8-1988

Evaluation of a Psychoeducational Curriculum for Promoting Psychological Health and Self-Esteem

Michele Susan Meola
Western Michigan University

EVALUATION OF A PSYCHOEDUCATIONAL CURRICULUM FOR PROMOTING PSYCHOLOGICAL HEALTH AND SELF-ESTEEM

by

Michele Susan Meola

A Dissertation
Submitted to the
Faculty of The Graduate College
in partial fulfillment of the
requirements for the
Degree of Doctor of Education
Department of Counselor Education
and Counseling Psychology

Western Michigan University
Kalamazoo, Michigan
August 1988

EVALUATION OF A PSYCHOEDUCATIONAL CURRICULUM FOR PROMOTING PSYCHOLOGICAL HEALTH AND SELF-ESTEEM

Michele Susan Meola, Ed.D.

Western Michigan University, 1988

This study was designed to investigate the effectiveness of a psychoeducational curriculum in psychological health skills, entitled Psychological Health and Self-Esteem (PHSE). The study evaluated PHSE which is a 10-week class offered through the Psychology Department at Michigan State University, East Lansing, and is part of the Health Promotion Program, partially funded by a Kellogg Foundation grant.

Two hundred students participated in the study, and complete data were obtained from 117, 56 of them enrolled in PHSE and 61 enrolled in a different class designated as a control group. The design of the study was a pretest-posttest quasi-experiment with a control group selected for similar demographic attributes.

The variables of interest in the study were: (a) self-esteem as measured by the Cheek and Buss (1981) Self-Esteem Scale and a shortened form of the Rosenberg (1965) Self-Esteem Scale (Cook, 1987); (b) depression as measured by the short form of the Beck Depression Inventory (Beck & Beck, 1972); (c) anxiety as measured by the State-Trait Anxiety Inventory (Spielberger, 1983); and (d) awareness of shame as measured by the Internalized Shame Scale (Cook, 1987). Additionally, a qualitative questionnaire was administered to the

experimental group which evaluated frequency of use and perceived effectiveness of the tools in building psychological health and positive self-esteem, as measured by the Evaluation Questionnaire.

The results of the analyses performed, using analysis of covariance with pretest as the covariate, showed that participants in PHSE did not demonstrate a significant difference in enhancing self-esteem or decreasing depression. However, as predicted, participants in the treatment group demonstrated significant decrease in anxiety and also a significant increase in their awareness of and ability to differentiate the affect of shame.

The depression and self-esteem instruments were judged as lacking sensitivity to reflect changes in a 10-week period of time. The positive results on the anxiety and shame measures support the effectiveness of PHSE in promoting psychological health. Further research is needed to follow up with more sensitive measures and over a longer period of time.

INFORMATION TO USERS

The most advanced technology has been used to photograph and reproduce this manuscript from the microfilm master. UMI films the text directly from the original or copy submitted. Thus, some thesis and dissertation copies are in typewriter face, while others may be from any type of computer printer.

The quality of this reproduction is dependent upon the quality of the copy submitted. Broken or indistinct print, colored or poor quality illustrations and photographs, print bleedthrough, substandard margins, and improper alignment can adversely affect reproduction.

In the unlikely event that the author did not send UMI a complete manuscript and there are missing pages, these will be noted. Also, if unauthorized copyright material had to be removed, a note will indicate the deletion.

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

Photographs included in the original manuscript have been reproduced xerographically in this copy. Higher quality 6" x 9" black and white photographic prints are available for any photographs or illustrations appearing in this copy for an additional charge. Contact UMI directly to order.

U·M·I

University Microfilms International
A Bell & Howell Information Company
300 North Zeeb Road, Ann Arbor, MI 48106-1346 USA
313/761-4700 800/521-0600

Order Number 8827194

Evaluation of a psychoeducational curriculum for promoting psychological health and self-esteem

Meola, Michele Susan, Ed.D.

Western Michigan University, 1988

U·M·I
300 N. Zeeb Rd.
Ann Arbor, MI 48106

Dedicated to

Margaret and Norman

ACKNOWLEDGMENTS

I should like to express my appreciation to those individuals who have greatly influenced or assisted me in completing this dissertation. Words seem inadequate to the task, but my gratitude goes to friends, teachers, and family for their contributions. They are:

Dr. Gershen Kaufman for his guidance and inspiration;

My committee, Dr. Robert Oswald, Dr. Robert Brashear, and Dr. Thelma Urbick, for their suggestions and support;

Dr. Jan Rosenberg, for her encouragement and kitchen table;

My parents and son for their patience in seeing me through this dissertation; and

The students who participated in the study and allowed me to learn from them.

Michele Susan Meola

TABLE OF CONTENTS

ACKNOWLEDGMENTS ii

LIST OF TABLES v

CHAPTER

I. INTRODUCTION AND STATEMENT OF THE PROBLEM 1

II. REVIEW OF THE SELECTED LITERATURE 4

Research on Psychoeducational Programs 4

Variables Under Study 6

Self-Esteem 6

Depression 9

Anxiety 15

Shame 19

Summary 22

III. THE PROGRAM 23

Theoretical Underpinnings of the Program 23

The Program 25

Organization and Goals of the Program 26

Format 27

Conceptual Definitions 29

IV. METHODOLOGY 32

Research Hypotheses 33

Participants 34

Procedures 35

Measures 36

Table of Contents--Continued

CHAPTER

Self-Esteem Scales 36

Beck Depression Inventory-Short Form 36

State-Trait Anxiety Inventory 36

Internalized Shame Scale 37

Research Design 37

Analysis of the Data 38

V. RESULTS 39

Tests for Differences on Pretests 39

Hypothesis 1 44

Hypothesis 2 45

Hypothesis 3 45

Hypothesis 4 45

Evaluation Questionnaire Results 46

Summary 49

VI. SUMMARY AND DISCUSSION 51

APPENDICES 55

A. Measures 56

B. Evaluation Questionnaire 63

C. Information and Consent Forms 67

D. Course Syllabus 74

E. Tools 78

F. PHSE Course Handouts 84

BIBLIOGRAPHY 93

LIST OF TABLES

1. Pretest *t* Tests on 11 Variables 39

2. Analysis of Covariance on 11 Variables 42

3. Means of Perceived Tool Effectiveness and Frequency of Use 46

CHAPTER I

INTRODUCTION AND STATEMENT OF THE PROBLEM

Trends within the field of mental health have changed from a preoccupation with pathology, or illness, to an acknowledgment of the need for preventive programs to provide individuals with necessary skills for living.

> I believe emphasis on the teaching of mental health is long overdue. We attempt to teach people almost everything except how to live with themselves and how to live with others. Everyone is guilty of passing the buck and everyone assumes that mental health is something one picks up along the way through life . . . a little at home, a little at school, and a little on the street. (Frisco, 1974, p. 21)

In recent years a number of mental health workshops and programs have been developed for students' growth, adaptation, or remediation of problems. Although many of these preventive programs have been conducted using a variety of approaches, there has been a paucity of evaluation as to their efficacy (Cain, 1967; Cudney, 1971). All too often practitioners and social agencies have acknowledged need for prevention efforts and then assumed that not enough is known about positive psychological health skills or not enough money was available for "experimentation" to put any programs into practice (Gurin, Gurin, Lao, & Beattie, 1969).

An example of such a program is Psychological Health and Self-Esteem (PHSE). PHSE is a credit course taught in the Psychology Department at Michigan State University (MSU), East Lansing. This

course is part of the MSU Health Promotion Project which is partially funded by a Kellogg Foundation grant. PHSE is a three credit course offered on a credit/no grade basis. Dr. Gershen Kaufman, a clinical psychologist at the MSU Counseling Center, developed and teaches the course.

The main focus of the study is to examine the question: Can psychological health skills be effectively taught in an educational setting? Kaufman (in press) believes that psychological principles for living healthy, emotionally well-adjusted lives are indeed learnable. He has designed a course taught in a university classroom setting which emphasizes psychological health and emotional well-being.

The change from the traditional medical model, that of treatment of existing disorders, to an innovative psychoeducational model implies that the psychologist might be better guided by developmental self-theory than by the model followed by medical professionals.

> The practicing psychologist following an educational model is one whose work would derive directly or indirectly from a concern not with "curing neurosis," and not with eliminating symptoms (or "complaints"), and not with intellectual growth per se, but rather with the teaching of interpersonal skills which the individual can apply to solve present and future psychological problems and to enhance his satisfaction with life. (Guerney, Guerney, & Stollak, 1971-1972, p. 239)

While other psychological health courses have aimed at teaching limited mental health skills, for example, elimination of self-defeating behaviors (Cudney, 1971), cognitive control (Ellis & Grieger, 1977), self-control methods (Mahoney, 1974), and affective awareness (Malamud, 1965), PHSE is exemplary of psychological health

education programs that purport to teach psychological health skills. PHSE combines features of psychological health and developing skills for emotional well adjustment. In addition, it seeks to integrate cognitive, affective, and behavioral theories into a unified approach which makes it unique. Evaluation of the effectiveness of PHSE is essential to support the value of teaching psychological health skills.

Prior studies have dealt with different populations and have used different theoretical bases than PHSE. The review of the literature disclosed evaluation studies of classes that contained some of the elements contained in PHSE, but none was found that included the integration of the concepts. An evaluation study of PHSE is unique because the content of the program is original and the method of evaluation had been tailored specifically to assess growth and changes in the course objectives: increase in self-esteem, decrease in depression and anxiety, and the ability to better differentiate and experience shame in everyday situations along with being able to identify specific sources of shame.

CHAPTER II

REVIEW OF THE SELECTED LITERATURE

Prior research is examined, first, in terms of psychoeducational programming and, second, in terms of the specific variables under study.

Research on Psychoeducational Programs

Psychoeducational programs which have been developed include life skills (Katz, 1974; Philip, Himsl, & Warren, 1972), human development instruction (Baygood, 1974), self-control training (Phelps, 1977), stress reduction (Barger, 1965), human relations (Malamud, 1965), psychosocial competence (Tyler & Gatz, 1976), and the principles of rational emotive-therapy (Ellis & Grieger, 1977).

One of the first classes to encourage increased awareness and exploration of feelings was a workshop on human relations conducted by Malamud (1965). This analytic workshop used films dealing with sensitive subject areas as catalysts for students' exploration of affect. Only a self-report questionnaire evaluation was conducted.

Stress reduction classes are another form of psychoeducational program, an example of which is a preventive stress class conducted at the University of Florida for freshmen and transfer students (Barger, 1965). While evaluation of stress-reduction classes is often descriptive or informal, more rigorous research was performed

by Griz (1982); he compared the effects of cognitive, affective, and cognitive-affective curricula in coping with stress. Griz found that the combined cognitive-affective approach was the most effective.

There exist various self-esteem enhancement classes which differ in their approaches. The program reported by Del Polito (1973) concentrates on communication skills to enhance self-concept. General self-concept and self-concept as a communicator were not found to improve significantly.

Various life skills courses have also been taught for the promotion of self-esteem. Schlesinger (1978), for example, used the skills for living classes offered in high school settings to validate measurement instruments on self-actualization, vocational maturity, locus of control, and self-esteem. Another life skills program targeted the economically disadvantaged and focused on behavioral management techniques (Philip et al., 1972). However, no evaluation was reported for either study.

Eliminating Self-Defeating Behaviors (ESDB) is another primary format developed by Cudney (1971) at Western Michigan University, Kalamazoo; it is based on the theory that individuals learn inappropriate behaviors to cope with anxiety or fear. Participants work through a seven-step process to eliminate their self-defeating behaviors (Parks, Becker, Chamberlain, & Crandel, 1975). This program is somewhat similar to PHSE. However, the essential difference between them is that PHSE emphasizes building positive skills for relating to the self, while ESDB focuses on eliminating negative behaviors.

Variables Under Study

In the study it was hypothesized that certain variables related to the experience of PHSE would change because of the treatment program. These variables included an increase in self-esteem, a decrease in depression, a decrease in anxiety, and an increase in the ability to differentiate internal patterns of experience which are shame producing. The variables were measured by the Cheek and Buss (1981) Self-Esteem Scale, the Beck Depression Inventory, short form (Beck & Beck, 1972), the State-Trait Anxiety Inventory (Spielberger, 1983), and the Internalized Shame Scale (Cook, 1987). The Internalized Shame Scale (ISS) includes seven items from the Rosenberg (1965) Self-Esteem Scale, which was also used as a second measure of self-esteem.

Self-Esteem

Self-esteem was used as a variable because it was postulated that assuming personal responsibility, seeing and making choices, and living from a position of personal power (PHSE objectives) ought to be reflected by feelings of positive self-worth.

Self-concept and the antecedents of self-esteem (Coopersmith, 1967; Wylie, 1961) have been of interest to many researchers. People's capacity for happiness and their ability to contribute effectively to society depend a great deal on how they value themselves. In order to maintain an adequate level of self-esteem each individual consciously or unconsciously struggles to achieve personal

worth as a human being. Defense mechanisms become activated whenever this is threatened. James (1892) viewed self-esteem as a universal human objective. He held that every individual carries a self-feeling that is relatively independent of objective conditions. Actual success or failure and the good or bad positions held in the world is the normal determinant of an individual's self-feelings. He saw that levels of self-esteem depend largely on what people consider themselves to be and what they do. He precisely described this process by equating self-esteem to a relationship between individual estimates of success and an individual's sense of pride. Rogers (1961) used "self-acceptance" or "positive self-regarding attitudes" for conveying the general idea of self-esteem, for client-centered therapy, he reported finding a substantial increase in positive self-regard and a decrease in both negative and ambivalent self-regarding attitudes, as well as increased accuracy in self-perception.

One of the best known self-esteem scales was constructed by Rosenberg (1965). He defined self-esteem as either a positive or negative attitude towards oneself. High self-esteem is found in the individuals who respect themselves, consider themselves worthy, who do not consider themselves better than others, yet do not view themselves worse. He stated:

> When we characterize a person as having high self-esteem, we are not referring to feelings of superiority, in the sense of arrogance, conceit, contempt for others, overweening pride; we mean, rather, that he has self-respect, considers himself a person of worth. . . . The person with high self-esteem has philotimo, not hubris; he does not necessarily consider himself better than most others but neither does he consider himself worse. The term "low self-esteem" does not suffer from this dual connotation.

> It means that the individual lacks respect for himself, considers himself unworthy, inadequate, or otherwise seriously deficient as a person. (p. 54)

Rosenberg (1965) also found the individual with high self-esteem to be a person who is capable of recognizing his or her limitations and who foresees--personal growth and improvement. Self-acceptance, self-assurance, and pride in self are indicative of a person's positive self-evaluation. Individuals must view themselves as being close to what they want to be and feel satisfied, they approve of themselves and see others as liking and approving of them as well, and they also view themselves as a model for others.

