

AN ABSTRACT OF THE THESIS OF

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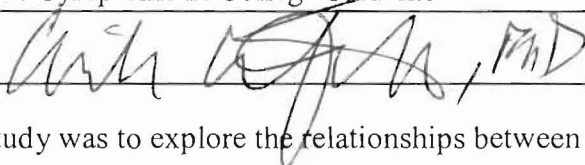
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Title: Correlations Between Levin's Affirming Messages, Developmental History, Self-Esteem, and Depressive Symptoms in College Students

Abstract approved:



The purpose of this study was to explore the relationships between Levin's affirming messages, developmental history, self-esteem levels, and depressive symptoms in a non-clinical sample of college students. It was hypothesized that students who received and internalized the affirming messages through life will report high levels of self-esteem, few traumatic events, few depressive symptoms, high frequency of automatic positive thoughts, and low frequency of automatic negative thoughts. Participants were 108 undergraduate college students at Emporia State University during the spring 2005 semester. Participants responded to a demographic questionnaire and to the Affirming Messages Self-Perception Scale (AMS), the Childhood Trauma and Adversity Questionnaire–Adapted Version (CTAQ), the Automatic Thoughts Questionnaire–Revised (ATQ-R; Kendall, 1989), the Rosenberg Self-Esteem Scale (RSE; Rosenberg, 1965), and the Beck Depression Inventory (BDI; Beck, 1996). Pearson correlation coefficients indicated significant but low correlations between the AMS, CTAQ, positive thoughts on the ATQ-R, and RSE. There were no significant correlations between the AMS, negative thoughts on the ATQ-R, and the BDI. Additional analyses showed that women's scores on the AMS were higher than men, indicating a slight gender difference on the AMS.

Subscale 2 on the AMS, the power of doing, was the most predictive dimension since it was significantly correlated with every instrument. Sexual abuse was significantly negatively correlated with scores on the AMS, and sexual and emotional abuse were found to be negatively correlated with scores on the BDI. For future studies, income levels, parents' level of education, gender differences, and parents-child relationship when growing up should be studied as factors controlling the correlations between the AMS and the instruments. It is also suggested to replicate the study with different populations and to validate the CTAQ and the AMS.

CORRELATIONS BETWEEN LEVIN'S AFFIRMING MESSAGES,
DEVELOPMENTAL HISTORY, SELF-ESTEEM, AND DEPRESSIVE SYMPTOMS
IN COLLEGE STUDENTS

A Thesis

Presented to

the Department of Psychology and Special Education

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In Partial Fulfillment

of the Requirements for the Degree

Master of Science

by

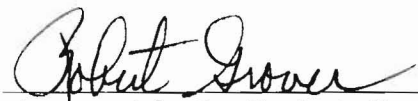
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CHAPTER 1

INTRODUCTION

Can positive statements help children, adolescents, and people in general advance through the psychosocial stages of development, develop a healthy self-esteem, and become socially-emotionally functional people? Encouraging words and phrases are present in almost every place where learning and personal development are promoted, including the radio and books. However, some specific positive messages target some specific psychological goals. For example, positive statements such as Levin's affirming messages are used as therapeutic techniques to bring about personal change, as teaching tools to increase parenting skills, and as a general intervention to nurture self-esteem and prevent depression (Bradshaw, 1990; Centers, 1999; Levin, 1988; Rosenberg & Kitaen-Morse, 1996).

There is a well-developed theory behind the affirming messages. The theory presents affirming messages as positive messages which provide the inner supports necessary to help a child develop confidence, sense of self-worth, and the ability to form close relationships (Rosenberg & Kitaen-Morse, 1996). Levin (1988) explained that affirming messages "reinforce adequacy, give permission, and support our natural developmental process" (p. 28). In addition to the theory, many studies have found that positive self-talk and self-affirmation are effective interventions to increase self-esteem, stop ruminative thinking leading to depression, and decrease depressive symptoms (Koole, Smeets, van Knippenberg, & Dijksterhuis, 1999; Peden, Rayens, Hall, & Beebe, 2001; Philpot & Bamburg, 1996), and that negative messages and self-talk lead to low

self-esteem and depressive symptoms (Peden, Hall, Rayens, & Beebe, 2000a, 2000b; Roberts & Monroe, 1992)

However, there are only a few empirical studies that support the theory behind the affirming messages (Centers, 1999). Even more, Centers reported a low correlation between belief in affirmations, personal development, and self-esteem. It is clear at this point that: (a) empirical studies support the belief that positive self-statements can increase self-esteem and decrease depressive symptoms, but (b) there is a lack of studies to support the benefit of using the affirming messages to foster people's self-esteem and sense of well being.

The purpose of this study is to explore the relationships among Levin's affirming messages, developmental history, self-esteem levels, and depressive symptoms in a non-clinical sample of college students. It is hypothesized that students who received and internalized the affirming messages through life will report high levels of self-esteem, less traumatic events, less depressive symptoms, more automatic positive thoughts, and less automatic negative thoughts. In the next section, the theoretical framework for the developmental affirming messages is presented. The literature concerning self-esteem, depressive symptoms, and positive/negative thinking are also reviewed.

Literature Review

What Are the Affirming Messages?

Levin (1988) defined affirming messages as "powerful, positive phrases we can use to replace negative ones ... affirmations are messages that reinforce adequacy, give permission and support our natural developmental process" (p. 28). Examples of the core affirming messages include: It's okay for you to be here, to be fed, touched and taken

care of; it's okay for you to move out in the world, to explore, to feed your senses, and be taken care of; it's okay for you to push and test, to find out limits, to say no and become separate from me; it's okay for you to have your own view of the world, to be who you are and to test your power; it's okay for you to learn how to do things your own way, to have your own morals and methods; it's okay for you to be sexual, to have a place among grown-ups, and to succeed (Levin). Similarly, Rosenberg and Kitaen-Morse (1996) explained that the messages provide the inner supports necessary in helping a child develop confidence, a sense of self-worth, and the ability to form close relationships.

Affirming messages can be anything that lets the individual know that he or she is lovable and capable, according to Clarke (as cited in Centers, 1999). Words, actions, and events can work as a message for people. For example, the verbal message "it's okay for you to move out in the world, to explore, and to feed your senses and be taken care of" (Levin, 1988, p.52) can also be expressed by the action of letting a child go around the playground and explore it with mom watching from the side. The messages can be passed from person to person, or they can be a person's cognitive understanding from life experiences (Levin).

Rosenberg and Kitaen-Morse (1996) use the affirmations as a mental health aid to promote personal awareness and reach higher levels of personal development. Levin (1988) presents the affirming messages as therapeutic tools too. Levin uses the messages to achieve a new consciousness in adulthood, overcome traumatic childhood experiences, and complete the developmental tasks within the different psychosocial stages of development. Clarke also explains that "the messages affirm people's need and ability to grow and to do their developmental tasks" (in Centers, 1999, p. 110).

Psychological Development and Affirming Messages

Levin (1988) presented a theory of personal development from birth to adulthood that very much resembles the psychosocial stages of development proposed by Erik Erikson (1959). Each of the seven psychosocial stages proposed by Levin has its own psychological needs and goals to be achieved. In addition, Levin identifies specific tasks corresponding to each psychosocial stage, which are to be carried out by the individual in order to become a fully developed person. Finally, each psychosocial stage has its own specific set of affirming messages matching the needs, goals, and tasks.

A fully developed person is someone who has accomplished the tasks proposed in the seven different psychological stages identified (Levin, 1988). The tasks involve developing seven different powers that we have as human beings, as proposed by Levin. Powers are developed in requisite order as follow: the power of being (birth to 6 months), the power of doing (6 to 18 months), the power of thinking (18 months to 3 years), the power of identity (3 to 6 years), the power of being skillful (6 to 12 years), the power of regeneration (12 to 18 years), and the power of recycling (18 years and older).

For a natural and healthy psychological development, the interactions between the individual and the environment (activities and people) should end with the accomplishment of the tasks, and development of the powers of each stage (Levin, 1988). The environment should be supportive and supply what is needed for the individual (e.g., care, encouragement, freedom, love, intellectual stimulation, limits), and the individual should be open and capable to perform the task and accomplish the goal. The role of the affirming messages is to provide support to the individual in the process of self development and development of the powers (Levin).

Nevertheless, interactions between the individual and the environment might not be supportive, causing a delay or stagnation in the developmental process of the person (Berne, 1972). Developmental delays happen when the environment does not satisfy the individual psychological needs, or the individual is not ready to perform the tasks yet. The resulting conclusions and interpretations from these unsatisfactory interactions stay with the individual in the form of scripts (Levin, 1988). Scripts are the way people think and feel about themselves based on how life was experienced. A lack of affirming messages while growing up leads to forming negative scripts or negative conclusions about the self and about what life is going to be like for the individual. The scripts interfere with the normal course of development, and keep the individual stuck in his or her process of development of the powers (Berne; Levin; Rosenberg & Kitaen-Morse, 1996).

