To the Graduate Council:

I am submitting herewith a dissertation written by Annie Lee Jones entitled "Delivery of Community Mental Health Services through a 5-Session Group Therapy Module." I recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, with a major in Psychology.

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DELIVERY OF COMMUNITY MENTAL HEALTH SERVICES THROUGH A 5-SESSION GROUP THERAPY MODULE

A Dissertation

Presented for the

Doctor of Philosophy

Degree

The University of Tennessee, Knoxville

Annie Lee Jones

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ABSTRACT

The purpose of this study was to explore one possible way to facilitate change in low-income groups through the use of a time-limited group therapy program. It was hoped that through the documentation of change with each case in the study it would be shown that change was possible for low-income persons utilizing psychotherapy, especially with realistic assessment of problems and the setting of realistic goals by the client and therapist.

The assessment data was obtained for each case through these instruments: A. Problems Checklist; B. Personal Data Sheet; C. The Zung Self-Rating Depression Scale; D. The Levenson Internal-External Scale; E. The Profile of Mood States; F. Bernreuter's Self-Sufficiency Scale; G. The Somatic Symptom Rating Scale; H. The FIRO-COPE Scale; I. The Global Improvement Rating Scale; and J. Self-statements.

It was found that three out of four low-income women who completed the treatment were reported as being quite a bit better to very much better. After treatment, these women were also much more capable of utilizing community resources to facilitate the achievement in their goals. Whereas prior to treatment they were ineffective in this area. It was also found that realistic assessment through the listing of problems prior to treatment and Global Improvement ratings from significant observers were the most valid measures used in the study.

In conclusion, it was demonstrated that realistic assessment of goals, and a time-limited group treatment program were effective in facilitating considerable improvement in some low-income women.

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SECTION I

INTRODUCTION

As a psychologist in a community based educational program for preschool aged children, with nineteen centers located in low-income neighborhoods across the city, it becomes necessary to explore some alternative ways to deliver services to the parents of these children who needed help with the identification, clarification, and solution of their personal problems. Now, the usual duties for the Preschool psychologist included the observation of children in their natural settings-classroom, neighborhood play areas, and homes, to facilitate the evaluation of their needs.

When parents identify themselves to the psychologist as persons needing help, the usual procedure would be to interview, evaluate, and refer them to community agencies for service. However, this way of handling the parents who came to the office has resulted in very poor follow-through by the parents. Many of them never bothered to contact the recommended agency. Those who did make the initial contacts, rarely went back for further consultation. The final result in both cases was that their unmet needs were again brought to the attention of the Preschool psychologist either by the parents themselves, or by their case workers.

After considerable discussion of this problem with the Head of the Social Service Component in the Preschool Program it became clear that several factors interfered with service delivery to these parents.

First, these parents were usually young, single, unskilled, unemployed women who had an average of three children (approximately 81% of these women met Federal low-income guidelines). They had experienced many contacts with family services agencies prior to seeking services through the Preschool psychologist. In many cases, they had been treated according to stereotypes of the "welfare recipient," and only the problems that interfered with the physical health and social welfare of their children received professional attention. From this kind of personal treatment they learned not to expect consideration of their own individual needs, even though some of these agencies were designed to also provide services to low-income adults.

So they approached the Preschool psychologist asking for help for themselves. Even with an understanding of the problems they faced in obtaining services, referral elsewhere was the only recourse other than starting one-to-one psychotherapy with a few troubled parents, while excluding the others. At this point, it was realized that a program had to be attempted that might promote individual improvement to the point where they were more able to state their needs clearly, and more able to mobilize their personal strengths to achieve what they want out of life. As they experienced some temporary improvements in personal adjustment, they would be more comfortable approaching some of these agencies again. They would be armed with clearer understandings of their own needs and expectations. They would also be more able to verbalize these needs.

The pressing need for community agencies to help people like these women make adaptations in their lives was tremendous. Practicing

clinicians have been called upon by many theoreticians to make changes in their usual procedures to help meet this need. This is clearly stated by Gendlin (1968):

> . . . Psychotherapists are challenged to find ways in which the essentials of a psychotherapeutic process can be built into new community patterns to that it is provided for many people.
> And
> . . . It is quite clear that only psychotherapists can develop models in which the psychotherapy process can be part of new community patterns. But it is just as clear that psychotherapists cannot do that alone.

In line with this, it was clear that a cooperative effort between agencies could provide the inputs needed to explore new ways to treat low-income persons in distress, so they, in turn, could go forth from these programs and find their own solutions, either through the prescribed traditional methods—as we know treatment—psychotherapy, or by finding a job, or by leaving town and family, or by finding and getting some form of training, or even by taking a lone walk each day.

The implementation problems and difficulties encountered while exploring this new type of treatment and referral procedure were immense. Hopefully, this attempt will encourage others to explore further the factors involved in service delivery to the poor.

Relevant Literature

Caplan (1964) pointed to the need for more involvement by clinicians in the provision of preventive mental health services to the poor. A variety of authors have developed ideas and concepts in different research areas that can be applied to the design of clinical treatment modalities for some segments of the low-income population.

Albert Ellis (1973) with his Rational-Emotive Therapy has outlined a cognitive approach to the treatment of individuals in distress which was based on the principle that emotional distress and ineffectual behavior were primarily related to a self-blaming, and self-defeatist attitude about one's abilities. This attitude or personal evaluation was believed to be based on suppositions derived from irrational personal and cultural beliefs. He stated that these irrational beliefs served to perpetuate self-defeating behaviors in the anxious nonpsychotic individual. This was also related to the incorporation of the sterotype of the "disadvantaged person," as held by mental health workers, by the low-income persons themselves. They gradually believed what was said about them, instilled these myths in their minds and utilized these unflattering images—no matter how irrational—as their self-evaluative reference points.

The low-income stigma from life in housing projects and continued contact with "welfare" agency representatives so affected their ability to maintain some degree of personal control and their individual levels of personal control that their individual levels of personal effectiveness and expectations for positive results from their own behavior decreased. And as Rotter (1966) and Levenson (1975) would hold, they began to expect events to occur according to these beliefs. They attempted to measure and describe the different types of personal expectancy through the concept of Internal-External control.

It was hypothesized that these personal expectancies are orientations to events which are primarily based upon myths, both cultural

and individual, that were fairly stable and readily available to each person, to be used to judge and interpret new events in their lives.

One orientation, Internality, was based on the belief that any life event's occurrance was under the control of the individual. The second orientation—Chance—was based on the belief that any event's occurrance was due to unknown, or unpredictable factors; and, third, the Powerful Others Orientation, was based on the beliefs that events occur in a given person's life according to the whims of Powerful Others (Levenson, 1975). Gurin, et. al. (1969) pointed out the need for internal-external concepts to be phrased in personal terms so that the issue of control could be assessed for minority and low-income groups who had tangible barriers to their efforts to achieve, who are also placed in somewhat of a dilemma, if they gave in to sometimes realistic appraisals of their abilities to effect changes in their lives. High internal or external orientations for poor persons would lead to maladjustment and ineffectiveness, whereas, high internal scores for middle class white Americans would be in line with realistically high achievement expectations.

The work of another investigator, Seligman (1967, 1975) appeared to be particularly applicable to efforts to formulate treatment strategies for low-income groups. From his findings on learned helplessness in dogs he generalized to clinical symptoms of depression in humans. He observed behavior that he labeled learned helplessness, and suggested that depression, learned helplessness, and a loss of personal control had much in common. He defined depression as the loss of instrumentality

through a loss of the ability to take advantage of new opportunities. That when previously effective behavior no longer generated the desired reinforcements to which the actors had been accustomed, or when effective behaviors were no longer possible for a person, depression was likely. He saw depression, as Ellis saw anxiety, as the accompanying emotional response to ineffectiveness and loss of personal esteem.

Others, such as Beck (1967), Meichenbaum (1972), and Mahoney (1975) have made clinical application of similar ideas. They have demonstrated that cognitive processes not only affect behavior, but that these cognitive processes can be measured and altered to achieve different behaviors in a more desirous direction.

The implication from these findings was that through a cognitive restructuring process, it would be possible to alter the personal expectancies of low-income persons to an expectancy level that would be more conducive to the occurrance of personally effective behavior. If such an approach was effective they would be able to realistically appraise their abilities and needs and then go out and change their situations themselves, which would eventuate in a heightened sense of personal esteem and effectiveness.

Purpose of Study

This study was designed to explore one way to facilitate and document change in some low-income women who needed help to find solutions to their numerous and varied personal problems. It was hoped that through the realistic assessment of problems and goals, the process of

change would be enhanced for these women. The time-limited group therapy approach to treatment was utilized to demonstrate that service to poor persons could be provided economically and effectively.

It was hoped that the women who completed the treatment procedure and also showed change on the assessment instruments would experience less discomfort, and would demonstrate the ability to utilize community resources to meet their needs and to obtain assistance with the solutions of their personal problems.

It was recognized from the beginning of this study that it would not be possible to attribute the observed changes solely to the treatment procedure. However, it was also hoped that at this stage of program development to meet mental health needs of the poor, documentation of changes with persons from this group would stimulate further research. Through an exploration of factors associated with change for this group, mental health care for a group in great need could become a reality.

SECTION II

METHOD

I. Subjects

Five women, between the ages of 36-39, volunteered to participate in this study. (See Consent Form in Appendix A). They were among seven women referred to the Mental Health Component of the Preschool Program during the Spring of 1976 by their case workers in the Preschool's Social Service Component. Of the five women selected for participation in this study only four actually completed the entire treatment program. Therefore, only the data from the four participants who actually completed the treatment program was discussed in this study.

II. Therapist

The investigator served as the group therapist. She was a 27 year old single black female clinical psychology fifth year graduate student, who was also employed as the Preschool Psychologist.

III. Setting

The study was conducted at the Claxton Preschool Center, where two of the subjects' children were enrolled. This site was selected by the participants as a central location for them.

IV. Measures

A. Problems Checklist. The Problems Checklist was developed to be used as a uniform method of cataloging the problems of each person

referred to the investigator for participation in this study. The checklist was a list of 20 items derived from a larger list that was compiled by the case workers and paraprofessionals who serve the parent population of the Preschool Program. They were asked to list as many problems as they could that might have been experienced by their clients. The 20 items for the checklist were taken from this pool after considerable discussion with some of the case workers.

The case worker who made a referral utilizing the checklist was asked to respond in a "Yes" or "No" fashion to items similar to the following: "She talks about herself favorably;" "She is unemployed, able to work, but does not;" "She believes she is dumb and ugly." An extra sheet was attached to the checklist for any additional problems the case worker wanted to mention. No reliability or validity data were obtained.

B. Personal Data Sheet. This sheet was completed by the client during the initial contact to provide personal background data, (age, race, educational level, marital status), and life goals and personal problems. For example Please write below all your life troubles and problems. This information was utilized in compiling the individual's case history. (Appendix B)

C. The Zung Self-Rating Depression Scale (Zung, 1972). The Zung is a 20 item scale that was based on clinical diagnostic criteria most commonly used to characterize depressive disorders in terms of moods, biological, and psychological disturbances. The items are phrased as sentences based on material the author collected from interviews of

patients with the particular symptoms. The client was asked to rate each of the 20 items in one of four quantitative terms (A little of the time; some of the time; good part of the time; most of the time), indicating how it applied to her at the time of testing. The terms have numerical values from one to four. The scale was devised so that the 20 items used, ten were worded symptomatically positive and ten were worded symptomatically negative, which must be taken into account in the scoring procedure. An index for the Zung was derived by dividing the sum of the Raw Score values obtained on the 20 items by the maximum possible score of 80 converted to a decimal and multiplied by 100. The possible range of scores following this conversion is 0 to 100. See Appendix C for the actual form of the scale as used in the study. Zung (1965) reported construct validity for the Zung and the Minnesota Multiphasic Personality Inventory-Depression Scale as between 0.70 and 0.65 for various psychiatric diagnostic categories. Zung does not report a single reliability coefficient for the scale, but McNair (1974) recommended the Zung above all other unidimensional and self-report measures of depression, stating it's reliability as being around .70 for test retest studies, with a short term time interval between measures.

D. The Levenson Internal-External Scale. (I-E) (1975), a revision of the Rotter (1966) I-E Scale, has 24 items, divided into three scales. The three scales I (Internal), C (Chance), and P (Powerful Others), each consists of eight items placed in a Likert-type format. Each client was asked to rate each item from -3 (strongly disagree) to +3 (strongly agree).

(See Appendix D). Some representative items from the scales are: I - When I get what I want, it's usually because I worked hard for it; C - To a great extent my life is controlled by accidental happenings; and P - My life is chiefly controlled by Powerful Others.

The internal consistency reliability coefficients for all three scales were moderate and compare favorably with those reported by Rotter (1966) for his I-E scale. The Kuder-Richardson reliabilities (coefficient alpha) yielded r = .64 for the I scale, .77 for the P scale, and .78 for the C scale. Split-half reliabilities (Spearman-Brown) were r = .62 (I scale), .66 (P scale), and .64 (C scale). Test-retest reliabilities for a one-week period were, rs - .64, .74, and .78 (Levenson, 1975).

E. Profile of Mood States (POMS). (McNair, Lorr, Droppleman, 1971). POMS is a factor analytically derived inventory of transient, fluctuating affective status. It was developed to measure six identifiable moods or affective states: Tension-Anxiety; Depression-Dejection; Anger-Hostility; Vigor-Activity; Fatigue-Inertia; and Confusion-Bewilderment. It has been demonstrated to be a sensitive instrument for assessing psychiatric out-patients and their various responses to different therapeutic approaches. The POMS is a 65 item scale with a five-point adjective rating system. The client was asked to respond to the questionnaire in terms of how each item described the way she had been feeling during the past week, including the day tested. The purpose of the one-week rating period in the directions was to

direct their attention to a period of time, both sufficiently long enough to depict the patient's typical and persistent mood reactions to her current life situations and sufficiently short to assess acute treatment effects. This enables the POMS to reflect changes in the client's response to time limited treatment procedures. Each client's scores on each of the six scales were converted to T scores using the Norms for female psychiatric out-patients (McNair, Lorr, Droppleman, 1971). (See Appendix E).