On the other side, Rosenberg (1965) found self-contempt, self-rejection, and low self-esteem. When these factors are present in the self, there is a lack of self-respect. In the picture the individuals paint of themselves, they wish it were otherwise. Low self-esteem deals with expressions of disappointment with self for failing to possess abilities or attributes which the individual desires to have.

Erikson's (1959) perception of self-esteem emphasizes successful resolution of each of the epigenetic crises in the life cycle. After each resolved crisis, self-esteem is confirmed; and the overall sense of ego-identity accrues after adolescence. The individual's self-esteem may be based on any or all of the major dimensions built into Erikson's theoretical system: trust, autonomy initiative, industry, ego-identity, intimacy, generating, and integrity. White (1959), on the other hand, conceptualized self-esteem as the cumulative sense of competence. Grasping and exploring, crawling and walking, attention

and perception, language and thinking, manipulating and changing the surroundings, all promote a competent interaction with the environment.

Coopersmith (1967) defined self-esteem as the attribution of positive or negative attitudes toward oneself. Among the social experiences antecedent to the development of positive self-esteem, he concluded the individuals' history of success, relative to their own values and aspirations.

Self-esteem is seen as a complex chain of beliefs and evaluations held by a person with reference to self. This suggestion is based on self-consistency theory, which indicates that individuals have a tendency to act in ways which defend and/or confirm their self-esteem. In the literature support for the self-consistency idea is found in the statement of Anastasi's (1968), who posits that self-esteem operates as a self-fulfilling prophecy.

Self-esteem is theorized to be a learned influence or behavior. Wylie (1961) made the assumption that an individual's self-regard is learned through the combining of rewards and punishments for one's behavior and characteristics. Certain things are learned through success and failure experiences when manipulating the environment, and a person's self-regard is of great importance in predicting his actions.

Depression

The construct of depression, along with Seligman's (1974) theory of learned helplessness, are of particular importance to this

evaluation. One objective of PHSE is to increase a sense of personal power. When feelings of power and competence are thwarted, depression is a frequent result. Kaufman and Raphael (1983) stated: "We are psychologically motivated by a need to feel a measure of personal control" (p. 16). Without this sense, feelings of worthlessness, helplessness, and pessimism can spiral one into depression.

Depression is a painful emotional state which has plagued human beings at least as long as history has been recorded. Depression has been described by Hippocrates, by Biblical scholars in the Book of Job, and by Shakespeare in his plays. Known throughout the ages as "the black bile," "melancholia," "manic-depression," or "depression," there have been as many labels and types as there are theories of the causes and treatment of the condition.

Many theorists and researchers (e.g., Beck, 1967; Becker, 1974) have described depression as being on a continuum with other unpleasant emotions: from "normal Monday-morning blues," to sadness, grief, disappointment, despondency, and, finally, depression. An individual's "level" of depression would depend upon the frequency, intensity, and duration of unpleasant feelings. Other authorities take an opposite view, such as Carroll (1974), who viewed depression as an illness which is categorically different from normal mood lowering. Lewinsohn (1974) took a moderate position and assumed depression to be a continuous variable which can be conceptualized as a <u>state</u> (which fluctuates over time) but also a <u>trait</u> (some people, "depressives," are more prone to becoming depressed than others). Lewinsohn (1974) provided an excellent description of depression.

> The term depression is used to refer to the syndrome of behaviors which have been identified in descriptive studies of depressed individuals (e.g., Grinker et al., 1961); including verbal statements of dysphoria, self-depreciation, guilt, material burden, social isolation, and somatic complaints; it also involves a reduced rate for behaviors. (p. 65)

Beck (1974b), probably the foremost contemporary authority on depression, delineated the signs and symptoms which characterize depressed individuals:

> Emotional: Sadness or apathy, crying spells, self-dislike; loss of gratification; loss of feelings of affection, loss of sense of humor.
>
> Cognitive: Negative self-concept; negative expectations; exaggerated view of problems; attribution of blame to self.
>
> Motivational: Increased dependency; loss of motivation; avoidance, indecisiveness, suicidal wishes.
>
> Physical and vegetative: Loss of appetite; sleep disturbance; fatiguability; loss of sexual interest. (p. 62)

Similarly, Seligman (1974) described the manifestations of depression:

> Passivity: The slower response initiation, retardation, and lowered amplitude of behavior. . . .
>
> Negative expectations: The readiness with which depressed patients view their actions, even if they succeed, as having failed or being futile. . . .
>
> The sense of helplessness: Hopelessness, and powerlessness which depressed patients frequently voice. (p. 89)

Seligman (1974) saw clinical depression as related to his concepts of learned helplessness. He wrote: "The label 'depression' denotes patients with negative cognitive sets about the effects of their own actions, who become depressed upon the loss of an important

source of gratification--the perfect case for learned helplessness to model" (p. 85).

Seligman (1974) suggested that the phenomenon of learned helplessness provides a laboratory analogue of human neurotic depression. More important, learned helplessness provides a model for understanding the developments of depressions in humans.

Beck (1974a) saw strong relationships between his own cognitive theory of human depression and Seligman's (1974) findings of learned helplessness. The idea that one is helpless is an irrational belief (Ellis, 1962) held by many depressed individuals. They "find evidence of their own worthlessness in every experience and feel compelled to blame themselves for faults" (Beck, 1974b, p. 63).

Beck (1974d) stated the belief that it must be cognitively demonstrated to patients that they are able to succeed:

> "Paralysis of the will" may be considered as a result of the patient's pessimism and hopelessness; since he expects a negative outcome, he is reluctant to commit himself to a goal or undertaking. Conversely, when he is persuaded that he can succeed at a particular task, he may be stimulated to pursue it. (Beck, 1974b, p. 71)

Beck (1967) defined depressive cognitive triad as a set of negative evaluations of the self, of the outside world, and of the future. The first component of Beck's "cognitive triad" is a negative view of the self. Depressed individuals see themselves as deprived of gratification, inadequate, and worthless. They believe that they are undesirable and perceive themselves as defective (Beck, 1974c). They believe they are responsible for irreversible and critical events and are beset with self-coercive injunctions such as

"should" and "must" (Horney, 1950). No matter how well they perform, they are plagued with the constant feeling that it is never good enough (Becker, 1974).

The second component of the cognitive triad is a negative view of experiences. The person interprets all interactions with the environment as overdemanding, blocking, depriving, depreciating, and defeating (Beck, 1974b; Becker, 1974). Finally, a "negative view of the future permeates ideation. As they look ahead, they see indefinite continuation of present difficulties and a life of unremitting deprivation, frustration and hardship" (Beck, 1974b, p. 71).

The causes of the negative cognitive set are traumatic life experiences. Once the cognitions are established, however, events with cue properties similar to the original traumatic event may trigger inappropriate depressive cognitions (Becker, 1974).

Beck's (1974b) method of treatment aims at thought or belief modification. After activity scheduling and mood elevation behaviors are instituted for depressed clients, Beck focused treatment on recording automatic thoughts. The therapist points out the self-defeating nature of the beliefs as the client practices distancing himself or herself from them: "dealing with such thoughts objectively, evaluating them rather than blindly accepting them" (Rimm & Masters, 1979, p. 406). This concept is similar to Kaufman and Raphael's (1983) detachment and self-observation. For Beck (1974b), homework assignments direct clients to write down self-defeating thoughts and then to invent a thought that counters the negative one. This highly structured technique is quite directive. In PHSE,

homework assignments are used to help students first observe and then record their self-critical, blaming, and devaluing inner voice patterns. Next, they are asked to construct a positive script (a key concept in PHSE) to replace the negative one.

Most of the research on Beck's (1967) method of changing cognitions deals with clients who are depressed. Many studies have used the Beck (1967) Depression Inventory to measure changes related to cognitions concerning hopelessness and depression. Rimm and Masters (1979) reported encouraging empirical support for Beck's methods (Taylor & Marshall, 1977; Weintraub, Segal, & Beck, 1974).

For Ellis (1962), change occurs from detecting and challenging negative or irrational thoughts. "The therapist determines precipitating external events, specific underlying beliefs, and then helps the client to change these beliefs" (p. 382). According to Ellis, as long as the individual's thinking is adaptive, there is no problem. But once thinking becomes maladaptive (irrational), problematic emotions and behaviors result.

Meichenbaum and Cameron (1974) reviewed several applications of self-instructional methods used to teach "healthy talk" to various client groups. Clients may be taught to change their evaluations of environmental consequences:

> Our research on cognitive factors in behavior modification has highlighted the fact that it is not the environmental consequences per se which are of primary importance, but what S says to himself about the consequences. However, what S says to himself, that is, how he evaluates and interprets these events [Ellis's (1962) irrational beliefs] is explicitly modifiable by many of the behaviors therapy techniques which have been used to modify maladaptive [overt] behaviors. (p. 103)

Thus, cognitive events become behaviorally modifiable.

Beck (1967, 1972) assigned primary significance to these cognitions as the causes of depression (Lewinsohn, 1974). "By proposing that the cognitive disorder precedes rather than follows the depressed state, he contributes alternative ways of 'thinking about etiology and approaches to therapy'" (Katz, 1974, p. 301).

In essence, the cognitive treatment of depression involves assisting individuals in becoming aware of the thoughts which mediate unpleasant emotions and maladaptive behaviors and in teaching them to think more effective and adaptive self-statements (Meichenbaum & Cameron, 1974). This approach is compatible with Kaufman's (Kaufman & Raphael, 1983) theory and approach in teaching PHSE. Once individuals are taught to correctly label their emotions and cognitions, they will be in a better position to deal with their emotional predicament. The underlying negative set is modified so that the total syndrome of depression may be influenced. Tomkins (1963) viewed depression as a syndrome of shame and distress, and Kaufman (1980) saw powerlessness as a prime source of depression. Hence, one objective of the course is to enable participants to reverse powerless situations and also to cope more effectively with negative affect states, such as depression.

Anxiety

The third variable to be examined is the construct of anxiety. Cattell and Scheier (1958) called attention to the lack of consensus among behavioral scientists concerning the meaning of the term

anxiety when they reported locating more than 300 definitions. Sarbin (1968) emphasized this lack of clarity and consensus by noting that anxiety has become a metaphor. He cautioned against at least two mistakes that have commonly been made: (a) thinking of anxiety as a distinct entity that has existence of its own independent of its behavioral referents, and (b) attributing a causal role to that entity. He suggested cognitive strain as a new, less opaque metaphor to replace the term anxiety because it is more patently descriptive, it tends to direct attention to behavioral referents, and it is less likely to be thought of as a cause in and of itself. Stress and strain are constructs which psychology has borrowed from the physical sciences. Stress refers to the forces applied to a structure or system and strain refers to changes in the system that result from the applied force. To the extent that this analogy is accurate, measures of anxiety may be thought of as indications of the amount of psychological strain a person is experiencing.

This study views anxiety from a phenomenological frame of reference, which regards this emotion as a human reaction that is characterized by an experiential or feeling quality. Spielberger and Gaudry (1971) reported that the typical paradigm employed in current research on emotions involves the manipulation of experimental conditions. Hence, emotional reactions can be defined by stimulus-response operations together with individual differences related to past experiences. The result is that the emotionality of anxiety will be reviewed as a personality state which exists at a moment in time, with a level of intensity, recurring when evoked by a stimulus

which endures over time for as long as the existing condition continues.

The concept of two quantitatively different types of anxiety, trait anxiety and state anxiety, came out of the factor analytic studies of Cattell and Scheier (1958, 1961). Trait anxiety refers to an individual's predisposition to respond anxiously in a variety of situations, and state anxiety is viewed as a transient individual response to varied types of stressors. Trait anxiety is seen as permanent and state anxiety as momentary. Spielberger (1983) has been the most active researcher with these two constructs and has developed scales for their measurement--the State-Trait Anxiety Inventory. He suggested that the distinction between the two loci of anxiety is primarily a conceptual one. People are only aware of the unitary state of emotional stress.

This interpretation is consistent with the hypothesis that psychological threats may differentially influence anxiety as the unitary emotional state, because life experiences cause people to develop different dispositions to respond to various stressors. The State-Trait Theory of Anxiety by Spielberger (1983) recognizes the centrality of cognitive appraisal when an anxiety state is evoked and the importance of cognitive and motoric responses (defense mechanisms) that serve to regulate anxiety states. The assumption which accompanies the theory is that the arousal of anxiety states involves a process or sequence of temporally ordered events initiated by either external or internal stimuli that are perceived to be dangerous or threatening by an individual.

Kaufman's (Kaufman & Raphael, 1983) objective in PHSE is to teach people effective tools to release their negative emotions. By releasing negative affect, people will be able to decrease and/or manage their negative feelings such as anxiety. Kaufman's tools include: the process of differentiated owning, detachment, self-observation, and imagery. Differentiated owning encompasses the ability to experience, name, and own all the distinctly different parts within the self:

> Owning means that a particular inner event, say a feeling or need, is experienced consciously. Then it is recognized and named accurately. Finally, it is owned as an inherent part of the self. Owning is the pathway toward integration of the self. (Kaufman & Raphael, 1983, p. 51)

Owning results from experiencing consciously and accurately labeling inner states. Detachment and self-observation are two additional dimensions of consciousness. Detachment refers to "learning to step back from a particular feeling or situation in order to observe it consciously and then let go of it" (Kaufman & Raphael, 1983, p. 69). Self-observation involves "learning to hold a part of the self back inside as a friendly observer. This enables us to experience events fully while simultaneously observing upon our experience" (p. 78). Imagery is the last process dimension conceptualized under the rubric of consciousness.

To understand Kaufman and Raphael's (1983) concepts, it is important to examine Tomkins's (1962, 1963, 1978) contributions. The affective component of their work is based on Tomkins's affect theory (1962, 1963) and script theory (1978). Tomkins described scripts as the rules for predicting, interpreting, or controlling critical

scenes which are encoded in memory and which have become fused with affect. A scene is the "basic element in life as it is lived. The simplest, most primitive scene includes at least one affect and at least one object of that effect" (Kaufman & Raphael, 1983, p. 211). Affects are fused with earliest and most significant scenes in one's life, so that one's life experience is formed by important scenes that have occurred throughout one's life. These scenes act to filter or color one's experience of the world, not just amplifying past experiences, but also future responses which are prompted by affects.

Kaufman (in press) employed Tomkins's (1978) theory in his concept of consciously experiencing affect. He stated the belief that one can increase conscious awareness or experiencing of inner states through the mechanism of retrieving those original scenes by means of imagery and reconstructing one's childhood scenes. These tools can be helpful in consciously experiencing, naming, and owning specific emotions, as well as in observing and differentiating other internal patterns, such as scripts.

Shame

Shame has only recently been acknowledged as having a major role in emotional adjustment.

