CALIFORNIA STATE UNIVERSITY, NORTHRIDGE

FEELINGS CLARIFICATION-EVALUATION

IN A HOSPITAL SETTING

A graduate project submitted in partial satisfaction of the requirements for the degree of Master of Public Health

by

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June 1976
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ACKNOWLEDGMENTS

We would like to express our sincere appreciation for the support, guidance and inspiration of our committee members, Waleed Ahmed Alkhateeb, M.P.H., and G. B. Krishnamurty, Dr. P.H.

Further recognition and acknowledgment is extended to Holy Cross Hospital and to the staff who participated and supported this project.

We would also like to thank Ann Davis for typing the final manuscript and Paul House for preparation of the graphs.
THE CHIEF CONCERN OF A WISE AND GOOD MAN IS HIS OWN REASON

- Epictetus

I know the past and plan ahead
Yet live the now that's real
I act by thought and logic
I just feel the way I feel
I don't confuse these separate things
Nor wind them on one reel

What scars remain from long ago,
What fogs still clog my brain
Yield to the daily tears and yawns
That let me think again.
My use of all my gains includes
Continual further gain.

-Harvey Jackins
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ABSTRACT

FEELINGS CLARIFICATION-EVALUATION
IN A HOSPITAL SETTING

by
Gary William Erbeck
and
Wayne Schilling Hansen, Jr.

Master of Public Health

This paper presents a study of a Feelings Clarification-Evaluation Program conducted in a local San Fernando Valley hospital. The Feelings Clarification-Evaluation Program was developed within a hospital setting as a means of helping hospital employees get in touch with their feelings about working in a stress-filled environment. The program was designed to help participants separate the emotional and stress-causing aspects of hospital work situations from action necessary to successfully accomplish those situations. This was achieved by encouraging participants to physically experience the emotional impact of situations through a process known as "discharge". Specific objectives of participants concerned recognizing emotional content of situations, discharging on that emotional content and re-evaluating subsequent action. The authors evaluated the participants' discharge process and subsequent
changes in stress-related feelings and behavior which, in part, were attributed to the discharge process.

Materials used included a private program room, a tape recorder, egg timers, and an instructional guide consisting of programmed behavior alternatives.

Methodology used in the study included both classroom instruction and individually oriented programmed instruction administered to ten volunteers representing a rough cross-section of hospital employees. Evaluative procedures were administered in a pre-post design.

Program and participant evaluation occurred throughout the duration of the six-week program based on results obtained from the Weedman, Warren, Marx Self-Concept Incongruency Scale and tests designed by the authors to measure participants' self-evaluation of progress. Both objective and subjective considerations are discussed.

It was found that sixty-six percent of the test population were able to discharge at one time or another during the course of the program. Evaluation of the Weedman, Warren, Marx Self-Concept Incongruency Scale did not show any significant change in participants' self-concept before and after the program. Significant improvement in feelings, however, was obtained from analysis of the Feelings Clarification-Evaluation scale.

A discussion based on program results and applicability of this program into occupational settings is also included.
CHAPTER I

INTRODUCTION

Since any project is only as good as the cooperative environment in which it seeks to operate, the authors wish to make note that throughout this particular project called Feelings Clarification-Evaluation in a Hospital Setting the perspective of the study had to include both an academic and an administrative point of view.

The authors initially gained access to a selected hospital as a result of a request from the Chairperson of their Continuing Education Committee for two graduate students in health education to develop a diabetes education program for the hospital. It did not take long to discover, however, that the need for a diabetes program was conceived strictly out of administrative convenience rather than real patient need. The hospital did not treat many diabetics, and a well-developed diabetes education program already existed in another local hospital. Nevertheless the authors developed a basic education program for the hospital, gained some additional respect and cooperation from the Committee and soon got down to the process of determining an education program which was really necessary.

A brainstorming session with interested representatives of the various aspects of patient care services at the hospital highlighted several points:

1. Patient education programs were necessary for aspects of catastrophic disease at both primary and secondary prevention.
2. Crisis counseling education was especially necessary for situations involving catastrophic disease and should involve everyone concerned, including patient, patient's family, and hospital staff.

3. Education and training in aspects of crisis adaptation in the hospital designed specifically for hospital employees was the underlying concern of the group. It was felt that the emotional impact of crisis and stress got in the way of ideal patient-oriented care. These findings along with some possible working objectives were presented to the Education Committee who gave approval to develop a program with the possibility of implementing it in the hospital.

The authors proposed a program to be used by hospital employees which would concentrate on an examination of feelings as they related to work situations, especially those situations which seemed to cause a "crisis" for the individual. The program encourages participants to discharge on those feelings and develop better-adjusted attitudes and behavior.

**Goals and Objectives**

To explore the results of incorporating Re-Evaluation Education into a hospital-oriented crisis adaptation program, the authors proposed the following goals and objectives:

**Program Goals**

1. Participants will improve their situation and problem-solving abilities on the job in the hospital.
2. Participants will improve their personal contact with their feelings as they relate to various situations, both on and off the job.

3. Participants will improve their feelings about themselves.

Program Objectives

Using the Programmed Instructional Guide along with one's own creative ability and imagination, participants will be able to:

1. Recognize the emotional content of speech.
2. Discharge on the emotional content of one's speech.
3. Identify manifestations of discharge.
4. Develop and explore (and use!) one's rational thought processes.

The program approach was based on the theory of Re-Evaluation Education which proposes a functional definition of human interaction and proposes a process which helps individuals overcome the highly influential effects of past distress experiences.

Past efforts to view the phenomenon of Re-evaluation Counseling as a "therapy," as a "mutual self-help" self-improvement program, as a community of determinedly loving people, as a needed catalyst for the liberation struggles of all groups of oppressed peoples, as a "leading edge" of the upward trend in the Universe, have been helpful.

It is also possible to view Re-evaluation Counseling as a process for attaining a more accurate picture of reality, particularly the reality of human nature, of human intelligence, of human relationships, and of human capabilities, by removing the occlusions upon it. These occlusions are caused by lack of information, by mis-function, and, especially, by the illusions created by distress patterns (Jackins, 1975, p. 25).

Re-evaluation Education seemed to be the most practical and applicable theory on which to base this program.
Real movement forward in the direction of uncluttering human intelligence and allowing it to operate is taking place in and around Re-evaluation Counseling. Attempts are being made elsewhere and in other ways, but compared to what takes place in Re-evaluation Counseling, very little happens. The best attempts of the various therapies and self-improvement systems, the dozens of schools of psychologists and psychiatrists, the human growth movements and the inspirational teachers, all accomplish very little. They are interesting as social phenomena and there are things to be learned from their occurrence and their multiplicity, but they are by no means effective (Jackins, 1974, p. 16).

We have come to realize these other theories not only do not work well and show no or poor practical results, but also that they are reactionary in their content. The theory of psychoanalysis, for example, portrays humans in an inhuman way. In practice, it becomes a tool for degrading people, for limiting their goals. This is true also of even the most optimistic of the modern humanistic psychologies or human growth theories. Their most positive conjectures are too limited to fit the reality of human beings. The best of the Perls and the Rogers and the Maslow theories (and these men are very positive human beings) would leave people disarmed in the full job of re-emergence by the gaps in their positiveness and the limitations they unawarely leave on the goals of humanity (Jackins, 1974, p. 17).

The adaptation of Re-evaluation Education to the requirements of this hospital program eliminated the one-to-one counseling interaction which depends on a strict mutual contract of trust, a contract of which we could not be assured in the hospital setting. The authors felt that the use of tape recordings were more protective of professional security, giving the participant free reign to explore his/her own feelings and behavior alternatives through reaction and analysis of his/her recorded discussion of problem situations.

The authors expected the program to be applicable to an occupational setting because the process is accomplished in relative privacy, it could be performed on a scheduled basis as
well as be adaptable to changes in participant availability. The program is simple, inexpensive, and easily maintained with a minimum of technical material and equipment. Finally it was felt that participation in the program would ultimately result in better patient care.

It was felt that the program would be quite feasible within the hospital, provided participants agreed with the underlying Re-evaluation Education theory and hospital administration felt the authors' program would not interfere with normal hospital operations. An evaluation of what actually happened is discussed in later chapters.

Statement of the Problem

This report consisted of an examination of a Feelings Clarification-Evaluation Program designed for use in a hospital setting and an analysis of the results of hospital employee participation. The program was designed for use by employees who must cope with relatively high levels of stress and crisis-oriented work environments. Helping a program participant examine and "experience" his/her feelings should be followed by a re-evaluation of stress-filled situations by the participants. This increases one's ability to arrive at appropriate solutions based on logical thinking. To test the accuracy of this process we proposed objectives to examine whether participants could:

1. Recognize emotional content of situations by listening to recordings of their speech.
2. Discharge on that emotional content.
3. Arrive at new solutions to those situations.
This study also tested the effect of this program on participants' feelings about themselves and about those feelings which pertained specifically to the objectives of the program.

Statement of the Hypothesis

This study was concerned with the testing of the tenability of the following hypotheses:

1. There is no difference between the way participants perceive their real self compared to their ideal self relative to the Self-Concept Incongruency test scores, pre- and post-program.

2. There is no difference between the way participants perceive themselves based on the Self-Concept Incongruency test scores pre- and post-program.

3. There is no difference in the participants' self perception pre- and post-program based on the Feelings Clarification-Evaluation Scale.

4. There is no perceived change by participants post-program.

5. There is no difference between the way participants perceive their real self compared to their ideal self relative to the Feelings Clarification-Evaluation Scale pre- and post-program.

6. There is no difference between actual change and perceived change pre- and post-program.

7. The actual results of the program are equal to the anticipated results.
Significance of the Problem

It was assumed that all humans possess a core being with qualities of lovingness, zest, intelligence, curiosity, cooperativeness, and communicativeness. This implies an innate genius for coping with each new life situation in a unique, rational manner. Previous distress, which all have suffered without significant resources to work off that distress through some sort of discharge, clouds that genius, occludes thinking processes so that reactions to stress are performed in rigid, ritualistic, and often irrational ways. This is called "patterned" behavior.

Stripping the emotional content from distress-causing problems by engaging in exercises which promote discharge should clear up one's thinking in distressful or restimulating situations.

The authors' combined experience from work in hospitals and witnessing of employee behavior leads them to believe that people's patterns and their handling of repeated distress can have a crippling effect on a person's ability to function optimally. This is particularly evident in the emotional and crisis-laden atmosphere of a hospital.

Emotional reaction often interferes with rational behavior. Rationality does not mean to negate the importance of emotion: both are very important factors in human interaction. The idea here, however, is that emotions should be felt, enjoyed and appreciated, but they should not influence one's professional decisions of action. In order to avoid the possible ill effects of undischarged distress in work situations, hospital personnel
need methods of releasing their emotions so they can deal with their patients on strictly rational levels.

Jackins believes that individuals do not let their emotions influence their actions and logical thinking when emotions are given appropriate avenues of expression (Jackins, 1965). The Feelings Clarification-Evaluation Project allows one to experience, in a safe and supportive setting, the emotional content of various work situations which may impair one's rational behavior and innate genius in finding new and creative methods of dealing with work situations.

