of untreated individuals.
- 4. Client-Centered Therapy--the typical client was "better off" than 74% of untreated individuals.
- 5. Psychodynamic Therapy--the typical client was "better off" than 72% of untreated individuals.
- 6. Eclectic Therapy--the typical client was "better

off" than 68% of untreated individuals.

7. Gestalt Therapy--the typical therapy client was "better off" than 60% of untreated individuals.

In a more recent meta-analysis of psychotherapy outcome studies, Smith and Glass (1980) found the following results of relative effectiveness between the various psychotherapies:

- Cognitive Therapies (other than Rational-Emotive)-the typical client was "better off" than 99% of untreated individuals.
- Hypnotherapy--the typical client was "better off" than 97% of untreated individuals.
- Cognitive-Behavioral Therapy--the typical client was "better off" than 87% of untreated individuals.
- 4. Systematic Desensitization--the typical therapy client was "better off" than 85% of untreated individuals.
- 5. Dynamic-Eclectic Therapy and Eclectic-Behavioral Therapy--the typical client was "better off" than 81% of the controls.
- 6. Behavior Modification--the typical client was "better off" than 77% of the controls.
- 7. Psychodynamic Therapy--the typical therapy client was "better off" than 75% of the controls.

Despite RSDH and related "cognitive therapies" (see 1 above) demonstrating better outcomes than all other therapeutic approaches, Smith and Glass report that when confounding of effects (i.e., the researcher's allegiance toward a therapeutic technique, internal validity, client solicitation, methods of outcomes measurement, etc.) were controlled or corrected, meta-analysis results yielded no reliable differences. Though Smith and Glass tend to see all therapies as essentially equivalent, this does not detract from the possibility that RSDH and related cognitive therapies may still demonstrate overall superiority--given the use of research procedures and instrumentation as are considered by Smith and Glass to be more appropriate.

RATIONAL STAGE DIRECTED HYPNOTHERAPY

Rational Stage Directed Hypnotherapy (RSDH) is a therapeutic technique originated by Tosi (1974) and Tosi and Marzella (1975) which emphasizes high cognitive control over affective, physiological and behavioral processes. In this psychotherapeutic approach, Tosi expanded the Ellis ("ABC") model to include: (1) point "D" (physiological concomitants); and, (2) point "E" (behavioral responses). In addition to the above expansion, Tosi's (1981) model includes various levels within each of the "A", "B", "C", "D", "E" components. A second major feature of the Tosi (1981) RSDH model includes developmental growth stages through which the cognitive restructuring procedures evolve. A detailed discription and review of literature concerning the RSDH model is discussed in the following pages.

Figure 1 depicts the Person and Environment model posited by Mooney (1963). Tosi (1974, 1981) adapted a similar model for use in explicating the RSDH psychotherapeutic approach. In the RSDH model an individual is represented by



A = SITUATIONAL CONDITIONS (a_1, a_2, a_3, a_4) B = COGNITIVE FUNCTIONS (b_1, b_2, b_3, b_4) C = AFFECTIVE RESPONSES (c_1, c_2, c_3, c_4) D = PHYSIOLOGICAL RESPONSES (d_1, d_2, d_3, d_4) E = BEHAVIORAL RESPONSES (e_1, e_2, e_3, e_4)

FIGURE 1. PERSON AND ENVIRONMENT INTERACTION

the broken circle as functioning within an open system relative to the environment (labelled "A"). The self consists of the following sets of operations: (B) cognitive, (C) affective, (D) physiological and (E) behavioral. These operations are relative to the person's internal as well as external human and non-human environment.

Tosi (1981) discusses this model in the following manner. Situational conditions (events within the person's environment) are designated as "A" with various subdesignations: "a1", "a2", "a3", etc. These situational conditions can include a variety of related events or circumstances with contribute to the psychological state of the individual at any given point in time. In the second phase, the individual's interpretations, appraisals or beliefs about their environmental influences are designated by the cognitive set "B". "B" encompasses four subclassifications designated as " b_1 " (the judgement or belief about the situation). " b_2 " (an appraisal of the individual's response to a situation such as a thought, image, cognitive operation, emotion, physiological response, or behavioral response), "b₃" (a personal self-evaluation within the context of this subsequence) and "b₄" (a set of learned and well integrated coping procedures displayed by the individual). Examples of such coping strategies include: disassociation/association, denial, repression, distortion avoidance, etc. This cognitive set "B" is explicated in Table 1.

TABLE 1

COGNITIVE SYMBOLIC OPERATIONS

B₁--Appraisal of Events B₂--Appraisal of Response to Event B₃--Generalized Appraisal of Self System B₄--Cognitive-Symbolic Coping Strategies 1. Disassociation-Association 2. Appraisal of Response to Event 3. Denial-Regression-Supression-Projection Logical-Critical-Divergent Thinking 4. 5. Imagining 6. Distortion Mislabelling a. b. Overgeneralizing c. Arbitrary Inference d. Magnification/Minimization e. Selective Abstraction Cognitive Polarization (Either-Or) f. g • Projection Destructive/Constructive Behavioral Approach-7.

Avoidance Options

• • ••

8. Proliferation

(Tosi, 1981)

The third set of operational conditions within the model are represented by the classification "C". This classification includes a series of subclassifications addressing the various emotions that occur as a result of any given stimulus event (A) and cognitive evaluation (B). Subclassifications are designated by points "c1, "c2", "c3", etc.

As a result of emotional arousal, Tosi (1981) reports that certain physiological responses follow (these being classified as "D"). Examples of such responses include heartrate, vasoconstriction, muscle tension gastric secretions, elevated blood pressure, etc. These physiological responses are depicted in the model as points " d_1 ", " d_2 ", " d_3 ", etc. A persistence of such physiological responses may result in such medical complications as viral and infectious diseases and/or psychosomatic disorders (Tosi, 1981)

Finally, behavioral responses are represented in the model by the classification "E" and the various subclassifications " e_1 ", " e_2 ", " e_3 ", etc. These behavioral responses are conceived as impacting the individual's environment (internal as well as external) and having implications for the likelihood of similar behaviors reoccurring in the future. A summary of Tosi's (1981) experiential themes is presented in Table 2. Table 3 demonstrates an example of this model as it would be applied to a typical problem that might reasonably be encountered in an aged nursing home

TABLE 2

EXPERIENTIAL THEMES

- A--Refers to an event or set of events (a₁,a₂,a₃,a₄) occurring in the internal or external world of a person related to a present, past, or future time occurring along an awareness continuum.
- B--Refers to a set of cognitive responses (b₁,b₂,b₃, b₄) to an event or set of events (a₁,a₂,a₃,a₄), internal or external, along an awareness and time continuum.
- C--Refers to a related set of affective responses (c1, c2,c3,c4) to B about A along an awareness and time continuum.
- D--Refers to a set of physiological concomitants (d₁, d₂,d₃,d₄) or resultants of C occurring along an awareness and time continuum.
- E--Refers to a set of overt or covert actions or behavioral possibilities (e1,e2,e3,e4) toward A occurring along an awareness and time continuum.

(Tosi, 1981)

TABLE 3

EXAMPLE OF THE ELABORATED ABCDE MODEL

Α.	Event	Mrs the doe	. Smith says "hello to Mrs. Jones in morning before breakfast. Mrs. Jones s not return the greeting.
В.	Cognitive Responses	B ₁	Mrs. Smith evaluates the situation with the thought: "I can't stand to be ignored."
		B ₂	Mrs. Smith evaluates her response to Mrs. Jones' behavior with the thought: "There is nothing I can do about being ignored."
		B ₃	Mrs. Smith evaluates herself with the thought: "I am worthlessno- likes me."
		Вц	Mrs. Smith operationalizes her cop- ing strategy with the thought: "I will not speak to her anymore."
с.	Affective		
	Responses	C 1	Anger
		C 2	Self-doubt
		C ₃	Anxiety
D .	Physio-		
2.	logical Responses	D ₁	Increased blood pressure
		D ₂	Increased heartrate
		D ₃	Gastric secretion
E.	Behavioral Responses	E ₁	Avoidance of Mrs. Jones
		E ₂	Hostility toward Mrs. Jones in the future
		Ез	Lack of attempt to investigate the reasons for Mrs. Jones' behavior in this situation

setting.

In accordance with the RSDH model, cognitive restructuring skills are developed, implemented and reinforced while the client is in a state of hypnotic relaxation. This relaxation, in conjunction with imagery, increases the realism and reinforcement power of the therapy. Via this therapeutic technique, the individual additionally employs imagery to focus upon negative emotional, physiological and behavioral sequences, and subsequently upon more positive (though contextually similar) sequences grounded in rational and realistic cognitions associated with more positive outcome states.

Cognitive restructuring is evolved within the framework of developmental growth stages. These stages, as are employed in the RSDH paradigm, were grounded in the work of Mooney (1963) and Quaranta (1971). Quaranta identified six stages in career development which are as follows: awareness, exploration, commitment, skill development and refinement, and redirection of career change. These stages were modified and redefined for use in the RSDH psychotherapeutic approach (Tosi, 1974, Tosi and Marzella, 1975). Stages provide a means by which the client can more clearly mark progress in therapy and reduce ambiguity for both the client and therapist. A paraphrased discussion of the stages, as per Tosi (1981), follows.

Awareness: In this stage of the psychotherapeutic process the individual becomes aware of new possibilities for growth. Here the person learns to discriminate between adaptive and maladaptive behavioral patterns. They witness, observe, discriminate, as well as participate in their own innermost thoughts, feelings, and physiological, behavioral, and interpersonal functioning. The client learns to redirect the focus of attention to new facts about the self, to consider relationships among cognitive, affective, physiological, behavioral and social processes; and to consider new goals and directions. The stage of awareness includes passive reflection and active subjective awareness which are defined as follows:

Passive reflective awareness--implies an ability to observe one's cognitive, affective, physiological, behavioral and social processes in a detached manner; that is, the client learns to observe their behaviors, both internal and external, as if they were watching themselves on a film.

Active subjective awareness--implies a subjective participation in thought, feelings, bodily responses and behavior. This is an associative and integrative process.

Exploration: Herein, the client experimentally employs cognitive and behavioral operations to test out insights (learned through therapy) in real life situations. At this point the therapist guides the client through a restructuring of the cognitions, while the individual is subjectively and concurrently experiencing a variety of emotional, physiological and social outcomes. This exploration takes place via imagery or hypnosis, but is eventually employed relative to objective, real life situations. During this stage, resistance to therapy may be evidenced by missed appointments, premature flights into health, failure to comply with homework, mind games, denial, exaggerated symptoms and premature therapy termination.

<u>Commitment:</u> In this stage the individual decides to implement constructive action by weighing the costs and rewards of conformity and irrationality. Commitment implies an expanding of self-awareness and self-exploration, a process in which the individual begins to think and act with full consideration of feelings, values and behaviors. Commitment serves as the threshold for higher motivation which tends to be realized via implementation of more responsible behavior relative to the environment. At this stage the client makes a decision to implement processes they believe will have some probability of success in effecting more optimal outcomes, both of an internal and external nature.

Implementation: In this phase the client displays the behavioral manifestation of commitment. This implies deliberate and constructive use of cognitive/behavioral skills developed in preceding stages. At this point the client implements, in a real life situation, behaviors which they have already practiced under the state of hypnosis and actually tested environmentally. The actual implementation of new behaviors by the client may be accompanied by

resistance. The therapist must be assertive and highly encouraging to facilitate client implementation of the new behaviors.

Internalization: This fifth stage is characterized by an integration of more constructive thoughts, feelings, bodily responses and behaviors in the self-system. As the rational notions about the self and the environment are internalized, they become integrated into the personality. These new thoughts, feelings and behaviors begin to function in a synchronized fashion natural to the organism. The self evolves and expands with each new experience, and develops a sense of well-being derived from the new realistic appraisals and evaluations of concrete and creative actions. This is associated with greater mastery of self and environment.

Behavioral Stabilization: The final stage of the RSDH experience is evidenced when behavioral changes, realized through the preceding stages, become more frequent, resistive to extinction and more permanent. Thus, meaningful, well-integrated learning has been achieved. At this point the client can work through additional concerns by using the six stages with any future problems that may occur.

Three different types of stage directed therapy have been developed and empirically investigated (Howard, 1979). These are as follows:

1. <u>Rational Stage Directed Therapy</u>--Cognitive skills are developed within the stage-directed framework,

but all therapy is conducted during the normal waking state.

- 2. <u>Rational Stage Directed Imagery</u>--the development of cognitive skills (within the stage directed framework) is enhanced by imagery and relaxation procedures (progressive muscle relaxation, meditation, or simply imagining a scene, with eyes closed, within a non-distracting atmosphere).
- 3. <u>Rational Stage Directed Hypnotherapy</u>--hypnosis and hypnotic imagery is used to facilitate the cognitive-behavioral restructuring process. Furthermore, during hypnosis the individual is directed through the stages, thus increasing the experiential quality of the therapy.

The results of several research studies support the effectiveness of Rational Stage Directed approaches. Marzella (1975) conducted a study that included the following groups: RSDH, RSDI, hypnosis and control. His findings indicated conditional positive results in the reduction of emotional stress for the RSDH, RSDI and hypnosis groups.

Boutin and Tosi (1981) studied the effectiveness of RSDH on the reduction of test anxiety in nursing students. RSDH was compared with a hypnosis only group, a placebo group and a control condition. It was found that RSDH proved to be the most effective treatment in the reduction of test anxiety. "Hypnosis Only also demonstrated significant results, although not as great as for RSDH. On a two month followup, it was found that the RSDH group had experienced still further decreases in test anxiety, while levels of anxiety in the hypnosis only group, placebo group and control condition remained the same as they had been at the post-test I measure. This finding suggests that clients who received RSDH were able to further integrate the treatment procedure and continue to utilize information they had learned.

Reardon and Tosi (1981) conducted a study on the effects of Rational Stage Directed Imagery (RSDI) and Rational Stage Directed Therapy (RSDT) on the modification of self-concept and physiological stress with delinquent adolescent females. In this study, RSDT employed imagery techniques similar to those discussed by Maultsby (1971). The RSDI treatment incorporated an elaborate cognitive relaxation procedure in addition to the imagery. Self-concept was measured with the Tennessee Self-Concept Scale (TSCS). Stress was measured with the client's scores on the empirical scales of the TSCS and by the clinical scales on the Multiple Affective Adjective Checklist. Through an intercomparison of RSDI, RSDT, a placebo group, and a control group, RSDI demonstrated significant positive changes in overall levels of anxiety. The RSDI treatment group was shown to have experienced even further improvement at the two month followup, while the other groups showed minimal
directional changes. The results of this study tend to support findings of Boutin (1976) and Boutin and Tosi (1981) that the client integrates the treatment procedure and information while continuing to employ learned techniques for continued improvement after therapy.

