Using Group Psychotherapy for Enhancing Late Adolescent Selfconcept: Comparing the Effects of Hypnosis and Rational-Emotive Therapy

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USING GROUP PSYCHOTHERAPY 
FOR ENHANCING LATE ADOLESCENT SELF-
CONCEPT: COMPARING THE EFFECTS OF 
HYPNOSIS AND RATIONAL-EMOTIVE THERAPY

by

James J. Buldas

A Dissertation 
Submitted to the 
Faculty of The Graduate College 
in partial fulfillment of the 
requirements for the 
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Kalamazoo, Michigan 
December 1984

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The purpose of this study was to determine whether university students, classified as late adolescents, could enhance their self-concept as measured by the Tennessee Self-Concept Scale (TSCS) Total Positive Score. Seven hypotheses which stated the null relationship between self-concept enhancement and the treatment modalities of hypnosis and rational-emotive therapy, when compared over an eight week period of time were derived. A review of the literature showed that the belief that low self-concept is etiologic in psychopathology is widespread in the clinical literature.

A sample of university students enrolled in Psychology 100 (N=54) were pre, post and follow-up tested using the TSCS, specific reference made to the Total Positive Score. The data were analyzed by a parametric statistical technique, the ANCOVA test of significance. Seven null hypotheses were validly analyzed for statistical significance. Each of the seven hypotheses was not rejected: self-concept scores of late adolescent subjects were not significantly enhanced after eight exposures of group psychotherapy with hypnosis or rational-emotive therapy. Reliability coefficients were similar to those found in the TSCS standardization. Also, results were consistent with the clinical literature that self-concept is a relatively...
stable formation.

Conclusions reached were suggestive of inappropriate subject selection and duration of treatment exposure. Also, issues of experimenter effectiveness were derived. Recommendations for future research were proposed.
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USING GROUP PSYCHOTHERAPY FOR ENHANCING LATE ADOLESCENT SELF-CONCEPT: COMPARING THE EFFECTS OF HYPNOSIS AND RATIONAL-EMOTIVE THERAPY

Western Michigan University

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I would like to dedicate this dissertation to the memory of my father, John, whose hard work and self-sacrifice made my education possible; to my mother, Pauline, whose support and drive during the early years of college made graduate school a reality; and to my wife, Connie, whose support and guidance made this endeavor worthwhile.

I will always be grateful to my sister, Marina, as she was my role model and friend. To my brother, George, who kept the memory of our father in my mind. I am also indebted to Dr. Robert Hopkins, Dr. Kenneth Bullmer, and Dr. Robert Brashear for their contribution to my doctoral studies and the completion of this dissertation.

James J. Buldas
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CHAPTER I

INTRODUCTION

Improving the self-concept appears to be one of the most motivating factors that bring people to those employed in the helping professions. Harland (1971) stated that in order for fulfilling human interaction and personal adjustment to be present a positive self-concept must also co-exist. Also, Brownfair (1952) concluded that instability within the self-concept is associated with psychological disturbance.

In order to stabilize the self-concept in a positive framework, the individual must feel a sense of worth and belonging. Rogers (1951) believes the people must face and accept themselves as having worth, even though they have limitations and disappointments. Once a more honest relationship formulates, the greater the chances are for them to make further adjustments to promote a more fulfilling life.

Need for the Study

Therapists, theorists, and researchers stress the importance of maintaining a positive self-concept (Carlson, 1965; Coopersmith, 1967; Davids and Folkof, 1975; Engel, 1959; Fitts, 1972; Gold and Mann, 1972; Lecky, 1951); however, in the review of related literature in this study there seemed to be very few researched procedures designed specifically to study treatment modalities in
conjunction with self-concept enhancement. Even more scarce are studies that deal with enhancing the self-concept of the adolescent.

Hansen and Maynard (1973) wrote:

An important underpinning of the perceptual point of view is that behavior is influenced not only by the accumulation of past and present experiences, but also, more importantly, by the personal meaning a person attaches to his perceptions of these experiences. Therefore, behavior is not simply a product of what has happened to a person from the outside, it is also a result of how he feels about himself on the inside... While it is true that a person's past experiences can have a vast influence on his present behavior, and while one cannot change what happened in the past, one can change how he feels about it today. Events cannot be changed, but perceptions about the events can be altered. Counseling, then, does not help a person in the sense of removing the problem, rather it assists an individual toward new perceptions of the problem so he can cope with it better. (pp. 20-21)

The concept of change put forth in Hansen and Maynard's statement is directly related to the premise of this study.

Fitts (1965), the developer of the *Tennessee Self-Concept Scale*, also commented on the importance of self-concept by stating:

The individual's concept of himself has been demonstrated to be highly influential in much of his behavior and also to be directly related to his general personality and state of mental health. Those people who see themselves as undesirable, worthless, or "bad" tend to act accordingly. (p. 1)

Following the completion of a literature review, in which Bibliographic Retrieval Services, an automated data base was employed, it was concluded that further research is needed in the area of enhancing adolescent self-concepts.

**Purpose of the Study**

The purpose of this study was to determine if group psychotherapy within the modalities of hypnosis or rational-emotive therapy...
has any significant effect on increasing self-concept as measured by the **Tennessee Self-Concept Scale** — specific reference made to the Total Positive Score. The Total Positive Score is the most valid and reliable measure of overall self-concept within the **Tennessee Self-Concept Scale** (Fitts, 1965). A significant increase in the Total Positive Score would suggest an improvement in self-concept. The study was also designed to compare these modes of group psychotherapy to determine whether one approach would have a greater likelihood of enhancing self-concept to a greater extent that the other approach.

**Definition of Terms**

In order to enhance the understanding of this study, the following definition of terms were used:

**Experimenter.** The person responsible for the administration of each treatment previously mentioned. The same experimenter was used for each treatment group.

**Subjects.** Male and female late adolescent students enrolled in Psychology 100 at West Chester State University during the winter semester, 1984. West Chester State University is located in West Chester, Pennsylvania.

**Self-Concept.** A term used to define the way individuals perceive themselves as measured by the Total Positive Score on the **Tennessee Self-Concept Scale**.

**Group Psychotherapy.** A therapeutic approach utilizing the resources of nine members focusing perceptions upon the study's main variable of self-concept enhancement.
Hypnosis. An altered state of consciousness brought about by a deep state of relaxation. Such a state heightens an individual's level of suggestibility to receive and act on auditory suggestions of thinking, feeling, and behaving in various problematic situations.

Rational-Emotive Therapy. An approach to therapy that confronts the existence of irrational belief through the use of ABCDE stage model.

Organization of the Dissertation

Chapter II contains a review of the related research and literature directly relevant to this investigation. It elaborates on various views and aspects of self-concept and how self-concept plays a major role in behavior and mental health. Also, limitations and hypotheses of this investigation are presented at the end of Chapter II.

Chapter III describes the population and sample utilized in this study, the procedures, and a detailed description of the procedure to be used in each treatment group. It also describes the instrument used in this study to measure self-concept, and a description of the statistical procedure which will be used for the analysis of the data.

Chapter IV presents an analysis of the data collected in the study and discussion based on the statistical findings. Tables and figures are also included depicting the data relevant to the study.

Chapter V offers a summary of the study. The chapter also contains recommendations for further research relevant to the area.
Limitations of the Study

The following are some of the limitations considered to be relevant to this study:

1. In order to control for the variable of the experimenter effectiveness, the author of this study will assume the responsibilities of conducting each experimental treatment; however, by the author assuming such responsibilities, experimenter bias must be looked upon as a variable that limits the generalizability of this research.

2. The population that will be used in this study is limited to only students enrolled in the winter semester, 1984, in Psychology 100 at West Chester State University in West Chester, Pennsylvania. For that reason, along with the experimenter bias variable, any findings made by this study can only directly apply to this population and age group.

3. The study will take place over an eight-week period of time. Therefore, each student receiving an experimental treatment will have only eight exposures to that treatment program.

4. It is anticipated that there may be a reluctance on the part of those students asked to participate in this study. Therefore, their motivational level may be lower than other persons seeking the same experience in therapy under normal circumstances.
CHAPTER II

REVIEW OF RELATED LITERATURE

The purpose of this chapter is to review some of the major theoretical and research writings concerning the definition and formation of self-concept, effects of adolescent self-concept, and changing self-concept. The literature represents the period of the early twentieth century until the present. The major areas of concern that are presented in this chapter, as stated above, are: Definition and Formation of Self-Concepts, Effects of Adolescent Self-Concept, Changing Self-Concept, and Summary.

Definition and Formation of Self-Concept

Contributing authors Meador and Rogers, in Corsini's (1979) book Current Psychotherapies, used the terms "self" and self-concept synonymously and defined it as:

Terms that refer to an organized, consistent, conceptual gestalt composed of perceptions of the characteristics of the "I" or "me" to others and to various aspects of life, together with the values attached to these perceptions. It is a gestalt which is available to awareness though not necessarily in awareness. (p. 147)

Roughly translated, the self-concept is one's image of oneself. Especially included are awareness of being (what "I" am) and awareness of function (what "I" can do). Rogers (1979) saw self-concept as a dynamic process which develops through interactions with one's environment.
In order for a positive self-concept to develop, these environmental interactions must result in a sense of "positive self-regard," a universal need in human beings.

Involvement with the environment appears to be an important factor in the developing sense of self as Mann, a contributing author in Corsini's (1979) book Current Psychotherapies, refers to self-concept as "a psychological construct that is useful in organizing the elements in the individual's awareness with which he particularly identifies." (p. 515).

