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This study examines the relative efficacies of the specific and non-specific factors in psychotherapy. Psychotherapy is conceptualized as having three common components: the problem component whose essence is low self-esteem; the interactional component which induces change through social influence; and the treatment component which elicits change through therapeutic techniques. The relative efficacy of each of these two change components - influence (nonspecific factor) and therapeutic techniques (specific factor) - is the central issue of the study. Four groups, each of 20 subjects, were matched according to their low levels of self-esteem. Each group was administered a different treatment in three, one-hour sessions over a period of two weeks, designed to enhance self-esteem. The four treatments involved: 1. An emphasis on techniques - cognitive behavior - with social influence minimized through pre-session inductions; 2. An emphasis on social influence with no "usual" therapeutic techniques other than talk; 3. An emphasis on both therapeutic techniques - cognitive-behavior and social influence maximized through pre-session inductions; and 4. A no-treatment control group. Social influence induction scales indicated that pre-session inductions successfully maximized and minimized conditions of influence. Post-treatment interview measures indicated that the "full-therapy" - with both techniques and influence maximized - was most effective. However, the therapies with maximized social influence obtained significantly higher degrees of acceptance of their therapy, and elicited significantly greater enhancement of self-
esteem, than did either the maximized technique, minimized influence therapy, or the no-treatment, control group. The therapy with minimized social influence showed no significant difference in its levels of acceptance, or in its enhancement of self-esteem, from the control group. These findings are interpreted to support the interactional view of psychotherapy; seeing therapeutic change as an influence process, and the therapeutic techniques as a means of further maximizing that influence. A case is made for a re-emphasis in psychotherapy on the interactional dynamics from a social psychological viewpoint.
Influence, Techniques, and Therapeutic Change:  
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the Common Components 
in 
Psychotherapy 

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INTRODUCTION

Statement of the Problem

The issue of specific versus nonspecific factors in psychotherapy continues to be a topic of central theoretical and practical importance. (Strupp, 1978, p. 16)

Traditionally, psychotherapy is synonymous with psychological theory and related therapeutic techniques. However, psychological theory and techniques are typically delivered in therapy in a context of powerful interactional dynamics which undoubtedly influence the outcome of the therapy. Generally, it is accepted that these interactional dynamics, or non-specific factors, enhance the effectiveness of the therapeutic techniques, specific factors. Nonetheless, with the current trend of prolific development of new therapies and new techniques, it does appear that it is generally assumed to be the techniques that are essentially effecting the change.

At the same time, running counter to the mainstream of psychotherapy's acceptance of therapeutic techniques as the specific factor in effecting the outcome, a slowly growing body of thought persistently promotes the non-specific factors as the core of what happens in therapy:

What happens of importance in therapy is the result of the therapist gaining a position of power, influence or ascendancy in the therapeutic interaction, (Gillis, 1979, p. 1)

With supportive evidence mostly gleaned from social psychology, some psychotherapists have taken up what may appear to many "tradition-
alists" a seemingly extreme position as to what effects change in therapy. These writers contend that psychological theory and therapeutic techniques are simply palliative, plausible placebos through which the essence of the real change agents - the interactional dynamics - are ritualized (Frank, 1974; Fish, 1973; Gillis, 1979).

The question of separating the interactional dynamics from techniques in psychotherapy has long vexed researchers. To deliver a therapeutic technique devoid of interaction, is not possible. To have an interaction between a therapist and a client without any semblance of techniques is equally contradictory. And yet, to attribute the outcome effects to the therapeutic techniques may be disguising the realities of what is happening in the therapy to effect that outcome. Witness the demise of one of the more clear-cut therapeutic techniques for change, systematic desensitization. Each component of this technique has been systematically shown to be insufficient or unnecessary for change and can be removed leaving the strategy "like a cheshire cat... with only its smile" (Yates, 1975, p. 162-163).

There is yet limited evidence that specific techniques are uniquely effective apart from 'nonspecific factors'.

(Strupp, 1978, p. 16)

Herein lies a dilemma which continues to cloud the perspective of just what happens in therapy to elicit change in clients.

Can aspects of the interactional dynamics be minimized successfully in a psychotherapy analogue, and if so what are the effects on the efficacy of the techniques in eliciting change?

What happens to the efficacy of therapy when recognizable therapeutic techniques are minimized and the main thrust for change
stems from the personal interaction?

Is the efficacy of the therapeutic techniques enhanced by increasing the social influence of the therapist?

This study attends to these as questions as central issues.

**Psychotherapy - Its Common Components**

Little has happened in psychotherapy in the past two decades that can be directed towards unravelling that "bewildering world" of which Frank (1972) spoke. What happens in therapy to elicit change in clients is by no means clear. Numerous therapeutic strategies and techniques, each with its own engaging rationale, have emerged, presenting an impressive collection of what a therapist might do in therapy. Just what happens in therapy to effect change in clients has patiently and persistently awaited for another day. Harper says of these developments in this "bewildering world" of psychotherapy that:

> tremendous changes have been made in the broad and increasingly amorphous area of psychotherapy. Certain tidy conceptions... held with cool confidence in the late fifties sound like the weak and soulful notes of an orthodox isolate in the sixties and seventies.

(Harper, 1974, p. xi)

The current state of the art of psychotherapy has the potential for creating havoc as to its own nature, for the therapist, the intending client, the researcher, the student, and the public generally. This "amorphous" state warrants clarification.

The roots of psychotherapy are diverse - medicine, hypnotism, religion, faith healing, and more recently existential and humanistic philosophies. Within such a multivariate melting pot, almost any
development is possible. The "disease model", inherent in the early medical approaches, has been superimposed with concepts of growth, well-being, and self-actualization. The passive-patient role of the medical model has been annexed by procedures that encourage and even provoke the client to be actively involved in, and responsible for, their own "healing". The dyadic, therapist-patient relationship has been extended to encompass any shape, size, and composition to form the therapy group. As for the techniques used, the array is "bewildering" and seemingly bearing little or no relationship to one another. Furthermore the theoretical positions purporting to support these techniques, reflect their diversity and remain uncompromising in their individuality. In all, this explosion in psychotherapy has rendered the label little more than a metaphor for almost any psychological intervention.

With the developments in psychotherapy tending to emphasize what therapists might do in therapy, what actually happens in therapy becomes less obvious. It does appear that psychotherapists have become mesmerized by their own techniques and their own inexhaustible energies to create new ones. Ironically, this is especially true of the rampant 'third force' in psychology.

Techniques are precisely what humanistic psychology is not about. Yet we cannot stop from inventing them, and once invented we cannot refrain from using them on every problem we encounter... As Abraham Kaplin (1964) points out... 'If you give a little boy a hammer he will find much that needs pounding'.

(Farson, 1978, p. 2)

The range of techniques dispensed in psychotherapy is vast and yet there is evidence that what happens during psychotherapy has strikingly similar effects on the clients. Eysenck (1952, 1966) reported they
have their ineffectiveness in common. However, other studies since, Bergin (1971), Luborsky, Singer and Luborsky (1975) and more recently Smith and Glass (1977) with more more exhaustive data, indicated that:

On the average the typical client is better off than 75% of untreated individuals. Few important differences in effectiveness could be established amongst many quite different types of psychotherapy. Moreover, virtually no differences in effectiveness was observed

(Smith and Glass, 1977, p. 753)

This suggests that whatever therapists do in therapy it seemingly effects similar results in the clients. It does appear then that what techniques therapists employ may not be the essence of what happens in eliciting change in clients, but merely the vehicle through which the change process operates. In an endeavour to capture the essence of psychotherapeutic change it can thus be argued that, if vastly differing therapeutic techniques effect similar results, then it may very well be that there are elements common to all therapies which are more powerful change agents than those actual techniques employed for change. From this stance it does seem appropriate to look at the common compon- ents that are shared by all effective therapies in a quest to establish some clarity as to what constitutes psychotherapeutic change.

This common ingredients approach to psychotherapeutic change is, of course, not new. Frank (1973), in a similar ecumenical drive, presented four elements common to all major psychotherapies. These were:

1. the particular type of relationship;
2. the particular helping setting;
3. a psychological rationale for the condition presented by the client; and
4. a strategy for treatment based on the rationale.
Strupp simplified the process further stating that all psychotherapy involves both a human relationship and techniques for bringing about personality and behavior change. (Strupp, 1978, p. 5)

A simple amalgamation of these elements is possible. Firstly, there are the interactional elements: elements that relate to the dynamics which exist between the therapist and the client. Frank's elements 1 and 2 would both be included in this as would Strupp's "human relationship" factor. This category is intended to be an all inclusive one, under the non-specific banner of all the interactional components. Likewise, elements relating to the specific factors - the psychological rationale and the subsequent therapeutic strategies and techniques - could make a second category under treatment components. Frank's elements 3 and 4 would fit into this category and would coincide with Strupp's "techniques for bringing about personality and behavior change" (see above). Furthermore, that common to all therapeutic situations is a "presenting problem", condition, or concern from which the client seeks relief or change. Thus, this study proposes these three elements as common components of all psychotherapies:

1. the problem component;
2. the interactional component; and
3. the treatment component.

Having extricated each of these components from one another, it is relevant to point out that operationally, each is integrally related with the other two and, as such, are inseparable. At the same time, it is contended that, by viewing psychotherapy at this common component level, what happens in therapy to elicit change may very well become more obvious.
The Problem Component

Clients present symptoms when they consult with a therapist. Paying lip service only to these symptoms and digging for the underlying disorder has been characteristic of psychotherapy from its inception, with the significant exception of the behavioral approaches (Goldstein and Simonson, 1971). The conditions that psychotherapy purports to treat are vast in their range: personality disorders, neurotic and psychotic reactions, identity crises, marital discord, addictions, phobias, anti-social behaviors, sexual dysfunctions...and so on. If, in therapy, symptoms are being changed to a similar degree as is suggested, then digging deeper below the symptoms may expose common elements of the symptoms: elements which may very well be related to the common therapeutic outcome effects.

Frank (1973) proposed that clients bring into the therapy room with them a feeling of demoralization:

they are conscious of having failed to meet their own expectations or those of others, or being unable to cope with some pressing problem.

(Frank, 1973, p. 271)

This demoralized state is characterized by:

a loss of self-confidence and feelings of failure, often accompanied by guilt or shame... (with) some degree of isolation or alienation... creating a vicious circle.

(Frank, 1973, p. 368)

This state of mind results from persistent failure to cope with life and its stresses as perceived by clients. An essential to therapy is an inescapable fact that the clients are dealing with attitudes they hold concerning themselves.

"The person's self-esteem is damaged"

(Frank, 1974).
Clients invariably have problems concerning low self-esteem (Murray and Jacobsen, 1971). Feelings of incompetence, unworthiness of love, lack of control, isolation, helplessness, despair, and thoughts that they have a fixed and unchangeable personality, permeate their self attitudes. Once again this is what Frank termed being demoralized. Frank (1974) added further support to this stance by seeing this demoralized condition as the additive necessary to provoke a person to seek therapy. He argued that in society generally there are very many persons who clearly exhibit symptoms appropriate for therapy, but only a small percentage of them actually do seek it out. He contended that the trigger condition for seeking professional help was the condition of demoralization accompanying the symptoms. This reasoning is further supported by the fact that many recover their "stability" without psychotherapy.

The most frequent symptoms expressed by clients are anxiety and depression (Frank, 1974) which interact in two ways with demoralization:

First the more demoralized a person is, the more severe his symptoms tend to be. Thus patients troubled with obsessions (or whatever) find them becoming worse when they are depressed. Second, by crippling a person, symptoms reduce his coping capacity, thereby aggravating his sense of failure. (Frank, 1974, p. 271)

Thus, typically clients present with these negative attitudes towards themselves and what happens in therapy is their low self-esteem is enhanced:

It is gradually being recognised that in all forms of psychotherapy the patient will typically experience changes in self-identity and self-acceptance; that is, regardless of behavioral change, successful psycho-
therapy produces changes, in the patient's 'inner experience' (Strupp, Fox and Lesser, 1969), a realization previously rejected but now often accepted by some behavior therapists. (Wachtel, 1977).

(Strupp, 1978, p. 10)

There is further support for taking such a stand. In studying characteristics of clients and non-clients in both the U.S. and England, Kellner and Sheffield (1973) found that feelings of isolation, helplessness, failure and unworthiness distinguished the two groups. They reported these underlying feelings of demoralization in those who sought therapy as opposed to those who did not, regardless of the symptoms. In a similar study, Katz (1971) compared depressed clients with depressed non-clients. Self accusatory and helplessness of those in therapy were the significant discriminators from those not in therapy. Luborsky and Auerback (1969) studied the affect states that emerged in psychoanalysis without regard to the presenting symptoms. They found that a common emotional context of a lack of self-control, helplessness, and hopelessness prevailed. This suggests that therapy typically doesn't help symptoms directly but operates more on restoring coping mechanisms through the treatment of underlying affect states related to self-esteem.

It does appear that self-esteem, and in particular, experiencing feelings that are associated with low self-esteem may be significant in distinguishing those who seek therapy from those who do not, regardless of the symptoms. This being the case, the essence with which therapists are dealing appears to involve enhancing these negative self-concepts to restore morale and renew a sense of control, worth, and competence. Such a change may enable clients to cope more adequately with their symptoms. Obviously such an approach does not preclude working with the symptoms as a means of restoring morale.
The Interactional Component

In all psychotherapies, interaction between the therapist and the client exist. Typically, in psychotherapy this interaction is seen as a unique therapeutic phenomenon with its own conceptualized language which has meaning only within that psychotherapeutic model. Thus, what happens in therapy happens only through that model's conceptualization of the interaction. On the other hand, if the therapist-client interaction is viewed as not atypical, but similar to any other social interaction, then a whole new frame of reference for what is happening in therapy presents itself.

There appears to be nothing atypical within the communication relationship dynamics that develop between a therapist and a client. This position was articulated by Gillis when speaking of the therapeutic interaction:

Therapy is not seen (by social influence therapists) as being unique. Constructs used seldom but in regard to psychotherapy - transference, resistance, congruence, and even empathy - are not regarded as particularly useful. We would discard these and use the same terms as would be used to describe what happens in any social interaction.

(Gillis, 1979, p. 4)

Furthermore, the limitations resulting from narrow, and often highly symbolic descriptions of interpersonal dynamics from various conceptual frameworks, are often extraordinary. To lift these unnecessary constraints by accepting, that the interaction of two persons, whether in therapy or not, is the interaction of two persons, greatly enhances the range and functional value of the interpersonal dynamics for change.
When one conceptualizes therapy as just another form of social interaction, the range of tactical alternatives open to the imaginative therapist is immensely expanded. (Gillis, 1979, p. 4)

Evidence for taking such a stand can once again be argued from the position of equal effectiveness across therapies (Bergin, 1971; Frank, 1972; Luborsky et. al., 1975; Smith and Glass, 1977). If the various interactional dynamics, as labelled by differing therapeutic orientations effect similar changes in clients, then these interactional processes may be similar and, are either being described in differing conceptual language, or being ignored as not occurring. It is suggested here, that the "usual" social influence dynamics are present in therapy, and these, not being philosophically fashionable descriptors of the therapeutic interaction, are therefore avoided. Gillis (1974) (citing Rioch, et. al., 1965; Beck, Kantor, Gelinern, 1963) gave further support to this stance. He pointed to evidence of persons with minimal training in therapy being able to function as adequate therapists, using what could be little more than "usual" social influence skills, gleaned from their "usual" social interactional dynamics. Thus, this approach contends that within the interactional dynamics of psychotherapy there are common ingredients which are similar to all other social interactions, and when described in the usual social psychological terms of control, power, influence, and expectancy, what essentially is happening in therapy becomes more obvious. It does appear then that the essence of any interaction between two people is the inescapable influence each exerts on the other through the communication dynamics. This social influence has a marked impact on what happens in therapy as regards the desired change being achieved.
Communication. Communication is the medium through which social influence is conveyed. Bateson's (1951) analysis of communication pointed out that all communication has two distinct functions, report and command. Essentially, the object of any communication is the information it carries. This is the report function. But far more important to the relationship between the two persons is the command. This refers to the interpersonal statement each communication bit carries - 'In relation to me I see you this way'. This command message is carried in how the information (report) is communicated. In this way, all bits of communication define relationships.

Every message has both a content (report) and a relationship (command) aspect; the former conveys information about facts, opinions, feelings, experiences etc., and the latter defines the nature of that relationship between the communicants. (Jackson, 1965, p. 8)

Through this definition of the relationship, control of the interaction is established and this leads to one influencing the other.

Control is an inevitable and unavoidable reality of any social interaction. It is expressed through the definition of the relationship, control being in the hands of the person who last defined it. Control is not necessarily a static condition remaining with one person but may continue to be dynamic in the communication. It is dependent not just on the message, but whether it is accepted, rejected or qualified by the other:

It must be emphasized that no one can avoid being involved in a struggle over the definition of his relationship with someone else. Everyone is constantly involved in defining the relationship or countering the other person's definition... A basic rule of communication theory demonstrates the point that it is impossible for a person to avoid defining, of taking control of the definition of, his
relationship with another... all messages are not only reports but they also influence or command.

(Haley, 1963, p. 9)

It is through communication control that the social influence of the therapist may be exerted (Haley, 1967; Watzlawick, Weakland, and Fisch, 1974). Some writers highlight this dynamic as having an important impact on the outcome of therapy.

psychological change occurs as a consequence of the interaction of psychological forces generated and altered in the exchange between counselor and client... the desired change then is brought about by the actions of the counselor in his conversations with the client.

(Strong and Matross, 1973, p. 25)

Gillis went more directly to the essence of how he views psychotherapeutic change occurring:

What happens of importance in therapy is the result of the therapist gaining a position of power, influence or ascendency in the therapeutic interaction, and then using this position to convince the client that he should adopt a new way of viewing himself and his situation.

(Gillis, 1979, p. 1)

Power, credibility, attractiveness. While control of the interaction is dependent upon the nature of how the messages are being communicated, power resides in client's perception of the therapist's resources. If the client perceives the therapist as a person who can meet his/her needs, therein lies dependence and a source of power from which the therapist may be able to exert influence. French (1956), and French and Raven (1959) presented a classification of five power bases from which therapeutic influence may be derived. These were expert, referent, legitimate, informational and ecological based power. Originally
these were described by French and Raven (1959). Expert, referent and legitimate power bases provide the main sources of power during the therapeutic interaction.

Expert power exists when the client perceives the therapist as having the knowledge and skills to meet his/her need in therapy. The profession's public image generally, and the individual therapist's specific reputation contribute initially to the perceived expertise. Referent power stems from interpersonal attraction, in this case the client's attraction towards the therapist. Such attraction occurs when people share strong similarities on important issues or perceive the other as having qualities which he/she values. As well, people who like one another tend to identify or assume they are similar in significant ways. A legitimate power base is derived, if the therapist is perceived by the client as having a legitimately sanctioned role within a system, an institution or the society itself. By seeking help from the therapist the client is accepting the therapist's role as a recognized helper, healer or whatever, and in doing so is attributing a legitimate power to the therapist.

Credibility and attractiveness, and to a lesser degree power, typically have been viewed as important dynamics of social influence. McGuire (1969), drew on Laswell's (1948) analysis of communication components - source, message, channel, receiver and destination - and spoke of source credibility and source attractiveness. In the case of therapy, the source refers to the therapist. Generally, it has been assumed that perceptions of high source credibility and attractiveness by the receiver (the client) enhance the influence of the source and the likelihood of change.
Kelman (1961) proposed another model of social influence process based on the psychological modes through which the source characteristics exert influence for change. He conceptualized three modes; internalization, identification and compliance. The internalization mode depends on the motivation of the receiver to be "right". Thus, influence is exerted to the extent the source is perceived by the receiver to be "correct" and willing to share this "correctness" with the receiver. The source credibility characteristics associated with this mode are expertise and trustworthiness. It is postulated that the extent to which the message is internalized into new beliefs, attitudes, or values is dependent upon the strength of the source credibility. However, research findings have cast some doubt as to this conceptualization. Studies have generally failed to confirm that source credibility does actually affect the learning of the content of the message (Bauer, 1965; Hoveland, Janis and Kelley, 1953; Watt and McGuire, 1964).

In the identification mode, the attitudinal change relies on the motivation of the receiver to seek a satisfying role relationship with the source, either in fact or fantasy. Source attractiveness is the operative criterion. Kelman proposed that with high source attractiveness, the role relationship becomes salient and attitudinal change occurs through the identification mode. Kelley (1955) threw some doubt on this seemingly plausible process of change. He found that continued advocacy through source identification is necessary for the attitudinal change to continue to be functional.

In the compliance mode, the receiver demonstrates public adoption of changed attitudes but without private commitment. Compliance is
derived from the power the source has over the receiver's attainment of desired goals. So it is the extent to which the source has positive or negative sanctions over the receiver that determines the source power and the degree of public attitudinal change. The change is functional to the extent the source has the ability to retain the sanction, monitor the change, and values the compliance. Removal of any one of these conditions, lifts the compliance and the change reverts.