The internal consistency reliabilities for the POMS were highly satisfactory (McNair and Lorr, 1964). All the indices of the extent to which the individual items within the test measure the factors represented by the six scales were near .90 and above. The test-retest reliabilities range from .65 for vigor to .74 for depression, when the measure is used in short-term (2-week) studies.

F. Bernreuter's Self-Sufficiency Scale. This scale was based on the thesis that there are individual differences in the extent to which people depend upon others to manage the affairs of everyday life. The degree and type of dependency a person has upon others could be a measure of the person's self-sufficiency. The S-S Scale was designed to give one score that reflected four aspects of a person's self-sufficiency: (a) need for sympathy, appreciation, and encouragement; (b) desire to be alone; (c) frequency of asking for advice; and (d) ability to handle responsibility. The scale is a 60-item measure that can also be used to determine a client's need for "advice" or professional counseling, and

also companionship. Indications of high needs in both areas could be useful signals of personal distress and interpersonal problems.

The S-S test was standardized on a group of 388 college men and 456 college women at colleges and universities across the country. with a range in scores of 13-57 for men, and 7-54 for women out of a possible 0-60 range. The mean sex difference for the two groups indicated that men tend to score significantly higher. Percentile norms based on the men and women used in the sample indicates the proportion of the total group (men and women) who scored below the particular score (see Appendix F for the test as used in this study). The scoring procedure for the S-S was a "Yes," "No" or "?" format for items such as - "Can you calm your own fears?," "Do you usually avoid asking advice?," "Do you like to shop alone?"

Reported test-retest reliability coefficient was .84, and split-half reliability coefficient was .85 (Bernreuter, 1933).

G. Somatic Symptom Rating Scale. The scale is a 21 item rating scale (see Appendix G) designed to measure the physical-emotional aspect of personal adjustment. The items were designed to tap the client's personal discomfort and stress complaints. All group members were asked to complete the scale according to how each item described the way she felt any personal distress, worry, or annoyance. This was done under the assumption that different kinds of persons display their symptomatology in different ways, either through bodily complaints, or emotional-cognitive distress. The client was asked to respond to items

such as - Weakness in parts of your body? Headaches? Poor appetite? - on a scale that ranged from 0 = not at all, to 4 = extremely, to indicate which phrase would best describe how much she felt distressed, worried by each problem during the past week including the day of testing. The interrater reliability between clients and their therapists as raters was found to be .89.

H. The FIRO COPE Scale. (Fundamental Interpersonal Relations-Orientation-Coping Operations Preference Enquiry). (Schultz, 1967). This test was designed to measure the respondent's preference for certain types of defenses or coping styles, while engaged in interpersonal interactions.

The test consists of a series of situations based on the various types of interpersonal anxiety suggested by the FIRO theory, and a choice of reactions to these situations, all phrased in terms of defenses and presented in a semi-projective format (see Appendix H). The respondent was instructed to rank order from most to least likely her preferences among five statements that represent the defense mechanisms of denial, isolation, projection, regression-dependency, and turning against-the-self.

The COPE was revised for this study so that the gender of nouns and pronouns would be sex appropriate, for face validity and possibly to increase the projective-reflective quality of the instrument for female clients.

I. The Global Improvement Rating Scale. The rater was asked to circle the number of the response that indicated how much the client had

improved at the end of treatment. The seven response categories were: (1) very much worse, (2) quite a bit worse, (3) a little worse, (4) no change, (5) a little better, (6) quite a bit worse, to (7) very much better.

McNair's (1974) review of self-assessment instruments used in antidepressant drug research indicated that the Global Improvement Rating Scale was unsurpassed in the measurement of overall change or improvement in response to treatment. This was true when the Global Improvement Scale was compared to 13 other widely known instruments, even though it was only a one-item scale.

J. Self-statements. Verbal or written statements made in the therapy sessions and judged as either a Positive, Negative, or Neutral self-statement. Verbal statements were transcribed from the audiotapes of the therapy sessions, and the written statements were made on worksheets during the therapy sessions by the group therapy members.

The verbal statements were scored by two female raters. The written statements were scored by the group members, and also by the two raters using the following criteria to judge whether the statements, verbal and written, were Positive, Negative, or Neutral:

1. A Positive self-statement was a statement that gave a positive self-reflection or personal reference. These were statements that indicated the well adjusted, happy, and emotionally secure aspects of each person's behaviors, feelings, and thoughts. Some examples were: (a) "I know

a lot of different kinds of jobs;" (b) "I like working in the garden;" (c) "I'm feeling much better about myself." Any statement that gave a pleasing unage if the self was a positive self-statement.

2. A Negative self-statement was a statement that gave a negative self-reflection or personal reference. These were statements that a person made about herself to indicate the areas of personal maladjustment, unhappiness, or discontent. Some examples were: (a) "I can't seem to do anything about my children;" (b) "I'm ugly and fat;" (c) "I don't have the education to get a better job." Any self-statement that gave a poor image of the self was a negative self-statement.

3. A Neutral self-statement was a statement that was judged to have no positive or negative self-reflections, if made about the speaker, and it could have been about other persons or events.

   (a) "The meeting started earlier yesterday."

   (b) "The little kid left it out on the sidewalk."

   (c) "It costs more to live these days."

   Any self-statement that made no obvious reference to the self was a Neutral self-statement.

V. Procedures

The procedure for this study consisted of a PREINTERVIEW, a PREEVALUATION, a 5-Session Group Therapy Module, a POSTINTERVIEW, a

POSTEVALUATION, and a Follow-up Interview.

A. Referral. Subjects were referred for participation in this study during the first three weeks of April, 1976. Each case worker surveyed her case load to determine if she had any women with motivational, adjustment, or emotional problems who would be willing to participate in the study. Then the case worker completed the Problems Checklist (See Measures Section for description), arranged the PREINTERVIEW, and returned this information to the investigator. Ths social worker informed them that they would be contacted by the investigator to confirm their meeting times.

B. Preinterview. Each referral was invited in for the PREINTERVIEW and told that she was recommended for participation in this study because her case worker felt that she might gain some benefit. It was explained that no guarantees could be made as to the outcome, but that it was hoped that she would find the experience rewarding. The purpose of the Personal Power Building Group was outlined as follows:

> The Personal Power Building Group Therapy Program consists of five sessions that will meet for two hours each day. There will be five participants in the group.
>
> The purpose of the group is to help each person achieve her own level of personal effectiveness and positive self-esteem. This will be done by changing the way each person talks to herself about herself so that her thinking will be self-enhancing and reinforcing of the behaviors and feelings necessary to be effective in this world. Then the client will be provided an example of how this is done, i.e., suppose you tell yourself everyday that you are sick of living like this and things would be better if you only had a job. You have this thought every morning, but do nothing to change the way you usually live out a given day. You may experience a slight feeling of depression, but you manage to overcome the feeling and go

> along as usual knowing that tomorrow you will experience the same thoughts during the day about different aspects of your life and yourself, manage to dismiss them for a while, never looking closely at what these self-evaluative thoughts 'really' mean, and manage to do nothing about your thoughts about yourself. You never take the time to look at how these thoughts, both positive and negative, affect your personal adjustment and ability to move through your world.

After explanation of the purpose the woman was asked if she would like to participate. If she declined the interview was terminated. If she agreed, she was asked to sign the Consent Form (see Appendix A).

When this was completed, the Problems Checklist was introduced to the client. The referral procedure was explained and the client was asked if she agreed with the problems listed. If not, she was allowed time to discuss and make any changes deemed appropriate. Then, the client was asked to describe herself fully, and to elaborate on any thoughts she was experiencing about herself, as this was the beginning of the self-assessment portion of the study.

C. Preevaluation. The following measures were individually administered following the interview to all clients, who agreed to participate in the study: The Zung Self-Rating Depression Scale, The Levenson I-E Scale, The Profile of Mood States, The Bernreuter S-S Scale, the Hopkins Symptoms Rating Scale, and the FIRO-COPE Scale. Next the client was shown how to score her own self-statements using the portion of the tape where she described herself.

A discussion of transportation needs, meeting place and time followed the administration of tests.

D. Treatment program. The treatment program (see Appendix B for the complete text of the entire five sessions of the program) was designed to treat motivational, and personal adjustment problems in young women. The program was based on cognitive therapy (Ellis, 1973; Beck, 1967; and Seligman, 1975) principles that attribute ineffectual and maladjustment problems to illogical and self-defeatist thoughts based on past experiences of failure. The assumption behind this treatment program was that if readjustments could be made in the thoughts the group members had about themselves to the point where they no longer saw themselves as ineffectual and maladjusted, then they would be more receptive to recommended strategies for positive change and more capable of following through to the point of achievement with repeated experiences of success on a small scale they would eventually become self-reinforcing which in turn would lead to a more positive self-evaluation and a better state of mental health.

A 5-Session Group Therapy Module designed for this program was in line with principles outlined by Mann (1973) who held that time limits placed on the length of treatment are reinforcing in and of themselves and forces the therapist and client to focus on the achievement of the treatment's objectives.

Each of the five sessions met for two hours and included presentations by the group therapist that were designed to generate discussions, and to provide information to be used in the completion of the written activities that were to serve as the participants' self-assessments exercises. The objectives and activities of each session were as follows:

Session I

Objectives for the Therapist:

1. To present the rationale behind the treatment procedure, along with some anticipated results.
2. To facilitate the identification of the way each participant speaks about herself.
3. To facilitate an understanding of personal power, learned helplessness, and their relationship to self-esteem.

Group Activities:

1. List of ways clients learned to be helpless.
2. List of self-statements.
3. List of self-interpretations of personal power.

Session II

Objectives for the Therapist:

1. To focus upon the effects of self-statements upon personal evaluations and individual behaviors.
2. To demonstrate what a Positive, Negative, and Neutral self-statement would be for each group member.

Group Activities:

1. List of self-statements.
2. Score individual self-statements according to criteria for Positive, Negative, and Neutral statements.

Session III

Objectives for the Therapist:

1. To clarify the group member's understanding of the types of self-statements.
2. To facilitate each group member's attempt to change the way she thinks about herself.

Group Activities:

1. List of self-statements.
2. List of Positive self-statements.
3. List of Negative self-statements.
4. List where group members attempted to rephrase Negative self-statements made in activity 3, to be Positive self-statements.

Session IV

Objectives for the Therapist:

1. To teach how to focus cognitively on thoughts related to self-esteem.
2. To enhance skill at thought control and positive thinking.

Group Activities:

1. List of self-statements.
2. List of Positive self-statements.
3. List of Negative self-statements.
4. List where group members attempted to rephrase

Negative self-statements made in activity 3, to be Positive self-statements.

Session V

Objectives for the Therapist:

1. To focus upon each client's behaviors as related to their personal expectations.
2. To facilitate awareness of how personal evaluation is reflected in the things we do.
3. To facilitate participants' awareness of the possible ways to change their behavior.

Group Activities:

1. Each member was asked to describe an interpersonal situation that they had experienced difficulty managing. The situation was then used in the group for role playing exercises.
2. Each group member role played her own interpersonal situation under the direction of the group therapist.
3. Group members were asked to give suggestions to each other that they felt might help them manage their situation better the next time it occurred.

E. Postinterview. The after treatment contacts varied in length depending upon the individual client. She was asked to state her reactions to the treatment process and state any changes in her life and feelings about herself. The client was also asked to explore some

alternative behaviors, for herself, that might be beneficial in achieving some limited goals. The investigator worked with each client at this time to clarify any goals they might have had, and to outline some possible strategies for achievement.

F. Postevaluation. The measures used for the PREEVALUATION were readministered after the POSTINTERVIEW.

G. Follow-up. This occurred between seven-ten days after treatment to determine what progress had been made by each client on the attainment of their goals. This was done on an informal basis, either in the client's home, her child's center, or in the neighborhood.

SECTION III

RESULTS

The findings from this study will be presented on an individual case by case basis in the following format: (1) case history, (2) test results, and (3) brief summary.

Some of the instruments used in the PRE and POST treatment evaluations were not particularly sensitive to the changes that occurred across clients. Therefore the results from a particular measure may be emphasized more strongly in one case than in another. The results from the COPE scale were not included at all because there was no way to evaluate the meaningfulness of change with it.

Unlike the traditional method of presenting results, the interpretations of the findings have been incorporated in this section to facilitate understanding by the reader.

Case History I

Terry was a 37 year old white married female with three small children. She completed the tenth grade in High School and has been variously employed as a clerk, secretary, and babysitter. For several years prior to treatment she was unemployed. However, for the last year she has been active in the Preschool Parent Volunteer Program.

Terry was a native of this city, as were her parents. Her mother recently died, but her father continues to live a few blocks from her home.

She described herself as a woman bothered by feelings of guilt and insecurity that she readily attributed to her distaste for the role of a housewife and her lack of a high school education. She said that she spent all her time doing housework because this was what her husband expected her to do, and what her mother always taught her to look forward to doing. She felt that if she had a better education she would have been able to earn some money doing a job she enjoyed, and the money she brought into the home would have justified all the time she spent away from the home. She felt that her family viewed her volunteer work as a waste of time because she never seemed to be caught up on her housework. Terry reported conflict filled interactions with her mother-in-law over her management of the household and the children. She said that she felt her best when she was out of the home doing something to give service, and that she wished she had a career that was as rewarding as her volunteer work.

She described herself as a fat, dumb, and ugly woman, with glasses that stood out in all her pictures. She said that she usually felt this way whenever she was out of the home and working around successful career women like those in the Preschool Program, yet she found herself continually drawn to them, and wishing that she could also be successful.

Terry was quite tearful during portions of her interviews, and some of the therapy sessions, as she talked about her feelings about the recent death of her mother. She was quite worried about some recent events where she had mistakenly thought that she saw her mother working in her garden after her death. This frightened her because she feared going crazy over the loss of her mother.

Terry saw the loss of her mother as adding impetus for seeking changes in her life. This pressure to seek change was compounded by the fact that her youngest child would be going on to the first grade of elementary school in the fall and she would no longer have the parent activities of the Preschool Program to channel her energies.

