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RESPONSE TO THERAPIST STYLE AS A FUNCTION OF SELF-ESTEEM AND PERSONAL INVOLVEMENT

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RESPONSE TO THERAPIST STYLE AS A FUNCTION OF SELF-ESTEEM AND PERSONAL INVOLVEMENT

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Abstract

This study was concerned with examining Ss' preferences and reactions to therapist response styles as a function of self-esteem and different levels of personal involvement. One hundred ninety male and female undergraduate psychology students served as subjects. They initially completed a self-esteem scale. They then received instructions that induced either a high or low degree of personal involvement in the task, and a transcript of a therapy session with either a positive, esteem-enhancing therapist or a negative, esteem-reducing therapist. They subsequently filled out measures of their affective responses and personal reactions to the therapist. The design was a 2 (high and low self-esteem) x 2 (high and low personal involvement instructions) x 2 (esteem-enhancing and esteem-reducing therapist transcript) factorial design. Two major theoretical orientations--esteem enhancement theory and consistency theory--were offered as models for predicting how individuals high and low in self-esteem would respond to the therapists in the transcripts.

It was hypothesized that all Ss, regardless of their level of self-esteem, would prefer the esteem-enhancing therapist and rate this therapist as more attractive and competent

than the esteem-reducing therapist. The results confirmed this hypothesis. A significant interaction was also obtained whereby all Ss tended to rate the esteem-enhancing therapist higher and the esteem-reducing therapist lower under conditions of low personal involvement than under high personal involvement conditions. It was also hypothesized that under high personal involvement instructions which created a greater potential threat to self-esteem, Ss would give responses that would be consistent with their initial levels of self-esteem. Although significance was not obtained, partial support for this prediction was found; low self-esteem Ss tended to prefer the esteem-reducing therapist while high self-esteem Ss tended to perceive the esteem-enhancing therapist as more attractive. It was also predicted that where there was minimal threat to Ss' self-esteem, as under the low personal involvement instructions, there would be a greater opportunity to enhance one's self-esteem. The results supported this prediction: both low and high self-esteem Ss preferred the esteem-enhancing therapist under low involvement conditions.

Implications of the results for self-esteem theory were discussed and a model for understanding Ss' responses to affective evaluations in terms of esteem enhancement theory was proposed.

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And finally, for their infinite patience and constant love, I dedicate this thesis to my family. To my mother, father, and brother, who have believed and trusted in me throughout, my very special thanks. And to Francesca, who has been ever present in my mind.

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CHAPTER I

Introduction

One of the major concerns in the literature on interpersonal perception has been investigating the criteria influencing one's behavior in response to evaluations received from others. Among the factors that have received attention, three have been delineated and focused upon in this study: the self-esteem of the person receiving an evaluation; the degree to which the evaluation received is gratifying and esteem-enhancing (positive) versus frustrating and esteem-reducing (negative; and the degree of esteem involvement in the evaluatory process. Specifically, this study attempts to examine one's preferences and reactions to therapist response styles that vary with regard to the degree of esteem-enhancement as a function of self-esteem under different levels of esteem-involvement.

Background and Rationale

The notion of the self and the self-concept has held a prominent place in the history of the development of psychology. William James (1890) was one of the first psychologists to emphasize the importance of the self-concept. However, the failure of the introspectionists to satisfactorily

operationalize the concept of the self led to its being overshadowed and largely ignored by the functionalists and behaviorists, the dominant schools of psychology in America in the early 20th century. To the behaviorists, "a clearer conception of internal states such as self-acceptance would seem to be best derived from the observable behaviors of the person, that is, his self-evaluative behaviors" (Crowne & Stephens, 1961).

While a concept of self was implicitly being developed by Freud and the psychoanalytic school, it was generally dismissed by American theorists because of its emphasis on the non-observable id and the unconscious. However, in Freud's later writings, as well as in the writings of the neo-Freudians (e.g., A. Freud, 1945; Hartmann, 1939; Horney, 1945; Sullivan, 1953), increasing attention was paid to the importance of the ego functions and ego ideal, with cognitive and motivational attributes assigned to this concept of self. Behavioristic theories with specified antecedent conditions were not adequate enough to account for the differential results accruing from group or individual differences in personality research. Thus theorists increasingly began to recognize a need to postulate a self-concept with motivational

properties. The place that has been assigned to the phenomenal self (i.e., a conscious self-concept) with behavior determining properties can be seen by referring to the theorists who have incorporated the self-concept into their theories (Wylie, 1968, 1974). A partial list of these theorists would include: Adler (Ansbacher & Ansbacher, 1956); Allport (1961); Angyal, (1941); Cattell (1966); Erikson (1950, 1959); Fromm (1939); Horney (1937); Jung (Progoff, 1953); Lecky (1945); Maslow (1954); McClelland (1951); Mead (1934); Rogers (1951); Snygg and Combs (1949); and Sullivan (1953).

While there is considerable overlap among these theories, there is also considerable ambiguity and variability in the definitions of what is meant by the phenomenal self, i.e., one's self-concept. In particular, there is a lack of empirical constructs, and consequently, little agreement on operational definitions (Wylie, 1968). Among the definitions offered, Rogers suggests:

> The self-concept or self-structure may be thought of as an organized configuration of perceptions of the self which are admissible to awareness. It is composed of such elements as the perceptions of one's characteristics and abilities; the percepts and concepts of the self in relation to others and to the environment; the value qualities which are perceived as associated with experiences and objects; and goals and ideals which are perceived as having positive or negative valence. (1951, p. 136)

According to Rogers, the self-concept also "serves to regulate behavior and may serve to account for uniformities in personality." (1951, p. 191)

Definition and Importance of Self-Esteem

In this paper, self-esteem will be considered to be the evaluative component of the self-concept, as defined by Coopersmith:

> The evaluation which the individual makes and customarily maintains with regard to himself: it expresses an attitude of approval or disapproval, and indicates the extent to which the individual believes himself to be capable, significant, successful, and worthy. In short, self-esteem is a personal judgment of worthiness that is expressed in the attitudes the individual holds toward himself. (1967, p. 4-5)

Self-esteem is of interest because of the importance attributed to it as a theoretical construct reflecting established and relatively enduring attitudes about oneself that are determinants of interpersonal perception and response in a variety of situations. Emphasis has been placed on these "perceptions, cognitions, and evaluations of aspects of the self...(as) the focal points around which other relevant perceptions get organized" (Deutsch & Solomon, 1959). Since these perceptions and attitudes are considered to have evolved from one's personal and social learning history, they tend to

create individual expectancies concerning future situations (Cooley, 1902; Crowne & Marlowe, 1964; Mead, 1934; Rotter, 1954; Coopersmith, 1967). And it is these expectancies, largely reflecting one's self-esteem and only partially based upon the actual contingencies of any given situation, which are often the best determinants of an individual's reaction to and behavior in a new situation (Bolles, 1972; Merton, 1948; Mischel, 1973; Rotter, 1954; Shrauger, 1975).

The notion that self-esteem is responsible for creating expectancies that differentially determine an individual's behavior in a new situation has been employed by researchers to explain why some people tend to seek approval, prefer success, and in general make choices that will lead to positive consequences, while others are motivated to avoid success, preferring instead negative outcomes and evaluations (Atkinson, 1957; Coopersmith, 1967; Wylie, 1961). While the dictates of common sense make it easy to understand why some individuals would prefer positive, esteem enhancing outcomes, it is more difficult to understand and explain why others choose the opposite. Both empirical findings and phenomenological observation reflect this disparity. In his formulation, James (1910) sees self-esteem as the ratio of one's

success to one's pretensions; according to this, it may be necessary to lower or place limitations upon one's pretensions or aspirations in order to maintain self-esteem. Or consider the words of a voice of our time who self-mockingly remarks: "I would never join a club that would have me as a member" (Marx, G.).

Everyday life offers perhaps the most obvious examples of this contrary to intuition situation. An individual consistently chooses alternatives or behaves in ways that are certain to lead to failure, punishment, or self-degradation. A person avoids promotion and success on the job, remaining satisfied with non-threatening mediocrity. How often have we seen or heard of someone choosing a romantic partner whom they, themselves, acknowledge offers only misery and frustration. Or just the person who seeks after and values only those who are rejecting, condescending, and unavailable, while turning away from anyone who may be approving, loving, and responsive.

The likelihood of individuals behaving in ways that portend negative consequences has long been recognized by clinical psychology. Freud's notion of transference (1924) as well as Sullivan's parataxic distortion (1948) considered

the genesis of perceptual distortions in interpersonal relationships as they are manifested in the course of psychoanalysis. Psychoanalytic theory holds that even though patients begin therapy ostensibly for positive gains, they will often enter into treatment-destructive negative transferences which threaten to limit or terminate their therapy. Indeed, a large portion of the therapeutic process entails the analysis and resolution of resistances that prevent one from feeling better, as well as the analysis of recurrent behavioral patterns that consistently result in undesirable and painful consequences.

Two major theoretical positions have been set forth to explain these seemingly paradoxical and contradictory expectations regarding one's response to evaluations. One position to be considered here will be referred to as consistency theory (Festinger, 1957; Heider, 1958; Lecky, 1945; Newcomb, 1961; Osgood, Suci & Tannenbaum, 1957). This theory implies that an individual has a need to maintain consistency in his cognitions about himself, and is therefore motivated to prefer information or evaluations which are consistent with these established notions regarding self-appraisal. Information or evaluations that are inconsistent with or contradictory to

one's expectancies will lead to unfavorable and negative responses. Accordingly, individuals with positive expectancies (i.e., high self-esteem) would be predicted to respond more favorably to positive evaluations and less favorably to negative evaluations in comparison to individuals with negative expectancies (i.e., low self-esteem).

The other major theoretical orientation under consideration is self-esteem or self-esteem enhancement theory. As originally formulated by Dittes (1959) and elaborated by Jones (1973), esteem enhancement theory presumes that everyone has a need to enhance their self-esteem and to increase or confirm feelings of personal worth. Esteem enhancement theory posits a drive reduction model whereby persons with low self-esteem would have a greater need for gratification and enhancement of esteem needs than would persons with high self-esteem. Thus, in contrast to consistency theory, esteem enhancement theory would predict that low self-esteem individuals would respond more favorably to positive evaluations and have a greater aversion to negative evaluations than high self-esteem individuals.

One situation in which an individual is particularly vulnerable to personal evaluations made by others is in

psychotherapy. Clinical research has stressed the importance of the therapist's communications upon the patient's receptivity to the therapist, as well as to the process of therapy itself (Rogers, 1954; Strupp, 1960, 1971, 1973; Truax, 1971, 1972). There is also empirical evidence that pre-therapy impressions can significantly affect one's perception of the therapist, and create expectancies regarding therapy that can either facilitate or diminish the potential effectiveness of the psychotherapy relationship (Goldstein, 1962, 1971; Litwack et al., 1968). While various schools of thought exist regarding which therapist response style is most efficacious, particularly when dealing with different categories of patient psychopathology (Hammer, 1968; Federn, 1952; Jacobson, 1971; Kernberg, 1975), scant attention has been given to individual patient preferences and expectancies based upon "normal" personality dimensions such as self-esteem (Bordin, 1974).

Since self-esteem has been considered to be a major component of one's expectancies regarding new situations, and as such a primary determinant of an individual's reaction to evaluations from others, this study will investigate how one's perception of and reaction to interpersonal evaluations

made by therapists are affected by one's initial level of self-esteem. Two major theoretical positions--consistency theory and esteem enhancement theory--will be compared and the outcomes as predicted by each will be examined.

Self-Esteem and Response to Evaluations from Others: Theoretical Background and Related Research

In the literature on interpersonal perception, two distinct theoretical perspectives--consistency theory and enhancement theory--have been offered as explanations for predicting how one will respond to evaluations received from others. This paper will consider these theories, as well as a modification (defensiveness theory), and examine the predictions and conditions under which each would be operative. A survey of the relevant empirical research will be undertaken in order to further differentiate between these theoretical models.

Consistency Theory

The basic assumption underlying the various consistency theories as promulgated by Festinger (cognitive consonance, 1957), Heider (cognitive balance, 1958), Lecky (self-consistency, 1945), Newcomb (symmetry, 1961), and Secord and Backman (cognitive consistency, 1964, 1965) among others, is that an individual will strive to organize his beliefs, attitudes,

emotions, perceptions and behavior so as to maintain a state of cognitive consistency. Inconsistent or incongruent cognitions are hypothesized as resulting in discomfort and giving rise to a need to reduce dissonance and restore consistency.

Self-esteem, conceptualized as reflecting deep-rooted and relatively enduring attitudes and perceptions one customarily maintains regarding oneself, would consequently be expected to be a primary determinant in the maintainance of behavioral and perceptual constancy. Accordingly, it would be implied from the various consistency theories that evaluations from others which are congruent with one's initial self-evaluations will be more favorably received than evaluations which are perceived to be incongruent (Shrauger, 1975). Specifically, high self-esteem individuals would be predicted to respond favorably to positive evaluations from others, while low self-esteem individuals would be expected to respond unfavorably to positive evaluations from others; in the latter situation, receiving positive feedback would be hypothesized to have created cognitive inconsistency for the low self-esteem individual, resulting in a negative affect state. In contrast, where there are negative or derogatory evaluations from others, high self-esteem persons would be predicted to be more negative in their acceptance of the

evaluatory information as well as to hold more unfavorable opinions about the source of the evaluation when compared to low self-esteem persons. That is, consistency theory leads one to expect a positive correlation between one's initial self-esteem and acceptance of positive evaluations from others, and a negative correlation when negative evaluations are received.