Since the authors suspect, as does Jackins, that the emotional impact of these work situations involves distress originating from a much earlier period of life, the authors encourage participants to discharge, experience emotion in situations where once the participant may not have allowed himself/herself the benefit of that emotion. Individuals who discharge while reviewing in their minds distressful situations often find they can re-analyze those situations and think of new logical action solutions.

Limitations of the Study

The following were recognized as limitations of this study:

1. The test population was small, consisting of ten volunteers who were employed by the hospital. The initial pilot program used ten student nurses who were receiving training at the hospital and who volunteered to participate in our program. In either case the test population was not randomly selected. The authors analyzed data from those who completed the six-week program.
2. The program had no control population. Lack of controls prohibits attribution of test results to effects of the Feelings Clarification-Evaluation Program.

3. Evaluation instruments for the Feelings Clarification-Evaluation Program were not standardized which may introduce bias into the authors' interpretation of results.

4. Testing instruments used were based on the participants' willingness and ability to self-evaluate their personal feelings and behavior which limited uniformity of measurement. Other factors which would tend to affect uniformity of measurement would be:

   a. Participants did not receive equal amounts of training preparatory to starting the Feelings Clarification-Evaluation Program. Some did not attend all training sessions which would increase the possibility of confusion and "drop-out" from the program.

   b. The program needed more supervision time than the authors could afford, leaving participants to work out problems for themselves.

5. Scheduling of participants' twice-weekly program sessions was haphazard due to the low priority status assigned to the program by hospital administration.

6. The program was designed to concentrate only on everyday stress situations and not on deep-seated psychiatric problems. The authors took pains to explain this limitation to participants.

7. Finally the program had to operate within the administrative constraints required by the hospital which stated,
briefly, that the program could not interfere with the normal hospital routine.

**Definition of Terms**

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<td>Counter-transference:</td>
<td>The phenomenon by which hospital staff involved in direct patient care unknowingly take on the symptoms of their patients, including aspects of attitude, feelings, and physical dysfunction.</td>
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<td>Crisis Situation:</td>
<td>An unexpected turn of events which offers no immediate and obvious solution. It often results in distress which further prevents ability to find solutions.</td>
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<td>Discharge:</td>
<td>This is a physical and/or psychological reaction to experiencing feelings and emotions. It has certain indicators such as laughing, shaking, warm or cold perspiration, crying, etc. One of the objectives of the Feelings Clarification-Evaluation Program is to recognize and be comfortable with discharge.</td>
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<td>Distress:</td>
<td>The experience of pain, both physical and emotional, which inhibits an individual's rational thought processes.</td>
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<td>Emotional Content:</td>
<td>That part of a situation which has particular significance to an individual and elicits strong feelings and related behavior.</td>
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<td>Pattern:</td>
<td>A learned, generalized response to a variety of related stimuli; the response is rigid, ritualistic, and often inappropriate to the specific stimulus situation. Situations which cause distress or remind one of past distress will elicit patterned behavior.</td>
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<tr>
<td>Control Pattern:</td>
<td>Behaviors developed during experiences of tension or distress which a person learns to use to hold in painful emotion. These often inhibit ability to discharge.</td>
</tr>
<tr>
<td>Restimulation:</td>
<td>Reaction (patterns, discharge) to situations which remind one of past painful situations.</td>
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CHAPTER II
LITERATURE REVIEW

People who are engaged in the helping professions are constantly being exposed to traumatic, stressful experiences throughout their working career. The sort of person that is attracted to this type of work is able to derive great personal satisfaction from helping others. To provide relief from pain, suffering and anguish to fellow human beings is a vitally essential task that they are able to perform with zest, lovingness and concern.

Countertransference and Patient Care

It has been noted in the literature, however, that "things" tend to obstruct a person's ability to carry on at one's peak effectiveness and efficiency (Geach, 1974; Davidson, 1971; Rickles, 1973; Suinn, 1964). As Sam Putnam states in issue number 2 of Re-evaluation Well-Being; "... more important is seeing how my own distress interferes with my being able to help somebody who's coping with a particular problem that has been very restimulating to them ..." (1976). These "things" (distress in the case above) have been assigned various labels. The most common one for the purposes of this project being countertransference. Countertransference has been described at various times as the displacement of the physical and mental symptoms of the patient to the provider (Geach, 1974; Kernberg, 1963). Obviously this is the opposite of transference where the object is for the patient to pick up on the providers strong, positive qualities and subconsciously incorporate those
into his/her own psyche so that a higher form of patient-provider relationship can flourish. Countertransference then would tend to diminish a provider's ability to work at their most effective levels. The issue of patient care enters here. If the provider is feeling ill, short-tempered and irritable, what sort of meaningful transference can be set up? Both parties suffer; the patient, because he/she is not receiving the full attention he/she deserves, and the provider because he/she is vaguely aware that "something is not quite right." In either case the returns from the patient-provider contact are severely limited.

How can one attempt to break the cycle? There are various methods available which could range from extensive, expensive psychotherapy for care providers, to firing a care provider each time it appears that he/she can no longer effectively establish contact with patients.

It is the contention of the authors of this paper and others (Ellis, 1962; Somers, 1972; Jackins, 1965, 1973; Rickles, 1973; Gray, 1974) that problems of this sort have their origins within each individual human being. Therefore, the solution must be generated internally rather than relying on some sort of external support. How does one go about contacting these internal resources when after (in most cases) many years of non-use they have atrophied? What sorts of processes need to be developed? Why do people hesitate to rely on their inner innate genius? We hurt, we hurt others, we try to protect ourselves from further hurt. What has gone wrong? Where lies that fundamental flaw which denies us the
full and joyful experience of life?

Re-evaluation Education Theory

Harvey Jackins, founder and main theorist of the Re-evaluation Education community, sees many of the answers to these questions hidden in the shadow of irrational behavior brought about by what he terms "patterns" (Jackins, 1962; 1965; 1973; 1976).

These patterns tend to disrupt the process of human intelligence.

Human intelligence is defined concretely as the ability to construct a new, unique, accurate response to each new, unique experience which confronts each human at each moment of his existence (Jackins, 1965, p. xi).

All living creatures, including humans, tend to actively respond to their environment, and in fact all tend to impose a sort of organization on the environment. Rocks do not do this; their approach to their environment (as far as we know) is strictly passive. What differentiates humans from other living creatures, Jackins contends, is that humans do not have to respond to the environment based on "pre-set patterns of response" (Jackins, 1962; 1965; 1973).

This ability is differentiated explicitly from the ability of plants and animals to "choose" responses from an inherited, restricted list of pre-set response patterns (Jackins, 1965, p. xi).

In non-humans the range of pre-set responses can go from few for a simple creature to large for a complex creature. What is important is that in either case the number of responses is finite and fixed. Since the responses are fixed it becomes necessary for non-humans to begin to categorize the many life experiences. Non-humans must
lump together many situations which are similar and meet them with
the same response.

When we (humans) are functioning in our distinctive human way we do not have to, nor do we, use any prefixed, inherent or previously worked out responses, but always and continuously create and use new precise responses that exactly match and successfully handle the new situation which we confront (Jackins, 1965, p. 12).

Human irrationality is explicitly defined as failure to create and present such a new, unique, accurate response. It is present as an acquired, non-inherent, unnecessary characteristic of present humans. The source of human irrationality is located in the distress experiences which the human has undergone and has not been permitted to recover from completely (Jackins, 1965, p. xi).

When we examine the common and typical attitudes of people operating under their imposed distress recordings ..., "we find that a great deal of usual behavior in this area (health and well-being) is remarkably unintelligent" (Jackins in issue number 2 of Health and Well-Being, p. 1, 1976). Re-evaluation Education is a technique and philosophy used to help individuals recover from past distress and regain their powers of rational thinking.

Re-evaluation Counseling is a process whereby people, regardless of age, education or experience, can learn how to exchange effective help with each other in order to free themselves from the effects of past distress experiences.

Re-evaluation Counseling theory provides a model of what a human being can be like in the area of his/her interaction with other human beings and his/her environment. The theory assumes that everyone is born with tremendous intellectual potential, natural zest and lovingness, but these qualities have become blocked and obscured in adults as the result of accumulated distress experiences (fear, hurt, loss, pain, anger, embarrassment, etc.) which begin in childhood.
The child could recover from distress spontaneously by virtue of the natural process of emotional discharge (crying, trembling, raging, laughing, etc.). However, this natural process is usually interfered with by well-meaning adults and older children ("Don't cry", "Don't be a sissy", etc.) who erroneously equate the emotional discharge (the healing of the hurt) with the hurt itself (Jackins, 1976, p. 5).

Discharge: A Natural Healing Process

It can be seen then that central to the core of the theory of Re-evaluation Education is the explanation of the development of patterns. Patterns are behavior traits that could most accurately be described as a pattern of behavior that controls the person (Jackins, 1965, 1972, 1976; Somers, 1972; Scheff, 1972). Patterns are not an inherited trait as with other animals, but develop in response to stress and tension. However;

When adequate emotional discharge can take place, the person is freed from the rigid pattern of behavior and feeling left by the hurt. The basic, loving, cooperative, intelligent, and zestful nature is then free to operate (Jackins, 1976, p. 5).

Discharge then seems to be an inherent natural healing process. All humans are born with the ability to work through emotional distresses in such a manner that they don't become distress recordings in the brain (Jackins, 1965; 1973). It would seem that what we have to do is to teach ourselves to use that ability once again. One has to learn this healing process (discharge) all over again. One of the things that distinguishes Re-evaluation Education from other therapies based on emotional release (catharsis, abreaction) is "balance of attention". A person's attention has to be divided equally between the past distressing event and the present safe environment (Jackins, 1965, 1972, 1976; Somers, 1972;
Once this occurs discharge will take place.

As discharge occurs, often for many or even hundreds of hours, the client is flooded with new memories and new insights concerning the distressful experience; he is able to see it from his present perspective, rather than as he did during the original experience (Somers, 1972, p. 68).

An individual may experience great difficulty in discharging on certain patterns which nevertheless still cause anxiety. These patterns are considered chronic in that individual, and essentially define the total fabric of reality for the individual. A chronic pattern is the result of a distress recording which plays all the time. It is then very difficult to gain any objectivity or balance of attention which would bring on discharge.

With the material which has become chronically restimulated in a client, however, it becomes a very difficult matter to draw any of the client's attention outside the pattern. This pattern has been lived with so long that it has become "adjusted to". What rational behavior goes on (and there is likely to be quite as much of it as with any other person) is nevertheless constrained and modified by the rigid framework of the patterns which are in chronic restimulation. (We may note these in other people and refer to them as "little idiosyncracies".)

Often it will be hard to make a satisfactory attack on these chronic patterns until considerable work has been done on more readily available material which has not yet been so "adjusted to" or which is in restimulation only sporadically (Jackins, 1970, pp. 13-14).