> Clinicians of all theoretical persuasion have been slow to recognize the significant part played by shame in the etiology and/or exacerbation of many emotional and behavioral problems of persons presenting for treatment. This situation is now changing rapidly but there is still very little empirical research that has focused on the phenomenon of shame. (Cook, 1988, p. 1)

Tomkins (1962, 1963) conceived of the affect system as the primary innate motivational system in human beings. Affects are innate systems which are activated at subcortical centers where specific programs for each affect are stored. Tomkins identified nine innate affects: interest-excitement, enjoyment-joy, surprise-startle, anger-rage, distress-anguish, fear-terror, shame-humiliation, disgust, and dissmell. Dissmell is defined as the innate smell response to bad smell (Tomkins, 1987). The human being is equipped from birth with these innate affective programs which then function as the blueprint for cognition, action, and memory. Each affect, in turn, has a characteristic set of facial responses. The shame response in particular is characterized by hanging the head, lowering the eyes, averting the eyes, or blushing.

Of the nine innate affects, six are primary and three auxiliary. Shame is one of the auxiliary affects, according to Tomkins (1987), because it is activated innately by the incomplete reduction of interest-excitement (a primary positive affect).

The significance of shame as an auxiliary affect is that it can become associated with any of the other affects, thus binding other emotional responses, such as anger, to the affect of shame. However, the innate function is to attenuate the affect of interest-excitement. Mild shame amplifies experience, whereas extreme or enduring shame becomes toxic through magnification. When shame becomes magnified in frequency, duration, and intensity, it may lead to the head fixed "in a permanent posture of depression, [and] can become malignant in extreme" (Tomkins, 1987, p. 150).

Kaufman (1985), drawing on Tomkins's (1978) theory, focused attention on shame. His concept of "shame-based identity" refers to an individual who has internalized shame to the degree that shame is now autonomous within the personality.

Lewis (1971, 1987), a psychoanalytically-oriented theorist, made a distinction between shame and guilt.

> Shame . . . involves more self-consciousness and more self-imaging than guilt. The experience of shame is directly about the self, which is the focus of a negative evaluation. In guilt, it is the thing done or undone that is the direct focus of negative evaluation. We say, "I am ashamed of myself" and "I am guilty of having done (or not done) something." (Lewis, 1987, p. 107)

Wurmser (1987), also writing from a psychoanalytic perspective, described shame:

> Shame is first the fear of disgrace, it is the anxiety about the danger that we might be looked at with contempt for having dishonored ourselves. Second it is the feeling when one is looked at with such scorn, . . . the affect of contempt directed against the self. . . . One feels ashamed for being exposed, . . . in short, (for) failing someone else's expectations or failing the demands of performance by one's own conscience, standing under the glare of one's own mind's eye. To disappear into nothing is the punishment for such failure. (p. 67)

Nathanson (1987) attempted to synthesize Tomkins's (1978) theory. He viewed the adult manifestations of shame as the result "of the slow, steady accumulation of experience added to an innate physiological mechanism, a mechanism to which the social or interactional is merely an accretion, rather than its essence" (p. 10). Nathanson relied on Tomkins's (1962, 1963) affect theory in describing "proto-shame, a major force in shaping the infantile self, and remains so throughout life" (p. 27). Shame has been linked to the

clinical and experimental data that have been accumulating from studying the affective development of infants and to work of object relations theorists such as Kohut (cited in Nathanson, 1987). From this perspective, shame is a critical component in the development of the self from birth on.

Summary

Four constructs are hypothesized to be influenced by PHSE: self-esteem, depression, anxiety, and shame. These concepts provide a theoretical framework to guide the evaluation of PHSE, a program which teaches psychological health skills. Psychological health is the context for PHSE and the various theoretical orientations which have contributed to Kaufman's (Kaufman & Raphael, 1983) program provide the premises for the study.

CHAPTER III

THE PROGRAM

In the following section, the experimental treatment program is described in detail, with theory, curriculum, and objectives of Psychological Health and Self-Esteem (PHSE) presented in detail.

Theoretical Underpinnings of the Program

To understand the theoretical formulation of PHSE, one must first understand the evolution of the program. Kaufman (1980, 1985, in press; Kaufman & Raphael, 1983) has presented a developmental theory of the self which integrates three distinct theoretical perspectives: object-relations theory, interpersonal theory, and affect theory. Kaufman conceived of the self as a developmental process involving movement from global undifferentiation toward increasing differentiation and integration. The developmental process embraces phases as well as tasks which are both interpersonal and internal. The image of the self is an evolving integration.

Kaufman's (1980) initial study of shame led him to investigate the phenomenon of power. He contended that people are not taught how to have feelings of self-worth, power, or competence. If anything, one is taught not to own one's power, competence, or adequacy. For Kaufman, shame and powerlessness are two different phenomena; however, there is a dynamic link between these two experiences. Shame

is an innate affect, while power is an interpersonal need.

PHSE originated when Kaufman (Kaufman & Raphael, 1983) began to wonder whether individuals could be taught that power offered possibilities for freeing the self from shame. He further wondered whether people could be taught to live from a position of personal power. Then he asked whether general psychological skills could be taught through a course. These were the questions which led to the creation of the program.

Kaufman's (in press) formulation draws on Tomkins's (1962, 1963) differentiation of the affect system, in which nine innate affects are identified. There are positive affects, interest-excitement and enjoyment-joy; the resetting affect, surprise-startle; and negative affects, distress-anguish, fear-terror, anger-rage, shame-humiliation, dissmell, and disgust. Tomkins (1978) expressed the belief that "affect is the primary innate biological motivating mechanism" (p. 201). Kaufman (Kaufman & Raphael, 1983) contended that one must have "conscious access to the entire range of primary affects . . . by the self to the self" (p. 53). Learning to differentiate, label, and be consciously aware of the different affects enables one to create a language of the self. Kaufman (in press) added three additional motivational systems to Tomkins's affect system: interpersonal needs, physiological drives, and future scenes of purpose.

The foregoing concepts provide a "language of the self," accurate labels for differentiating inner experience. Kaufman and Raphael (1983) have translated this language into learnable tools

which enhance the ability to live consciously. These tools can help one become more conscious of basic dimensions of the self-system and learn to differentiate, label, and experience interpersonal needs, affects, drives, and purposes.

> Following the naming of feelings, needs, etc., comes owning each as an inherent part of the self. All feelings are valid. They are not to be questioned, criticized, or judged. Feelings are not good or bad, they just are. Likewise, all of our human needs are valid, and must be experienced, named, and finally owned as natural parts of the self. (p. 65)

To summarize, Kaufman's theory of the process of the self is one that can lend itself to translation into learnable tools. If the task of learning a language of the self can be mastered, one can build a conscious self which can evolve into an integrated self-identity.

The Program

PHSE is a three-credit course offered by the Psychology Department at Michigan State University (MSU), East Lansing. It is offered on a pass/no grade basis. Kaufman designed the class originally as a workshop and taught it first through the MSU Evening College and later through the Counseling Center, where it was offered as a non-credit workshop entitled, Reality Coping Workshop. Kaufman and Raphael (1983) subsequently co-developed and co-taught the class as a special section of EAD 415, a multi-section course in Student Leadership Training. Kaufman and Raphael (1983) coauthored The Dynamics of Power: Building a Competent Self based on their program.

Psychological Health and Self-Esteem (PHSE) is the latest version of that program. It is partially supported by the Kellogg Health Promotion Program at MSU. The course now accommodates 100 students per term. The format combines weekly lectures along with weekly discussion sections.

Organization and Goals of the Program

The program is organized into five 2-week units:

1. Powerlessness-Affect-Stress Cycles, where the central concepts of power, powerlessness, affect, and stress are examined.

2. Shame and Self-Esteem, focusing on old shame scenes and the development of the shame profile.

3. Identity or the Self's Relationship With the Self, which encompasses replacing negative identity scripts and inner voices; developing an internal sense of how much is good enough; distinguishing two sources of guilt versus shame (disappointing self versus disappointing others); self-nurturance and self-forgiveness, representing the inner child; and attaining a self-affirming identity.

4. Affect Management and Release Tools, which include the skills of owning, detachment, self-observation, and imagery--methods to become aware of and label inner feelings, needs, values, and drives.

5. Interpersonal Competence with peers, parents, and partners through observing relationship scenes, observing the other person, matching expectations with reality, staying defended, and regaining equal power.

Kaufman (in press) stated the belief that personal growth hinges on a personal sense of competence which emerges from translating the four pivotal principles--responsibility, choice, power, and living consciously--into action strategies. Kaufman contended that the ability to learn and use the tools is an important consideration in evaluating actual internal changes. These four principles are the foundations from which the program's objectives were formulated.

The specific objectives include reducing stress, enhancing self-esteem, developing personal identity, effective management of affect, and developing interpersonal competence. Additionally, students are taught a series of experiential tools which aid in building a competent self. These practical tools are translations of psychological principles into action.

Format

The course combines weekly lectures with weekly discussion sections. The entire class meets in lecture one class period each week and then is divided into three discussion sections the second class period each week. Two teaching assistants conduct two of these discussion sections. The tools are presented sequentially in short didactic explanations. In teaching the class, Kaufman explains the theory, purpose, and structure of the tools, giving personal examples. Class members are encouraged to share their experiences with the tools, including problems they may have in mastering them.

Kaufman (Kaufman & Raphael, 1983) designed the course to function as an educational class, not as a therapy group. Students are

not necessarily expected to self-disclose, although some class members will offer personal experiences as they apply within the context of the concepts being taught.

Kaufman (Kaufman & Raphael, 1983) attempts to integrate the theory of self-esteem with the tools, so that students do not just learn about self-esteem, they "learn to do self-esteem" (Kaufman & Raphael, 1983, p. 31). Kaufman requires participants to practice the tools for the week following their presentation, since behavior change must be practiced to be mastered. He stresses that students may find just a few tools at the time of the class that they can use to change their feelings about themselves; they can discover which tools best fit their needs and choose accordingly. The instructors encourage students to change or combine tools to suit their needs.

The discussion sections begin with a discussion of students' experiences with the tools practiced that week. "Discussion centers around individual reactions to the tools, successes, or difficulties encountered, discoveries about self, unique applications, and personal usefulness of the tool in promoting positive mental health" (Kaufman & Raphael, 1983, p. 3).

Each of the discussion section leaders presents personal experiences using the tools, since "modeling is a key vehicle for the transmission of knowledge" (Kaufman & Raphael, 1983, p. 3). Each discussion leader describes the evolution of his or her own awareness of inner states and his or her ability to build positive feelings of inner security through using the principles and the tools. Sessions end with discussion and questions, followed by new assignments.

Requirements for the course include writing weekly two-page reaction papers, detailing how participants are practicing the tools. The goal of this "journal" is to keep the practice of the tools conscious and to obtain feedback on students' progress or difficulties. There is also a final term paper which provides an opportunity to reflect on the overall experience of working with course concepts and tools.

There are two texts required as outside reading to support class discussions: The Dynamics of Power: Building a Competent Self (Kaufman & Raphael, 1983) and Shame: The Power of Caring (Kaufman, 1985). These two books are used in conjunction in order to deepen awareness of inner experience and to learn more effective strategies for coping with the sources of disturbing inner states. One book focuses on shame dynamics, while the other focuses on power. The course aims to integrate these "two primary poles of inner experience" (Kaufman, in press).

Conceptual Definitions

Key concepts related to PHSE will be defined for the purpose of clarity.

1. Responsibility: The ability to be responsible for one's feelings and actions; the task is owning inner experiences.

2. Choice: The ability to consciously determine one's reactions to life's events and to behaviors, responses, and feelings toward oneself and others.

3. Power: Power is a motive, a need rooted in one's helplessness at infancy. Power is a need for personal control which motivates one to maintain equal power in relation to others. Conversely, "any situation or life event which thwarts our experience of inner control" would be described as the experience of powerlessness (Kaufman, in press).

4. Living consciously: The ability to be fully conscious in the present moment of inner events such as feelings, interpersonal needs, physiological drives, and future purposes as well as outer events or interactions. The four dimensions of living consciously are (a) differentiated owning, (b) detachment, (c) self-observation, and (d) imagery.

4a. Differentiated owning: The ability to consciously experience, accurately name, and finally, own a feeling, interpersonal need, drive, or purpose as an inherent part of the self. This is a learnable developmental task.

4b. Detachment: "Learning to step back from a particular feeling or situation in order to observe it consciously and then let go of it" (Kaufman & Raphael, 1983, p. 69).

4c. Self-observation: The third step involves "learning to hold a part of the self back inside as a friendly observer. This enables us to experience events fully while simultaneously observing upon our experience" (Kaufman & Raphael, 1983, p. 78).

4d. Imagery: Visual, auditory, and kinesthetic imagery is a tool to achieve differentiated owning, detachment, and self-observation.

5. Identity scripts and inner voices: One's ongoing pattern of inner relating (inner voices), which either reproduce positive feelings toward the self or negative feelings. These scripts combine affect, imagery, and language.

6. Psychological health: This is the conception of psychological health which rests upon the central concepts: responsibility, choice, power, and living consciously. Psychological health evolves through internalizing these concepts and by translating them into action strategies or tools. "Through living consciously from a position of personal power, one learns to build a competent self" (Kaufman, in press).

7. Tools: Basic concepts are translated into action strategies which participants in the program learn through practice. This is the experiential core of the program.

CHAPTER IV

METHODOLOGY

The purpose of the study was to investigate the effectiveness of a psychoeducational program in psychological health skills entitled Psychological Health and Self-Esteem (PHSE). The variables of interest in the study were: (a) self-esteem, as measured by the Cheek and Buss (1981) Self-Esteem Scale and the shortened form of the Rosenberg (1965) Self-Esteem Scale, which was a subscale of the Internalized Shame Scale (Cook, 1987); (b) depression, as measured by the short form of the Beck Depression Inventory (Beck & Beck, 1972); (c) anxiety, as measured by the State-Trait Anxiety Inventory (Spielberger, 1983); and (d) the ability to better differentiate feelings of shame and identify shame producing experiences as measured by the Internalized Shame Scale (Cook, 1987). The design of the study was a pretest-posttest quasi-experiment with a control group selected for similar demographic attributes and for similarity in content of the class experience, except for the treatment condition.