Esteem Enhancement Theory

This theory, as originally proposed by Dittes (1959), assumes that everyone has a need to be seen favorably, receive approval, and generally have one's esteem enhanced. The esteem enhancement view is essentially a drive reduction model whereby it is posited that the lower one's self-esteem, the greater will be the need for gratification and enhancement of esteem.

Since low self-esteem individuals are viewed as being more frustrated in their needs for esteem enhancement than high self-esteem individuals, they would be expected to respond more favorably to evaluations from others that are positive and gratifying to esteem needs, and more unfavorably to negative or frustrating evaluations. In addition, those low in self-esteem would express more liking toward positive

evaluators and greater disliking toward negative evaluators than those high in self-esteem. Therefore, in response to positive or gratifying evaluations, a negative correlation would be predicted (i.e., the lower one's self-esteem, the greater the preference for the positive evaluation and liking for the evaluator), while a positive correlation would be predicted as a consequence of negative or frustrating evaluations (i.e., the lower one's self-esteem, the more negative or unfavorable the response to the evaluation and evaluator).

Defensiveness Theory of Self-Esteem

As will be explored in the review of the empirical research, clear support for either consistency or enhancement theory has not always been found; thus, several mitigating variables and alternative or modifying explanations have been suggested. One modifying view which is of theoretical and empirical relevance for this study is the defensiveness notion of self-esteem. As explained by Cohen (1959), this view states that:

> Communications and/or communicators who threaten an individual's general picture of himself may be expected to influence persons of different levels of self-esteem differentially. Such threatening appeals may be rejected more by those of high self-esteem than by those of low self-esteem. On the

> other hand appeals which enhance an individual's self-picture might be more accepted by the highs than by the lows. Thus, one determinant...may be the differential responsiveness to threats of negative changes in the self-picture on the part of those with high and low self-esteem. (p. 119)

Basically, the proponents of this view suggest that persons of high self-esteem are better able to ward off and protect themselves against actual or anticipated negative judgments, failure, anxiety, or other threats to self-esteem (Cohen, 1956, 1959; Coopersmith, 1967; Cutick, 1962; Engel, 1959; Stotland et al., 1957, 1962). The hypothesis advanced is that whereas high esteem subjects rely upon avoidance defenses such as denial, repression and reaction formation in the service of protecting their self-esteem from external challenges, low self-esteem subjects employ expressive defenses like projection that leave them less able to reject negative and derogatory evaluations from external sources. That is, those who are high in self-esteem are seen as possessing a more impenetrable and stable self-concept which enables them to selectively respond to evaluations which will enhance and maintain their high esteem level. In contrast, those low in self-esteem are viewed as being more responsive and vulnerable to esteem threatening critical evaluations and

external feedback in general. Thus, the predictions generated by this view would be that high self-esteem subjects would respond favorably to positive evaluations and be relatively unaffected by negative evaluations, while low self-esteem subjects would be responsive to negative evaluations and either threatened or unaffected by positive evaluations.

Empirical Research

In order to differentiate between these theories as they appear in the empirical research literature it is necessary to look at the contingencies in each study such as the nature of the task, situational factors, and the specific aspect of evaluatory information one is being asked to respond to. Basically, each study to be considered measures or manipulates the self-evaluation of subjects and then measures some particular response to positive or negative evaluations or feedback from others. There are, however, several means by which this has been accomplished in the various studies, with contradictory results accruing from each. One important difference concerns the criterion selected for assessing self-esteem. While some studies employ a global measure of self-esteem as the initial self-evaluation, others have induced an independent initial self-evaluation in the subjects by virtue

of providing subjects with experimenter manipulated ratings of their performance on some specific task or tested ability. Another difference is whether an experimental design was used to measure response to evaluations or if the researchers relied upon self reports from subjects to obtain correlational data. In addition, an important factor seems to be whether the evaluation supplied to the subjects was focused upon cognitive abilities as opposed to affective or personality related qualities. Finally, the dependent variable chosen seems to result in differential findings. This review will look at some of the results that have been obtained based primarily upon the nature of the dependent variables employed such as changes in self-evaluation, actual performance following feedback, assessment of the evaluator's competence, and attraction to the evaluator. However, since this study is concerned with high and low self-esteem subjects' perception and attraction to positive or negative evaluators, emphasis will be placed on those studies that bear directly on this issue.

General Findings. This section will review the results based upon a number of measures of response to evaluation. The results of empirical studies that have looked at the re-

lationship between initial expectancies and response to evaluatory feedback have been inconsistent, and generally have failed to provide clear support for one particular theoretical perspective. While some studies seem to be more in accord with the predictions of consistency theory (Aronson & Carlsmith, 1962; Backman & Secord, 1962; Berger, 1952; Brock, 1965; Deutsch & Solomon, 1959; Dutton & Arrowood, 1971; Kiesler & Baral, 1970; Omwake, 1954; Silverman, 1964; Stotland et al., 1957; Suinn, 1962; Wiest, 1965; Wilson, 1965), others offer results that are more consonant with esteem enhancement theory (Dion & Dion, 1975; Dittes, 1959; Jacobs et al., 1971; Jones et al., 1969, 1973; Krauss & Critchfield, 1975; Rosenberg, 1965; Walster, 1965). In addition, other studies offer results which are equivocal and not clearly supportive of either of the above theoretical positions (Cohen, 1959; Feather & Simon, 1971; Fitch, 1970; Harvey & Clapp, 1965; Leventhal & Perloe, 1962; Maracek & Mettee, 1972; Mettee, 1971; Perez, 1973; Schalon, 1968; Shrauger & Lund, 1975; Shrauger & Patterson, 1974; Shrauger & Rosenberg, 1970; Solley & Stagner, 1956; Ziller et al., 1969). This section will undertake a brief survey of some of the more representative studies and attempt to delineate the factors contribut-

ing to the contradictory predictions. Particular emphasis will be given to the nature of the response task chosen as the dependent variable in each study; that is, what response is required from the subjects.

Among the tasks chosen as dependent variables, Ss' recall of material following evaluation of performance was employed in several studies. In general, these studies found that Ss demonstrated better recall when the feedback was consistent with initial expectancies. Thus, Silverman (1964) found that following success or failure feedback on a current events test, high self-esteem Ss (HSE) recalled more of their correct answers in the success feedback condition than in the failure feedback condition, while low self-esteem Ss (LSE) recalled more in the failure condition. Likewise, Crary's (1966) HSE Ss had higher recall when they performed anagram and block design tasks better than their partners, while recall for LSE Ss was more accurate when their partner scored better. In both cases, recall of one's performance tended to be in conformity with initial expectancies. In another study where Ss were first asked to rate themselves on personality attributes and then given false ratings ostensibly from their classmates, accuracy of recall of these ratings

decreased as the discrepancy between the feedback and initial self-ratings increased (Suinn, Osborn & Page, 1962).

A number of other studies have offered partial support for the consistency theory position. What the studies here have in common is that they ask Ss to make some judgment of competence following evaluatory feedback--either of themselves, of another person, or of the task or measure employed. When Shrauger and Lund (1975) informed Ss that they had been either positively or negatively rated by a clinical interviewer on some personality attribute, they found that HSE Ss rated the interviewer as more competent in the positive feedback situation; LSE Ss' ratings of the interviewer were unrelated to the feedback condition. Korman (1968) asked Ss to evaluate a new test of intellectual competence; HSE Ss rated the test more favorably when they were told they had passed it than when told they had failed it. For LSE Ss, their evaluation of the test was again unaffected by whether they had passed or failed it.

A different pattern was found in studies where Ss were asked to reassess themselves following feedback. In a study where Ss were given feedback on a measure of social sensitivity, HSE Ss who were given positive feedback raised their

self-ratings, while those given negative feedback did not change their self-ratings (Shrauger & Rosenberg, 1970). The opposite relationship held for LSE Ss; that is, they lowered their self-ratings following negative feedback, but their self-ratings remained the same following positive feedback. Similar results were obtained in a study by Harvey and Clapp (1965) where feedback was moderately discrepant from initial expectancies. HSE Ss, with positive expectancies, raised their ratings following positive feedback, while LSE Ss, with negative expectancies, lowered their ratings following negative feedback. No changes were observed when feedback was not in the expected direction.

While the above results provide partial support for predictions based on consistency theory, they can also be explained by Cohen's defensiveness theory of self-esteem (1959). That is, there will be greater acceptance and better recall of feedback when the discrepancy is in agreement with one's initial expectancies. When the discrepant information is in the opposite direction of one's initial expectancies, however, Ss tend to defend differentially against the feedback so as to be relatively unaffected by it.

Shrauger (1975) points out, however, that inasmuch as

these studies employed false and inaccurate feedback, it becomes difficult to determine whether the results are attributable to differential defensive operations regarding negative feedback, or indicative of "the extent to which people actively develop assessments of their own behavior rather than relying on external appraisals" (p. 586).

Rather than assessing cognitive responses to evaluations, several studies chose to examine Ss' affective reactions to evaluations. The dependent variables in these studies were generally one's report of liking for or satisfaction with the feedback, and one's reaction to and attraction to the evaluator. In those studies which measured Ss' verbal satisfaction with feedback, positive feedback resulted in more favorable responses than negative feedback (Feather, 1969; Harvey & Clapp, 1965; Ilgen, 1971; Millimet & Gardner, 1972), regardless of whether initial expectancies were experimentally induced or based on global self-esteem. Thus, these studies provide support for the esteem-enhancement view and tend to refute the predictions of consistency theory.

Those studies that are concerned with Ss' attraction to the person responsible for the evaluation (rather than the evaluation itself) are of particular interest and will be

mentioned in detail below.

Findings Related to Perception of and Attraction to Interpersonal Evaluations. This section will primarily review those studies where the dependent variable was some aspect of a subject's attraction to the evaluator. In general, these studies have tended to support the esteem-enhancement view that Ss with low self-evaluations will express a preference for people offering positive evaluations over those offering negative evaluations, and that this attraction will be stronger than in Ss with high self-evaluations.

An important distinction between those studies where consistency results and enhancement results were obtained seems to be whether Ss were asked to make cognitive judgments--of the accuracy or competency of the evaluator--or to give affective reactions--attraction to and liking of the evaluator. This distinction is explored further below. Self-report studies and experimental designs will be considered.

Self-report Studies: The general format of these studies has been to ask subjects to evaluate themselves on some dimension, then have them additionally estimate how others would evaluate them on that dimension. A correlation is obtained which reflects the degree of agreement between the

self-rating and the estimated rating--i.e., the degree of interpersonal congruence.

Among the studies supporting consistency theory, Newcomb (1956) found a significant correlation between one's self-description and an estimate of how others would describe oneself. Based on their model of interpersonal congruency, Secord and Backman (1962) looked at the overlap between female college students' perception of the adjectives that others would attribute to them and those they believed were characteristic of themselves. Congruency was greatest on ratings attributed to better liked others. Wiest (1965) asked elementary school children to rate their attraction for other class members, then correlated this with each student's perception of the other members' liking of them. Wiest found that interpersonal congruence, that is, the agreement between attraction for another and perception of one's likeability, increased as self-esteem increased--a prediction Wiest had made based upon Heider's balance theory.

Correlational support for esteem theory comes from a study in which self-evaluation was correlated with experimenter controlled derogatory evaluations ostensibly from observers (Jones et al., 1959). From self-consistency theory, it would

be expected that Ss with low self-evaluation would more positively evaluate an observer who gave them a negative evaluation (i.e., a negative correlation), while the expectations of esteem theory would be that the lower the self-evaluation of Ss the more negative would be the evaluation of the negative evaluator (i.e., a positive correlation). Underlying these predictions is the notion that if consistency theory is operable, then the more accurate the evaluation, the more accepted it would be; and according to esteem theory, the more damaging the evaluation to esteem needs, the more unacceptable it would be. A highly positive correlation was found ($r = .84$) between self-evaluation and evaluation of others as predicted by esteem theory.

Support for the self-esteem position also comes from Rosenberg's (1965) correlational finding that the lower a student's self-esteem was, the more concerned he was with another person having a poor opinion of him.

Jones (1973) suggests that there may be some confusion in the interpretation of results supporting consistency theory versus esteem theory from correlational studies. Specifically, in studies where both self-evaluation and evaluation of others are dependent variables, it is difficult

to ascertain whether congruity between negative self-evaluations and negative evaluations of others is attributable to the maintenance of consistency or the need to preserve self-esteem.

Experimental Approaches: Experimental approaches have generally obtained measures of self-evaluation by two methods. One approach has been to either ask subjects directly or to obtain some measure (by using self-esteem scales) of a relatively fixed and enduring self-evaluative quality. The alternative method that has been employed is to provide subjects with experimenter controlled feedback which can be manipulated to induce an initial level of self-evaluation in subjects. In furnishing evaluations from others to subjects, most experiments have relied upon evaluations that were, in actuality, controlled and manipulated by the experimenter.

An important and frequently cited study in support of self-consistency in interpersonal evaluations is that of Deutsch and Solomon (1959). The experimenters manipulated subjects' self-esteem by telling them that they had either succeeded or failed on a task; subjects were then supplied with favorable or unfavorable evaluations from others. The

results revealed a significant main effect whereby subjects preferred the positive evaluations from others. In addition, an interaction effect was found in which subjects with high self-evaluations (i.e., those in the success condition) preferred the positive feedback while those with low self-evaluations (i.e., those in the failure condition) rated the negative evaluator higher (though non-significantly).