Obvious similarities exist between French's conceptualization and Kelman's model. French's expertise and referent power bases correspond approximately to Kelman's source credibility and attractiveness, while the coercion and legitimate power may be combined to equate with Kelman's source power function. Furthermore, other writers have suggested similar concepts. Beslo and Lemert (1961) factor analyzed ratings of source characters and found three significant bipolar components: expert versus ignorant, admirable versus contemptible, and aggressive versus meek. These three factors closely approach Kelman's credibility, attractiveness and power.

Social influence dynamics exist between the therapist and the client and have an impact on the efficacy of the therapy. It therefore behoves the therapist to be aware of them, and to structure them such that they enhance the possibility of attaining the desired therapeutic goal.

Expectancy. Clients bring with them to therapy a range of perceptions concerning the experience, significant amongst which is an expectancy of the outcome. This dynamic is a common ingredient of all therapies and is viewed by many as exerting impact on what happens in the therapy.
a substantial proportion of treatment effects
can be attributed to a patient's expectations
of benefit.

(Gillis, 1979, p. 6)

The interactional dynamics and the therapeutic outcome will be different for a client who really believes in the therapist and the therapy, and expects to change, than for a client who has no faith in the therapist nor his/her therapy, and expects that it will have no effect.

There is a strong positive relationship between a patient's perception of psychotherapy and its ultimate success.

(Orne and Wender, 1965, p. 1202)

The client's perception as to the outcome is not the only source of this expectancy dynamic in the therapeutic interaction. Therapists also carry with them expectations as to the effectiveness of their therapy. Each expectation, the therapist's and the client's, is affected according to the interaction. The therapists' expectancy relates to their own interests in the therapy which, in part are derived from their reaction to the client. Mutual attraction, liking and client suitability (Shapiro, et. al., 1976; Strupp, 1960; Goldstein, 1962), and likelihood of acceptance of treatment (Brill and Storrow, 1963) are sources of developing interest and heightening the therapist's expectancy. The client's expectancy stems from past experiences, whether they be general attitudes which show weak effects, or more specific attitudes which tend to have a stronger impact on the therapy (Goldstein, 1960; Goldstein and Shipman, 1961). As with the therapist, the client's expectancy is also subject to the therapeutic interaction. If positive expectancies build up within the interaction (and the therapist has the power, influence and control potentials to do this) then positive outcomes are more likely.
The more favourable the patient and staff attitudes in the milieu, the greater the therapeutic potential.  
(Honigfield, 1963, p. 343)

Few clients come to therapy without hope that some change may occur. This hope is a source of motivation to be there and to participate.

The client's beliefs about treatment determine his valuation of the process... and... this valuation is the determinant of his motivation to participate.

(Krause, 1967, p. 359)

Hope is a dynamic that may be enhanced through interacting with the therapist. Increasing this hope, belief, and even faith in the therapist and the therapy, is to heighten the expectancy of a positive outcome. Many see this heightened positive expectancy of outcome as the major contributor to the non-specific change agents in therapy.

A patient's expectancy of benefit from treatment in itself may have enduring and profound effects on his physical and mental state. It seems plausible... that the successful effect of all forms of psychotherapy depend in part on their ability to foster such attitudes in the patient.

(Frank, 1959, p. 17)

This expectancy construct has emerged from "placebo effects" in medical literature (Fish, 1973). In medicine, placebo refers to a patient being administered an inert substance while believing that it is a potent medication which will cure the symptoms. In such circumstances there is a high probability that the symptoms will be alleviated. The analogy for psychotherapy is obvious. In therapy, the client's belief in the therapy and the resultant high expectancy for positive outcomes by participating in it, has the placebo effect of producing a high probability that the desired outcomes will result:
"if the therapist believes this is my problem and that this action will 'cure' it, and I have faith in the therapist, then I believe and expect this action to 'cure' my problem".

The history of placebo cures is long and well documented dating back to the Hebrew Bible with its Latin translation placebo meaning "I shall please". It took on a secular meaning in the twelfth century and found relevance in medical science and practice. Psychological factors in medical cures have been recognized from the time of Hippocrates. The treatments wrought by physicians in the name of medical science were very clearly dependent upon some other curing process - and what other than the psychic. For centuries physicians prescribed what we know now to have been useless and often dangerous medications, as they "purged, puked, poisoned, punctured out, cut, cupped, blistered, bled, leached, heated, sweated and shocked" (Shapiro, 1971)... and they worked! An important consideration here is, that at the same time as physicians practised such treatments they were held in the highest esteem along with the religious, philosophers, scientists, and teachers: their knowledge was unquestionable, their ethics impeccable, their expertise unchallenged. This position of honour, respect and therefore power, was never challenged. Belief by the masses in the physician, his knowledge, wisdom, and practices provided him, knowingly or not, with the influence which formed the basis of his success in healing and was acted out often through innocuous prescriptions (placebos).

In applying this model to psychotherapy, if we say that what the therapist needs to do is to gain the client's confidence and convince him/her what is causing the problem, and to do such and such and they will be cured, then, why the change? One can be sure that many clients
have been told what to do to resolve the problem prior to therapy by many of their friends and yet, it does not seem to work. What is different about the therapeutic message? The therapist is in a very different position of power, and therefore, influence. His/her message is usually being delivered in the context of a learned psychological theory and acted out through less-than-usual behaviours (therapeutic techniques). Thus the message is being delivered from an influential person in whom the client believes, through a healing ritual in which both the client and therapist demonstrate belief. This is the essence of the placebo effect in psychotherapy.

The whole history of healing is full of examples of faith cures. From the Congo to Lourdes, from Harley Street to the herbalist, from the religious revivalist to the Maharishi, spontaneously people's lives are being changed, their health improved, their psychic relieved as their existence becomes re-energized with new meaning and direction because they have 'seen the light' and believe. Witch doctors rely on belief in tribal lore for their power, naturalists look to their trust in nature, while religious healers attribute their cures to faith in God. This puts the mere physician's bag of medical science at somewhat of a disadvantage, for unlike tribal lore, nature, and God, science can be proven wrong. As for psychotherapists they cannot remain vulnerable commoners. They too must have a source of power that is out of the general knowledge and/or comprehension of the average client from which to draw. Thus, the therapist's psychological theory and practice provide a plausible frame of reference in which the patient's faith, belief, and hopes can be raised in the form of expectancy for outcome:
Witch doctors prescribe witchery; naturalists prescribe nature; faith healers prescribe hands; priests prescribe God; physicians prescribe drugs; psychotherapists prescribe psychotherapy. It is through faith in these rituals and their prescribers that change can be wrought.

This approach suggests that change may not be coming from the actual therapeutic techniques but from the powerful influence of the therapist exerted through the interactional dynamics. If the experience of the technique has an intrinsic positive effect, then a combination of the two may very well maximize the overall efficacy of the process.

The Treatment Component

All psychotherapies have as their raison d'être, strategies and techniques through which the treatment is conveyed. Therapists do "things" to/with clients to achieve effects. To differing degrees these strategies and techniques are supported by their own theoretical orientation and to a lesser degree still, they are backed up by research. Many therapeutic techniques owe their usage, more to their popular appeal amongst therapists and clients than they do to any serious scientific support, logical rationale or common sense. If it feels good; if it is new, different, challenging, outrageous; if there is a possibility that life might be more meaningful and growthful with new exciting experiences, then do it, in the name of therapy, do it. In a climate of restlessness of people, with visions of unheralded possibilities for the human species, what Watzlawick, et. al., (1974) referred to as the "Utopian syndrome", techniques of all hues and strengths have emerged from the rooms, pens, and mouths of therapists. The proliferation of what is done in therapy has been extraordinary.
What is done in therapy may be broad but what happens in effective therapies is similar in nature and degree. Change is what happens: change toward a desired therapeutic goal (although at times with many "new therapies" this goal is quite fuzzy). As is witnessed above this change is of similar effect size (Smith and Glass, 1977; Luborsky, 1975; Bergin, 1971). The common motive behind all therapeutic techniques then, is change: change in behaviors, feelings, beliefs, values, attitudes, skills, life style, personality traits, a disordered condition, a relationship or whatever; change to remediate a state, or change to become a more fully functioning person. What effective therapeutic techniques do, is set in motion the change process. So at a common ingredients level, therapeutic techniques converge as change agents, and an analysis of techniques is an analysis of the process of change.

Schein (1973) proposed possibly the most comprehensive model in social science literature of how change occurs through interpersonal processes.

the most notable feature of his (Schein's) approach is that it encompasses the complete cycle of change from one relatively stable pattern of attitudes and behaviors to another relatively stable pattern.

(Pentony, 1981, p. 9)

His model is as applicable to a whole range of socialization processes, as it is to psychotherapy. It contends that purposive change in people through interpersonal contact occurs in a systematic way involving three major stages:

Stage 1. unfreezing of current conceptualizations concerning themselves, others, and/or their view of reality;
Stage 2. changing cognitions based on new information; and
Stage 3. refreezing of these new cognitions into their own concept of themselves, others and their world.

Each of these stages are defined by underlying mechanisms through which they operate. In a recent publication, Pentony (1981) expressed surprise at the limited attention Schein's model has received from the therapy world (p. 8), as he conceptualized it as one of three models of influence in psychotherapy. It is intended here to incorporate Schein's three stage model and the underlying mechanisms for change into a general model for psychotherapeutic change.

Unfreezing. Typically clients present for therapy with symptoms which show some "unfreezing" already having occurred. In their life experiences clients have encountered some "disconfirmation" or lacked "confirmation" of their set patterns of thinking, feeling, and/or behaving. This produces a loosening-up of the conceptual frame that they hold concerning themselves, others and/or life experiences, leading to a much more fluid and insecure state. Schein saw this state typified by guilt-anxiety reactions with other related emotional responses emerging. Luborsky, et. al., (1974) reported that not only were anxiety and depression the two most commonly presented emotions for therapy but that these emotions indicated a readiness for change. Low affect states indicate a poor prognosis for change:

almost any affect is better than no affect, and anxiety and depression are probably the two best initial affects (for therapeutic change).

(Luborsky, et. al., 1971, p. 145)

These two mechanisms, disconfirmation/confirmation and guilt-anxiety were seen by Schein as essential motivators for change:
Change will occur in the attempt to reduce or, more commonly, to avoid guilt-anxiety. 
(Schein, 1968, p. 342)

As stated above, most often the symptoms of the unfreezing process (disconfirmation, guilt-anxiety) are brought by the client to therapy. Furthermore, techniques from a variety of therapies may be conceptualized as eliciting this unfreezing process so as to produce a readiness for change. These techniques are especially obvious in encounter groups, where confrontation, personal feedback, and lack of usual structure are common. Provocation, EST-style, is a most dramatic example. Much of the slightly unusual techniques which various therapies practise (e.g. confusion tactics, silences, meta-level control, non-directive responses, processing experiences) produce or heighten the client's unfreezing.

Change is made possible through the client's attempts to reduce the undesirable symptoms of unfreezing. This is most likely to happen, in a climate of "psychological safety". This Schein saw as the third mechanism necessary for the unfreezing to lead to change. All therapies provide this safety, if not through deliberate techniques, certainly through the client's perceptions of the therapist as a professional, competent in dealing with such states. Some therapies emphasize the provision of such a climate through relationship building techniques, e.g. Rogerian, while others structure reassurance through their technological competence, e.g. Behavioral, and still others rely more on perceived status, acceptance and reputation within the community, e.g., Psychoanalytical. Most therapies recognize the importance of these dynamics and usually strive to provide a climate in which these expert and referent power based dynamics provide adequate psychological safety
for this initial stage of therapeutic change.

These three unfreezing mechanisms have a critical interrelationship especially if change is to be effected:

- A change or influence can only be started when there is some optimum balance of disconfirmation, guilt-anxiety and psychological safety.

  (Schein, 1973, p. 142)

If the disconfirmation is consistently too harsh or the guilt-anxiety too intense, avoidance or defensive responses will preclude change. If the psychological safety is too supportive then a dampening of the disconfirmation effects may result in repression of emotions. Whereas low psychological safety may produce high vulnerability in clients and minimal disconfirmation may become highly threatening. Defensiveness, avoidance, repression, vulnerability and resistance, amongst others, are among the usual responses to pending change processes and most therapies have strategies and techniques to counter or use these reactions so that change is not precluded.

It does appear then, that clients either present with symptoms of unfreezing, or that these symptoms are encouraged initially in therapy to set up conditions for change. Furthermore, in response to these symptoms, the therapist employs techniques to create a climate and relationship of psychological safety, in which change becomes more of a possibility.

Changing. Effecting the desired changes is the next stage. Approaches to change are well documented. Johnson and Matross, in Kanfer and Goldstein (eds.), (1975), presented five major approaches on which most therapeutic techniques are based: Learning Theory; Cognitive Theories; Functional Approaches; Social Influence Methods; and Structural-Process

...
Approach. However, what is happening in therapy is examined, it
does appear that essentially all real changes are eventually incor-
porated into a single identifiable process and outcome, viz. the
conceptual reframing of beliefs, attitudes, and values a person holds.

The first step in the change process, then, is
to develop alternative assumptions and beliefs
through a process of cognitive redefinition of
the situation.

(Schein, 1975, p. 349)

Unfreezing provides the openness to new information while the
change process is "the actual assimilation of new information resulting
in cognitive redefinition" (Schein, 1973, p. 349). Therapies prescribe
many techniques in the name of change and the overt changes they effect
are quite varied. However, it is contended that all change is accom-
panied more covertly by a change in the conceptual frame which clients
hold concerning themselves, those around them, and/or their life situa-
tions. The essence of change lies in shifts in the beliefs, attitudes
and values a person holds concerning him/herself, others and his/her
world.

This conceptualization of problems is not new to human thinking:

Man is disturbed not by things but the
views he takes of them.

(Epicetus, The Enchiridion)
nor to psychology:

It all depends on what you see yourself
as being.

(James, 1890)
nor to psychotherapy:

Much of psychotherapy ... is based on the
assumption that recognizing and restructur-
ing a patient's verbal statements about
himself and his world will result in a
corresponding reorganization of the patient's
behavior with respect to that world.

(Risley and Hart, 1968)
The central issue in this approach is that people develop a conceptual frame through which they view themselves and the world. This frame consists of beliefs, attitudes, and values that are organized around the self concept. For any significant change, it is necessary for a conceptual shift to occur which, in turn, impacts both on their own self-concept as well as their emotions and behaviors.

Some therapies very obviously deal directly with effecting such changes: Rational Emotive Therapy and Cognitive-Behavior Therapy both use altering internal dialogue as a cognitive restructuring technique to form their central strategy. Other therapies seek changes in conceptual frames but are less direct in their techniques: Strategic therapy and Logotherapy both use paradoxical intention or symptoms scheduling techniques to produce conceptual shifts; Social Influence therapies employ influence dynamics and placebo effects as techniques for changes in a client's perspective. While those therapies mentioned above have conceptual shifts as their stated objective, others do not. However, in achieving their objectives these other therapies effect such changes: Behavior Therapy focuses on changes in behavior which, if significant and lasting, are accompanied by changes in perspective concerning self, others, and/or a situation. Insight therapies, Structural Analysis, Gestalt, Client-Centered Approaches, Body Therapies, Encounter Groups, all employ techniques to increase self-awareness leading to new conceptual frames. All therapies may be seen to provide opportunities for changes in the self-concept of clients, how they conceptualize their relationships with others and the world around them.

Schein presented two sources from which information may be derived
to effect a cognitive redefinition. The first is through "identification" with some influential person; the second through "scanning" a wide range of relevant sources. Simply, identification involves the client being fully influenced by all the interpersonal cues from the therapist which are then used as a basis for redefinition. Whereas scanning involves a similar interpersonal process but from a wide variety of sources. Usually with scanning, the contact is more content-oriented as opposed to the personal orientation involved in identification.

In therapy the major source of information that may effect a cognitive redefinition comes from the therapist and his/her psychological theories through the strategies and techniques used. As discussed in the previous section, interactional dynamics are influential in therapy. Some therapies recognize their power and base their change on such dynamics e.g. all interactional therapies - social influence, placebo, Ericksonian approaches, hypnosis and communication techniques - Rational Emotive Therapy. However, most prefer to ignore these dynamics and present their information through therapeutic strategies even thought at times the influence is pervasive, e.g. Rogerian therapy and Psycho-analysis. Interestingly many therapies tend to employ techniques that make the major source of information the client themselves. Psycho-analysis, Gestalt, Ericksonian therapy and more recently Neuro-Linguistic Programming are excellent examples of therapies that tap the unconscious resources of the client for "information". In such cases the therapist's techniques are the vehicle through which clients are able to access themselves and use the resources (information) that lay dormant within.
Whatever therapists do, either from their personal interaction with the client, or from the content of what they present in therapy, or from the impact of their techniques, "information" is gained by the client which may lead to new awarenesses, insights, understanding, from which a cognitive redefinition may emerge, and with it, change. Such is what happens in therapy.

Refreezing. The process of change is not complete without a comfortable integration of that change into the person's general functioning and life style. A lack of congruence within the person or dissonance between him/her and others, will be unsettling and lead to either a rejection of the change or a disconfirmation/confirmation stage once again. In the latter case, the concern is often not resolved, for simply, the solution now becomes the new problem. "Refreezing" the change is a necessary process if that change is to be substantially adopted. This is a process of integrating the change into the person's wider belief and value systems, and life style generally. Secondly, it is a process of ensuring that the change will meet with acceptance of those he/she values, and that the person has sufficient skills and ability to deal with the dissonance that the change may evoke.

Matching the therapeutic message and technique with the client is an important factor in how well that therapy is accepted by the client. This is an ongoing process throughout the whole interaction and relates very much to the influence dynamic. If the therapist functions from a strong social influence level, then the likelihood of acceptance of more radical techniques and messages of change is increased. Witness some of the bizarre therapeutic strategies of Milton Erickson in which
cognitive redefinitions have been wrought through the power of an influential therapist (Haley, 1973). At the other end of the influence spectrum are the behaviorists, whose personal influence may have little effect, but whose obviously logical, concrete techniques are readily understandable and acceptable. On a micro-level of techniques, matching communication modalities has been highlighted by the work of Bandler and Grinder (1979) in their Neuro-Linguistic Programming strategies.

Although joining the client and matching therapeutic strategies with their style has received much credence, a lot less attention has been given to developing techniques for a smooth integration from the therapy room back to their real world, independent of the therapist. The importance of personal integration and closure has been stressed by some humanistic therapies, especially Gestalt therapy, and appropriate strategies have been included in their work. However, most therapies do not attend to this aspect very well. This problem seems more acute with the highly influential therapist and the more dependent client.

Refreezing is very much dependent upon whether the change is confirmed, and thereby reinforced back with the client's immediate and significant social contacts. Homework, in-vivo trials and various relationship skills (e.g. assertive training) provide the client with opportunities to practice refreezing and/or deal with any further disconfirmation concerning the change. The most effective therapeutic strategy for ensuring the confirmation of the changes is through involving significant others in the therapy. Couples or family therapy is based not only on the diagnosis of the concern as interactional, but also aims at increasing significantly the chance of any change by one
being accepted and reinforced by the other(s). Refreezing is built on to such a therapeutic strategy.

In conclusion then, this analysis contends that underlying psychotherapeutic strategies and techniques is a common process of change. It has been proposed that the essence of the change that therapy effects, is the redefining of conceptualizations which clients hold. This redefining or restructuring occurs in systematic stages of unfreezing, changing cognitions, and refreezing the change. Therapies and therapeutic techniques can be interpreted as contributors to this change process.

The Synthesis

This dissertation concerns the relative efficacy of the common components of psychotherapy.

The above analysis conceptualizes these common components as: the presenting problem of the client, the interactional dynamics between the therapist and the client, and the psychological treatment techniques employed by the therapist to elicit change. These common components have been analyzed for their essential ingredients. Low self-esteem is proposed as an underlying element of problems presented for therapy. The social influence of the therapist is seen as a potentially powerful dynamic for change and an essential ingredient of the interaction. Change strategies aimed at conceptual shifts in attitudes that persons hold especially concerning themselves, are proposed to be the essential ingredient of therapeutic treatments. In short, the essence of psychotherapy is conceptualized as: enhancing self-esteem through the social influence exerted by the therapist, and therapeutic techniques designed to elicit a cognitive redefinition.
This study examines the relative efficacy of each of these two change components to the extent in which they can be separated from each other. In one situation, the social influence is maximized and conveyed through a therapeutic message to the subjects. No "usual" therapeutic techniques are utilized other than communication - the therapist simply tells the subjects the message. In the other situation, the social influence of the therapist is minimized and therapeutic techniques designed to redefine cognitions are used as the "sole" change agent. These two change components seek to enhance the self-esteem of the subjects.