Terry's goals for the group were: (a) clarification of personal expectations, and (b) formulation of strategies for change. Her Problems Checklist was completed by the social worker in charge of parent involvement activities in the Preschool Program. She checked eight problems in living for Terry. During the PREINTERVIEW, Terry agreed that the following were definite problems in her life at this time:

1. Unable to see herself in a positive light.
2. Low self-evaluation.
3. Sees a dim future for herself.
4. Has trouble saying "No."
5. Unemployed, able to work, but doesn't.
6. Sees self as unqualified to talk to persons more highly educated than herself.
7. Unable to ask for advice or assistance.
8. Distrusts own assessment of things.

Test results. Terry's Global Improvement Ratings from all three observers indicated considerable improvement in her overall adjustment after participation in the group. Her rating from the social worker who referred her for treatment was 7 - very much better, from the Group

Therapist it was 6 - quite a bit better, and her own personal rating was 6 - quite a bit better. There was considerable agreement on the amount of improvement she showed in and outside of treatment. This indicated that Terry's self-assessment of the change she had made was supported by all observers.

On the Zung Self-Rating Depression Scale, she received a PRE score of 60, and a POST score of 40, showing a decrease of 20 points after treatment. This posttreatment finding may possibly be attributed to the combined effect of the treatment program and the passing of her acute mourning period. Terry's mother died a few days prior to the beginning of the treatment program.

Terry's scores from the Profile of Mood States was as shown in Table I.

Her posttreatment increases on the Anger-Hostility and Fatigue Scales of the POMS suggested an increased willingness to express some of her personal difficulties. Her performance on the POMS was at or near the expected means for female psychiatric outpatients on both PRE and POST measures.

Terry's Somatic Symptom Rating Scale scores showed a four point posttreatment decrease. She reported a large number of somatic complaints on both the PRE (27) and POST (23) measures.

The Bernreuter was not particularly sensitive to Terry's changes in status after treatment. She received a PRE score of 17 and a POST score of 20 - a slight decrease in her assessment of her functioning in the area of self-sufficiency.

TABLE I

PROFILE OF MOOD STATES: PRE AND POST SCORES FOR TERRY

	PRE	POST	Differences
Tension-Anxiety (T-A)	49	49	0
Depression-Dejection (D-D)	51	49	-2
Anger-Hostility (A-H)	45	56	+11
Vigor (V)	53	54	+1
Fatigue (F)	54	60	+6
Confusion (C)	49	48	-1

The results from the I-E Scale are shown in Table II.

Terry had high Internal-External and Powerful Others scores prior to treatment, but after treatment she showed a seven point decrease on the Powerful Other dimension. This decrease suggested a change toward believing less in the effect of Powerful Others on events in her life. Little change was observed on the Chance or Internal dimensions.

Terry had the following ratings for her verbal statements from all five sessions: Positive (276), Negative (323), and Neutral (325), and Total (924). It can be noted that she made more Negative and Neutral statements in the therapy sessions than Positive, indicating a poorer self-reflection than would be expected from a person receiving the high Global Improvement ratings that she was given by her observers. One explanation for the difference between her results and the expected performance might be that the degree of overall improvement was more related to her willingness to express herself as reflected in her total number of statements rather than in the type of statements she made during the short-term treatment. This supposition is supported by the fact that she had more total written statements than the two clients rated as less improved. She had 220 written statements.

Brief summary. The data from the case history and test results indicated that Terry was able to utilize the Brief Group Therapy Module to clarify some problems. Her quick response to treatment as shown by her Global Improvement Ratings indicated that she would probably make a good candidate for psychotherapy on a one-to-one basis, if she so desired.

TABLE II

INTERNAL-EXTERNAL SCALE: PRE AND POST SCORES FOR TERRY

	PRE	POST	Difference
Internal	40	39	-1
Powerful Others	32	25	-7
Chance	26	28	+2

Terry used her POSTINTERVIEW to formulate these goals:

1. Obtain a high school diploma.
2. Lose weight.
3. Locate part-time employment.
4. Explore options for further treatment.

At the end of the POSTINTERVIEW, telephone calls were made to the Adult Education Center to arrange her first contact with the agency. This was for goal number one. She promised to follow through on the arrangements made with the Adult Education Center, and to also work on her other three goals herself. She responded well to suggestions from the investigator, about ways she could outline her needs specifically to other agencies she might contact.

Several days later, a follow-up meeting revealed that Terry had taken the placement tests for the G.E.D. (High School Diploma Equivalency Exam) at the Adult Education Center and also had an appointment with a scholastic tutor from the center, who would assist her in her efforts to pass the final examinations for the diploma. Terry had also begun to diet, but reported having trouble sticking to it, even though she had lost a few pounds. At this time Terry had also located a part-time job as a bus driver for the Preschool Center her child attended. Finally, Terry decided against exploring any of the therapy possibilities recommended to her in the POSTINTERVIEW, stating that she would rather try to solve her personal problems on her own.

Case History II

Mamie was a 39 year old white divorced female with five children in the home. She has obtained a G.E.D. high school equivalency diploma, and is presently employed as a trainee at the Preschool Program through friends from the local Manpower Agency. Mamie's father is deceased, but her mother has continued to reside in the city. She has three brothers and two sisters.

Mamie said that she joined the group because she needed help with the clarification of her problems for herself, so that she would be able to make some decisions concerning the appropriate steps to take to solve her problems.

Prior to beginning the treatment program Mamie was overcome by an inability to swallow food for fear of choking to death. After a week or so, she was admitted to a local hospital for exploratory surgery to determine the possible cause. Three days after surgery, Mamie was released from the hospital and given a referral to a local mental health center for psychiatric care, because the physicians were unable to locate any physical abnormalities.

Mamie said the physicians told her that her problem with swallowing had an emotional etiology and that she should see a psychologist. So she came to the Preschool Psychologist for assistance. At this time, Mamie had returned to work but was constantly upset and crying over her inability to swallow.

The swallowing was not her only problem that had reached crisis proportions. She was served several notices to appear in court due to

unpaid bills; her brief reconciliation with her estranged alcoholic husband ended in failure; her oldest son was institutionalized due to violent and disruptive behavior in the home; her status as a trainee at the Preschool Program was jeopardized by her constant complaining and tearful behavior; and lastly she was abruptly dropped by a boyfriend with whom she thought there was a future.

At this point, her supervisors directed Mamie to make arrangement for therapy at the local mental health center if she was to continue in the training progam. This upset her more, but she did start treatment at the mental health center, although she also continued to threaten not to follow through with the next scheduled sessions.

As a result, a social worker in the Social Service Component referred her as a possible candidate for participation in the treatment program, so that she could clarify her needs. Mamie's Problem Checklist was completed by this social worker. She checked 13 problems in living for her. Mamie agreed with the social worker, that the following were definite problems in her life at this time:

1. Inability to accept compliments.
2. Unable to talk about herself positively.
3. Sees future as dim and bleak.
4. Unable to budget her money.
5. Trouble adjusting to divorce.
6. Does not demand respect from male companions.
7. Has trouble saying "No."
8. Whines a lot about her problems.

9. Fears failure, and never tries anything new.
10. Has little patience with her children.
11. Sees self as dumb and ugly.
12. Unable to trust others.
13. Inability to swallow.

Test results. Mamie's Global Improvement Ratings were highly consistent across raters. She was given a 7 - very much better by the Group Therapist, a 6 - quite a bit better by the social worker who made the original referral, and her own self-assessment was a 7 - very much better. Her total Improvement Rating (20) was the highest of all group members. This overall multidimensional measure of the amount of improvement she showed after treatment added considerable support to signs of improvement detected by the following unidimensional measures.

On the POMS, she showed considerable improvement on all scales. In Table III it can be noted that her greatest improvement was shown on the Tension-Anxiety Scale, with a decrease after treatment of 15 points. Even though the results from the POMS certainly supports her Global Improvement Ratings, that indicated considerable after treatment change, her overall POMS PROFILE is still reflective of those from female psychiatric outpatients prior to treatment.

Mamie showed a small decrease in somatic complaints after treatment. This was reflected in her scores on the Somatic Symptom Rating Scale, PRE (34) and POST (31). She still experienced considerable somatic distress after treatment even though she showed some improvement. This

TABLE III

PROFILE OF MOOD STATES: PRE AND POST SCORES FOR MAMIE

	PRE	POST	Difference
Tension-Anxiety (T-A)	57	42	-15
Depression-Dejection (D-D)	57	51	-6
Anger-Hostility (A-H)	63	56	-7
Vigor (V)	48	54	+6
Fatigue (F)	54	49	-5
Confusion (C)	55	51	-4

is very significant since Mamie's list of problems prior to treatment indicated that this was one of her major distress areas.

On the Zung, Mamie received a PRE score of 36 and a POST score of 33, indicating a decrease in depressive symptomatology after treatment. An examination of the individual items from her PRE and POST test forms indicated that after treatment she no longer experienced excessive heart palpitations or unwanted weight loss. This was again an indication of improvement for her.

Mamie showed a slight after treatment decline on all three dimensions of the Levenson I-E Scale. The results are shown in Table IV. The near equality of all three scales in Mamie's personal expectancy orientation was indicative of her belief orientation to the factors that affected her life. Her belief orientation was probably based on the realization that many events occurred in her life completely without warning (C); that there were others in powerful positions who dictated event outcomes to her (P.O.), i.e. the courts, Manpower Agency, and lastly, that she was responsible for the way some of the events turned out (I).

Mamie received the following verbal statement scores from the therapy sessions: Positive (181), Negative (148), Neutral (233), and Total (562). She had many more neutral self-statements than any other type. She had more positive self-statements than negative, which was indicative of a healthy self-reflection, even with the larger number of neutral self-statements. Mamie had 220 written statements from the therapy sessions, which was equal to those from the other group member

TABLE IV

INTERNAL-EXTERNAL SCALE: PRE AND POST SCORES FOR MAMIE

	PRE	POST	Difference
Internal (I)	39	35	-4
Powerful Others (P.O.)	39	36	-3
Chance (C)	41	38	-3

who showed improvement and more than the two members who showed less improvement.

Brief summary. Mamie's Global Improvement ratings and the results from the assessment measures support the improvement she reported. Apparently the group treatment was effective in providing her some relief from discomfort, a change in her orientation to her environment, and support for seeking solutions to her problems. During the period of treatment she managed to do the following: (1) she set and made court appearances to make arrangements to gradually pay off her debts; (2) she petitioned the court on behalf of her son to question his possibly inappropriate placement in a home for delinquents, rather than in a psychiatric treatment center for children; (3) she accepted the relative merit of extended psychotherapy treatment for her; (4) she made several applications for regular employment around the city; (5) she checked out her feelings for men in her life with the group members.

Prior to treatment Mamie was unwilling to admit that her swallowing difficulty and other problems might have had an emotional etiology, even with the results from the hospital. But, after treatment in the POSTINTERVIEW, she verbalized her fears about what might happen to her emotionally if she admitted that her inability to swallow was "in her mind." However, she agreed to continue her psychotherapy treatment at the mental health center and to share the issues she explored in the group with her therapist. This was probably one of her most meaningful gains from the treatment program.

Her Follow-up interview was held briefly at one of the Preschool Centers, one week later. Mamie had kept her appointment at the mental health center, and was pleased with her therapist's receptiveness to her disclosures from her group participation. She emphasized her need for continued treatment, by acknowledging the wisdom of her physician for making the initial referral - something she was completely unable to do prior to treatment.

Case History III

Mary was a 36 year old black woman who had never been married, but was the mother of one child. She quit school at the age of 14, but reported that she had earned the G.E.D. high school equivalency diploma. Mary was very concerned about her level of educational attainment and her inability to read and write very well. She had been employed in a variety of unskilled and semi-skilled jobs, and was a trainee through the Manpower Agency.

Even though her level of training was not very high, Mary has been able to buy a home, send her daughter away to school, and purchase a new automobile. She has worked very hard most of her life and her feeling of having missed out on all the fun her youth could have brought, apparently distressed her very much. Mary was an attractive, petite woman who looked much younger than her age, but who saw herself as being unattractive, and not very smart. She valued educational attainment, the state of marriage, and physical beauty, but could not see any of these as possible for her. Mary has difficulty with reading comprehension

and expressive writing. These two educational deficits were seen by her as permanent, and responsible for her sadness.

The social worker most familiar with her case checked seven problems in living for her from the Problems Checklist. Mary agreed with the social worker that the following were her most prominent personal problems.

1. Inability to accept compliments.
2. Inability to handle sexual frustrations.
3. Fears failure, never tries anything new.
4. Centers all attention on her daughter.
5. Feels insecure and inferior.
6. Low self-esteem centered around marital status.
7. Inability to write and read for needs of present job.

Test results. Mary's total Global Improvement Ratings indicated a change in her overall status after treatment. She received the following ratings: the social worker, 5 - a little better; the Group Therapist, 5 - a little better. Mary's self-assessment was 6 - quite a bit better. The two outside observers agreed with each other, but not with Mary's own assessment of the extent of change she had made after treatment.

On the Zung, Mary's PRE (54) and POST (44) treatment scores indicated that she did have a decrease in depressive symptomatology after treatment. This measure appeared to be sensitive to changes in Mary's level of personal distress.

On the POMS Mary received the profile shown in Table V. It can be noted that she showed slight decreases after treatment in two mood states: Tension-Anxiety and Depression-Dejection, and slight posttreatment increases in the other four mood states, with the increase in vigor being an indication of increased energy levels.

Mary received PRE (18) and POST (22) scores on the Bernreuter S-S Scale, which showed a slight increase in reported self-sufficiency after treatment.

Table VI shows Mary's scores on the I-E Scale. It can be seen that her most significant changes were on the Powerful Others and Chance dimensions. It appeared that after treatment she experienced a rise in her belief in the effects these factors had on events in her life. This may have been related to the sudden disclosure by the local Manpower Agency that they would not be able to fund her trainee position after the end of the summer, when she had expected it to last for at lease six more months.

The Somatic Symptom Rating Scale was not particularly sensitive to Mary's particular symptom profile, as shown by her very low PRE (3) and POST (1) scores. These low scores may be attributed to either of these factors: (1) Mary did not express her distress through the Somatic dimension that this scale measures, or (2) Mary's poor reading comprehension affected her test performance adversely. Either or both of these might serve as an explanation for her extremely low scores.