Howard (1979) investigated the effects of Rational Stage Directed Hypnotherapy (RSDH) on the modification of neuro-muscular performance, the facilitation of muscular growth, the reduction of anxiety, and the enhancement of self-concept with thirty-two male volunteers who were members of the Ohio State Barbell Club. In addition to the RSDH, Howard also employed group treatments utilizing cognitive restructuring (CR) and hypnosis only (HO). A nontreatment control group was also employed. Results demonstrated that the RSDH treatment was significantly effective on all dependent variables. Furthermore, on two dependent variables (the P score on the Tennessee Self-Concept Scale and a measure of arm size) RSDH subjects showed continued positive significance on dependent measures.

In another study, Tosi and Eshbaugh (1981) report success in the use of RSDH in crisis intervention with a client who displayed symptoms of depression, maladaptive hyperactivity and interpersonal hostility. The researchers state: "A restructuring of client beliefs should result in: (a) more personal control over the existing crisis situation; (b) greater control of future crisis situations; and,

(c) greater control over the general level of emotional functioning."

A series of case studies have further demonstrated the positive effectiveness of RSDH in the treatment of various disorders. These case studies are reviewed below.

Tosi, Fuller, and Gwynne (1980) completed a case study employing RSDH in the treatment of learning anxiety with a child diagnosed as hyperactive and learning disabled. In this study, RSDH successfully helped the child reduce anxiety in the learning situation and focus attention on the learning task. Results of this case study further indicated that RSDH appeared to have a positive effect in helping the child increase academic achievement in the area of reading.

Tosi, Howard, and Gwynne (1981) reported that RSDH seemed to be effective in treating anxiety neurosis. Furthermore, they state that RSDH appeared to positively affect symptoms at all levels (cognitive, emotional, physiological and behavioral). This study also showed a cognitively based therapy to be successful with an individual of somewhat lower intellectual capacities (measured I.Q. of 88).

Two case studies were reported in the area of assertiveness. First, Gwynne, Tosi and Howard (1978) reported the effectiveness of RSDH in the treatment of pathological nonassertion with a twenty year old female client enrolled at a work rehabilitation program administered by Goodwill Industries. In a discussion of results, the investigators posit that many non-assertive individuals cognitively doubt their abilities to perform. This self-doubting tends to lead to poor performance and reinforcement of the individual's low self-opinion. A second case study using Rational Stage Directed techniques in the treatment of assertiveness is reported by Howard and Tosi (1982). They found RSDI and behavioral rehearsal effective in the treatment of assertiveness with a nineteen year old male having a measured I.Q. of 85. This case study again demonstrated success of a cognitively based psychotherapeutic approach with a client of borderline intellectual abilities.

A final case study was reported in the literature by Reardon, Tosi and Gwynne (1977). They found positive success in the treatment of depression with an individual who demonstrated schizophrenic ideation and affective disturbance. The researchers report that RSDH considerably diminished the client's anxiety, enhanced his awareness and perhaps enabled him to get past the intensity of his disturbance. The client further employed RSDH techniques to modify both his behaviors and self-perceptions.

Research concerning the relationship between cognitive factors and psychophysiological disorders (using responses from the Common Beliefs Inventory III) found that psychosomatic patients were more perfectionistic, self-downing and prone to blame others than were a medical control group (Foreman, Tosi and Rudy, 1980). Similarly, Tosi and Rudy (1981) reported positive effects in helping hypertensive clients control blood pressure. They employed cognitive therapy approaches similar to RSDH in conjunction with a biofeedback model. In these studies behavioral therapy techniques were combined with medical care.

Tosi (1980) discusses the contributions of RSDH to behavioral medicine. In this paper he explores interactions between psychological disorders and physiological states.

Though qualified, further support concerning the effectiveness of RSDH is reported by Smith and Glass (1980). From a meta-analysis of therapy approaches, prior to controlling or correcting for confounded outcome effects, the higher average effect size was produced by the cognitive therapies other than, but similar to, Ellis's rational-emotive psychotherapy. They report that therapies falling within this highly effective group include: Systematic Rational Restructuring, Rational Stage Directed Therapy, Cognitive Rehearsal and Fixed Role Therapy.

An examination of the above related literature suggests the possibility that the use of RSDH might prove efficacious in the treatment of self-concept and depression with institutionalized (nursing home) geriatric patients. The purpose of this study is to examine such a possibility.

CHAPTER III

METHODOLOGY

This chapter addresses the research methodology as employed in this study. To facilitate this process, the chapter is organized in the following manner: (1) selection of the subjects; (2) selection of the instruments; (3) research design; (4) statistical analysis techniques; (5) treatment therapist; (6) treatments (including mehods of delivery, content of treatment sessions and rationale); and, (7) general summary.

The experimental design for the study includes a 4 x 3, one between groups (RSDH, CR, HO and C) and one within groups (temporal measurements: pre-test; post-test I; and, post-test II) factorial. The purpose of the study is to determine the effectiveness of three therapeutic approaches with respect to the treatment of self-concept and depression in a geriatric nursing home population.

The research design included one control (non-treatment) group (C) and three treatment groups: (1) Rational Stage Directed Hypnotherapy (RSDH); (2) Cognitive Restructuring Only (CR); and, (3) Hypnosis Only (HO). Each group contained eight subjects and met for eight sessions.

The dependent measures for this study were given at a

pre-test session (one week before treatment began), a posttest I session (upon culmination of treatment) and a posttest II session (one month after the administration of post-test I measures). The instruments employed in this study include: (1) The Tennessee Self-Concept Scale (Total P Score); and, (2) the Minnesota Multiphasic Personality Inventory (Depression Scale).

The specific null hypothesis for this study is that group means on the dependent variables of self-concept and depression will not differ significantly across time (pretest, post-test I and post-test II) or treatment (RSDH, CR, HO and Control). Alternate hypotheses are as follows: (1) group means representing dependent variables of self-concept and depression will be superior for the RSDH group as compared to the HO, CR and Control groups across time of measurement (pre-test, post-test I and post-test II); and, (2) means representing dependent variables of self-concept and depression will be superior for both the HO and CR groups as compared to the Control group across time of measurement (pre-test, post-test I and post-test II).

SELECTION OF SUBJECTS

This study was conducted at the Heritage House Nursing Home in Columbus, Ohio. This facility is a Jewish Home for the aged which serves a wide variety of clientele including: (1) those who have physical illnesses preventing them from living independently; (2) those who experience senile dementia such that they are prevented from living under independent circumstances; and, (3) those who are cognitively aware and reasonably physically able, but who choose to live in an environment which provides the security of immediate medical attention which could not otherwise be easily obtained under their former living conditions. Residents are assigned to specific living quarters within the facility on the basis of their physical and cognitive functioning levels.

Possible candidate subjects for the study were drawn from a candidate pool that was formally screened by both medical staff (including physicians) and by social service staff. The criteria used in identifying subjects for the selection pool were that: (1) the individual was considered to be cognitively aware; (2) the individual was free from physical diseases which might be complicated by the relaxation component of this treatment; and, (3) the individual was free from psychotic type, mental disorders.

After pre-screening of candidates was completed, the program was presented to the candidates at a general meeting of residents. This presentation was subsequently followed by a solicitation of volunteers on an individual basis. The solicitation proceeded by presenting candidates with a written explanation of the study, its purposes, possible risks and benefits. The importance of the personal

interview was emphasized so as to afford each individual an opportunity to ask any questions they may have concerning the project before making a decision as to their willingness to participate.

Finally, from a pool of thirty-eight volunteers, thirty-two were assigned to treatment groups. An attempt was made to randomly assign subjects to treatment groups. However, a variety of circumstances interfered with total randomization. For example, the Heritage House provides a rich variety of daily activities including occupational therapy, physical therapy, educational classes, music concerts, dining out and short recreational trips. Since residents participated voluntarily in these activities, each resident had a different daily schedule. The treatment schedules therefore, had to be considered when making group assignment. Visitations also posed a problem. Each resident was visited at different times by family members and friends. In many instances visitations were unannounced. Many visits resulted in residents leaving the home for a couple hours, an entire day or longer. When visits were scheduled, the mere coordination of two or more schedules posed considerable difficulty. Finally, interpersonal conflicts seriously limited any possibility of complete randomization. Due to the fact that residents were in a situation of constant contact with one another over extended periods of time, various interpersonal

conflicts arose. Finally, subjects would specifically state that that they would not attend a group session where certain other individuals would be present. However, within the above stated frame of constraints, every effort was made to randomize to the greatest possible extent.

The final pool of subjects participating in the study ranged in age from 68 years to 96 years. The mean age of participants was 81.3 years. These subjects were cognitively aware and were in permanent placement at the Heritage House.

SELECTION OF INSTRUMENTS

Instruments selected for measure of dependent variables included the Tennessee Self-Concept Scale and the Depression Scale of the Minnesota Multiphasic Personality Inventory. The instrumentation was limited to these two measures due to the age and physicial condition of the subjects.

Many subjects experienced poor eyesight and a low threshold of fatigue. Hence, it was necessary to read items on the above inventories to each subject individually. This occurred in twenty to thirty minute testing sessions. During these testing periods subjects were provided with copies of the instruments which were printed in large type. To the extent that their physical circumstances permitted, subjects could then follow along as the items were read by the examiner. The examiner formally recorded the verbally given responses on scoring forms. In the case of the Tennessee Self-Concept Scale, published computer forms were utilized and computerized results were obtained, In the case of the MMPI Depression Scale, hand scoring was employed.

Tennessee Self-Concept_Scale (TSCS):

The TSCS is an inventory which consists of 100 selfdescriptive statements to which the subject responds on a five point scale ranging from completely true to completefalse. Ten of the items (which came directly from the MMPI L-Scale) constitute the Self-Criticism Score--a measure of overt defensiveness. The remaining 90 items were drawn from a large pool of self-descriptive statements. These items were originally selected for inclusion in the instrument by agreement of seven clinical psychologists as to their classification and content (Fitts, 1965).

The TSCS Manual (Fitts, 1965) describes the instrument along with the computation and interpretation of its various scores. This document also contains a description of the instrument's development and data regarding the reliability, validity and intercorrelations of scores.

The overall self-concept is indicated by the Total Positive Score (Total P Score) and is reflective of an individual's general level of self-esteem. The Total P Score evolves from a 3 x 5 matrix of subscores with are explained as follows:

The horizontal rows are concerned with how individuals describe themselves from an internal frame of reference. Row 1 is concerned with basic identity or how persons perceive themselves at the most basic level. Row 2 gives a measure of self-satisfaction or how well individuals accept themselves. Row 3 deals with the person's focusing on: (1) what they are; (2) how they feel about themselves; and, (3) what they do (Hamner, 1968).

The five vertical columns deal with the external frame of reference individuals use to describe themselves, which are as follows:

- Column A: <u>Physical Self</u>--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: <u>Personal Self-personal worth or adequacy</u>, self respect, and self-confidence.
- Column D: <u>Family Self</u>-the individual's relationship with their primary group (family and close friends) and their sense of adequacy as a family member.
- Column E: <u>Social Self</u>--the individual's sense of adequacy or worth in relationships with people or society in general (Fitts, et. al., 1971).

The Total P Score is ascertained from a 3 x 5 matrix composed of the above aforementioned rows and columns. High Total P Scores indicate that the person has a feeling of confidence, self-like, and self-worth. Low Total P Scores represent self-views of undesirability and little self-confidence.

An examination of TSCS profiles further provides information relevant to an individual's approach to taking the test. "Distribution Scores" reflect the number of times the subject responds to each of the five categories of response selection--(1) completely false; (2) mostly false; (3) partly false and partly true; (4) mostly true; and, (5) completely true. The "Distribution Score" ("D Score") is a summary score derived from the five categories. Low "D" scores reflect high uncertainty and a poorly differentiated conception of the self, while high "D" scores reflect cognitive rigidity and an over-definate conception of self. A balanced cognitive set is reflected by midrange "D" scores.

"Conflict Scores" measure the amount of conflict the person perceived between negatively and positively worded self-discriptive statements. The "Net Conflict Score" measures the direction and amount of conflict (over-selecting positive statements, inability to deny negative statements, over denying negative statements and inability to affirm positive statements). The "Total Conflict Score" gives an absolute measure of the amount of conflict without regard to direction. Fitts (1965) states that "high scores indicate confusion, contradiction and general conflict in perception; whereas low scores have the opposite interpretation. The "True-False Ratio" serves as a measure of response set (whether or not the individual agrees or disagrees with items with no real regard for the content of the items). Mid-range "True-False Ratio" Scores are probably the most healthy while scores at the extremes reflect a deviancy in the individual's self-description.

The "Total V Score" on the TSCS represents the amount of variability for the entire test. "Variability Scores" provide a measure of consistancy from one area of self-perception to another. Therefore, variability in terms of "internal reference" and in terms of "external reference" are also summarized by variations within rows and columns respectively (Fitts, 1965).

In addition to the various scales already presented, the TSCS also includes six empirical scales designed to differentiate various clinical populations. In the development of these scales for the TSCS, the following populations and respective sample sizes were employed:

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

Items that differentiated each group from all other groups were then used to compose six "empirical" (clinical)

scales that follow the same dimensions as are listed above. These six empirical scales are formally listed as follows:

> Defensive Positive Scale (DP)--This scale consists of 29 items which differentiate psychiatric patients having Total P Scores above the norm group 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.

<u>Psychosis Scale (Psy)</u>--This scale comprises 23 items. These items best differentiate psychotic patients from the other groups.

<u>Personality Disorder Scale (PD)</u>--This scale is composed of 27 items which distinguish this psychiatric classification from the norm, psychotic, personality integration and defensive groups.

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

<u>Personality Integration (PI)</u>--This scale is composed of 25 items which represent a group of subjects adjudged, by outside criteria, to have a better than average level of adjustment.

The Scale's best index of psychological disturbance is the 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.

In developing the general population TSCS norms, individuals from across the country were selected and administered the instrument. The norm sample included both males and females who ranged in age from 12 to 68. The norm sample was representative of all social, economic and educational levels from sixth grade through the Ph.D. degree. However, the sample is over-represented by the age group 12 to 30 years and has an excess of college students and white subjects. Fitts (1965) stated that the research suggested that there was no need for the establishment of separate norms for age, sex, race or other variables.

The test-retest reliability co-efficient of all major scales on the Tennessee Self-Concept Scale ranges from .60 to .92 with an average of .80 (Fitts, 1965).

In the area of validity this instrument was reviewed by a panel of expert judges in order to determine (1) content validity; (2) discrimination between groups; (3) personality changes under particular conditions; and, (4) correlation with other personality measures. The judges agreed that the content measured self-concept. In a correlational study by Quinn (1957) it was found that there was a -.534 correlation between the Total P Score of the TSCS and the MMPI.

