# REFRAMING TECHNIQUE AND GUILT LEVELS IN DEPRESSED WOMEN

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To the Provost of the Graduate School:

I am submitting herewith a dissertation written by W. James Robertson entitled "Reframing Technique and Guilt Levels in Depressed Women" I have examined the final copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, with a major in Nursing.

Donna A. Vokaty, Major Professor

We have read this dissertation
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Provost of the Graduate School

DEDICATION

To all the hills and valleys

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REFRAMING TECHNIQUE AND GUILT LEVELS

IN DEPRESSED WOMEN

W. JAMES ROBERTSON

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ABSTRACT

The purpose of this research was to ascertain the effectiveness of reframing, a paradoxical strategy, in reducing guilt and depression levels in females diagnosed with depression. Reframing therapy was given to 15 females who were randomly assigned to the experimental group and reframing therapy was not given to 15 subjects who randomly assigned to the control group.

The subjects were chosen from two outpatient mental health clinics. The Mosher Guilt Inventory and the Beck Depression Inventory were used as pretest and posttest measurements of guilt and depression levels with a convenience sample of 30 subjects who met the criteria for inclusion in the study.

Five hypotheses were developed for this study. An experimental, explanatory, before and after, design was used. The alpha level was $p < .05$. A two-way analysis of

variance with repeated measures used to test the hypotheses. The Pearson's Product Moment Correlation Coefficient (r) was used to test the reliability of the instruments as well as to assess significant relationships of the appropriate hypotheses.

The results from the investigation revealed the following: a) reframing therapy significantly reduced depression levels whereas, guilt levels were not significantly reduced, b) no significant relationship was found between age and length of time taking medication with or without reframing therapy prior to reframing therapy and guilt and depression levels, c) a significant positive relationship was established between Black females, who scored higher on the pretest guilt inventory, than non-white females, d) no significant relationship was found between time taking medication without reframing therapy and guilt and depression levels.

Further research should be directed toward the severity of guilt in females and the types of guilt which could lead to new perceptions about the dysfunctional behaviors associated with guilt and depression.

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# Chapter 1

Guilt is a word that suggests a variety of images, one of which is a perception of failure. For example, individuals could feel guilty for disobeying or violating their own personal standards, civil laws, or religious injunctions. Further, they might feel guilty for not fulfilling the expectations of family or community.

The psychological effects of guilt can be healthy or unhealthy. If guilt is viewed as a dysfunctional system of internal behaviors which produces unhealthy effects, these unhealthy effects could obviously be minimized. Bandler and Grinder (1982) have stated that all behavior, including the negative, can be useful somewhere. The key is "where". When the mental health professional and the client work together to identify "where", this process is termed reframing. Through the utilization of this psychotherapeutic technique, interventions can be initiated to change the context and meaning of a dysfunctional behavioral system and thereby decrease or possibly eliminate the untoward effects of

guilt (Bateson, Jackson, Haley & Weakland, 1956; Clark, 1977; Haley, 1963; Watzlawick, Beavin & Jackson, 1967).

Guilt is manifested in the psychiatric population on a daily basis. Whether this population consists of classifications such as: substance abuse, masochistic behavior, self-destructive behavior, obsessive-compulsive neurosis, or depression, guilt is one of the predominant features (Lynd, 1958; MacKenzie, 1962; Prosen, Clark, Harrow & Fawcett, 1983). Negative feelings about the self are widely regarded as an important feature of depression. In several relevant studies (Foulds, Caine & Creasy, 1960; Friedman, 1964; Laxer, 1964; Foulds, 1965; Harrow, Colbert, Detre & Bakeman, 1966; Harrow & Amdur, 1971) in which the feelings of guilt and depression were examined, evidence was provided to support the association between guilt and depression. One conclusion that could be reached from these data was that persons diagnosed as depressed tend to endorse feelings of guilt with greater frequency than do other psychiatric groups and normal subjects.

## Problem of Study

The prevalence of depression and its accompanying association of guilt in the female population represents a mental health problem of grave proportions (American Psychiatric Association, 1980). Therefore, the central question in this study was: Will the use of reframing as a paradoxical psychotherapeutic intervention be effective in reducing the level of guilt in females diagnosed with a depressive disorder?

## Rationale for the Study

Guilt in Western culture creates serious mental health and social problems (Ausubel, 1955). Guilt is psychologically destructive in the sense that it is disintegrating in its effects on psychic life (Schneiders, 1968). Treatment of the depression associated with guilt can financially drain private and public mental health resources.

Guilt is a complex and powerful emotion which lies just beneath the surface in one's psychological development. Because it is exhibited in attributional

and attitudinal ways like many other psychological responses, guilt has taken on a blurring or masked quality which theorists and researchers apparently find difficult to study and isolate. This difficulty may be due to the very private nature of guilt and to the fact that description, categorization and prediction must come first before other concerns can be addressed. While these approaches serve a necessary purpose, guilt still remains an important construct demanding attention and consideration in the mental health arena. If guilt can be isolated as a distinct phenomenon and an appropriate intervention technique applied, the untoward effects of this dysfunctional system can be minimized.

There seems to be some general agreement in the literature that guilt is a common feature of depressive patients. Conversely, the literature concerning guilt and its relation to mental patients in general or depressive disorders in particular is much more scant (Harrow & Amdur, 1971). In one study (Harrow et al., 1966), it was determined that some, but not all, depressive patients expressed feelings of guilt. In addition, the researchers found that although

depressives tended to feel guiltier than a comparison sample of schizophrenics, the differences were not statistically significant in all areas related to guilt. In another study (Foulds et al., 1960) of 40 melancholic and psychopathic subjects, both groups were found to feel guiltier than other groups of patients including neurotic depressives.

The issue of guilt and conscience in relation to psychopathology as it pertains to depression has been the subject of previous investigations (Harrow & Amdur, 1971; Amdur & Harrow, 1972; Beck, 1974a). The results of these studies suggested tentative evidence that some or many depressed patients did not have feelings of guilt. However, there were indicators that some depressed patients had stricter consciences than nondepressed patients.

In a study (Prosen, Clark, Harrow & Fawcett, 1983) of 60 subjects, in which depression, conscience, low self-esteem, and guilt were examined, the results indicated that severe guilt was prominent only in a moderate percentage of depressed patients. Further, guilt was significantly more common in depressed

patients than in normal subjects; however, it was not determined definitively whether depressed patients felt guiltier than some other disturbed patient groups, such as schizophrenic patients. Moreover, differences in self-esteem between depressed patients and normal control subjects were more apparent than were differences in guilt. Seventy-five percent of the depressed patients showed considerable feelings of worthlessness, but only 20% had very high levels of guilt.

Rosenthal and Klerman (1966) in a factor analytic study indicated that guilt was an important feature which was closely related to the 'classical' picture of endogenous depression and may cut across neurotic-psychotic distinctions as they are presently understood. In another study (Gudjonsson & Roberts, 1983) focusing on guilt and self-concept in 105 secondary psychopaths, the findings suggested that guilt was partly related to a high level of trait anxiety and partly to poor self-concept. Since guilt in psychopaths did not markedly increase with trangression against the subjects' internal standards, the researchers argued

that this may explain why guilt failed to inhibit unacceptable behavior in some psychopaths.

According to Lewis (1971), guilt can be unhealthy and dysfunctional in its psychological effects. These effects upon human behavior result in psychic energy being used in non-productive ways and prevent positive growth and psychological well-being. Belgum (1985) stated that inappropriate guilt does not lead to constructive personality functioning. The observation of guilt as an underpinning in the psychic development of an individual has been noted since Biblical time (The Iliad, approximately 760-850 B.C.).

Guilt is the feeling people have when they believe that they have done something wrong, are possibly going to be punished, or will evoke someone's displeasure (Campbell, 1978). People feel guilty when there is an inconsistency between how they view themselves and how they perform. Distorted, nonfunctional, or neurotic guilt describes how one feels about a 'persumed' violation about which there really is no such consensus in the group to which one belongs (Belgum, 1985). Guilt can also be a type of anxiety and a fear of receiving

disapproval and punishment, either from internal sources or external sources (Bowles, 1978).

Guilt is part of a variety of emotional dysfunctional patterns, one of which is depression. The importance of guilt as a factor in depression is recognized by many authors in the mental health field (Arieti, 1959; Cameron, 1963; Freedman & Kaplan, 1976; Murphy, 1978). Freud (1917) psychoanalytically related guilt and depression. Mayer-Gross, Slater and Roth (1960) in their discussion of involutional melancholia stated that "there is often a rich development of delusions centering around the patient's feeling of guilt, frequently hypochondriacal and grossly bizarre" (p. 215). Redlich and Freedman (1966) described guilt as a complex emotion related to anxiety, disgust and shame.

Beck (1972) described guilt as a correlative factor in depression. Moreover, in the field of behavioral disorders, where the construct of guilt was usually viewed somewhat less moralistically, guilt has been implicated as an important feature of various psychiatric disorders, including depression (Harrow &

Amdur, 1971). The American Psychiatric Association (1980) reported that depression was the single most prevalent psychiatric condition and accounted for approximately 75% of all psychiatric hospitalizations; in any one year, 15% of the adult population experienced notable depressive symptoms.

Reports of the prevalence of pathologic depression in adults and children varied widely. However, according to Beck (1979), some researchers stated that 25% of their child and adolescent clinic population was depressed, and at an adolescent client the figure was 40%. In the general population, Klerman and Weissman (1980) observed that women were more likely to experience depression than men by a 2:1 ratio. This difference was related in part to traditional socialization practices in the western culture. For this reason, this study focused on adult females where there should be a larger concentration of depressed subjects.

Many of the studies cited have left unanswered questions. In none of these studies did investigators attempt to relieve guilt, or reduce its psychogenic

pain. The studies were primarily focused on guilt, not as an isolated phenomenon, but only as a feature association with some other construct.

Limited research approaches aimed at reducing the intensity of guilt have been found. Abrams and Finesinger (1953) used referrals as an intervention to reduce guilt for cancer patients and their families. Guilt was viewed as a serious enough concern to warrant action. (referral only). Abrams and Finesinger summarized their findings:

> Feeling of guilt were in 93% of a series of sixty unselected patients with cancer; feelings of guilt were responsible to a marked extent (1) for the patient's delay in seeking medical attention; (2) for stimulating attitudes or feelings of inferiority, inadequacy, dependency and rejection; and (3) for inhibiting the patient's ability to communicate. Feelings of guilt could be relieved by giving patients, members of their families, and the professional person caring for them an opportunity to discuss thoroughly this reaction. (p. 482).

Even with referrals as the only method of intervention, it was evident that guilt was important enough that action be taken. Although the patient classification was cancer, depressed patients could have been substituted and the depressed patients appear to have some of the same characteristics. Further, it was suggested that a cooperative effect by doctors, nurses, and social workers to diminish or eliminate feelings of guilt in cancer patients might do much toward improving the mental health of potential cancer patients and all those professionals who care for these individuals. This notion of cooperation would work well for depressed and guilty clients as well.

In another study related to diminishing guilt feelings, Johnson (1984) interviewed 14 couples who had a child die during the previous twelve months. A descriptive, exploratory design was used to test the researcher's grief theme model as it related to a model of guilt with parents who have had death of a child. The findings indicated that those couples in "short preparation group" (SPG) and "long preparation group" (LPG) verbalized 451 guilt statements. Every parent in

the SPG expressed guilt feelings and this group had more guilt statements than the LPG and the women had more guilt than the men. From this study four types of guilt emerged: personal, existential, anticipatory, and retrospective. Johnson (1984) identified four types of guilt but did not offer any concrete solutions for guilt reduction. Rather, the investigator indicated that critical care nurses had the opportunity to deal with guilt first hand because of their presence during stressful and crisis situations in which the use of counseling would be most effective in preventing guilt.

Finally, the mental and emotional pain of guilt in depressed women has not been addressed in previous research, although Abrams and Finesinger (1953) did attempt to reduce guilt feelings in their cancer subjects and their families by referrals to the mental health professionals. Because some evidence from the literature has been shown in the description, categorization and prediction of guilt, and because some conceptual and theoretical linkages can be identified, these foundations will be used to support the following theoretical framework. This research will attempt to

provide a new perspective and a sense of understanding by experimentation with a new approach of a commonly used paradoxical psychotherapeutic technique, reframing.

## Theoretical Framework

In this study the theory of change and communication related to a paradoxical type of intervention (Watzlawick et al., 1967; Watzlawick, Weakland & Fisch, 1974) will be used. These theorists defined change in terms of levels. These levels of change are first and second-order change. First-order change refers to change within a given system. Specifically, the system itself remains unchanged; the parts, simultaneously, which make up the system undergo the change (Watzlawick et al., 1974). First-order change appears to be linear, stepwise, or automatic using the same problem-solving strategies over and over again. It is a change in quantity but not in quality. Each new problem is approached mechanically. If the problem resists resolution, the same approaches are used and are usually more energetically applied. The result is either more of a behavior or less of a behavior along

some continuum. For example, a father might attempt to deal with his son's chronic misbehavior by using more and more punishment. This approach to the problem reflects the concept of first-order change because the structure of the interaction between the father and son remains constant.

Second-order change refers to a change of the system itself. The system is transformed structurally and/or communicationally. Second-order change tends to be sudden and radical; it represents a quantum jump in the system to a different level of functioning. This type of change is intermittent and qualitative. It is not logically predictable and often appear abrupt, illogical and unexpected. Paradoxical intervention produces second-order change and is sometimes called paradoxical change. In the example given for first-order change, the father tried the same solution over and over again. A second-order change solution to the same problem would involve trying something radically different or unexpected by the therapist's suggestion such as encouraging the son to misbehave whenever he thinks his father is feeling sad, or when he

thinks his parents might fight (Watzlawick et al., 1974).

Paradoxical change is also grounded in principles of communication and cybernetics. The key concept is feedback. According to Watzlawick et al. (1967), if in a chain of events a produces b, b produces c, and so on, a linear deterministic system is produced. If, however, c leads back to a, a circular system is produced. In a circular system there are two types of feedback, negative and positive. Negative feedback inhibits change in a system or produces a constant state. This kind of feedback is error-activated, and is much like the thermostat in a house. Negative feedback maintains the status quo or homeostasis of living systems. The other type of feedback is positive feedback. This type of feedback promotes change or disequilibrium. Paradoxical techniques are positive feedback introduced into the system. This kind of feedback, if properly conceived, should topple the dysfunctional system of behavior by forcing it to recalibrate. Therefore, positive feedback forces the system to a point at which the old rules are experienced as no longer useful. At

this point the system becomes temporarily confused and attempts to solve the problem by reconstituting itself in a different way. The system changes itself in a qualitative way behaviorally and/or phenomenologically (Watzlawick et al., 1967).

If guilt were to be seen as a dysfunctional system of internal behaviors and the theory of change and communication is used, paradoxically, guilt can be reduced by initiating a paradoxical technique called reframing. Watzlawick et al. (1974) defined reframing as a mean to change "...the conceptual and/or emotional setting or viewpoint in relation to which a situation is experienced and to place it in another frame which fits the 'facts' of the same concrete situation especially well or even better, and thereby changes its entire meaning" (p. 95). Moreover, the meaning attributed to the situation is changed. Watzlawick et al. (1974) transformed this concept into clinical practice by the use of basically prescriptive paradoxes. Prescriptive paradox refers to the technique of symptom prescription and symptom scheduling. In prescriptive paradox, the therapist directs the client to continue with the

symptom. For example, the therapist would be directing a depressed client to continue to feel depressed until the next scheduled session. In symptom scheduling, which is a variation of prescriptive paradox, the therapist tells the client to continue the symptom for a specified period of time, when exactly to intensify the symptom and under what specific circumstances the symptoms should be carried out. To illustrate, the therapist would direct the depressed client to feel guilty and depressed exactly for 35 minutes every evening at 6:00 p.m. until the next session. Therefore, if guilt could be reduced by using reframing, the impact of this technique would cause the dysfunctional system of internal behavior (guilt) to topple and thereby readjust itself to a different level of functioning. It would seem logical, too, that depression would be lessened (Watzlawick et al., 1974).

This study proposed to investigate reframing therapy by exploring the effective use of this particular psychotherapeutic intervention in reducing the level of guilt experienced by depressed women. By administering this treatment, logically there should be

a concomitant reduction in the intensity level of depression experienced in this target group.

## Assumptions

The study was based on the following assumptions:

(1) Human communication is synonymous with interaction and feedback is necessary for communication to occur (Watzlawick et al., 1967).

(2) Changing focuses on the "here and now" and, in addition, changing involves cognitive and affective behaviors (Watzlawick et al., 1974).

(3) Reframing occurs when the context is changed to fit another frame; consequently, the meaning changes as a result (Watzlawick et al., 1967).

(4) Paradoxical change is the method used to confuse the system, thus causing the system to set itself at a new calibration (Watzlawick et al., 1974).

## Hypotheses

The following hypotheses were proposed for this study:

1. Depressed females who are exposed to the reframing technique will have less guilt than those females who are not exposed to the reframing technique.

2. Depressed females who are exposed to the reframing technique will have less depression than those females who are not exposed to the reframing technique.

3. Age and length of time taking medication with therapy will be positively related to the levels of guilt and depression before treatment with reframing.

4. Ethnic background, marital status, religious background and type of medication will be related to the levels of guilt and depression before treatment with reframing.

5. Length of time taking medication without reframing will be positively related to guilt and depression levels.

## Definition of Terms

Key terms used in this study are defined as follows:

1. Depression: Depression is an affective disorder characterized by a disturbed coping pattern in which the person feels extreme sadness, withdraws socially, feels guilty and expresses self-deprecating thoughts. Intense feelings of despondence, hopelessness, and emptiness are also evident (Wilson & Kneisl, 1979; Beck, Rawlins & Williams, 1984). Depression is measured by the score obtained on the Beck Depression Inventory (Beck, 1967) (Appendix A).

2. Depressive Disorder: Depressive disorders are those classifications according to the Diagnostic and Statistical Manual of Mental Disorders (DSM-III) in which depressive disorders are classified as major affective disorders that include bipolar disorders and recurrent depression. These disorders are characterized by mood disturbances of feelings related to sadness, despair, loss, guilt, and discouragement. Depressive disorders are operationally defined as those diagnoses that appear on the patient's chart after being assessed

by a psychiatrist, clinical nurse specialist in psychiatric nursing, or psychologist according to the (DSM-III) manual classification, or those females who exhibit depressive symptoms according to the above classification and are in the process of being diagnosed.

3. Guilt: Guilt is a painful, negative, psychological feeling directed toward oneself, with an accompanying belief that one has not lived up to or has violated one's own internal values or standards about how one should live or behave (Harrow & Amdur, 1971). Guilt is operationally defined as the score on the Mosher Guilt Inventory (Mosher & Vonderheide, 1985) (Appendix B).

4. Paradoxical Psychotherapy: Paradoxical psychotherapy is defined as those interventions in which the therapist promotes the worsening of problems rather than their removal. The client is advised or instructed to continue or increase symptomatic behavior for the time being, and this is usually explained as a way of more quickly solving the problem (Watzlawick et al., 1976). Paradoxical psychotherapy is operationally

defined as a method and process by which the therapist and the client enter into a therapeutic relationship using verbal and nonverbal communication behaviors to discuss client goals and methods of problem-solving and present concerns.

5. Reframing: Reframing is a technique used in paradoxical psychotherapy. Reframing is a way to alter a person's point of view by placing a situation in a different 'frame', which changes the meaning of the observed situation (Watzlawick et al., 1974). Reframing is operationally defined as the specific psychotherapeutic intervention used in a therapeutic relationship with a client who wishes assistance in changing the meaning and context of a particular concern. The therapist assists the client in identifying problem areas and reframes the difficulty whereby the context and meaning is changed for the client. This is called reframing technique. This process requires affective and cognitive behaviors.

## Limitations

This study has the following limitations:

1. A convenience sample was drawn from a population of depressed females in two specific psychiatric-mental health clinics. Therefore the findings cannot be generalized beyond this sample.

2. The therapist in this study is black and male, and some of the clients will be white and female. These variables can have an impact on the therapeutic relationship and could possibly influence the findings of this study by raising or lowering the guilt and depression scores.