Studies on affirming messages, positive self-talk, negative messages, and/or negative cognitive content assess a person's functioning and positive adjustment in life (Kendall, Howard, & Hays, 1989; Mruk, 1995; Peden et al., 2000a; Philpot & Bamburg, 1996). Self-esteem and depressive symptoms were found to be the two most common ways to measure the effect of positive or negative messages on the self in general. Just to mention briefly, the results of the studies show strong correlations between positive self-talk and self-esteem (Peden et al.; Philpot & Bamburg, 1996), and negative messages and depressive symptoms (Kendall et al., 1989). Considering that self-esteem has assessed a person's functioning in life and is closely related to positive/negative self-talk, a section of this literature review is devoted to the topic of self-esteem and its relationship with the affirming messages.

What Is Self-Esteem?

Self-esteem has been studied for decades; researchers, theorists, and professionals have proposed several different but related definitions of self-esteem that make it difficult to know exactly what self-esteem is (Baumeister, 1993). For this reason, this study used the phenomenological definition of self-esteem proposed by Mruk (1995). Mruk arrived at his definition based on the analysis of previous major definitions of self-esteem in the field, important theories explaining the phenomenon, and authors who contributed to understand this phenomenon (viz., James, White, Rosenberg, Coopersmith, Branden, Epstein, and others). Mruk's phenomenological definition of self-esteem is a description of the essential elements of the phenomenon.

Self-esteem is “the lived status of one's individual competence and personal worthiness at dealing with the challenges of life over time” (Mruk, 1995, p. 21). To understand it better, each part of the definition is explained further. First, self-esteem is not just an abstract concept; it is lived cognitively and emotionally. The cognitive experience of self-esteem involves both judgment and self-awareness. This evaluation/conclusion about us can be either positive or negative. The emotional experience of self-esteem refers to the feeling state that self-esteem fosters in us. Second, self-esteem has two core components identified by many authors and theories: competence and worthiness (Mruk). Competence is the behavioral and observable expression of self-esteem. It basically includes the ability of a person to master the environment and live a good life. Worthiness is a self-evaluation of an individual as a human being. This evaluation is based on cultural and personal values. Mruk makes it clear that both components, competence and worthiness, work together to produce self-

esteem. Third, self-esteem is a developmental phenomenon and emerges gradually by “dealing with the challenges of life over time” (Mruk, p. 21). Self-esteem, once formed, stays stable and pervades the person’s perceptions, experiences, and behaviors. However, it is also open to change when interacting with new challenges in life (Mruk).

The Development of Self-Esteem

Self-esteem develops as we mature (Erikson, 1959). People do not come to the world with self-esteem. As mentioned above, it is a developmental phenomenon that is formed as we grow and become adults. There are two factors related to competence and worthiness that contribute to the development of self-esteem: developmental forces and self-esteem moments (Mruk, 1995).

Developmental forces, or developmental precursors of self-esteem, are present in early childhood, middle childhood, and adolescence. Mruk (1995) stated that in the early stages of development, self-esteem is a reaction of the individual to the environmental forces. The precursors of self-esteem related to competence are the amount and quality of success versus failures experienced by a child. On the other hand, precursors related to worthiness are love, care, and acceptance versus rejections that a child received from parents, relatives, teachers, siblings, and others. When passing to the middle and adolescent period of development, the sources of self-esteem shift from external to internal ones. Self-esteem is now the result of the person’s own self evaluations and not just a reaction to the environment (Mruk). It is in this period where a style or type of self-esteem begins to form. The same author said that at this point, a more stable self-esteem’s style (low, high, narcissistic, or pseudo self-esteem) starts to pervade the person’s perceptions, behaviors, and identity in life.

Self-esteem moments are present in adult life (Mruk, 1995). Self-esteem continues to change over time whenever the individual is confronted with important life experiences. There are two kinds of life experiences that impact self-esteem: activity-related experiences of success or failure (competence), and interpersonal-related experiences of acceptance or rejection (worthiness). Mruk proposes that people will have an increased self-esteem as much as they succeed in life activities. In the same way, it is expected that self-esteem will increase as much as the individual is accepted within his or her interpersonal relationships.

In addition to developmental forces and self-esteem moments, Mruk (1995) identifies transitional periods in life when people have an opportunity to change and increase their self-esteem. These transitional periods, or “self-esteem turning points” (Mruk, p. 153), have a main characteristic; they involve problematic, biographic self-esteem themes. Self-esteem turning points usually evoke unresolved developmental issues concerning competence and worthiness. A turning point is a time to deal with present challenges of life, as well as with biographical patterns of failures and rejections in terms of competence and worthiness, the same author says. Transitional moments can have two effects on self-esteem. Mruk identifies that a positive effect is probable if the person breaks old patterns and deals effectively with the present challenge, and that a negative effect is likely if the person gives in to old pattern of behavior and thinking and deals poorly with the present challenge.

Self-esteem is identified as a developmental phenomenon nourished by developmental forces, self-esteem moments, and transitional periods in life, all of these explained above (Mruk, 1995). In addition, in his effort to reach a more comprehensive

approach explaining self-esteem, he discovered, in previous research, some consensus among psychologists and researchers pertaining to self-esteem. He found that there are parental factors like parental involvement, parental warmth, and parental respect which will foster self-esteem throughout the psychosocial stages of development. Furthermore, Mruk found that self-esteem can be enhanced by an accepting and caring environment, by consistent positive (affirming) feedback, and by generating positive self-feedback through cognitive restructuring, among other factors.

Self-Esteem and Affirming Messages

Affirming messages promote personal development (Levin, 1988) and form a healthy self-esteem (Bradshaw, 1990). Theorists and practitioners have presented the affirmations as a technique that helps to develop people's self-esteem. For example, Clarke (as cited in Centers, 1999) answered the question of how affirmations can help us in this way: "we can use affirmations to help us raise our self-esteem so that we have healthier bodies and healthier minds. Our posture improve, we are more attractive, productive, loving and joyful" (p. 110). Mruk (1995) found consensus among researches on the fact that consistent, positive (affirming) feedback helps to develop a stronger self-esteem. Even more, Mruk indicates that generating positive self-talk by cognitive restructuring is an effective technique to enhance self-esteem.

One of the research findings that Mruk (1995) found on self-esteem is that people with high self-esteem tend to be more open to positive feedback, present a more positive affect, and have a more effective functioning in life than people with low self-esteem. Studies in this area support this belief. For instance, the correlation between high self-

esteem and positive thoughts and self-talk is well documented in the literature (Peden et al., 2000a; Philpot & Bamburg, 1996).

Along these lines, there is support for cognitive-behavioral interventions that help to reduce negative thinking will have a significant positive impact on self-esteem and depressive symptoms (Peden et al., 2000b; Peden et al., 2001; Philpot & Bamburg, 1996). Indeed, interventions with self-affirmations and positive self-talk showed to be effective increasing self-esteem and decreasing depressive symptoms (Koole et al., 1999; Peden et al., 2001; Philpot & Bamburg). For example, Koole et al. found that self-affirmations help people to stop ruminative thinking leading to failure in life and depressive symptoms, and that those affirmations have a positive effect on implicit self-evaluations. In the other direction, Peden et al.'s (2000a) study presented the notion that negative thinking (negative self-talk) is the main key mediating the effect of low self-esteem on the development of depressive symptoms in college women. It was mentioned in previous sections that negative messages are correlated to low self-esteem and depressive symptoms. Even more, Levin (1988, 2003) explained that a lack of affirming messages within an unsupportive environment lead to negative attributions to the self.

Low Self-esteem, Depressive Symptoms, and Negative Messages

Negative attributions to self can result from the negative, unsupportive experiences in life (Levin, 1981, 1988; Mruk, 1995). These attributions negatively pervade the individual's perceptions, present experiences, and behaviors through what is called self-talk (Mruk). One study supports the idea that negative experiences in life have an impact on personal growth and self-esteem through the cognitive conclusions reached. Turner and Butler (2003) suggest that traumatic events and adverse life conditions (e.g.,

neglect and abuse of a child) during the psychosocial stages of development can lead to negative attributions of self. They found strong correlations between traumas in childhood, low self-esteem, less personal resources, and early onset of depression. Childhood adversity leads to a decreased self-esteem that, in combination with other factors such as life strain and lack of family support, prompts for an increase in depressive symptoms, as reported by Turner and Butler.

The effect of negative self-statements on self-esteem and depressive symptoms has been studied extensively. Kendall et al. (1989) reported a strong correlation between more negative self-statements endorsed on the Automatic Thoughts Questionnaire and elevated scores on the Beck Depression Inventory among college students and clinical population. In addition, several studies found that negative thinking mediates the effect of self-esteem on depressive symptoms in adolescents and college students (Fennell, 2004; Marcotte, Fortin, Potvin, & Papillon, 2002; Peden et al., 2000a). Negative thinking has been found to have a direct, significant effect on depression (Burgess & Haaga, 1994; Henriques & Leitenberg, 2002; Koole et al., 1999). Furthermore, Baumeister (1993) stated that low self-esteem can be better explained “as the absence of positive views of the self rather than as the presence of negative views” (p. 204).

