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AN EVALUATION OF A PSYCHOEDUCATIONAL SELF-ESTEEM CURRICULUM

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ABSTRACT
An Evaluation of a Psychoeducational Self-Esteem Curriculum

By

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The present study evaluates Affect and Self-Esteem, a psychoeducational curriculum taught at Michigan State University, that meets the increasing demand for new short-term and group-focused approaches to psychotherapy. This psychoeducational curriculum is an attempt to translate the central processes and functions of psychotherapy into a time-limited, group-focused educational program. The present study evaluates Affect and Self-Esteem in terms of four constructs: polarity theory, depression, openness to feelings, and the ability to differentiate the affect of shame. Results showed that subjects in Affect and Self-Esteem scored significantly higher on the humanistic ideological position of the Polarity Scale following the treatment condition. Subjects in the treatment condition at the end of the semester scored significantly lower on a measure of depression, reported significantly less internalized shame, and scored significantly higher on a measure of openness to feelings.

To Fiona, my wife.

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Chapter 1

INTRODUCTION

The purpose of this investigation is to evaluate a psychoeducational self-esteem curriculum developed by Dr. Gershen Kaufman at Michigan State University. This program has been implemented as an undergraduate course in the Psychology Department at Michigan State University, titled Affect and Self-Esteem (ASE) and is designed to accomplish the twin goals of psychological intervention and prevention in an educational setting. The present investigation aims to show that ASE is an effective treatment and prevention program that could be implemented in a wide range of educational and therapeutic settings.

Kaufman has argued that "the challenge we face is one of creating new forms for psychotherapy that will carry us into the next century" (1996, p.245). Kaufman cites an increasing demand for new short-term and group-focused approaches to psychotherapy, in part due to the increasing reluctance of treatment facilities to provide extended psychotherapy, as well as the increasing reluctance of insurers to reimburse for unlimited psychotherapy. This psychoeducational curriculum is an attempt to address that challenge, and to translate the central processes and functions of psychotherapy into a time-limited, group-focused educational program. Its purpose is founded in the conviction that "the specialists in the psychology of human behavior and educational development must pass on to as many individuals as possible our cloistered wisdom" (Kaufman & Raphael, 1991, p.2).

The primary questions posed by Kaufman that led to the development of ASE are: "Can we teach individuals psychological skills necessary for effective living? Can we translate psychological principles into practical tools that can be learned through practice?" (1996, p.245). The response to these questions by ASE students has been overwhelmingly positive, and this investigation aims to lend empirical support to their subjective evaluations.

ASE involves a number of specific psychological principles that are drawn from a variety of psychological theories and treatment modalities. The review of the literature revealed a number of curricula that contain some elements included in ASE, but none were found to include or integrate all of the concepts contained in ASE. Empirical evaluation studies have also been conducted on previous versions of ASE (Mayne, 1990; Meola, 1988; Rosenberg, 1984). Mayne (1990) found a significant decrease in the number of pathogenic stories given by participants in the program. Meola (1988) found ASE to produce a significant decrease compared to controls in anxiety, as well as a significant increase compared to controls in participants' ability to differentiate and be aware of the affect of shame. Rosenberg (1984) found that participants in ASE demonstrated a significant increase in differentiation of affects and positive inner dialogue patterns, when compared to participants in a control group. However, the ASE curriculum has been expanded and changed significantly since these studies were undertaken, thus warranting further research.

Kaufman's ASE represents an important departure from the traditional medical model of psychology. Primarily it is a change from an exclusive focus on the treatment

of specific existing disorders to a wider-focussed educational and preventive model. Such a shift in focus is described by Guerney, Stollak, and Guerney:

> The practicing psychologist following an educational model is one whose work would derive directly or indirectly from a concern not with "curing neuroses," and not with eliminating symptoms (or "complaints"),...but rather with the teaching of interpersonal skills which the individual can apply to solve present and future psychological problems and to enhance his satisfaction with life. (1970, p.14)

Kaufman's approach is distinct from medical model orientations toward treatment in its emphasis upon building a broad range of psychological skills deemed necessary for positive mental health. The curriculum integrates a wide variety of psychodynamic, affective, and cognitive-behavioral theories into a unified approach designed to produce skill development in a wide range of psychologically relevant dimensions. These include identity development, interpersonal competence, affect regulation, stress reduction, and self-esteem enhancement. The curriculum emphasizes both theory and practice in that "we do not merely speak about self-esteem, we learn and experience self-esteem." (Kaufman & Raphael, 1991 p.5). Students have consistently reported surprise at the extent to which they have been personally affected by, and benefited from, the class.

Mental health educational workshops have been sponsored by colleges and university counseling centers throughout the country. However, the positive effects of these experiences are typically taken for granted, and there have been few formal outcome investigations of their efficacy. At best, descriptive evaluations are collected, and although these yield important data, they lack the systematic reliability and validity

needed to conclusively demonstrate effectiveness (Cudney, 1975; Cain, 1967). Although the need for evaluation studies in this area has been established (Novis & Larsen, 1976), the literature in this area reveals that few empirical studies have actually been conducted.

Bloom (1976) argues that the lack of evaluation of mental health programs is a result of a number of factors. These include loosely defined program objectives, and a vague delineation of the recipient group whose level of pathology is often not precisely assessed. Klein (1976) has argued that because psychoeducational programs are typically applied unsystematically to small populations, their evaluation is unreliable. The present investigation will attempt to remedy these difficulties.

Chapter 2

LITERATURE REVIEW

Psychoeducational curricula have been as varied as the field of psychology itself. Numerous psychoeducational programs have been developed for implementation in different settings and for different populations. These include human relations (Malamud, 1965), stress reduction (Barger, 1965), life skills training (Katz, 1974; Philip, Himsl, & Warren, 1972), psychosocial competence (Tyler & Gatz, 1976), self-control training (Phelps, 1977), and rational emotive-therapy (Ellis & Grieger, 1977). Furthermore, psychoeducational curricula reflect a wide range of theoretical perspectives. Barger (1965) developed a program that focused on behavioral management techniques. Cudney (1975) designed a program to eliminate self-defeating behaviors. Del Polito (1973) developed a program that focused on the development of communication skills to enhance self concept. Schlesinger (1978) focused on self-actualization, locus of control, and self-esteem in his evaluation of high school psychoeducational programs.

More recently, psychoeducational interventions have been developed to improve perceived social support. Brand, Lakey, & Berman (1995) developed a psychoeducational intervention that included elements of cognitive therapies aimed at recognizing positive qualities in oneself, and correcting cognitive distortions regarding the self. Program participants were also taught to reconceptualize relationships with their family of origin, and improve their social competence by interrupting and modifying negative biases in interpreting supportive behaviors. The program was found to lead to a

statistically significant increase in self-esteem, perceived social support, and frequency of self-reinforcement.

Psychoeducation has also been recently investigated as a possible treatment modality for more severe forms of pathology such as schizophrenia and bipolar disorder. Berkowitz et al. (1990) demonstrated that psychoeducation can lead to a reduction in the relapse rate for people with schizophrenia. Honig et al. (1997) describe a family psychoeducational program for people suffering from bipolar disorder. The program produced less frequent hospitalizations when compared with controls, and family members demonstrated significantly lower levels of expressed emotion, a variable associated with relapse rates, following the program. Fristad et al. (1998) developed a psychoeducational family intervention to treat mood disorders and suicide risk in children and adolescents. This program also focused on reducing expressed emotion in families with children suffering from severe mood disorders.

School-Based Programs

Although ASE is currently implemented as an undergraduate credit course in the Psychology Department at Michigan State University, Kaufman has designed the program to allow implementation in either of two ways: as a direct mode of psychotherapeutic treatment and as a curriculum with in the education system. ASE is unique in its attempt to implement an analog of a complete psychotherapeutic experience in a formal educational setting. Kaufman states that it is to our schools that "we must turn, and at all ages, if we are to reach the broadest population" (1996, p.260). The literature concerning the role of psychology in the schools is lacking in emphasis and

awareness of this possibility. Nevertheless, a number of authors have pointed in this direction.

In addressing the role schools might play in fostering psychological health and aiding children who evidence psychological difficulty, Garbarino & Gilliam refer to the school as, next to the family, "the most important socializing agent in America."

> Because schools are concerned with the *whole child*, seeking help for the child in trouble is quite compatible with educational objectives.... American education is potentially a major resource for helping abused children and their families. But this potential has rarely been tapped and, as yet, has never been fully utilized. (1980, p.286)

Garbarino (1987) argues that the school is the community's principal bridge to children, and represents an opportunity to establish and nurture a social network for the child outside of the family. He proposes that schools can serve the joint functions of nurturance and feedback, which in turn, form the basis of social support.

Research into "stress resistant children" (Garmezy & Rutter, 1983) has demonstrated that these children, rather than being resistant to psychological stress, are differentiated due to "counterbalancing influences" in their environment. Children without these counterbalancing influences are most susceptible to psychological maladies, while those who receive compensatory doses of psychological nurturance and sustenance are able to overcome even severely adverse conditions in their environment. Gabarino, Guttman, & Seeley (1986) argue that the school can be the vehicle for providing the necessary compensatory dose.