## Summary

The use of reframing as a technique in the reduction of guilt and depression is the central focus for this study and has been described above. Rationales for studying this problem were: (1) the blurred or masked quality of guilt; (2) lack of research which focused on depressed females and guilt; and (3) lack of research focused on approaches to reduce the untoward effects of guilt upon the female psyche. Theories of

change and communication were described in relation to their use in psychotherapy as they relate to psychiatric-mental health nursing. Four assumptions were presented from the theory. Research hypotheses and definitions of terms were developed. Finally, two limitations of the study were listed.

Chapter 2 contains a review of published literature available on the research question and a survey of appropriate research conducted in the area where paradoxical intervention has been used in general. Chapter 3 describes how the data were collected and the actual use of the instruments. Chapter 4 contains an analysis of the data, the results of the study, and an interpretation of findings. A summary of the study, conclusions, implications and recommendations for future research are included in Chapter 5.

# Chapter 2

## Review of Literature

Mental health professionals have attempted for many years to influence clients' maladaptive behavior through the use of numerous psychotherapeutic techniques, skills and practices. Since the 1920's, a group of psychotherapeutic techniques in which the therapist, instead of joining with the client to withstand the symptom(s), instructs or advises the client to continue, heighten, or extend them has gained prominence. The focus of this paradoxical strategy is to lessen or eliminate the problematic behavior through the unusual means of encouraging it. The concept of guilt is explored and presented first. The paradoxical treatment, reframing, is explored and presented second. This chapter is divided into the following sections: guilt and its association with depression, defining a paradox, the use of paradox, types of paradoxical interventions, research studies using paradoxical interventions, and reframing research with various diorders.

## Guilt and Its Association with Depression

### The Nature and Origin of Guilt

According to Ausubel (1955), guilt is one of the most important psychological mechanisms through which an individual becomes socialized in the ways of that individual's culture. Guilt is also an important mechanism for cultural survival since it constitutes a most efficient 'watchdog' within each individual, serving to keep the individual's behavior compatible with the moral values of the society in which the individual lives (Ausubel, 1955). Freud (1923/1961) was clear and succinct when he said, "The sense of guilt is the most important problem in the development of civilization..." (p. 81).

Schneiders (1968) stated that, depending on its nature and its origins, guilt can work its way into the marrow of the human mind. Thus, guilt can destroy the mind's tenuous fiber, or twist it into a caricature of itself. After this process, guilt can be exhibited in psychosomatic processes or the behavior of the individual and consequently, set up the conditions for

eventual destruction. Zilboorg (1951) reported that when a psychoanalyst speaks of guilt, this practitioner speaks only of unconscious, neurotic, non-realistic, irrational sense of guilt with which a sadistic superego makes a person psychologically ill, and which can lead the person to suicide. Guilt, whether conscious or unconscious, real or neurotic, also has religious and moral, as well as social and cultural, implications (Mowrer, 1967).

## Guilt and Morality

In Christian literature, guilt as an integral part of man is expressed in early Biblical writings---Adam expressed guilt and remorse after disobeying the word of God and was thrown out of the Garden of Eden in punishment. This trend has continued in Christian (primarily Western) cultures. Harrow (1971) stated that guilt is usually discussed from a moralistic viewpoint, with the view that guilt is a punishment by a presumed higher authority (God) for actual or spiritual wrongdoing.

Studies of the presence of guilt in various countries from the seventeenth century corroborate the evidence that guilt is a learned, selective trait. Murphy (1978) pointed out that until the sixteenth century, cases exhibiting exaggerated guilt feelings were rare. In Asia and Africa, he claimed, these symptoms are rare even today, except among the westernized societies. According to Murphy (1978), there must be something in Western cultures that propogates strong moralistic viewpoints. As previously mentioned, Christianity is a strong force in Western cultures. According to Gardner (1970), religions were the conveyors of appropriate ethical and moral values which, when transgressed, would be associated with appropriate guilt. Christianity offers a method of alleviating guilt through confession and absolution. Gardner (1970) reported that individuals experiencing guilt frequently state: I have sinned, God is punishing me for my sins, I have blasphemed God and shall suffer eternal damnation.

A second important factor in Western cultures which leads to an overactive conscience is child-rearing

practices (Murphy, 1978). In the twentieth century, marked changes occurred in child-rearing practices. These practices focused on a more affectionate attitude toward children; an increased consideration for their personal needs, and a moral concern for the child's upbringing. Murphy (1978) concluded that the more consistently children are treated, the more likely children are to develop an individual superego and to believe that their happiness and unhappiness are the results of their own actions. Murphy (1978) pointed out that under these circumstances, children are more likely to seek causes from within themselves when they do feel unhappy, and either blame themselves for this unhappiness or develop psychosomatic symptoms which will enable them to attribute the trouble to their bodies.

Children incorporate the values, standards and morals of their parents in two major steps. First, children begin to note which behaviors or actions are rewarded by the parents and which behaviors or actions are punished by the parents (Murphy, 1978). According to Gordon (1963), when withdrawal of love is used as a punishment, children are more likely to internalize as a

means of regaining the feeling of being loved and they are more likely to be imitative of the parents who love them (and only parents who love can withdraw it) than of parents who do not use withdrawal of love as punishment, because they give too little to withdraw.

Gordon (1963) suggested that the second step in the internalization of parental norms is that the children begin to respond to themselves when alone in the same manner as their parents in order to reward themselves and enhance their concept. Gordon (1963) stated that the children receive three rewards for internalization of parental norms:

1. Direct reward children receive from their parents for the imitative behavior.
2. Secondary reward associated with the words the children tell themselves in response to their own behavior.
3. As children internalize, they are better able to stay out of trouble with a resultant decrease in fear of punishment which further reinforces the internalization.

From the writings of Freud, the notions about internalization of parental norms are in agreement with Gordon's (1963) view. Freud's (1923/1961) notion was that feelings of guilt stem from moral anxiety in which the individual does something or contemplates doing something in conflict with the person's superego or moral values. Haber (1978) defined the superego as the aspect of the personality that contains the rigid, absolute rules directing the person's thoughts, feelings and actions. The superego is that part of the personality which is associated with the internalized parental and societal controls. The superego houses an individual's standards, morals, and self-criticism. The superego or conscience seems to demand not merely obedience or compliance with its dictates, but also punishment if these dictates are disobeyed (McKenzie, 1962). According to Freud (1923/1961) the superego develops in early childhood after the development of the id and ego. The superego is frequently called the "parent" personality, or the "conscience." The child develops the superego by incorporating standards of significant others, usually the parent. Erikson (1963)

felt that guilt developed during the stage of locomotor and genital development with its oedipal struggles; moreover, Erikson agreed with Freud in stating that the roots of ego formation occurred earlier during oral development.

According to Piers and Singer (1953), guilt is the remorse that comes from an awareness of having done something wrong. The origin of guilt is psychological. From childhood, there is a conditioning process in which family and society dictates actions to within defined standards of reasonableness and decency (McKenzie, 1962). Haber (1978) stated that gradually, over a period of years, these standards are internalized and modified to become the core of what is called "conscience." When an individual does something that violates these internalized standards, guilt is felt (McKenzie, 1962). If the individual has been brought up in a religious environment, there is an added measure of guilt when the person breaks what is precieved to be a divine commandment (Mowrer, 1967). Whenever the individual does not play according to the person's own internalized rules, the person feels miserable, and this

misery is what guilt is all about (Piers & Singer, 1953).

## Guilt and Shame

As defined earlier, Harrow and Admur (1971) stated that guilt was a painful, negative psychological feeling directed towards oneself, with an accompanying belief that one has not lived up to or violated one's own internal values or standards about how one should live or behave. Mosher (1968) further defined guilt as a generalized expectancy of self-mediated punishment for violating or anticipating violating internalized standards of proper conduct. The behavioral referents for the construct of guilt include resistance to temptation and the inhibition and suppression of hostile and sexual behaviors, or following the commission of a prohibited act, self-punishment, reports of painful feelings of self-remorse, self-criticism, and self-blame, confession, and expiatory and restitutional behavior (Mosher, 1968).

Izard (1979) defined guilt, or self-reproach as being based on the internalization of values, notably parental values--in contrast to shame, which is based on disapproval coming from outside, from other persons. An important distinction is emphasized here because in the literature concerning guilt, these two concepts (shame and guilt) have frequently been interchanged when in reality these concepts represent two different emotions.

Shame is frequently an accompaniment of guilt. Shame is concerned with the self, whereas, guilt is concerned with the things or actions that are done or not done. In other words, guilt involves less experience of the self than shame. Shame is about the self; guilt involves activity of the self, with less perceptual feedback from the self's activity (Lewis, 1971; Piers & Singer, 1971).

Izard (1979) concluded that ideation is often identical to that of guilt, shame is a relatively wordless state. The experience of shame often occurs in the form of imagery, of looking or being looked at. Shame is thus regarded by adults as a reaction in which body functions have gone out of control. Shame is also

regarded as an irrational reaction for this reason. Izard (1979) pointed out that shame is seen by adults as irrational while guilt is not seen as irrational.

Lynd (1958) further contrasted the two emotions by stating that whereas guilt is generated whenever a boundary is touched or transgressed, shame occurs when a goal is not being reached. Guilt-anxiety accompanies transgression, shame and failure. Guilt is, therefore, an internal criticism for things done or not done in conflict with one's own set of standards, where shame is an external criticism from other people for not having lived up to one's expectations (Lynd, 1958).

Guilt and shame play significant roles in social functioning and there influence on behavior in both healthy and emotionally disturbed persons needs better understanding and appreciation. The striking feature of guilt-ridden persons is the continual striving for punishment or absolution for the perceived sins. In some cases, if the person has actually committed a violation or wrongdoing, this continual striving for absolution can be seen as healthy for the person then feels psychologically better (Lewis, 1971).

Scott (1971) maintained that, on the other hand, if the person only perceives a violation or wrongdoing, this continual striving for absolution can be and often is dysfunctional and psychologically damaging. According to Scott (1971), a striking feature of guilt is the seeking of punishment which then sets it apart from the ordinary laws of learning.

The person who has transgressed, rather than trying to avoid punishment, or even waiting passively for it to come, actively seeks out the authorities, confesses, and receives punishment with apparent relief. Persons may also, or instead, go to great lengths to make restitution. Were it not for these phenomena of punishment-seeking and self-sacrificing restitution, guilt would be easy to dismiss as merely the kind of fear associated with anticipation of certain kinds of punishment (Lynd, 1958).

White (cited in McKenzie, 1962) added that the need to atone for real or supposed guilt is endemic in human nature. The sacrifice of the Cross, which the Church celebrates daily in the celebration of the Eucharist, meets a deep emotional need as well as a rational need

without which full atonement is impossible. In other words, guilt has to be paid for. Fear of punishment, or withdrawal of love, is intimately linked with the internalization of parental standards, values and norms.

Gordon (1963) stated that avoidance responses appear very high in the innate response hierachy, and are so effective in drive reduction that they are very difficult to replace or supplant. From fear of punishment derived from internalization of parental norms and the strong innate drive to avoid pain, the individual who contemplates or commits a perceived wrongdoing fervently seeks immediate resolution of the pain received from the strong sense of guilt.

The origin of guilt has been presented; however, a concise delineation of other forms of guilt is necessary. According to several authors (Becker, 1967; Belgum, 1967; Buber, 1958; Elasser, 1967; Horney, 1950; Schneiders, 1968) guilt can be seen as a psychic process.

## Forms of Guilt

As a psychic process, guilt is far removed from culturally determined guilt, or from guilt as a moral evaluation. In this context, guilt is more meaningfully interpreted and more readily understood as an unconscious self-rejection, which is inseparably bound up with shame, anxiety, and hostility in clearly definable syndrome of alienation. In addition, guilt can be regarded as 'objective' or as 'subjective'. These terms are useful in distinguishing different forms of guilt (Becker, 1967).

Guilt as 'subjective' refers to instances of "wrongdoing" that are: contrary to duly established laws or codes, those behaviors that are contrary to well-established moral principles or ethical systems, and those forms of guilt that set up some kind of barrier between the guilty person and important authority figures or significant other in the person's life (Elasser, 1967). In the literature, psychological and sociological theorists are seemingly more concerned with 'subjective' guilt, which includes conscious guilt, unconscious guilt, guilt as unconscious need for

punishment, and guilt as self-rejection or self-hatred (Horney, 1950).

According to Schneiders (1968), while conscious guilt is ordinarily equivalent to moral and legalistic guilt, unconscious guilt or guilt as the need for punishment or as self-rejection is distinctively psychological in quality and has little to do with legal, moral, or social concerns. Conscious guilt is experienced as a failure to measure up to objective standards; whereas unconscious guilt has little to do with norms, laws, or codes. The connection between conscious and unconscious guilt is the process of alienation, because alienation can be brought into focus by both objective and subjective guilt.

Subjective guilt has a triad of characteristics associated with it. This triad, according to Schneiders (1968), includes endopsychic, biopsychic, and intrapsychic characteristics, to which may be added a parapsychic dimension to identify guilt that has become distorted through intrapsychic relationships. These terms refer to characteristics and not to different forms of guilt. These characteristics apply

particularly to 'guilt feelings,' whether conscious or unconscious.

To refer to guilt as endopsychic means that it is not objectively determined by moral or legal restriction, but that it is generated by a series of events or internal qualities that make it distinctively subjective (Schneiders, 1963). Endopsychic also means that it is embedded in and functions within the confines of the psychic structure, and tends to wreak its havoc and vengeance on its victim in place of being expiated by prayer or confession, or projected in typical scapegoat fashion onto a hapless minority group. Countless instances can be observed in which guilt is projected to other persons or events or displaced to other functions. Sexual guilt can also be displaced to eating, causing anorexia which indicates a potential for guilt to function at a truly endopsychic, unconscious level.

A second characteristic of subjective and unconscious guilt is its biopsychic quality, which means that guilt cannot be understood simply as a feeling state, but that it has deep roots in the biophysical

aspect of personality, and that is may also express itself somatically in different physical symptoms. As Menninger (1938) has stated:

> The sense of guilt is particularly liable to become evident in connection with violations of sexual conventions, and it is not surprising that organic lesions of the genito-urinary organs should arise in direct relation to such episodes...Indeed, I am convinced from my observations that even veneral disease is sometimes acquired partly because the victim invites the infection, not only by his behavior (e.g. carelessness) but by some unknown subtle modification of tissue resistance (p. 336).

According to Menninger (1938), pathology of the eyes are often traceable to powerful unconscious guilt feelings and these feelings can be understood by remembering that the eyes are closely related to one's sexual life more than any other organ except the genitals themselves.

To understand subjective guilt, guilt must be identified by its relationships with other endopsychic and unconscious processes with which it is often confused (Schneiders, 1963). These related processes

include shame, anxiety, and hostility, to which a derivative of hostility--self-hatred--should be added. These processes interfere with personality development and can cause serious damage to the personality once they are set in motion (Ward, 1972). Significantly, no one of these dynamic feelings can be tolerated for any serious length of time without erosion of the personality. All such processes cause alienation. Guilt is alienation from significant existence; shame is alienation from self; anxiety is alienation from reality; and hostility is alienation from other persons. If to this group is added self-hatred, with its obvious implications for shame and guilt, then it is easy to see how a person can become completely estranged from almost everything that gives meaning to human existence (Ward, 1972).

Because of these deep interrelationships, one form of alienation tends to reinforce others--a fact of considerable significance for the understanding of guilt and its treatment. This deep interrelationship is what intrapsychic means. These processes function at a subjective, often unconscious, level so as to form a

true syndrome. Thus, the logic as well as the psychologic of each process become more meaningful as we understand their intrapsychic connections.

More recently, authors (Alpert, 1983; Belgum, 1985; Johnson, 1984) have further clarified the notion of guilt. Guilt takes three forms: real, neurotic, and existential. Real guilt follows after an individual does something which that individual considers to be wrong. This type of guilt is a conscious phenomenon following real action of some sort. After committing a wrong action, a person can seek expiation and make restitution, thereby alleviating the guilt.

Neurotic guilt, on the other hand, can exist without committing any wrong actions. The very intention or desire to do something wrong is enough to cause neurotic guilt. Unlike real guilt, neurotic guilt has its roots deep in the unconscious mind. Also, unlike the person experiencing real guilt, the neurotically guilty person cannot get rid of the guilt by the usual methods of atonement. Example: someone secretly wishes that an irritating relative would die. The relative suddenly dies of natural causes. Then, the

person wishing the death starts experiencing guilt for having 'killed' the relative and becomes obsessed with a sense of being guilty (Tournier, 1962).

According to Belgum (1985) and Hyder (1971), existential guilt is different from both real and neurotic guilt. So different, in fact, that it might be more accurate not to call it guilt. Existential guilt is a sort of inner nagging, an inner experience of discomfort, of dissatisfaction, of something being out of sorts and demanding attention. This tension-state of being in the present moment and compelled to act is, to a degree, overwhelming. Existential guilt may require continued activity in the service of alleviating human suffering rather than merely a discrete act of restitution in order to afford one a continuing sense of self-worth (Ross, 1975). Indeed, for some persons there is existential obstacle to the development of personal competence, achievement, and success. The complexity of guilt cannot be underestimated for it has many associated variables. As Hyder (1971) has stated:

> Guilt is an uncomfortable feeling. It is partly the unpleasant knowledge that something wrong has been done. It is shame, regret, or remorse. It is a feeling of low self-worth. It leads to alienation. Guilt, therefore, is partly depression and partly anxiety (p. 113).

## Guilt, Negative Self-Image, and Depression

From these authors, some general agreement and substantive evidence to conclude that guilt is a common feature of depression has been shown (Harrow & Amdur, 1971; Harrow et al., 1966; Prosen et al., 1983). In Harrow and Amdur's (1971) study, these researchers confirmed that the trend found using other instruments from a previous investigation (Harrow et al., 1966) continued to demonstrate that neurotic depressives are guiltier than nondepressives. Further, some evidence suggested that perhaps psychotic depressives are also guiltier than nondepressives.

According to Harrow and Amdur (1971), guiltier clients tended to have negative self-images, and nonguilty clients had more positive self-images. From a

further analysis of the data, these investigators indicated that a significant relationship between negative self-images and guilt was true for the depressive subsample when considered alone and also for the nondepressive subsample when considered alone (Harrow & Amdur, 1971).

From the study (Prosen et al., 1983), which examined differences between depressed subjects and self-esteem; normal subjects and self-esteem, these investigators concluded that there were large, significant differences between the depressed and normal subjects in self-esteem. The depressed subjects experienced more negative self-esteem and feelings of worthlessness. According to Prosen et al. (1983), almost no depressed subjects had high self-esteem. In addition, a surprise finding was more uniformity than expected concerning low self-esteem and feelings of worthlessness among depressed subjects.

## Defining a Paradox

The word 'paradox' comes from the Greek 'para' (meaning: contrary) and 'doxa' (meaning: received opinion) denoting a violation of common sense or what is expected (O'Connell, 1983). In the literature, various researchers (Beck and Strong, 1982; Feldman, Strong and Danser, 1982; Mavissakalian, Michelson, Greenwald, Karnblith and Greenwald, 1983) have operationalized paradox by having the therapist invite the clients to continue experiencing their symptom(s). In general, clients come to therapy with the expectation that in the course of the therapeutic process, their behavior will change. However, the therapist tells the client to continue experiencing the symptom(s)---thus, the paradox.

Watzlawick (1967) defined paradox as "a contradiction that follows correct deduction from consistent premises" (p. 188). Kraft (1985) stated that paradoxical definitions are the product of inconsistencies within our language. Paradoxical

definitions are semantic statements that contain two messages that contradict one another but follow from correct deduction and consistent premises (Kraft, 1985).

## The Uses of Paradox

Although the use of paradoxical techniques is considered a new approach, therapeutic paradox can be traced to the eighteenth century. O'Connell (1983) cited a 1786 report of the paradoxical curing of impotency by telling a client to prevent himself from having an erection. Yates (1958) reported successful use of the paradox with tics; Gentry (1973) with migraine headaches; Teismann (1979) with jealousy in couples; Frankl (1975) with phobias and obsessions; Selvini-Palazzoli, Cecchin, Boscalo and Prata (1978) with schizophrenia; Watzlawick et al. (1974) with help-rejection; Haley (1976) with family fights and Fay (1976) with suicidal threats.

In addition, research in the area of psychotherapeutics involving paradoxical techniques has shown paradoxes to be useful in treating persons with depression, insomnia, urinary retention, and

procrastination. Paradoxical techniques are most often used with emotional problems in which something occurs too much or not enough. Ascher and Turner (1979) reported that paradoxical techniques are used with behavior that "cannot be fully placed under voluntary control" (p. 410).