However, in a replication of Deutsch and Solomon's study, Skolnick (1971) was unable to obtain similar results. Rather, he found that ratings obtained from low self-evaluators were more favorable toward positive evaluators and less favorable for negative evaluators in comparison to high self-evaluators.

In a study by Wilson (1965), after subjects' self-evaluations were manipulated by informing them that they had failed on a task, half were given the choice of continuing on to a second task, while the others were told that they were, by "chance," not going to continue. Subjects who had chosen not to continue were considered to have adopted negative self-evaluations. When members of this group were then given negative evaluations of incompetence--supposedly from their partners--they rated their partners as more accurate and

attractive than members of this group who received positive evaluations of competence from their partners. In contrast, in the chance group, partners who supposedly had given positive evaluations were rated as more accurate and attractive than partners giving negative evaluations.

While this study has been cited as support for the validity of self-consistency theory, another interpretation is possible. Wilson has assumed that negative self-evaluations prevailed in the group that personally decided not to continue, but that the group which did not continue by chance was spared from adopting negative self-evaluations; that is because of this chance manipulation they did not assume personal responsibility for their decision. While this may have been so, there is no evidence to support this assumption. Rather, it seems more likely that both groups of subjects--as a consequence of having been told that they failed the task--held negative self-evaluations. The crucial factor differentiating these groups seems to be whether or not they were responsible for their decision. Where one was responsible for his decision, the evaluation may have been perceived as being merited and unavoidable, and therefore the consistency prediction would be expected. However, in the

other group, there was no responsibility assigned for the decision and each subject was then free to compensate for their negative self-evaluation; they could enhance their low self-esteem by preferring the positive evaluations of their partners. Thus, the question of whether or not an individual will ultimately be held responsible for his choice may be an important determinant differentiating self-consistent from self-enhancing behavior.

Another study that ostensibly supported self-consistency theory predictions also neglected to control for personal responsibility involved in the evaluation process. Dutton and Arrowood (1971) asked subjects to perform a task which consisted of reading arguments on the draft prepared by the experimenter. Self-evaluation was manipulated by having the subjects read either a clearly written argument and receive "no anxiety" physiological feedback (i.e., "good" self-evaluation), or a poorly written argument with "anxiety" physiological feedback (i.e., "poor" self-evaluation). When Ss were then given evaluatory feedback (from others) of "good" or "poor" performance, the good self-evaluators preferred positive feedback over negative feedback, while the poor self-evaluators preferred the negative evaluative feed-

back. This was taken as offering clear support for consistency theory.

Here again, however, the question of the extent of personal involvement and responsibility felt by the individual for the experimentally induced self-evaluation must be considered. In the Dutton and Arrowood study there is a question as to whether passively reading a prepared statement is of any consequence for an individual's self-evaluation; rather, knowledge of one's performance on the task may merely create a cognitive, task-induced response set that has little if anything to do with self-esteem. Alternatively, if one's self-esteem is actually felt to be at stake, then task-oriented cognitive responses which result in consistency theory predictions are the best means of preserving one's assigned "self-evaluation."

Dittes (1959) was the first to experimentally test the predictions made by self-esteem theory. Self-reports of esteem were obtained from subjects involved in a group discussion. Experimentally manipulated evaluations from the other group members were then given to each subject. Dittes found an interaction between self-esteem and evaluation received from the group. Among those subjects receiving negative

evaluations, the lower their self-esteem the more negative their response to the group. Among the subjects receiving positive evaluations, those low in self-esteem tended to respond slightly more favorably to the group than those high in self-esteem. This follows from the predictions of esteem theory: individuals with low self-esteem will have a greater need to avoid negative evaluatory information and a greater need to receive feedback that will enhance their self-esteem.

In a study in which self-esteem was manipulated by providing false evaluations based upon personality tests, Walster (1965) found that low self-esteem female subjects responded more positively to a male suitor. In a second study where self-esteem was manipulated by indicating a female's reaction to the dating skills of male subjects, it was found that low esteem Ss responded more positively than high esteem Ss to an accepting female evaluator, but low esteem Ss also responded more negatively than high esteem Ss when the female evaluator was rejecting (Jacobs, Berscheid & Walster, 1971). Again, the need to enhance esteem when positive evaluation is available and to avoid negative evaluation was greater for the low self-esteem individuals, in support of esteem enhancement theory.

In examining the above studies, several variables can be distinguished which might be helpful in accounting for the apparently contradictory results. In general, these studies have all pre-selected one dimension of behavior or personality functioning and experimentally manipulated subjects' scores, inducing an externally determined notion of self-evaluation. However, while some studies have chosen a specific skill for evaluation, others have relied upon more general evaluations based on some personal quality of the individual. In studies where a specific skill is being evaluated (Deutsch & Solomon, 1959; Dutton & Arrowood, 1971; Wilson, 1965), it would seem that a specific task-induced response set has been created. Whether subjects are responding freely based upon their self-evaluations or according to the task-induced response set is not clear.

Another factor which differentially determines whether Ss will give affective reactions to evaluations as opposed to cognitive responses to the demands of the task would be the consequences of their response. Jones (1973) addresses the issue of when one can expect results that conform to esteem-enhancement or consistency theory predictions. He states that while people generally prefer to receive approval

and obtain gratification of their esteem needs, whether they do so or not when given the opportunity will be dependent upon the future consequences of their decision. If future self-exposure, public embarrassment or failure is likely to accrue from the acceptance of undeserved or discrepant evaluations, the individual is more likely to protect his self-esteem by preferring evaluations from others that are consistent with his own perceived worth. That is, if there is anticipated threat to self-esteem, esteem enhancement is best served by making responses that are consistent with one's self-evaluations. In essence, then, one preserves self-esteem by making a cognitive decision.

Jones and Ratner (1967), in an attempt to study the effect of anticipating future personal decisions upon interpersonal evaluations, manipulated the results on personality tests so that Ss were led to believe that they had scored poorly on a specific ability (personality inference). This created a negative self-evaluation. All subjects were then advised that they could anticipate future evaluation on their personality inference ability. Half of the Ss were then asked to make a decision concerning a future task; following this decision, these Ss responded to experimenter controlled

positive and negative evaluations from others. By having Ss make their decision prior to obtaining their response to evaluations from others, Jones and Ratner intended to eliminate the threat of future consequences for these Ss. The other Ss, in contrast, were asked to respond to the evaluations from others before they made a decision concerning a future task. This was intended to maintain the threat of anticipated consequences; that is, these Ss were still personally responsible and liable for their decisions. The results indicated that while the Ss who had already made a decision preferred the positive evaluations, the Ss who still anticipated making a decision rated the negative evaluations more favorably. The authors explained that while the latter groups preferred accurate and consistent information in anticipation of having to make a future decision, the former group was free to seek gratification of their esteem needs and thus preferred the esteem-enhancing positive evaluations from others.

In summary, the authors suggest that where there is no anticipation of threat to their self-esteem, Ss are free to give an affective response and enhance their self-esteem; that is, esteem enhancement outcomes would be expected. However, where Ss anticipate possible negative consequences

attendant upon their decision, the risk of failure or future devaluation of self-esteem exists. In this situation, a response that is cognitively consistent with one's initial evaluation based upon the demands of the task would best serve to safeguard Ss from potential threats to self-esteem; that is, consistency theory is predicted to be operating.

A similar study in which subjects were led to expect or not expect public evaluation obtained results in support of the hypothesis that anticipation of future consequences will result in either esteem-enhancing or consistent responses to interpersonal evaluations (Jones & Pines, 1968).

Eagly and Acksen (1971) measured changes in self-evaluation on a dimension of creativity following either positive or negative evaluations from others under two conditions. In one condition Ss expected a test of their creativity; in the other, no test was expected. Results indicated that only those Ss expecting no test and receiving positive evaluations regarding their creativity favorably changed their evaluations, i.e., enhanced their self-evaluations.

In general, these studies have looked at the effect of anticipated future consequences by pre-selecting one dimension of behavior or personality functioning and experimentally manipulating subjects' scores, thus inducing an ex-

ternally determined notion of self-evaluation. In these situations, it would seem, a specific task-induced response set has been created. Subjects are implicitly informed that they should disregard any previous self-evaluatory notions they may have held, whether good or bad. They are being asked to temporarily suspend their beliefs and to accept the cognitive dictates of the specific experimental situation. This fosters and reinforces a participation--not unlike the observing ego situation in therapy--where each subject becomes aware that they are being asked to cooperate and comply with the demands of the situation. Thus, when these subjects are subsequently asked to respond based upon their experimentally assigned self-evaluation, it would seem difficult to determine whether their behavior is a consequence of their belief in and their consonance with this evaluation, or merely an appropriate cognitive response to the demands of the task. That is, rather than hypothesizing that one's behavior is due to anticipating future consequences to self-esteem, it may just be that one's performance reflects an induced compliance that is in accord with expectations of how one is desired to evaluate oneself for the particular task.

The present study will employ a global measure of self-esteem in attempting to differentiate between esteem theory and consistency theory. By using a global measure of self-esteem as opposed to an experimentally manipulated self-evaluation, it is intended that the likelihood of inducing a cognitive response set as well as experiment-wise behavior will be minimized. In addition, it has been suggested that self-evaluations are more easily affected by situational factors than is global self-regard (Wylie, 1961), and in some cases manipulated self-evaluations may actually be modified by initial self-esteem (Deutsch & Solomon, 1959).

In addition, following from Jones' (1973) and Rosenberg's (1969) work on evaluation apprehension, this study will differentiate between a task in which Ss are asked to participate without any anticipation of threat to their self-esteem and a task in which Ss are informed that they are going to be personally liable for their responses. In the latter task set, it is expected that there may be more personal involvement and responsibility for responses, with consequent anticipation of some degree of threat to one's self-esteem.

Therapist Response Style

The therapist-patient dyad represents a situation in which one person, the patient, is typically the target of some form of evaluative feedback from the therapist. Since one's response to evaluatory feedback has been shown to be at least in part a function of one's initial expectancies, this section will examine the relationship between self-esteem--as a measure of one's initial expectancies--and therapist response style. The importance of considering self-esteem as a patient variable, and its relevance for the development of the working alliance in therapy, will be discussed.

Choice of Therapy Style

"Theories of therapy must come to a point where they will make it possible to select the therapy which is good for a patient and not the patient which is good for a therapy" (Rapaport, 1960, p. 115). At present, there is a lack of concensus regarding the criteria for selecting the treatment that will ensure a potential patient the greatest likelihood of successful outcome. Traditionally, a clinical assessment of the patient is made, with the ensuing diagnostic classification providing at best a theoretical prescription

for treatment. The literature is replete with references to treatment styles and approaches based upon diagnosis. Thus, we have suggestions for the treatment of schizophrenia (Arieti, 1955; Federn, 1952; Searles, 1965; Spotnitz, 1969), the borderline and narcissistic personality (Kernberg, 1975; Kohut, 1971), depressives (Beck, 1976; Jacobson, 1971) and the paranoid (Meissner, 1978) among others. Recently, however, the validity of relying upon diagnostic classifications exclusively has been questioned and some researchers have begun to place increasing emphasis on other factors including the patient's expectations and preferences for therapist response style (Bordin, 1974; Lorr, 1965; Raush & Bordin, 1957; Rice, 1968; Strong, 1968; Truax, 1972; Truax & Carkhuff, 1967).

While the various methodological difficulties inherent in the assessment of the therapeutic relationship have mitigated against finding agreement on any particular preferred response style or the outcomes accruing to these styles, there is evidence that patients' prior expectations and preferences can function to enhance or diminish the potential effectiveness of therapy (Lorr, 1965; Rosen, 1968). Several researchers have found that successful therapy outcome is

most likely when there is congruence between a patient's prior expectations about the therapist's style and the actual style (Frank, 1973; Goldstein, 1962; Orne & Wender, 1968; Severinsen, 1966; Shapiro, 1971).

Attractiveness to Therapist Response Style

Several researchers have addressed themselves to the question of whether there is a preferred therapist response style that will be perceived by patients as being more attractive and potentially effective. There is widespread support for the notion that successful therapy outcome is related to a warm and empathic therapist style (Fiedler, 1950; Heine, 1950; Rice, 1968; Rogers, 1951; Strong, 1968; Strupp, 1972; Truax, 1972; Truax & Carkhuff, 1967; Truax & Mitchell, 1971; Truax et al., 1965). In addition, attitude change research offers evidence suggesting that attractiveness plays a role in one's ability to influence others (Back, 1951; Burdick & Burnes, 1958; Sapolsky, 1960).

Based on this assumption that an individual will be more susceptible to influence by a therapist who is perceived as attractive and likeable, Greenberg (1969) informed Ss that a therapist was considered to be either "warm" or "cold" by colleagues. He found that therapists labeled "warm"

were responded to as being subjectively more attractive. In addition, Ss were found to be more receptive to being influenced and persuaded by the communications of the "warm" therapists. Heller (1972) obtained more favorable responses to interviewers who were positive and friendly as opposed to interviewers who were negative or ambiguous. In another study (Heller et al., 1968), it was found that while positive interviewers were preferred over negative interviewers, the amount of patient verbalization and content discussed was unaffected by this variable. However, whether the interviewer was active or passive did have an effect, with greater verbalization in response to the active interviewer; in addition, a passive-negative interviewer was experienced as disturbing by some Ss.

In contrast to the above, Reisman and Yamokoski (1974) and Venzor et al. (1976) suggest that a variety of response styles are acceptable, and that an empathic response is not differentially preferred. While asking Ss to enumerate the qualities they would prefer consistently resulted in a descriptive preference for a nurturing, empathic therapist response style, asking Ss to respond to different styles as presented in a therapy transcript revealed no preference for

the empathic style. In another study where therapists were labeled as empathy-enhancing or empathy-reducing, Helms (1976) observed no difference in preference.