According to Gabarino (1987) the school can perform at least three functions in the psychological care of children. Schools can monitor the mental health of children including such variables as emotional development, social competence, and intellectual functioning. This monitoring can lead to proper referrals and swift treatment of any pathology. Schools can provide a psychologically positive climate that bolsters self-esteem and presents a model of nurturance. This includes avoiding impersonal, cold, and rejecting settings and relationships. Schools can act as "therapeutic/rehabilitative" agents under the direction of school psychologists and social workers. This may include collaborating with other agencies and cooperating with treatment plans developed by mental health professionals. In spite of Gabrino's discussion of the positive role of schools in psychological development and treatment, the direct mention of psychoeducational curricula is lacking, which is typical of the literature in this area.

ASE, in addition to functioning as a psychological intervention *per se*, is designed as a preventive mental health program. The focus on preventive psychological services has a long history, although it still remains on the fringes of current psychological intervention. Spaulding & Balch (1983) report that as early as the mid-19th century, superintendents of asylums considered the potential benefits of preventive efforts. President John F. Kennedy (1963), upon enactment of the Community Mental Health Centers Act of 1963, argued for the desirability and economic superiority of a preventive approach to mental health. Perry & Jessor (1985) demonstrate that changing the health behavior of children and adolescents may promote stable long-term healthful behavior patterns in adulthood. Despite the long history of calls for preventive efforts, primary prevention in the schools remains a relatively new orientation and focus.

One of the most widely cited conceptualizations of prevention is that of Caplan (1964). He differentiated three levels of implementation: primary, secondary, and tertiary. Primary prevention aims at reducing the incidence of occurrence of a particular disorder within a given population. Secondary prevention, in contrast, involves the early identification and treatment of students already experiencing disorders, while tertiary prevention aims at preventing further deterioration in those with serious problems.

A number of authors have discussed various means by which primary prevention interventions can be put into operation (Peterson, 1988; Conyne, 1987; Peterson & Mori, 1985). Zins, Conyne, & Ponti outline six basic methods of primary prevention that are typically used in various combinations with one another. Community organization and systems intervention are efforts that help communities or institutions foster more positive interrelationships among their members. Competency promotion includes activities designed to develop feelings of self-worth, care for others, and belief in oneself. Natural care giving refers to the encouragement of social support systems and nurturing relationships. Consultation/collaboration involves the development of relationships with administrators, teachers, parents, and mental health professionals. Empowerment strategies aim to enable children to take appropriate control over their lives so that they may avoid problems and engage in health-enhancing behaviors. Finally, education is cited as a broad preventive strategy that involves information dissemination, heightening student awareness, and influencing student behavior.

A number of school-based prevention programs have been presented in the literature. Rotheram et al. (1982) developed a 12-week assertiveness training program for fourth- and fifth-grade students. A number of different modalities including didactic

instruction, contingent reinforcement, successive approximation, and modeling were used to teach a variety of skills associated with assertiveness and problem solving. Students were introduced to a new topic each week, and the program included a significant degree of student participation. When compared to students in a control group, program participants were found to demonstrate higher quality problem solving, and perform better on tests measuring assertiveness and group decision making abilities. Program participants were also found to achieve higher GPAs, exhibit more acceptable behavior than control students, and initiate a greater number of contacts with their teacher.

Botvin & Dusenbury (1987) designed a life skills training program for junior and senior high school students. Their program aimed at preventing substance abuse among this population by enhancing the student's personal and social skills. Intervention modalities include education about the physiological and psychological consequences of substance abuse, strategies for resisting peer pressure, decision-making and critical thinking skill development, anxiety reduction and relaxation methods, and social skills development. Students in the program demonstrated significant improvements in health knowledge, assertiveness, self-confidence, and self-management. Students in the program were also found to have reduced rates of cigarette, alcohol and marijuana use.

Rustad, & Rogers (1975) describe a curriculum and present research results for a psychoeducational program designed for high school students. The curriculum consists of several sequential phases designed to progressively develop the students' ability to empathize and take into consideration the perspective of another. Phase I consisted of the development of classroom cohesion, listening skills, and a collegial atmosphere between staff and students. Phase II consisted of developing general communication skills for

building trust and self-confidence. Phase III consisted of an initial attempt at peer counseling before any actual discussion or teaching of counseling skills was presented. Phase IV consisted of the development of active listening skills such as those described by Rogers (1965). Phase V consisted of teaching non-verbal behavior patterns and beginning role-play counseling. Phase VI consisted of a shift from role-play counseling to counseling peers with real problems. Phase VII consisted of stimulating the transfer of training by encouraging the use of the learned skills with nonclassmates. Outcome measures demonstrated an impressive degree of success for the program. The curriculum was determined to promote movement on the natural stages of growth in adolescence such as ego state development (Loevinger & Wessler, 1970) and moral state development (Kohlberg, 1972). Students also showed significant improvement on their counseling skills. Moreover, students retained all of these gains at a one year follow-up.

THE PROGRAM

ASE is designed as a 15-week program that meets twice a week for 90-minute sessions. When offered specifically in a treatment mode, ASE can accommodate 15 to 20 participants because of its psychodeducational focus. When offered in a formal educational setting, classes of sixty or more students have been reached effectively. ASE is currently taught as a three credit course at Michigan State University and is offered on a pass/no-grade basis. The format of the program involves a combination of didactic and experiential work. Each week, new concepts are introduced, discussed, and then examined experientially. In addition to the presentation of psychological theories and principles, participants are expected to work directly with various "tools" that are designed to translate these principles into action strategies. Students write nine reaction papers throughout the semester detailing their personal experiences with each tool. In effect, students engage in a series of psychological experiments in which they function as both the subject and the observer.

ASE is founded theoretically on object-relations theory, affect theory, and interpersonal theory. Kaufman conceives of the self as a developmental process that involves movement from global undifferentiation toward increasing differentiation and integration. This development involves processes that are both internal and interpersonal. ASE is aimed at teaching participants to develop an inner sense of competence, find direction and meaning in life, cope with inevitable stressors and losses, develop mutual

and satisfying relationships, and maintain an inner sense of security in the face of life's challenges.

Kaufman's (1996) theoretical formulation is based on Tomkins's (1962, 1963, 1991, 1992) differentiation of the affect system, in which nine innate affects have been identified. The positive affects include interest—excitement and enjoyment—joy. The negative affects include distress—anguish, fear—terror, anger—rage, shame—humiliation, dissmell, and disgust. Tomkins further identified the resetting affect of surprise—startle. Kaufman uses this formulation of the affects as a beginning "map" of inner experience, and argues that psychological health rests on having "conscious access to the entire range of primary affects" (Kaufman & Raphael, 1991, p.11). Kaufman has translated the goal of becoming conscious of the full range of one's inner experience into specific tools designed to increase conscious awareness and nurture the development of a self-affirming identity. Once an inner feeling, drive, or interpersonal need can be observed consciously, it can then be owned as a valid part of the self.

> We learn to live consciously through becoming aware of inner and outer events *as they are happening*. A conscious self is able to experience in full awareness all of the distinctly different components of the self, including affects, needs, drives, and purposes. (Kaufman & Raphael, 1991, p.53)

Each session begins with participants discussing course concepts and tools in small groups of 10 participants each. Participants are not necessarily expected to self-disclose, although they naturally relate personal experiences as they apply within the

context of course concepts or working with course tools. Following the small group discussions, concepts underlying the next group of tools are presented in didactic fashion. The theory, purpose, and structure of the tools are presented, and the instructor's personal experiences in developing and working with the tools are shared where appropriate. Kaufman believes that "modeling is a key vehicle for the transmission of knowledge" (Kaufman and Raphael, 1991). Three texts are required for the course: Dynamics of Power: Fighting Shame, and Building Self-Esteem (Kaufman & Raphael, 1991), The Psychology of Shame (Kaufman, 1996), and Shame the Power of Caring (Kaufman, 1992).

ASE is divided into five units. Unit I introduces a wide variety of psychological theories of motivation, concentrating on Affect Theory (Tomkins, 1962, 1963, 1991, 1992) and Script Theory (Tomkins, 1987b). According to script theory, individuals internalize their experience through imagery, and this imagery when combined with affect is stored in memory as a scene. These scenes then become the basis of personality (Kaufman, 1996). In addition to learning to recognize scenes from the past, students are taught specific tools to collect new scenes of positive affect and healthy pride. Unit I also includes a discussion of the dynamics of power and powerlessness and powerlessness-affect-stress cycles. The concept of choice is introduced as an antidote to powerlessness, and participants are encouraged to apply this principle to a current situation in their lives in which they are experiencing powerlessness.

Unit II focuses on the relationship between shame and self-esteem. The phenomenology and forms of shame are presented with special attention given to the sources of shame over the life cycle. The process by which shame is internalized and

bound to various internal experiences is outlined in detail. The psychological magnification of shame is examined by identifying defending scripts that guard against shame, as well as identity scripts that reproduce shame are outlined. The significance of shame for gender, minorities, culture, and society is also discussed, followed by discussion of the role of ideology and the dynamics of hatred. Participants are encouraged to examine the role of shame in their own lives, and are asked to describe in writing a shame scene from their past, and also identify any affects, drives, and interpersonal needs that have become bound by shame.