Despite the presentation of all TSCS scales in this chapter, the Total P scores were the only ones utilized for this study. This resolves from research evidence showing that the Total P Score provides as much information concerning self-concept as any other TSCS score (Hansen, Pound and Petro, 1976). Additionally, Fitts (1965) emphasizes that the "Total P Score" is comprised of all subscale scores and is one of the most important scores on the instrument (see Appendix A for a copy of the Tennessee Self Concept Scale Computer Form and a copy of the TSCS typed in large print for use by this visually handicapped aging population).

Minnesota Multiphasic Personality Inventory (MMPI):

The Minnesota Multiphasic Personality Inventory, first published in 1943, is the most widely used personality inventories in the United States (Lubin, Wallis, and Paine, 1971). It is an instrument containing 550 items with a structured response (true/false) format. This personality inventory contains ten main clinical scales and three validity scales, along with numerous content scales which can be interpreted via various computer report packages.

Originally, nine clinical scales were developed for use in this inventory and those scales were named for the abnormal conditions on which their construction was based. These nine clinical scales were not expected to measure pure traits nor to represent discrete etiological or prognostic entities. They have since been shown to have meaning within the normal range of behaviors and are now known by their abbreviations or code numbers as follows: Scale 1--Hs (hypochondriasis); Scale 2--D (depression); Scale 3--Hy (hysteria); Scale 4--Pd (psychopathic deviate); Scale 5--Mf (masculinity-feminity); Scale 6--Pa (paranoia); Scale 7--Pt (psychasthenia); Scale 8--Sc (schizophrenia); and Scale 9--Ma (hypomania). Many other scales have subsequently been derived from the same pool of items. Of those, the most frequently scored include Scale 10--Si (social introversion) and the three validating scales: L (lie); F (Validity); and K (correction) (Hathaway and Mckinley, 1967).

Interpretation of clinical scales is derived from results of copious research studies. In order to aid clinicians with summaries of these interpretations, several popular interpretation manuals have been published. Table 4 represents a short summary of clinical interpretative guides for high and low scores for each of the ten clinical scales, as well as for the validity scales (Graham, 1977).

Due to the age and physical condition of the subjects involved in this study, it was not possible to administer the entire MMPI over three different time periods. Therefore, it was found that only the depression scale could be realistically utilized in this study. This presented a possible limitation to this study since the work of Endicott and Endicott (1963) has shown that the D scale provides an excellent index of momentary depressive levels. However, since group means were used in the statistical analysis, rather than individual score comparisons, some of the possible problem concerning momentary levels of depression vs. long term changes was alleviated.

Test-retest reliability on the Depression scale of

<u>Table 4</u>

SAMPLE INTERPRETIVE INFERENCES FOR STANDARD MMPI SCALES

Scale Name	<u>Scale</u> Abbreviation	Scale No.	Interpretation of High Scores	Interpretation of Low Scores	
	L		Trying to create favor- able impression not be- ing honest in respond- ing to items; conven- tional; rigid; moralis- tic; lacks insight	Responded frankly to items; confident; perceptive; self-re- liant; cynical	
	F	_	May indicate invalid profile; severe patho- logy; moody; restless; dissatisfied	Socially conforming: free of disabling psychopathology; may be "faking good"	
	К		May indicate invalid profile; defensive; inhibited; intolerant; lacks insight	May indicate invalid profile; exaggerates problems; self-criti- cal; lacks insight; cynical	
Hypochondriasis	Нs	1	Excessive bodily con- cern; somatic symptoms; narcissistic; pessimis- tic; demanding; criti- cal; long standing pro- blems	Free of somatic pre- occupation; optimis- tic; sensitive; in- sightful	
Depression	D	2	Depressed; pessimistic; irritable; dissatis- fied; overcontrolled;	Free of psychological turmoil; optimistic; energetic; impulsive;	79

Table 4 (Continued)

SCALE INTERPRETATIVE INFERENCES FOR STANDARD MMPI SCALES

<u>Scale</u> Name	<u>Scale</u> Abbreviation	Scale No.	Interpretation of High Scores	Interpretation of Low Scores
Depression (con't)	D	2	lacks self-confidence; introverted	competitive; under- controlled; exhibi- tionistic
Hysteria	Ну	3	physical symptoms of functional origin; lacks insight; self- centered; socially in- volved; demands atten- tion and affection	Constricted; conven- tional; narrow inter- ests; limited social participation; un- trusting; hard to get to know; realistic
Psychopathic Deviate	P d	4	Asocial or antisocial; rebellious; impulsive; poor judgement; imma- ture; creates good first impression; su- perficial relation- ships; aggressive; free of psychological turmoil	Conventional; conform- ing; accepts authori- ty; low drive level; concerned about status and security; persis- tent; moralistic
Masculinity- femininity	Mf	5	Male: aesthetic inter- ests; insecure in mas- culine role; creative; good judgement; sensi- tive; passive depen- dent; good self-con- trol	Male: overemphasizes strength and physical prowess; adventurous; narrow interests; in- flexible; contented; lacks insight

Table 4 (Continued)

SCALE INTERPRETATIVE INFERENCES FOR STANDARD MMPI SCALES

.

<u>Scale</u> Name	<u>Scale</u> Abbreviation	Scale No.	Interpretation of High Scores	Interpretation of Low Scores
Masculinity- 'femininity	Mf	5	Female: rejects tradi- tional female role; masculine interests; assertive; competitive; self-confident; logi- cal; unemotional	Female: accepts tra- ditional female role; passive; yielding to males; complaining; critical; constrict- ed
Paranoia	Pa	6	May exhibit frankly psychotic behavior; suspicious; sensitive; resentful; projects; rationalizes; moralis- tic; rigid	May have frankly psy- chotic symptoms; eva- sive; defensive; guarded; secretive; withdrawn
Psychasthenia	Pt	7	Anxious; worried; dif- ficulties in concen- trating; ruminative; obsessive; compulsive; insecure; lacks self- confidence; organized; persistent; problems in decision making	Free from disabling fears and anxieties; self-confident; res- ponsible; adaptable; values success and status
Schizophrenia	Sc	8	May have thinking dis- turbance; withdrawn; self-doubts; feels alienated and unaccept- ed; vague goals	Friendly; sensitive; trustful; avoids deep emotional en- volvement; conven- tional; unimaginative

Table 4 (Continued

SCALE INTERPRETATIVE INFERENCES FOR STANDARD MMPI SCALES

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<u>Scale</u> Name	<u>Scale</u> Abbreviation	<u>Scale</u> <u>No.</u>	Interpretation of High Scores	Interpretation of Low Scores
Hypomania	Ma	9	Excessive activity; im- pulsive; lacks direc- tion; unrealistic self- appraisal; low frustra- tion tolerance; friend- ly manipulative; epi- sodes of depression	Low energy level; apa- thetic; responsible; conventional; lacks self-confidence; over- controlled
Social Introversion	Si	0	Socially introverted; shy; sensitive; over- controlled; conform- ing; problems in de- cision making	Socially extroverted; friendly; active; com- petitive; impulsive; self-indulgent

the MMPI was found to be .77 with a group of normals (Hathaway and Mckinley, 1967).

In the area of validity a high score on the D scale has been found to positively predict the corresponding final diagnosis or estimate in more than sixty percent of new psychiatric admissions (Mckinley and Hathaway, 1943).

See Appendix B for a copy of the MMPI Depression Scale items typed in large print for use with this visuallimited, aging population.

RESEARCH DESIGN

A 4 x 3 model design was employed with one between subjects variable (levels of treatment) and one within subjects measure (time of measurements). This model is depicted in Figure 1. All subjects were assigned to one of four treatments. An attempt at random assignment was completed within the constraints posed by the aforementioned limitations. Each group received a live presentation of their respective treatments which was read by the therapist from transcripts (see Appendices C through F). All subjects were unaware of the hypotheses posed for the study outcomes.

Within the RSDH group a total of five separate transcript protocols were prepared for use in either a single session or a pair of sessions as follows: sessions I and II; sessions III and IV; sessions V and VI; session VII;



FIGURE 2. 4 x 3 MODEL

and, session VIII. An identical pattern was followed with a different set of transcripts for the CR group, while a single transcript, read repeatedly during each of eight treatment sessions, was utitlzed for the HO group.

All subjects received pre-test, post-test I and posttest II measures. The pretest was given one-week before the beginning of treatment and post-test I was given upon completion of the treatment. One month following the final treatment session, post-test II was administered.

STATISTICAL ANALYSIS

There are four reasonable ways in which to assess change across groups as a result of treatment or time. These methods include: (1) the establishment of group equality at time one, time two and time three and the examination of group equality over time; (2) an examination of the raw differences in mean scores across groups over time of measurement; (3) a repeated measures ANOVA for the assessment of the interaction of group x time; and, (4) the Analysis of Covariance to assess the amount of residual change (change due to group membership) between groups across time.

Given that the initial group differences are small, that the effect of the treatment is large, and that the ANOVA assumptions are satisfied, then all four methods should yield the same conclusions (Myers, 1979). In this respect, and for purposes of this study, statistical outcomes permit "change" to be assessed by all four of the above methods. However, the Analysis of Covariance was chosen as the optimal statistical test. Reasoning for this choice posits that while there is no way to correct for initial group differences, the Analysis of Covariance does correct for a phenomenon of regression towards the mean over time, and therefore makes the test of group differences more efficient statistically (Myers, 1979). Chapter V presents a detailed report of the study's results and discusses not only the Analysis of Covariance with its post-hoc test followup, but also the results of the repeated measures analysis.

TREATMENT THERAPIST

An advanced doctoral student in the area of counseling served as the therapist in all treatment groups. A psychologist, licensed by the State of Ohio Board of Psychology, was present during all of the sessions which involved hypnotherapy. This psychologist did not participate in the therapy, however, his presence was required to assure protection of the subjects.

TREATMENTS

Control (C):

This condition was a no treatment control group. As such, subjects were administered pre-test, post-test I and post-test II measures, but received no treatment.

Hypnosis Only (HO):

The Hypnosis Only treatment involved the following components:

- The initial treatment session involved an explanation of the hypnosis/relaxation process--refer to Appendix C (Kroger, 1977). Questions concerning the relaxation procedure were answered and misconceptions or fears alleviated.
- 2. Following explanations and question answering, a standard hypnotic (relaxation) induction was presented consisting of the following four steps:
 - A. The subjects were asked to make themselves comfortable in their chairs and to close their eyes. Following this initial request, the subjects were asked to focus on a deep breathing exercise through which they were lead.
 - B. Next, the subjects were guided through a progressive cognitive muscle relaxation procedure in which they were asked to concentrate on relaxing various parts of their body, progressing from the forehead to the toes.
 - C. Following the muscle relaxation component, a counting procedure was employed to help subjects deepen their relaxed state.
 - D. Finally, the subjects were asked to visualize a relaxing scene. This stage consisted of a very

peaceful and relaxing beach scene. Subjects were aided in their experiencing by means of guided imagery.

Each of the HO treatment's eight sessions were read from a pre-written transcript by the therapist and were identical in both format and wording (see Appendix D). This treatment did not make any attempt at dealing with problems that might directly affect the lives of the subjects. The use of guided imagery was restricted to the relaxation process which embodied the visualization of a beach scene. Cognitive Restructuring Only (CR):

Cognitive restructuring is based upon the A-B-C paradigm popularized by Albert Ellis (1962) in his Rational Emotive Therapy Model. The major premise of this theory is that maladaptive emotional, behavioral and physiological states are associated with irrational thinking processes. The model provides a vehicle through which irrational thinking may be confronted, evaluated and restructured in a scientific manner for the purpose of teaching clients more realistic, and rational thinking patterns. The theory posits that these new, more rational and realistic thoughts are in turn associated with more positive and functional, behavioral and physiological states. The procedure used in this treatment sequence was didactic/educational in nature and was read to the subjects by the therapist from a prewritten transcript (see Appendix E). In this study no written materials (in the form of books, pamphlets or

written homework) were utilized due to the age and physical condition of the subjects. CR treatment sessions were delivered by the therapist with the aid of a microphone (as were all treatments across groups).

The Cognitive Restructuring (CR) procedures used in the treatment involved the following informational format: Sessions I and II:

These sessions are an introduction to the cognitive restructuring model. The treatments follow the A-B-C format found in Ellis's Rational Emotive Therapy (1962). An example of the irrational thinking sequence is given along with an example of the rational sequence. Both sequences are employed relevant to the same set of circumstances normally encountered in daily living and demonstrate outcomes reasonably flowing from such sequences.

Sessions III and IV:

These sessions review concepts presented in Sessions I and II. They further describe some of the thinking patterns and subsequent emotions that are common in the irrational process. The concept that certain types of behavior follow both rational and irrational thinking sequences is presented. Subjects are provided the opportunity to think about one of their own life events and challange their own irrational thinking patterns.

Sessions V and VI:

These sessions again review the concepts presented

in the prior four sessions. However, the idea of self-concept is presented and its importance is discussed. It is further demonstrated to the subjects that they can use the CR model to help them feel better about themselves, behave more appropriately and facilitate their getting what they want.

Session VII:

In this session all the concepts presented in previous sessions are reviewed and summarized. Suggestions for continued use and practice between sessions are made.

Session VIII:

The same review and summarization as presented in session VII is given. Suggestions for continued use of the model, in order to help make rational thinking a natural and routine pattern for personal coping, are presented. Rational Stage Directed Hypnotherapy (RSDH):

Rational Stage Directed Hypnotherapy (RSDH) is a systematic, therapeutic technique which makes use of relaxation and guided imagery procedures in order to help clients develop and learn cognitive restructuring and behavioral coping strategies. In this procedure the client is directed through a series of developmental stages with the use of relaxation and vivid imagery. Again, due to the age and physical condition of the subjects written material in terms of books, pamphlets, or written homework, was not utilized. In addition, all treatments were read by the therapist to the subjects with the aid of a microphone. Rational Stage Directed Therapy procedures used in the treatment are as follows (see Appendix F).

Sessions I and II:

These sessions contain the same treatment procedures and content as presented in each of the Hypnosis Only sessions. The reader is referred back to the Hypnosis Only discussion in this chapter and to Appendix D for more complete details.

Session III and IV:

These sessions begin with an explanation of cognitive restructuring presented without the use of a relaxed state. Not only is the basic A-B-C model presented, but also the concept which poses that any thinking sequence eventually affects the physiological state, as well as the person's behaviorial concomitants. Following this discussion, the four part hypnotic/relaxation induction procedure (see Appendix F) is used. As the therapy continues, the subjects are guided through a rational and irrational thinking sequence and asked to get in touch with feelings associated with each sequence. Aspects of physiological and behavioral states are presented to the subjects as well as emotional consequences flowing from such states. Sessions V and VI:

The sessions again begin with the reading of the four part hypnotic/relaxation induction (see Appendix F,

Sessions III and IV). After the induction, the cognitive restructuring concepts presented in the previous sessions are reviewed. Important percepts surrounding self-concept and its relevance are discussed. Parallels are drawn between rational thinking and a positive self-concept. Finally, still under the protection of the highly relaxed state, the clients are lead through a personal situation that was disturbing to them and could have involved a poor self-concept. They are asked to get in touch with their emotional responses to the situation, as well as their physiological and behaviorial responses. Then, they are guided through the procedure of changing irrational self-talk to a rational sequence and the process of experiencing favorable consequences. It is suggested that they might want to try using their new rational thinking model between sessions whenever they find themselves in a distressing situation.