Various labels have been used to describe paradoxical interventions. Frankl (1960, 1975, 1978) has used the term 'paradoxical intention'; Tennen, Rohrbaugh, Press and White (1981) used the term paradoxical intervention; Fay (1976, 1978) used the term paradoxical therapy; and the therapeutic double bind was the term used by Haley (1963) and Watzlawick (1965). Similar approaches include provocative therapy (Farrelly and Brandsma, 1974), paradigmatic psychotherapy (Coleman-Nelson, 1962; Stean, 1964), and direct analysis (Rosen, 1953, 1962).

According to Haley (1976) and Weeks and L'Abate (1978), reframing, a paradoxical technique, consists of verbal messages to clients from the therapist that cast the client's symptoms in a positive light and are incongruent with the context of the therapy milieu.

Watzlawick et al. (1974) and Selvini-Palazzoli et al. (1978) stated that reframing may alter a situation's conceptual and/or emotional context of therapy, placing the situation in a new frame. Jackson (1968) described this process as the counselor's interpretation of the client's message in a positive light; Haley (1973) described defining all events as being for the good of the family.

Reframing has been called relabeling (Haley, 1963) and positive connotation (Beck & Strong, 1982). Reframing can have positive or negative connotations. Watzlawick et al. (1967) viewed positive reframing as involving the context of therapy which takes two general forms, incongruence with the client's evaluation of the disliked current state of behavior and incongruence with the expectancy of change. Further, Watzlawick et al. (1976) suggested that if both the therapist and clients agree that a disliked behavior trait being demonstrated by the clients should be changed, the therapist request for that change will only increase the clients resistence to that change. However, if the therapist is permissive and even positive about the disliked behavior

and even to the extent of urging clients not to change, positive reframing mobilizes their ability to bring about change.

Negative reframing in therapy often occurs as a result of cognitive re-organization stimulated by the incongruence between client beliefs and their ideas presented in interpretations and ultimately, a result of the client's concern for psychological stability (Strong & Matross, 1973). When the client perceives inconsistencies between behaviors and values distress and discomfort are created. In response, the client may change to relieve this distress and discomfort. In an attempt to gain credibility, persons strive for consistency in actions, thoughts and resulting behavior (Aronosom, 1969; Festinger, 1957; Heider, 1958).

According to Watzlawick et al. (1967), only two ways are available to therapeutically influence another person's behavior: a) to directly persuade the person to behave differently or, b) to persuade the person to remain the same. The impact of this therapeutic influence is an attempt to encourage clients' to behave differently. Therapeutic influence is described as

movement away from the client's present behaviors. However, this strategy often fails to positively influence clients' troubled by symptoms over which the client professes to have little or no control because the intervention implies that the client already has control over one's own behavior and can change. Therefore, conflicts with the person's experiences and beliefs about the nature of the person's symptom(s) result.

To illustrate reframing as a paradoxical intervention, the following example is presented: Seeing a glass of water as "half-full or half-empty." Considering a half-filled glass of water as half-empty is often referred to as pessimisum. This example is analogous to seeing only the maladaptive aspects of a client's behavior. Viewing a full-filled glass of water as half-full, or the optimistic view, is analogous to seeing mentally healthy aspects of a person's behavior and overlooking the maladaptive aspects. From time to time, mental health professionals rarely overlook maladaptive behavior, but experience some difficulty perceiving the adaptive aspects of a person's behavior.

Even though various terms are used to describe reframing as a paradoxical strategy, theorists, researchers, and clinicians agree that the essence of paradoxical thought is captured in Buda's (1972) view that:

> Paradoxical communications consists of promoting in the patient some of the motivational tendencies or interactional strategies which have consequences that interfere with symptomatic behavior. This leads almost inevitably to change at some level, either in the patient's relationship with the therapist or in the behavior outside of the therapist's office (p. 201).

## Types of Paradoxical Interventions

During a review of literature about uses of paradox in general and reframing in particular, it became evident that two basic types of paradoxical interventions were used in experimental research. These two types (paradoxical directives and positive reframing) are discussed since they typify the treatment modality used in this research.

Paradoxical directives are analogous to the techniques of symptom prescription and symptom scheduling. Symptom prescription occurs when the therapist instructs the client to continue with the symptom(s) (Frankl, 1970). An example would be a therapist instructing a guilty and depressed client to feel guilty and depressed until the next session commences. A slight variation of symptom prescription is symptom scheduling (Newton, 1968). With this strategy, the therapist instructs the client to continue the symptom(s) for: 1) a specified period of time, 2) a specified time of day and, 3) under what specified conditions. Expanding on this example, the therapist would instruct the guilty and depressed client to feel guilty for exactly fifteen minutes of each day and feel depressed for exactly twenty minutes on alternate days until the next session commences.

The second type of paradoxical strategy found in the review of literature was reframing. Reframing, as stated previously, is "changing the conceptual and/or emotional context or point of view in relation to which a situation is experienced and to place it in another

frame which fits the 'facts' of the same concrete situation equally well or even better, and thereby changes its entire meaning" (Watzlawick et al., 1974, p. 95). Reframing has been called redefinition (Tennen, 1977) and positive connotation (Beck & Strong, 1982).

## Research Studies Using Paradoxical Interventions

The focus of this present investigation was to ascertain whether the use of reframing, a paradoxical technique, would be effective in reducing guilt in depressed women. None of the studies reviewed had a central focus of guilt reduction, per se. However, thirteen experimental or quasi-experimental studies have been conducted in which paradoxes were used (Ascher & Turner, 1979; Ascher & Turner, 1980; Beck, 1981; Beck & Strong, 1982; Feldman, Strong, & Danser, 1982; Jessee, 1984; Kraft, 1985; Lopez & Wambach, 1982; Mavissakalian et al., 1983; Newton, 1968; Turner & Ascher, 1979; Turner & Ascher, 1982; Wright & Strong, 1982).

## Reframing Research and Depression

Since an association between guilt and depression has been established, five of the above studies have particular relevance to this study. These five studies cited below used reframing as a treatment modality in reducing depressive symptoms (Beck, 1981; Beck & Strong, 1982; Feldman et al., 1982; Jessee, 1984; Kraft, 1985).

Beck (1981) using an experimental, three group, before and after design with repeated measures, compared the effectiveness of positive and negative reframing on change (reduction in depression). A convenience sample of thirty subjects, who expressed a desire to make modest gains in overcoming the negative feelings associated with depression, were randomly assigned to one of three conditions. The three conditions were: positive reframing, negative reframing and a interview condition. A short term therapy format was used to operationalize positive and negative reframing.

The results indicated that both intrepretation conditions were followed by a dramatic drop in the

subjects' level of depression, but the change in the positive interpretation condition was significantly ($p < .001$) greater one month after therapy was discontinued, than was change from the negative interpretation. By the time the one month after treatment follow-up had been administered, the positive interpretation subjects had shown a durable, resilient change in their level of depression, whereas the negative interpretation subjects had increased their level of depression almost to pre-test levels. The positive reframing appeared to effect a more durable and resilient change than did the negative reframing.

Similarly, Beck and Strong (1982) conducted an experimental study with a three group, pre and posttest design with a convenience sample of thirty subjects. The purpose of the study was to compare the ability of positive and negative connotative interpretations (positive and negative reframing) to effect change (reduce depression) in moderately depressed college students. Using multivariate analysis of variance (MANOVA), both treatment groups showed significantly ($p < .005$) decreased depression scores after treatment.

However, subjects in the negative connotation group relapsed after the treatment was terminated, whereas subjects in the positive connotation group continued in remission. Both types of reframing initiated change, but only the positive reframing group's improvement lasted until a one month follow-up.

Using an experimental, five group, pre and posttest design Feldman et al. (1982) examined the effects of paradoxical and nonparadoxical interpretations and directives in brief therapy with moderately depressed college students. Forty-nine subjects were randomly assigned to one of the five conditions. A stratified random procedure was used to ensure equivalent pretest means for the groups on the Beck Depression Inventory. The data were analyzed using the MANOVA with repeated measures.

The results indicated conditions containing paradoxical interpretation were significantly ($p < .01$) higher than conditions containing nonparadoxical interpretations. The conditions containing paradoxical directives were significantly ($p < .05$) higher than conditions containing the nonparadoxical directives.

The interpretation and directive interaction effect and the effects in time were not significant.

Further, the results showed that the consistent paradoxical condition was not superior to the inconsistent condition with paradoxical interpretations and nonparadoxical directives. The consistent nonparadoxical condition was not inferior to the inconsistent condition with the nonparadoxical interpretations and paradoxical directive. Instead, conditions containing paradoxical interpretations were superior to conditions containing nonparadoxical interpretions regardless of the nature of the directive associated with them. Feldman et al. (1982) reasoned that because the different interpretations did not generate different perceptions of the interviewers on empathy, unconditional regard, or resistance, this observation seemed to be unlikely that some quality of the specific paradoxical and nonparadoxical interpretations chosen in this study generated the observed differences on depression.

Beck and Strong (1982) also found paradoxical interpretation to be a more powerful intervention than

nonparadoxical interpretation in treating moderately depressed college students in brief therapy. However, these researchers found that paradoxical and nonparadoxical interpretations were associated with equivalent therapeutic change during treatment. Furthermore, students who received nonparadoxical interpretations experienced significant symptom relapse by a one month follow-up, whereas students who received paradoxical interpretations maintained their therapeutic change.

According to Feldman et al. (1982), paradoxical interpretations were associated with stronger therapeutic effects than were nonparadoxical interpretations in both treatment and follow-up conditions. When taken together, the results of the two studies support paradoxical interpretations as effective interventions in the treatment of moderately depressed clients in brief therapy.

Using a two group, pretest-posttest, single-case research design, Jessee (1984) investigated the use of paradoxical treatment (positive reframing and symptom prescription) for depression within the context of

marital therapy. In this study, marital therapy was considered a treatment where one partner in the marital dyad is the identified patient (IP). From twelve couples, five couples were selected on the basis of the couple's Beck Depression Inventory (BDI) scores and a screening procedure conducted by an Affective Disorder Clinic. Three couples were placed in one group and two couples were placed in group two. These couples were subjected to three phases of treatment: baseline phase, treatment phase 1, and treatment phase 2, and follow-up.

The results of this study indicated that the major hypothesis was neither confirmed nor disconfirmed by the findings. Self-reported and interactional measures of depression decreased for all subjects; however, several subjects' baseline trends toward improvement on both measures made it impossible to say that the treatment alone was responsible for the positive change (Jessee, 1984). Since cause and effect cannot be established with a one group, nonexperimental design, Jessee's (1984) assertion was appropriate. Jessee (1984) maintained that the results must not be discounted because two similar studies found that the interaction

difficulties had initially worsened or remained the same instead of improving as Jessee's (1984) results indicated. Further, Jessee (1984) stated no awareness of any study in which the majority of chronically depressed patients improved naturally and were maintained at nonclinical levels without treatment. In addition, Jessee (1984) reported:

> If improvement were readily achieved, chronic depression would not be the difficult problem that it remains today. Therefore, despite inconclusive evidence for cause-and-effect treatment effectiveness, it is likely that the treatment was in some way instrumental in the improvement (p. 80, 81).

For the purpose of clarity, single-case design research has historically been used almost exclusively in behavior modification investigations (Leitenberg, 1973). Presently, it has been suggested that single-case research can be applied to the practice of marital and family therapy (Rabin, 1981). Jessee (1984) claimed that his application seemed appropriate; this approach eliminated the problems of collecting

homogenous client groups, obscuring individual outcomes in group averages, and observing individual progression and change during treatment. Furthermore, according to Jessee (1984), "single-case design seemed suited to strategic treatment approaches because it allowed a therapist to test ideas about treatment and create new, empirically validated techniques" (p. 86).

Kraft (1985) explored the effects of positive reframing statements and paradoxical directives, using a brief therapy model with moderately depressed college students. Using an experimental, four group, pretest-posttest design with a convenience sample of forty-six subjects, and using a 2 x 2 MANOVA factorial analysis, the data indicated that positive reframing condition reduced the (BDI) scores significantly ($p < .0001$) more than the no reframing condition. Subjects who received the positive reframing statements also showed greater internal attributions for changes that occurred during the study than subjects who received no reframing statements. Further, the determination was made that subjects who received paradoxical directives showed a decline in scores similar to the subjects who

received the nonpardoxical directives. All subjects improved across time, regardless of the type of directive that was given. The combined paradoxical condition demonstrated effectiveness similar to the positive reframing statements combined with the nonparadoxical directive.

These five studies (Beck, 1981; Beck & Strong, 1982; Feldman et al., 1982; Jessee, 1984; Kraft, 1985) have direct implications for the present study. These investigations have demonstrated that reframing (positive reframing and symptoms prescription-directives) can result in depression reduction.

## Reframing Research with Various Disorders

In the following eight studies, paradoxical interventions have been used in treating various disorders: procrastination, agoraphobia, insomnia, and other diverse symptoms (Ascher & Turner, 1979; Ascher & Turner, 1980; Lopez & Wambach, 1982; Mavissakalian et al., 1983; Newton, 1968; Turner & Ascher, 1979; Turner & Ascher, 1980; Wright & Strong, 1982).

Ascher and Turner (1979) compared the effectiveness of three behavioral techniques: stimulus control, progressive relaxation, and the paradoxical intervention of symptom prescription to treat insomnia. Three treatment conditions were compared using a five group design with placebo and nontreatment comprising the fourth and fifth groups. The prescriptions to the subjects were: to remain awake during the night; not be active, nor get involved in any activity that might prevent sleep.

All three experimental groups (SC, PR, and SP) were significantly ($p < .001$) more effective in the treatment of insomnia as compared to the placebo and nontreatment groups. Discriminant analysis showed no significant difference in effectiveness of treatment between the three experimental groups.

In a continuation of their research, Ascher and Turner (1980) compared the effectiveness of two methods for the administration of paradoxical intention. Forty subjects were randomly assigned to one of four treatment conditions: paradoxical intention (type A administration) in which subjects were provided with a

rationale based on the researcher's understanding between performance anxiety and sleep onset difficulties; paradoxical intention (type B administration) where subjects were given an alternate rationale of following the paradoxical suggestion of remaining awake at bedtime; placebo control and nontreatment control.

Using a one-way MANOVA, the results indicated that the type A method was superior ($p < 0.01$) to the type B procedure when the same method for administering paradoxical intention was applied to a randomized group of individuals. Further, Ascher and Turner (1979) eliminated the two behavioral treatments found in Turner and Ascher (1979) and compared paradoxical intention with placebo and nontreatment control conditions. The determination was that paradoxical intention indicated significantly better results in reducing sleep onset concerns than the two control conditions.

Lopez and Wambach (1982) compared the effectiveness of self-control and symptom prescription (directives) to a nontreatment control group. Thirty-two subjects who reported having a serious and recurring procrastination

problem were randomly assigned to either of two directive interview conditions (paradoxical or self-control) or to a non-interview control condition.

Using an ANOVA with repeated measures, the result indicated that both directive groups exhibited generally greater ($p < .001$) improvement over time than controls and that the opposing forms of direction promoted different change patterns on self-report measures of problem frequency and controllability. Further, subjects exposed to paradoxical directives reported a sharper rate of change in their procrastination without viewing their problem behavior as significantly more controllable.

Mavissakalian and his colleagues (1983) compared paradoxical intervention-paradoxical intention (PI)-with self-statement training (SST) with subjects who were agoraphobic. Using symptom prescription, the subjects were instructed on how they were to behave.

Paradoxical intention, as used by these researchers, did not include prescribing the symptom behavior as is customary. Clients were not told to continue their symptomology. Instead, a desensitization

procedure, in which subjects were positively reframed was initiated.

Two treatments (PI and SST) exhibited similar characteristics. However, the two treatments differed. SST caused coping activities as compared to PI which caused increased anxiety.

Paradoxical intention, in Mavissakalian's study, followed the humor focus of Frankl's (1975) work mentioned earlier. Using a pretest, posttest, two group design with repeated measures, twenty-six agoraphobics were randomly assigned to the (PI) group or (SST) group. The results indicated statistically significant ($p < 0.001$) improvement over time with both treatments. Analyses of covariance that were performed revealed superior effects on several agoraphobia measures for the (PI) condition at post-treatment. By the six-month follow-up, the groups were equal due to marked improvement during the follow-up phase in the (SST) condition.

In another study, Newton (1968) examined the effects of symptom scheduling with respect to two theoretical positions: negative practice and the

therapeutic paradox. However, this investigation was somewhat confusing since the investigator did not actually examine the effects (do they work) as the title implied. Newton (1968) stated, "the aim of the research, however, is not directed at answering the question 'does it work,' as important (and complex) as the question is, but rather it is addressed to certain theoretical considerations of the techniques" (p. 68). The study focused on the rationales behind the two different interventions.

The theoretical formulations of Dunlap (1949) and Haley (1963) were discussed in detail. The theory of Dunlap (1949) focused on behaviors being practiced or learned and Haley's (1963) view focused on the therapist being benevolent and permissive or encouraging the client to continue the symptom(s). Newton (1968) relabeled 'negative practice' as a study of symptoms conducted for science and the subjects were called volunteers. Newton called the therapeutic paradox something that is done by the therapist in the arena of psychotherapy. The difference centered on the type of rationale given to the client. Ratings of the

therapist's behavior on initiative, therapeutic climate, and depth-directedness indicated that the therapist had treated the two groups (twelve in group 1 and eight in group 2) in a similar manner. There was no difference between the the two types of interventions in regard to client improvement.

Like Lopez and Wambach (1982), Wright and Strong (1982) studied subjects who exhibited procrastination using a paradoxical technique. Twenty college student procrastinators were given two interviews in which interviewers directed them either to continue to procrastinate exactly as they had been doing or to choose some of their procrastination behaviors to continue. Ten other procrastinating students did nc receive interviews. Students who received interviews, decreased procrastination dramatically, whereas those not receiving interviews did not. The only difference between the directive conditions were in students' free response descriptions of how they changed. Students receiving the exact directive tended to attribute their change to spontaneous nonvolitional causes, whereas those receiving the choice directive emphasized

volitional choosing and doing. The investigators for this study used a three group, pretest-posttest design and the results, as indicated above, showed a decreased in subjects procrastination ($p < .001$) behaviors.

## Summary

Reframing, as a paradoxical psychotherapeutic technique, is a powerful tool in which the therapist, instead of joining the client to combat the symptom(s), tells or advises the client to continue, heighten, or extend them. This strategy is unexpected because the client comes to therapy hoping for a lessening of symptom(s) rather than the promotion of them for a time. Past investigations of reframing technique used to reduce depression produced successful results. Guilt and depression can be psychologically damaging to productive functioning as psychological energy is used with guilt seeking expiation or absolution. With depression, the energy is used to perpetuate the low self concept, esteem, and worth.

Three types of guilt were explained as well as the delineation between guilt and shame. Neurotic guilt is

the most difficult condition to relieve. If guilt could be 'reframed,' an avenue to block dysfunctional behavior could be discovered.

A definition of paradox and examples were given as well as evidence to support the various uses of paradoxical techniques. Thirteen studies were examined and analyzed in relation to reframing. Five studies were related specifically to depression. It should be noted that none of these studies had guilt as a focus however, evidence was supplied to support that guilt is a common feature of depression. In addition, the remaining studies showed a wide variety of uses of reframing techniques. Finally, the association of guilt and depression was explored.

# Chapter 3

## Procedure for Collection and Treatment of Data

An experimental, explanatory approach was used to examine the effectiveness of reframing therapy in the reduction of guilt and depression in female subjects. A two-group before-after design with repeated measures and random assignment to alternate groups was used (Abdellah & Levine, 1979). Three instruments were employed for data collection to address the five hypotheses: 1) Depressed females who are exposed to reframing therapy will have less guilt than those females who are not exposed to reframing therapy and 2) depressed females who are exposed to reframing therapy will have less depression than those who are not exposed to reframing therapy and 3) age and length of time taking medication with therapy will positively related to the levels of guilt and depression before treatment with reframing and 4) ethnic background, marital status, religious background and type of medication will be related to the levels of guilt and depression before treatment with reframing and 5) length of time taking medication

without reframing will be positively related to guilt and depression levels. The independent variable, reframing therapy, was assigned to the experimental group. The first dependent variable, guilt, was measured by a score on the Mosher Guilt Inventory (MGI). The second dependent variable, depression, was measured by the Beck Depression Inventory (BDI) score.