Unit III focuses on identity which is defined as the self's relationship with the self. Participants are taught to recognize self-shaming scripts and replace them with self-affirming scripts. The "object-relations" underlying self-shaming scripts are brought into awareness by tools designed to examine the sources of shaming inner voices, and the tool of reparenting imagery is introduced to enable participants to create new scenes of self-nurturance and self-acceptance. Temperament, sexual-orientation, and sexuality are all considered within the context of a self-affirming identity.

Unit V is designed to address interpersonal relationships. The dynamics of power in relationships are discussed in detail, and the relationship between power and shame is revisited. Participants are introduced to the concept of equal power, and primary relationships such as parental and romantic partnerships are addressed as well. The sources of shame in relationships are reviewed, and participants are taught to match needs and expectations with the realities of any given relationship. Participants are also taught to consciously identify and observe their often subliminal relationship scenes in order to make their own needs and expectations of any given relationship consciously available.

In addition, participants are taught to consciously and objectively observe the other person with whom they are relating in order to determine how that individual actually functions as a self.

Program Research

Earlier versions of ASE have been empirically evaluated, although the curriculum has changed significantly since these earlier investigations were undertaken. It has also been expanded from a 10-week to a 15-week format. Rosenberg (1984) found that participants demonstrated a significant increase in their ability to differentiate affects and in positive inner dialogue patterns when compared to participants in a control group. Meola (1988) found that participants in ASE demonstrated a significant decrease in anxiety and a significant increase in their ability to differentiate the affect of shame compared to a control group. Participants were not found to demonstrate a significant difference in their self-esteem or level of depression following the intervention. Mayne (1990), in a fascinating study measuring pathogenesis, found that ASE significantly reduced the pathogenesis scores of participants in comparison to a control group. Pathogenesis is defined as the degree to which one unconsciously uses dependent individuals to satisfy one's own needs, despite conflict between one's own needs and those of the dependents (Meyer & Karon, 1967). Specifically, in a situation where the needs of the caregiver and the dependent are in conflict, the pathogenic caregiver will unconsciously choose their own needs over that of their dependent.

Chapter 3

Design of the Present Study

The present study aims to evaluate ASE in terms of four constructs: Tomkins' polarity theory, depression, the ability to differentiate the affect of shame, and openness to feelings. These will be the principle variables for determining the effectiveness of this psychoeducational self-esteem curriculum.

Polarity Theory

Polarity theory w as developed by Silvan Tomkins (1963, 1965) and arose out of his investigations of human ideology and the socialization of affect. Tomkins describes discovering a single "sustained recurrent polarity" between the "humanistic" and "normative" orientations that appears throughout a wide range of human thought and behavior (1963, p.26). Tomkins traces this polarity back to the Greek philosophers, Protagoras, who argued for the priority of man as the measure of all things, and Plato, who argued for the priority of the realm of essence. Tomkins describes the fundamental difference between the two poles in terms of their respective view of man.

> The issues are simple enough. Is man the measure, an end in himself, an active, creative, thinking, desiring, loving force in nature? Or must man realize himself, attain his full stature only through struggle toward, participation in, and conformity to a norm, a measure, an ideal essence basically prior to and independent of man? (1995, p.117)

Tomkins traces this polarity through domains as diverse as the foundations of mathematics and philosophy, political theory, theory of aesthetics, epistemology, theory

of perception, theory of value, theory of child rearing, theory of psychotherapy, and personality testing (Tomkins, 1963, 1995).

Tomkins argues that the fundamental basis of this polarity is the belief that human beings have about human beings. The humanistic perspective sees the person as fundamentally valuable and an end in themselves, while the normative perspective holds that value exists independently of human beings, and human beings must strive to attain it. Tomkins describes this polarity as follows:

> No question with which man confronts himself engages him more than the question of his own worth. On the left [humanistic pole] he conceives himself to be an end in himself, to be of ultimate value; he wishes to be himself and to realize the potentialities which are inherent in him. On the right [normative pole] man is at best neutral, without value. There exists a norm, an objective value, independent of him, and he may become valuable by participation in, conformity to, or achievement of this norm. (1995, p.126)

Tomkins argues that one derivative of this polarity is a belief about a human being's basic nature. The humanistic ideology affirms our basic goodness, while the normative position affirms our basic badness. The humanistic perspective tends to focus on man's potentials, his capacity for growth and progress, the value of novelty, and the excitement of discovery. The normative perspective tends to focus on the maintenance of law and order, with the belief that offenders should always be punished. It is believed that if left alone, human beings will tend to go astray. The differences in orientation can be easily seen in attitudes about punishment, correction, and norm violation. The

humanistic perspective urges forgiveness and offers nurture, believing that changes in others should be brought about by love, compassion, and personal example. The normative position urges contempt for the norm violator, and contends that authority should always be the object of respect and fear.

Humanistic individuals tend to have a positive view of affect in general and are at home in the realm of feeling. Believing that affect inhibition is toxic and should be minimized, humanistic individuals tend to give value to the maximal satisfaction of the full spectrum of human drives, needs, and feelings. Normative individuals tend to be uneasy about affect per se, lest it endanger norm attainment, and tend to urge the control of drives in the interest of norm conformity.

This polarity is also theorized by Tomkins to be reflected in styles of relationship. The humanistic orientation tends to be sociophillic and values intimacy in relations with others, while the normative orientation tends to be sociophobic and more focused on norm attainment and compliance. Humanistic ideology implies that humans should be loved unconditionally, while the normative position implies that people should be loved only in the condition where they are worthy. Tomkins (1995) describes a study using a picture arrangement test that lends support to these relationship patterns among humanistic and normative individuals. On the picture arrangement test, which is a broad-spectrum projective-type personality test, humanistic subjects told more stories involving positive human contact and relationships.

Tomkins argues that an individual resonates to a particular ideological pole as a result of their prior socialization of affect. This can be illustrated by examining the differences in the parenting styles of humanistic and normative parents. Tomkins

describes this difference by pointing to the parenting literature of his time and demonstrating a polarization in parenting focus between loving and controlling the child. From the humanistic perspective, the primary goal of parenting is to love and nurture the child who is viewed as being basically good in nature. Alternatively, from the normative perspective, the most important goal of parenting is the child's conformity to norms and social rules. From this perspective the child is seen to be fundamentally bent to behave wrongly and needs correction if they are to be saved. This perspective was represented in the parenting literature of Tomkins's time by an emphasis on complete obedience and submission to authority, even to the point of "breaking the will of the child" (1962, p.123). Conversely, discipline from a humanistic perspective tended to focus on leading the child to the right and good through explanation and persuasion rather than some form of corporeal punishment.

The role of polarity in the socialization of affect can be further illustrated by examining the socialization of distress affect from each perspective. Confronted with a crying child, a parent with a humanistic orientation will most likely attempt to comfort the child, possibly through physical contact or soothing words such as, "I'm here to help you. You're safe." A parent with a normative perspective will tend to view the child's distress affect as a norm violation and require the child to stop crying, perhaps saying something like "If you don't stop crying, I'll give you something to cry about." Tomkins points out that if the child internalizes their parent's ideological posture toward distress affect, they have "learned a very basic posture toward suffering, which will have important consequences for ideological beliefs quite remote from the nursery and the home (Tomkins, 1963, p.27). Tomkins describes the differential socialization of all the

nine affects based on polarity theory, and argues that this affect socialization forms the basis of an individual's resonance to a particular ideological pole.

Depression

Depression is a painful emotional state that has been addressed by philosophers and physicians since the beginning of recorded history. Depression has been called "the black bile," "melancholia," and "the dark night of the soul" by sources as varied as Hippocrates, Shakespeare, and the Bible. Theories of depression are too numerous to be treated exhaustively, but a sampling is instructive.

The original psychoanalytic formulation of depression was Abraham's (1911), who argued that depression resulted from an attitude of hate which paralyzed the individual's capacity to love. Abraham felt that guilt arose from the repression of hatred, leading to depression, anxiety, and self-reproach. Thus, the patient's feeling of emotional poverty were theorized to result from a repressed perception of their own incapacity to love.

In "Mourning and Melancholia," Freud regarded both normal mourning and depression as being responses to the loss of someone or something loved. Freud argued that in contrast to the mourner, the depressive suffers "an extraordinary diminution in his self regard, an impoverishment of his ego on a grand scale" (1955, p.245). In 1923, Freud reconsidered the problem of depression in light of his new structural theory. He argued that, while the ego rebels against the superego in obsessional neurosis, in the case of depression the ego admits its guilt and offers no objection to its punishment. Following the formulation of the dual instinct theory, Freud argued that in the case of depression, "what is now holding sway in the superego is, as it were, a pure culture of the

death instinct" (1920, p.17). The ego, in effect gives up because it feels hated and persecuted by the superego instead of loved. Freud relates this situation to the anxiety of separation from the good protecting mother.