A question arises as to just what is meant by empathy. Cartwright and Lerner (1963) suggest that empathy is not merely warmth and support as often defined by others, but rather the accuracy of understanding. Thus, whether a patient experiences a therapist as empathic and is attracted to a particular therapist's response style may be differentially determined by that patient's preferences based upon their initial expectancies.

Self-Esteem and Therapist Response Style

Since self-esteem has been shown to be a reflection of one's initial expectancies, it may be a determining factor in one's response to and preference for a particular therapist style. In this study, two distinct therapist response styles have been set forth: an esteem-enhancing style and an esteem-reducing style.

If consistency theory is operating in this situation, then therapist responses that are congruent with one's self-image would be preferred. High self-esteem Ss would possess an initial expectancy of being responded to in a positive,

warm and esteem-enhancing way, while low self-esteem Ss would have an initial expectancy of being responded to in a negative, critical and esteem-reducing manner. However, if esteem-enhancement theory is functioning, then an esteem-enhancing therapist response style, i.e., one that is positive, warm and supportive of one's esteem, would be preferred.

This study will examine Ss responses to esteem-enhancing versus esteem-reducing therapist response styles as a function of self-esteem under varying degrees of esteem involvement.

Summary

Two major theoretical orientations--esteem enhancement theory and consistency theory--have been offered as models for predicting how individuals differing in level of self-esteem will respond to affective evaluations received from others.

Perhaps the contrast in the expectations ensuing from each theoretical position can be summarized and put into perspective by using Laing's paradigms in Knots (1970) and variations thereof. "I am good/ you love me/ therefore you are good" typifies the response of the individual with high self-esteem who prefers positive evaluatory feedback from

others and evaluates that other person in a favorable light. As explained by consistency theory, where there is congruence or agreement between an individual's self-evaluation and the evaluation received from another, then that individual will respond favorably to the other person. Likewise, esteem enhancement theory allows that one would be predisposed to prefer and evaluate favorably someone who gratifies one's need for esteem enhancement. Thus, in individuals with high self-esteem, both theories would predict a favorable response to a person offering a positive and gratifying evaluation or experience.

The distinction between the two theories, however, is clearly apparent in the diverse responses by low self-esteem individuals to confirmatory negative evaluatory information. While the response to "I am bad/ you dislike me" would be predicted to be "therefore you are good" by consistency theory, the response as predicted by enhancement theory would be "therefore you are bad."

Further, the response of low self-esteem individuals to positive feedback would also differ. Enhancement theory could be represented by the syllogism "I am bad/ you like me/ therefore you are good." In this case the evaluation, "you

like me," is perceived as gratifying and fulfills the low self-esteem individual's need for esteem enhancement. In contrast, "I am bad/ you like me/ therefore you are bad" reflects the prediction arising from consistency theory for the low self-esteem individual when faced with inconsistent evaluatory information. According to this view, consistency would be maintained and a favorable response expected when one's initial self-esteem and the evaluation received are congruent.

The present study will look at the responses given by individuals high or low in global self-esteem to evaluations made by a therapist. The therapist will be operationally defined as being either esteem-enhancing and positive in response style, or esteem-reducing and negative in response style.

From the review of the literature, it was suggested that one of the important variables that differentiates between the outcomes as predicted by esteem enhancement theory versus consistency theory is the degree to which one's self-esteem is felt to be involved in the task. Specifically, where there is a minimal degree of personal involvement, it is postulated that there is less anticipation of threat to

one's self-esteem attendant upon accepting esteem-enhancing evaluations, even when they are inconsistent with one's self-evaluation.

In contrast, an increased sense of personal involvement is conceptualized as increasing the risk of threat to or devaluation of self-esteem; that is, a sense of evaluation apprehension (Rosenberg, 1969) is created where one is being held personally responsible and liable for his or her responses. Therefore, preservation of self-esteem is best served by accepting evaluations that are consistent with one's self-evaluation. That is, with low personal involvement esteem enhancement results are expected, and with greater personal involvement outcomes compatible with consistency theory are expected.

The following variables will be employed in this study:

A. Self-Esteem
    1. High self-esteem
    2. Low self-esteem
B. Therapist Response Style
    1. Positive: esteem-enhancing and supportive
    2. Negative: esteem-reducing and critical

C. Instructions to Subjects

1. High personal involvement

2. Low personal involvement

D. Dependent Measures of Response to Therapist Style

1. Therapist's attractiveness and likeability

2. Therapist's competence

3. Personal reactions to the therapist

Hypotheses

The following hypotheses are predicted:

A. Main Effects

All Ss will perceive the positive, esteem-enhancing therapist as more attractive and competent, and will have more favorable personal reactions to this therapist.

B. Two-Way Interactions: Instructions x Therapist Style

There will be a significant interaction with low personal involvement instructions, in comparison to the high personal involvement instructions, resulting in higher ratings for all Ss with the positive, esteem-enhancing therapist and lower ratings with the negative, esteem-reducing therapist.

C. Three-Way Interactions: Self-Esteem x Therapist Style x Instructions

There will be a significant interaction between Ss' self-

esteem, therapist style and instructions. The specific predictions are:

High Personal Involvement Instructions x Self-Esteem x Therapist style.

1. Low self-esteem Ss will prefer the negative, esteem-reducing therapist style.

2. High self-esteem Ss will prefer the positive, esteem-enhancing therapist style.

3. High self-esteem Ss will rate the positive, esteem-enhancing therapist higher than will low self-esteem Ss.

4. Low self-esteem Ss will rate the negative, esteem-reducing therapist more favorably than will high self-esteem Ss.

Low Personal Involvement Instructions x Self-Esteem x Therapist Style.

5. Low self-esteem Ss will rate the positive, esteem-enhancing therapist more favorably than the negative, esteem-reducing therapist.

6. High self-esteem Ss will rate the positive, esteem-enhancing therapist more favorably than the negative, esteem-reducing therapist.

7. Low self-esteem Ss will show a stronger preference for the positive, esteem-enhancing therapist than high self-esteem Ss.

8. Low self-esteem Ss will have a greater aversion to the negative, esteem-reducing therapist than high self-esteem Ss; i.e., high self-esteem Ss will rate the negative therapist higher.

Low Self-Esteem x Therapist Style x Instructions.

9. Low self-esteem Ss will rate the positive, esteem-enhancing therapist higher under the low personal involvement instructions than under the high personal involvement instructions.

10. Low self-esteem Ss will rate the negative, esteem-reducing therapist less favorably under low personal involvement instructions than under high personal involvement instructions.

High Self-Esteem x Therapist Style x Instructions.

11. High self-esteem Ss will rate the positive, esteem-enhancing therapist similarly under both sets of instructions; i.e., no significant differences are predicted.

12. High self-esteem Ss will show no significant differential preference for the negative, esteem-reducing therapist under the two sets of instructions.

CHAPTER II

Method

This section will outline the experimental design and procedures employed in this study. The following will be discussed: Subjects; Measures and Instrumentation; Procedure; Experimental Design; and Statistical Analysis.

Subjects

One hundred ninety undergraduate psychology students in the New York City area served as subjects in this study. There were 60 males and 130 females. All participants were volunteers who agreed to participate in this research. Ss were treated according to the ethical standards of the American Psychological Association (APA, 1973) and each signed a written consent form (see Appendix A).

Measures and Instrumentation

Self-Esteem Scale. This scale, developed by Rosenberg (1965), is a 10 item scale which measures the self-acceptance aspect of self-esteem (see Appendix B). Ss are asked to agree or disagree with a short statement regarding how they feel about themselves.

A Guttman scale reproducibility coefficient of .92 was

obtained for this scale, and a test-retest reliability of .85 after two weeks was found (Silber and Tippett, 1965). Crandall (1973) found a significant correlation of .59 and .60 with Coopersmith's Self-Esteem Inventory (1967). For the purpose of scoring a 7 point scale with "Agree" to "Disagree" as the bipolar choices was employed in this study.

Marlowe-Crowne Social Desirability Scale. This scale is designed to determine the extent to which Ss describe themselves in favorable, socially desirable terms in order to obtain the approval of others (1964). It consists of 33 statements to which Ss are asked to respond either "True" or "False" as they feel each statement pertains to them. Test-retest reliability over a one month interval was .88 on this scale; a Kuder-Richardson coefficient of internal consistency was .88 (see Appendix C).

Instructions. There were two sets of instructions used in this study as presented in the Procedure and in Appendix D.

1) High Personal Involvement Instructions. By informing Ss that their responses were being compared to the responses of advanced psychology students, these instructions were intended to create in Ss a greater sense of personal involvement and responsibility for their responses. That is,

following from Jones (1973), and Rosenberg (1969), these instructions were designed to induce a mild anticipation of threat to Ss' self-esteem. Rosenberg (1969) in his work on evaluation apprehension found that instructions which created an anticipation of evaluation were more involving and resulted in differential responses by Ss.

2) Low Personal Involvement Instructions. By informing Ss that their responses were only going to help establish norms for purposes of future evaluation, these instructions were intended to create a cognitive, task-oriented response set where Ss would have little anticipation of threat to their self-esteem and a low degree of personal involvement and responsibility for their responses.

Transcripts of a Therapy Session. Transcripts of a therapy session were constructed by the author for this study and were designed to reflect two distinct therapist response styles: 1) Positive, esteem-enhancing and supportive; 2) Negative, esteem-reducing and critical. These transcripts can be found in Appendix E.

In both transcripts, the patients' statements were identical; the therapist's comments differed on three occasions. Judgments by 5 raters resulted in 100% agreement on

the transcripts as reflecting either a positive, supportive, esteem-enhancing therapist response style or a negative, critical, esteem-reducing therapist response style. In a pilot study, 38 Ss were asked to rate one of the two transcripts on measures of therapist attractiveness and competence; a significant difference was found on the dimensions of attractiveness ($t = 4.82$; $p < .05$) and competence ($t = 8.95$; $p < .05$) (Rich, 1978).

Semantic Differential Scale. A semantic differential scale was constructed by the author for the purpose of evaluating the perceived attractiveness and competence of the esteem-enhancing and esteem-reducing therapists as portrayed in the transcripts. The adjectives composing the scale were selected from a larger scale employed in previous research which measured Ss' perception of three therapists; in that study, three orthogonal factors were revealed across all three therapists (La Crosse and Barak, 1975). The scale employed in this study consisted of those adjectives which had high factor loadings on either the dimension of therapist attractiveness or competence, but not both; 7 adjectives were chosen for each dimension in the final version of the scale (see Appendix F). Placement of positive and negative

poles of the bipolar adjective pairs was varied randomly to prevent response bias.

Questionnaire. An 11 item questionnaire was constructed by the author for the purpose of eliciting Ss' reactions to the therapists in the transcripts. Items were selected so as to reflect Ss' evaluations on two distinct dimensions: 1) how Ss felt the patient in the transcript regarded the therapist; i.e., whether Ss thought that the patient liked the therapist and perceived him as helpful; and 2) how Ss themselves evaluated the therapist in the transcript, including his perceived attractiveness and competence. Responses were on a 7 point scale, varying from a low rating of "not at all" to a high rating of "very much so" (see Appendix F).

Demographic Questionnaire. This questionnaire solicited the following information from the Ss: a) sex; b) previous experience as a patient in therapy; c) whether S intended to become a therapist; d) number of older and younger siblings, if any (see Appendix F).

Procedure

The complete experimental protocol as contained in the Appendices was distributed to students in advanced undergraduate psychology classes. All Ss were informed that their

participation in the study was voluntary. Ss were instructed to read the materials provided and to answer all questions. Experimental protocols were randomly distributed so that a fairly equal distribution of each experimental condition was obtained from each group of Ss.

After signing a voluntary consent form, Ss were given Rosenberg's Self-Esteem Scale and the Marlowe-Crowne Social Desirability Scale. Upon completion of these scales, Ss read one of the following sets of instructions:

a) High Personal Involvement Instructions

> You are about to read a transcript of a therapy session. The purpose of this study is to obtain your reactions and evaluations of the therapist.
>
> Previously, graduate students in clinical psychology who have had extensive experience with therapy participated in this study. Their evaluations of the therapist were found to be highly consistent and therefore have been used as standards by which the effectiveness of the therapist was assessed.
>
> We are interested in how your performance while still an undergraduate student will compare with the standards set by those advanced graduate students.
>
> The patient in the session that you are about to read is a student at this university who sought help because of personal difficulties and problems with social relationships.
>
> As you read the transcript of the session, try to put yourself in the place of the patient, and imagine how you, as the patient, would react to the therapist.

b) Low Personal Involvement Instructions

> You are about to read a transcript of a therapy session. The purpose of this study is to obtain your reactions and evaluations of the therapist so that we can establish standards by which the effectiveness of the therapist can be assessed.
>
> The patient in the session that you are about to read is a student at this university who sought help because of personal difficulties and problems with social relationships.
>
> As you read the transcript of the session, try to put yourself in the place of the patient, and imagine how you, as the patient, would react to the therapist.

Following the instructions, Ss read either the positive, esteem-enhancing therapist transcript or the negative, esteem-reducing therapist transcript. After having read the transcript, Ss evaluated the therapist on the semantic differential scale designed to provide measures of perceived therapist attractiveness and competence, and then filled out the questionnaire.

Following completion of the experimental protocol a debriefing session was held during which the nature of the study was explained to the Ss and all relevant questions were answered by the experimenter.

Experimental Design

The design of this study was a 2 x 2 x 2 factorial

design. The independent variables were: a) high versus low self-esteem; b) esteem-enhancing and esteem-reducing therapist response styles; c) high-involvement versus low-involvement instructional sets.

Those Ss who scored in the lower third of the self-esteem distribution were considered to be low self-esteem Ss (LSE); those Ss who scored in the upper third of the distribution were designated as high self-esteem Ss (HSE). In addition, the purpose of administering the Marlowe-Crowne Social Desirability Scale was to ascertain whether those HSE Ss who also scored above the median on need for social approval should be distinguished from HSE Ss with lower need for social approval. Previous research (Allen, 1975; Dion & Dion, 1975; Hewitt & Goldman, 1974; Schneider & Turkat, 1975) has suggested that those individuals who score high on self-esteem and high on the Marlowe-Crowne scale demonstrate markedly different response patterns, and in general tend to function more similar to LSE Ss. This category has been labeled "Defensive Self-Esteem" (DSE), and the need to treat these Ss as a distinct group was taken into consideration.

The dependent variables were: a) perceived therapist attractiveness; b) perceived therapist competence; c) question-

naire scores of Ss personal reactions to the therapist.

Statistical Analysis

Raw data was first scored, then coded and transformed for compatibility with computer data analysis. The coded data was professionally key-punched and the punched data was then verified by another professional key-puncher. All data analysis, including analyses of variance, factor analyses, post-hoc comparisons among groups, and correlations, was done using the SPSS (Nie, et al., 1975) computer programs and an IBM 370 computer.

CHAPTER III

Results

The results of the statistical analysis of the data will be presented in this chapter. The first section of this chapter describes the data base, including a breakdown of subject variables and their distribution across experimental groups. This section will also report on the measurement and scoring of Ss' self-esteem and their division into "High" and "Low" self-esteem groups. The second section is concerned with the summarization and factor analysis of the criterion variables. Finally, the results of the tests of the hypotheses, as obtained through analyses of variance and post-hoc comparisons, are presented in the third section.

All results were obtained using the SPSS (Nie et al., 1975) computer program manual and the CUNY IBM 370 computer.

Subjects and Experimental Groups

There were 190 Ss consisting of 60 males and 130 females. Ss were randomly assigned to one of the four experimental groups: 1) High personal involvement instructions with the positive, esteem-enhancing therapist transcript (HiInv/Pos); 2) Low personal involvement instructions with the positive,

esteem-enhancing therapist transcript (LoInv/Pos); 3) High personal involvement instructions with the negative, esteem-reducing therapist transcript (HiInv/Neg); and 4) Low personal involvement instructions with the negative, esteem-reducing therapist transcript (LoInv/Neg).

There were 47 Ss in the HiInv/Pos group, 41 Ss in the HiInv/Neg group, and 51 Ss in each of the LoInv/Pos and LoInv/Neg groups. Table 1 contains the distribution of Ss by sex within each experimental group.

Of the 184 Ss who responded to the demographic questionnaire, 141 Ss (76.6%) reported never having been in therapy and 43 Ss (23.5%) reported having been in therapy at least briefly. Of the latter group, 22 Ss (12%) had been in therapy for at least 6 months.

In response to the question concerning whether they were planning on becoming a therapist, 106 Ss (57.9%) indicated that they presently were not planning upon becoming a therapist while 77 Ss (42.1%) were planning to do so. The distribution of these variables by experimental group can be seen in Tables 2 and 3 respectively.

Self-Esteem. Correlations between Ss' scores on each of the individual items on the Rosenberg Self-Esteem Scale

Table 1

Distribution of Ss within Experimental Groups

	M	F	Total	%
HiInv/Pos	12	35	47	24.7
LoInv/Pos	17	34	51	26.8
HiInv/Neg	12	29	41	21.6
LoInv/Neg	19	32	51	26.8

Table 2

Ss' Previous Therapy

Group	No Previous Therapy	At Least Briefly	(> than 6 mos)	Total	%
HiInv/Pos	40	7	(4)	47	25.5
LoInv/Pos	39	11	(5)	50	27.2
HiInv/Neg	30	9	(3)	39	21.2
LoInv/Neg	32	16	(10)	48	26.1
Total	141	43	(22)	184	100

Table 3

Ss Planning to become Therapists

Group	No	Yes	Total	%
HiInv/Pos	31	16	47	25.7
LoInv/Pos	28	22	50	27.3
HiInv/Neg	20	18	38	20.8
LoInv/Neg	27	21	48	26.2
Total	106	77	184	100

and a summation score for the 10 items revealed significance at the $p < .001$ level in each case (see Table 4). Therefore, all further statistical analyses involving Ss' self-esteem were based on this summation score.

Self-esteem scores ranged from a low of 25 to a high of 70 with a mean of 57.23 (SD = 9.66). The mean self-esteem scores for each experimental group were 57.71 (SD = 9.02) in the HiInv/Pos group, 58.54 (SD = 7.92) in the HiInv/Neg group, 55.76 (SD = 11.34) in the LoInv/Pos group, and 57.37 (SD = 9.78) in the LoInv/Neg group. An analysis of variance between these groups resulted in a non-significant F ($F_{3,186}$= 0.65; $p > .05$; n.s.). Tests for homogeneity of variances between the groups using the Scheffé method for comparisons revealed no significant differences ($p > .05$).

All correlations between self-esteem and other variables including demographic variables and criterion measures were non-significant with the exception of whether or not an S had previously been in therapy; this variable yielded a negative correlation of -0.2003 ($p < .003$).

The self-esteem distribution was then transformed into "High" and "Low" self-esteem groups, with the top third being designated as "High Self-Esteem" (HSE) Ss (N=67) and the

bottom third being designated as "Low Self-Esteem" (LSE) Ss (N=70). The slight imbalance in Ns was due to tied scores at the cutoff points. The mean self-esteem score for the HSE Ss was 66.39 (SD = 2.60); LSE Ss had a mean score of 47.20 (SD = 7.76). Table 5 presents the means for each of the experimental groups.

Table 4

Correlations of Individual Items on Rosenberg's Self-Esteem Scale with Self-Esteem Summation Score

Item	Correlation with Summation Score*	Item	Correlation with Summation Score*
1	0.5904	6	0.7830
2	0.5696	7	0.6942
3	0.6529	8	0.7176
4	0.5509	9	0.6799
5	0.6077	10	0.7392

* All correlations were significant at $p < .001$

Table 5

Mean Self-Esteem Scores for High and Low Self-Esteem Ss within Groups

		Experimental Groups				
Self-Esteem		HiInv/Pos	LoInv/Pos	HiInv/Neg	LoInv/Neg	Total
High	$\bar{X}$	66.47	66.53	65.94	66.59	66.39
	S.D.	2.21	2.24	2.91	2.85	2.60
	N	15	19	16	17	67
Low	$\bar{X}$	47.44	45.74	49.00	44.94	47.20
	S.D.	6.80	8.60	4.64	14.03	7.76
	N	16	23	13	18	70

Dependent Variables

Separate principal components factor analyses with varimax rotation were run on each of the dependent measures employed. Both of the semantic differential criterion variables as well as the questionnaire revealed single factor solutions. For those items on the semantic differential relating to therapist attractiveness, the principal factor had an eigenvalue of 4.23 and accounted for 60.3% of the variance. The factor loadings for each item are presented in Table 6. Table 7 presents factor loadings for semantic differential items concerning therapist competence; the principal factor in this analysis had an eigenvalue of 4.64 and accounted for 66.3% of the variance. The principal factor for the questionnaire items had an eigenvalue of 6.69 and accounted for 74.3% of the variance (see Table 8).

In order to determine whether the above measures represented orthogonal factors or demonstrated communality, all semantic differential items as well as 9 questionnaire items were combined and submitted to factor analysis.

A principal factor analysis yielded three factors with eigenvalues greater than 1.00. Before rotation, the eigenvalue of the largest factor was 13.29 and accounted for 57.8%

Table 6

Factor Analysis of Semantic
Differential Items for Attractiveness

Item	Factor Loading	Item	Factor Loading
Agreeable	0.53	Likeable	0.90
Warm	0.86	Compatible	0.69
Friendly	0.85	Sociable	0.81
Close	0.74		

Table 7

Factor Analysis of Semantic
Differential Items for Competence

Item	Factor Loading	Item	Factor Loading
Experienced	0.77	Intelligent	0.78
Informed	0.81	Expert	0.83
Prepared	0.75	Competent	0.87
Skillful	0.88		

Table 8

Factor Analysis of Questionnaire
(See Appendix F for complete statement)

Item	Factor Loading	Item	Factor Loading
Comfortable	0.78	Recommend Therapist	0.92
Helpful to Self	0.90	Therapist Competent	0.83
Helpful to Patient	0.86	Work with Therapist	0.91
Patient Liked	0.71	Like Therapist	0.91
Choose Therapist	0.92		

of the variance. The second and third factors had eigenvalues of 1.72 and 1.35 respectively. Together, the three factors accounted for 71.1% of the variance.

Table 9 contains the rotated factor loadings for all 23 items involved in the factor analysis.

Upon rotation, the first factor was found to consist of the following bi-polar descriptive items regarding Ss' ratings of the therapist: skillful - unskillful; competent - incompetent; experienced - inexperienced; expert - inexpert; prepared - unprepared; informed - ignorant; and intelligent - stupid. The above items are presented in descending order of their factor loadings. The lowest factor loading value was 0.64. With the exception of one item from the questionnaire--"Do you think this therapist is competent?" (0.72)--none of the other items had a loading on this factor greater than 0.45. This factor was named the "Therapist Competency" factor; all subsequent analyses of items contained in this factor were treated as a single score.

The second factor contained items from the questionnaire exclusively and for future reference will be labeled as the "Ss' Personal Reactions" factor. While all items in

Table 9

Rotated Factor Matrix
for all Dependent Variable Items

Item	Factor 1	Factor 2	Factor 3
Agreeable.....	0.18	0.05	0.53
Warm.....	0.22	0.39	0.75
Friendly.....	0.16	0.34	0.75
Close.....	0.12	0.46	0.61
Likeable.....	0.31	0.40	0.74
Compatible.....	0.43	0.08	0.63
Sociable.....	0.27	0.26	0.75
Experienced.....	0.73	0.39	0.02
Informed.....	0.67	0.30	0.36
Prepared.....	0.69	0.13	0.36
Skillful.....	0.79	0.34	0.22
Intelligent.....	0.64	0.21	0.45
Expert.....	0.70	0.42	0.21
Competent.....	0.76	0.33	0.33
Comfortable.....	0.17	0.72	0.34
Helpful to Self.....	0.42	0.77	0.24
Helpful to Patient.....	0.43	0.70	0.24
Patient Liked Therapist..	0.15	0.55	0.50
Choose this Therapist....	0.38	0.83	0.22
Recommend Therapist.....	0.45	0.76	0.27
Therapist Competent.....	0.72	0.48	0.26
Work well with Therapist.	0.41	0.75	0.31
Like Therapist.....	0.38	0.73	0.39

this cluster had a loading value of approximately 0.70 or greater, two did not by virtue of their communality with Factor 1 and 3 respectively: 1) "Do you think this therapist is competent?" and 2) "Do you think that the patient liked the therapist?"

The third meaningful cluster consisted of the following items presented in descending order of their respective factor loadings: friendly - unfriendly; sociable - unsociable; warm - cold; likeable - unlikeable; compatible - incompatible; close - distant; and agreeable - disagreeable. This factor was labeled "Therapist Attractiveness."

Analyses of variance to test the hypotheses were then run for each of the factors.

Tests of Hypotheses

The mean scores for all groups on each of the criterion measures--attractiveness, competence, and Ss' personal reactions--are presented in Table 10.

A 3-way analysis of variance was run for each of the principal factors--therapist attractiveness, therapist competence, and Ss' personal reactions to the therapist--with level of self-esteem (high versus low), instructions (high personal involvement versus low personal involvement), and

Table 10

Mean Scores for All Groups
on Attractiveness, Competence, and Ss' Personal Reactions

Positive, Esteem-Enhancing Therapist

Variable		HSE		LSE	
		Hi-Inv.	Lo-Inv.	Hi-Inv.	Lo-Inv.
Attractiveness	$\bar{x}$	34.33	37.00	32.06	38.09
	SD	5.85	8.14	7.95	4.94
Competence	$\bar{x}$	33.00	37.74	30.06	38.09
	SD	7.74	7.04	9.97	5.35
Personal Reactions	$\bar{x}$	37.13	41.79	27.44	45.73
	SD	11.58	10.38	12.47	9.73

Negative, Esteem-Reducing Therapist

Variable		HSE		LSE	
		Hi-Inv.	Lo-Inv.	Hi-Inv.	Lo-Inv.
Attractiveness	$\bar{x}$	29.00	27.24	33.31	24.78
	SD	6.97	9.38	6.47	7.92
Competence	$\bar{x}$	30.31	28.53	35.92	28.39
	SD	9.36	10.00	3.95	8.91
Personal Reactions	$\bar{x}$	30.93	23.65	37.31	26.12
	SD	15.04	13.28	12.26	10.33

therapist style (positive, esteem-enhancing versus negative, esteem-reducing) as the independent variables. In addition, separate analyses of covariance were run employing the same variables as above to assess the contribution of the Marlowe-Crowne Social Desirability scores. This analysis of covariance revealed no significant F values attributable to the effect of Marlowe-Crowne scores ((attractivnesss: $F_{1,125}$= 2.84; $p > .05$) (competence: $F_{1,125}$= 1.36; $p > .05$) (Ss' personal reactions: $F_{1,125}$= 1.16; $p > .05$)). In addition, taking the Marlowe-Crowne scores into consideration did not change the probability of finding a significant interaction; when the two sets of analyses of variance were compared, the probabilities with Marlowe-Crowne scores were actually slightly decreased. Therefore, the Marlowe-Crowne scores did not enter into subsequent analysis of the data.

Tables 11, 12 and 13 present summaries of the analyses of variance for each of the three principal factors. Significant results are reported below.

A. Main Effects: Therapist Style. The specific prediction was that all Ss will perceive the positive, esteem-enhancing therapist as more attractive and competent, and will have more favorable personal reactions to this therapist.

Table 11

Analysis of Variance for Therapist Attractiveness

Source	df	MS	F	p
Self-Esteem	1	1.57	0.03	--
Therapist Style	1	1808.35	33.56	.001*
Instructions	1	1.50	0.03	--
Esteem x Style	1	13.90	0.26	--
Esteem x Instructions	1	14.32	0.27	--
Style x Instructions	1	684.07	12.70	.001*
Esteem x Style x Instructions	1	207.24	3.85	.05*
Error	126	53.89		

Table 12

Analysis of Variance for Therapist Competence

Source	df	MS	F	p
Self-Esteem	1	8.87	0.14	--
Therapist Style	1	897.97	14.55	.001*
Instructions	1	64.84	1.05	--
Esteem x Style	1	79.12	1.28	--
Esteem x Instructions	1	20.79	0.34	--
Style x Instructions	1	1053.23	17.07	.001*
Esteem x Style x Instructions	1	255.69	4.14	.04*
Error	126	61.70		

Table 13

Analysis of Variance for Ss' Personal Reactions

Source	df	MS	F	p
Self-Esteem	1	23.25	0.17	--
Therapist Style	1	3192.83	22.81	.001*
Instructions	1	142.96	1.02	--
Esteem x Style	1	327.18	2.34	--
Esteem x Instructions	1	246.65	1.76	--
Style x Instructions	1	3519.11	25.14	.001*
Esteem x Style x Instructions	1	629.62	4.50	.04*
Error	126	139.97		

All analyses supported this hypothesis. Therapist response style was found to be highly significant for all factors, with the positive, esteem-enhancing therapist being seen as more attractive ($F_{1,126}$= 33.56; $p < .001$), more competent ($F_{1,126}$=14.55; $p < .001$), and eliciting more favorable personal reactions ($F_{1,126}$= 22.81; $p < .001$) than the negative esteem-reducing therapist.

B. Two-Way Interactions: Therapist Style x Instructions. According to this hypothesis, a significant interaction with low personal involvement instructions, in comparison to the high personal involvement instructions, resulting in higher ratings for all Ss with the positive, esteem-enhancing therapist and lower ratings with the negative, esteem-reducing therapist, was expected. The significance of this interaction was confirmed for the three factors: attractiveness ($F_{1,126}$= 12.70; $p < .001$); competence ($F_{1,126}$= 17.07; $p < .001$); and Ss' personal reactions ($F_{1,126}$= 25.14; $p < .001$). Means for the Low Personal Involvement Instructions group were consistently higher when the therapist was esteem-enhancing and lower when the therapist was esteem-reducing, regardless of self-esteem level.

C. Three-Way Interactions: Therapist Style x Self

Esteem x Instructions. This hypothesis predicted that there would be a significant interaction between Ss' self-esteem, therapist style and instructions. A significant interaction confirming this hypothesis was obtained for attractiveness ($F_{1,126}$= 3.85; $p < .05$), competence ($F_{1,126}$= 4.14; $p < .04$), and Ss' personal reactions ($F_{1,126}$= 4.50; $p < .04$).

Post-hoc comparisons between the experimental groups were performed in order to test the specific predictions of esteem enhancement theory versus consistency theory. Table 14 presents the results of the post-hoc comparisons for each factor; the probabilities resulting from both the LSD and Scheffé methods of comparison are shown.

Under High Personal Involvement Instructions:

1. This hypothesis predicted that low self-esteem Ss would prefer the negative, esteem-reducing therapist style. It was found, however, that low self-esteem Ss did not prefer the esteem-reducing therapist to a significant degree on any of the three factors (Scheffé $p > .05$). However, ratings of therapist competence (LSD $p < .05$) and Ss' personal reactions (LSD $p < .05$) indicated that there was a tendency towards significance with LSE Ss preferring the esteem-reducing therapist over the esteem-enhancing therapist.

Table 14

Post-Hoc Comparisons Between Groups
on Attractiveness, Competence, and Ss' Personal Reactions

		Attractiveness		Competence		Ss' Personal Reactions	
Hypotheses	Groups*	LSD	Scheffé	LSD	Scheffé	LSD	Scheffé
1	1-3	n.s.	n.s.	.05	n.s	.05	n.s.
2	5-7	.05	n.s.	n.s.	n.s.	n.s.	n.s.
3	1-5	n.s.	n.s.	n.s.	n.s.	.05	n.s.
4	3-7	n.s.	n.s.	n.s.	n.s.	n.s.	n.s.
5	2-4	.01	.01	.01	.05	.01	.01
6	6-8	.01	.05	.05	n.s.	.01	.01
7	2-6	n.s.	n.s.	n.s.	n.s.	n.s.	n.s.
8	4-8	n.s.	n.s.	n.s.	n.s.	n.s.	n.s.
9	1-2	.05	n.s.	.05	n.s.	.01	.01
10	3-4	.05	n.s.	.05	n.s.	.05	n.s.
11	5-6	n.s.	n.s.	n.s.	n.s.	n.s.	n.s.
12	7-8	n.s.	n.s.	n.s.	n.s.	n.s.	n.s.

*Groups

1 - LSE - HiInv/Pos
2 - LSE - LoInv/Pos
3 - LSE - HiInv/Neg
4 - LSE - LoInv/Neg
5 - HSE - HiInv/Pos
6 - HSE - LoInv/Pos
7 - HSE - HiInv/Neg
8 - HSE - LoInv/Neg

2. It was predicted that high self-esteem Ss would prefer the positive, esteem enhancing therapist style. The results demonstrated that the esteem-enhancing therapist was not preferred over the esteem-reducing therapist by the High Self-Esteem Ss (Scheffé $p > .05$). HSE Ss did, however, demonstrate a tendency toward finding the esteem-enhancing therapist more attractive than the esteem-reducing therapist (LSD $p < .05$).

3. It was also hypothesized that high self-esteem Ss would rate the positive, esteem-enhancing therapist higher than would low self-esteem Ss. This hypothesis was not confirmed. High self-esteem Ss did not rate the esteem-enhancing therapist significantly higher than Low self-esteem Ss (Scheffé $p > .05$). However, HSE Ss did show a tendency towards significance giving more favorable personal reactions than LSE Ss to the esteem-enhancing therapist (LSD $p < .05$).

4. It was predicted that low self-esteem Ss would rate the negative, esteem-enhancing therapist more favorably than would high self-esteem Ss. Contrary to this prediction there were no significant differences between the HSE Ss and LSE Ss on their ratings of the negative, esteem-reducing therapist (Scheffé $p > .05$).

Under Low Personal Involvement Instructions:

5. It was expected that low self-esteem Ss would rate the positive, esteem-enhancing therapist more favorably than the negative, esteem-reducing therapist. As predicted, under low personal involvement instructions, Low self-esteem Ss rated the positive, esteem-enhancing therapist significantly more attractive (Scheffé $p < .01$), competent (Scheffé $p < .05$), and favorably on personal reactions (Scheffé $p < .01$) than the negative, esteem-reducing therapist.

6. It was hypothesized that high self-esteem Ss would rate the positive, esteem-enhancing therapist more favorably than the negative, esteem-reducing therapist. This prediction was confirmed. High self-esteem Ss, with low personal involvement instructions, rated the esteem-enhancing therapist as significantly more attractive (Scheffé $p < .05$) and favorably in their personal reactions (Scheffé $p < .01$) than the esteem-reducing therapist. HSE Ss also demonstrated a tendency to see the esteem-enhancing therapist as being more competent (LSD $p < .05$).

7. It was expected that low self-esteem Ss would show a stronger preference for the positive, esteem-enhancing therapist than would the high self-esteem Ss. This hypothesis

was rejected. There were no significant differences between HSE Ss and LSE Ss when rating the esteem-enhancing therapist under low personal involvement instructions (Scheffé $p > .05$).

8. It was also predicted that low self-esteem Ss would have a greater aversion to the negative, esteem-reducing therapist than would the high self-esteem Ss. This hypothesis was also rejected. Under low personal involvement instructions, HSE Ss and LSE Ss demonstrated no significant differences in their ratings of the esteem-reducing therapist on any of the criterion measures.

Low Self-Esteem x Therapist Style x Instructions:

9. The hypothesis that low self-esteem Ss would rate the positive, esteem-enhancing therapist higher under the low personal involvement instructions than under the high personal involvement instructions was partially confirmed. Low self-esteem Ss demonstrated significantly more favorable personal reactions to the esteem-enhancing therapist under low personal involvement instructions than under high personal involvement instructions (Scheffé $p < .01$). There was a tendency towards significance with the esteem-enhancing therapist being viewed as more attractive and competent under low involvement instructions (LSD $p < .05$).

10. Support for the hypothesis that low self-esteem Ss would rate the negative, esteem-reducing therapist less favorably under low personal involvement instructions than under high personal involvement instructions was not demonstrated. Significance was not obtained for low self-esteem Ss' ratings of the esteem-reducing therapist under varied instructions. There was, however, a tendency towards significance with the negative, esteem-reducing therapist being seen as less attractive and less competent, and to have less favorable personal reactions under the low personal involvement instructions as opposed to the high personal involvement instructions (LSD $p < .05$).

High Self-Esteem x Therapist Style x Instructions:

11. It was predicted that there would be no significant differences in the ratings of the high self-esteem Ss for the positive, esteem-enhancing therapist under the two sets of instructions. This was confirmed by the results. No significant differences were found on the high self-esteem Ss' ratings of the esteem-enhancing therapist, regardless of the instructional set (Scheffé $p > .05$).

12. It was also predicted that high self-esteem Ss would show no differential preference for the negative, esteem-

reducing therapist under the two sets of instructions. As predicted, high self-esteem Ss demonstrated no significant preference for the esteem-reducing therapist as a function of the instructions (Scheffé $p > .05$).

CHAPTER IV

Discussion

This section will examine the outcome of the data analysis in terms of the specific hypotheses of the study. Implications for level of self-esteem in conjunction with the degree of involvement of one's esteem as determinants of evaluatory responses to a therapist style that is either esteem-enhancing or esteem-reducing will be discussed. Finally, the implications for self-esteem theory will be explored.

Therapist Response Style

As hypothesized, a positive, esteem-enhancing therapist response style was significantly preferred over a negative, esteem-reducing response style. All Ss, regardless of their initial self-esteem, found the esteem-enhancing therapist to be more attractive and competent than an esteem-reducing therapist. Additionally, Ss expressed more favorable personal reactions to the positive therapist.

These findings are consonant with the view held by many clinical researchers that a warm, empathic therapist style is generally preferred by patients (Fiedler, 1950; Heine, 1950; Rice, 1968; Rogers, 1951; Strong, 1968; Strupp, 1972;

Truax, 1972; Truax & Carkhuff, 1967; Truax & Mitchell, 1971; Truax, et al., 1965).

While the present study is highly supportive of this view, it also demonstrates that additional interactive factors will significantly affect one's responsiveness to therapist style and therefore, these factors merit consideration.

Interaction Effect of Therapist Style and Instructions

Rosenberg (1969), in his work on "evaluation apprehension," has highlighted the effect of instructional set upon experimental results. He demonstrates how instructions with varying explanations regarding the nature of the task at hand as well as the nature of the subject's involvement can increase or decrease subject anxiety, with dramatic differential results as a consequence. Although the instructions employed in this study did not result in a significant main effect, they did interact significantly with therapist style across all dependent measures, regardless of level of self-esteem. As consistently demonstrated by the findings, Ss given the low personal involvement instructions, i.e., those who were asked to merely help in the task of gathering normative data, preferred the esteem-enhancing therapist to a

greater extent than their more involved counterparts, i.e., those Ss who received instructions designed to induce evaluatory apprehension. Likewise, the less involved Ss expressed stronger unfavorable reactions to the esteem-reducing therapist.

In the case of the low personal involvement instructions, it is assumed that subjects were at little risk to freely express their preferences and/or dissatisfactions with the therapists. In contrast, with the high personal involvement instructions, subjects responded in a fashion that suggests that they were apprehensive about the possibility of being held accountable for their ratings. Consequently, they were less free to express their affective reactions, and their ratings of the two therapists tended to be less extreme; that is, the higher evaluation apprehension condition seemed to create a regression to the means on the dependent measures.

Interaction Effect of Therapist Style, Self-Esteem, and Instructions

As hypothesized, a significant interaction was obtained on all dependent measures with therapist style being differentially responded to under varying degrees of personal involvement as a function of high versus low self-esteem. The implications of this interaction for differentiating between

the predictions of the two major theoretical orientations--esteem enhancement theory and consistency theory--will be discussed.

As mentioned in the review of the literature, Jones (1973) suggests that whether enhancement or consistency effects will be obtained rests to a large extent upon the implications the task holds for threatening future evaluation, self-exposure and potential threat to self-esteem. That is, where Ss can anticipate some future threat to self-esteem, their interests are best served by giving responses that will safeguard their self-esteem, i.e., their responses tend to be consistent with their own self-evaluations. However, if there is no anticipated threat, one is free to choose to respond to evaluations that enhance one's self-esteem while rejecting evaluations that derogate one's self-esteem.

The instructions in this study were intended to induce just this effect: the high personal involvement instructions created a sense of evaluation apprehension where there was an anticipated risk to self-esteem, while the low personal involvement instructions carried with them little or no anticipation of future evaluation with an attendant threat to self-esteem.

The specific hypotheses will first be examined to assess the effect of the specific instructional conditions and then in light of the predictions stemming from consistency theory and esteem-enhancement theory.

High Personal Involvement. It has been assumed that the high personal involvement instructions would induce evaluation apprehension in subjects and consequently some degree of threat to self-esteem. Thus, the results accruing from the experimental groups exposed to these instructions would be expected to conform to the predictions of consistency theory as opposed to esteem-enhancement theory.

Specifically, the first hypothesis that follows from the consistency model is that low self-esteem Ss would make responses that are cognitively consonant with their self-evaluations in order to safeguard their already low self-esteem. That is, LSE Ss would show a preference for the esteem-reducing therapist over the esteem-enhancing therapist on the criterion measures since the evaluation contained in the esteem-reducing transcript would be consistent with their low self-esteem. While confirmation of this hypothesis was not obtained at a significant level of confidence, a tendency towards significance was demonstrated where the LSE Ss viewed

the esteem-reducing therapist as more competent and expressed more favorable personal reactions to this therapist. Thus, while the findings for low self-esteem subjects under conditions of high esteem involvement do not definitively confirm the consistency model, there is some support for its predictions. In addition, the esteem-enhancement prediction of low self-esteem subjects preferring the enhancing therapist while expressing a strong aversion to the reducing therapist under this instructional set is directly contradicted.

Another corrollary prediction of consistency theory is that high self-esteem subjects will prefer the esteem-enhancing therapist over the esteem-reducing therapist since the evaluations given in the former transcript would be seen as consistent with their own initial self-evaluations, while the evaluations in the latter transcript would be inconsistent. No significant results were obtained in support of this prediction. There was, however, a tendency towards significance for HSE Ss to perceive the esteem-enhancing therapist as more attractive than the esteem-reducing therapist.

From this, it would seem that some modification of the theory might be offered. One possible explanation rests

upon the tenets of the defensiveness theory of self-esteem as proposed by Cohen (1959). This theory holds that high self-esteem individuals are less vulnerable to external threats to their self-esteem than are low self-esteem individuals. That is, they have a more stable and impenetrable self-concept. Consequently, they would be better able to defend against negative evaluations, and in the present case, would be relatively unaffected by the esteem-reducing therapist. Thus, while there may be a tendency toward preferring the enhancing therapist, as consistency theory suggests, significance is not attained.

It would also be expected from consistency theory that high self-esteem Ss would rate the esteem-enhancing therapist higher than their low self-esteem counterparts, while the reverse would hold true for the esteem-reducing therapist. That is, whereas favorable ratings for the esteem-enhancing therapist would be consistent with initial self-evaluations for HSE Ss, it would be inconsistent for LSE Ss. And conversely, the evaluations made by the esteem-reducing therapist in the transcript would be consistent for LSE Ss, but inconsistent for HSE Ss. Again, while a tendency towards significance was demonstrated for HSE Ss to express more favorable

reactions to the esteem-enhancing therapist, the overall differences between the self-esteem groups in their ratings of the two therapists were not significant, and unequivocable support for consistency theory was not demonstrated.

One possible reason for the failure to obtain significant findings that would clearly support a consistency theory explanation may be that the high involvement instructions employed in the present study did not induce a sufficient degree of evaluation apprehension with subsequent anticipation of threat to self-esteem. If this was the case, the subjects may have felt their self-esteem to be only minimally at risk in the task, thus mitigating the results. In the present study, concern for respecting the ethical standards of the American Psychological Association regarding treatment of subjects may have contributed to a reduction of the threat to esteem under the high involvement instructions.

Low Personal Involvement. The low personal involvement instructions were intended to create little or no evaluation apprehension and concomitant threat to self-esteem. Under these instructions subjects were free to respond to the therapists with little risk to their self-esteem. Therefore, these instructions should provide a test of the predictions of es-

teem-enhancement theory.

The critical test of esteem-enhancement theory concerns the prediction that low self-esteem individuals, having a need for esteem-enhancement, will prefer to receive evaluations that enhance their self-esteem. Thus, when they are free to choose between an esteem-enhancing or reducing therapist at no risk to their esteem, the LSE Ss would be expected to significantly prefer the esteem-enhancing therapist over the esteem-reducing therapist. This prediction was confirmed, with significant differences on all dependent measures: LSE Ss perceived the enhancing therapist as more attractive and competent, and had more favorable reactions to the therapist in the esteem-enhancing transcript.

A further test of esteem-enhancement theory would be to compare the responses of low self-esteem subjects under the two sets of instructions. According to enhancement theory, where there is little or no threat to self-esteem, that is under the low involvement instructions, LSE Ss will be free to choose to have their esteem enhanced. In contrast, under the more esteem-threatening high involvement instructions, LSE Ss would be less able to accept enhancing evaluations. Thus, it would be expected that in response to the

esteem-enhancing therapist, LSE Ss in the low involvement group would rate the therapist significantly more favorably than their counterparts in the high involvement group. For personal reactions to the therapist in the transcript, a significant difference was found in support of the above notions. A tendency towards significance was also seen, indicating that LSE Ss, when free to have their esteem enhanced, view an esteem-enhancing therapist as more attractive as well as more competent than an esteem-reducing therapist.

An additional prediction of esteem-enhancement theory is that the LSE Ss, when under no threat to their esteem, will show a greater aversion to derogatory evaluations than when there is threat and they are to be held accountable for their response. Thus, LSE Ss under low involvement instructions would be predicted to demonstrate a greater dislike for the esteem-reducing therapist than those LSE Ss in the high involvement instructions group. Although significant differences were not found between the two LSE groups, all dependent measures reflected tendencies toward significance in support of the above hypothesis.

Turning to the high self-esteem subjects, under low involvement instructions, they perceived the esteem-enhancing

therapist as significantly more attractive, had significantly more favorable reactions to this therapist, and demonstrated a tendency towards viewing the therapist in the enhancing transcript as more competent.

Esteem-enhancement theory, in its extreme form, would predict that in comparison with these high self-esteem subjects, the low self-esteem subjects would demonstrate significantly more favorable ratings of the esteem-enhancing therapist and less favorable ratings of the esteem-reducing therapist under the low involvement instructions. This prediction is based upon the assumption that low self-esteem individuals, by virtue of their lower initial self-evaluation, have a greater need for esteem-enhancement than high self-esteem individuals. When the high and low self-esteem groups under low involvement instructions were compared, there were no significant differences in ratings of attractiveness, competence or personal reactions to the esteem-enhancing therapist. Likewise, there were no significant differences in ratings for the esteem-reducing therapist. Thus, the extreme version of self-enhancement theory was not confirmed.

Implications for Self-Esteem Theory and Research

This study examined the responses of individuals high

and low in self-esteem to evaluations made by others, in this case, therapists in a transcript of a therapy session.

In support of esteem-enhancement theory as proposed by Dittes (1959) and Jones (1973) that people generally prefer to receive approval and obtain gratification of their esteem needs, the present study found that a therapist perceived as offering positive, esteem-enhancing evaluations was preferred over a therapist viewed as negative and esteem-reducing. However, as suggested by Jones (1973), the extent to which individuals actually feel free to respond favorably to esteem-enhancement when given the opportunity to do so seems to be largely dependent upon the future consequences of their decision.

Thus, a self-enhancement model of response to evaluation can be seen as providing a sufficient explanation for the differential results of this study, including the apparent tendency for subjects to react according to the predictions of consistency theory; while subjects may tend, at times, to give responses that conform to consistency theory, this can be understood and subsumed by the esteem-enhancement model. That is, for low self-esteem subjects, if acceptance of undeserved or discrepant enhancing evaluations is likely to

result in potential failure, future embarrassment or public exposure, then their self-esteem is best maintained and safeguarded by preferring evaluations from others that are consistent with their own initial self-evaluations. Thus, if there is anticipated threat to self-esteem as was assumed under the high personal involvement instructions, esteem-enhancement is best served by making responses that tend to be consistent with one's initial self-esteem.

Indeed, low self-esteem subjects in this study, under the esteem-threatening experimental instructions, did demonstrate a tendency to give cognitively consistent responses, preferring the evaluations of the esteem-reducing therapist. In contrast, under the low personal involvement instructions where one was relatively free of threat to self-esteem, subjects chose to enhance their self-esteem and preferred the positive, esteem-enhancing therapist.

From the above, it follows that when considering individuals' affective responses to interpersonal evaluations based upon initial self-esteem, it behooves the experimenter to take into account such variables as the consequences implicit in the instructions as well as other potential threats to self-esteem that might mediate against subjects'

freely choosing to enhance their self-esteem and lead to outcomes that initially appear to suggest support for a consistency model of response. Rather, the present study clearly demonstrates that only when the consequences are clearly specified and controlled for by the experimenter can the differential results be understood and a theoretical framework established.

APPENDIX A

Subject Consent Form

I hereby voluntarily consent to participate in this questionnaire study.

I understand that all my responses will be kept confidential, and that I may withdraw from this study at any time.

Name:_____

Date:_____

APPENDIX B

Rosenberg Self-Esteem Scale

Please read each of the 10 statements below and place a check in any one of the 7 spaces that best describes how strongly you agree or disagree with the statement as it applies to you.

For example, if you agree with the statement, but not strongly, you would place a check in one of the spaces near "Agree":

Agree _ _ ✓ _ _ _ _ Disagree

Remember, check only one space for each statement depending on how much it agrees or disagrees with how you feel.

* * * * * * * * * * * * * * *

1. I feel that I'm a person of worth, at least on an equal basis with others.

Agree _ _ _ _ _ _ _ Disagree

2. I feel that I have a number of good qualities.

Agree _ _ _ _ _ _ _ Disagree

3. All in all, I am inclined to feel that I am a failure.

Agree _ _ _ _ _ _ _ Disagree

4. I am able to do things as well as most other people.

Agree _ _ _ _ _ _ _ Disagree

5. I feel I do not have much to be proud of.

Agree _ _ _ _ _ _ _ Disagree

6. I take a positive attitude toward myself.

Agree _ _ _ _ _ _ _ Disagree

7. On the whole, I am satisfied with myself.

Agree _ _ _ _ _ _ _ Disagree

8. I wish I could have more respect for myself.

Agree _ _ _ _ _ _ _ Disagree

9. I certainly feel useless at times.

Agree _ _ _ _ _ _ _ Disagree

10. At times I think I am no good at all.

Agree _ _ _ _ _ _ _ Disagree

APPENDIX C

Marlowe-Crowne Social Desirability Scale

Listed below are a number of statements concerning personal attitudes and traits. Read each item and decide whether the statement is true or false as it pertains to you personally.

1. __ Before voting I thoroughly investigate the qualifications of all the candidates.
2. __ I never hesitate to go out of my way to help someone in trouble.
3. __ It is sometimes hard for me to go on with my work if I am not encouraged.
4. __ I have never intensely disliked anyone.
5. __ On occasion I have had doubts about my ability to succeed in life.
6. __ I sometimes feel resentful when I don't get my way.
7. __ I am always careful about my manner of dress.
8. __ My table manners at home are as good as when I eat out in a restaurant.
9. __ If I could get into a movie without paying for it and be sure I was not seen, I would probably do it.
10. __ On a few occasions, I have given up doing something because I thought too little of my ability.
11. __ I like to gossip at times.
12. __ There have been times when I felt like rebelling against people in authority even though I knew they were right.
13. __ No matter who I'm talking to, I'm always a good listener.
14. __ I can remember "playing sick" to get out of something.
15. __ There have been occasions when I took advantage of someone.
16. __ I'm always willing to admit it when I make a mistake.
17. __ I always try to practice what I preach.
18. __ I don't find it particularly difficult to get along with loud mouthed, obnoxious people.
19. __ I sometimes try to get even, rather than forgive and forget.

20. __ When I don't know something I don't at all mind admitting it.

21. __ I am always courteous, even to people who are disagreeable.

22. __ At times I have really insisted on having things my own way.

23. __ There have been occasions when I felt like smashing things.

24. __ I would never think of letting someone else be punished for my wrongdoings.

25. __ I never resent being asked to return a favor.

26. __ I have never been irked when people expressed ideas very different from my own.

27. __ I never make a long trip without checking the safety of my car.

28. __ There have been times when I was quite jealous of the good fortune of others.

29. __ I have almost never felt the urge to tell someone off.

30. __ I am sometimes irritated by people who ask favors of me.

31. __ I have never felt that I was punished without cause.

32. __ I sometimes think when people have a misfortune they only got what they deserved.

33. __ I have never deliberately said something that hurt someone's feelings.

APPENDIX D

Instructions

1) High Personal Involvement*

2) Low Personal Involvement*

*In the actual experimental protocol, the instructions were not labeled as either "High Personal Involvement Instructions" or "Low Personal Involvement Instructions."

HIGH PERSONAL INVOLVEMENT INSTRUCTIONS

You are about to read a transcript of a therapy session. The purpose of this study is to obtain your reactions and evaluations of the therapist.