Session VII:

This session also begins with the usual four part hypnotic/relaxation induction (see Appendix F, Sessions III and IV) of a highly relaxed state. All information previously presented is reviewed. Then, as in previous sessions, the subjects are guided through the irrational/ rational sequences utilizing a personal event. They are asked to get in touch with feelings, physiological sensations and behaviors connected with each sequence. At the

end of the session, it is suggested that subjects are experiencing quite positive self-concepts and will utilize these techniques in their lives between sessions.

Session VIII:

The content involved in this session is identical to that of Session VII with the exception of the following suggestions: (1) subjects will continue to use the techniques; (2) subjects will continue to experience greater control over their own emotions as well as over their environment; and, (3) subjects will further experience a progressive increase in self-concept as they continue to make rational thinking a habitual behavior.

CHAPTER IV

ANALYSIS OF DATA

The analysis of data will examine the hypotheses set forth in Chapter I. These hypotheses include: (1) are the effects of Rational Stage Directed Hypnotherapy (RSDH) superior to those of Cognitive Restructuring (CR), Hypnosis Only (HO) and Control (C) on both self-concept and depression as measured by the TSCS Total P Score and the MMPI Depression Scale; and (2) are the effects of Cognitive Restructuring and Hypnosis Only superior to the Control condition on the aforementioned dependent measures.

The experimental design was a 4 X 3 one between groups (RSDH, CR, HO and C) and one within groups (time of measurement -- pre-test, post-test I and post-test II) factorial. During each evaluation phase, two dependent measures were taken (self-concept and depression).

The statistical design required the following tests: (1) an Analysis of Variance on pre-test scores for determining whether individual performance across groups was similar with respect to dependent measures; (2) a Multivariate Analysis of Variance for Residual Change across groups at levels of post-test I and post-test II measures to determine group differences at those levels; (3) An Analysis

of Covariance of post-test I self-concept and depression scores (using pre-test scores as covariate) to determine residual change (pre-test to post-test I) due to treatment effects; (4) Duncan's Multiple Range Test on residual posttest I self-concept and depression scores to determine grouping; and, (5) an Analysis of Variance for the interaction between treatment and repeated measures for both self-concept and depression scores.

The Analysis of Variance on pre-test scores across groups on the Tennessee Self-Concept Scale produced an F (3, 28) = .37, p < .77. The Analysis of Variance of pretest scores across groups on the MMPI Depression Scale resulted in an F (3, 28) = .21, p < .89 (refer to Tables 5 and 6). These findings indicate that there were no significant differences in subjects across groups in self-concept and depression measures and that subjects were similar with respect to dependent measures at the pre-test level.

The differences between the four groups with respect to post-test I residual scores in self-concept and depression were tested by a Multivariate Analysis of Variance. The multivariate means of the four groups were different by the Wilk's Test, F (6, 54) = 24.89, p < .0001. This fact allows for the interpretation of the Analysis of Variance for Residual Change in both depression and self-concept.

The Analysis of Variance applied to self-concept residual change scores (pre-test to post-test I) reveals

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-		_	_	_	

	ANALYSIS	OF	VARIANCE	ON	PRE-TEST	TENNESSEE	SELF-CONCEPT	SCORES
SOURCE	DI	<u>F</u>			<u>SS</u>	F		PROBABILITY OF F
GROUPS		3		2	4.75	.37		p < .77
SUBJECTS WI GROUPS	THIN 28	8		6 2	0.75			
TOTAL	3	1		64	5.50			

TABLE 6

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	ANALYSIS OF	VARIANCE ON PRE-TES	T MMPI DEPRESSION	SCORES
SOURCE	DF	SS	<u>F</u>	PROBABILITY OF F
GROUPS	3	55.09	. 2 1	p < .89
SUBJECTS WITHI	<u>n</u> 28	2464.63		
TOTAL	31	2519.72		

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that the four groups change by differing amounts during therapy. The Analysis of Residual Change may also be referred to as the "Analysis of Covariance" (as displayed in Table 7). The change effect was quite strong ($\omega^2 = .82$ with an F (3, 27) = 41.39, p < .0001).

An analysis of Table 9 indicates that the Duncan Grouping, derived from the Duncan's Multiple Range Test on residual post-test I self-concept scores, demonstrates three different groupings of treatment means which are as follows: (1) the RSDH group differed in change effects from all other groups and displayed the largest mean difference over pretest results; (2) the HO group differed in change effects from all other groups and displayed the second largest mean difference over pre-test results; and (3) the CR group and the C group could not be differentiated from one another in terms of group means and were therefore singularly classified as groups with the least change by the Duncan Grouping procedure.

The Analysis of Variance applied to depression residual change scores--pre-test to post-test I (also referred to as the "Analysis of Covariance" as displayed in Table 8), reveals that the four groups change by differing degrees on the depression variable during therapy. Again, the change effect was quite strong (ω^2 = .78 with an F (3, 27) = 32.77, p < .0001.

Table 10 displays the Duncan Grouping for the depression
	ANALYSIS	OF	COVARIANCE	OF POST-	<u>TEST I TENNESSEE SELE</u>	-CONCEPT SCORES
			(USING	PRE-TEST	SCORES AS COVARIATE)	
SOURCE		DF	<u>SS</u>	F	ω^2 (RESIDUAL CHANGE)	PROBABILITY OF F
GROUPS		3	2058.99	41.39	.82	p < .0001
SUBJECTS GROUPS	WITHIN	27	447.72			
TOTAL		31	2506.71			

Т	A	B	L	E	8	

<u>A</u>	NALYSIS OF	COVARIA (USING)	NCE OF PO PRE-TEST	DST-TEST I MMPI DEPRESSIO SCORES AS COVARIATE)	ON SCORES
SOURCE	DF	<u>SS</u>	F	ω^2 (RESIDUAL CHANGE)	PROBABILITY OF F
GROUPS	3	2559.58	32.77	.78	p < .0001
SUBJECTS WITHI GROUPS	<u>N</u> 27	703.20			
TOTAL	31	3262.98			

(NOTE: COVARIATE - PRE-TEST SCORE HAS 1 DEGREE OF FREEDOM)

.

	DUNCAN'S	MULTIPLE	RANGE	TEST	ON	RESIDUAL	POST-TEST	I SELF-CO	NCEPT S	CORES
GROUP	MEAN	RAW POST-	-TEST	SCORE	-	RESIDUAL	POST-TEST	MEAN	DUNCAN	GROUPING
RSDH		60.12	25				12.099			A
HYPNOS	<u>IS</u>	48.75	50				2.405			В
RET		41.12	2 5				-7.160			с
CONTRO	L	39.00	00				-7.344			С

TABLE 10

DUNCA	N'S MULTIPLE	RANGE TEST ON	RESIDUAL POST-TEST I MMPI DE	EPRESSION SCORES
GROUP	MEAN RAW PO	ST-TEST SCORE	RESIDUAL POST-TEST MEAN	DUNCAN GROUPING
RSDH	60	.625	-8.920	В
HYPNOSIS	60	.125	-8.958	В
RET	79	.000	9.362	Α
CONTROL	75	.750	8.514	А

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•

scores at the post-test I level. The table reveals that two different groupings of treatment means were found which were as follows: (1) the RSDH group and the HO group means could not be differentiated from each other, indicating that change in both groups was about the same as the result of treatment and (2) the CR group and the C group means could not be differentiated from each other, indicating that change in both of these groups was about the same.

The overall results, as demonstrated by the Duncan Grouping procedure, indicate an added effect of the RSDH treatment over the HO treatment in the change of measured self-concept, but no such added effect in the change of measured depression. They further indicated that the CR group did not change significantly more than the C group. These results will be discussed in detail in Chapter 5.

The differences between the four groups, with respect to the self-concept and depression post-test II residual scores, were tested by a Multivariate Analysis of Variance. The multivariate means of the four groups showed no significant differences by the Wilk's Test, F (6, 54) = 1.69, p < .14. These results would indicate that no significant changes occurred between post-test I and post-test II measures and would suggest that therapy effects remained stable during the first month after termination of treatment. The non-significance of the MANOVA at the post-test II level also eliminates the need for further statistical analysis

at that level.

The Analysis of Variance for the interaction between treatment groups and repeated measures scores yielded the same results as reported above in the Analysis of Covariance procedures (as expected since the initial group differences were small, the effects of the treatments were large and the ANOVA assumptions were satisfied). These results are recorded for self-concept in Table 11 and for depression in Table 12. Findings indicate significant results for the interaction between treatment groups and self-concept repeated measures scores with an F (6, 56) = 44.98, p < .0001 and for the interaction between treatment groups and depression repeated measures scores with an F (6, 56) = 21.74, p < .0001.

Figures 2 and 3 demonstrate graphically and clearly the effects of RSDH, HO, CR and C over time (refer to Tables 13 and 15 for plotted cell means). It is apparent from inspection of the graphs that RSDH did significantly reduce depression and enhance self-concept. Additionally, the graphs illustrate that the effects of the HO treatment were also significant in the reduction of depression and the enhancement of self-concept. The effects of HO on the increase of self-concept, however, were not nearly as great as the effects of the RSDH treatment. Further examination of the graphs indicates that the effects of HO appeared to be quite close to the RSDH effects in the reduction of

ANALYSIS OF VARIANCE	FOR TREATMENT	GROUPS x	SELF-CONCEPT	REPEATED MEASURES SCORES
SOURCE	DF	<u>SS</u>	F	PROBABILITY OF F
GROUP	3	3273.333	13.40	p < .0001
SUBJECTS WITHIN GROUPS	28	2279.500		
<u>TEST TIME</u>	2	1012.333	90.85	p < .0001
TEST TIME x GROUP	6	1503.667	44.98	p < .0001
SUBJECTS x TEST TIME WITHIN GROUP	56	312.000		

ANALYSIS OF VARIANCE	FOR TREATMENT	GROUPS x MMPI	DEPRESSION	REPEATED MEASURES SCORES
SOURCE	DF	SS	F	PROBABILITY OF F
GROUPS	3	2951.875	4.39	p < .0118
SUBJECTS WITHIN GROUPS	28	6272.750		
TEST TIME	2	2076.020	73.83	p < .0001
TEST TIME x GROUP	6	1833.312	21.74	p < .0001
SUBJECTS x TEST TIME WITHIN <u>GROUP</u>	56	787.000		

ΤA	BLE	12

Υ.





	CELL N	MEANS FOR TENNESSEE	SELF-CONCEPT TOTAL SCORES	
	RSDH	HYPNOSIS ONLY	COGNITIVE RESTRUCTURING	CONTROL
PRE-TEST	40.875	39.250	41.125	39.250
POST-TEST I	60.125	48.750	41.125	39.000
POST-TEST II	61.125	47.375	39.875	38.625

TABLE 14

	CELL	STANDARD	DEVIATIONS	FOR	TENNESSEE	SELF-CONCEPT	TOTAL	SCORES	
		RSDH	HYPNOSIS	ONLY	COGN	TIVE RESTRUC	CURING	CON	TROL
PRE-TEST		3.79	4.94			4.79		5	.17
<u>POST-TEST</u>	Ţ	7.67	7.18			4.42		4	.31
POST-TEST	II	7.37	5.73			5.08		4	.93

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CELL MEANS FOR MMPI DEPRESSION SCALE SCORES

	RSDH	HYPNOSIS ONLY	COGNITIVE RESTRUCTURING	CONTROL
PRE-TEST	79.500	78.875	79.625	76.375
POST-TEST I	60.625	60.125	79.000	75.750
POST-TEST II	57.375	63.250	78.500	75.250

TABLE 16

	CELL STANDAR	D DEVIATIONS FOR	MMPI DEPRESSION SCALE SCORES	
	RSDH	HYPNOSIS ONLY	COGNITIVE RESTRUCTURING	CONTROL
PRE-TEST	8.21	7.79	10.528	10.636
POST-TEST I	7.50	5.08	12.433	9.468
POST-TEST II	6.55	5.65	11.096	11.498

depression over the treatment period; however, during the post-treatment interval HO effects showed a tendency to decline while RSDH effects showed a tendency to increase. The graphs demonstrate that both the CR and C groups did not change with respect to either self-concept or depression as a result of this study. Finally, an impression gained from visually inspecting these figures is that overall results remained predominately stable over the posttest I to post-test II period.

Finally, a comment on the statistical power of the ANOVA tests in this particular study is appropriate. With only eight subjects per group and four groups, the power of the ANOVA F test is quite low unless differences between group means in the population are quite large. For example, if group differences account for about 6% of the variance in the dependent variable (what Cohn (1977) defines as a "moderate" effect) the power of the F test is only 17% at p < .05. In retrospect, however, group differences in this study appear quite large, accounting for as much as 82% of the variance. Therefore, while sample size could have been a serious limitation of this study, that fortunately is not the case.

In conclusion, the RSDH group showed significance on both dependent variables (self-concept as measured by the TSCS Total P Score and depression as measured by the MMPI Depression Scale) and was significantly superior to both the CR and Control conditions in overall treatment effects. HO effects for post-test I measures were significant on the TSCS dependent measure, though not as strong as RSDH effects. With respect to post-test I outcomes, HO effects on the MMPI Depression measure were about equal in significance to those of the RSDH treatment. However, on the post-test II measure, although not significant, effects had a slight tendency to decline for the HO treatment and to increase for the RSDH treatment. CR and Control conditions did not significantly differ across time or treatment.

CHAPTER V

SUMMARY AND CONCLUSIONS

This study evaluated the effects of Rational Stage Directed Hypnotherapy (RSDH), Cognitive Restructuring (CR), Hypnosis Only (HO) and a Non-Treatment Control Condition (C) on the enhancement of self-concept and the reduction of depression in a geriatric nursing home population. Measures of the above two dependent variables were completed by means of the Tennessee Self-Concept Scale "Total P Score" and the Depression Scale of the MMPI.

Thirty-two volunteers (two males and thirty females) from a population of residents at the Heritage House Nursing Home served as subjects for this study. The mean age of the subjects was 81.3 years. Although some problems with total random assignment to groups were encountered (due to physical illness, family visits, house activities and personal social group preferences), the Analysis of Variance of pre-test data indicated that subjects across groups performed similarly on dependent measures.

The experimental design was a 4 x 3, one between groups (RSDH, CR, HO and C) and one within groups (temporal measurements: pre-test, post-test I and post-test II) factorial.

The statistical analyses included (1) an Analysis of Variance on pre-test scores; (2) a Multivariate Analysis of Variance for Residual Change across groups at levels of post-test I and post-test II dependent measures; (3) an Analysis of Covariance of post-test I self-concept and depression scores (using pre-test scores as covariate); (4) Duncan Multiple Range Test for self-concept and depression measures; and (5) an Analysis of Variance of main effects for repeated measures.