Klein (1935) described a theory of depression that involved a splitting of objects, and of the ego, into good and bad. The concern of the infant at the depressive stage revolves around the recognition that the bad object, which is sadistically attacked, is but one aspect of the good object. The fear develops that the loved good object will be lost, and guilt is experienced for the aggression impulse toward the object. Klein named this stage in development the depressive position, and argued that the normal outcome is the internalization of the good object. If this fails to occur, then the stage is set for later depressive illness.

Bowlby (1969) focussed on the role of attachment in the genesis of depression. He observed that all human infants exhibit attachment behavior, which is a complex, biologically based behavior including such activities as smiling, sucking, clinging, crying, and following. Bowlby has argued that when the mothering figure is temporarily unavailable, separation anxiety and protest will ensue. When the mother figure continues to be unavailable, the infant will eventually exhibit the triad of protest, despair, and detachment. This childhood mourning is theorized to be the pathogenic circumstance for later depressive illness.

Kaufman (1996), following Tomkins (1963a), views depression as a prolonged experience of the affects of shame and distress in heightened combination. Kaufman (1996) outlines the mechanisms by which depression is reproduced internally, and argues that these mechanisms differ across various types of depression. Identity scripts such as

self-blame and comparison-making further distinguish and perpetuate the depressive process. Thus, depression is seen as an enduring affect state or mood in which distress affect and shame affect have been raised to peak intensity and are being reproduced internally over time.

Openness to Feelings

One goal of ASE is teaching participants to identify and name each aspect of their inner experience. The development of this inner sensitivity is facilitated throughout the program, and is a primary goal of many of the tools and exercises that participants undertake. Participants are taught to experience consciously, name, and then own, all of their feelings.

> Conscious access to the entire range of the innate affects is essential. Each feeling must be capable of expression by the self to the self. Expression of affects by the self to others, though important, is secondary to their being consciously experienced. The key is learning to recognize the internal signs of each affect and to name the affect accurately. (Kaufman & Raphael, 1991, p.56)

Research shows that access to affect-laden material and internal affect states relates to the personality traits of tolerance of ambiguity and openness to experience as measured by the Openness to Experience domain of the NEO-Personality Inventory (McCrae & Costa, in press). The domain of openness to experience has been gaining increasing attention as an important construct of personality. Beyond Neuroticism, Extroversion, Agreeableness, and Conscientiousness is a fifth domain, Openness to

Experience, which includes intellectual curiosity, aesthetic sensitivity, liberal values, and emotional differentiation.

Readett (1998) explored the relationship between creative functioning, openness to experience, and shame. One hundred and three undergraduate students were administered the Creative Functioning Test, the Openness to Experience domain of the NEO-Personality Inventory, and the Internalized Shame Scale. Creative functioning was found to be significantly correlated positively with both Openness to Experience and the ability to consciously identify the affect of shame.

Shame

Shame theory (Kaufman, 1992, 1996) provides an explanation for why some individuals are more capable of consciously accessing affect-laden inner experience than others. Those who have difficulty remaining open to their inner experience, and are therefore conceivably inhibited creatively, are more likely to be suffering from the effects of internalized shame.

Shame has been understood theoretically in a number of ways, but systematic investigation of shame has begun only recently. The two primary theoretical perspectives on shame originate in Freudian psychoanalytic theory and Tomkins's affect theory.

In psychoanalytic theories of shame, the primary human motivational force is seen to be either libidinal drives or interpersonal relationships. In each case, affect is seen to play a subordinate role. Freud originally understood shame to be a reaction formation against morally forbidden, sexually exhibitionist impulses and drives (Miller, 1985). Miller argues that this view is too narrow, and that the experience of shame is not

limited solely to bodily concerns. The sources and effects of shame are much more generalized that Freud's formulation of shame would seem to allow.

Wurmser (1981) argues that shame results from a failure to meet the standards set by internalized images. Although Wurmser recognizes that our culture often equates shame with sexual exposure, he argues that shame often involves a broader experience of weakness or failure. For example, shame can be triggered by appearing weak or dirty or defective in one's own eyes. A person's original shame traumas can result in a profound sense of unloveability, and can also generate various forms of psychopathology. In this way, Wurmser believes that shame conflicts are the root cause of much severe psychopathology.

Certain psychoanalytic theorists have understood shame as an outgrowth of interpersonal experience. Lewis (1987) argues that shame is a "super-ego experience" which alerts the self that "its basic affectional ties are threatened". Shame is described as a state of self-devaluation that results from experiencing vicariously the negative evaluation of the self by another. Thus, shame necessarily develops out of relationships with others, and is seen to be originally caused by a failure of the central attachment bond. But shame is nevertheless viewed in the context of super-ego functioning.

In contrast to the stress placed upon physiological drives and interpersonal relationship characteristics of psychoanalytic theories of shame, Tomkins's (1962, 1963, 1987, 1991, 1992) theory of affect conceptualizes affect as the primary innate motivational force in human beings. Tomkins identified nine innate affects: interest—excitement, enjoyment—joy, surprise—startle, distress—anguish, fear—terror, anger—rage, shame—humiliation, dissmell, and disgust (Tomkins, 1987). The primary site of

affect expression is the face, and affect is viewed primarily as facial behavior. It is from the facial expression of affect that conscious awareness of affect is informed. The facial response to shame is characterized by hanging the head, lowering or averting the eyes, and blushing.

Shame is viewed by Tomkins as an auxiliary affect (Tomkins, 1987a) which modulates the expression of some other presently occurring positive affect, notably interest or enjoyment. Thus in Tomkins's view, shame always requires the prior experience of positive affect. Kaufman (1992, 1996) has expanded Tomkins's theory of shame and clarified the mechanism by which shame exerts its inhibiting effects.

According to Kaufman (1996), the expression of any affect, positive or negative, can be responded to in ways that then permanently link it to shame.

> As a result of shame's unique binding effects, expression of the shamed, hence forbidden, affect may become completely silenced, disguised, replaced by a more acceptable affect, or entirely hidden from view. When all affects meet with shaming, a total affect-shame bind results, and affect per se becomes shameful. (1996, p.60)

Kaufman argues that the internalization of shame in the form of an "affect-shame bind" is ultimately responsible for an individual's inability to consciously access his or her affect-laden inner experience.

The specific mechanism by which shame becomes internalized according to Kaufman is based upon script theory (Tomkins, 1987b, 1992). According to script theory, individuals internalize their experience though imagery and this imagery, when combined with affect, is stored in memory in the form of a scene. These scenes then

become the basis of personality (Kaufman, 1996). When an affect, drive, or interpersonal need is followed by shaming, shame binds are created. The creation of a shame bind involves an internalized connection between shame and a particular affect, drive or interpersonal need. Once a shame bind has been formed, it is stored in memory in the form of a scene. Later recurrence of the shame-bound affect, drive, or interpersonal need will then reactivate the original scene, thereby spontaneously eliciting shame. Because the affect, drive, or interpersonal need is now always experienced in conjunction with shame, its expression becomes restricted. With regard to creative functioning, Tomkins succinctly argues, a person "who is constantly afraid or ashamed or distressed cannot also be interested in the exploration of novelty" (1963, p.353).

Chang (1988) examined the relationship between shame and self-esteem. Shame was assessed by using the Internalized Shame Scale (Cook, 1984), and self-esteem was assessed by means of the Rosenberg self-esteem scale (Rosenberg, 1965) and a six item scale by Cheek and Buss (1981). Chang reported a correlation of -.90 between the Internalized Shame Scale and both of the self-esteem scales. In addition, Chang examined the correlation of the shame and self-esteem scales individually with a large number of external variables including depression, anxiety, and anger. Finding the pattern of correlations to be nearly identical for the shame and self-esteem measures, Chang concluded that shame and self-esteem, as measured in his investigation, are "not only almost perfectly correlated, but also parallel in their correlation with outside variables. They are unidimensional by both the test for internal consistency and the test for external consistency (or parallelism). It is, therefore, proposed that shame and self-

esteem are the same dimension. That is, there is only one dimension of shame and self-esteem" (p.87).

Other research has demonstrated a close link between shame and psychopathology. A recent study by Akashi (1994) demonstrates the pervasive role played by shame in the psychopathology of a clinical population. The psychopathology variables were obtained from the Brief Symptom Checklist (Derogatis, 1994). Akashi found significant correlation between shame and all categories of psychopathology on the SCL-50. Shame has been shown play a central role in the etiology of bulimia nervosa (Frish-McCreery, 1991). In this study, bulimics reported significantly higher levels of shame than non-bulimics. Also, bulimics rated the interpersonal needs theorized by Kaufman (1996) as significantly more shameful than non-bulimics. In addition, shame has been significantly correlated with depression. Bloomberg & Izard (1986) found that among children, college students, and adults, the common core of emotions in depression included sadness, inner-directed hostility, and shame. Hoblitzelle (1987) found a significant correlation between the Internalized Shame Scale and the Beck Depression Inventory. Additional research has pointed to the role of shame in obsessive-compulsive disorder, interpersonal sensitivity, anxiety, hostility, psychoticism, phobic anxiety, and paranoid ideation.