Depression, or depressive symptoms, is considered here for its association with self-esteem. The diagnostic criteria for depressive disorders are closely related to the elements of self-esteem cited above: worthiness and competence. The criteria to diagnose depression and dysthymic disorders include feeling of worthlessness, diminished ability to think and take actions, and low self-esteem (American Psychiatric Association, DSM-IV-TR, 2000). Concluding, studies show that negative attributions to self, as a result of

negative experiences, have an impact on self-esteem. In the same way, self-esteem is negatively correlated to depressive symptoms.

Summary

In conclusion, affirming messages are supportive messages that satisfy people's psychological needs, help people develop self-esteem, and encourage people to develop their powers (Centers, 1999; Levin, 1988, 2003). Self-esteem is a developmental phenomenon contingent to life experiences. Affirming messages offered by the environment in the form of approval and success can nourish people's self-esteem by providing the person with a positive and supportive self-talk (Centers; Levin, 1988; Mruk, 1995). However, negative experiences and adverse conditions in life lead to negative interpretations and negative beliefs about the self (Levin, 1988, 2003; Mruk; Turner & Butler; 2003). Accordingly, negative interpretations and negative beliefs about the self lead to low self-esteem and depressive symptoms (Burgess & Haaga, 1994; Fennell, 2004; Henriques & Leitenberg, 2002; Marcotte et al., 2002; Peden et al., 2000a; Koole et al., 1999).

Hopefully, these interpretations and negative attributions to self can be improved using specific therapeutic techniques. Positive thinking and self-affirmations have been successfully tried to improve self-esteem and reduce depressive symptoms (see Clarke, as cited in Centers, 1999; Koole, et al., 1999; Peden et al., 2000b; Peden et al., 2001; Philpot & Bamberg, 1996). Therefore, it is thought that people who received affirming messages in life and come to believe them, have few traumatic and adverse events throughout life, have more positive thinking, show positive self-esteem, and have few depressive symptoms than people who did not. Indeed, the purpose of this study is to

examine the correlations between Affirming Messages, traumatic events in life, self-esteem, automatic thoughts, and depressive symptoms under the light of Levin's theory of human development.

Hypotheses

This study tested these hypotheses:

1. There is a positive correlation between levels of affirming messages and self-esteem levels.
2. There is a negative correlation between levels of affirming messages and depressive symptoms.
3. There is a negative correlation between levels of affirming messages and cumulative traumas and adverse events.
4. There is a positive correlation between levels of affirming messages and frequency of positive thoughts.
5. There is a negative correlation between levels of affirming messages and frequency of negative thoughts.

CHAPTER 2

METHOD

Participants

The participants were 109 undergraduate psychology students enrolled in psychology courses in the Department of Psychology and Special Education, Emporia State University, in spring of 2005. They received course points for their participation. One participant was dropped from the sample due to being 17 years old. The demographic questionnaire (see Appendix A) revealed that the sample for this study included 42 men and 66 women, whose mean age was 21.3 years ($SD = 3.69$). Seventy-nine percent of the participants considered themselves as White, 7.5% Black, 4.5% Hispanic-American, 2% African, 2% Asian, 2% Native-American, 2% multi-racial, and 1% Pacific-Islander. About 25.3% of the study population grew up with a household income of less than \$30,000 per year, 32% with a household income from \$30,001 to \$50,000 per year, and 42.7% with a household income larger than \$50,001 per year. Most of the sample population (82%) lived with the mother and the father when growing up, and at least one of the parents (57.5%) went to college (approximately half of these parents who went to college in fact finished it).

Instruments

Six instruments were used in this study: (a) Childhood Trauma and Adversity Questionnaire – Adapted Version (see Appendix B), (b) Automatic Thoughts Questionnaire – Revised (Kendall, Howard, & Hays, 1989; see Appendix C), (c) Rosenberg Self-Esteem Scale (Rosenberg, 1965; Appendix D), (d) Beck Depression

Inventory (Beck, 1996), (e) Affirming Messages Self-Perception Scale (Appendix E), and (f) Demographic Information Questionnaire.

Childhood Trauma and Adversity Questionnaire – Adapted Version (CTAQ). The CTAQ (Turner & Butler, 2003) is a 32-item questionnaire that measures adversity and traumatic events in childhood and adolescence. It is an adapted version of the questionnaire used by Turner and Butler. Items included violent traumas, non-violent traumas, abuse and neglect, and adverse familial conditions that were considered to be harmful for a healthy psychological development of a person. Items were answered in a dichotomous way; participants gave a yes or no answer to the questions. Information about the validity and reliability of the questionnaire was not available in the literature.

Automatic Thoughts Questionnaire – Revised (ATQ-R). The ATQ-R (Kendall, Howard, & Hays, 1989) was used in order to gather information on what the participants think about themselves in a daily basis. The ATQ-R is a 40-item inventory of negative and positive self-statements. The inventory has 30 negative items and 10 positive items. Studies have reported that this questionnaire has high discriminant validity ($Z = 2.65, p < .005$) and concurrent validity with the Beck Depression Inventory ($sr^2 = .16, p < .001$), and discriminates between patients with depression disorder and patients with other psychiatric disorders (Burgess & Haaga, 1994; Kendall, Howard, & Hays, 1989). Participants were asked to grade the frequency of each thought over the last week using a Likert scale ranged from 1 = not at all to 5 = all the time. Scores for the positive and negative messages on the ATQ-R were calculated to obtain the correlations. In addition, ratios of positive to negative thoughts were calculated to obtain each participant's score on this questionnaire. Scores on the positive thoughts scale range from 10 to 50 points,

and scores for the negative thoughts scale range from 30 to 150. Ratios of 1 and above represented having more positive thoughts during the last week before the study.

Rosenberg Self-esteem Scale (RSE). The RSE was used to measure levels of self-esteem. Items in the RSE cover the areas of self-worth, self-acceptance, and self-competence. Two-week test-retest reliability were between $r = .85$ to $r = .88$ (Rosenberg, 1979). Similarly, the RSE showed good construct validity. People with low scores in the RSE were identified as often gloomy and frequently disappointed by nurses in one study (Rosenberg, 1979). Higher scores on the RSE indicate a stronger reported self-esteem.

Beck Depression Inventory (BDI). The BDI measures levels of depressive symptoms. It is a 21-item inventory covering several different symptoms of depression such as sadness, pessimism, suicidal thoughts, agitation, and crying. Participants responded to each item by choosing one of the four provided options as the answer that best described the way they felt during the last two weeks previous to the study. Studies on the BDI reported good psychometric properties of the instrument (Farmer, 2001a, 2001b). Coefficient alpha showed to be very high for the BDI, being .92 for outpatients and .93 for the nonclinical sample; test-retest reliability was reported to be .93 (Farmer, 2000b). A moderately high correlation of $r = .71$, between the BDI and the Hamilton Psychiatric Rating Scale for Depression-Revised, showed that the BDI has a good concurrent validity (Farmer, 2000a). However, in another study the authors recommended using the BDI with other assessments to reduce false positives that can be related to transitory distress (Kendall, Hollon, Beck, Hammen, & Ingram, 1987). Higher scores on the BDI indicate more depressive symptoms experienced by the participant

during the two weeks previous to the study. Scores above 19 are considered of moderate to severe levels of depressive symptoms.

Affirming Messages Self-Perception Scale (AMS). A scale containing the affirming messages was created for the purpose of this study. Levin (1988) proposed 37 positive messages and the exact same messages were used in this study, as recommended by Centers (1999), using a Likert scale. Center reported that changing the way the messages have been constructed could harm the results of the study. She recommended using the messages in the form of “you-statements,” as initially proposed. To respond to the AMS, participants reported how much they thought they received the affirming messages throughout their life. They used a Likert scale from 1 (almost never) to 5 (almost always), for each message. In order to calculate participants’ scores on the AMS, all the numbers selected for each statement on the Likert scale were added up to generate grand totals. In addition, subtotals for Levin’s developmental stages were calculated. Each developmental stage, Stage 1 the power of being, Stage 2 the power of doing, Stage 3 the power of thinking, Stage 4 the power of identity, Stage 5 the power of being skillful, and Stage 6 the power of regeneration, has six affirming messages except for Stage 4 which has seven. Higher scores on the grand total and subtotals indicate that the person received more of these messages when growing up. Scores on the AMS range from 37 to a maximum of 185. Since AMS was created for this study, complete reliability and validity information were not yet available. Cronbach’s alpha coefficients were calculated for the AMS, these indicate that items in the AMS are highly correlated with one another, $\alpha(107) = .97$.

Demographic Information Questionnaire. In order to obtain demographic information that could help explain the results, participants responded to a short questionnaire. Sex, age, race, number of family members in the house when growing up, social economic status, and parents' level of education were collected from the participants. These demographics were thought to have an impact on the delivery of the messages from parents to children, on the interpersonal context in which the participants grew, and on the conditions in which the participants lived when growing up.