The null hypothesis for this study states that group means on dependent variables of self-concept and depression will not differ significantly across time (pre-test, posttest I and post-test II) or treatment (RSDH, CR, HO and Control). The alternate hypotheses are as follows: (1) group means representing dependent variables of self-concept and depression will be superior for the RSDH group as compared to the HO, CR and Control groups across time of measurement (pre-test, post-test I and post-test II); and, (2) means representing dependent variables of self-concept and depression will be superior for both the HO and the CR groups as compared to the Control group across time of measurement (pre-test, post-test I and post-test II).

An examination of the group means of pre-test scores in depression indicated that subjects obtained an average of 76.375 t-score to 79.625 t-score on the MMPI depression scale prior to treatment. Such T-score ranges are suggestive

of levels of depression which are clinically significant. Individuals scoring within these ranges tend to worry over even minor issues. Psychiatric patients often score within these ranges. The discomfort that is reflected by this elevation may provide the necessary motivation to suggest a favorable prognosis (Lachar, 1974).

Similarly, an examination of group means of pre-test scores on the Tennessee Self-Concept indicates that t-scores associated with the Total P Score ranged from 39.250 to 41.125. Individuals with Total P Scores within these ranges are described as depressed, unhappy, and as possessing little self-confidence and maintaining undesirable views of self (Fitts, 1965).

No significant differences were found for the ANOVA on pre-test data, indicating that subjects across all groups performed similarly on dependent measures before treatment.

The Multivariate Analysis of Variance of residual change for both self-concept and depression across groups, at levels of post-test I and post-test II, detected significance at the post-test I level but not at the post-test II level. This indicated that the group means changed significantly as a result of treatment and that change effects remained relatively stable over the post-treatment, non-intervention phase. The Analysis of Variance for posttest I residual change indicated a very strong change effect across RSDH and HO groups during therapy. The Duncan's Multiple Range test further analysed the change effects to find that on the dependent variable of self-concept, RSDH obtained a significantly larger mean difference than did all other treatments, with HO also significant but not to as great an extent as for RSDH effects. In addition, the Duncan's Multiple Range Test found that on the depression variable both RSDH and HO appeared to elicit about the same level of significant effects, while the CR and Control groups showed no change as a result of the study. The Analvsis of Variance for the interaction between the treatment groups and repeated measures further indicated significance, as was expected from results of the Analysis of Covariance. Examination of graphed cell means indicate that even though the RSDH and HO groups both show similar effects (both statistically significant). the RSDH effects demonstrate a tendency to increase over the post-treatment, non-intervention phase, while HO effects displayed a tendency to decrease over the post-study non-treatment period.

The null hypothesis is rejected with respect to selfconcept, given that the RSDH treatment effects were significantly superior to all other treatment effects, However, in the case of depression, the null hypothesis cannot be rejected, in that both RSDH and HO effects were equally superior over alternative treatment effects. Hence, the alternate hypothesis (that means across dependent variables will be superior for the RSDH group as compared to HO, CR,

and C groups) can be accepted only in the case of selfconcept. The alternate hypotheses stating that means representing dependent variables will be superior for both the HO and CR groups, as compared to the Control group, are also rejected since the CR group effects did not significantly differ from the control condition effects.

DISCUSSION

RSDH is shown to be a treatment of significant effect in facilitating both a reduction of depression and an enhancement of self-concept as it applies to the geriatric nursing home population employed with this study. Furthermore, favorable ourcomes generated from the use of RSDH demonstrated a tendency to increase over time on the selfconcept dependent measure (during the post-treatment, nonintervention period). This finding is consistent with other research using the RSDH approach (Reardon and Tosi, 1977; Howard, 1979).

However, findings for this study also indicate that the HO condition had significant effects on the enhancement of self-concept (although not as great as RSDH), as well as significant effects (equal to that of RSDH) in the alleviation of depression with institutionalized aging persons. This finding seems to indicate that HO is a powerful treatment component when employed alone with this population. However, close examination of Figures 3 and 4, along with a study of subtle changes of cell means between post-test I and post-test II measures (refer to Tables 13 and 15), suggest a tendency for the HO treatment effects to decline over the post-treatment period, while the effects of RSDH display a tendency to increase over this same period of time. The tendency for the RSDH to continue to display enhancing effects after the actual treatment has ceased may be due to an interaction of the several treatment components employed in that model.

The fact that the RSDH treatment demonstrated a greater effect (pre-test to post-test I) over the HO treatment on the variable of self-concept, but not on the variable of depression, may suggest that the learned ability to relax was sufficient to help this population alleviate depressive periods, while other components of the RSDH paradigm (cognitive restructuring and guided imagery) were needed to provide the more optimal results in the area of self-esteem and self-concept.

In yet another vein, a question arises concerning the role that cognitive restructuring (a treatment that individually was ineffective) may have played in obtaining overall superior effects for the RSDH treatment.

Informal, non-solicited feedback provided to the researchers by subjects and staff during the study, as well as informal observation by the researchers, suggests that subjects in the RSDH group did not learn the cognitive restructuring paradigm. Subjects could speak of the fact

that there were five components called "A", "B", "C", "D". and "E", but seemed to have no idea as to the nature of the components. However, the subjects did appear to be very impressed with the RSDH treatment (a phenomenon that did not appear to exist as strongly in the HO group). It is hypothesized that cognitive restructuring possibly lent an "air of authenticity" to the treatment, eliciting greater motivation with respect to subject's participation during treatment sessions. This hypothesis seems to be reasonable as based on recent research literature by Krantz and Schultz (1980). In their research, they found that by providing structured information to institutionalized elderly, those subjects appeared to find the institutional staff and researchers more credible. Subjects appeared to hold the roles of communications of such staff as correct and important. As a result, subjects reported feeling that through the accurate information they had received, they could achieve greater control over their lives. Other, peripheral outcomes disclosed that these institutionalized elderly appeared to be healthier and happier than institutionalized elderly who did not receive the structured information.

RECOMMENDATIONS FOR FUTURE RESEARCH

In view of statistically significant outcomes posed in this study by the RSDH treatment, and the tendency for some treatment benefits to slightly increase after termination of actual treatment, it is concluded that RSDH is an effective approach for use in treatment of self-concept and depression with institutionalized aging individuals. However, it's effectiveness may be seen to flow from a synergistic interaction of the various RSDH components (cognitive restructuring, hypnosis/relaxation, and guided imagery). In order to determine the extent of effectiveness contributed by each of the various RSDH components, and possibly so order them as to optimize the benefits posed by RSDH in use with the elderly, the following recommendations for future research are posed:

- (1) The exploration of the effects contributed by guided imagery, a component which provides a safe, non-threatening vehicle for subjects to familiarize themselves with difficult situations and emotions and to practice alternative, more rational behaviors.
- (2) The utilization of instruments to verify whether the cognitive component does induce a change in cognitions for the institutionalized elderly when cognitive restructuring is employed as a part of the RSDH model.
- (3) An exploration of possible alternative roles posed by cognitive restructuring when used as a component of the RSDH model. Research is needed in this

area to determine whether the above proposed hypothesis concerning the possible "air of authenticity" is the more accurate contribution provided by cognitive restructuring.

- (4) An assessment of various roles played by RSDH components in enhancing effects of RSDH treatments over post-treatment periods.
- (5) A systematic evaluation of RSDH and its use in eliciting effects with a variety of other socioeconomic and ethnic aging populations.
- (6) An exploration of effects posed by RSDH in application to non-institutionalized elderly--what with only 5% of our elderly presently being institutionalized (Grollman, 1974).
- (7) The use of this model with aging populations residing in different geographical areas of the United States.
- (8) The employment of more male subjects to determine sex specific differences (if any) in the effectiveness of RSDH treatment.
- (9) The development of procedures for total randomization of treatment groups by addressing problems posed by schedules and interpersonal conflicts.
- (10) An exploration of RSDH treatment effects with younger geriatric populations (under the age of 81).

- (11) The use of RSDH treatment with a variety of other institutionalized elderly aside from nursing homes--hospitals, short term convalescent centers and mental health facilities.
- (12) The use of RSDH with elderly subjects who are less cognitively aware.

These recommendations for research concern the specific effectiveness contributed by each of the RSDH components, the extent/nature of any hypothesized synergistic interactions, and the use of this treatment relevant to a variety of populations and specific conditions. Results may be seen to contribute greatly to the currently limited understanding of what appears to be a potent and highly promising treatment model for use with aging populations. Thus, future research with RSDH may result in greater understanding and further refinement of a much needed treatment modality which could enhance the health and welfare of our aging population.

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APPENDIX A

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TENNESSEE SELF CONCEPT SCALE

ΒY

William H. Fitts, Ph.D.

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APPENDIX D

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HYPNOSIS ONLY TREATMENT

FOUR PART HYPNOTIC/RELAXATION INDUCTION

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This section includes a transcript used in the Hypnosis Only treatment. The transcript, as presented, represents an exact copy of the one read by the therapist. Punctuation as utilized in this transcript is structured for the purpose of indicating vocal emphases and pauses of the therapist during the actual therapy sessions. Therefore, punctuation found herein may not follow the rules of grammer.

SESSIONS I-VIII

Part I: Deep Breathing

Start taking in deep breaths and feel the air circulating around your lungs into the very bottom 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 let your eyes close, you find yourself becoming even more comfortably relaxed. You may notice outside noises and talking, but nothing will bother you...nothing will affect your becoming 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 in a very comfortable...a very warm...a very relaxed state...a very deeply relaxed state. You can stop deep breathing now (if you have not already done so) and begin to concentrate on the second part of our relaxation process...the muscle relaxation.

Part II: Cognitive Muscle Relaxation

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

Concentrate now on all of the muscles in your forehead; feeling them losing 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 coming over them. This feeling of comfort is coming from your shoulders to your back...around your sides...to your chest. Your muscles completely relax. And, as you concentrate on allowing your muscles to become even more relaxed...they do so automatically. Your chest wall moves up and down effortlessly ...up and down...you can feel it floating as you become

absolutely relaxed. You may be experiencing a very warm and very comfortable floating sensation...a very safe sensation. 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... becoming very relaxed. The muscles feel like they are just melting into relaxation...and they are now completely relaxed. From your knees to the tips of your toes, you find yourself in a very deep state of relaxation; a very deep and pleasant state...a very beautiful and comfortable state.

As you are in this very relaxed, comfortable, safe, state, you can go very easily and automatically into the third stage of the relaxation process which involves the scene.

Part III: Relaxing Scene

Now imagine yourself on a beach. It can be any beach you like--any beach you are familiar with. But you are all alone. There is no one there to disturb you. There is a blue sky overhead and a very calm, gentle sea in front of you. You can feel the warmth of the sun's rays as they touch your face. It is a perfectly glorious summer day. There is a very pleasant, cool breeze coming off of the water. You are feeling very relaxed and just enjoying the beauty of nature...the sea...the sky...the wind against your body. As you look out to sea, you notice that you can see that hazy blue line on the horizon where the sky meets the sea. And as you look at the horizon, you can see (in the distance), that the water is rolling, rolling, rolling toward the shore. As you watch it rolling, rolling, rolling toward the shore, you see that the rolling mounds of water become waves. You can see the waves continue rolling, rolling, rolling in, until they finally come up to the shore as white surf and retreat back, the waves come up to the shore as white surf and retreat back. You may even be able to hear the sounds of the waves as they come up to the shore. As you stand on the beach, you can hear the sound of the seagulls as they glide in over the beach and the water. You may be able to feel the dampness of the wet sand beneath your bare feet. Or you may be able to feel the coolness of the water as the edge of the surf

gently comes up and covers your feet and retreats back, comes up and covers your feet and then retreats back. Overhead you see some beautiful white fluffy clouds, and you are so deeply relaxed that it is almost as if you are up there floating with those clouds. And you feel so completely free, free from all the worries of the world as you simply take time out for this mini-imagination vacation trip and enjoy the extreme comfort of a state of complete relaxation. And while you are in the beautiful scene, I will count from one to twenty. And as I count from one to twenty you will feel yourself becoming more and more deeply relaxed until finally at the count of twenty you will find yourself in a total complete state of relaxation in which every part of your body is completely free from tension.

Part IV: Deepening Procedure

One, two, three, more and more relaxed; four, five six, deeper and deeper into relaxation; seven, eight, nine, you are becoming extremely relaxed now, extremely relaxed; ten, eleven, twelve, deeper and deeper; thirteen, fourteen, fifteen, very, very relaxed, deeper and deeper and deeper; sixteen, seventeen, you are almost there, almost completely relaxed...completely relaxed; eighteen, nineteen, you are profoundly relaxed, almost completely relaxed...almost totally relaxed; twenty, you are now totally and completely, relaxed. And while you are in this deep state of relaxation I will pause for a few moments to simply allow you to have some time to really enjoy the state of relaxation. Because it is a very beautiful state indeed. And after a few moments I will count from one to five and on the count of five you will wake up feeling very, very relaxed indeed, and with possibly more energy than you had in the very beginning of the day. Now I will pause and let you enjoy the state of relaxation for a few moments.

(Pause about thirty seconds)

Awakening Procedure

Now I will count from one to five. On the count of five you will wake up feeling very, very refreshed indeed, and with perhaps more energy than you had at the very beginning of the day; because this is a physiological process as well as a psychological process. When you relaxed your muscles you also relaxed yourself along with your muscles. One...two...three...four...five. APPENDIX E

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COGNITIVE RESTRUCTURING ONLY TREATMENTS

This section includes transcripts used in the Cognitive Restructuring Only treatment. Transcripts, as presented, represent an exact copy of those read by the therapist. Punctuation as utilized in these transcripts is structured for the purpose of indicating vocal emphases and pauses of the therapist during the actual therapy sessions. Therefore, punctuation found herein may not necessarily follow the rules of grammer.

SESSIONS I and II

The purpose of this group is to learn how our emotions are formed and how to change our feelings at will in the future. In other words, we are going to learn how to never be unhappy, depressed, angry, or frustrated again unless we want to do so. Most people believe that they feel the way they do because of the things that people say to them, and do to them, during the course of their daily activities. However, this is not really the case. Today we will begin to learn about the scientific reasons behind the way we feel, and why we do the things we do. This process involves using more rational and positive thoughts or attitudes, about the things that happen around us. It is known as rational thinking or cognitive restructuring. When a person understands the basic ideas involved in why emotions work, they are on their way to controlling their feelings if they wish to do so.

Cognitive restructuring operates with the idea that certain irrational beliefs are associated with negative feelings and behaviors. By changing the irrational thoughts to more rational thoughts, we can feel more positive feelings, experience a decrease in negative feelings, and also decrease the times our actions prevent us from getting what we want.