Purpose and Design of the Study

The purpose of this study was to investigate the effectiveness of a psychoeducational self-esteem program entitled Affect and Self-Esteem (ASE). The variables of interest were (a) polarity, as measured by the Polarity Scale; (b) depression, as measured by the Beck Depression Inventory (Beck et al., 1961); (c) the ability to better

differentiate the affect of shame, as measured by the Internalized Shame Scale (Cook, 1987); and (d) openness to feelings as measured by the "Feelings" dimension of the NEO – Personality Inventory (Costa & McCrae, 1985b). The design of the study was a pretest-posttest quasi-experiment with a control group selected for similar demographic attributes and for similarity in content of the class experience.

Course descriptions, as listed in the Michigan State University Catalogue (Michigan State University, 1993), for the two classes are as follows:

> [Treatment Group] Affect and Self-Esteem – Fall, Spring. Psychological study of affect as a mediator of stress, self-esteem, and powerlessness. Development of psychological health, personal identity, and interpersonal competence through principles of affect.
>
> [Control Group] Health Psychology – Fall, Spring. Social, psychological, and biological factors affecting health, illness, and the use of health services. Stress and coping processes, lifestyles, and illness management.

Hypothesis

1. In comparison to the control group, the treatment group will become more humanistic in ideological orientation as measured by the Polarity Scale (Tomkins, 1963).

2. In comparison to the control group, the treatment group will experience a decrease in depression at posttest, as measured by the Beck Depression Inventory (Beck & Beck, 1972).
3. In comparison to the control group, the treatment group will experience an increase in their openness to affect as measured by the "Feelings" sub-scale of the NEO – Personality Inventory (Costa & McCrae, 1985b).
4. In comparison to the control group, the treatment group will increase in ability to consciously identify shame as measured by the Internalized Shame Scale (Cook, 1987).

Chapter 4

METHODOLOGY

Subjects

The participants in the study were students at Michigan State University who were enrolled in either Psychology 325 or Psychology 320. The treatment group consisted of 60 students who enrolled in Psychology 325 (ASE) and volunteered for participation in this study. This group typically contained students who ranged in age from 18 to 40. The typical racial concentration was primarily Caucasian, with a small group of students of African American and Asian-Pacific background. Typically, females outnumbered males, and undergraduate majors was varied. The control group consisted of 150 students who enrolled in Psychology 320 (Health Psychology) and who volunteered for participation in this study. This group typically contained students who ranged in age from 18-23, although older students occasionally attended. The typical racial concentration, like Psychology 325, was Caucasian, although there was a significant number of African American and Asian-Pacific students.

Measures

The Polarity Scale

To test his theory of polarity, Tomkins developed the Polarity Scale, which assesses an individual's normative vs. humanistic position on a broad spectrum of

ideological issues. The following are a few sample items from the 20 item scale. Subjects rate themselves by agreeing with either A or B for each item.

1.	A. Play is childish.	B. Nobody is too old to play.
2.	A. To see an adult cry is disgusting.	B. To see an adult cry is pathetic.
3.	A. Sometimes life leaves a bad smell.	B. Sometimes life leaves a bad taste in the mouth.
4.	A. Human beings are basically evil.	B. Human beings are basically good.

Tomkins (1963) tested the validity of the scale by examining the correlations of answers between the various ideological domains tested, and found that ninety-seven percent of these correlations were positive as expected, with an average correlation of +.30. For example, in an individual agrees with the proposition "human beings are basically good" then they agree with most of the other items keyed as humanistic. Test-retest reliability in this study was reported to be .80.

The Beck Depression Inventory

The revised Beck Depression Inventory (BDI) (Beck, Rush, Shaw & Emery, 1979) was designed as an indicator of the level of depression present in adolescents and adults. The original BDI was based upon clinical observations and descriptions of symptoms frequently given by depressed patients (Beck et al., 1961). The descriptions of symptoms were systematically consolidated into 21 symptoms and attitudes which are rated on a four-point scale of severity (Beck et al., 1988). These include suicidal ideas, social withdrawal, loss of libido, irritability, guilt etc. Concurrent validity was found to

be .72 between clinical ratings of depression and the BDI for psychiatric patients. Alpha-reliability is reported to be .90. Groth-Marnat (1990) reported test-retest reliability to be up to .86 for a short interval of re-testing on the BDI and as low as .48 for longer intervals between testing.

The Internalized Shame Scale

The Internalized Shame Scale (ISS) was developed to measure enduring, chronic shame that has become an internalized part of one's identity (Cook, 1990). The ISS consists of 30 Likert-scaled items that yield two basic scale scores. The two scales include a 24-item shame scale and a 6-item self-esteem scale. The scale was initially developed in 1984 and since that time has been administered to over 3,000 subjects in both clinical and non-clinical settings (Cook, 1990). Extensive reliability and validity studies have resulted in four revisions of the scale. Alpha reliability coefficients for the most recent version range are in the range of .95 for the shame scale and .88 for the self-esteem scale. Test-retest reliability coefficients range from .71 to .84. A series of studies comparing the ISS with three other self-concept/self-esteem measures led to the conclusion that the ISS was measuring "a trait that contributed more the development of emotional problems than did low self-esteem alone" (Cook, 1990). Research using the ISS has repeatedly demonstrated a strong positive relationship between the level of internalized shame and psychopathology generally (Rybeck, 1991; Firestone, 1991; Tangney, 1990).

The "Feelings" sub-scale of the NEO-Personality Inventory

The NEO-Personality Inventory (NEO-PI) is a 181-item questionnaire developed through factor analysis to fit a five-dimensional model of personality (Costa & McCrae,

1985b). An earlier version of the test, the NEO Inventory (McCrae & Costa, 1983a), measured traits in the three domains of neuroticism, extroversion, and openness to experience. Recent modifications (McCrae & Costa, 1987) have added two new scales to measure agreeableness and conscientiousness. Internal consistency and 6-month test-retest reliability for the Neuroticism, Extroversion, and Openness scales range from .85 to .93 (McCrae & Costa, 1983a). The Openness to Experience domain assesses proactive seeking and appreciation of experience for its own sake as well as toleration for and exploration of the unfamiliar. In this way it closely approximates the dimension of novelty-seeking derived from Tomkins's formulation of excitement as the primary affect underlying creativity. High scorers on this domain tend to be curious, have broad interests, are creative, original, imaginative, intellectually curious, emotionally responsive, sensitive, empathic, and value their own feelings. Low scorers tend to have a narrow range of emotions, are narrow minded, and do not enjoy intellectual challenges. The "Feelings" sub-scale of Openness to Experience domain was used in this investigation to determine openness and sensitivity to the experience of affect.

Procedures

The examiner invited for participation in this study on the first day of class in both Psychology 325 and Psychology 320, during which participation in the study was stressed to be both anonymous and voluntary. Students who agreed to participate were then presented with a consent form and a questionnaire packet. Completion of the questionnaires took approximately 35 minutes. The examiner returned to both classes during the last week of the semester and re-administered the scales. Participants from the

treatment and control groups completed four measures: the Polarity Scale, the BDI, the ISS, and the "Feelings" sub-scale of the NEO-PI.

Data Analysis

Data was analyzed for changes in group means over the course of the semester and between the treatment and control conditions. A one-way Anova was used to examine group changes on the Polarity Scale, the BDI, the "Feelings" subscale of the NEO-PI, and the ISS for both the treatment condition and the control group pre and post-test. Correction was made for error of measurement. The results of this analysis was used to identify trends in the data, and examine the effects of the treatment condition on the variables in the study in comparison with the control condition.

Chapter 5

RESULTS

Subjects

Fifty-eight subjects participated in the investigation from Psychology 325. A large majority of these were women, and the average age was 20 years. Out of the sixty students enrolled in Psychology 325 only two individuals declined to participate in the investigation. Sixty-seven subjects participated in the investigation from Psychology 320. A smaller majority of these subjects were women, and the average age was 19 years.

Hypotheses

Hypothesis I

The effect of ASE on subjects' ideological orientation was measured using Tomkins' Polarity Scale (Tomkins, 1962). An analysis of variance indicated significant differences in scores between groups on the Polarity Scale ($F = 5.619$, $p \leq .001$). Post-hoc Tukey HSD tests were performed in order to compare specific means. Results showed that subjects in ASE scored significantly higher on the humanistic ideological position of the Polarity Scale following the treatment condition ($p \leq .024$). This also indicates an equivalent significant decrease in the normative ideological position among these subjects. In contrast, the scores on the Polarity Scale did not differ significantly

between the pre and post-tests for the control group ($p \leq .430$). Although there was no significant difference between the treatment and control conditions at the beginning of the semester ($p \leq .997$), at the end of the semester, there was a significant difference between the treatment and control conditions ($p \leq .001$), with the direction of change being in the hypothesized direction. Means and standard deviations on the Polarity Scale are reported for both treatment and control groups in Table 1.