It is recognized that neither a "pure-techniques" nor a "pure-influence" state can be structured in therapy but only approximated. This study strives, through maximizing one, while minimizing the other, to approach this condition.
CHAPTER II

LITERATURE REVIEW

Self-Esteem

The statement that "Self-esteem has been related to almost everything at one time or another" (Crandall, 1973, p. 45) may appear glib, but in fact does have some substance. In psychological literature, reference to the concept of "self" is extensive and has provided a central focus for much theory, research and practice. The cognizance that William James (1890) paid to self-esteem; the emphasis afforded the 'ego' by the psychodynamic approaches (Freud, S., 1923; Horney, 1945; Freud, A., 1946; Sullivan, 1953; Jung, 1960); the essential core of the phenomenal self, which the field theorists structured (Lewin, 1936; Raimy, 1948; Snygg and Combs, 1949); and the essence of humanism which self-actualization was for the self theorists (Maslow, 1954; Rogers, 1951), all attest to the persistence and increasing pervasiveness of concepts related to the self as a central theme in psychology.

Unfortunately, despite this attention, the concept of self is by no means clear. On the contrary, a review of the literature reveals that the term self, and others relating to it, are often inconsistent and vague in their use, blurred in their distinction from each other and indecisive in their definition. Alternative terms for self are common: ego (Freud, 1923; Sherif and Cantril, 1947; Jung, 1960); the proprium (Allport, 1955) and identity (Erickson, 1956). The nature of the self varies: the essential nature of man (Fromm, 1941; Maslow, 1954); the inner of subjective being (James, 1950); the individual as known to him/herself (Hilgard, 1949; Raimy, 1948; Rogers, 1951);
the core of a psychophysical field (Koffka, 1935; Lewin, 1936); a constellation of attitudes (James, 1950; Sherif and Cantril, 1947); and a mental process related to inner drives (Freud, 1933). To add to this confusion is an abundance of related terms: self-regard, self-esteem, self-image, self-worth, self-acceptance, self-picture, self-attitude, self-evaluation, self-respect.

It is not intended here to attempt to reduce this polyglot to a state of sublime clarity, but in lieu, attempts are made to draw out from the literature aspects of self-esteem which are of relevance to this study.

"Self" Concepts as Attitudes

Concepts of "self" have generally been referred to as attitudes (Wells and Markwell, 1976, p. 64; Burns, 1979). Throughout the literature, definitions of these concepts frequently state them as an aspect of self-attitudes in general. Rogers (1950) referred to "self-regarding attitudes" as the basic units of the self-concept. Rosenberg (1965) described self-esteem as "a positive or negative attitude towards a particular object, namely, Self" (p. 30). In a similar vein, Coopersmith (1967) spoke of self-esteem as an attitude of approval or disapproval concerning oneself. There appears to be in the literature, a consistent reference to concepts of self as attitudes or sets of attitudes.

Although there is by no means a consensus as to the nature of attitudes (Fishbein and Ajzen, 1975), there is some agreement as to the components of which they are composed. Burns (1979) presented four common ingredients of attitudes distilled from a range of acceptable definitions. These are:

1. a belief, knowledge, or a cognitive aspect;
2. an evaluative aspect;
3. an affect or emotional aspect; and
4. a predisposition to respond aspect.

To apply these aspects to concepts of self may provide a functional framework for this study.

The cognitive aspect. Through objective evidence or subjective experience, an individual builds up knowledge, understanding and a set of beliefs or opinions concerning some object or situation. This is the cognitive aspect of the attitude, knowledge or belief the person holds concerning that object or situation. The affective and behavioral aspects associated with these cognitions, may be seen as largely determined by what evaluation the person places on that cognition (Plutchik, 1977). If the evaluation of that cognition is positive (e.g. good, pleasurable, beneficial) then the affect and behavioral response will most likely be different to that elicited by a negative evaluation (e.g. bad, painful, harmful) (Plutchik, 1977). So, what is critical is the evaluation of "good" or "bad", associated with the cognitive aspect.

all action somewhere is evaluated on dimensions which grossly display positive or negative ends.

(Cottle, 1965, p. 70)

Operationally, attitudes may be conceptualized in this way. If the concept of self is conceptualized as an attitude, then it may be interpreted in a manner similar to that of an attitude. A person develops knowledge, beliefs, cognitions concerning him/herself. These may be true or false based either on objective evidence and/or subjective opinions. For example: "I spend a lot of time by myself for I am a
very shy person". Such cognitions form one's self-perception. A global self-perception is formed by the aggregate of many unitary perceptions. In the literature, some would view these perceptions as the self-concept. The self-concept is composed of such elements as the perceptions of one's characteristics and abilities; the percept and concepts of the self in relation to others and to the environment; (Rogers, 1951, p. 136)

It is these perceptions of oneself, the self-concept, that distinguishes the uniqueness of that individual from all others.

The evaluative aspect. What is of significance to this cognitive aspect is the evaluative overtones that are attached to it.

Each person places some kind of estimate upon himself as an object of value. (Shibutani, 1961, p. 433)

What is of importance to the individual is not so much having the cognition itself, but what value that individual places on that cognition. For example, to continue the previously stated self-perceptions, the individual might say: "Being a shy, quiet person is ok, but I don't like being a loner." In the literature reference to this evaluative component is common. James (1890) saw self-esteem being derived from the individual's perceptions of his/her own standing in relation to others in similar positions. Cooley (1902) and Mead (1934) spoke of self-evaluation being determined through how others evaluated the individual. Rogers (1951) stressed the importance of positive self-regard and saw it growing out of the internalization of positive experiences with others. Most writers refer to this evaluative component as self-esteem.

Self-esteem refers to:
The evaluation that 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.

(Coopersmith, 1967, p. 4)

Rosenberg (1965) spoke of self-estimation as "how the individual actually rates himself with regard to a particular characteristic" (p. 246), and that self-esteem "is a positive or negative attitude towards a particular object, namely self" (p. 30). Wells and Markwell (1976) pointed out that self-esteem is currently the most frequently used term for self-evaluative behaviors and generally "observed phenomena" concerning the self. It is often used as the all-embracing self-referring term, covering the concept of self.

The affect aspect. Self-evaluation does not stop with the assessment. Affect and a predisposition to respond usually accompany how a person esteems the whole or some aspects of him/herself. Referring back to the example, the response of the evaluation might sound like, "I feel afraid when I am with people I don't know well. I think it is better to avoid them." The direction of this affect and predisposition to respond in a particular manner, was viewed by Candless (1977), and Plutchik (1977) as being determined by, and consequential to, the evaluation of stimulus, in this case the self-perceptions.

This delineation between evaluation and affection is not always clear and their separation in the manner suggested, is somewhat problematic. The individual's feelings about him/herself are clearly associated with the self-evaluation he/she makes (Wells and Markwell, 1976). Some writers stress the importance of the affect and describe
it in much the same language as the evaluation itself:

The actual self-perceptions are important but....
they are probably secondary to the emotional tone
or the esteem value of the perception.

(Fitts, et. al., 1971, p. 23)

This stance tends to emphasize the cathectic response as more directly
related to a self-attitude than is the evaluative process. Rogers
(1950) speaks of "emotionalized self-attitudes" keying in on this self-
affection. This emphasis usually involves behavioral consequences
which were often seen, especially for Rogers, in adjustment or mental
health terms. However, other writers stress the evaluative process per
se, and in doing so, place emphasis on skills, abilities, behaviors
and personal features, and that individual's assessment of these char-
acteristics. This approach leads to an emphasis on the cognition as the
process involved in making comparisons between the individual's skills
and some other evaluative standard (Wells and Markwell, 1976). This
cognitive evaluation of self was seen to lead to a consequential affect
and a predisposition to respond.

Staines summed up aspects of this view by defining the self-concept
as:

a conscious system of percepts, concepts, and
evaluations of the individual as he appears to
the individual. It includes a cognition of the
evaluative responses made by the individual to
perceived and conceived aspects of himself;

(Staines, 1954, p. 87)

This viewpoint stresses that it is how a person evaluates the percepts
and concepts he/she holds concerning the self, that initiates specific
affective responses and leads to particular behavioral outcomes.

The predisposition to respond aspect. As with affect, the connection,
between self evaluations and a predisposition to respond is not always clear. Essentially, in the literature the self has been viewed by some as a structure within the personality, and by others, as a process within ongoing behavior. It appears appropriate to this study to consider behavioral responses to concepts of self in relation to this dichotomy of structure and process.

For the structural approach, cognitive and phenomenological psychologies have most relevance. Both these theories have as a general basic tenet, that behavior results from an individual's perception of the object or situation (Burns, 1979). Field theory and phenomenology spoke most of the self in this regard.

Lewin (1936) postulated the self-concept as the core of an individual's "life space", and that all behavior arose out of the interaction of this "life space" with the total field. Snygg and Combs (1949) hypothesized a "phenomenal self" and viewed it as holding most of the surface self-perceptions, while the inner core contained the individual's more vital and important self understanding. They suggested that this inner core provided the individual's stable and characteristic organization and formed the self-concept. Together these composed the "phenomenal field" from which all that individual's behavior may be determined. For both Lewin, and Snygg and Combs, self-perceptions were at the core of the life-space and it was through their interaction with the total field that resulted in a particular behavior or a predisposition to respond in a particular manner.

Raimy (1948) added to this approach by defining the self-concept in terms of "a learned perceptual system which functions as an object in the perceptual field" (p. 154). This approach viewed the self-concept
in fully perceptual terms, proposing that behavior was determined through the interaction of the perceptual object in a perceptual field. Rosenberg (1965) followed this structural approach by stressing the organization of the self-cognitions rather than the isolated self-perceptions. He referred to the person as the object of perceptions distinguishing him/her from the perceptions themselves. The perceptions he viewed as cognitions about the object and referred to them as self-images. What appears important to Rosenberg's view of the self-concept is the nature of, and relationship amongst these various self-images. Rogers (1951), although he did not distinguish between the object and content of perceptions, did subscribe to this structural view, speaking of the self-concept as "an organized configuration of perceptions of self" (p. 136). He theorized that the self develops concepts through reflexive thought concerning the percepts, and it is in the context of the evaluation of these concepts and percepts of self that a person develops a predisposition to a behavioral response.

In summary, this stance proposed that the perceptions persons hold concerning themselves form the core which predisposes them to interact with the environment in a particular manner. The emphasis here is on the structural nature of the perceptions, how they are learned, maintained, and changed.

Viewing the self in terms of a process places emphasis on the social context within which the individual functions. The self is seen to emerge out of the interaction with the social milieu reflecting societal influences in its formation.

It was James (1890) who first spoke of the "social-self" and postulated self-esteem as being partially derived from a person's relation-
ships with others. Cooley (1902) placed much more emphasis on this aspect, seeing the self and the society, inextricably entwined. From this perspective, he introduced the concept of the "looking-glass" self; proposing that the individual's self-concept is influenced by how others react to him/her.

A self idea... seems to have three principle elements: the imagination of our appearance to the other person; an imagination of his judgments of that appearance and some sort of self-feeling.

(Cooley, 1902, p. 159)

Mead (1934) developed this approach even further with the idea that the entire social process is contained in the complete self. More specifically, Mead saw a person's self-concept as emerging from social interaction through the process of observing how others react to him/her. The self-concept was viewed as the object through which society is able to exercise control over the behavior of that individual.

It is the social process of influencing others in a social act and then taking the attitude of the others aroused by the stimulus, and then reacting in turn to this response, which constitutes a self.

(Mead, 1934, p. 171)

Of importance to this study are the differential emphases each of these two approaches have, in functional terms, on the self. The structural approach involves cognitive processes and can be described without reference to external interaction. Thus, the self lies essentially within the cognitive structures influencing actual behavior or a predisposition to respond. On the other hand, the process approach stresses the influence social contact has on the self, and the self's dependence on this interaction for its content. This content is manifested through behavioral expression only within the social context. For each of the two approaches there is a different emphasis:
one emphasizes perceptual (cognitive) structures, the other social (influence) processes.

Assumptions concerning self-esteem. For the purpose of this study the following assumptions have been adopted from the literature reviewed above.

1. the concept of self may be conceptualized as a reflexive attitude, or sets of reflexive attitudes.
2. The self-concept refers to the belief, knowledge or cognitive aspects of these reflexive attitudes.
3. Self-esteem refers to the evaluative aspect as it is applied to these self-concepts.
4. An affect response may be viewed as an inevitable consequence of the evaluative aspect of self-esteem.
5. Self-esteem, and the consequential affect, may predispose a person to respond in a particular way.
6. Concepts of the self may be interpreted as being developed, maintained, or changed from a viewpoint of a social influence process and/or through altering perceptual, cognitive structure.

Measurement of Self-Esteem

Conceptualizing self-esteem as an attitude does not of itself, resolve the problem of measurement; it simply inherits the framework, and the difficulties of attitudinal measurement. Self-esteem with its own conceptual difficulties, adds these to an already problematical field. Attitude measurement has a long history of theoretical and methodological problems (Wylie, 1961, 1974). To this condition, self-esteem adds a concept steeped in theoretical vagueness, obscure in its phenomeno-
logical nature, and buried in the ego-related depths of each individual. Nonetheless, these difficulties have not deterred psychology, especially social psychology, to be anything short of prolific in its output on self-esteem measurement. Perhaps this simply attests to the importance of the concept to psychological theory, research and practice.

A survey of the literature indicates that the vast majority of the instruments developed have been of the self-report style, mostly of the paper-and-pencil variety. As well as sharing the usual methodological problems as alluded to above, measuring self-esteem in this manner - one reporting on oneself - has a host of difficulties relating to the inherent private nature of the self. Combs and Soper (1957) highlighted the distinction between the nature of the self-concept, and the nature of the self report of the self-concept: the former is how one sees oneself; the latter, how one reports to another, how one sees oneself. Furthermore, they suggested such functional difficulties as a lack of awareness, a paucity of verbal skills, and unwillingness to disclose such intimate perceptions, as contaminations of such modes of measurement. The problems of measuring self-esteem through self-reports are well documented (Scott, 1968), but what is of importance is to know "at least the limitations and possibilities of such assessment techniques" (Burns, 1979, p. 77).

There are ways other than the self-reports to measure self-esteem. In fact, Wells and Markwell (1976) suggested the self-report style as being the prototype for other self-esteem measures. To them, it is not so much the question of what is the best technique, but more of a question of what is the most appropriate mode of measurement. In selecting
or developing self-esteem measures questions such as:

What behavior does the measuring procedure ask the respondent to perform? How is a score obtained from this behavior? What aspect of self-esteem does the procedure seem (or purport) to index? (Wells and Markwell, 1976, p. 109)

are relevant. The mode of measurement has an obvious and direct connection with how self-esteem is conceptualized. Is the conceptualization such that it views self-esteem as being adequately expressed for measurement through a paper-and-pencil activity? Or, are there other measurable modes of expression?

There has been some development of the observational approach to the measurement of self-esteem. This procedure involves the observation of some aspect or aspects of a person's typical behavior from which inferences concerning their self-esteem are drawn and evaluated. This mode of measurement may lack some of the objectivity of the more standard paper-and-pencil varieties, but as Combs (1965) points out, it allows for greater involvement and sensitive exploration, thus providing a richer data source. The emphasis is more on the observer making inferences, sometimes highly subjective, concerning how that person esteems him/herself, rather than the subject deciding how he/she will report in someone else's terms and framework.

The unstructured interview is by no means an uncommon example of this observational approach to the measurement of self-esteem. There are examples in the literature illustrating various degrees of structure/unstructure. Silber and Tippett (1965) developed a 90 minute face-to-face interview based on open-ended questions with a built-in flexibility in the approach. The interviews were audio-taped and later coded. Bodwin and Bruck (1960) had judges rating the subjects'
interviews on various concepts of the 'self', such as self-confidence and self-liking. They used a 5-point scale. Wylie (1965) examined self-regard through 10 minute personal autobiographies from the subjects. Friedenberg and Gillis (1980) adapted from Davidoff guidelines for judging self-referring statements made by subjects in response to open-ended stimulus questions presented in interviews. These were judged as positive, neutral, or negative to develop a score which he proposed as a measure of some aspect of self-esteem. Obviously, the most common use of this open interview evaluation is in the clinical setting. Therapists and counselors interview their patients and make educated clinical judgments, often as related to the patient's self-esteem. Unfortunately, most examples of the observational interview remain unpublished and unresearched except for being mentioned as validation criteria for already existing self-report measurements (Wells and Markwell, 1976).

This study will utilize three types of self-esteem measurements: a self-report, paper-and-pencil type; an interview, open-ended question style, with systematic coding procedures to assess the responses; and a clinical-type rating following a 10 minute interview.

Changing Self-Esteem

In this study, self-esteem has been conceptualized as an attitude, and, as such, any consideration of change is a consideration of attitudinal change.

Four theoretical approaches of attitudinal change have been presented by McGuire (1969). These include perception theory, functional theory, consistency theory, and learning theory. None of these approaches fully explain attitudinal change with all its contingencies.
Nonetheless, all four of these compliment each other in dealing with the complexities of such change. Insko (1967) presented a thorough and systematic overview of the theories to attitudinal change. These theories, however, have only a broad application to this study, providing a general frame of reference within which attitude change may occur.

As seen above, self-esteem literature provides a dichotomous theoretical perspective. Self-esteem theories were conceptualized as: either a process based on social interaction and influence of others; or a structure in which perception, especially cognitions, were seen as the basic determinants of self-esteem. Adopting this dichotomy, this study views self-esteem change as occurring through either the process perspective - change through the influence of a significant other - or through the structural approach - altering cognitions a person holds concerning him/herself. Obviously, both of these change processes may occur in unison. This study interprets them as components of psychotherapy, both individually, and collectively: changing self-esteem through social influence, through cognitive restructuring, and through cognitive restructuring with social influence.

**Social Influence**

Self-esteem has been conceptualized above, as a process in which the influence of others is viewed as a major function through which self-attitudes are formed. That is, how a person evaluates himself can be influenced by others. From this perspective, it can be argued that a therapist, through his/her influence on the client, may be able to enhance the client's self-esteem. Through structuring high source credibility and attractiveness, the therapist may develop his/
her social influence on the client such that the client may become more receptive to the therapist's message of the importance of esteeming oneself highly. It does appear then, that self-esteem may be open to change through social influence dynamics.

Research Literature on Source Characteristics

Source characteristics have formed a focal point of much empirical work as to their nature and their capacity to influence others towards attitudinal change. This study conceptualizes source credibility and source attractiveness as two social influence dynamics which may be utilized for attitudinal change.

Research findings on these two dynamics are well represented in the literature.

Source credibility. Source credibility has general empirical support in the literature. (Inski, 1967) commented on the consistent trend in the literature, supporting high source credibility as being more influential on the receiver than low source credibility. Greenberg and Miller (1966) further attested to this by ascribing the influential power of high source credibility as a "fairly established generalization" (p. 127). Furthermore, others saw this general finding as not simply relating high source credibility to a high influence condition, but also relating it to subsequent attitudinal change:

The most pervasive general finding is that highly credible communicators produce more attitude change than communicators having low credibility. (Sigall and Aronson, 1967, p. 179)

It has been consistently found in research that a source perceived to have high credibility, does exert more influence to bring about attitudinal changes, than sources perceived to have low credibility.
However, the question as to how much actual learning of the message occurs through source credibility and subsequent attitudinal change, is far from conclusive. Anderson (1966) found that high source credibility, although effecting attitudinal change, was not as effective in inducing the learning of the message as a neutral source, even though the neutral source was less effective in attitudinal change. Acceptance of credibility may blind a receiver to the critical review of the message being presented. A less accepting receiver may examine the message more closely, thus bringing about greater learning (Bauer, 1965).

Source credibility is derived from two components "expertise" - perceived capacity for correctness - and "trustworthiness" - a perceived willingness to communicate this knowledge objectively. The potency of each component in developing influence and producing attitudinal change has been investigated.

A long history of research findings confirming the effectiveness of the expertise component exists. Expertise form the basis of much of the early attitudinal change research. Influence and attitudinal change are both affected by high source credibility derived through expertise.

There is considerable literature showing that the amount of attitude change produced by a given message can be varied by ascribing the messages to sources that differ on such social desirable dimensions as knowledge, education, intelligence, social status, professional attainment, age, etc. (McGuire, 1969, p. 182)

Being perceived as an expert with "correct" information has consistently been shown to develop high source credibility and social influence.

The findings on trustworthiness are mixed, and less conclusive.
Hoveland and Weiss (1951) found more initial influence resulting from high source credibility built on trustworthiness than low source credibility similarly developed. However, there was no difference in message recall between the two groups, and furthermore, a follow-up one month later found the influence effect had dissipated. Hovland and Mandel (1952) cast further doubt on the effect of this dimension by finding no difference in influence between groups structured on high and low source trustworthiness. In contrast, Choo (1964) found that high source trustworthiness did induce attitudinal change. Using the issue of smoking and cancer in his study, Choo may have developed a more personal involvement from his subjects in the change process.

The relative potency of expertise and trustworthiness also has been investigated. Aronson and Golden (1962) had elementary school students rate various communicators delivering a message. Source credibility derived from the expertise dimension was higher than that derived from trustworthiness. Lower levels of influence also resulted from the trustworthiness dimension of source credibility. Generally, literature indicates that the expertise dimension has a greater potency for developing credibility than does trustworthiness.