Mary had a relatively low number of written statements (125) from the therapy sessions. She had more total verbal statements (total-1375)

TABLE V

PROFILE OF MOOD STATES: PRE AND POST SCORES FOR MARY

	PRE	POST	Difference
Tension-Anxiety	36	33	-3
Depression-Dejection	40	36	-4
Anger-Hostility	39	40	+1
Vigor	51	53	+2
Fatigue	38	40	+2
Confusion	39	40	+1

TABLE VI

INTERNAL-EXTERNAL SCALE: PRE AND POST SCORES FOR MARY

	PRE	POST	Difference
Internal	34	31	-3
Powerful Others	18	27	+9
Chance	26	33	+7

than any other group member, improved or unimproved. Her other scores were: Positive (550), Negative (450) and Neutral (375), giving her the largest amount of session verbal output. The effect of her poor reading skills on her performances in this study may be demonstrated by the contrasts between her written and verbal statements. She had one of the lowest total scores for written statements, and the highest total score for verbal statements. Also, she had the largest total number of positive statements for the treatment program. When this is considered in light of her low Global Improvement Rating, the question arose as to why she had more positive things to say about herself than anyone else, but received one of the lowest Global ratings. This may be attributed to Mary's unwillingness to self-disclose and her desire to give a favorable impression to others. At this point in her report the fact that she had earned the G.E.D. high school equivalency diploma came into question, due to Mary's apparent inability to communicate with words, either reading or writing. This also points to her desire to give a favorable impression.

Brief summary. Mary's low Global Improvement ratings from observers and her somewhat higher ratings probably indicated that Mary had not been able to recognize many of her personal problems. Also, since many of her test results did not show much change, it appeared to be quite likely that she spent considerable energy in counter-productive activities,both behavioraly and cognitively. Mary was very verbal in the group sessions, spending considerable amounts of time supporting

herself on the way she handled events in the past, and never quite approaching her present personal concerns. She also allowed little time for others to comment on her self-appraisals in the group meetings. She would simply move on to another event in her past.

However, during the POSTINTERVIEW, Mary did make concrete plans for the solution of some of her problems. Specifically, she made an appointment at the Adult Education Center for a tutor in reading comprehension; and she explored scholarship opportunities for women over 30 who would like to return to school. She phoned the Financial aid and Scholarship office at the local university, while still in the investigator's office.

She questioned the investigator directly over her performance in the group and successfully avoided answering the questions herself when they were redirected to her. She seemed to expect a categorical appraisal of herself after the treatment program which probably related to her low personal esteem. Mary avoided dealing with any of the other problems she had mentioned prior to treatment. And the investigator failed to confront her on her evasiveness and it's effect on her productivity.

In the brief follow-up meeting, it was learned that Mary had started classes with a reading tutor, and had registered for career counseling at the university before exploring scholarship opportunities. She also discussed her need for psychotherapy "to find out what's going on with me," but declined an offer by the investigator to refer her to a local mental health center. Mary did not feel she was ready for that yet.

Case History IV

Betty was a 36 year old white, married, unemployed female from a small mining town in Pennsylvania, where she completed high school and two years of business college. She has three small children that she rears alone, since her husband travels as a long distance truck driver. She had been employed as a medical secretary and personnel clerk prior to moving to Knoxville. Both of her parents, and her two sisters continue to live in Pennsylvania.

Betty was a quiet soft-spoken woman who spoke in a direct and precise fashion. She asked quite a few questions about the procedure for group participation and about the investigators' expectations from her.

Most of the personal concerns she voiced were related to her desire to work again, and her fear of exploding violently. She reported that she was in constant fear of over-reacting angrily, so she usually remained quiet. She was able to say that she needed to learn how to communicate her feelings verbally, especially in interpersonal relations, so that she would feel less inhibited and bottled up. She said she became angry when she thought about things she has let pass rather than deal with at the appropriate time. She experienced this most acutely in her relationships with her children, who present her with a management problem.

She said that most of her energies were spent coping with her anger, self-disappointment, and fear of criticism.

Her Problems Checklist was completed by her social worker, who checked 15 problems in living for her. Betty agreed with her that the following were definite problems in living for her at this time:

1. Inability to speak about self favorably.
2. Has trouble saying "No."
3. Getting involved in petty manipulations.
4. Unemployed, able to work, but doesn't.
5. Have a lot of self-destructive behaviors.
6. Is selfish and too self-centered.
7. Has very little patience with children.
8. Believes she is dumb and ugly.
9. Does not take advantage of community services.
10. Has withdrawn from all social activities that are not related to children's welfare.
11. Lacks self-confidence.
12. Unable to make decisions.
13. Has financial problems.
14. Inability to control temper.
15. Unable to manage children.

Test results. Betty received the lowest total Global Improvement Rating of all group members. The social worker and the therapist agreed with Betty that she had shown a little improvement after treatment. The total of the three ratings was 15.

Betty's scores on the POMS were all near the expected mean for female psychiatric outpatients, except those for Vigor. Her Vigor scores

were very high, and the ten point posttreatment decrease was probably a regression back towards the mean for female psychiatric outpatients. In Table VII, it can be seen that the posttreatment differences varied considerably. The highest posttreatment decrease was in Vigor - the measure of energy levels. She showed no change in Depression-Dejection, and relatively little in Confusion and Fatigue. There was a slight decrease in Tension and Anxiety, with an increase in Anger and Hostility, the mood state she was most concerned about in the treatment program.

Her scores on the I-E Scale showed a little posttreatment change, although her Chance score increased six points. Her results are shown in Table VIII.

On the Zung, Betty received PRE (58) and POST(49) treatment scores that indicated a decrease in depressive symptomatology after treatment.

Her PRE and POST scores on the Somatic S-R Scale were 11 and 15, respectively, indicating a rise in somatic complaints after treatment. This is probably related to the loss in Vigor and slight increase in Fatigue that was picked up by the POMS. Also related to the above would be her decrease in reported self-sufficiency on the S-S Scale. Her scores were PRE (23) and POST (19).

Betty made fewer verbal statements than any other group member: Positive (70), Negative (120), Neutral (90), and Total (280). She made more Negative and Neutral than Positive statements, indicating a tendency to give a poor self-reflection in the way she spoke about herself. She also had fewer written statements (190) than two of the

TABLE VII

PROFILE OF MOOD STATES: PRE AND POST SCORES FOR BETTY

	PRE	POST	Difference
Tension-Anxiety (T-A)	52	48	-4
Depression-Dejection (D-D)	44	44	0
Anger-Hostility (A-H)	56	64	+8
Vigor (V)	77	67	-10
Fatigue (F)	49	50	+1
Confusion (C)	43	45	+2

TABLE VIII

INTERNAL-EXTERNAL SCALES: PRE AND POST SCORES FOR BETTY

	PRE	POST	Difference
Internal	37	38	+1
Powerful Others	20	20	0
Chance	17	23	+6

other group members, even though she was the most highly educated member of the group. This indicated that she was unwilling to self-explore, either verbally or privately in writing

Brief summary. Betty's Global Improvement Ratings were indications of very little posttreatment changes. Her score on the various self-report measures seemed to fluctuate very much at random rather than in a meaningful pattern. This may be related to her inability to express her needs or to seek some solutions to her problems. Her fear of exploding was related to her many disappointments, fears and hurt feelings she kept bottled up inside of her. Betty has adapted to her environment by withdrawing and maintaining only minimal contact with those in her environment.

Betty spoke very little about her husband. It was quite apparent that some of the welled up anger might be related to her feelings of abandonment by him.

During the POSTINTERVIEW she thanked the investigator for selecting her to participate in the study, and had little else to say. Her response to the list of problems was that she knew they all were true but she was unable to do anything about them right now.

She did pick up on the investigator's suggestion that she explore some outlets for personal gratification through the local woman's center. She did not see any possibility for further treatment on an individual basis, however.

On a later date, at her child's Preschool Center, follow-up questions were asked to see if she had contacted the woman's center or

given any further thought to individual treatment. Her response was "No" to all of the above, and she ended the conversation by stating that she was going to speak to her husband about getting a job next year.

Case History V

Doris was a 37 year old white divorced female who was unemployed and supporting her child with Aid to Dependent Children funds. She had a history of epilepsy and was being followed closely by a local physician. She was brought to the PREINTERVIEW by her social worker and the social worker and therapist picked her up at her home for the first session of the treatment program. Prior to the second session she did not answer the door when the therapist went to pick her up. She participated minimally in both meetings and did not attend the other four therapy sessions. Several attempts were made to get her to come to the sessions or to determine her reasons for quitting, but she would not let anyone in her home for an interview. This woman clearly did not want to participate.

Summary of Results

The Global Improvement Ratings of each participant made by the social worker who referred the client, the group therapist, and the client, as well as the total for all three raters are presented in Table IX. This measure was the one criterion that permitted assessment of the validity of the clients' reports of their response to treatment. There was excellent agreement across raters on treatment outcome. Two clients, Terry and Mamie, were judged by all three raters as having

TABLE IX

GLOBAL IMPROVEMENT RATINGS FOR EACH GROUP MEMBER BY ALL THREE RATERS

	Terry	Mamie	Mary	Betty
Social Worker Who Made Referral	6**	7***	5*	5
Group Therapist	7	6	5	5
Group Member (Client)	7	6	6	5
Total of Three Ratings	20	19	16	15

*** Very much better

** Quite a bit better

* A little better

made improvement. One client, Betty, was rated by all three raters as showing only a little improvement. The other client, Mary, rated herself as having improved "quite a bit," while the therapist and the social worker rated her as showing only "a little" improvement. It would appear that Mary's rating of herself reflected, more accurately, the changes in her ability to find satisfaction of her needs through community resources, than did the ratings of the social workers or the therapist.

All clients showed some degree of improvement after treatment.

SECTION IV

DISCUSSION

In trying to serve low-income mothers it became apparent that a number, if not many, of them were unable to make use of the resources within the community that were "designed" to meet their needs. Traditional assessment and referral practices were ineffective. Directly relevant literature to assist with this problem was unavailable. It was hypothesized that these women did not perceive the so-called available services as being available. Existing ideas within the psychological literature, regarding locus of control, learned helplessness, and cognitive training aided in the formulation of the diagnosis and treatment of this group of women.

Treatment Outcome

The treatment outcomes for this study were good to excellent, or at the very least encouraging. Three out of four clients showed "quite a bit" to "very much" improvement after treatment. Two of the clients who rated themselves as very much improved had their ratings substantiated by the ratings from the therapist and the social worker (who did not participate in the treatment). All three clients who saw themselves as improved increased their utilization of community resources to meet their needs. These three clients also showed some changes on the psychological instruments used in the study that indicated that different group members experienced improvement in various aspects of their personality.

The most consistent results were found on the Zung for all group members. On the other tests the results were much less consistent across the group members, although some significant changes were observed for the clients on different measures. There were no across the board changes in mood disturbance and somatic symptom distress, indicative that with this particular population it might be unrealistic to expect changes of this nature with the short term treatment procedure.

At the conclusion of the study it became apparent that, if the clients had been asked to rate--at the end of the study—how much they had improved on the items of the Problems Checklist, then clearer documentation of the impact of the treatment could have been presented in numerical and more systematic terms. The Coping Operations Preference Enquiry, the Bernreuter Self-Sufficiency Scale, and the Levenson Revision of the Internal-External Scale could have been dropped from the study without any significant loss of information about the client's status on response to treatment.

Treatment Process

Prior to treatment, all group members were seen as ineffective in changing their environment. But, through the group treatment process, where focus was placed on their ability to change their behavior and event outcomes, by first changing the way they thought about themselves, they became able to go out and find solutions to their problems. They also began to feel better.

The treatment program facilitated the clarification of personal goals for each of the three improved members, by continually focusing upon their images of themselves and their personal expectations.

The therapeutic process began with the PREINTERVIEW. It served as part of the total treatment process, rather than simply as a time to select subjects. At this time the interest and concern the therapist had for the welfare of the clients was communicated to them. The PREEVALUATION was part of the PREINTERVIEW, in that the therapist remained at the client's side while they completed the assessment instruments. They were also introduced to the concepts of self-statements with valences by explaining to them the criteria the raters would use to score their verbal productions in the therapy sessions. The concept was received well by the clients, in that they drew on their own experiences to clarify their understandings of the Positive, Negative, and Neutral self-statements.

The 5-Session Group Therapy Program was well received by the clients. They participated in all the group activities and had many more questions than time was allowed for in the discussion segments of the program. The written activities might have been more of a barrier to one of the clients, Mary, if she had not sought assistance in reading the directions on the worksheet. The themes of cognitive refocusing and thought control were well received. The clients seemed reluctant at first to "tamper" with their thoughts, but after the third session they were volunteering their thoughts for consideration in the group.

Portions of the treatment procedures might be changed. The investigator would suggest that a session-by-session outline be given to each client in the first session. In this way they would have had a global picture of what was to occur in each session, as well as the

ideas that would be presented. Another change might be adding limited homework assignments that would serve as carry-over activities for each client, between each session.

Structure provided for the therapist with verbatim programs to follow for each session, especially for the psychologist who was new to working with this population and who was not particularly familiar with cognitive therapy concepts and group therapy procedures. The two hour sessions and the ten hour time limited treatment program seemed to serve to keep the group on track and prevented excessive dependency upon the therapist that might occur in treatment programs without a definite termination date. The time limits served the purpose of motivating the clients to get out on their own. Lastly, the time limited procedure has the advantage of being an economical usage of time and staff to achieve the treatment goals.

One last suggestion for the therapy process would be that further study be conducted to achieve a better balance between the structure that comes with the time limited process and therapist flexibility. It was an absolute must, that the therapist stick to the treatment program in order to complete each session as described within the two hour time limit. No time was allotted for the elaboration of concepts the group might have had difficulty with, or for extensive discussion by group members of a particularly relevant issue. As a word of caution, what the therapist saw as important for the client to know in order to effect change in their lives, might not have coincided with what the clients felt was needed. Therefore therapist flexibility should also be part

of the treatment process. The therapist was continually aware of her desire to successfully treat these clients. This was evidently a catalyst for the clients as well. Although there were times in the treatment process when this therapist's attitude interfered with the therapist's effectiveness and the client's progress.

The fact that three out of four participants in the Brief Group Therapy Module have continued to work with their recommended resources indicates that the procedure did facilitate an active pursuit of their goals. Whether or not this can be particularly attributed to the cognitive restructuring nature of the treatment procedure itself, compared to some other theoretical orientations to achieving change, is open to question.