Research has indicated that most of our feelings and behaviors are actually caused by what we are thinking; or,

in other words, by what we are telling ourselves about the situation in which we find ourselves. With the method of cognitive restructuring, a very simple model has been developed for understanding our feelings and how they work. According to this model we come in contact with a situation which we will call point "A". This can be the result of an interaction with a resident, a family member, a staff member or any other event that occurs. Following this event you have some thoughts and beliefs about the incident. These thoughts and beliefs we shall call point "B". These are the things we are telling ourselves and believing about ourselves -- a form of self-talk. From this self-talk we then experience feelings that are directly related to what we were thinking. These feelings and emotions occur at what we shall call point "C". Thus, when an event occurs, and we think rational or positive thoughts about it, we feel better. We generally experience warmer feelings, and as a result we are more able to handle an event in a more optimal manner. The result is usually that we are better able to get what we want out of situations.

Now that we have learned that our feelings occur in the "A", "B", "C" fashion, let us quickly review the model and see how it would apply to a situation in our own lives. Remember that our model tells us that feelings start with an event. This is called point "A". Following this event we tend to think and believe things about it and that is

the point we call point "B". Then, depending on what we thought and believed at point "B" we experience an emotion that is called point "C".

Now let us use the model in a practical way in order to see how it can give us the secret to never having to feel negative thoughts again unless we want to do so.

In this example, let us say that you get up in the morning and say "hello" to a fellow resident in the hall on the way to breakfast. The other person simply does not respond. This is the incident or the situation we will now call point "A". Next you experience some "self-talk" or some thoughts and beliefs about the situation. You may think that the other person is ignoring you and that the other person does not like you. This thought or self-talk is what we will call point "B". At this point you decide that you do not like them, since it is your belief that they do not like you. This unpleasant feeling of anger is your "emotional" response that we call point "C". After you feel this anger you may act in a angry way by saying something negative to the other person, or simply deciding that you will not let them be your friend. You may also feel physical tension as you feel these uncomfortable emotional feelings. This is the way your emotions work when negative feelings are produced.

Now, in keeping with our objective of trying to learn how never to have to feel uncomfortable feelings again, let

us look at the same situation again. This time, however, let us look at it in a more rational manner. Again you get up in the morning and say "hello" to the resident in the hall. Again the other person does not respond. This is the point we have already called point "A". However, this time your thoughts and beliefs at the point we call "B" are somewhat different. They are more rational. This time you think that the other person may not have been able to hear you, and you believe that they would have spoken to you if they knew that you had said "hello" to them. You think that if they had heard you speaking to them, then they would have really appreciated your gesture. These are the new thoughts and beliefs (at point "B"). After having these thoughts you do not feel anger at point "C". You realize that the other person has a hearing problem. You still want very much to communicate your morning's greeting to them. Your feeling or emotion (at point "C") is one of calm patience that leads you to feeling more comfortable and at ease inside. You are then able to walk up to that other person, gently tap them on the shoulder, and tell them good morning in a voice that they can hear. This behavior results in the fellow resident giving you a warm smile and showing appreciation for your kind gesture. The result of this is more good feelings.

By this example, you can see how important your thoughts are in producing your feelings. During the time

between this meeting and the next you may want to experience how your feelings can be effected by thinking more rational thoughts. In order to do this, simply ask what it is that you are telling yourself the next time a situation occurs where you experience bad feelings. Then see that when you change your irrational thoughts to more rational thoughts you will feel better and be able to behave in ways which result in your getting what you want out of a situation.

SESSIONS III and IV

During the last two/three sessions we discussed the basic concepts of Rational Thinking. We talked about the idea, that thoughts have a direct affect on feelings and emotions, and that those feelings and emotions lead to behaviors that we display when we deal with people and situations within our environment. During this session, we will review the Rational A-B-C Model, and further explore ways in which we can use the model to have a positive affect upon our lives.

First, you will remember that the model we discussed last week had three basic components. First, there was a situation. This could be an event that happened to us which involved other people, or something around us. This situation or event we called point "A". Following point "A", we began to notice that we experienced some thoughts or attitudes about the situation. Those thoughts were our evaluation of what was happening at situation "A". We could have had positive thoughts about situation "A"-like: I really enjoyed that experience or that thing that someone else did; I feel good about that situation; or, I would like to experience a similar situation in the future. We could also have negative thoughts about situation "A"-like: this is really scary; that situation makes me feel badly; or, I dislike that other person involved in the situation. These thoughts we have about the situation, we

call "self-talk", which is, of course, point "B". Now, after we experience the "self-talk" (our thoughts and attitudes we are telling ourselves about the situation "A"), we will find ourselves experiencing a feeling or an emotion. If the "self-talk" ("B") about the situation ("A") is rational, the emotion, will be more positive--like happiness, a feeling of satisfaction or a feeling of pleasure. If the "self-talk" at point "B" is negative or irrational, then the emotion at point "C" will also be negative. These negative emotions ("C") may include: anger; hate; discontent; or, fear. We can, therefore, see that the things we think and believe about a situation or event ("A") can have a significant effect on our emotions and feelings.

One might believe that the process ends there, but it does not. After a person feels or experiences certain emotions, their behaviors (that follow those emotions) reflect the type of feelings that the person experienced. These behaviors, or the things we do in certain situations, are what we do as a consequence of our rational or irrational feelings.

We can better learn to use this model, to help ourselves obtain more positive feelings and do more positive things, if we take examples of situations which have occurred in our own lives, and examine them according to our new A-B-C model. Therefore, I would like for you to think back and remember a situation that occurred to you in the

past in which you felt some emotional discomfort. (pause) This situation could involve your interactions with other persons or your interactions with things around you. It could also involve a combination of these two things. (pause) Now that you have a situation in mind, you can call that situation point "A". As you imagine this situation get in touch with how you felt about that situation. lf this was a situation that caused you discomfort you may have felt anger, boredom, frustration, loneliness, failure, worry, anxiety, etc. This feeling or emotion that you experienced is point "C". Now, I would like for you to think about your "self-talk" (your beliefs and attitudes that you held about the situation). These beliefs and attitudes we call point "B". Examples of negative self-talk could be: I cannot do it; I hate that person; I hate this place; I do not feel that other people care about my problems; etc. After you have gotten in touch with your self-talk at point "B", notice how your negative self-talk leads logically to your negative emotions at point "C". Now, look at the things you did when you experienced this uncomfortable feeling. Examples of behaviors that follow negative feelings might be yelling at others, being sarcastic, crying, being too demanding, overeating, etc. Notice how negative thoughts lead to negative feelings, and negative feelings lead to actions that we may not want to display, and that may prevent us from getting what we want.

Now, let's take the same situation and think about the type of thoughts and beliefs that we could have had that would have lead to a different, more desirable feeling. Go back to your original situation "A". Now, this time, instead of thinking the same negative, irrational thoughts at point "B" that you had previously thought, just replace those thoughts with more rational thoughts. At point "B" you begin to realize that you are a very worthwhile human being, and even if another person says something that displeases you, that does not detract from the fact that you are still very worthwhile. You begin to realize that the other person may not mean the thing that is being said or done, or that the other person may be responding to their own problems. If the situation does not involve people, you may view it in such a manner that you realize it is alright to make mistakes, and that everything in life does not have to be exactly as you would like it. You may realize, that you are still a good human being even if everything does not go your way, or if everyone does not like everything about you. These new "self-talk" statements are your point "B" statements. Notice how your feelings become much more calm when you think the new rational statements at point "B". Your new feelings "C" about the situation "B" are much less disturbing and may be somewhat positive. You begin to feel good about yourself. You will notice that these better feelings and emotions are soon followed

by more appropriate behaviors.

I would like for you to be conscious of our new Rational model, and use this model between sessions whenever you experience anything that may be discomforting. In changing your irrational "self-talk" to more rational "selftalk", you will learn to automatically experience more optimal feelings in the future, unless you do not wish to experience them.

SESSIONS V and VI

During the last four/five sessions we discussed the basic concepts of Rational Thinking. As you will remember, we have discussed the idea that thoughts have a direct effect on feelings and emotions, and that those feelings lead to behaviors we use when we interact with other people and with the world about us. We explored the A-B-C model as it would apply to a situation in our own lives. During this session we will continue to learn about the rational model. However, this session will also make you aware of the importance of your self-concept, how it may affect your feelings, and the way you handle the things that occur in your life.

Now, your self-concept is basically the feelings and beliefs that you hold about yourself, and the beliefs you hold concerning your ability to deal with the world. This fits in conveniently with the cognitive restructuring model. If we begin to substitute the more positive and rational beliefs for our irrational and negative beliefs, we find that we are able to change our self-concept in a positive manner. When our self-concept increases, we usually are able to handle events in our lives in a manner which is more satisfactory to us. In other words, when we have a higher self-concept, we will be more likely to behave in a way that gets us what we want, and also helps us feel good about our actions.

When you think more positive things about yourself, you tend to feel positive emotions about yourself and others. When you improve your self-concept, you improve the way you feel about and interact with your environment. There is also research that indicates that when you improve your self-concept, you will begin to feel better physically, and you will tend to be ill less frequently. It is for these reasons that it is important to recognize your positive self-worth. If you are blaming yourself for any mistakes that you may have made in the past, it is important to recognize and understand that anything you did in the past does not have a significant impact on your behaviors today, unless you continually tell yourself that it does. You might put yourself down because you feel that you are not making significant contributions or progress in life. It is important to realize that by putting yourself down, you are really lowering your self-concept, lowering your confidence, and you may become depressed. You may become unable to explore alternatives and possibilities for doing things that you feel are worthwhile and positive. You may become angry at yourself for past conflicts with family members. You may feel that there were some things that you would have liked to have handled differently. If you do not blame yourself for such past mistakes, you will find that you will become increasingly better able to deal with such situations in the future, in a more positive and

satisfying manner.

As you can see, it is important to be aware of the times that you tell yourself negative things that make you feel inferior, or not as good as other people. Today we will use our rational A-B-C model in order to see how it is possible to change negative self-talk to more rational, positive, self-talk that will result in a more positive selfconcept.

Now think of a time when you were in a situation, and felt badly about the way you handled that situation; or, about what happened in the situation. Again, this situation will be what we will call the event or the situation "A". In this situation you were telling yourself (at point "B") negative things that were making you feel badly about yourself. You may have been thinking that you were not as good as the other people in the situation, and you may have been putting yourself down. Your self-talk was making you feel badly. At point "C" you felt a feeling of being less worthwhile and possibly somewhat depressed. Or, perhaps you felt angry because you could not handle the situation in the way you wanted. These emotions may have lead to some negative feelings about yourself and your worth as a person. You may have even felt some physical discomfort as you experienced these negative feelings.

Now, think of the same situation. Only, in this case, instead of thinking the negative self-thoughts about your-

self, you are thinking more positive thoughts which lead to a good feeling about yourself and the sit. ation. You may think that you are quite capable of handling the situation, and that your beliefs and ideas are as valuable as other's beliefs in that situation. Your thoughts (at point "B") are not designed to put yourself down. You begin to realize that you are still a good person--a worthwhile human being--even if everything does not go your way, or if everyone around you does not like everything about you. You also notice that you are able to handle the situation in a manner that is more satisfactory with you. You realize that when you think more rational, positive thoughts about yourself, and therefore feel better about yourself, you are able to deal with situations more effectively, and feel better both emotionally and physically.

I would like for you to be conscious about the things you are telling yourself which affect your self-concept, as well as the things you tell yourself which affect other feelings that you experience. You may want to explore these concepts between this session and the next, whenever you are experiencing anything that is discomforting to you. In changing your irrational self-talk, about yourself, and about the world around you, you will learn to automatically experience positive feelings in the future, unless you do not wish to experience them.

SESSION VII

During the past six group sessions we discussed the concepts of Rational Thinking. To review these concepts, you will remember that we discussed the idea that thoughts have a direct affect on feelings and emotions; and, that those feelings lead to the behaviors we use when we interact with other people and with the world around us. You have learned about the A-B-C model, as it applies to situations in your life. You have learned that at point "A" an event or situation occurs. Then you form thoughts or beliefs (called "self-talk") about the situation at point "A". Following this sequence you feel an emotion or feeling at point "C", and that leads to what you do about the situation. We have discussed how this model works in developing our self-concept. You now know that if we think more rational thoughts about ourselves, and about our abilities to affect the world around us, we will have a more positive self-concept and will feel better about ourselves, our abilities, and how we interact with others. You know that when you improve your self-concept you improve the way you interact with others, and you are more likely to get you want out of any given situation.

Over the past few sessions we have looked at situations in your lives and you changed your irrational "selftalk" into more rational "self-talk", You have found that when you have done this, you feel better about yourself

and about the situation. Between sessions, you have observed incidents in your life in which your use of more rational "self-talk" has lead to a more satisfying outcome from a situation and a better feeling of yourself. Today, I want you to recall some of those recent times and review them as to how your emotions and actions changed when your self-talk became more rational. Recall a time when something happened that began with a situation "A" that could have resulted in irrational, negative "self-talk" (point "B"), and subsequently you started feeling badly about yourself and about the situation. However, at point "B", this time, you became aware of your irrational "self-talk" and changed these thoughts and beliefs to more rational ones designed to help you feel better about yourself and the things you do. As a result of using more rational "selftalk" at point "B", this time you found that you did in fact handle the situation better, and you found that you felt like a more worthwhile person. These more positive emotions were a result of your new rational thoughts. You may even have felt that you were more capable than before of positively affecting others around you and of getting what you want out of situations.

As you continue to use this model between this session and the next session, notice how much more effective you become in your communication with others, and how you feel progressively better about yourself. You will be able to

think and use more rational self-talk in different areas of your life. You will find that with some practice in thinking rationally, you will start thinking rationally without having to be totally aware of it. Rational thinking will become a habit, just as your irrational thinking may presently be a habit. With your new habitual form of rational thinking behavior, you will be able to use the rational model with your family, your fellow residents, the home staff, and with all other areas of your life that you will encounter in the future.

Between this session and the next I would like for you to continue practicing the rational model in more and more areas of your life. I would also like for you to notice how the use of this new rational thinking model affects your feelings about yourself and your self-concept. In the next, and the last session, we will again review these important principles involved in developing better feelings and emotions, and help you learn to use your new rational model very effectively in the future.

SESSION VIII

During the past seven sessions we discussed the concepts of Rational Thinking. To review these concepts, you will remember that we discussed the idea that thoughts have a direct affect on feelings and emotions; and, that those feelings lead to the behaviors we use when we interact with other people and with the world around us. You have learned about the A-B-C model as it applies to situations in your life. You have learned that (at point "A") an event or situation occurs that you form some thoughts or beliefs about (at point "B"). These thoughts or beliefs become your "self-talk" or what you are telling yourself about situation "A". Following this sequence you feel an emotion or feeling at point "C", and that then leads to how you feel emotionally and what you do about the situation behaviorally. We have also discussed how this model works in developing our self-concept. You now know that if you think more rational thoughts about yourself, and about your abilities to affect the world around you, you will have a more positive self-concept and will feel better about yourself, your abilities, and how you interact with others. You know that when you improve your self-concept, you improve the way you interact with others, and you are more likely to get what you want out of any given situation.