In summary, the empirical findings generally support the notion that high source credibility does establish high levels of influence and attitudinal change. There is some doubt as to the persistence of that change and the improved learning of the message based on source credibility. Both the expertise and trustworthiness dimensions of source credibility are effective in developing influence, with the expertise dimension showing more potency to do this than the trustworthiness dimension.
Source Attractiveness. Source attractiveness has been investigated on three dimensions: "similarity" between the source and the receiver, "familiarity" between the source and the receiver, and "liking" of the source by the receiver. These three aspects are interrelated. McGuire (1969) initially suggested the relationship may be casual: similarity leads to familiarity which leads to liking. Newcomb (1961) previously had suggested the reverse order. McGuire summed up by describing it as probably making up "a reverberating circuit" (p. 187). The three dimensions are integrally related. The structuring of liking through pre-session inductions is far more feasible than it is for the other two. Similarity and familiarity are more on-going dimensions. For this reason, and because of the group nature of the study, liking is the major focus.

As with source credibility, the obvious hypothesis is that liking the source leads to greater influence from that source. The literature supports this logical observation. McGuire (1969) stated that there is a "certain amount of evidence" to support the hypothesis that liking induces high source attraction and leads to influence and attitudinal change. He cited (p. 192) (French and Snyder, 1959); Griffin and Ehrlich, 1963; Horowitz, Lyons and Parlmutter, 1951; Sampson and Insko, 1964; Sherwood, 1965; Thrasher, 1954; Wallach, Kogan, and Beur, 1962).

Factors involved in liking have been examined. In a study using cosmetically produced attractiveness and unattractiveness, high source physical attractiveness was perceived as intelligent, friendly, assertive, trustworthy, competent and effective (Cash, Begley, McGower and Weise, 1964). Greenberg (1969) studied the warmth dimension. Through
pre-session inductions of subjects he established a warmth or coldness source characteristic. The source presentation was on an audiotape. The warmth induction established significantly more source attraction and receptivity to influence. In a series of studies it was established that source attraction could be successfully induced through inductions describing the warmth of the source (Goldstein, 1971). Other earlier studies support the relevance of warmth for the structuring of liking in source attractiveness (Asch, 1946; Kelley, 1950).

The literature supports source attractiveness as an effective source component in establishing influence on the receiver, and in inducing attitudinal change. Liking, and particularly establishing a perception of the source as a warm person, has been found to produce high source attractiveness.

Source credibility and attractiveness. Some studies have investigated the relative effectiveness of these two source characteristics. Greenberg (1969) structured various combinations of warm/cold, experienced/inexperienced source characteristics through verbal inductions. The effects were measured on the source attractiveness and influence that was elicited, and the persuasive effect of the message on the subjects. The warmth induction developed significantly higher effects on all three variables than did the cold inductions. The experience characteristic was higher on attractiveness and influence, but not significantly different on persuasability. The warmth/experience combination also indicated significantly higher effects on all three dimensions. However, the warmth characteristic produced more attraction and influence regardless of the level of experience, i.e., warm/inexperience
was as effective in developing source attraction and influence as warm/experience. This effectiveness of structuring perceptions of source warmth, gained further support in similar studies by Simonson (1968), and Goldstein and Simonson (1971).

However, Strong and Dixon (1971) obtained results that cast some doubt on this question. Using inductions of attractive/unattractive and expert/inexpert source characteristics, they failed to find influence differences between the attractive/unattractive induction effects. Following up on this situation, they found that the inexpert inducted group, when exposed to an attractive induction showed greater influence than when given an unattractive induction. Strong (1978) suggested that other such studies as cited above, may not have gained induction differences for the attractive/unattractive characteristics because of the overriding impact of the expertness induction.

Clinical Studies of Source Characteristics

Of further importance to this study are the empirical findings as to effects of source characteristics in clinical settings. Some studies in this area have examined the perceived characteristics of professional helpers in terms of developing source credibility and attractiveness. Strong, Handel, and Bratton (1971) found college students perceived counselors as high in source attractiveness dimensions of warmth and friendliness. Schmidt and Strong (1970) investigated the cues students perceived as discriminating experts from inexperts. They found that experts demonstrated such behaviors as attentiveness, confidence, and as being relaxed, organized and systematic: whereas they perceived inexperts did not. Dell and Schmidt (1976) replicated these findings on a wider range of observers. Both studies, however, found
that observers were not able to distinguish experts who were professionally trained, from those who were not. That is, observable characteristics of experts were not necessarily determined by professional training skills, but stemmed more from how a person appears and behaves.

Further, to these studies, trustworthiness was found to be observed through facial expression and gestures (Strong and Schmidt, 1970). Other studies have attested to the importance of non-verbal cues. Kaul and Schmidt (1971), and Roll, Schmidt and Kaul (1972) both reported findings indicating that the counselor's gestures, facial cues, and manner are as equally effective in establishing trustworthiness as is their message content.

There are other aspects of source characteristics that are perceived by clients as enhancing credibility or attractiveness. The title referring to a "psychologist" was perceived by students as denoting more competence in helping with personal concerns than one which referred to counselor (Gelso and Karl, 1974). The use of psychological jargon also increased significantly the subjects' perceptions of the psychological knowledge possessed by the therapist (Atkinson and Carskaddon, 1975).

In the same manner, source credibility may be established for the therapist by having his/her credentials known. Greenberg's (1969) work cited above, used inductions related to the therapist's credentials: Ph.D. and experienced, versus an inexperienced graduate student. He found that the higher credentialed therapist was perceived as having higher credibility, and was described as being more expert and more competent. Similarly, source attractiveness has been structured concerning therapists. Greenberg (1969), also as cited above, developed
higher source attractiveness of a therapist through inductions of warmth and coldness. Both Bergin (1962), and Guttman and Haase (1972), used similar pre-session inductions of high and low source credibility - Ph.D., experienced, in a prestigious clinical setting, versus an inexperienced graduate student in an unattractive room. Bergin found highly significant attitude changes associated with the high source credibility. Guttman and Haase found that the low source credibility subjects indicated a higher degree of real learning effects than the higher source credibility subjects. The latter demonstrated a better memory for the content, but reported the message as not having the same personal impact. These findings suggest that a similar learning differential for high/low source credibility exists in clinical settings, as was stated above from the non-clinical research findings.

Beutler, Johnson, Neville, Elkins, and Jobe (1976) provide further results that are related to source credibility effect. Psychotherapy patients' ratings of their therapist's credibility were found to be positively related to the patient's self-rating of their own improvement. Attitude changes were positively related to the discrepancy in pre-session attitudes between the therapist and the patient. Attitude change was not related to the improvement. These findings suggest, as do those cited above, that credibility is a factor in psychotherapy, but its relationship with other dynamics, especially with change and learning, is somewhat clouded. The fact that credibility does allow the subject to be open to the influence of the therapist - and this usually being a positive, optimistic influence - then, perceiving high source credibility may be providing a "hope", a perceived improvement, a more positive outlook for the client.
The findings of Deutler, et. al., appear to be suggesting this.

Findings concerning the effects developed through source attractiveness appear to be even less convincing than those cited for source credibility. Firstly, developing influence through source attractiveness appears more difficult. Studies using a matching induction, that is, structuring a perception of similarities and dissimilarities between the client and therapist, generally have not been shown to effect source influence. Goldstein (1971) and Spiegol (1976) with college students and counselors, and Cheney (1975) with mandatory detoxification inmates and therapists, all found no source attraction developed through inductions based on matching. Furthermore, Goldstein (1971) found that the warm versus cold inductions with psychiatric inmates did not increase source attractiveness as it did for the non-patient college students.

However, self-disclosure by the therapist of similarities with the clients during the session, appear to develop source attractiveness and influence. Mann and Murphy, 1975; Murphy and Strong (1972) found that immediate self-disclosures by the therapist elicit perceptions of the therapist as having empathy, regard and congruence. The therapist's self-disclosures also induced similar behaviors in the client, and increased the return appointment rate. Likewise, Hoffman-Graff (1975), found that self-disclosure of similarities in procrastination by the counselor, increased procrastinating students attraction to her.

Studies establishing influence effects stemming from source attraction are even less impressive. Schmidt and Strong (1971) successfully structured source attractiveness through similarity self-disclosures and expressing liking and warmth during a counseling interview. How-
ever, they found no significant influence effect. Sell (1974), and Strong and Dixon (1971) cited above, also failed to detect any significant influence resulting from source attractiveness.

In summary, the source characteristics research as related to the clinical setting, appears less consistent than that of the general social psychological work. However, there are significant findings relevant to therapy. To know what nonverbal cues, attitudes, and behaviors clients perceive as belonging to an attractive, trustworthy expert, allows these to be structured so as to develop influence. Status, credentials, and learned psychological jargon, have been effective in building credibility for therapeutic influence. Perceived warmth and friendliness, and on-going self-disclosures, have been demonstrated as effective in establishing attraction of the client to the therapist and developing subsequent influence. In the literature a question of conflict exists in the effects the developed influence has on the acceptance of the "message" from the therapist, and the changes that may result. There are conflicting results in this area which reflect the position of the research into source characteristics effects generally. What may be of real importance in this regard to therapy, is that the change may be in perception the client has of his/her problem, as opposed to the actual change in the problem.

Finally, numerous studies have successfully structured high source characteristics of credibility and attractiveness in therapeutic settings. Through pre-therapy inductions and on-going manipulations during therapy sessions, source characteristics of expertise, trustworthiness, and attractiveness, have been enhanced leading to greater social influence of the therapist.
Cognitive Restructuring

In contrast to the social influence process approach discussed above, self-esteem has been conceptualized from a structural perspective. That is, self-esteem may be viewed as perceptions, conceptions, beliefs, and attitudes one holds about the object, viz., the "self". The emphasis in this perspective of self, is on the perceptual process, especially cognition -- cognitions a person hold concerning him/herself. Changing or enhancing self-esteem then becomes a process of changing or enhancing these reflexive cognitions. Such a process is termed cognitive restructuring.

An Historical and Theoretical Perspective

There are sound theoretical considerations for adopting this approach. The Perceptual Theory views attitude change as a process more akin to changing the perceptions you hold of the object rather than your opinion you have about that object (Asch, 1952). For example, one taste of that round, orange-coloured, piece of citrus fruit may lead you to the opinion that it is a very sour orange. Then the name "grapefruit", printed on the bag, produced a cognitive redefinition, and a new perception which may lead you to the opinion that this is a very tasty and juicy grapefruit. The object and the experience are the same, your cognitive restructuring brought about a perceptual shift, leading you to perceive this piece of fruit in a new light. Your opinion of oranges, sour or otherwise, has not changed. McGuire (1969) referred to this as a "recode (of) his cognitive field" (p. 267). In a like manner, it is hypothesized that self-esteem may be enhanced not so much by changing the opinion you have about yourself, but altering your perspective of that opinion: e.g., "I am lousy at maths, I am stupid!" versus "I am lousy at maths, so what!"
From this perceptual theory the question now becomes one of how do perceptual shifts occur? Cognitive and semantic theories and therapies have grown up around this idea "that we are influenced not by 'facts' but by our interpretation of facts" (Adler, in Meichenbaum, 1978, p. 183). The approach these therapies take is to modify the self-defeating premises and thoughts that underlie the client's cognitions, which may be seen as directly responsible for the disturbed feelings and behaviors. Ellis (1969) points out that it is not so much your mother-in-law or the boss that makes you angry, it is the way you view their behavior. If you perceive their behavior differently, your own emotional reactions will change. Various therapists have adopted this casual connection between reason, emotion and behavior: Dubois (1905); Coué (1922); Low (1050: Kelley (1055); Phillips (1957); Ellis (1962); Lazarus (1972); and Beck (1976).

Internal dialogue. Essential to the cognitive restructuring procedure is the monitoring of one's own "internal dialogue", "inner speech", or "self-talk": in the case of self-esteem, "what you tell yourself about yourself".

For a good part of their waking life, people monitor their thoughts, wishes, feelings, and actions. Sometimes there is an internal debate as the individual weighs alternatives and courses of action and makes decisions. Plato refers to this phenomenon as an "internal dialogue."

(Beck, 1976, p. 176)

The significance of internal dialogue is the role it plays in influencing cognitive structures and behaviors. Sokolov (1972) stresses inner speech as being "instrumental in the logical processing of sensory data, in their realization and comprehension with a definite
system of concepts and judgments" (Sokolov, 1972). That is, the inner speech or internal dialogue, is indicative of cognitive structures - "a definite system of concepts and judgments" - and must be taken into consideration in the change process (Meichenbaum, 1978). Neisser (1962) describes cognitive structural changes occurring through three stages: absorption of new cognitions to effectively contain the old; displacement of old cognitions to be accompanied side-by-side with the new; and integration with new structures comfortably coexisting with the old. This approach reflects closely Schein's model of change presented above. It is postulated that the internal dialogue's script is written by the cognitive structures, and changing these structures, changes the script. In a reciprocal manner, changing the inner dialogue, not simply the words but more the word-skills, changes the cognitive structures (Meichenbaum, 1978).

The connection between internal dialogue and behavior is problematic. The simple, sequential model connecting thought, emotion, and behavior presented so far in this study, is more of a model of change than it is of usual functioning. Emotional and behavioral reactions are typically automatic reactions and not always dependent upon thinking, before we feel or act. Beck (1976) speaks of "automatic thoughts" in this case, to describe internal dialogue that emerges so automatically and idiosyncratically. Most social interactions take place on a habit basis and rather than cognitions directing them, other factors such as time, mental energy, and redundancy of contact are more likely determinants (Thorngate, 1976). The significant point for cognitive structures, and internal dialogue, is that, although we don't always think before we feel and act, to change an emotional or behavioral
response we must think (Meichenbaum, 1978). Registering the cognitions on which a person's reactions are based, through monitoring internal dialogue, de-automatizes the process. This then, enables new, more adaptive cognitions to be restructured so that change occurs.

Therapies. Cognitive restructuring has spawned much therapeutic intervention both informally and formally. When a person has a problem others usually try to tell them what to do, or talk them out of some crazy idea, or help them see reason or common sense. This is a fairly typical way human beings assist one another. Some therapists have formalized this process, mostly involving an internal dialogue intervention within their particular framework. Albert Ellis (1970) and Ellis and Harper (1961) incorporate identifying, challenging, and changing irrational statements on which a person operates, through monitoring what they are telling themselves about the situation. Beck (1970, 1974) developed a cognitive restructuring therapy based on identifying faulty thinking patterns in what a person is telling himself/herself, which results in selective attending to, and inaccurately anticipating consequence.

At the same time, others came at cognitive restructuring through internal dialogue, from a whole different framework. Behaviorally oriented therapists and researchers were employing inner speech in skill development programs. Adopting similar strategies from interpersonal instruction and learning, an intrapersonal self-instruction model was developed utilizing inner speech of self-talk. McKinney (1973) saw the process as 1) identifying the stimulus attributes; 2) directing the subjects focus on relevant dimensions; 3) aiding in hypotheses formulation; and 4) maintaining information in short-term memory. The
tact, techniques, and terminology are different, but essentially the
process is similar, and new programs developed. Goodman and Meichen-
baum (1971), and Bugenthal, et. al., (1975) employed self instructional
procedures in working with hyperactive children. Meichenbaum (1975)
developed and used a comprehensive program of self-statements and self-
instructions with non-creative college students. Meichenbaum and
Cameron (1973), used a similarly based program and successfully taught
schizophrenics to use private speech overtly to cope with sensory
motor tasks. The patients learned to monitor both their own and others'
behaviors in order to covertly emit task - relevant self-instruction.

The development of coping skills, especially for stress reactions,
based on internal dialogue, increased rapidly. In programs on public
speaking anxiety, test-anxiety, and managing stress generally, the cen-
tral change mechanisms was organized around altering self-defeating ego-
related statements, to statements that were task-related, skill based,
and generally positive. Meichenbaum's (1976) "Stress-Innoculation
Training" is a comprehensive coping-skills program incorporating self-
statements in a context of behavioral learning techniques. The compon-
ents of the program include:

1. Teaching the client the role of cognitions in contributing to
   the problem either through Ellis's Socratic logic or guided
   self discovery;

2. Training in the discrimination and systematic observation of
   self-statements and images and in self-monitoring of maladap-
   tive behaviors;

3. Training in the fundamentals of problem solving (problem defi-
   nition, anticipation of consequences, evaluating feedback);

4. Modeling of the self statements and images associated with both
   overt and cognitive skills;

5. Modeling rehearsal and encouragement of positive self evalua-
   tion and of coping and attentional focusing skills;
6. The use of various behavior therapy procedures, e.g. relaxation training, coping imagery training and behavioral rehearsal; and


The program is conducted on a three stage model: Stage 1 - the education phase; Stage 2 - the rehearsal phase; Stage 3 - the application training. This represents a treatment program whose process is essential cognitive restructuring but whose procedures are very much behavioral. From such different tactics as Perceptual Theory and traditional Learning Theory has emerged a Cognitive-Behavior Therapy.

Cognitive-Behavior Therapy

It has been with a good deal of resistance, especially from traditionalists in the behavioral camp (Goldiamond, 1976; Skinner, 1977; Wolpe, 1978; Ledwidge, 1978), that the merger of these two therapeutic procedures has happened. It appears to have evolved through the cognitive therapists reacting to their initial paucity of techniques, and some behaviorists, throwing off the shackles of the Stimulus-Response framework to delve into mediational processes in their continued attempt to modify behavior.

It is significant from the common components perspective which this study has adopted, that Donald Meichenbaum (1978), who first dared to merge the two words cognitive-behavior, chose to quote Jerome Frank at the time of the merger:

The attempt to describe features common to all forms of psychotherapy requires consideration of a wide variety of patterned personal and social interactions. To keep our bearing in this exploration, a general conceptual framework is needed.

(Frank, 1974, p. 24; in Meichenbaum, 1978, p. 215)
Essentially, this conceptual framework for change is what Meichenbaum and cognitive-behavior is about, and is approached very much from a technology-for-change viewpoint. What is the process of change and what techniques elicit that change? The process of change is cognitive restructuring: the technology is behavior therapy.

For Meichenbaum, the scenario is a three phase model of behavior change involving the interaction of internal dialogue, cognitive structures, and behavior and their resultant outcomes:

If an individual is going to change his pattern of responding, he must introduce an intentional mediational process... (and this) involves the recognition of maladaptive behavior... which must come to elicit inner speech that is different in content from that engaged in prior to therapy. The altered private speech must then trigger coping behaviors... (for which) the technology of behavior therapy is of particular value.

(Meichenbaum, 1978, p. 218 - 219)

The model has marked similarities to that of Schein as discussed in detail in Chapter 1. It consists of:

**Phase 1: Self-Observation.**

The client observes his/her own behavior through heightened awareness and deliberate attention.

Comment: Similar to Schein's Unfreezing Stage, in particular disconfirmation, and not unlike what most therapies do in their own way.

**Phase 2: Incompatible thoughts and behaviors.**

The client learns cognitions and behaviors that are incompatible with the present ones.

Comment: Again similar to Schein's Change Stage in which new information is gained to challenge and redefine old cognitions.

**Phase 3: Cognition's Concern Change.**

The client introduces the new cognitions and behaviors into his/her everyday world and assesses the behavioral outcomes.
To this author, cognitive-behavior therapy provides a comprehensive model for therapeutic change whose process is cognitive restructuring and whose procedure emphasize the technology of behavior therapy.

The Study

This study concerns the relative efficacy of the common components of psychotherapy. These components have been conceptualized as:

- The problem component;
- The interactional component; and
- The treatment component.

Self-esteem has been distilled out as the essence of the problem component and will be the dependent variable for the study. Conceptually, development of self-esteem was viewed as a dichotomy of either, a process involving social interaction with others, or as a perceptual structure involving the cognitions concerning one's self. This being the case, enhancement of self-esteem may be approached through either social influence, or cognitive restructuring. Each of these two dynamics relate back to the common components of psychotherapy: the interactional component, and the treatment component, respectively. These two common components now form the central focus for the development of treatment programs aimed at enhancing self-esteem. The interactional component bases its treatment on social influence which is developed through building high source expertise, trustworthiness and attractiveness. It minimizes all "usual" therapeutic techniques, as it maximizes the interactional component. The technique component utilizes cognitive-behavior strategies for its treatment, and minimizes the interactional component as it maximizes the treatment techniques. The
treatment effects on enhancing self-esteem are measured in three ways: a paper-and-pencil self report, an interview rating, and analysis of self-referring verbalizations. The relative efficacies are assessed by comparing these various treatment effects.
CHAPTER III

METHOD

Subjects

The subjects for this study were drawn from students enrolled in an introductory psychology course at Oregon State University. One hundred and ninety-seven male and female students were given the Personal Orientation Inventory (POI), Shostrom (1966), and four groups of 20 subjects were formed, matched according to their self-regard and self-acceptance scores on the POI. To do this, subjects were initially rank ordered on the basis of their self-regard score with the lowest 120 scores forming a pool of the prospective subjects. These students were then divided into two groups, viz., low and average self-regard. The low self-regard group were those who fell less than one standard deviation below the mean. The others formed the average self-regard group. The self-acceptance scores of these 120 students were then divided into low, average and high categories according to the centile rankings of 25th, 75th, 100th respectively. The self-regard and self-acceptance categories were then combined to form six categories: low (self-regard), low (self-acceptance); low, average: low, high: average, low; average, average; and average, high. Subjects were then randomly allocated to four groups matched by numbers from each of the six categories. 80 subjects (20 by 4) made up the four groups and the others were discarded. Each of the four matched groups contained 1 low low, 2 low average, 2 low high, 4 average low, 9 average average, and 2 average high. An analysis of variance of the means of self-regard scores indicated that there was no significant difference across the four
groups. It was then assumed that each group was matched with each other group according to self-regard and self-acceptance as measured by the POI.