Kelly (1955) viewed self-concept in the same phenomenological framework as Rogers (1979), Coopersmith (1967), and Mann (1970). Kelly stated that each individual creates a unique perception of the world. This perception is created by the responses the individual receives from experiences with the world.

Gelfard (1962) tended to agree with the idea that an individual must have experiences with the world and uniquely perceive it in order to construct a view of self. He stated that the value an individual places upon past success and failure experiences is directly related to the value one has for self. This view tends to be consistent with Rogers' (1979) construct of positive self-regard.

In remaining consistent with the notion of environmental experiences and self-observations influencing the development of self-concept, Bem (1972) stated that the perceptions an individual has of self are obtained from self-observations and interactions with significant others:

1. Individuals come to 'know' their own attitudes, emotions, and other internal states partially by inferring
them from observations of their own overt behavior and/or the circumstances in which this behavior comes.

2. To the extent that internal cues are weak, ambiguous, or uninterpretable, the individual is functionally in the same position as an outside observer, an observer who must necessarily rely upon those same external cues to infer the individual's inner states. (p. 2)

Bem (1972) divided self-concept into the following categories: (1) interactions with others, and (2) self-observations within these interactions. Davidson and Lang (1960) also viewed self-concept as developing from two categories -- interactions with others and interactions with self.

In an attempt to combine these categories, Simpson and Hastings (1974) defined self-concept as "...a personal judgment of his worthiness as a person, indicating the extent to which he believes himself to be capable, significant, and successful." (p. 174). Also, "locus of control" has been found to be significantly correlated with self-concept (Lefcourt, Lewis and Silverman, 1969). These researchers found a significant positive correlation within individuals who view self positively and assume that consequences of one's own actions are under personal control -- having an internal locus of control. On the other hand, people who have an external locus of control usually fail to develop an adequate internal persona, which appears to be necessary in the formation of a positive self-concept. They see their destiny as being in the hands of fate or of those who yield power (MacDonald, 1971).

Rotter (1966) stated that the locus of control construct originates from social learning theory (Rotter, 1966). Internally controlled
individuals believe rewards can be manipulated by person intervention and are therefore under immediate control. Externally controlled individuals believe factors such as luck, fate, or chance are mediating reinforcement, and thus they operate on the premise that they lack power to effectively change and control events.

Rychman and Sherman (1973) found that the locus of control and self-concept relationship does not vary between women and men. Rust and McCraw (1984) stated that the relationship between androgyny, locus of control, and self-esteem in college students have shown that androgyny, rather than sex typing, leads to better adjustment in adult life. Thus, from these studies, it can be assumed that a sex difference is not an important variable in this relationship; however, androgynous qualities have been positively correlated with internal locus of control and a positive self-concept (Bem and Lenney, 1976; Block, 1973; Hefner, Rebecca and Oleshansky, 1975; Pleck, 1975).

In researching this relationship with pre-adolescence, Carlson (1965) compiled similar results and reported that no evidence exists in differentiating girls and boys.

Therefore, in combining Bem's (1972) categories with interactions with significant others and self-observations, it can be assumed that children who are being helped by consistent parental discipline to develop an internal locus of control are being helped to believe in oneself and be in control of the environment around them.

In assuming that environmental interactions begin with parents or parental figures, Bandura and Huston (1961) investigated the effects of parent-child relationships upon the formation of self-
concept. Their study has shown that an overwhelming amount of a child's early development is based upon "imitation" and "modeling" behavior. Due to this identification, a child will very likely develop a self-concept much like the parents.

Related aspects of the Bandura and Huston research were investigated by Baker (1964). Baker examined the consequences of parental styles and stated that children who were raised under an authoritarian approach showed higher self-concepts than those children who were raised under democratic practices.

Coopersmith (1967) reached the same conclusions as Bandura and Huston and Baker. Coopersmith stated that the most crucial factor leading to the development of self-esteem seemed to be "parental behavior and the consequences of the rules and regulations that parents established for their children." (p. 236). Coopersmith observed:

These relationships indicate that definite and enforced limits are associated with high rather than low self-esteem; that families which establish and maintain clearly defined limits permit greater rather than less deviation from conventional behavior, and fewer individual expression, than do families without such limits; that families which maintain clear limits utilized less drastic forms of punishment; and that the families of children with high self-esteem exert greater demands for academic performance and excellence. Taken together, these relationships . . . suggest that parents who have definite values, who are able and willing to present and enforce their beliefs are more likely to rear children who view themselves highly. (p. 236)

Ruble, Feldman, and Boggiano (1976) investigated another aspect of environmental interactions upon self-concept formation. They studied both pre-school and middle childhood years looking for relative differences in how children in these respective age groups
perceive the role of other similar age group children. Their study concluded that, during the preschool years, positive self-concepts are formed from the sense of accomplishment each child feels in mastering new skills, regardless of what other children are able to do. During middle childhood, however, social comparisons become the main factor in determining what value children place on themselves. Feelings of competence and adequacy at this time depend less on what children are actually able to do than on their perceptions of themselves as more or less able than their peers. This research tends to be consistent with the previously cited research of Bem (1972) and Davidson and Lang (1960) who stated that interactions with others and self-observations are crucial elements in self-concept formation.

Also, Ruble, Feldman and Boggiano suggest that one's sense of accomplishment and mastery over the environment carries extreme importance in a positive self-concept, which is a crucial factor within the Rogerian theory of establishing and maintaining a positive self-regard.

The roots of Ruble, Feldman and Boggiano's research also rest in early Rogerian theory. Rogers (1959) stated that a major part of the child's actualizing tendency begins when the organism begins to distinguish the self from the rest of the world. Rogers stated that the "phenomenal field" differentiates into knowing what one is able to control and what is out of one's control.

One further theory about self-concept formation was presented by Horney (1945) and described in Hansen and Maynard's (1973) book, Youth: Self-Concept and Behavior. Hansen and Maynard said:
There were two distinct sets of characteristics that led to the normal development of the self-concept. Every human being is born with certain innate determinants of behavior; and every human being acquires or learns many behaviors or qualities. Horney acknowledged the fact of innate differences in behavior from subject to subject, and recognized that some behavior was determined by such innate events, she saw such factors as having only limited effect on the formation of the self-concept. (p. 12)

It seems only natural to believe that a human being is born into the world with some degree of predetermined genetic characteristics, and further research into this area is needed.

Effects of Adolescent Self-Concept

An individual's self-concept is an important aspect as determining behavior. Lecky (1945) stated that the self-concept imposes certain limits on a person's overt behavior and inner experiences. Lecky concluded that a person will strive to behave in ways consistent to the concept of self. Such writings give strong suggestion that an individual behaves, feels and thinks in accordance with the self-concept.

Janis, Mahl, Kagan and Holt (1969) investigated the aspects of social parental identification effecting the self-concept in the
The child's self-concept consists, in part, of his evaluation of the degree to which his attributes match those that the culture has designated as desirable. To some extent the child's evaluation is determined by his social experiences. For instance, his self-concept of power is based to some extent on his ability to defeat a rival, demonstrate his strength on an athletic field, or achieve good grades. But the child is also prone to label himself on the basis of his identification with a model. The boy who has developed an identification with an intelligent father begins to regard himself as intelligent. A girl who is identified with a beautiful mother views herself as more attractive than she would if her parents were not beautiful.

Negative self-evaluations can be established in a similar manner, if a model's attributes are undesirable. One critical antecedent of psychopathology is the child's belief that he shares basic similarities with a negatively valued parent. Intensive interviews with seriously disturbed adults including those with schizophrenic reactions, have provided evidence that many of these people feel unworthy, incompetent, or basically evil because they believe that they are fundamentally similar to a parent whom they regard as unworthy, incompetent, or unloving. The severely disturbed and unhappy person does not want to possess these undesirable traits, but the identification that has taken place has caused these beliefs.

Such findings of parental identification are in accordance with the previously cited work of Coopersmith (1967).

Rogers and Dymond (1954) also believed that people with low self-concepts frequently feel inadequate and unworthy, and lack the motivational level required to enhance their situations. Coopersmith (1967) and Gowan (1960) have found that better achievers generally have higher self-concepts.

Another area in which a poor self-concept may have direct results upon an individual's personality can be found in research conducted on delinquency. Investigators have compared delinquents and nondelinquents from the same general background. Results show
delinquents to be more resentful, hostile, suspicious, impulsive, destructive, and lacking self-control (Davids and Falkof, 1975). Such characteristics suggest a defensiveness in personality and reflects a poor self-concept (Gold and Mann, 1972).

Freud, The Standard Edition of the Complete Psychological Works of Sigmund Freud, (Huebner, 1958) purports a more psychoanalytic view of adolescent psychopathology. He stated that the more an adolescent repeats acting-out behavior patterns, rather than verbalizing feelings, the more deeply involved are the dynamic conflicts of his pathology, and the more difficult that person will be to treat. In Freud's view, adolescence is a stormy period of life, and instead of being introspective and reflective about inner dynamic tensions, the adolescent is prone to translate them in behavior.

Maslow's (1968) view of human nature and his hierarchy of needs presents another view of conceptualizing an adolescent's antisocial behavior. Maslow's assumption is that people are basically good and have an innate need to be competent and accepted. He postulated that there is a hierarchy of human needs and suggests that lower level needs must be met before an individual can respond to higher order needs. Therefore, acting-out behavior is not viewed as intrinsic, but rather as a reaction to the frustration incurred when the individual's basic needs are not met.

Adolescents who are isolated from their peers and exhibit symptoms of depressed affect often lack the social skills necessary for effective social interaction (Gresham and Nagle, 1980). Those adolescents are openly rejected by their peers, which in turn, further
limits their opportunities for social and developmental learning. Research indicates that isolated and depressed adolescents are more likely to exhibit higher incidences of school maladjustment (Gronlund and Anderson, 1963), dropping out of school (Ullman, 1957), delinquency (Roff, Sells and Golden, 1972), impaired cognition and academic performance (Cartledge and Milburn, 1978), and later emotional difficulties (Cowen, Pederson, Babigan, Izzo, and Frost, 1973).

Beck (1974) stated that adolescent depression consists primarily of a cognitive and comprised negative view toward oneself, the world, and the future. Seligman (1974) reported that it is a state of learned helplessness revolving around the feeling of being unable to control the events in one's life. Such self-perceptions have been directly linked to a negative self-concept (MacDonald, 1971; Rotter, 1975).

Bagley (1975) reviewed a number of studies involving suicidal behavior and delinquency in adolescence. His conclusions suggest a positive correlation exists between suicidal behavior and delinquency. Furthermore, Bagley stated that the family structure was another important variable of adolescent suicide, and encouraged further investigation into this dimension of the adolescent's life.

Such an investigation was conducted by Wenz (1978), who studied the effect of family normlessness and family powerlessness on adolescent suicide potential. The results of this study suggest that family structures characterized as powerless and showing a great amount of deviation from traditional family norms tend to have high suicide-risk adolescents. Such results are in line with Coopersmith's (1967)
research of self-concept and family structure.

Based upon Lefcourt, Lewis and Silverman's (1969) research in locus of control, it can be inferred that the individual with an internal locus of control and a positive self-concept will more frequently assume responsibility for her/his life. The same individual would also be expected to try to alter situations in a more beneficial way rather than take a passive role in life. McGhee and Crandell (1968) found high school seniors with a more internal orientation obtained higher grades than did high school seniors who were more externally oriented. When locus of control and self-concept have been studied together, the correlations between the two have been moderate, with a tendency for individuals with higher self-concepts to be more internally controlled (Fish and Karabenick, 1971; Lambert, DiJulio and Cole, 1976). Sadowski and Wenzel's (1982) research into hostility factors reported that externals appear to have greater levels of hostility and aggression than did internals. Also, Parrott and Strongman (1984) stated that adolescents classified as delinquent have been found to be more external. In contrast to this, high self-concept and an internal locus of control have been found to be a good predictor of possessing traits that were more socially acceptable (DiCindio, Floyd, Wilcox and McSevency, 1983). Such findings tend to be in line with previously cited work on delinquency, locus of control and self-concept.

In the area of self-concept stability between sexes, Carlson (1965) and Engel (1959) suggest that such stability is relatively constant in adolescence and is independent of sex differences.
Present literature seems to conflict in issues of sex differentiation in self-concept stability (Kohlberg, 1966; Monge, 1973; Howard, 1972; Piers and Harris, 1964; Rosenberg, 1964; Simmons and Rosenberg, 1975).

Kohlberg (1966), and Offer and Howard (1972) investigated self-concept and body image in adolescence and concluded that girls have more difficulty with such aspects of self than do boys. Piers and Harris (1964) and Rosenberg (1965), however, suggest that girls and boys have about the same amount of self-concept stability. Simmons and Rosenberg (1975) agree that there is an increase in self-concept instability during early adolescence for both groups, but the greatest amount of instability was found with girls. Monge (1973) offered the following explanation for greater instability with girls:

As the child matures, it becomes increasingly difficult to incorporate the demands of home and society for emotional, financial, and behavioral independence with educational authority. It is perhaps easier for boys to live through this period with their better defined and more concrete picture of the future, while girls apparently find the ambivalence of society's attitudes toward school, work and marriage more difficult to handle. (p. 392)

Such results in self-concept stability do not seem to be reflection of the past decade's liberalized climate. The early research of McKee and Sheriffs (1957) reported that girls had more difficulty in self-concept stability than do boys. Therefore, greater reported findings of self-concept instability in girls than boys is not a present-day phenomena. Due to this conflicting literature, the issues of sex differentiation in self-concept stability warrants further investigation.
One further theory about the effects of adolescent self-concept was put forth by Freud (1960). Freud believed that the ego defense system of the individual is continuously disrupted by a developmental increase in sexual drive. Such an increase may require the adolescent to form different concepts of self and of members of the opposite sex.

From each of the theories presented in this chapter, it is predicted that the adolescent's view of self will change considerably during these unsettled years.

Changing Self-Concept

Evidence seems to indicate a change in behavior will lead to a change in self-concept (Bandura, 1969). Bandura stated that a basic change in behavior provides an individual with an objective basis for self-evaluation to take place. This statement is consistent with the previously cited work of Bem (1972) who suggested that self-evaluation and evaluation one obtains while interacting with others are important factors in the formation of self-concept. From this, a logical assumption may be made as a change in behavior may influence one's entire evaluation process. Bower and Hilgard (1981) wrote:

This judgment is based on a social comparison, that compares the behavior in question to the norms of the social group. The neurotic has learned to behave in ways that are personally, legally, or socially disapproved and considered deviant. . . . . The assumption of the behavioral approach
is that people learn neurotic habits; they learn to be strange, or even miserable. The function of psychotherapy, in this view, is to remove or replace the deviant behavior which is causing the misery. That behavior is alleged to be controlled by certain social stimuli and reinforcement contingencies. To eliminate deviant behaviors (or to replace them with approved behaviors), the therapist is to find the controlling stimuli or reinforcers, and remove them or alter them so that the deviant behaviors are extinguished or so approved behaviors are strengthened in their place. The immediate goal of therapy should be to change the deviant behavior directly. (p. 288)

Short-term changes in behavior do not always affect self-concept however. Homme and Rosi (1979) felt that individuals who have acquired poor self-concepts seem to reject their own success experiences at first. The researchers' explanation for such a denial centered around the person's perception of the experiences to be incongruent with their self-concepts. However, if specific behavioral changes are employed over a long period of time the resulting effects might be in a changed self-concept. Bandura suggests that long-lasting behavioral changes in areas of concern do lead to changes in attitudes toward self.

Meichenbaum (1975) took the same behavioral viewpoint as Bandura. According to Meichenbaum, the elicitation of positive statements about self and their contingent reinforcements can result in a more positive self-concept. Such a viewpoint is consistent with the previously cited work of Bower and Hilgard (1981). Therefore, evidence tends to support the combination of positive statements and contingent reinforcements in conjunction with behavioral changes as being the necessary ingredients in altering self-concept.

One therapeutic approach utilizing the aspects of positive
statements, contingent reinforcements, and behavioral changes is hypnosis. One of the main variables in hypnosis that combines these aspects and is responsible for change in personal feelings is suggestibility. Hilgard (1965) combined the terms of hypnosis and suggestibility, and wrote:

The suggestibility theory of hypnosis is so widely accepted that hypnosis and suggestibility come to be equated by some writers on hypnosis. Both Hull (1933) and Weitzenhoffer (1953) see the relationship between hypnosis and suggestibility to be so intimate that they link the terms in the titles of their books . . . It is often convenient to study hypnosis in terms of alterations in suggestibility, regardless of how these changes come about. (p. 10)

Zeig (1982) also equated hypnosis and suggestibility and referred to it as a form of concentration with heightened levels of attention and "receptive concentration." With these levels raised, the individual's "peripheral awareness" becomes increasingly diminished. Thus, the stage is set for actively initiating and structuring the achievement of agreed-on goals.

Along the same view as Zeig, Cautela (1975) used mental imagery for the achievements of such goals. In reference to phobias, patients were instructed to imagine a variety of situations and then place the self within each situation. The therapist would positively or negatively reinforce the patient as to how self was perceived in each situation. Results of the study suggest that mental imagery coupled with contingent reinforcement tended to lower reported anxiety levels of these phobic patients.

Using the same process as Cautela, Shour (1974) coined the term "Psycho-imagination therapy," which means that with the utilization of
imagination, inner conflicts can be resolved. Once the patient is taught to accomplish the utilization of imagination on inner conflicts can be resolved. Once the patient is taught to accomplish the utilization of imagination on inner conflicts, he/she can then attempt to change emotional reactions to reality situations. The essence of Shour's treatment, as in any therapy with reconstructive goals, is to make the individual aware of unconscious strategies that alienate the individual from self and others. He wrote:

"It is the hope of psycho-imagination therapy to strengthen the role of the situation, to encourage patients in their choice of actions within situations, and ultimately lead them to greater choice and freedom in their being-in-the-world. (p. 44)"

One of the many treatment approaches in psycho-imagination therapy is directed-imagery. In directed-imagery, the therapist directs the patient throughout the imagination process. The patient is presented with the task of imagining a problematic situation where attention to fears, anxieties, doubts, etc., are closely examined in that situational context. It is believed that repeated directed guidance within this imagined problematic situation, coupled with contingent reinforcement, will allow the patient to develop an understanding of his/her defensive nature, and will motivate the patient to change his/her behavior. Shour (1972) offered the following explanation as the goal of psycho-imagination therapy:

"Psycho-imagination therapy is to help the patient become aware of the discrepancy between his definition of himself and the false definition his significant others hold for him. (p. 77)"

Based upon previous documentation provided in this section of the chapter, evidence has been brought forth building the rationale
for positive statements and contingent reinforcements in enhancing self-concept; it is assumed that the likelihood of transferring the improved self-concept from the therapist's office to other environments would be increased when a behavioral component is added.

Another approach incorporating positive statements, contingent reinforcements, and behavioral changes is rational-emotive therapy (RET). According to Ellis (1979), "problems" are defined quite simply as an individual's irrational beliefs which arise from home, family, and social development. The aim of therapy is to rid the patient of those irrational ideas by isolating the patient's irrational beliefs and replacing them with more realistic and adaptive ones. This objective is accomplished by the therapist's active and direct interventions.

The first study validating the effectiveness of RET was completed by Ellis in 1957. Ellis studied his own effectiveness as a therapist during three developmental periods of his professional career; orthodox psychoanalysis, psychoanalytically oriented psychotherapy, and rational-emotive psychotherapy. At the time of termination, Ellis found that of the patients receiving orthodox psychoanalysis, 50% showed little or no improvement, 37% some distinct improvement, and only 13% considerable improvement. With the analytically oriented therapy the respective figures were: 37%, 45% and 18%. The patients treated with RET showed the greatest trend toward success: 10%, 46%, and 44%.

Since Ellis' initial study, other researchers (Beck, Rush, Shaw and Emery, 1979; Ellis, 1962; Gorman and Simon, 1977; MacDonald and
Games, 1972, Rokeach, 1968; Wasserman and Vogrin, 1979) have demonstrated that the endorsement of irrational beliefs is related to psychopathology. Laughridge (1975) compared the effects of RET to the more traditional technique for counseling-psychotherapy. The study was conducted on students who were actively seeking counseling at a university counseling center. The author concluded from the statistical results that RET was more effective in inducing more positive gains in short-term therapy. Theoretical (Ellis, 1972) and indirect empirical data (Tosti and Eshbaugh, 1976) suggest a relationship between levels of self-concept and irrational beliefs. However, there has been little research designed to directly and systematically investigate a relationship between self-concept and irrational beliefs. Whiteman and Shorkey (1978), in a validation study, found a significant correlation between self-concept and the rationality of one's rational belief system. Their study systematically investigated the relationship between Ellis' theory of irrational beliefs and the psychosocial construct of self-esteem on 251 university students and reported a significant negative correlation between high self-esteem and irrational beliefs.

In a different vein, Maultsby (1974), utilizing RET as a primary prevention measure, developed a program that is essentially designed for use in high school and teaches students skills for dealing with emotional difficulties and provides a means of preventing psychiatric problems. Maultsby, Knipping, and Carpenter (1974) investigated the use of Maultsby's original Rational-Self Counseling program as a means of primary prevention in a series of progressive studies.
the initial study, two groups of already emotionally disturbed high school students were used as the sample population. One group received RET and the other did not. Only the RET group exhibited significant differences in a positive direction. A second study using "normal" college students, again demonstrated that the group receiving RET showed higher pre-post test improvement on the same variables. These two studies indicate that a course based on RET principles can be utilized as an effective, preventative mental health educational model with "normal" adult populations and that RET's effectiveness is not limited to clinical problems.

Ellis developed an ABCDE model to be used in therapy. The first stage is in establishing the A; the activating event, which if irrational, results in internal, negative verbalizations. For example, the patient may say to self, "I must always do what people ask of me to be good." This is an irrational belief, and therapy helps to bring it out.

B, the second stage, is the belief system and it may contain both rational and irrational thoughts. Naturally, in order to be a "good" person some aspects of reaching out to others is necessary, but it would be totally irrational to believe that such extensions of oneself occur whenever another person requests it; or be faced with feelings of worthlessness. The third stage is the effective consequence, C, which represents the painful emotions resulting from the irrational belief system. The fourth or D stage, disputation, is the therapist's efforts to get the individual to face the irrational self-talk and replace it with rational thinking. At this stage, the
therapist is confrontational and begins the aspects of "explaining and teaching" new forms of thinking and behaving (Ellis, 1979). For example, the therapist might urge the patient to look at the belief, "If I don't do what others ask of me then I am worthless." The therapist will dispute such a belief by investigating from whom it originated.

The final step is E, the effect, and is the formulation of more effective and rational goals for the future. Ellis wrote that "at E they will experience a new Effect - a more rational philosophy and a level of affect which is compatible with effective problem solving." (p. 210). The patient now has replaced the irrational thoughts in the belief system, e.g., can now say, "Jim asks a great deal from me and this time I did not do what he wanted; I feel a little disappointed, but I've done things for him in the past and probably, from time to time, will continue to do so."

Positive results have been documented when imagery and rational-emotive therapy were combined (Maultsby and Ellis, 1974; Tosti and Reardon, 1976).

Maultsby and Ellis (1980) used imagery to assist patients in visualizing themselves in various problematic situations. These researchers believed that increasing the patient's level of suggestibility would enhance the quality in the disputational aspect. Tosti and Reardon (1976) concluded that the use of imagery helps guide adult patients through all five stages of RET.
Summary

This chapter has provided a selective review of literature stressing the extreme importance of an individual's self-concept. It has shown that childhood and adolescent experiences with parents, peers, and society are crucial elements in the formation of self-concept (Coopersmith, 1967; Hansen and Maynard, 1973; Janis, Mahl, Kagan and Holt, 1969).

The effect of a poor self-concept usually manifests itself in thoughts and feelings of inadequacy and unworthiness (Rogers and Dymond, 1954), and has been found to cause acts of destruction against self or others (Weiner, 1970).

Evidence suggests that a person has a greater likelihood of producing positive changes in self-concept when concentration is placed upon changing present behavior (Bandura, 1969; Meichenbaum, 1975). Documented research investigating therapeutic contributions in self-concept enhancement using hypnosis, visual-imagery, psycho-imagination therapy, and rational-emotive therapy, were available. Based upon the general principles of these four therapeutic modalities, it was suggested that each or the combination of these general principles would be beneficial in self-concept enhancement.
CHAPTER III

METHODS AND PROCEDURES OF THE STUDY

The purpose of this chapter is to describe the methods and procedures to be used in the study. A description of the instrument to be used in the study to measure self-concept, the Tennessee Self-Concept Scale (TSCS), begins the chapter. The population and its sample are then described. An explanation of the treatment given to each group follows: The statistical procedures and hypotheses related to the study conclude the chapter.

Description of the Instrument to be Used

Tennessee Self-Concept Scale (TSCS)

In 1955 Fitts (1965), the author, and the Tennessee Department of Mental Health began the developmental work on the TSCS to develop an adequate self-concept scale capable of uniting theory with clinical research and findings. Along with this, the scale was to be simple to administer and take, well standardized, and multi-dimensional in its description of the self-concept. The TSCS consists of 100 self-descriptive statements used in constructing a profile of the subjects' view of themselves. The scale is self-administered for either individuals or groups, and can be used with subjects of age 12 or older who have at least a sixth grade reading level. Its applicability for psychological adjustment spans the range from healthy, well-adjusted people to psychotic patients.

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Two forms of the scale are available, a Counseling Form and a Clinical and Research Form. The major difference between these two forms is in the scoring and profile system. Due to the Counseling Form dealing with fewer variables and scores, a more concise self-concept score can be obtained.

Items within the original pool of the TSCS were derived from a number of other self-concept measures, including those developed by Balester (1956), Engel (1959), and Taylor (1953). Also, many items were taken from self-descriptions written by patients and nonpatients. Classifying the items into the 13 sub-scales found on the instrument were made by seven clinical psychologists employed as judges.

Fitts (1965), in his test manual, provided a description of the 13 sub-scales of the TSCS (See Appendix A).

The following section describes the test norms, validity, and reliability:

Norms. A total of 626 people comprised the sample of the standardization groups from which the norms were developed. The range of the sample spanned the ages from 12 to 68 representing various occupational and geographical locations. There were approximately equal numbers of both sexes, both Negro and Caucasian, and the intellectual levels from sixth grade through the doctoral degree.

Reliability. All major sub-scales were evaluated by test-retest reliability coefficients. Coefficients were generally in the 80's, with a range from .60 to .92.

Validity. In order to assure content validity, each item was accepted only by unanimous agreement by the seven judges of clinical
psychologists that it was classified correctly.

Population and Sample

Population

The population of this study consisted of students who were enrolled in Psychology 100 (ages 18-21) and registered in the winter semester, 1984, at West Chester State University in West Chester, Pennsylvania. There were approximately 600 students in Psychology 100. The majority of these students were residents of the state of Pennsylvania. Approximately 95 per cent of them were in their first year of undergraduate study. The mean age of the group was approximately 19 years. The population was composed of approximately 57 per cent women and 43 per cent men. Education was the primary career objective for approximately 89 per cent of the group.

Sample

The sample used in this study consisted of 54 students (27 male; 27 female) who were randomly selected from the population. The 54 students were then randomly assigned to one of the three experimental groups.

Procedures for the Study

The 36 students who were assigned to the two treatment groups were contacted to find out whether they would be willing to participate in research that would require their involvement as group psychotherapy members. The 36 students were told that they would be a member of either a hypnosis group or rational-emotive therapy group,
and an explanation of each group was provided. Students were asked
to provide the experimenter with days and times during the winter
semester that would be convenient to meet. The 18 students that
were placed within the control group were contacted and asked to
participate in a study that would require them to complete the TSCS
on three separate occasions (pre-test, post-test, and follow-up
testings); however, at no time were either the control group sub-
jects or the treatment group subjects made aware of the fact that
each of the three testings would be with the TSCS, nor were they
told that the study dealt with the enhancement of self-concept.

All 36 students within the treatment group were assigned
appointment times that were kept for the next eight weeks. Each
treatment group had one 50-minute session a week with the experimen-
ter. The eight-week treatment program: Hypnosis or rational-
emotive therapy was administered after 5:00 p.m. on assigned week-
days. The students were cautioned not to miss any session because
of the progressive nature of the treatment program.

All 54 students were informed that they would be given credit
towards a grade in their Psychology 100 class if they took part in
this study. It was believed this would be enough incentive for all
of the participants to be in the study.

All students signed a contract and appointment schedule commit-
ing them to be a member of this study - - treatment and control
group contracts varied slightly (See Appendix B).

One week prior to the onset of the first treatment session, all
54 students were pre-tested with the TSCS, specifically using the
Total Positive Score as the pre-test measure. One week after termination of the treatment program, all 54 students were post-tested with the TSCS, specifically using the Total Positive Score as the post-test measure. Sixty days later, all 54 students were again tested on the same scale as the follow-up measure. After the follow-up period, the students were debriefed and permitted to ask questions regarding any aspect of the study -- treatment and control group debriefing letters varied slightly (See Appendix C). The follow-up testing and debriefing aspect of the study was conducted through the mail for all 54 students.

The following is a description of the three treatment groups. The same room and furnishings were used for each group. A brief introduction period took place in the beginning of each group's first session.

**Hypnosis Group**

The room that was used was such that when desired, all external light could be blocked from entering. It contained both chairs and padded cushions randomly placed.

At the very beginning of each session, with the students seated in either the chairs or on padded cushions and the lights in the room softly lit, the group leader gave the students the instructions that apply to the group (See Appendix D). The same instructions were given at each session.

Upon the completion of these instructions, the process of hypnosis was used to recreate a problematic situation (See Appendix E).
Emphasis was placed upon the thoughts, feelings, and behaviors within this imagined recreation; and suggestions for the improvement of such thoughts, feelings, and behaviors were read to the group during each session.

Upon the completion of these suggestions, the following directions were read to the group:

As I begin to slowly count backwards from 10 to 1, you will slowly be able to allow yourself to depart from your mental pictures and begin remembering where you actually are. When I get to 1, I want you to open your eyes and stay seated. You will feel comfortable and relaxed just as though you have had a good night's sleep. You will feel refreshed and remember everything that took place during this relaxation session.

At this time, the experimenter counted backwards from 10 to 1 slowly. When the students opened their eyes, the group leader assumed that everything went well, and reminded them of their next appointment.

Rational-Emotive Therapy Group

The seating within the room was arranged into a circle. Students had the option of choosing chairs or padded cushions. Each session began with the group leader asking one of the students to present a troubling problem. Initially, the group leader assumed total responsibility in attempting to identify the C, which stands for Emotional Consequences. The group leader determined the C and then asked for help from the other group members in identifying other possible emotional consequences. Once the C was established, the group leader taught the group that A, which stands for Activating Experience or Activating Event, does not cause C; rather B causes C. At this point B, which stands for Beliefs or Belief System, was designated as the
cause of the emotional consequences. Group members were encouraged to state their reactions to this rational way of thinking. It is important that group members and the group leader share an appreciation for the impact that Beliefs (B) have upon Emotional Consequences (C). After an equal appreciation appears to be present, the group leader encouraged group members to question and challenge the presenter concerning the C's and B's. The goal of therapy is to help the person discover and articulate the illogical belief that is at the source of the emotional disturbance. (For clarification of illogical beliefs, Appendix F provides eleven major illogical ideas of philosophies behind the concept of irrationality in one's belief system).

Many times group members will identify their irrational beliefs and then complain that they still feel the same way they did when they entered therapy (Wagner, 1963, p. 2). Therefore, the next step, D, was used to help group members give up irrational beliefs and replace them with rational beliefs. D stands for Disputing or Debating the logic behind the irrational belief, and this is best accomplished by directly questioning the presenter on the following basic questions: "Can the presently held irrational belief be rationally supported? What evidence exists of the falseness of this belief?" (Wagner, 1963, p. 2).

After the group leader had determined that the last step, E, was ready to be employed, he began to deal separately with thoughts, feelings, and behaviors. E stand for Effects of debating irrational beliefs.
At the end of the 50-minutes, the group leader reminded the students of their next appointment.

Hypotheses

The following seven null hypotheses will be tested in this study:

1. There will be no significant improvement in self-concept by the use of hypnosis as measured by the Total Positive Score on the Tennessee Self-Concept Scale (TSCS).

2. Hypnosis will not be significantly better at improving self-concept than rational-emotive group therapy as measured by the Total Positive Score on the TSCS.

3. Hypnosis will not be significantly better at improving self-concept than no therapeutic intervention at all as measured by the Total Positive Score on the TSCS.

4. There will be no significant improvement in self-concept by the use of rational-emotive group therapy as measured by the Total Positive Score on the TSCS.

5. Rational-emotive group therapy will not be significantly better at improving self-concept than hypnosis as measured by the Total Positive Score on the TSCS.

6. Rational-emotive group therapy will not be significantly better at improving self-concept than no therapeutic intervention at all as measured by the Total Positive Score on the TSCS.

7. There will be no significant improvement in self-concept by receiving no therapeutic intervention at all as measured by the Total Positive Score on the TSCS.
Data Analysis

In order to increase the precision within the design, an analysis of covariance (ANCOVA) statistical procedure with a .05 level of significance was used to compare the pre and post-test means of each treatment group.

By using the same statistical procedure (ANCOVA), the post-test and follow-up measures were compared to determine whether or not significant differences occurred.
CHAPTER IV

ANALYSIS OF THE DATA

The purpose of this study was to compare the effects of hypnosis and rational-emotive group therapy when applied to improve self-concept, as measured by the Total Positive Score on the Tennessee Self-Concept Scale (TSCS). Seven hypotheses which stated the null relationship of self-concept and specific therapeutic intervention were derived. The data was analyzed by the analysis of covariance test (ANCOVA).

Prior to the ANCOVA test, baseline information using the TSCS, was obtained by the analysis of variance test (ANCOVA), comparing the two treatment groups of hypnosis, rational-emotive group therapy, and the control group. The pre-test means of each group was investigated for statistical significance at the .05 level. The computed F-score (.340) fell within the confidence interval set by the critical F-value (3.18), indicating that there was no significant difference between pre-test means. The relationship of pre-test means are presented in Table I.
TABLE I

Analysis of Variance Summary Table for Two Treatment Groups and One Control Group

<table>
<thead>
<tr>
<th>GROUP</th>
<th>PRE-TEST SCORES</th>
</tr>
</thead>
<tbody>
<tr>
<td>I (HYPNOSIS)</td>
<td>MEAN 337.167</td>
</tr>
<tr>
<td></td>
<td>SD 20.85</td>
</tr>
<tr>
<td>II (RATIONAL-EMOTIVE GROUP THERAPY)</td>
<td>MEAN 342.722</td>
</tr>
<tr>
<td></td>
<td>SD 27.04</td>
</tr>
<tr>
<td>III (CONTROL)</td>
<td>MEAN 366.556</td>
</tr>
<tr>
<td></td>
<td>SD 23.77</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>SOURCE</th>
<th>SS</th>
<th>df</th>
<th>MS</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>BETWEEN GROUPS</td>
<td>424.778</td>
<td>2</td>
<td>207.796</td>
<td>.340075*</td>
</tr>
<tr>
<td>WITHIN GROUPS</td>
<td>31214.556</td>
<td>51</td>
<td>611.031</td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>31639.333</td>
<td>53</td>
<td></td>
<td></td>
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</table>

*F .05 (2,51) = 3.18

Table II presents the ANCOVA data, comparing the two treatment groups of hypnosis, rational-emotive group therapy, and the control group. The average of the pre-test scores served as the covariate and the average of the post-test scores served as the dependent or criterion variable. The computed F-score (8.30) fell within the confidence interval set by the critical F-value (3.18), indicating that each of the seven null hypotheses did not reach a level of appropriate
statistical significance to suggest a rejection of the proposed null hypotheses; however, although not significant, individual analysis of each hypothesis suggested that hypnosis had a greater effect upon self-concept enhancement than did rational-emotive group therapy. This will be shown within the results section as each hypothesis is presented separately.

**TABLE II**

Summary of Analysis of Covariance of TSCS Post-test Scores with Pre-Test as Covariate

<table>
<thead>
<tr>
<th>GROUP</th>
<th>PRE-TEST SCORES</th>
<th>POST-TEST SCORES</th>
<th>MEAN DIFFERENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>I (HYPNOSIS)</td>
<td>MEAN 337.167</td>
<td>344.111</td>
<td>+6.944</td>
</tr>
<tr>
<td></td>
<td>SD 20.85</td>
<td>28.28</td>
<td></td>
</tr>
<tr>
<td>II (RATIONAL-EMOTIVE</td>
<td>MEAN 342.722</td>
<td>341.444</td>
<td>-1.278</td>
</tr>
<tr>
<td>GROUP THERAPY)</td>
<td>SD 27.04</td>
<td>29.01</td>
<td></td>
</tr>
<tr>
<td>III (CONTROL)</td>
<td>MEAN 366.556</td>
<td>341.278</td>
<td>+4.722</td>
</tr>
<tr>
<td></td>
<td>SD 23.77</td>
<td>25.02</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SOURCE</th>
<th>SS</th>
<th>df</th>
<th>MS</th>
<th>F</th>
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<tbody>
<tr>
<td>BETWEEN GROUPS</td>
<td>544.474</td>
<td>2</td>
<td>272.237</td>
<td>.830067*</td>
</tr>
<tr>
<td>WITHIN GROUPS</td>
<td>16389.5</td>
<td>50</td>
<td>327.970</td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>16943.0</td>
<td>52</td>
<td>325.826</td>
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</table>

*F .05 (2,50) = 3.18
Results

Hypothesis 1: There will be no significant improvement in self-concept by the use of hypnosis as measured by the Total Positive Score on the TSCS.

Table I illustrates that hypnosis did not significantly enhance self-concept; however, it should be noted that the hypnosis group did show the largest mean gain of all groups tested: Hypnosis (+6.944); RET (-1.278); Control (4.722). Therefore, Hypothesis 1 was not rejected.

Hypothesis 2: Hypnosis will not be significantly better at improving self-concept than rational-emotive group therapy as measured by the Total Positive Score on the TSCS.

Table I illustrates that hypnosis did not significantly enhance self-concept more than rational-emotive group therapy. Even though a greater mean difference was found in favor of hypnosis (+6.944; -1.278), the nonsignificant F-test suggests this mean difference cannot be attributed to the varying treatment modalities. Therefore, Hypothesis 2 was not rejected.

Hypothesis 3: Hypnosis will not be significantly better at improving self-concept than no therapeutic intervention at all as measured by the Total Positive Score on the TSCS.

Table I illustrates that hypnosis did not significantly enhance self-concept more than no therapeutic intervention at all (+6.944; 4.722). Thus, Hypothesis 3 was not rejected.

Hypothesis 4: There will be no significant improvement in self-concept by the use of rational-emotive group therapy as measured by
the Total Positive Score on the TSCS.

Table I illustrates that rational-emotive group therapy did not significantly enhance self-concept. In fact, the mean difference indicated a decrease after exposure to the treatment (342.722; 341.444). The nonsignificant F-test suggests this mean difference cannot be attributed to the rational-emotive treatment modality. Thus, Hypothesis 4 was not rejected.

Hypothesis 5: Rational-emotive group therapy will not be significantly better at improving self-concept than hypnosis as measured by the Total Positive Score on the TSCS.

Table I illustrates that rational-emotive group therapy did not significantly enhance self-concept more than hypnosis (-127.78; +6.944). The nonsignificant F-test suggests this mean difference cannot be attributed to varying treatment modalities. Therefore, Hypothesis 5 was not rejected.

Hypothesis 6: Rational-emotive group therapy will not be significantly better at improving self-concept than no therapeutic intervention at all as measured by the Total Positive Score on the TSCS.

Table I illustrates that rational-emotive group therapy did not significantly enhance self-concept more than no therapeutic intervention at all (-1.278; +4.722). Thus, Hypothesis 6 was not rejected.

Hypothesis 7: There will be no significant improvement in self-concept by receiving no therapeutic intervention at all as measured by the Total Positive Score on the TSCS.

Table I illustrates that no therapeutic intervention at all did not significantly enhance self-concept; however, it should be noted
that the no therapeutic intervention group showed the second largest mean gain of all groups tested: Hypnosis (+6.944); Control (+4.722); RET (-1.278). Therefore, Hypothesis 7 was not rejected.

The follow-up testing was concerned with determining whether significant increases in self-concept would be maintained over a six-week period of time. As previously stated, Table II illustrates a nonsignificant F-test when pre and post-test scores were analyzed; therefore, no significant increases were established. Table III illustrates that no significant gain was recorded after the completion of a six-week follow-up period in which no therapy at all was provided to any of the experimental groups. The computed F-test (1.80) fell within the confidence interval set by the critical F-value (3.18); therefore, it can be concluded that the data continues to support all previously stated null hypotheses.
TABLE III

Summary of Analysis of Covariance of TSCS Follow-up Test Scores with Post-test as Covariate

<table>
<thead>
<tr>
<th>GROUP</th>
<th>POST-TEST SCORES</th>
<th>FOLLOW-UP SCORES</th>
<th>MEAN DIFFERENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>I (HYPNOSIS)</td>
<td>MEAN 344.111</td>
<td>340.500</td>
<td>+3.611</td>
</tr>
<tr>
<td></td>
<td>SD 29.01</td>
<td>21.75</td>
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<tr>
<td>II (RATIONAL-EMOTIVE GROUP THERAPY)</td>
<td>MEAN 341.444</td>
<td>339.167</td>
<td>-2.277</td>
</tr>
<tr>
<td></td>
<td>SD 28.28</td>
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<td></td>
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<tr>
<td>III</td>
<td>MEAN 341.278</td>
<td>342.056</td>
<td>+.778</td>
</tr>
<tr>
<td>CONTROL</td>
<td>SD 25.02</td>
<td>27.06</td>
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<td>BETWEEN GROUPS</td>
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<td>1.27977*</td>
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<td>WITHIN GROUPS</td>
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<td>50</td>
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<tr>
<td>TOTAL</td>
<td>3454.74</td>
<td>52</td>
<td>66.437</td>
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*F .05 (2,50) = 3.18

It should be noted, however, that the control group recorded the largest mean gain of all groups tested although the difference was not statistically significant. As a result of the nonsignificant F-test, it is unknown whether this gain was due to the continuation of no therapeutic intervention or some chance effect.

Table IV is concerned with showing the main difference between pre-test and follow-up scores, and indicating whether a significant difference exists within the means.
### TABLE IV

Summary of Analysis of Covariance of TSCS Follow-up Test Scores with Pre-test as Covariate

<table>
<thead>
<tr>
<th>GROUP</th>
<th>PRE-TEST SCORES</th>
<th>FOLLOW-UP SCORES</th>
<th>MEAN DIFFERENCE</th>
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<tbody>
<tr>
<td>I (HYPNOSIS)</td>
<td>MEAN 337.167</td>
<td>340.500</td>
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<td></td>
<td>SD 20.85</td>
<td>29.65</td>
<td></td>
</tr>
<tr>
<td>II (RATIONAL-EMOTIVE GROUP THERAPY)</td>
<td>MEAN 342.722</td>
<td>339.167</td>
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<tr>
<td></td>
<td>SD 27.04</td>
<td>26.65</td>
<td></td>
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<tr>
<td>III CONTROL</td>
<td>MEAN 336.556</td>
<td>342.056</td>
<td>+5.500</td>
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<tr>
<td></td>
<td>SD 23.77</td>
<td>27.94</td>
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<tr>
<td>BETWEEN GROUPS</td>
<td>541.525</td>
<td>2</td>
<td>270.762</td>
<td>.63089*</td>
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<td>WITHIN GROUPS</td>
<td>21458.760</td>
<td>50</td>
<td>420.175</td>
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<tr>
<td>TOTAL</td>
<td>22000.285</td>
<td>52</td>
<td>417.325</td>
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*F .05 (2,50) = 3.18

The computed F-test (.63089) fell within the confidence interval set by the critical F-value (3.18); therefore, it can be concluded that the data continues to support all previously stated null hypotheses. It should be noted, however, that the control group recorded the largest mean gain of all groups tested. As a result of the nonsignificant F-test, it is unknown whether this gain was due to the continuation of no therapeutic intervention or some chance effect.
A graphical representation of each subject's Total Positive Score is presented in Figures 1, 2 and 3. The Total Positive Score has a ceiling score of 450 and a base score of 150. The results are similar with those in the original standardization sample as the standardization group mean was 345.57, with the standard deviation at 30.70.
Figure 1. Illustration of Distribution of Hypnosis
Figure 3. Illustration of Distribution of Control Group
From Figures 1, 2 and 3, it appears that the reliability of the TSCS Total Positive Score is similar to the original standardization sample ($r = .92$).
CHAPTER V

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Summary

The purpose of this study was to investigate and compare the effects of hypnosis and rational-emotive group therapy on the enhancement of self-concept as measured by the Total Positive Score on the Tennessee Self-Concept Scale (TSCS). The study was designed to provide those in the helping profession further knowledge of these treatment modalities when applied over an eight-week period to a late adolescent population, in an effort to enhance self-concept. Seven null hypotheses for the relationship of self-concept and the previously stated treatment modalities were derived.

A review of the literature showed that the belief that self-concept is etiologic in pathological conditions is widespread in the clinical literature. The empirical research showed consistent results when self-concept levels were compared to pathological conditions.

Introductory psychology students (N=54) were randomly assigned to one of the three experimental groups and all subjects were administered the TSCS as a pre-test condition factor. Subjects in the two treatment groups received one therapy session a week, for eight consecutive weeks, with each session lasting approximately 50 minutes. The control group did not receive any therapy during the eight weeks. At the end of the eight-week experimental period all 54 subjects were administered the TSCS as a post-test condition factor. At the end of
a six-week follow-up period all 54 subjects were again administered the TSCS.

Raw score data obtained from the pre and post-test and the post and follow-up tests were analyzed using an analysis of covariance procedure. Test results were considered for statistical significance at the .05 level. Each of the seven null hypotheses were validly analyzed for statistical significance. All seven null hypotheses were accepted: There will be no significant improvement in self-concept by the use of hypnosis as measured by the Total Positive Score on the TSCS; hypnosis will not be significantly better at improving self-concept than rational-emotive group therapy as measured by the Total Positive Score on the TSCS; hypnosis will not be significantly better at improving self-concept than no therapeutic intervention at all as measured by the Total Positive Score on the TSCS; there will be no significant improvement in self-concept by the use of rational-emotive group therapy as measured by the Total Positive Score on the TSCS; rational-emotive group therapy will not be significantly better at improving self-concept than hypnosis as measured by the Total Positive Score on the TSCS; rational-emotive group therapy will not be significantly better at improving self-concept than no therapeutic intervention at all as measured by the Total Positive Score on the TSCS; there will be no significant improvement in self-concept by receiving no therapeutic intervention at all as measured by the Total Positive Score on the TSCS.
Conclusions

The results obtained from the analysis of the data indicate that the treatment modalities of hypnosis and rational-emotive group therapy did not significantly enhance self-concept, as measured by the Total Positive Score on the TSCS. Also, no significant improvement was obtained, as measured by the TSCS, when subjects received no therapeutic intervention at all. Closer examination, however, reveals that the hypnosis group showed the largest mean gain of all groups tested; the "no therapy" group showed the second largest mean gain; and the subjects of the rational-emotive therapy group showed an overall mean score decrease between pre and post-testing. Due to these extremely minimal changes between pre and post-testing, results tend to suggest that self-concept is a relatively stable trait. A graphical representation of this stability can be seen in Figures 1, 2 and 3.

The present results appear to be consistent with Lecky's (1951) investigation demonstrating that self-appraisals are relatively resistant to change due to the individual's need for psychological consistency. Along with this, Coopersmith (1967) postulated that shifts in appraisals of self-image are affected by incidents and environmental circumstances, but remain at a customary level when conditions return to normal. Both researchers have suggested that an individual's self-concept is relatively stable with minor fluctuations occurring in the context of natural environmental changes. Along the lines of Lecky's theory of psychological consistency, the research of Aronson (1959) shows that people are unwilling to
accept evidence that they are better or worse then they themselves have decided, resolving any evidence or dissonance by their typical mode of judgment.

Even though empirical evidence has been brought forth suggesting a significant correlation exists between self-concept and the rationality of one's rational belief system (Ellis, 1962; Rokeach, 1968; Tosti and Eshbaugh, 1976; Whitman and Shorkey, 1978), changing one's belief system has been shown to be a difficult task (Aronson, 1959; Lecky, 1951); usually resulting in minor fluctuations at the time of intervention and returning to its customary level after intervention has stopped (Coopersmith, 1967).

Within the present study, another variable which needs to be accounted for is the sensitivity factor of the TSCS. The TSCS provides its user with a representation of how one feels and thinks about self, and can be used as a predictor of behavior; however, the scale is merely a predictor of self report based upon the interpretations of its user and does not directly represent the individual behaviorally. Therefore, the TSCS may not be an adequate instrument in measuring possible behavioral changes that take place in subjects whose self report was relatively unchanged, deteriorated, or increased. Even though self-reports within this study suggested no significant changes had occurred at the time of post-testing and follow-up, unmeasurable behavioral changes may have taken place which the TSCS could not account for.

In evaluating the effectiveness of hypnosis and rational-
emotive group therapy, the present study may attempt to suggest a comparison between its present laboratory use of these treatment modalities with a "natural" field study, however, such a comparison can hardly be made due to the violation of the "necessary prerequisites" in subject/client selection and preparation. Empirical studies have shown that the effectiveness of hypnosis is related to the degree of responsiveness to hypnosis (Barber and Calverley, 1963; Hilgard and Hilgard, 1975), and the proper facilitory process which provides a sense of mastery for the hypnotic process by orienting the individual through simple induction techniques (Diamond, 1974; Fromm, 1972; Gardner, 1976; Gooding, 1969; Harland, 1971). The logic of hypnotic susceptibility and providing an adequate period of time for a sense of mastery to develop are factors which will provide a more general account of laboratory research to actual field work.

The principles underlying rational-emotive therapy are of an active-directive orientation, which, for some individuals, may not be the most appropriate therapeutic strategy. As in the case of hypnosis, a selection process would appropriately match individuals to the desired form of intervention. Also, careful analysis needs to be undertaken in determining one's appropriateness for group work.

In any case, an appropriate selection process would appear to be a necessary prerequisite before beginning therapeutic intervention; and in the case of hypnosis, adequate time spent in developing a sense of mastery within a desired induction technique appears to be beneficial.
Although no significant differences were established within the ANCOVA test, pre and post-test mean differences were greatest within the hypnosis group; post-test and follow-up mean differences were greatest within the control group; and pre-test and follow-up mean differences were greatest within the control group. Also, in such statistical analysis where group means were analyzed within a before and after design, the RET group showed a consistent mean decrease. It is believed that such results must be viewed in the context of the relatively short eight-week treatment exposure.

Of the two treatment groups, hypnosis and RET, RET is by far the most direct/confrontational modality and one cannot assume that such an approach can be initiated and successfully completed in only eight exposures. For example, if one is prone to believing that he is not the cause of his emotional distress and then is encouraged to believe that his belief system is the cause, the result may be felt in a negative fluctuation within his self-concept. The hypnosis process promotes relaxation and encourages the individual to develop better ego strength without a highly direct/confrontational approach, and within a limited time period of eight-weeks would probably be seen as a more effective therapeutic intervention. In fact, no therapeutic intervention at all would be seen as more effective, given only eight (one session per week) exposures, than a therapy which is of a direct/confrontational modality.

In each treatment used, standardized procedures were used to insure consistency in therapist effectiveness; however, even though the experimenter had been formally trained in each treatment.
modality, other therapists who have been board certified/licensed could have been used to rule out the variable of therapist ineffectiveness.

**Recommendations**

The following eleven recommendations were made upon completion of the present study:

1. In order to control for experimenter bias, a design involving a separate experimenter for each experimental group would allow greater generalizability.

2. In order to rule out therapist ineffectiveness, each treatment modality needs to be conducted by a board certified/licensed psychologist with experience and formal education in each modality.

3. A design which increases the amount of exposure to each treatment procedure would provide a more realistic experience of therapy under normal conditions.

4. The use of a hypnotic suggestibility scale would provide knowledge of how suggestible a subject would be to the hypnotic process.

5. A design which incorporates gradual mastery techniques for hypnotic induction would facilitate a learning process to hypnosis, reassure subjects' apprehensions and would resemble an actual therapeutic session in a more realistic way.

6. Similar research with other age groups within the overall adolescent range would provide a more global view of self-concept stability within this developmental time period.

7. Similar research with other treatment modalities would provide a more global view of the effects of psychotherapy upon self-concept.

8. The Tennessee Self-Concept Scale provides normative data into a wide variety of psychopathology and further research into these areas is needed.

9. A longer period of time between pre and post-test would more adequately resemble a realistic therapy encounter.
10. The use of other instruments to measure self-concept and change, such as the Beck Behavioral Inventory and the Rotter Internal/External Scale might have been used as a check against the Tennessee Self-Concept Scale.

11. Similar research conducted upon individuals separately rather than in a group fashion.
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Tosti, D. J. & Reardon, J. The treatment of guilt through rational stage directed therapy. *Rational Living, 1976, 11, 8-11.*


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APPENDIX A

(14 Sub-Scales of the Tennessee Self-Concept Scale)

(1) The Self-Criticism Score. This scale is composed of ten items. These are all mildly derogatory statements that most people admit as being true for them. Individuals who deny most of these statements most often are being defensive and making a deliberate effort to present a favorable picture of themselves. High scores generally indicate a moral, healthy openness and capacity for self-criticism. Extremely high scores (above the 99th percentile) indicate that the individual may be lacking in defenses and may, in fact, be pathologically undefended. Low scores are probably artificially elevated by this defensiveness.

(2) The Total Positive Score. This is the most important single score. It reflects the overall level of self-esteem. Persons with high scores tend to like themselves, feel that they are persons of value and worth, have confidence in themselves, and act accordingly. People with low scores are doubtful about their own worth; see themselves as undesirable, often feel anxious, depressed, and unhappy; and have little faith or confidence in themselves.

(3) The Self-Satisfaction Score. These are the "how I feel about myself" items. This score comes from those items where the individual describes how he feels about the self he perceives. In general this score reflects the feeling of self-satisfaction or self-acceptance.

(4) The Identity Score. These are the "what I am" items that say "this is what I do, or this is the way I act." Thus, this score measures the individual's perception of his own behavior or the way he functions.

(5) The Physical Self Score. Here the individual is presenting his view of his body, his state of health, his physical appearance, skills and sexuality.

(6) The Moral-Ethical Self Score. This score describes the self from a moral-ethical frame of reference -- moral worth, relationship to God, feelings of being a "good" or "bad" person and his evaluation of his personality apart from his body or his relationship to others.

(7) The Personal Self. This score reflects the individual's sense of personal worth, his feeling of adequacy as a person and his evaluation of his personality apart from his body or his relationship to others.
(8) The Family Self. This score reflects one's feelings of adequacy, worth, and value as a family member. It refers to the individual's perception of self in reference to his closest and most immediate circle of associates.

(9) The Social Self. This is another "self as perceived in relation to others" category but pertains to "others" in a more general way. It reflects the person's sense of adequacy and worth in his social interaction with other people in general.

(10) Total Variability. This represents the total amount of variability for the entire record. It is a measure of consistency of self-perception and personal rigidity.

(11) Column Total Variability. This score measures and summarizes the variations within the columns.

(12) Row Total Variability. This score is the sum of variations across the row.