## Setting

Approval was obtained from two outpatient mental health facilities which served as the setting for this study. The Mental Science Institute is located in a large medical center in the Southwestern portion of the United States, and provides a broad spectrum of psychiatric services for children, adolescents, and adults; and offers individual, group and family therapies as well as hospitalization served as the setting for this study. The Mental Science Institute is primarily an outpatient facility which anticipates some 30,000 office visits this year. This institute is a part of a larger university system and serves a large

metropolitan area; further, the adult outpatient clinic provides diagnostic and treatment for adults between the age of 18 and 65 with affective disorders and personality disorders. Medication and psychological testing are provided as well as forensic evaluations for various legal proceedings.

The total number of visits to the Adult Affective Disorder Clinic for 1986 was 4,927. The actual outpatient service volume during the last six months of FY86 suggested that service volume in FY87 will include 4,762 patients and provide 38,304 outpatient visits. One hundred seventeen people are employed within the mental science institute (Appendix C).

The second outpatient mental health facility is located in a small town with a population of approximately 24,000 people. An average of 31 clients are seen each week. More than half of these clients are female with a diagnosis of depression. This facility is part of the state mental health system and provides mental health services for diagnosis and treatment for adults with affective disorders as well as other mental and emotional concerns. This facility is a modern

outpatient clinic and employees twelve people (Appendix D).

## Population and Sample

A convenience sample of 30 subjects were selected from among the population of depressed females at the Mental Science Institute and from another outpatient clinic in East Texas during June through September, 1987. Participation was on a voluntary basis. For inclusion in the study, the subjects met the following criteria:

1. Be between 18 and 65 years of age and female.
2. Meet the Freedman and Kaplan's (1976) criteria for Primary Affective Disorders, which are:
    a. Dysphoric Mood
    b. At least five of the following:
        1. Poor appetite or weight loss
        2. Sleep difficulty
        3. Loss of energy
        4. Guilt or self reproach
        5. Loss of interest or libido
        6. Concentration difficulty

7. Agitation
8. Crying spells

3. Express a desire to make modest gains in overcoming the negative feelings associated with guilt and depression.
4. Currently be on an outpatient basis.
5. Except for those placed in the control group, be asked to engage in one-to-one therapy for (3) three sessions, (30) thirty minutes each.
6. Give written informed consent to participate.
7. Be able to read, write, speak, and understand English.
8. Be expected to complete the full course of the study.
9. Be expected to complete the Beck Depression Inventories and the Mosher Guilt Inventories.

A list of 30 subjects, last name and first-name initial, was compiled. Using a table of random numbers (Wilson, 1952), subjects were randomly assigned to one of two groups: experimental or control. A letter which asked for their participation and explained the study was given to each of the 30 subjects (15 in the

experimental group and 15 in the control group). The letter given to the experimental group identified reframing therapy and its procedure (Appendix E) whereas, the letter given to the control group identified the use of a paradoxical psychotherapeutic technique (Appendix F). If the subjects agreed to participate, each subject in the experimental group was asked to sign a consent form (Appendix G); likewise the control group of subjects were asked to sign a consent form (Appendix H). Both of these consent forms were simular with one exception, the experimental group had the therapy specifically identified whereas, the control did not. After this procedure had been completed, the subjects who were placed in the experimental group were asked to make individual appointments with the investigator (therapist) for reframing therapy on a one-to-one basis for three separate sessions for thirty minutes each while the control group subjects were instructed to continue on with their respective treatment regimes. Following the arrangements for individual therapy, both experimental and control groups were pretested using the MGI and the BDI. After the

completion of reframing therapy with the experimental group, both experimental and control groups were posttested using the MGI and the BDI. In addition, each therapist was questioned to make certain that reframing therapy was not being used as a treatment for any subject who had agreed to participate in this study.

## Protection of Human Subjects

This study adhered to the criteria set forth by the Human Research Review Committee at Texas Woman's University and the Human Rights Committee at the facility from which the sample was drawn (Appendix I). Each subject was informed regarding the intent to study the effectiveness of a particular paradoxical technique with depressed and guilty women. Confidentiality and privacy were maintained throughout the study by keeping the studies data under lock and key in the investigator's desk and by keeping the content from the one-to-one therapy confidential during the data collection and destroying the data at the end of the study. Potential benefits and negative consequences from participation in the research were outlined in the

letter of explanation of the study (Appendix E, F). The benefit of assisting mental health workers to gain more effective ways of dealing with the client concerns was explained. The subjects were told that although emotional discomfort from the nature of the information needed was not anticipated, if it occurred, the therapist or their regular therapists were available for consultation. Further, the subjects were also told that the MGI asked them to respond to questions of a private nature and this may be upsetting; however it was emphasized that the purpose of the question was not designed to ascertain whether or not the subject practiced the behavior, but was attempting to assess their feelings about particular practices.

## Instruments

Three instruments were used to determine the subject's guilt and level of depression: a demographic data sheet, the Mosher Guilt Inventory (MGI) (Mosher, 1961, 1966, 1968, 1979a; Mosher & Vonderheide, 1985) and the Beck Depression Inventory (BDI) (Beck, 1967).

## Demographic Data Sheet

The demographic data sheet was completed by each participant to assess the characteristics of the sample. Data elicited included: gender, age, race, marital status, religion, type of medication the subject was currently taking, months in therapy taking medication, and months in therapy without medication (Appendix J).

## Mosher Guilt Inventory

The Revised Mosher Guilt Inventory consists of 114 items, arranged in pairs of responses to the same sentence completion stem, in a 7-point Likert format to measure: (1) Sex-Guilt--50 items, (2) Hostility-Guilt--42 items, and (3) Guilty-Conscience--22 items. Items were selected from an item analysis of the 151 Forced-Choice items in the original inventories. Subjects respond to items by rating their responses on a 7-point scale where 0 means NOT AT ALL TRUE OF (FOR) ME, and 6 means EXTREMELY TRUE OF (FOR) ME. Items are arranged in sets of two different completions to a single stem (the limited comparison format) to permit subjects to compare the intensity of TRUENESS for

themselves since people generally find one alternative is more or less TRUE for themselves. Scores are summed for each subscale by reversing the nonguilty alternatives.

The revised Mosher Guilt Inventory was refined from work done in previous years. The Mosher Guilt Inventories (1961, 1966, 1968) were developed from responses given to sentence completion stems in 1960. The weights used in scoring the sentence completion were assigned to items from the scoring manual to construct True-False and Forced-Choice inventories for men and women. The scoring manual has been subsequently developed to score each sex separately. O'Grady and Janda (1979) demonstrated there was no need to use weights since a 1 or 0 scoring procedure for guilty and nonguilty responses was correlated $r$=.99 with the weighted system. To compare the sexes it was necessary either to transform the raw scores to standard scores, or to give the same inventory to both sexes, which seemed to create no problems. During the past 25 years, the range of guilt scores has been truncated as the means have dropped, particularly for sex guilt (Mosher &

O'Grady, 1979b). The 39 items, in comparison to 28 for men, in the female form of the Forced-Choice Sex Guilt Inventory guilt has continued to be a successful predictor of a broad range of sexually related behavior, cognitions, and affects in spite of containing items drawing 100% nonguilty choices (Kelly, 1985).

Multitrait-multimethod matrices have provided evidence for the discriminant validity of the three guilt subscales (Mosher, 1966, 1968). Given the unusually strong evidence of construct validity for the inventories, Mosher was reluctant to generate a new set of items which might be conceptually better but which would limit generalization from past research. Instead, Mosher submitted the non-overlapping items contained in both male and female versions of the True-False (233 items) and the Forced-Choice (151 items) to a sample of 187 male and 221 female University of Connecticut undergraduates for an updated item analysis. As suspected, many guilty True-items and guilty Forced-Choice alternatives were uniformly rejected in the current sample. The resulting Revised Mosher Guilt Inventory (MGI) continues to measure Sex-Guilt,

Hostility-Guilt, and Morality-Conscience, but it is now in a limited comparison format that was selected to increase the range of response and to eliminate complaints about the forced-choice format (Mosher & Vonderheide, 1985). The item subscale-total correlations for selected items ranged from $\underline{r}$=.32 to $\underline{r}$=.62 with a mean of .46. In addition, to ensure discriminant validity between the subscales, 90% of the items had a correlation with its own subscale that was significantly different from the item-other subscale-totals. Several Morality-Conscience items were too highly correlated with Sex-Guilt, and thus were eliminated. This subscale was renamed Guilty-Conscience to more adequately reflect the retained items. The inventory is suited for adult populations (Mosher & Vonderheide, 1985; Green & Mosher, 1985) (Appendix B).

## Beck Depression Inventory

The Depession Inventory (Beck, 1967) is composed of 21 (A - U) categories of symptoms and attitudes. Each category describes a specific behavioral manifestation of depression and consists of a graded series of four

self evaluative statements. The statements are ranked to reflect the range of severity of the symptom, from neutral to maximal severity. Numerical values from 0-3 are assigned each statement to indicate the degree of severity. In many nosological categories, two alternative statements are presented at a given level and are assigned the same weight; these equivalent statements are labeled a and b (that is, 2a, 2b) to indicate that they are at the same level. A total score is obtained by summing the scores of the individual symptom categories.

Two studies were used as a basis for determining reliability and validity. In study one, the sample size was 226, with 40.7% male and 59.3% female. The second study had a sample size of 183, with 37.2% male and 62.8% female. However, Beck (1967) reported that in later studies where the Depression Inventory was administered, a total of 966 patients became the sample. According to Beck (1967), two methods for evaluating internal consistency of the inventory was employed. With the use of the Kruskal-Wallis Non-Parametric Analysis of Variance by ranks, it was determined that

all categories showed significant relationship to the total score for the inventory. Significance was beyond the .001 level for all categories except category 19 (Weight-loss) which was significant at the .01 level. Further, a later item analysis of 606 cases showed that the categories correlated positively with the total Depression Inventory score (range .31 to .68). These correlations were all significant at the .001 level.

The second method of evaluation was determined by the split-half reliability. Ninety-seven cases from the first study were selected. The Pearson Product Moment Correlation Coefficient between the odd and even categories were computed and yielded a reliability coefficient of $r$=.86; with the Spearman-Brown correction, this coefficient rose to $r$=.93 (Beck & Beamersderfer, 1974b).

Two types of validity, concurrent and construct, were used to evaluate the Depression Inventory. Concurrent validity is evaluated by demonstrating how well the test scores correspond to other measures of depression, such as clinical evaluation and scores on other psychometric tests of depression. In study I (the

original group) and the replication group (study II), the Kruskal-Wallis was used to evaluate the statistical significance of the means and standard deviations. Metcalfe and Goldman (1965) using a sample of 409 patients determined that the two previous studies paralleled their findings.

According to Beck (1967), a Pearson biserial correlation was computed to determine the correlation between the scores on the Depression Inventory ad the clinical judgement depth of depression. The criterion rating was reduced from four to two (none and mild, moderate and severe). The results yielded a biserial coefficient of rpbi=.65 in study I and rpbi=.67 in study II. In the Metcalfe's study, Kendall's rank correlation coefficient was calculated to determine the degree of association between psychiatrists' ratings and the Depression Inventory score. The correlation coefficient was .61 ($p<.001$).

The construct validity of the Depression Inventory was supported by theory and research. Beck (1967) stated that the theory of scoring high on the Depression Inventory was due to life experiences during the

development of the individual which predisposed those individuals to react to stress later by the appearance of, or exacerbation of depressive symptomatology. Moreover, because of these early life experiences, these persons have a negative view of themselves and the world that is manifested in their dreams, in their responses to certain projective tests, and in their conscious self-concept.

Beck and Ward (1961a) conducted research using the Depression Inventory as the criterion measure (either alone or in combination with clinical ratings of the degree of depression). These researchers supported the hypotheses contained in the theory. Further support was offered by Beck and Stein (1960); Beck (1961b); Beck, Sethi and Tuthill (1963) and Loeb (1964, 1966). The use of the Depression Inventory by other investigators provided further evidence of construct validity. Gottschalk, Gleser, and Springer (1963) found a significant correlation $r$=.47 between scores on the Depression Inventory and scores on a Hostility-Inward Scale, designed to measure the direction of hostility in samples of free associations of patients; as expected,

there was a negative correlation with the Hostility-Out Scale. Nussbaum and Michaux (1963) found a significant negative association between scores on a sense of humor test and scores on the Depression Inventory. In both studies the results confirmed the theoretical hypotheses (Appendix A).

## Data Collection

A list, numbered from 1 to 30, identifying each subject by last name and first-name initial was developed. The list comprised a convenience sample of 30 subjects. Using a table of random numbers (Wilson, 1952) and making a random start on the page of random numbers, 15 subjects were randomly assigned to the experimental group and the remaining 15 subjects composed the control group. Both groups were asked to fill out the demographic data sheet and both groups were pretested using the MGI and the BDI. Following pretesting, 15 subjects in the control group were instructed to continue following the already perscribed on-going psychiatric regimes. These on-going psychiatric regimes, so long as they did not include

reframing therapy, were considered a form of treatment. The fifteen subjects in the experimental group were asked to sign up for 1:1 reframing therapy with the investigator which was completed in 3 separate, 30 minute sessions. Each session consisted of problem exploration (13 minutes) and positive reframing and a directive (17 minutes). Two positive reframing messages were stated at five minute intervals followed by a directive for the subject to follow until the next session.

After the experimental group of subjects had completed all 3 individual sessions, both groups, experimental and control, were posttested using the MGI and the BDI. When all data were collected from the two groups, instruments were scored and data analyzed.

## Treatment of Data

Because of the experimental, explanatory nature of this study, a large volume of data were first subjected to descriptive analysis. Following the descriptive analysis, inferential statistics were used to test the research hypotheses.

## Descriptive Data Analysis

A detailed description of the variables under study was conducted to facilitate data analysis. To describe the sample with respect to the demographic data elicited, descriptive statistics were employed (Downie & Starry, 1977). The sample was examined and described with respect to gender, age, race, marital status, religion, type of medication being taken, medication with therapy and medication without therapy. Crosstabulation tables, measures of central tendency and variability were reported according to the level of measurement for each variable. The nominal level variables of type of medication, gender, religion, race, and marital status were reported by number and percent in each category in the frequency distributions. The mode and percentage served as measures of central tendency and variability for each variable (Downie & Starry, 1977).

The ratio level variables of age, days in therapy with medication and days in therapy without medication were presented by number and percent in the frequency

distributions. The mode, mean, range, and standard deviation were reported for each variable (Downie & Starry, 1977).

## Inferential Data Analysis

Further exploration of the data was done by examining the interval level variables obtained from the MGI and the BDI inventories. To determine if there was a significant difference within groups and in the gain scores between the experimental Group 1 and the control Group 2, a two-way analysis of variance (ANOVA) with repeated measures was applied to the data (Downie & Starry, 1977). Each hypotheses was tested using inferential statistics. These were:

Hypothesis 1. Depressed females who are exposed to the reframing technique will have less guilt than those females who are not exposed to the reframing technique. To compare the means of the two groups, a two-way (ANOVA) was computed to determine if there was a significant difference.

Hypothesis 2. Depressed females who are exposed to

the reframing technique will have less depression than those females who are not exposed to the reframing technique. To ascertain if there was a difference between the two groups, a two-way (ANOVA) was computed to determine if there was a significant difference between the means.

Hypothesis 3. Age and length of time taking medication with therapy will be positively related to the levels of guilt and depression before treatment with reframing. These ratio level variables were subjected to the Pearson's Product Moment Correlation statistic ($r$) to compare and identify the relationship that may exist.

Hypothesis 4. Ethnic background, marital status, religious background and type of medication will be related to the levels of guilt and depression before treatment with reframing. These nominal level variables were reported by number and percent in each category in the frequency distribution. The mode and percentage served as measures of central tendency and variability for each variable. Analysis of variance was computed to determine if significant relationships existed between

the nominal level variables and the interval level MGI and BDI.

Hypothesis 5. Length of time taking medication without reframing will be positively related to guilt and depression levels. The ratio level variable of time taking medication was compared to the guilt and depression levels using the Pearson's Product Moment Correlation (*r*).

Both sets of data analysis were conducted. The results were displayed in appropriate tables and frequency distributions. Alpha was set at: $p < .05$ for all tests of significance.

## Pilot Study

A pilot study was conducted to test the methodology of this research project using a small sample of depressed females who met the criteria for inclusion in the study. A convenience sample of 20 subjects, 10 in the experimental group and 10 in the control group, was drawn from a population of depressed females being seen on an outpatient basis at two separate outpatient mental

health clinics in the Southeastern region of the United States.

From this process, a determination was made that all planned tests be retained; that rather than obtaining clients from two separate outpatient clinics, one location was more feasible. In addition, older subjects, over 65 years of age, required more assistance during testing due to visual problems. These outcomes lead to the present changes in the study. A two-way (ANOVA) with repeated measures was applied to the raw scores of the MGI and the BDI inventories. The data was analyzed using the BMDP and SPSS-X statistical program packages. The two-way (ANOVA) with repeated measures showed that the experimental and control groups did not differ significantly with regard to pre and posttest guilt and depression scores. The level of significant was $p < .05$. An interaction effect between pre and posttest guilt and depression scores was significant.

## Summary

An experimental, two-group, before and after design was used to study whether the use of reframing as a paradoxical psychotherapeutic technique would reduce the level of guilt and a lessening of the intensity of depression. In an outpatient setting, reframing therapy was conducted with a randomly assigned sample of 10 subjects in the experimental group and 10 subjects in the control group. Guidelines were established for the protection of human subjects and for the collection of data. Results of the previous pilot study were presented. Finally, the treatment of data was outlined to answer the five research hypotheses of this study.

# Chapter 4

## Analysis of Data

This study was undertaken to determine the effectiveness of reframing therapy on guilt and depression reduction. The purpose was to ascertain whether the use of reframing, a paradoxical strategy, would reduce guilt and depression levels in females with a diagnosis of depression and thereby yield new information for mental health professionals. The major hypotheses were:

Hypothesis 1: Depressed females who are exposed to the reframing technique will have less guilt than those females who are not exposed to the reframing technique and,

Hypothesis 2: Depressed females who are exposed to the reframing technique will have less depression than those females who are not exposed to the reframing technique and,

Hypothesis 3: Age and length of time taking medication with therapy will be positively related to the levels of guilt and depression before treatment with reframing and,

Hypothesis 4: Ethnic background, marital status, religious background and type of medication will be positively related to the levels of guilt and depression before treatment with reframing and,

Hypothesis 5: Length of time taking medication without reframing will be positively related to guilt and depression levels.

Data were collected from a sample of 30 women who were being seen on an outpatient basis at a major mental health facility and a small mental health facility in the Southeastern portion of Texas. All 30 subjects completed the study. Descriptive techniques such as frequencies, means, and standard deviations were used to summarize the demographic variables. Total scores were calculated for the following variables: depression and guilt levels. Analyses of variance (ANOVA's) were used to test the hypotheses. Pearson's Product Moment Correlation Coefficient (*r*) was used to calculate the

reliability of the instruments. This statistic was also used to ascertain any relationships that may be found in hypotheses 3, 4, and 5.

## Description of the Sample

The 30 females who completed the study varied in age from 20 to 57 years with a mean age of 36.6 years and a standard deviation of 10.8 years. The largest group (23.3%) of subjects fell within the 36 to 40 years age bracket with the next largest group (16.7%) being between the ages of 20 to 35 years (see Table 1).

Table 1

Characteristics of the Sample on the Variable of Age

| Characteristics | Frequency | Per Cent |
|---|---|---|
| Age | | |
| 20-30 | 10 | 23.4 |
| 31-40 | 12 | 40.0 |
| 41-50 | 4 | 13.3 |
| 51-60 | 4 | 13.3 |
| Total | 30 | 100.0 |

n=30

Of the 30 females in the sample, the majority, 14 subjects or 46.7% of the group, were currently married, while the rest of the women (53.3%) were single never married, divorced, or separated (see Table 2).

Table 2

Characteristics of the Sample on the Variable of Marital Status

| Characteristics | Frequency | Per Cent |
|---|---|---|
| Marital Status | | |
| Single | 8 | 26.6 |
| Married | 14 | 46.7 |
| Divorced | 6 | 20.0 |
| Separated | 2 | 6.7 |
| Total | 30 | 100.0 |

n=30

Of the 30 females in the sample, 22 (73.4%) were Anglo-Americans, 7 (23.3%) were Black-Americans and one (3.3%) who was a Mexican-American (see Table 3). With respect to religious affiliation, 22 (73.3%) were

Protestants; 3 (10.3%) Catholics; 2 (6.7%) Jewish; 2 (6.7%) identifying various forms of affiliations and one (3.3%) identifying no affiliation (see Table 3).