Treatments

This study utilized four treatments - three experimental treatments and one control treatment. The three experimental treatments were all aimed at enhancing the self-esteem of the subjects. One treatment stressed "specific" therapeutic techniques based on cognitive-behavior strategies, and was delivered under conditions of minimum social influence as induced by a pre-session minimal social influence induction. The second treatment emphasized "non-specific" factors and was based on maximizing the social influence of the therapist on the subjects induced by a pre-session maximum social influence induction. The third treatment consisted of the identical cognitive-behavior program as in Treatment 1, but conducted under maximized social influence conditions induced by a pre-session social influence induction. The fourth treatment was the control treatment which received no therapy of any kind. The interpersonal contact between the therapist and the subjects in the control treatment was minimized.

Treatment 1. The cognitive-behavior therapy was based essentially on the work by Meichenbaum (1978). It aimed at enhancing the subjects' self-esteem by the cognitive-restructuring of self-deprecating statements, as evidenced in their internal dialogue, into new, and realistically positive, self-statements. These new positive self-statements were then incorporated into the subjects' general attitude towards him/herself using a series of behavioral techniques. The treatment was conducted on a group basis for three one-hour sessions.
The major stages involved:

Session 1

Unfreezing Stage: Learning your self-deprecating thoughts.

Each subject:

. identifies a situation in which they feel inadequate, insecure or threatened;
. learns how to monitor internal dialogue associated with this situation; and
. identifies self-deprecating internal dialogue concerning that situation.

Session 2

Change Stage: Developing positive selfstatements and incorporating them into internal dialogue.

Each subject:

. challenges self-deprecating internal dialogue;
. alters these negative statements to positive self-esteeming statements; and
. rehearses these new statements as internal dialogue.

Session 3

Refreezing Stage: Behavior rehearsal and application of new positive self-statements.

Each subject:

. role plays a threatening situation using appropriate positive self-statements;
. monitors thoughts, feelings and behaviors; and
. new learning concerning positive self-statements and esteem were discussed in small groups.

The treatment was delivered in a cognitive-behavior therapy format and involved techniques of modeling, imagery, self-monitoring, didactic learning, relaxation training, guided imagery, graduated learning, role playing, structured homework and workbooks. No reinforcement schedule was used. Verbal reinforcement was emphasized by the therapist.

Prior to each session of this treatment, a minimum social influence induction was given. This involved the introduction of the ther-
apist in neutral terms. This was delivered by a high source credibility - an academic departmental chairperson. The aim of the induction was to minimize as much as possible, any influence effect of the therapist. A full text of the induction is included in the next section. Furthermore, in the delivery of this treatment, the therapist adopted the stance of an instructor implementing a program based on a series of concrete tasks which he introduced, taught, and provided practice for in a class-style atmosphere. At all times, the therapist endeavored to conduct himself in a technically competent manner. Thus, further minimizing the therapist's social influence in an endeavor to isolate the power of the techniques in the therapy. The program was developed by the therapist (experimenter). The therapist's manual and the subjects' workbooks (Appendix 1.1) were closely followed throughout the program.

Treatment 2. This treatment was based on the social influence of the therapist. Essentially there were three components:

- a social induction prior to each session to maximizing the influence of the therapist;
- a further reinforcement of this influence through personal interactions structured by the therapist during the therapy; and
- a therapeutic message concerning the importance of self-esteem.

The social induction was based on source credibility and attractiveness with "expertise", "trustworthiness", and "liking" dimensions being developed. It was delivered from a position of high source credibility, the inductor as before was the academic departmental chairperson. A full text of the induction is included in the next section.

The social influence of the therapist was initially presented
through the above mentioned social inductions. The maintenance and development of this influence was attempted through the personal interactions of the therapist with the subjects. Influence enhancing "tactics" were employed by the therapist at appropriate times through the therapy, both at a group and individual level. Tactics that sought to increase source attractiveness included: a warm, open, friendly, attentive and involved manner (liking); appropriate self-disclosures (familiarity); and using personal examples from the therapist's student-life (similarity). Source credibility tactics consisted of: appropriate examples to illustrate content points drawn from professional case work, workshops, and conferences; subtle references to status positions and responsibilities held in professional roles (expertise); and the adoption of the attitude of a free, objective willingness to share the information (trustworthiness). In this way, the influence context of the therapy was built.

Finally, the therapeutic message was presented in the above-mentioned context of structured social influence. The message contained information on three themes, one for each session. They were:

1. the intrinsic value of each individual human being;
2. the interconnectedness of each person with all things and the value of this; and
3. how literature supports the importance of each person having high self-esteem.

Homework was prescribed after each session, mostly to match as closely as possible the procedures of Treatment 1. It consisted simply of the subject recording what he/she learned of importance in each session. A full text of the treatment is included in Appendix 1.2.
Treatment 3. This treatment involved the cognitive-behavior therapy program as described in Treatment 1 but this time conducted under conditions of social influence as induced by the maximum social influence induction used in Treatment 2. No other aspects of the treatment varied.

Treatment 4. The control treatment consisted of a series of three movies with a "general psychological" theme without reference to self-esteem, therapy, or social influence. The movies were: Madness and Medicine; Man, The Incredible Machine; and Plato's Drinking Party - see Appendix 1.3 for details. These were presented without any social influence inductions and under conditions of minimal interaction with the therapist. Homework consisted of each subject writing his/her reaction to each movie.

All treatments were conducted in groups under similar environmental conditions. The spacing of the sessions for each group was identical and the general format followed by each group was matched as closely as possible.

The therapist was the experimenter and the writer of the therapeutic programs being conducted. He was 39 years old with a M.S. in Counseling and had had 12 years experience in full-time counseling and therapy mostly on college campuses. He was not present at any of the induction and was blind to which inductions were being made to which group. He was well known to the inductor.

Social Influence Inductions

Social influence inductions were delivered prior to each therapeutic treatment session in accordance with that treatment program.
The inductions aimed at developing pre-treatment perceptions by the subjects of the therapist, as having either high or low source characteristics of credibility and attractiveness. In this way, levels of social influence were hypothesized to be structured as being maximized or minimized.

The inductor was a 41 year old male Associate Professor and Program Director of Counselor Education at Oregon State University. He holds a Ph.D. in Counseling Psychology. He was introduced to each group as:

Dr. (full name)  
Department Chairperson:  
Coordinator of Counselor Education; and  
Director of this research project.

The following are the actual inductions given:

Minimal Social Influence Induction:

Session 1:

"One of my students, (name), a graduate student in Counseling, is going to try out with you as a group a new program he has designed to see if it works. I think this is the first time this student has presented it so he might be a bit unsure of himself and a bit mechanical at times for he seems to be a clinical type of person. Don't be put off by him. Anyway, I suggest you give it a try and see how it turns out for you."

Session 2:

"Well, how did it go? If you found (first name) was a bit unsure and dry in his presentation, remember this is new for him too and basically he is no expert in it either. It may have something in it so give it another go and try to overlook (first name) lack of expertise in running his program."

Session 3:

"Well, this is the final session, hang in there and see what happens."
Maximum social influence induction:

Session 1:

"It is with pleasure and confidence that I introduce (name), a visiting Counseling Psychologist, who is going to run the three sessions with you. (First name) has 12 years experience in clinical psychology, counseling, and psychotherapy, both here in the U.S. and in home country of Australia. At present he is the senior counselor and directing a college counseling service in Australia. On this visit here to OSU, this university has been fortunate enough to employ him in personal counseling on this campus. He is particularly interested in the self concept and stresses the importance of positive thoughts and feelings persons hold about themselves for dealing with life problems. This has been the major focus of much of his therapy, and he has developed many skills in helping persons to think and feel better about themselves, thus enabling them to cope more readily with their life hassles. He has devised a very interesting and promising program for you and I think you are indeed fortunate to be the recipients. I am sure you will all benefit from (first name) expertise. Besides this, I find him a most personable, easy going and likeable guy, who is friendly and approachable. I am sure you will enjoy him and benefit from his program."

Session 2:

"Well, I'm sure you found the first session interesting and worthwhile and (first name) very capable. He was telling me during the week about some of the extensive professional experiences he has been involved in. He has run numerous intensive workshops in the past 12 months, most of them dealing with the central issue of the self concept. He has had some remarkable successes in this regard. Hey, I told you he was a friendly guy. I'm sure you found him that way. Anyway, he is back today with your second session. Enjoy it and continue to get much benefit from it."
Session 3:

"Well, (first name) is going to wrap up this three session program today. Judging from how you answered the questionnaire the other day, (first name) and his program are making some impact on you. Most of you experience him as I do, a friendly person, and most competent in his work. Well anyway, he is going to tie things up today. I'm sure you will all continue to enjoy (first name) and take advantage of his expertise."

Measures

The Personal Orientation Inventory (POI), Shostrom (1966) and, in particular, the Self Regard Scale (S_R) and the Self Acceptance Scale (S_A) were used for selection of subjects and matching of the groups. The POI consists of 150 items each presenting a choice between two statements reflecting values and behaviors thought to be of importance in the development of an individual's self actualization. The items are scored twice to produce two basic scales: one of personal orientation (Time Incompetence/competence (T_I/T_C), and Other/Inner Directedness (O/I)); and a second basic scale consisting of ten subscales each measuring a conceptually important element of self actualization. The S_R and S_A scales are two of these ten scales. The S_R consists of 16 items (X = 11.5, SD = 2.2); the S_A has 26 items (X = 13.7, SD = 3.1) (Jenkins, 1966). The S_R scale measures "affirmations of self because of worth and strength", the S_A scale measures "affirmations or acceptance of self in spite of weaknesses or deficiencies" (Shostrom, 1964).

The POI was developed using the statements of observed value judgments of clinically troubled patients as reported by therapists in private practice. The resultant items all fit within the research and theoretical formulations in Humanistic and Existential Therapy.
Statistical validation evidence is presented by Shostrom (1964) when he compared the POI results against groups clinically-judged as being significantly different in levels of self-actualization. The POI overall and the $S_R$, $S_A$ scales particularly, discriminated significantly (.01 level).

Correlations of the POI with other scales further support its validity. Shostrom and Knapp (1966) report POI scales to be generally "consistent in the direction and significance" against certain scales of the Minnesota Multiphasic Personality Inventory (MMPI). The Depression Scales of the MMPI appears to have most meaning for the POI suggesting that the related POI $S_R$ and $S_A$ scales ($r = -.4$) are tapping "emotional morale". In this study an advanced therapy group was seen to have higher self-regard ($S_R$) and inner direction (I). In a study of test-retest reliability over a one week period, $S_R$ and $S_A$ scores correlated at .75 and .80 levels, while the two basic scales I and $T_C$ showed correlations of .84 and .71 respectively. The POI has been normed on a wide variety of populations, the norms of relevance to this study are based on a sample of 2,607 entering college freshmen at Western and Midwestern liberal arts colleges, 1,514 males and 1,093 females.

The Tennessee Self Concept Scale, Fitts (1964), was used to measure the treatment effects on the self-esteem of the subjects. The scale consists of 100 self-descriptive items, of which half are stated positively, half negatively, to obviate acquiescence, and which are responded to on a five-point scale ranging from "completely true" to "completely false". The scale was devised to measure how an individual perceives him/herself, which was thought to be influential in much of
his/her behavior and directly related to mental health. The scale consists of two subscales: Self Criticism (SC), composed of 10 items from the L scale of the MMPI which are mildly derogatory, and to which most people admit to being true; and the Positive Subscale (P) consisting of 90 items, constituting measures of eight aspects of the self-concept, and providing an overall measure of self-esteem. The whole scale is an untimed self report taking up to 20 minutes to complete.

Initially, the scale was developed through seven clinical psychologists' perfect agreement on items finally included and further validated through studies of discrimination between known groups. Fitts (1964) reports significant differences at a <.001 confidence level were found between patient and non-patient groups. He reports other studies with similar findings (Congdon, 1958; Piety, 1958; Havener, 1961; Wayne, 1963). Studies relating it to other scales generally show positive significant correlations: McGee (1960) with the MMPI; Sundby (1062) with the EPI. Fitts (1964) reports its test-retest reliability over a two week period ranged from .75 for the SC scale to .92 for the P scale (Counseling form). Congdon (1958) obtained a .88 correlational coefficient for the P scale. The test has been normed on a broad sample of 626 persons aged 12-68 years representative of the general population.

A Social Influence Induction Scale (called Session Evaluation Form for presentation to subjects) was used to assess the impact of the inductions, and the persistence of this impact over the three treatment programs. Tape Evaluation Form (Friendenberg and Gillis, 1980) was adapted to form this scale (see appendix 2.1). It consists of three items:
an open-ended invitation to state the message of each session; the degree of acceptance of that message; and the evaluation of the therapist (group leader) as to 12 characteristics based on the source characteristics of expertise, trustworthiness and attractiveness. The latter two items were incorporated on 100mm bipolar scales (10, 1 cm points) adopted from Norman (1976) and used by Freidenberg and Gillis (1980). A test-retest reliability coefficient of .88 and .92 was established by the experimenter for items two and three over a one week period (N = 30).

A ten-minute individual interview with the stated purpose of encouraging each subject to talk about him/herself was conducted by trained interviewers under standardized guidelines (see Appendix 2.2). This provided two measures of self-esteem. Firstly, the interviewers judged each subject’s attitude to him/herself, according to as the interviewer experienced them in that interview, on a 10-point scale (10 very high, 1 very low). Secondly, a tape of each interview was analysed by an independent sophisticated evaluator to identify self-referring statements, and to classify them according to their positive or negative content. Criteria for rating self-referring statements developed by Davidoff (1969) and modified by Friedenberg and Gillis (1980) provided the guidelines for this analysis (see Appendix 2.3).

The seven interviewers were either practicing counselors or masters degree students in counseling. They were selected from volunteers as competent interviewers and instructed by the experimenter in the interview format to be followed. All interviewers were blind to the nature of the study and the treatment groups from which the interviewees came. An intrajudge reliability coefficient (alpha = .89) was established.
The evaluator of the audio-taped interviews was a 23 year old post-graduate student in psychology who was paid a fee for his services. He was blind both to the full nature of the study and to the various treatment groups from which each subject came.

Hypotheses

The specific hypotheses for the study are stated as follows:

1. Subjects receiving maximum social influence inductions perceive the therapist as having higher levels of source characteristics than subjects who received the minimal social influence inductions under similar treatment conditions.

2. Subjects receiving maximum social influence inductions, whether receiving further influence treatments or not, show higher levels of source characteristics than all other subjects.

3. Subjects receiving maximum social influence inductions show more acceptance of the treatment message than those who received the minimal social influence inductions.

4. Subjects receiving cognitive-behavior therapy treatment under conditions of minimal social influence inductions - maximized specific factors and minimized non-specific factors - show higher levels of self-esteem than subjects in the control no-treatment group.

5. Subjects receiving a therapeutic message under conditions of maximum social influence inductions - minimized specific factors and maximized non-specific factors - show higher levels of self-esteem than subjects in the control no-treatment group.
6. Subjects receiving cognitive-behavior therapy under conditions of maximum social influence inductions - maximized specific factors and maximized non-specific factors - show higher levels of self-esteem than subjects in the control no-treatment group.

Procedures

Of the four matched groups, one was randomly designated as a control group, the other three became the experimental groups. Each group participated in three, one-hour treatment sessions similarly spaced over the same two week period. The individual group treatments were as follows:

Group 1 - Experimental

A therapeutic program based on cognitive-behavior therapy under conditions of social influence minimized by inductions and the impersonal approach of the therapist and aimed at enhancing self-esteem - Treatment 1.

Group 2 - Experimental

A therapeutic program based on cognitive-behavior therapy delivered as in Treatment 1 but with increased social influence of the therapist through maximum social influence inductions, and aimed at enhancing self-esteem - Treatment 2.

Group 3 - Experimental

A therapeutic program based on the maximized social influence of the therapist with the therapeutic message of the importance of self-esteem being delivered. No "usual" therapeutic technique other than "talk" was utilized - Treatment 3.

Group 4 - Control

A non-therapeutic program consisting of three movies - one each session. Each movie was related to psychology generally but unrelated to therapy, self-esteem, and social influence. The therapist's interaction with the subjects was kept to a minimum - Treatment 4.
Essentially the procedure that was followed for each session of all three experimental groups consisted of:

1. a social influence induction given by the inductor with the therapist not present;
2. the therapeutic treatment according to the prescribed procedures;
3. instructions for between sessions homework; and
4. a measure of the impact of the social influence of the therapist - first and third sessions only.

The control group's treatment procedure differed in that no social induction nor therapeutic treatment was administered, otherwise the procedure was similar. It involved the screening of a movie, the instructions for between sessions homework, and a measure of the social influence of the therapist for the first and third sessions.

The cognitive-behavior therapy administered to Groups 1 and 2 was standardized as much as possible in both content and manner of presentation. The therapist was blind to the nature of the social influence inductions given to Groups 1 and 2 whilst being aware of the maximum social influence inductions given to Group 3. All groups used a similarly presented workbook format for their in-session work and between sessions homework. The content varied in accordance with content of treatment program.

The following measures were used:

1. Social Influence Induction Scale was used to measure the impact of the social influence of the therapist and the degree of message acceptance for all groups at the conclusion of each of the first and third treatment sessions.
2. The Tennessee Self-Concept Scale was administered in random order on an individual basis to all subjects three days after their final treatment. It gave measures of the subject's total self-concept and a self-criticism score.

3. The individual interviews were conducted with each subject by a trained interviewer immediately after completing the Tennessee Self-Concept Scale. The interview provided three scores: an interviewer rating as to the subjects self-esteem, and a frequency of positive and negative self referring statements.

The data was collated and analyzed in a series of one-way analyses of variance to test for significant difference amongst groups on measures of self-esteem. A .05 level of probability was tolerated. When significance was detected amongst the groups, a Tukey - HSD Multiple Comparison procedure was utilized to locate the between group differences. Paired T-tests were used to detect any significant changes in the source characteristics within and between groups over the three treatment sessions.
CHAPTER IV

Results

The hypotheses for this study are organized on three levels:

1. Questions as to the success of structuring varying degrees of social influence in therapy - Hypotheses 1, 2;
2. A question as to the effect of social influence on the acceptance of the therapeutic message - Hypothesis 3;
3. Questions as to the relative efficacy of therapies with maximized and minimized techniques and social influence, specific and non-specific factors - Hypotheses 4, 5, 6.

Although the relative efficacy questions are central to this study, they only become so, through the successful manipulation of the social influence. Thus is the vital relevance of the first two questions.

Hypothesis 1:

Subject receiving maximum social influence inductions will perceive the therapist as having higher levels of source characteristics than subjects who receive the minimal social influence inductions under similar treatment conditions.

Groups 1 and 2 both offered cognitive-behavior therapy under similar conditions of treatment. They differed in the social influence inductions administered: Group 1 was given a minimal social influence induction, while the induction administered to Group 2 aimed at maximizing the social influence. Tables 1 and 2 set out the statistically significant differences found to exist between Group 1 and Group 2 on measures of the characteristics of the therapist as perceived by the subjects. There are twelve source characteristics grouped under three dimensions - Expertise, Trustworthiness, Attractiveness - with each dimension having four of these characteristics.
Table 1 contains data collected after Treatment Session 1, while the data in Table 2 were collected following Treatment Session 3.

Table 1 shows that there are statistically significant differences existing between Groups 1 and 2 in all twelve source characteristics measured after Treatment Session 1. All but one of these differences was at a probability level <.0001; the other one was at p < .001 level. Table 2 indicates that nine of the twelve source characteristics retain that significant difference to the end of the third treatment. Seven of these characteristics had a probability level of < .0001, while the other two showed a p < .001. There are no statistically significant differences in the three source characteristics - honest, pleasant, and friendly - in the second testing, i.e., the post-treatment session 3 evaluation. In all cases, the significant differences between the means are in the direction of the maximum social influence induction.