Procedure

After the Institutional Review Board (see Appendix F) approved this study, it was posted in the Department of Psychology and Special Education where students signed up for one of the nine sessions that were held. There were an average 12 participants in each session. Participants were asked to read and sign the Informed Consent (see Appendix G), and after they agreed their participation, the researcher read them a script containing the instructions on how to take the questionnaires (see Appendix H). The order of administration of the instruments was counterbalanced to avoid sequence effects and carry over effect from one instrument to the others (Smith & Davis, 2001). The script was read accordingly to the administration of the instruments. Names and personal information that could identify the participants were not collected; and if it happened to appear on the questionnaires, it was blanked out. Contact information for the Student Life and Counseling Center was provided in the informed consent for participants who may need additional information or services. Contact information for the researcher was also provided for participants who may want to know more about the study.

Statistical Analysis

The statistical analysis for this study consisted of a series of one-tailed Pearson product-moment correlations. A correlation matrix was created for all variables, with specific focus on coefficients for: (a) affirming messages and self-esteem (Hypothesis 1), (b) affirming messages and depressive symptoms (Hypothesis 2), (c) affirming messages and cumulative traumas and adverse events (Hypothesis 3), (d) affirming messages and frequency of positive thoughts (Hypothesis 4), and (e) affirming messages and frequency of negative thoughts. Supplemental analyses were conducted for all variables. A correlation matrix was created to report coefficients among the instruments used for this study. Similarly, a correlation matrix was created to report coefficients among Levin's psychosocial stages of development and the other instruments. Since there were enough women and men, independent *t* tests were conducted to identify any gender differences. Lastly, independent *t* tests for selected items on the CTAQ were conducted in order to identify traumas and adverse events impacting the scores on the other instruments.

CHAPTER 3

RESULTS

Total mean scores and standard deviations on the Childhood Trauma and Adversity Questionnaire – Adapted Version, Automatic Thoughts Questionnaire – Revised (Kendall, Howard, & Hays, 1989), Rosenberg Self-esteem Scale (Rosenberg, 1965), Beck Depression Inventory (Beck, 1996), and Affirming Messages Self-Perception Scale are presented in Table 1. A correlational matrix containing the correlation coefficients for the variables is presented in Table 2.

Hypothesis 1

Hypothesis 1 predicted a positive correlation between levels of affirming messages and self-esteem levels. A correlation coefficient was calculated to evaluate the relationship between AMS total scores and RSE total scores. Affirming messages were significantly correlated with self-esteem, $r(106) = .19, p = .03$. These results support Hypothesis 1. As scores on the affirming messages scale increased, scores on the self-esteem scale also increased and vice-versa.

Hypothesis 2

Hypothesis 2 predicted a negative correlation between scores on the AMS and BDI. Affirming messages were not significantly correlated with amount of depressive symptoms, $r(106) = -.11, p = .12$. These results do not support Hypothesis 2, showing that the 2 scores are not significantly related.

Hypothesis 3

Hypothesis 3 predicted a negative correlation between levels of affirming messages and cumulative traumas and adverse events. Scores on the AMS were

Table 1

Descriptive Statistics for Each Instrument (N = 108)

	Range	<i>M</i>	<i>SD</i>
1. CTAQ	0 to 32	7.25	4.13
2. ATQ-R Positive	10 to 50	32.41	8.14
3. ATQ-R Negative	30 to 150	55.89	21.96
4. ATQ-R Ratio P/N	-	2.06	1.00
5. RSE	0 to 30	21.22	5.59
6. BDI	0 to 84	12.00	9.17
AMS, Stage 1	6 to 30	21.48	6.34
AMS, Stage 2	6 to 30	21.68	6.27
AMS, Stage 3	6 to 30	20.09	6.01
AMS, Stage 4	7 to 35	24.17	7.55
AMS, Stage 5	6 to 30	21.38	6.08
AMS, Stage 6	6 to 30	21.60	5.40
AMS total score	37 to 185	130.41	33.08

Note. CTAQ = Childhood Trauma and Adversity Questionnaire – Adapted Version; ATQ – R = Automatic Thoughts Questionnaire – Revised, frequency of positive thoughts; ATQ – R = Automatic Thoughts Questionnaire – Revised, frequency of negative thoughts; ATQ – R = Automatic Thoughts Questionnaire – Revised, ratio of positive to negative thoughts; RSE = Rosenberg Self-Esteem Scale; BDI = Beck Depression Inventory; Affirming Messages Self-Perception Scale.

Table 2

Correlations Between Affirming Messages Scale (AMS) Grand Total and the CTAQ, ATQ-R, RSE, and BDI (N = 108)

Variable	1	2	3	4	5	6	7
1. CTAQ - AV							
2. ATQ-R Positive	-.08						
3. ATQ-R Negative	.01	-.55**					
4. ATQ-R Ratio P/N	-.01	.84**	-.81**				
5. RSE	.001	.68**	-.73**	.77**			
6. BDI	.16*	-.63**	.75**	-.70**	-.69**		
7. AMS	-.20*	.31**	-.06	.18*	.19*	-.11	

Note. CTAQ = Childhood Trauma and Adversity Questionnaire – Adapted Version; ATQ – R = Automatic Thoughts Questionnaire – Revised, frequency of positive thoughts; ATQ – R = Automatic Thoughts Questionnaire – Revised, frequency of negative thoughts; ATQ – R = Automatic Thoughts Questionnaire – Revised, ratio of positive to negative thoughts; RSE = Rosenberg Self-Esteem Scale; BDI = Beck Depression Inventory; Affirming Messages Self-Perception Scale.

* $p < .05$ (1-tailed)

** $p < .01$ (1-tailed)

significantly negatively correlated with scores on the CTAQ, $r(106) = -.20, p = .02$.

These results support Hypothesis 3. As scores on the affirming messages scale decreased, scores on the traumas and adverse events questionnaire tend to increase and vice-versa.

Hypothesis 4

Hypothesis 4 predicted a positive correlation between scores on the AMS and frequency of positive thoughts on the ATQ-R. Affirming messages were significantly correlated to frequency of positive thoughts, $r(106) = .31, p = .001$. These results support Hypothesis 4. As scores on the affirming messages scale increased, the frequency of positive thoughts are higher and vice-versa.

Hypothesis 5

Hypothesis 5 predicted a negative correlation between affirming messages and frequency of negative thoughts. Scores on the AMS were not significantly negatively correlated to frequency of negative thoughts on the ATQ-R, $r(106) = -.06, p = .28$. These results do not support Hypothesis 5, showing no significant relationships.

Supplemental Analyses

Additional analyses were conducted to see whether or not there were correlations between the instruments (see Table 2). The results of these correlational analyses showed that scores on the CTAQ were correlated with scores on the BDI indicating that as scores on the traumas and adversity questionnaire increased, scores on the depression inventory also increased. Scores on the CTAQ were not significantly correlated with frequency of positive thoughts, frequency of negative thoughts, and scores on the RSE.

Frequency of positive thoughts on the ATQ-R was found to be significantly correlated with scores on the RSE and significantly negatively correlated with scores on

the BDI. These results indicate that as positive thoughts increased, self-esteem increased and depressive symptoms decreased. Similarly, frequency of negative thoughts on the ATQ-R was found to be significantly negatively correlated with scores on the RSE, and significantly correlated with scores on the BDI. These results indicate that as negative thoughts increased, self-esteem decreased and depressive symptoms increased.

Subtotals for Levin's developmental stages (Stage 1 the power of being, Stage 2 the power of doing, Stage 3 the power of thinking, Stage 4 the power of identity, Stage 5 the power of being skillful, and Stage 6 the power of regeneration) were calculated and correlated with each of the instruments (see Table 3). It was found that AMS Stage 1 (which includes messages 1 through 6) was significantly negatively correlated with scores on the CTAQ and significantly correlated with ratios of positive to negative thoughts on the ATQ-R. AMS Stage 2 (which includes messages 7 through 12) was significantly negatively correlated with scores on the CTAQ, significantly correlated with ratios of positive to negative thoughts on the ATQ-R, significantly correlated with scores on the RSE, and significantly negatively correlated with scores on the BDI. AMS Stage 3 (which includes messages 13 through 18) was significantly negatively correlated with scores on the CTAQ. AMS Stage 6 (which includes messages 32 through 37) was significantly correlated with ratios of positive to negative thoughts on the ATQ-R, and significantly correlated with scores on the RSE. Lastly, frequency of positive thoughts on the ATQ-R was significantly correlated to each one of Levin's psychosocial developmental stages (see Table 3). These results indicate that as scores on the AMS scales increased, the frequency of positive thoughts were higher and vice-versa.

Table 3

Pearson Correlations Coefficients Between Levin's Stages of Psychosocial Development and CTAQ, ATQ-R, RSE, and BDI (N = 108)

AMS Stages	ATQ-R		ATQ-R	RSE	BDI	AMS total	
	CTAQ	Positive	Negative				Ratio P/N
Power of Being	-.31**	.23**	-.03	.16*	.15	-.06	.78**
Power of Doing	-.26**	.36**	-.10	.24**	.21*	-.18*	.88**
Power of Thinking	-.18*	.26**	-.03	.12	.15	-.10	.92**
Power of Identity	-.11	.28**	-.02	.15	.17*	-.11	.93**
Power of Being Skillful	-.15	.20*	-.02	.08	.14	-.04	.89**
Power of Regeneration	-.06	.26**	-.12	.18*	.18*	-.10	.85**

Note. CTAQ = Childhood Trauma and Adversity Questionnaire – Adapted Version; ATQ – R = Automatic Thoughts Questionnaire – Revised, frequency of positive thoughts; ATQ – R = Automatic Thoughts Questionnaire – Revised, frequency of negative thoughts; ATQ – R = Automatic Thoughts Questionnaire – Revised, ratio of positive to negative thoughts; RSE = Rosenberg Self-Esteem Scale; BDI = Beck Depression Inventory; Affirming Messages Self-Perception Scale.

* $p < .05$ (2-tailed)

** $p < .01$ (2-tailed)

Independent samples *t* tests were also conducted for selected variables. An independent samples *t* test analysis was conducted to see if there were differences between men and women on the questionnaires. Women's ($M = 7.21, SD = 4.20$) and men's ($M = 7.30, SD = 4.07$) mean scores on the CTAQ were almost the same. There were non-significant trends between women and men on the ATQ-R, RSE, BDI, and AMS. However, women scored significantly higher on Stage 1 (the power of being) of the AMS than men ($t = -2.29, p = .02$). Women and men scored the same on Stages 2, 3, 4, 5, and 6 on the AMS (see Table 4). Differences between women and men on stages 2, 3, and total score on the AMS approach significance.

In order to identify which traumas and adverse events would affect people's psychosocial development the most, some independent samples *t* tests were run for selected items in the CTAQ and the affirming messages scale. Item 19 on the CTAQ (having experienced emotional abuse) was found to be significantly related to scores on the affirming messages scale (see Table 5). People who answered "yes" to item 19 on the CTAQ had a significantly lower scores ($M = 123.39$) on their affirming messages scale compared to participants who answered "no" to it ($M = 136.24$). Seventy four percent of the people who answered "yes" to item 19 were women. Reports on sexual abuse (items 12 and 13) and on physical abuse (item 15) were not significantly related to the affirming messages scale's scores (see Table 5). Similarly, sexual and emotional abuse (items 12, 13, and 19 on the CTAQ) were significantly related to scores on the BDI, indicating that people who scored "yes" to sexual and emotional abuse presented more depressive symptoms than people who did not (see Table 6).

Table 4

Gender Differences on the Instruments (N = 108)

		<i>N</i>	<i>M</i>	<i>SD</i>	<i>t</i>
CTAQ	Men	42	7.31	4.07	.12
	Women	66	7.21	4.19	
ATQ-R Positive	Men	42	33.88	7.63	1.50
	Women	66	31.48	8.37	
ATQ-R Negative	Men	42	52.98	21.05	-1.10
	Women	66	57.74	22.48	
ATQ-R Ratio P/N	Men	42	2.24	1.03	1.57
	Women	66	1.94	.97	
RSE	Men	42	22.40	5.27	1.77
	Women	66	20.47	5.70	
BDI	Men	42	9.95	7.09	-1.87
	Women	66	13.30	10.11	
AMS, Stage 1	Men	42	19.76	6.16	-2.29*
	Women	66	22.57	6.26	
AMS, Stage 2	Men	42	20.71	6.40	-1.29
	Women	66	22.30	6.15	
AMS, Stage 3	Men	42	18.71	5.92	-1.92
	Women	66	20.97	5.96	
AMS, Stage 4	Men	42	22.48	7.78	-1.88
	Women	66	25.24	7.25	
AMS, Stage 5	Men	42	20.14	6.36	-1.70
	Women	66	22.17	5.81	
AMS, Stage 6	Men	42	20.83	6.03	-1.18
	Women	66	22.09	4.94	
AMS total score	Men	42	122.64	34.05	-1.97
	Women	66	135.34	31.72	

Note. CTAQ = Childhood Trauma and Adversity Questionnaire – Adapted Version; ATQ – R = Automatic Thoughts Questionnaire – Revised, frequency of positive thoughts; ATQ – R = Automatic Thoughts Questionnaire – Revised, frequency of negative thoughts; ATQ – R = Automatic Thoughts Questionnaire – Revised, ratio of positive to negative thoughts; RSE = Rosenberg Self-Esteem Scale; BDI = Beck Depression Inventory; Affirming Messages Self-Perception Scale.

* $p < .05$

Table 5

Independent Samples t Test for Selected CTAQ Items on the Affirming Messages Self-Perception Scale (N = 108)

	Yes		No		<i>t</i>
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	
Emotional Abuse	123.39	34.80	136.24	30.66	2.04*
	<i>n</i> = 49		<i>n</i> = 59		
Sexual Abuse 1	119.11	21.80	131.43	33.81	1.07
	<i>n</i> = 9		<i>n</i> = 99		
Sexual Abuse 2	119.30	37.48	132.93	31.68	1.68
	<i>n</i> = 20		<i>n</i> = 88		
Physical Abuse	121.14	34.00	131.79	32.90	1.12
	<i>n</i> = 14		<i>n</i> = 94		

* $p < .05$

Table 6

Independent Samples t Test for Selected CTAQ Items on the Beck Depression Inventory
(N = 108)

	Yes		No		<i>t</i>
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	
Emotional Abuse	14.43	11.04	9.98	6.71	-2.57*
	<i>n</i> = 49		<i>n</i> = 59		
Sexual Abuse 1	22.11	12.21	11.08	8.33	-3.65**
	<i>n</i> = 9		<i>n</i> = 99		
Sexual Abuse 2	16.40	10.80	11.00	8.51	-2.43*
	<i>n</i> = 20		<i>n</i> = 88		
Physical Abuse	12.36	9.62	11.95	9.15	-.16
	<i>n</i> = 14		<i>n</i> = 94		

* $p < .05$

** $p < .01$

CHAPTER 4

DISCUSSION

The results of this study partially support the theory behind the affirming messages (Centers, 1999; Levin, 1988; Rosenberg & Kitaen-Morse, 1996) stating that these messages promote people's psychosocial development, people's ability to grow and deal with life, people's sense of worth, and people's self-esteem. Although the correlations were low (Sprinthall, 2003), affirming messages were positively correlated with self-esteem, automatic positive thoughts, and ratio of positive to negative thoughts; and were negatively correlated with traumas and adverse events in life. There was not a significant correlation between affirming messages and depressive symptoms.

Interpreting the Results

About the theory. The results showed low correlations between the AMS and the instruments. The theory presenting the affirming messages as promoters of self-esteem, sense of worth, and less depressive symptoms (Bradshaw, 1990; Levin, 1988; Rosenberg & Kitaen-Morse, 1996) was not even moderately supported by the correlations. In a previous study, Centers (1999) found weak correlations between similar affirming messages, psychosocial development, and self-esteem. With the intention to replicate and extend Centers' study, this present study followed her suggestion to use the original messages which are expressed in "you statements." She discussed that by changing the wording of the original messages into "I statements," the study changed one of the main theoretical constructs of the messages: that people receive the messages from others. Centers stated that it could jeopardize the results and validity of her study.

Even though the modification was included, results from the present study closely resemble what Centers already found. The weak correlations obtained between affirming messages, self-esteem, traumas and adverse events, and frequency of positive/negative thoughts indicate that the theory may not be predictive and factors other than the affirming messages are playing major roles on people's self-esteem and sense of worth.

Affirming messages as positive thoughts supporting emotional development.

Another interpretation for the correlations would be that the affirming messages are just positive thoughts. There was a trend of significant correlations between frequency of positive thoughts and reported having received the affirming messages for each of Levin's psychosocial stages of development; however, the correlations were low (see Table 3). Frequency of positive thoughts on the ATQ-R was also highly correlated with scores on the RSE and scores on the BDI (see Table 3). In a similar way, ratios of positive to negative thoughts on the ATQ-R were significantly correlated with scores on the RSE. It means that as ratios of positive to negative thoughts increased, levels of self-esteem also tend to increase. Ratios of positive to negative thoughts on the ATQ-R were also found to be significantly negatively correlated with scores on the BDI. It indicates that people who experienced more positive thoughts during the week before the study reported having less depressive symptoms during the two weeks previous to the study. The correlations show substantial relationship between ratio of positive to negative thoughts and self-esteem and depressive symptoms.

Results may indicate that there is nothing special in the way that the affirming messages are worded, and that it is the positive content of the messages that counts for a healthy self-esteem, sense of worth, and less depressive symptoms and that any kind of

affirmations or positive statement will foster people's self-esteem and prevent the development of depressive symptoms. Levin (1988) explained that people can word the messages in different ways, and Clarke (see in Centers, 1999) also presented the affirmations as anything that reminds people that they are lovable and capable. In addition, the literature reviewed also indicated that positive self-talk and affirmations increased levels of self-esteem and decrease depressive symptoms (Mruk, 1995; Peden et al., 2001). However, in addition to a positive component, affirming messages may include an emotional component that ordinary positive thoughts do not. Affirming messages were significantly correlated to traumas and adverse events in life, but frequency of positive thoughts on the ATQ-R was not correlated to traumas and adverse events. It indicates that affirming messages contain an emotional component related to people's psychosocial development.

Affirming messages, traumatic and adverse events, and depressive symptoms.

The results show that accumulative traumas and adverse events could be one of the factors impacting negatively the scores on the affirming messages scales and the scores on the depression inventory. On average, participants reported about 7 traumas and adverse events experienced in their life ($M = 7.25$, $SD = 4.13$). As it was noted above on the results section, item 19 (emotional abuse) was the one having a significant impact on the affirming messages scale (see Table 5).

These results can be understood in two different ways. First, that people who did not receive the affirming messages were more exposed to emotional and sexual abuse than people who did receive them. Hence, if the relationship with their caregivers was not supportive, it was totally the opposite; it was emotionally abusive most of the time.

Second, these can be understood as that emotional abuse seems to counter the work done by the caregivers. The demographics showed that 88% of the participants lived with both parents when growing up. It can be that emotional or sexual abuse coming from people other than the parents had the power to counter all the emotional and social support received throughout early childhood. This is an important piece of information when it comes to consider what matters in the process of psychosocial development. In either way, it seems that emotional and sexual abuse comes to overshadow the emotional support a person could get by affecting two of the Levin's psychosocial stages of development: stage 1 the power of being and stage 2 the power of doing (see Table 5). These two stages theoretically are similar to Erikson's (1963) psychosocial stages of development: trust vs. mistrust and autonomy vs. shame.

In addition, CTAQ items 12 (sexual abuse), 13 (sexual abuse), and 19 (emotional support) made significant differences on the BDI scores (see Table 6). Since the BDI would reflect depressive symptoms (e.g. sadness, crying, sleep and eating habits disturbances, etc.) experienced during the two weeks previous to the study, these show that the effect of traumatic and adverse events early in life could last longer if sexual and emotional abuse occurred during childhood and adolescence. Turner and Butler (2003) also reported that cumulative traumas and adverse events in life were found to be correlated with both early onset of depressive disorder and later depressive symptoms among college students. These findings are consistent with the significant differences found on the BDI scores for people who answered "yes" to items 12, 13, and 19 on the CTAQ compared with people who answered "no" (the relation between women and men who scored "yes" to these items was 4 to 1).

Focusing on Stage 2. Pearson moment-product correlations showed that AMS Stage 2 was consistently correlated with all the instruments; however, the correlations were relatively low (see Table 3). The core message for Stage 2 is “it’s okay for you to move out in the world, to explore, to feed your senses and be taken care of” (Levin, 1988, p. 52). Levin explains that in Stage 2, which involves the development of the power of doing, children require support, attention, and approval from the people who take care of them in order to explore, experiment, and do things. The results from this study showed that cumulative traumas and adverse events (CTAQ) may counter the process of receiving these messages and support, that people who did not receive these messages and support would have less positive automatic thoughts (ATQ-R) in a daily basis, that people who did receive these messages would report a strong self-esteem, and that people who did not receive these messages would show more depressive symptoms later in life. It should call the attention of mental health professionals, parents, and educators who care for children’s welfare to take a close look at Stage 2 affirming messages and developmental issues in order to bring this knowledge when working to support children’s healthy emotional and social development. Being successful and capable of doing things seem to be very important in people’s life in order to have a good self-esteem, more positive thoughts, and less depressive symptoms.

Limitations

One of the most important limitations of this study is having a skewed distributed sample population. Since the population was composed of college students, it is hypothesized they show high levels of functioning, more positive thoughts, less traumas and adverse events in life, and better self-esteem than the general population. Similarly,

college students usually have more coping skills that allow them to succeed in life. It might be also that participants who had experienced traumas and adverse events in life and reached college level were able to overcome adversity and accomplish what they wanted in life. It can be that these people accomplish their psychosocial development despite the adversity in their life, or that these participants actually had lower levels of traumas and adverse events compared to other populations. The results of the study can only be compared with similar populations and lack generalizability to other populations.

Second, the literature about memory processes calls us to carefully read the participants' reports on the different questionnaires, especially on the CTAQ and the AMS. Eacott and Crawley (2000) and Nelson (1993) indicated that accurate memories start between ages 3 to 4. On the other hand, Schacter (1996) reported that memories and recollections from the past tend to fade, change over time, and are not identical copies of the original episodes. The affirming messages scale reported participants' perception on how much they received the messages when growing up; so to speak, it reflected participants' recollections from birth to the present. It should be taken into account that reports could be inaccurate or distorted. In addition to memory problems, the questionnaires are subjective measurements. Participants had to report their perceptions on how much their received the messages when growing up, their thoughts during the week before the study, and their perceptions of being worthy and capable. Every time a study deals with self-reported measurements, it deals with subjectivity and potential inaccuracy too.

The third identified limitation has to do with the Affirming Messages Self-perception Scale (AMS). This scale was constructed for the purpose of this study,

following the suggestions of Centers (1999) as noted above. This scale is divided into subscales to match Levin's psychosocial stages of development. There were very high correlations (see Table 3) between each of the subscales scores and the scale total scores. Hence, each stage equally contributed to the total score showing that the scale has good level of consistency. However, only AMS subscale 2, Stage 2 the power of doing, was consistently significantly correlated with the other instruments (but the correlations were low). Such thing did not happen with the other subscales. Similarly, an overall Cronbach's alpha coefficient of .97 shows a good item to item reliability. However, the AMS has 37 items that are similar to one another just by looking at them (face validity). High levels of correlations among items, and among subscales, could be indicating that the scale is redundant and with fewer items or fewer subscales it can measure perception of receiving the messages throughout life more efficiently.

The fact that the AMS is a new scale indicates that it needs more studies before it is considered valid and reliable. For validity, it is unknown if the AMS actually relates to people's developmental history, or it is just reporting positive thoughts that people had throughout their life. In addition, it is unknown how the instrument will respond to test-retest reliability analysis. It could be that other factors were affecting participants' perception of receiving the messages, and that perception of receiving the messages could change from time to time. Since accuracy on self-report was very important for this study, it is considered as a limitation for the AMS as well as for the entire study.

The CTAQ also brings up some questions about the validity of this instrument related to the AMS. As it was noted above, women and men had almost the same mean for the CTAQ; indicating same amount of traumas and adverse events for women and

men. In addition, women scored higher than men on the AMS and across its subscales. It was highlighted before that as scores on the CTAQ increased, scores on the AMS tend to decrease. Hence, these indicate that scores on the CTAQ for women and for men will behave similarly on the AMS. However, an in-depth analysis of selected items for the CTAQ indicated that different traumas and adverse events weighted differently. When items on sexual, physical, and emotional abuse were analyzed, there were found that women were four times more exposed to sexual and emotional abuse than men, and equally exposed to physical abuse than men. But, women consistently scored slightly high on the AMS scale and subscales. It could be indicating that items in the CTAQ are very much different from one another and that simply adding the number of traumas and adverse events does not measure the impact of traumas and adverse events on people's psychosocial development since their impact are different. The difficulty to measure the impact of traumas and adverse events on people's developmental process could be another explanation for the low correlations found and is considered a limitation for this study.

Suggestions for Future Studies

This study could be replicated with clinical samples. It is expected that a clinical population will show more cumulative traumas and adverse events, low self-esteem, more depressive symptoms, and a more delayed psychosocial development than a college population. Thus, it is hypothesized that clinical populations will show higher correlations between the AMS and the other instruments. Information on how these variables are correlated with clinical population could also provide support for using these affirming messages as therapeutic tools, as suggested by Bradshaw (1990), Levin

(1988), and Rosenberg and Kitaen-Morse (1996). In the same way, affirmations in general were used as therapeutic techniques to help people develop a stronger self-esteem, decrease depressive symptoms, and improve functioning in life (Centers, 1999; Peden et al., 2000b, 2001; Philpot & Bamburg, 1996).

Future studies on this subject and with a clinical population could provide information about whether or not the affirming messages could be used as effective therapeutic tools to bring about change on people and counter the negative effects of traumas and adverse events in life (Bradshaw; Levin; Rosenberg & Kitaen-Morse). It is also suggested the Affirming Messages Self-perception scale and the Childhood Trauma and Adversity questionnaire be validated as an instruments that measures people's psychosocial development and the impact of traumas and adverse events. These instruments need to be studied in depth before they are considered valid and reliable.

It is also suggested to use other statistical analysis with this data. Multiple regressions could help researches to find out more about the main factors introducing the variances on the AMS. In similar way, other factors, which could work as third variables controlling the correlations between the AMS and the other instruments, could be introduced in the statistical model. Factors such as income level, living conditions (whether they lived with the mother and the father when growing up), gender differences, and parents' educational level could be responsible for the correlations found in the study. These factors were reported as demographic information, but not included in the statistical model used for this study.

The intention of this study was to find out more about the theory supporting the affirming messages. These results show that the theory behind the affirmation was

partially supported; the correlations were low. Even though the affirming messages were correlated with people's self-esteem, cumulative traumas and adverse events, and frequency of positive thoughts, the results indicate that Levin's affirming messages may not be the a primary factor predicting them.

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APPENDICES

Appendix A

Demographic Information Questionnaire

Demographic Information

1. Sex: ___ M ___ F
2. Age: _____
3. How do you identify yourself in regard to race/ethnicity?

4. When growing up, how much was the family income?
 ___ 10.000.- to 20.000.-
 ___ 20.000.- to 30.000.-
 ___ 30.000.- to 40.000.-
 ___ 40.000.- to 50.000.-
 ___ 50.000.- to 60.000.-
 ___ 60.000.- to 70.000.-
 ___ 70.000.- and more
 Other _____
5. Mark all the people whom you lived with when growing up:
 ___ Mother
 ___ Father
 ___ Stepmother
 ___ Stepfather
 ___ Grandparents (How many _____?)
 ___ Aunts and uncles (How many _____?)
 ___ Sister (How many _____?)
 ___ Brother (How many _____?)
 ___ Stepsister (How many _____?)
 ___ Stepbrother (How many _____?)
 ___ Others
6. Mark your parents educational level:
 ___ 6th Grade
 ___ 9th Grade
 ___ Less than 3 years of High School
 ___ High School Diploma
 ___ Less than 3 years of college
 ___ Technical college degree
 ___ College's degree
 ___ Master's degree
 ___ Ph. D.

Appendix B

Childhood Trauma and Adversity Questionnaire – Adapted Version

Childhood Trauma and Adversity Questionnaire
(Turner & Butler, 2003)

Below are some questions about your personal life story. We appreciate you answering this questionnaire in a frank and honest way. Thank you very much.

QUESTIONS	YES	NO
1. In your whole life, were you ever in a VERY SERIOUS fire, explosion, flood, tornado, hurricane, earthquake, or other disaster?		
2. In your whole life, have you ever lived near a war zone or been present during a political uprising?		
3. In your whole life, were you ever in a VERY SERIOUS accident (at home, school, or in a car) where you were injured and had to be hospitalized?		
4. In your whole life, did you ever have a VERY SERIOUS illness where you had to be hospitalized?		
5. At any point in your life, has someone you were really close to had a VERY SERIOUS illness where he or she had to be hospitalized?		
6. When you were in elementary school, junior high, or high school, did you ever have to do a school year again?		
7. When you were growing up, were there times when the main provider for your household was unemployed when he or she wanted to be working?		
8. Was there ever a time when you were growing up that your family was forced to live on the street or in a shelter?		
9. When you were a child or teenager, was there a time when your parents or guardians didn't take care of your basic needs even when they were at home?		
10. When you were a child or teenager were you ever sent away or taken away from your parents for any reason?		
11. When you were a child or teenager, did either of your parents, stepparents, or guardians have to go to prison?		
12. In your whole life, were you ever forced or threatened into having sexual intercourse when you didn't want to?		
13. [Other than that/those time(s)] has there ever been a time (including when you were a child or teenager) when someone touched your genitals (or breasts) or made you touch their private parts when you didn't want him or her to?		
14. In your whole life, have you ever been BADLY beaten up—punched, kicked, or hit very hard—by a family member, like a parent, stepparent, sibling, or other relative?		
15. In your whole life, have you ever been BADLY beaten up—punched, kicked, or hit very hard—by someone other than a family member, like a friend, or someone at school or in the neighborhood?		
16. In your whole life, have you ever been actually shot with a gun or injured with some other weapon, like a knife or bat?		

17.	In your whole life, has someone (including friends, family members, or strangers) ever threatened or attacked you with a gun, knife, or some other weapon even though you were not injured?		
18.	In your whole life, have you ever been chased, but not caught, by a gang, “bully,” or someone you were frightened of, when you thought you could really get hurt?		
19.	In your whole life, have you ever been emotionally abused by a parent, sibling, relative, teacher, or friend?		
20.	In your whole life, has anyone ever tried to kidnap you or force you into a car?		
21.	In your whole life, have you ever seen a dead body in someone’s house, on the street, or somewhere in your neighborhood (other than in connection with a funeral)?		
22.	Have you ever personally seen or heard someone you were really close to getting BADLY beaten up (that is, punched, kicked or hit very hard) by either a stranger or someone you knew? [Probe: this would include times when someone in your family hurt another family member.]		
23.	Have you ever personally seen or heard someone you were really close to getting shot with a gun or injured with some other weapon like a knife or a bat?		
24.	Have you ever personally seen or heard someone you were really close to threatened or attacked with a gun, knife, or some other weapon, even though he/she was not injured?		
25.	Have you ever seen someone you were really close to getting chased, but not caught, by a gang, “bully,” or someone he or she was frightened of, when you thought he or she could really get hurt? [Probe: this would include times when someone in your family chased another family member.]		
26.	Other than on television or in movies, have you ever personally seen someone else get BADLY beaten up, or shot, injured, or threatened with a gun or other weapon? [Probe: this would include a stranger, acquaintance, or someone else you were not close to.]		
27.	When you were growing up was there ever a time that a family member drank or used drugs that it caused problems?		
28.	When you were a child or teenager, did either of your parents, stepparents, or guardians ever have a mental illness or “nervous breakdown”?		
29.	Has there ever been a time when you were living with your parents or stepparents when they were always arguing, yelling, and angry at one another?		
30.	Was there a time in your life when you were frequently teased, harassed, or treated badly because of your race, nationality, religion, your sexual orientation, or physical appearance?		
31.	Has someone you were very close to ever died?		
32.	Were your parents ever separated or divorced? If yes, how old were you when it happened? Your age when it happened: _____		

Appendix C

Automatic Thoughts Questionnaire – Revised (Kendall, 1989)

Automatic Thoughts Questionnaire – Revised
(Kendall 1989)

Listed below are a variety of thoughts that pop into people's heads. Please read each thought and indicate how frequently, if at all, the thought occurred to you *over the last week*. Please read each item carefully and circle the appropriate answers on the answer sheet in the following fashion:

1=not at all, 2=sometimes, 3=moderately often, 4=often 5=all the time.

Thoughts	Responses
1. I feel like I'm up against the world.	1 2 3 4 5
2. I'm no good.	1 2 3 4 5
3. I'm proud of myself.	1 2 3 4 5
4. Why can't I ever succeed?	1 2 3 4 5

Remember, each sentence that you read is a thought that you may have had often, less frequently, or not at all. Tell us how often over the last week you have had each of the thoughts.

5. No one understands me.	1 2 3 4 5
6. I've let people down.	1 2 3 4 5
7. I feel fine.	1 2 3 4 5
8. I don't think I can go on.	1 2 3 4 5
9. I wish I were a better person.	1 2 3 4 5
10. No matter what happens, I know I'll make it.	1 2 3 4 5
11. I'm so weak.	1 2 3 4 5
12. My life's not going the way I want it to.	1 2 3 4 5
13. I can accomplish anything.	1 2 3 4 5
14. I'm so disappointed in myself.	1 2 3 4 5
15. Nothing feels good anymore.	1 2 3 4 5
16. I feel good.	1 2 3 4 5
17. I can't stand this anymore.	1 2 3 4 5
18. I can't get started.	1 2 3 4 5
19. What's wrong with me?	1 2 3 4 5
20. I'm warm and comfortable.	1 2 3 4 5
21. I wish I were somewhere else.	1 2 3 4 5
22. I can't get things together.	1 2 3 4 5
23. I hate myself.	1 2 3 4 5
24. I feel confident I can do anything I set my mind to.	1 2 3 4 5
25. I'm worthless.	1 2 3 4 5
26. Wish I could just disappear.	1 2 3 4 5

1=not at all, 2=sometimes, 3=moderately often, 4=often 5=all the time.

27. What's the matter with me?	1	2	3	4	5
28. I feel very happy.	1	2	3	4	5
29. I'm a loser.	1	2	3	4	5
30. My life is a mess.	1	2	3	4	5
31. I'm a failure.	1	2	3	4	5
32. This is super!	1	2	3	4	5
33. I'll never make it.	1	2	3	4	5
34. I feel so helpless.	1	2	3	4	5
35. Something has to change.	1	2	3	4	5
36. There must be something wrong with me.	1	2	3	4	5
37. I'm luckier than most people.	1	2	3	4	5
38. My future is bleak.	1	2	3	4	5
39. It's just not worth it.	1	2	3	4	5
40. I can't finish anything.	1	2	3	4	5

Appendix D

Rosenberg Self-Esteem Scale (Rosenberg, 1965)

Rosenberg Self-esteem Scale

Below is a list of statements dealing with your general feeling about yourself. If you strongly agree, circle SA. If you agree with the statement, circle A. If you disagree, circle D. If you strongly disagree, circle SD.