Over the past few sessions you have looked at situations in your own life and you changed your "irrational

self-talk" into more "rational self-talk." You have found that when you have done this, you feel better about yourself and about the situation. Between sessions, you have observed times in your life in which your use of more rational self-talk has lead to a more satisfying outcome from a situation or a better feeling about yourself. Today, I want you to recall some of those recent times and review them as to how your emotions and actions changed when your self-talk became more rational. Recall a time when something happened that began with a situation ("A") that could have resulted in your thinking irrational, negative selftalk (point "B"), and subsequently your feeling badly about yourself and about the situation. However, at point "B", you may have thought more rational thoughts, now that you have learned about this new rational model designed to help you feel better about yourself and the things you do. As a result of using more rational self-talk at point "B", this time you found that you did, in fact, handle the situation better, and you found that you felt like more worthwhile person. These more positive emotions were a result of your new rational thoughts. You may even have felt that you were more capable than before of positively affecting others around you and of getting what you want out of situations.

As you continue to use this model, notice how much more effective you become in your communication with others, and how you feel progressively better about yourself. You will be able to think and use more rational self-talk in a wider variety of areas in your life. You will find that with some practice in thinking rationally, you will begin to think rationally more and more of the time without having to be totally aware of it. Rational thinking will become a habit, just as your irrational thinking may have been a habit in the past. With your new habitual form of rational thinking behavior, you will be able to use the rational model with your family, your fellow residents, the home staff, and with all other areas of your life that you will encounter in the future.

After this session I would like for you to continue practicing the rational model in a wider variety of areas of your life. I would like for you to notice how the continued use of this new rational thinking model effects your feelings about yourself and your self-concept. In the future you will find that these principles will be of great use in developing better feelings and emotions.

Now that you have attended eight sessions, during which you have learned the Rational A-B-C model, you have also learned to use a powerful new technique designed to help you in almost any type of disturbing situation. You will find, as you continue to use this technique, that you will feel better and better about yourself. You will develop a better self-concept. You will also find it easier to cope with daily situations in your life that might have

previously disturbed you. As you continue to apply the technique in more and more situations, you will find that you will have greater ability to cope with your world and you will develop a greater sense of self-satisfaction.

In stressful situations you need only remember the A-B-C model, and change your irrational thoughts to more rational thoughts, and you will have control over the way you feel. If you continue to practice this method, and continue to practice thinking more rationally in your daily life, you will find that this new way of thinking will become easier and easier, until it becomes the natural way in which you approach situations. You will find that this new way of thinking and believing is a key to feeling happier and more self-fulfilled.

APPENDIX F

RATIONAL STAGE DIRECTED THERAPY TREATMENTS

This section includes transcripts used in the Rational Stage Directed Therapy treatment. Transcripts, as presented, represent an exact copy of those read by the therapist. Punctuation as utilized in these transcripts is structured for the purpose of indicating vocal emphases and pauses of the therapist during the actual therapy sessions. Therefore, punctuation found herein may not necessarily follow the rules of grammer.

SESSIONS I and II

Part I: Deep Breathing

Start taking in deep breaths and feel the air circulating around your lungs into the very bottom 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 let your eyes close, you find yourself becoming even more comfortably relaxed. You may notice outside noises and talking, but nothing will bother you...nothing will affect your becoming 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 in a very comfortable...a very warm...a very relaxed state...a very deeply relaxed state. You can stop deep breathing now (if you have not already done so) and begin to concentrate on the second part of our relaxation process...the muscle relaxation.

Part II: Cognitive Muscle Relaxation

Begin to concentrate on allowing all of the muscles in your body to become completely relaxed. You will find,

as you let your muscles relax, that you can get even deeper into relaxation.

Concentrate now on all of the muscles in your forehead; feeling them losing tension...becoming very, very soft and relaxed...absolutely relaxed and comfortable. With all of 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 coming over them. This feeling of comfort is coming from your shoulders to your back...around your sides...to your chest. Your muscles effortlessly relax. And, as you concentrate on allowing your muscles to become even more relaxed...they do so automatically. 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 very comfortable floating sensation...a very safe sensation. Now, with each muscle in your chest absolutely relaxed...beautifully relaxed...concentrate on all of 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... becoming very relaxed. The muscles feel like they are just melting into relaxation...and they are now completely relaxed. From your knees to the tips of your toes, you find yourself in a very deep state of relaxation; a very deep and pleasant state...a very beautiful and comfortable state.

As you are in this very relaxed comfortable, safe, state, you can go very easily and automatically into the third stage of the relaxation process which involves the scene.

Part III: Relaxing Scene

Now imagine yourself on a beach. It can be any beach you like--any beach you are familiar with. But you are all alone. There is no one there to disturb you. There is a blue sky overhead and a very calm, gentle sea in front of you. You can feel the warmth of the sun's rays as they touch your face. It is a perfectly glorious summer day. There is a very pleasant cool breeze coming off of the water. You are feeling very relaxed and just enjoying the beauty of nature...the sea...the sky...the wind against your body. As you look out to sea, you notice that you can see that hazy blue line on the horizon where the sky meets the sea. And as you look at the horizon, you can see (in the distance), that the water is rolling, rolling, rolling toward the shore. As you watch it rolling, rolling, rolling toward the shore, you see that the rolling mounds of water become waves. You can see the waves continue rolling, rolling, rolling in, until they finally come up to the shore as white surf and retreat back, the waves come up to the shore as white surf and retreat back. You may even be able to hear the sounds of the waves as they come up to the shore. As you stand on the beach, you can hear the sound of the seagulls as they glide in over the beach and the water. You may be able to feel the dampness of the wet sand beneath your bare feet. Or you may be able to feel the coolness of the water as the edge of the surf
gently comes up and covers your feet and retreats back, comes up and covers your feet and then retreats back. Overhead you see some beautiful white fluffy clouds, and you are so deeply relaxed that it is almost as if you are up there floating with those clouds. And you feel so completely free, free from all the worries of the world as you simply take time out for this mini-imagination vacation trip and enjoy the extreme comfort of a state of complete relaxation. And while you are in the beautiful scene, I will count from one to twenty. And as I count from one to twenty you will feel yourself becoming more and more deeply relaxed until finally at the count of twenty you will find yourself in a total, complete state of relaxation in which everypart of your body is completely free from tension.

Part IV: Deepening Procedure

One, two, three, more and more relaxed; four, five, six, deeper and deeper into relaxation; seven, eight, nine, you are becoming extremely relaxed now, extremely relaxed; ten, eleven, twelve, deeper and deeper; thirteen, fourteen, fifteen, very, very relaxed, deeper and deeper and deeper; sixteen, seventeen, you are almost there, almost completely relaxed...completely relaxed; eighteen, nineteen, you are profoundly relaxed, almost completely relaxed...almost totally relaxed; twenty, you are now totally and completely relaxed. And while you are in this deep state of relaxation I will pause for a few moments to simply allow you to have some time to simply enjoy the state of relaxation. Because it is a very beautiful state indeed. And after a few moments I will count from one to five and on the count of five you will wake up feeling very, very relaxed indeed, and with possibly more energy than you had in the very beginning of the day. Now I will pause and let you enjoy the state of relaxation for a few moments.

(Pause about thirty seconds)

Awakening Procedure

Now I will count from one to five. On the count of five you will wake up feeling very, very refreshed indeed, and with perhaps more energy than you had at the very beginning of the day; because this is a physiological process as well as a psychological process. When you relaxed your muscles you really relaxed yourself along with your muscles. One...two...three...four...five.

SESSIONS III and IV

Section I: To be presented without relaxed state

In this session we will begin to learn how to use our relaxed state in order to learn and experience how our thoughts and attitudes affect our feelings. The process of using more rational or positive thoughts, in various situations, in order to change our emotions to more pleasant ones, is called "cognitive restructuring". Cognitive restructuring operates under the idea that certain irrational beliefs are associated with negative emotional, physiological, and behavioral responses. By changing the irrational thoughts to more rational thoughts we can feel more positive emotions, experience a decrease in some types of physical disorders, and change behaviors in such a way that we can have much more positive effects over our surroundings.

Most people believe that feelings are caused by what others do to us. If another person says something to us that we do not like, it is believed that that other person makes us angry or hurt by what they are saying to us. However, research has indicated that most of our emotional and physiological behaviors are actually caused by what we are thinking or by what we are telling ourselves. In cognitive restructuring there has been developed a very simple model for understanding our emotions and how they work. According to this model we come in contact with a situation which we call point "A". Following this incident we have some thoughts and beliefs about the incident. These thoughts we call point "B". They are the things that we are telling ourselves or the "self-talk". Following our "self-talk" we will then experience an emotion that is directly connected with the type of self-talk that we used. It sounds as if the process would end there--but it does not. If we are actually using this irrational or negative self-talk, we can then develop some physiological or physical problems that are discomforting--such as headaches or nausia. These body discomforts occur at a place that we will call point "D". So when we have both unpleasant self-talk and unpleasant physical feelings, we may be behaving in a manner where we loose positive (or desirable) control over our environment.

An example of this could be, that you get up in the morning and say "hello" to a fellow resident in the hall on the way to breakfast. The other person simply does not respond. This is the incident or the situation that we will call point "A". Next, you have some self-talk or thoughts and beliefs about this situation. You may think that that other person is ignoring you and that that other person does not like you. This thought is your self-talk we will call point "B". From this point you may begin to feel very angry toward this person. You may decide that

you do not like the other person since you believe that they do not like you. This unpleasant feeling of anger is your emotional response that is known as point "C". After you experience this anger you may be aware of the fact that it affects you physically. You may feel your muscles tighten, you may feel tension surrounding different parts of your body, this may lead eventually to headaches or even to such things as digestive problems. Such anger or unpleasant emotions could also lead to other undesirable physical feelings or disorders. These physical responses are what we will call point "D". At point "E", you may followup your anger and discomfort by striking out--by doing something. You may say to the other person that you do not like them and that you do not intend to speak to them anymore. This behavioral response is what we will call point "E". Notice that when your thoughts and beliefs are irrational or negative, the rest of the sequence is also negative and uncomfortable.

Using this same example you could get up in the morning and say "hello" to one of your fellow residents in the hall. This is again point "A". They do not respond. However, this time, you think that the other person cannot hear you. You think that if they knew you were speaking to them they would really appreciate your gesture. These are thoughts that you have at point "B". Along with these thoughts you do not feel anger this time at point "C". You realize that the other person has a hearing problem. You also want very much to communicate your morning greeting to them. Your emotion "C" is one of calm patience that leads to physical responses that are not negative. You do not feel uptight or tense inside. At this point (called "D") your physical feelings are those of being very calm. At point "E", since you want to communicate with your fellow resident, who did not hear you, you walk up to that person and gently tap them on the shoulder and tell them good morning in a voice that they can hear. This behavior results in the fellow resident giving you a warm smile and showing appreciation of your kind gesture. The result is more good feelings.

In the exercise that we will do today, we will follow the same procedure as we have followed in the past. We will imagine the beautiful scene, and will experience the pleasantness of being totally relaxed. After our deepening procedure (where I count from one to twenty), we will go through the example we just reviewed of irrational and rational behaviors, and we will experience the resulting feelings of that situation while we are in the protection of our highly relaxed state.

Section II: Four Part Induction

Part I: Deep Breathing

Start taking in deep breaths and feel the air

circulate around your lungs into the very bottom 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 inhaling relaxation--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. As you let your eyes close, you find yourself becoming even more comfortably relaxed. You may notice outside noises and talking, but nothing will bother you...nothing will affect your becoming 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 in a very comfortable...a very warm...a very relaxed state...a very deeply relaxed state. You can stop deep breathing now (if you have not already done so) and begin to concentrate on the second part of our relaxation process..the muscle relaxation.

Part II: Cognitive Muscle Relaxation

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

Concentrate now on all of the muscles in your forehead; feeling them losing tension...becoming very, very soft

and relaxed...absolutely relaxed and comfortable. With all of 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 coming over them. This feeling of comfort is coming from your shoulders to your back...around your sides...to your chest. Your muscles effortlessly relax. And, as you concentrate on allowing your muscles to become even more relaxed...they do so automatically. Your chest wall moves effortlessly up and down ... up and down... you can feel it floating as your become absolutely relaxed. You may be experiencing a very warm and very comfortable floating sensation ... a very safe sensation. Now, with each muscle in your chest absolutely relaxed...beautifully relaxed...concentrate on all of 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 mus cle in the lower half of your body to become completely and totally relaxed. Starting with all the muscles in your hips, allow those muscles to become very, very relaxed... becoming very relaxed. The muscles feel like they are just melting into relaxation...and they are now completely relaxed. From your knees to the tips of your toes, you find yourself in a very deep state of relaxation; a very deep and pleasant state...a very beautiful and comfortable state.

As you are in this very relaxed, comfortable, safe, state; you can go very easily and automatically into the third stage of the relaxation process which involves the scene.

Part III: Relaxing Scene

Now imagine yourself on a beach. It can be any beach you like--any beach you are familiar with. But you are all alone. There is no one there to disturb you. There is a blue sky overhead and a very calm, gentle sea in front of you. You can feel the warmth of the sun's rays as they

touch your face. It is a perfectly glorious summer day. There is a very pleasant cool breeze coming off of the water. You are feeling very relaxed and just enjoying the beauty of nature...the sea...the sky...the wind against your body. As you look out to sea, you notice that you can see that hazy blue line on the horizon where the sky meets the sea. And as you look at the horizon, you can see (in the distance), that the water is rolling, rolling, rolling toward the shore, you see that the rolling mounds of water become waves. You can see the waves continue rolling, rolling, rolling in, until they finally come up to the shore as white surf and retreat back, the waves come up to the shore as white surf and retreat back. You may even be able to hear the sounds of the waves as they come up to the shore. As you stand on the beach, you can hear the sound of the seagulls as they glide in over the beach and the water. You may be able to feel the dampness of the wet sand beneath your bare feet. Or you may be able to feel the coolness of the water as the edge of the surf gently comes up and covers your feet and retreats back, comes up and covers your feet and then retreats back. Overhead you see some beautiful white fluffy clouds, and you are so deeply relaxed that it is almost as if you are up there floating with those clouds. And you feel so completely free, free from all the worries of the world as you

simply take time out for this mini-imagination vacation trip and enjoy the extreme comfort of a state of complete relaxation. And while you are in the beautiful scene, I will count from one to twenty. And as I count from one to twenty, you will feel yourself becoming more and more deeply relaxed until finally at the count of twenty you will find yourself in a total complete state of relaxation in which every part of your body is completely free from tension.