These data show that there is a difference in the perceived source characteristics between Groups 1 and 2. With the cognitive-behavior therapy treatment being similar for both groups, this difference in the perceived source characteristics can be attributed to the effects of the maximum and minimal social influence inductions. In all cases where differences exist, the subjects receiving the maximum social influence inductions perceived the therapist as having a higher level of expertise, trustworthiness, and attractiveness than did the subjects receiving the minimal social influence inductions. These findings support Hypothesis 1 - the social influence inductions have manipulated statistically significant differences (p < .05) in the perceptions of the therapist in the direction predicted.
TABLE 1


**POST-TREATMENT SESSION 1**

<table>
<thead>
<tr>
<th>Source Characteristics</th>
<th>Group 1</th>
<th>Group 2</th>
<th>F-Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean (Stand. Dev.)</td>
<td>Mean (Stand. Dev.)</td>
<td>F-Ratio</td>
</tr>
<tr>
<td>EXPERTISE</td>
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<td></td>
<td></td>
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<tr>
<td>Skilled</td>
<td>7.50 (1.3572)</td>
<td>9.10 ( .7881)</td>
<td>22.960 *</td>
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<tr>
<td>Informed</td>
<td>8.05 (1.3169)</td>
<td>9.30 ( .8013)</td>
<td>17.862 *</td>
</tr>
<tr>
<td>Professional</td>
<td>7.55 (1.6694)</td>
<td>9.15 ( .9333)</td>
<td>7.870 *</td>
</tr>
<tr>
<td>Competent</td>
<td>7.55 (1.5720)</td>
<td>9.40 ( .6806)</td>
<td>18.832 *</td>
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<tr>
<td>TRUSTWORTHINESS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trustworthy</td>
<td>7.85 (1.2258)</td>
<td>9.20 (1.0052)</td>
<td>14.459 *</td>
</tr>
<tr>
<td>Honest</td>
<td>8.35 (1.3098)</td>
<td>9.35 (1.7452)</td>
<td>10.076 *</td>
</tr>
<tr>
<td>Acceptable</td>
<td>8.45 (.9445)</td>
<td>9.60 (.5982)</td>
<td>12.672 *</td>
</tr>
<tr>
<td>Dependable</td>
<td>7.70 (1.0311)</td>
<td>9.05 (1.0501)</td>
<td>9.623 *</td>
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<tr>
<td>ATTRACTIVENESS</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Pleasant</td>
<td>8.60 (.9947)</td>
<td>9.40 (.5982)</td>
<td>12.880 *</td>
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<tr>
<td>Approachable</td>
<td>7.80 (1.2814)</td>
<td>8.85 (1.3485)</td>
<td>7.499 **</td>
</tr>
<tr>
<td>Friendly</td>
<td>8.45 (.9987)</td>
<td>9.35 (.7452)</td>
<td>9.033 *</td>
</tr>
<tr>
<td>Warm</td>
<td>7.30 (1.7502)</td>
<td>8.65 (1.3089)</td>
<td>11.809 *</td>
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</tbody>
</table>

* Significant at the .0001 level
** Significant at the .001 level
TABLE 2


POST-TREATMENT SESSION 3

<table>
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<th>Source Characteristics</th>
<th>Group 1</th>
<th>Group 2</th>
<th>F-Ratio</th>
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<td>Min. S.I. Ind.</td>
<td>Max. S.I. Ind.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mean (Stand. Dev.)</td>
<td>Mean (Stand. Dev.)</td>
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<td>EXPERTISE</td>
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<tr>
<td>Skilled</td>
<td>7.60 (1.1425)</td>
<td>9.00 (1.2978)</td>
<td>15.532 *</td>
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<tr>
<td>Informed</td>
<td>8.10 (1.0208)</td>
<td>9.25 (1.0697)</td>
<td>27.082 *</td>
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<tr>
<td>Professional</td>
<td>7.70 (1.2183)</td>
<td>9.35 (.7452)</td>
<td>19.570 *</td>
</tr>
<tr>
<td>Competent</td>
<td>7.80 (1.2814)</td>
<td>9.35 (.7452)</td>
<td>18.938 *</td>
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<td>TRUSTWORTHINESS</td>
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<tr>
<td>Trustworthy</td>
<td>7.75 (1.2927)</td>
<td>8.95 (1.4681)</td>
<td>11.260 *</td>
</tr>
<tr>
<td>Honest</td>
<td>8.25 (1.6182)</td>
<td>8.95 (2.0125)</td>
<td>4.938 NSD</td>
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<tr>
<td>Acceptable</td>
<td>8.50 (1.2183)</td>
<td>9.35 (1.1367)</td>
<td>9.615 *</td>
</tr>
<tr>
<td>Dependable</td>
<td>7.40 (1.1425)</td>
<td>9.15 (1.3089)</td>
<td>6.980**</td>
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<tr>
<td>ATTRACTIVENESS</td>
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<td>Pleasant</td>
<td>7.80 (2.0157)</td>
<td>9.10 (1.1192)</td>
<td>7.740 NSD</td>
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<tr>
<td>Approachable</td>
<td>7.70 (1.2183)</td>
<td>8.90 (1.2524)</td>
<td>7.933 *</td>
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<tr>
<td>Friendly</td>
<td>8.50 (1.3179)</td>
<td>9.40 (.8826)</td>
<td>12.342 NSD</td>
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<tr>
<td>Warm</td>
<td>7.70 (1.2607)</td>
<td>8.95 (1.3563)</td>
<td>6.122**</td>
</tr>
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</table>

* Significant at the .0001 level.
** Significant at the .001 level.
NSD No Significant Difference
Hypothesis 2:

Subjects receiving maximum social influence inductions, whether receiving further influence or not, show higher levels of source characteristics than all other subjects.

Treatment Groups 2 and 3 both received maximum social influence inductions prior to each session. During the treatment sessions, strategies designed to enhance the effect of these inductions, were implemented in Group 3, but not in Group 2. Nonetheless, in both groups, attempts to develop social influence have been purposively undertaken. On the other hand, Groups 1 and 4 were given minimal social influence inductions and no induction, respectively. Therefore, if social influence is operative in the desired pattern for the study, Groups 2 and 3 will demonstrate more social influence from the therapist than will Groups 1 and 4. The relevant comparisons then are:

Group 3 compared with Groups 1 and 4; and
Group 2 compared with Groups 1 and 4.

Table 3 summarizes the significant differences existing between the means of these four comparisons (3 and 1, 3 and 4, 2 and 1, 2 and 4) on source characteristic scores taken after the first and third treatment sessions.

Group 3 (Comparison 2) indicates statistically significant differences ($p < .0001$) on all perceived source characteristics for both testings when compared with the control group, Group 4. When compared with Group 1 (Comparison 1), Group 3 shows similar significant differences for the initial testing on ten characteristics - nine at $p < .0001$, one at $p < .001$. There is no statistically significant difference existing between the two groups on the trustworthiness characteristics of honest and dependable. Furthermore, these two,
together with another trustworthiness characteristic, acceptable, also fail to show significant differences in the second testing.

Group 2 (Comparison 3) shows statistically significant difference in all twelve perceived source characteristics on the initial rating when compared with Group 1. Eleven out of twelve of these characteristics had a \( p < .0001 \). On the post-treatment session 3 measure, three of these characteristics - honest, pleasant and friendly - had altered from the first testing to show no significant difference to Group 1. When initially compared with Group 4 (Comparison 4), all but two source characteristics of Group 2 are significantly different at a \( p < .0001 \) level. Approachable and warm are the two attractiveness characteristics that show no significant difference. However, when measured again following Treatment Session 3, statistically significant differences do appear for both of these characteristics. On this testing all source characteristics perceived by Group 2 are significantly different from the perceptions held by Group 4 - eleven characteristics at \( p < .0001 \), one at \( p < .01 \) levels.

Further to these maximum and minimal influence comparisons, it is worthy of note that when the two maximum social influence groups are compared, no statistically significant differences exist on any one of the twelve source characteristics for either testing (Comparison 5). The same non-significant difference exists for the two minimal social influence groups - Groups 1 and 4 - when they are compared on the twelve source characteristics for both testings.

These data indicate that statistically significant differences (\( p < .05 \)) do exist between the groups receiving maximum social influence inductions - Groups 2 and 3 - and groups that received minimal or no social influence inductions - Groups 1 and 4. Furthermore,
### TABLE 3

A Summary of the Significant Differences Existing in Sources Characteristics between Groups Receiving Maximum Social Influence Through Inductions or Otherwise, and Groups Receiving Minimal, or no Social Influence Inductions

<table>
<thead>
<tr>
<th>Source Characteristics</th>
<th>Comparison 1 Gp 3 X Gp 1 (Max.) (Min.)</th>
<th>Comparison 2 Gp 3 X Gp 4 (Max.) (Min.)</th>
<th>Comparison 3 Gp 2 X Gp 1 (Max.) (Min.)</th>
<th>Comparison 4 Gp 2 X Gp 4 (Max.) (Min.)</th>
<th>Comparison 5 Gp 3 X Gp 2 (Max.) (Min.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expertise</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skilled</td>
<td>SD</td>
<td>SD</td>
<td>SD</td>
<td>SD</td>
<td>NSD</td>
</tr>
<tr>
<td>Informed</td>
<td>SD</td>
<td>SD</td>
<td>SD</td>
<td>SD</td>
<td>NSD</td>
</tr>
<tr>
<td>Professional</td>
<td>SD</td>
<td>SD</td>
<td>SD</td>
<td>SD</td>
<td>NSD</td>
</tr>
<tr>
<td>Competent</td>
<td>SD</td>
<td>SD</td>
<td>SD</td>
<td>SD</td>
<td>NSD</td>
</tr>
<tr>
<td>Trustworthiness</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trustworthy</td>
<td>SD</td>
<td>SD</td>
<td>SD</td>
<td>SD</td>
<td>NSD</td>
</tr>
<tr>
<td>Honest</td>
<td>NSD</td>
<td>NSD</td>
<td>SD</td>
<td>SD</td>
<td>NSD</td>
</tr>
<tr>
<td>Acceptable</td>
<td>SD</td>
<td>NSD</td>
<td>SD</td>
<td>SD</td>
<td>NSD</td>
</tr>
<tr>
<td>Dependable</td>
<td>NSD</td>
<td>NSD</td>
<td>SD</td>
<td>SD</td>
<td>NSD</td>
</tr>
<tr>
<td>Attractiveness</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pleasant</td>
<td>SD</td>
<td>SD</td>
<td>SD</td>
<td>NSD</td>
<td>NSD</td>
</tr>
<tr>
<td>Approachable</td>
<td>SD*</td>
<td>SD</td>
<td>SD</td>
<td>SD*</td>
<td>NSD</td>
</tr>
<tr>
<td>Friendly</td>
<td>SD</td>
<td>SD</td>
<td>SD</td>
<td>SD</td>
<td>NSD</td>
</tr>
<tr>
<td>Warm</td>
<td>SD</td>
<td>SD</td>
<td>SD</td>
<td>SD</td>
<td>NSD</td>
</tr>
</tbody>
</table>

SD  Significant at the .0001 level  
SD* Significant at the .001 level  
SD** Significant at the .01 level  
NSD  No Significant Difference
an inspection of the means indicates that the differences are in the
direction predicted, viz., the maximum influence inductions induced
higher perceptions of source characteristics. Hypothesis 2 is thus
supported and the social influence of the therapist has been structured
successfully to a substantial degree.

Hypothesis 3:

Subjects receiving maximum social influence inductions will
show more acceptance of the treatment message than subjects
who receive the minimal or no social influence inductions.

Table 4 presents the findings of a one-way analyses of variance
for the four groups, and the results of the subsequent multiple
comparison test: the Tukey - HSD procedure. For both analyses -
post-treatment session 1, and post-treatment session 2 testings -
statistically significant F-ratios exist. The initial, post-treatment
session 1 testing, shows variance at a p < .001 level, while the
latter testing indicates a < .0001 level of probability. The multi-
ple comparison procedure reveals a statistically significant differ-
ence between the mean message acceptance scores in Groups 2 and 4.
There are no other significant differences in the initial measure.
However, in the final testing following the treatment session 3,
statistically significant differences do exist: Group 2 with both
Groups 1 and 4, and Group 3 also with Groups 1 and 4. In all cases
Groups 2 and 3 show higher message acceptance scores than do Groups
1 and 4. Groups 2 and 3 show no significant difference in message
acceptance scores on either testing. Likewise, no significant diff-
erence exists between Groups 1 and 4 but for the first testing only.

Groups 2 and 3 were inducted with maximum social influence, while
Groups 1 and 4 had minimal and no social influence inductions respect-
ively. So the above findings indicate significant differences (p < .05)
TABLE 4

Multiple Comparisons of the Mean Scores* for Each Treatment Group on the Message Acceptable Scale After Treatment Sessions 1 and 3

<table>
<thead>
<tr>
<th>Message Acceptance Test</th>
<th>Group Means</th>
<th>F-Ratio</th>
<th>Significance</th>
<th>Multiple Comparisons</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post-Treatment Session 1</td>
<td>Min.S.I.Ind. Cog-Beh.Ther. $M_1$</td>
<td>7.75 (1.2085)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Max.S.I.Ind. Cog-Beh.Ther. $M_2$</td>
<td>8.80 (1.0052)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Max.S.Infl. Ther. Message $M_3$</td>
<td>8.50 (1.9002)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>No Induct. No Therapy $M_4$</td>
<td>7.40 (1.9574)</td>
<td>4.479</td>
<td></td>
</tr>
<tr>
<td>Post-Treatment Session 2</td>
<td>Min.S.I.Ind. Cog-Beh.Ther. $M_1$</td>
<td>7.25 (1.3717)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Max.S.I.Ind. Cog-Beh.Ther. $M_2$</td>
<td>8.80 (1.1517)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Max.S.Infl. Ther. Message $M_3$</td>
<td>8.70 (1.3803)</td>
<td>4.8</td>
<td>36.115</td>
</tr>
<tr>
<td></td>
<td>No Induct. No Therapy $M_4$</td>
<td>4.8</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Standard Deviations are in Parentheses
and in the direction predicted, but only for the post-treatment session 3 testing. Only one significant difference (p < .05) amongst the groups exists on this dimension at the post-treatment session 1 measure. To this substantial degree, hypothesis 3 is supported.

In this study five self-esteem related measures were utilized under two classifications: The Tennessee Self-Concept Scale, with measures of the Total Self-Concept and Self-Criticism; and Interviews Measures including a rating by an interviewer and a frequency count of positive and negative self-referring statements of the subjects. Table 5 presents the results of one-way analyses of variance run on each of these five measures across the four treatment groups. It also summarizes the findings of the subsequent multiple comparison procedure, Tukey - HSD.

On the five self-esteem related measures, the F-ratios presented in Table 5, indicate that the statistically significant differences exist across the groups on four of these measures. There is no significant difference across the groups for the Total Self-Concept Score.

Hypothesis 4:

Subjects receiving cognitive-behavior therapy treatment under conditions of minimal social influence show higher levels of self-esteem than subjects in the control no-treatment group.

For this hypothesis, Groups 1 and 4 are involved. Table 5 indicates that no statistically significant difference exists between the means of any of the five self-esteem measures for Groups 1 and 4. Statistically, the self-esteem levels on all measures utilized, are the same for both groups. Hypothesis 4 is not supported. Cognitive-behavior therapy when conducted under conditions of minimal social influence showed no enhancement of levels of self-esteem beyond those
**TABLE 5**

Multiple Comparisons of the Mean Scores* for Each of the Four Treatment Groups on Five Measures of Self-Esteem.

<table>
<thead>
<tr>
<th>Group Means</th>
<th>F-Ratio</th>
<th>Significance</th>
<th>Multiple Comparisons</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TENNESSEE SCALE</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total S-C Scale</td>
<td>349.50 (27.1070)</td>
<td>358.90 (26.5368)</td>
<td>352.20 (27.5960)</td>
</tr>
<tr>
<td>Self-Criticism Scale</td>
<td>36.20 (5.1155)</td>
<td>36.15 (4.3682)</td>
<td>38.60 (4.8710)</td>
</tr>
<tr>
<td>INTERVIEW MEASURES</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interview Rating</td>
<td>7.0 (1.9194)</td>
<td>7.85 (1.4244)</td>
<td>7.15 (1.2680)</td>
</tr>
<tr>
<td>Positive Self-Statements</td>
<td>7.65 (2.3902)</td>
<td>10.25 (2.9890)</td>
<td>8.65 (2.7391)</td>
</tr>
<tr>
<td>Negative Self-Statements</td>
<td>3.45 (1.7312)</td>
<td>3.05 (1.0501)</td>
<td>3.25 (1.2085)</td>
</tr>
</tbody>
</table>

* Standard Deviations are in parenthesis.
elicited in the control no-treatment group.

Hypothesis 5:

Subjects receiving a therapeutic message under conditions of maximum social influence show higher levels of self-esteem than subjects in the control no-treatment group.

For this hypothesis, Groups 3 and 4 are involved. Table 5 indicates that on three of the five self-esteem measures there exists statistically significant differences (p < .05) between the means of Groups 3 and 4. Subjects from Group 3 show significantly higher scores on the Tennessee Self-Criticism Scale and on the Positive Self-Statements measure than do the subjects in Group 4. Also, subjects in Group 3 show significantly lower scores on the Negative Self-Statements measure than subjects in Group 4. There are no statistically significant differences existing between Groups 3 and 4 on the other two self-esteem measures - Tennessee Total Self-Concept Scale and the Interview Rating measure. In summary then, subjects receiving a therapeutic message under conditions of maximum social influence show statistically higher levels of self-esteem on three of the five measures used than do subjects in the control no-treatment group. To this degree, Hypothesis 5 is supported.

Hypothesis 6:

Subjects receiving cognitive-behavior therapy under conditions of maximum social influence inductions show higher levels of self-esteem than subjects in the control no-treatment group.

For this hypothesis, Groups 2 and 4 are involved. Table 5 indicates that on three of the five self-esteem measures there exists statistically significant differences (p < .05) between the means of Groups 2 and 4. Subjects from Group 2 show significant difference in
means on the three Interview Measures - Interview Rating, Positive Self-Statements, and Negative Self-Statements - than do the subjects in Group 4. The differences are in the directions predicted: higher on the first two measures and lower on the latter measure. There are no statistically significant differences existing between Groups 2 and 4 on either of the Tennessee Self-Concept measures. In summary, subjects receiving cognitive-behavior therapy under conditions of maximum social influence inductions show statistically higher levels of self-esteem on three of the five measures used than do subjects in the control no-treatment group. To this degree Hypothesis 6 is supported.

The relativity of the efficacies of the treatments is the issue of this study. Table 6 summarizes the statistically significant differences of all self-esteem measures when each treatment group is compared with the no-treatment, control group. For Group 1, the minimal induction cognitive-behavior therapy group, there is no significant differences on any one of the five measures of self-esteem. Group 2, which was the same cognitive-behavior therapy, but with maximum social influence inductions, does show significantly enhanced self-esteem on all three Interview measures. It is the only treatment that is statistically higher in self-esteem generally, as rated by trained interviewer. Group 3, which involved maximized social influence with a therapeutic message, shows enhanced levels of self-esteem on three measures, two of which relate to the use of positive and negative self-statements. Statistically significant increases in self-esteem are not evident for Group 3 in either of the "general" self-esteem measures as is evidenced for Group 2 (Interviewer Rating).
In summary, there is evidence that treatments used in Groups 2 and 3 are significantly more efficacious than the treatment utilized in Group 1. Furthermore, the Group 2 treatment being the only treatment to produce a statistically significant enhancement of self-esteem on a "general" measure, is thus interpreted as generally more efficacious than either of the other two treatments. That is, the treatment which included both maximized specific and non-specific factors, shows relatively more efficacy in enhancing self-esteem than do treatments which maximize only one of these factors. In turn, the treatment that maximized non-specific factors, shows relatively more efficacy in enhancing self-esteem than the treatment that maximized specific factors only. Specific factors when used under conditions of minimized non-specific factors are least efficacious in enhancing self-esteem, and in fact, this treatment shows no statistically higher levels of self-esteem enhancement than does a no-treatment group.
TABLE 6

A Summary of the Significant Differences in Five Measures of Self-Esteem for Each Therapy Treatment Group When Compared With the Control Group.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>TENNESSEE SCALE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Self-Concept</td>
<td>NSD</td>
<td>NSD</td>
<td>NSD</td>
</tr>
<tr>
<td>Self-Criticism</td>
<td>NSD</td>
<td>NSD</td>
<td>SD**</td>
</tr>
<tr>
<td>INTERVIEW MEASURES</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interview Rtg.</td>
<td>NSD</td>
<td>SD**</td>
<td>NSD</td>
</tr>
<tr>
<td>Pos. Self-Statements</td>
<td>NSD</td>
<td>SD**</td>
<td>SD**</td>
</tr>
<tr>
<td>Neg. Self-Statements</td>
<td>NSD</td>
<td>SD**</td>
<td>SD**</td>
</tr>
</tbody>
</table>

* Control Group
SD** Significant at the .001 level.
SD*** Significant at the .0001 level.
NSD No significant difference.
CHAPTER V

DISCUSSION

This study asked the question as to the relative efficacy of the two change components of psychotherapy. An answer has been given. The therapy, with its emphasis on techniques, gained no more message acceptance nor enhancement of self-esteem than did the no-therapy, control group. The therapy with its emphasis on social influence gained more message acceptance than did the no-therapy, control group, and indicated some effectiveness in enhancing self-esteem. However, as hypothesized the 'full therapy' fared best. When the therapy maximized both techniques and social influence, it gained consistently higher message acceptance, and greater enhancement of self-esteem, as compared with all other treatments. That is, the two components together proved more efficacious than either of the components separately.