Table 1

Means and Standard Deviations for the Polarity Scale

	Mean	Standard Deviation
ASE Pre-test	16.09	2.29
ASE Post-test	17.35	2.13
Control Pre-test	16.17	2.30
Control Post-test	15.61	2.58

Hypothesis II

The effect of ASE on subjects' level of depression was measured using the Beck Depression Inventory (Beck & Beck, 1972). An analysis of variance was performed to determine the means and standard deviations for each group. Means and standard deviations on the Beck Depression Inventory are reported for both treatment and control groups in Table 2. Once these results were corrected for error of measurement, a statistically significant drop in depression scores was observed in the treatment condition ($D = -1.28$, $d = -.2$, $p \leq .05$). The control group demonstrated no change ($D = -.59$, $d = -.08$). An analysis of the self-impact correlation, which measures the interaction within groups, demonstrated a significant effect in the treatment condition, and indicated that the more depressed a person was at the beginning of treatment, the more their score on the Beck Depression Inventory dropped at the end of the semester. The control group showed no such effect.

Table 2

Means and Standard Deviations for the Beck Depression Inventory

	Mean	Standard Deviation
ASE Pre-test	7.91	7.12
ASE Post-test	6.63	6.77
Control Pre-test	8.53	6.90
Control Post-test	7.94	7.58

Hypothesis III

The effect of ASE on subjects' openness to affect was measured by the "Feelings" sub-scale of the NEO-Personality Inventory (Costa & McCrae, 1985b). An analysis of variance was performed to determine the means and standard deviations for each group. Means and standard deviations on the NEO – Personality Inventory are reported for both treatment and control groups in Table 3. Once these results were corrected for error of measurement, a statistically significant increase in scores was observed in the treatment condition ($D = .66$, $d = .21$, $p \leq .05$). The control group demonstrated no significant change ($D = -.55$, $d = -.11$).

Table 3

Means and Standard Deviations for the "Feelings" subscale of the NEO-PI

	Mean	Standard Deviation
ASE Pre-test	34.52	3.42
ASE Post-test	35.17	2.96
Control Pre-test	33.91	3.88
Control Post-test	33.36	6.80

Hypothesis IV

The effect of ASE on subjects' ability to consciously identify shame was examined as measured by the Internalized Shame Scale (Cook, 1987). An analysis of variance was performed to determine the means and standard deviations for each group. Means and standard deviations on the Internalized Shame Scale are reported for both treatment and control groups in Table 4. Once these results were corrected for error of measurement, a statistically significant drop in shame scores was observed in the treatment condition ($D = -3.95$, $d = -0.22$, $p \leq .05$). The control group demonstrated no statistically significant change ($D = .01$, $d = -.00$).

Table 4

Means and Standard Deviations for the Internalized Shame Scale

	Mean	Standard Deviation
ASE Pre-test	31.33	19.74
ASE Post-test	27.38	17.53
Control Pre-test	29.62	19.33
Control Post-test	29.61	21.93

Chapter 6

DISCUSSION

The goal of this study was to evaluate Affect and Self-Esteem (ASE), an undergraduate course currently being taught at Michigan State University. ASE is a 20 year-old experiment in psychoeducation that aims to accomplish the twin goals of psychological treatment and prevention in a formal educational setting. The results of the present study demonstrated the success of ASE in reaching these goals, and provide a compelling rationale for further research.

ASE has a long history of qualitative data that supports its success. Michigan State University has a formal evaluation procedure for each class that provides an opportunity for students to anonymously state their opinions and impressions of the class as well as evaluate it on a number of specific dimensions such as work-load, lecture quality, and relevance of the material presented. Students in ASE have given overwhelmingly positive evaluations of the curriculum each semester. The degree of this positive reaction to ASE is atypical compared to evaluations of other comparable classes at Michigan State University. Additionally, over the past seven years, at least 40% of all ASE students make the unsolicited comment on their evaluation that this class should be a university required course, and many students recount ways in which ASE has significantly impacted their lives in a variety of domains. ASE demands a high degree of written work compared to most other psychology courses at Michigan State University,

and even though ASE is offered on a pass/no-grade basis, students are typically prompt and thorough with their work for class. Both class attendance and class participation are strong, and a majority of students report resonating to a number of the tools and psychological strategies presented in class. Recently, through the use of a class alumni e-mail list open to both current and former students, there is evidence to suggest that some students continue using these tools well after the class has ended.

Adding to this qualitative data, the results of the present study lend empirical support to the success of ASE in attaining its' goals and provide strong justification for further research. Perhaps the most theoretically interesting finding is that involving Tomkins' Polarity Theory (Tomkins, 1963). Tomkins's Polarity Theory hypothesizes a single underlying polarity that can be identified in domains as diverse as mathematics, politics, and child-rearing. Tomkins identifies the two extremes of this polarity as the humanistic orientation, which tends to view humans as the measure of all things and the final source of value, and the normative orientation, which tends to focus on compliance to abstract and transcendental norms that humans must strive to attain. According to Tomkins, one's position on this polarity has wide-ranging implications for the way one approaches a wide variety of life situations. For example, one dimension of this polarity that has particular relevance for the field of psychology involves attitudes toward affect. Tomkins states:

> Nowhere is the polarity between humanistic and normative orientations sharper than in the attitudes toward man's affects... The humanistic orientation stresses the toxicity of affect control and inhibition...and is more alarmed at the cost to the individual

> of defending himself against the expression of distress, shame, aggression, excitement, or enjoyment than he is at the cost of freely expressing his affects.... The normative orientation sets itself firmly against such intrusions [of affect] and argues for the importance of controlling affects in the interests of morality, achievement, piety, or classic beauty (1963, p.127-134).

Many psychological theories, from cognitive-behavioral orientations to psychoanalytic theory, stress the importance to psychological health of being as conscious as possible of all inner experience of drives and affects. ASE specifically aims to develop conscious access to the entire range of the innate affects as well as the capacity of free expression of all feelings by the self to the self. Many of the goals of ASE, like this one, are directly in line with the humanistic orientation of ideological polarity described by Tomkins. It was hypothesized in this study that students in ASE would be observably changed in this direction as a result of the course as measured by Tomkins's Polarity Scale. Consistent with this hypothesis, following ASE students scored significantly higher on the humanistic ideological position of the Polarity Scale, while subjects in the control group became more normative in orientation, although the latter change failed to reach significance.

These results are not surprising given that ASE is positioned squarely in the humanistic orientation of Tomkins's polarity theory, both in terms of theory and practice. Although consideration and attention is given to ideological positions all along the polarity continuum, psychological functioning is primarily addressed from the humanistic standpoint of the individual's own experience of life. Furthermore, ASE extensively

examines socialization from the standpoint of re-writing social, ideological, and personal scripts that inhibit the participants conscious experience of their own affects, drives and interpersonal needs. An entire unit of ASE is dedicated to developing a self-affirming identity by working directly with early socialization experiences and scripts that might have produced the opposite. In this way, rather than encouraging the acceptance of social norms as the primary human value, ASE actually calls into question the validity and utility of much that has been previously accepted. For example, ideologies such as those expressed by traditional gender differences in the socialization of affect are examined and directly questioned.

Another area in which ASE's humanistic ideological orientation is particularly clear is its approach to human relationships. Tomkins (1963) has argued that the humanistic individual tends to be sociophillic and values intimacy in relations with others compared to normative individuals, and ASE contains many exercises and features that reflect these skills and values. To begin with, students in ASE report on their personal experiences with class tools each week in small groups of about ten students. Many of these tools are personal in nature, and although participation in the small groups is not required, it is certainly encouraged. Recently a class email list was added to the course in order to provide a forum for discussion of class concepts and tools between class meetings. This email list has been popular and has generated extensive discussion. Additionally, a number of class exercises, such as "facial gazing" in which pairs of students look into each other's eyes for several minutes without speaking, directly address issues of intimacy. ASE aims to teach individuals how to be sensitive to others' inner experiences, while remaining open and authentic about their own.

In addition to the psychological, interpersonal, and educational implications of this finding discussed above, there may be important social ramifications as well. Our society is currently facing a number of challenges in the areas of tolerance, hatred, and violence prevention. It is likely that a curriculum which moves individuals from a normative orientation to a more humanistic one may offer some assistance with these larger societal problems. In support of this possibility, it can be observed that Tomkins makes a clear distinction between the humanistic and normative orientations with respect to attitudes toward other people. Specifically, a normative orientation stresses the use of contempt affect toward other people in the service of norm enforcement, and tends to devalue intimacy and connection with others except for the sake of norm conformity and the demonstration of norm allegiance. In contrast, Tomkins argues that under circumstances of norm violation the humanistic orientation "counsels empathy and understanding" and in general tends to value intimacy and other forms of "knowing in which the distinctions between the subject and object are lost or minimized" (1995, p.131).

These two alternative orientations would appear to have clear implications for one's style of conflict resolution and one's tendency to use conflict and violence as coping skills. Tomkins lends support to this idea by reporting a study which demonstrates a direct relationship between the normative orientation and the dominance of contempt affect. This study found that when exposed to binocular rivalry between a smiling face and one displaying contempt affect, individuals with a humanistic orientation, as determined by the Polarity Scale, tended to perceive the smiling face, while the normative individuals tended to perceive the face displaying contempt. Tomkins (1963)

explains this by theorizing that the normative orientation may have evolved out of the demands of warfare upon affect socialization. For example, he argues that affects such as anger and contempt may provide a clear advantage in conditions of war. As an alternative to this strategy of human relations, a humanistic orientation tends to focus on communication and cooperation, with sanctions of any kind being used only as a last resort when other methods of persuasion have failed.