Previously, graduate students in clinical psychology who have had extensive experience with therapy participated in this study. Their evaluations of the therapist were found to be highly consistent and therefore have been used as standards by which the effectiveness of the therapist was assessed.

We are interested in how your performance while still an undergraduate student will compare with the standards set by those advanced graduate students.

The patient in the session that you are about to read is a student at this university who sought help because of personal difficulties and problems with social relationships.

As you read the transcript of the session, try to put yourself in the place of the patient, and imagine how you, as the patient, would react to the therapist.

LOW PERSONAL INVOLVEMENT INSTRUCTIONS

You are about to read a transcript of a therapy session. The purpose of this study is to obtain your reactions and evaluations of the therapist so that we can establish standards by which the effectiveness of the therapist can be assessed.

The patient in the session that you are about to read is a student at this university who sought help because of personal difficulties and problems with social relationships.

As you read the transcript of the session, try to put yourself in the place of the patient, and imagine how you, as the patient, would react to the therapist.

APPENDIX E

Positive, Esteem-Enhancing Therapist Transcript*

Negative, Esteem-Reducing Therapist Transcript*

*For purposes of illustration, the differences in wording for each transcript are underlined in this appendix. In the actual experiment there were no underlinings. In addition, the transcripts were not labeled as "Positive, Esteem-Enhancing Transcript" or "Negative, Esteem-Reducing Transcript" in the experimental situation.

POSITIVE, ESTEEM-ENHANCING THERAPIST TRANSCRIPT

Patient: Hi, how are you today?

Therapist: Okay, and how are you?

Patient: Okay...sort of.... Actually, this hasn't been such a good week for me. As a matter of fact, it's been pretty bad.

Therapist: Would you like to tell me about it?

Patient: Yeah, but I don't know what it is exactly.... I don't know...I guess I've just been feeling anxious. It's like...like I can't seem to relax, and everything's been bothering me, getting on my nerves.

T: Can you be a little more specific about what's been bothering you?

P: Oh, everything...I really can't say...

T: That's okay...we have time.

P: ...Let's see...Okay. One thing that really bothers me is the way I'm treated. It's like my feelings are never considered, like my feelings never count...and that really upsets me.

T: Can you tell me some more about what upsets you?

P: Let's see...yeah, here's something. I can't stand always having to account for everything I do. Every time I come home I get the second degree. "Where have you been? Don't you know what time it is? Why didn't you call?".... And I really can't stand it...it's so annoying.

T: Uh huh.

P: And here's another thing.... The other day when I came home from school all I heard was how I don't do enough

around the house anymore, how I never take any responsibility.... And that's just bullshit!...it's just not true.

T: How do you feel about responsibility?

P: Oh, I'm always being bugged to do things...and no matter what I do, there's always something else.... And I have my own school work to do, you know.... And that takes a lot of time. How can I get all my work done if everyone's bugging me to do things all the time?

T: How have you been doing with your school work?

P: Well, okay...but just okay. Right now nothing comes easy for me. I feel like I can't do anything right.... I feel so much pressure, you know, and I don't seem to have enough time for anything anymore...it's like...oh, I don't know.... It's making me anxious just to talk about it...I just can't relax, there's so much pressure... and sometimes I feel like I just can't cope with it anymore.

T: I can understand that you're feeling this way right now. But you've talked in the past about having similar feelings from time to time...<u>and it's pretty clear to me that you're capable of handling pressure in a fairly successful way</u>.

P: Yeah, I remember. But right now it feels like I'll never be able to relax...I don't think I've ever been so anxious.

T: Is there any particular situation that comes to mind when you think about being anxious?

P: Oh, let me think about that.... Well, I'm not sure, but I can tell you about one thing that gets to me.

T: Okay.

P: Remember I told you about Professor X's class, and how I feel like I don't know enough in that class.... He makes me feel like I'm stupid, and I get real nervous

that he's going to call on me...and that I'll look foolish in front of everyone...you know, and everyone will think I'm stupid.

T: Do you often worry about appearing stupid?...or foolish?

P: No, not very often...but I can almost feel myself starting to get anxious right now.

T: What are you thinking about?

P: I don't know...let me see.... Well, yeah, there is something...I like everyone to see me as being a confident person...you know, that I know what I'm talking about and that...that I'm acting pretty cool...I hate to look stupid in front of people.

T: Uh huh. I hear what you're saying...<u>but I don't see that you have any reason to worry about that....</u> <u>You generally seem to be a confident, self-assured person</u>.

P: I guess I know that...but it still upsets me that I might look foolish in front of someone anyway.

T: Are you thinking of anyone in particular?

P: No, no one in particular.... Just people in general, you know...like the other students in my class, my profs...

T: How do you feel when you're with your friends?

P: Okay, that's not a problem.... Yeah, I feel pretty good about myself when I'm with my friends.

T: So...everything's okay when you're with your friends.

P: ...Well, maybe there is one thing....

T: Yes? Can you tell me about it?

P: Well, it's ...uhh, this is hard to say.... I don't know exactly how to put it.... It's just that, uh, sometimes I wonder about...uh...I think about how I am compared to

my friends, uh, sexually.... You know, like who's more attractive...things like that.... Yeah, I guess I think about that.

T: Does it make you anxious to talk about this?

P: Well, I suppose I worry about things like that...like how much someone really likes me...and if I'll be able to have a really good relationship that'll work out...you know...sexually and emotionally.... It's really hard to have a good relationship these days. What do you think about all this?

T: Let's see.... Okay. First of all, it seems to me that you're generally a pretty strong person, and I'm confident that you'll have hardly any difficulty dealing with this anxiety and working everything out.... And I have the feeling you can be successful at whatever you want.... For instance, I think you're good at organizing your time, and you're responsible enough to decide for yourself what's most important and what has to come first...and once you do that, you'll feel a lot better about your work situation. As far as worrying about how you compare to others, your feelings are understandable. But from what I know about you, you usually end up right near the top, and you generally do just fine.... As for your concern about your sexuality, and relationships, we should spend some time talking about that...and maybe we can evaluate exactly what the problem is in that area. (session then continues)

NEGATIVE, ESTEEM-REDUCING THERAPIST TRANSCRIPT

Patient: Hi, how are you today?

Therapist: Okay, and how are you?

Patient: Okay...sort of.... Actually, this hasn't been such a good week for me. As a matter of fact, it's been pretty bad.

Therapist: Would you like to tell me about it?

Patient: Yeah, but I don't know what it is exactly...I don't know...I guess I've just been feeling anxious. It's like...like I can't seem to relax, and everything's been bothering me, getting on my nerves.

T: Can you be a little more specific about what's been bothering you?

P: Oh, everything.... I really can't say...

T: That's okay...we have time.

P: ...Let's see.... Okay. One thing that really bothers me is the way I'm treated. It's like my feelings are never considered, like my feelings never count...and that really upsets me.

T: Can you tell me some more about what upsets you?

P: Let's see...yeah, here's something. I can't stand always having to account for everything I do. Every time I come home I get the second degree. "Where have you been? Don't you know what time it is? Why didn't you call?".... And I really can't stand it...it's so annoying.

T: Uh huh.

P: And here's another thing.... The other day when I came home from school all I heard was how I don't do enough

around the house anymore, how I never take any responsibility.... And that's just bullshit!...it's just not true.

T: How do you feel about responsibility?

P: Oh, I'm always being bugged to do things...and no matter what I do, there's always something else.... And I have my own school work to do, you know.... And that takes a lot of time. How can I get all my work done if everyone's bugging me to do things all the time?

T: How have you been doing with your school work?

P: Well, okay.... But just okay. Right now nothing comes easy for me. I feel like I can't do anything right...I feel so much pressure, you know, and I don't seem to have enough time for anything anymore...it's like...oh, I don't know.... It's making me anxious just to talk about it...I just can't relax, there's so much pressure... and sometimes I feel like I just can't cope with it anymore.

T: I can understand that you're feeling this way right now. And you've talked in the past about having similar feelings from time to time...<u>and it's pretty clear to me that you're not capable of handling pressure in a successful way</u>.

P: Yeah, I remember. But right now it feels like I'll never be able to relax.... I don't think I've ever been so anxious.

T: Is there any particular situation that comes to mind when you think about being anxious?

P: Oh, let me think about that.... Well, I'm not sure, but I can tell you about one thing that gets to me.

T: Okay.

P: Remember I told you about Professor X's class, and how I feel like I don't know enough in that class.... He makes me feel like I'm stupid, and I get real nervous

that he's going to call on me...and that I'll look foolish in front of everyone...you know, and everyone will think I'm stupid.

T: Do you often worry about appearing stupid?...or foolish?

P: No, not very often.... But I can almost feel myself starting to get anxious right now.

T: What are you thinking about?

P: I don't know...let me see.... Well yeah, there is something...I like everyone to see me as being a confident person...you know, that I know what I'm talking about and that...that I'm acting pretty cool.... I hate to look stupid in front of people.

T: Uh huh. I hear what you're saying...and I can see that you have some reason to worry about that.... You generally seem to be a person who lacks confidence and self-assurance.

P: I guess I know that...but it still upsets me that I might look foolish in front of someone anyway.

T: Are you thinking of anyone in particular?

P: No, no one in particular.... Just people in general, you know...like the other students in my class, my profs....

T: How do you feel when you're with your friends?

P: Okay, that's not a problem.... Yeah, I feel pretty good about myself when I'm with my friends.

T: So...everything's okay when you're with your friends.

P: ...Well, maybe there is one thing....

T: Yes? Can you tell me about it?

P: Well, it's...uhh, this is hard to say.... I don't know exactly how to put it.... It's just that, uh, sometimes

I wonder about...uh...I think about how I am compared to my friends, uh, sexually.... You know, like who's more attractive...things like that.... Yeah, I guess I think about that.

T: Does it make you anxious to talk about this?

P: Well, I suppose I worry about things like that...like how much someone really likes me...and if I'll be able to have a really good relationship that'll work out... you know...sexually and emotionally.... It's really hard to have a good relationship these days. What do you think about all this?

T: Let's see.... Okay. First of all, it seems to me that you're generally not such a strong person, and I expect that you'll have some difficulty dealing with this anxiety and working everything out.... And I have the feeling that you will face some difficulty being successful at whatever you want.... For instance, I think you're not very good at organizing your time, and you aren't responsible enough to decide for yourself what's most important and what has to come first...once you can do that, you'll feel a lot better about your work situation. As far as worrying about how you compare to others, your feelings are understandable. And from what I know about you, you usually aren't able to end up on top, and you generally don't do so well.... As for your concern about your sexuality, and relationships we should spend some time talking about that...and maybe we can evaluate exactly what the problem is in that area. (session then continues)

APPENDIX F

Dependent Measures: Semantic Differential Questionnaire

Below is a list of adjective pairs. For each pair, place a check showing which of the two adjectives best describes the therapist you just read about. Check any one of the 7 spaces, depending upon how closely you think one of the adjectives describes the therapist.

For example, if your impression is that the therapist was more "active" than "passive" (but not extremely active), you would place a check near "active":

Active _ _ ✓ _ _ _ _ Passive

And if you're not sure, or feel that both adjectives apply equally, place a check in the middle:

Active _ _ _ ✓ _ _ _ Passive

Remember, check only one space for each pair of adjectives. Do not leave out any pair. Try to rely on your first impression.

* * * * * * * * * * * * * * * * *

Experienced _ _ _ _ _ _ _ Inexperienced

Disagreeable _ _ _ _ _ _ _ Agreeable

Warm _ _ _ _ _ _ _ Cold

Informed _ _ _ _ _ _ _ Ignorant

Unprepared _ _ _ _ _ _ _ Prepared

Friendly _ _ _ _ _ _ _ Unfriendly

Unskillful _ _ _ _ _ _ _ Skillful

Intelligent _ _ _ _ _ _ _ Stupid

Distant _ _ _ _ _ _ _ Close

Unlikeable _ _ _ _ _ _ _ Likeable

Inexpert _ _ _ _ _ _ _ Expert

Compatible _ _ _ _ _ _ _ Incompatible

Competent _ _ _ _ _ _ _ Incompetent

Sociable _ _ _ _ _ _ _ Unsociable

* * * * * * * * * * * * * * * * *

Please answer the following questions as carefully as you can. Remember to check only one space for each question.

Would you feel comfortable talking with this therapist?

not at all _ _ _ _ _ _ _ _ very much so

Do you feel that this therapist could help you if you had a problem?

not at all _ _ _ _ _ _ _ _ very much so

Do you think this therapist was helpful to the patient you just read about?

not at all _ _ _ _ _ _ _ _ very much so

Do you think that the patient liked the therapist?

not at all _ _ _ _ _ _ _ _ very much so

If you were going to choose a therapist for yourself, would you choose this one?

not at all _ _ _ _ _ _ _ _ very much so

Did you find this therapist to be supportive?

not at all _ _ _ _ _ _ _ _ very much so

Would you recommend this therapist to a friend?

not at all _ _ _ _ _ _ _ _ very much so

Do you think this therapist is competent?

not at all _ _ _ _ _ _ _ _ very much so

Did you find this therapist to be critical?

not at all _ _ _ _ _ _ _ _ very much so

Do you think that you could work well with this therapist?

not at all _ _ _ _ _ _ _ _ very much so

Did you like this therapist?

not at all _ _ _ _ _ _ _ _ very much so

Have you ever been in psychotherapy?

No	Briefly	Up to 3 Months	Up to 6 Months	More than 6 Months

Do you plan on becoming a therapist? Yes___ No___

How many older brothers or sisters do you have? ___

How many younger brothers or sisters do you have? ___

Male___ Female___

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