Several clients showed trends in their individual verbal self-statement profiles that warrants further investigation on an experimental basis to ascertain whether or not there are any true correlations between what a person says about herself, and her affective state—both transient and stable. If some correlation were substantiated then it might one day be possible to forego standardized measures as we know them today and simply utilize the rich data bank an individual brings to an interview when she talked about herself. This study did not explore this aspect thoroughly enough to suggest any particular factors.

The Module's Group Process results demonstrated that this might be an efficient use of time for evaluation of a group of clients to determine their choices of problem solutions, and to provide some

symptom relief. This process would make follow-through by the client more likely to occur, which in the long run would have extensive payoffs for all service providers involved with this particular population.

General Considerations

The needs for more individualized criteria for improvement after treatment was highlighted by this study. With individualized criteria for improvement, the person's environment, abilities and emotional status prior to treatment could be used as a reference point for measuring change rather than a general norm or the therapist's expectations.

Along with this would go a more individualized assessment procedure where the individual determined his/her own need hierarchy and strategies for change. In this way determinants of improvement of change and improvement could be assessed from a realistic position for each client by determining what changes she had made after treatment.

The potentials for further developments from this study appeared to be unlimited, if the psychological community would pick up the impetus for more investigations in the areas of mental health service delivery to persons from low-income communities. Community psychologists, clinicians, and others have given lip service to this increasingly desperate need for years, but few have ventured from their ivory towers to attempt some form of implementation of treatment on any one group of subjects. This study only tapped a small segment of poor people. Further study is needed to determine the kinds of changes needed in traditional psychotherapy so that one day any person in need of help can locate a trained person able and willing to assist them with the solutions of their problems.

The era where psychotherapy was a luxury only sanctioned for the wealthy has been over for a long time. The federal government has spent millions of taxpayers dollars on the development and expansion of community mental health centers with the expressed contention that they give service to those who could not afford therapy if it had to be contracted privately. But, instead of carrying out the federal mandate to serve all who ask for services, the community mental health centers have systematically erected barriers to keep the poor out. The exclusion process begins with the location of the centers in posh to middle-class neighborhoods, rather than in low-income communities; to the "atmosphere" in the waiting rooms; to the "snobbish attitudes" of the middle class receptionist; and finaly, if the "poor-low-income-disadvantaged" person makes it this far, is the traditionalist clinicians who sit in their plush offices on the second floor waiting to disqualify the potential client because he/she does not fit his/her expectations for a client that he/she wanted to treat. Their traditional expectations for suitable clients are based on their beliefs that only clients who gross 10,000 dollars a year, have some college education, and came from families like their own are "verbal" enough to respond to their treatment. All other potential clients who did not meet these criteria were dutifully interviewed and dismissed three sessions later as uncurable or "resistant." There are presently no federal monitoring systems that could serve to make community mental health centers accountable to the entire community.

Hopefully, this work will stimulate efforts to provide some impetus for the field to seek suitable changes in priorities for those designated to treat the mentally distressed, whatever their background.

BIBLIOGRAPHY

BIBLIOGRAPHY

Beck, Aaron T. Depression: Clinical Experimental and Theoretical. New York: Harber, 1967.

Bernreuter, Robert. The Measurement of Self-Sufficiency. The Journal of Abnormal and Social Psychology, Vol. 38, 1933-34, p. 291-300.

Caplan, Gerald. Principles of Preventure Psychiatry. New York: Basic Books, 1964.

Ellis, Albert. Humanistic Psychotherapy. New York: McGraw-Hill Book Company, 1973.

Fisher, A . Personal communication, 1976.

Gendlin, E. T. Psychotherapy and Community Psychology, Psychotherapy: Theory, Research and Practice. 1968, 5, pp. 67-72.

Gurin, P., J. D. Gurin, R. C. Lao, & M. Beattie. Internal-External Control in Motivational Dynamics of Negro Youth. Journal of Social Issues, 1969, 25, p. 29-53.

Levenson, H. Activism and Powerful Others. Distinctions within the concept of the internal-external control. Journal of Personality Assessment, 1975.

Mahoney, M. J. Cognition and Behavior Modification. Cambridge, Massachusetts: Ballinger Publishing Company, 1975.

McNair, Douglas M. Self-Evaluations of Antidepressants. Psychopharmacologia. (Berl.) 37, pp. 281-302, 1974.

McNair, Douglas M., Maurice Lorr, & Leo Droppleman. Profile of Mood States Manual. Educational and Industrial Testing Service, San Diego, California, 1971.

Mann, A., Time Limited Psychotherapy, Cambridge, Mass., Harvard University Press, 1973.

Meichenbaum, D. Self-instructional Training: A Cognitive Prosthesis for the Aged. Paper presented at the Ninth International Congress of Gerontology, Kiev, Soviet Union, 1972.

Meichenbaum, D. Enhancing Creativity by Modifying what S's Say to Themselves. Unpublished Manuscript. University of Waterloo, 1972.

Rotter, J. B. Generalized Expectancy's for Internal Versus External Control of Reinforcement. Psychology Monographs: Vol. 80, No. 1 Whole No. 609, 1966.

Schutz, William C. The FIRO Scales Manual. Palo Alto: Consulting Psychologists Press, Inc., 1967.

Seligman, M. E. Helplessness: San Francisco. W. H. Freeman and Company, 1975.

Seligman, M. & Marcis, S. Failure to Escape Traumatic Shock. Journal of Experimental Psychology, 1967, 74, 1-9.

Zung, W. Factors Influencing the Self-Rating Depression Scale. Archives of General Psychiatry. Vol. 6, (May, 1967), pp. 543-547.

APPENDICES

APPENDIX A

INFORMED CONSENT AGREEMENT

HELLO,

You have been selected to participate in group sessions designed to develop your personal effectiveness. It is hoped that after completion of all the meetings you will feel more capable of using your strengths to achieve in your everyday life.

Each meeting will be taped. It is important to me that your identity remain confidential, therefore, the tapes will be seen only by my research assistants, your case worker, and myself. The data from this study will demonstrate that it is important to devise new ways to bring health care services to all sections of this community.

It cannot be promised that you will gain any particular benefits from participation in this study other than that which comes from group meetings in general, but it is hoped that the ability to control your own environment and yourself in such ways as is necessary to achieve your personal goals will be enhanced.

I appreciate your participation.

PERMISSION SLIP

I give my permission for the results of data collected as a result of my participation in this study to be used for research and training purposes only.

Signed: _____

Mailing Address: _____

_____

Telephone Number: _____

APPENDIX B

PERSONAL DATA SHEET

Date _____

Name _____ Age _____ Birthdate _____

Race: B W (circle one) Phone number _____

Educational level _____ Number of children _____
(write in last grade completed)

Marital Status: single _____ married _____ widowed____ divorced___

What kind of work have you done? _____

_____

_____

Family History:

a. Marital status of parents. _____

b. How many brothers? _____ Sisters? _____

c. Where do parents live? _____

Please write below all your life goals _____

_____

_____

_____

Please write below all your life troubles and problems .....

_____

_____

_____

_____

_____

_____

_____

_____

Note: You may write on back of form also.

APPENDIX C

SOCIAL WORKER: _____ NAME OF CLIENT: _____

PROBLEMS CHECKLIST

(Please answer yes or no to the following statements depending on whether or not YOU feel the statements describe some aspect of your CLIENT'S behavior, thinking, and adjustment).

		check one please	
		YES	NO
1.	She is able to accept compliments		
2.	She talks about herself favorably		
3.	She believes she has a bright future		
4.	She is able to budget her money		
5.	She adjusted to divorce without much trouble		
6.	She handles sexual frustrations well		
7.	She gets along well with people		
8.	She demands respect from male companions		
9.	She does have trouble saying "No"		
10.	She whines a lot about her problems		
11.	She gets involved in petty manipulations		
12.	She wants everything given to her		
13.	She is unemployed, able to work, but does not		
14.	She seems to have a lot of self-destructive behaviors		
15.	She tends to be selfish and self-centered		
16.	She fears failure, and never tries anything new		
17.	She has little patience with her children		
18.	She believes she is dumb and ugly		
19.	She takes advantage of all community services		
20.	She has withdrawn from all social activities that are not related to her child's welfare		

APPENDIX D

SOMATIC SYMPTOM RATING SCALE

Below is a list of problems people have. Please read each one carefully. Then fill in ONE space under the answer to the right which best describes HOW MUCH YOU FELT DISTRESSED, BOTHERED, OR WORRIED BY EACH PROBLEM DURING THE PAST WEEK INCLUDING TODAY. The numbers refer to the following descriptive phrases.

0 = Not at all

1 = A little

2 = Moderately

3 = Quite a bit

4 = Extremely

1.	Tenseness, nervousness or shakiness?	0 1 2 3 4 5
2.	Feeling hopeless about the future?	0 1 2 3 4 5
3.	Bad dreams?	0 1 2 3 4 5
4.	Feeling easily annoyed, irritated or angered?	0 1 2 3 4 5
5.	Trouble remembering things?	0 1 2 3 4 5
6.	Drowsiness during the day?	0 1 2 3 4 5
7.	Weakness in parts of your body?	0 1 2 3 4 5
8.	Nausea, vomiting?	0 1 2 3 4 5
9.	Heart of chest pains?	0 1 2 3 4 5
10.	Faintness or dizziness?	0 1 2 3 4 5
11.	Feeling anxious, uneasy or worried for no clear reason?	0 1 2 3 4 5
12.	Feeling anxious or uneasy about specific matters or problems?	0 1 2 3 4 5
13.	Difficulty speaking at times?	0 1 2 3 4 5

14.	Being unable to get rid of troublesome thoughts or ideas.	0 1 2 3 4 5
15.	Temper outbursts you could not control?	0 1 2 3 4 5
16.	Feeling slowed down or low in energy?	0 1 2 3 4 5
17.	Constipation?	0 1 2 3 4 5
18.	Heart pounding or racing?	0 1 2 3 4 5
19.	Hot or cold spells?	0 1 2 3 4 5
20.	Breathing difficulty?	0 1 2 3 4 5
21.	Difficulty getting to sleep or staying asleep?	0 1 2 3 4 5
22.	Accomplishing less than you could in the past?	0 1 2 3 4 5
23.	Your mind going blank?	0 1 2 3 4 5
24.	Feeling ill will, dislike or anger toward others?	0 1 2 3 4 5
25.	Having to avoid certain places, activities, or things because they frighten you?	0 1 2 3 4 5
26.	Poor appetite?	0 1 2 3 4 5
27.	Heartburn?	0 1 2 3 4 5
28.	Heavy feelings in your arms or legs?	0 1 2 3 4 5
29.	Headaches?	0 1 2 3 4 5
30.	Sweating?	0 1 2 3 4 5
31.	Feeling no interest in things?	0 1 2 3 4 5
32.	Blaming, criticizing or condemning yourself?	0 1 2 3 4 5
33.	Worry over the appearance of your body or part of your body?	0 1 2 3 4 5
34.	Difficulty making decisions?	0 1 2 3 4 5
35.	Loss of sex interest or pleasure?	0 1 2 3 4 5
36.	Menstrual difficulties?	0 1 2 3 4 5

37.	Trouble swallowing?	0 1 2 3 4 5
38.	Numbness or trembling in parts of your body?	0 1 2 3 4 5
39.	Stomach pains?	0 1 2 3 4 5
40.	Twitching or trembling in parts of your body?	0 1 2 3 4 5
41.	Feeling as if you are caught or trapped?	0 1 2 3 4 5
42.	Feeling others are critical, unfriendly or dislike you?	0 1 2 3 4 5
43.	Crying easily?	0 1 2 3 4 5
44.	Feeling things around you seem unreal or unnatural?	0 1 2 3 4 5
45.	Having unacceptable or disturbing thoughts about sex?	0 1 2 3 4 5
46.	Low back pains?	0 1 2 3 4 5
47.	Itching?	0 1 2 3 4 5
48.	Hives or skin rashes?	0 1 2 3 4 5
49.	Loose bowels or diarrhea?	0 1 2 3 4 5
50.	Being overweight?	0 1 2 3 4 5
51.	Concern about a sex problem?	0 1 2 3 4 5
52.	Feeling lonely?	0 1 2 3 4 5
53.	Feeling inadequate or inferior to others?	0 1 2 3 4 5
54.	Fearing that something may be wrong with your body?	0 1 2 3 4 5
55.	Having to check and double check what you do?	0 1 2 3 4 5
56.	Feeling blue, depressed or dejected?	0 1 2 3 4 5
57.	Feeling guilty or sorrowful about things you have done or thought?	0 1 2 3 4 5
58.	Trouble concentrating?	0 1 2 3 4 5
59.	Feeling shy or uneasy with the opposite sex?	0 1 2 3 4 5
60.	Thoughts of ending your life?	

Make sure you have answered every item.

APPENDIX E

PROFILE OF MOOD STATES

Name _____ Date _____

Below is a list of words that describe feelings people have. Please read each one carefully. Then fill in ONE space under the answer to the right which best describes HOW YOU HAVE BEEN FEELING DURING THE PAST WEEK INCLUDING TODAY. The numbers refer to the following descriptive phrases.