Table 3

Characteristics of the Sample on Variables of Ethnicity and Religious Preference

| Characteristics | Frequency | Per Cent |
|---|---|---|
| Ethnicity | | |
| Anglo-American | 22 | 73.4 |
| Black-American | 7 | 23.3 |
| Mexican-Americar | 1 | 3.3 |
| Total | 30 | 100.0 |
| Religion | | |
| Protestant | 22 | 73.3 |
| Catholic | 3 | 10.0 |
| Jewish | 2 | 6.7 |
| Other | 2 | 6.7 |
| No Affiliation | 1 | 3.3 |
| Total | 30 | 100.0 |

n=30

The types of medication(s) the subjects reported taking while in this study are identified in Table 4. Five (16.7%) of the 30 subjects in the sample were not taking any medication(s) when data collection began. Sixteen (53.3%) of the subjects were taking an anti-depressant; 5 (16.7%) in the sample were taking an anti-anxiety agent while 4 (13.3%) of the subjects were taking a combination of an anti-depressant and anti-anxiety type agent.

Table 4

Characteristic of the Sample on the Variable of Type of Medication(s) Currently Being Taken

| Characteristic | Frequency | Per Cent |
|---|---|---|
| Medication | | |
| None | 5 | 16.7 |
| Anti-depressant | 16 | 53.3 |
| Anti-anxiety | 5 | 16.7 |
| A combination | 4 | 13.3 |
| Total | 30 | 100.0 |

n=30

The number of days each subject reported taking medication in conjunction with therapy is depicted in Table 5. Fourteen (46.5%) had taken medication 100 days or less; six (20%) had been been medicated 101 to 200 days; four (13.3%) were medicated 201 to 300 days; two (6.6%) had taken medication 301 to 400 days, while one (3.3%) was medicated between 401 to 500 days; and three (10.3%) had taken medication 501 to 600 days while in therapy.

Table 5

Characteristic of the Sample
on the Variable of Days Taking Medication
While in Therapy

| Characteristic | Frequency | Per Cent |
|---|---|---|
| Number of Days Taking Medication while in Therapy | | |
| 0-100 | 14 | 46.5 |
| 101-200 | 6 | 20.0 |
| 201-300 | 4 | 13.3 |
| 301-400 | 2 | 6.6 |
| 401-500 | 1 | 3.3 |
| 501-600 | 3 | 10.3 |
| Total | 30 | 100.0 |

n=30

The number of days taking medication without the benefit of therapy is identified in Table 6. In the sample of 30 subjects, twenty-five (83.3%) were not taking any medication without the benefit of therapy. One subject (3.3%) identified six days of taking medication without the benefit of therapy. At twenty-one days, one subject (3.3%) was identified. At thirty days, another subject (3.3%) was identified

followed by one subject (3.3%) at 54 days, and with one (3.3%) subject identifying 140 days of taking medication without the benefit of therapy. The mean number of days taking medication without the benefit of therapy was 8.36 with a standard deviation of 27.41 (see Table 6).

Table 6

Characteristic of the Sample
On the Variable of Days Taking Medication
Without Therapy

| Characteristic | Frequency | Per Cent |
|---|---|---|
| Number of Days Taking Medication Without Therapy | | |
| 0-50 | 28 | 93.4 |
| 51-100 | 1 | 3.3 |
| 101-200 | 1 | 3.3 |
| Total | 30 | 100.0 |

n=30

The number of days in therapy without the benefit of medication is identified in Table 7. Of the 30 subjects in the sample, 27 (90.0%) had zero days in therapy without the benefit of medication. One subject

(3.3%) identified 62 days in therapy without taking medication. Ninety days was identified by one (3.3%) in the sample with respect to days in therapy without medication. The last subject (3.3%) in the sample identified 210 days in therapy without medication. The mean number of days in therapy without medication was 12.06 and a standard deviation of 42.21 (see Table 7).

Table 7

Characteristic of the Sample on the Variable of Days in Therapy Without Medication

| Characteristic | Frequency | Per Cent |
|---|---|---|
| Number of Days in Therapy Without Medication | | |
| 0-50 | 27 | 90.0 |
| 51-100 | 2 | 6.7 |
| 101-200 | 0 | 0.0 |
| 201-300 | 1 | 3.3 |
| Total n=30 | 30 | 100.0 |

The demographic data were summarized for both experimental and control groups. The mean ages of the experimental and control groups were identical at 18.33 years. Subjects in the experimental group varied in age from 20 to 57 years, while the control group subjects' ages were from 21 to 56.

Experimental and control groups varied on the characteristics of ethnicity and marital status in the following ways. Ten (33.3%) of the subjects in the experimental group were Anglo-American versus 12 (40%) in the control group (see Table 8). Four (13.3%) Black-Americans were in the experimental group versus three (10%) in the control group. The experimental group contained one (3.3%) Mexican-American, while the control group did not.

Table 8

Ethnicity of Experimental and Control Groups

| Characteristic | Frequency/Per Cent Experimental | Control |
|---|---|---|
| Ethnicity | | |
| Anglo-American | 10/33.4% | 12/40% |
| Black-American | 4/13.3% | 3/10% |
| Mexican-American | 1/ 3.3% | |
| Total | 15/50.0% | 15/50% |
| n=30 | 30/100% | |

The experimental and control groups differed in the following ways on the characteristic of marital status. In the experimental group, five (16.7%) were single whereas, in the control group three (10%) were single. In both the experimental and control groups, seven (23.3%) of the subjects were married while two (6.7%) of the subjects in the experimental group were divorced and four (13.3%) subjects in the control group were divorced. One (3.3%) subject each comprised the separated category (see Table 9).

Table 9

Marital Status
of the Experimental and Control Groups

| Characteristic | Frequency/Per Cent Experimental | Control |
|---|---|---|
| Marital Status | | |
| Single | 5/16.7% | 3/10.1% |
| Married | 7/23.3% | 7/23.3% |
| Divorced | 2/ 6.7% | 4/13.3% |
| Separated | 1/ 3.3% | 1/ 3.3% |
| Totals | 15/50.0% | 15/50.0% |
| n=30 | 30/100% | |

In the experimental group, eight (26.7%) were Protestant, while 14 (46.7%) were in the control group. There were two (6.7%) Catholics in the experimental group and one (3.3%) in the control group. The control group had no other affiliations identified whereas, the experimental group had two (6.7%) Jewish, two (6.7%) classified as other, and one (3.3%) identified as no affiliation (see Table 10).

Table 10

Religious Preference
of the Experimental and Control Groups

| Characteristic | Frequency/Per Cent Experimental | Control |
|---|---|---|
| Religion | | |
| Protestant | 8/26.7% | 14/46.7% |
| Catholic | 2/ 6.7% | 1/ 3.3% |
| Jewish | 2/ 6.7% | |
| Other | 2/ 6.7% | |
| No affiliation | 1/ 3.3% | |
| Total | 15/50.0% | 15/50.0% |
| n=30 | 30/100% | |

The type of psychotropic medication that the subjects in the experimental and control groups were taking are displayed in Table 11. Three (10%) subjects in the experimental group were taking no medication at all, versus two (6.7%) in the control group. Ten (33.3%) subjects in the experimental group were taking an anti-depressant whereas, six (20%) subjects were in the control group. Anti-anxiety medication was being taken by one (3.3%) subject in the experimental group

and four (13.3%) subjects in the control group. A combination of an anti-depressant and anti-anxiety agent was being taken by one (3.3%) subject in the experimental group versus three (10%) subjects in the control group.

Table 11

Type of Psychotropic Medication Currently Being Taken by Subjects in the Experimental and Control Groups

| Characteristic | Frequency/Per Cent Experimental | Control |
|---|---|---|
| Psychotropic Medication | | |
| None | 3/10.0% | 2/ 6.7% |
| Anti-depressant | 10/33.4% | 6/20.0% |
| Anti-anxiety | 1/ 3.3% | 4/13.3% |
| Combination | 1/ 3.3% | 3/10.0% |
| Total n=30 | 15/50.0% | 15/50.0% 30/100% |

In the experimental and control groups, the number of days taking a psychotropic medication while in

therapy varied in the following ways. Of the 15 subjects in the experimental group, three (10%) subjects were taking no medication while in therapy. Of the 15 subjects in the control group, five (16.7%) subjects were taking no medication while in therapy. The remaining 12 subjects in the experimental group varied in the number of days taking medication while in therapy from 1 day to 420 days. The remaining 10 subjects in the control group ranged in number of days taking medication while in therapy from 100 days to 600 days (see Table 12).

Table 12

The Number of Days
Taking Medication While in Therapy
in the Experimental and Control
Groups

| Characteristic | Frequency/Per Cent | |
|---|---|---|
| | Experimental Group | |
| Days Taking Medication in Therapy | | |
| 0-100 | 8 | 26.7% |
| 101-200 | 2 | 6.7% |
| 201-300 | 3 | 10.0% |
| 301-400 | 1 | 3.3% |
| 401-500 | 1 | 3.3% |
| 501-600 | 0 | 00.0% |
| Total | 15 | 50.0% |
| | Control Group | |
| 0-100 | 6 | 20.0% |
| 101-200 | 4 | 13.3% |
| 201-300 | 1 | 3.3% |
| 301-400 | 1 | 3.3% |
| 401-500 | 0 | 00.0% |
| 501-600 | 3 | 10.1% |
| Total | 15 | 50.0% |
| Total | 30 | 100.0% |

In the experimental group, the number of days taking medication without therapy was 15 (50%). However, in the control group, 10 subjects (33.3%) had zero days of taking medication without therapy, while five (16.7%) subjects identified 6 days, 21 days, 30 days, 54 days, and 140 days, respectively.

The number of days in therapy without medication was identified by each subject in the sample. In the experimental group, 13 (43.3%) subjects had zero days in therapy without medication, while one (3.3%) subject identified 62 days and one (3.3%) subject was in therapy 210 days without therapy. In the control group, 14 (46.7%) subjects were in therapy without medication and one (3.3%) subject was in therapy 90 days without medication.

## Findings

Further exploration of data was done by examining the interval level variables obtained from the Mosher Guilt Inventory and the Beck Depression Inventory. To determine if there was a significant difference within groups and in the scores obtained between the

experimental Group 1 and the Control Group 2, a two-way analysis of variance with repeated measures was applied to the data. A two-group before and after design was used resulting in pre and posttest scores on the MGI and BDI. The MGI and BDI were administered to each of the 30 subjects in the sample yielding pretest scores. After the experimental group had been exposed to the reframing technique, both groups were posttested using the MGI and BDI yielding posttest scores. The pretest and posttest means for guilt and depression are presented in Table 13 and Table 14.

Table 13

Pretest Mean Scores of Sample on Attribute of Guilt

| Group | n | M | SD |
|---|---|---|---|
| Experimental | 15 | 230.66667 | 109.51299 |
| Control | 15 | 283.06667 | 130.26537 |

n=30

Posttest Mean Scores of Sample on Attribute of Guilt

| Group | n | M | SD |
|---|---|---|---|
| Experimental | 15 | 175.20000 | 96.07676 |
| Control | 15 | 263.60000 | 95.35857 |

Note: The higher the score, the greater the scripted guilt.

n=30

Table 14

Pretest Mean Scores of Sample on Attribute of Depression

| Group | n | M | SD |
|---|---|---|---|
| Experimental | 15 | 31.26667 | 7.51633 |
| Control | 15 | 30.20000 | 6.85774 |

n=30

Posttest Mean Scores of Sample on Attribute of Depression

| Group | n | M | SD |
|---|---|---|---|
| Experimental | 15 | 23.00000 | 7.88307 |
| Control | 15 | 27.60000 | 7.45271 |

Note: Possible range for scale is 0 to 63. Normal range, 0 to 9; mild depression, 10 to 15; mild-moderate depression, 16 to 19; moderate-severe, 20 to 29; severe, 30 to 63. n=30

## Hypotheses Testing

All five hypotheses were tested for significance. The alpha was set at $p < .05$. A two-way analysis of

variance with repeated measures was used to test Hypotheses 1 and 2. Hypothesis 1 was: Depressed females who are exposed to the reframing technique will have less guilt than those females who are not exposed to the reframing technique. Hypothesis 2 was: Depressed females who are exposed to the reframing technique will have less depression than those females who are not exposed to the reframing technique.

In Hypothesis 1, after the sample of 30 females was randomly assigned to either the experimental or control groups, reframing therapy was given to the experimental group of females. Scores on the Mosher Guilt Inventory (MGI) and the Beck Depression Inventory (BDI) were obtained before and after treatment. The MGI was used as the quantitative measure of the level of guilt. The BDI was used as the quantitative measure of depression. No difference in pretest means of both groups was found.

No significant difference in guilt levels was found between the depressed females who were exposed to reframing therapy and those females who were not. The analysis of variance (ANOVA) yielded a calculated $\underline{F}=4.09$ ($p = .0528$) between the group who received

reframing therapy and the group who had no reframing therapy. Thus, no support was found for Hypothesis 1. The results are displayed in Table 15.

In Hypothesis 2, scores on the Beck Depression Inventory (BDI) were also obtained before and after the reframing treatment. The BDI was used as the quantitative measure of the level of depression. No difference in pretest means of both groups was found. No significant difference in depression levels was found between those females who were exposed to reframing therapy and those females who were not exposed to reframing therapy. The analysis of variance yielded a calculated $F=.72$ ($p=.4023$) between the group who received reframing therapy and the group who had no reframing therapy. Thus, no support was found for Hypothesis 2 (see Table 16).

The measuring of the level of guilt during the pretesting phase of this study showed that the control group's mean was higher on the MGI than the experimental group. Measuring of the level of depression during the pretesting phase of this study showed that the mean scores on the BDI of the experimental group was

marginally higher than the control group's mean score. The pretest means for the experimental and control groups are depicted in Tables 13 and 14, respectively.

After the experimental group was exposed to the treatment variable of reframing, the posttesting of both experimental and control groups was completed. No significant difference in guilt levels was found between the depressed females who were exposed to reframing and those depressed females who were not. The analysis of variance with repeated measures on the attribute of guilt yielded a calculated $F=3.86$ ($p=.0595$) and no statistical difference was found between the pretest and posttest scores for guilt. Thus, no support was found for Hypothesis 1. The results are displayed in Table 15.

For measuring the level of depression during the posttesting phase of this study, an analysis of variance (ANOVA) with repeated measures was calculated. No significant difference in depression levels was found between those females who were exposed to reframing therapy and those females who were not exposed to reframing therapy.

The analysis of variance with repeated measures yielded a $F=9.65$ ($p=.0043$) which indicated that a statistically significant difference was found between the pretest means and the posttest means depression scores. Thus, no support was found for Hypothesis 2. The data showed a significant decrease because from pretest depression scores to posttest depression scores in both the experimental and control groups (see Table 16).

After the experimental group was exposed to the treatment variable of reframing, the posttesting of both experimental and control groups showed a considerable drop in the mean score between the pretest mean of the experimental group and the posttest mean of the control group. On the other hand, the pretest mean of the control and the posttest mean was marginally smaller.

The posttesting of both experimental and control groups showed that the experimental group's mean score was lower than the pretesting mean score, after the experimental group was exposed to the treatment variable of reframing. The mean scores between pre and posttesting of the experimental group on the attribute

of depression was 8.26 points. In comparison, the control group's pre and posttesting mean scores were marginally smaller by 2.6 points (see Table 14).

Table 15

Summary of Analysis of Variance with Repeated Measure on Attribute of Guilt

| Source of Variance | Sum of Squares | df | Mean Square | F | Prob |
|---|---|---|---|---|---|
| Between Groups | 74342.40000 | 1 | 74342.40000 | 4.09 | .0528 |
| Error | 509217.53333 | 28 | 28509217.53333 | | |
| Within Groups | 21056.26667 | 1 | 21056.26667 | 3.86 | .0595 |
| Pre/Post | | | | | |
| Interaction | 4860.00000 | 1 | 4860.00000 | .89 | .3534 |
| Error | 152788.73333 | 28 | 5456.74048 | | |
| Total | 762264.93333 | 59 | | | |

Significant $F=4.08$
$p < .05$

Table 16

Summary of Analysis of Variance with Repeated Measure on Attribute of Depression

| Source of Variance | Sum of Squares | df | Mean Square | F | Prob |
|---|---|---|---|---|---|
| Between Groups | 46.81667 | 1 | 46.81667 | .72 | .4023 |
| Error | 1812.66667 | 28 | 64.73810 | | |
| Within Groups | | | | | |
| Pre/Post | 442.81667 | 1 | 442.81667 | 9.65 | .0043* |
| Interaction | 120.41667 | 1 | 120.41667 | 2.63 | .1164 |
| Error | 1284.26667 | 28 | 45.86667 | | |
| Total | 3706.98335 | 59 | | | |

Significant F=4.08
*p <.05

The third hypothesis was: Age and length of time taking medication with therapy will be positively related to levels of guilt and depression before treatment with reframing. Pearson's Product Moment Correlation Coefficient (r) was calculated to compare and identify the relationship between age, length of time taking medication with therapy and levels of guilt

and depression before treatment with reframing therapy (see Table 17).

Table 17

Pearson's Correlation of Age and Pretest Guilt and Depression Scores

| Variables | r | | p | |
|---|---|---|---|---|
| | Pretest Scores | | | |
| | Guilt | Depression | Guilt | Depression |
| Age | -.2709 | .1416 | .074 | .288 |
| Number of days Taking Medication While in Therapy | -.1933 | -.0696 | .153 | .357 |
| Number of days Taking Medication Without Therapy | .0525 | .1073 | .391 | .286 |

n=30
p <.05

During data collection, subjects were asked to give their ages. Subjects were also asked to identify the number of days taking medication while in therapy as well as the number of days taking medication without being in therapy. These variables were correlated with

each subject's pretest guilt and depression score using Pearson's Product Moment Coefficient (r). None of the correlations between age, number of days taking medication with or without therapy were statistically significant. Thus, no support was found for Hypothesis 3 (see Table 17).

The fourth hypothesis was: Ethnic background, marital status, religious background and type of medication will be related to the levels of guilt and depression before treatment with reframing technique. One-way ANOVA's were calculated for each nominal level variable with the dependent variables of pretest guilt and depression levels. The categories for ethnic background were: Anglo, Black, Mexican, Native, Asian and Other. The citizenship classification was American for each category.

Table 18

Summary of Analysis of Variance of Pretest Guilt Scores and Ethnicity

| Source of Variance | Sum of Squares | df | Mean Square | F | Sig. |
|---|---|---|---|---|---|
| Between Groups | 103310.7459 | 2 | 51655.3729 | 4.3212 | .0235* |
| Within Groups | 322752.7208 | 27 | 11953.8045 | | |
| Total | 426063.4667 | 29 | | | |

n=30
*p <.05

Table 19

Summary of Analysis of Variance of Pretest Guilt Scores and Marital Status

| Source of Variance | Sum of Squares | df | Mean Square | F | Sig. |
|---|---|---|---|---|---|
| Between Groups | 41198.9667 | 3 | 13732.9889 | .9277 | .4413 |
| Within Groups | 384864.5000 | 26 | 14802.4808 | | |
| Total | 426063.4667 | 29 | | | |

n=30
p <.05

Table 20

Summary of Analysis of Variance of Pretest Guilt Scores and Religion

| Source of Variance | Sum of Squares | df | Mean Square | F | Sig. |
|---|---|---|---|---|---|
| Between Groups | 34611.3455 | 4 | 8652.8364 | .5526 | .6989 |
| Within Groups | 391452.1212 | 25 | 15658.0848 | | |
| Total | 426063.4667 | 29 | | | |

n=30
p <.05

Table 21

Summary of Analysis of Variance of Pretest Guilt Scores and Type of Medication

| Source of Variance | Sum of Squares | df | Mean Square | F | Sig. |
|---|---|---|---|---|---|
| Between Groups | 15407.3167 | 3 | 5135.7722 | .3252 | .8071 |
| Within Groups | 410656.1500 | 26 | 15794.4673 | | |
| Total | 426063.4667 | 29 | | | |

n=30
p <.05

The data for ethnic background and pretest guilt scores revealed that a significant relationship existed between

ethnicity and pretest guilt levels. Support was found for Hypothesis 4. To determine which ethnic category was significantly higher on guilt, a Newman Keuls post hoc test was done. The results revealed that the pretest guilt levels of Black-Americans were significantly higher (M=353.3750, SD=158.8368) than the pretest guilt levels of subjects in the Anglo American category (M=221.7727, SD=83.9086). The result are displayed in Table 22.