Course descriptions, as listed in the Michigan State University Catalogue--1988 (Michigan State University [MSU], 1987), for the two classes are as follows:

> [Control group]: Health Psychology--Spring, Fall 3(3-0) PSY 160 or PSY 170. Psychological factors influencing health and illness. Topics will include stress and coping, personality and health, symptom perception and reporting, heart disease, cancer, compliance, social support, and health maintenance and promotion. (p. A-180)

> [Treatment group]: Psychological Health and Self-Esteem--Winter, Spring, Fall 3(3-0) PSY 160 or PSY 170, PSY 225; or approval of department. Psychological understandings of affect as a mediator of stress, self-esteem, and powerlessness. Development of psychological health, personal identify, and interpersonal competence through principles of affect. (Approved through Fall 1990.) (MSU, 1987, p. A-180)

The evaluation was designed to determine if the following program objectives were met: (a) enhancement of self-esteem, (b) decrease in feelings of depression, (c) decrease in feelings of anxiety, and (d) increase in ability to differentiate feelings of shame and to identify shame producing experiences. In addition to the psychological measures the treatment group received an Evaluation Questionnaire to determine which tools were perceived by the treatment group as most effective and useful.

Research Hypotheses

1. In comparison with the control group, the treatment group will score higher on self-esteem scales at posttest, as measured by Cheek and Buss (1981) Self-Esteem Scale and the Internalized Shame Scale (Cook, 1987).

2. In comparison to the control group, the treatment group will experience a decrease in depression at posttest, as measured by the Beck Depression Inventory, short form (Beck & Beck, 1972).

3. In comparison to the control group, the treatment group will experience a decrease in anxiety at posttest as measured by the State-Trait Anxiety Inventory, short form (Spielberger, 1983).

4. In comparison with the control group, the treatment group will increase in ability to identify shame and consciously differentiate internal patterns of experience which are shame producing. This will be measured by the Internalized Shame Scale (Cook, 1987).

Participants

Participants in the study included 200 Michigan State University students enrolled in either PSY 320 or PSY 325 (100 per class). Analyses were based on 117 subjects from whom complete data were obtained.

The treatment group consisted of 56 participants who elected to take PSY 325 (PHSE). The group contained 6 freshmen, 10 sophomores, 25 juniors, and 15 seniors. Ages of the students ranged from 18 to 31. The racial composition was primarily Caucasian, with 3 blacks and 2 Asian-Pacific students. Sixty-three percent of the group was female and 37% male. Undergraduate majors in the treatment group varied. Most of the students' off-campus residences were located in the state of Michigan.

The control group consisted of 61 participants who completed both the pretest and posttest instruments. This group was composed of 7 freshmen, 8 sophomores, 32 juniors, and 16 seniors. Ages of the control participants ranged from 18 to 33. The racial composition was mostly Caucasian with 3 black students. Sixty-nine percent of the group was female and 31% male. Undergraduate majors varied as in the treatment group. Most of the students' off-campus residences were located in Michigan.

The experimental group met for a total of 40 hours, comprised of meetings for 2 hours a day twice a week for 10 weeks. The control group met for a total of 30 hours, twice a week for 1-1/2 hours during 10 weeks.

In terms of demographic characteristics, the two populations used for treatment and control groups were similar.

Procedures

Participants from treatment and control groups completed four measures: the Self-Esteem Scale (Cheek & Buss, 1981), the short form of the Beck Depression Inventory (Beck & Beck, 1972), the State-Trait Anxiety Inventory (Spielberger, 1983), and the Internalized Shame Scale (Cook, 1987). The instruments were administered in a random order in the classroom setting during the second and ninth weeks of the term.

During all administrations of the instruments, students were asked to answer questions about themselves honestly, taking time to give serious consideration to their responses. The nature of some of the items was sensitive so the participants were instructed to only respond to questions they felt comfortable answering. Thorough instructions were given to both treatment and control group before administration of the tests. Students were given identification numbers so they could remain anonymous while their pretest and posttest scores could be matched. Informed consent was obtained from all participants and confidentiality was protected for all participants.

Measures

Self-Esteem Scales

The two self-esteem scales included the Cheek and Buss (1981) Self-Esteem Scale and the short form of the Rosenberg (1965) Self-Esteem Scale, which was a subscale of the Internalized Shame Scale (Cook, 1987). These scales primarily measure the self-acceptance aspects of self-esteem. The Cheek and Buss Self-Esteem Scale has five items, and the Rosenberg Self-Esteem Scale has seven items.

Beck Depression Inventory-Short Form

The Beck Depression Inventory (BDI), short form (Beck & Beck, 1972) was designed as an indicator of the level of depression present in the subjects. The scale purports to measure the various psychological, physiological, and behavioral manifestations of depression. The short form is a 13-item form correlating .96 with the total BDI.

State-Trait Anxiety Inventory

The State-Trait Anxiety Inventory (STAI) (Spielberger, 1983) measures anxiety on two dimensions: trait anxiety, which refers to an individual's predisposition to respond anxiously in a variety of situations, and state anxiety, which is viewed as transient individual responses to varied types of stressors. The STAI is a 40-item questionnaire with 20 questions for each.

Internalized Shame Scale

The Internalized Shame Scale (ISS) (Cook, 1986) measures shame on several factors. There is a 35-item total score--a 7-item self-esteem scale and a 28-item scale which has a 4-factor breakdown: inadequate and deficient, exposed and self-critical, insignificant and fragile, and empty and lonely.

Research Design

The pretest-posttest control group design was selected for the purpose of quantitative research. The sample in the study was self-selected, so random sampling and random assignment were not feasible. Generalization to a greater population of college students who might volunteer for psychology health courses for college credit might be justified (Campbell & Stanley, 1963). The control group was selected for similarity in demographic attributes such as age, sex, and race and for similar class content. Both groups participated in MSU courses pertaining to psychological health. The students were all volunteer subjects from the two classes, PSY 320 and PSY 325.

There were *t* tests performed on the pretest to see if the two groups were similar. Analysis of covariance was used to reduce the bias between the groups on the variables which showed significance on the pretest and to increase the power in the case where the differences on the *t*-test pretests were nonsignificant.

Analysis of the Data

There were *t* tests employed on the pretest means for all the scales to determine whether groups were significantly different at pretest. An analysis of covariance was conducted on the posttest scores of all the instruments. The pretest scores were used as a covariate. The criterion level of significance for rejecting the null hypotheses was .05.

The results of the Evaluation Questionnaire did not lend themselves to quantitative analysis using tests for statistical significance. A qualitative approach was used to describe the data obtained for each scale of the Evaluation Questionnaire. Specifically, the response to items in each category were used to estimate the mean and standard deviation.

The results of the hypotheses and additional findings are presented in Chapter V.

CHAPTER V

RESULTS

In this chapter, the results of the analyses of the hypotheses are presented. Qualitative descriptive data from the respondents for the evaluation questionnaire are also presented.

Tests for Differences on Pretests

The *t* tests on the means of the instruments used in the study were conducted to determine whether groups were significantly different at pretest. The mean values for the treatment and control group pretests are presented in Table 1.

Table 1

Pretest *t* Tests on 11 Variables

	Mean	Standard error	*t*	Prob.
Beck Depression Inventory				
Control	3.29	0.45	-2.32	.02
Experimental	5.06	0.58		
Self-Esteem Scale				
Control	23.48	0.61	0.30	.76
Experimental	23.23	0.58		

Table 1--Continued

	Mean	Standard error	t	Prob.
Internalized Shame Scale (35 items)				
Control	82.73	2.40	-1.89	.06
Experimental	89.08	2.33		
State-Trait Anxiety Inventory				
Control	86.62	2.26	0.23	.08
Experimental	85.92	2.02		
Self-Esteem (ISS)				
Control	25.53	0.83	0.48	.63
Experimental	25.00	0.74		
Factor I (ISS)				
Control	21.17	0.73	-2.60	.01
Experimental	24.27	0.89		
Factor II (ISS)				
Control	18.28	0.75	-1.40	.16
Experimental	19.81	0.77		
Factor III (ISS)				
Control	10.49	0.45	-2.28	.02
Experimental	11.99	0.47		

Table 1--Continued

	Mean	Standard error	t	Prob.
Factor IV (ISS)				
Control	8.49	0.42	-1.71	.08
Experimental	9.57	0.45		
State Anxiety				
Control	47.74	0.76	1.11	.26
Experimental	46.67	0.62		
Trait Anxiety				
Control	46.53	0.89	0.52	.60
Experimental	47.10	0.67		

The t tests on the means of variable on the BDI and on the ISS Factor I and Factor II showed significant differences. The other variables, on Self-Esteem, Trait Anxiety, State Anxiety, and on the total ISS and Factors III and IV, did not show any significant difference when using .05 alpha level.

An analysis of covariance was performed on the dependent measure, the posttest scores (see Table 2). The pretests were held as a covariate.

Scores for the different subscales on the ISS and STAI were factored out. The STAI has two dimensions: State Anxiety and Trait Anxiety. The ISS has a total 35-item score, a 7-item Self-Esteem

scale, and a 28-item Shame scale with four factor subscales within the 28 item Shame scale.

Table 2

Analysis of Covariance on 11 Variables

Source	df	SS	MS	F	Prob. > F
Beck Depression					
Pretest	1	213.31	213.31		
Treatment	1	52.20	52.20	2.44	.1212
Error	113	2418.80	21.39		
Self-Esteem					
Pretest	1	30.29	30.29		
Treatment	1	30.61	30.61	1.21	.2753
Error	107	2701.57	25.25		
ISS					
Pretest	1	19.15	19.15		
Treatment	1	1419.71	1419.71	4.06	.0463
Error	115	40217.38	349.72		
ISS (Self-Esteem)					
Pretest	1	7.87	7.87		
Treatment	1	16.43	16.43	0.34	.5615
Error	115	5571.10	48.44		

Table 2--Continued

Source	df	SS	MS	F	Prob. > F
ISS (Shame)					
Pretest	1	27.78	27.78		
Treatment	1	1720.31	1720.31	4.09	.0454
Error	115	48356.24	420.49		
ISS (Shame--Factor I)					
Pretest	1	0.67	0.67		
Treatment	1	155.37	155.37	3.03	.0847
Error	115	5906.64	51.36		
ISS (Shame--Factor II)					
Pretest	1	15.06	15.06		
Treatment	1	138.66	138.66	3.68	.0577
Error	115	4338.00	37.72		
ISS (Shame--Factor III)					
Pretest	1	5.11	5.11		
Treatment	1	60.01	60.01	2.63	.1076
Error	106	2415.21	22.78		
ISS (Shame--Factor IV)					
Pretest	1	9.39	9.39		
Treatment	1	65.74	65.74	4.30	.0405
Error	104	1589.26	15.28		

Table 2--Continued

Source	df	SS	MS	F	Prob. > F
State					
Pretest	1	44.79	44.79		
Treatment	1	59.94	59.94	1.30	.2566
Error	114	5256.62	46.11		
Trait					
Pretest	1	290.26	290.26		
Treatment	1	465.23	465.23	8.86	.0037
Error	91	477.46	52.50		

Hypothesis 1

In comparison with the control group, the treatment group will score higher on the self-esteem scales at posttest, as measured by the Cheek and Buss (1981) Self-Esteem Scale and the short form of the Rosenberg (1965) Self-Esteem Scale, which is a subscale of the ISS (Cook, 1986).

Hypothesis 1 tested whether or not the treatment subjects increased in self-esteem as a result of their participation in PHSE, when compared to the control subjects who were enrolled in a different class, PSY 320. The results were not significant for this hypothesis and the null hypothesis was retained.

Hypothesis 2

In comparison to the control group, the treatment group will experience a decrease in depression at posttest, as measured by the Beck Depression Inventory (BDI), short form (Beck & Beck, 1972).

Hypothesis 2 measured whether or not the treatment subjects decreased in their depression as a result of their experience, when compared to the control group. The results were not significant and the null hypothesis was retained.

Hypothesis 3

In comparison to the control group, the treatment subjects will experience a decrease in anxiety at posttest as measured by the State-Trait Anxiety Inventory (STAI) (Spielberger, 1983).

Hypothesis 3 measured whether or not the treatment subjects, as a result of their experience, when compared to the control group, experienced less anxiety. Results were significant and the null hypothesis was rejected.

Hypothesis 4

In comparison with the control group, the treatment group will be able to identify shame and consciously differentiate internal patterns of experience which are shame producing, as measured by the Internalized Shame Scale (ISS) (Cook, 1986).

Hypothesis 4 was concerned with shame and whether or not the treatment subjects as a result of their experience would be able to

better identify shame experiences and shame affects when compared to the control group. Significant results were found and the null hypothesis was rejected.

Evaluation Questionnaire Results

Perceived effectiveness of the tools taught in PHSE and frequency of use of the tools were measured using the Evaluation Questionnaire, a self-report questionnaire which was administered to the treatment group only at posttest. The questionnaire uses a 7-point Likert scale for rating items.

The means for each tool for effectiveness and frequency of use were derived (Table 3) for the participants.

Table 3

Means of Perceived Tool Effectiveness and Frequency of Use

Tool	Perceived effectiveness		Frequency of use	
	Mean	Standard deviation	Mean	Standard deviation
Tool 1: Collecting happiness	5.48	1.20	3.72	1.53
Tool 2: Collecting adequacy	5.14	1.39	3.53	1.50
Tool 3: Inner dialogue	5.52	1.71	4.41	1.31
Tool 4: Nurturing self	5.52	1.21	4.30	1.40

Table 3--Continued

Tool	Perceived effectiveness		Frequency of use	
	Mean	Standard deviation	Mean	Standard deviation
Tool 5: Inner child	4.09	1.95	2.67	1.73
Tool 6: Consultation with self	5.40	1.52	4.40	1.85
Tool 7: Values and expectations	5.52	1.30	4.62	1.34
Tool 8: Meditation	4.73	1.90	3.42	1.93
Tool 9: Bubble meditation	3.41	1.87	2.30	1.81
Tool 10: Refocusing attention	5.61	1.34	4.73	1.77
Tool 11: Self-observation	5.50	1.33	4.41	1.62
Tool 12: Imagery	4.91	1.82	3.86	1.81
Relationship tools				
Tool 1: What am I looking for in my relationships	5.81	1.09	5.00	1.36
Tool 2: Casing the person realistically	5.61	1.37	4.75	1.65
Tool 3: Trial balloons	4.19	1.88	3.30	1.79

Table 3--Continued

Tool	Perceived effectiveness		Frequency of use	
	Mean	Standard deviation	Mean	Standard deviation
Tool 4: Staying defended	5.04	1.61	4.46	1.83
Tool 5: Assessing power: sharing power	5.57	1.49	4.86	1.58
Tool 6: How real and honest can we be	5.48	1.24	4.75	1.54
Tool 7: Commitment: Security vs. freedom	5.54	1.31	4.64	1.53
Tool 8: Matching expectations	5.45	1.48	4.70	1.49

The results showed that Tools 10, 3, and 4, refocusing attention, inner dialogue, and nurturing the self, were perceived as most effective for treatment participants. Tools 10 and 7, refocusing attention and values and expectations, were used most frequently.