Kaufman (1996) has hypothesized a close relationship between contempt affect and hatred. He argues that the dynamics of group hatred are "not just made up of anger in the extreme, but more important, are governed by contempt" (p.298). As described by Tomkins (1961), contempt is an affect blend consisting of dissmell and anger. This learned affect blend can be observed in the characteristic facial sneer of contempt, where the lip is raised on one side of the face in the expression of dissmell and the other side of the face displays anger. These affects, Kaufman argues, are the fundamental building blocks of prejudice and hatred, because dissmell and anger, particularly when combined, are unique among the affects in their power to create emotional distance between whatever elicits them and the person experiencing them. In a context where individuals are different in some way from the majority, the majority will respond as if this difference is a threat, and attempt to repudiate those who are different. Kaufman (1996) argues that, "only contempt affect has the ideological power to fuel the punitive distancing of the repudiated other, who is now deemed unfit for the human condition" (p.299). If contempt affect plays the role in hatred suggested by Kaufman, then moving individuals away from a normative orientation of contempt toward a more humanistic one may, as one result, reduce hatred and thereby prevent the violence it engenders.

The finding of movement toward the humanistic orientation among students in ASE also has clear implications for parenting education. As described by Tomkins, the legacy of parenting from a normative orientation includes extensive corporeal punishment and a focus on complete and utter submission of the child as well as obedience to authority at all costs. According to Tomkins (1995) the normative orientation can go so far as to lead to "breaking the will of the child" (p. 122). Normative parenting tends to deny the validity of the child's own feelings, and sees as relevant only external standards of value and achievement. Alternatively, a humanistic orientation toward parenting tends to focus on the inherent value and potential of children as they are, and growth is seen as springing spontaneously and naturally from the child's own inner self and inherent goodness. From a humanistic perspective, children are encouraged to maximize their potentials and use their own feelings as a guide for decision making. ASE, which also has been adapted for young children (Kaufman, Raphael & Espeland, 1999), states that parents should pay special attention to the child's basic interpersonal needs, which are outlined and discussed in detail. ASE encourages a balanced humanistic approach to parenting that focuses on actively nurturing the child's emotional and psychological health, as well as encouraging external achievements that are appropriate to the child's specific temperament and abilities.

In addition to demonstrating that it is possible to significantly shift ideological commitments through a psychoeducational format, the present study also found trends in the data which suggest that ASE impacts several other areas of psychological functioning. One such finding involves the variable of depression. Students in ASE were found to have a greater reduction in reported depression on the Beck Depression

Inventory (Beck & Beck, 1979) than controls at the end of the semester. This result reached statistical significance. Furthermore, the more depressed a student was at the beginning of the semester, the larger the effect of the class on their depression scores. These findings provide initial empirical support for recognizing ASE to be an effective treatment for depression. In its task force on empirically supported therapies, the American Psychological Association set forth guidelines for use in establishing a psychological treatment as empirically valid (Sanderson & Woody, 1995). According to these guidelines, a therapy is "probably efficacious" when two experiments have shown that it is superior in outcome to a control group. The current research provides initial support for this designation, and indicates that further research on a clinical population is warranted.

This finding of depression reduction is reasonable given that ASE directly addresses many aspects of psychological functioning that have been theorized to impact depression. An entire unit of ASE aims to provide the participants with theories and tools designed to create a "self-affirming identity." In addition to tools aimed at developing skills such as self-nurturance and self-acceptance, past experiences in the form of scenes of abuse, neglect or other psychological trauma are re-visited through tools that are designed to bring these events more fully into consciousness and reverse their negative impact on current psychological functioning. For example, the tool of "reparenting imagery" is taught to students as a way of utilizing imagery in order to confront scenes of past psychological trauma and bring those scenes to resolution. Many students have reported successfully using this tool to work through even extreme experiences of abuse or other trauma. The findings of the present study suggest that further research is

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warranted to determine if ASE is an effective form of treatment for depression. It is possible that ASE may be a cost effective way of both treating and preventing this disorder.

A similar trend was found concerning the variable of openness to feelings. Scores on openness to feelings as measured by the "Feelings" sub-scale of the NEO-PI (McCrae & Costa, 1987) significantly increased among subjects in ASE over the course of the semester. Scores on openness dropped for the control group, but did not reach statistical significance. Several theories of psychology encourage making the unconscious conscious, and ASE is founded on the belief that psychological growth is possible only when affect, along with all other inner experiences, is available to conscious awareness. Tools such as "self-observation" are taught to ASE students for the specific purposes of expanding their awareness of all types of inner experiences, including affects, drives, and interpersonal needs. ASE aims to teach a vocabulary of inner experience that enables students to more accurately experience and describe all affective states, and ASE values this skill as a fundamental building block of psychological health.

It was hypothesized that this emphasis on increasing the ability to be aware of all affects, even painful ones, would in turn bring about an increase in reporting the experience of shame in the experimental group over the course of the semester. Research on an earlier version of ASE found that participants demonstrated a significant increase in their ability to differentiate the affect of shame compared to a control group (Meola, 1988). Based on ASE theory and this earlier research, the present study hypothesized that ASE scores on the Internalized Shame Scale (Cook, 1989) would increase over the course of the semester. However, the opposite was found. The ASE participants actually

decreased level of reported shame at post-test. This effect reached statistical significance. Shame scores among controls remained the same.

There is an explanation for why the current results appear to contradict earlier research on ASE. When Meola's 1988 research was conducted, the curriculum was offered in a 10-week format, whereas ASE currently operates in a 15-week format. Given the newly added emphasis on transforming shame, in addition to making it more conscious, it is possible that the current longer version of ASE may in fact reduce the level of enduring shame among participants.

Shame can be a crippling affect, and it is a central focus of ASE; an entire unit of ASE focuses on the relationship between shame and self-esteem. Tools are presented to teach students how to identify self-shaming scripts and then replace them with self-affirming ones. The process by which shame is internalized and bound to various internal experiences is presented, and students are encouraged to examine the role of shame in their own lives and socialization. The findings of this research indicate that the current, longer version of ASE, in addition to increasing awareness of shame, actually reduces overall levels of internalized shame.

The findings of the current study, taken together, support the effectiveness of ASE, and psychoeducational programs generally, to influence fundamental beliefs and attitudes concerning a wide range of human experience, and to have a positive impact on psychological health generally in observable ways. Initial support is also indicated for ASE being an effective treatment for depression. The emphasis in ASE on experiential learning, in addition to more typical cenceptual learning, plays an important role in its effectiveness. Students in ASE are encouraged to directly engage the psychological

theories and principles they are learning through the use of tools designed to provide them with a direct encounter with psychological theory in their own lives. In certain cases, this goes so far as to provide significant corrective emotional experiences, and to inspire significant personal insight on the part of ASE participants. In other cases it may provide innoculation against the future development of psychopathology. Kaufman argues (Kaufman & Raphael, 1991) that one motivation for developing this curriculum was to provide an analog to psychotherapy in a formal educational context. The success of ASE could become a model as well as inspiration for more widespread dissemination of the wisdom and benefits that psychology has to offer humanity both in our educational system and in our culture generally.

Clearly many individuals who could benefit from some form of psychological intervention go untreated in our society. There are many reasons for this, including insurance companies' hesitation to pay for necessary long-term treatment, the stigma that is associated with therapy, the lack of public knowledge of what psychology has to offer, and the lack of emphasis on prevention. ASE addresses each of these issues. It is cost-effective relative to other treatment modalities. It is offered in the relatively benign setting of a university course. It educates a significant number of individuals each semester about what psychology has to offer those seeking to improve the quality of their lives. And it may well provide innoculation against the development of future psychopatholgy. ASE is a promising treatment approach that deserves wider attention as well as continued study.

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APPENDICES

APPENDIX A:

POLARITY SCALE

(Tomkins, 1963)

Instructions: Consider each of the following 20 pairs of ideas and check the one you agree with. Please choose the one that you agree with most. The blank on the left is for the idea on the left, and the blank on the right is for the corresponding idea on the right.

Play is childish. Although it is proper_____ *for children to play, adults should concern themselves with more important things.*	_____**Play is important for** *all human beings. No one is too old to enjoy playing.*
*To assume that most people are well-*_____ *meaning brings out the best in people.*	_____*Too assume that most people are well meaning is asking for trouble.*
*Parents should first of all be gentle*_____ *with children.*	_____*Parents should first of all be firm with children.*
*A child must be loved so that he can*_____ *grow up to be a fine adult.*	_____*A child must be taught how to act so that he can grow up to be a fine adult.*
When people are in trouble, they _____ **trouble,** *should help themselves and not depend on others.*	_____**When people are in** *they need help and should be helped.*
The most important characteristic _____ *of a friend is that (s)he is worthy of our respect and admiration.*	_____*The most important characteristic of a friend is that (s)he be warm and responsive to one.*
The main purpose of education _____ *should be to enable the young to discover and create novelty.*	_____*The main purpose of education should be to teach the young wisdom of the past.*
When a man faces death, he _____ *learns how basically insignificant he is.*	_____*When a man faces death he learns who he is, and how much he loved life.*
The important thing in science _____ *is to be right, and make as few errors as possible.*	_____*The important thing in science is to strike into the unknown –right or wrong.*
Great achievements require _____ *first of all, great imagination.*	_____*Great achievements require first of all, severe self-*

discipline.