One usually finds that as humans begin to remove major patterns in their life they will notice (as well as those around them) an increased level of intelligence, increased self-control, increased sensitivity and an increased sense of well-being. In essence rationality is the freedom from repetitive behavior (Ellis, 1962; Jackins, 1962, 1965, 1973, 1976). This can probably be best achieved through the process of discharging on distressful emotions.
Once imagined and discharged on, new solutions and logical approaches to once distressful situations acted upon in ritualistic and often irrational ways become evident. Thus where behavior was once irrational and ritualistic, it now has the potential to be rational and unique.

Applicability to a Hospital Setting

The methods and techniques of Re-evaluation Education do have supporters in the health care profession, and it does seem feasible that they can be incorporated into hospital routine.

... (a hospital) recently suggested each hospital team should have a "crying and support room" for the staff ... to discharge! (A'Heeh Smith in issue number 2 of Health and Well-Being, 1976, p. 8).

Even though staff time is at a premium in a hospital setting, concerned health care providers seem to make the best of spare moments.

I use my R.C. with patients at the scarce moments available. I'd love to see hospitals allow time for nurses to listen to patients more. I'm convinced it would cut down in the long run on crises, budget problems, and other negativistic titles that are thrown at feeling nurses (Eleanor Kerr in issue number 2 of Health and Well-Being, 1976, p. 7).

There does appear to be a need for such a "space" to develop in this country's health care facilities. The tenants of Re-evaluation Education seem best suited to the task.

Programmed Instruction

For teaching purposes the use of feedback mechanisms which elicit a limited variety of responses can be programmed in advance (Reese, et al., 1973). Armed with a guide to all potential behavior pathways, a student can follow his/her progress along a
desired pathway and a researcher can analyze, in a systematic fashion, just which pathways are taken. This is known as programmed behavioral response and was influential in the design of the authors teaching technique.

Although Re-evaluation Education traditionally uses two individuals, each taking turns as counselor and client to help the other discharge on patterns (Jackins, 1962), the authors felt that techniques could be used to teach individuals to discharge using a tape recorder rather than another individual. This was considered necessary due to the occupational setting of the program. Participants would discharge on problem situations which might cause potential embarrassment if discussed with co-workers or colleagues. The authors felt that a tape recorder would provide the security necessary for discharge.

The interaction between individual and tape recorder represents a feedback mechanism adapted from Barbara Brown's discussion of Bio-feedback (Brown, 1974). Brown generalizes bio-feedback as any procedure which makes ordinarily unconscious, autonomic processes apparent to the individual who can use this new information to change or modify those processes. Thus physical processes which were once under involuntary control are now subject to conscious control. Other feedback techniques using programmed logic sequences similar to the authors' use of programmed behavioral response have been used to design computer programs used for counseling purposes.

The mechanism used in this project to train participants in
Feelings Clarification-Evaluation makes use of just such a feedback mechanism. Through the use of a programmed instructional guide and a tape recorder, participants can explore, step-by-step, the depths and significance of feelings of which, though influential in their behavior, were hidden from conscious awareness. The result of this exploration, as will be shown, is discharge, re-evaluation of feelings and behavior, and the awareness of new, unique solutions to once distressful work situations.
CHAPTER III

METHODOLOGY

This chapter will be concerned with the procedures employed and the relevant methods of research design which were necessary to successfully complete the project.

Specific consideration will be given to: target population, program design, instruments used for collecting data, project administration, access to the hospital system, and evaluation procedures.

Defining the Target Population

The authors determined that in the realm of "crisis adaptation", patients would benefit most from such a program if hospital personnel were first trained in crisis adaptation techniques. The countertransference phenomenon lead the authors to suspect that hospital personnel who had difficulty maintaining their emotional equilibrium in the face of a hospital's highly crisis-laden atmosphere would be of questionable benefit to patients grappling with their own individual crisis; adaptation to the effects of catastrophic disease. The authors then determined to design the crisis adaptation program for hospital personnel who would at some time have direct or indirect contact with the patient.

Program Design

The design of the project was determined by available material and hospital cooperation and consisted of tests administered before and after the program. The tests were designed to measure the participants' self-evaluation of feelings,
attitudes and behavior. Changes in the participants' responses, pre- and post-program, were partly attributed to the effect of the program. The effectiveness of the program was monitored by periodic evaluations of participants throughout the duration of the study. A pilot program to assess adequacy and applicability of the program and test instruments was performed previous to the study. Due to the relatively small number of participants (n=10) a control design to test changes in attitudes without the benefit of the program was not determined.

The Feelings Clarification-Evaluation Program consisted of two segments, both designed to help a participant benefit from an examination and "experience" of his/her feelings followed by a re-evaluation of their subsequent behavior.

Orientation Instruction

Orientation instruction (see Appendix H) was given in two one-hour segments which introduced participants to the basic theory of Re-evaluation Education and the application of this theory to use in the hospital. The instruction was designed to involve as much group participation as possible. Participants were also instructed on the use of the Programmed Instructional Guide (see Appendix G) and the applicability of skills learned in the orientation sessions with processes outlined in the guide.

Programmed Instructional Guide

The Programmed Instructional Guide (see Appendix G) offers step-by-step, timed exercises in recognizing emotional content of speech, recognizing discharge, and re-evaluating problem situations
and possible solutions. The concept of designing a sequence of programmed behavioral responses for educational purposes was derived from Reese and Woolfenden (1973) and the adaptation of this design to concepts of Re-evaluation Education was inspired by Dr. G. B. Krishnamurti (Cal-State University, Northridge). Applicability for use in a hospital setting was the responsibility of the authors. Participants engaged in program sessions alone in a specifically designated room which offered privacy and quiet. Participants were expected to allow themselves twelve private sessions in six weeks.

**Testing Instruments**

Prior to the actual participation in the project, the participants were asked to complete the Weedman, Warren, Marx Self-Concept Incongruency Scale (Weedman, et al., 1974, see Appendix C). The Self-Concept Incongruency Scale is a semantic differential type instrument derived from the Tennessee Self-Concept Scale and consists of sixteen scales. This instrument was used to measure two aspects of an individual's self-concept, *The Way I See Myself* and *The Way I Would Like to Be*. This instrument is designed to measure self-concept incongruence. This is defined as the degree of difference between the real and ideal self (Weedman, et al., 1974). A low difference between the two scores would indicate little disparity between actual and ideal self-concepts and thus a high level of self-esteem. Conversely, a high difference between the two scores would suggest a large disparity between actual and ideal self-concepts and would indicate a low level of self-esteem. Split half methods were used to establish reliability. "The correlation
between odd and even items when correlated for test length, was 0.83 (p .001)" (Weedman, et al., 1974). This scale was administered to the participants before the program and six weeks later at the conclusion of the program.

**Feelings Clarification-Evaluation Scale**

The other testing instruments used in the program were developed by the authors. The Likert method was selected in the construction of these test instruments because of the relative ease of administration, scoring, simplicity of construction and potential reliability with a few items. The Likert scaling provides more precise information about degree of agreement and/or disagreement.

Even though identical scores on the Likert scale may have entirely different meanings, the Likert scales tend to perform very well when it comes to a reliable, rough ordering of people in regard to a particular attitude.

The modified Likert scale questionnaires were developed to measure participant's self-evaluation of their progress during the program.

The scale developed for the project contained eight statements each with a six-choice Likert-type response continuum.

The questionnaire also gave space for the participant to list personal goals for the program and to offer comments and/or suggestions that could be useful in developing a final evaluation instrument or to modify the program as it was in progress.

Interviews with the pilot program participants provided the
major source of items for the questionnaires.

Wording of statements attempted to use language similar to the usage of the participants. Use was made of as simple and clear language as possible to convey a single idea in each statement.

The questionnaires were pre-tested with a group of ten Licensed Vocational Nursing students who participated in the pilot project. The ten participants were asked to fill out the questionnaires and to comment on clarity, content and value of the instrument. The results of the pilot program showed that there were no problems in comprehension of the questionnaires. The pre-test was designed to evaluate clarity of directions; to elicit participant reaction to questionnaire content and usage; and to test the mechanics of administration. The final survey instruments (the questionnaires) were modified based on the pilot program group results.

The pre-test (see Appendix C) consisted of two eight-item Likert type scales. The first was titled The Way I Am Now. The second portion of the pre-test was titled The Way I Expect to Be. The authors were attempting to measure the real-ideal gap as it related specifically to the goals and objectives of the program. The post-test consisted of two more Likert-type scales with the eight identical questions as the pre-test. What is important here are the headings used. The first instrument was titled The Way I Am Now, and the second The Way I Remember Myself Before the Program. The authors were attempting to measure the participant's perceived change after the program. No attempt was made to establish the reliability of these instruments.
Personal Evaluation Forms

The Personal Evaluation Forms (see Appendix E) were an eight-item questionnaire to be completed by the participants each time they completed one fifteen-minute session. This instrument was an attempt to measure the participant's immediate reactions to the session and to see how well the participants were meeting the goals and objectives of the program.

Final Program Evaluation Form

The Final Program Evaluation Form (see Appendix D) was completed by the participants at the end of the six-week program time. This was a ten-item Likert scale which attempted to elicit data about the participants overall reaction to the program. The questions that were constructed dealt with specific questions and issues that the participants had raised with the authors both during the orientation sessions and from the list of objectives the participants stated on the Feelings Clarification-Evaluation pre-test form.

Program Administration

The hospital program was conducted much like the pilot program, with orientation, in-hospital sessions, and final evaluation components. Participation in the program was strictly voluntary. Several program rooms were selected at two locations; an empty room in the nursing office trailer and on the critical care ward. The rooms were outfitted with the machinery necessary for the program:

1. The Programmed Instructional Guide.

2. A cassette tape recorder and blank tape.
3. A three-minute timer.
4. A fifteen-minute timer.
5. Personal Evaluation Forms.

Participants first attended the Orientation Program consisting of two one-hour sessions. When ready to begin their individual sessions, participants first filled out the pre-test questionnaires, then were given the following instructions:

You are now ready to begin your 15-minute session with the Program Instructional Guide.

1. Always start each session from the beginning of the Program Instructional Guide.
2. You can discuss new material or return to previous material, but always start from the beginning of the Program Instructional Guide. If you have nothing specific to discuss, then just talk about the first thing that comes to mind.
3. Make sure the Program tape is in the recorder.
4. Set the 60-minute timer for 15 minutes.
5. Start the Program Instructional Guide.
6. At the end of the 15-minute session, erase your tape completely, then fill out the Personal Evaluation Form (Questionnaire #3).

These are your objectives:

Using the Program Instructional Guide along with your own creative ability and imagination:

1. You will be able to recognize the emotional content
of your speech.

2. You will be able to discharge on that emotional content.

3. You will be able to identify manifestations of discharge.

4. You will be able to develop and explore (and use!) your rational thought processes.

Participants were also asked to evaluate (via the Personal Evaluation Forms) their progress or reactions each time they completed their session, twice a week for six weeks. Evaluations were collected weekly for interpretation. Participants' individual sessions were scheduled in advance, though there also were unscheduled hours when program rooms could be used if participants felt the urge. Supervisors were alerted to the program, both personally and by memo, and all volunteers had to have supervisor approval before they could participate.