0 = Not at all

1 = A little

2 = Moderately

3 = Quite a bit

4 = Extremely

1. Friendly	0	1	2	3	4	5
2. Tense	0	1	2	3	4	5
3. Angry	0	1	2	3	4	5
4. Worn out	0	1	2	3	4	5
5. Unhappy	0	1	2	3	4	5
6. Clearheaded	0	1	2	3	4	5
7. Lively	0	1	2	3	4	5
8. Confused	0	1	2	3	4	5
9. Sorry for things done	0	1	2	3	4	5
10. Shaky	0	1	2	3	4	5
11. Listless	0	1	2	3	4	5
12. Peeved	0	1	2	3	4	5
13. Considerate	0	1	2	3	4	5
14. Sad	0	1	2	3	4	5
15. Active	0	1	2	3	4	5
16. On edge	0	1	2	3	4	5
17. Grouchy	0	1	2	3	4	5
18. Blue	0	1	2	3	4	5
19. Energetic	0	1	2	3	4	5
20. Panicky	0	1	2	3	4	5
21. Hopeless	0	1	2	3	4	5
22. Relaxed	0	1	2	3	4	5
23. Unworthy	0	1	2	3	4	5
24. Spiteful	0	1	2	3	4	5
25. Sympathetic	0	1	2	3	4	5
26. Uneasy	0	1	2	3	4	5
27. Restless	0	1	2	3	4	5
28. Unable to concentrate	0	1	2	3	4	5
29. Fatigued	0	1	2	3	4	5
30. Helpful	0	1	2	3	4	5
31. Annoyed	0	1	2	3	4	5
32. Discouraged	0	1	2	3	4	5
33. Resentful	0	1	2	3	4	5
34. Nervous	0	1	2	3	4	5
35. Lonely	0	1	2	3	4	5
36. Miserable	0	1	2	3	4	5
37. Muddled	0	1	2	3	4	5
38. Cheerful	0	1	2	3	4	5
39. Bitter	0	1	2	3	4	5
40. Exhausted	0	1	2	3	4	5
41. Anxious	0	1	2	3	4	5
42. Ready to fight	0	1	2	3	4	5

43. Good natured	0 1 2 3 4 5
44. Gloomy	0 1 2 3 4 5
45. Desperate	0 1 2 3 4 5
46. Sluggish	0 1 2 3 4 5
47. Rebellious	0 1 2 3 4 5
48. Helpless	0 1 2 3 4 5
49. Weary	0 1 2 3 4 5
50. Bewildered	0 1 2 3 4 5
51. Alert	0 1 2 3 4 5
52. Deceived	0 1 2 3 4 5
53. Furious	0 1 2 3 4 5
54. Efficient	0 1 2 3 4 5
55. Trusting	0 1 2 3 4 5
56. Full of pep	0 1 2 3 4 5
57. Bad tempered	0 1 2 3 4 5
58. Worthless	0 1 2 3 4 5
59. Forgetful	0 1 2 3 4 5
60. Carefree	0 1 2 3 4 5
61. Terrified	0 1 2 3 4 5
62. Guilty	0 1 2 3 4 5
63. Vigorous	0 1 2 3 4 5
64. Uncertain about things	0 1 2 3 4 5
65. Bushed	0 1 2 3 4 5

HANNA LEVENSON

LEVINSON'S REVISED INTERNAL-EXTERNAL SCALE

ATTITUDE STATEMENT SURVEY

	Strongly disagree	Disagree somewhat	Slightly disagree	Slightly agree	Agree somewhat	Strongly agree
1. Whether or not I get to the leader depends mostly on my ability.	-3	-2	-1	+1	+2	+3
2. To a great extent my life is controlled by accidental happenings.	-3	-2	-1	+1	+2	+3
3. I feel like what happens in my life is mostly determined by powerful people.	-3	-2	-1	+1	+2	+3
4. Whether or not I get into a car accident depends mostly on how a good driver I am.	-3	-2	-1	+1	+2	+3
5. When I make plans, I am almost certain to make them work.	-3	-2	-1	+1	+2	+3
6. Often there is no chance of protecting my personal interest from bad luck happenings.	-3	-2	-1	+1	+2	+3
7. When I get what I want, it's usually because I'm lucky.	-3	-2	-1	+1	+2	+3
8. Although I might have good ability, I will not be given leadership responsibility without appealing to those in positions of power.	-3	-2	-1	+1	+2	+3
9. How many friends I have depends on how nice a person I am.	-3	-2	-1	+1	+2	+3
10. I have often found that what is going to happen will happen.	-3	-2	-1	+1	+2	+3
11. My life is chiefly controlled by powerful others.	-3	-2	-1	+1	+2	+3
12. Whether or not I get into a car accident is mostly a matter of luck.	-3	-2	-1	+1	+2	+3
13. People like myself have very little chance of protecting our personal interests when they conflict with those of strong pressure groups.	-3	-2	-1	+1	+2	+3
14. It's not always wise for me to plan too far ahead because many things turn out to be a matter of good or bad fortune.	-3	-2	-1	+1	+2	+3
15. Getting what I want requires pleasing those people above me.	-3	-2	-1	+1	+2	+3

HANNA LEVENSON

	Strongly disagree	Disagree somewhat	Slightly disagree	Slightly agree	Agree somewhat	Strongly agree
16. Whether or not I get to be a leader depends on whether I'm lucky enough to be in the right place at the right time.	-3	-2	-1	+1	+2	+3
17. If important people were to decide they didn't like me, I probably wouldn't make many friends.	-3	-2	-1	+1	+2	+3
18. I can pretty much determine what will happen in my life.	-3	-2	-1	+1	+2	+3
19. I am usually able to protect my personal interests.	-3	-2	-1	+1	+2	+3
20. Whether or not I get into a car accident depends mostly on the other driver.	-3	-2	-1	+1	+2	+3
21. When I get what I want, it's usually because I worked hard for it.	-3	-2	-1	+1	+2	+3
22. In order to have my plans work, I make sure that they fit in with the desires of people who have power over me.	-3	-2	-1	+1	+2	+3
23. My life is determined by my own actions.	-3	-2	-1	+1	+2	+3
24. It's chiefly a matter of fate whether or not I have a few friends or many friends.	-3	-2	-1	+1	+2	+3

APPENDIX F

COPE SCALE

DIRECTIONS: The following questionnaire is designed to see how you would guess certain kinds of people might feel in different situations. Several situations are described here by a person who has observed an incident. You are to guess which of the five alternatives best describes the way the person in the story feels. In the space beside each choice, rank your guesses: Place a 1 beside that alternative you feel is MOST likely, a 2 beside the one next most likely, down to 5 of the alternative LEAST likely to apply in the situation. (If you have any questions, please ask your examiner).

EXAMPLE: HARASSED HARRY

3 a.
1 b. (MOST LIKELY)
2 c.
5 d. (LEAST LIKELY)
4 e.

NAME: _____

DATE: _____ AGE: _____

ONE

ACTIVE ANN

"Yesterday something happened to Ann which seemed to make her feel disturbed. ann usually does everything together with people, and when others do things, she tends to join them.

Yesterday a group of friends came over and asked her to go out with them. Ann seemed not to want to go, but went anyway. She appeared to realize that she might enjoy herself more if she didn't always join people, but spent more time by herself.

She still appears to be concerned about this. How would you guess she really feels now?"

_____ a) She's not worried. She feels this isn't a very important problem.

_____ b) She may do too many things with others, but she doesn't feel this has much to do with how much she enjoys people.

_____ c) Although she may do too many things with others, she feels that this is because other people expect her to.

_____ d) She feels that she may do too many things with others, but with help from someone more experienced she could change.

_____ e) She realizes that the fault for doing too many things with others lies completely with herself and with no one else.

TWO

COOL CAROL

"Yesterday Carol realized something about herself which appeared to disturb her. When she is with people, she usually acts rather cool and reserved. She is the kind of person who doesn't get very close to people or confide in them her feelings and worries.

During a long conversation yesterday, Carol seemed to want to confide in a friend the things she worries about and how she feels, but she didn't. It appears that she became aware for the first time of the fact that she might enjoy her relations with people more if she were not so cool and reserved; if she were warmer and more personally involved with her friends.

Today Carol still appears concerned about her realization of yesterday. How would you guess she really feels now?"

_____ a) She realizes that the fault for being cool toward others is completely her own and no one else's.

_____ b) She feels that this isn't a very important problem. She isn't worried.

_____ c) She feels that she may be cool toward others, but with help from someone more experienced, she could change.

_____ d) Although she may be cool toward others, she feels that this is because other people behave that way toward her.

_____ e) She may be cool toward others, but she doesn't feel this has much to do with how much she enjoys people.

THREE

DOMINANT DANAH

"During a club meeting yesterday, Danah appeared to realize something about herself which seemed to disturb her. When she is with people, she is usually quite domineering. She takes charge of things and makes most of the decisions.

After volunteering for the role of chairman, it occurred to her that she would have been happier just being a committee member. She seemed to realize for the first time that she would enjoy people more if she were not so domineering; not always making decisions for people.

Today Danah still appears concerned about her new realization of yesterday. How would you guess she feels now?"

_____ a) She realizes that the fault for being too domineering lies completely with herself and with no one else.

_____ b) She isn't worried. She feels this isn't a very important problem.

_____ c) She may be too domineering, but she doesn't feel this has much to do with how much she enjoys people.

_____ d) Although she may be too domineering she feels that this is because other people expect this of her.

_____ e) She feels that she may be too domineering, but with help from someone more experienced, she could change.

FOUR

PERSONAL PAULA

"Paula is a very outgoing type of person. She tends to become very close and personally involved with others. She confides to them her innermost feelings and worries.

Yesterday she spoke to the friend and told her a great deal about herself. After thinking over her talk, she seemed to feel that she would have felt more comfortable if she had not confided so much. Perhaps she would enjoy her relations with people more if she didn't become so close and personal; if she were more cool and reserved.

This morning Paula still appears concerned. How would you guess she really feels now?"

_____ a) She may be too personal toward others, but she doesn't feel that this has much to do with how much she enjoys people.

_____ b) She realizes that the fault for being too personal with others lies with herself and with no one else.

_____ c) She feels that this isn't a very important problem. She isn't worried.

_____ d) She feels that she may be too personal with others, but that with help from someone more experienced, she could change.

_____ e) Although she may be too personal toward others, she feels that this is mainly because other people behave that way toward her.

FIVE

SUBMISSIVE SARAH

"In a group meeting yesterday, Sarah who rarely takes charge of things even when it might be appropriate appeared to be very disturbed. When a request was made for volunteers for the chairmanship, Sarah suddenly seemed to realize that she might like the job. She appeared to feel that she might enjoy her relations with people more if she were not so reluctant to be more assertive.

Today she appears to be still concerned. How would you guess she really feels now?"

_____ a) Although she may take too little responsibility, she feels that this is mainly because other people expect this of her.

_____ b) She feels that she may take less responsibility than she should, but with help from someone more experienced she could change.

_____ c) She may take less responsibility than she should, but she doesn't feel this has much to do with how much she enjoys people.

_____ d) She feels this isn't a very important problem. She isn't worried.

_____ e) She realizes that the fault for taking too little responsibility lies completely with herself and with no one else.

SIX

WITHDRAWN MARY

Last night Mary was thinking over the fact that she usually does things by herself and hardly ever includes other people in her activities.

Some time later a group of students from one of her classes came by and asked her to go out with them. Almost automatically, she refused. After they left, she seemed to realize that she would enjoy her relations with others more if she didn't always do things by herself; if she spent more time with people.

This morning she still seems concerned. How would you guess she really feels now?"

_____ a) She feels that she may do too many things by herself, but that with help from someone more experienced she could change.

_____ b) Although she may do too many things by herself she feels that this is mainly because other people are too busy to include her.

_____ c) She realizes that the fault for doing too many things by herself lies completely with her and no one else.

_____ d) She may do too many things by herself, but she doesn't feel that this has much to do with how much she enjoys people.

_____ e) She feels this isn't a very important problem. She isn't worried.

Paula		Ann
_____	a	_____
_____	b	_____
_____	c	_____
_____	d	_____
_____	e	_____

Sarah		Carol
_____	a	_____
_____	b	_____
_____	c	_____
_____	d	_____
_____	e	_____

Mary		Danah
_____	a	_____
_____	b	_____
_____	c	_____
_____	d	_____
_____	e	_____

List the rankings for each of the above in the appropriate column. They must then be transferred to the appropriate box to the right.

	D	Is	P	R	T
Ann	A ___	B ___	C ___	D ___	E ___
Carol	B ___	E ___	D ___	C ___	A ___
Danah	B ___	C ___	D ___	E ___	A ___
Paula	C ___	A ___	E ___	D ___	B ___
Sarah	D ___	C ___	A ___	B ___	E ___
Mary	E ___	D ___	B ___	A ___	C ___
Total	_____	_____	_____	_____	_____
DECILE	_____	_____	_____	_____	_____
RANK	_____	_____	_____	_____	_____

Add numbers in each column to obtain totals; then enter DECILES from Table 19 of the manual for the FIRO Scales. In the bottom row columns may be ranked from highest to lowest.

APPENDIX G

NAME _____

BERNREUTER S-S SCALE

YES	NO	?	
			1. Would you rather work for yourself than carry out the program of a superior whom you respect?
			2. Do you usually enjoy spending an evening alone?
			3. Have books been more entertaining to you than companions?
			4. Do you feel the need of wider social contacts than you have?
			5. Are you easily discouraged when the opinions of others differ from your own?
			6. Does admiration gratify you more than achievement?
			7. Do you usually prefer to keep your opinions to yourself?
			8. Do you dislike attending the movies along?
			9. Would you like to have a very congenial friend with whom you could plan daily activities?
			10. Can you calm your own fears?
			11. Do jeers humiliate you even when you know you are right?
			12. Do you think you could become so absorbed in creative work that you would not notice the lack of intimate friends?
			13. Are you willing to take a chance alone in a situation of doubtful outcome?
			14. Do you find conversation more helpful in formulating your ideas than reading?
			15. Do you like to shop alone?
			16. Does your ambition need occasional stimulation through contacts with a successful people?

YES	NO	?	
			17. Do you have difficulty in making your own mind for yourself?
			18. Would you prefer making your own arrangements on a trip to a foreign country to going on a prearranged trip?
			19. Are you much affected by praise, or blame, of many people?
			20. Do you usually avoid taking advice?
			21. Do you consider the observance of social customs and manners an essential aspect of life?
			22. Do you want someone with you when you receive bad news?
			23. Does it make you uncomfortable to be "different" or unconventional?
			24. Do you prefer to make hurried decisions alone?
			25. If you were to start out in research work would you prefer to be an assistant to another's project rather than an independent worker on your own?
			26. When you are low in spirits do you try to find someone to cheer you up?
			27. Have you preferred being alone most of the time?
			28. Do you prefer traveling with someone who will adventure of traveling alone?
			29. Do you usually work things out rather than get someone to show you?
			30. Do you like especially to have attention from acquaintances when you are ill?
			31. Do you prefer to face dangerous situations alone?
			32. Can you usually see wherein your mistakes lie without having them pointed out to you?
			33. Do you like to make friends when you go to new places?
			34. Can you stick to a tiresome task for long without someone prodding or encouraging you?