When a person feels sorry for themselves, they really need more sympathy from others.

_____ *When a person feels sorry for themselves, they really should be ashamed of themselves.*

No one has the right to threaten Or punish another person.

_____ *Some people respond only to punishment or the threat of punishment.*

Those who err should be forgiven.

_____ *Those who err should be corrected.*

Anger should be directed against the oppressors of mankind.

_____ *Anger should be directed against those who undermine law and order.*

Familiarity, like absence, makes the heart grow fonder.

_____ *Familiarity breeds contempt.*

Numbers were invented. _____

_____ *Numbers were discovered.*

To act on impulse is to act childishly. _____

_____ *To act on impulse occasionally makes like more interesting.*

Life sometimes smells bad. _____

_____ *Life sometimes leaves a bad taste in the mouth.*

The mind is like a lamp which illuminates whatever it shines upon.

_____ *The mind is like a mirror which reflects whatever strikes it.*

Things are beautiful or ugly independent of what human beings think.

_____ *Beauty or ugliness is in the eye of the beholder.*

APPENDIX B:

THE BECK DEPRESSION INVENTORY

(Beck & Beck, 1972)

Instructions: Read each group of statements carefully. After reading each group, select the number next to the one statement in each group which *best* describes the way you have been feeling during the *past week, including today.* Be sure to read all the statements in each group before making your choice.

0. I do not feel sad.
1. I feel sad.
2. I am sad all the time and I can't snap out of it.
3. I am so sad or unhappy that I can't stand it.

0. I am not particularly discouraged about the future.
1. I feel discouraged about the future.
2. I feel I have nothing to look forward to.
3. I feel that the future is hopeless and that things cannot improve.

0. I do not feel like a failure.
1. I feel I have failed more than the average person.
2. 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.

0. I get as much satisfaction out of things as I used to.
1. I don't enjoy things the way I used to.
2. I don't get real satisfaction out of anything anymore.
3. I am dissatisfied or bored with everything.

0. I don't feel particularly guilty.
1. I feel guilty a good part of the time.
2. I feel guilty most of the time.
3. I feel guilty all of the time.

0. I have not lost interest in others.
1. I am less interested in other people than I used to be.
2. I have lost most of my interest in other people.
3. I have lost all interest in others.

0. I make decisions as well as ever.
1. I put off making decisions more than I used to.
2. I have greater difficulty making decisions than before.
3. I can't make decisions at all.

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 that make me look unattractive.
3. I believe that I look ugly.

0. I can work as well as before.
1. It takes an extra effort to get Started doing something.
2. I have to push myself very hard to do anything.
3. I can't do any work at all.

0. I can sleep as well as usual.
1. I don't sleep as well as I used to.
2. I wake up earlier than usual and

0. I don't feel I am being punished.
1. I feel I may be punished.
2. I expect to be punished.
3. I feel I am being punished.

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

0. I don't feel I am any worse than anyone else.
1. I am critical of myself for my weaknesses or mistakes.
2. I blame myself all the time for my faults.
3. I blame myself for everything bad that happens.

0. I don't have any thoughts of killing myself.
1. I have thoughts of killing myself, but I would not carry them out.
2. I would like to kill myself.
3. I would kill myself if I had the chance.

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.
3. I used to be able to cry, but now I can't cry even though I want to.

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 now.
3. I don't get irritated at all by the things that used to irritate me.

find it hard to get back to sleep.
3. I wake up much earlier than usual and cannot get back to sleep.

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

0. My appetite is no worse than usual.
1. My appetite is not as good as it gets.
2. My appetite is much worse now.
3. I have no appetite at all anymore.

0. I haven't lost much weight 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.

0. I am no more worried about my health than usual.
1. I am worried about physical problems such as aches and pains upset stomach or constipation.
2. I am very worried about physical problems.
3. I am so worried about my physical health that I cannot think of anything else.

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.
3. I have lost all interest in sex.

APPENDIX C:

THE "FEELINGS" SUB-SCALE OF THE NEO PERSONALITY INVENTORY

(McCrae & Costa,)

Instructions: Please read the following statements carefully. Then indicate in the answer blank whether you Strongly Disagree, Disagree, Neutral, Agree, or Strongly Agree with the statement. In the blank next to the question mark **SD** if you *Strongly Disagree,* **D** if you *Disagree*, **N** if you are *Neutral,* **A** if you *Agree*, and **SA** if you *Strongly Agree.*

1. _____ Without strong emotions, life would be uninteresting to me.
2. _____ How I feel about things is important to me.
3. _____ I rarely experience strong emotions.
4. _____ I seldom pay much attention to my feelings of the moment.
5. _____ I experience a wide range of emotions or feelings.
6. _____ I seldom notice the moods that different environments produce.
7. _____ I find it easy to empathize – to feel myself what others are feeling.
8. _____ Odd things – like certain scents or names of distant places – can evoke strong moods in me.

APPENDIX D:

THE INTERNALIZED SHAME SCALE

(Cook,)

Directions: Below is a list of statements describing feelings or experiences that you may have from time to time. Most of these statements describe feelings or experiences that are generally painful or negative in some way. Everyone has had some of these feelings at some time. Try to be as honest as you can in responding. Read each statement carefully and circle the number to the left that indicates the frequency with which you find yourself feeling or experiencing what is described in the statement. Use the scale below:

0=Never 1=Seldom 2=Sometimes 3=Often 4=Almost Always

Scale:

0 1 2 3 4 1) I feel like I am never quite good enough.

0 1 2 3 4 2) I feel somehow left out.

0 1 2 3 4 3) I think that people look down on me.

0 1 2 3 4 4) All in all, I am inclined to feel that I am a success.

0 1 2 3 4 5) I scold myself and put myself down.

0 1 2 3 4 6) I feel insecure about others opinions of me.

0 1 2 3 4 7) Compared to other people, I feel like I somehow never measure up.

0 1 2 3 4 8) I see myself as being very small and insignificant.

0 1 2 3 4 9) I feel I have much to be proud of.

0 1 2 3 4 10) I feel intensely inadequate and full of self doubt.

0 1 2 3 4 11) I feel as if I am somehow defective as a person, like there is something basically wrong with me.

0 1 2 3 4 12) When I compare myself to others I am just not as important.

0 1 2 3 4 13) I have an overpowering dread that my faults will be revealed in front of others.

0 1 2 3 4 14) I feel I have a number of good qualities.

0 1 2 3 4 15) I see myself striving for perfection only to continually fall short.

0 1 2 3 4 16) I think others are able to see my defects.

0 1 2 3 4 17) I could beat myself over the head with a club when I make a mistake.

0 1 2 3 4 18) On the whole, I am satisfied with myself.

0 1 2 3 4 19) I would like to shrink away when I make a mistake.

0 1 2 3 4 20) I replay painful events over and over in my mind until I am overwhelmed.

0 1 2 3 4 21) I feel I am a person of worth at least on an equal plan with others.

0 1 2 3 4 22) At times I feel like I will break into a thousand pieces.

0 1 2 3 4 23) I feel as if I have lost control over my body functions and my feelings.

0 1 2 3 4 24) Sometimes I feel no bigger than a pea.

0 1 2 3 4 25) At times I feel so exposed that I wish the earth would open up and swallow me.

0 1 2 3 4 26) I have this painful gap within me that I have not been able to fill.

0 1 2 3 4 27) I feel empty and unfulfilled.

0 1 2 3 4 28) I take a positive attitude toward myself.

0 1 2 3 4 29) My loneliness is more like emptiness.

0 1 2 3 4 30) I feel like there is something missing.

APPENDIX E:

CONSENT FORM

DEPARTMENTAL RESEARCH CONSENT FORM

1. I have freely consented to take part in a scientific study being conducted by Brenden Readett under the supervision of Dr. Gershen Kaufman.

This research will require that I answer some questions about myself and about my feelings and experiences. Participation in this experiment usually takes approximately 1/2 hour.

2. The study has been explained to me and I understand the explanation that has been given and what my participation will involve.

3. I understand that I am free to discontinue my participation in the study at any time without penalty. I understand that I may leave blank any individual questions I do not wish to answer.

4. I understand that the results of the study will be treated in strict confidence and that *I will remain anonymous.* Your privacy will be protected to the maximum extent allowable by law. Within these restrictions, results of the study will be made available to me at my request.

5. I understand that my participation in the study does not guarantee any beneficial results to me.

6. I understand that, at my request, I can receive additional explanation of the study after my participation is completed. For further information you may contact Brenden Readett at 355-2310.

If you have questions or concerns regarding you or your child's rights as a research participant, feel free to contact David Wright, University Committee on Research Involving Human Subjects at (517) 355-2100.

Signed:_____
Print Name:_____