From the perspective of the third component, the findings may be restated thus: self-esteem was most susceptible to enhancement through social influence and therapeutic techniques conjointly, and indicated more susceptibility to social influence than it did to therapeutic techniques. In component terms, the essence of the problem component, self-esteem, was open to change more through the interactional component, social influence, than the techniques of the treatment components. It does appear appropriate to discuss the results in terms of each component.

The Interactional Component

The interactional component in the study was focussed through the social influence of the therapist. It is significant that the treatments
which gained higher levels of message acceptance and enhancement of self-esteem, had in common the high social influence component. The therapy in which this element was minimized, differed in no way from the no-therapy, control group. In its own right, social influence elicited some desired treatment effects, but when the therapeutic techniques were added, the therapeutic impact was enhanced. These findings suggest that social influence provides an essential context in which psychotherapy becomes effective.

The development of influence. Subjects came to the study with positive attitudes which were reflected in their unanimously high initial ratings of the therapist-experimenter. The lowest single group mean of any source characteristic for either testing, was the control group's 6.85, on a 10-point scale for the "informed" dimension. This group consistently rated the therapist in the 7-plus area, and up to 8.35 on friendliness, despite the fact that all he did was ask them to sit, then switched off the lights and switched on a previously set-up film projector. A positive predisposition to this therapy-analogue situation and the therapist, existed. It appears plausible to suggest that clients seeking out a therapist, generally share this positive predisposition to the therapist and his/her therapy.

The subjects' apparent positive pre-disposition to the therapist can be built upon. In keeping with the literature generally, positive pre-session inductions were found to enhance significantly, the subjects' perceptions of the therapist's qualities: expertise, trustworthiness, attractiveness (Table 1). What was done subsequently in treatment, seemingly did not contribute more to the subjects' already enhanced, positive perceptions of the therapist (Tables 1 and 2). When the therapist endeavored to build systematically on the positive inductions, no
significant improvement occurred (Table 3, Comparison 5). Similarly, subjects whose perceptions of the therapist were not enhanced prior to treatment, did not show any major change in enhancement through the treatment (Tables 1 and 2, Group 1). That is, therapeutic skills with neutral interpersonal contact, was not sufficient to enhance the therapist's credibility or attractiveness. It does appear then, that credibility and attractiveness may not develop readily - sight unseen - but may need to be encouraged through the therapist and his/her environment. Pre-session inductions appear to be an economical and methodical way of developing maximum positive perceptions of the therapist and his/her therapy.

One feature of the structuring of influence in this study, was the continued use of inductions prior to each treatment session over a two week period. It was observed that only two of the twelve characteristics for all four groups, showed any significant change (p < .05) after the first session. Follow-up Paired T-tests showed that warmth and acceptance in the control group, both decreased significantly. For the other 46 pairs (12 characteristics X 4 groups), the perceptions gained by the end of the first session remained stable for the duration of the treatment. The question still remains: if the two further inductions did not change already established levels of perceptions, what role did they play in maintaining these levels? The results in this study suggest that the perceptions of the therapist are not so much maintained by the inductions, but by the experience of the treatment. When the experience is positive, the client's positive perceptions of the therapist are maintained; when they are not, these perceptions may deteriorate. The maintenance of high levels of source characteristics in the positive, constructive treatment programs, and the decrease in warmth
and acceptance in the no-therapy, minimal interaction control group, support this contention. However, the stability of the initially developed perceptions of the therapist, after the first induction and treatment, is noteworthy. It is somewhat akin to the often referred to, persistent nature of first impressions.

In the present study, accurately monitoring the differential development of various source characteristics, was not the focus. To the extent to which this was done, comment can be made. Expertise characteristics - skilled, informed, professional and competent - as established by the inductions, tended to show more stability over the treatment period. Dimensions of trustworthiness and attractiveness did vary over the three sessions. This may be explained by these latter two characteristics being more subject to interpersonal dynamics, and thereby more susceptible to change, than are the more tangible, concrete dimensions, which compose credibility. Strong's (1978) suggestion that the attractiveness characteristics are overridden by credibility characteristics when presented together, seems to be supported, although there is no clear way in which a more definitive comment can be made from this study.

In summary then, influence is a factor in therapy, and strong influential perceptions already exist prior to the commencement of treatment. This influence can be enhanced in at least two ways: by the usual social interaction between persons; and by introducing a client into a therapeutic 'environment' which has been structured with influential information. In this study, structuring influential information on an induction format, did enhance the clients' perceptions of the therapist to such a degree, that specific influencing tactics constantly used in one treatment, did not show any further increase of influence,
e.g., Group 3. Furthermore, demonstrating competency in utilizing therapeutic techniques, added nothing to the therapist's credibility and attractiveness in the eyes of the clients, e.g., Group 1.

Influence and acceptance. The measuring of the subject's stated acceptance of the therapist's message, is one way in which the effects of influence may be assessed. Does the acceptance of therapist's message vary with the social influence he/she has with the client?

The study found that subjects who developed higher levels of influence showed significantly more message acceptance. However, of more specific importance is that, subjects receiving the same cognitive-behavior therapy treatment, showed significant differences in their acceptance of the message in accordance with the social inductions they received. Subjects in Group 2 had developed through inductions significantly higher levels of therapist influence, than did subjects in Group 1. At the end of the therapy, Group 2 subjects indicated a higher level of acceptance of the same therapy message than did subjects in Group 1 (Table 4).

In literature, this connection has been somewhat problematical, with some studies finding acceptance occurring in the direction of the influence (Bergin, 1962; Greenberg, 1969; Goldstein and Simonson, 1971); others finding no such influence effects (Strong and Dixon, 1971; Guttman and Haase, 1972). This study found highly significant influence effects on the acceptance of the message, but this acceptance took time to develop. On the first assessment, immediately following the first induction and treatment, no significant difference was registered in the message acceptance. However, on the second assessment, immediately following the third induction and treatment, the highly significant difference appeared (Table 4).
This suggests that the acceptance of the therapeutic message, may not simply be an unidimensional connection between influence and acceptance. It appears to be more a function involving the interaction of the therapist's influence with the treatment, over a period of time - with time being the observable variable significant in this study. For, as was stated above, the influence did not increase significantly from the first session, as did the subjects' acceptance of the message.

It has been suggested in the literature, that the plausibility of the message is one of the factors that interacts with influence. It seems reasonable to suggest that the subjects' need for the plausibility of the message may be affected by influence. The higher the influence, the less plausible the message needs to be for its acceptance. With lower influence levels, the message itself may need to be more plausible. Naturally, what normally would be a highly plausible message in its own right to an individual, would only have its plausibility reinforced by high influence. This would appear to be the most highly susceptible state for message acceptance: both therapist and client believing in the therapy from the start. From the findings of this study a direct relationship between influence and message acceptance is not substantiated.

From a therapy viewpoint, all this has relevance. The findings suggest that the therapy may take time in gaining acceptance from the client, regardless of the initial influence. On the other hand, influence is a factor involved in gaining that acceptance more readily in time. It has been proposed that the plausibility of the therapy may be an important aspect of the therapeutic outcome: matching the therapy with the client. The client's need to believe, need to accept, or need to have the therapy, is a factor related to acceptance, but not typically structured for in therapy as it is in the consumer world.
Influence and change. The effects of influence may also be measured in terms of change outcomes, in this case, change in self-esteem. When compared with the control group, subjects from two groups showed significant change effects - both of these groups had treatment under conditions of maximum social influence inductions (Table 6). The therapy group who received the minimal social influence induction and indicated lower levels of influence, did not differ significantly from the control group on any of the self-esteem measures (Table 6, Comparison 1). These findings are even more significant when it is considered that, in the case of subjects in Groups 1 and 2, their therapies were the same: they only differed in their maximum, minimal social influence inductions. The impact of the influence stemming from the inductions, has contributed that element to the cognitive-behavior therapy which has made the treatment effective in eliciting change. This is not to say that the influence in itself has produced the change, but the combination of the therapeutic techniques in the context of the enhanced social influence, has. Whether the techniques simply add further to the influence, or whether they add an element of intrinsic value for change in their own right, or both, are other questions.

The Treatment Component

In this study, the treatment component, or technique for change, was introduced through cognitive-behavior therapy. Cognitive-behavior techniques were offered in two groups under differing social influence conditions. As such, the efficacy of the techniques showed significant variance, despite it being offered in identical formats. The critical variable appears to be the social influence context in which they are delivered. The findings suggest that these cognitive-behavior techniques
are significantly more efficacious, if the therapist is seen by the subjects as having high expertise, trustworthiness, and attractiveness.

Developing influence through techniques. Obviously, the subjects and the therapist interacted during the cognitive-behavior therapy, albeit in a socially minimized fashion. The therapist endeavored to present as a competent professional, skilled in the techniques of therapy. Nonetheless, all of the significant differences in the twelve source characteristics between Groups 1 and 2 (Table 1) are attributable to the inductions, rather than subjects' perceptions of the therapist gained through his performance of the techniques. Furthermore, paired-T tests indicated that there were no significant changes in how Group 1 subjects perceived the therapist from post-session 1 to post-session 3 (Tables 1 and 2).

The interaction of the therapist with the subjects through the techniques, did not counter the induction effect in expertise over the three sessions (Table 3). On another three, more interpersonal characteristics - honest, pleasant, friendly - the expertise of the therapist through the techniques countered the inductions (Table 3). Thus, the study indicates that perceiving the therapist through the technical performance of therapy is less effective in building positive attitudes towards the therapist than it is to be told beforehand, that the therapist is a trustworthy and attractive expert.

Effects of techniques. There were no significant treatment effects attributable to the cognitive-behavior techniques when offered in minimized social influence conditions (Group 1). On message acceptance (Table 3), and on all measures of self-esteem (Table 4), this treatment showed no significant differences from the control group. When these non-effects of cognitive-behavior techniques under minimized social
influence, are compared with the encouraging results the same cognitive-behavior techniques gained with maximum social inductions (Tables 3 and 4), the relative power of techniques isolated from influence, stand in stark contrast. The importance of the context for delivering therapeutic techniques is highlighted by these findings.

Techniques and psychotherapy. The question now becomes one of what is the role of techniques in psychotherapy? Are techniques, when offered in a particular social climate, the real agents of change? Or, are they simply that palliative, that placebo as discussed above, through which the real change agents - social influence - are ritualized? This study did not seek to analyse the potency which each individual technique has in its capacity for 'unfreezing, changing, and refreezing'. Perhaps, in doing this, the same demise as discussed above, may occur for cognitive-behavior techniques as it did for the systematic desensitization techniques. This study found that, in this non-coercive format, a comprehensive program of therapeutic techniques of change were effective in enhancing self-esteem, when embedded in the context of high credibility and attractiveness of the therapist. Whereas, social influence with only 'talk techniques' did elicit some change. So, at times, elaborate therapeutic techniques may not be necessary.

This suggests, as before, that it may be a matter of the client's susceptibility to making "conceptual shifts". Some clients may be highly susceptible to the influence of others, and the "wizardry" of the therapist's influence may be sufficient per se. Others might not develop belief in such an intangible, and may require change through more obvious and plausible modes. For others again, conceptual changes may only come through lengthy processes of behavioral modification.
That is, some clients may be able to believe in the therapist, while others in the therapy, if they perceive it working. In this approach, therapeutic techniques, ranging in plausibility from those that wrought "magical" conceptual shifts, to those that grind out change through a series of observable, tangible, and thus, believable stages, may be necessary. However, it is contended here that therapists need techniques that eloquently effect conceptual shifts in brief psychotherapeutic encounters, whether these shifts are in the conscious awareness of the client or not. In keeping with the study's findings, interpersonal influence appears to be an essential ingredient for this to happen.

The Problem Component

Self-esteem was conceptualized as the common component of problems presented for therapy, and, in this study was the dependent variable. Enhancement of self-esteem on some measures was effected by some treatments, when compared with the no-therapy, control group (Table 6). More specifically, changes in self-esteem were effected by cognitive-behavior therapy under conditions of maximum social inductions (Table 5). Being told a message from a position of high social influence gained some enhancement, while techniques with minimized influence proved ineffective in changing self-esteem (Table 5). That is, under the conditions of this study, self-esteem was most open to change through influence and restructuring techniques offered conjointly.

As discussed above, Beutler, et al. (1976) found that the high social influence of the therapist, related to the clients' own perception of their improvement, not necessarily their actual improvement. The clients thought they were improving, they felt they were improving, and in fact, for them, they were improving. Perhaps what Frank (1973) spoke
of as a state of demoralization, of low self-esteem, is what Beutler et al. (1976) were tapping. The influence of the therapist was changing the clients' perception of their problem by building their morale and enhancing their self-esteem. The results of this study indicate that self-esteem is more open to enhancement in a context of high social influence of the therapist, than it is to cognitive restructuring techniques with minimized influence.

**Measurement of Self-Esteem.** The procedures adopted in this study for measuring self-esteem are noteworthy. The statistical significance that was found in the enhancement of self-esteem, was only detected through the observational interview mode of measuring. The self-report, Tennessee Self-Concept Scale, showed no statistically significant differences amongst the groups on the total self-concept score (Table 5). It is interesting to note that the form the therapy took - restructuring negative internal dialogue into positive self-referring statements - is very much closer in nature to the interview style of measurement than it is to the paper-and-pencil, self-report of the Tennessee. The frequency count of positive and negative self-statements is more directly related to how well a person learns the cognitive-restructuring technique, than is demonstrating self-esteem through attitudes to a wide range of dimensions on a self-report scale. The former is more directly related to the overt factors of the change process, while the latter taps deeper, more covert aspects of the self which underlie the outcome effects.
The significance of Group 3's score on the self-criticism scale is also worthy of comment (Table 6). The Self-Criticism Scale registers an openness to admit to mildly derogatory failings that most persons have and to which they usually admit. The maximum social influence group with 'talk techniques' only, proved to be the sole group that was statistically significantly different from the control group in this regard. It may be that the self-disclosures utilized by the therapist in further developing source attractiveness during the treatment, elicited similar behaviors in these subjects. This is in keeping with findings by Mann and Murphy (1975), and Murphy and Strong (1972). This author sees further development of observational type self-esteem measures such as the interview one utilized here, would contribute greatly to validity of much of this type of research.

Conclusions

Naturally, drawing implications from an analogue study such as the present one, is fraught with limitations. The subjects are not "real" clients. Their problems, motivations, perceptions, expectations, are not those of "real" clients. The treatments are not "real" therapies. The procedures employed and climates created are not those of the "real" psychotherapeutic experience. These, and other factors, distance the analogue from reality, and thereby limit the degree of assurance with which conclusions can be made and implications drawn. Nonetheless, conclusions and implications are there, and can be stated with guarded cognizance as to these limiting factors.

This dissertation conceptualized psychotherapy in a common components approach. It separated the "specific" from the "non-specific" factors,
tested their relative efficacy, and interpreted the results in terms of their relationship to eliciting change.

Psychotherapy is an interactional process leading to change. This interactional process involves interpersonal interaction, and interaction through therapeutic techniques. Sometimes, the former may be sufficient in itself for change, other times it may require structured therapeutic techniques. When the interaction is operationalized through both the personal influence and the techniques, the therapy is most efficacious. It may be that plausible therapeutic techniques simply add to the personal influence of the therapist, and that this influence component is the main change agent in psychotherapy. Perceiving the problem differently by gaining a new perspective of oneself, thus enhancing one's morale and self-esteem, may very well be the central focus of therapeutic change. This may be what psychotherapy does best, in fact, it may be all that psychotherapy can do. The problem does not change, but the client's capacity to cope with it does.

Implications

This dissertation has implications on two levels: a micro-level involving specific aspects of the study; and a macro-level concerning the conceptualization and practice of psychotherapy.

Social influence was the major experimental dynamic. Many of the findings in this study added support to the already fairly consistent body of literature. Others suggested areas of further research. Research into the effects of continuing inductions over a period of time; the further developing of the maintenance role such inductions play over a period of time; and their relationship with on-going interactions, confirming and disconfirming these inductions, all seem to be profitable lines of further social influence research. Secondly, the effects of
social influence need clarification. The separation by some researchers of the social influence effects into actual and perceived change, and the learning of the message by the subjects, would contribute greatly to the attitudinal change, and in particular, to the therapeutic attitudinal change literature. Finally, in this regard, it is now up to the therapist to take these well-established findings, particularly in how to develop social influence, and subtly structure them within his/her environment, so that pre-therapy perceptions are most conducive to post-therapeutic change.

For those who are involved in the teaching and practice of psychotherapy there are implications. It does appear appropriate to put back in perspective, the distinct emphasis that has typified the development of psychotherapy over the past decade or so, and to which, this author referred above. The rampant development of techniques, things to do to clients, is not necessarily of value to the therapeutic process, regardless of how creative the new packaging appears. This dissertation asks for a re-emphasis by therapists and their educators, on the interactional context in which therapies function. Furthermore, it joins a persistent group, who seem to be lodged firmly in the wings of psychotherapy urging for the interpretation of the interactional dynamics in social psychological terms. Control, power and influence are inevitable in any social interaction. Recognizing them, and utilizing their potency may offer much, in fact, may be the very essence that determines the efficacy of psychotherapy.
BIBLIOGRAPHY


Bauer, R.A. A revised model of source effect. Presidential address of the division of consumer psychology, American Psychological Association annual meeting, Chicago. 1965.


Farson, R. *The technology of humanism.* *Journal of Humanistic Psychology, 1978, 18, 2*


Goldstein, A.P. Patient expectancies and nonspecific therapy as a basis for (un)spontaneous remission. *Journal of Clinical Psychology, 1960, 16, 399-403*


James, W. Principles of Psychology. New York: Holt, 1890.


McGee, R.K. Personal Communication. 1960


Norman, R. What is said is important: A comparison of expert and attractive source. Journal of Experimental Social Psychology, 1976, 12, 294-300.


APPENDICES

1.0 Treatment Programs

1.1 Cognitive-Behavior Therapy Program
1.2 Social Influence Treatment Program
1.3 Control Group Treatment

2.0 Measurement Instruments

2.1 Session Evaluation Form
2.2 Interview Guidelines and Questions
2.3 Criteria for Rating Self-Referring Statements
Cognitive-Behavior Therapy Program

Detailed Procedures

This is the therapist's manual of a three session therapeutic program based on cognitive-behavior modification principles and designed to enhance the attitudes the subjects hold about themselves (self-esteem).

By:

Ian L. Lynagh
Dept. of Counselor Education
Oregon State University

December 1980
Introduction:

The therapist is introduced by a professor from the Dept. of Psychology who is known to the subjects. The therapist is not present at the introduction and is blind to which treatment group received which social influence induction (see Social Influence Inductions). The therapist is not known to the group nor any individual subject within the group.

Therapist's approach:

The therapist adopts the stance of an instructor implementing a program based on a series of concrete tasks which he/she introduces, teaches and directs in a class style atmosphere. The therapist conducts himself in a technical competent manner maximizing the power of the technology of the program keeping personal dynamics at a minimum.

Session 1. Unfreezing Stage.

Orientation remarks:

Goal: To increase self esteem.

Process: To alter negative thoughts that the subjects hold about themselves to more positive, self-appreciative thinking.

Program: Three sessions of approximately 45 minutes each with some homework after each session.

Distribute workbooks

Questions

Step 1 & 2

The therapist models an imaginary situation in which a person feels insecure, inadequate and personally threatened, then monitors his/her internal reactions.

Situation: Meeting a new group of people in an unfamiliar social setting.

Self monitoring reactions:

Thoughts: "Oh, I do not know a soul; nobody is interested in me; I look so stupid; I don't belong here; people will think I'm dumb; how embarrassing!"

Physiological: "My stomach is churning; pulse racing; tense across the forehead; my hands are gittery."
Feeling: "I feel highly anxious; very tense, nervous and a little afraid."

Behavioral: "I hang back, look down a lot, speak softly with a nervous tone. When I do speak, I don't make much eye contact and withdraw as soon as I can. I have my fist clenched in one pocket and grip firmly on a glass with the other."

Each subject is asked to identify a situation where they experience some insecurity, inferiority, inadequacy or threat. Urged to make it as simple as possible. Asked to reconstruct that situation in as much detail as possible. Asked to re-experience it and then to monitor their thoughts, physiological, feeling and behavior responses. Record in workbook.

Step 3

This is a didactic stage in which the cognitive model is presented. The following points are to be made:

- The long held view of the close connection amongst reason, emotion and behavior as alluded to by Greek and Roman philosophers, Buddhist thinkers, and many 20th Century theorists and practitioners in the field of human behavior.

- The role ideational content plays in how a person feels and behaves.

- A simple, linear sequential model of the mediational factors between a stimulus and a response:

<table>
<thead>
<tr>
<th>Stimulus</th>
<th>Cognition</th>
<th>Physiological and Emotional Reaction</th>
<th>Behavioral Response</th>
</tr>
</thead>
</table>

- The control effect of our cognitions over our other internal reactions.

- The relationship between our internal dialogue and our cognitions.

Step 4

A. Therapist demonstrates focussing on his thoughts, what he is himself about himself, i.e., his internal dialogue concerning the threatening social situation.

Internal dialogue: "Nobody is interested in me. I'm so dull and everyone here is so bright and sociable. I'm not very interesting nor important. People are not interesting in talking to a nobody. Anyway even if they did, I wouldn't know
what to say. I just am no good at making conversation and I will make a fool of myself and be so embarrassed. How awful!"

B. Subjects are asked to tune into their thoughts, what they are telling themselves, i.e., their internal dialogue concerning their threatening situation. Record in workbook.

**Step 5**

A. The therapist identifies some specific self-deprecating internal dialogue by asking what I am saying about myself to myself. Lists specific statements:

1. I am an uninteresting, dull and boring person.
2. I am not important.
3. I am so inadequate with people.
4. People don't like me.
5. I have no social or conversational skills.
6. People will think I am a fool.
7. This is awful and terrible for me.

B. The therapist then asks the subjects to identify specific self-deprecating internal dialogue and/or the beliefs, attitudes or suppositions that these indicate the subject holds about him/herself in that situation. Record in workbook.

**Homework assignment:**

**End of Session**
Session 2. Change Stage

Introduction: Short discussion on reactions to homework

Step 1:

The therapist goes back to the specific self-deprecating internal statements from the previous session and delineates three or four of the most significant ones.

1. "I am unimportant, without value and worth."
2. "People might not like me and that's terrible and awful."
3. "I am no good at talking with people."
4. "I am a social failure."

Each subject lists theirs. The therapist then demonstrates altering these statements to positive self-appreciating statements, realistic in their content. e.g.

1. "I am important, I do have value and worth the same as every other human being, simply because I am."
2. "Some persons will like me others won't, just the same way I like some and don't take to others; and that's ok. Not everyone has to like me."
3. "I sometimes, in some situations, have some difficulty talking with some people. I'd like to improve this, but meanwhile I'll do my best and be happy with that."
4. "Sometimes in the past, I haven't been the social hit that I would have liked to have been. But I'm me, with my own individual way of doing things; I'm not perfect, but who is? It is ok being myself for I value my uniqueness as I work to improve myself in every way."

Each subject is asked to change their self-deprecating statements to realistic, positive, self-appreciating sentences.

Step 2:

The therapist introduces the following framework in which the subjects are asked to write their new internal dialogue.

"I am. No person with exactly my qualities has ever existed before or will ever exist again. I am unique. I have value, worth, status and prestige to the same degree as any other human being, simply because I am, I am unique, I exist, I am alive, I am human."
No matter what I own or don't own, what I can do or can't do, how talented or how I look, I have value, I am important, I have worth the same as every other human being. I have a right to be me. I accept myself as I am and have the right to expect others to accept me for what I am...

(each subject adds his/her own)

Using the therapist's suggestions and the changed internal dialogue, each subject then writes 'their own' positive, self-appreciating scripts in a simple, streamline form (six or seven short significant and easy to remember sentences), e.g.

"I am unique, valuable and worthwhile. I have faults; but that's ok, I have much to offer from my uniqueness. Some might not like me, that's ok, many others will. I have rights, status and prestige the same as every other human being. I accept me for who and what I am. I have a right to expect others to accept me for who and what I am. For I am me, I am alive, I am unique and I value that uniqueness."

Record in workbook.

Step 3:

The therapist induces a relaxed state in the subjects heightening awareness of his/her internal states. Then he states aloud the above self-appreciating statements that he has constructed, thus modelling the use of incorporating the new internal dialogue.

The subjects then are asked to practise incorporating their own changed internal dialogue into their cognitions concerning themselves in a series of graduated steps ---- a) the therapist saying them out loud, b) therapist whispering, c) subject aloud, d) subject whispering, 3) subject thinking them only.

Step 4:

The subjects are then asked to focus on their internal states monitoring their physiological, feeling and behavioral reactions to their experience of their new internal dialogue. Changes in positive directions of enhanced self-esteem are reinforced in discussion and encouragement is given for further practice.

Record in workbook.

Homework assignment

End of Session
Session 3. Refreezing Stage

Introduction: Short discussion on reaction to homework and review of the development of new internal dialogue and its impact on cognitive structures (attitudes/beliefs) concerning themself.

Step 1 and 2:

Role playing as an exercise is explained and demonstrated by the therapist. Subjects are then asked to identify a personally threatening situation in their life involving one other person - if possible it should be the same situation identified and used in the first session.

Record in workbook.

Subjects are then asked to develop appropriate internal dialogue to enhance their self-esteem to approach this situation.

Record in workbook.

Subjects then work in dyads with one subject first: a) describing the situation and the person bringing about the threat; then, b) the subject enhances his/her self-esteem through the use of new positive internal dialogue; and, c) the other partner role plays the threatening person.

A brief episode is played out with the subject endeavoring to maintain high positive self-esteem during the experience. The subject is then asked to monitor their internal states and have they handled the situation generally. The other adds constructive comment from their observations and reactions. The roles are then reversed and the process repeated.

Record in workbook.

Step 3:

The subjects are divided into small discussion groups and asked to share their thoughts and feelings regarding the following:

a. their role playing experience;
b. the impact of positive internal dialogue on their behavior and subsequent self esteem;
c. their attitudes to themselves in the light of the new internal dialogue.

Record in workbook.

Conclusion: General group discussion on above matters and generalization of the technique of altering internal dialogue.
This workbook is to be used for each of the three sessions and the between sessions work. It is to be handed to the instructor on the completion of the third session. All work is to be completely anonymous, subjects using the 'Code No.' only. All information in it will be treated as confidential being used strictly for the purposes of the assessment of the program. All books will be destroyed on completion of the project.

Program conducted by:
Ian L. Lynagh
Dept. of Counselor Educ.
Oregon State University

January 1981
Session 1

A. Description of a threatening situation:

Personal reactions to the situation:

Thoughts --

Physiological --

Feelings --

Behavioral --

B. Model of processes involved:

<table>
<thead>
<tr>
<th>Situation</th>
<th>Thoughts. What you tell yourself about you in that situation</th>
<th>Physiological and Feeling reactions</th>
<th>Action</th>
</tr>
</thead>
</table>

Notes:

C. Thoughts that you have about the situation (what you are saying to yourself):

Specific self-deprecating statements:

1.

2.

3.

4.

5.
Homework for Session 1

A. Situations identified in which you feel inferior or inadequate:

B. General reactions to these situations:
   
   Physiological:

   Feelings:

   Behavioral:

C. Thoughts you have concerning yourself in these situations:

D. Significant reoccurring self-deprecating thoughts (internal dialogue):
   
   1.
   2.
   3.
   4.
   5.

General reactions/comments/new learnings:
Session 2

A. Three significant self-deprecating statements you tell yourself:

1.

2.

3.

B. Altered statements to positive self appreciating statements:

1.

2.

3.

C. New positive self appreciating internal dialogue:

D. Reactions to guided fantasy using altered internal dialogue:

   Physiological --

   Feeling --

   Behavioral --

E. General reactions/comments/new learnings:
Homework:

A. Situation approached:

B. Internal dialogue used:

C. Reactions to the experience:
   Physiological:

   Feeling:

   Behavioral:

D. Comments/general reactions/new learnings:
Session 3

A. Situation for role play:

B. Internal dialogue employed:

C. Reactions:
   - Physiological --
   - Feeling --
   - Behavioral --

D. What is your attitude to yourself now in ego threatening situations?

Does this represent any change in your attitude to yourself, how you regard and accept yourself, that is, your self concept? Yes. No. Please comment:
Social Influence Treatment

Detailed Content

This is the manual of a three-session treatment program in which the therapist, operating under conditions of maximum social influence, presents information supporting the importance of high self-esteem.

December 1980

By:
Ian L. Lynagh
Dept. of Counselor Education
Oregon State University
Introduction

The therapist will be introduced by Dr. J. Firth whose position and credentials are known by the group. The therapist will not be present at the introduction but will be aware that a maximum social influence induction has been given. The therapist is not known to the group nor any individual subject in the group.

Therapist's approach

The therapist's task is twofold: to further enhance his influence on the group; and secondly, to deliver persuasively, information concerning the importance of having high self-esteem. No 'usual' therapeutic techniques will be employed at any time.

Session 1

Aim: To develop a relationship with the group which reinforces the induction of trustworthiness, expertise and attractiveness. To present some basic positive views of the nature of a person drawn from humanistic psychology.

Step 1

Enhancing the social influence induction:
- making contact, building rapport, being warm, open, attractive, but always retaining control of the communication dynamics (Haley);
- recounting in a conversational way, some of the more successful achievements as a therapist, researcher, teacher, etc., and generally presenting as a credible expert.

Step 2

The therapist presented a personal philosophic paper which he had written some time previously. The paper was simple, graphic, and thought to be engaging and persuasive in its language. The essence of its message is the humanistic tenets that: 'I am, I am unique, I am free, I am whole, I am experiencing, I am unfolding my potentials, and I value these capacities.

Step 3

Discuss these qualities using communication gambits (Erickson, Gillis) to retain control influence on the group.

Homework:
- Explain the task of keeping a journal of what these sessions are about drawing out what learning is meaningful for you as an individual.
Session 2

Aim: To maintain and further develop the social influence of the therapist.
To extend the information concerning the value of the individual person to the transpersonal concept of interconnectedness.

Step 1

As for previous session.

Step 2

The therapist introduces the movie "Where all things belong" (see below) with a strong personal recommendation as to its meaning and importance to him. He predicted its positive impact on, and value for, each member of the group.

WHERE ALL THINGS BELONG 28 minutes color sound
Today's world is not going to pieces. In fact, we can witness the vital and vibrant process of rebirth all around us -- not only in nature but in individuals who touch our lives daily. It is not a great sweeping social reform based upon politics, economics or philosophy. Rather it is a private, quiet, personal transformation. This film is a hymn to the job of humans guiding their own destinies. In a context of universal oneness, joy and risk is its main theme.

Session 3

Aim: To reinforce the social influence of the therapist.
To re-establish some of the important self-esteem concepts of the previous sessions.
To deliver from a position of social influence some research data and literature supporting the importance of positive self-esteem.

Step 1

Discussion concerning the ideas presented so far. Summary of the message:

A. 'You are'
   'You are unique'
   'You are free'
   'You have worth and value the same as every other person.'
   'You have potentials and capacities to be alive, to deal with life, to grow and be more than you are right now.'

B. Your interconnectedness with all other things:
   'You are an integral part of this universe, related and connected to every thing else, and you make an unique contribution to this Universe.'

C. In summary:
   'To appreciate, respect and value yourself is to start being really alive and fully appreciating that aliveness.'
You are unique, valuable and worthwhile and so is everyone else.'

D. Finally:
You need to know, respect and to operate on these ideas.

Step 2

The therapist then presented in a semi-formal academic talk on 'Towards Developing a Healthy Self-Image.' These ideas were taken exclusively from:


Major ideas presented:
'The voluminous literature related to the idea of the self and self-concept leaves little doubt but that mental health and personal adjustment depends deeply on each individual's basic feelings of personal adequacy.'

'Attaining a healthy self-image with its concomitant feelings of adequacy, ableness, personal worth, and confidence is not some lofty goal beyond mortal reach.....It is an attitude.....which (is) learned and acquired, which means that sometimes 'bad' (negative, destructive, self-defeating) attitudes must be replaced by healthier attitudes.'

'.....even though we cannot change what happened yesterday, we can change how we feel about it today. We cannot change past experiences, but we can change our feelings about those experiences, which is one step in moving towards a healthier self-image.'

Some self-acceptance research that was reviewed in session: McCandless in reviewing 12 studies found 'that people who are highly self-critical are less well adjusted than those who are at least moderately satisfied in themselves.'

'Wylie's review suggested that 'a high regard for self is reflected in a high level of personal adjustment.....people who are self accepting are more accepting of others.'

'Inferiority is developmental or learned, rather than organic or innate. This means inferiority is in no sense necessary, and with insight into causes and consequences, it can be handled, coped with, and in many instances dispelled:

'Attitudes of this sort (failure/inferiority) can dominate and condition a person to the point where he is left with a general feeling of not being able to do anything very well.'

'Increasing literature and research.....leaves little doubt but that mental health depends deeply on the quality of a person's
feelings about himself. Just as an individual must maintain a healthy view of the world around him, so must he learn to perceive himself in positive ways. A person who has a strong, self-accepting attitude presents a behavioral picture very much the opposite of one who feels inadequate and inferior.'

Signs of a healthy, positive self-image:

The eleven elements that Hamachek presents as characterizing a healthy self-image were presented (page 249).

In summary:

'Healthy people, research shows, see themselves as liked, wanted, acceptable, able, and worthy. Not only do they feel that they are people of dignity and worth, but they behave as though they were. Indeed, it is in this factor of how a person sees himself that we are likely to find the most outstanding differences between high and low self-image people. It is not the people who feel that they are liked and wanted and acceptable and able who fill our prisons and mental hospitals. Rather, it is those who feel deeply inadequate, unliked, unwanted, unacceptable, and unable.'

'A person's feelings about himself are learned responses. Sometimes bad feelings have to be unlearned and new feelings acquired. This is not always easy, but it is possible. Sometimes this means 'Taking stock of oneself - a kind of personal self-inventory. ....it means changing those things which one can and accepting those which one cannot.'

Step 3

The program was concluded with a reiteration of the major points and one final message:

'Start right now, appreciating, valuing and respecting yourself in a more positive, constructive way for you all have the capacity to be fully alive, to enjoy and deal with life, and be more than you are right now, and you do know how!'
CONTROL GROUP TREATMENT

The following movies were shown to the control group -- one in each of the three sessions.

MADNESS AND MEDICINE 45 minutes color sound

This film goes into mental institutions to investigate the uses of three of the more radical types of therapeutic methods: drugs, electrashock and psychosurgery. According to the film's producer, the intent is to "explore these modes of modifying antisocial behavior, how prevalent they are, who is for them, who is against them, how valid the research is, and how we must balance societies needs against the individual rights. "Many psychiatrists and psychologists will find points of contention in this critical film evaluation of clinical methods. Some points are refuted by featured psychiatrists and psychologists, but others must be considered by individual viewers of in-class discussion.

CRM McGraw Hill Films 1977 donated by the Psychology Department 1978

MAN: THE INCREDIBLE MACHINE 28 minutes color sound

A colorful exposition of the ingenious design and adaptability of the human body. Slow motion sequences of a gymnast in action is shown. The camera probes the mechanisms of the senses, looking into the workings of the eyes, ears, and vocal chords. Another segment of the film concerns the workings of the mind, X-ray motion pictures of the skeleton and joints a mimed dramatization of the body's muscular arrangement and spectacular color footage of heat emitted from parts of the body.

NGS 1976 donated by Physical Education Dept. 1977

PLATO'S DRINKING PARTY 40 minutes b/w sound

Plato's dialog on 'love', written almost 500 years before the birth of Christ and presented as an after dinner discussion between four men attending a college reunion. The contemporary setting gives the viewer a clear picture of Socrates, Aristophanes, Agathen, and Alabiades. It's entertaining, informative and more importantly, there is a 'newness' to the various opinions and thoughts, making the film particularly compelling in the age of the dialogue.
Session Evaluation Form

1. Please write briefly as to what the message of this session was about.

Directions: On each line below, place an 'X' at the point which indicates your rating for that item. For example:

Happy

Sad

2. I accept the message of the session.

Not at all

Completely

3. I thought the group leader was:

Skilled

Unskilled

Approachable

Unapproachable

Unpleasant

Pleasant

Trustworthy

Untrustworthy

Informed

Uninformed

Dishonest

Honest

Acceptable

Unacceptable

Nonfriendly

Friendly

Professional

Amateurish

Incompetent

Competent

Warm

Distant

Dependable

Undependable
INTERVIEWING GUIDELINES:  

Appendix 2.2

Location: Interviewing rooms, Dept. of Counselor Education.

Conditions: Interviews are to be conducted in complete privacy, free as possible from any distraction. Interviewer and interviewee are to be seated at a comfortable distance apart (chairs 18" to 24") position at about 60° angle.

Audiotaping: Each interview will be audiotaped with the interviewee being identified by his/her code number which is to be stated by the interviewer at the start of each interview, e.g., "Interview B16. Start...."

Length of interview: Taping of each interview is to be 10 minutes in duration and being comfortably concluded off tape if necessary. Tapes will be supplied.

Purpose: To encourage the subject to talk for 10 minutes about him/herself.

Procedure: Introduction - first name only.

Set the interviewee at ease and reassure confidentiality if necessary (2 minutes mas.).

Obtain Code No.

Start tape. Announce code number

Commence with first stimulus statement.

Continue with other questions in given order intervening at times when the interviewee strays significantly from the subject, namely, him or herself.

Be as encouraging and supportive as you wish, but please remember it is the interviewee's words that are being sought.

On the conclusion of the interviews, please note the subject's attitudes toward him/herself (self-esteem) according to as you experienced them in that interview on a 10 point scale:

10 very high 1 very low

Please record this rating on your rating sheet and also on the interview rating slip. Please give the latter to the interviewee. The process is then completed.

Interviewer reliability needs to be gauged. To do this the researcher will select one cassette at random and ask all the interviewers to listen to it, then independently rate the same 10 interviews on that tape. This can be done during the following week.

I thank you sincerely for your willingness to participate in this study. Your expertise are greatly appreciated.
INTERVIEW PROMPTING QUESTIONS

1. How do you see yourself as a person?

2. How would you describe yourself to another person?

3. What are some of your strengths and weaknesses?

4. Is there something about yourself that worries or pleases you?

5. Describe yourself as you think others see you; how would you like them to see you?

6. How pleased are you with the way you are? Why?

7. If someone asked you, "Who are you," how would you answer?

8. How confident do you feel about your relationships with others?

9. What are your feelings about your abilities in school and in your future vocation?

10. How do you think you measure up as compared with most people?

11. How much do you like and respect yourself as a person?

12. What would you like to change about yourself or are you satisfied with the way you are?
CRITERIA FOR RATING SELF-REFERRING STATEMENTS

A statement was defined as a clause with subject and verb, recognizable as either:

1. a simple sentence
2. a complex sentence
3. a coordinate clause of a compound sentence
4. a subordinate clause of a complex sentence
5. a clause containing a subject and verb but never completed.

Raters counted self-referring statements according to the following rules:

1. Any statement which contains one or more references to "I", "me", "we", "us", regardless of whether it occurs in a main or subordinate clause, should be treated as one self-referring statement.
2. "My", "mine", "our", "ours", should be counted as self-referring only when they refer to the subject's own mental or physical person, life, group, achievement or performance. Do not count "my", "mine", "our", "ours" if they primarily refer to objects outside the person -- relatives, friends, professionals, etc. Example: Count "my family", "my hobby"; do not count "my father", "my car".
4. Count self-referring statements twice if they are repeated for emphasis.
5. Count self-referring quotations, even if the self-reference has been transformed to "you" or "he" for grammatical reasons. However, if "you" refers to a substitute for "people", (they tell you to go home), do not count unless it is clear substitute for "me".
6. Do not count self-referring statements in poetry recited.


All compound sentences were analyzed into their component coordinate clauses and treated as two or more simple sentences. Sometimes several clauses jointed by "and", or "or" or "but" had the necessary number of verbs for each clause but were missing a stated subject. If they clearly expressed two or more separate thoughts, they were treated as separate coordinate clauses, instead of as a compound verb in a simple or complex sentence.
7. Certain expressions have become conversational cliches which automatically express certain ideas. The expressions which follow and their like should be counted only when they are followed by or preceded by self-referring words or when they refer to actual thoughts, opinions, or feeling of the individual subject, as opposed to statements of fact. The expressions which follow should also be counted as self-referring if they contain a direct object.

Expressions

| I think                  | I don't know                  |
| I'll tell you           | I believe it was              |
| Why, I don't know       | As far as I know              |
| As I say                | I mean                        |
| I would say             | I suppose                     |
| Know what I mean?       | I guess                       |
| As I understood it      | Last I heard                  |
| Like I say              | I hear                        |
| I do believe            | As I said before              |
| I don't know of         | I remember                    |
| I know                  | I mentioned                   |

8. Do not count as self-referring questions to the interviewer about the task, the experiment, the interviewer, the hospital facilities, etc. And if expressions similar to the following refer to the present situation, do not count them as self-referring:

Expressions:

| I can't think of the word | Believe me |
| What else can I tell you? | My foot's asleep |
| Should I keep on?         | How am I doing? |
| What else do I do?        | I'd like a cigarette |
| Let me think              | I'm lost |
| That's about all I could say | I have to leave |