Access to the Hospital System

Up to the implementation of the Feelings Clarification-Evaluation Program, support and enthusiasm for the authors' efforts was maintained through periodic reports and discussions with the hospital's Continuing Education Committee. Fortunately the program, or at least the theory behind the program, gained immediate high level support both from Administration and Nursing Services, and the Medical Staff evidenced some interest. Delays and apparent roadblocks in the actual implementation of the program were the apparent result of routine administrative procedures rather than any overt hostility toward the program.

During the implementation process all action was planned and
discussed in advance with the hospital administrator and other key administrative and service staff with periodic followup discussion meetings during the course of the program.

The Pilot Project

Before initiating the Feelings Clarification-Evaluation Program in the hospital, the Education Committee felt, and the authors agreed, that it would be wise to pre-test the program with the student nurses who would soon be training at the hospital. The authors obtained permission from a local college to ask for volunteers from their Licensed Vocational Nurse program, and after hearing our introductory lecture everyone joined. The authors conducted three one-hour orientation sessions during classroom time, then opened a program room on the same ward where many of the students were working. Appropriate hospital staff were alerted to the program to reduce time conflicts and misunderstandings. The Licensed Vocational Nursing students participated in the individual program twice a week for six weeks.

Ordinarily one would assume a fairly smooth and speedy transition between presentation of the pilot program results to the hospital and beginning implementation of the hospital program. The fact that there were delays between these two events despite relative top-level sanction of the program needs to be pointed out. Since the authors research could not continue without the hospital approval, a combination of administrative and political methods became highly important at this point. Below are actions which the authors feel are basic to gaining access to any system to do research:
1. Forecast administrative attitudes and develop strategies appropriate to those attitudes.

2. Schedule presentations for Key Administrative and Staff meetings.

3. Outline one's strategy of presentation (see Appendix H).

4. Continuous informal contact with key supportive hospital personnel.

5. Periodic good-will gestures.

Evaluation

Evaluation procedures were implemented throughout the course of the program. The following is a list of sources of data for evaluation:

I. Subjective Data
   A. Feedback from meetings.
   B. The authors' personal observations of program participants.
   C. Individual strategy sessions with key hospital personnel.
   D. Interviews and taped responses.

II. Objective Data
   A. Participants' self-evaluation pre- and post-program (see Appendices C and D).
   B. Participants self-evaluation of progress in program:
      1. Personal Evaluation Form. Completed after each fifteen-minute session (see Appendix E).
      2. Total program evaluation (see Appendix D).
C. Self-Concept Incongruency Scale (see Appendix C).

Due to the very private nature of subjects discussed by each participant during his/her various program sessions, records of topics of discussion could not be kept, but participants could easily self-evaluate what happened to them during their sessions, i.e., did discharge occur? Did they arrive at any new solutions?

The compilation of data was based on the participants' willingness and ability to evaluate his own progress. The authors feel this is a practical and fairly reliable source of evaluation.

Periodic interviews with participants were meant to give participants a chance to clear up problems with the program and to ask questions, but at the same time the authors could assess their own interpretation of the participants' progress.

Assessment of actual translation of education into behavior change on the wards was impossible because most of our contact was outside the bedside environment. Testimonials were offered, however, indicating (telling the authors of) changes or new solutions in patient-staff situations.
CHAPTER IV
RESULTS AND DISCUSSION

In this chapter, analysis and interpretation of the data obtained in this study are presented.

The seven null hypotheses of the study were tested using statistical methods employing the use of the t-test of significant differences between test scores.

The seven null hypotheses are listed in Table III.

Intervening Variables

Reluctant though the authors are to admit it, the program results were affected by a variety of intervening variables. Since this was meant as an exploratory project created in the midst of the already furious activity of today's modern hospital, the fact that the program was implemented at all is cause enough for self-congratulation. There is no possibility of scientifically controlling for the multiplicity of influences to which the participants were subjected during the course of the six-week program, and what effect those interventions had on the program results is difficult to say.

Aside from the continuing daily routine to which the program offered participants a brief respite, other additional events at the hospital were competing for attention with the program. Many participants were expected to attend an administrative workshop (of unspecified length) orienting the hospital staff to the expected move into newly constructed buildings. The hospital staff found themselves having to cope with increased workloads (or so the
The authors were told during periodic interviews with participants) while at the same time operate under an increasing burden of anxiety as preparations for a doctors' strike became imminent. Finally the effects of the strike itself, coming just at the end of the program, resulted in widespread feelings of confusion, anxiety and apathy. Ironically, the authors feel that though the program was not intended for use in quite so emotionally charged an atmosphere, it would nevertheless have offered a chance at least for personal re-evaluation and logical thinking at a time when many people were thinking illogically.

**Weedman, Warren and Marx Self-Concept Incongruency Scale**

One of the first measures from the Weedman, et al., Self-Concept Incongruency Scale to be presented and discussed has to do with measuring the difference scores between The Way I See Myself pre- and post-program (the two useful ways of analyzing data from this test instrument are shown in Table I). This difference score is a measurement of self-perception at two points in time. These scores can also relate indirectly to self-esteem; since one's self-esteem affects the way in which we perceive ourselves. A certain level of self-esteem is required of all human service providers because if one does not have some positive regard for oneself then it becomes extremely difficult to provide the empathy, support and care that a patient requires from such health care providers. The results (number 1 in Table III) show that the calculated \( t \) score \( (t_c = 0.278) \) is less than the \( t \)-score from the \( t \)-table for nine degrees of freedom at the five percent level \( (t_{.05}^{975} = 2.26) \). The
TABLE I
CODING AND DATA COMBINATIONS OF THE SELF-CONCEPT INCONGRUENCY SCALE

<table>
<thead>
<tr>
<th>Title</th>
<th>Letter Code</th>
<th>Data Combinations for Analyses</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Way I See Myself</td>
<td>A</td>
<td>1. The difference of A and B compared to the difference of C and D. (Self-Concept Incongruency)</td>
</tr>
<tr>
<td>The Way I Would Like to Be</td>
<td>B</td>
<td></td>
</tr>
<tr>
<td>Pre-test</td>
<td></td>
<td>2. A comparison of the difference of scores for A and C. (Changes in Self-Perception)</td>
</tr>
<tr>
<td>The Way I See Myself</td>
<td>C</td>
<td></td>
</tr>
<tr>
<td>The Way I Would Like to Be</td>
<td>D</td>
<td></td>
</tr>
<tr>
<td>Post-test</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
difference was not statistically significant. There was no difference in the way the participants perceived themselves before and after the program as related to the scales on this test.

The next factor that was examined was the difference scores between The Way I See Myself and The Way I Would Like to Be, pre- and post-program (number 2 in Table III). A difference score here measures the degree of self-concept incongruency or, the real-ideal gap. If the difference in the real-ideal score was lower post-program this would suggest that a more harmonious accommodation or improved compatibility between real and ideal images occurred. The differences were not significant ($t_c = 0.86$). These results indicate the real-ideal gap harmony did not exist any differently before and after the program.

Feelings Clarification-Evaluation Scales

The program evaluation instruments that were devised by the authors yielded some interesting results, although they cannot be generalized to a larger population. First (the five useful ways of analyzing data from these test instruments are shown in Table II) the difference in scores between The Way I Am Now pre- and post-program were obtained. This difference in score measures the change in self-perception over time as related to the program goals and objectives (see number 3 in Table III). One can also regard this measure as some indication of the progress that the participants were making towards expectations that they had before the program. The results here are significant ($t_c = 3.11$). This means that there was a positive significant difference in the way
### TABLE II
CODING AND DATA COMBINATIONS OF THE FEELINGS
CLARIFICATION-EVALUATION SCALE

<table>
<thead>
<tr>
<th>Title</th>
<th>Letter Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Way I Am Now</td>
<td>A'</td>
</tr>
<tr>
<td>The Way I Expect to Be</td>
<td>B'</td>
</tr>
<tr>
<td>Pre-test</td>
<td></td>
</tr>
<tr>
<td>The Way I Am Now</td>
<td>C'</td>
</tr>
<tr>
<td>Post-test</td>
<td></td>
</tr>
<tr>
<td>The Way I Remember Myself Before the Program</td>
<td>D'</td>
</tr>
</tbody>
</table>

**Data Combinations for Analysis**

3. The difference in scores for A' and C'. (Self-Perception)
4. The difference in scores for C' and D'. (Perceived Change)
5. The difference in scores for A' and B'. (Real-Ideal Gap)
6. The difference in scores for A' and C' compared to the difference in scores for C' and D'. (Program Results)
7. The difference in scores for A' and B' compared to the difference in scores for A' and C'. (Meeting Personal Goals)
### TABLE III

**THE T-TEST OF THE SIGNIFICANCE OF DIFFERENCE BETWEEN TEST SCORES ON TWO SCALES**

<table>
<thead>
<tr>
<th>Hypothesis</th>
<th>Instrument</th>
<th>Comparison is Between</th>
<th>N</th>
<th>t</th>
<th>Inference</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. No difference in the real-ideal gap, pre- and post-program.</td>
<td>Self-Concept Incongruency</td>
<td>The Way I See Myself and The Way I Would Like to Be Differences pre- and post-program.</td>
<td>10</td>
<td>0.66</td>
<td>Fail to reject hypothesis of no difference. Disparity between real-ideal self-concepts remained unchanged.</td>
</tr>
<tr>
<td>2. No difference in the way program participants perceive themselves pre- and post-program.</td>
<td>Self-Concept Incongruency</td>
<td>The Way I See Myself pre- and post-program.</td>
<td>10</td>
<td>0.273</td>
<td>Fail to reject hypothesis of no difference. There is no significant difference in the level of self-perception pre- and post-program.</td>
</tr>
<tr>
<td>3. No difference in self-perception-pre- and post-program.</td>
<td>Feelings Clarification-Evaluation Scale</td>
<td>The Way I Am Now-pre- and post-program.</td>
<td>10</td>
<td>3.11</td>
<td>Reject hypothesis of no difference. Indicative of change due to program.</td>
</tr>
<tr>
<td>4. There is no perceived change post-program.</td>
<td>Feelings Clarification-Evaluation Scale</td>
<td>The Way I Am Now-pre-program and The Way I Remember Myself Before the Program.</td>
<td>10</td>
<td>4.83</td>
<td>Reject hypothesis of no difference. There is a positive significant difference in the way program participants perceive themselves.</td>
</tr>
<tr>
<td>5. No difference in the real-ideal gap, pre- and post-program.</td>
<td>Feelings Clarification-Evaluation Scale</td>
<td>The Way I Am Now and The Way I Expect to Be-pre-program.</td>
<td>10</td>
<td>2.51</td>
<td>Reject hypothesis of no difference. Program participants expected a positive change.</td>
</tr>
<tr>
<td>6. No difference between actual change and perceived change-pre- and post-program.</td>
<td>Feelings Clarification-Evaluation Scale</td>
<td>The difference between the results of #3 and #4.</td>
<td>10</td>
<td>2.35</td>
<td>Reject hypothesis of no difference.</td>
</tr>
<tr>
<td>7. The actual results of the program are equal to the anticipated results.</td>
<td>Feelings Clarification-Evaluation Scale</td>
<td>The difference between the results of #5 and #3.</td>
<td>10</td>
<td>1.70</td>
<td>Fail to reject hypothesis of no difference. Participants were meeting personal goals for program</td>
</tr>
</tbody>
</table>

*Significant at the .05 level.
the participants perceived themselves before and after the program as related to the program goals and objectives. This could possibly be due to program effects such as raising the level of self-esteem or perhaps the participants merely began to set more realistic goals as to how they would like to be.