	Strongly agree	Agree	Disagree	Strongly disagree
1. On the whole, I am satisfied with myself.	SA	A	D	SD
2. At time I think I am no good at all.	SA	A	D	SD
3. I feel that I have a number of good qualities.	SA	A	D	SD
4. I am able to do things as well as most other people.	SA	A	D	SD
5. I feel I do not have much to be proud of.	SA	A	D	SD
6. I certainly feel useless at times.	SA	A	D	SD
7. I feel that I'm a person of worth, at least on an equal plane with others.	SA	A	D	SD
8. I wish I could have more respect for myself.	SA	A	D	SD
9. All in all, I am inclined to feel that I am a failure.	SA	A	D	SD
10. I take a positive attitude toward myself.	SA	A	D	SD

Appendix E

Affirming Messages Self-Perception Scale

Affirming Messages Self-Perception Scale
(based on Pamela Levin's affirming messages)

This scale contains statements that parents and/or guardians usually transmit by actions or words to their children. In a scale that goes from 1=almost never to 5=almost always, circle the answer that best fit your opinion about how much "YOU RECEIVED" these messages when growing up.

Almost never 1	sometimes 2	moderately often 3	often 4	almost always 5	
1. It's okay for you to be here, to be fed, touched and taken care of.	1	2	3	4	5
2. You have a right to be here!	1	2	3	4	5
3. I'm glad you're a girl/boy.	1	2	3	4	5
4. I like to hold you, to be near you and to touch you.	1	2	3	4	5
5. You don't have to hurry; you can take your time.	1	2	3	4	5
6. Your needs are okay with me.	1	2	3	4	5
7. It's okay for you to move out in the world, to explore, to fed your senses and be taken care of.	1	2	3	4	5
8. It's okay to explore and experiment.	1	2	3	4	5
9. You can do things and get support at the same time.	1	2	3	4	5
10. It's okay for you to initiate.	1	2	3	4	5
11. You can be curious and intuitive.	1	2	3	4	5
12. You can get attention or approval and still act the way your really feel.	1	2	3	4	5
13. It's okay for you to push and test, to find out limits, to say no and become separate from me.	1	2	3	4	5
14. You can think for yourself...you don't have to take care of other people by thinking for them.	1	2	3	4	5
15. You don't have to be uncertain; you can be sure about what you need.	1	2	3	4	5
16. You can think about your feelings and you can feel about your thinking.	1	2	3	4	5
17. You can let people know when you feel angry.	1	2	3	4	5
18. I'm glad you're growing up!	1	2	3	4	5
19. It's okay for you to have your own view of the world, to be who you are and to test your power.	1	2	3	4	5
20. You can be powerful and still have needs.	1	2	3	4	5
21. You don't have to act scary or sick or sad or mad to get taken care of.	1	2	3	4	5
22. It's okay for you to explore who you are.	1	2	3	4	5
23. It's important for you to find out what you're about.	1	2	3	4	5
24. It's okay to imagine things without being afraid you'll make them come true.	1	2	3	4	5
25. It's okay to find out the consequences of your own behavior.	1	2	3	4	5
26. It's okay for you to learn how to do things your own way, to have your own morals and methods.	1	2	3	4	5

Almost never	sometimes	moderately often	often	almost always
1	2	3	4	5

27. You don't have to suffer to get what you need.	1	2	3	4	5
28. Trust your feelings to guide you.	1	2	3	4	5
29. You can think before you make that your way.	1	2	3	4	5
30. It's okay to disagree.	1	2	3	4	5
31. You can do it your way.	1	2	3	4	5
32. It's okay for you to be sexual, to have a place among grown-ups, and to succeed.	1	2	3	4	5
33. You can be a sexual person and still have needs.	1	2	3	4	5
34. It's okay to be responsible for your own needs, feelings, and behaviors.	1	2	3	4	5
35. It's okay to be on your own.	1	2	3	4	5
36. You're welcome to come home again.	1	2	3	4	5
37. My love goes with you.	1	2	3	4	5

Appendix F

Institutional Review Board's Letter of Approval



EMPORIA STATE UNIVERSITY

1200 Commercial
Emporia, Kansas
66801-5087

620-341-5351
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GRADUATE STUDIES AND RESEARCH
RESEARCH AND GRANTS CENTER
Campus Box 4003

February 1, 2005

Marcos Prono
1201 Triplett Dr. Apt F63
Emporia, KS 66801

Dear Mr. Prono:

Your application for approval to use human subjects, entitled "Correlations Between Levin's Affirming Messages, Developmental History, Self-Steem, and Depressive Symptoms in College Students," has been reviewed. I am pleased to inform you that your application was approved and you may begin your research as outlined in your application materials.

On behalf of the Institutional Review Board, I wish you success with your research project. If I can help you in any way, do not hesitate to contact me.

Sincerely,

A handwritten signature in cursive script, appearing to read "Jeffrey Tysinger".

Dr. Jeffrey Tysinger
Chair, Institutional Review Board

pf

cc: Michael Leftwich

Appendix G
Informed Consent

Informed Consent

Study Name: Affirming Messages and your psychological development.

Graduate Student Researcher: Marcos A. Prono, Clinical Psychology Student

Telephone Number: (620) 340 0268

The Department of Psychology and Special Education at Emporia State University supports the practice of protection for human subjects participating in research and related activities. The following information is provided so that you can decide whether you wish to participate in the present study. You should be aware that even if you agree to participate, you are free to withdraw at any time, and that if you do withdraw from the study, you will not be subjected to reprimand or any other form of reproach.

You are going to be asked to complete 5 questionnaires related to your personal life story, self-esteem, automatic thoughts, and depressive symptoms. You also are going to be asked to complete an extra questionnaire about demographic information. The study will last approximately 50 minutes.

Participating in the study can be beneficial to you. You will read positive statements that you can use later in life. Completing a questionnaire on self-esteem and on depressive symptoms can also be a learning experience for you. On top of all, you will receive credits for your participation for the classes you are taking at the Department of Psychology and Special Education. However, since you will be asked to recall sensitive information about your past and about your family environment, you might get contact with unpleasant memories and feelings. Remember, you can withdraw at any time from the study without any penalty.

The researcher is obligated to provide you with basic information about the study after it is finished. If you would like to know more about the study and/or obtain the results, please feel free to contact the Department's office, information is provided below. If for any reason you were upset by the questionnaires and want to talk with a counselor, please contact the Student Life and Counseling Center, information is provided below.

Your signature in the space provided indicates that you have been informed of your rights as a participant, and you have agreed to volunteer on that basis.

"I have read the above statement and have been fully advised of the procedures to be used in this project. I understand the potential risks involved and I assume them voluntarily. I likewise understand that I can withdraw from the study at any time without being subjected to reproach."

Signature of Participant

Date

Department of Psychology and Special Education 327B Visser Hall Phone: (620) 341 5317	Student Life and Counseling Center 211 South Morse Phone: (620) 341 5221
---	--

Appendix H

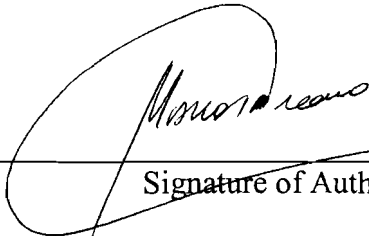
Script

Instructions for the instruments:

1. You will find 6 questionnaires here; in total, you will spend approximately 60 minutes answering them.
2. First, you find a demographic questionnaire which is self explanatory.
3. Secondly, you will find the Childhood Trauma and Adversity Questionnaire. You have to answer the questions by checking the “yes” or the “no” boxes. Make sure you read the whole question before answering it.
4. Thirdly, you will answer the Automatic Thoughts Questionnaire – Revised. You have to tell how often over the last week you have had each of the thoughts in a scale that goes from 1 = not at all, to 5 = all the time.
5. Fourth, there is the Rosenberg Self-esteem Scale. After you read each of the statements, you circle the answer depending on whether you Strongly Agree, Agree, Disagree, or Strongly Disagree.
6. Fifth, you will have the Beck Depression Inventory. It is on the front and the back of the paper. This questionnaire has 21 items and you choose your answer by picking out one of the four statements that best describe the way you feel during the past two weeks.
7. Lastly, there is the Affirming Messages Self-perception scale. This questionnaire is asking you to report in what degree (1 = almost never, to 5 = almost always) you think you have had received each message when growing up.
8. Whenever you feel confused, read the instructions on top of each questionnaire to guide you on what to do.
9. **Before starting, remember that there is no right or wrong answers and that you are not being graded this time. Breathe deeply 3 times; it will help you concentrate better.**

Permission to Copy Page

I, Marcos Prono, hereby submit this thesis to Emporia State University as partial fulfillment of the requirements for an advanced degree. I agree that the Library of the University may make it available for use in accordance with its regulations governing materials of this type. I further agree that quoting, photocopying, or other reproduction of this document is allowed for private study, scholarship (including teaching) and research purposes of a nonprofit nature. No copying which involves potential financial gain will be allowed without written permission of the author.



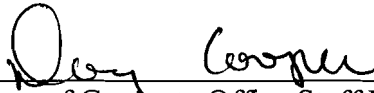
Signature of Author

05/12/05

Date

Correlations Between Levin's Affirming Messages,
Developmental History, Self-Esteem, and Depressive
Symptoms in College Students

Title of Thesis



Signature of Graduate Office Staff Member

5-16-05

Date Received

received