The means of effectiveness and frequency of use items for the Evaluation Questionnaire were used to estimate a grand mean for all the tools. The grand mean for the perceived effectiveness of all the tools was 5.07 (1.86, standard deviation). The grand mean for the frequency of use for all the tools was 4.64 (1.96, standard deviation).

The eight relationship tools showed that the most frequently used were Tools 1 and 2, what am I looking for in my relationships and casing the person realistically. The grand mean for the use of the tools was 5.34 (1.43, standard deviation). The relationship tools were employed the most often of all the tools. The perceived effectiveness showed that Tools 1 and 2 were used most frequently; they also had the highest perceived effectiveness means. The grand mean was 4.56 (1.60, standard deviation).

These results show fairly high satisfaction with the contribution PHSE had made to psychological health and the degree to which students believe the changes have remained.

Summary

In this chapter, results were presented on the four measures used to evaluate the class. Four hypotheses were tested. Results from the Evaluation Questionnaire, which measured the perceived effectiveness of the tools and the frequency of reported use of the tools were offered.

1. Hypothesis 1 tested whether or not the treatment subjects increased in self-esteem as a result of their participation in PHSE, when compared to the control subjects who were enrolled in a different class, PSY 320. The results were not significant for this hypothesis and the null hypothesis was retained.

2. Hypothesis 2 measured whether or not the treatment subjects decreased in their depression as a result of their experience, when compared to the control group. The results were not significant for

this hypothesis and the null hypothesis was retained.

3. Hypothesis 3 measured whether or not the treatment subjects, as a result of their experience, when compared to the control group, experienced less anxiety. Results were significant and the null hypothesis was rejected.

4. Hypothesis 4 was concerned with shame and whether or not the treatment subjects as a result of their experience would be able to better identify shame experience and shame affect, when compared to the control group. Significant results were found and the null hypothesis was rejected.

5. The means for perceived effectiveness and frequency of use of tools, based on self-report information on the Evaluation Questionnaire, were estimated. The results show fairly high (5.09 points out of 7 points) satisfaction with the effectiveness of the tools and moderately high (4.64 points out of 7 points) usage of the tools. The relationship tools showed the most frequent use grand mean 5.34.

CHAPTER VI

SUMMARY AND DISCUSSION

The purpose of the study was to examine the effectiveness of a psychoeducational curriculum which teaches psychological health skills. The study evaluated a course entitled, Psychological Health and Self-Esteem (PHSE), a 10-week class offered through the Psychology Department at Michigan State University.

The main question directing this research is whether psychological health skills can be taught effectively in the classroom setting.

The lack of significant results on the self-esteem scales and the depression scale can be interpreted in two ways, either the program is not effective in producing change on these variables or these particular instruments are not sensitive enough to pick up changes in a 10-week time period. The self-report questionnaire does suggest that participation in PHSE has a positive effect on participants which counters the first interpretation. Since positive results were obtained on the other instruments the likely interpretation is that lack of sensitivity of the instruments is the reason why change was not observed.

The anxiety measure, STAI, demonstrated significant change in the direction of lower anxiety in the treatment group. For the sample studied, positive results were obtained as predicted. When the state versus trait was examined, significant results were

observed on the trait dimension of anxiety. Since posttest occurred the week before final exams, it is likely that each group was experiencing a temporary elevation in state anxiety at the time of posttest. This makes the significant difference between the two groups all the more important. Even though anxiety may be situationally affected in the direction of a temporary increase, the treatment group experienced a significant decrease in the more enduring trait anxiety. This further supports the effectiveness of the program in reducing stress.

With regard to shame the treatment group scored significantly higher on the Shame scale at the time of posttest in comparison to the pretest. Their awareness of shame and ability to report shame had definitely become enhanced as predicted. PHSE, thus, is affective in increasing awareness of specific negative emotions like shame. PHSE fosters the ability to differentiate affect.

In addition to differentiating affect, PHSE also teaches effective tools for more effective management of affect as indicated by the observed decrease in trait anxiety scores.

To summarize the main findings, the results of the study demonstrate that PHSE has a positive impact on the participants' psychological health. Students enrolled in PHSE showed a decrease in trait anxiety and an increase in their ability to recognize shame affect. These results lend support to the idea that psychological health is teachable.

The subjects in this study were volunteers who agreed to take part in an educational presentation of psychological health skills.

Thus, volunteerism introduced a selection bias into the sampling procedure. This sampling bias was magnified by a second voluntary agreement, participation in a research study. The subject sample, then, was two steps removed from a true representative sample of the population.

While partial data were collected on 200 participants, complete data were collected on only 117 participants. Only the latter were included in the study. The posttest occurred during the ninth week of the term, finals week at MSU. This was not an ideal time to achieve a high return rate. Many students did not attend class the last week and this was true of both treatment and control groups.

Another major concern as already mentioned is the lack of sensitivity of two types of instruments. The depression inventory and the self-esteem scales were judged as not sensitive enough to pick up changes in a 10-week period of time. There is evidence that the treatment group does impact the participants' ability to experience increase in the awareness of emotions as demonstrated by the STAI and ISS. Perhaps instruments that are more finely tuned like the STAI and ISS would reflect significant differences.

Additionally, a longer period of follow-up time between pretesting and posttesting would be valuable to observe whether changes are stable. The ability to master the treatment tools and concepts within 10-weeks time and then put them into practice as behavioral action strategies is likely to be a process that takes a longer time than the 10 weeks allowed for in this study.

While the present study adds continued support for PHSE, further research is needed to identify other instruments to pick up changes coupled with more extensive follow-up beyond conclusion of the program.

APPENDICES

Appendix A

Measures

SELF-EVALUATION QUESTIONNAIRE

Developed by Charles D. Spielberger
in collaboration with
R. L. Gorsuch, R. Lushene, P. R. Vagg, and G. A. Jacobs

STAI Form Y-1

Name _____ Date _____ S ___

Age _____ Sex: M ___ F ___ T ___

DIRECTIONS: A number of statements which people have used to describe themselves are given below. Read each statement and then blacken in the appropriate circle to the right of the statement to indicate how you feel *right* now, that is, *at this moment*. There are no right or wrong answers. Do not spend too much time on any one statement but give the answer which seems to describe your present feelings best.

	NOT AT ALL	SOMEWHAT	MODERATELY SO	VERY MUCH SO
1. I feel calm	①	②	③	④
2. I feel secure	①	②	③	④
3. I am tense	①	②	③	④
4. I feel strained	①	②	③	④
5. I feel at ease	①	②	③	④
6. I feel upset	①	②	③	④
7. I am presently worrying over possible misfortunes	①	②	③	④
8. I feel satisfied	①	②	③	④
9. I feel frightened	①	②	③	④
10. I feel comfortable	①	②	③	④
11. I feel self-confident	①	②	③	④
12. I feel nervous	①	②	③	④
13. I am jittery	①	②	③	④
14. I feel indecisive	①	②	③	④
15. I am relaxed	①	②	③	④
16. I feel content	①	②	③	④
17. I am worried	①	②	③	④
18. I feel confused	①	②	③	④
19. I feel steady	①	②	③	④
20. I feel pleasant	①	②	③	④

Consulting Psychologists Press
577 College Avenue, Palo Alto, California 94306

SELF-EVALUATION QUESTIONNAIRE

STAI Form Y-2

Name _____ Date _____

DIRECTIONS: A number of statements which people have used to describe themselves are given below. Read each statement and then blacken in the appropriate circle to the right of the statement to indicate how you *generally* feel. There are no right or wrong answers. Do not spend too much time on any one statement but give the answer which seems to describe how you generally feel.

	ALMOST NEVER	SOMETIMES	OFTEN	ALMOST ALWAYS
21. I feel pleasant	①	②	③	④
22. I feel nervous and restless	①	②	③	④
23. I feel satisfied with myself	①	②	③	④
24. I wish I could be as happy as others seem to be	①	②	③	④
25. I feel like a failure	①	②	③	④
26. I feel rested	①	②	③	④
27. I am "calm, cool, and collected"	①	②	③	④
28. I feel that difficulties are piling up so that I cannot overcome them	①	②	③	④
29. I worry too much over something that really doesn't matter	①	②	③	④
30. I am happy	①	②	③	④
31. I have disturbing thoughts	①	②	③	④
32. I lack self-confidence	①	②	③	④
33. I feel secure	①	②	③	④
34. I make decisions easily	①	②	③	④
35. I feel inadequate	①	②	③	④
36. I am content	①	②	③	④
37. Some unimportant thought runs through my mind and bothers me	①	②	③	④
38. I take disappointments so keenly that I can't put them out of my mind	①	②	③	④
39. I am a steady person	①	②	③	④
40. I get in a state of tension or turmoil as I think over my recent concerns and interests	①	②	③	④

Appendix B

Evaluation Questionnaire

Directions: Rate each tool according to how personally useful each is and also how regularly you are utilizing each one. Circle the appropriate number.

1. Collecting Happiness: Collecting and storing good feelings	How personally useful is this: 1 2 3 4 5 6 7 not useful very useful How regularly are you utilizing this: 1 2 3 4 5 6 7 rarely regularly
2. Collecting Adequacy: Collecting and storing adequacy	How personally useful is this: 1 2 3 4 5 6 7 not useful very useful How regularly are you utilizing this: 1 2 3 4 5 6 7 rarely regularly
3. Inner Dialogue: Becoming conscious of and changing to a positive one	How personally useful is this: 1 2 3 4 5 6 7 not useful very useful How regularly are you utilizing this: 1 2 3 4 5 6 7 rarely regularly
4. Cultivating Ways of Nurturing Self: Caring and forgiveness of self	How personally useful is this: 1 2 3 4 5 6 7 not useful very useful How regularly are you utilizing this: 1 2 3 4 5 6 7 rarely regularly
5. Talking to Our Inner Child Through Imagery	How personally useful is this: 1 2 3 4 5 6 7 not useful very useful How regularly are you utilizing this: 1 2 3 4 5 6 7 rarely regularly
6. Consultation With Self: Feelings Needs Values Body	How personally useful is this: 1 2 3 4 5 6 7 not useful very useful How regularly are you utilizing this: 1 2 3 4 5 6 7 rarely regularly
7. Values and Expectations	How personally useful is this: 1 2 3 4 5 6 7 not useful very useful How regularly are you utilizing this: 1 2 3 4 5 6 7 rarely regularly
8. Meditation: Focusing attention on one point such as breath counting	How personally useful is this: 1 2 3 4 5 6 7 not useful very useful How regularly are you utilizng this: 1 2 3 4 5 6 7 rarely regularly

Directions: Rate each tool according to how personally useful each is and also how regularly you are utilizing each one. Circle the appropriate number.

9. Bubble Meditation: Focusing attention on the bubbles	How personally useful is this: 1 2 3 4 5 6 7 not useful very useful How regularly are you utilizing this: 1 2 3 4 5 6 7 rarely regularly
10. Refocusing Attention: Learning to let go	How personally useful is this: 1 2 3 4 5 6 7 not useful very useful How regularly are you utilizing this: 1 2 3 4 5 6 7 rarely regularly
11. Self-Observation: Learning to observe consciously	How personally useful is this: 1 2 3 4 5 6 7 not useful very useful How regularly are you utilizing this: 1 2 3 4 5 6 7 rarely regularly
12. Letting Go Through Imagery	How personally useful is this: 1 2 3 4 5 6 7 not useful very useful How regularly are you utilizing this: 1 2 3 4 5 6 7 rarely regularly

Directions: Rate each tool according to how personally useful each is and also how regularly you are utilizing each one. Circle the appropriate number.

1. What Am I Looking For in My Relationships	How personally useful is this: 1 2 3 4 5 6 7 not useful very useful How regularly are you utilizing this: 1 2 3 4 5 6 7 rarely regularly
2. Casing the Person Realistically	How personally useful is this: 1 2 3 4 5 6 7 not useful very useful How regularly are you utilizing this: 1 2 3 4 5 6 7 rarely regularly
3. Trial Balloons	How personally useful is this: 1 2 3 4 5 6 7 not useful very useful How regularly are you utilizing this: 1 2 3 4 5 6 7 rarely regularly
4. Staying Defended	How personally useful is this: 1 2 3 4 5 6 7 not useful very useful How regularly are you utilizing this: 1 2 3 4 5 6 7 rarely regularly
5. Assessing Power: Sharing the Power	How personally useful is this: 1 2 3 4 5 6 7 not useful very useful How regularly are you utilizing this: 1 2 3 4 5 6 7 rarely regularly
6. How Real and Honest Can We Be	How personally useful is this: 1 2 3 4 5 6 7 not useful very useful How regularly are you utilizing this: 1 2 3 4 5 6 7 rarely regularly
7. Commitment: Security vs. Freedom	How personally useful is this: 1 2 3 4 5 6 7 not useful very useful How regularly are you utilizing this: 1 2 3 4 5 6 7 rarely regularly
8. Matching Expectations	How personally useful is this: 1 2 3 4 5 6 7 not useful very useful How regularly are you utilizing this: 1 2 3 4 5 6 7 rarely regularly

Appendix C

Information and Consent Forms

Information About Research Project

Hello,

My name is Michele Meola. I am a doctoral student in the Department of Counselor Education and Counseling Psychology at Western Michigan University. As a dissertation project, I am conducting a research study into the effectiveness of various classes in promoting psychological health at Michigan State University. I would like to request your participation in this study.

Your part will include taking five questionnaires at the beginning of the term and five questionnaires at the end of the term. The tests measure how you think about situations you commonly experience as students and individuals. All five tests will take about one half hour to complete, and will be administered in your class for your convenience.

Individual scores will be kept strictly confidential by the experimenter and will not be released by anyone. For the purpose of the experiment, only group data will be reported. The nature of some of the questions may be sensitive, answer only the questions you are comfortable responding to.

Only students who agree to participate and sign informed consent forms will be assessed. Participants interested in receiving results of the study will have the opportunity at the time of the posttest to sign up on a sheet and then receive feedback when the study is completed. Please listen carefully before starting.

You have all received your packets. Please take out the Healthy U form first and complete the form. This is demographic information requested by the university for all those participating in a Healthy U project. This information will also help in looking at the participants in the research study.

Next please read the informed consent form and sign the form if you agree to participate in the study. I will be glad to answer any questions about the research and your participation. There are no known risks in filling out the inventories. The questions tend to ask about thoughts and feelings, answer only the questions you are comfortable responding to.

Next take out the answer sheets. Please do not write your name on the sheets. Instead write the first letter of your last name in the box. In the next box write the last four digits of your social security number -- do not write your student number. This code will allow me to match your pre and posttest and keep you anonymous.

When you are done filling in the boxes you may begin. Please take the questionnaires in the order of your packet -- your neighbor most likely has the inventories in a different order of administration. This is intentional for the purpose of the study.

Raise your hand if you have any questions, and I will come around to you. Thank you for agreeing to participate in the study.