(13) The Distribution Score. This score is divided into one main and five (5) sub-scores. It is a summary score of the way one distributes his answers across the five available choices in responding to the items of the scale. It is also interpreted as a measure of the way one sees himself. Psychopathological disorders can also be detected through this scale.
APPENDIX B
(Treatment Group)

I, _________________________________, do hereby agree to be a participant in James J. Buldas' dissertation study. I do so fully understand that my involvement in this study will be kept strictly confidential and that I will not, at any time, be involved in any situation detrimental to my well-being or beyond my control.

With the above in mind, I agree to make myself present at the prescribed location, every week (d) __________ at (time) ___________. I understand that I am responsible for attending these appointments at that same time for a period of eight consecutive weeks.

As a result of my participation in this study I understand that I am to receive ______ points of credit for every session I attend, which will be applied toward my grade in Psychology 100.

Student: ____________________________

Principal Investigator: ____________________________

Questions and concerns about the conduct of this research may be addressed to the principal investigator (692-2085) or by contacting the Department of Psychology, West Chester State College.
APPENDIX B
(Control Group)

I, ______________________________________, do hereby agree to be a participant in James J. Buldas' dissertation study. I do so fully understand that my involvement in this study will be kept strictly confidential and that I will not, at any time, be involved in any situation detrimental to my well-being or beyond my control.

With the above in mind, I agree to take part in completing all testing material I receive in regards to this study. I understand that I am responsible for the completion of this material and for an immediate return to the principal investigator.

As a result of my participation in this study I understand that I am to receive ____ points of credit for every completed testing material returned, which will be applied toward my grade in Psychology 100.

Student: ______________________

Principal Investigator: ________________

Questions and concerns about the conduct of this research may be addressed to the principal investigator (692-2085) or by contacting the Department of Psychology, West Chester State University.
APPENDIX C
(Treatment Group)

The purpose of this study was to determine if group psychotherapy within the treatment modalities of hypnosis or rational-emotive therapy, had any significant affect on increasing self-concept as measured by the Tennessee Self-Concept Scale -- specific reference made to the Total Positive Score.

To date, the analysis of the study is incomplete and, therefore, the results are unavailable to the participants at this time. However, during the summer semester when the data analysis has been completed the results of the investigation can be made available to all participants upon request. A request for such information can be made by calling either 296-6883 or 692-2085, stating your name, providing a brief description of the study, and leaving an address as to where the information can be sent.

I am available at the above telephone numbers for any questions regarding this study. Thank you very much for your participation in this study.

Sincerely,

James J. Buldas, M.A.
APPENDIX D

Instructions For The Hypnosis Group

Find a comfortable place within the room that will allow you to relax without much hesitation. (Pause) Take a deep breath and release it slowly. Do this a couple more times and allow yourself to feel a beginning sense of relaxation. (Pause) In order to bring about a more total sense of relaxation we are going to utilize a technique called body focusing. We will be focusing on various parts of the body with the intention of affectively relaxing that area of the body. Let's begin by closing our eyes and begin concentrating only on the feeling and sound of breathing. Feel and listen to yourself breathe. Feel and hear the warm, soothing air as you draw it in and fill your lungs. (Pause) Concentrate on breathing in the warm, calming, soothing air and exhale the tension of the day. Breathe in the calmness and exhale the tension. Allow yourself to become more and more relaxed with each breath you take. (To be repeated as many times as necessary). Now, I would like you to shift your attention to the muscles of your face and forehead. Allow yourself to take the incoming air to the muscles of the jaw, the cheeks, the eyes, and forehead, and have the warm, calm, soothing air relax those muscles. (Pause) Inhale the calmness and exhale the tension; inhale the calmness, exhale the tension. Now, I would like you to shift your attention to the muscles of the neck and shoulders. Just as you did before, draw in the warm relaxing air and direct it to the muscles
of the neck and shoulders. (Pause) Inhale the calm soothing air and exhale the tension; inhale the calmness, exhale the tension. You're becoming more and more relaxed, and more and more comfortable; more and more comfortable and more and more relaxed. (Pause) Now, allow the soothing air to flow down the upper back and into the lower back. Begin to direct the flow of warm, soothing air to the muscles of your upper back and then allow it to flow into the lower back. Allow the air to comfort these muscles, to relax them, to ease them. Each breath is allowing you to become deeper and deeper and more deeply relaxed. (Pause) Now, shift your focus of attention to the muscles of the chest, stomach, and abdomen. Just as before, direct the air flow to the muscles of the chest and allow the air to find its way to the stomach and abdomen. Allow the air to soothe these muscles, to calm these muscles, to relax these muscles. Inhale the calmness and exhale the tension; inhale the calmness and exhale the tension. (Pause) Now, direct the air flow to the thighs, the buttocks, and down into the lower legs and feet. Relax these areas with each breath and exhale the tension. Allow yourself to let it go, to let it go. Feel yourself becoming more and more deeply relaxed; more and more deeply relaxed. (Pause) Now, take a few minutes to focus on the entire body, specifically looking for areas that may need further comfort and relaxation. If such an area is found, direct the flow of air to that area and comfort it and relax it. Remember that the inhaled air soothes and relaxes, and the exhaled air takes away the tensions. Each breath allows you to move deeper and deeper into relaxation. (Pause)
I want you to use your imagination and picture before you, with your eyes still closed, an elevator with the doors closed. You're standing outside of the elevator awaiting the door to open. Allow yourself to clearly picture the elevator doors. Notice the texture and color. Reach out and touch the doors and feel its temperature and texture. (Pause) At this point, allow the doors to open and enter into the elevator. Turn around and face the entrance. Notice that on the right side there is a control panel with 10 white buttons, each clearly marked with a black number, starting at the top with 10 and going downward to 1. The top button is lit indicating that you are presently on the 19th floor and you want to reach the 1st floor. Press the 1st floor button and slowly allow the doors to close. Begin to feel the elevator slowly and very safely travel downward, and with it taking you deeper and deeper into relaxation; deeper and deeper into comfort; and deeper and deeper into calmness. Each floor that is reached will indicate a deeper sense of comfort and relaxation. The 9th floor button is now lit and you're feeling very relaxed and very comfortable. (Pause) The 8th, 7th, and now 6th. You're feeling very, very relaxed; very, very relaxed. (Pause) You're traveling deeper and deeper into relaxation. Each floor indicates an even deeper level of relaxation. (Pause) Continue traveling downward. You're on the 5th, the 4th, the 3rd, the 2nd, and now the 1st. Feel the elevator stop and keep the doors closed. Understand your relaxation, feel the comfort of your body and mind being totally relaxed; totally at ease. (Pause)
APPENDIX E

The Hypnosis Process

Take a few moments to remember a situation that has taken place in the past. A situation where you viewed yourself as inferior to others. A specific situation where you had feelings of sadness, nervousness, and possible anger. A specific situation where your thoughts, your self-talk, were a negative view of your self. (Pause) After remembering such a situation, allow the elevator doors to open and there before you will be your memory of that specific situation. You are viewing this as an outsider. The people in this situation cannot see you as you are a viewer that others cannot perceive as being there. There is a self that is viewing this situation and the original self that is within this situation. (Pause) Allow the recreation of this specific situation to take place. Just as they happened before, allow the same sequence of events to take place. The self that is the viewer is able to think more clearly and feel more confident than the self within this situation. Pay attention to each member within this situation, but pay particularly close attention to the one member who is yourself. How are you feeling? What are you thinking? What are you doing? (Pause) The self that is viewing this situation is able to think more clearly and feel more confident; think more clearly and feel more confident. Become aware of the differences in thinking and level of confidence between the viewing self and the self who is within this situation. Become
increasingly aware of the difference. (Pause) You have a crystal clear mind. You can absorb all thought and retain all thought. You can bring these thoughts into immediate action when and where you want.

It is now time to depart. Take with you the knowledge of this experience. Return to the opened doors of the elevator and enter. (Pause) Turn and press the 19th floor button, allow the doors to close, and feel the sensation of traveling upward. Each floor represents new heights of confidence in yourself. The 2nd, 3rd and 4th floor is now reached and you're feeling very good about yourself; feeling very confident and very, very good about yourself. The 5th, 6th and now 7th floor and you can feel yourself growing stronger. Feel the blood flowing through your veins and your chest expanding as you inhale the refreshing energizing air. You are confident. 8th, 9th and 10th. Allow the elevator to stop with the doors remaining closed.
APPENDIX F

Ellis (1962) had identified eleven major illogical ideas or philosophies which lead to widespread neurosis in western civilization. These eleven ideas, as presented in Reason and Emotion in Psychotherapy, are paraphrased as follows:

1. The idea that it is a dire necessity for a person to be loved or approved by virtually every significant other person in the community.

2. The idea that one should be thoroughly competent, adequate and achieving in all possible respects if one is to consider oneself worthwhile.

3. The idea that certain people are bad, wicked, or villainous, and that they should be severely blamed and punished for their villany.

4. The idea that it is awful and catastrophic when things are not the way one would very much like them to be.

5. The idea that human happiness is extremely caused and that people have little or no ability to control their sorrows and disturbances.

6. The idea that if something is or may be dangerous or fearsome, one should be terribly concerned about it and should keep dwelling on the possibility of its occurring.

7. The idea that it is easier to avoid than to face certain life difficulties and self-responsibilities.

8. The idea that one should be dependent on others and needs someone stronger than oneself on whom to rely.

9. The idea that one's past history is an all-important determinant of one's present behavior and that because something once strongly affected one's life, it should indefinitely have a similar effect.

10. The idea that one should become quite upset by other people's problems and disturbances.
11. The idea that there is invariably a right, precise and perfect solution to human problems and that it is catastrophic if this perfect solution is not found.
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