Part IV: Deepening Procedure

One, two, three, more and more relaxed; four, five six, deeper and deeper into relaxation; seven, eight, nine, you are becoming extremely relaxed now, extremely relaxed; ten, eleven, twelve, deeper and deeper; thirteen, fourteen, fifteen, very, very relaxed, deeper and deeper and deeper; sixteen, seventeen, you are almost there, almost completely relaxed..completely relaxed; eighteen, nineteen, you are profoundly relaxed, almost completely relaxed..almost totally relaxed; twenty, you are now totally and completely relaxed.

Section III: Cognitive Therapy Session (Continues):

Now, I want you to imagine the situation that we discussed earlier. I will read it exactly as I did before, and as I read it, I would like for you to get in touch with the anger of the irrational or negative thought sequence-and with the positive (better) feelings associated with the rational thought sequence. Now, imagine that you are

in the hallway in the morning and you say "hello" to a resident. The other person simply does not respond. This is the incident or the situation that we will call point "A". Next you have some self-talk or thoughts and beliefs about this situation. You may think that the other person is ignoring you and that that other person does not like This thought or self-talk we will call point "B". you. From this point you may begin to feel very angry toward this person. You may decide that you do not like them either. This unpleasant feeling of anger is your emotional response that is known as point "C". After you experience this anger you may be aware of the fact that it affects you physically. You may feel your muscles tighten, you may feel tension surrounding different part of your body. This may lead eventually to headaches or even to such things as digestive problems. Such anger or unpleasant emotions could also lead to undesirable physical feelings or disorders. These physical responses are what we call point "D". At point "E", you may followup your anger and discomfort by doing something--by striking out. You may say to the other person that you do not like them either and that you do not intend to speak to them anymore. This behavioral response is what we call point "E". Notice that when your thoughts and beliefs are irrational or negative, the rest of the sequence is also negative and uncomfortable.

Now, that you are aware of the unpleasant feelings

associated with the irrational thought sequence, you are going to experience, this time, the more pleasant situation. Again, imagine you are in the hallway on the way to breakfast. You say "hello" to a fellow resident who does not respond. The difference is that this time you think more rational thoughts about this situation "A" at your point You think that the other person cannot hear you, and "B". you believe that they are not simply ignoring you. You think and believe that if the other person knew that you were speaking to them, they would really appreciate your gesture. These are the thoughts that you are now having at point "B". Along with these new thoughts, notice that you do not feel anger this time at point "C". You realize that the other person has a hearing problem. You also want very much to communicate your morning greeting to them. Your "C" emotion, therefore, is one of calm patience that leads to physical responses that are not negative. You do not feel uptight or tense inside. At this point "D", your physical feelings are calm and relaxed. At point "E", since you wanted to communicate with your fellow resident, who did not hear you, you walk up to that person and gently tap them on the shoulder and tell them good-morning in a voice that they can hear. This behavior results in the fellow resident giving you a warm smile and showing appreciation for your kind gesture. The overall result is good feelings. Notice how you are actually feeling good

as you imagine yourself engaged in this particular rational thought sequence. Remember the differences in the feelings that you can get simply by changing your thoughts and beliefs. You may want to try this technique between sessions whenever you encounter a difficult situation in which you develop a negative, uncomfortable emotion which you would like to change.

Now, return to your beautiful beach scene, and experience the pleasant sensations of deep relaxation. Enjoy the calmness and serenity of being on a beach. Now that you have had a chance to return to your highly relaxed state I will count from one to five. Again as I count, you will slowly wake up and experience being extremely refreshed and comfortable. One...two...three...four...five.

SESSIONS V and VI

Note: The beginning of these sessions will be conducted with the therapist reading the four part induction as it appears in Sessions III and IV (refer to that section for a copy of that induction procedure). The four components included in the induction are (1) Deep Breathing; (2) Cognitive Muscle Relaxation; (3) the Relaxing Scene; and, (4) the Deepening Procedure. Following the completion of that introduction the therapist proceeds with the following transcript.

During the last two sessions we discussed how thoughts control emotions, physical responses and behavior. We learned about the A-B-C-D-E model which included "A"--the event or situation; "B"--the thoughts or self-talk about the situation "A"; "C"--the feelings that result from your thinking and belief system; "D"--the physical responses that your body makes when you experience those feelings; and, "E"--what you do about the situation. You learned, that if your thoughts were rational and more positive, the sequence would be positive and pleasant; and that if your thoughts were irrational or negative, the sequence would be unpleasant or negative.

During this session I would like for you to become aware of the importance of your self-concept, and how it may affect your feelings and the way you handle things that occur in your life. Now, your self-concept is basically

composed of feelings and beliefs that you hold about yourself, and beliefs you hold about your ability to deal with the world. When you think more rational thoughts about yourself, you tend to feel that you have more self-worth and you therefore, begin to feel positive emotions about yourself. You also tend to feel better about others who are around you. And when you improve your self-concept, you improve the way you feel and interact about your environment. There is also research that indicates that when you improve your self-concept you will begin to feel better physically, and will tend to be ill less frequently. It is for these reasons that it is important to recognize your positive self-worth.

You may be blaming yourself for mistakes that you made in the past. It is important to understand that anything you did in the past does not have significant affects on your behaviors today, unless you continually tell yourself that it does. You may put yourself down because you feel that you are not making significant contributions or progress in life. It is important to realize that by putting yourself down, and lowering your self confidence, you may become depressed. You may become unable to explore alternatives and possibilities for doing things that you feel are worthwhile and positive. You may feel that there were conflicts with your family that could have been handled better, or other things you would have liked handled

differently. If you do not blame yourself for such past mistakes, you may find that you would be better able to deal with family situations in the future, in a more positive and satisfying manner.

In our exercise today I would like for you to now imagine a situation in your past, that caused you to feel somewhat disturbed. The situation may have lead to feelings that were negative about yourself, and you may have begun to put yourself down for what you did. As you continue to imagine yourself in this disturbing situation, I would like for you to concentrate on the thoughts that you had while you were feeling disturbed. As you see these thoughts in your mind, you will begin to see how these thoughts lead to emotional and physical discomfort.

Now stop thinking the disturbing thoughts and imagine yourself in the same situation; only, this time, imagine yourself behaving like you would have liked to have behaved. You are calm, in control, and not-disturbed. You may be able to discuss any misunderstanding you have--calmly--with the other person, or you may be thinking rational, more positive thoughts that do not lead to discomfort. Now, I would like for you to concentrate on these positive or rational thoughts that lead to better feelings. You will also notice that, as you think the more rational thoughts, you feel better physically; and, you have less trouble doing what you would like to do to handle the situation in a non-disturbing manner. You feel very good about yourself, and you realize that by thinking these positive or rational thoughts, you can be of much help to the other person involved.

You have just experienced how rational thoughts can help you in situations that had the potential for being discomforting. These can also lead to better feelings about yourself and others--resulting in a better self-concept.

Now I would like for you to again return to the beautiful beach scene. I want you to feel the serenity of the beach and the comfort of your highly relaxed state. I will give you a few moments to simply enjoy this state before I count from one to five.

Now, I will count from one to five, and when I get to five you will wake up feeling very refreshed indeed, because, this is a physiological process as well as a phychological process. When you relax your muscles, you also relax yourself along with your muscles. When you wake up you will also have had an experience in which you learned how to use your new rational thinking to help you to feel better, and you will therefore, have a new stronger tool to use in the future in similar situations. Now I will count from one to five, and when I get to five you will wake up feeling refreshed and with even more energy than you had in the very beginning of the day. One...two... .

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SESSION VII

Note: The beginning of this session will be conducted with the therapist reading the four part induction as it appears in Sessions III and IV (refer to that section for a copy of that induction procedure). The four components included in the induction are (1) Deep Breathing; (2) Cognitive Muscle Relaxation; (3) the Relaxing Scene; and, (4) the Deepening Procedure. Following the completion of that introduction the therapist proceeds with the following transcript:

In previous sessions we learned how our thoughts and attitudes determine how we feel about things that happen to us, affect our physical conditions and lead to what we do about those things (our behaviors). We learned about the A-B-C-D-E model which includes: (A) the situation or event; (B) our thoughts or attitudes about the the situation; (C) our emotional feelings; (D) what happens to us physically; and, (E) what we choose to do about the situation. We also learned about our self-concept and how important our selfconcept is in helping us feel and act the way we would like to act. We learned that if we had a good self-concept (we thought rational, positive things about ourselves and our abilities to deal with the world) we would be more efficient and happier.

In this session I would like for you to experience the positive affect of being confident about yourself, in

situations, that may be threatening or disturbing, and experience yourself behaving the way you would like to behave. Your thoughts and attitudes are rational, and are designed to help you feel and behave in an optimal manner.

Now, I want you to imagine yourself in a situation that has typically (in the past) been disturbing. This could be something that may happen in the house that you do not like. It could be a policy of the house, or it could be something more personal. It could be an event, or a feeling that you get when you are in contact with one or more of the residents that you live near. It may also be a problem or feeling that may occur when you think of a family member. The situation can be anything that may be disturbing to you, or has been disturbing to you in the past. Get in touch with the feelings (both emotional and physical) that you typically experience in that situation. Feel their discomfort.

Now, I want you to imagine that you feel very good about yourself, and you are very confident of your abilities to handle things in your life. You feel that you do have some control, about what happens to you; and, that you experience warm positive, feelings about yourself. Imagine that you know, that by using your rational thoughts and attitudes, you can feel the way you want to feel, and you can act in the ways that help you get what you want. Now place yourself in the former disturbing situation once

more, and experience yourself, handling the situation with this warm positive feeling about yourself. You are thinking more rational thoughts about the situation. You are feeling more positive emotions, and you notice that your body is calm and not tense. You are experiencing the same sensation, that you experienced the time that you had a great success or were very happy about yourself. Get in touch with those emotional and physical feelings. Get in touch with the appropriateness of your response to the other people.

Now, you can stop imagining the situation. You have experienced some positive successes with your newly learned technique. You have discovered the difference that rational thoughts (about yourself and the situations around you) can make in the way you feel and in the things that you do. You will now be ready to use these new techniques in the real world when disturbing things occur. During the next few days, you will find yourself using these rational behaviors and positive self-image to produce more pleasant feelings in yourself. You will feel very good about your successes.

Now, you can go back to your beach scene and enjoy the pleasant feelings of being in your relaxed state. Again in a few moments, I will count from one to five and you will slowly wake up feeling very refreshed. Now, just take a few moments to enjoy your profoundly relaxed state. Now, I will count from one to five, and when I get to five, you will wake up feeling very refreshed indeed, because, this is a physiological process as well as a psychological one. When you relax your muscles, you also relax yourself. And when you wake up, you will experience even more energy than you had in the very beginning of the day. One...two...three...four...five.

SESSION VIII

Note: The beginning of this session will be conducted with the therapist reading the four part induction as it appears in Sessions III and IV (refer to that section for a copy of that induction procedure). The four components included in the induction are (1) Deep Breathing; (2) Cognitive Muscle Relaxation; (3) the Relaxing Scene; and, (4) the Deepening Procedure. Following the completion of that introduction, the therapist proceeds with the following transcript:

In previous sessions we learned how our thoughts and attitudes determine how we feel about things that happen to us, affect our physical conditions and lead to what we do about those things (our behaviors). We learned about the A-B-C-D-E model which includes: (A) the situation or event; (B) our thoughts or attitudes about the situation or event; (C) our emotional feelings; (D) what happens to us physically; and, (E) what we choose to do about the situation. We also learned about our self-concept and how important our self-concept is in helping us feel and act the way we would like to. We learned that if we had a good self-concept (we thought rational, positive things about ourselves and our abilities to deal with the world) we would be more efficient and happier.

In this session I would again like for you to experience the positive affect of being confident about yourself in situations that may be threatening or disturbing, and experience yourself behaving the way you would like to behave. Your thoughts and attitudes are rational, and are designed to help you feel and behave in an optimal manner.

Now, just imagine yourself in a situation that has typically (in the past) been disturbing. This could be something that you do not like that may happen in the house. It could be a policy of the house, or it could be something more personal. It could be an event, or a feeling that you get when you are in contact with one or more of your fellow residents. It may also be a problem or feeling that may occur when you think of a family member. The situation can be anything that may be disturbing to you, or has been disturbing to you in the past. Get in touch with the feelings, both emotional and physical, that you typically experience in that situation. Feel their discomfort.

Now, just imagine that you feel very good about yourself, and that you are very confident of your abilities to handle things in your life. You feel that you do have some control, about what happens to you, and that you experience warm, positive feelings about yourself. Imagine that you know that by using your rational thoughts and attitudes, you can feel the way you want to feel, and you can act in ways that help you get what you want. Now place yourself in the former disturbing situation once more, and experience warm, positive feelings about yourself. Imagine

yourself handling the situation in the way you wish to handle it. You are thinking more rational thoughts about the situation. You are feeling more positive emotions, and you notice that your body is calm and not tense. You are experiencing the same sensation, that you experienced the last time that you had a great success, or when you were very, very happy about something. You feel warm and positive. You handle the situation in a way that makes you feel very successful, and good about yourself. Get in touch with those emotional and physical feelings. Get in touch with the appropriateness of your response to the other people.

Now, you can stop imagining the situation. You have experienced some positive successes with your newly learned technique. You have discovered the difference that rational thoughts (about yourself and the situations around you) can make in the way you feel, and in the things that you do. You will now be ready to use these new techniques in the real world when disturbing things occur. During the next few days, you will find yourself using these rational behaviors, and positive self-images to produce more pleasant feelings in yourself. You will feel very good about your successes.

Now, you can go back to your beach scene and enjoy the pleasant feclings of being in your relaxed state. Again, in a few moments, I will count from one to five and you will slowly wake up feeling very refreshed. Now, just take a few moments to enjoy your profoundly relaxed state.

(Pause here for about thirty seconds)

Now that you have attended eight sessions, during which you have learned the relaxation process and the use of the A-B-C-D-E model, you have also learned to use a powerful new technique designed to help you in almost any type of disturbing situation. You will find, as you continue to use the technique, that you will feel better and better about yourself. You will develop a better self-concept. You will also find it easier to cope with daily situations in your life that might have previously disturbed you. In stressful situations you need only concentrate on two things, so as to experience the satisfaction and power of having control over how you feel. One, concerns your relaxing yourself (both mentally and physically) in the face of a stressful situation or event; and, the other concerns asking yourself, what you are thinking concerning that problem situation or event--insuring that only rational thoughts are present. Relaxing and thinking appropriately are the keys to a happier and more self-fulfilled you. As you commit yourself to using this technique, in more and more situations you will experience greater abilities to cope with your world; and you will experience greater selfsatisfaction. You will also notice that as you begin to use this technique in a variety of facits within your daily

life, the process of rational thinking will become a habit, and you will not have to concentrate on it in order to practice rational thinking.

Now, I will count from one to five, and when I get to five, you will wake up feeling very refreshed indeed, because this is a physiological process as well as a psychological process. When you relax your muscles, you also relax yourself along with your muscles. And when you wake up, you will experience even more energy than you had in the very beginning of the day. One...two...three...four... five.