INFORMED CONSENT FORM

Title of HEALTHY U Subproject: Psycho-Educational Curriculum for Promoting Health and Wellness

Subproject Director: Gershen Kaufman, Ph.D.

I have been informed that participating in this project, a part of the HEALTHY U PROGRAM, will include the following activities or procedures: completing a series of questionnaires.

I have been given an opportunity to ask any questions I may have had about my participation and any such questions have been answered to my satisfaction.

I have been told about any potential risks that could result from my participation. I understand that all data collected in this project will be kept strictly confidential and will be maintained in a secure manner. I understand that any data used for publication purposes will be summarized for groups of participants and that my anonymity will be protected. No information about specific individuals will be made available to any individual or agency outside of the subproject staff or the HEALTHY U evaluation team without written permission.

I understand that the activities involved in this project are intended for basically healthy participants and I am not aware that I have any health condition that should preclude my participation.

I understand that my participation is voluntary and that I am free to withdraw my consent and terminate my participation at any time without penalty.

I have been told that if I have any other questions about the procedures to be used in this project I may call Dr. Gershen Kaufman at 355-8270. Furthermore, if I have any concerns or complaints, I am encouraged to call the HEALTHY U Program Manager, Dr. Margaret Holmes at 353-2596.

Knowing all this, I freely agree to participate in this project.

_____
Participant's signature

Date: _____

HEALTHY U PARTICIPANT BACKGROUND QUESTIONNAIRE

To evaluate how successful the HEALTHY U PROGRAM is at reaching individuals from throughout the M.S.U. community, we would like to know some information about the backgrounds of those who participate in the various HEALTHY U sub-projects. The following set of questions is designed to provide us with this information. Please, answer the questions below and return the completed questionnaire to the researcher. Be assured that any information you give us about yourself will be kept in strictest confidence.

1. What is your sex?

[ ] Male
[ ] Female

2. In what year were you born? (please, write in the year)

_____

3. What is your present marital status?

[ ] Single
[ ] Married
[ ] Widowed
[ ] Divorced
[ ] Separated

4. Are you a U.S. citizen?

[ ] Yes
[ ] No

5. Where were you born?

[ ] United States
[ ] Canada
[ ] A Central or South American country
[ ] A European country
[ ] A Middle-Eastern country
[ ] An African country
[ ] Australia or New Zealand
[ ] An Asian or Pacific country

6. Which category best describes your race or ethnic group?

[ ] White--not Hispanic
[ ] Hispanic-American or Hispanic
[ ] Afro-American or African
[ ] Native American Indian
[ ] Asian Pacific American or Asian
[ ] Other (please name): _____

7. What is your principal status with M.S.U.?

[ ] Freshman
[ ] Sophomore
[ ] Junior
[ ] Senior
[ ] Master's student
[ ] Doctoral student
[ ] Graduate/professional student
[ ] Employee--academic
[ ] Employee--non-academic
[ ] Retiree--academic
[ ] Retiree--non-academic
[ ] No relationship with M.S.U.
[ ] Other (please specify) _____

8. How many years have you been attending or employed by M.S.U.?

Please write in the number _____

9. With which unit at M.S.U. are you currently affiliated?

[ ] Agriculture & Natural Resources
[ ] Arts and Letters
[ ] Business
[ ] Communication
[ ] Education
[ ] Engineering
[ ] Human Ecology
[ ] Human Medicine
[ ] James Madison
[ ] Nursing
[ ] Osteopathic Medicine
[ ] Social Science
[ ] Veterinary Medicine
[ ] Other academic area (no major declared at present)
[ ] University Services
[ ] Housing & Food Services
[ ] Personnel & Employee Relations
[ ] Physical Plant
[ ] Public Safety
[ ] Student Affairs & Services
[ ] Health Services & Facilities
[ ] Libraries
[ ] Central Administration
[ ] Other Educational Units (please specify)_____
[ ] Other (please specify)_____

10. Do you live on-campus (including married housing)?

[ ] Yes (please, see question 10a)
[ ] No (please, see question 10b)

10a. If you answered YES to #10, please indicate in which dormitory or housing complex you live:

[ ] Abbot Hall
[ ] Akers Halls
[ ] Armstrong Halls
[ ] Bailey Hall
[ ] Bryan Hall
[ ] Butterfield Hall
[ ] Campbell Hall
[ ] Case Halls
[ ] Emmons Hall
[ ] Gilchrist Hall
[ ] Holden Halls
[ ] Holmes Halls
[ ] Hubbard Halls
[ ] Landon Hall
[ ] Mason Hall
[ ] Mayo Hall
[ ] McDonel Halls
[ ] Owen Halls
[ ] Phillips Hall
[ ] Rather Hall
[ ] Shaw Halls
[ ] Snyder Hall
[ ] VanHoosen Hall
[ ] Williams Hall
[ ] Wilson Halls
[ ] Wonders Hall
[ ] Yakeley Hall
[ ] Cherry Lane Apartments
[ ] University Apartments
[ ] Spartan Village Apartments
[ ] Other (please specify)_____

10b. If you answered NO to #10, in what kind of residence do you presently live?

[ ] Fraternity or sorority
[ ] Single room off-campus
[ ] Apartment or condominium
[ ] Cooperative housing off-campus
[ ] Single-family house
[ ] Duplex, triplex, or fourplex house
[ ] Other (please specify)_____

11. How long does it usually take you to get from your residence to a central campus location such as the library or administration building using whatever mode of transportation you most commonly use?

Please write in the time: _____ minutes

12. Had you heard about the HEALTHY U PROGRAM before receiving this questionnaire?

[ ] Yes (please, see question #12a)
[ ] No (please, go to question #13)

12a. If you answered YES to #12, how did you hear about the HEALTHY U PROGRAM? (Please check all that apply)

[ ] on radio
[ ] on cable TV
[ ] in The State News
[ ] in the HEALTHY U publications
[ ] from posters or flyers on campus
[ ] during registration for classes
[ ] at Olin Health Center
[ ] in a current course
[ ] in a previous course
[ ] from an administrator
[ ] from a faculty member
[ ] from a student
[ ] from a colleague or co-worker
[ ] from a friend or relative
[ ] other (please specify)_____

13. Have you taken or are you taking any (other) courses which you believe are part of the HEALTHY U PROGRAM?

[ ] Yes (if yes, please specify which ones) _____
[ ] No
[ ] Uncertain

14. Have you participated or are you participating in any (other) activities which you believe are part of the HEALTHY U PROGRAM?

[ ] Yes (if yes, please specify which ones) _____
[ ] No
[ ] Uncertain

15. Based on what you know of the HEALTHY U PROGRAM, in which of the following ways do you feel HEALTHY U has made significant contributions at M.S.U.?
(please check no more than three)

[ ] On my personal health
[ ] On the well-being of members of my family
[ ] On the content of my courses
[ ] On the training of health-care professionals
[ ] On the University's general curriculum
[ ] On the University as a place to work
[ ] On the University's reputation as a leader in health promotion
[ ] Not sufficiently familiar to judge

16. In general, what is your overall perception of the quality of the HEALTHY U PROGRAM?

[ ] Very positive
[ ] Generally positive
[ ] Neutral; neither positive nor negative
[ ] Generally negative
[ ] Very negative
[ ] Not sufficiently familiar to judge

We are interested in determining what effects participation in the sub-projects of the HEALTHY U PROGRAM might have in the long run on individual's general health and health-related attitudes and behaviors. To accomplish this, we would like to ask individuals who have participated in at least one of the sub-projects if we could send them a general health-related questionnaire at some time in the future. To enable us to identify which individuals, over several terms or years, participate in more than one HEALTHY U sub-project, we would like you to please write in the first letter of your last name followed by the last four digits of your social security number in the space below. This will be your HEALTHY U ID number. Again, we can assure you that any information you give us will be kept in strictest confidence.
NO INFORMATION connecting you to any information you give us will be made public.

HEALTHY U ID # ___ - ___ ___ ___ ___

If you would be willing to allow us to send you such a questionnaire, please fill out the attached form and return it to the sub-project representative. Agreeing to allow us to send you a questionnaire does not obligate you at this time to complete the questionnaire; rather, it simply lets us send it to you so that you might fill it out if you choose to at that time.

THANK YOU VERY MUCH FOR COMPLETING THIS QUESTIONNAIRE

Appendix D

Course Syllabus

PSY 325 Syllabus
Dr. Gershen Kaufman
Office Hours: Tu/Th 1:30-3 pm

Spring 1988
Office: 207 SSB
Phone: 355-8270

PSYCHOLOGICAL HEALTH AND SELF-ESTEEM

Development of psychological health through explorations of affect as the critical mediator of stress and self-esteem. Exploration of powerlessness-affect-stress cycles. Development of personal identity and interpersonal competence through translating psychological principles into effective tools for living.

I. Overview

What is most important to learn about living life is given least attention: How are we to create an inner sense of competence as well as effective power in the world? How are we to discover direction or purpose for ourselves? How are we to overcome life's stresses and manage its uncertainties? How can we learn to feel secure in an environment of accelerating uncertainty and powerlessness? How do we build satisfying and supportive relationships with peers, parents and partners? Problems in living arise when individuals have not learned how to effectively accomplish these essential developmental tasks. This course will offer an educational experience in developing these necessary psychological skills by exploring the sources of power and shame as foundations for competence. Through living consciously from a position of personal power, we learn to build a competent self

II. Objectives

The specific objectives include reducing stress, enhancing self-esteem, developing personal identity, effectively managing affect, and developing interpersonal competence. Additionally, students will be taught a series of experiential tools which aid in building a competent self. These practical tools are translations of psychological principles into action.

III. Format

The course will combine weekly lectures with smaller section meetings to facilitate group discussion. The first class meeting of each week will be conducted as a lecture with all sections meeting together. The second class meeting of each week will be conducted as individual section meetings. Regular and consistent attendance is required.

IV. Required Texts

Kaufman, G. (1985). Shame: The Power of Caring. Cambridge: Schenkman. Second Edition.

Kaufman, G., with Raphael, L. (1983). Dynamics of Power: Building a Competent Self. Cambridge: Schenkman.

V. Written Assignments

1. Weekly Reaction Papers

A two-page reaction paper will be due each Thursday. These papers must (1) reflect your personal experience with the new tools presented each week and (2) demonstrate your knowledge of the theory and specific concepts presented in the assigned readings for that week. Papers must be typewritten, double-spaced, and handed in on time.

2. Term Paper

An eight-ten page integrative term paper will be due Monday of finals week. First, the term paper must demonstrate your mastery of course concepts by (1) relating the various psychological principles to their respective tools and (2) relating both principles and tools to the larger process of psychological health and self-esteem. You may discuss these, for example, in terms of the dynamics of stress and the dynamics of addiction. Second, describe in depth your experience applying concepts from this course in your personal life. Discuss your experience with the tools and concepts from an experiential as well as conceptual perspective. The paper must demonstrate your understanding of the theory behind the tools as well as how you have actually applied them in your own life. Finally, evaluate the effectiveness of your experiment in applying these principles and tools: Are they worth learning? Do they build personal competence, power, and competent relationships? You must include lectures, class discussions, personal experience with the tools, and both texts in organizing your paper. Be specific. Papers must be typewritten, double-spaced, and handed in on time.

VI. Grading

PSY 325 is a 3-credit, pass/no-grade course. In order to receive a P grade, students must complete all weekly reaction papers and term paper, and must participate in class meetings. Please note: Students are responsible for all material presented or work assigned when they are absent.

VII. Graduate Assistants

The two graduate assistants for this course are Lisa Cowden and Richard Myer. They will be responsible for conducting two of the three section meetings and for all assigned work from students in their respective sections.

COURSE OUTLINE

Class Meetings	Units	Readings	Paper Due
Week 1 & 2	I. Powerlessness-Affect-Stress Power Powerlessness Affect Stress	Power, Ch. 1	Reaction Paper Due Each Thursday
Week 3 & 4	II. Shame and Self-Esteem Dynamics of Shame Shame Profile Self-Concept Addiction	Shame, Ch. 1-5	
Week 5 & 6	III. Identity: The Self's Relationship With the Self Inner Voices Guilt and Self-Care Inner Child Self-Affirming Identity	Power, Ch. 2	
Week 7 & 8	IV. Dimensions of Consciousness: Tools For Releasing Affect Owning Detachment Self-Observation Imagery	Power, Ch. 3	
Week 9 & 10	V. Interpersonal Competence Developmental Perspective Relationship Principles Relationship Process Power and Shame	Power, Ch. 4-5	Term Paper due Monday of Finals Week

Appendix E

Tools

PSY 325
Dr. Gershen Kaufman

Reaction Paper #1

I. Tools (one page)

Discuss your personal experiences working with the following tools, give specific examples along with your honest reactions and also describe any difficulties or discoveries encountered:

1. Happiness List: Make a list of five events every day which leave you feeling happy, a smile on your face.

2. Adequacy List: Make a list of five events every day which leave you feeling proud of yourself.

II. Theory (one page)

Answer the following study questions based on Dynamics of Power, Ch. 1:

1. How do the happiness and adequacy tools relate to the four central concepts, responsibility, choice, living consciously and power

2. How does power relate to powerlessness?

Reaction Paper #2

I. Tools (one page)

Discuss your personal experiences working with the following tools, give specific examples along with your honest reactions and also describe any difficulties or discoveries encountered:

1. Describe a current situation of powerlessness.

2. Identify your affective reactions during it.

3. Identify two choices for coping differently with that situation that could enable you to take back the power.

II. Theory (one page)

Answer the following study questions based on Dynamics of Power, Ch.1:

1. What is the meaning of the concept of power as described in the text?

2. How does the need for power develop?

PSY 325
Dr. Gershen Kaufman
Winter 1988

Reaction Paper #3

I. Tools (one page)

Discuss your personal experiences working with the following tools, give specific examples along with your honest reactions and also describe any difficulties or discoveries encountered:

1. Describe an old shame scene from childhood. It can be of any intensity or variety (embarrassment, shyness, guilt, self-consciousness, discouragement, inferiority). It can be from any setting (family, school, peer group). Describe your reactions during and after that scene.

2. Discuss how that old shame scene continues to affect you today, either positively or negatively.

II. Theory (one page)

Answer the following study questions based on Shame, Ch. 1-3:

1. What is the significance of shame and how does shame develop?

2. How does shame influence the development of personality and identity?

Reaction Paper #4

I. Tools (one page)

Discuss your personal experiences working with the following tools, give specific examples along with your honest reactions and also describe any difficulties or discoveries encountered:

1. Apply the Shame Profile to your own personality. Discuss the particular affects, needs, drives and purposes which, for you, have become fused with shame.