YES	NO	?	
			35. Do you experience periods of loneliness?
			36. Do you like to get many views from others before making an important decision?
			37. Would you dislike any work which might take you into isolation for a few years, such a forest ranging, etc.?
			38. Do you prefer a play to a dance?
			39. Do you usually try to take added responsibility upon yourself?
			40. Do you make friends easily?
			41. Can you be optimistic when others about you are greatly depressed.
			42. Do you try to get your own way even if you have to fight for it?
			43. Do you like to be with other people a great deal?
			44. Do you get as many ideas at the time of reading as you do from a discussion of it afterwards?
			45. In sports do you prefer to participate in individual competitions rather than in team games?
			46. Do you usually face your troubles alone without seeking help?
			47. Do you see more fun or humor in things when you are in a group than when you are alone?
			48. Do you dislike finding your way about in strange places?
			49. Can you work happily without praise or recognition?
			50. Do you feel that marriage is essential to your happiness?
			51. If all but a few of your friends threatened to break relations because of some habit they considered a vice in you, and in which you saw no harm, would you stop the habit to keep friends?

YES	NO	?	
			52. Do you like to have suggestions offered to you when you are working a puzzle?
			53. Do you usually prefer to do your own planning alone rather than with others?
			54. Do you usually find that people are more stimulating to you than anything else?
			55. Do you prefer to be alone at times of emotional stress?
			56. Do you like to bear responsibilities alone?
			57. Can you usually understand a problem better by studying it out alone than by discussing it with others.
			58. Do you find that telling others of your own personal good news is the greatest part of the enjoyment of it?
			59. Do you generally rely on your judgment?
			60. Do you like playing games in which you have no spectators?

APPENDIX H

Name of Client: _____

GLOBAL IMPROVEMENT RATING SCALE

Please circle the number of the item that indicates how you feel after completing the group.

Circle one please

1. very much worse
2. quite a bit worse
3. a little worse
4. no change
5. a little better
6. quite a bit better
7. very much better

Note: A Global Improvement Rating must be completed by investigator and referrer social worker.

APPENDIX I

5 SESSION BRIEF GROUP THERAPY TREATMENT PROGRAM

SESSION I

Objectives for the Therapist:

1. To present the rationale behind the treatment procedure, along with some anticipated results.
2. To facilitate the identification of the way each participant speaks about herself.
3. To facilitate an understanding of personal power, learned helplessness, and their relationship to self-esteem.

Group Activities:

1. List of ways clients learned to be helpless.
2. List of self-statements.
3. List of self-interpretations of personal power.

Provide all the clients with name tags and pencils. Allow a few minutes for brief introductions and comments, then begin:

> First, I am glad each of you agreed to participate in this program and I hope that each of you will find it beneficial. I would like to describe for you the rationale behind this program, which is called "a Brief Approach to Personal Power". It is designed to affect some of those components of human behavior which are necessary to achieve personal effectiveness and positive self-esteem. Personal effectiveness is defined as the ability to move through one's environment with maximum ease-achieving personality desirous goals. Personal power is a combination of personal effectiveness and positive self-esteem. Self-esteem is influenced by what a person says to herself about herself, therefore, a person with high self-esteem is

someone who "talks" to herself about herself in a very positive "self-talk", or who generates only negative self-statements, is someone who probably has a low self-evaluation, feels badly, and complains of being inert, and unable to change things. A person who generates some positive self-statements, but mainly thinks negative or poorly of herself may also complain of the same problems, and sees herself as unhappy and depressed.

The ability to give yourself the benefit of the doubt in a difficult situation; to pat yourself on the back for a job well done; is a trait of a healthy and happy person and plays a prominent role in her overall personal adjustment; as well as her level of goal directed behavior.

Let's spend some time discussing these ideas and see how they may be reflected in the way your lives have gone.

(ENCOURAGE EACH CLIENT TO CONTRIBUTE TO THE DISCUSSION USING THEIR OWN PROBLEMS CHECKLIST AS A STARTING POINT—ALLOT 10-15 MINUTES).

CONTINUE...

feelings of helplessness and powerlessness are learned and carried over from one situation to the next. A person interprets the outcome of her efforts to achieve, in such a way that reflects her lowered expectations for achievement and feelings that she is helpless to determine the outcome of a given situation by her own behaviors. If she has had repeated experiences with failure, then her expectations for future outcomes is usually determined by these experiences and tends to be negative unless she has also learned how to evaluate each outcome on its own merits. Also that lack of achievement in a given area does not necessarily determine her overall personal worth.

(ENCOURAGE GROUP DISCUSSION ALLOW 10-15 MINUTES THEN CONTINUE).

You all may have heard this old saying—You are what you eat!—Well, you are also what you think! The way you think about yourself and the things you do affect the thoughts that follow, even if you find yourself in a new situation. If you change the way you think about yourself and your own unique ways of handling situations, then your feelings will change accordingly. In order to be certain of positive self-enhancing self-statements it is necessary to first learn to identify and separate personal reference self-statements from irrelevant thoughts. This can be done with relative ease if you have an understanding of the concepts presented in this session and if you allow yourself to think freely about yourself in many different ways.

(ENCOURAGE DISCUSSION FOR 10-15 MINUTES, THEN MOVE INTO THE WORK SESSION AS DESCRIBED BELOW).

Each of you please take a copy of Worksheet-Session One and make a list of all the different ways you feel helpless. This is a simple accounting of examples of your feelings and experiences with helplessness. If you will think closely about your past behavior you will come up with numerous examples. Be sure to think freely about yourself. If you have any questions, please raise your hand and bring the question up to the group. After you have completed your list please give it to me, and then we will move to the next section.

CONTINUE...

Now, I would like for each of you to make a list of your own interpretations of personal power. This should be done by giving examples of what having personal power over your life, thoughts, behaviors, and feelings means to you. This exercise can also be the beginning of goal setting for each of you. If you have any questions, please bring them up to the group. After you have completed your lists please turn them in to me.

(TAKE UP ALL LISTS AND PROCEDE TO THE NEXT ASSESSMENT. ALLOW 10-15 MINUTES FOR ANY DISCUSSION).

CONTINUE...

I would like for each of you to make a list of self-statements. Self-statements are thoughts you have about yourself and your behavior. Be sure to write examples of the many different ways you think about yourself in particular situations, if this will help you assess your different ways of thinking about yourself. You can also draw on the variety of ways you feel at different moments in this group meeting. After you complete your lists we can talk about what is going on in your individual lives right now!

(ENCOURAGE EACH MEMBER OF THE GROUP TO CONTRIBUTE SOMETHING ABOUT THEIR LIVES AT THIS TIME. WHEN THIS IS COMPLETED, END THE SESSION BY GIVING THE DATE OF THE NEXT MEETING. SEE APPENDIX FOR WORKSHEETS).

SESSION II

Objectives for the Therapist:

1. To focus upon the effects of self-statements upon personal evaluations and individual behaviors.

2. To demonstrate what a Positive, Negative, and Neutral self-statement would be for each group member.

Group Activities:

1. List of self-statements.

2. Score individual self-statements according to criteria for Positive, Negative, and Neutral statements.

AFTER EACH CLIENT HAS SETTLED INTO A CHAIR AND IF THERE ARE NO PROCEDURAL QUESTIONS CONTINUE WITH THE FOLLOWING:

> Let's begin by looking closely at what a person thinks about herself and her behavior, and how her self-directed thoughts determine her reactions to events and her personal expectations for fulfillment and achievement. The internal monologues a person has with herself play an important role in her emotional adjustment. It has been shown that debilitating fears, inhibitory beliefs, and useless behaviors are developed and maintained by "self-talk." A large number of personal problems involve illogical thinking and confused conversations with oneself. It is the job of each person in this group to focus upon the different ways we think that are not helpful, and to begin the process of developing positive alternatives to our present ways of behaving. It is expected that this process will enhance the development of positive self-talk. We will begin by focusing upon personal evaluations, self-critical beliefs and ideas, and repetitive thoughts, which will begin the process of looking at yourself and your thoughts systematically, and recording what these thoughts are. Let's discuss these ideas and bring in our own personal examples.

(ENCOURAGE TOTAL PARTICIPATION. IT WOULD BE APPROPRIATE TO CALL ON INDIVIDUALS BY NAME TO ENCOURAGE PARTICIPATION. ALLOW 10-15 MINUTES)

CONTINUE...

> Now, I would like for each of you to take a bunch of these small slips of paper and a pencil. Place these in front of you. This is the way we will learn to monitor our thoughts. I would like for you to take five minutes to train your attention on your innermost thoughts. Let your attention move freely from thought to thought. As you become aware of each thought's occurrance begin to focus upon yourself. Think

about who you are! What you are! How you feel! The condition you are in today! Continue to focus upon your thoughts and let yourself become the subject of your self-verbalizations. Do any of you have any questions?

(ALLOW TIME FOR SELF-DISCLOSURES AND QUESTIONS).

Now, let's continue to think about ourselves in as many different ways as possible. Ask yourself questions that will reflect both positive and negative views of yourself. Remember that there are some things you do well and there are other things you do not do well, would like to change or eliminate. Some possible ways to get at these feelings is to answer questions like these:

Who am I?
What am I living for?
Where am I headed in life?
Where do my dreams lead me?
Where can I start to bring all my hopes to reality?

Let your mind flow smoothly over these questions and you begin to generate your own. Start to make self-statements about yourself and take a slip of paper from in front of you and write each self-statement down. Write each self-statement on a separate slip of paper then put it aside until later. If you have a recurring thought that keeps popping up, write it down every time. It is alright to do so, just continue to think about you. Do not worry about how well the thought is written out, just make sure you can read it. You will have ten minutes to complete this task.

(MOVE THROUGH THE GROUP AND GIVE ASSISTANCE WHERE NEEDED. ALLOW TEN MINUTES, THEN MOVE ON TO THE NEXT TASK).

Before we discuss the self-statements you have made, I would like for each of you to take a worksheet for Session Two and read the directions. (Pause) Now, as the directions say, I would like for you to write down all of the self-statements you have written before on the slips of paper and then score the self-statements as to whether they are positive, negative, or neutral. Be sure to write all your self-statements on the worksheet before scoring them. It is important that you use your own understanding of what a positive, negative, or neutral self-statement might be. We will discuss this further, after you have finished your lists. You will have ten minutes to work on this section.

(AFTER ALL CLIENTS HAVE COMPLETED THEIR WORKSHEETS, ENCOURAGE A GROUP DISCUSSION OF THEIR SELF-STATEMENTS AND THE SCORES THEY GAVE EACH ONE. IT IS IMPORTANT HERE THAT EACH CLIENT TAKES HER TURN AT PRESENTING A SELF-STATEMENT TO THE GROUP AND DISCLOSING HER REASONS FOR SCORING IT THE WAY SHE DID. THE REST OF THE GROUP TIME SHOULD BE USED FOR THIS AND AT THE END OF THE SESSION THE WORKSHEETS AND SLIPS OF PAPER SHOULD BE COLLECTED).

(SEE APPENDIX FOR WORKSHEETS).

SESSION III

Objectives for the Therapist:

1. To clarify the group members' understanding of the types of self-statements.
2. To facilitate each group member's attempt to change the way she thinks about herself.

Group Activities:

1. List of self-statements.
2. List of Positive self-statements.
3. List of Negative self-statements.
4. List where group members attempted to rephrase Negative self-statements made in activity 3, to be Positive self-statements.

BEGIN THE SESSION BY ELABORATING ON THE IMPORTANCE OF INTERNAL MONOLOGUES A PERSON HAS WITH HERSELF AND THE EFFECT THIS HAS ON THE WAY SHE FEELS EACH DAY. BE SURE TO POINT OUT THAT FEARS, INHIBITORY BELIEFS, ETC. ARE MAINTAINED BY WHAT SHE SAYS TO HERSELF IN A GIVEN SITUATION. OPEN THIS UP FOR DISCUSSION BY ASKING INDIVIDUALS TO TELL THE GROUP HOW THEY MIGHT HAVE FELT WHEN THEY FOUND THEMSELVES IN UNUSUAL AND POSSIBLY THREATENING NEW ENVIRONMENTS. ENCOURAGE ALL TO PARTICIPATE WITH THEIR OWN EXAMPLES.

CONTINUE...

> I am going to present some ideas that I expect each of you to apply to yourself in your own particular way. Consider them carefully. First, the choices we make in everyday life

to do something or not is directly related to how we view our chances for achievement of our goals. Often the evaluations we make of ourselves and our abilities are lower than they might possibly be if we were able to give ourselves the "ole benefit of the doubt." We tend to use old fashioned and illogical beliefs to maintain a nonproductive way of thinking about ourselves. All of this combined, prevents us from seeking new avenues for achievements. These self-evaluations may bring us slight or gross discomforts, but we do nothing to bring about change—positive change that is!

Let's start now to see if we can't learn how to think differently about ourselves, our feelings, our future potential. In order to rid yourself of habitual self-defeating, and self-critical thoughts, it is necessary to learn how to replace them with more positive, encouraging self-talk. Self-defeating thoughts are negative in that they prevent you from attempting all the things you dare to dream about, as well as interferes with your health. A guy named Coue' provides us with a good example: Everyone put your hands together like this -

(SHOW THEM AND MAKE SURE EVERYONE PARTICIPATES)

Now I want you to tell yourself repeatedly that you cannot pull them apart. Say: I can't pull them apart, I can't do it, I can't do it, I can't do it, etc., and try to pull them apart at the same time. See what happens. You can't.

ENCOURAGE GROUP DISCUSSION, ALLOW TEN MINUTES, THEN MOVE ON TO THE NEXT SECTION.

CONTINUE...

Other negative self-defeating thoughts are; "I'm not smart," "No one would hire me," "everything I do turns out wrong," "I never do well in school," "the Lord made me this way, so I will stay this way, etc." These nonproductive self-critical thoughts prevent us from creating opportunities to achieve, as well as seeing and taking advantage of opportunities that are readily available and staring us in our faces. Let's talk about your examples of negative thoughts before we go on to the next work section.

(ALLOW TEN MINUTES FOR DISCUSSION THEN PASS OUT SHEETS A,B,C, AND D. INSTRUCT ALL CLIENTS TO WRITE THEIR FIRST NAMES IN THE UPPER LEFT HAND CORNER OF EACH SHEET OF PAPER, THEN CONTINUE).

If everyone has her worksheet, let's move on to the first part of this work section. Try to focus upon the many

different thoughts you have about yourself while engaged in different activities during a regular day. On sheet A, please list as many different statements about yourself as possible. You will be allowed ten minutes. After you are finished please turn the sheet over in front of you.

(ALLOW THE TEN MINUTES FOR WORK, THEN MOVE ON TO SHEET B).

On sheet B, please write as many positive self-statements about yourself that you can think of. A positive self-statement is a thought about yourself that reflects the best parts of you and that is enhancing. Be frank with yourself and give yourself the benefit of the doubt. Allow your best features to become real on paper. Be sure to keep in mind the various ways you think about yourself during the day, and while engaged in your favorite activity. You will again be allowed ten minutes, when you have finished, please turn the sheet over in front of you.

(AFTER TEN MINUTES HAVE ELAPSED MOVE ON TO SHEET C).

Now, on sheet C, while you are focusing on the various ways you see yourself, as reflected in your thoughts, I would like for you to write as many negative self-statements about yourself as possible. Be sure to be frank and honest with yourself. You will remember that negative self-statements are thoughts that give a bad reflection of you. Negative thoughts are self-deflating, discouraging, etc., and you are probably very familiar with your own examples of negative thinking. Again you will be allowed ten minutes. Feel free to comment about your process at any time during this work section.

(AFTER TEN MINUTES HAVE ELAPSED MOVE ON TO THE REPHRASE SECTION).

Now, we will work with sheet C and D. Place sheet D in front of you and notice that it is divided into two sections, ONE and TWO. Now place sheet C with your negative self-statements along side sheet D. In the section of sheet D labeled ONE, please rephrase your negative statements so they will be positive. In other words restate the negative things you said about yourself in such a way that they will be enhancing, favorable and give a positive self-reflection. You will be allowed ten minutes to complete this task. I will signal when your time is up.

(ALLOW TEN MINUTES FOR THE COMPLETION OF THIS TASK, THEN MOVE ON).

Now, let us discuss all the statements you wrote on side ONE. Each of you can take turns stating the negative self-statements and then give us the way you rephrased them. We will take rounds until all have had a few turns. Feel free to take time to share your reactions.

CONTINUE...

It is important that you change the ways you think about yourself if progress is to be made in your lives. This is true because you are what you think, just as you are what you eat. It does not matter what opportunities are really available to you if you have decided that all your abilities are useless and that your dreams will never come true. If you feel that your goals are beyond your reach, then you will do nothing to prepare yourself to obtain them.

Now, we all have dreams that are impractical for our present situation, but you can use your own gut level reactions to determine a true evaluation of each and every wish.

It is at these times that reinforcement of a positive way of thinking can be very effective in your efforts to make personal changes. Clear restatement of self-directed thoughts can help you change the way you feel and the things you attempt to do. I know all of you can give examples of your secret little "self-talks" that are often downright put-downish, if you look at them closely. Let's discuss this a little.

(DISCUSS THE ABOVE FOR 10-15 MINUTES, THEN MOVE ON TO THE NEXT SECTION).

CONTINUE...

Now fold sheet D in half through the middle so that the side labeled TWO is on top and rewrite your negative self-statements again, but in a more positive fashion, reflecting the insights brought out in the group. Also add any positive self-statements, at the bottom of the page, that you think up in addition to the ones rephrased. You will be given another ten minutes to complete this task.

(END THE SESSION WITH THE ABOVE AND ANNOUNCE THE NEXT MEETING DATE).

SESSION IV

Objectives for the Therapist:

1. To teach how to focus cognitively on thoughts related to self-esteem.

2. To enhance skill at thought control and positive thinking.

Group Activities:

1. List of self-statements.

2. List of Positive self-statements.

3. List of Negative self-statements.

4. List where group members attempted to rephrase Negative self-statements made in activity 3. to be Positive self-statements.

BEGIN THE SESSION BY POINTING OUT THAT THIS SESSION WILL AGAIN FOCUS UPON THE EFFECTS OF COGNITIVE ACTIVITY ON OUR MOODS AND SELF-ESTEEM. IT IS A REEDUCATIONAL APPROACH IN THAT WE ENCOURAGE PARTICIPANTS TO TAKE PART IN THE GUIDED IMAGERY SECTION AND THEN TO FULLY DISCUSS THEIR EFFECTIVE REACTIONS AND FEELINGS ABOUT THEMSELVES AFTER THE EXPERIENCE.

> What you think about yourself determines how you feel about yourself and your present mood level. Your self-esteem is determined by how well you feel you handled a situation, any situation. If you feel that whatever you do will turn out wrong, this will be reflected in your mood level and self-judgments.

(PASS OUT A SECOND SET OF SHEETS A, B, C, AND D INSTRUCTING EACH CLIENT TO WRITE HER FIRST NAME IN THE UPPER LEFT HAND CORNER OF HER SHEETS, THEN PROCEDE AS FOLLOWS)

> Each of you have completed these worksheets before. This is a second attempt at cognitive focusing with another dimension added. First, allow yourself to think about yourself as an individual, separate from your children, but trying to make a world for yourself first and your family.
>
> The first part of this procedure requires that each of you try to focus on the many different thoughts you have about yourself during different parts of the day and in different activities. On sheet A, please list as many different statements about yourself as possible. You will be allowed ten minutes. After you finish please turn the sheet over in front of you.

(AFTER TEN MINUTES HAVE ELAPSED MOVE ON TO SHEET B).

> On sheet B, please write as many positive self-statements about yourself that you can think of. Be frank with yourself

and allow those thoughts to become real on paper. Keep in mind the various ways you think during the day, and while engaged in different activities. You will again be allowed ten minutes. When you have finished turn the sheet over in front of you.

(AFTER TEN MINUTES HAVE ELAPSED MOVE ON TO SHEET C)

Now on sheet C, while you are focusing on the various ways you see yourself, I would like for you to write as many negative self-statements about yourself as possible. Be frank and keep in mind the different ways you think about yourself during a day and while engaged in everyday activities. You will be allowed ten minutes more to complete your list.

(AFTER TEN MINUTES HAVE ELAPSED MOVE ON TO THE REPHRASE SECTION, WITH SOME TIME FOR DISCUSSION).

Now we will work with sheets C and D. Place sheet D in front of you and notice that it is divided into two sections, ONE, and TWO. Now place sheet C with your negative self-statements along side sheet D. In this section of sheet D labeled ONE, please rephrase your negative statements so they will be positive. In other words, restate the negative things you said about yourself in such a way that they will be favorably enhancing and give a positive self-reflection. You will be allowed ten minutes for this task. I will signal you when your time is up.

(AFTER TEN MINUTES ARE UP, ASK EACH CLIENT FOR A NEGATIVE SELF-STATEMENT FROM SHEET C AND PROVIDE THEM WITH AN EXEMPLARY POSITIVE REPHRASING, WHICH SHOULD LEAD TO FURTHER DISCUSSION. ALLOW 15 MINUTES FOR THIS).

It is important for you to change the way you think about yourself, if you expect to change your lives. Old fears, anxieties, and "superstitious" beliefs, that are not based on reality, but on assumptions you made about your abilities long ago, are depriving you of fulfillment and happiness today. This process can be interrupted if you will only try.

(CALL ON INDIVIDUAL PARTICIPANTS FOR VIEWPOINTS, ALLOW TEN MINUTES THEN MOVE ON TO NEXT SECTION).

"Please fold sheet D in half through the middle so that the side labeled TWO is on top and place it aside."

(THIS IS THE GUIDED IMAGERY SECTION. BE SURE TO SPEAK IN A SOFT VOICE AND BE SURE THAT EACH PARTICIPANT IS RELAXED AND APPEARS ON TASK).

> Please sit back in your chairs, put your written material aside and begin to relax. Try to focus upon yourselves and think deeply. Before now, each of you have been generating self-directed, and self-reflective thoughts and changing them, if they were negative, by thinking about them and rewriting them on paper in a more positive manner. It is time now to see if you can transfer what you have learned to your own private way of thinking. Continue to sit back in your chairs and relax. Relax and think about yourself deeply. Relax and close your eyes and picture the "you" that gives you pleasure. Keep your eyes closed and try to pull together all those positive ideas of "you" that come through from your self-statements and reflections in the group. As you relax with your eyes still closed, think about "you" at your best, when most beautiful, and feeling just right. The thoughts are a part of you, you must simply pull them together now. Keep your eyes closed and smile softly to yourself. Let your smile be a sign to me and the world that you are on task and able to put together the best aspects of you.

(PAUSE, CONTINUE SOFTLY).

> "Raise your finger to let me know when you have gotten your positive image."

(NOW CONTINUE TO TALK SOFTLY USING THIS PATTERN UNTIL ALL PARTICIPANTS HAVE SHOWN A FINGER. ALLOW FIVE ADDITIONAL MINUTES, THEN CONTINUE AS FOLLOWS).

> Now each of you should have your images complete, and ready to prepare yourself for sharing your experiences with the group. Let's begin to sit up in your chairs and stretch.

(PAUSE AND ALLOW TIME FOR COMMENTS AND FOR THE PARTICIPANTS TO MAKE THEMSELVES COMFORTABLE, THEN CONTINUE AS FOLLOWS).

> Each of you please take turns and share your images with the group.

(AFTER EACH CLIENT HAS DESCRIBED HER IMAGE WITH SOME DISCUSSION OF REACTIONS, MOVE ON TO THE FINAL SECTION).

> The final portion of this session is a second attempt at rephrasing the negative self-statements you wrote on sheet C

earlier. Please take side TWO of sheet D and rewrite your negative self-statements if you wish. You will be allowed ten minutes, then the session will end.?

SESSION V

Objectives for the Therapist:

1. To focus upon each client's behaviors as related to their personal expectations.
2. To facilitate awareness of how personal evaluation is reflected in the things we do.
3. To facilitate participant's awareness of the possible ways to change their behavior.

Group Activities:

1. Each member was asked to describe an interpersonal situation that they had experienced difficulty managing. This situation was then used in the group for role playing exercises.
2. Each group member role played her own interpersonal situation under the direction of the group therapist.
3. Group members were asked to give suggestions to each other that they felt might help them manage their situation better the next time it occurred.

BEGIN...

Let us deal with the behavioral component of the human system—You. We have pointed out how the way you think affects what you choose to do and not to do. Well, this also holds true for the effects your behavior has on your thoughts and feelings. You see, your system is different components all

interrelated and continually affecting one another. If effective living is your goal you must also focus on your behavior. It is the maladaptive behaviors that prevent you from performing the necessary behaviors needed to achieve a highly desired goal. This is true since effective behaviors and ineffectual behaviors are incompatible in the same system. Therefore a healthy adjustment and performance is impossible unless changes are made. Therefore, if negative, dysfunctional self-statements are to be prevented, one must also prevent inhibitory and dysfunctional behaviors by replacing them with appropriate assertive behaviors, that are effective in achieving highly desirous goals. These positive thoughts and behaviors will become self-reinforcing and you will have the beginning of a healthy, well-functioning person. Changes in thoughts and behaviors should make you feel better, and you should experience a lighter spirit, with a rhythmic balance in your personality.

(ALLOW TIME FOR DISCUSSION, THEN MOVE INTO THE WORK SECTION AS FOLLOWS).

This session will now focus on individual behaviors that are produced and not produce in your everyday lives. Ask yourselves... What are the things I do that I would like to change in order to achieve my personal goals? Do you ever catch yourself saying, "I wish I didn't do that!" or "I wish I could do that!"

(ALLOW TEN MINUTES FOR DISCUSSION AND THEN PASS OUT EACH INDIVIDUAL'S SHEET C AND TWO 5 x 7 INDEX CARDS).

Each of you have your sheet C with your negative self-statements made during Session IV, I would like for you to take two index cards each. Now, read over your negative self-statements and begin to formulate a situation or scene that would incorporate their personal evaluations you made about yourself when you wrote those statements. After you have given this some thought, please write out a scene to be role played. Are there any questions?

(TAKE TEN MINUTES FOR QUESTIONS AND EXPLAIN THE TECHNIQUES INVOLVED IN ROLE PLAYING THEN PROCEDE ON).

Label this scene you are writing # 1. This scene will be acted out in the group and we will follow each scene with a discussion of dynamics involved in each one.

(EACH PARTICIPANT WILL BE DEALT WITH INDIVIDUALLY IN ROLE PLAYING THEIR SITUATION AS DESCRIBED ON THEIR CARDS. THE GROUP FACILITATOR SERVES AS COACH AND DIRECTOR AND HELPS DRAMATIZE EACH SCENE. NO PREPARED SCRIPT

IS USED BECAUSE THIS IS A THERAPEUTIC DISPLAY OF THE BEHAVIORS AS SEEN BY THE INDIVIDUAL AND GROUP MEMBERS. GROUP INTERPRETATIONS AND INSIGHTS ARE ENCOURAGED AND COMPARED. AFTER ALL PARTICIPANTS HAVE SHARED IN ROLE PLAYING, EACH WILL BE ASKED TO REWRITE HER SCENE ON CARD # 2, AND TO INCORPORATE THE SUGGESTED CHANGES MADE BY THE GROUP. THE FINAL SELF-EVALUATION WILL BE A LIST OF SELF-STATEMENTS ON WORKSHEET V. THIS WILL BE FOLLOWED BY A GENERAL REACTION TO THE WHOLE PROCESS BY GROUP MEMBERS).

VITA

Annie Lee Jones was born in Augusta, Georgia on April 10, 1949. She attended elementary schools in that city and was graduated from Lucy Craft Laney High School in 1967. The following September she entered Augusta College, and in June, 1971, she received a Bachelor of Arts degree in Psychology. In the summer of 1971, she accepted a National Institute of Mental Health Fellowship to the University of Tennessee, Knoxville and began study toward a Doctoral degree in Clinical Psychology.

She received the Doctor of Philosophy degree with a major in Psychology in August, 1976. She is a member of the American Psychological Association, The Association of Black Psychologists, The National Black Feminist Organization, and Epsilon Tau Epsilon.

She is the daughter of Mrs. Thelma Holiday Jones.