Table 22

Summary Table of Newman Keuls Post Hoc Test

| Group | Count | M | SD | Minimum Score | Maximum Score |
|---|---|---|---|---|---|
| Group 1 | 22 | 221.7727 | 83.9086 | 107.0000 | 387.0000 |
| Group 2 | 8 | 353.3750 | 158.8386 | 134.0000 | 646.0000 |
| Total | 30 | 256.8667 | 121.2099 | 107.0000 | 646.0000 |

The fifth hypothesis was: Length of time taking medication without reframing will be positively related

to guilt and depression levels. Pearson's Product Moment Correlation Coefficient (r) was calculated to identify the relationship between length of time of taking medication without reframing and pretest levels of guilt and depression.

During data collection, subjects were asked to identify the length of time taking medication without reframing therapy. The length of time (see Table 6) was calculated in days. A majority, 28 (93%) subjects identified zero to 50 as the number of days of taking medication without reframing therapy. Length of time (in days) of taking medication without being exposed to reframing therapy was correlated with the subject's guilt and depression levels.

Using the Pearson's Product Moment Coefficient (r), the results showed no significant relationship between length of time (in days) of taking medication without reframing therapy and the level of guilt $r=.0525$ ($p=.391$). When length of time (in days) of taking medication without reframing therapy was correlated with depression levels, the results showed no significant relationship $r=.1073$ ($p=.286$). Therefore, no

significant relationship was identified. Thus, Hypothesis 5 was not supported.

## Summary

In summary, the data were summarized and displayed in tables in this chapter. In Hypothesis 1, the independent variable, reframing therapy, did not statistically lower the dependent variables, guilt and depression levels. Therefore, no support was found for Hypothesis 1.

For Hypothesis 2, the independent variable, reframing therapy, did not statistically lower the dependent variable of guilt levels however, the independent variable, reframing therapy, did show a significant difference between pretest means and posttest means on the dependent variable, depression levels. In Hypothesis 3, no relationship was found between age and length of time (in days) of taking medication before treatment with reframing therapy.

A relationship was found in Hypothesis 4 between ethnicity and pretest guilt levels. Thus, support was found for Hypothesis 4. The fifth Hypothesis results

indicated that no significant relationship between length of time (in days) of taking medication without reframing and guilt and depression levels. Thus, no support was found for Hypothesis 5. A discussion of the findings, conclusions and implications for the study are discussed in Chapter 5. In addition, recommendations for further study are outlined.

# Chapter 5

## Summary of the Study

The problem under study during this investigation was: Will the use of reframing as a paradoxical psychotherapeutic intervention be effective in reducing the level of guilt in females diagnosed with a depressive disorder? The psychological effects of guilt can be healthy or unhealthy. If guilt was viewed as a dysfunctional system of internal behaviors which produced unhealthy effects, these unhealthy effects could be minimized by using reframing, a paradoxical strategy. Through the use of reframing, interventions can be initiated to change the context and meaning of a dysfunctional behavioral system and thereby decrease or possibly eliminate the negative effects of guilt (Watzlawick et al., 1967).

In this study the hypotheses under investigation were:

1) Depressed females who are exposed to the reframing technique will have less guilt than those females who are not exposed to the reframing technique;

2) Depressed females who are exposed to the reframing technique will have less depression than those females who are not exposed to the reframing technique;

3) Age and length of time taking medication with therapy will be positively related to the levels of guilt and depression before treatment with reframing;

4) Ethnic background, marital status, religious background and type of medication will be related to the levels of guilt and depression before treatment with reframing, and;

5) Length of time taking medication without reframing will be positively related to guilt and depression levels. The ultimate purpose was to determine the effectiveness of reframing therapy on guilt and depression reduction with depressed females.

## Summary

Thirty females from two outpatient clinics, who agreed to participate in the study and met the criteria for inclusion, were randomly assigned, using a table of random numbers, to either the experimental or control groups. All 30 of the subjects completed the data

collection process. After baseline data collection was completed, the 15 subjects assigned to the experimental group were exposed to three, one-to-one therapy sessions in which the reframing technique was used. Upon completion of the therapy sessions, all subjects completed the posttest data.

In Hypothesis 1, reframing therapy did not reduce the levels of guilt. In Hypothesis 2, a statistically significant difference between pretest means and posttest means on depression levels was found. No correlations between age and length of time taking medication with therapy were found in Hypothesis 3.

A relationship between ethnicity and pretest guilt levels was found in Hypothesis 4. In the fifth Hypothesis, no relationship was found between length of time (in days) of taking medication with or without therapy and guilt and depression levels.

## Discussion of Findings

The purpose of this study was to determine the effectiveness of reframing therapy on guilt and depression reduction with females diagnosed with

depression. In the literature, guilt and depression were found to be related (Foulds et al., 1960; Laxer, 1964; Harrow & Amdur, 1971). One conclusion that could be reached from these data was that persons diagnosed as depressed tend to endorse feelings of guilt with greater frequency than do other psychiatric groups and normal subjects. Yet, the literature concerning guilt and its relation to mental patients in general or depressive disorders in particular was scant (Harrow & Amdur, 1971).

According to Lewis (1971), guilt can be unhealthy and dysfunctional in its psychological effects. These effects upon human behavior result in psychic energy being used in non-productive ways and prevent positive growth and psychological well-being.

Beck (1981) and Kraft (1985) found that by using, in therapy, a paradoxical strategy, reframing, with depressive subjects, depression could be significantly reduced. From these data, one conclusion was since guilt is associated with depression, the negative effects of guilt could possibly be reduced.

Research Hypotheses

Hypothesis 1: Depressed females who are exposed to reframing technique will have less guilt than those females who are not exposed to the reframing technique. Beck (1981) and Kraft (1985) found statistical evidence that reframing therapy reduced depression levels. Subjects, in this present study, did not have a significant reduction in guilt levels. The subjects' scores on the Mosher Guilt Inventory did decrease slightly; however the decrease in guilt levels was not statistically significant. No support was found for this hypothesis. From the review of literature, no other studies were found in which guilt reduction was the focus. Therefore, no comparison of like findings can be identified.

Hypothesis 2: Depressed females who are exposed to reframing technique will have less depression than those females who are not exposed to the reframing technique. Feldman et al. (1982) and Watzlawick et al. (1974) concluded that reframing therapy was effective in depression reduction. From the results of the present investigation, a significant difference was found

between the subjects' pretest means depression levels and the posttest means depression levels. Support was found for Hypothesis 2 which also has been identified by previous research investigations (Beck & Strong, 1982; Kraft, 1985). In support of theory, postive reframing statements (Watzlawick et al., 1967) do qualify as therapeutic double binds in reducing depression scores. In addition, this current investigation may also lend support for Harrow and Amdur's (1971) notion that all depressed persons may not necessarily exhibit the elements of guilt. The possibility exists that the positive reframing statements were not worded exactly in prescribing the subject's symptoms from one session to the next. For example, the therapist could have said, "Continue, just as you have been doing, to feel (the subject's own descriptive words for the negative feelings)" instead of "set aside exactly 15 minutes each day and feel (the negative feeling(s))". The wording may be crucial for an effective change in the guilt experience.

Hypothesis 3: Age and length of time taking medication with therapy will be positively related to

the levels of guilt and depression before treatment with reframing. Beck (1967) wrote that as one ages the more likely one is to become depressed. In the current study, the mean age of the females subjects was 36.6 years. Klerman and Weissman (1980) stated that women past 40 years of age are more likely to suffer from depression than younger women. However, this assertion does not account for the present or absence of guilt associated with depression in females. No relationship was found between guilt and depression levels and length of time taking medication. Hypothesis 3 was not supported.

Hypothesis 4: Ethnic background, marital status, religious backgound and type of medication will be related to the level of guilt and depression before treatment with reframing. Results from the present investigation revealed that Black-Americans' pretest guilt levels were higher than Anglo-Americans' guilt levels. Thus, a significant relationship was found between ethnicity and pretest guilt levels. Anthropological, developmental and sociological theorists have hypothized, studied and discussed ethnic

and cultural differences in child-rearing practices between Anglo and Black-Americans for years; and, since guilt is a learned behavior (Murphy, 1978), this observation may account for this finding.

Hypothesis 5: Length of time taking medication without reframing will be positively related to guilt and depression levels. One of the aims of this investigation was to add to existing data and explore whether reframing therapy would be effective in the treatment of guilt associated with depression. From this research, a majority, 53% of the subjects, was taking an anti-depressant. Since medicating of subjects suffering from depressive disorders is standard practice from a medical perspective, the lowering of guilt and depression levels from medication alone was a consideration. The Pearson's Product Moment Correlation Coefficient ($r$) calculations revealed no relationship was found between length of time taking medication without reframing therapy and guilt and depression levels. Therefore, hypothesis 5 was not supported.

## Conclusions and Implications

Reframing, a paradoxical intervention, was found to be effective in reducing depression scores but not guilt scores. Additionally, while depression scores decreased, reframing therapy did not increase guilt scores by its paradoxical effects either. The findings of this study were:

1) Reframing therapy was effective in reducing depression scores.

2) Reframing therapy did not significantly reduce guilt scores.

3) No relationship was found between age and length of time taking medication with therapy and guilt and depression levels.

4) A significant relationship was found between Black females and guilt levels. The data revealed Black females had higher pretest guilt levels than White females.

5) No relationship was found between the length of time taking medication without reframing therapy and guilt and depression levels.

## Implications for Psychiatric-Mental Health Nursing Practice

From a theoretical and practice perspective, reframing, a paradoxical intervention, was found to be effective in reducing depression. Guilt reduction was not shown to be significant with the use of reframing therapy. The psychiatric-nurse therapist may come to see the value in the use of reframing technique by adding it to a list of viable alternatives in therapy when dealing with depressive clients.

A thorough self-report and analysis of the client's perception(s) of how they were reared may provide valuable data as to whether reframing could or would be effective in guilt reduction with respect to the negative feelings associated with it. One of the ultimate goals in therapy is therapeutic change. If positive reframing technique can bring about this change with respect to depression, then with use, a way may be found to reduce the negative effects of guilt as well.

Guilt is difficult to identify apart from other dysfunctional behaviors due to the private nature of guilt. However, a consciousness-raising within the

mental health community about the need to focus on the role that guilt plays within the Western culture is extremely important. From a dysfunctional perspective, guilt consumes vast amounts of energy which, if reframed, could be used to promote an individual's psychological well-being. And finally, through further research and sensitivity in therapy practice with adult females, nurse-therapists can contribute to improve practice models for such groups and foster mental health-promoting relationships within the client view of the self.

## Recommendations for Further Study

Several recommendations have evolved from the current investigation and are presented as they relate to the research design, analysis of the data, further study, and nursing practice.

1) Develop and test an instrument which more closely measures guilt in relation to paradoxical-type interventions in therapy. Data from such an instrument should strongly correlate with less dysfunctional types of behavior.

2) Develop and test an instrument which identifies the type and severity of guilt in females with depressive disorders. Such an instrument would aid in selecting the appropriate intervention for therapy and ease the intensity of psychic pain.

3) Include significant others in the therapy process. This type of involvement might have more impact on viewing the self more openly.

4) Compare real, neurotic, and existential guilt in relation to dysfunctional behavior found in a population of guilt-ridden females. This comparison would add knowledge about each group's perception of dysfunctional behavior.

5) Correlate a perception of child-rearing practice scale with demographic characteristics of age, marital status, education, and ethnicity as well as economic factors, number of children, degree of social change and role perception. Patterns may emerge that have predictive value for further research.

6) Replicate the study with a larger sample, longer therapeutic sessions times, larger number of sessions, and follow-up protocols after therapy has terminated.

These replications might lead to predictions of differences among various protocols.

7) Repeat the study with older females and compare them with younger females who exhibit guilt. Validation of content and the effects on type of reframing used might emerge.

8) With women suffering from the negative feelings of guilt, give the exact worded directive for each encounter versus altering the verbal directive as to wording. Comparisons of this protocol could lead to refinement of the postive reframing technique and its impact.

## References


Abdellah, F. G., & Levine, E. (1979). Better patient care through nursing research (2nd ed.). New York: Macmillan.

Abrams, R. D., & Finesinger, J. E. (1953). Guilt reactions in patients with cancer. Cancer, 6, 474-482.

Alpert, H. S. (1983). A quantitative theory of guilt and its resolution in group therapy. In L. R. Wolberg & M. Arsonson (Eds.). Group and Family Therapy. New York: Brunner-Mazel.

Amdur, M. J., & Harrow, M. (1972). Conscience and depressive disorders. British Journal of Psychiatry, 120, 259-264.

American Psychiatric Association. (1980). Diagnostic and statistical manual of mental disorders (3rd ed.). Washington, DC: Author.

Arieti, S. (1959). American handbook of psychiatry. New York: Basic Books.

Aronosom, E. (1969). The theory of cognitive dissonance: A current perspective. In L. Berkowitz (Ed.). Advances in experimental social psychology, Vol. 4. New York: Academic Press.

Ascher, L. M., & Turner, R. M. (1979). Paradoxical intention and insomnia: An experimental investigation. Behavioral Research and Therapy, 17, 408-411.

Ascher, L. M., & Turner, R. M. (1980). A comparison of two methods for the administration of paradoxical intention. Behavior Research and Therapy, 18, 121-126.

Ausubel, D. (1955). Relationship between shame and guilt in the socializing process. Psychological Review, 62, 378-391.

Bandler, R., & Grinder, J. (1982). Reframing. Utah: Real People Press.

Bateson, G., Jackson, D. D., Haley, J., & Weakland, J. (1956). Toward a theory of schizophrenia. Behavioral Science, 1(4), 251-264.

Beck, A. T., & Stein, D. (1960). The self concept in depression. Unpublished manuscript.

Beck, A. T. (1961a). An inventory for measuring depression. Archives of General Psychiatry, 4, 561-571.

Beck, A. T. (1961b). A systematic investigation of depression. Comprehensive Psychiatry, 2, 162-170.

Beck, A. T., & Ward, C. H. (1961c). Dreams of depressed patients: Characteristic themes in manifest content. Archives of General Psychiatry, 5, 462-467.

Beck, A. T., Sethi, B., & Tuthill, R. (1963). Childhood bereavement and adult depression. Archives of General Psychiatry, 9, 295-302.

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

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

Beck, A. T. (1974a). Depressive neurosis. In S. Arieti (Ed.). American handbook of psychiatry: Vol. 3. Basic Books.

Beck, A. T., & Beamersderfer, A. (1974b). Assessment of depression: The depression inventory. Psychological Measurements in Psychopharmacology, 7, 151-169.

Beck, A. T. (1979). Cognitive therapy of depression. New Guilford Press.

Beck, C. M., Rawlins, R. P., & Williams, S. R. (1984). Mental health psychiatry nursing: A holistic life-cycle approach. St. Louis: C. V. Mosby.

Beck, J. T. (1981). Effects of positive and negative reframing on change in short term counseling. Dissertation Abstracts International, 41, 363-B (University Microfilms No. 42/01-B, 363).

Beck, J. T., & Strong, S. R. (1982). Stimulating therapeutic change with interpretations: A comparison of positive and negative connotation. Journal of Counseling Psychology, 29, 551-559.

Becker, R. J. (1967). Sin, illness, and guilt. In D. Belgum (Ed.). Religion and Medicine: Essays on Meaning, Values of Health. Iowa: Iowa State University Press.

Belgum, D. (1967). Patient or penitent. In D. Belgum (Ed.). Religion and Medicine: Essays on Meaning, Values and Health. Iowa: Iowa State University Press.

Belgum, D. (1985). Guilt. Counseling and Values, 29(4), 128-140.

Bowles, C. (1978). Guilt: how it affects your patients, how it affects you. Nursing Care, 12, 10.

Buber, M. (1958). Guilt and guilt feeling. Cross Current, 8, 193-210.

Buda, B. (1972). Utilization of resistance and paradox communication in short-term psychotherapy. Psychotherapy & Psychosomatics, 20(3-4), 200-211.

Cameron, N. (1963). Personality development and psychopathology. Boston: Houghton Mifflin.

Campbell, C. (1978). Nursing diagnosis and intervention. New York: John Wiley & Sons.

Clark, C. C. (1977). Reframing. American Journal of Nursing, 77, 598-601.

Coleman-Nelson, M. (1962). Effect of paradigmatic techniques on the psychic economy of borderline patients. Psychiatry, 25(2), 119-134.

Downie, N. M., & Starry, A. R. (1977). Descriptive and inferential statistics. New York: Harper & Row.

Dunlap, I. (1949). Habits: Their making and unmaking (2nd ed.). New York: Liveright.

Elasser, G. (1967). Objective guilt and neurosis. In D. Belgum (Ed.). Religion and Medicine: Essays on Meaning, Values and Health. Iowa: Iowa State University Press.

Erikson, E. (1963). Childhood and society (2nd ed.). New York: Norton.

Farrelly, F., & Brandsma, J. (1974). Provocative therapy. California: Meta Publications.

Fay, A. (1976). Clinical notes on paradoxical therapy. Psychotherapy: Theory, Research and Practice, 13(2), 118-122.

Fay, A. (1978). Making things better by making them worse. New York: Hawthorne.

Feldman, D. A., Strong, S. R., & Danser, D. B. (1982). A comparison of paradoxical and nonparadoxical interpretations and directives. Journal of Counseling Psychology, 29, 572-579.

Festinger, L. (1957). A theory of cognitive dissonance. Evanton: Row, Peterson.

Fisch, R., Weakland, J. H., & Segal, L. (1982). The tactics of change: Doing therapy briefly. San Francisco: Jossey-Bass.

Foulds, G. A., Caine, T. M., & Creasy, M. A. (1960). Aspects of extra-and intro-punitive expression in mental illness. Journal of Mental Science, 106, 599-610.

Foulds, G. A. (1965). Personality and personal illness. London: Tavistock.

Frankl, V. E. (1960). Paradoxical intention: A logotherapeutic technique. American Journal of Psychotherapy, 14, 520-535.

Frankl, V. E. (1970). Psychotherapy and existentialism: Selected papers on logotherapy. London: Sourvenir Press.

Frankl, V. E. (1975). Paradoxical intention and dereflection. Psychotherapy: Theory, Research and Practice, 12(3), 226-237.

Frankl, V. E. (1978). The unheard cry for meaning: Psychotherapy and humanism. New York: Simon & Schuster.

Freedman, A. M., & Kaplan, H. I. (Eds.). (1976). Comprehensive textbook of psychiatry. Baltimore: Williams & Wilkins.

Friedman, A. S. (1964). Minimal effects of severe depression on cognitive functioning. Journal of Abnormal and Social Psychology, 69, 237-243.

Freud, S. (1917). Mourning and melcholia. In Collected Papers. Vol. 4. London: Hogarth Press and The Institute of Psychoanalysis.

Freud, S. (1923/1961). The ego and the id. In J. Strachey (Ed. and Trans.), The standard edition of the complete psychological works of Sigmund Freud (Vol. 19, pp. 3-66). London: Hogarth Press. (Original work published 1923).

Gardner, R. A. (1970). The use of guilt as a defense against anxiety. Psychoanalytic Review, 57(1), 124-136.

Gentry, D. (1973). Directive therapy techniques in the treatment of migraine headaches: A case study. Psychotherapy: Theory, Research and Practice, 10, 308-311.

Gordon, J. E. (1963). The socialization of primary drives. Personality and Behavior. New York: MacMillan.

Gottschalk, M. R., Gleser, G. C., & Springer, R. R. (1963). Hostility in depression: A clinical view. Journal of Consulting and Clinical Psychology, 43, 375-383.

Green, S. E., & Mosher, D. L. (1985). A causal model of sexual arousal to erotic fantasies. The Journal of Sex Research, 21, 1-23.

Gudjonsson, G. H., & Roberts, J. C. (1983). Guilt and self-concept in secondary psychopaths. Personality & Individual Differences, 4(1), 65-70.

Haber, J., Leach, A. M., Schudy, S. M., & Sideleau, B. F. (1978). Comprehensive Psychiatric Nursing. New York: McGraw-Hill.