The difference scores between The Way I Am Now and The Way I Remember Myself Before the Program (number 4 in Table III) gives a measure of how the participants perceived a change in him/herself. It is also an indication of how well the participants think s/he met their personal goals for the program. The results here are significant at the five percent level ($t_c = 4.83$). This an indication that there was a significant difference in the way the participants perceived themselves after the program. An examination of the individual scores (raw data) shows a trend that the participants saw themselves as being "better" after the program.

The difference between the scores received on the questionnaires The Way I Am Now and The Way I Expect to Be (number 5 in Table III) give some indication of what the participants expectations were for participation in the project. This is a measure of personal goals to strive for and what the ideal change could be for that person. It is also another measure of the real-ideal gap. The results here were also significant ($t_c = 2.51$). Besides being a measure of the personal goals for each participant as stated before, it gives some indication that the participants were interested in affecting a change in themselves.

A look at the scores between the actual and perceived change
(number 6 in Table III) shows that there is a significant difference \((t_c = 2.35)\). An examination of the individual scores (raw data) for this section shows that in the majority (six out of ten) of cases the actual change was greater than the perceived change. This led the authors to believe that most of the participants tended to underestimate the change that they had achieved (in their self-analysis of feelings).

The difference in scores between the anticipated change and the actual change (number 7 in Table III) indicates how close the participants met their anticipated change. The \(t\)-test for differences was not significant \((t_c = 1.70)\). Therefore the null hypothesis that the actual outcome of the program is equal to the anticipated outcome could not be rejected. This again would indicate that for this study group they were able to meet their own personal goals for the program. In addition the participants were able to meet their goals but were unaware that they had actually surpassed their goals.

**Participant Goals**

What about the goals of the participants? How did they want to benefit from participation in the program? In order to ascertain this the authors asked the participants to list their goals on the pre-test (see Appendix C). Some of the typical responses are given below:

To be more effective...and therefore a more effective employee in dealing with various situations.

Relieve stress at the end of the day.
Hope to improve my acceptance of the limitations and constraints of my job.

Continued growth and development—understand—accept myself, worth (sic) and others I deal with.

To be able to recognize my emotional responses to work-related situations— to distinguish between my emotional and rational behavior. To understand more clearly what fears and insecurities produce which emotional response — and deal with those fears and insecurities.

Better understanding of why I make certain decisions and improve my method of thinking out problems.

Being in touch with myself.

Gain better understanding and insight into the changes which have occurred in my position and relationship to … (the) hospital. Determine what my response to those changes should be in the context of my personal and professional survival.

For the most part the participants were concerned with personal growth and development. They saw this as a pathway to improved job performance (whether it was decision-making or dealing with other people).

Participant Expectations

The pre-test (Appendix C) also asked the participants to state how their chosen goals related to their role as health care professionals. Some of the typical responses are given below:
Directly.

Might help me to decide whether I can remain in this particular setting and/or how I can beat this system of health care delivery.

I can identify my own feelings and emotional responses juxtapose (sic) empirical data, I can better evaluate problems arising from work situations and more quickly and easily see solutions and/or alternatives.

It would be helpful in that I would be in better contact with myself and those around me.

Decision will impact significantly my career direction and development.

**Personal Evaluation Form**

The authors asked the participants to complete a questionnaire (Appendix E) at the conclusion of each fifteen-minute session that would give the authors some indication of how well the participants thought they were meeting the stated program objectives. The results for six of the questions on the Personal Evaluation Form are shown in Figure I. All of the participants utilized the sessions in a purposeful manner and talked about a particular problem. Fifty-six percent of the time the participants felt different at the end of a fifteen-minute session and sixty-six percent of the time they experienced some sort of discharge. The participants indicated that sixty-six percent of the time after a session they were able to identify what sparked the discharge as well as fifty-eight percent of the time having a better personal understanding
Do You Feel Any Different After 15 Minutes with Program?
YES 55%

Do You Know What You Said That Caused the Discharge?
YES 66%

Did You Experience Any Sort of Discharge?
YES 66%

Did You Talk About Things in General Most of the Time?
YES 18%

Do You Have a Better Personal Understanding of the Problem?
YES 58%

Did You Talk About a Particular Problem?
YES 100%

FIGURE I
BAR GRAPH OF CUMULATIVE RESPONSE TO SIX QUESTIONS ON THE PERSONAL EVALUATION FORM
(This form was completed at the end of each fifteen minute session. This represents participant response for the entire project time span (six weeks) )
of the problem that they choose to talk about.

The objective of being able to experience discharge as well as identify the discharge process was met by the participants (see Figures II and III). As can be seen in Figure II, the discharge indicators that were described most often were changes in speech patterns, followed by laughter, tears and warm perspiration. Although these were the discharge indicators most often described they are by no means representative of the entire spectrum of such indicators. As can be seen from Figure III, when discharge did occur it occurred most often in the first four steps of the program. This is interesting when combined with the fact that the median step completed in the program per fifteen-minute session was just a little short of step six (see Figure IV). This represents more than half of the programmed instructions as being completed at any one session.

The participants were also asked to describe, if they could, any difference in the way they were feeling at the conclusion of each fifteen-minute session. Most of the responses to this question seemed to be cautious in nature, but for the most part the participants stated things such as: "I feel less nervous", "more relaxed, feeling better about myself", or as one participant stated: "I still feel frustrated". Some participants were concerned about the longevity of their new found "rationality": "My dilemma has been clarified and there is a small improvement in attitude and approach to (the) situation. (I) will have to see if it lasts". One participant was hesitant to use the tape recorder
It is possible for one person to have all the forms of discharge.
Step 1
Step 3
Step 4
Step 5
Step 6
Step 7

NUMBER OF POSITIVE RESPONSES

FIGURE III

BAR GRAPH OF CUMULATIVE RESPONSE TO QUESTION SIX
(WHEN IN PROGRAM DID DISCHARGE OCCUR?)
ON THE PERSONAL EVALUATION FORM

(This form was completed at the end of each fifteen
minute session. This represents participant responses
for the entire project time span (six weeks))
FIGURE IV

CUMULATIVE FREQUENCY POLYGON SHOWING THE MEDIAN STEP COMPLETED IN FEELINGS CLARIFICATION-EVALUATION PROGRAMMED GUIDE BOOK
set up and stated:

I am able to 'discharge' my emotions at home when I 'talk to myself'. I find that the tape recorder is an inhibiting element for me -- I simply do not feel comfortable talking to the recorder. I also find that I (have) given false answers to my own questions when using the recorder, whereas I am much more truthful when alone at home.

Participant Interview

The one particular participant who offered the above comment eventually ceased participating in the program. Not wanting to have similar situations occur, the authors elicited responses from other participants. We could find no other evidence of "tape recorder fright" and one participant allowed us to use the transcript of the interview here. The authors feel that this interview represents the general consensus of the remaining participants.

Comments

Initially I felt that the tape recorder was frightening; I likened it to stage fright. Once that was overcome, talking was fairly easy but to pick out a key word or phrase was difficult, since it seemed that the entire talk was filled with emotion. Most of the discussion was on a feeling level.

Discharge

I was able to notice that I was getting much better at identifying speech indicators such as speeding up, slowing down and chopping off words. Once I became able to do this the discharge process seemed easier. Discharge occurred most often for me at the end of the fifth step.
Variation in Method

I have been experimenting with variations from the instructions and sequences that were in the programmed instructional guide. Basically I repeated step three and played back the tape a second time. I was able to then hear beyond the words...aha! That's what I'm saying about myself.

As was stated previously a quick survey of the other participants convinced the authors that initial contact with the tape recorder was a bit stifling, but with more practice the tape recorder became less and less of an "inhibitory factor".

Final Program Evaluation

At the completion of the Feelings Clarification-Evaluation Program, each participant was asked to complete a ten-item Likert scale evaluation form (Appendix D). The questions on this form were derived from the personal goals that each person had listed on the pre-test. In this manner the participants progress towards their collectively stated goals and what they thought of the program could be assessed simultaneously. The frequency distribution and mean response for each item are shown in Figure V. Overall, the program received a favorable evaluation with the mean response to all ten questions being 3.0. This means that in the view of the participants the program was a success. The program was able to meet their stated goals and expectations. Examination of this data also convinced the authors of the purposefullness and acceptance of the Feelings Clarification-Evaluation Program by the participants. The participants were able to experience and identify discharge (Figures II and III) in such a manner that indicates to the authors that for this particular population the
**FIGURE V**

**FREQUENCY DISTRIBUTION AND MEAN RESULTS OF POST-PROGRAM EVALUATION**

<table>
<thead>
<tr>
<th>Question</th>
<th>Very Strongly Agree</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>Very Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The program helped me solve situations and problems which arose as part of my work in the hospital.</td>
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<td>2. The program improved my personal contact with feelings I encountered during the course of my work day.</td>
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<td>3. The program improved my feelings about myself.</td>
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<td>4. The program helped me understand situations and problems</td>
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<td>5. The program helped me feel more capable as a hospital employee.</td>
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<td>6. Participation in this program was convenient and accessible in spite of my work schedule.</td>
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<td>7. The program helped me achieve a better understanding of topics I chose to discuss.</td>
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<td>8. The program relaxed me.</td>
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<td>9. The program made me feel more confident.</td>
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<td>10. This program would be a practical and valuable addition to a hospital.</td>
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</table>

Mean Response to all Ten Questions

Number of participants responding in each category.
program was beneficial to the performance of their jobs as health care professionals.

Follow-up and Behavior Related Change

Since the authors could not follow participants through their daily routine to determine if any program objectives were incorporating themselves into work behavior, the best the authors could do was to ask for a self-evaluation of this. Results from interviews and evaluation forms at the end of the program indicate that to some extent this translation of program-oriented behavior (the program itself demanded behavior change) to work-oriented behavior did occur (see Final Program Evaluation, page 48 and Figure V, page 49). However, participants sensing the authors' enthusiasm and high hopes may have answered evaluation in ways which would please the authors or would have pleased themselves rather than stick to facts. It is reassuring to note that many participants adapted the feelings evaluation methods into their own personal versions of achieving the same goal: peaceful and logical thinking.

A possible follow-up study could involve interviewing non-participating supervisors, questioning them of behavior changes in their participant employees. Obvious problems here involve violation of privacy codes.

This program at least reached far enough into behavior change to get some evaluation of retrospective behavior change, evident in post-test questions and final evaluation. Participation in the program itself demanded behavior change. Any good health education program can ask no less.
Program Flaws

Despite all the efforts of the educators of the world, often-times one just has to learn by making mistakes. Considered retrospectively some problems with the program which were once rather mysterious become quite clear.

Problems Involved in Low Priority Status of Program

Although the hospital administration approved the program, it was still assigned a low priority of commitment. The following are some of the major problems that the authors were able to identify.

1. Volunteers first participated out of curiosity, then only when they had little else to do.

Why?
The program takes a degree of commitment; it involves some anxiety and frustration at first, then results make the effort worthwhile.

Irony
People who are hassled are reluctant to put out a little more energy to become unhassled (that is why tranquilizers are so popular; they involve no expenditure of additional energy). People are also reluctant to try new, unfamiliar methods.

2. The Program is not self-sustaining.
The point of the program was to create something deemed so necessary by the participants that their enthusiasm would sustain it. The program, however, required the authors constant supervision.
3. Bona fide time conflicts; participants' job demands just got in the way.

4. The program site, though well conceived, was inaccessible to some.

Problems Involving Participants

1. Those that needed the program the most participated the least.

2. Stigma: Participants may have been shy of the possible stigma associated with a "counseling" program. Some participants said they had trouble talking to a tape recorder, which may have been another way of saying they were afraid someone might hear them.

Problems Involving a New Program

1. This program proposes a new and slightly radical idea; it appeals to the curiosity but also involves some initial confusion.

2. The authors had originally planned to run the program without any orientation sessions, but this would not have worked, even though the Program Packet (Appendix F) contained all of the material presented in the orientation.

3. There was a lot of coaching necessary, not so much in theory, but in encouraging participants to get up enough "nerve" to actually do the exercise..."mental calisthenics".
Hospital Dynamics: Staff and Administrative Reactions to the Project

Although the authors have no hard data to substantiate these findings, observations of hospital dynamics during the process of the project development and implementation showed that key management and administrative staff who were initially involved in the project development were more knowledgable about the program than the rest of the hospital staff. However, they still did not truly realize the projects' objectives and applicability until we all engaged in strategy sessions preparatory to the presentation of the pilot project results to the hospital.

During the pilot project our presence on the hospital wards had been given unofficial approval from previously mentioned key staff. Hence, the authors received cooperation from the ward staff although most of them were unaware of the basic intent of the authors' efforts.

Since the subjects in the pilot were student nurses, our efforts at this point had little effect on hospital routine. The authors' efforts did cause some mild ripples of concern from hospital administration which were eventually superseded by great tidal waves of concern caused by the first doctors' strike.

Administrative concern and anxiety increased proportionately with increased awareness of the project during the authors' public relations campaign just previous to presenting the project to the hospital and asking for volunteers. Although this preparatory period increased administrative concern, the results of the authors' presentation and the assurance of key staff further increased
knowledge, reduced anxiety and enhance administrative cooperation. Concern remained at relatively low levels throughout the duration of the project in the hospital and was finally erased by the effects of the second doctors' strike (see Figure VI).

Although the authors feel that the need for mechanisms which help people cope with stress is widespread, and that this program and its theoretical framework represents a viable means of dealing with this situation in a variety of occupational settings, conclusions reached in this particular study are based on a relatively small cross-section of employees in a hospital. In general, the authors were quite pleased with the results of the program. The program itself is intriguing, pertinent, shows good potential for effective use (all opinions of participants). It is inexpensive, simple and indicates the potential for behavior change. The authors are thoroughly convinced of the adequacy of the program mechanism and it's background theory, but it's administration and integration into the traditional hospital routine needs work.

Future Applicability

The Feelings Clarification-Evaluation Program seems to (based on the results of this project) have a good potential to provide an inexpensive, quick and accessible support system to human service providers. If the quality of patient care is to surpass (or even maintain) it's present level, care providers must be able to function in a logical and rational manner. From the patient's standpoint, medical treatment and care can involve many kinds of distress ranging from simple physical pain to anguish or anxiety
Key:

--- General administrative and staff knowledge of/about Project.

--- Key staff knowledge of/about Project.

--- Administrative concern (anxiety) over Project.

**FIGURE VI**

*CHRONOLOGY OF HOSPITAL DYNAMICS*

(This graph is a representation of the various hospital dynamics of which the authors were aware during the development and implementation of the Project. Key staff knowledge and understanding of the Project increased during developmental phases while general hospital staff knowledge remained low until presentation of pilot results. Administrative concern increased proportionately with increased knowledge of project but dropped off after Pilot presentation. The doctors' strikes had marked effects on hospital administrative concern over Project.)

*This graph is meant as a visual aid; it is not based on existing hard data but rather on interpolation and intuition.*
over results or imagined results of catastrophic disease. A similar program oriented towards patients' needs can be designed to deal with distress and perhaps actually promote healing. A program such as this has a definite place in the continuity of patient care.

**Significance to Health Education**

It is important to point out that this type of program does work, but it is not self-sustaining. Therefore, it is essential that a person with skills in the area of program planning, research, group dynamics, communication skills, administrative knowledge and evaluation, i.e., a health educator, be involved as much as possible before a program such as this is considered for implementation. Health educators not only possess the necessary skills to implement such a program but their orientation is towards prevention. The program is a step in the direction of mental health promotion.
CHAPTER V

SUMMARY

The Feelings Clarification-Evaluation Program was conceived as a response to felt needs of the target population; employees of a local hospital. In order to intervene between the population’s emotional reaction to crisis in the hospital and the often crippling effect this reaction has on the employee's ability to function adequately (rationally), a program was designed to help participants distinguish emotion from action and to re-evaluate subsequent behavior in the light of rational thinking.

The theoretical framework of the study was based on Harvey Jackins' Re-evaluation Education Theory which assumes that all humans have an innate, though often occluded, genius for approaching each life situation as a fresh, new experience with a unique solution. The program embodies many of the strategies used by Jackins to help individuals recover their innate genius. This study limits the potential for such recovery due to the use of a programmed text and a tape recorder instead of another human being as a counselor. Specific objectives of participants concerned recognition of emotional content of situations, ability to discharge on that emotional content and to re-evaluate subsequent action behavior.

Methods employed included participation of ten hospital employees who engaged in group training sessions which introduced them to the concepts of the program and individual private sessions using the Programmed Instructional Guide, a fifteen-minute timer,
and a tape recorder. Participant and program evaluation was instituted before and after as well as throughout the duration of the program. Test data was based on results of the Weedman, Warren and Marx Self-Concept Incongruency Scale and tests designed by the authors to measure participant's self-evaluation of progress. Both objective and subjective considerations were discussed.

Program results show that sixty-six percent of the test population were able to discharge sometime during the course of the program. Evaluation of the Weedman, Warren and Marx Self-Concept Incongruency Scale did not show any significant change in participant's self-concept before and after the program, but significant improvement in feelings were evident from analysis of the Feelings Clarification-Evaluation Scale. Evaluation of both objective and subjective data indicated that program objectives were met in addition to significant measurable improvement in participants' feelings about themselves and their work in the hospital.

Aspects of behavior-related follow-up, program flaws, and ongoing hospital dynamics during the course of the program are also discussed. The program is seen as having significant applicability in occupational settings, particularly in stress-filled or crisis-oriented settings.
REFERENCES


5. Davidson, P. O., and Hiebert, S. F. "Relaxation Training, Relaxation Instruction and Repeated Exposure to a Stressor Film," J. of Abnormal Psychology. 78 (2), 1971, 154-159.


APPENDIX A

Hospital Memo Announcing Project

July 30, 1975

To: Administrative Council
    Management Council

From: Personnel Department

Subject: Special Joint Meeting

A joint meeting of Administrative and Management Councils has been scheduled for Tuesday, August 5, 1975 at 8:30 AM in the Dayroom.

Wayne Hansen and Gary Erbeck who are graduate students in Health Science at Cal State University Northridge will be presenting their thesis project to us.

Their project, entitled "Feelings Evaluation-Clarification in a Hospital Setting," requires extensive research on their part in a hospital. The purpose of this meeting is to introduce the project to us and to solicit our cooperation in allowing them to conduct their research at __ __ __ __.

Please plan on attending.
APPENDIX B

Memo to Solicit Volunteer Participants

FEELINGS EVALUATION-CLARIFICATION
IN A HOSPITAL SETTING

You are invited to participate in a research project conducted by Master of Public Health degree candidates Wayne Hansen and Gary Erbeck under the auspices of Holy Cross Hospital. The Project will begin with two ORIENTATION MEETINGS scheduled for Tuesday, Sept. 23 and Thursday, Sept. 25, 1975, at 3:00 PM in the _____________________.

This is a PROJECT where you learn to talk to yourself! Not only do you talk to yourself, you learn to listen to yourself and increase your understanding of your personal relationship with day-to-day work situations. In our work both at Cal. State, Northridge and here at ____________________, we have found that using the guidelines set up in our Program:

1. people DO take the time to listen to themselves, and
2. they end up feeling better about themselves, and
3. gain a new grasp and understanding of their relationship to their work situations.

To us this means that people can improve their use of their OWN innate creative resources to gain a better satisfaction both with themselves and their work.

The ORIENTATION MEETINGS will introduce participants to the basic theory behind the techniques of Feelings Evaluation-Clarification, as well as introduce the programmed instruction booklet. These meetings will involve examples and participation from you, so we will be learning from each other while becoming familiar with the Program.

Here is a tentative SCHEDULE OF EVENTS for these meetings:

I. TUESDAY, SEPT. 23, 3:00 - 4:30 PM
   A. Introduction
      1. Philosophy
      2. Theory
   B. Definition of terms
   C. Applying the theory
   D. Introduction to the PROGRAM

II. THURSDAY, SEPT. 25, 3:00 - 4:30 PM
   A. Review of Theory and Definitions
   B. Active Listening: Recognition of Emotion-filled Speech
   C. "Zeroing In"
   D. Dry Run through the PROGRAM
APPENDIX C

Pre-test Package

FEELINGS CLARIFICATION-EVALUATION

QUESTIONNAIRE #1

Following is a list of statements which could be made about people. Beside each statement is a scale with spaces ranging from VERY STRONGLY AGREE to VERY STRONGLY DISAGREE. This scale measures how you feel about each statement as it pertains to you, i.e., how do you feel about the statement, and how strong are those feelings? Please check the space which feels right to you.

Page A. and page B. contain the same statements. Page A. should reflect your feelings AS YOU SEE YOURSELF NOW. Page B. should reflect your feelings AS YOU EXPECT TO BE by the end of the six-week program period.

Thanks!
THE WAY I AM NOW

1. I feel good about myself.
2. I am in touch with the many feelings I encounter during the course of the work day.
3. Decisions I make in relation to my job are determined by my feelings or emotions.
4. I am able to understand situations and problems which arise as part of my job in the hospital.
5. I am able to solve situations and problems which arise as part of my job in the hospital.
6. A person who laughs a great deal is probably happy most of the time.
7. I feel capable in my job as a hospital employee.
8. A person who seems to cry easily is an unhappy person.

***** IN ADDITION PLEASE ANSWER THE FOLLOWING *****

a) What personal goals do you hope to achieve or improve as a result of participating in this program?

b) How do these goals relate to your role as a health care professional?
**THE WAY I EXPECT TO BE**

<table>
<thead>
<tr>
<th></th>
<th>Very Strongly Agree</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>Very Strongly Disagree</th>
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<tbody>
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<td>1.</td>
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<td>8.</td>
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1. I feel good about myself.
2. I am in touch with the many feelings I encounter during the course of the work day.
3. Decisions I make in relation to my job are determined by my feelings or emotions.
4. I am able to understand situations and problems which arise as part of my job in the hospital.
5. I am able to solve situations and problems which arise as part of my job in the hospital.
6. A person who laughs a great deal is probably happy most of the time.
7. I feel capable in my job as a hospital employee.
8. A person who seems to cry easily is an unhappy person.
This is a study of attitudes. Below you will find sixteen scales. Each scale has opposite words which describe the scale. Notice that the scales have seven spaces. Your task is to read each pair of words and choose one of the seven spaces which best describes how you see yourself on that scale. For example, on the first scale if you see yourself as an "extremely friendly" person then check the far left-hand space. If you see yourself as an "extremely unfriendly" person then check the far right-hand space. The remaining spaces represent varying degrees between the two extremes and the middle space is the neutral point. Please do not skip a scale.

THE WAY I SEE MYSELF

| Friendly       |        |        |        |        |        |        | Unfriendly   |
| Weak          |        |        |        |        |        |        | Strong       |
| Motivated     |        |        |        |        |        |        | Aimless      |
| Cruel         |        |        |        |        |        |        | Kind         |
| Deep          |        |        |        |        |        |        | Shallow      |
| Slow          |        |        |        |        |        |        | Fast         |
| Happy         |        |        |        |        |        |        | Sad          |
| Soft          |        |        |        |        |        |        | Hard         |
| Sociable      |        |        |        |        |        |        | Unsocial     |
| Excitable     |        |        |        |        |        |        | Calm         |
| Bad           |        |        |        |        |        |        | Good         |
| Free          |        |        |        |        |        |        | Constrained  |
| Passive       |        |        |        |        |        |        | Active       |
| Wise          |        |        |        |        |        |        | Foolish      |
| Humorous      |        |        |        |        |        |        | Serious      |
| Complex       |        |        |        |        |        |        | Simple       |
On this page please rate how you would like to be.

**THE WAY I WOULD LIKE TO BE**

<table>
<thead>
<tr>
<th>Friendly</th>
<th>Weak</th>
<th>Motivated</th>
<th>Cruel</th>
<th>Deep</th>
<th>Slow</th>
<th>Happy</th>
<th>Soft</th>
<th>Sociable</th>
<th>Excitable</th>
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- Unfriendly
- Strong
- Aimless
- Kind
- Shallow
- Fast
- Sad
- Hard
- Unsocial
- Calm
- Good
- Constrained
- Active
- Foolish
- Serious
- Simple
Following is a list of statements which could be made about people. Beside each statement is a scale with spaces ranging from VERY STRONGLY AGREE to VERY STRONGLY DISAGREE. This scale measures how you feel about each statement as it pertains to you, i.e., how do you feel about the statement, and how strong are those feelings? Please check the space which feels right to you.

Page A. and page B. contain the same statements. Page A. should reflect your feelings as YOU SEE YOURSELF NOW. Page B. should reflect your feelings AS YOU REMEMBER YOURSELF BEFORE THE FEELINGS CLARIFICATION-EVALUATION PROGRAM.

Thanks!
FEELINGS CLASSIFICATION-EVALUATION SCALE

THE WAY I AM NOW

<table>
<thead>
<tr>
<th></th>
<th>Very Strongly Agree</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>Very Strongly Disagree</th>
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<tbody>
<tr>
<td>1. I feel good about myself.</td>
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<td>2. I am in touch with the many feelings I encounter during the</td>
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<td>course of the work day.</td>
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<td>3. Decisions I make in relation to my job are determined by my</td>
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<td>feelings or emotions.</td>
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<td>4. I am able to understand situations and problems which arise</td>
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<td>as part of my job in the hospital.</td>
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<td>5. I am able to solve situations and problems which arise as</td>
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<td>part of my job in the hospital.</td>
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<td>6. A person who laughs a great deal is probably happy most of</td>
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<td>the time.</td>
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<td>7. I feel capable in my job as a hospital employee.</td>
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<td>8. A person who seems to cry easily is an unhappy person.</td>
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</tbody>
</table>
### The Way I Remember Myself Before the Program

<table>
<thead>
<tr>
<th>Statement</th>
<th>Very Strongly Agree</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>Very Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I feel good about myself.</td>
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<td>2. I am in touch with the many feelings I encounter during the</td>
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<td>course of the work day.</td>
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<td>3. Decisions I make in relation to my job are determined by my feelings</td>
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<td>or emotions.</td>
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<td>4. I am able to understand situations and problems which arise as part</td>
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<td>of my job in the hospital.</td>
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<tr>
<td>5. I am able to solve situations and problems which arise as part of my</td>
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<td>job in the hospital.</td>
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<td>6. A person who laughs a great deal is probably happy most of the time.</td>
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</tbody>
</table>

**B.**
FINAL PROGRAM EVALUATION

NOW - ABOUT OUR PROGRAM ...

Below is a list of statements which could be made about the Feelings Evaluation-Clarification Program. Below each statement is a scale with spaces ranging from "very strongly agree" to "very strongly disagree". This scale measures how you feel about each statement as it pertains to you, and the intensity of those feelings. This helps tell us about your reaction to our Program. Please check the space which feels right to you.

<table>
<thead>
<tr>
<th>Very Strongly Agree</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>Very Strongly Disagree</th>
</tr>
</thead>
</table>

1. The Program helped me solve situations and problems which arose as part of my work in the hospital.  
2. The Program improved my personal contact with feelings I encountered during the course of my work day.  
3. The Program improved my feelings about myself.  
4. The Program helped me understand situations and problems which arose as part of my work in the hospital.  
5. The Program helped me feel more capable as a hospital employee.  
6. Participation in this Program was convenient and accessible in spite of my work schedule.  
7. The Program helped me achieve a better understanding of topics I chose to discuss.  
8. The Program relaxed me.  
9. The Program made me feel more confident.  
10. This Program would be a practical and valuable addition to a hospital.
APPENDIX E

Personal Evaluation Form

Please complete this each time you finish the Program 15 min.

PERSONAL EVALUATION

Name:

Date:

1. How far did you go in the Program?

2. a) Did you talk about a particular problem?  YES  NO

   b) Did you arrive at a better personal understanding of the problem?  YES  NO

3. Did you talk about "things in general" (no specific problem) most of the time?  YES  NO

4. Did you experience any sort of DISCHARGE?
   Example: lively talking, laughing, sweating or warm flashes, shivering, shaking, crying...  YES  NO

5. Describe your discharge briefly.

6. When in the Program did it occur?

7. Do you know what you said that caused the discharge?  YES  NO
   (Try talking about the same thing next time if you like.)

8. Do you feel any different now that you have spent your 15 minutes with the Program?  YES  NO
   Please describe that difference in 3 words or less!
APPENDIX F

Feelings Clarification-Evaluation Program Packet

FEELINGS CLARIFICATION-EVALUATION
IN A HOSPITAL SETTING

PROGRAM PACKET

This is the program packet for the FEELINGS CLARIFICATION-EVALUATION PROGRAM. It contains important introductory material and the Programmed Instructional Guide which are designed for self-instruction ... as well as your enjoyment! Use the program in 15-minute sessions twice a week for six weeks. To clear up any possible questions or problems, we will try to arrange an interview with you soon after you start. You're also welcome to call Wayne Hansen (466-6417) or Gary Erbeck (896-1161, X266).

If you plan to use the program room in the Nursing Office Trailer to conduct your sessions, be sure to schedule your session time with Wayne or Gary.

Please be sure to read and study the introductory material in this Packet before starting on the Programmed Instructional Guide.

Ready to start? Congratulate yourself ... and begin!
FEELINGS CLARIFICATION-EVALUATION IN A HOSPITAL SETTING

INTRODUCTION

We feel that all humans possess a core being with qualities of lovingness, zest, intelligence, curiosity, cooperativeness, and communicativeness. This implies an innate genius for coping with each new life situation in a unique, rational manner. Previous distress, which we all have suffered without significant resources to work off that distress through some sort of discharge, clouds that genius; occludes our thinking so that we react to stress in rigid (ritualistic) and often irrational ways.

The stress-filled atmosphere of a hospital is a good place to try and deal with stress problems through a program which allows discharge. The emotional content of a particular problem occludes one's ability to think of a logical, rational solution. To another person for whom this particular problem has no emotional content or significance, a logical, rational approach to the problem may be quite obvious. Stripping the emotional content from problems through discharge should clear up one's thinking in that area. One of the objectives of this program is to help in that process.

We would like to take this opportunity to thank each one of you for volunteering your valuable time to participate in this innovative program. We sincerely hope that this program will prove to be a satisfying, growth stimulating process for all of us. Thank you.
FEELINGS CLARIFICATION-EVALUATION

IN A HOSPITAL SETTING

PROJECT DESCRIPTION

A. Abstract:

This is a project where you learn to talk to yourself! Not only do you talk to yourself, you learn to listen to yourself and increase your understanding of your personal relationship with day-to-day work situations. In our work both at Cal. State Northridge and here at Holy Cross Hospital, we have found that using the guidelines set up in our program:

1. People DO take the time to listen to themselves.
2. They end up feeling better about themselves.
3. They gain a new grasp and understanding of their relationship to their work situations.

To us this means that people can improve their use of their OWN innate creative resources to gain a better satisfaction both with themselves and their work.

We would like to emphasize that this is a research project necessary for the completion of our Masters Degree requirements. We're not trying to sell anything to the hospital, in fact we will probably learn much more than the participants in the program. We really need your commitment and participation, however, or all our preparatory work will go down the drain. Remember we've already conducted a pilot project in this field which was quite a success with the LVN student nurses here in the Spring, and you should have quite a lot to gain from this project as well as have some fun at the same time!

B. Objectives:

We feel that this program will:

1. improve your situation and problem-solving abilities on the job here in the hospital.
2. improve your personal contact with feelings as they relate to various situations, both on and off the job.
3. improve your feelings about yourself.
C. Mechanics of the Program - how it works:

In this project you learn by listening to yourself. This project provides a unique setting and simple guidelines where you can really listen to yourself in a creative way. The content or specific situations about which you talk are not important to us; what IS important is that you learn from yourself, achieve a new solution, a new perspective on yourself and your work.

1. Orientation
2. Read Guidelines
3. Talk into tape recorder
4. Listen
5. Evaluate reactions
DEFINITIONS

PROBLEM: Any story or feelings surrounding a recent problem that is bothering you. Talk about the problem only from your personal point of view as it affects your feelings.

DISCHARGE: This is a physical and/or physiological reaction to experiencing your feelings and emotions. It has certain indicators such as laughing, shaking, warm perspiration, cold perspiration, crying, etc. One of the objectives of the Feelings Clarification-Evaluation Program is to recognize and be comfortable with discharge.

MEMORY SCAN: Think back to an earlier (or the earliest) event related to the current problem under consideration. Take the time to describe it in great detail, including colors, smells, time, or any other sensations-----any detail (specific) which comes into your mind.

EMOTIONAL PHRASE: Any phrase you may have used that has emotional meaning to you. These are areas of concentration in the program.

THE PRESENT: The "Here and Now"-----the things that surround you and your experience of them at this moment. Getting in touch with the present is very important for discharge. It is the balance between present and past distress that helps bring about discharge. Any familiar thing can bring you back to the present.

SINKING INTO THE PAST: In order for discharge to take place, your attention needs to be divided equally between the present time and the material you are working on. This is essential if you are to feel secure enough for discharge to take place. When you sink into the past too much of your attention is focused on your material and discharge cannot occur.

SYMBOLIC MOTOR ACTIONS: Real acting out of emotional desires is not allowed. Doing it in your head is just as effective as the real thing.
<table>
<thead>
<tr>
<th>Emotional Content Indicators</th>
<th>Kind of Painful Emotional Tension</th>
<th>Discharge Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;Emotional Phrase&quot;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Long Pauses</td>
<td>Boredom</td>
<td>Laughter</td>
</tr>
<tr>
<td>Pounding on Table</td>
<td>Heavy Angers</td>
<td>Warm Perspiration</td>
</tr>
<tr>
<td>Use of Strong Verbs, Adjectives, Swear Words</td>
<td>Anger</td>
<td>Angry Noises</td>
</tr>
<tr>
<td>Increasing Volume of Voice</td>
<td>Anger</td>
<td>Warm Perspiration</td>
</tr>
<tr>
<td>Hesitation</td>
<td>Light Fears</td>
<td>Violent Movements</td>
</tr>
<tr>
<td>Stumbling over Words, Stuttering</td>
<td>Embarrassment</td>
<td>Warm Perspiration</td>
</tr>
<tr>
<td>Trailing off of Voice at End of Sentences</td>
<td>Light Fears</td>
<td>Violent Movements</td>
</tr>
<tr>
<td>Decreasing Volume of Voice</td>
<td>Fears, Griefs</td>
<td>Laughter</td>
</tr>
<tr>
<td>Change in Pitch of Voice</td>
<td>Fears, Griefs</td>
<td>Cold Perspiration</td>
</tr>
<tr>
<td></td>
<td>Physical Hurts, Pain</td>
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<tr>
<td></td>
<td></td>
<td>Yawning, Stretching, Scratching</td>
</tr>
</tbody>
</table>
APPENDIX G

Feelings Clarification-Evaluation
Programmed Instructional Guide

Feelings Clarification-Evaluation

PROGRAM
INSTRUCTIONAL
GUIDE
FEELINGS CLARIFICATION-EVALUATION
IN A HOSPITAL SETTING

INSTRUCTIONS A

If this is your FIRST 15-minute session, please complete Questionnaire #1 and Questionnaire #2 BEFORE going on to the Program Instructional Guide. There is no need to use your name on these two questionnaires, and when you are through with them place them in the box.

If this is NOT your first 15-minute session, go on to the next page.
FEELINGS CLARIFICATION-EVALUATION

IN A HOSPITAL SETTING

INSTRUCTIONS B

You are now ready to begin your 15-minute session with the Program Instructional Guide.

1. Always start each session from the beginning of the Program Instructional Guide.

2. You can discuss new material or return to previous material, but always start from the beginning of the Program Instructional Guide. If you have nothing specific to discuss, then just talk about the first thing that comes to mind.

3. Make sure the Program tape is in the recorder.

4. Set the 60-minute timer for 15 minutes.

5. Start the Program Instructional Guide.

6. At the end of the 15-minute session, erase your tape completely, then fill out the Personal Evaluation Form (Questionnaire #3).

THESE ARE YOUR OBJECTIVES:

Using the Program Instructional Guide along with your own creative ability and imagination:

1. You will be able to recognize the emotional content of your speech.

2. You will be able to discharge on that emotional content.

3. You will be able to identify manifestations of discharge.

4. You will be able to develop and explore (and use!) your rational thought processes.
SET THE 60-MINUTE TIMER FOR 15 MINUTES

1. IN ORDER TO HELP YOU RELAX AND BRING YOUR ATTENTION TO THE PRESENT TIME, BRIEFLY TALK ABOUT A PLEASANT THOUGHT OR EVENT THAT HAS HAPPENED THIS WEEK.
START TAPE RECORDER IN "RECORD" MODE  

START THE 3-MINUTE TIMER  

2. TALK ABOUT ANY SITUATION OR FEELINGS THAT ARE ON YOUR MIND AND THAT YOU WOULD LIKE TO EXPLORE.

(something that's important to YOU or something you might want to clarify to YOURSELF.)

AT THE END OF THE THREE-MINUTE TIME PERIOD STOP:REWIND THE TAPE RECORDER AND GO TO THE NEXT PAGE.
3. PLAY BACK THE CASSETTE AND CAREFULLY LISTEN TO YOUR VOICE. NOTE THE FIRST EMOTION-FILLED WORD OR PHRASE USED.

DID YOU NOTICE ANY EMOTION-FILLED WORDS OR PHRASES?

YES

NO

go to next step

#2 and repeat

EMOTION-FILLED WORD OR PHRASE: This can be any word or phrase which has emotional significance for you.
START TAPE RECORDER IN "RECORD" MODE
START THE 3-MINUTE TIMER

4.
SCAN YOUR MEMORY AND TALK ABOUT SOME PREVIOUS EXPERIENCE RELATED TO THE EMOTION-FILLED PHRASE YOU FOUND. OPEN YOUR MIND AND LET YOURSELF GO. BE ALERT FOR SOME SORT OF DISCHARGE WHILE YOU TALK. IT MAY APPEAR IN THE FORM OF LAUGHTER, SHAKING, SWEATY PALMS, CRYING, ETC.

AT THE END OF THE THREE-MINUTE TIME PERIOD, STOP.

GO ON TO THE NEXT STEP.

MEMORY SCAN: Relax your mind and think back to an earlier event related to the current problem under consideration. You may pick the first that comes to mind. Describe it in great detail.

DISCHARGE: This is a physical and/or physiological reaction to experiencing your feelings and emotions. It has certain indicators such as laughing, shaking, cold sweat, crying, etc. One of the objectives of the Feelings Evaluation Program is recognize and be comfortable with discharge.
**SINKING INTO THE PAST:** In order for discharge to take place your attention needs to be divided equally between the present time and the material you are working on. This is essential if you are to feel secure enough for discharge to take place. When you sink into the past too much of your attention is focused on your material and discharge cannot occur.
5. SMELL, TASTE OR DESCRIBE ANYTHING THAT WILL BRING YOUR ATTENTION BACK TO THE PRESENT.

(describe something that makes you happy)

ARE YOU IN TOUCH WITH THE PRESENT?

YES

NO

go to step #6 repeat step #5

THE PRESENT: This is the here-and-now, the things that surround you and your experience of them at this moment. Any familiar thing can bring you back to the present, even the act of switching the tape recorder off and on.
6. Go back to the emotion-filled phrase that triggered your discharge and repeat it. Concentrate on its full implications. Let yourself go.

go to step #7
7. **CONTINUE DISCHARGE**

**HAVE YOU FINISHED DISCHARGING**

**ON THIS MATERIAL?**

- **YES**
  - go to step #8
- **NO**
  - return to step #6
  - and continue discharge
8. ARE YOU ABLE TO DEFINE THE PROBLEM BETTER?

YES  NO

go to step #9  you may need more discharge or more help and/or information in this area. Use your own judgment; try the exercise again if you have time.
9. WANT TO STOP?

YES

compliment yourself  go to step #10

NO

out loud, and then

stop
10. WANT TO WORK ON A NEW PROBLEM?

YES

- go to step #2

NO

- go to step #8

and repeat
APPENDIX H

Feelings Clarification-Evaluation Orientation Checklist

I. Orientation Packet
   A. Introduction
   B. Outline of Program
   C. Program Instructions
   D. Operational Definitions
   E. Small Copy of Programmed Instructional Guide
   F. Personal Evaluation Forms
   G. Feelings Clarification-Evaluation Scales
   H. Self-Discrepancy Inventories

II. Introductions: New and Good; Names
   A. Program Philosophy
      1. Humans are inherently good, creative, cooperative.
      2. Origin of distress recordings.
         a. Unblock your creativity by feeling your emotions.
      4. Demonstrate how this frees one rational responses.

III. Discussion of Discharge
   A. Handout of Discharge Indicators. Go through step by step.
   B. Discharging - have to have some discussion about goals of this exercise. It is not done necessarily to "feel good" but the end result-rationality-that is important.

IV. Applying the Theory
   A. Applications to an Occupational Setting
      1. Care-giving people.
      2. Stress takes away one's free attention.
3. Emotions, countertransference.
4. Talk, set goals, and time for questions.

V. Introduction to the Programmed Instructional Guide
   A. Go over it point by point
   B. How it works in this setting
   C. Procedure for time off
   D. Going to the rooms; setting up your schedule
   E. Introduction to evaluation forms
   F. Description of what one will find in the rooms

VI. End with listening exercise.
APPENDIX I

Schedule of Events for Implementation of Feelings Clarification-Evaluation in a Hospital Setting

A. Preparation

1. Feelings Clarification-Evaluation Program explained and Pilot Project results reported at hospital assembly. Volunteers requested.

2. Program again discussed in Hospital Newspaper.

3. Memos distributed to section chiefs announcing Orientation Sessions and asking for volunteers and supervisory approval.

B. Orientation Program

1. Introduction: Re-evaluation Education philosophy and theory.

2. Definition of terms.

3. Applying the theory.

4. Introduction to the Feelings Clarification-Evaluation Program.

5. Practical applications, demonstrations and group participation.
   a. Recognizing feelings from memory
   b. Recognizing feelings from speech
   c. Use of the tape recorder
   d. Discharge
   e. Re-evaluation; discovering solutions


C. In-hospital

1. Pre-test.

2. Individual session (total of 12 over a 6-week period).

3. Personal Evaluation Form (completed at each session).
4. Interview.
5. Scheduling of sessions.
6. Post-tests.
7. Final Program Evaluations.
APPENDIX J

Pilot Program: Outline of Events

The following outline gives the framework that was utilized by the authors in the organization of the Feelings Clarification-Evaluation Pilot Program.

I. Orientation
   A. Lecture and questions
   B. Demonstrations of Re-evaluation Education techniques
   C. Group participation

II. In-hospital Program
   A. Pre-test
   B. In-depth orientation related to hospital material
   C. Program sessions
   D. Evaluation
   E. Interview
   F. On-going evaluation

III. Program Evaluation
   A. Post-test
   B. Final group meeting and their evaluation of the program
   C. Research evaluation based on data gathered