2. Discuss the role of shame in your own life, how shame has affected you.

II. Theory (one page)

Answer the following study questions based on Shame, Ch. 4, 5, and Epilogue:

1. What are the consequences and significance of shame internalization?

2. What are essential aspects of the healing or therapy process in regard to shame?

PSY 325
Dr. Gershen Kaufman
Winter 1988

Reaction Paper #5

I. Tools (one page)

Discuss your personal experiences working with the following tools, give specific examples along with your honest reactions and also describe any difficulties or discoveries encountered:

1. Observe, accurately name and describe your inner voices, your characteristic negative identity scripts (self-blame, self-contempt, comparison-making). What is their source?

2. Attempt to replace negative voices/scripts with a new self-affirming voice/script and discuss your observations.

II. Theory (one page)

Answer the following study questions based on Dynamics of Power, Ch. 2:

1. How does the self's relationship to the self originate and what is necessary for changing it to a satisfying one?

2. What is the significance of defining "identity" as the "self's relationship with the self"?

Reaction Paper #6

1. Tools (one page)

Discuss your personal experiences working with the following tools, give specific examples along with your honest reactions and also describe any difficulties or discoveries encountered:

1. Experiment with inner child imagery or reparenting imagery and discuss your observations of the experience.

2. Work with the inner child tool through verbal or behavioral methods and discuss your observations.

II. Theory (one page)

Answer the following study questions based on Dynamics of Power, Ch. 2:

1. What is the meaning or significance of the inner child concept?

2. How does the inner child concept relate to the concept of identity?

PSY 325
Dr. Gershen Kaufman
Winter 1988

Reaction Paper #7

I. Tools (one page)

Discuss your personal experiences working with the following tools, give specific examples along with your honest reactions and also describe any difficulties or discoveries encountered:

1. Practice the consultation with self tool daily and discuss your observations.

2. Discuss which affects, needs, and bodily states you are consciously aware of readily, and which are hardest for you to recognize.

3. Discuss scenes of purpose ("values" in the text) in terms of your imagined dreams for your future.

II. Theory

Answer the following study questions based on Dynamics of Power, Ch. 3:

1. Why is a "language of the self" necessary and useful?

2. How is "differentiated owning" related to "living consciously"?

Reaction Paper #8

I. Tools (one page)

Discuss your personal experiences working with the following tools, give specific examples along with your honest reactions and also describe any difficulties or discoveries encountered:

1. Practice several of the detachment tools (bubble meditation, refocusing attention, letting go imagery, detachment imagery, writing, humor, self-observation) and discuss your observations.

2. Discuss which methods are most effective for which situations.

II. Theory (one page)

Answer the following study questions based on Dynamics of Power, Ch. 3:

1. What is the significance of detachment and self-observation?

2. How does "imagery" relate to the other three dimensions of consciousness (owning, detachment and self-observation)?

PSY 325
Dr. Gershen Kaufman
Winter 1988

Reaction Paper #9

I. Tools (one page)

Discuss your personal experiences working with the following tools, give specific examples along with your honest reactions and also describe any difficulties or discoveries encountered:

1. Discuss three different, current relationships (friend, family, romantic) along the following dimensions:

   a) Determine what you are needing, expecting, or looking for in each of the three relationships by observing your recurring relationship scenes.

   b) Objectively observe each of the three individuals in order to determine how well your expectations (imagined scenes) match reality in each relationship.

   c) Examine each of the three relationships for power/powerlessness and also for shame.

II. Theory (one page)

Answer the following study questions based on Dynamics of Power, Ch.4 and 5:

1. What is the relationship between "staying defended" and "vulnerability"?

2. What is the relationship among power, shame and intimacy?

Term Paper

I. Tools (4-5 pages)

1. Describe in depth your experience applying concepts from this course in your personal life. Discuss your experience with the tools and concepts from an experiential as well as conceptual perspective.

2. The paper must demonstrate your understanding of the theory behind the tools as well as how you have actually applied them in your own life. Evaluate the effectiveness of your experiment in applying these principles and tools: Have they enhanced your own psychological health?

II Theory (4-5) pages)

1. Demonstrate your mastery of course concepts by (1) relating the various psychological principles to their respective tools and (2) relating both principles and tools to the larger process of psychological health.

2. Discuss the dynamics of the four central dimensions of psychological health: self-esteem, stress, personal identity and interpersonal competence.

3. Discuss the dynamics of addiction and eating disorders.

Appendix F

PHSE Course Handouts

DEVELOPMENTAL THEORY OF SHAME AND IDENTITY: THE ROLE OF AFFECT, IMAGERY AND LANGUAGE

GERSHEN KAUFMAN, PH.D.
MICHIGAN STATE UNIVERSITY

DEVELOPMENTAL PROCESS:	
AFFECT	SHAME
FACIAL SIGNS	Head Down Eyes Down Blushing
SECONDARY REACTIONS	Fear Distress Rage
MANIFESTATIONS	Discouragement Self-Consciousness Embarrassment Shyness Shame Guilt
INNATE ACTIVATOR	Incomplete Reduction of the Positive Affects, Interest/Joy
INTERPERSONAL ACTIVATOR	Breaking the Interpersonal Bridge
DEVELOPMENTAL SOURCES	Preverbal Childhood Adolescence Culture Adulthood: Powerlessness Vocation Relationships Aging
INTERNALIZATION	Affect-Shame Binds Drive-Shame Binds Need-Shame Binds
IMAGERY: MAGNIFICATION BY SCENES	Families of Scenes of Shame ⟶ SHAME PROFILE: Character Competence Feelings Body Needs Relationships
TRANSFORMATION BY LANGUAGE: VERBAL AMPLIFICATION	SHAME FEELING STATES: Inferiority Worthlessness Loneliness Rejection Alienation Self-Doubt CHARACTER SHAME: Unloveable Deficient Defective Failure
TRANSFORMATION BY TEMPERAMENT	Introversion Extroversion - Cycloid
DEFENDING SCRIPTS	Rage Contempt Striving for Perfection Striving for Power Transfer of Blame Internal Withdrawal
IDENTITY SCRIPTS	Self-Blame Comparison-Making Self-Contempt ⟶ Disowning ⟶ Splitting of the Self
SHAME-BASED SYNDROMES	SHAME POSTURES: Paranoid Schizoid Depressive SHAME-BASED COMPULSIVE SYNDROMES: Physical Abuse Sexual Abuse Addictions Eating Disorders

THE AFFECT SYSTEM[1]

Positive

1) Interest-Excitement: eyebrows down, track, look, listen

2) Enjoyment-Joy: smile, lips widened up and out

3) Surprise-Startle: eyebrows up, eye blink

Negative

4) Distress-Anguish: cry, arched eyebrows, mouth down, tears, rhythmic sobbing

5) Fear-Terror: eyes frozen open, pale, cold, sweaty, facial trembling, with hair erect

6) Anger-Rage: frown, clenched jaw, red face

7) Shame-Humiliation: eyes down, head down

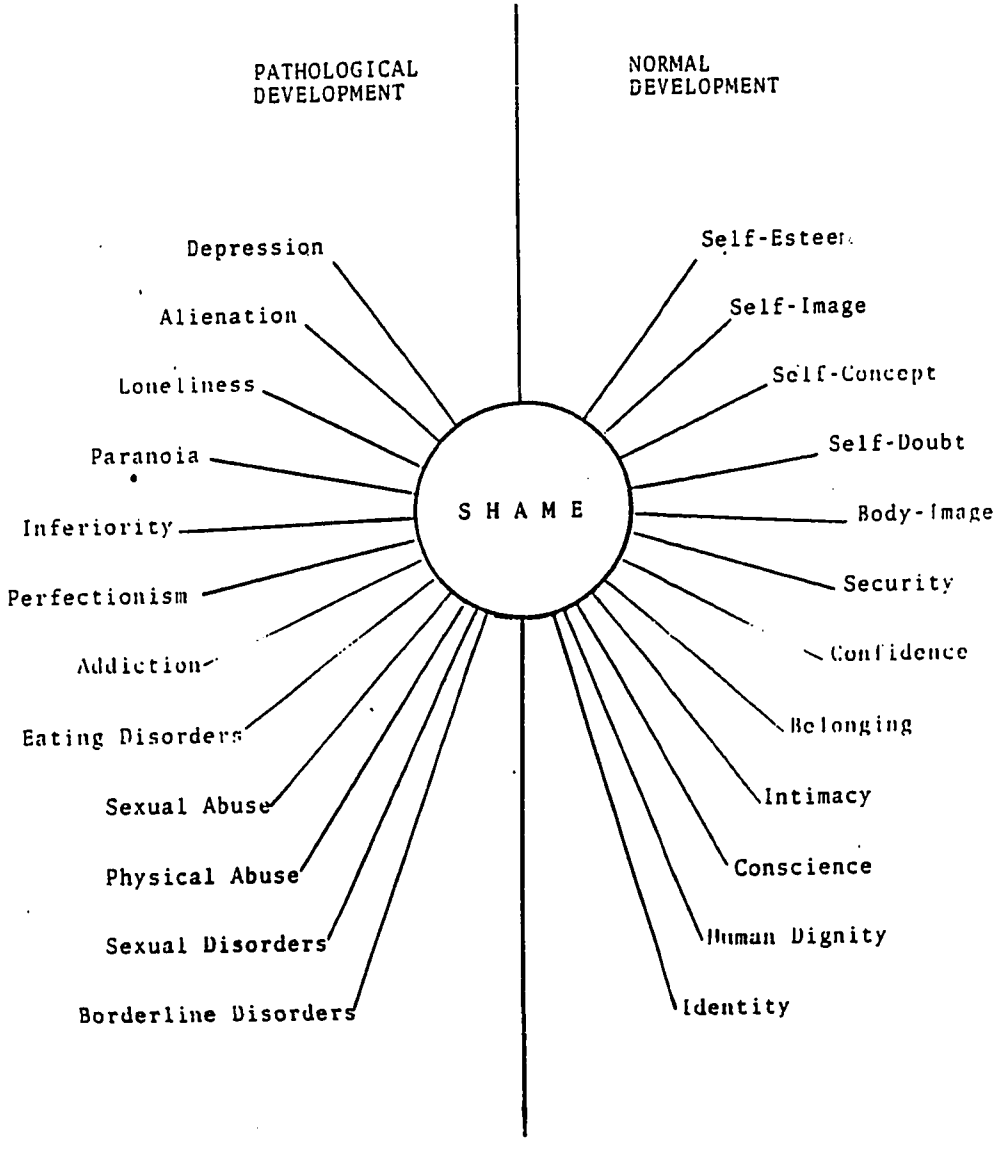
8) Dissmell: upper lip raised

9) Disgust: lower lip lowered and protruded

[1]Tomkins, S.S. (1962). Affect, imagery, consciousness. Vol. 1., New York: Springer and Co., p.337.

Tomkins, S.S. (1982). Affect theory. In P. Ekman (Ed.), Emotion in the human face. Cambridge: Cambridge University Press.

Tomkins, S.S. (1987). Shame. In D.L. Nathanson (Ed.), The many faces of shame. New York: Guilford.



DEVELOPMENTAL SOURCES OF SHAME

Gershen Kaufman, Ph.D.
Michigan State University

INNATE ACTIVATOR: Incomplete Reduction of Positive Affects, Interest/Joy

INTERPERSONAL ACTIVATOR: Breaking the Interpersonal Bridge

PREVERBAL SHAME ACTIVATION

SHAME AND ABANDONMENT

SHAME IN LATER CHILDHOOD:

- Shame On You
- You Are Embarrassing Me
- I Am Disappointed In You
- Disparagement
- Transfer of Blame
- Contempt
- Humiliation
- Performance Expectations

ADOLESCENCE AND SHAME

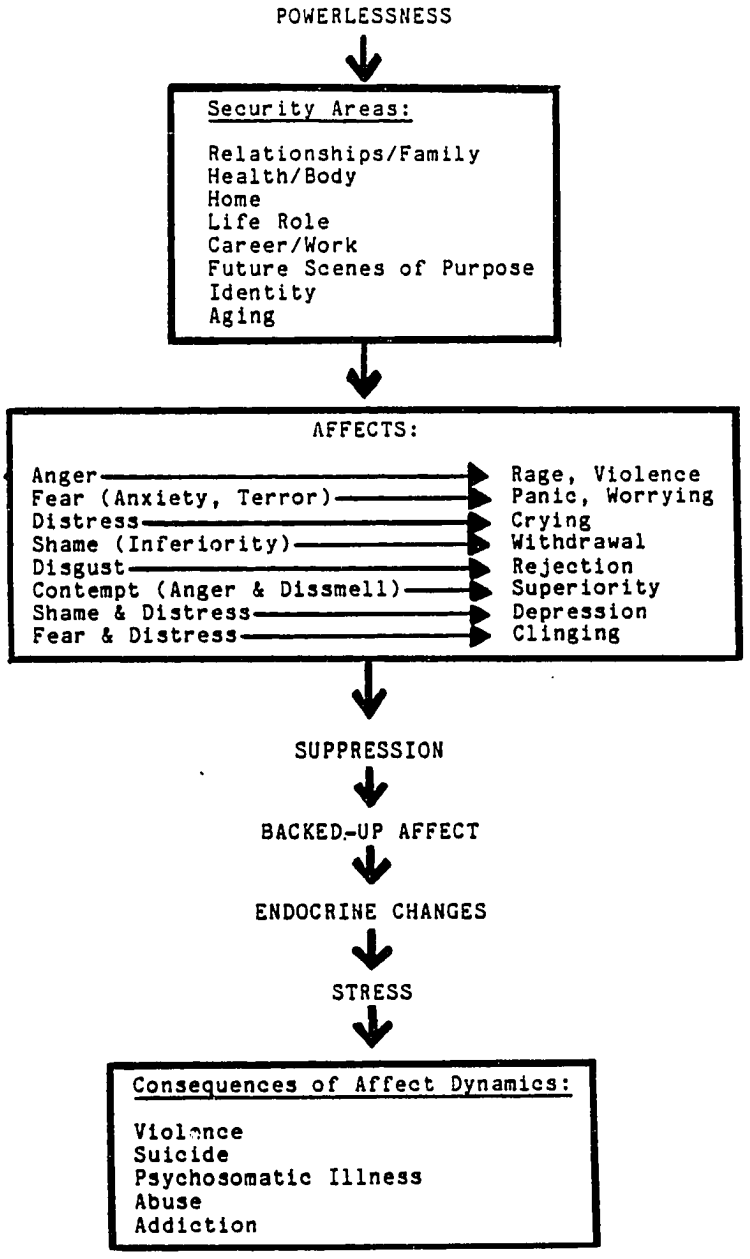
CULTURE AND SHAME:

- Compete For Success
- Be Independent And Self-Sufficient
- Be Popular And Conform

SHAME IN ADULTHOOD:

- Powerlessness
- Vocation
- Relationships
- Aging

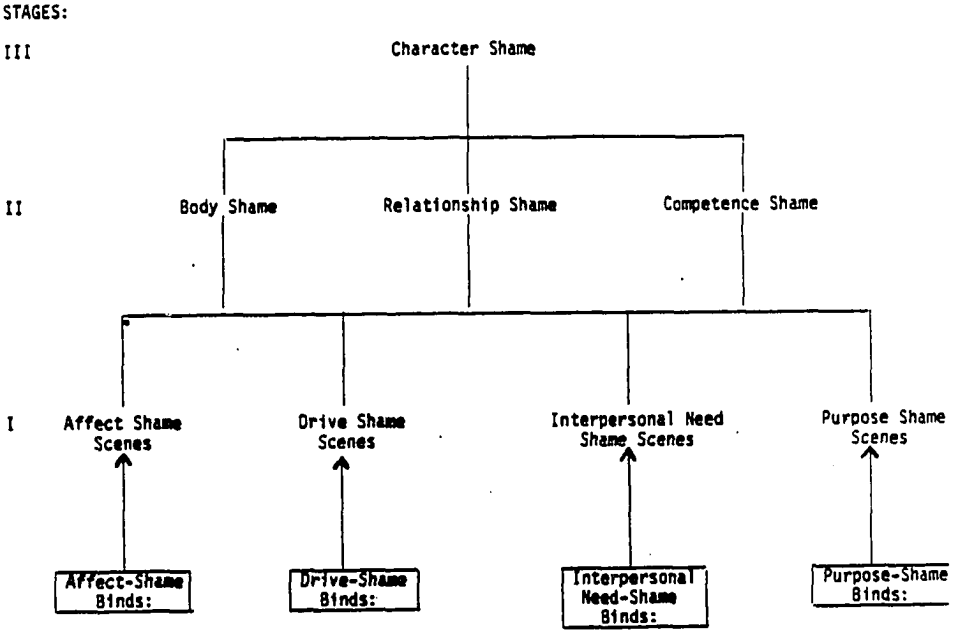
POWERLESSNESS--AFFECT--STRESS CYCLE



SHAME PROFILE:

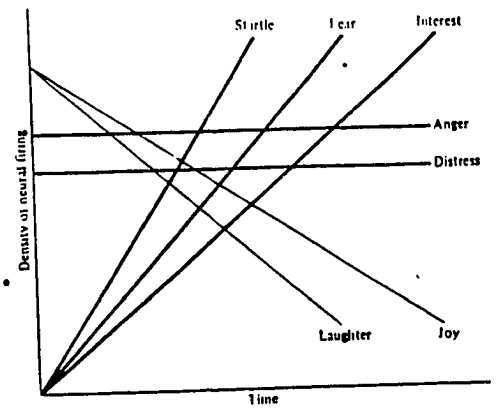
STAGES IN PSYCHOLOGICAL MAGNIFICATION

Gershen Kaufman, Ph.D.
Michigan State University



Differential Shaming For Women and Men:

Women:	Men:
Anger	Fear
	Distress
Power	Touching/Holding
Differentiation	Identification



Model of the innate activators of affect.

Tomkins, S.S. (1962). Affect, imagery, consciousness. Vol. 1., New York: Springer and Co., p.337.

Tomkins, S.S. (1982). Affect theory. In P. Ekman (Ed.), Emotion in the human face. Cambridge: Cambridge University Press.

Tomkins, S.S. (1987). Shame. In D.L. Nathanson (Ed.), The many faces of shame. New York: Guilford.

Time-limited Group-Focused Treatment Approach for Shame-Based Syndromes

Theory:	Tools:
1. Powerlessness-Affect-Stress Cycles	
(1) Power	H/A Tool
(2) Powerlessness	Powerlessness Scene
(3) Affect	
(4) Stress	
2. Shame and Self-Esteem	Shame Scene
(1) Self-Concept	
(2) Addiction	Shame Profile
3. Identity: The Self's Relationship with the Self	Inner Voices/Identity Scripts
(1) Replacing negative identity scripts and inner voices	
(2) Developing an internal sense of how much is good enough	Reparenting Imagery
(3) Distinguishing two sources of guilt and shame: disappointing self vs. disappointing others.	Self-Nurturance
(4) Self-Nurturance	
(5) Self-Forgiveness	
(6) Inner Child	
(7) Self-Affirming Identity	
4. Affect Management and Release Tools	
(1) Owning	Consulting Self
(2) Detachment	Detachment
(3) Self-Observation	Self Observation
(4) Imagery	
5. Interpersonal Competence	
(1) Peers	Observing Relationship Scenes
(2) Parents	Observing Other Person
(3) Partners	Matching Expectations with Reality
	Staying Defended
	Trial Balloons
	Regaining Equal Power

BIBLIOGRAPHY

Anastasi, A. (1968). Psychological testing (3rd ed.). New York: Macmillan.

Barger, B. (1965). Preventive action in college mental health. Unpublished doctoral dissertation, University of Florida, Gainesville.

Baygood, B. T. (1974). An evaluation of the effectiveness of human development instruction. Unpublished doctoral dissertation, Texas A&M University, College Station.

Beck, A. T. (1967). Depression: Clinical, experimental, and theoretical aspects. New York: Hoeber Medical Division, Harper and Row.

Beck, A. T. (1972). Depression: Causes and treatment. Philadelphia: University of Pennsylvania Press.

Beck, A. T. (1974a). Cognitive modification in depressed, suicidal patients. Paper presented at the meeting of the Society of Psychotherapy Research, Denver, CO.

Beck, A. T. (1974b). Depressive neurosis. In S. Arieti & E. B. Brody (Eds.), American handbook of psychiatry: Adult clinical psychiatry (2nd ed., Vol. 3, pp. 61-90). New York: Basic Books.

Beck, A. T. (1974c). The development of depression: A cognitive model. In R. J. Friedman & M. M. Katz (Eds.), The psychology of depression: Contemporary theory and research (pp. 3-20). Washington, DC: Winston.

Beck, A. T. (1974d). Recent developments in cognitive therapy. Paper presented at the eighth annual convention of the Association for the Advancement of Behavior Therapy, Chicago.

Beck, A. T., & Beck, R. (1972). Screening depressed patients in family practice: A rapid technique. Postgraduate Medicine, 52(6), 82-85.

Becker, J. (1974). Depression: Theory and research. Washington, DC: Winston.

Cain, A. C. (1967). The perils of prevention. American Journal of Orthopsychiatry, 37, 640-642.

Campbell, D. T., & Stanley, J. C. (1963). Experimental and quasi-experimental designs for research. Boston: Houghton Mifflin.

Caplan, G. (1964). Principles of preventive psychiatry. New York: Basic Books.

Carroll, B. J. (1974, February). Review of clinical research strategies in affective illness. In Implications of some recent biological studies of depressive illness. Symposium conducted at the meeting of the American Association for the Advancement of Science, San Francisco.

Cattell, R. B., & Scheier, I. H. (1958). The nature of anxiety: A review of thirteen multivariate analyses comprising 814 variables. Psychological Reports, 4, 351-388.

Cattell, R. B., & Scheier, I. H. (1961). The meaning and measurement of neuroticism and anxiety. New York: Ronald.

Cheek, J. M., & Buss, A. H. (1981). Shyness and sociability. Journal of Personality and Social Psychology, 41, 330-339.

Cook, D. R. (1987). The internalized shame scale. Unpublished instrument, University of Wisconsin-Stout, Menomonie.

Cook, D. R. (1988). Development and validation of the Internalized Shame Scale. Unpublished manuscript, University of Wisconson-Stout, Menomonie.

Coopersmith, S. (1967). Antecedents of self-esteem. San Francisco: Freeman.

Cudney, M. R. (1971). Elimination of self-defeating behaviors. Kalamazoo: Western Michigan University Press.

Del Polito, C. M. (1973). Development, implementation, and evaluation of a self-concept enhancement program. Unpublished doctoral dissertation, University of Notre Dame, South Bend, IN.

Ellis, A. (1962). Reason and emotion in psychotherapy. New York: Stuart.

Ellis, A., & Grieger, R. (1977). Handbook for rational emotive therapy. New York: Springer-Verlag.

Erikson, E. H. (1959). Identity and the life cycle. New York: International Universities Press.

Frisco, R. (1974). Mental health elective. School Health Review, 5, 20-21.

Grinker, R. R., Miller, J., Sabshin, M., Nunn, R., & Nunnally, J. C. (1961). The phenomena of depressions. New York: Harper and Row.

Griz, W. M. (1982). Training health maintenance organization subscribers in affective and cognitive coping skills as a primary prevention approach to mental health and health education. Unpublished doctoral dissertation, Michigan State University, East Lansing.

Guerney, B., Jr. (1973). The practicing psychologist as educator. Unpublished manuscript, Michigan State University, East Lansing.

Guerney, B., Jr., Guerney, L., & Stollak, G. (1971-1972). The potential advantages of changing from a medical to an educational model in practicing psychology. Interpersonal Development, 2, 238-245.

Gurin, P., Gurin, G., Lao, R. C., & Beattie, M. (1969). Internal-external control in the motivational dynamics of youth. Journal of Social Issues, 25, 29-53.

Horney, K. (1950). Neurosis and human growth. New York: Norton.

James, W. (1892). Psychology: The briefer course. New York: Holt.

Katz, M. M. (1974). Epilogue: On future directions. In R. J. Friedman & M. M. Katz (Eds.), The psychology of depression: Contemporary theory and research (pp. 294-301). Washington, DC: Winston.

Kaufman, G. (1980). Shame: The power of caring. Cambridge, MA: Schenkman.

Kaufman, G. (1985). Shame: The power of caring (rev. ed.). Cambridge, MA: Schenkman.

Kaufman, G. (in press). The psychodynamics of shame. New York: Springer.

Kaufman, G. (undated). Evaluation questionnaire. Unpublished questionnaire, Michigan State University, East Lansing.

Kaufman, G., & Raphael, L. (1983). The dynamics of power: Building a competent self. Cambridge, MA: Schenkman.

Lewinsohn, P. M. (1974). Clinical and theoretical aspects of depression. In K. S. Calhoun, H. E. Adams, & K. M. Mitchell (Eds.), Innovative treatment methods in psychopathology (pp. 63-120). New York: Wiley.

Lewis, H. B. (1971). Shame and guilt in neuroses. New York: International Universities Press.

Lewis, H. B. (1987). Shame and the narcissistic personality. In D. L. Nakanson (Ed.), The many faces of shame (pp. 93-132). New York: Guilford.

Mahoney, M. J. (1974). Self-control: Power to the person. Monterey, CA: Brooks/Cole.

Malamud, D. (1965). Teaching a human relations workshop. Brookline, MA: Center for the Study of Liberal Education for Adults.

Meichenbaum, D. H. (1977). Cognitive-behavior modification. New York: Plenum.

Meichenbaum, D. H., & Cameron, R. (1974). The clinical potential of modifying what clients say to themselves. Psychotherapy: Theory, Research, and Practice, 11(2), 103-117.

Michigan State University. (1987). Michigan State University Catalogue--1988. East Lansing: Author.

Nathanson, D. L. (1987). A timetable for shame. In D. L. Nathanson (Ed.), The many faces of shame (pp. 1-63). New York: Guilford.

Novis, E., & Larsen, J. (1976). Critical issues in mental health service delivery: What are the priorities? Hospital and Community Psychiatry, 27, 561-565.

Parks, C., Becker, W. N., Chamberlain, J. M., & Crandel, J. M. (1975). Eliminating self-defeating behaviors and change in locus of control. Journal of Psychology, 91, 115-120.

Phelps, R. E. (1977). Effects of self-control training upon perceived locus of control. Unpublished doctoral dissertation, Arizona State University, Tempe.

Philip, T., Himsl, W., & Warren, P. W. (1972). A life skills course: A preliminary report of its effects on personality and attitude measures. Saskatchewan Journal of Educational Research and Development, 2, 56-65.

Rimm, D. C., & Masters, J. C. (1979). Behavior therapy: Techniques and empirical findings (2nd ed.). New York: Academic Press.

Rogers, C. (1961). On becoming a person. Boston: Houghton Mifflin.

Rosenberg, M. (1965). Society and the adolescent self-image. Princeton, NJ: Princeton University Press.

Sanford, F. H. (1955). Creative health and the principle of habeas mente. American Psychologist, 10, 829-835.

Sarbin, T. R. (1968). Ontology recapitulates philology: The mythic nature of anxiety. American Psychologist, 23, 411-418.

Schlesinger, L. (1978). Assessing student outcomes in psychological education: A validation study of measures of self-esteem, locus of control, self-actualization, and vocational maturity. Unpublished doctoral dissertation, University of Toledo, Toledo, OH.

Seligman, M. E. P. (1974). Depression and learned helplessness. In R. J. Friedman & M. M. Katz (Eds.), The psychology of depression: Contemporary theory and research (pp. 83-113). Washington, DC: Winston.

Spielberger, C. D. (1983). Manual for the State-Trait Anxiety Scale Inventory (self-evaluation questionnaire). Palo Alto, CA: Consulting Psychologists Press.

Spielberger, C. D., & Gaudry, E. (1971). Anxiety and educational achievement. Sydney, Australia: Wiley.

Taylor, F. G., & Marshall, W. L. (1977). Experimental analysis of a cognitive behavioral therapy for depression. Cognitive Therapy and Research, 1(1), 59-72.

Tomkins, S. S. (1962). Affect/imagery/consciousness: Vol. 1. The positive affects. New York: Springer.

Tomkins, S. S. (1963). Affect/imagery/consciousness: Vol. 2. The negative affects. New York: Springer.

Tomkins, S. S. (1978). Script theory: Differential magnification of affects. Nebraska Symposium on Motivation, 26, 201-236.

Tomkins, S. S. (1987). Shame. In D. L. Nathanson (Ed.), The many faces of shame (pp. 133-161). New York: Guilford.

Tyler, F. B., & Gatz, M. (1976). Development of individual psychosocial competence in a high school setting. Journal of Consulting and Clinical Psychology, 45, 441-449.

Weintraub, M., Segal, R. M., & Beck, A. T. (1974). An investigation of cognition and affect in the depressive experiences of normal man. Journal of Consulting and Clinical Psychology, 42, 911.

White, R. W. (1959). Motivation reconsidered: The concept of competence. Psychological Review, 66(5), 297-333.

Wurmser, L. (1981). The mask of shame. Baltimore: Johns Hopkins University Press.

Wurmser, L. (1987). Shame: The veiled companion of narcissism. In D. L. Nathanson (Ed.), The many faces of shame (pp. 64-92). New York: Guilford.

Wylie, R. (1961). The self-concept. Lincoln: University of Nebraska Press.