Haley, J. (1963). Strategies of psychotherapy. New York: Grune & Stratton.

Haley, J. (1973). Uncommon therapy. New York: Ballantine Books.

Haley, J. (1976). Problem-solving therapy. San Francisco: Jossey-Bass.

Harrow, M., Colbert, J., Detre, T., & Bakeman, R. (1966). Symptomatology and subjective experience in current depressive states. Archives of General Psychiatry, 14, 203-212.

Harrow, M., & Amdur, M. J., (1971). Guilt and depressive disorders. Archives of General Psychiatry, 25, 240-246.

Heider, F. (1958). The psychology of interpersonal relations. New York: Wiley.

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

Hyder, O. Q. (1971). The christian's handbook of psychiatry. New Jersey: Revell.

Izard, C. E. (1979). Patterns of emotions: A new analysis of anxiety and depression. New York: Academic Press.

Jackson, D. (1968). Family interaction, family homeostatis and some implications for conjoint family therapy. In D. Jackson (Ed.). Therapy, communication, and change (Human Communications, Vol. 2). Palo Alto: Science and Behavior Books.

Jessee, E. H. (1984). The paradoxical treatment of depression in married couples. Dissertation Abstracts International, 45, 1018-B (University Microfilms No. 45/03-B, 1018).

Johnson, S. (1984). Counseling families experiencing guilt. Dimensions of Critical Care Nursing, 3(4), 238-244.

Kelly, K. (1985). Sex, sex guilt, and authoritarianism: Differences in responses to explicit heterosexual and masturbatory slides. The Journal of Sex Research, 21, 68-85.

Klerman, G. L., & Weissman, M. M. (1980). Depression among women: their nature and causes. In M. Guttenlag, S. Salasin, & D. Belle (Eds.). The mental health of women. New York: Academic Press.

Kraft, R. G. (1985). Exploring two types of paradoxical interventions: The effects of positive reframing statements and a paradoxical directive. Dissertation Abstracts International, 46, 1520-A (University Microfilms No. 46/01-A, 1520).

Laxer, R. M. (1964). Relation of real self rating to mood and blame and their interaction in depression. Journal of Consulting Psychology, 28, 533-546.

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

Litenberg, H. (1973). The use of single-case methodology in psychotherapy research. Journal of Abnormal Psychology, 82, 87-101.

Loeb, A., Feshback, S., Beck, A. T., & Wolf, A. (1964). Some effects of reward upon the social perception and motivation of psychiatric patients varying in depression. Journal of Abnormal Social Psychology, 68, 609-616.

Loeb, A., Beck, A. T., Diggory, J. C., & Tuthill, R. (1966). The effects of success and failure on mood, motivation, and performance as a function of predetermined level of depression. Unpublished manuscript.

Lopez, R. G., & Wambach, C. A. (1982). Effects of paradoxical and self-control directives in counseling. Journal of Counseling Psychology, 29, 115-124.

Lynd, H. M. (1958). On shame and the search for identity. New York: Harcourt, Brace.

MacKenzie, J. G. (1962). Guilt: Its meaning and significance. New York: Abingdon Press.

Mavissakalian, M., Michelson, L., Greenwald, D., Kornblith, S., & Greenwald, M. (1983). Cognitive-behavioral treatment of agoraphobia: Paradoxical intention vs self-statement training. Behavioral Research and Therapy, 21, 75-86.

Mayer-Gross, W., Slater, E., & Roth, M. (1960). Clinical Psychiatry. (p. 215). London: Casell.

Menninger, K. (1938). Man against himself. New York: Harcourt, Brace.

Metcalfe, M., & Goldman, E. (1965). Validation of an inventory for measuring depression. British Journal of Psychiatry, 111, 240-242.

Mosher, D. L. (1961). The development and validation of a sentence completion measure of guilt. Unpublished Doctoral Dissertation. The Ohio State University.

Mosher, D. L. (1966). The development and multitrait -multimethod matrix analysis of three measures of three aspects of guilt. Journal of Consulting Psychology, 30, 35-39.

Mosher, D. L. (1968). Measurement of guilt in females by self-report inventories. Journal of Consulting and Clinical Psychology, 32, 690-695.

Mosher, D. L. (1979a). The meaning and measurement of guilt. In C. E. Izard (Ed.). Emotions in Personality and Psychopathology. New York: Plenum Press.

Mosher, D. L., & O'Grady, K. E. (1979b). Sex guilt, trait anxiety, and females' subjective sexual arousal to erotica. Motivation and Emotion, 3, 235-249.

Mosher, D. L., & Vonderhiede, S. G. (1985). Contributions of sex guilt and masturbation guilt to women's contraceptive attitude and use. The Journal of Sex Research, 21, 24-39.

Mowrer, O. H. (1967). Morality and mental health. Chicago: Rand McNally.

Murphy, H. B. (1978). The advent of guilt as a common depressive symptom: A historical comparison on two continents. Psychiatry, 41, 229-241.

Newton, J. R. (1968). Therapeutic paradoxes, paradoxical intentions, and negative practices. American Journal of Psychotherapy, 22, 68-81.

Nussbaum, R. C., & Michaux, L. (1963). Direct decision therapy. Los Angeles: Knapp.

O'Connell, D. S. (1983). Symptom perscription in psychotherapy. Psychotherapy: Theory, Research and Practice, 20, 12-20.

O'Grady, K. E., & Janda, L. H. (1979). Factor analysis of the Mosher Forced-Choice Guilt Inventory. Journal Consulting and Clinical Psychology, 47, 1131-1133.

Piers, G., & Singer, M. B. (1953). Shame and guilt: a psychoanalytic and a cultural study. Springfield: Thomas.

Piers, G., & Singer, M. B. (1971). Shame and guilt. New York: Norton.

Prosen, M., Clark, D. C., Harrow, M., & Fawcett, J. (1983). Guilt and conscience in major depressive disorders. American Journal of Psychiatry, 140(7), 839-844.

Rabin, C. (1981). The single-case design in family therapy evaluation research. Family Process, 20, 351-366.

Redlich, F. C., & Freedman, D. X. (1966). The theory and practice of psychiatry. (pp. 98, 534). New York: Basic Books.

Rosen, J. N. (1953). Direct analysis: Selected papers. New York: Grune & Stratton.

Rosen, J. N. (1962). Direct psychoanalytic psychotherapy. New York: Grune & Stratton.

Rosenthal, S. H., & Klerman, G. L. (1966). Content and consistency in the endogenous depressive pattern. British Journal of Psychiatry, 112, 471-484.

Ross, A. (1975). On guilt, responsibility and punishment. California: University of California Press.

Schneiders, A. A. (1963). The anarchy of feeling. New York: Sheed & Ward.

Schneiders, A. A. (1968). The nature and origins of guilt. Transactions of The New York Academy of Science, 30, 705-713.

Scott, J. F. (1971). Internalization of norms: a socio-cultural social theory of moral committment. New Jersey: Prentice-Hall.

Selvini-Palazzoli, M., Boscolo, L., Cecchin, G., & Prata, G. (1978). Paradox and counterparadox. New York: Jason Aronson.

Stean, H. S. (1964). The contribution of paradigmatic psychotherapy to psychoanalysis. Psychoanalytic Review, 51(3), 29-45.

Strong, S., & Matross, R. (1973). Change processes in counseling and psychotherapy. Journal of Counseling Psychology, 20, 25-37.

Teismann, M. W. (1979). Jealousy: systematic, problem-solving therapy with couples. Family Process, 18, 151-160.

Tennen, H. (1977). Perspectives on paradox: Application and explanations. In M. Rohrbaugh, Paradoxical strategies in psychotherapy, paper presented to the American Psychological Association, San Francisco, California.

Tennen, H., Rohrbaugh, M., Press, S., & White, L. (1981). Reactance theory and therapeutic paradox: A compliance-defiance model. Psychotherapy: Theory, Research and Practice, 18(1), 14-22.

Tournier, P. (1962). Guilt and grace. New York: Harper.

Turner, R. M., & Ascher, L. M. (1979). Controlled comparison of progressive relaxation, stimulus control, and paradoxical intention therapies for insomnia. Journal of Consulting and Clinical Psychology, 47, 500-508.

Turner, R. M., & Ascher, L. M. (1982). Therapist factor in the treatment of insomnia. Behavioral Research and Therapy, 20, 33-40.

Ward, H. P. (1972). Shame: A necessity for growth in therapy. American Journal of Psychotherapy, 26, 232.

Watzlawick, P. (1965). Paradoxical predictions. Psychiatry, 28, 368-374.

Watzlawick, P., Beavin, J., & Jackson, D. D. (1967). Pragmatics of human communication. New York: W. W. Norton.

Watzlawick, P., Weakland, J., & Fisch, R. (1974). Change: Principles of problem formation and problem resolution. New York: W. W. Norton.

Week, G., & L'Abate, L. (1978). A bibliography of paradoxical methods in the psychotherapy of family systems. Family Process, 17, 95-98.

Wilson, E. B. (1952). An introduction to scientific research. New York: McGraw-Hill.

Wilson, H. S., & Kneisl, C. R. (1979). Psychiatric nursing. Menlo Park: Addison-Wesley.

Wilson, H. S. (1985). Research in nursing. Menlo Park: Addison-Wesley.

Wolberg, L. R. (1965). The technic of short-term psychotherapy. In L. R. Wolberg (Ed.). Short-term Psychotherapy. New York: Grune and Stratton.

Wright, R. M., & Strong, S. R. (1982). Stimulating therapeutic change with directives: An exploratory study. Journal of Counseling Psychology, 29, 199-202.

Yates, J. (1958). The application of learning theory to the treatment of tics. Journal of Abnormal and Social Psychology, 56, 175-182.

Zilboorg, G. (1951). Sigmund Freud: His exploration of the life of the mind of man. New York: Scribners' Sons.

# APPENDIX A

## Beck Depression Inventory

NAME _____ DATE _____

# DEPRESSION INVENTORY

**DIRECTIONS**

**On this questionnaire are groups of statements. Please read the entire group of statements in each category. Then pick out the one statement in that group which best describes the way you feel today, that is right now! Circle the letter that corresponds to the statement you have chosen.**

A. (SADNESS)

0 I do not feel sad
1 I feel blue or sad
2a I am blue or sad all the time and I can't snap out of it
2b I am so sad or unhappy that it is quite painful
3 I am so sad or unhappy that I can't stand it

B. (PESSIMISM)

0 I am not particularly pessimistic or discouraged about the future
1a I feel discouraged about the future
2a I feel I have nothing to look forward to
2b I feel that I won't ever get over my troubles
3 I feel that the future is hopeless and that things cannot improve

C. (SENSE OF FAILURE)

0 I do not feel like a failure
1 I feel I have failed more than the average person
2a I feel I have accomplished very little that is worthwhile or that means anything
2b As I look back on my life all I can see is a lot of failures
3 I feel I am a complete failure as a person (parent, husband, wife)

D. (DISSATISFACTION)

0 I am not particularly dissatisfied
1a I feel bored most of the time
1b I don't enjoy things the way I used to
2 I don't get satisfaction out of anything any more
3 I am dissatisfied with everything

E. (GUILT)

0 I don't feel particularly guilty
1 I feel bad or unworthy a good part of the time
2a I feel quite guilty
2b I feel bad or unworthy practically all the time now
3 I feel as though I am very bad or worthless

F. (EXPECTATION OF PUNISHMENT)

0 I don't feel I am being punished
1 I have a feeling that something bad may happen to me
2 I feel I am being punished or will be punished
3a I feel I deserve to be punished
3b I want to be punished

G. (SELF—DISLIKE)

0 I don't feel disappointed in myself
1a I am disappointed in myself
1b I don't like myself
2 I am disgusted with myself
3 I hate myself

H. (SELF--ACCUSATIONS)

0 I don't feel I am any worse than anybody else
2 I am critical of myself for my weaknesses or mistakes
2 I blame myself for my faults
3 I blame myself for everything bad that happens

I. (SUICIDAL IDEAS)

0 I don't have any thoughts of harming myself
1 I have thoughts of harming myself but I would not carry them out
2a I feel I would be better off dead
2b I feel my family would be better off if I were dead
3a I have definite plans about committing suicide
3b I would kill myself if I could

J. (CRYING)

0 I don't cry any more than usual
1 I cry more now than I used to
2 I cry all the time now. I can't stop it
3 I used to be able to cry but now I can't cry at all even though I want to

K. (IRRITABILITY)

0 I am no more irritated now than I ever am
1 I get annoyed or irritated more easily than I used to
2 I feel irritated all the time
3 I don't get irritated at all at the things that used to irritate me

L. (SOCIAL WITHDRAWAL)

0 I have not lost interest in other people
1 I am less interested in other people now than I used to be
2 I have lost most of my interest in other people and have little feeling for them
3 I have lost all my interest in other people and don't care about them at all

M. (INDECISIVENESS)

0 I make decisions about as well as ever
1 I try to put off making decisions
2 I have great difficulty in making decisions
3 I can't make any decisions at all any more

N. (BODY IMAGE CHANGE)

0 I don't feel I look any worse than I used to
1 I am worried that I am looking old or unattractive
2 I feel that there are permanent changes in my appearance and they make me look unattractive
3 I feel that I am ugly or repulsive looking

O. (WORK RETARDATION)

0 I can work about as well as before
1a It takes extra effort to get started at doing something
1b I don't work as well as I used to
2 I have to push myself very hard to do anything
3 I can't do any work at all

P. (INSOMNIA)

0 I can sleep as well as usual
1 I wake up more tired in the morning than I used to
2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep
3 I wake up early every day and can't get more than 5 hours sleep

Q. (FATIGABILITY)

0 I don't get any more tired than usual
1 I get tired more easily than I used to
2 I get tired from doing anything
3 I get too tired to do anything

R. (ANOREXIA)

0 My appetite is no worse than usual
1 My appetite is not as good as it used to be
2 My appetite is much worse now
3 I have no appetite at all any more

S. (WEIGHT LOSS)

0 I haven't lost much weight, if any lately
1 I have lost more than 5 pounds
2 I have lost more than 10 pounds
3 I have lost more than 15 pounds

T. (SOMATIC PREOCCUPATION)

0 I am no more concerned about my health than usual
1 I am concerned about aches and pains or upset stomach or constipation
2 I am so concerned with how I feel or what I feel that it's hard to think of much else
3 I am completely absorbed in what I feel

U. (LOSS OF LIBIDO)



0 I have not noticed any recent change in my interest in sex
1 I am less interested in sex than I used to be
2 I am much less interested in sex now
3 I have lost interest in sex completely

# APPENDIX B

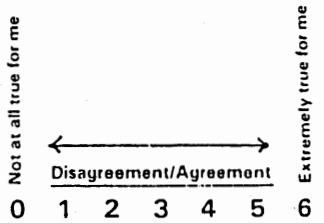
## Mosher Guilt Inventory

# REVISED MG INVENTORY

**DIRECTIONS:**

**This inventory consists of 114 items arranged in pairs of responses written by college students in response to sentence completion stems such as "When I have sexual dreams...". You are to respond to each item as honestly as you can by rating your response on a 7-point scale from 0, which means NOT AT ALL TRUE OF (FOR) ME to 6, which means EXTREMELY TRUE OF (FOR) ME. Ratings of 1 to 5 represent ratings of agreement-disagreement that are intermediate between the extreme anchors of NOT AT ALL TRUE and EXTREMELY TRUE for you. The items are arranged in pairs of two to permit you to compare the intensity of TRUENESS for you. This limited comparison is often useful since people frequently agree with only one item in a pair. In some instances, it may be the case that both items or neither item is true for you, but you will usually be able to distinguish between items in a pair by using different ratings from the 7-point range for each item.**

**Rate each of the 114 items from 0 to 6 as you keep in mind the value of comparing items within pairs. Record your answer on the machine scoreable answer sheet by filling in the blank opposite the item number with your rating from 0 to 6. Please do not omit any items; 0's must be filled in to be read by the computer.**




I PUNISH MYSELF...

1. very infrequently.
2. when I do wrong and don't get caught.

WHEN ANGER BUILDS INSIDE ME...

3. I let people know how I feel.
4. I'm angry at myself.

"DIRTY" JOKES IN MIXED COMPANY...

5. do not bother me.
6. are something that make me very uncomfortable.

MASTURBATION...

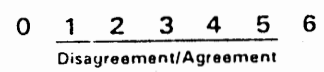
7. is wrong and will ruin you.
8. helps one feel eased and relaxed.

I DETEST MYSELF FOR...

9. nothing, I love life.
10. for my sins and failures.

SEX RELATIONS BEFORE MARRIAGE...

11. should be permitted.
12. are wrong and immoral.



Not at all true for me — Disagreement/Agreement — Extremely true for me

0 1 2 3 4 5 6

SEX RELATIONS BEFORE MARRIAGE...
13. ruin many a happy couple.
14. are good in my opinion.

UNUSUAL SEX PRACTICES...
15. might be interesting.
16. don't interest me.

WHEN I HAVE SEXUAL DREAMS...
17. I sometimes wake up feeling excited.
18. I try to forget them.

AFTER AN OUTBURST OF ANGER...
19. I am sorry and say so.
20. I usually feel quite a bit better.

WHEN I WAS YOUNGER, FIGHTING...
21. didn't bother me.
22. never appealed to me.

ARGUMENTS LEAVE ME FEELING...
23. depressed and disgusted.
24. elated at winning.

"DIRTY" JOKES IN MIXED COMPANY...
25. are in bad taste.
26. can be funny depending on the company.

I DETEST MYSELF FOR...
27. nothing at present.
28. being so self-centered.

WHEN SOMEONE SWEARS AT ME...
29. I swear back.
30. it usually bothers me even if I don't show it.

PETTING...
31. I am sorry to say is becoming an accepted practice.
32. is an expression of affection which is satisfying.

WHEN I WAS YOUNGER, FIGHTING...
33. disgusted me.
34. was always a thrill.

0 1 2 3 4 5 6
Disagreement/Agreement

Not at all true for me ← Disagreement/Agreement → Extremely true for me

0 1 2 3 4 5 6

UNUSUAL SEX PRACTICES...
35. are not so unusual.
36. don't interest me.

AFTER A CHILHOOD FIGHT, I FELT...
37. good, if I won; bad, otherwise.
38. hurt and alarmed.

AFTER AN ARGUMENT...
39. I am sorry for my actions.
40. I feel mean.

SEX...
41. is good and enjoyable.
42. should be saved for wedlock and childbearing.

AFTER AN OUTBURST OF ANGER...
43. I usually feel quite a bit better.
44. I feel ridiculous and sorry that I showed my emotions.

AFTER AN ARGUMENT...
45. I wish I hadn't argued.
46. I feel proud in victory, understanding in defeat.

I DETEST MYSELF FOR...
47. nothing, I love life.
48. not being more nearly perfect

A GUILTY CONSCIENCE...
49. is worse than a sickness to me.
50. does not bother me too much.

"DIRTY" IN MIXED COMPANY...
51. are coarse to say the least.
52. are lots of fun.

WHEN I HAVE SEXUAL DESIRES...
53. I enjoy it like all healthy human beings.
54. I fight them for I must have complete of my body.

AFTER AN ARGUMENT...
55. I am disgusted that I allow myself to become involved.
56. I usually feel better.

0 1 2 3 4 5 6

Disagreement/Agreement

| | Not at all true for me ← Disagreement/Agreement → Extremely true for me | | | | | | |
|---|---|---|---|---|---|---|---|
| | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| OBSCENE LITERATURE... | | | | | | | |
| 57. helps people become sexual perverts. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 58. should be freely published. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ONE SHOULD NOT... | | | | | | | |
| 59. lose his temper. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 60. say "one should not." | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| UNUSUAL SEX PRACTICES... | | | | | | | |
| 61. are unwise and lead only to trouble. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 62. are all in how you look at it. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| UNUSUAL SEX PRACTICES... | | | | | | | |
| 63. are O.K. as long as they're heterosexual. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 64. usually aren't pleasurable because you have preconceived about their being wrong. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| I REGRET... | | | | | | | |
| 65. all of my sins. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 66. getting caught, but nothing else. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| SEX RELATIONS BEFORE MARRIAGE... | | | | | | | |
| 67. in my opinion, should not be practiced. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 68. are practiced too much to be wrong. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| AFTER AND OUTBURST OF ANGER... | | | | | | | |
| 69. my tensions are relieved. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 70. I am jittery and all keyed up. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| AS A CHILD, SEX PLAY... | | | | | | | |
| 71. is immature and ridiculous. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 72. was indulged in. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| I PUNISH MYSELF... | | | | | | | |
| 73. By denying myself a privilege. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 74. for very few things. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| UNUSUAL SEX PRACTICES... | | | | | | | |
| 75. are dangerous to one's health and mental condition | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 76. are the business of those who carry them out and no one else's. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| | Disagreement/Agreement | | | | | | |

Not at all true for me ← Disagreement/Agreement → Extremely true for me

0 1 2 3 4 5 6

ARGUMENTS LEAVE ME FEELING...
77. depressed and disgusted.
78. proud, they certainly are worthwhile.

AFTER AN ARGUMENT...
79. I am disgusted that I let myself become involved.
80. I feel happy if I won or still stick to my own views if I lose.

WHEN I HAVE SEXUAL DESIRES...
81. I attempt to repress them.
82. they are quite strong.

PETTING...
83. is not a good practice until after marriage.
84. is justified with love.

AFTER A CHILDHOOD FIGHT, I FELT...
85. as if I had done wrong.
86. like I was a hero.

SEX RELATIONS BEFORE MARRIAGE...
87. help people adjust.
88. should not be recommended.

IF I ROBBED A BANK...
89. I should get caught.
90. I would live like a king.

AFTER AN ARGUMENT...
91. I am sorry and see no reason to stay mad.
92. I feel proud in victory and understanding in defeat.

MASTURBATION...
93. is wrong and a sin.
94. is a normal outlet for sexual desire.

AFTER AN ARGUMENT...
95. I am sorry for my actions.
96. if I have won, I feel great.

WHEN ANGER BUILDS INSIDE ME...
97. I always express it.
98. I usually take it out on myself.

0 1 2 3 4 5 6

Disagreement/Agreement

Not at all true for me ← Disagreement/Agreement → Extremely true for me

0 1 2 3 4 5 6

AFTER A FIGHT, I FELT...
99. relieved.
100. it should have been avoided for nothing was accomplished.

MASTURBATION...
101. is alright.
102. is a form of self destruction.

UNUSUAL SEX PRACTICES...
103. are awful and unthinkable.
104. are alright if both partners agree.

I DETEST MYSELF FOR...
105. thoughts I sometimes have.
106. nothing, and only rarely dislike myself.

IF I HAD SEX RELATIONS, I WOULD FEEL...
107. all right, I think.
108. I was being used not loved.

ARGUMENTS LEAVE ME FEELING...
109. exhausted.
110. satisfied usually.

MASTURBATION...
111. is all right.
112. should not be practiced.

AFTER AN ARGUMENT...
113. it is best to apologize to clear the air.
114. I usually feel good if I won.

0 1 2 3 4 5 6

Disagreement/Agreement

# APPENDIX C

## Agency Approval

TEXAS WOMAN'S UNIVERSITY
COLLEGE OF NURSING
DENTON, TEXAS 76204

DALLAS CENTER
1810 INWOOD ROAD
DALLAS, TEXAS 75235

HOUSTON CENTER
1130 M. D. ANDERSON BLVD.
HOUSTON, TEXAS 77030

## AGENCY PERMISSION FOR CONDUCTING STUDY*

THE Nacogdoches County MHMR Center

GRANTS TO W. James Robertson, RN, MSN
a student enrolled in a program of nursing leading to a Doctoral Degree at Texas Woman's University, the privilege of its facilities in order to study the following problem:

Will the use of reframing as a psychotherapeutic intervention technique be effective in reducing the level of guilt in females diagnosed with a depressive disorder?

The conditions mutually agreed upon are as follows:

1. The agency (may) (may not) be identified in the final report.
2. The names of consultative or administrative personnel in the agency (may) (may not) be identified in the final report.
3. N/A The agency (wants) (does not want) a conference with the student when the report is completed.
4. N/A The agency is (willing) (unwilling) to allow the completed report to be circulated through interlibrary loan.
5. Other Agency may request a conference with student upon completion, requests a copy of final report and receives rights to dissemination until final review

Date: 6-30-87

Larry Horton
Signature of Agency Personnel

W. James Robertson
Signature of Student

Signature of Faculty Advisor

* Fill out and sign three copies to be distributed as follows: Original-Student; First copy - agency; Second copy - TWU College of Nursing.

/bc

# APPENDIX D

## Agency Approval

TEXAS WOMAN'S UNIVERSITY
COLLEGE OF NURSING
DENTON, TEXAS 76204



DALLAS CENTER
1810 INWOOD ROAD
DALLAS, TEXAS 75235

HOUSTON CENTER
1130 M. D. ANDERSON BLVD.
HOUSTON, TEXAS 77030

## AGENCY PERMISSION FOR CONDUCTING STUDY*

THE University of Texas Mental Sciences Institute

GRANTS TO W. James Robertson, RN, MSN
a student enrolled in a program of nursing leading to a Doctoral Degree at Texas Woman's University, the privilege of its facilities in order to study the following problem:

Will the use of reframing as a paradoxical technique effectively reduce the level of guilt in females diagnosed with a depressive disorder?

The conditions mutually agreed upon are as follows:

1. The agency (may) (may not) be identified in the final report.
2. The names of consultative or administrative personnel in the agency (may) (may not) be identified in the final report.
3. The agency (wants) (does not want) a conference with the student when the report is completed.
4. The agency is (willing) (unwilling) to allow the completed report to be circulated through interlibrary loan.
5. Other _____

Date: 4/28/87

Signature of Agency Personnel

Signature of Student

Signature of Faculty Advisor

* Fill out and sign three copies to be distributed as follows: Original-Student; First copy - agency; Second copy - TWU College of Nursing.

/bc

# APPENDIX E

## Letter of Introduction

# APPENDIX E

## Letter of Introduction

March 1, 1987

My name is W. James Robertson. I am a doctoral student at Texas Woman's University, Houston Campus. I am conducting a study as a part of the requirements for my doctorate. I am trying to study the effectiveness of a particular psychotherapeutic technique called reframing. If you agree to participate, you will be asked to attend three (3) individual thirty minute brief therapy sessions in which this technique of reframing will be used. You will also be asked to respond to two (2) paper and pencil inventories. One inventory contains questions of a personal nature. The questions are designed to find out how you feel about a particular issue, not whether you participate in the issue being presented. These inventories will be given prior to the

beginning of the brief therapy sessions and again the end of the therapy sessions. The format of these sessions will go like this: you will state something to the effect of "I want to stop X-ing." I will ask something like "Is there some place in your life where behavior X is useful and appropriate?" and so on during the thirty minute therapy sessions.

Answering the inventories and receiving instructions with the investigator present should take only one (1) hour of your time. If you agree to participate, traveling to the area of testing will be at your expense. Participation in this study may not benefit you directly. However, a possible indirect benefit would be that the information obtained from the inventories and therapy will assist the mental health workers in providing more effective ways of dealing with your concerns, thereby helping you live fuller and more productive life.

In the course of this study, you may feel uncomfortable while responding to the inventories or participating in the reframing therapy. If you have any of these feelings, the investigator will be present to

assist you in dealing with them. Also, your regular therapist will be available to assist you. If, in the event, you continue to feel uncomfortable and you decide not to participate, you may withdraw at any time. None of the information obtained will placed in your record(s) unless you wish to share this information with your therapist. Your withdrawal will in no way influence the quality of care you receive from the members of the mental health team at this facility. There are no alternatives to this treatment technique other than your regular therapy. If you wish to return to your regular regime, you are free to withdraw at any time.

All information obtained will be strictly confidential. No information will be placed in your record(s). Your name will not be used in the findings. However, I will be happy to share the overall findings upon request. Although no injury is anticipated, if such injury does occur, there will be no compensation provided to you by the investigator, the facility, or the university.

If you have any questions, I would be very pleased to talk with you. You may call me at (409) 569-6891 (nights) or (409) 568-1712 (days). Thank you very much for your participation.

Sincerely,

W. James Robertson, RN, MSN.

# APPENDIX F

## Letter of Introduction

# APPENDIX F

## Letter of Introduction

March 1, 1987

My name is W. James Robertson. I am a doctoral student at Texas Woman's University, Houston Campus. I am conducting a study as a part of the requirements for my doctorate. I am trying to study the effectiveness of a particular psychotherapeutic technique. If you agree to participate, you will be asked to attend three (3) individual thirty minute brief therapy sessions in which this technique of reframing will be used. You will also be asked to respond to two (2) paper and pencil inventories. One inventory contains questions of a personal nature. The questions are designed to find out how you feel about a particular issue, not whether you participate in the issue being presented. These inventories will be given prior to the beginning of the

brief therapy sessions and again the end of the therapy sessions. The format of these sessions will go like this: you will state something to the effect of "I want to stop X-ing." I will ask something like "Is there some place in your life where behavior X is useful and appropriate?" and so on during the thirty minute therapy sessions.

Answering the inventories and receiving instructions with the investigator present should take only one (1) hour of your time. If you agree to participate, traveling to the area of testing will be at your expense. Participation in this study may not benefit you directly. However, a possible indirect benefit would be that the information obtained from the inventories and therapy will assist the mental health workers in providing more effective ways of dealing with your concerns, thereby helping you live fuller and more productive life.

In the course of this study, you may feel uncomfortable while responding to the inventories or participating in the reframing therapy. If you have any of these feelings, the investigator will be present to

assist you in dealing with them. Also, your regular therapist will be available to assist you. If, in the event, you continue to feel uncomfortable and you decide not to participate, you may withdraw at any time. None of the information obtained will placed in your record(s) unless you wish to share this information with your therapist. Your withdrawal will in no way influence the quality of care you receive from the members of the mental health team at this facility. There are no alternatives to this treatment technique other than your regular therapy. If you wish to return to your regular regime, you are free to withdraw at any time.

All information obtained will be strictly confidential. No information will be placed in your record(s). Your name will not be used in the findings. However, I will be happy to share the overall findings upon request. Although no injury is anticipated, if such injury does occur, there will be no compensation provided to you by the investigator, the facility, or the university.

If you have any questions, I would be very pleased to talk with you. You may call me at (409) 569-6891 (nights) or (409) 568-1712 (days). Thank you very much for your participation.

Sincerely,

W. James Robertson, RN, MSN.

# APPENDIX G

## Consent Form

# APPENDIX G

## INFORMED CONSENT

I understand that W. James Robertson is conducting a study which is a part of his requirements for a doctoral degree. Further, I understand that this study is to determine the outcome after the use of a particular counseling method called reframing.

I understand that if I agree to be in this study, I will be asked to attend three (3) individual thirty minute brief therapy sessions. In addition, I, also, understand that I will be asked to take two (2) paper and pencil tests and that two (2) tests will be given before the counseling meetings and two (2) tests after the counseling meetings. I understand that one (1) of the test has questions of a personal nature. However, the questions are designed to find out how I feel about a particular issue and they are not designed to see if I participate in the issue(s) being discussed.

I understand that the counseling meetings will be set up in this way. I will say something like this: "I want to stop X-ing." The counselor will ask me "Is there some place in my life where behavior X is useful and proper?" and so on during the thirty minute counseling meetings. I understand that taking the tests and getting directions from Mr. Robertson should take only one (1) hour of my time. Further, I understand that traveling to the place of testing will be at my own cost, which is the case if discharged during the course of the study and I come to the clinic for an appointment.

I understand that there is no direct benefit to my participation in this study. I do understand that a possible indirect benefit would be that the information obtained from the tests and counseling meetings may help the mental health workers in providing better ways of dealing with my needs, thereby helping me to live a fuller and more productive life.

I understand that in the course of this study I may feel uncomfortable while answering the test questions or

during the counseling meetings and that if I do feel uncomfortable, Mr. Robertson will be present to help me. I, also, understand that my regular counselor will be available to help me, if needed. But, in the event, that I continue to feel uncomfortable and I want to stop being a part of this study, I understand that I can freely withdraw at any time. None of the information obtained will be placed in my record(s) unless I wish to share this information with my counselor.

My withdrawal will in no way influence the quality of care that I receive from the members of the mental health team at this facility. I understand that there is no other counseling method which can be substituted for this one except my regular counseling, and I understand that if I wish to return to my regular counseling I may withdraw from the study. All information obtained from me will be kept strictly confidential; therefore, no information will be placed in my record(s). My name will not be used in the findings. However, I will be able to ask about the overall results should I choose to do so.

I understand that no injury to me is expected, but in the event such injury does occur, I understand that there is no monies paid to me by Mr. Robertson, the facility, or the university. I understand that if I have any questions, I may contact Mr. Robertson at the following numbers: (409) 569-6891 (nights) or (409) 568-1712 (days). By my signing below, I am indicating my willingness to be a part of this study.

SIGNATURE_____

WITNESS_____

DATE_____

# APPENDIX H

## Consent Form

# APPENDIX H

## INFORMED CONSENT

I understand that W. James Robertson is conducting a study which is a part of his requirements for a doctoral degree. Further, I understand that this study is to determine the outcome after the use of a particular counseling method.

I understand that if I agree to be in this study, I will be asked to attend three (3) individual thirty minute brief therapy sessions. In addition, I, also, understand that I will be asked to take two (2) paper and pencil tests and that two (2) tests will be given before the counseling meetings and two (2) tests after the counseling meetings. I understand that one (1) of the test has questions of a personal nature. However, the questions are designed to find out how I feel about a particular issue and they are not designed to see if I participate in the issue(s) being discussed.

I understand that the counseling meetings will be set up in this way. I will say something like this: "I want to stop X-ing." The counselor will ask me "Is there some place in my life where behavior X is useful and proper?" and so on during the thirty minute counseling meetings. I understand that taking the tests and getting directions from Mr. Robertson should take only one (1) hour of my time. Further, I understand that traveling to the place of testing will be at my own cost, which is the case if discharged during the course of the study and I come to the clinic for an appointment.

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I understand that in the course of this study I may feel uncomfortable while answering the test questions or

during the counseling meetings and that if I do feel uncomfortable, Mr. Robertson will be present to help me. I, also, understand that my regular counselor will be available to help me, if needed. But, in the event, that I continue to feel uncomfortable and I want to stop being a part of this study, I understand that I can freely withdraw at any time. None of the information obtained will be placed in my record(s) unless I wish to share this information with my counselor.

My withdrawal will in no way influence the quality of care that I receive from the members of the mental health team at this facility. I understand that there is no other counseling method which can be substituted for this one except my regular counseling, and I understand that if I wish to return to my regular counseling I may withdraw from the study. All information obtained from me will be kept strictly confidential; therefore, no information will be placed in my record(s). My name will not be used in the findings. However, I will be able to ask about the overall results should I choose to do so.

I understand that no injury to me is expected, but in the event such injury does occur, I understand that there is no monies paid to me by Mr. Robertson, the facility, or the university. I understand that if I have any questions, I may contact Mr. Robertson at the following numbers: (409) 569-6891 (nights) or (409) 568-1712 (days). By my signing below, I am indicating my willingness to be a part of this study.

SIGNATURE_____

WITNESS_____

DATE_____

# APPENDIX I

## Survey Data Sheet

# PRE-TEST
# SURVEY DATA SHEET

## DIRECTIONS

**Please respond to the requested information by writing in the information requested or circling the appropriate number.**

A. Age:_____

B. Ethnic background:

1. Anglo-american
2. Black-american
3. Mexican-american
4. Native-american
5. Asian or Asian-american
6. Other: Please specify:_____

C. Marital status:

1. Single, never married
2. Married
3. Divorced
4. Separated
5. Widowed
6. Common law

D. Religious background:

1. Protestant
2. Catholic
3. Jewish
4. Other: Please specify:_____
5. No particular religious affiliation

E. Type of medication being currently taken:

1. none
2. anti-depressant
3. anti-anxiety
4. anti-psychotic
5. a combination. Please specify: _____

(Use more space, if necessary - bottom of next page)

F. How long have you been taking the medication you have identified while in therapy?

_____days _____weeks _____month(s) _____year(s)

G. How long have you been taking the medication without therapy?

_____days _____weeks _____month(s) _____year(s)

H. How long have you been in therapy without medication?

_____days _____weeks _____month(s) _____year(s)

# APPENDIX J

## Human Subjects Review Form

TEXAS WOMAN'S UNIVERSITY
Box 23717, TWU Station
Denton, Texas 76204



HUMAN SUBJECTS REVIEW COMMITTEE

Name of Investigator: W. James Robertson Center: Houston

Address: P. O. Box 4640, SFA Date: 1-16-87

Nacogdoches, Texas 75962

Dear Mr. W. James Robertson

Your study entitled REFRAMING TECHNIQUE AND GUILT LEVELS IN DEPRESSED WOMEN

has been reviewed by a committee of the Human Subjects Review Committee and it appears to meet our requirements in regard to protection of the individual's rights.

Please be reminded that both the University and the Department of Health and Human Services regulations typically require that signatures indicating informed consent be obtained from all human subjects in your studies. These are to be filed with the Human Subjects Review Committee. Any exception to this requirement is noted below. Furthermore, according to HHS regulations, another review by the Committee is required if your project changes.

Any special provisions pertaining to your study are noted below:

___ Add to informed consent form: No medical service or compensation is provided to subjects by the University as a result of injury from participation in research.

___ Add to informed consent form: I UNDERSTAND THAT THE RETURN OF MY QUESTIONNAIRE CONSTITUTES MY INFORMED CONSENT TO ACT AS A SUBJECT IN THIS RESEARCH.

___ The filing of signatures of subjects with the Human Subjects Review Committee is not required.

✓ Other: see attached

___ No special provisions apply.

Sincerely,

William P. Hosten

Chairman, Human Subjects
Review Committee

at Houston

2-17-87

2-17-87

W. James Robertson:

The HSRC felt that the benefits are overstated in your consent form and cover letter. Remove all references regarding direct benefits and add a statement that there are no direct benefits. Also state early in the consent form and cover letter that the questionnaire contains personal questions.

William P. Harden
Chairman

TEXAS WOMAN'S UNIVERSITY
HOUSTON CAMPUS
HUMAN RESEARCH REVIEW COMMITTEE
REPORT

STUDENT'S NAME W. James Robertson

PROPOSAL TITLE REFRAMING TECHNIQUE AND GUILT LEVELS IN DEPRESSED WOMEN

COMMENTS:

DATE: 17 FEB 87

Disapprove Approve

Disapprove Approve

Disapprove Approve

Disapprove Approve

Approve

ls

The University of Texas
Health Science Center at Houston



The Committee for the
Protection of Human Subjects

MSMB 1.168
P.O. Box 20036
Houston, Texas 77225
(713) 792-5048

NOTICE OF APPROVAL TO BEGIN RESEARCH June 26, 1987

HSC-O-TWU-87-003 - "Reframing Techniques and Guilt Levels in Depressed Women"
P.I.: James Robertson, Ph.D. Student; Susan Nunchuck-Burns, M.S.N.

APPROVED: At a Convened Meeting

APPROVAL DATE: June 26, 1987 EXPIRATION DATE: June 30, 1988

PROVISIONS:

CHAIRPERSON: Walter M. Kirkendall, M.D.

Upon receipt of this letter, and subject to any provisions listed above, you may now begin this research. This approval, contingent upon compliance with the following stipulations, will expire as noted above:

CHANGES - The P.I. must receive approval from the CPHS before initiating any changes, including those required by the sponsor, which would affect human subjects. Such changes include changes in methods or procedures, numbers or kinds of human subjects, or revisions to the informed consent document or process. The addition of co-investigators must also receive approval from the CPHS. In addition, the P.I. will notify the CPHS as to the disposition of the research upon leaving the institution.

UNANTICIPATED RISK OR HARM, OR ADVERSE DRUG REACTIONS - The P.I. will immediately inform the CPHS of any unanticipated problems involving risks to subjects or others, of any serious harm to subjects, and of any adverse drug reactions. For applicable research, this notification may be accomplished by sending copies of reports filed with the sponsor/the FDA.

RECORDS - The P.I. will maintain adequate records, including signed consent documents if required, in a manner which ensures confidentiality. With the exception of review by such Federal agencies as HHS or the FDA, CPHS policy relating to maintenance of subject confidentiality will be followed during any monitoring/verification of data by an outside agency or sponsor. Such records may also be used during any necessary internal investigation.

SUBSEQUENT REVIEW - The P.I. will respond promptly to CPHS review requests, which will occur prior to the expiration date noted above.

COPY: